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Acthar Gel, Cortrophin Gel



Prior Authorization Guideline

Guideline ID	GL-235210
Guideline Name	Acthar Gel, Cortrophin Gel
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2025

1 . Criteria

Product Name:Acthar Gel vial	
Diagnosis	Infantile spasm (i.e., West Syndrome)*
Approval Length	4 Week(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of infantile spasms (i.e., West Syndrome)*	

AND

2 - Patient is less than 2 years old

AND

3 - BOTH of the following:

3.1 Initial dose: 75 units per meters squared intramuscular (IM) twice daily for 2 weeks

AND

3.2 After 2 weeks, dose should be tapered according to the following schedule: 30 units per meters squared IM in the morning for 3 days; 15 units per meters squared IM in the morning for 3 days; 10 units per meters squared IM in the morning for 3 days; 10 units per meters squared IM every other morning for 6 days (3 doses)

Notes

*Acthar Gel is not medically necessary for treatment of acute exacerbations of multiple sclerosis.

Product Name: Acthar Gel, Cortrophin Gel

Diagnosis	Opsoclonus-myoclonus syndrome (i.e., OMS, Kinsbourne Syndrome)*
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Opsoclonus-myoclonus syndrome (i.e., OMS, Kinsbourne Syndrome)*

AND

2 - If the request is for Cortrophin Gel, trial and failure or intolerance to Acthar Gel (verified via paid pharmacy claims or submission of medical records/chart notes)

Notes	*Acthar Gel is not medically necessary for treatment of acute exacerbations of multiple sclerosis.

2 . Revision History

Date	Notes
4/7/2025	For infantile spasm, update to product name list to specify Acthar gel vial. Addition of new GPIs for Acthar/Cortrophin autoinjector/prefilled syringe formulations to OMS section. Minor verbiage updates in infantile spasm and OMS sections with no changes to clinical intent.

Actimmune



Prior Authorization Guideline

Guideline ID	GL-140909
Guideline Name	Actimmune
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Actimmune	
Diagnosis	Chronic Granulomatous Disease (CGD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chronic granulomatous disease	

Product Name:Actimmune	
Diagnosis	Chronic Granulomatous Disease (CGD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient does not show evidence of progressive disease while on Actimmune	

Product Name:Actimmune	
Diagnosis	Severe, Malignant Osteopetrosis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of severe, malignant osteopetrosis	

Product Name:Actimmune	
Diagnosis	Severe, Malignant Osteopetrosis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient does not show evidence of progressive disease while on Actimmune	

Product Name:Actimmune	
Diagnosis	Primary Cutaneous Lymphomas
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has ONE of the following diagnoses: • Mycosis fungoides (MF) • Sézary syndrome (SS)	

Product Name:Actimmune	
Diagnosis	Primary Cutaneous Lymphomas
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient does not show evidence of progressive disease while on Actimmune	

Product Name:Actimmune	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Actimmune will be approved for uses supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1, 2A, or 2B.

Product Name:Actimmune	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Actimmune therapy	

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Adacel TDAP vaccine



Prior Authorization Guideline

Guideline ID	GL-140794
Guideline Name	Adacel TDAP vaccine
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	6/1/2023

1 . Criteria

Product Name:Adacel	
Diagnosis	Pregnant Patients 19 years of age and older*
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Vaccine is being used to prevent pertussis in infants younger than 2 months of age	

AND	
2 - Patient is 19 years of age or older	
AND	
3 - Both of the following:	
• Patient is pregnant • Vaccine is being administered during 3rd trimester of pregnancy	
Notes	*Patients under 19 years of age must get immunization from PCP or pediatrician through the VFC (Vaccines For Children) Program

2 . Revision History

Date	Notes
5/11/2023	Matching FFS

Adalimumab



Prior Authorization Guideline

Guideline ID	GL-541212
Guideline Name	Adalimumab
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Humira, Abrilada, Amjevita, Cyltezo, Brand Adalimumab-adbm^, Hadlima^^, Brand Adalimumab-bwwd, Hulio, Brand Adalimumab-fkjp^^^, Hyrimoz, Brand Adalimumab-adaz, Idacio, Brand Adalimumab-aacf, Simlandi, Brand Adalimumab-ryvk, Yuflyma, Brand Adalimumab-aaty, Yusimry, newly launched adalimumab products	
Diagnosis	Rheumatoid Arthritis (RA)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderately to severely active rheumatoid arthritis (RA)	

AND

2 - Paid claims or submission of medical records (e.g., chart notes) documenting history of failure to a 3 month trial of ONE non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] at maximally indicated doses within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

3 - Prescribed by or in consultation with a rheumatologist

AND

4 - If the request is non-preferred*, history of failure to ALL preferred* adalimumab biosimilars

Notes	Approval Length: 12 months. If approving a preferred adalimumab, please enter the group authorization AZADALIMUM. If approving a non-preferred adalimumab, please enter the following: 1) The group authorization AZADALIMUM 2) An authorization for the non-preferred adalimumab at GPI-12 level *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC CP ^The following NDC for Brand Adalimumab-adbm is preferred: 00597058589. The following NDCs for Brand Adalimumab-adbm are non-preferred: 00597057540, 00597057550, 00597057560, 82009014422, 00597054522, 00597054544, 00597054566, 82009014822, 00597055580, 00597056520, 82009014622, 00597059520, 82009015022. ^^The following NDCs for Hadlima products are preferred: 78206018701, 78206018401, 78206018601, 78206018301. The following NDCs for Hadlima products are non-preferred: 50090670700, 50090670600, 50090670400, 50090670500. ^^^The following NDCs for Brand Adalimumab-fkjp products are preferred: 49502041602, 83257002232, 49502041702, 83257002042, 49502041802, 83257002142. The following NDCs for Brand Adalimumab-fkjp products are non-preferred: 49502041606, 49502041706, 49502041806.

Product Name:Humira, Abrilada, Amjevita, Cyltezo, Brand Adalimumab-adbm^, Hadlima^^, Brand Adalimumab-bwwd, Hulio, Brand Adalimumab-fkjp^^^, Hyrimoz, Brand Adalimumab-adaz, Idacio, Brand Adalimumab-aacf, Simlandi, Brand Adalimumab-ryvk, Yuflyma, Brand Adalimumab-aaty, Yusimry, newly launched adalimumab products	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (PJIA)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis (PJIA) AND 2 - Paid claims or submission of medical records (e.g., chart notes) confirming a history of failure to a minimum duration of a 6-week trial, contraindication, or intolerance to ONE of the following conventional therapies at maximally tolerated doses: • leflunomide • methotrexate AND 3 - Prescribed by or in consultation with a rheumatologist AND 4 - If the request is non-preferred*, history of failure to ALL preferred* adalimumab biosimilars	
Notes	Approval Length: 12 months. If approving a preferred adalimumab, please enter the group authorization AZADALIMUM. If approving a non-preferred adalimumab, please enter the following: 1) The group authorization AZADALIMUM 2) An authorization for the non-preferred adalimumab at GPI-12 level *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC

	CP ^The following NDC for Brand Adalimumab-adbm is preferred: 00597 058589. The following NDCs for Brand Adalimumab-adbm are non-preferred: 0 0597057540, 00597057550, 00597057560, 82009014422, 00597054 522, 00597054544, 00597054566, 82009014822, 00597055580, 005 97056520, 82009014622, 00597059520, 82009015022. ^^The following NDCs for Hadlima products are preferred: 782060187 01, 78206018401, 78206018601, 78206018301. The following NDCs for Hadlima products are non-preferred: 5009067 0700, 50090670600, 50090670400, 50090670500. ^^^The following NDCs for Brand Adalimumab-fkjp products are prefe rred: 49502041602, 83257002232, 49502041702, 83257002042, 495 02041802, 83257002142. The following NDCs for Brand Adalimumab-fkjp products are non-pref erred: 49502041606, 49502041706, 49502041806.

Product Name:Humira, Abrilada, Amjevita, Cyltezo, Brand Adalimumab-adbm^, Hadlima^^, Brand Adalimumab-bwwd, Hulio, Brand Adalimumab-fkjp^^^, Hyrimoz, Brand Adalimumab-adaz, Idacio, Brand Adalimumab-aacf, Simlandi, Brand Adalimumab-ryvk, Yuflyma, Brand Adalimumab-aaty, Yusimry, newly launched adalimumab products	
Diagnosis	Ankylosing Spondylitis (AS)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of active ankylosing spondylitis (AS) AND 2 - Paid claims or submission of medical records (e.g., chart notes) documenting history of failure to TWO NSAIDs (non-steroidal anti-inflammatory drugs) (e.g., ibuprofen, naproxen) at maximally indicated doses, each used for at least 4 weeks within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced AND	

3 - Prescribed by or in consultation with a rheumatologist

AND

4 - If the request is non-preferred*, history of failure to ALL preferred* adalimumab biosimilars

Notes	Approval Length: 12 months. If approving a preferred adalimumab, please enter the group authorization AZADALIMUM. If approving a non-preferred adalimumab, please enter the following: 1) The group authorization AZADALIMUM 2) An authorization for the non-preferred adalimumab at GPI-12 level *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC CP ^The following NDC for Brand Adalimumab-adbm is preferred: 00597058589. The following NDCs for Brand Adalimumab-adbm are non-preferred: 00597057540, 00597057550, 00597057560, 82009014422, 00597054522, 00597054544, 00597054566, 82009014822, 00597055580, 00597056520, 82009014622, 00597059520, 82009015022. ^^The following NDCs for Hadlima products are preferred: 78206018701, 78206018401, 78206018601, 78206018301. The following NDCs for Hadlima products are non-preferred: 50090670700, 50090670600, 50090670400, 50090670500. ^^^The following NDCs for Brand Adalimumab-fkjp products are preferred: 49502041602, 83257002232, 49502041702, 83257002042, 49502041802, 83257002142. The following NDCs for Brand Adalimumab-fkjp products are non-preferred: 49502041606, 49502041706, 49502041806.

Product Name: Humira, Abrilada, Amjevita, Cyltezo, Brand Adalimumab-adbm^, Hadlima^^, Brand Adalimumab-bwwd, Hulio, Brand Adalimumab-fkjp^^^, Hyrimoz, Brand Adalimumab-adaz, Idacio, Brand Adalimumab-aacf, Simlandi, Brand Adalimumab-ryvk, Yuflyma, Brand Adalimumab-aaty, Yusimry, newly launched adalimumab products

Diagnosis	Rheumatoid Arthritis (RA), Polyarticular Juvenile Idiopathic Arthritis (PJIA), Ankylosing Spondylitis (AS)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Prescribed by or in consultation with a rheumatologist

AND

3 - If the request is non-preferred*, history of failure to ALL preferred* adalimumab biosimilars

Notes

Approval Length: 12 months. If approving a preferred adalimumab, please enter the group authorization AZADALIMUM. If approving a non-preferred adalimumab, please enter the following:

- 1) The group authorization AZADALIMUM
- 2) An authorization for the non-preferred adalimumab at GPI-12 level

*PDL link: <https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC CP>

^The following NDC for Brand Adalimumab-adbm is preferred: 00597058589.

The following NDCs for Brand Adalimumab-adbm are non-preferred: 00597057540, 00597057550, 00597057560, 82009014422, 00597054522, 00597054544, 00597054566, 82009014822, 00597055580, 00597056520, 82009014622, 00597059520, 82009015022.

^^The following NDCs for Hadlima products are preferred: 78206018701, 78206018401, 78206018601, 78206018301.

The following NDCs for Hadlima products are non-preferred: 50090670700, 50090670600, 50090670400, 50090670500.

^^^The following NDCs for Brand Adalimumab-fkjp products are preferred: 49502041602, 83257002232, 49502041702, 83257002042, 49502041802, 83257002142.

The following NDCs for Brand Adalimumab-fkjp products are non-preferred: 49502041606, 49502041706, 49502041806.

Product Name:Humira, Abrilada, Amjevita, Cyltezo, Brand Adalimumab-adbm^, Hadlima^^, Brand Adalimumab-bwwd, Hulio, Brand Adalimumab-fkjp^^^, Hyrimoz, Brand Adalimumab-adaz, Idacio, Brand Adalimumab-aacf, Simlandi, Brand Adalimumab-ryvk, Yuflyma, Brand Adalimumab-aaty, Yusimry, newly launched adalimumab products	
Diagnosis	Psoriatic Arthritis (PsA)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of active psoriatic arthritis (PsA) AND 2 - Paid claims or submission of medical records (e.g., chart notes) documenting history of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced AND 3 - Prescribed by or in consultation with ONE of the following: • Rheumatologist • Dermatologist AND 4 - If the request is non-preferred*, history of failure to ALL preferred* adalimumab biosimilars	
Notes	Approval Length: 12 months. If approving a preferred adalimumab, please enter the group authorization AZADALIMUM. If approving a non-preferred adalimumab, please enter the following: 1) The group authorization AZADALIMUM 2) An authorization for the non-preferred adalimumab at GPI-12 level *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC CP

	^The following NDC for Brand Adalimumab-adbm is preferred: 00597058589. The following NDCs for Brand Adalimumab-adbm are non-preferred: 00597057540, 00597057550, 00597057560, 82009014422, 00597054522, 00597054544, 00597054566, 82009014822, 00597055580, 00597056520, 82009014622, 00597059520, 82009015022. ^^The following NDCs for Hadlima products are preferred: 78206018701, 78206018401, 78206018601, 78206018301. The following NDCs for Hadlima products are non-preferred: 50090670700, 50090670600, 50090670400, 50090670500. ^^^The following NDCs for Brand Adalimumab-fkjp products are preferred: 49502041602, 83257002232, 49502041702, 83257002042, 49502041802, 83257002142. The following NDCs for Brand Adalimumab-fkjp products are non-preferred: 49502041606, 49502041706, 49502041806.

Product Name:Humira, Abrilada, Amjevita, Cyltezo, Brand Adalimumab-adbm^, Hadlima^^, Brand Adalimumab-bwwd, Hulio, Brand Adalimumab-fkjp^^^, Hyrimoz, Brand Adalimumab-adaz, Idacio, Brand Adalimumab-aacf, Simlandi, Brand Adalimumab-ryvk, Yuflyma, Brand Adalimumab-aaty, Yusimry, newly launched adalimumab products	
Diagnosis	Psoriatic Arthritis (PsA)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy AND 2 - Prescribed by or in consultation with ONE of the following: • Rheumatologist • Dermatologist AND 3 - If the request is non-preferred*, history of failure to ALL preferred* adalimumab biosimilars	

Notes	Approval Length: 12 months. If approving a preferred adalimumab, please enter the group authorization AZADALIMUM. If approving a non-preferred adalimumab, please enter the following: 1) The group authorization AZADALIMUM 2) An authorization for the non-preferred adalimumab at GPI-12 level *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC CP ^The following NDC for Brand Adalimumab-adbm is preferred: 00597058589. The following NDCs for Brand Adalimumab-adbm are non-preferred: 00597057540, 00597057550, 00597057560, 82009014422, 00597054522, 00597054544, 00597054566, 82009014822, 00597055580, 00597056520, 82009014622, 00597059520, 82009015022. ^^The following NDCs for Hadlima products are preferred: 78206018701, 78206018401, 78206018601, 78206018301. The following NDCs for Hadlima products are non-preferred: 50090670700, 50090670600, 50090670400, 50090670500. ^^^The following NDCs for Brand Adalimumab-fkjp products are preferred: 49502041602, 83257002232, 49502041702, 83257002042, 49502041802, 83257002142. The following NDCs for Brand Adalimumab-fkjp products are non-preferred: 49502041606, 49502041706, 49502041806.

Product Name: Humira, Abrilada, Amjevita, Cyltezo, Brand Adalimumab-adbm^, Hadlima^^, Brand Adalimumab-bwwd, Hulio, Brand Adalimumab-fkjp^^^, Hyrimoz, Brand Adalimumab-adaz, Idacio, Brand Adalimumab-aacf, Simlandi, Brand Adalimumab-ryvk, Yuflyma, Brand Adalimumab-aaty, Yusimry, newly launched adalimumab products	
Diagnosis	Plaque Psoriasis (PsO)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderate to severe chronic plaque psoriasis (PsO) AND	

2 - Greater than or equal to 3% body surface area involvement, palmoplantar, facial, or genital involvement, or severe scalp psoriasis

AND

3 - BOTH of the following:

3.1 Paid claims or submission of medical records (e.g., chart notes) documenting history of failure to ONE of the following topical therapies, unless contraindicated or clinically significant adverse effects are experienced:

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Vtama
- Zoryve 0.3% cream

AND

3.2 Paid claims or submission of medical records (e.g., chart notes) documenting history of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

4 - Prescribed by or in consultation with a dermatologist

AND

5 - If the request is non-preferred*, history of failure to ALL preferred* adalimumab biosimilars

Notes	Approval Length: 12 months. If approving a preferred adalimumab, please enter the group authorization AZADALIMUM. If approving a non-preferred adalimumab, please enter the following: 1) The group authorization AZADALIMUM 2) An authorization for the non-preferred adalimumab at GPI-12 level *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

	^The following NDC for Brand Adalimumab-adbm is preferred: 00597058589. The following NDCs for Brand Adalimumab-adbm are non-preferred: 00597057540, 00597057550, 00597057560, 82009014422, 00597054522, 00597054544, 00597054566, 82009014822, 00597055580, 00597056520, 82009014622, 00597059520, 82009015022. ^^The following NDCs for Hadlima products are preferred: 78206018701, 78206018401, 78206018601, 78206018301. The following NDCs for Hadlima products are non-preferred: 50090670700, 50090670600, 50090670400, 50090670500. ^^^The following NDCs for Brand Adalimumab-fkjp products are preferred: 49502041602, 83257002232, 49502041702, 83257002042, 49502041802, 83257002142. The following NDCs for Brand Adalimumab-fkjp products are non-preferred: 49502041606, 49502041706, 49502041806.

Product Name:Humira, Abrilada, Amjevita, Cyltezo, Brand Adalimumab-adbm^, Hadlima^^, Brand Adalimumab-bwwd, Hulio, Brand Adalimumab-fkjp^^^, Hyrimoz, Brand Adalimumab-adaz, Idacio, Brand Adalimumab-aacf, Simlandi, Brand Adalimumab-ryvk, Yuflyma, Brand Adalimumab-aaty, Yusimry, newly launched adalimumab products	
Diagnosis	Hidradenitis Suppurativa (HS)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderate to severe hidradenitis suppurativa (HS) (i.e., Hurley Stage II or III) AND 2 - Paid claims or submission of medical records (e.g., chart notes) documenting history of failure to at least ONE oral antibiotic (e.g., doxycycline, clindamycin, rifampin) at maximally indicated doses within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced AND	

3 - Prescribed by or in consultation with a dermatologist

AND

4 - If the request is non-preferred*, history of failure to ALL preferred* adalimumab biosimilars

Notes	Approval Length: 12 months. If approving a preferred adalimumab, please enter the group authorization AZADALIMUM. If approving a non-preferred adalimumab, please enter the following: 1) The group authorization AZADALIMUM 2) An authorization for the non-preferred adalimumab at GPI-12 level *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC CP ^The following NDC for Brand Adalimumab-adbm is preferred: 00597058589. The following NDCs for Brand Adalimumab-adbm are non-preferred: 00597057540, 00597057550, 00597057560, 82009014422, 00597054522, 00597054544, 00597054566, 82009014822, 00597055580, 00597056520, 82009014622, 00597059520, 82009015022. ^^The following NDCs for Hadlima products are preferred: 78206018701, 78206018401, 78206018601, 78206018301. The following NDCs for Hadlima products are non-preferred: 50090670700, 50090670600, 50090670400, 50090670500. ^^^The following NDCs for Brand Adalimumab-fkjp products are preferred: 49502041602, 83257002232, 49502041702, 83257002042, 49502041802, 83257002142. The following NDCs for Brand Adalimumab-fkjp products are non-preferred: 49502041606, 49502041706, 49502041806.

Product Name:Humira, Abrilada, Amjevita, Cyltezo, Brand Adalimumab-adbm^, Hadlima^^, Brand Adalimumab-bwwd, Hulio, Brand Adalimumab-fkjp^^^, Hyrimoz, Brand Adalimumab-adaz, Idacio, Brand Adalimumab-aacf, Simlandi, Brand Adalimumab-ryvk, Yuflyma, Brand Adalimumab-aaty, Yusimry, newly launched adalimumab products	
Diagnosis	Plaque Psoriasis (PsO), Hidradenitis Suppurativa (HS)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Prescribed by or in consultation with a dermatologist

AND

3 - If the request is non-preferred*, history of failure to ALL preferred* adalimumab biosimilars

Notes

Approval Length: 12 months. If approving a preferred adalimumab, please enter the group authorization AZADALIMUM. If approving a non-preferred adalimumab, please enter the following:

- 1) The group authorization AZADALIMUM
- 2) An authorization for the non-preferred adalimumab at GPI-12 level

*PDL link: <https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC CP>

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The following NDCs for Brand Adalimumab-adbm are non-preferred: 00597057540, 00597057550, 00597057560, 82009014422, 00597054522, 00597054544, 00597054566, 82009014822, 00597055580, 00597056520, 82009014622, 00597059520, 82009015022.

^^The following NDCs for Hadlima products are preferred: 78206018701, 78206018401, 78206018601, 78206018301.

The following NDCs for Hadlima products are non-preferred: 50090670700, 50090670600, 50090670400, 50090670500.

^^^The following NDCs for Brand Adalimumab-fkjp products are preferred: 49502041602, 83257002232, 49502041702, 83257002042, 49502041802, 83257002142.

The following NDCs for Brand Adalimumab-fkjp products are non-preferred: 49502041606, 49502041706, 49502041806.

Product Name: Humira, Abrilada, Amjevita, Cyltezo, Brand Adalimumab-adbm^, Hadlima^^, Brand Adalimumab-bwwd, Hulio, Brand Adalimumab-fkjp^^^, Hyrimoz, Brand Adalimumab-adaz, Idacio, Brand Adalimumab-aacf, Simlandi, Brand Adalimumab-ryvk, Yuflyma, Brand Adalimumab-aaty, Yusimry, newly launched adalimumab products

Diagnosis	Adult Crohn's Disease (CD)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active Crohn's disease (CD)

AND

2 - ONE of the following:

2.1 Paid claims or submission of medical records (e.g., chart notes) documenting history of failure to ONE of the following conventional therapies at maximally indicated doses within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced:

- Corticosteroids (e.g., prednisone, methylprednisolone, budesonide)
- Azathioprine (Imuran)
- 6-mercaptopurine (Purinethol)
- Methotrexate (Rheumatrex, Trexall)

OR

2.2 Patient has lost response or intolerant to infliximab (e.g., Remicade, Inflectra, Renflexis)

AND

3 - Prescribed by or in consultation with a gastroenterologist

AND

4 - If the request is non-preferred*, history of failure to ALL preferred* adalimumab biosimilars

Notes	Approval Length: 12 months. If approving a preferred adalimumab, please enter the group authorization AZADALIMUM. If approving a non-preferred adalimumab, please enter the following: 1) The group authorization AZADALIMUM 2) An authorization for the non-preferred adalimumab at GPI-12 level *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC CP ^The following NDC for Brand Adalimumab-adbm is preferred: 00597058589. The following NDCs for Brand Adalimumab-adbm are non-preferred: 00597057540, 00597057550, 00597057560, 82009014422, 00597054522, 00597054544, 00597054566, 82009014822, 00597055580, 00597056520, 82009014622, 00597059520, 82009015022. ^^The following NDCs for Hadlima products are preferred: 78206018701, 78206018401, 78206018601, 78206018301. The following NDCs for Hadlima products are non-preferred: 50090670700, 50090670600, 50090670400, 50090670500. ^^^The following NDCs for Brand Adalimumab-fkjp products are preferred: 49502041602, 83257002232, 49502041702, 83257002042, 49502041802, 83257002142. The following NDCs for Brand Adalimumab-fkjp products are non-preferred: 49502041606, 49502041706, 49502041806.

Product Name: Humira, Abrilada, Amjevita, Cyltezo, Brand Adalimumab-adbm^, Hadlima^^, Brand Adalimumab-bwwd, Hulio, Brand Adalimumab-fkjp^^^, Hyrimoz, Brand Adalimumab-adaz, Idacio, Brand Adalimumab-aacf, Simlandi, Brand Adalimumab-ryvk, Yuflyma, Brand Adalimumab-aaty, Yusimry, newly launched adalimumab products	
Diagnosis	Pediatric Crohn's Disease (CD)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderately to severely active Crohn's disease (CD) AND	

2 - Paid claims or submission of medical records (e.g., chart notes) documenting history of failure to ONE of the following conventional therapies at maximally indicated doses within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced:

- Corticosteroids (e.g., prednisone, methylprednisolone, budesonide)
- Azathioprine (Imuran)
- 6-mercaptopurine (Purinethol)
- Methotrexate (Rheumatrex, Trexall)

AND

3 - Prescribed by or in consultation with a gastroenterologist

AND

4 - If the request is non-preferred*, history of failure to ALL preferred* adalimumab biosimilars

Notes	Approval Length: 12 months. If approving a preferred adalimumab, please enter the group authorization AZADALIMUM. If approving a non-preferred adalimumab, please enter the following: 1) The group authorization AZADALIMUM 2) An authorization for the non-preferred adalimumab at GPI-12 level *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC CP ^The following NDC for Brand Adalimumab-adbm is preferred: 00597058589. The following NDCs for Brand Adalimumab-adbm are non-preferred: 00597057540, 00597057550, 00597057560, 82009014422, 00597054522, 00597054544, 00597054566, 82009014822, 00597055580, 00597056520, 82009014622, 00597059520, 82009015022. ^^The following NDCs for Hadlima products are preferred: 78206018701, 78206018401, 78206018601, 78206018301. The following NDCs for Hadlima products are non-preferred: 50090670700, 50090670600, 50090670400, 50090670500. ^^^The following NDCs for Brand Adalimumab-fkjp products are preferred: 49502041602, 83257002232, 49502041702, 83257002042, 49502041802, 83257002142. The following NDCs for Brand Adalimumab-fkjp products are non-preferred: 49502041606, 49502041706, 49502041806.

Product Name:Humira, Abrilada, Amjevita, Cyltezo, Brand Adalimumab-adbm^, Hadlima^^, Brand Adalimumab-bwwd, Hulio, Brand Adalimumab-fkjp^^^, Hyrimoz, Brand Adalimumab-adaz, Idacio, Brand Adalimumab-aacf, Simlandi, Brand Adalimumab-ryvk, Yuflyma, Brand Adalimumab-aaty, Yusimry, newly launched adalimumab products	
Diagnosis	Ulcerative Colitis (UC)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderately to severely active ulcerative colitis (UC) AND 2 - Paid claims or submission of medical records (e.g., chart notes) documenting history of failure to ONE of the following conventional therapies at maximally indicated doses within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced: • Corticosteroids (e.g., prednisone, methylprednisolone, budesonide) • 6-mercaptopurine (Purinethol) • Azathioprine (Imuran) • Aminosalicylates (e.g., mesalamine, sulfasalazine) AND 3 - Prescribed by or in consultation with a gastroenterologist AND 4 - If the request is non-preferred*, history of failure to ALL preferred* adalimumab biosimilars	
Notes	Approval Length: 12 months. If approving a preferred adalimumab, please enter the group authorization AZADALIMUM. If approving a non-preferred adalimumab, please enter the following: 1) The group authorization AZADALIMUM 2) An authorization for the non-preferred adalimumab at GPI-12 level *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC

	CP ^The following NDC for Brand Adalimumab-adbm is preferred: 00597058589. The following NDCs for Brand Adalimumab-adbm are non-preferred: 00597057540, 00597057550, 00597057560, 82009014422, 00597054522, 00597054544, 00597054566, 82009014822, 00597055580, 00597056520, 82009014622, 00597059520, 82009015022. ^^The following NDCs for Hadlima products are preferred: 78206018701, 78206018401, 78206018601, 78206018301. The following NDCs for Hadlima products are non-preferred: 50090670700, 50090670600, 50090670400, 50090670500. ^^^The following NDCs for Brand Adalimumab-fkjp products are preferred: 49502041602, 83257002232, 49502041702, 83257002042, 49502041802, 83257002142. The following NDCs for Brand Adalimumab-fkjp products are non-preferred: 49502041606, 49502041706, 49502041806.

Product Name:Humira, Abrilada, Amjevita, Cyltezo, Brand Adalimumab-adbm^, Hadlima^^, Brand Adalimumab-bwwd, Hulio, Brand Adalimumab-fkjp^^^, Hyrimoz, Brand Adalimumab-adaz, Idacio, Brand Adalimumab-aacf, Simlandi, Brand Adalimumab-ryvk, Yuflyma, Brand Adalimumab-aaty, Yusimry, newly launched adalimumab products	
Diagnosis	Adult Crohn's Disease (CD), Pediatric Crohn's Disease (CD), Ulcerative Colitis (UC)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy AND 2 - Prescribed by or in consultation with a gastroenterologist AND 3 - If the request is non-preferred*, history of failure to ALL preferred* adalimumab biosimilars	

Notes	Approval Length: 12 months. If approving a preferred adalimumab, please enter the group authorization AZADALIMUM. If approving a non-preferred adalimumab, please enter the following: 1) The group authorization AZADALIMUM 2) An authorization for the non-preferred adalimumab at GPI-12 level *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC CP ^The following NDC for Brand Adalimumab-adbm is preferred: 00597058589. The following NDCs for Brand Adalimumab-adbm are non-preferred: 00597057540, 00597057550, 00597057560, 82009014422, 00597054522, 00597054544, 00597054566, 82009014822, 00597055580, 00597056520, 82009014622, 00597059520, 82009015022. ^^The following NDCs for Hadlima products are preferred: 78206018701, 78206018401, 78206018601, 78206018301. The following NDCs for Hadlima products are non-preferred: 50090670700, 50090670600, 50090670400, 50090670500. ^^^The following NDCs for Brand Adalimumab-fkjp products are preferred: 49502041602, 83257002232, 49502041702, 83257002042, 49502041802, 83257002142. The following NDCs for Brand Adalimumab-fkjp products are non-preferred: 49502041606, 49502041706, 49502041806.

Product Name: Humira, Abrilada, Amjevita, Cyltezo, Brand Adalimumab-adbm^, Hadlima^^, Brand Adalimumab-bwwd, Hulio, Brand Adalimumab-fkjp^^^, Hyrimoz, Brand Adalimumab-adaz, Idacio, Brand Adalimumab-aacf, Simlandi, Brand Adalimumab-ryvk, Yuflyma, Brand Adalimumab-aaty, Yusimry, newly launched adalimumab products

Diagnosis	Uveitis (UV)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of non-infectious uveitis (UV) AND	

2 - Uveitis is classified as ONE of the following:

- intermediate
- posterior
- panuveitis

AND

3 - Paid claims or submission of medical records (e.g., chart notes) documenting history of failure to at least ONE corticosteroid (e.g., prednisolone, prednisone) at maximally indicated dose within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced

AND

4 - Paid claims or submission of medical records (e.g., chart notes) documenting history of failure to at least ONE systemic non-biologic immunosuppressant (e.g., methotrexate, cyclosporine, azathioprine, mycophenolate) at a maximally indicated dose within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced

AND

5 - Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Ophthalmologist

AND

6 - If the request is non-preferred*, history of failure to ALL preferred* adalimumab biosimilars

Notes

Approval Length: 12 months. If approving a preferred adalimumab, please enter the group authorization AZADALIMUM. If approving a non-preferred adalimumab, please enter the following:

- 1) The group authorization AZADALIMUM
- 2) An authorization for the non-preferred adalimumab at GPI-12 level

*PDL link: <https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP>

	^The following NDC for Brand Adalimumab-adbm is preferred: 00597058589. The following NDCs for Brand Adalimumab-adbm are non-preferred: 00597057540, 00597057550, 00597057560, 82009014422, 00597054522, 00597054544, 00597054566, 82009014822, 00597055580, 00597056520, 82009014622, 00597059520, 82009015022. ^^The following NDCs for Hadlima products are preferred: 78206018701, 78206018401, 78206018601, 78206018301. The following NDCs for Hadlima products are non-preferred: 50090670700, 50090670600, 50090670400, 50090670500. ^^^The following NDCs for Brand Adalimumab-fkjp products are preferred: 49502041602, 83257002232, 49502041702, 83257002042, 49502041802, 83257002142. The following NDCs for Brand Adalimumab-fkjp products are non-preferred: 49502041606, 49502041706, 49502041806.

Product Name: Humira, Abrilada, Amjevita, Cyltezo, Brand Adalimumab-adbm^, Hadlima^^, Brand Adalimumab-bwwd, Hulio, Brand Adalimumab-fkjp^^^, Hyrimoz, Brand Adalimumab-adaz, Idacio, Brand Adalimumab-aacf, Simlandi, Brand Adalimumab-ryvk, Yuflyma, Brand Adalimumab-aaty, Yusimry, newly launched adalimumab products	
Diagnosis	Uveitis (UV)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy AND 2 - Prescribed by or in consultation with ONE of the following: • Rheumatologist • Ophthalmologist AND	

3 - If the request is non-preferred*, history of failure to ALL preferred* adalimumab biosimilars	
Notes	Approval Length: 12 months. If approving a preferred adalimumab, please enter the group authorization AZADALIMUM. If approving a non-preferred adalimumab, please enter the following: 1) The group authorization AZADALIMUM 2) An authorization for the non-preferred adalimumab at GPI-12 level *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC CP ^The following NDC for Brand Adalimumab-adbm is preferred: 00597058589. The following NDCs for Brand Adalimumab-adbm are non-preferred: 00597057540, 00597057550, 00597057560, 82009014422, 00597054522, 00597054544, 00597054566, 82009014822, 00597055580, 00597056520, 82009014622, 00597059520, 82009015022. ^^The following NDCs for Hadlima products are preferred: 78206018701, 78206018401, 78206018601, 78206018301. The following NDCs for Hadlima products are non-preferred: 50090670700, 50090670600, 50090670400, 50090670500. ^^^The following NDCs for Brand Adalimumab-fkjp products are preferred: 49502041602, 83257002232, 49502041702, 83257002042, 49502041802, 83257002142. The following NDCs for Brand Adalimumab-fkjp products are non-preferred: 49502041606, 49502041706, 49502041806.

2 . Revision History

Date	Notes
3/4/2026	Added new GPI for Adalimumab-ryvk 80mg/0.8mL auto-injector as a target. No changes to clinical criteria.

Adbry (tralokinumab-ldrm)



Prior Authorization Guideline

Guideline ID	GL-152441
Guideline Name	Adbry (tralokinumab-ldrm)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	9/1/2024

1 . Criteria

Product Name:Adbry	
Diagnosis	Atopic Dermatitis
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderate to severe atopic dermatitis	

AND

2 - Submission of documentation (e.g., chart notes) demonstrating ONE of the following:

- Involvement of at least 10% body surface area (BSA)
- SCORing Atopic Dermatitis (SCORAD) index value of at least 25

AND

3 - Patient is 12 years of age or older

AND

4 - Prescribed by or in consultation with ONE of the following:

- Dermatologist
- Allergist/Immunologist

AND

5 - History of failure, contraindication, or intolerance to BOTH of the following topical therapies: (document drug, date of trial, and/or contraindication to medication)*

- One topical calcineurin inhibitor [e.g., Elidel (pimecrolimus), Protopic (tacrolimus)]
- Eucrisa (crisaborole) ointment

Notes	*Note: Claims history may be used in conjunction as documentation of drug, date, and/or contraindication to medication

Product Name: Adbry	
Diagnosis	Atopic Dermatitis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of documentation (e.g., chart notes) demonstrating positive clinical response to therapy as evidenced by at least ONE of the following:

- Reduction in body surface area involvement from baseline
- Reduction in SCORing Atopic Dermatitis (SCORAD) index value from baseline

2 . Background**Clinical Practice Guidelines****Table 1. Relative potencies of topical corticosteroids**

Class	Drug	Dosage Form	Strength (%)
Very high potency	Augmented betamethasone dipropionate	Ointment, gel	0.05
	Clobetasol propionate	Cream, foam, ointment	0.05
	Diflorasone diacetate	Ointment	0.05
	Halobetasol propionate	Cream, ointment	0.05
High Potency	Amcinonide	Cream, lotion, ointment	0.1
	Augmented betamethasone dipropionate	Cream, lotion	0.05
	Betamethasone dipropionate	Cream, foam, ointment, solution	0.05
	Desoximetasone	Cream, ointment	0.25
	Desoximetasone	Gel	0.05
	Diflorasone diacetate	Cream	0.05

	Fluocinonide	Cream, gel, ointment, solution	0.05
	Halcinonide	Cream, ointment	0.1
	Mometasone furoate	Ointment	0.1
	Triamcinolone acetonide	Cream, ointment	0.5
Medium potency	Betamethasone valerate	Cream, foam, lotion, ointment	0.1
	Clocortolone pivalate	Cream	0.1
	Desoximetasone	Cream	0.05
	Fluocinolone acetonide	Cream, ointment	0.025
	Flurandrenolide	Cream, ointment, lotion	0.05
	Fluticasone propionate	Cream	0.05
	Fluticasone propionate	Ointment	0.005
	Mometasone furoate	Cream, lotion	0.1
	Triamcinolone acetonide	Cream, ointment, lotion	0.1
Lower-medium potency	Hydrocortisone butyrate	Cream, ointment, solution	0.1
	Hydrocortisone probutate	Cream	0.1
	Hydrocortisone valerate	Cream, ointment	0.2
	Prednicarbate	Cream	0.1
Low potency	Alclometasone dipropionate	Cream, ointment	0.05
	Desonide	Cream, gel, foam, ointment	0.05
	Fluocinolone acetonide	Cream, solution	0.01
Lowest potency	Dexamethasone	Cream	0.1
	Hydrocortisone	Cream, lotion, ointment, solution	0.25, 0.5, 1
	Hydrocortisone acetate	Cream, ointment	0.5-1

3 . Revision History

UnitedHealthcare Community Plan of Arizona Clinical Pharmacy Program Guidelines

Date	Notes
8/20/2024	Added new GPI for Adbry to the guideline. No changes to criteria.

ADHD Agents



Prior Authorization Guideline

Guideline ID	GL-609194
Guideline Name	ADHD Agents
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name: Brand Adderall, generic amphetamine/dextroamphetamine, Brand Adderall XR, generic amphetamine/dextroamphetamine ER, Brand Concerta, generic dexamethylphenidate tabs, Brand Focalin XR, Brand Methylin, generic methylphenidate tabs, generic methylphenidate ER (CD) caps, Brand Vyvanse caps/chew tabs, generic atomoxetine, generic dextroamphetamine tabs, Brand Adzenys XR-ODT, generic amphetamine ER ODT, generic amphetamine tabs, Brand Aptensio XR, Azstarys, Cotelma XR-ODT, Brand Desoxyn, Brand Dexedrine, generic dexamethylphenidate ER, generic dextroamphetamine ER, Dyanavel XR, Brand Focalin, Jornay PM, generic methamphetamine, methylphenidate ER tabs, generic methylphenidate ER (OSM), Methylphenidate ER (OSM), generic methylphenidate ER (LA) caps, generic methylphenidate ER (XR) caps, Mydayis, Brand Procentra, Qelbree, Quillichew ER, Quillivant XR, Relexxii, Brand Ritalin, Brand Ritalin LA, Brand Strattera, Zenzedi, generic dextroamphetamine oral soln, Brand Evekeo, generic methylphenidate patches/soln, methylphenidate chew tabs, generic lisdexamfetamine caps/chew tabs	
Approval Length	12 month(s)

Guideline Type	Prior Authorization
Approval Criteria 1 - If the patient is under 6 years old, ALL of the following: 1.1 The requesting clinician has documented that the child has a diagnosis of attention deficit hyperactivity disorder (ADHD) AND 1.2 The requesting clinician has documented that psychosocial issues have been evaluated before request for ADHD medications AND 1.3 The requesting clinician has documented non-medication alternatives that have been attempted before request for ADHD medications AND 1.4 The requested dose does NOT exceed the Food and Drug Administration (FDA) recommended maximum daily dosage unless the provider has submitted clinical justification for the dose exceeding the FDA maximum AND 2 - If the request is non-preferred*, BOTH of the following: 2.1 The patient has a history of failure, contraindication, or intolerance to a trial of FOUR preferred products** AND 2.2 If the request is for a multi-source brand medication (i.e., MSC O), ONE of the following:	

2.2.1 BOTH of the following:

2.2.1.1 The brand is being requested because of an adverse reaction, allergy, or sensitivity to the generic and the prescriber must attest to submitting the FDA (Food and Drug Administration) MedWatch Form for allergic reactions to the medications

AND

2.2.1.2 The patient has tried three generic formulations (if available) of the requested brand product

OR

2.2.2 ONE of the following:

- The brand is being requested due to a therapeutic failure with the generic (please provide reason for therapeutic failure)
- The brand is being requested because transition to the generic could result in destabilization of the patient (rationale must be provided)
- Special clinical circumstances exist that preclude the use of the generic equivalent of the multi-source brand medication for the patient (rationale must be provided)

Notes

*PDL link: <https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC>
CP
**Alternatives may require prior authorization.

Product Name: clonidine tabs, clonidine ER 12 hr, guanfacine, generic guanfacine ER, Brand Intuniv

Approval Length 12 month(s)

Guideline Type Prior Authorization

Approval Criteria

1 - If the patient is under 6 years old, ONE of the following:

1.1 ALL of the following:

1.1.1 The requesting clinician has documented that the child has a diagnosis of attention deficit hyperactivity disorder (ADHD)

AND

1.1.2 The requesting clinician has documented that psychosocial issues have been evaluated before request for ADHD medications

AND

1.1.3 The requesting clinician has documented non-medication alternatives that have been attempted before request for ADHD medications

AND

1.1.4 The requested dose does NOT exceed the Food and Drug Administration (FDA) recommended maximum daily dosage unless the provider has submitted clinical justification for the dose exceeding the FDA maximum

OR

1.2 BOTH of the following:

1.2.1 Diagnosis of insomnia

AND

1.2.2 Trial and failure, contraindication, or intolerance to melatonin

AND

2 - If the request is non-preferred*, BOTH of the following:

2.1 The patient has a history of failure, contraindication, or intolerance to a trial of FOUR preferred products**

AND

2.2 If the request is for a multi-source brand medication (i.e., MSC O), ONE of the following:

2.2.1 BOTH of the following:

2.2.1.1 The brand is being requested because of an adverse reaction, allergy, or sensitivity to the generic and the prescriber must attest to submitting the FDA (Food and Drug Administration) MedWatch Form for allergic reactions to the medications

AND

2.2.1.2 The patient has tried three generic formulations (if available) of the requested brand product

OR

2.2.2 ONE of the following:

- The brand is being requested due to a therapeutic failure with the generic (please provide reason for therapeutic failure)
- The brand is being requested because transition to the generic could result in destabilization of the patient (rationale must be provided)
- Special clinical circumstances exist that preclude the use of the generic equivalent of the multi-source brand medication for the patient (rationale must be provided)

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP **Alternatives may require prior authorization.

Product Name:Arynta	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria	

1 - If the request is non-preferred*, the patient has a history of failure, contraindication, or intolerance to a trial of THREE preferred products**

AND

2 - The patient has a history of failure, contraindication, or intolerance to Brand Vyvanse capsules

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC CP **Alternatives may require prior authorization.

Product Name:Onyda XR	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - If the request is non-preferred*, the patient has a history of failure, contraindication, or intolerance to a trial of THREE preferred products** AND 2 - The patient has a history of failure, contraindication, or intolerance to generic clonidine patch	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC CP **Alternatives may require prior authorization.

Product Name:Xelstrym	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - If the request is non-preferred*, the patient has a history of failure, contraindication, or intolerance to a trial of THREE preferred products**

AND

2 - The patient has a history of failure, contraindication, or intolerance to generic methylphenidate patch

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP ** Alternatives may require prior authorization.

2 . Revision History

Date	Notes
5/11/2026	Added criteria for new target drug, Arynta. Updates to GPI table or product name list, where applicable.

Aemcolo



Prior Authorization Guideline

Guideline ID	GL-140679
Guideline Name	Aemcolo
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Aemcolo	
Approval Length	1 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of travelers' diarrhea AND	

2 - History of failure, contraindication, or intolerance to ONE of the following:

- Azithromycin (generic Zithromax)
- Ciprofloxacin (generic Cipro)
- Levofloxacin (generic Levaquin)
- Ofloxacin (generic Floxin)

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Afinitor, Torpenz (everolimus)



Prior Authorization Guideline

Guideline ID	GL-151825
Guideline Name	Afinitor, Torpenz (everolimus)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	9/1/2024

1 . Criteria

Product Name:Brand Afinitor, generic everolimus tablet, Brand Afinitor Disperz, generic everolimus tablet for oral suspension, Torpenz	
Diagnosis	Neuroendocrine tumors
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following:	

- Neuroendocrine tumors of pancreatic origin
- Neuroendocrine tumors of gastrointestinal origin
- Neuroendocrine tumors of lung origin
- Neuroendocrine tumors of thymic origin

AND

2 - Disease is progressive

AND

3 - ONE of the following:

- Disease is unresectable
- Disease is locally advanced
- Disease is metastatic

AND

4 - If the request is for Brand Afinitor, Brand Afinitor Disperz, or Torpenz, history of failure, intolerance, or contraindication to generic everolimus tablet or generic everolimus tablet for oral suspension

Product Name: Brand Afinitor, generic everolimus tablet, Brand Afinitor Disperz, generic everolimus tablet for oral suspension, Torpenz

Diagnosis	Renal cell cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of renal cell cancer

AND

2 - ONE of the following:

2.1 Disease has relapsed

OR

2.2 BOTH of the following:

- Medically or surgically unresectable tumor
- Diagnosis of Stage IV disease

AND

3 - ONE of the following:

3.1 Patient with non-clear cell histology

OR

3.2 BOTH of the following:

3.2.1 Patient with predominantly clear cell histology

AND

3.2.2 History of failure, contraindication, or intolerance to at least one prior systemic therapy [e.g., Nexavar (sorafenib), Sutent (sunitinib), Opdivo (nivolumab), Cabometyx (cabozantinib)]

AND

4 - If the request is for Brand Afinitor, Brand Afinitor Disperz, or Torpenz, history of failure, intolerance, or contraindication to generic everolimus tablet or generic everolimus tablet for oral suspension

Product Name:Brand Afinitor, generic everolimus tablet, Brand Afinitor Disperz, generic everolimus tablet for oral suspension, Torpenz	
Diagnosis	Renal Angiomyolipoma with Tuberous Sclerosis Complex
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of renal angiomyolipoma and tuberous sclerosis complex (TSC), not requiring immediate surgery AND 2 - If the request is for Brand Afinitor, Brand Afinitor Disperz, or Torpenz, history of failure, intolerance, or contraindication to generic everolimus tablet or generic everolimus tablet for oral suspension	

Product Name:Brand Afinitor, generic everolimus tablet, Brand Afinitor Disperz, generic everolimus tablet for oral suspension, Torpenz	
Diagnosis	Subependymal Giant Cell Astrocytoma Associated with Tuberous Sclerosis Complex
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of subependymal giant cell astrocytoma (SEGA) associated with tuberous sclerosis (TS) AND 2 - Patient is NOT a candidate for curative surgical resection	

AND

3 - If the request is for Brand Afinitor, Brand Afinitor Disperz, or Torpenz, history of failure, intolerance, or contraindication to generic everolimus tablet or generic everolimus tablet for oral suspension

Product Name: Brand Afinitor, generic everolimus tablet, Brand Afinitor Disperz, generic everolimus tablet for oral suspension, Torpenz

Diagnosis	Waldenströms Macroglobulinemia or Lymphoplasmacytic Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following:

- Waldenströms macroglobulinemia
- Lymphoplasmacytic lymphoma

AND

2 - ONE of the following:

- Disease is non-responsive to primary treatment
- Disease is progressive
- Disease has relapsed

AND

3 - If the request is for Brand Afinitor, Brand Afinitor Disperz, or Torpenz, history of failure, intolerance, or contraindication to generic everolimus tablet or generic everolimus tablet for oral suspension

Product Name: Brand Afinitor, generic everolimus tablet, Brand Afinitor Disperz, generic everolimus tablet for oral suspension, Torpenz	
Diagnosis	Breast Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of breast cancer AND 2 - ONE of the following: 2.1 Disease is recurrent OR 2.2 Disease is metastatic AND 3 - ONE of the following: 3.1 Disease is hormone receptor positive (HR+) [i.e., estrogen-receptor-positive (ER+) or progesterone-receptor-positive (PR+)] OR 3.2 BOTH of the following: • Disease is hormone receptor negative (HR-) • Disease has clinical characteristics that predict a HR+ tumor	

AND

4 - Disease is human epidermal growth factor receptor 2 (HER2)-negative

AND

5 - ONE of the following:

5.1 Patient is a postmenopausal woman

OR

5.2 BOTH of the following:

- Patient is a premenopausal woman
- Patient is being treated with ovarian ablation/suppression

OR

5.3 Patient is male

AND

6 - ONE of the following:

6.1 BOTH of the following:

6.1.1 Used in combination with Aromasin (exemestane)

AND

6.1.2 ONE of the following:

6.1.2.1 Disease progressed while on or within 12 months of non-steroidal aromatase inhibitor [e.g., Arimidex (anastrozole), Femara (letrozole)] therapy

OR

6.1.2.2 Patient was treated with tamoxifen at any time

OR

6.2 Used in combination with ONE of the following:

- fulvestrant
- tamoxifen

AND

7 - If the request is for Brand Afinitor, Brand Afinitor Disperz, or Torpenz, history of failure, intolerance, or contraindication to generic everolimus tablet or generic everolimus tablet for oral suspension

Product Name: Brand Afinitor, generic everolimus tablet, Brand Afinitor Disperz, generic everolimus tablet for oral suspension, Torpenz

Diagnosis	Hodgkin Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of classical Hodgkin lymphoma

AND

2 - ONE of the following:

- Disease is refractory

- Disease has relapsed

AND

3 - If the request is for Brand Afinitor, Brand Afinitor Disperz, or Torpenz, history of failure, intolerance, or contraindication to generic everolimus tablet or generic everolimus tablet for oral suspension

Product Name: Brand Afinitor, generic everolimus tablet, Brand Afinitor Disperz, generic everolimus tablet for oral suspension, Torpenz

Diagnosis	PEComa (perivascular epithelioid cell tumor), recurrent angiomyolipoma, lymphangioleiomyomatosis, or gastrointestinal stromal tumor (GIST)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 ONE of the following diagnoses:

- PEComa (perivascular epithelioid cell tumor)
- Recurrent angiomyolipoma
- Lymphangioleiomyomatosis

OR

1.2 ALL of the following:

1.2.1 Diagnosis of Gastrointestinal Stromal Tumor (GIST)

AND

1.2.2 Disease has progressed after single agent therapy with ONE of the following:

- Gleevec (imatinib)
- Sutent (sunitinib)
- Stivarga (regorafenib)

AND

1.2.3 Used in combination with ONE of the following:

- Gleevec (imatinib)
- Sutent (sunitinib)
- Stivarga (regorafenib)

AND

2 - If the request is for Brand Afinitor, Brand Afinitor Disperz, or Torpenz, history of failure, intolerance, or contraindication to generic everolimus tablet or generic everolimus tablet for oral suspension

Product Name: Brand Afinitor, generic everolimus tablet, Brand Afinitor Disperz, generic everolimus tablet for oral suspension, Torpenz	
Diagnosis	Thymic Carcinoma or Thymoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: • Diagnosis of thymic carcinoma • Diagnosis of thymoma AND 2 - ONE of the following:	

2.1 History of failure, contraindication, or intolerance to at least one prior first-line chemotherapy regimen

OR

2.2 Patient has extrathoracic metastatic disease

AND

3 - If the request is for Brand Afinitor, Brand Afinitor Disperz, or Torpenz, history of failure, intolerance, or contraindication to generic everolimus tablet or generic everolimus tablet for oral suspension

Product Name: Brand Afinitor, generic everolimus tablet, Brand Afinitor Disperz, generic everolimus tablet for oral suspension, Torpenz

Diagnosis	Follicular carcinoma, Hürthle cell carcinoma, or papillary carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following:

- Follicular carcinoma
- Hürthle cell carcinoma
- Papillary carcinoma

AND

2 - ONE of the following:

- Unresectable locoregional recurrent disease
- Persistent disease
- Metastatic disease

AND

3 - ONE of the following:

- Patient has symptomatic disease
- Patient has progressive disease

AND

4 - Disease is refractory to radioactive iodine treatment

AND

5 - If the request is for Brand Afinitor, Brand Afinitor Disperz, or Torpenz, history of failure, intolerance, or contraindication to generic everolimus tablet or generic everolimus tablet for oral suspension

Product Name: Brand Afinitor, generic everolimus tablet, Brand Afinitor Disperz, generic everolimus tablet for oral suspension, Torpenz

Diagnosis	Meningioma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of meningioma

AND

2 - Disease is recurrent or progressive

AND

3 - Surgery and/or radiation is not possible

AND

4 - Used in combination with bevacizumab (e.g., Avastin, Mvasi, Zirabev)

AND

5 - If the request is for Brand Afinitor, Brand Afinitor Disperz, or Torpenz, history of failure, intolerance, or contraindication to generic everolimus tablet or generic everolimus tablet for oral suspension

Product Name: Brand Afinitor, generic everolimus tablet, Brand Afinitor Disperz, generic everolimus tablet for oral suspension, Torpenz

Diagnosis	Endometrial Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of endometrial carcinoma

AND

2 - Used in combination with letrozole

AND

3 - If the request is for Brand Afinitor, Brand Afinitor Disperz, or Torpenz, history of failure, intolerance, or contraindication to generic everolimus tablet or generic everolimus tablet for oral suspension

Product Name: Brand Afinitor, generic everolimus tablet, Brand Afinitor Disperz, generic everolimus tablet for oral suspension, Torpenz

Diagnosis	Tuberous Sclerosis Complex associated Partial-Onset Seizures
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of tuberous sclerosis complex associated partial-onset seizures

AND

2 - Used as adjunctive therapy

AND

3 - If the request is for Brand Afinitor, Brand Afinitor Disperz, or Torpenz, history of failure, intolerance, or contraindication to generic everolimus tablet or generic everolimus tablet for oral suspension

Product Name: Brand Afinitor, generic everolimus tablet, Brand Afinitor Disperz, generic everolimus tablet for oral suspension, Torpenz

Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Use supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1, 2A, or 2B.

AND

2 - If the request is for Brand Afinitor, Brand Afinitor Disperz, or Torpenz, history of failure, intolerance, or contraindication to generic everolimus tablet or generic everolimus tablet for oral suspension

Product Name: Brand Afinitor, generic everolimus tablet, Brand Afinitor Disperz, generic everolimus tablet for oral suspension, Torpenz

Diagnosis	All indications
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient does not show evidence of progressive disease while on therapy

2 . Revision History

Date	Notes
8/21/2024	Update to guideline name. Added Torpenz and new generics for Afinitor/Afinitor Disperz as targets to the guideline. Added embedded step in initial auth sections for all indications. Consolidated all reauth sections into one section. Updated initial auth sections for meningioma and PEComa etc. Cosmetic/formatting updates.

Afrezza



Prior Authorization Guideline

Guideline ID	GL-140631
Guideline Name	Afrezza
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2020

1 . Criteria

Product Name:Afrezza	
Diagnosis	Type 1 or Type 2 diabetes mellitus
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following:	

1.1 Diagnosis of type 1 diabetes mellitus and used in combination with a basal insulin or continuous insulin pump

OR

1.2 Diagnosis of type 2 diabetes mellitus

AND

2 - Patient is unable to self-inject medications (e.g. Humalog, Lantus, Levemir) due to ONE of the following:

- Physical impairment
- Visual impairment
- Lipohypertrophy
- Documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-5 for specific phobia diagnostic criteria)

AND

3 - Forced Expiratory Volume (FEV1) within the last 60 days is greater than or equal to 70% of expected normal as determined by the physician

AND

4 - Afrezza will not be approved in patients with ONE of the following:

- Who smoke cigarettes
- Who recently quit smoking (within the past 6 months)
- With chronic lung disease (e.g. asthma, chronic obstructive pulmonary disease)

Product Name: Afrezza	
Diagnosis	Type 1 or Type 2 diabetes mellitus
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Repeat pulmonary function test confirms that patient has NOT experienced a decline of 20% or more in Forced Expiratory Volume (FEV1) AND 2 - Patient continues to be unable to self-inject short-acting insulin due to ONE of the following: • Physical impairment • Visual impairment • Lipohypertrophy • Documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-5 for specific phobia diagnostic criteria) AND 3 - Patient continues to not smoke cigarettes	

2 . Revision History

Date	Notes
3/31/2020	Bulk Copy C&S New York to C&S Arizona for effective date of 5/1

Agamree (vamorolone)



Prior Authorization Guideline

Guideline ID	GL-145522
Guideline Name	Agamree (vamorolone)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2024

1 . Criteria

Product Name:Agamree	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of Duchenne muscular dystrophy (DMD)	

AND

2 - Patient is 2 years of age or older

AND

3 - Patient has received genetic testing for a mutation of the dystrophin gene

AND

4 - Submission of medical records (e.g., chart notes) documenting one of the following:

4.1 Patient has a confirmed mutation of the dystrophin gene

OR

4.2 Muscle biopsy confirmed an absence of dystrophin protein

AND

5 - Submission of medical records (e.g., chart notes) or paid claims confirming patient has had a trial and failure or intolerance to prednisone or prednisolone given at a dose of 0.75 mg/kg/day (milligrams per kilogram per day) or 10 mg/kg/weekend

AND

6 - Prescribed by or in consultation with a neurologist who has experience treating children

AND

7 - One of the following:

7.1 For patients less than or equal to 50kg, dose will not exceed 6mg/kg of body weight once daily

OR

7.2 For patients greater than 50kg, dose will not exceed 300mg/day

Product Name:Agamree	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting patient has experienced a benefit from therapy (e.g., improvement in preservation of muscle strength) AND 2 - One of the following: 2.1 For patients less than or equal to 50kg (kilograms), dose will not exceed 6mg/kg (milligrams per kilogram) of body weight once daily OR 2.2 For patients greater than 50kg, dose will not exceed 300mg/day AND 3 - Submission of medical records (e.g., chart notes) or paid claims confirming patient has had a trial and failure or intolerance to prednisone or prednisolone given at a dose of 0.75 mg/kg/day or 10 mg/kg/weekend	

2 . Revision History

UnitedHealthcare Community Plan of Arizona Clinical Pharmacy Program Guidelines

Date	Notes
4/9/2024	New guideline

Aldurazyme



Prior Authorization Guideline

Guideline ID	GL-603191
Guideline Name	Aldurazyme
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Aldurazyme	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following: 1.1 Confirmed diagnosis of Hurler or Hurler-Scheie forms of Mucopolysaccharidosis I (MPS I)	

OR

1.2 Both the following:

1.2.1 Confirmed diagnosis of Scheie form of Mucopolysaccharidosis I (MPS I)

AND

1.2.2 Have moderate to severe symptoms

2 . Revision History

Date	Notes
5/6/2026	Updated title. Changed "and" to "or" criterion 1.1: Confirmed diagnosis of Hurler "OR" Hurler-Scheie forms of Mucopolysaccharidosis I (MPS I)

Alinia



Prior Authorization Guideline

Guideline ID	GL-140658
Guideline Name	Alinia
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	2/1/2021

1 . Criteria

Product Name: Brand Alinia, generic nitazoxanide	
Diagnosis	Diarrhea caused by Giardia lamblia
Approval Length	3 Day(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of giardiasis	

AND

2 - History of failure, contraindication, or intolerance to metronidazole

Product Name: Brand Alinia, generic nitazoxanide	
Diagnosis	Diarrhea caused by Cryptosporidium parvum
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of cryptosporidiosis	

2 . Revision History

Date	Notes
12/15/2020	Added generic tablet GPI

Alkeran



Prior Authorization Guideline

Guideline ID	GL-140662
Guideline Name	Alkeran
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	4/1/2021

1 . Criteria

Product Name: Brand Alkeran tabs, generic melphalan tabs	
Diagnosis	Multiple Myeloma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of palliative treatment of multiple myeloma	

AND

2 - If the request is for generic melphalan, there is a reason or special circumstance the patient cannot use brand Alkeran

Product Name:Brand Alkeran tabs, generic melphalan tabs	
Diagnosis	Ovarian Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of palliative treatment of nonresectable epithelial ovarian AND 2 - If the request is for generic melphalan, there is a reason or special circumstance the patient cannot use brand Alkeran	

Product Name:Brand Alkeran tabs, generic melphalan tabs	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - The use for Alkeran is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	

AND

2 - If the request is for generic melphalan, there is a reason or special circumstance the patient cannot use brand Alkeran

Product Name:Brand Alkeran tabs, generic melphalan tabs	
Diagnosis	Multiple Myeloma, Ovarian Cancer, NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - There is documentation of positive clinical response to Alkeran therapy	

2 . Revision History

Date	Notes
2/23/2021	New policy specific to Arizona.

Alkindi Sprinkle, Khindivi Oral Solution (hydrocortisone)



Prior Authorization Guideline

Guideline ID	GL-534290
Guideline Name	Alkindi Sprinkle, Khindivi Oral Solution (hydrocortisone)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Alkindi Sprinkle, Khindivi	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of adrenocortical insufficiency	

AND

2 - If the request is for Khindivi, patient is between 5 and 18 years of age

AND

3 - ONE of the following:

3.1 Patient has a contraindication (e.g., age) or intolerance to other corticosteroids (e.g., prednisolone, prednisone)

OR

3.2 Patient is unable to swallow a solid dosage form (e.g., age, physical impairment, dysphagia, patient is using a feeding tube or nasal gastric tube)

OR

3.3 Dosage requirements cannot be met with a solid dosage form

AND

4 - Prescribed by or in consultation with an endocrinologist

Product Name:Alkindi Sprinkle, Khindivi	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient demonstrates positive clinical response to therapy	

2 . Revision History

Date	Notes
3/3/2026	Updated guideline name. Added Alkindi Sprinkle products as targets. Specified age restriction (in initial auth section) only applies to Khindi vi requests.

Alpha Interferons



Prior Authorization Guideline

Guideline ID	GL-140933
Guideline Name	Alpha Interferons
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name: Intron A	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of hairy cell leukemia OR	

2 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of condylomata acuminata (genital or perianal)

OR

3 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of AIDS (acquired immunodeficiency syndrome)-related Kaposi's sarcoma

OR

4 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of leptomeningeal metastases

OR

5 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of meningiomas

OR

6 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of kidney cancer

OR

7 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting treatment of myeloproliferative neoplasms (MPNs) such as essential thrombocythemia (ET), polycythemia vera (PV), or primary myelofibrosis (PM)

OR

8 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of follicular lymphoma

OR

9 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of adult T-cell leukemia, lymphoma

OR

10 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of mycosis fungoides, Sézary syndrome

OR

11 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of desmoid tumors/aggressive fibromatosis

OR

12 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of giant cell tumor of the bone

OR

13 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of malignant melanoma

Product Name:Alferon N	
Approval Length	8 Week(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting	

treatment of refractory or recurring external condylomata acuminata (genital or venereal warts) due to human papillomavirus (HPV) infection

2 . Revision History

Date	Notes
8/8/2022	C&S to match AZM 10.1.22

Alyftrek (vanzacaftor/tezacaftor/deutivacaftor)



Prior Authorization Guideline

Guideline ID	GL-604200
Guideline Name	Alyftrek (vanzacaftor/tezacaftor/deutivacaftor)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Alyftrek	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of cystic fibrosis (CF)	

AND

2 - Submission of medical records (e.g., chart notes) or laboratory results confirming the presence of at least one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene

AND

3 - ONE of the following:

3.1 CFTR mutation is responsive based on clinical or in vitro data

OR

3.2 CFTR mutation results in the production of CFTR protein

AND

4 - Patient is 6 years of age or older

AND

5 - Prescribed by or in consultation with a specialist affiliated with a CF care center

AND

6 - ONE of the following:

6.1 Submission of medical records (e.g., chart notes) or paid claims documenting history of failure or inadequate response to Trikafta (elexacaftor/tezacaftor/ivacaftor)

OR

6.2 Submission of medical records (e.g., chart notes) demonstrating that the patient has a

documented CFTR gene mutation that is responsive to Alyftrek but is not responsive to Trikafta (a complete up-to-date list of responsive mutations can be referenced in the Trikafta Prescribing Information)

Product Name:Alyftrek	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting that patient demonstrates positive clinical response to therapy (e.g., stable or improved lung function [percent predicted forced expiratory volume in one second {PPFEV1}], decreased number of pulmonary exacerbations) AND 2 - Prescribed by or in consultation with a specialist affiliated with a cystic fibrosis (CF) care center	

2 . Revision History

Date	Notes
5/7/2026	Updated initial auth criteria. Defined CF abbreviation in reauth section. Removed table in background section.

Alzheimer's Agents



Prior Authorization Guideline

Guideline ID	GL-140666
Guideline Name	Alzheimer's Agents
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name: Brand Aricept, generic donepezil, Brand Namenda/Namenda XR, generic memantine/memantine XR, Brand Razadyne, generic galantamine hydrobromide, Brand Razadyne ER, generic galantamine ER	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of dementia of the Alzheimer's type	

Product Name:Brand Exelon, generic rivastigmine	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of dementia of the Alzheimer's type OR 2 - Diagnosis of dementia associated with Parkinson's disease	

Product Name:Adlarity	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of dementia of the Alzheimer's type AND 2 - One of the following: 2.1 History of failure, contraindication, or intolerance to ALL of the following preferred drugs* (verified via paid pharmacy claims): • generic donepezil • generic galantamine IR/ER • generic memantine • generic oral rivastigmine OR	

2.2 Both of the following:

2.2.1 History of failure, contraindication, or intolerance to generic rivastigmine patch*
(verified via paid pharmacy claims)

AND

2.2.2 Patient is unable to swallow oral formulations or has documented swallowing difficulties

Notes	*PA may be required.

2 . Revision History

Date	Notes
8/8/2022	C&S to match AZM 10.1.22

Amondys 45 (casimersen)



Prior Authorization Guideline

Guideline ID	GL-539206
Guideline Name	Amondys 45 (casimersen)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Amondys 45	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming BOTH of the following: 1.1 Diagnosis of Duchenne muscular dystrophy (DMD)	

AND

1.2 Disease is confirmed by the presence of a mutation of the dystrophin gene amenable to exon 45 skipping

AND

2 - Patient is 7 years of age or older

AND

3 - Prescribed by or in consultation with a neurologist with expertise in the treatment of DMD

AND

4 - Dose will NOT exceed 30 milligrams per kilogram of body weight infused once weekly

AND

5 - Submission of medical records including results of baseline North Star Ambulatory Assessment (NSAA) confirming the patient is ambulatory without needing an assistive device (e.g., without side-by-side assist, cane, walker, wheelchair) as evidenced by NSAA scoring

AND

6 - Patient will NOT receive Amondys 45 in combination with Duvyzat (givinostat) or other exon-skipping therapies for DMD [e.g., Exondys 51 (eteplirsen), Viltepso (viltolarsen), Vyondys 53 (golodirsen)]

Product Name:Amondys 45	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is tolerating therapy

AND

2 - Prescribed by or in consultation with a neurologist with expertise in the treatment of DMD

AND

3 - Dose will NOT exceed 30 milligrams per kilogram of body weight infused once weekly

AND

4 - Submission of medical records including results of recent North Star Ambulatory Assessment (NSAA) confirming patient is maintaining ambulatory status without needing an assistive device (e.g., without side-by-side assist, cane, walker, wheelchair) as evidenced by NSAA scoring

AND

5 - Patient will NOT receive Amondys 45 in combination with Duvyzat (givinostat) or other exon-skipping therapies for DMD [e.g., Exondys 51 (eteplirsen), Viltepso (viltolarsen), Vyondys 53 (golodirsen)]

2 . Revision History

Date	Notes
3/4/2026	Added submission of NSAA testing for confirmation of ambulatory status

Anthelmintics



Prior Authorization Guideline

Guideline ID	GL-140680
Guideline Name	Anthelmintics
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Brand Albenza, generic albendazole	
Diagnosis	See Note section*
Approval Length	1 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Enterobius vermicularis (pinworm)	

OR

2 - Diagnosis of Hydatid Disease [Echinococcosis (Tapeworm)]

OR

3 - Diagnosis of Ancylostoma/Necatoriasis (Hookworm)

OR

4 - Diagnosis of Ascariasis (Roundworm)

OR

5 - Diagnosis of Mansonella perstans (Filariasis)

OR

6 - Diagnosis of Toxocariasis (Roundworm)

OR

7 - Diagnosis of Trichinellosis

OR

8 - Diagnosis of Trichuriasis (Whipworm)

OR

9 - Diagnosis of Capillariasis

Notes	* Enterobius vermicularis (pinworm), Hydatid Disease [Echinococcosis (Tapeworm)] Ancylostoma/Necatoriasis (Hookworm), Ascariasis (Roundworm), Mansonella perstans (Filariasis), Toxocariasis (Roundworm), Trichinellois, Trichuriasis (Whipworm), Capillariasis

Product Name: Brand Albenza, generic albendazole	
Diagnosis	Neurocysticercosis
Approval Length	6 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of neurocysticercosis	

Product Name: Brand Stromectol, generic ivermectin	
Approval Length	1 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of intestinal strongyloidiasis due to the nematode parasite Strongyloides stercoralis OR 2 - Diagnosis of onchocerciasis due to the nematode parasite Onchocerca volvulus	

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Anti-Parkinson's Agents (Crexont, Duopa, Rytary, Vyalev)



Prior Authorization Guideline

Guideline ID	GL-501228
Guideline Name	Anti-Parkinson's Agents (Crexont, Duopa, Rytary, Vyalev)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Crexont, Rytary, Brand Carbidopa/Levodopa ER caps	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following diagnoses: • Parkinson's disease • Post-encephalitic parkinsonism	

- Symptomatic parkinsonism that may follow carbon monoxide and/or manganese intoxication

AND

2 - History of failure (after a minimum 30 day trial) or adverse reaction to ONE of the following:

- generic carbidopa-levodopa immediate release
- generic carbidopa-levodopa extended release tablets

Product Name:Duopa	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of advanced Parkinson's disease AND 2 - Patient is levodopa-responsive AND 3 - Patient experiences disabling "off" periods for a minimum of 3 hours per day AND 4 - Disabling "off" periods occur despite therapy with BOTH of the following: • Oral levodopa-carbidopa	

- One drug from a different class of anti-Parkinson's disease therapy (e.g., COMT [catechol-O-methyltransferase] inhibitor [entacapone, tolcapone], MAO-B [monoamine oxidase-B] inhibitor [selegiline, rasagiline], dopamine agonist [pramipexole, ropinirole])

AND

5 - Has undergone or has planned placement of a procedurally-placed tube

AND

6 - Prescribed by or in consultation with a neurologist

Product Name:Vyalev	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of advanced Parkinson's disease AND 2 - Patient is levodopa-responsive AND 3 - Patient experiences disabling "off" periods for a minimum of 2.5 hours per day AND 4 - Disabling "off" periods occur despite therapy with BOTH of the following:	

- Oral levodopa-carbidopa
- One drug from a different class of anti-Parkinson's disease therapy (e.g., COMT [catechol-O-methyltransferase] inhibitor [entacapone, tolcapone], MAO-B [monoamine oxidase-B] inhibitor [selegiline, rasagiline], dopamine agonist [pramipexole, ropinirole])

AND

5 - Prescribed by or in consultation with a neurologist

Product Name: Crexont, Rytary, Brand Carbidopa/Levodopa ER caps, Duopa, Vyalev	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient demonstrates positive clinical response to therapy	

2 . Revision History

Date	Notes
1/16/2026	Updated guideline name. Added Rytary and Brand Carbidopa/Levodopa ER caps (MSC M) as targets to same criteria sections as Crexont. Specified alt as generic carbidopa-levodopa extended release "tablets" in initial auth section for Crexont, Rytary, and Brand Carbidopa/Levodopa ER caps. Updated GPI entry for Vyalev.

Anticonvulsants



Prior Authorization Guideline

Guideline ID	GL-572198
Guideline Name	Anticonvulsants
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name: Brand Aptiom, generic eslicarbazepine, Brand Briviact tabs/oral soln, generic brivaracetam tabs/oral soln, Brand Vimpat tabs/oral soln, generic lacosamide tabs/oral soln, Xcopri	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting ONE of the following: 1.1 ALL of the following:	

1.1.1 ONE of the following diagnoses:

- Partial-onset seizures
- Primary generalized tonic-clonic seizures (Applies to Brand Vimpat and generic lacosamide only)

AND

1.1.2 If the request is for a non-preferred^ product, history of greater than or equal to 8 week trial of at least TWO of the following* (any release formulation qualifies):

- Brand Briviact
- Carbamazepine
- Divalproex
- Gabapentin
- Lamotrigine
- Levetiracetam
- Oxcarbazepine
- Phenytoin
- Pregabalin
- Topiramate
- Valproic acid
- Zonisamide
- Fycompa
- Generic lacosamide
- Xcopri

AND

1.1.3 If the request is for a non-preferred^ product, ONE of the following:

1.1.3.1 BOTH of the following:

- Documented history of persisting seizures after titration to the highest tolerated dose with each medication trial of preferred formulary alternatives
- Lack of compliance as a reason for treatment failure has been ruled out

OR

1.1.3.2 BOTH of the following:

- Documentation of failure of preferred formulary alternatives due to intolerable side effects
- Reasonable efforts were made to minimize the side effect (e.g., change timing of dosing, divide dose out for more frequent but smaller doses, etc.)

AND

1.1.4 If the request is for Brand Vimpat, trial and failure, contraindication, or intolerance to generic lacosamide

OR

1.2 For continuation of prior therapy for a seizure disorder

Notes	*Drug may require PA. ^PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name: Motpoly XR	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting ONE of the following: 1.1 BOTH of the following: 1.1.1 Diagnosis of ONE of the following: • partial-onset seizures • primary generalized tonic-clonic seizures AND	

1.1.2 Patient weighs at least 50 kg (kilograms)

OR

1.2 For continuation of prior therapy for a seizure disorder

Product Name:Brand Fycompa, generic perampanel	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting ONE of the following: 1.1 BOTH of the following: • Diagnosis of partial-onset or primary generalized tonic-clonic seizures • If the request is for generic perampanel, trial and failure, contraindication, or intolerance to Brand Fycompa OR 1.2 For continuation of prior therapy for a seizure disorder	

Product Name:Epidiolex	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting ONE of the following:	

1.1 Diagnosis of seizures associated with Dravet syndrome

OR

1.2 Diagnosis of seizures associated with Lennox-Gastaut syndrome

OR

1.3 Diagnosis of seizures associated with tuberous sclerosis complex (TSC)

OR

1.4 For continuation of prior therapy for a seizure disorder

Product Name:Diacomit	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of Dravet syndrome and currently taking clobazam OR 2 - For continuation of prior therapy for a seizure disorder	

Product Name:Fintepla	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting ALL of the following:

1.1 Diagnosis of seizures associated with Dravet syndrome

AND

1.2 History of greater than or equal to 8-week trial of at least TWO of the following* (any release formulation qualifies):

- Divalproex (e.g., generic Depakote)
- Epidiolex
- Levetiracetam (e.g., generic Keppra)
- Topiramate (e.g., generic Topamax)
- Valproic acid (e.g., generic Depakene)
- Zonisamide (generic Zonegran)

AND

1.3 ONE of the following:

1.3.1 BOTH of the following:

1.3.1.1 Documented history of persisting seizures after titration to the highest tolerated dose with each medication trial of preferred formulary alternatives

AND

1.3.1.2 Lack of compliance as a reason for treatment failure has been ruled out

OR

1.3.2 BOTH of the following:

1.3.2.1 Documentation of failure of preferred formulary alternatives due to intolerable side effects

AND

1.3.2.2 Reasonable efforts were made to minimize the side effect (e.g., change timing of dosing, divide dose out for more frequent but smaller doses, etc.)

OR

2 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting ALL of the following:

2.1 Diagnosis of seizures associated with Lennox-Gastaut syndrome

AND

2.2 History of greater than or equal to 8 week trial, contraindication, or intolerance of at least TWO of the following* (any release formulation qualifies):

- Banzel (rufinamide)
- Clobazam
- Divalproex
- Felbamate
- Lamotrigine
- Topiramate
- Valproic Acid
- Epidiolex

AND

2.3 ONE of the following:

2.3.1 BOTH of the following:

- Documented history of persisting seizures after titration to the highest tolerated dose with each medication trial of preferred formulary alternatives
- Lack of compliance as a reason for treatment failure has been ruled out

OR

2.3.2 BOTH of the following:

- Documentation of failure of preferred formulary alternatives due to intolerable side effects
- Lack of compliance as a reason for treatment failure has been ruled out

OR

3 - For continuation of prior therapy for a seizure disorder

Notes	*Drug may require PA.

Product Name:Brand Banzel, generic rufinamide	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting BOTH of the following: 1.1 Diagnosis of seizures associated with Lennox-Gastaut syndrome AND 1.2 If the request is for Brand Banzel, trial and failure, contraindication, or intolerance to generic rufinamide OR 2 - For continuation of prior therapy for a seizure disorder	

Product Name:Brand Onfi, generic clobazam	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting ONE of the following:

1.1 BOTH of the following:

- Diagnosis of seizures associated with Lennox-Gastaut syndrome
- If the request is for Brand Onfi, trial and failure, contraindication, or intolerance to generic clobazam

OR

1.2 ALL of the following:

- Diagnosis of Dravet syndrome
- Patient is currently taking Diacomit
- If the request is for Brand Onfi, trial and failure, contraindication, or intolerance to generic clobazam

OR

2 - For continuation of prior therapy for a seizure disorder

Product Name: Sympazan	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting ONE of the following: 1.1 ALL of the following: 1.1.1 Diagnosis of seizures associated with Lennox-Gastaut syndrome (LGS)	

AND

1.1.2 BOTH of the following:

- Used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment)
- Not used as primary treatment

AND

1.1.3 History of greater than or equal to 8 week trial, contraindication, or intolerance of at least TWO of the following* (any release formulation qualifies):

- Brand Banzel suspension/tablets or rufinamide tablets
- Divalproex
- Felbamate
- Lamotrigine
- Topiramate
- Valproic acid

AND

1.1.4 Prescriber provides a reason or special circumstance the patient cannot use generic clobazam tablets or suspension

OR

1.2 ALL of the following:

1.2.1 Diagnosis of refractory partial onset seizures (four or more uncontrolled seizures per month after an adequate trial of at least two antiepileptic drugs)

AND

1.2.2 BOTH of the following:

- Used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment)

- Not used as primary treatment

AND

1.2.3 History of greater than or equal to 8 week trial of at least TWO of the following* (any release formulation qualifies):

- Carbamazepine
- Divalproex
- Fycompa
- Gabapentin
- Lacosamide
- Lamotrigine
- Levetiracetam
- Oxcarbazepine
- Phenytoin
- Pregabalin
- Topiramate
- Valproic acid
- Xcopri
- Zonisamide

AND

1.2.4 Prescriber provides a reason or special circumstance the patient cannot use generic clobazam tablets or suspension

OR

1.3 ALL of the following:

1.3.1 Diagnosis of Dravet syndrome

AND

1.3.2 Patient is currently taking Diacomit

AND

1.3.3 Prescriber provides a reason or special circumstance the patient cannot use generic clobazam tablets or suspension

OR

1.4 For continuation of prior therapy for a seizure disorder

Notes	*Drug may require PA.

Product Name:tiagabine	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting ONE of the following: 1.1 ALL of the following: 1.1.1 Diagnosis of partial-onset seizures AND 1.1.2 Used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment) AND 1.1.3 Not used as primary treatment OR 1.2 For continuation of prior therapy for a seizure disorder	

Product Name: Brand Sabril powd pack, generic vigabatrin powd pack, Vigadrone powd pack, Vigpoder powd pack, Vigafyde	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of infantile spasms OR 2 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting ALL of the following: 2.1 Diagnosis of complex partial seizures AND 2.2 Used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment) AND 2.3 Not used as primary treatment AND 2.4 History of greater than or equal to 8 week trial of at least TWO of the following* (any release formulation qualifies): • Carbamazepine • Divalproex • Fycompa • Gabapentin • Lacosamide • Lamotrigine	

- Levetiracetam
- Oxcarbazepine
- Phenytoin
- Pregabalin
- Topiramate
- Valproic acid
- Xcopri
- Zonisamide

OR

3 - For continuation of prior therapy for a seizure disorder

Notes	*Drug may require PA.

Product Name: Brand Sabril tabs, generic vigabatrin tabs, Vigadrone tabs	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting ONE of the following:

1.1 ALL of the following:

1.1.1 Diagnosis of complex partial seizures

AND

1.1.2 Used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment)

AND

1.1.3 Not used as primary treatment

AND

1.1.4 History of greater than or equal to 8 week trial of at least TWO of the following* (any release formulation qualifies):

- Carbamazepine
- Divalproex
- Fycompa
- Gabapentin
- Lacosamide
- Lamotrigine
- Levetiracetam
- Oxcarbazepine
- Phenytoin
- Pregabalin
- Topiramate
- Valproic acid
- Xcopri
- Zonisamide

OR

1.2 For continuation of prior therapy for a seizure disorder

Notes	*Drug may require PA.

Product Name: Brand Trokendi XR, generic topiramate ER, Brand Qudexy XR, generic topiramate ER sprinkle	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting ONE of the following: 1.1 BOTH of the following: 1.1.1 Diagnosis of partial-onset seizures	

AND

1.1.2 If the request is for a non-preferred[^] product, trial and failure, contraindication, or intolerance to BOTH of the following:

- Generic topiramate immediate-release (IR) tablet or preferred[^] topiramate IR sprinkle capsule
- Brand Trokendi XR

OR

1.2 For continuation of prior therapy for a seizure disorder

Notes	[^] PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:topiramate 50 mg sprinkle	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting ONE of the following: 1.1 BOTH of the following: 1.1.1 Diagnosis of partial-onset seizures AND 1.1.2 Trial and failure, contraindication, or intolerance to generic topiramate immediate-release (IR) tablet or preferred[^] topiramate IR sprinkle capsule	

OR	
1.2 For continuation of prior therapy for a seizure disorder	
Notes	^PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name: Gabarone	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 ALL of the following: 1.1.1 Patient is 3 years of age or older AND 1.1.2 Submission of medical records (e.g., chart notes) documenting diagnosis of partial onset seizures AND 1.1.3 Trial and failure or intolerance to generic immediate-release gabapentin (generic for Neurontin) OR 1.2 ALL of the following: 1.2.1 Patient is 18 years of age or older	

AND

1.2.2 Submission of medical records (e.g., chart notes) documenting diagnosis of postherpetic neuralgia (PHN)

AND

1.2.3 Trial and failure or intolerance to generic immediate-release gabapentin (generic for Neurontin)

AND

1.2.4 Trial and failure or intolerance to Brand Gralise*

Notes	*Drug may require PA.

2 . Revision History

Date	Notes
4/10/2026	Added generic brivaracetam tabs/oral soln as targets. Updated product name list and GPI table, where applicable. Updated prerequisite to specify "Brand" Briviact, where applicable.

Antidepressants



Prior Authorization Guideline

Guideline ID	GL-553190
Guideline Name	Antidepressants
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	4/12/2026

1 . Criteria

Product Name:citalopram oral soln, fluoxetine soln, generic sertraline oral soln	
Diagnosis	Requests for patients greater than 12 years of age
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - The patient is unable to swallow the oral tablet/capsule	
Notes	For group code ACUAZPH, antidepressant medications for patients with co-existing behavioral health conditions should be provided through the Regional Behavioral Health Authority (RBHA). Examples of behav

	ioral health conditions include, but are not limited to: anxiety, depression, obsessive-compulsive disorder, and panic disorder.

Product Name:generic mirtazapine, generic mirtazapine ODT, trazodone, generic citalopram tabs, citalopram oral soln, generic escitalopram tabs, generic fluoxetine caps, fluoxetine soln, fluvoxamine IR, generic paroxetine IR tabs, generic sertraline tabs/oral soln, generic duloxetine 20 mg and 30 mg and 60 mg, venlafaxine tabs, generic venlafaxine ER caps, amitriptyline, amoxapine, generic clomipramine, generic desipramine, generic desvenlafaxine ER, doxepin caps/conc, imipramine, generic nortriptyline, nortriptyline soln, protriptyline, trimipramine, bupropion tabs, generic bupropion ER (SR), generic bupropion ER (XL) 150 mg and 300 mg	
Diagnosis	PREFERRED DRUG Requests for patients 6 years of age or younger
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - The patient is unresponsive to other treatment modalities, unless contraindicated (i.e., other medications or behavioral modification attempted) AND 2 - The physician attests that the requested medication is medically necessary (Document rationale for use)	
Notes	For group code ACUAZPH, antidepressant medications for patients with co-existing behavioral health conditions should be provided through the Regional Behavioral Health Authority (RBHA). Examples of behavioral health conditions include, but are not limited to: anxiety, depression, obsessive-compulsive disorder, and panic disorder.

Product Name:Brand Remeron, Brand Remeron Soltab, Marplan, Brand Nardil, generic phenelzine, Emsam, generic tranylcypromine, Brand Parnate, nefazodone, Brand Viibryd, generic vilazodone, Trintellix, Brand Celexa, Citalopram caps, Brand Lexapro, escitalopram caps, escitalopram soln, Brand Prozac, fluoxetine tabs, fluvoxamine ER, Brand Paxil, generic paroxetine susp, Brand Paxil CR, generic paroxetine ER, paroxetine caps, Brand Zoloft, sertraline caps, Brand Pristiq, Desvenlafaxine ER, Brand Cymbalta, duloxetine 40 mg, Fetzima, Fetzima Titration, Brand Effexor XR, venlafaxine ER tabs, Brand Anafranil, Brand Norpramin, Brand Pamelor, Brand Wellbutrin SR, Brand Wellbutrin XL, Bupropion ER (XL) 450 mg, Forfivo XL, Aplenzin, Drizalma Sprinkle, Auvelity, Exxua	

Diagnosis	Non-Preferred Drugs
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - The patient is unresponsive to other treatment modalities, unless contraindicated (i.e., other medications or behavioral modification attempted) AND 2 - The physician attests that the requested medication is medically necessary (Document rationale for use) AND 3 - Patient has a history of failure, contraindication, or intolerance to at least 3 of the following preferred alternatives*: • Bupropion (Generic Wellbutrin) • Bupropion SR (Generic Wellbutrin SR) • Bupropion XL (Generic Wellbutrin XL) 150 mg and 300 mg • Citalopram (Generic Celexa) • Generic desvenlafaxine ER (Generic Pristiq) • Duloxetine 20mg, 30mg, or 60 mg capsules • Escitalopram tablets (Generic Lexapro) • Esketamine (Spravato) • Fluoxetine capsules (Generic Prozac) • Fluoxetine solution (Generic Prozac) • Fluvoxamine tablets (Generic Luvox) • Mirtazapine (Generic Remeron) • Paroxetine tablets (Generic Paxil) • Sertraline tablets (Generic Zoloft) • Trazodone (Generic Desyrel) • Venlafaxine (Generic Effexor) • Venlafaxine ER capsules (Generic Effexor ER)	
Notes	For group code ACUAZPH, antidepressant medications for patients with co-existing behavioral health conditions should be provided through the Regional Behavioral Health Authority (RBHA). Examples of behavioral health conditions include, but are not limited to: anxiety, depression

	on, obsessive-compulsive disorder, and panic disorder. *Drug may require PA.

Product Name: Venlafaxine besylate ER	
Diagnosis	Non-Preferred Drugs
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - The patient is unresponsive to other treatment modalities, unless contraindicated (i.e., other medications or behavioral modification attempted) AND 2 - The physician attests that the requested medication is medically necessary (Document rationale for use) AND 3 - Patient has history of failure or intolerance to preferred generic venlafaxine or venlafaxine ER capsules AND 4 - Patient has a history of failure, contraindication, or intolerance to at least 2 of the following preferred alternatives*: • Bupropion (Generic Wellbutrin) • Bupropion SR (Generic Wellbutrin SR) • Bupropion XL (Generic Wellbutrin XL) 150 mg and 300 mg • Citalopram (Generic Celexa) • Generic desvenlafaxine ER (Generic Pristiq) • Duloxetine 20mg, 30mg, or 60 mg capsules • Escitalopram tablets (Generic Lexapro) • Esketamine (Spravato) • Fluoxetine capsules (Generic Prozac)	

• Fluoxetine solution (Generic Prozac) • Fluvoxamine tablets (Generic Luvox) • Mirtazapine (Generic Remeron) • Paroxetine tablets (Generic Paxil) • Sertraline tablets (Generic Zoloft) • Trazodone (Generic Desyrel)	
Notes	For group code ACUAZPH, antidepressant medications for patients with co-existing behavioral health conditions should be provided through the Regional Behavioral Health Authority (RBHA). Examples of behavioral health conditions include, but are not limited to: anxiety, depression, obsessive-compulsive disorder, and panic disorder. *Drug may require PA.

Product Name:Raldesy	
Diagnosis	Non-Preferred Drugs
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Trial and failure, or intolerance to trazodone oral tablet OR 2 - Patient is unable to swallow the oral tablet formulation of trazodone	
Notes	For group code ACUAZPH, antidepressant medications for patients with co-existing behavioral health conditions should be provided through the Regional Behavioral Health Authority (RBHA). Examples of behavioral health conditions include, but are not limited to: anxiety, depression, obsessive-compulsive disorder, and panic disorder.

2 . Revision History

Date	Notes
3/16/2026	Moved generic desvenlafaxine ER (generic Pristiq) products as targets to preferred drug requests criteria section for pts 6 years of age or

	younger. Added generic desvenlafaxine ER (generic Pristiq) as an alt to embedded steps under NP and Venlafaxine besylate ER criteria sections. Updated product name lists and GPI tables accordingly.

Antiemetics



Prior Authorization Guideline

Guideline ID	GL-150390
Guideline Name	Antiemetics
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	8/1/2024

1 . Criteria

Product Name:Anzemet, granisetron tablet	
Diagnosis	Nausea and vomiting associated with cancer chemotherapy
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Prevention or treatment of nausea and vomiting associated with cancer chemotherapy	

Product Name:Anzemet, granisetron tablet

Diagnosis	Nausea and vomiting associated with radiotherapy
Approval Length	3 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Prevention or treatment of nausea and vomiting associated with radiotherapy (total body irradiation, single high-dose fraction to the abdomen, or daily fractions to the abdomen)	

Product Name:Anzemet, granisetron tablet	
Diagnosis	Postoperative nausea and/or vomiting
Approval Length	1 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Prevention of postoperative nausea and/or vomiting (administration prior to induction of anesthesia)	

2 . Revision History

Date	Notes
7/24/2024	Update to guideline name. Removed ondansetron 24mg tab as a target. Removed GPI for obsolete Anzemet 100mg strength. Updated product name lists and GPI tables accordingly. No changes to criteria.

Antiglaucoma Agents



Prior Authorization Guideline

Guideline ID	GL-518221
Guideline Name	Antiglaucoma Agents
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name:generic brinzolamide ophth susp, generic tafluprost ophth soln	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of elevated intraocular pressure due to ocular hypertension or open angle glaucoma	

Product Name:Omlonti

Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of elevated intraocular pressure due to ocular hypertension or open angle glaucoma AND 2 - Trial and failure, contraindication, or intolerance to ALL of the following: • dorzolamide • bimatoprost • latanoprost • travoprost	

2 . Revision History

Date	Notes
2/11/2026	Added criteria for new target drug, Omlonti.

Antipsoriatic Agents



Prior Authorization Guideline

Guideline ID	GL-140713
Guideline Name	Antipsoriatic Agents
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name: Brand Dovonex cream, generic calcipotriene cream, Brand Calcitrene ointment, generic calcipotriene ointment, Brand Vectical, generic calcitriol ointment	
Diagnosis	Psoriasis
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of psoriasis	

AND

2 - History of failure, contraindication, or intolerance to TWO medium to Very high potency corticosteroid topical treatments (see Table 1 in Background section)

2 . Background

Benefit/Coverage/Program Information

Table 1. Relative Potency of Selected Topical Corticosteroid Products

Drug	Dosage Form	Strength
Super High Potency		
Augmented betamethasone dipropionate (Diprolene)	Gel, Ointment	0.05%
Clobetasol propionate (Temovate, Temovate E)	Cream, Solution	0.05%
Halobetasol propionate (Ultravate)	Cream	0.05%
High Potency		
Augmented betamethasone dipropionate (Diprolene, Diprolene AF)	Cream, Lotion	0.05%
Betamethasone dipropionate	Lotion, Ointment	0.05%
Fluocinonide (Lidex, Lidex E)	Cream, Solution	0.05%
Triamcinolone acetonide (Kenalog)	Cream, Ointment	0.5%
Medium Potency		

Betamethasone valerate (Beta-Val)	Cream	0.1%
Fluocinolone acetonide (Synalar)	Cream, Ointment	0.025%
Fluticasone propionate (Cutivate)	Cream, Lotion	0.05%
	Ointment	0.005%
Hydrocortisone butyrate (Locoid)	Ointment, Solution	0.1%
Mometasone furoate (Elocon)	Cream, Ointment, Solution	0.1%
Prednicarbate (Dermatop)	Cream	0.1%
Triamcinolone acetonide (Kenalog)	Cream, Lotion, Ointment	0.1%
	Ointment	0.025%

3 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Antipsychotics



Prior Authorization Guideline

Guideline ID	GL-459188
Guideline Name	Antipsychotics
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	12/1/2025

1 . Criteria

Product Name: Brand Abilify tabs, generic aripiprazole tabs, aripiprazole oral soln, generic ziprasidone caps, Brand Geodon caps, Brand Latuda, lithium carbonate, generic lithium carbonate ER, Brand Lithobid, generic risperidone tabs/soln, Brand Risperdal tabs/soln, risperidone ODT, generic quetiapine, Brand Seroquel, Brand Zyprexa, generic olanzapine, generic olanzapine ODT, Brand Zyprexa Zydis, generic lurasidone	
Diagnosis	Patients Under 6 Years Old
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria	

1 - The patient has been diagnosed per current DSM (Diagnostic and Statistical Manual of Mental Disorders) criteria with one of the following disorders:

- Bipolar Spectrum Disorder
- Schizophrenic Spectrum Disorder
- Tourette's or other tic disorder
- Autism Spectrum Disorder

AND

2 - The requesting clinician has documented that psychosocial issues have been evaluated before request for antipsychotic medications

AND

3 - The requesting clinician has documented non-medication alternatives that have been attempted before request for antipsychotic medications

AND

4 - The above documentation includes information on the expected outcomes and an evaluation of potential adverse events

AND

5 - The patient does not have a known hypersensitivity to the requested agent

Notes	For group code ACUAZPH, antipsychotic medications for patients with co-existing behavioral health conditions should be provided through the Regional Behavioral Health Authority (RBHA). Examples of behavioral health conditions include, but are not limited to: anxiety, depression, obsessive-compulsive disorder, and panic disorder.

Product Name:haloperidol tabs/oral conc, loxapine, thioridazine, molindone, thiothixene, pimozide, fluphenazine tabs/elix/oral conc, trifluoperazine, perphenazine, chlorpromazine tabs

Diagnosis	Patients Under 12 Years Old
Approval Length	12 month(s)

Guideline Type	Prior Authorization
Approval Criteria 1 - The patient has been diagnosed per current DSM (Diagnostic and Statistical Manual of Mental Disorders) criteria with one of the following disorders: • Bipolar Spectrum Disorder • Schizophrenic Spectrum Disorder • Tourette's or other tic disorder • Autism Spectrum Disorder AND 2 - The requesting clinician has documented that psychosocial issues have been evaluated before request for antipsychotic medications AND 3 - The requesting clinician has documented non-medication alternatives that have been attempted before request for antipsychotic medications AND 4 - The above documentation includes information on the expected outcomes and an evaluation of potential adverse events AND 5 - The patient does not have a known hypersensitivity to the requested agent	
Notes	For group code ACUAZPH, antipsychotic medications for patients with co-existing behavioral health conditions should be provided through the Regional Behavioral Health Authority (RBHA). Examples of behavioral health conditions include, but are not limited to: anxiety, depression, obsessive-compulsive disorder, and panic disorder.

Product Name:generic clozapine, Brand Clozaril, clozapine ODT, generic haloperidol decanoate, Brand Haldol Decanoate, fluphenazine decanoate, haloperidol lactate inj	
Diagnosis	Patients Under 18 Years Old
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following: 1.1 ONE of the following: 1.1.1 The requested medication must be used for an FDA approved indication or 1.1.2 The use of the drug is supported by information in ONE of the following appropriate compendia of literature: Food and Drug Administration approved indications and limits Published practice guidelines and treatment protocols Comparative data evaluating the efficacy, type, and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits, and potential patient outcomes Drug Facts and Comparisons American Hospital Formulary Service Drug Information United States Pharmacopeia - Drug Information DRUGDEX Information System UpToDate MicroMedex Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data, and pharmacoeconomic studies Other drug reference resources AND 1.2 The patient meets the FDA minimum age limit or the prescriber attests they are aware of FDA labeling regarding the use of the antipsychotic medication and feels the treatment with the requested medication is medically necessary	

or	
2 - The patient is currently on the requested medication	
Notes	For group code ACUAZPH, antipsychotic medications for patients with co-existing behavioral health conditions should be provided through the Regional Behavioral Health Authority (RBHA). Examples of behavioral health conditions include, but are not limited to: anxiety, depression, obsessive-compulsive disorder, and panic disorder.

Product Name: Abilify Asimtufii, Abilify Maintena	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has ONE of the following diagnoses: - Schizophrenia or schizoaffective disorder - Bipolar disorder AND 2 - ONE of the following: 2.1 BOTH of the following: 2.1.1 Patient is non-adherent with oral atypical antipsychotic dosage forms AND 2.1.2 Patient has established tolerability with aripiprazole OR	

2.2 Patient is unable to take oral solid alternatives

AND

3 - If the patient is less than 18 years of age, the prescriber attests they are aware of FDA (Food and Drug Administration) labeling regarding use of long acting injectable antipsychotic products in patients less than 18 years of age and feels the treatment with the requested product is medically necessary (document rationale for use)

Notes	For group code ACUAZPH, antipsychotic medications for patients with co-existing behavioral health conditions should be provided through the Regional Behavioral Health Authority (RBHA). Examples of behavioral health conditions include, but are not limited to: anxiety, depression, obsessive-compulsive disorder, and panic disorder.

Product Name: Abilify Mycite	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ALL of the following: 1.1 Patient is 18 years of age or older AND 1.2 Patient has ONE of the following: • Schizophrenia or schizoaffective disorder • Bipolar disorder • Autism • Major depressive disorder • Tourette's AND	

1.3 Submission of medical records or claims history documenting the patient is currently prescribed aripiprazole and tolerates the medication

AND

1.4 Submission of medical records or claims history documenting the patient's adherence to aripiprazole is less than 80 percent within the past 6 months (medication adherence percentage is defined as the number of pills absent in a given time period divided by the number of pills prescribed during that same time, multiplied by 100)

AND

1.5 ALL of the following strategies (if applicable to the patient) to improve patient adherence have been tried without success:

- Utilization of a pill box
- Utilization of a smart phone reminder (ex. alarm, application, or text reminder)
- Involving family members or friends to assist
- Coordinating timing of dose to coincide with dosing of another daily medication

AND

1.6 Submission of medical records or claims history documenting patient has experienced life-threatening or potentially life-threatening symptoms, or has experienced a severe worsening of symptoms leading to a hospitalization which was attributed to the lack of adherence to aripiprazole

AND

1.7 Prescriber acknowledges that Abilify MyCite has not been shown to improve patient adherence and attests that Abilify MyCite is medically necessary for the patient to maintain compliance, avoid life-threatening worsening of symptoms, and reduce healthcare resources utilized due to lack of adherence

AND

1.8 Prescriber agrees to track and document adherence of Abilify MyCite through software provided by the manufacturer

AND

1.9 The patient has a history of failure, contraindication, or intolerance or reason or special circumstance they cannot use TWO of the following (drug may require PA):

- Abilify Maintena
- Invega Sustenna
- Risperdal Consta
- Aristada
- Perseris

OR

2 - ONE of the following:

2.1 The patient has been receiving treatment with the requested non-preferred behavioral health medication and is new to the plan (enrollment effective date within the past 90 days)

OR

2.2 The patient is currently receiving treatment with the requested non-preferred behavioral health medication in the hospital and must continue upon discharge

Notes	For group code ACUAZPH, antipsychotic medications for patients with co-existing behavioral health conditions should be provided through the Regional Behavioral Health Authority (RBHA). Examples of behavioral health conditions include, but are not limited to: anxiety, depression, obsessive-compulsive disorder, and panic disorder.

Product Name:Abilify Mycite

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation that patient is clinically stable on Abilify MyCite

AND	
2 - Submission of medical records or claims history documenting that the use of Abilify MyCite has increased adherence to 80 percent or more	
AND	
3 - Prescriber attests that the patient requires the continued use of Abilify MyCite to remain adherent	
Notes	For group code ACUAZPH, antipsychotic medications for patients with co-existing behavioral health conditions should be provided through the Regional Behavioral Health Authority (RBHA). Examples of behavioral health conditions include, but are not limited to: anxiety, depression, obsessive-compulsive disorder, and panic disorder.

Product Name:Aristada, Aristada Initio	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has a diagnosis of schizophrenia or schizoaffective disorder AND 2 - ONE of the following: 2.1 BOTH of the following: 2.1.1 Patient is non-adherent with oral atypical antipsychotic dosage forms AND 2.1.2 Patient has established tolerability with oral aripiprazole	

OR

2.2 Patient is unable to take oral solid alternatives

AND

3 - If the patient is less than 18 years of age, the prescriber attests they are aware of FDA (Food and Drug Administration) labeling regarding use of long acting injectable antipsychotic products in patients less than 18 years of age and feels the treatment with the requested product is medically necessary (document rationale for use)

Notes	For group code ACUAZPH, antipsychotic medications for patients with co-existing behavioral health conditions should be provided through the Regional Behavioral Health Authority (RBHA). Examples of behavioral health conditions include, but are not limited to: anxiety, depression, obsessive-compulsive disorder, and panic disorder.

Product Name:Erzofri, Invega Sustenna	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has a diagnosis of schizophrenia or schizoaffective disorder AND 2 - ONE of the following: 2.1 BOTH of the following: 2.1.1 Patient is non-adherent with oral atypical antipsychotic dosage forms AND	

2.1.2 Patient has established tolerability with oral paliperidone or oral risperidone

OR

2.2 Patient is unable to take oral solid alternatives

AND

3 - If the patient is less than 18 years of age, the prescriber attests they are aware of FDA (Food and Drug Administration) labeling regarding use of long acting injectable antipsychotic products in patients less than 18 years of age and feels the treatment with the requested product is medically necessary (document rationale for use)

AND

4 - If the request is for Erzofri, history of failure or adverse reaction to Invega Sustenna

Notes	For group code ACUAZPH, antipsychotic medications for patients with co-existing behavioral health conditions should be provided through the Regional Behavioral Health Authority (RBHA). Examples of behavioral health conditions include, but are not limited to: anxiety, depression, obsessive-compulsive disorder, and panic disorder.

Product Name: Invega Trinza	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has a diagnosis of schizophrenia or schizoaffective disorder AND 2 - Patient has been treated with Invega Sustenna for at least 4 months	

AND	
3 - If the patient is less than 18 years of age, the prescriber attests they are aware of FDA (Food and Drug Administration) labeling regarding use of long acting injectable antipsychotic products in patients less than 18 years of age and feels the treatment with the requested product is medically necessary (document rationale for use)	
Notes	For group code ACUAZPH, antipsychotic medications for patients with co-existing behavioral health conditions should be provided through the Regional Behavioral Health Authority (RBHA). Examples of behavioral health conditions include, but are not limited to: anxiety, depression, obsessive-compulsive disorder, and panic disorder.

Product Name: Invega Hafyera	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has a diagnosis of schizophrenia or schizoaffective disorder AND 2 - Patient has been treated with Invega Sustenna or Invega Trinza for at least 6 months AND 3 - If the patient is less than 18 years of age, the prescriber attests they are aware of FDA (Food and Drug Administration) labeling regarding use of long acting injectable antipsychotic products in patients less than 18 years of age and feels the treatment with the requested product is medically necessary (document rationale for use)	
Notes	For group code ACUAZPH, antipsychotic medications for patients with co-existing behavioral health conditions should be provided through the Regional Behavioral Health Authority (RBHA). Examples of behavioral health conditions include, but are not limited to: anxiety, depression, obsessive-compulsive disorder, and panic disorder.

Product Name:Opipza	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 BOTH of the following:

- Patient is 13 years of age or older
- Diagnosis of schizophrenia

OR

1.2 BOTH of the following:

- Patient is 18 years of age or older
- Diagnosis of major depressive disorder (MDD)

OR

1.3 BOTH of the following:

- Patient is 6 years of age or older
- Diagnosis of autistic disorder

OR

1.4 BOTH of the following:

- Patient is 6 years of age or older
- Diagnosis of Tourette's disorder

AND

2 - BOTH of the following:

2.1 ONE of the following:

- History of failure or intolerance to aripiprazole oral tablets
- History of failure or intolerance to aripiprazole oral solution

AND

2.2 Provider submits clinical rationale documenting why patient is unable to take aripiprazole ODT formulation

AND

3 - If the patient is less than 18 years of age, the prescriber attests they are aware of FDA (Food and Drug Administration) labeling regarding use of long acting injectable antipsychotic products in patients less than 18 years of age and feels the treatment with the requested product is medically necessary (Document rationale for use)

Notes	For group code ACUAZPH, antipsychotic medications for patients with co-existing behavioral health conditions should be provided through the Regional Behavioral Health Authority (RBHA). Examples of behavioral health conditions include, but are not limited to: anxiety, depression, obsessive-compulsive disorder, and panic disorder.

Product Name:Perseris	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has a diagnosis of schizophrenia or schizoaffective disorder AND 2 - ONE of the following: 2.1 BOTH of the following:	

2.1.1 Patient is non-adherent with oral atypical antipsychotic dosage forms

AND

2.1.2 Patient has established tolerability with oral risperidone

OR

2.2 Patient is unable to take oral solid alternatives

AND

3 - If the patient is less than 18 years of age, the prescriber attests they are aware of FDA (Food and Drug Administration) labeling regarding use of long acting injectable antipsychotic products in patients less than 18 years of age and feels the treatment with the requested product is medically necessary (document rationale for use)

Notes	For group code ACUAZPH, antipsychotic medications for patients with co-existing behavioral health conditions should be provided through the Regional Behavioral Health Authority (RBHA). Examples of behavioral health conditions include, but are not limited to: anxiety, depression, obsessive-compulsive disorder, and panic disorder.

Product Name: Brand Risperdal Consta, Uzedly	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has ONE of the following diagnoses: - Schizophrenia or schizoaffective disorder - Bipolar disorder AND	

2 - ONE of the following:

2.1 BOTH of the following:

2.1.1 Patient is non-adherent with oral atypical antipsychotic dosage forms

AND

2.1.2 Patient has established tolerability with oral risperidone

OR

2.2 Patient is unable to take oral solid alternatives

AND

3 - If the patient is less than 18 years of age, the prescriber attests they are aware of FDA (Food and Drug Administration) labeling regarding use of long acting injectable antipsychotic products in patients less than 18 years of age and feels the treatment with the requested product is medically necessary (document rationale for use)

Notes	For group code ACUAZPH, antipsychotic medications for patients with co-existing behavioral health conditions should be provided through the Regional Behavioral Health Authority (RBHA). Examples of behavioral health conditions include, but are not limited to: anxiety, depression, obsessive-compulsive disorder, and panic disorder.

Product Name: Rykindo, generic risperidone ER IM	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has ONE of the following diagnoses: Schizophrenia or schizoaffective disorder	

- Bipolar disorder

AND

2 - ONE of the following:

2.1 BOTH of the following:

- Patient is non-adherent with oral atypical antipsychotic dosage forms
- Patient has established tolerability with oral risperidone

OR

2.2 Patient is unable to take oral solid alternatives

AND

3 - History of failure, contraindication, or intolerance to ALL of the following:

- Perseris
- Risperdal Consta
- Uzedly

AND

4 - If the patient is less than 18 years of age, the prescriber attests they are aware of FDA (Food and Drug Administration) labeling regarding use of long acting injectable antipsychotic products in patients less than 18 years of age and feels the treatment with the requested product is medically necessary (Document rationale for use)

Notes	For group code ACUAZPH, antipsychotic medications for patients with co-existing behavioral health conditions should be provided through the Regional Behavioral Health Authority (RBHA). Examples of behavioral health conditions include, but are not limited to: anxiety, depression, obsessive-compulsive disorder, and panic disorder.

Product Name: Brand Abilify tabs, aripiprazole ODT, Brand Clozaril, generic ziprasidone caps, Brand Geodon caps, Brand Haldol Decanoate, generic paliperidone ER, Brand Invega, Brand Latuda, loxapine, Brand Lithobid, fluphenazine tabs/inj, Brand Risperdal tabs/soln, generic risperidone soln, Brand Saphris, generic asenapine SL, Secuado, generic

olanzapine/fluoxetine, Brand Symbyax, Brand Seroquel, generic quetiapine ER, Brand Seroquel XR, chlorpromazine tabs, perphenazine/amitriptyline, Versacloz, Brand Zyprexa, Brand Zyprexa Zydis, haloperidol lactate inj	
Diagnosis	Non-Preferred Drugs**
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ALL of the following: 1.1 ONE of the following: 1.1.1 Patient has a history of failure, contraindication, or intolerance to at least FOUR of the following: Aripiprazole oral Aripiprazole injectable formulations Clozapine/clozapine ODT Lurasidone Olanzapine/olanzapine ODT Paliperidone oral*** Paliperidone injectable formulations Quetiapine Risperidone/risperidone ODT Risperidone injectable formulations or 1.1.2 There are no preferred formulary alternatives for the requested drug AND 1.2 If the request is for a multi-source brand medication, ONE of the following: 1.2.1 BOTH of the following: 1.2.1.1 The brand is being requested because of an adverse reaction, allergy, or sensitivity to the generic, and the prescriber must attest to submitting the FDA MedWatch	

Form for allergic reactions to the medications

AND

1.2.1.2 If there are generic product, the patient has tried at least three

or

1.2.2 ONE of the following:

1.2.2.1 The brand is being requested due to a therapeutic failure with the generic

or

1.2.2.2 The brand is being requested because transition to the generic could result in destabilization of the patient

or

1.2.2.3 Special clinical circumstances exist that preclude the use of the generic equivalent of the multi-source brand medication for the patient

AND

1.3 ONE of the following:

1.3.1 The requested drug must be used for an FDA-approved indication

or

1.3.2 The use of this drug is supported by information from ONE of the following appropriate compendia of current literature:

FDA approved indications and limits

Published practice guidelines and treatment protocols

Comparative data evaluating the efficacy, type, and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits, and potential patient outcomes

Drug Facts and Comparisons

American Hospital Formulary Service Drug Information

United States Pharmacopeia - Drug Information

DRUGDEX Information System

UpToDate

MicroMedex

Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data, and pharmacoeconomic studies

Other drug reference resources

AND

1.4 ONE of the following:

1.4.1 The drug is being prescribed within the manufacturer's published dosing guidelines

or

1.4.2 The drug falls within dosing guidelines found in ONE of the following compendia of current literature:

FDA approved indications and limits

Published practice guidelines and treatment protocols

Comparative data evaluating the efficacy, type, and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits, and potential patient outcomes

Drug Facts and Comparisons

American Hospital Formulary Service Drug Information

United States Pharmacopeia - Drug Information

DRUGDEX Information System

UpToDate

MicroMedex

Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data, and pharmacoeconomic studies

Other drug reference resources

AND

1.5 The drug is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plans' program*

or

2 - The requested medication is a behavioral health medication and ONE of the following:

2.1 The patient has been receiving treatment with the requested non-preferred behavioral health medication and is new to the plan

or

2.2 The patient is currently receiving treatment with the requested non-preferred behavioral health medication in the hospital and must continue upon discharge

Notes

For group code ACUAZPH, antipsychotic medications for patients with co-existing behavioral health conditions should be provided through the Regional Behavioral Health Authority (RBHA). Examples of behavioral health conditions include, but are not limited to: anxiety, depression, obsessive-compulsive disorder, and panic disorder.

*Medications used for anti-obesity/weight loss, cosmetic (e.g., alopecia, actinic keratosis, vitiligo), erectile dysfunction, and sexual dysfunction purposes are NOT medically accepted indications and are NOT recognized as a covered benefit. Erectile dysfunction drugs (Cialis/Tadalafil) are covered for clinical diagnoses other than ED.

**PDL link: <https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP>

***If the request is for generic paliperidone ER tablets, please omit "paliperidone oral" as an alternative.

2 . Revision History

Date	Notes
11/19/2025	Moved Uzedy to same criteria section as Brand Risperdal Consta. Updated embedded step to add Uzedy as an alternative in Rykindo/generic risperidone ER IM criteria section and Non-Preferred Drugs criteria section. Removed GPI for Brand Invega 1.5 mg strength as it is now obsolete.

Anxiolytics



Prior Authorization Guideline

Guideline ID	GL-140805
Guideline Name	Anxiolytics
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	8/1/2023

1 . Criteria

Product Name:buspirone, Brand Xanax tabs, Brand Xanax XR, generic alprazolam tabs, alprazolam ODT, generic alprazolam ER/XR, chlordiazepoxide, generic clorazepate dipotassium, Brand Tranxene T, Brand Valium tabs, generic diazepam tabs, diazepam conc, diazepam intensol, generic lorazepam, Brand Ativan, lorazepam conc, lorazepam intensol, oxazepam, generic clonazepam tabs, Brand Klonopin tabs, clonazepam ODT, alprazolam intensol, Loreev XR	
Diagnosis	Requests for patients less than 6 years of age
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria	

1 - The patient is unresponsive to other treatment modalities, unless contraindicated (i.e., other medications or behavioral modification attempted)

AND

2 - The physician attests that the requested medication is medically necessary (document rationale for use)

Product Name:Loreev XR

Diagnosis	Requests for Patients 6 years of age and older

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - Trial and failure, or contraindication to generic lorazepam

AND

2 - The physician attests that the requested medication is medically necessary (document rationale for use)

Product Name:buspirone, Brand Xanax tabs, Brand Xanax XR, generic alprazolam tabs, alprazolam ODT, generic alprazolam ER/XR, chlordiazepoxide, generic clorazepate dipotassium, Brand Tranxene T, Brand Valium tabs, generic diazepam tabs, diazepam conc, diazepam intensol, generic lorazepam, Brand Ativan, lorazepam conc, lorazepam intensol, oxazepam, generic clonazepam tabs, Brand Klonopin tabs, clonazepam ODT, alprazolam intensol, Loreev XR

Diagnosis	Greater than 1 Anxiolytic in 30 days

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - The medication is being used to adjust the dose of the drug

OR

2 - The medication will be used in place of the previously prescribed drug, and not in addition to it

OR

3 - The medication dosage form will be used in place of the previously prescribed medication dosage form, and not in addition to it

OR

4 - The physician attests they are aware of the multiple anxiolytics prescribed to the patient and feels treatment with both medications is medically necessary (document rationale for use)

2 . Revision History

Date	Notes
7/13/2023	Updated Indication for Greater than 1 Anxiolytic in 30 days to remove reject number and type.

Anzupgo (delgocitinib)



Prior Authorization Guideline

Guideline ID	GL-510407
Guideline Name	Anzupgo (delgocitinib)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name:Anzupgo	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is 18 years of age or older	

AND

2 - Diagnosis of severe chronic hand eczema (CHE)

AND

3 - Patient is experiencing functional impairment due to severe chronic hand eczema, which may include, but is not limited to, activities of daily living (ADLs), skin infections, sleep disturbances, etc.

AND

4 - Provider attests patient has been counseled regarding avoidance of irritants and allergens

AND

5 - Submission of medical records or paid pharmacy claims documenting that patient is using emollients (e.g., Aquaphor, Eucerin) consistently

AND

6 - Submission of medical records or paid pharmacy claims documenting trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to ALL of the following:

- Medium or higher potency topical corticosteroid
- One calcineurin inhibitor (e.g., tacrolimus ointment)
- Eucrisa (crisaborole)
- Opzelura (ruxolitinib)
- Vtama (tapinarof)
- Zoryve (roflumilast) 0.05% or 0.15% cream
- Adbry (tralokinumab-ldrm)

AND

7 - NOT used in combination with other Janus kinase (JAK) inhibitors or potent immunosuppressants (e.g., azathioprine or cyclosporine)

AND

8 - Prescribed by or in consultation with ONE of the following:

- Dermatologist
- Allergist/Immunologist

Product Name:Anzupgo	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient demonstrates positive clinical response to therapy (e.g., erythema, scaling, hyperkeratosis, fissures) AND 2 - NOT used in combination with other JAK inhibitors or potent immunosuppressants (e.g., azathioprine or cyclosporine)	

2 . Background

Clinical Practice Guidelines			
Table 1. Relative potencies of topical corticosteroids			
Class	Drug	Dosage Form	Strength (%)

UnitedHealthcare Community Plan of Arizona Clinical Pharmacy Program Guidelines

Very high potency	Augmented betamethasone dipropionate	Ointment	0.05
	Clobetasol propionate	Cream, foam, ointment	0.05
	Diflorasone diacetate	Ointment	0.05
	Halobetasol propionate	Cream, ointment	0.05
High Potency	Amcinonide	Cream, lotion, ointment	0.1
	Augmented betamethasone dipropionate	Cream	0.05
	Betamethasone dipropionate	Cream, foam, ointment, solution	0.05
	Desoximetasone	Cream, ointment	0.25
	Desoximetasone	Gel	0.05
	Diflorasone diacetate	Cream	0.05
	Fluocinonide	Cream, gel, ointment, solution	0.05
	Halcinonide	Cream, ointment	0.1
	Mometasone furoate	Ointment	0.1
Medium potency	Triamcinolone acetonide	Cream, ointment	0.5
	Betamethasone valerate	Cream, foam, lotion, ointment	0.1
	Clocortolone pivalate	Cream	0.1
	Desoximetasone	Cream	0.05
	Fluocinolone acetonide	Cream, ointment	0.025
	Flurandrenolide	Cream, ointment	0.05
	Fluticasone propionate	Cream	0.05
	Fluticasone propionate	Ointment	0.005
	Mometasone furoate	Cream	0.1
Lower-medium potency	Triamcinolone acetonide	Cream, ointment	0.1
	Hydrocortisone butyrate	Cream, ointment, solution	0.1
	Hydrocortisone probutate	Cream	0.1
	Hydrocortisone valerate	Cream, ointment	0.2
Low potency	Prednicarbate	Cream	0.1
	Alclometasone dipropionate	Cream, ointment	0.05
	Desonide	Cream, gel, foam, ointment	0.05
Lowest potency	Fluocinolone acetonide	Cream, solution	0.01
	Dexamethasone	Cream	0.1
	Hydrocortisone	Cream, lotion, ointment, solution	0.25, 0.5, 1
	Hydrocortisone acetate	Cream, ointment	0.5-1

3 . Revision History

Date	Notes
2/5/2026	Updates to initial auth criteria section.

Apomorphine products (Apokyn, Onapgo)



Prior Authorization Guideline

Guideline ID	GL-231254
Guideline Name	Apomorphine products (Apokyn, Onapgo)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2025

1 . Criteria

Product Name:Brand Apokyn, generic apomorphine injection, Onapgo	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting all of the following: 1.1 Diagnosis of Parkinson's disease	

AND

1.2 Medication will be used as intermittent treatment for OFF episodes

AND

1.3 Patient is currently on a stable dose of a carbidopa/levodopa-containing medication and will continue receiving treatment with a carbidopa/levodopa-containing medication while on therapy

AND

1.4 Patient continues to experience greater than or equal to 2 hours of OFF time per day despite optimal management of carbidopa/levodopa therapy including BOTH of the following:

- Taking carbidopa/levodopa on an empty stomach or at least one half-hour or more before or one hour after a meal or avoidance of high protein diet
- Dose and dosing interval optimization

AND

1.5 History of failure, contraindication, or intolerance to TWO anti-Parkinson's disease therapies from the following adjunctive pharmacotherapy classes (trial must be from two different classes):

- Dopamine agonists (e.g., pramipexole, ropinirole)
- Catechol-O-methyl transferase (COMT) inhibitors (e.g., entacapone)
- Monoamine oxidase (MAO) B inhibitors (e.g., rasagiline, selegiline)

AND

2 - Prescribed by or in consultation with a neurologist or specialist in the treatment of Parkinson's disease

Product Name: Brand Apokyn, generic apomorphine injection, Onapgo

Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy AND 2 - Patient will continue to receive treatment with a carbidopa/levodopa-containing medication	

2 . Revision History

Date	Notes
4/1/2025	Added Onapgo, removed Kynmobi, updated guideline name.

Aqneursa (levacetylleucine)



Prior Authorization Guideline

Guideline ID	GL-254205
Guideline Name	Aqneursa (levacetylleucine)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	6/1/2025

1 . Criteria

Product Name:Aqneursa	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Niemann-Pick disease type C (NPC)	

AND

2 - Submission of medical records (e.g., chart notes) documenting the diagnosis has been confirmed by ONE of the following:

2.1 Genetically confirmed (deoxyribonucleic acid [DNA] sequence analysis) by mutations in both alleles of NPC1 or NPC2

OR

2.2 Mutation in only one allele of NPC1 or NPC2 plus either positive filipin staining or elevated cholestane triol/oxysterols (>2 x upper limit of normal)

AND

3 - Patient has at least one neurological symptom of the disease (e.g., hearing loss, vertical supranuclear gaze palsy, ataxia, dementia, dystonia, seizures, dysarthria, or dysphagia)

AND

4 - Patient weighs greater than or equal to 15 kg (kilogram)

AND

5 - Requested drug will NOT be used in combination with Miplyffa (arimoclomol)*

AND

6 - Prescribed by or in consultation with a specialist knowledgeable in the treatment of Niemann-Pick disease type C

Notes

*The use of both Miplyffa and Aqneursa concomitantly is not covered due to lack of evidence to support the use of both products at the same time and the lack of a Miplyffa and Aqneursa head-to-head study.

Product Name:Aqneursa	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient demonstrates positive clinical response to therapy (e.g., slowing of disease progression, improvement in neurological symptoms of the disease) AND 2 - Requested drug will NOT be used in combination with Miplyffa (arimoclomol)*	
Notes	*The use of both Miplyffa and Aqneursa concomitantly is not covered due to lack of evidence to support the use of both products at the same time and the lack of a Miplyffa and Aqneursa head-to-head study.

2 . Revision History

Date	Notes
5/8/2025	Added note regarding concomitant use with Miplyffa, no change to clinical criteria.

Aquadeks



Prior Authorization Guideline

Guideline ID	GL-140697
Guideline Name	Aquadeks
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Aquadeks	
Diagnosis	Cystic Fibrosis
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of cystic fibrosis	

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Arcalyst (rilonacept)



Prior Authorization Guideline

Guideline ID	GL-155104
Guideline Name	Arcalyst (rilonacept)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name:Arcalyst	
Diagnosis	Cryopyrin-Associated Periodic Syndromes (CAPS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting a diagnosis of Cryopyrin-Associated Periodic Syndromes (CAPS) [including Familial Cold Auto-inflammatory Syndrome (FCAS), Muckle-Wells Syndrome (MWS)]	

AND

2 - Prescribed by or in consultation with ONE of the following:

- Immunologist
- Allergist
- Dermatologist
- Rheumatologist
- Neurologist
- Specialist with expertise in the management of CAPS

AND

3 - The medication will NOT be used in combination with another biologic agent

Product Name:Arcalyst	
Diagnosis	Cryopyrin-Associated Periodic Syndromes (CAPS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting patient has experienced disease stability or improvement in clinical symptoms while on therapy as evidenced by ONE of the following: • Improvement in rash, fever, joint pain, headache, or conjunctivitis • Decreased number of disease flare days • Normalization of inflammatory markers (C-reactive protein [CRP], erythrocyte sedimentation rate [ESR], serum amyloid A [SAA]) • Corticosteroid dose reduction • Improvement in MD global score or active joint count	

Product Name:Arcalyst

Diagnosis	Deficiency of Interleukin-1 Receptor Antagonist (DIRA)
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting ALL of the following: 1.1 Diagnosis of deficiency of interleukin-1 receptor antagonist (DIRA) AND 1.2 Patient weighs at least 10 kg (kilograms) AND 1.3 Patient is currently in remission (e.g., no fever, skin rash, and bone pain; no radiological evidence of active bone lesions; C-reactive protein [CRP] less than 5 mg/L [milligrams per liter])	

Product Name:Arcalyst	
Diagnosis	Recurrent Pericarditis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) or paid claims documenting BOTH of the following: 1.1 Diagnosis of recurrent pericarditis as evidenced by at least 2 episodes that occur a minimum of 4 to 6 weeks apart	

AND

1.2 History of failure, contraindication, or intolerance to ALL of the following:

- nonsteroidal anti-inflammatory drugs (e.g., ibuprofen, naproxen)
- colchicine
- corticosteroids (e.g., prednisone)

AND

2 - Prescribed by or in consultation with a cardiologist

Product Name:Arcalyst	
Diagnosis	Recurrent Pericarditis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy	

2 . Revision History

Date	Notes
9/17/2024	Updated guideline name. Updated CAPS criteria. Added new criteria for DIRA and recurrent pericarditis.

Arikayce



Prior Authorization Guideline

Guideline ID	GL-140917
Guideline Name	Arikayce
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Arikayce	
Diagnosis	Refractory Mycobacterium avium complex (MAC) lung disease
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of refractory Mycobacterium avium complex (MAC) lung disease	

AND

2 - Submission of medical records (e.g., chart notes, laboratory values) or claims history documenting respiratory cultures positive for MAC within the previous 6 months

AND

3 - Submission of medical records (e.g., chart notes, laboratory values) or claims history documenting the patient has been receiving a multidrug background regimen containing at least TWO of the following agents for a minimum of 6 consecutive months within the past 12 months (prescription claims history may be used in conjunction as documentation of medication use, dose, and duration):

- Macrolide antibiotic* (e.g., azithromycin, clarithromycin)
- Ethambutol*
- Rifamycin antibiotic* (e.g., rifampin, rifabutin)

AND

4 - Patient will continue to receive a multidrug background regimen

AND

5 - Documentation that the patient has not achieved negative sputum cultures after receipt of a multidrug background regimen for a minimum of 6 consecutive months

AND

6 - In vitro susceptibility testing of recent (within 6 months) positive culture documents that the MAC isolate is susceptible to amikacin with a minimum inhibitory concentration (MIC) of less than or equal to 64 micrograms per milliliter (mcg/mL)

AND

7 - Prescribed by or in consultation with one of the following:

• Infectious disease specialist • Pulmonologist	
Notes	*Drug may require PA)

Product Name:Arikayce	
Diagnosis	Refractory Mycobacterium avium complex (MAC) lung disease
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Documentation that the patient has achieved negative respiratory cultures OR 1.2 ALL of the following: 1.2.1 Patient has not achieved negative respiratory cultures while on Arikayce AND 1.2.2 Physician attestation that patient has demonstrated clinical benefit while on Arikayce AND 1.2.3 In vitro susceptibility testing of most recent (within 6 months) positive culture with available susceptibility testing documents that the Mycobacterium avium complex (MAC) isolate is susceptible to amikacin with an minimum inhibitory concentration (MIC) of less than 64 micrograms per milliliter (mcg/mL)	

AND

1.2.4 Patient has NOT received greater than 12 months of Arikayce therapy with continued positive respiratory cultures

AND

2 - Submission of medical records (e.g., chart notes, laboratory values) or claims history documenting that the patient continues to receive a multidrug background regimen containing at least TWO of the following agents (prescription claims history may be used in conjunction as documentation of medication use, dose, and duration):

- Macrolide antibiotic* (e.g., azithromycin, clarithromycin)
- Ethambutol*
- Rifamycin antibiotic* (e.g., rifampin, rifabutin)

AND

3 - Prescribed by or in consultation with one of the following:

- Infectious disease specialist
- Pulmonologist

Notes	*Drug may require PA

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Attruby (acoramidis)



Prior Authorization Guideline

Guideline ID	GL-208214
Guideline Name	Attruby (acoramidis)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	4/1/2025

1 . Criteria

Product Name:Attruby	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of transthyretin-mediated amyloidosis with cardiomyopathy (ATTR-CM)	

AND

2 - Submission of medical records (e.g., chart notes) documenting one of the following:

2.1 Presence of a transthyretin (TTR) mutation (e.g., V122I) as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA)

OR

2.2 Cardiac or noncardiac tissue biopsy demonstrating histologic confirmation of TTR amyloid deposits

OR

2.3 Both of the following:

- Cardiac magnetic resonance imaging or scintigraphy scan suggestive of amyloidosis
- Absence of light-chain amyloidosis

AND

3 - Submission of medical records (e.g., chart notes) documenting patient has New York Heart Association (NYHA) Functional Class I, II, or III heart failure

AND

4 - Requested drug is not used in combination with a TTR silencer (e.g., Amvuttra) or a TTR stabilizer (e.g., Diflunisal)

AND

5 - Prescribed by, or in consultation with, a cardiologist

Product Name:Attruby	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting patient continues to have New York Heart Association (NYHA) Functional Class I, II, or III heart failure AND 2 - Requested drug is not used in combination with a TTR silencer (e.g., Amvuttra) or a TTR stabilizer (e.g., Diflunisal) AND 3 - Prescribed by, or in consultation with, a cardiologist	

2 . Revision History

Date	Notes
3/5/2025	New guideline

Austedo (deutetrabenazine)



Prior Authorization Guideline

Guideline ID	GL-157496
Guideline Name	Austedo (deutetrabenazine)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	11/1/2024

1 . Criteria

Product Name:Austedo*, Austedo XR*	
Diagnosis	Moderate to Severe Tardive Dyskinesia
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderate to severe tardive dyskinesia (TD) secondary to treatment with a centrally acting dopamine receptor blocking agent (DRBA)	

AND

2 - Prescribed by or in consultation with a psychiatrist or neurologist

AND

3 - Patient is 18 years of age or older

AND

4 - Patient has an Abnormal Involuntary Movement Scale (AIMS) score of 3 or 4 on any one of the AIMS items 1 through 9

AND

5 - Austedo is not prescribed concurrently with tetrabenazine or Ingrezza

AND

6 - Dose does not exceed 48 mg (milligrams) per day

Notes	*Patients will be approved for ONE strength of Austedo/Austedo XR ONLY: Approve ALL requests at GPI-14. Confirm there is only 1 active PA on file for ALL Austedo products. End-date/Retire all other active P A's for Austedo products.

Product Name:Austedo*, Austedo XR*	
Diagnosis	Moderate to Severe Tardive Dyskinesia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is responding positively to therapy as evidenced by a reduction in the baseline score of any one of the Abnormal Involuntary Movement Scale (AIMS) items 1 through 9

AND

2 - Austedo is not prescribed concurrently with tetrabenazine or Ingrezza

AND

3 - Dose does not exceed 48 mg per day

Notes	*Patients will be approved for ONE strength of Austedo/Austedo XR ONLY: Approve ALL requests at GPI-14. Confirm there is only 1 active PA on file for ALL Austedo products. End-date/Retire all other active P A's for Austedo products.

Product Name:Austedo*, Austedo XR*	
Diagnosis	Chorea Associated with Huntington Disease
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chorea associated with Huntington's Disease AND 2 - Prescribed by or in consultation with a neurologist AND 3 - Patient is 18 years of age or older	

AND

4 - Targeted mutation analysis demonstrates a cytosine-adenine-guanine (CAG) trinucleotide expansion of greater than or equal to 36 repeats in the huntingtin (HTT) gene

AND

5 - Patient has a Unified Huntington Disease Rating Scale (UHDRS) score ranging from 1 to 4 on any one of UHDRS chorea items 1 through 7

AND

6 - Austedo is not prescribed concurrently with tetrabenazine or Ingrezza

AND

7 - Dose does not exceed 48 mg per day

Notes	*Patients will be approved for ONE strength of Austedo/Austedo XR ONLY: Approve ALL requests at GPI-14. Confirm there is only 1 active PA on file for ALL Austedo products. End-date/Retire all other active P A's for Austedo products.

Product Name:Austedo*, Austedo XR*	
Diagnosis	Chorea Associated with Huntington Disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is responding positively to therapy as evidenced by a reduction in the baseline score of any one of the Unified Huntington Disease Rating Scale (UHDRS) chorea items 1 through 7	

AND 2 - Austedo is not prescribed concurrently with tetrabenazine or Ingrezza AND 3 - Dose does not exceed 48 mg per day	
Notes	*Patients will be approved for ONE strength of Austedo/Austedo XR ONLY: Approve ALL requests at GPI-14. Confirm there is only 1 active PA on file for ALL Austedo products. End-date/Retire all other active P A's for Austedo products.

2 . Revision History

Date	Notes
10/15/2024	Added note regarding only one strength of Austedo/Austedo XR can be approved at a time. No changes to clinical criteria.

Azole Antifungals



Prior Authorization Guideline

Guideline ID	GL-565280
Guideline Name	Azole Antifungals
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name: Brand Sporanox capsules, generic itraconazole capsules	
Diagnosis	Systemic Fungal Infections
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following 1.1 Diagnosis of ONE of the following:	

- Blastomycosis
- Histoplasmosis
- Aspergillosis

OR

1.2 BOTH of the following:

1.2.1 Diagnosis of coccidioidomycosis

AND

1.2.2 Patient has a history of failure, contraindication, intolerance, or resistance to fluconazole (generic Diflucan) as evidenced by submission of medical records or claims history

Product Name: Brand Sporanox capsules, generic itraconazole capsules	
Diagnosis	Onychomycosis Fingernails
Approval Length	2 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of fingernail onychomycosis confirmed by ONE of the following: • KOH (potassium hydroxide) test • Fungal culture • Nail biopsy AND 2 - Patient has a history of at least a 6-week trial resulting in therapeutic failure, contraindication, intolerance, or resistance to Terbinafine as evidenced by submission of medical records or claims history	

Product Name:Brand Sporanox capsules, generic itraconazole capsules	
Diagnosis	Onychomycosis Fingernails
Approval Length	2 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following: 1.1 Three months have elapsed since completion of initial therapy for fingernail onychomycosis AND 1.2 Documentation of positive clinical response to therapy	

Product Name:Brand Sporanox capsules, generic itraconazole capsules	
Diagnosis	Onychomycosis Toenails
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of toenail onychomycosis confirmed by ONE of the following: • KOH (potassium hydroxide) test • Fungal culture • Nail biopsy AND 2 - Patient has a history of at least a 12-week trial resulting in therapeutic failure,	

contraindication, intolerance, or resistance to Terbinafine as evidenced by submission of medical records or claims history

Product Name:Brand Sporanox capsules, generic itraconazole capsules	
Diagnosis	Onychomycosis Toenails
Approval Length	3 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following: 1.1 Nine months have elapsed since completion of initial therapy for toenail onychomycosis AND 1.2 Documentation of positive clinical response to therapy	

Product Name:Brand Sporanox oral solution, generic itraconazole oral solution	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following diagnoses: • Oropharyngeal candidiasis • Esophageal candidiasis	

Product Name:Brand Vfend tablets, generic voriconazole tablets	
Approval Length	12 month(s)

Guideline Type	Prior Authorization
	Approval Criteria 1 - ONE of the following: 1.1 Diagnosis of invasive aspergillosis including <i>Aspergillus fumigatus</i> OR 1.2 ALL of the following: • Diagnosis of Candidemia • Patient is non-neutropenic • Patient has a history of failure, contraindication, intolerance, or resistance to fluconazole (generic Diflucan) as evidenced by submission of medical records or claims history OR 1.3 BOTH of the following: 1.3.1 ONE of the following diagnoses: • Candida infection in the abdomen • Candida infection in the kidney • Candida infection in the bladder wall • Candida infection in wounds • Disseminated Candida infections in skin • Esophageal candidiasis AND 1.3.2 Patient has a history of failure, contraindication, intolerance, or resistance to fluconazole (generic Diflucan) as evidenced by submission of medical records or claims history OR

1.4 Diagnosis of *Scedosporium apiospermum* infection (asexual form of *Pseudallescheria boydii*)

OR

1.5 Diagnosis of *Fusarium* spp. infection including *Fusarium solani*

OR

1.6 Diagnosis of *Exserohilum* species infection

Product Name: Brand Vfend powder for oral suspension, generic voriconazole powder for oral suspension

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - BOTH of the following:

1.1 ONE of the following:

1.1.1 Diagnosis of invasive aspergillosis including *Aspergillus fumigatus*

OR

1.1.2 ALL of the following:

- Diagnosis of Candidemia
- Patient is non-neutropenic
- Patient has a history of failure, contraindication, intolerance, or resistance to fluconazole (generic Diflucan) as evidenced by submission of medical records or claims history

OR

1.1.3 ONE of the following diagnoses:

- Candida infection in the abdomen
- Candida infection in the kidney
- Candida infection in the bladder wall
- Candida infection in wounds
- Disseminated Candida infections in skin
- Esophageal candidiasis

OR

1.1.4 Diagnosis of *Scedosporium apiospermum* infection (asexual form of *Pseudallescheria boydii*)

OR

1.1.5 Diagnosis of *Fusarium* spp. infection including *Fusarium solani*

OR

1.1.6 Diagnosis of *Exserohilum* species infection

AND

1.2 Physician has provided rationale for the patient needing to use voriconazole oral suspension instead of voriconazole tablets

Product Name: Brand Noxafil tablets, generic posaconazole tablets	
Diagnosis	Prophylaxis of Systemic Fungal Infections
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria	

1 - BOTH of the following:

1.1 Used as prophylaxis of invasive fungal infections caused by ONE of the following:

- Aspergillus
- Candida

AND

1.2 ONE of the following conditions:

1.2.1 Patient is at high risk of infections due to severe immunosuppression from ONE of the following conditions:

- Hematopoietic stem cell transplant (HSCT) with graft-versus-host disease (GVHD)
- Hematologic malignancies with prolonged neutropenia from chemotherapy [eg, acute myeloid leukemia (AML), myelodysplastic syndromes (MDS)]

OR

1.2.2 Patient has a prior fungal infection requiring secondary prophylaxis

AND

2 - BOTH of the following:

- Patient is 2 years of age or older
- Patient weighs at least 40 kg

Product Name: Brand Noxafil oral suspension, generic posaconazole oral suspension, Noxafil suspension packets (PowderMix)

Diagnosis	Prophylaxis of Systemic Fungal Infections
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - BOTH of the following:

1.1 Used as prophylaxis of invasive fungal infections caused by ONE of the following:

- Aspergillus
- Candida

AND

1.2 ONE of the following conditions:

1.2.1 Patient is at high risk of infections due to severe immunosuppression from ONE of the following conditions:

- Hematopoietic stem cell transplant (HSCT) with graft-versus-host disease (GVHD)
- Hematologic malignancies with prolonged neutropenia from chemotherapy [eg, acute myeloid leukemia (AML), myelodysplastic syndromes (MDS)]

OR

1.2.2 Patient has a prior fungal infection requiring secondary prophylaxis

AND

2 - ONE of the following:

2.1 If the request is for Noxafil or posaconazole oral suspension, patient is 13 years of age or older

OR

2.2 If the request is for Noxafil suspension packets (Noxafil PowderMix), BOTH of the following:

- Patient is 2 years of age or older
- Patient weighs between 10 kg to 40 kg

Product Name:Brand Noxafil tablets, generic posaconazole tablets, Noxafil suspension packets (PowderMix)	
Diagnosis	Treatment of Systemic Fungal Infections
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of invasive aspergillosis AND 2 - Patient is 2 years of age or older AND 3 - ONE of the following: 3.1 If the request is for Noxafil or posaconazole oral tablets, patient weighs greater than 40 kg OR 3.2 If the request is for Noxafil suspension packets (Noxafil PowderMix), patient weighs between 10 kg to 40 kg	

Product Name:Brand Noxafil oral suspension, generic posaconazole oral suspension	
Diagnosis	Oropharyngeal Candidiasis (OPC)
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria	

1 - BOTH of the following:

1.1 Diagnosis of oropharyngeal candidiasis (OPC)

AND

1.2 The patient has a history of failure, contraindication, intolerance, or resistance to TWO of the following as evidenced by submission of medical records or claims history:

- Fluconazole* (generic Diflucan)
- Itraconazole* (generic Sporanox)
- Clotrimazole Lozenges*

AND

2 - Patient is 13 years of age or older

Notes

*Drug may require PA.

Product Name:Cresemba

Approval Length

3 month(s)

Guideline Type

Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 BOTH of the following:

1.1.1 Diagnosis of invasive aspergillosis

AND

1.1.2 Patient has a history of failure, contraindication, intolerance, or resistance to voriconazole* (generic Vfend) as evidenced by submission of medical records or claims history

OR	
1.2 Diagnosis of invasive mucormycosis	
AND	
2 - BOTH of the following: - Patient is 6 months of age or older - Patient weighs 16 kg or greater	
Notes	*Drug may require PA.

Product Name:Tolsura	
Approval Length	3 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following: 1.1 Diagnosis of ONE of the following fungal infections: - Blastomycosis - Histoplasmosis - Aspergillosis AND 1.2 Patient has a history of failure, contraindication, intolerance, or resistance to itraconazole* capsules (generic Sporanox) as evidenced by submission of medical records or claims history	
Notes	*Drug may require PA.

Product Name: Brand Sporanox capsules, generic itraconazole capsules, Brand Sporanox oral solution, generic itraconazole oral solution, Brand Vfend tablets, generic voriconazole tablets, Brand Vfend powder for oral suspension, generic voriconazole powder for oral suspension, Brand Noxafil tablets, generic posaconazole tablets, Brand Noxafil oral suspension, generic posaconazole oral suspension, Noxafil suspension packets (PowderMix), Cresemba, Tolsura	
Diagnosis	All Other Diagnoses
Guideline Type	Prior Authorization
Approval Criteria 1 - The use of this drug is supported by information from ONE of the following appropriate compendia of current literature: Food and Drug Administration approved indications and limits Published practice guidelines and treatment protocols Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes Drug Facts and Comparisons American Hospital Formulary Service Drug Information United States Pharmacopeia – Drug Information DRUGDEX Information System UpToDate MicroMedex Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies Other drug reference resources AND 2 - The medication is being prescribed by or in consultation with an infectious disease specialist	
Notes	Authorization duration based on provider recommended treatment durations, not to exceed 12 months.

2 . Revision History

Date	Notes

4/7/2026	Added generic posaconazole oral susp as a target, where applicable. Updated GPI tables and product name lists, where applicable. Updated criteria for all Noxafil/posaconazole products. New criteria added for Noxafil/posaconazole tabs and Noxafil PowderMix for tx of systemic fungal infections. Minor cosmetic updates.

Baclofen products (Fleqsuvy, Lyvispah, Ozobax, Ozobax DS)



Prior Authorization Guideline

Guideline ID	GL-228240
Guideline Name	Baclofen products (Fleqsuvy, Lyvispah, Ozobax, Ozobax DS)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2025

1 . Criteria

Product Name: Brand Fleqsuvy, generic baclofen suspension, Lyvispah, Brand Ozobax, generic baclofen oral solution, Ozobax DS, Brand Baclofen oral solution	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Trial and failure, or intolerance to baclofen tablets OR	

2 - Patient is unable to swallow oral tablets

2 . Revision History

Date	Notes
3/31/2025	Updated title. Added Brand/generic Fleqsuvy products as targets

Baxdela



Prior Authorization Guideline

Guideline ID	GL-140698
Guideline Name	Baxdela
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Baxdela	
Diagnosis	Community-Acquired Bacterial Pneumonia
Approval Length	10 Days*
Guideline Type	Prior Authorization
Approval Criteria 1 - For continuation of therapy upon hospital discharge	

OR

2 - As continuation of therapy when transitioning from intravenous antibiotics that are shown to be sensitive to the cultured organism for the requested indication

OR

3 - All of the following:

3.1 Diagnosis of community-acquired bacterial pneumonia (CABP)

AND

3.2 Infection caused by an organism that is confirmed to be or likely to be susceptible to treatment with Baxdela

AND

3.3 History of failure, contraindication, or intolerance to THREE of the following antibiotics or antibiotic regimens:

- Amoxicillin**
- A macrolide**
- Doxycycline**
- A fluoroquinolone**
- Combination therapy with amoxicillin/clavulanate or cephalosporin AND a macrolide or doxycycline

Notes	*Note: Authorization will be issued for up to 10 days. **Drug may require PA

Product Name:Baxdela	
Diagnosis	Acute Bacterial Skin and Skin Structure Infections
Approval Length	14 Days*
Guideline Type	Prior Authorization

Approval Criteria

1 - For continuation of therapy upon hospital discharge

OR

2 - As continuation of therapy when transitioning from intravenous antibiotics that are shown to be sensitive to the cultured organism for the requested indication

OR

3 - All of the following:

3.1 One of the following diagnoses:

3.1.1 Both of the following

3.1.1.1 Acute bacterial skin and skin structure infections

AND

3.1.1.2 Infection caused by methicillin-resistant *Staphylococcus aureus* (MRSA) documented by culture and sensitivity report

OR

3.1.2 Both of the following:

3.1.2.1 Empirical treatment of patients with acute bacterial skin and skin structure infections

AND

3.1.2.2 Presence of MRSA infection is likely

AND

3.2 History of failure, contraindication, or intolerance to linezolid (generic Zyvox)

AND

3.3 History of failure, contraindication, or intolerance to ONE of the following antibiotics:

- Sulfamethoxazole-trimethoprim (SMZ-TMP)**
- A tetracycline**
- Clindamycin**

OR

4 - All of the following:

4.1 Diagnosis of acute bacterial skin and skin structure infections

AND

4.2 Infection caused by an organism that is confirmed to be or likely to be susceptible to treatment with Baxdela

AND

4.3 History of failure, contraindication, or intolerance to THREE of the following antibiotics:

- A penicillin**
- A cephalosporin**
- A tetracycline**
- Sulfamethoxazole-trimethoprim (SMZ-TMP)**
- Clindamycin**

Notes

*Note: Authorization will be issued for up to 14 days.

**Drug may require PA

Product Name:Baxdela	
Diagnosis	Off-Label Uses*
Guideline Type	Prior Authorization
Approval Criteria 1 - For continuation of therapy upon hospital discharge OR 2 - As continuation of therapy when transitioning from intravenous antibiotics that are shown to be sensitive to the cultured organism for the requested indication	
Notes	*Note: Authorization duration based on provider recommended treatment durations, up to 6 months.

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Belbuca, Butrans



Prior Authorization Guideline

Guideline ID	GL-140760
Guideline Name	Belbuca, Butrans
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	1/1/2023

1 . Criteria

Product Name:Belbuca, Brand Butrans, generic buprenorphine patches*	
Diagnosis	Cancer/Hospice/End of Life related pain
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - The patient is being treated for cancer, hospice, or end of life related pain	

AND

2 - If the request is for Belbuca or generic buprenorphine patches, BOTH of the following:

2.1 Prescriber attests the information provided is true and accurate to the best of their knowledge and they understand that a routine audit may be performed; and medical information necessary to verify the accuracy of the information provided may be requested

AND

2.2 The patient has a history of failure, contraindication, or intolerance to BRAND Butrans

Notes	*If the patient is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. If the patient is currently taking the requested long-acting opioid for at least 30 days and has met the medical necessity authorization criteria requirements for treatment with an opioid, but has not tried brand buprenorphine patches a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. Additionally, a 12 month authorization should be entered for brand buprenorphine patches.

Product Name:Belbuca, Brand Butrans, generic buprenorphine patches	
Diagnosis	Cancer/Hospice/End of Life related pain
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - The patient is being treated for cancer, hospice, or end of life related pain (Document diagnosis and date of diagnosis)	

AND

2 - If the request is for Belbuca or generic buprenorphine patches **ONLY**: Prescriber attests the information provided is true and accurate to the best of their knowledge and they understand that a routine audit may be performed; and medical information necessary to verify the accuracy of the information provided may be requested

Product Name:Belbuca, Brand Butrans, generic buprenorphine patches*	
Diagnosis	Non-cancer pain/Non-hospice/Non-end of life care pain
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Prescriber attests to ALL of the following:

1.1 The information provided is true and accurate to the best of their knowledge and they understand that a routine audit may be performed; and medical information necessary to verify the accuracy of the information provided may be requested

AND

1.2 Treatment goals are defined, including estimated duration of treatment

AND

1.3 Treatment plan includes the use of a non-opioid analgesic and/or non-pharmacologic intervention

AND

1.4 Patient has been screened for substance abuse/opioid dependence

AND

1.5 If used in patients with medical comorbidities or if used concurrently with a benzodiazepine or other drugs that could potentially cause drug-drug interactions, the prescriber has acknowledged that they have completed an assessment of increased risk for respiratory depression

AND

1.6 Pain is moderate to severe and expected to persist for an extended period of time

AND

1.7 Pain is chronic

AND

1.8 Pain is not postoperative (unless the patient is already receiving chronic opioid therapy prior to surgery, or if the postoperative pain is expected to be moderate to severe and persist for an extended period of time)

AND

1.9 Pain management is required around the clock with a long-acting opioid

AND

2 - The patient has a history of failure, contraindication, or intolerance to a trial of tramadol IR (immediate release), unless the patient is already receiving chronic opioid therapy prior to surgery for postoperative pain, or if the postoperative pain is expected to be moderate to severe and persist for an extended period of time (Drug may require PA)

AND

3 - If the request is for neuropathic pain (examples of neuropathic pain include neuralgias, neuropathies, fibromyalgia), BOTH of the following must be met:

3.1 Unless it is contraindicated, the patient has not exhibited an adequate response to 8 weeks of treatment with gabapentin (Neurontin) or pregabalin (Lyrica) titrated to a therapeutic dose (document date of trial)

AND

3.2 Unless it is contraindicated, the patient has not exhibited an adequate response to at least 6 weeks of treatment with a tricyclic antidepressant titrated to the maximum tolerated dose (document drug and date of trial)

AND

4 - If the request is for Belbuca or generic Butrans, the patient has a history of failure, contraindication or intolerance to BRAND Butrans

Notes	*If the patient is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. If the patient is currently taking the requested long-acting opioid for at least 30 days and has met the medical necessity authorization criteria requirements for treatment with an opioid, but has not tried brand buprenorphine patches a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. Additionally, a 6 month authorization should be entered for brand buprenorphine patches.

Product Name: Belbuca, Brand Butrans, generic buprenorphine patches*	
Diagnosis	Non-cancer pain/Non-hospice/Non-end of life care pain
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates meaningful improvement in pain and function (document improvement in function or pain score improvement)

AND

2 - Identify rationale for not tapering and discontinuing opioid (document rationale)

AND

3 - Prescriber attests to ALL of the following:

3.1 The information provided is true and accurate to the best of their knowledge and they understand that a routine audit may be performed; and medical information necessary to verify the accuracy of the information provided may be requested

AND

3.2 Treatment goals are defined, including estimated duration of treatment

AND

3.3 Treatment plan includes the use of a non-opioid analgesic and/or non-pharmacologic intervention

AND

3.4 Patient has been screened for substance abuse/opioid dependence

AND

3.5 If used in patients with medical comorbidities or if used concurrently with a benzodiazepine or other drugs that could potentially cause drug-drug interactions, the prescriber has acknowledged that they have completed an assessment of increased risk for respiratory depression

AND

3.6 Pain is moderate to severe and expected to persist for an extended period of time

AND

3.7 Pain is chronic

AND

3.8 Pain is not postoperative (unless the patient is already receiving chronic opioid therapy prior to surgery, or if the postoperative pain is expected to be moderate to severe and persist for an extended period of time)

AND

3.9 Pain management is required around the clock with a long-acting opioid

AND

4 - If the request is for Belbuca or generic Butrans, the patient has a history of failure, contraindication, or intolerance to BRAND Butrans

Notes	*If the patient is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. If the patient is currently taking the requested long-acting opioid for at least 30 days and has met the medical necessity authorization criteria requirements for treatment with an opioid, but has not tried brand buprenorphine patches a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. Additionally, a 6 month authorization should be entered for brand buprenorphine patches.

Product Name: Belbuca, Brand Butrans, generic buprenorphine patches	
Guideline Type	Quantity Limit
Approval Criteria 1 - The requested dose cannot be achieved by moving to a higher strength of the product AND 2 - The requested dose is within the FDA (Food and Drug Administration) maximum dose per day, where an FDA maximum dose per day exists	
Notes	Approval durations: 12 months for cancer pain/hospice/end of life related pain; 6 months for non-cancer pain/non-hospice/non-end of life related pain

2 . Revision History

Date	Notes
12/12/2022	Updated prerequisite options for neuropathic/nerve pain in Non-cancer pain/Non-hospice/Non-end of life care pain initial auth section.

Benefit Determination Mifeprex



Prior Authorization Guideline

Guideline ID	GL-434343
Guideline Name	Benefit Determination Mifeprex
Formulary	Medicaid - Community & State Arizona Medicaid - Community & State Florida MMA Medicaid - Community & State Indiana Medicaid - Community & State Kansas Medicaid - Community & State Michigan Medicaid - Community & State Nebraska Medicaid - Community & State Pennsylvania Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Texas Medicaid - Community & State Virginia Medicaid - Community & State Nevada

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name: Brand Mifeprex, generic mifepristone	
Approval Length	1 month(s)

Guideline Type	Benefit Determination
Approval Criteria 1 - Provider attests patient requires treatment for purposes identified in the Hyde amendment and any applicable state laws and regulations AND 2 - Submission of all necessary state form(s) and/or certification document(s)	

2 . Revision History

Date	Notes
11/4/2025	Added Nevada Formulary

Benlysta



Prior Authorization Guideline

Guideline ID	GL-140941
Guideline Name	Benlysta
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	12/1/2022

1 . Criteria

Product Name: Benlysta SQ	
Diagnosis	Systemic Lupus Erythematosus
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of systemic lupus erythematosus	

AND

2 - Patient is 5 years of age or older

AND

3 - Laboratory testing has documented the presence of autoantibodies [e.g., ANA, Anti-dsDNA, Anti-Sm, Anti-Ro/SSA, Anti-La/SSB]

AND

4 - Patient is currently receiving standard immunosuppressive therapy [e.g., hydroxychloroquine, chloroquine, prednisone, azathioprine, methotrexate]

AND

5 - Patient does NOT have severe active central nervous system lupus

AND

6 - Patient is not receiving Benlysta in combination with a biologic DMARD (disease modifying anti-rheumatic drug) [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Kineret (anakinra)]

Product Name: Benlysta SQ	
Diagnosis	Active Lupus Nephritis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of active lupus nephritis

AND

2 - Patient is 5 years of age or older

AND

3 - Patient is currently receiving standard immunosuppressive therapy for systemic lupus erythematosus [e.g., hydroxychloroquine, chloroquine, prednisone, azathioprine, methotrexate]

AND

4 - Patient does NOT have severe active central nervous system lupus

AND

5 - Patient is not receiving Benlysta in combination with a biologic DMARD (disease modifying anti-rheumatic drug) [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Kineret (anakinra)]

Product Name:Benlysta SQ

Diagnosis	Systemic Lupus Erythematosus, Active Lupus Nephritis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Benlysta therapy

AND

2 - Patient is not receiving Benlysta in combination with a biologic DMARD (disease modifying anti-rheumatic drug) [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Kineret (anakinra)]

2 . Revision History

Date	Notes
10/24/2022	Updated age requirement.

Benznidazole



Prior Authorization Guideline

Guideline ID	GL-140632
Guideline Name	Benznidazole
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2020

1 . Criteria

Product Name: Benznidazole	
Diagnosis	Chagas disease (American trypanosomiasis)
Approval Length	60 Day(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Chagas disease (American trypanosomiasis) due to Trypanosoma cruzi	

2 . Revision History

Date	Notes
3/31/2020	Bulk Copy C&S New York to C&S Arizona for effective date of 5/1

Besremi



Prior Authorization Guideline

Guideline ID	GL-435256
Guideline Name	Besremi
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State New Jersey Medicaid - Community & State New York Medicaid - Community & State New York EPP Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Arizona Medicaid - Community & State Nevada Medicaid - Community & State Virginia Medicaid - Community & State Washington Medicaid - Community & State Indiana Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Besremi	
Diagnosis	Polycythemia Vera
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of polycythemia vera	

Product Name:Besremi	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	

Product Name:Besremi	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Besremi therapy	

2 . Revision History

Date	Notes
11/4/2025	Combined formularies - added AZ, NV, VA, WA, IN, NM. No clinical changes.

Biltricide



Prior Authorization Guideline

Guideline ID	GL-434344
Guideline Name	Biltricide
Formulary	Medicaid - Community & State Arizona Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Indiana Medicaid - Community & State Maryland Medicaid - Community & State New Jersey Medicaid - Community & State New Mexico Medicaid - Community & State New York Medicaid - Community & State New York EPP Medicaid - Community & State Pennsylvania Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Virginia Medicaid - Community & State Washington Medicaid - Community & State Nevada

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Biltricide, generic praziquantel	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Infections due to schistosoma OR 1.2 Infections due to the liver trematodes (flukes), Clonorchis sinensis/Opisthorchis viverrini (i.e., clonorchiasis or opisthorchiasis)	

2 . Revision History

Date	Notes
11/4/2025	Added Nevada Formulary

Bimzelx (bimekizumab-bkzx)



Prior Authorization Guideline

Guideline ID	GL-605188
Guideline Name	Bimzelx (bimekizumab-bkzx)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Bimzelx	
Diagnosis	Plaque Psoriasis (PsO)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming ALL of the following:	

1.1 Diagnosis of moderate to severe plaque psoriasis (PsO)

AND

1.2 ONE of the following:

- At least 3% body surface area (BSA) involvement
- Severe scalp psoriasis
- Palmoplantar (i.e., palms, soles), facial, or genital involvement

AND

1.3 Minimum duration of a 4-week trial and failure, contraindication, or intolerance to ONE of the following topical therapies:

- corticosteroids (e.g., betamethasone, clobetasol)
- vitamin D analogs (e.g., calcitriol, calcipotriene)
- tazarotene
- calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)

AND

1.4 History of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

1.5 History of failure, contraindication, or intolerance to ONE of the following topical therapies:

- Vtama
- Zoryve 0.3% cream

AND

1.6 History of failure, contraindication, or intolerance to ALL of the following:

• A preferred^ adalimumab biosimilar or Enbrel (etanercept) • infliximab • Otezla (apremilast) • A preferred^ ustekinumab biosimilar AND 2 - Prescribed by or in consultation with a dermatologist	
Notes	^PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:Bimzelx	
Diagnosis	Plaque Psoriasis (PsO)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming positive clinical response to therapy as evidenced by ONE of the following: • Reduction in the body surface area (BSA) involvement from baseline • Improvement in symptoms (e.g., pruritus, inflammation) from baseline AND 2 - Prescribed by or in consultation with a dermatologist	

Product Name:Bimzelx	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) or verification of paid claims documenting ALL of the following: 1.1 Diagnosis of active psoriatic arthritis (PsA) AND 1.2 History of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced AND 1.3 History of failure, contraindication, or intolerance to ALL of the following: • A preferred^ adalimumab biosimilar or Enbrel (etanercept) • infliximab • Orencia (abatacept) • Otezla (apremilast) • Xeljanz (tofacitinib) oral tablet (IR or XR) • A preferred^ ustekinumab biosimilar AND 2 - Prescribed by or in consultation with ONE of the following: • Dermatologist • Rheumatologist	
Notes	^PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name: Bimzelx

Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming positive clinical response to therapy as evidenced by ONE of the following: • Reduction in the total active (swollen and tender) joint count from baseline • Improvement in symptoms (e.g., pain, stiffness, pruritus, inflammation) from baseline • Reduction in the body surface area (BSA) involvement from baseline AND 2 - Prescribed by or in consultation with ONE of the following: • Dermatologist • Rheumatologist	

Product Name:Bimzelx	
Diagnosis	Non-radiographic Axial Spondyloarthritis (nr-axSpA)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) or verification of paid claims documenting ALL of the following: 1.1 Diagnosis of active non-radiographic axial spondyloarthritis (nr-axSpA)	

AND

1.2 Patient has objective signs of inflammation (e.g., C-reactive protein [CRP] levels above the upper limit of normal and/or sacroiliitis on magnetic resonance imaging [MRI], indicative of inflammatory disease, but without definitive radiographic evidence of structural damage on sacroiliac joints)

AND

1.3 History of a minimum duration of one month trial, contraindication, or intolerance to TWO different nonsteroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen, naproxen) at maximally tolerated doses

AND

1.4 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred^ adalimumab biosimilar or Enbrel (etanercept)
- infliximab
- Xeljanz (tofacitinib) oral tablet (IR or XR)

AND

2 - Prescribed by or in consultation with a rheumatologist

Notes	^PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC CP

Product Name:Bimzelx	
Diagnosis	Non-radiographic Axial Spondyloarthritis (nr-axSpA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming positive clinical response to therapy as evidenced by improvement from baseline for at least ONE of the following:

- Disease activity (e.g., pain, fatigue, inflammation, stiffness)
- Function
- Lab values (erythrocyte sedimentation rate, C-reactive protein level)
- Axial status (e.g., lumbar spine motion, chest expansion)
- Total active (swollen and tender) joint count

AND

2 - Prescribed by or in consultation with a rheumatologist

Product Name:Bimzelx	
Diagnosis	Ankylosing Spondylitis (AS)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) or verification of paid claims documenting ALL of the following: 1.1 Diagnosis of active ankylosing spondylitis (AS) AND 1.2 History of a minimum duration of one month trial, contraindication, or intolerance to TWO different nonsteroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen, naproxen) at maximally tolerated doses	

AND

1.3 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred^ adalimumab biosimilar or Enbrel (etanercept)
- infliximab
- Xeljanz (tofacitinib) oral tablet (IR or XR)

AND

2 - Prescribed by or in consultation with a rheumatologist

Notes	^PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:Bimzelx	
Diagnosis	Ankylosing Spondylitis (AS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming positive clinical response to therapy as evidenced by improvement from baseline for at least ONE of the following: • Disease activity (e.g., pain, fatigue, inflammation, stiffness) • Function • Lab values (erythrocyte sedimentation rate, C-reactive protein level) • Axial status (e.g., lumbar spine motion, chest expansion) • Total active (swollen and tender) joint count AND 2 - Prescribed by or in consultation with a rheumatologist	

Product Name:Bimzelx	
Diagnosis	Hidradenitis Suppurativa (HS)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of moderate to severe hidradenitis suppurativa (HS) (i.e., Hurley Stage II or III) AND 2 - Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure, contraindication, or intolerance to a preferred^ adalimumab biosimilar AND 3 - Prescribed by or in consultation with a dermatologist	
Notes	^PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:Bimzelx	
Diagnosis	Hidradenitis Suppurativa (HS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Submission of medical records (e.g., chart notes) confirming positive clinical response to therapy as evidenced by at least ONE of the following:

- Reduction in the abscess and inflammatory nodule count from baseline
- Reduced formation of new sinus tracts and scarring
- Improvement in symptoms (e.g., pain, suppuration) from baseline

AND

2 - Prescribed by or in consultation with a dermatologist

2 . Revision History

Date	Notes
5/6/2026	For nr-AxSpA (initial auth section), added embedded step requirement and updated notes section to include PDL link.

Blood Glucose Monitors



Prior Authorization Guideline

Guideline ID	GL-140734
Guideline Name	Blood Glucose Monitors
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Non-preferred Blood Glucose Monitors*	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is visually impaired	
Notes	*Please reference background table for list of Non-preferred Blood Glucose Monitors. *Approve Glucose Monitor at NDC Level.

2 . Background

Benefit/Coverage/Program Information			
Non-preferred Blood Glucose Monitors			
CONTOUR KIT NEXT LNK	EASY TOUCH KIT MONITOR	EASYMAX V KIT SYSTEM	
CONTOUR NXT KIT LINK 2.4	KROGER BGM KIT SYSTEM	EASYMAX NG KIT SYSTEM	
CONTOUR KIT NEXT EZ	ELEMENT AUTO KIT SYSTEM	MEIJER BGM KIT ESSENTIA	
CONTOUR KIT NEXT	SMARTEST KIT EJECT	MEIJER GLUCO KIT MONITOR	
CONTOUR KIT MONITOR	SMARTEST KIT PROTEGE	MEIJER BGM KIT PREMIUM	
RELION MICRO KIT	SMARTEST KIT PRONTO	FORA V30A KIT	
RELION KIT MONITOR	SMARTEST KIT PERSONA	FORA TN'G KIT VOICE	
BD LOGIC KIT MONITOR	GLUCOCOM KIT MONITOR	REFUAH PLUS KIT SYSTEM	
BD LATITUDE KIT	RIGHTEST SYS KIT GM300	KROGER BGM KIT	
BD LATITUDE KIT SYSTEM	RIGHTEST SYS KIT GM100	KROGER BGM KIT PREMIUM	
QUICKTEK KIT	RIGHTEST SYS KIT GM550	CONTOUR KIT LINK 2.4	
ADVANCE KIT INTUITIO	IGLUCOSE KIT	EASYMAX V KIT SYSTEM	
GLUCOCARD KIT SHNE CON	NOVA MAX KIT SYSTEM	EASYMAX NG KIT SYSTEM	

GLUCOCARD KIT SHNE EXP	WAVESENSE KIT KEYNOTE	MYGLUCOHEALT KIT SYSTEM
GLUCOCARD KIT EXPRESSI	AGAMA JAZZ KIT WRLSS 2	MICRODOT KIT SYSTEM
POCKETCHEM KIT EZ	AGAMATRIX KIT PRESTO	ONE TOUCH KIT VERIO FL
GLUCOCARD 01 KIT SYSTEM	WAVESENSE KIT AMP	RELION TRUE KIT MET AIR
GLUCOCARD 01 KIT MINI	SOLUS V2 KIT SYSTEM	VERASENS KIT
GLUCOCARD KIT X- METER	COOL MONITOR KIT	INFINITY KIT VOICE
GLUCOCARD KIT VITAL	TRUERESULT KIT MONITOR	OPTIUM KIT BL GLUC
RELION PREMI KIT COMP SYS	TRUERESULT KIT SYSTEM	PRECISION KIT XTRA
SMART SENSE KIT GLUC SYS	MEIJER BGM KIT ESSENTIA	PRECISION KIT LINK
CVS GLUCOSE KIT METER	MEIJER GLUCO KIT MONITOR	BIOTEL CARE KIT SYSTEM
INFINITY KIT SYSTEM	MEIJER BGM KIT PREMIUM	BIOTEL CARE KIT
EASYPRO KIT MONITOR	FORA V30A KIT	FREESTYLE KIT SIDEKICK
EASYPRO PLUS KIT	FORA TN'G KIT VOICE	FREESTYLE KIT FREEDOM
PRODIGY PCKT KIT METER	REFUAH PLUS KIT SYSTEM	KROGER BGM KIT PREMIUM
PRODIGY AUTO KIT MONITOR	KROGER BGM KIT	CONTOUR KIT LINK 2.4
PRODIGY VOIC KIT METER		
PRODIGY KIT NO CODIN		

3 . Revision History

Date	Notes
8/26/2022	C&S to match AZM 10.1.22

Blujepa (gepotidacin)



Prior Authorization Guideline

Guideline ID	GL-534288
Guideline Name	Blujepa (gepotidacin)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Blujepa	
Diagnosis	Uncomplicated Urinary Tract Infection (uUTI)
Approval Length	5 Day(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of an uncomplicated urinary tract infection (uUTI)	

AND

2 - Patient is 12 years of age or older

AND

3 - Patient weighs at least 40 kg (kilograms)

AND

4 - Trial and inadequate response, contraindication, or resistance to one alternative oral antibacterial treatment option (e.g., nitrofurantoin, trimethoprim-sulfamethoxazole, ciprofloxacin)

AND

5 - Infection is caused by ONE of the following:

- Escherichia coli
- Klebsiella pneumoniae
- Citrobacter freundii complex
- Staphylococcus saprophyticus
- Enterococcus faecalis

Product Name:Blujepa	
Diagnosis	Uncomplicated Urogenital Gonorrhea
Approval Length	3 Day(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of uncomplicated urogenital gonorrhea susceptible to gepotidacin	

AND

2 - Patient is 12 years of age or older

AND

3 - Patient weighs at least 45 kg (kilograms)

AND

4 - Trial and inadequate response, contraindication, or resistance to one alternative antibacterial treatment option (e.g., IM ceftriaxone, oral azithromycin)

2 . Revision History

Date	Notes
3/2/2026	Update to criteria section for uUTI. Added new criteria for uncomplicated urogenital gonorrhea.

Bonjesta and Diclegis



Prior Authorization Guideline

Guideline ID	GL-140634
Guideline Name	Bonjesta and Diclegis
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2020

1 . Criteria

Product Name:Bonjesta, Brand Diclegis, generic doxylamine/pyridoxine	
Diagnosis	Nausea and vomiting associated with pregnancy
Approval Length	9 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of nausea and vomiting associated with pregnancy	

AND

2 - Documented failure or contraindication to lifestyle modifications (e.g., diet, avoidance of triggers)

AND

3 - Documented trial and failure or contraindication to a five day trial of over-the-counter doxylamine taken together with pyridoxine (i.e., not a combined dosage form, but separate formulations taken concomitantly)

2 . Revision History

Date	Notes
3/31/2020	Bulk Copy C&S New York to C&S Arizona for effective date of 5/1

Breast Cancer



Prior Authorization Guideline

Guideline ID	GL-140709
Guideline Name	Breast Cancer
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name: Brand Arimidex, generic anastrozole	
Diagnosis	Breast Cancer
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Adjuvant treatment of postmenopausal patients with hormone receptor-positive early breast cancer	

OR

1.2 First-line treatment of postmenopausal patients with hormone receptor-positive or hormone receptor status unknown locally advanced or metastatic breast cancer

OR

1.3 Postmenopausal patients with disease progression following tamoxifen therapy

Product Name:Brand Aromasin, generic exemestane	
Diagnosis	Breast Cancer
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Adjuvant treatment of postmenopausal patients with estrogen receptor-positive early breast cancer who have received 2 to 3 years of tamoxifen and are switched to exemestane for completion of a total of 5 consecutive years of adjuvant hormonal therapy OR 1.2 Treatment of advanced breast cancer in postmenopausal patients whose disease has progressed following tamoxifen therapy	

Product Name:Brand Fareston, generic toremifene	
Diagnosis	Breast Cancer
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Treatment of metastatic breast cancer in postmenopausal patients with estrogen receptor positive tumors or with tumors of unknown estrogen receptor status

Product Name: Brand Arimidex, generic anastrozole, Brand Aromasin, generic exemestane, Brand Fareston, generic toremifene

Diagnosis	National Comprehensive Cancer Network (NCCN) Recommended Regimens

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Use supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1, 2A, or 2B.

Product Name: Brand Arimidex, generic anastrozole, Brand Aromasin, generic exemestane, Brand Fareston, generic toremifene

Diagnosis	National Comprehensive Cancer Network (NCCN) Recommended Regimens

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

2 . Revision History

UnitedHealthcare Community Plan of Arizona Clinical Pharmacy Program Guidelines

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Brexafemme



Prior Authorization Guideline

Guideline ID	GL-140768
Guideline Name	Brexafemme
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	3/1/2023

1 . Criteria

Product Name: Brexafemme	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Requested drug is being used for a Food and Drug Administration (FDA)-approved indication AND	

2 - Trial and failure, contraindication, or intolerance to BOTH of the following:

- One intravaginal product (e.g., clotrimazole, miconazole, tioconazole, terconazole, boric acid)
- Oral fluconazole for a minimum of 3 days duration

2 . Revision History

Date	Notes
2/3/2023	Updated all criteria and approval duration.

Breztri, Trelegy Ellipta



Prior Authorization Guideline

Guideline ID	GL-397212
Guideline Name	Breztri, Trelegy Ellipta
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2025

1 . Criteria

Product Name:Trelegy Ellipta	
Diagnosis	Asthma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of asthma	

AND

2 - History of failure, contraindication, or intolerance to treatment with ALL of the following preferred products:

- Wixela Inhub, generic fluticasone-salmeterol diskus, or Advair HFA
- Dulera
- generic budesonide-formoterol (generic for Symbicort)

Product Name:Trelegy Ellipta	
Diagnosis	Asthma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy	

Product Name:Breztri, Trelegy Ellipta	
Diagnosis	COPD
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chronic obstructive pulmonary disease (COPD), including chronic bronchitis and/or emphysema	

AND

2 - History of failure, contraindication, or intolerance to treatment with at least a 30 day trial of BOTH of the following used in combination:

- Stiolto Respimat (tiotropium-olodaterol)
- Brand Flovent HFA or generic fluticasone propionate

Product Name: Breztri, Trelegy Ellipta	
Diagnosis	COPD
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy	

2 . Revision History

Date	Notes
9/15/2025	Updated prerequisites in initial authorization section for all target drugs.

Brinsupri (brensocatib)



Prior Authorization Guideline

Guideline ID	GL-449198
Guideline Name	Brinsupri (brensocatib)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	12/1/2025

1 . Criteria

Product Name:Brinsupri	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following: 1.1 Diagnosis of non-cystic fibrosis bronchiectasis (NCFB)	

AND

1.2 Diagnosis has been confirmed by computed tomographic (CT) scan

AND

2 - Diagnostic testing confirms patient does NOT have cystic fibrosis

AND

3 - Submission of medical records (e.g., chart notes) confirming patient has a clinical history consistent with non-cystic fibrosis bronchiectasis (e.g., chronic cough or sputum production or recurrent respiratory tract infections)

AND

4 - Patient is 12 years of age or older

AND

5 - ONE of the following:

5.1 If patient is 12 to 17 years of age, patient has had at least one (1) documented pulmonary exacerbation requiring treatment with systemic antibiotics in the previous 12 months

OR

5.2 If patient is 18 years of age or older, patient has had at least two (2) documented pulmonary exacerbations requiring treatment with systemic antibiotics in the previous 12 months

AND

6 - ONE of the following:

6.1 For patients with co-existing COPD, submission of medical records (e.g., chart notes) or paid claims documenting that the patient is receiving ONE of the following therapies:

- Triple therapy (i.e., an inhaled corticosteroid [ICS] [e.g., budesonide], a long-acting muscarinic antagonist [LAMA] [e.g., tiotropium, umeclidinium], and a long-acting beta agonist [LABA] [e.g., salmeterol, arformoterol, formoterol])
- If ICS are contraindicated, a LAMA and a LABA

OR

6.2 For patients with co-existing asthma, submission of medical records (e.g., chart notes) or paid claims documenting that the patient is currently being treated with ONE of the following unless there is a contraindication or intolerance to these medications:

6.2.1 BOTH of the following:

- Inhaled corticosteroid (ICS) (e.g., fluticasone propionate)
- Additional asthma controller medication (e.g., leukotriene receptor antagonist [LTRA] [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], long-acting muscarinic antagonist [LAMA] [e.g., tiotropium])

OR

6.2.2 One combination ICS/LABA product (e.g., Advair, Breo Ellipta)

AND

7 - Prescribed by or in consultation with a pulmonologist

Product Name:Brinsupri	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Patient demonstrates positive clinical response to therapy (e.g., stabilization or reduction in number of pulmonary exacerbations)

2 . Revision History

Date	Notes
11/11/2025	New program for ACUAZ/ACUAZEC.

Bronchitol



Prior Authorization Guideline

Guideline ID	GL-434346
Guideline Name	Bronchitol
Formulary	Medicaid - Community & State Arizona Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Indiana Medicaid - Community & State Maryland Medicaid - Community & State New Jersey Medicaid - Community & State New Mexico Medicaid - Community & State New York Medicaid - Community & State New York EPP Medicaid - Community & State Pennsylvania Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Virginia Medicaid - Community & State Nevada

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Bronchitol	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of cystic fibrosis (CF) AND 2 - Used in conjunction with standard CF therapies [e.g., chest physiotherapy, bronchodilators, antibiotics, anti-inflammatory therapy (e.g., ibuprofen, oral/inhaled corticosteroids)] AND 3 - Patient has passed the Bronchitol Tolerance Test	

Product Name:Bronchitol	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Bronchitol therapy	

2 . Revision History

Date	Notes

11/4/2025	Added Nevada Formulary, - LKC

Buprenorphine Sublingual Tablet



Prior Authorization Guideline

Guideline ID	GL-502188
Guideline Name	Buprenorphine Sublingual Tablet
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:buprenorphine SL tablets	
Approval Length	6 Months*
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of opioid abuse/dependence AND	

2 - ONE of the following:

2.1 Patient is pregnant or breastfeeding*

OR

2.2 BOTH of the following:

2.2.1 Patient had an intolerance or side effect to generic buprenorphine-naloxone sublingual tablet or brand Suboxone film

AND

2.2.2 Side effects or intolerances to generic buprenorphine-naloxone sublingual tablet or brand Suboxone films were not resolved with a trial of anti-emetics (e.g., ondansetron) or non-opioid analgesics

OR

2.3 Patient has a contraindication to naloxone

OR

2.4 BOTH of the following:

2.4.1 Patient has a severe allergy to naloxone [e.g., Stevens-Johnson syndrome, DRESS (Drug Rash with Eosinophilia and Systemic Symptoms)]

AND

2.4.2 Provider has submitted a copy of the MedWatch Form 3500 to the Food and Drug Administration documenting the adverse reaction

AND

3 - Patient is not currently on ANY of the following:

- Benzodiazepines (e.g., Alprazolam, Diazepam, Lorazepam)
- Hypnotics (e.g., Temazepam, Rozerem, Zolpidem)
- Opioids (e.g., Oxycodone, Tramadol, Hydrocodone)

AND

4 - Prescriber attests that the Arizona State Board of Pharmacy Controlled Substance Prescription Drug Monitoring Program database has been reviewed and that patient has been warned about the dangers of ingesting concurrent sedating medications

Notes	*Approve for 1 year if pregnant or breastfeeding

2 . Revision History

Date	Notes
1/14/2026	Specified Brand Suboxone film and generic buprenorphine-naloxone SL tablets are the preferred prerequisites

Bylvay (odevixibat)



Prior Authorization Guideline

Guideline ID	GL-451221
Guideline Name	Bylvay (odevixibat)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	12/1/2025

1 . Criteria

Product Name:Bylvay	
Diagnosis	Progressive Familial Intrahepatic Cholestasis (PFIC)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming a molecular diagnosis of progressive familial intrahepatic cholestasis (PFIC)	

AND

2 - Patient does NOT have a ABCB11 variant resulting in non-functional or complete absence of bile salt export pump protein (BSEP-3)

AND

3 - Patient is experiencing BOTH of the following:

- Moderate to severe pruritus
- Patient has a serum bile acid concentration above the upper limit of the normal reference for the reporting laboratory

AND

4 - Patient is 3 months of age or older

AND

5 - Patient has had an inadequate response to at least TWO of the following treatments used for the relief of pruritus:

- Ursodeoxycholic acid (e.g., Ursodiol)
- Antihistamines (e.g., diphenhydramine, hydroxyzine)
- Rifampin
- Bile acid sequestrants (e.g., Questran, Colestid, Welchol)

AND

6 - Prescribed dose is consistent with FDA (Food and Drug Administration)-approved package labeling and does not exceed a total daily dose of 6 mg (milligrams)

AND

7 - Prescribed by or in consultation with a hepatologist or gastroenterologist

Product Name:Bylvay	
Diagnosis	Progressive Familial Intrahepatic Cholestasis (PFIC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy (e.g., reduced serum bile acids, improved pruritus) AND 2 - Prescribed dose is consistent with FDA-approved package labeling and does not exceed a total daily dose of 6 mg	

Product Name:Bylvay	
Diagnosis	Alagille Syndrome (ALGS)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming both of the following: 1.1 Diagnosis of Alagille Syndrome (ALGS) AND 1.2 Molecular genetic testing confirms mutations in the JAG1 or NOTCH2 gene	

AND

2 - Patient is experiencing BOTH of the following:

- Moderate to severe pruritus
- Patient has a serum bile acid concentration above the upper limit of the normal reference for the reporting laboratory

AND

3 - Patient is 12 months of age or older

AND

4 - Patient has had an inadequate response to at least TWO of the following treatments used for the relief of pruritus:

- Ursodeoxycholic acid (e.g., Ursodiol)
- Antihistamines (e.g., diphenhydramine, hydroxyzine)
- Rifampin
- Bile acid sequestrants (e.g., Questran, Colestid, Welchol)

AND

5 - Prescribed by or in consultation with a hepatologist or gastroenterologist

Product Name:Bylvay	
Diagnosis	Alagille Syndrome (ALGS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Documentation of positive clinical response to therapy (e.g., reduced bile acids, reduced pruritus severity score)

2 . Revision History

Date	Notes
11/12/2025	Updated diagnostic criteria for PFIC

Cablivi



Prior Authorization Guideline

Guideline ID	GL-518206
Guideline Name	Cablivi
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name:Cablivi	
Approval Length	2 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is 12 years of age or older	

AND

2 - Diagnosis of acquired thrombotic thrombocytopenic purpura (aTTP)

AND

3 - Cablivi was initiated in the inpatient setting in combination with plasma exchange therapy

AND

4 - Cablivi will be used in combination with immunosuppressive therapy (e.g., corticosteroids)

AND

5 - Total treatment duration will be limited to 58 days beyond the last therapeutic plasma exchange

Product Name:Cablivi	
Approval Length	2 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Request is for a new (different) episode requiring the re-initiation of plasma exchange for the treatment of acquired thrombotic thrombocytopenic purpura (aTTP) (Documentation of date of prior episode and documentation date of new episode required) AND 2 - Patient is 12 years of age or older	

2 . Revision History

Date	Notes
2/10/2026	Added age criteria. Aligned with AZM

Cabotegravir Containing Agents



Prior Authorization Guideline

Guideline ID	GL-565276
Guideline Name	Cabotegravir Containing Agents
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:Vocabria	
Diagnosis	Treatment of HIV-1 Infection
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ALL of the following: 1.1 Diagnosis of HIV (human immunodeficiency virus)-1 infection	

AND

1.2 Patient is 12 years of age or older

AND

1.3 Patient's weight is greater than or equal to 35 kilograms

AND

1.4 Patient is currently virologically suppressed [HIV-1 RNA (ribonucleic acid) less than 50 copies/milliliter] on a stable, uninterrupted antiretroviral regimen for at least 6 months

AND

1.5 Patient has no history of treatment failure or known/suspected resistance to either cabotegravir or rilpivirine

AND

1.6 Provider attests that patient would benefit from long-acting injectable therapy over standard oral regimens

AND

1.7 Prescribed by or in consultation with a clinician with HIV expertise

OR

2 - For continuation of prior therapy

Product Name:Vocabria

Diagnosis	HIV-1 Pre-Exposure Prophylaxis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Requested drug is being used for pre-exposure prophylaxis (PrEP) to reduce the risk of sexually acquired HIV (human immunodeficiency virus)-1 infection AND 2 - Patient's weight is greater than or equal to 35 kilograms AND 3 - BOTH of the following: 3.1 Patient has a negative HIV-1 test AND 3.2 Provider confirms that the patient will be tested for HIV-1 infection with each subsequent injection AND 4 - ONE of the following: 4.1 Trial and failure, contraindication or intolerance to BOTH of the following: • emtricitabine-tenofovir (generic Truvada) • Descovy	

OR

4.2 Submission of medical records (e.g., chart notes) from provider documenting BOTH of the following:

- Patient would benefit from long-acting injectable therapy over standard oral regimens
- Patient would be adherent to testing and dosing schedule

Product Name:Vocabria	
Diagnosis	HIV-1 Pre-Exposure Prophylaxis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Provider attests that patient is adherent to the testing appointments and scheduled injections of Apretude AND 2 - BOTH of the following: 2.1 Patient has a negative HIV-1 test AND 2.2 Provider confirms that the patient will be tested for HIV-1 infection with each subsequent injection	

2 . Revision History

UnitedHealthcare Community Plan of Arizona Clinical Pharmacy Program Guidelines

Date	Notes
4/6/2026	Updated HIV testing requirements in both initial and reauth sections f or HIV-1 pre-exposure prophylaxis. Minor cosmetic updates.

Camzyos (mavacamten)



Prior Authorization Guideline

Guideline ID	GL-140937
Guideline Name	Camzyos (mavacamten)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	12/1/2022

1 . Criteria

Product Name:Camzyos	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of obstructive hypertrophic cardiomyopathy (HCM)	

AND

2 - Patient has New York Heart Association (NYHA) Class II or III symptoms (e.g., shortness of breath, chest pain)

AND

3 - Patient has a left ventricular ejection fraction of greater than or equal to 55%

AND

4 - Patient has valsalva left ventricular outflow tract (LVOT) peak gradient greater than or equal to 50 mmHg at rest or with provocation

AND

5 - Trial and failure, contraindication, or intolerance to both of the following at a maximally tolerated dose:

- non-vasodilating beta blocker (e.g., bisoprolol, propranolol)
- calcium channel blocker (e.g., verapamil, diltiazem)

AND

6 - Prescribed by or in consultation with a cardiologist

Product Name:Camzyos	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Documentation of positive clinical response to therapy (e.g., improved symptom relief)

AND

2 - Patient has a left ventricular ejection fraction of greater than or equal to 50%

AND

3 - Prescribed by or in consultation with a cardiologist

2 . Revision History

Date	Notes
10/21/2022	New GL

Carbaglu (carglumic acid)



Prior Authorization Guideline

Guideline ID	GL-140887
Guideline Name	Carbaglu (carglumic acid)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name: Brand Carbaglu, Generic carglumic acid	
Diagnosis	Acute Hyperammonemia due to N-acetylglutamate Synthase (NAGS) Deficiency
Approval Length	3 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of acute hyperammonemia due to N-acetylglutamate synthase (NAGS) deficiency	

AND

2 - Medication will be used as adjunctive therapy to other ammonia lowering therapies (e.g., protein restriction, ammonia scavengers, dialysis)

AND

3 - Prescribed by or in consultation with a specialist focused in the treatment of metabolic disorders

Product Name: Brand Carbaglu, Generic carglumic acid

Diagnosis	Acute Hyperammonemia due to Propionic Acidemia (PA) or Methylmalonic Acidemia (MMA)
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of acute hyperammonemia due to propionic acidemia (PA) or methylmalonic acidemia (MMA)

AND

2 - Medication will be used as adjunctive therapy to other ammonia lowering therapies (e.g. intravenous glucose, insulin, protein restriction, dialysis)

AND

3 - Patient's plasma ammonia level is greater than or equal to 50 micromol/L

AND

4 - Medication will be used for a maximum duration of 7 days

AND

5 - Prescribed by or in consultation with a specialist focused in the treatment of metabolic disorders

Product Name:Brand Carbaglu, Generic carglumic acid

Diagnosis	Chronic Hyperammonemia due to N-acetylglutamate Synthase (NAGS) Deficiency

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of chronic hyperammonemia due to N-acetylglutamate synthase (NAGS) deficiency

AND

2 - NAGS deficiency has been confirmed by genetic/mutational analysis

AND

3 - Medication will be used as maintenance therapy

AND

4 - Prescribed by or in consultation with a specialist focused in the treatment of metabolic disorders

Product Name:Brand Carbaglu, Generic carglumic acid	
Diagnosis	Chronic Hyperammonemia due to N-acetylglutamate Synthase (NAGS) Deficiency
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting a positive clinical response to therapy (e.g., plasma ammonia level within the normal range)	

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Casgevy (exagamglogene autotemcel)



Prior Authorization Guideline

Guideline ID	GL-502270
Guideline Name	Casgevy (exagamglogene autotemcel)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Casgevy	
Diagnosis	Sickle Cell Disease (SCD)
Approval Length	1 Time Authorization in Lifetime*
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records including but not limited to laboratory and genetic testing to confirm sickle cell disease (SCD)	

AND

2 - Patient is 12 years of age or older

AND

3 - Provider attests that patient is clinically stable and eligible to undergo hematopoietic stem cell transplant (HSCT)

AND

4 - Provider attests the patient has experienced recurrent vaso-occlusive crises (VOCs) defined as two or more documented VOCs per year in the previous 24 months:

- Acute pain event requiring a visit to a medical facility and administration of pain medications (opioids or intravenous [IV] non-steroidal anti-inflammatory drugs [NSAIDs]) or red blood cell (RBC) transfusions
- Acute chest syndrome
- Priapism lasting greater than 2 hours and requiring a visit to a medical facility
- Splenic or hepatic sequestration

AND

5 - Submission of medical records (e.g., chart notes) confirming patient has obtained a negative test result for ALL of the following prior to cell collection:

- Hepatitis B virus (HBV)
- Hepatitis C virus (HCV)
- Human immunodeficiency virus (HIV)

AND

6 - Provider attests the patient is clinically stable and fit for transplantation

AND

7 - BOTH of the following:

7.1 Patient has never received any previous sickle cell gene therapy treatment in their lifetime (i.e., Casgevy, Lyfgenia)

AND

7.2 Patient has never received prior allogeneic transplant

AND

8 - Prescribed by a provider at a SCD treatment center with expertise in gene therapy

AND

9 - Prescribed by ONE of the following:

- Hematologist/Oncologist
- Specialist with expertise in the diagnosis and management of sickle cell disease

Notes	*Per prescribing information, Casgevy is for one-time, single dose intravenous use only.

Product Name:Casgevy	
Diagnosis	Transfusion-dependent beta-thalassemia (TDT)
Approval Length	1 Time Authorization in Lifetime*
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of transfusion-dependent beta-thalassemia (TDT)	

AND

2 - Submission of medical records (e.g., chart notes) confirming presence of a mutation at both alleles of the beta-globin gene (i.e., beta0/beta0, beta0/beta+, beta+/beta+, beta0/betaE)

AND

3 - Submission of medical records (e.g., chart notes) confirming ONE of the following:

- Patient has a history of requiring at least 100 mL/kg/year of red blood cell (RBC) transfusions in the prior 2 years
- Patient requires 10 units/year of RBC transfusions in the prior 2 years

AND

4 - Patient is 12 years of age or older

AND

5 - Provider attests that patient is clinically stable and eligible to undergo hematopoietic stem cell transplant (HSCT)

AND

6 - Submission of medical records (e.g., chart notes) confirming patient has obtained a negative test result for ALL of the following prior to cell collection:

- Hepatitis B virus (HBV)
- Hepatitis C virus (HCV)
- Human immunodeficiency virus (HIV)

AND

7 - Patient is anticipated to provide an adequate number of cells to meet the minimum recommended dose of 3×10^6 CD34+ cells/kg

AND

8 - Patient does NOT have any of the following:

- Severely elevated iron in the heart (e.g., patients with cardiac T2* less than 10 msec by magnetic resonance imaging [MRI])
- Advanced liver disease
- MRI results of the liver demonstrating liver iron content greater than or equal to 15 mg/g (unless biopsy confirms absence of advanced disease)

AND

9 - BOTH of the following:

9.1 Iron chelation therapy (e.g., deferoxamine, deferasirox) will be discontinued for at least 7 days prior to initiating myeloablative conditioning therapy

AND

9.2 Hydroxyurea, Oxbritya (voxelotor), and Adakveo (crizanlizumab) will be discontinued at least 8 weeks prior to start of mobilization and conditioning

AND

10 - Patient will receive BOTH of the following:

10.1 Full myeloablative conditioning with busulfan prior to treatment with Casgevy

AND

10.2 Anti-seizure prophylaxis with agents other than phenytoin prior to initiating busulfan conditioning

AND

11 - BOTH of the following:

11.1 Patient has never received any previous transfusion dependent beta-thalassemia gene therapy treatment in their lifetime (i.e., Casgevy, Zynteglo)

AND

11.2 Patient has never received prior allogeneic transplant

AND

12 - Prescribed by a provider at a treatment center with expertise in gene therapy

AND

13 - Prescribed by ONE of the following:

- Hematologist/Oncologist
- Stem transplant specialist

Notes	*Per prescribing information, Casgevy is for one-time, single dose intravenous use only.

2 . Revision History

Date	Notes
1/23/2026	New program for ACUAZ/ACUAZEC.

Cayston



Prior Authorization Guideline

Guideline ID	GL-140846
Guideline Name	Cayston
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2020

1 . Criteria

Product Name:Cayston	
Diagnosis	Cystic Fibrosis (CF)
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of cystic fibrosis (CF)	

2 . Revision History

Date	Notes
3/31/2020	Bulk copy C&S New York SP to C&S Arizona SP for 5/1 effective

Ceprothin



Prior Authorization Guideline

Guideline ID	GL-140875
Guideline Name	Ceprothin
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	6/1/2022

1 . Criteria

Product Name:Ceprothin	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of severe congenital Protein C deficiency	

AND

2 - Medication is being used for prevention or treatment of venous thrombosis and/or purpura fulminans

AND

3 - Medical record documentation of ONE of the following:

- Low protein C activity
- Low protein C antigen
- Genetic testing demonstrating biallelic mutations in the PROC gene

AND

4 - Prescribed by, or in consultation with, a hematologist, or other specialist with expertise in the diagnosis and management of Protein C deficiency

AND

5 - Dosing is in accordance with the U.S. Food and Drug Administration (FDA) approved labeling and is adjusted based on the patient's weight, severity of deficiency, and whether treatment is for acute episodes or prophylaxis

Product Name:Ceprotin	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has previously received Ceprotin	

AND

2 - Documentation of positive clinical response to Ceprotin

AND

3 - Dosing is in accordance with the FDA approved labeling and is adjusted based on the patient's weight, severity of deficiency, and whether treatment is for acute episodes or prophylaxis

2 . Revision History

Date	Notes
3/31/2022	New Guideline

CGRP Inhibitors



Prior Authorization Guideline

Guideline ID	GL-502273
Guideline Name	CGRP Inhibitors
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Aimovig, Emgality 120 mg/mL	
Diagnosis	Preventive Treatment of Migraine
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 BOTH of the following:	

1.1.1 Diagnosis of episodic migraines

AND

1.1.2 Patient has 4 to 14 migraine days per month, but no more than 14 headache days per month

OR

1.2 ALL of the following:

1.2.1 Diagnosis of chronic migraines

AND

1.2.2 Patient has greater than or equal to 15 headache days per month, of which at least 8 must be migraine days for at least 3 months

AND

1.2.3 Medication overuse headache has been considered and potentially offending medication(s) have been discontinued

AND

2 - Patient is 18 years of age or older

AND

3 - TWO of the following:

3.1 ONE of the following:

3.1.1 History of failure (after at least a two month trial) or intolerance to Elavil (amitriptyline) or Effexor (venlafaxine)

OR

3.1.2 Patient has a contraindication to both Elavil (amitriptyline) and Effexor (venlafaxine)

OR

3.2 ONE of the following:

3.2.1 History of failure (after at least a two month trial) or intolerance to Depakote/Depakote ER (divalproex sodium) or Topamax (topiramate)

OR

3.2.2 Patient has a contraindication to both Depakote/Depakote ER (divalproex sodium) and Topamax (topiramate)

OR

3.3 ONE of the following:

3.3.1 History of failure (after at least a two month trial) or intolerance to ONE of the following beta blockers: atenolol, propranolol, nadolol, timolol, or metoprolol

OR

3.3.2 Patient has a contraindication to ALL of the following beta blockers: atenolol, propranolol, nadolol, timolol, metoprolol

AND

4 - Prescribed by or in consultation with ONE of the following specialists:

- Neurologist
- Pain specialist
- Headache specialist*

AND

5 - BOTH of the following:

5.1 Medication will not be used in combination with another CGRP inhibitor for the PREVENTIVE treatment of migraines

AND

5.2 Patient will use only ONE CGRP for the PREVENTIVE treatment of migraines and ONE CGRP for the ACUTE treatment of migraines

Notes

*Headache specialists are physicians certified by the United Council f or Neurologic Subspecialties (UCNS).

Product Name:Aimovig, Emgality 120 mg/mL

Diagnosis Preventive Treatment of Migraine

Approval Length 12 month(s)

Therapy Stage Reauthorization

Guideline Type Prior Authorization

Approval Criteria

1 - Patient has experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity

AND

2 - Use of acute migraine medications [e.g., nonsteroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen, naproxen), triptans (e.g., eletriptan, rizatriptan, sumatriptan)] has decreased since the start of CGRP therapy

AND

3 - Prescribed by or in consultation with one of the following specialists:

- Neurologist
- Pain specialist
- Headache specialist*

AND

4 - For Chronic Migraine only: Patient continues to be monitored for medication overuse headache (MOH)

AND

5 - BOTH of the following:

5.1 Medication will not be used in combination with another CGRP inhibitor for the PREVENTIVE treatment of migraines

AND

5.2 Patient will use only ONE CGRP for the PREVENTIVE treatment of migraines and ONE CGRP for the ACUTE treatment of migraines

Notes	*Headache specialists are physicians certified by the United Council f or Neurologic Subspecialties (UCNS).

Product Name:Emgality 100 mg/mL	
Diagnosis	Episodic Cluster Headaches
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of episodic cluster headache	

AND

2 - Patient has experienced at least 2 cluster periods lasting from 7 days to 365 days, separated by pain-free periods lasting at least three months

AND

3 - Patient is 18 years of age or older

AND

4 - Prescribed by or in consultation with ONE of the following specialists:

- Neurologist
- Pain specialist
- Headache specialist*

AND

5 - BOTH of the following:

5.1 Medication will not be used in combination with another CGRP inhibitor for the PREVENTIVE treatment of migraines

AND

5.2 Patient will use only ONE CGRP for the PREVENTIVE treatment of migraines and ONE CGRP for the ACUTE treatment of migraines

Notes	*Headache specialists are physicians certified by the United Council f or Neurologic Subspecialties (UCNS).

Product Name:Emgality 100 mg/mL	
Diagnosis	Episodic Cluster Headaches
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity AND 2 - Prescribed by or in consultation with ONE of the following specialists: • Neurologist • Pain specialist • Headache specialist* AND 3 - BOTH of the following: 3.1 Medication will not be used in combination with another CGRP inhibitor for the PREVENTIVE treatment of migraines AND 3.2 Patient will use only ONE CGRP for the PREVENTIVE treatment of migraines and ONE CGRP for the ACUTE treatment of migraines	
Notes	*Headache specialists are physicians certified by the United Council f or Neurologic Subspecialties (UCNS).

Product Name:Ajovy, Qulipta	
Diagnosis	Preventive Treatment of Migraine
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 BOTH of the following:

1.1.1 Diagnosis of episodic migraines

AND

1.1.2 Patient has 4 to 14 migraine days per month, but no more than 14 headache days per month

OR

1.2 ALL of the following:

1.2.1 Diagnosis of chronic migraines

AND

1.2.2 Patient has greater than or equal to 15 headache days per month, of which at least 8 must be migraine days for at least 3 months

AND

1.2.3 Medication overuse headache has been considered and potentially offending medication(s) have been discontinued

AND

2 - ONE of the following:

2.1 Patient is 18 years of age or older

OR

2.2 BOTH of the following (applies to Ajovy for episodic migraines ONLY):

- Patient is 6 years of age or older
- Patient weighs 45 kg (kilograms) or greater

AND

3 - TWO of the following:

3.1 ONE of the following:

3.1.1 History of failure (after at least a two month trial) or intolerance to Elavil (amitriptyline) or Effexor (venlafaxine)

OR

3.1.2 Patient has a contraindication to both Elavil (amitriptyline) and Effexor (venlafaxine)

OR

3.2 ONE of the following:

3.2.1 History of failure (after at least a two month trial) or intolerance to Depakote/Depakote ER (divalproex sodium) or Topamax (topiramate)

OR

3.2.2 Patient has a contraindication to both Depakote/Depakote ER (divalproex sodium) and Topamax (topiramate)

OR

3.3 ONE of the following:

3.3.1 History of failure (after at least a two month trial) or intolerance to ONE of the following beta blockers: atenolol, propranolol, nadolol, timolol, or metoprolol

OR

3.3.2 Patient has a contraindication to ALL of the following beta blockers: atenolol, propranolol, nadolol, timolol, metoprolol

AND

4 - Trial and failure, contraindication, or intolerance to BOTH of the following:

- Aimovig
- Emgality

AND

5 - Prescribed by or in consultation with ONE of the following specialists:

- Neurologist
- Pain specialist
- Headache specialist*

AND

6 - BOTH of the following:

6.1 Medication will not be used in combination with another CGRP inhibitor for the PREVENTIVE treatment of migraines

AND

6.2 Patient will use only ONE CGRP for the PREVENTIVE treatment of migraines and ONE CGRP for the ACUTE treatment of migraines

Notes

*Headache specialists are physicians certified by the United Council f or Neurologic Subspecialties (UCNS).

Product Name:Ajovy, Qulipta	
Diagnosis	Preventive Treatment of Migraine
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity AND 2 - Use of acute migraine medications [e.g., nonsteroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen, naproxen), triptans (e.g., eletriptan, rizatriptan, sumatriptan)] has decreased since the start of CGRP (calcitonin gene-related peptide) therapy AND 3 - Trial and failure, contraindication, or intolerance to BOTH of the following: • Aimovig • Emgality AND 4 - Prescribed by or in consultation with ONE of the following specialists: • Neurologist • Pain specialist • Headache specialist* AND 5 - For Chronic Migraine only: Patient continues to be monitored for medication overuse headache (MOH)	

AND

6 - BOTH of the following:

6.1 Medication will not be used in combination with another CGRP inhibitor for the preventive treatment of migraines

AND

6.2 Patient will use only ONE CGRP for the PREVENTIVE treatment of migraines and ONE CGRP for the ACUTE treatment of migraines

Notes	*Headache specialists are physicians certified by the United Council f or Neurologic Subspecialties (UCNS).

Product Name:Nurtec ODT	
Diagnosis	Preventive Treatment of Episodic Migraine
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following: 1.1 Diagnosis of episodic migraines AND 1.2 Patient has 4 to 18 migraine days per month, but no more than 18 headache days per month AND	

2 - Patient is 18 years of age or older

AND

3 - TWO of the following:

3.1 ONE of the following:

3.1.1 History of failure (after at least a two month trial) or intolerance to Elavil (amitriptyline) or Effexor (venlafaxine)

OR

3.1.2 Patient has a contraindication to both Elavil (amitriptyline) and Effexor (venlafaxine)

OR

3.2 ONE of the following:

3.2.1 History of failure (after at least a two month trial) or intolerance to Depakote/Depakote ER (divalproex sodium) or Topamax (topiramate)

OR

3.2.2 Patient has a contraindication to both Depakote/Depakote ER (divalproex sodium) and Topamax (topiramate)

OR

3.3 ONE of the following:

3.3.1 History of failure (after at least a two month trial) or intolerance to ONE of the following beta blockers: atenolol, propranolol, nadolol, timolol, or metoprolol

OR

3.3.2 Patient has a contraindication to ALL of the following beta blockers: atenolol, propranolol, nadolol, timolol, metoprolol

AND

4 - Trial and failure, contraindication, or intolerance to BOTH of the following:

- Aimovig
- Emgality

AND

5 - Prescribed by or in consultation with ONE of the following specialists:

- Neurologist
- Pain specialist
- Headache specialist*

AND

6 - BOTH of the following:

6.1 Medication will not be used in combination with another CGRP inhibitor for the PREVENTIVE treatment of migraines

AND

6.2 Patient will use only ONE CGRP for the PREVENTIVE treatment of migraines and ONE CGRP for the ACUTE treatment of migraines

Notes	*Headache specialists are physicians certified by the United Council f or Neurologic Subspecialties (UCNS).

Product Name:Nurtec ODT	
Diagnosis	Preventive Treatment of Episodic Migraine
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity AND 2 - Use of acute migraine medications [e.g., nonsteroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen, naproxen), triptans (e.g., eletriptan, rizatriptan, sumatriptan)] has decreased since the start of CGRP therapy AND 3 - Prescribed by or in consultation with ONE of the following specialists: • Neurologist • Pain specialist • Headache specialist* AND 4 - BOTH of the following: 4.1 Medication will not be used in combination with another CGRP inhibitor for the PREVENTIVE treatment of migraines AND 4.2 Patient will use only ONE CGRP for the PREVENTIVE treatment of migraines and ONE CGRP for the ACUTE treatment of migraines	
Notes	*Headache specialists are physicians certified by the United Council f or Neurologic Subspecialties (UCNS).

Product Name:Nurtec ODT, Zavzpret

Diagnosis	Acute Treatment of Migraine
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of migraine with or without aura AND 2 - Will be used for the acute treatment of migraine AND 3 - Patient has fewer than 15 headache days per month AND 4 - Patient is 18 years of age or older AND 5 - Patient has a history of a one-month trial resulting in therapeutic failure, contraindication, or intolerance to FOUR of the following as evidenced by submission of medical records or claims history: • naratriptan tablets • rizatriptan tablets/ODT (Oral Disintegrating Tablets) • sumatriptan tablets/auto injection/cartridge • sumatriptan nasal spray • zolmitriptan tablets/ODT • Zomig nasal spray (Brand only)	

AND

6 - Patient has a history of a one-month trial resulting in therapeutic failure, contraindication, or intolerance to Ubrelyv as evidenced by submission of medical records or claims history**

AND

7 - If patient has 4 or more headache days per month, patient must meet **ONE** of the following:

7.1 Currently being treated with Elavil (amitriptyline) or Effexor (venlafaxine) unless there is a contraindication or intolerance to these medications

OR

7.2 Currently being treated with Depakote/Depakote ER (divalproex sodium) or Topamax (topiramate) unless there is a contraindication or intolerance to these medications

OR

7.3 Currently being treated with a beta blocker (i.e., atenolol, propranolol, nadolol, timolol, or metoprolol) unless there is a contraindication or intolerance to these medications

AND

8 - Prescribed by or in consultation with **ONE** of the following specialists:

- Neurologist
- Pain specialist
- Headache specialist*

AND

9 - **BOTH** of the following:

9.1 Medication will not be used in combination with another CGRP inhibitor for the ACUTE treatment of migraines

AND	
9.2 Patient will use only ONE CGRP for the PREVENTIVE treatment of migraines and ONE CGRP for the ACUTE treatment of migraines	
Notes	*Headache specialists are physicians certified by the United Council f or Neurologic Subspecialties (UCNS). **Patients requesting initial authorization who were established on the rapy via the receipt of a manufacturer supplied sample at no cost in th e prescriber's office or any form of assistance from the manufacturer s ponsored programs shall be required to meet initial authorization criter ia as if patient were new to therapy.

Product Name:Nurtec ODT, Zavzpret	
Diagnosis	Acute Treatment of Migraine
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has experienced a positive response to therapy (e.g., reduction in pain, photophobia, phonophobia, nausea) AND 2 - Prescribed by or in consultation with ONE of the following specialists: • Neurologist • Pain specialist • Headache specialist* AND 3 - BOTH of the following:	

3.1 Medication will not be used in combination with another CGRP inhibitor for the ACUTE treatment of migraines

AND

3.2 Patient will use only ONE CGRP for the PREVENTIVE treatment of migraines and ONE CGRP for the ACUTE treatment of migraines

Notes

*Headache specialists are physicians certified by the United Council f or Neurologic Subspecialties (UCNS).

Product Name:Ubrelvy

Diagnosis Acute Treatment of Migraine

Approval Length 3 month(s)

Therapy Stage Initial Authorization

Guideline Type Prior Authorization

Approval Criteria

1 - Diagnosis of migraine with or without aura

AND

2 - Will be used for the acute treatment of migraine

AND

3 - Will not be used for preventive treatment of migraine

AND

4 - Patient has fewer than 15 headache days per month

AND

5 - Patient is 18 years of age or older

AND

6 - Patient has a history of a one-month trial resulting in therapeutic failure, contraindication, or intolerance to TWO of the following as evidenced by submission of medical records or claims history:

- naratriptan tablets
- rizatriptan tablets/ODT (Oral Disintegrating Tablets)
- sumatriptan tablets/auto injection/cartridge
- zolmitriptan tablets/ODT
- Zomig nasal spray (Brand only)
- sumatriptan nasal spray

AND

7 - If patient has 4 or more headache days per month, patient must meet ONE of the following:

7.1 Currently being treated with Elavil (amitriptyline) or Effexor (venlafaxine) unless there is a contraindication or intolerance to these medications

OR

7.2 Currently being treated with Depakote/Depakote ER (divalproex sodium) or Topamax (topiramate) unless there is a contraindication or intolerance to these medications

OR

7.3 Currently being treated with a beta blocker (i.e., atenolol, propranolol, nadolol, timolol, or metoprolol) unless there is a contraindication or intolerance to these medications

AND

8 - Prescribed by or in consultation with ONE of the following specialists:

- Neurologist
- Pain specialist
- Headache specialist*

AND

9 - BOTH of the following:

9.1 Medication will not be used in combination with another CGRP inhibitor for the ACUTE treatment of migraines

AND

9.2 Patient will use only ONE CGRP for the PREVENTIVE treatment of migraines and ONE CGRP for the ACUTE treatment of migraines

Notes

*Headache specialists are physicians certified by the United Council f or Neurologic Subspecialties (UCNS).

Product Name:Ubrelvy	
Diagnosis	Acute Treatment of Migraine
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has experienced a positive response to therapy (e.g., reduction in pain, photophobia, phonophobia, nausea) AND 2 - Will not be used for preventive treatment of migraine	

AND

3 - Prescribed by or in consultation with **ONE** of the following specialists:

- Neurologist
- Pain specialist
- Headache specialist*

AND

4 - **BOTH** of the following:

4.1 Medication will not be used in combination with another CGRP inhibitor for the **ACUTE** treatment of migraines

AND

4.2 Patient will use only **ONE** CGRP for the **PREVENTIVE** treatment of migraines and **ONE** CGRP for the **ACUTE** treatment of migraines

Notes	*Headache specialists are physicians certified by the United Council f or Neurologic Subspecialties (UCNS).

2 . Revision History

Date	Notes
1/21/2026	For all targets and indications, updated concomitant use criterion and added criterion that pt may only be on one CGRP for preventative tr eatment of migraines and one CGRP for acute treatment of migraine s.

Chenodiol Products



Prior Authorization Guideline

Guideline ID	GL-355242
Guideline Name	Chenodiol Products
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	9/1/2025

1 . Criteria

Product Name:Chenodal*	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming ALL of the following: 1.1 Diagnosis of radiolucent gallstones	

AND

1.2 Patient has a well-opacifying gallbladder visualized by oral cholecystography

AND

1.3 Trial and failure, contraindication, or intolerance to ursodiol

AND

1.4 Patient is not a candidate for surgery

AND

1.5 Stones are not calcified (radiopaque) or radiolucent bile pigment stones

AND

2 - Prescribed by or in consultation with ONE of the following:

- Gastroenterologist
- A provider who has specialized expertise in the management of gallstones

Notes	*If patient meets criteria above, please approve at NDC level.

Product Name:Chenodal*	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Patient's disease status has been re-evaluated since the last authorization to confirm the patient's condition warrants continued treatment as evidenced by oral cholecystograms or ultrasonograms

AND

2 - Prescribed by or in consultation with ONE of the following:

- Gastroenterologist
- A provider who has specialized expertise in the management of gallstones

Notes

*If patient meets criteria above, please approve at NDC level.

Product Name: Ctexli^

Approval Length 12 month(s)

Therapy Stage Initial Authorization

Guideline Type Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming ALL of the following:

1.1 Diagnosis of cerebrotendinous xanthomatosis (cholestanol storage disease)

AND

1.2 Disease is confirmed by the presence of pathogenic variant(s) in the CYP27A1 gene, as detected by an FDA (Food and Drug Administration)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA)

AND

2 - Prescribed by or in consultation with ONE of the following:

- Neurologist
- Geneticist

Metabolic disease specialist	
Notes	^If patient meets criteria above, please approve at NDC level.

Product Name:Ctexli^	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient demonstrates positive clinical response to therapy (e.g., stabilization or improvement in symptoms, reduction in biochemical markers [e.g., serum cholestanol, urine 23S-pentol])	
Notes	^If patient meets criteria above, please approve at NDC level.

2 . Revision History

Date	Notes
8/6/2025	New program.

Cholbam



Prior Authorization Guideline

Guideline ID	GL-140913
Guideline Name	Cholbam
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Cholbam	
Diagnosis	Bile Acid Synthesis Disorder
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of a bile acid synthesis disorder	

AND

2 - It is due to single enzyme defects

Product Name:Cholbam

Diagnosis	Peroxisomal Disorders Including Zellweger Spectrum Disorders
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of peroxisomal disorders including Zellweger spectrum disorders

AND

2 - Patient exhibits manifestations of liver disease, steatorrhea, or complications from decreased fat soluble vitamin absorption

AND

3 - It is being used as adjunctive treatment

Product Name:Cholbam

Diagnosis	All Indications
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Cholbam therapy

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Cialis for BPH



Prior Authorization Guideline

Guideline ID	GL-140729
Guideline Name	Cialis for BPH
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Brand Cialis 5mg, generic tadalafil 5mg	
Diagnosis	Benign Prostatic Hyperplasia (BPH)
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - All of the following: 1.1 The patient has a diagnosis of benign prostatic hyperplasia (BPH)	

AND

1.2 History of failure, intolerance, or contraindication to BOTH of the following:

- Alpha Blockers (e.g., tamsulosin, alfuzosin ER, doxazosin, or terazosin)
- 5-alpha reductase inhibitors (e.g., finasteride)

AND

1.3 Dose does not exceed 5 milligrams once daily

AND

2 - Provider attests that patient is not using any form of organic nitrate (for example, nitroglycerin, isosorbide dinitrate, isosorbide mononitrate or amyl nitrate) or Adempas

2 . Revision History

Date	Notes
8/9/2022	C&S to match AZM 10.1.22

Cibinqo (abrocitinib)



Prior Authorization Guideline

Guideline ID	GL-144105
Guideline Name	Cibinqo (abrocitinib)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	4/1/2024

1 . Criteria

Product Name:Cibinqo	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of moderate to severe atopic dermatitis	

AND

2 - Submission of medical records documenting ONE of the following:

- Involvement of at least 10% body surface area (BSA)
- SCORing Atopic Dermatitis (SCORAD) index value of at least 25

AND

3 - Prescribed by or in consultation with ONE of the following:

- Dermatologist
- Allergist/Immunologist

AND

4 - Submission of medical records (e.g., chart notes, lab work, imaging) or paid claims history documenting ALL of the following**:

4.1 History of failure, contraindication, or intolerance to the following topical therapies: (document drug, date of trial, and/or contraindication to medication)*

- One topical calcineurin inhibitor [e.g., Elidel (pimecrolimus), Protopic (tacrolimus)]
- Eucrisa (crisaborole)

AND

4.2 Trial and failure of a minimum 12-week supply of Dupixent (dupilumab)

AND

4.3 Trial and failure of a minimum 12-week supply of Adbry (tralokinumab-ldrm)

AND

5 - Not used in combination with biologic immunomodulators (e.g., Dupixent, Adbry) or other immunosuppressants (e.g., azathioprine, cyclosporine)

AND

6 - Patient is 12 years of age or older

Notes

*Note: Claims history may be used in conjunction as documentation of drug, date, and/or contraindication to medication

**PA may be required. PDL link: <https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHCCPA>

Product Name: Cibinqo

Approval Length 12 month(s)

Therapy Stage Reauthorization

Guideline Type Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting a positive clinical response to therapy as evidenced by at least **ONE** of the following:

- Reduction in body surface area involvement from baseline
- Reduction in SCORing Atopic Dermatitis (SCORAD) index value from baseline

AND

2 - Not used in combination with biologic immunomodulators (e.g., Dupixent, Adbry) or other immunosuppressants (e.g., azathioprine, cyclosporine)

2 . Background

Clinical Practice Guidelines**Table 1. Relative potencies of topical corticosteroids**

Class	Drug	Dosage Form	Strength (%)
Very high potency	Augmented betamethasone dipropionate	Ointment, gel	0.05
	Clobetasol propionate	Cream, foam, ointment	0.05
	Diflorasone diacetate	Ointment	0.05
	Halobetasol propionate	Cream, ointment	0.05
High Potency	Amcinonide	Cream, lotion, ointment	0.1
	Augmented betamethasone dipropionate	Cream, lotion	0.05
	Betamethasone dipropionate	Cream, foam, ointment, solution	0.05
	Desoximetasone	Cream, ointment	0.25
	Desoximetasone	Gel	0.05
	Diflorasone diacetate	Cream	0.05
	Fluocinonide	Cream, gel, ointment, solution	0.05
	Halcinonide	Cream, ointment	0.1
	Mometasone furoate	Ointment	0.1
	Triamcinolone acetonide	Cream, ointment	0.5
Medium potency	Betamethasone valerate	Cream, foam, lotion, ointment	0.1
	Clocortolone pivalate	Cream	0.1
	Desoximetasone	Cream	0.05
	Fluocinolone acetonide	Cream, ointment	0.025
	Flurandrenolide	Cream, ointment, lotion	0.05

	Fluticasone propionate	Cream	0.05
	Fluticasone propionate	Ointment	0.005
	Mometasone furoate	Cream, lotion	0.1
	Triamcinolone acetonide	Cream, ointment, lotion	0.1
Lower-medium potency	Hydrocortisone butyrate	Cream, ointment, solution	0.1
	Hydrocortisone probutate	Cream	0.1
	Hydrocortisone valerate	Cream, ointment	0.2
	Prednicarbate	Cream	0.1
Low potency	Alclometasone dipropionate	Cream, ointment	0.05
	Desonide	Cream, gel, foam, ointment	0.05
	Fluocinolone acetonide	Cream, solution	0.01
Lowest potency	Dexamethasone	Cream	0.1
	Hydrocortisone	Cream, lotion, ointment, solution	0.25, 0.5, 1
	Hydrocortisone acetate	Cream, ointment	0.5-1

3 . Revision History

Date	Notes
3/8/2024	Updated criteria to include submission of records where applicable and updated notes section. Added embedded step through Adbry in initial auth section.

Cimzia (certolizumab)



Prior Authorization Guideline

Guideline ID	GL-329201
Guideline Name	Cimzia (certolizumab)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	8/1/2025

1 . Criteria

Product Name:Cimzia, Cimzia Starter Kit	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming ALL of the following:	

1.1 Diagnosis of moderately to severely active rheumatoid arthritis (RA)

AND

1.2 History of failure to a 3 month trial of ONE non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] at maximally indicated doses within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

1.3 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred^ adalimumab biosimilar or Enbrel (etanercept)
- infliximab
- Orencia (abatacept)
- Xeljanz (tofacitinib) oral tablet (IR or XR)
- A preferred^ tocilizumab biosimilar

AND

2 - Prescribed by or in consultation with a rheumatologist

Notes	^PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:Cimzia, Cimzia Starter Kit	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (PJIA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of active polyarticular juvenile idiopathic arthritis (PJIA)

AND

2 - Submission of medical records (e.g., chart notes) or paid claims documenting BOTH of the following:

2.1 Minimum duration of a 6-week trial and failure, contraindication, or intolerance to ONE of the following conventional therapies at maximally tolerated doses:

- methotrexate
- leflunomide

AND

2.2 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred^ adalimumab biosimilar or Enbrel (etanercept)
- Orencia (abatacept)
- Xeljanz (tofacitinib) oral tablet
- A preferred^ tocilizumab biosimilar

AND

3 - Prescribed by or in consultation with a rheumatologist

Notes	^PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:Cimzia, Cimzia Starter Kit	
Diagnosis	Ankylosing Spondylitis (AS), Non-Radiographic Axial Spondyloarthritis (nr-axSpA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming ALL of the following:

1.1 ONE of the following diagnoses:

- Active ankylosing spondylitis (AS)
- Active non-radiographic axial spondyloarthritis (nr-axSpA)

AND

1.2 History of failure to TWO NSAIDs [non-steroidal anti-inflammatory drugs (e.g., ibuprofen, naproxen)] at maximally indicated doses, each used for at least 4 weeks within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced

AND

1.3 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred^ adalimumab biosimilar or Enbrel (etanercept)
- infliximab
- Xeljanz (tofacitinib) oral tablet (IR or XR)

AND

2 - Prescribed by or in consultation with a rheumatologist

Notes	^PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:Cimzia, Cimzia Starter Kit	
Diagnosis	Rheumatoid Arthritis (RA), Polyarticular Juvenile Idiopathic Arthritis (PJIA), Ankylosing Spondylitis (AS), Non-Radiographic Axial Spondyloarthritis (nr-axSpA)
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy AND 2 - Prescribed by or in consultation with a rheumatologist	

Product Name:Cimzia, Cimzia Starter Kit	
Diagnosis	Crohn's Disease (CD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming ALL of the following: 1.1 Diagnosis of moderately to severely active Crohn's disease (CD) AND 1.2 History of failure to ONE of the following conventional therapies at maximally indicated doses within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced: • Corticosteroids (e.g., prednisone, methylprednisolone, budesonide) • 6-mercaptopurine (Purinethol) • Azathioprine (Imuran) • Methotrexate (Rheumatrex, Trexall)	

AND

1.3 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred^ adalimumab biosimilar
- infliximab
- A preferred^ ustekinumab biosimilar

AND

2 - Prescribed by or in consultation with a gastroenterologist

Notes	^PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:Cimzia, Cimzia Starter Kit	
Diagnosis	Crohn's Disease (CD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy AND 2 - Prescribed by or in consultation with a gastroenterologist	

Product Name:Cimzia, Cimzia Starter Kit	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming ALL of the following: 1.1 Diagnosis of active psoriatic arthritis (PsA) AND 1.2 History of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced AND 1.3 History of failure, contraindication, or intolerance to ALL of the following: • A preferred^ adalimumab biosimilar or Enbrel (etanercept) • infliximab • Otezla (apremilast) • Orencia (abatacept) • Xeljanz (tofacitinib) oral tablet (IR or XR) • A preferred^ ustekinumab biosimilar AND 2 - Prescribed by or in consultation with ONE of the following: • Rheumatologist • Dermatologist	
Notes	^PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:Cimzia, Cimzia Starter Kit

Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy AND 2 - Prescribed by or in consultation with ONE of the following: • Rheumatologist • Dermatologist	

Product Name:Cimzia, Cimzia Starter Kit	
Diagnosis	Plaque Psoriasis (PsO)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming ALL of the following: 1.1 Diagnosis of moderate to severe plaque psoriasis (PsO) AND 1.2 Greater than or equal to 3% body surface area involvement, palmoplantar, facial, or genital involvement, or severe scalp psoriasis	

AND

1.3 History of failure to ONE of the following topical therapies, unless contraindicated or clinically significant adverse effects are experienced:

- corticosteroids (e.g., betamethasone, clobetasol, desonide)
- vitamin D analogs (e.g., calcitriol, calcipotriene)
- tazarotene
- calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)

AND

1.4 History of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

1.5 History of failure, contraindication, or intolerance to ONE of the following topical therapies:

- Vtama
- Zoryve 0.3% cream

AND

1.6 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred^ adalimumab biosimilar or Enbrel (etanercept)
- infliximab
- Otezla (apremilast)
- A preferred^ ustekinumab biosimilar

AND

2 - Prescribed by or in consultation with a dermatologist

Notes	^PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:Cimzia, Cimzia Starter Kit	
Diagnosis	Plaque Psoriasis (PsO)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy AND 2 - Prescribed by or in consultation with a dermatologist	

2 . Revision History

Date	Notes
7/16/2025	Reformatting of criteria sections. Updates to initial and reauth sections for all indications.

CMV and Herpes Virus Agents



Prior Authorization Guideline

Guideline ID	GL-392195
Guideline Name	CMV and Herpes Virus Agents
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2025

1 . Criteria

Product Name: Brand Valcyte tabs/oral soln, generic valganciclovir tabs/oral soln	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Medication is being used for ONE of the following: 1.1 Cytomegalovirus disease prophylaxis or	

1.2 Cytomegalovirus retinitis

or

1.3 Cytomegalovirus retinitis prophylaxis

or

1.4 BOTH of the following:

1.4.1 The use of this drug is supported by information from ONE of the following appropriate compendia of current literature:

American Hospital Formulary Service Drug Information

National Comprehensive Cancer Network Drugs and Biologics Compendium

Thomson Micromedex DrugDex

Clinical pharmacology

AND

1.4.2 The drug is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plan's program*

Notes

*Medications used for anti-obesity/weight loss, cosmetic (e.g., alopecia, actinic keratosis, vitiligo), erectile dysfunction, and sexual dysfunction purposes are NOT medically accepted indications and are NOT recognized as a covered benefit. Erectile dysfunction drugs (Cialis/Tadalafil) are covered for clinical diagnoses other than ED.

Product Name:famciclovir tabs

Approval Length

12 month(s)

Guideline Type

Prior Authorization

Approval Criteria

1 - Medication is being used for ONE of the following:

1.1 Herpes genitalis

or 1.2 Herpes genitalis prophylaxis or 1.3 Herpes labialis or 1.4 Herpes simplex virus infection or 1.5 Herpes zoster infection or 1.6 BOTH of the following: 1.6.1 The use of this drug is supported by information from ONE of the following appropriate compendia of current literature: American Hospital Formulary Service Drug Information National Comprehensive Cancer Network Drugs and Biologics Compendium Thomson Micromedex DrugDex Clinical pharmacology AND 1.6.2 The drug is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plan's program*	
Notes	*Medications used for anti-obesity/weight loss, cosmetic (e.g., alopecia, actinic keratosis, vitiligo), erectile dysfunction, and sexual dysfunction purposes are NOT medically accepted indications and are NOT recognized as a covered benefit. Erectile dysfunction drugs (Cialis/Tadalafil) are covered for clinical diagnoses other than ED.

Product Name: Brand Valtrex tabs, generic valacyclovir tabs	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Medication is being used for ONE of the following: 1.1 Herpes genitalis or 1.2 Herpes genitalis prophylaxis or 1.3 Herpes labialis or 1.4 Herpes simplex virus infection or 1.5 Herpes zoster infection or 1.6 Varicella infection or 1.7 BOTH of the following 1.7.1 The use of this drug is supported by information from ONE of the following appropriate compendia of current literature: American Hospital Formulary Service Drug Information National Comprehensive Cancer Network Drugs and Biologics Compendium	

Thomson Micromedex DrugDex Clinical pharmacology AND 1.7.2 The drug is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plan's program*	
Notes	*Medications used for anti-obesity/weight loss, cosmetic (e.g., alopecia, actinic keratosis, vitiligo), erectile dysfunction, and sexual dysfunction purposes are NOT medically accepted indications and are NOT recognized as a covered benefit. Erectile dysfunction drugs (Cialis/Tadalafil) are covered for clinical diagnoses other than ED.

2 . Revision History

Date	Notes
9/10/2025	New program for ACUAZ/ACUAZEC.

Colony Stimulating Factors



Prior Authorization Guideline

Guideline ID	GL-605213
Guideline Name	Colony Stimulating Factors
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Fulphila, Fylnetra, Granix, Leukine, Neulasta, Neulasta Onpro, Neupogen, Nivestym, Nypozi, Nyvepria, Releuko, Stimufend, Udenyca, Udenyca Onbody, Zarxio, Ziextenzo, newly launched CSF/biosimilar products	
Diagnosis	Bone Marrow/Stem Cell Transplant
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Patient has non-myeloid malignancies and is undergoing myeloablative chemotherapy followed by autologous or allogeneic bone marrow transplant (BMT)	

OR

1.2 Used for mobilization of hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis

OR

1.3 Patient has had a peripheral stem cell transplant (PSCT) and has received myeloablative chemotherapy

AND

2 - Prescribed by, or in consultation with, a hematologist or oncologist

AND

3 - If the request is non-preferred*, patient has a history of failure, contraindication, or intolerance to ALL preferred* colony stimulating factor products

Notes	Approval Length: 3 months. If approving a preferred colony stimulating factor product, please enter the group authorization AZFILGRAST. If approving a non-preferred colony stimulating factor product, please enter the following: 1) The group authorization AZFILGRAST 2) An authorization for the non-preferred colony stimulating factor product at GPI-12 level *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:Fulphila, Fylnetra, Granix, Leukine, Neulasta, Neulasta Onpro, Neupogen, Nivestym, Nypozi, Nyvepria, Releuko, Stimufend, Udenyca, Udenyca Onbody, Zarxio, Ziextenzo, newly launched CSF/biosimilar products

Diagnosis	AML Induction or Consolidation Therapy
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of acute myeloid leukemia (AML)

AND

2 - Patient has completed either induction or consolidation chemotherapy

AND

3 - Prescribed by, or in consultation with, a hematologist or oncologist

AND

4 - If the request is non-preferred*, patient has a history of failure, contraindication, or intolerance to ALL preferred* colony stimulating factor products

Notes	Approval Length: 3 months. If approving a preferred colony stimulating factor product, please enter the group authorization AZFILGRAST. If approving a non-preferred colony stimulating factor product, please enter the following: 1) The group authorization AZFILGRAST 2) An authorization for the non-preferred colony stimulating factor product at GPI-12 level *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:Fulphila, Fylnetra, Granix, Leukine, Neulasta, Neulasta Onpro, Neupogen, Nivestym, Nypozi, Nyvepria, Releuko, Stimufend, Udenyca, Udenyca Onbody, Zarxio, Ziextenzo, newly launched CSF/biosimilar products	
Diagnosis	Neutropenia Associated with Cancer Chemotherapy - Dose Dense Chemotherapy
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Patient is receiving National Cancer Institute's Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer

OR

1.2 Patient is receiving a dose-dense chemotherapy regimen for which the incidence of febrile neutropenia (FN) is unknown

AND

2 - Prescribed by, or in consultation with, a hematologist or oncologist

AND

3 - If the request is non-preferred*, patient has a history of failure, contraindication, or intolerance to ALL preferred* colony stimulating factor products

Notes	Approval Length: 3 months. If approving a preferred colony stimulating factor product, please enter the group authorization AZFILGRAST. If approving a non-preferred colony stimulating factor product, please enter the following: 1) The group authorization AZFILGRAST 2) An authorization for the non-preferred colony stimulating factor product at GPI-12 level *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC CP

Product Name: Fulphila, Fylmetra, Granix, Leukine, Neulasta, Neulasta Onpro, Neupogen, Nivestym, Nypozi, Nyvepria, Releuko, Stimufend, Udenyca, Udenyca Onbody, Zarxio, Ziextenzo, newly launched CSF/biosimilar products

Diagnosis	Primary Prophylaxis of Chemotherapy-Induced Febrile Neutropenia (FN)

Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Patient is receiving chemotherapy regimen(s) associated with greater than 20 percent incidence of febrile neutropenia (FN) OR 1.2 BOTH of the following: • Patient is receiving chemotherapy regimen(s) associated with 10-20 percent incidence of FN • Patient has one or more risk factors associated with chemotherapy-induced infection, FN, or neutropenia AND 2 - Prescribed by, or in consultation with, a hematologist or oncologist AND 3 - If the request is non-preferred*, patient has a history of failure, contraindication, or intolerance to ALL preferred* colony stimulating factor products	
Notes	Approval Length: 3 months. If approving a preferred colony stimulating factor product, please enter the group authorization AZFILGRAST. If approving a non-preferred colony stimulating factor product, please enter the following: 1) The group authorization AZFILGRAST 2) An authorization for the non-preferred colony stimulating factor product at GPI-12 level *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC CP

Product Name:Fulphila, Fylnetra, Granix, Leukine, Neulasta, Neulasta Onpro, Neupogen, Nivestym, Nypozi, Nyvepria, Releuko, Stimufend, Udenyca, Udenyca Onbody, Zarxio, Ziextenzo, newly launched CSF/biosimilar products	
Diagnosis	Secondary Prophylaxis of Febrile Neutropenia (FN)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is receiving myelosuppressive anti-cancer drugs associated with neutropenia [absolute neutrophil count (ANC) less than or equal to 500 cells per mm³ (cubic millimeter)] AND 2 - Patient has a history of febrile neutropenia (FN) during a previous course of chemotherapy AND 3 - Prescribed by, or in consultation with, a hematologist or oncologist AND 4 - If the request is non-preferred*, patient has a history of failure, contraindication, or intolerance to ALL preferred* colony stimulating factor products	
Notes	Approval Length: 3 months. If approving a preferred colony stimulating factor product, please enter the group authorization AZFILGRAST. If approving a non-preferred colony stimulating factor product, please enter the following: 1) The group authorization AZFILGRAST 2) An authorization for the non-preferred colony stimulating factor product at GPI-12 level *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC CP

Product Name:Fulphila, Fylnetra, Granix, Leukine, Neulasta, Neulasta Onpro, Neupogen, Nivestym, Nypozi, Nyvepria, Releuko, Stimufend, Udenyca, Udenyca Onbody, Zarxio, Ziextenzo, newly launched CSF/biosimilar products	
Diagnosis	Treatment of Febrile Neutropenia (FN) (off-label)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is receiving myelosuppressive anti-cancer drugs associated with neutropenia [absolute neutrophil count (ANC) less than or equal to 500 cells per mm³ (cubic millimeter)] AND 2 - Diagnosis of febrile neutropenia (FN) and patient is considered high risk for infection-associated complications AND 3 - Prescribed by, or in consultation with, a hematologist or oncologist AND 4 - If the request is non-preferred*, patient has a history of failure, contraindication, or intolerance to ALL preferred* colony stimulating factor products	
Notes	Approval Length: 1 month. If approving a preferred colony stimulating factor product, please enter the group authorization AZFILGRAST. If approving a non-preferred colony stimulating factor product, please enter the following: 1) The group authorization AZFILGRAST 2) An authorization for the non-preferred colony stimulating factor product at GPI-12 level *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC CP

Product Name:Fulphila, Fylnetra, Granix, Leukine, Neulasta, Neulasta Onpro, Neupogen, Nivestym, Nypozi, Nyvepria, Releuko, Stimufend, Udenyca, Udenyca Onbody, Zarxio, Ziextenzo, newly launched CSF/biosimilar products	
Diagnosis	Severe Chronic Neutropenia (SCN)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of severe chronic neutropenia (SCN) [i.e., congenital, cyclic, and idiopathic neutropenias with chronic absolute neutrophil count (ANC) less than or equal to 500 cells per mm³ (cubic millimeter)] AND 2 - Prescribed by, or in consultation with, a hematologist or oncologist AND 3 - If the request is non-preferred*, patient has a history of failure, contraindication, or intolerance to ALL preferred* colony stimulating factor products	
Notes	Approval Length: 12 months. If approving a preferred colony stimulating factor product, please enter the group authorization AZFILGRAST. If approving a non-preferred colony stimulating factor product, please enter the following: 1) The group authorization AZFILGRAST 2) An authorization for the non-preferred colony stimulating factor product at GPI-12 level *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC CP

Product Name:Fulphila, Fylnetra, Granix, Leukine, Neulasta, Neulasta Onpro, Neupogen, Nivestym, Nypozi, Nyvepria, Releuko, Stimufend, Udenyca, Udenyca Onbody, Zarxio, Ziextenzo, newly launched CSF/biosimilar products	
Diagnosis	HIV-Related Neutropenia (off-label)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of human immunodeficiency virus (HIV) infection

AND

2 - Patient has an absolute neutrophil count (ANC) less than or equal to 1,000 cells per mm³ (cubic millimeter)

AND

3 - Prescribed by, or in consultation with, ONE of the following:

- Hematologist
- Oncologist
- Infectious disease specialist

AND

4 - If the request is non-preferred*, patient has a history of failure, contraindication, or intolerance to ALL preferred* colony stimulating factor products

Notes	Approval Length: 6 months. If approving a preferred colony stimulating factor product, please enter the group authorization AZFILGRAST. If approving a non-preferred colony stimulating factor product, please enter the following: 1) The group authorization AZFILGRAST 2) An authorization for the non-preferred colony stimulating factor product at GPI-12 level *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC CP

Product Name: Fulphila, Fylmetra, Granix, Leukine, Neulasta, Neulasta Onpro, Neupogen, Nivestym, Nypozi, Nyvepria, Releuko, Stimufend, Udenyca, Udenyca Onbody, Zarxio, Ziextenzo, newly launched CSF/biosimilar products

Diagnosis	Hepatitis C Treatment Related Neutropenia (off-label)

Guideline Type	Prior Authorization
	Approval Criteria 1 - ONE of the following: 1.1 ALL of the following: • Diagnosis of hepatitis C virus • Patient is undergoing treatment with Peg-Intron (peginterferon alfa-2b) or Pegasys (peginterferon alfa-2a) • Documentation of neutropenia [absolute neutrophil count (ANC) less than or equal to 500 cells per mm³ (cubic millimeter)] after dose reduction of Peg-Intron or Pegasys OR 1.2 BOTH of the following: 1.2.1 Documentation of interferon-induced neutropenia (ANC less than or equal to 500 cells per mm³) due to treatment with Peg-Intron (peginterferon alfa-2b) or Pegasys (peginterferon alfa-2a) AND 1.2.2 ONE of the following: • Diagnosis of human immunodeficiency virus (HIV) co-infection • Status post liver transplant • Diagnosis of established cirrhosis AND 2 - Prescribed by, or in consultation with, a hematologist, oncologist, gastroenterologist, hepatologist, or infectious disease specialist AND

3 - If the request is non-preferred*, patient has a history of failure, contraindication, or intolerance to ALL preferred* colony stimulating factor products	
Notes	Approval Length: 12 months. If approving a preferred colony stimulating factor product, please enter the group authorization AZFILGRAST. If approving a non-preferred colony stimulating factor product, please enter the following: 1) The group authorization AZFILGRAST 2) An authorization for the non-preferred colony stimulating factor product at GPI-12 level *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:Fulphila, Fylmetra, Granix, Leukine, Neulasta, Neulasta Onpro, Neupogen, Nivestym, Nypozi, Nyvepria, Releuko, Stimufend, Udenyca, Udenyca Onbody, Zarxio, Ziextenzo, newly launched CSF/biosimilar products	
Diagnosis	Hematopoietic Syndrome of Acute Radiation Syndrome
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has been acutely exposed to myelosuppressive doses of radiation AND 2 - Prescribed by, or in consultation with, a hematologist or oncologist AND 3 - If the request is non-preferred*, patient has a history of failure, contraindication, or intolerance to ALL preferred* colony stimulating factor products	
Notes	Approval Length: 3 months. If approving a preferred colony stimulating factor product, please enter the group authorization AZFILGRAST. If approving a non-preferred colony stimulating factor product, please enter the following: 1) The group authorization AZFILGRAST 2) An authorization for the non-preferred colony stimulating factor

	product at GPI-12 level *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC CP

2 . Revision History

Date	Notes
5/8/2026	Added new GPI for Neulasta 4 mg/0.4 mL soln as a target. Updated GPI entry for Neulasta Onpro kit. No changes to clinical criteria.

Combination Basal Insulin-GLP-1 Receptor Agonist



Prior Authorization Guideline

Guideline ID	GL-421252
Guideline Name	Combination Basal Insulin-GLP-1 Receptor Agonist
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	11/1/2025

1 . Criteria

Product Name:Soliqua	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of type 2 diabetes mellitus	

AND

2 - Inadequately controlled on BOTH of the following

- GLP-1 (glucagon-like peptide-1) receptor agonist [e.g., Adlyxin (lixisenatide), Trulicity (dulaglutide), Victoza (liraglutide), Bydureon (exenatide extended-release), Byetta (exenatide)]
- Basal insulin (e.g., insulin glargine, insulin degludec, insulin detemir)

AND

3 - Provider attests that the requested medication will NOT be used concurrently with a DPP-4 inhibitor-containing agent [e.g., Januvia (sitagliptin), Jentadueto (linagliptin-metformin), Tradjenta (linagliptin)] or a plan has been developed to address concomitant use

Product Name:Xultophy	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of type 2 diabetes mellitus AND 2 - Inadequately controlled on BOTH of the following: • GLP-1 (glucagon-like peptide-1) receptor agonist [e.g., Adlyxin (lixisenatide), Trulicity (dulaglutide), Victoza (liraglutide), Bydureon (exenatide extended-release), Byetta (exenatide)] • Basal insulin (e.g., insulin glargine, insulin degludec, insulin detemir) AND	

3 - History of failure, intolerance, or contraindication to Soliqua

AND

4 - Provider attests that the requested medication will NOT be used concurrently with a DPP-4 inhibitor-containing agent [e.g., Januvia (sitagliptin), Jentadueto (linagliptin-metformin), Tradjenta (linagliptin)] or a plan has been developed to address concomitant use

Product Name: Soliqua, Xultophy

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Provider attests that the requested medication will NOT be used concurrently with a DPP-4 inhibitor-containing agent [e.g., Januvia (sitagliptin), Jentadueto (linagliptin-metformin), Tradjenta (linagliptin)] or a plan has been developed to address concomitant use

2 . Revision History

Date	Notes
10/13/2025	Added dx and reauth criteria for Soliqua

Compounds and Bulk Powders



Prior Authorization Guideline

Guideline ID	GL-143553
Guideline Name	Compounds and Bulk Powders
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	3/1/2024

1 . Criteria

Product Name:Requests for Compounds or Bulk Powders	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Administrative
Approval Criteria 1 - One of the following: 1.1 The compound is an antibiotic. or	

1.2 Each active ingredient in the compounded drug is a covered medication

AND

2 - ONE of the following:

2.1 Each active ingredient in the compounded drug is to be administered for an FDA-approved indication

or

2.2 The use of each active ingredient in the compounded drug is supported by information from ONE of the following appropriate compendia of current literature:

American Hospital Formulary Service Drug Information

National Comprehensive Cancer Network Drugs and Biologics Compendium

Thomson Micromedex DrugDex

Clinical pharmacology

United States Pharmacopoeia-National Formulary

AND

3 - If a drug included in the compound requires prior authorization and/or step therapy, all drug specific clinical criteria must also be met

AND

4 - The compounded drug must not include any ingredient that has been withdrawn or removed from the market due to safety reasons.

AND

5 - ONE of the following:

5.1 A unique vehicle is required for topically administered compounds

or

5.2 A unique dosage form is required for a commercially available product due to patient's age, weight, or inability to take a solid dosage form

or

5.3 A unique formulation is required for a commercially available product due to an allergy or intolerance to an inactive ingredient in the commercially available product

or

5.4 There is a shortage of the commercially available product per the FDA Drug Shortage database or the ASHP Current Drug Shortages tracking log

AND

6 - Coverage for compounds and bulk powders will NOT be approved for any of the following:

6.1 For topical compound preparations, requested compound contains any FDA approved ingredient that is not FDA approved for TOPICAL use

or

6.2 If the requested compound contains topical fluticasone, topical fluticasone will NOT be approved unless both of the following are met:

6.2.1 Topical fluticasone is intended to treat a dermatologic condition

AND

6.2.2 Patient has a contraindication to all commercially available topical fluticasone formulations

or

6.3 Requested compound contains any ingredients when used for cosmetic purposes

or

6.4 Requested compound contains any ingredient which are on the FDA's Do Not Compound List

Product Name:Requests for Compounds or Bulk Powders	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Administrative
Approval Criteria 1 - Patient demonstrates positive clinical response to therapy	

2 . Background

Benefit/Coverage/Program Information
Table 1: Example topical compound preparations that contain any FDA approved ingredient that are not FDA approved for TOPICAL use, including but NOT LIMITED TO the following: (1) Ketamine (2) Gabapentin (3) Flurbiprofen (topical ophthalmic use not included) (4) Ketoprofen (5) Morphine (6) Nabumetone

- (7) Oxycodone
- (8) Cyclobenzaprine
- (9) Baclofen
- (10) Tramadol
- (11) Hydrocodone
- (12) Meloxicam
- (13) Amitriptyline
- (14) Pentoxifylline
- (15) Orphenadrine
- (16) Piroxicam
- (17) Levocetirizine
- (18) Amantadine
- (19) Oxytocin
- (20) Sumatriptan
- (21) Chorionic gonadotropin (human)
- (22) Clomipramine
- (23) Dexamethasone
- (24) Hydromorphone
- (25) Methadone
- (26) Papaverine
- (27) Mefenamic acid
- (28) Promethazine

- (29) Succimer DMSA
- (30) Tizanidine
- (31) Apomorphine
- (32) Carbamazepine
- (33) Ketorolac
- (34) Dimercaptopropane-sulfonate
- (35) Dimercaptosuccinic acid
- (36) Duloxetine
- (37) Fluoxetine
- (38) Bromfenac (topical ophthalmic use not included)
- (39) Nepafenac (topical ophthalmic use not included)

Table 2: Example compounds that contain ingredients for cosmetic purposes:

- (1) Hydroquinone
- (2) Acetyl hexapeptide-8
- (3) Tocopheryl Acid Succinate
- (4) PracaSil TM-Plus
- (5) Chrysaderm Day Cream
- (6) Chrysaderm Night Cream
- (7) PCCA Spira-Wash
- (8) Lipopen Ultra
- (9) Versapro

- (10) Fluticasone
- (11) Mometasone
- (12) Halobetasol
- (13) Betamethasone
- (14) Clobetasol
- (15) Triamcinolone
- (16) Minoxidil
- (17) Tretinoin
- (18) Dexamethasone
- (19) Spironolactone
- (20) Cycloserine
- (21) Tamoxifen
- (22) Sermorelin
- (23) Mederma Cream
- (24) PCCA Cosmetic HRT Base
- (25) Sanare Scar Therapy Cream
- (26) Scarcin Cream
- (27) Apothederm
- (28) Stera Cream
- (29) Copasil
- (30) Collagenase
- (31) Arbutin Alpha

- (32) Nourisil
- (33) Freedom Cepapro
- (34) Freedom Silomac Andydrous
- (35) Retinaldehyde
- (36) Apothederm

Table 3: Example ingredients on the FDA's Do Not Compound List:

- (1) 3,3',4',5-tetrachlorosalicylanilide
- (2) Adenosine phosphate
- (3) Adrenal cortex
- (4) Alatrofloxacin mesylate
- (5) Aminopyrine
- (6) Astemizole
- (7) Azaribine
- (8) Benoxaprofen
- (9) Bithionol
- (10) Camphorated oil
- (11) Carbetapentane citrate
- (12) Casein, iodinated
- (13) Cerivastatin sodium
- (14) Chlormadinone acetate
- (15) Chloroform

- (16) Cisapride
- (17) Defenfluramine hydrochloride
- (18) Diamthazole dihydrochloride
- (19) Dibromsalan
- (20) Dihydrostreptomycin sulfate
- (21) Dipyrone
- (22) Encainide hydrochloride
- (23) Etretinate
- (24) Fenfluramine hydrochloride
- (25) Flosequinan
- (26) Glycerol, iodinated
- (27) Grepafloxacin
- (28) Mepazine
- (29) Metabromsalan
- (30) Methapyrilene
- (31) Methopholine
- (32) Methoxyflurane
- (33) Mibefradil dihydrochloride
- (34) Nomifensine maleate
- (35) Novobiocin sodium
- (36) Oxyphenisatin acetate
- (37) Oxyphenisatin

- (38) Pemoline
- (39) Pergolide mesylate
- (40) Phenacetin
- (41) Phenformin hydrochloride
- (42) Phenylpropanolamine
- (43) Pipamazine
- (44) Potassium arsenite
- (45) Propoxyphene
- (46) Rapacuronium bromide
- (47) Rofecoxib
- (48) Sibutramine hydrochloride
- (49) Sparteine sulfate
- (50) Sulfadimethoxine
- (51) Sweet spirits of nitre
- (52) Tegaserod maleate
- (53) Temafloxacin hydrochloride
- (54) Terfenadine
- (55) Ticrynafen
- (56) Tribromsalan
- (57) Trichloroethane
- (58) Troglitazone
- (59) Trovafloxacin mesylate:

(60) Urethane

(61) Valdecoxib

(62) Zomepirac sodium

3 . Revision History

Date	Notes
2/26/2024	Changed initial approval duration to 6 months and added reauth with 12 month approval duration.

Constipation Agents



Prior Authorization Guideline

Guideline ID	GL-502195
Guideline Name	Constipation Agents
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Brand Amitiza, generic lubiprostone	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 ONE of the following diagnoses:	

- Opioid-induced constipation in an adult with chronic, non-cancer pain
- Opioid-induced constipation in patients with chronic pain related to prior cancer or its treatment who do not require frequent (e.g., weekly) opioid dosage escalation
- Chronic idiopathic constipation

OR

1.2 BOTH of the following:

- Diagnosis of irritable bowel syndrome with constipation
- Patient was female at birth

AND

2 - BOTH of the following:

2.1 Trial and failure, contraindication, or intolerance to an osmotic laxative (e.g., lactulose, polyethylene glycol, sorbitol)

AND

2.2 Trial and failure, contraindication, or intolerance to ONE of the following:

- Bulk Forming Laxatives (e.g., psyllium, fiber)
- Stimulant Laxatives (e.g., bisacodyl, senna)

Product Name:lbsrela	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of irritable bowel syndrome with constipation	

AND

2 - History of failure, contraindication, or intolerance to BOTH of the following:

- Lactulose
- Polyethylene glycol (Miralax)

AND

3 - History of failure, contraindication, or intolerance to ONE of the following:

- Lubiprostone
- Linzess

Product Name:Linzess	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 BOTH of the following: • Diagnosis of irritable bowel syndrome with constipation (IBS-C) • Patient is 7 years of age or older OR 1.2 BOTH of the following: • Diagnosis of chronic idiopathic constipation (CIC) • Patient is 18 years of age or older	

OR

1.3 ALL of the following:

- Diagnosis of functional constipation
- Patient is 6-17 years of age
- The request is for Linzess 72 mcg

AND

2 - BOTH of the following:

2.1 Trial and failure, contraindication, or intolerance to an osmotic laxative (e.g., lactulose, polyethylene glycol, sorbitol)

AND

2.2 Trial and failure, contraindication, or intolerance to ONE of the following:

- Bulk Forming Laxatives (e.g., psyllium, fiber)
- Stimulant Laxatives (e.g., bisacodyl, senna)

Product Name: Brand Motegrity, generic prucalopride	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chronic idiopathic constipation AND 2 - BOTH of the following:	

2.1 History of failure, contraindication, or intolerance to BOTH of the following:

- Lactulose
- Polyethylene glycol (Miralax)

AND

2.2 History of failure, contraindication, or intolerance to BOTH of the following:

- Linzess
- Lubiprostone

Product Name: Movantik	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following diagnoses: • Opioid-induced constipation in patients being treated for chronic, non-cancer pain • Opioid-induced constipation in patients with chronic pain related to prior cancer or its treatment who do not require frequent (e.g., weekly) opioid dosage escalation	

Product Name: Symproic	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - ONE of the following diagnoses:

- Opioid-induced constipation in patients being treated for chronic, non-cancer pain
- Opioid-induced constipation in patients with chronic pain related to prior cancer or its treatment who do not require frequent (e.g., weekly) opioid dosage escalation

AND

2 - History of failure, contraindication, or intolerance to BOTH of the following:

- Lactulose
- Polyethylene glycol (Miralax)

AND

3 - History of failure, contraindication, or intolerance to Movantik

Product Name:Zelnorm	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of irritable bowel syndrome with constipation AND 2 - Patient was female at birth AND 3 - History of failure, contraindication, or intolerance to BOTH of the following:	

- Lactulose
- Polyethylene glycol (Miralax)

AND

4 - History of failure, contraindication, or intolerance to ONE of the following:

- Lubiprostone
- Linzess

Product Name: Brand Amitiza, generic lubiprostone, Ibsrela, Linzess, Brand Motegrity, generic prucalopride, Movantik, Symproic, Zelnorm

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

2 . Revision History

Date	Notes
1/14/2026	Updated age criterion for Linzess, IBS-C due to expanded indication

Continuous Blood Glucose Monitoring Devices (CGM)



Prior Authorization Guideline

Guideline ID	GL-503307
Guideline Name	Continuous Blood Glucose Monitoring Devices (CGM)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Continuous Glucose Monitors, sensors, and transmitters (all brands)	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Patient is already established on the requested continuous blood glucose monitoring	

(CGM) system [Submission of medical records (e.g., chart notes) is required if the request is non-preferred*]

OR

1.2 Patient is insulin dependent as confirmed by paid claims for insulin within the past 60 days and the request is for a preferred* product

OR

1.3 ALL of the following [Submission of medical records (e.g., chart notes, lab results) is required if the request is non-preferred*]:

1.3.1 ONE of the following:

1.3.1.1 If the request is preferred*, ONE of the following:

1.3.1.1.1 BOTH of the following:

- Diagnosis of Type I or II Diabetes Mellitus
- Frequent insulin adjustments are required based on the results of blood glucose monitoring or CGM testing results

OR

1.3.1.1.2 ONE of the following diagnoses:

- Gestational Diabetes
- Hypoglycemia Unawareness (HU) (defined as the onset of neuroglycopenia, low blood glucose in the brain, before the appearance of autonomic warning symptoms, or the failure to sense a significant fall in blood glucose below normal levels)
- Postprandial Hyperglycemia
- Recurrent Diabetic Ketoacidosis

OR

1.3.1.1.3 Patient requires short term use (72 hours) to determine baseline insulin levels prior to insulin pump initiation

OR

1.3.1.2 If the request is non-preferred*, ONE of the following:

1.3.1.2.1 ALL of the following:

- Diagnosis of Type I or II Diabetes Mellitus
- Patient is insulin dependent as demonstrated by paid claims within the past 60 days
- Frequent insulin adjustments are required based on the results of blood glucose monitoring or CGM testing results

OR

1.3.1.2.2 ONE of the following diagnoses:

- Gestational Diabetes
- Hypoglycemia Unawareness (HU) (defined as the onset of neuroglycopenia, low blood glucose in the brain, before the appearance of autonomic warning symptoms, or the failure to sense a significant fall in blood glucose below normal levels)
- Postprandial Hyperglycemia
- Recurrent Diabetic Ketoacidosis

OR

1.3.1.2.3 Patient requires short term use (72 hours) to determine baseline insulin levels prior to insulin pump initiation

AND

1.3.2 Patient must meet the FDA approved age for the requested product

AND

1.3.3 ONE of the following:

- Hemoglobin A1c > 7.0%
- Frequent hypoglycemic episodes

- Patient has a diagnosis that is not defined by elevated hemoglobin A1c or frequent hypoglycemia (e.g., Gestational Diabetes)

AND

1.3.4 Provider attests patient is enrolled or has completed a comprehensive diabetes education program

AND

1.3.5 If the request is non-preferred*, patient has tried and failed ALL preferred* products

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:Continuous Glucose Monitors, sensors, and transmitters (all brands)	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is using the same continuous glucose monitoring device on a regular basis as evidenced through the patient's claims history and the providers chart notes AND 2 - Patient is adherent to using the device AND 3 - Patient has shared the device readings with physician or healthcare professional for review as part of overall diabetes management	

2 . Revision History

Date	Notes
1/20/2026	Cleaned up GPI list. No changes to clinical criteria.

Copper Chelating Agents



Prior Authorization Guideline

Guideline ID	GL-141006
Guideline Name	Copper Chelating Agents
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	12/1/2023

1 . Criteria

Product Name: Brand Depen Titratab, generic penicillamine tablets	
Diagnosis	Severe active rheumatoid arthritis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of severe active rheumatoid arthritis	

Product Name:Brand Depen Titratab, generic penicillamine tablets	
Diagnosis	Severe active rheumatoid arthritis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Depen Titratabs therapy	

Product Name:Brand Depen Titratab, generic penicillamine tablets	
Diagnosis	Wilson's disease (i.e., hepatolenticular degeneration), Cystinuria
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has ONE of the following diagnoses: • Diagnosis of Wilson's disease (i.e., hepatolenticular degeneration) • Diagnosis of Cystinuria	

Product Name:Brand Cuprimine, generic penicillamine capsules	
Diagnosis	Wilson's disease (i.e., hepatolenticular degeneration), Cystinuria, Severe active rheumatoid arthritis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Patient has ONE of the following diagnoses:

- Wilson's disease (i.e., hepatolenticular degeneration)
- Cystinuria
- Severe active rheumatoid arthritis

AND

2 - History of failure or intolerance to Depen (penicillamine)

Product Name:Brand Cuprimine, generic penicillamine capsules

Diagnosis	Wilson's disease (i.e., hepatolenticular degeneration), Cystinuria, Severe active rheumatoid arthritis

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Cuprimine (penicillamine) therapy

Product Name:Brand Syprine, generic trientine, generic Clovique

Diagnosis	Wilson's disease (i.e., hepatolenticular degeneration)

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Wilson's disease (i.e., hepatolenticular degeneration)

AND

2 - History of failure, contraindication, or intolerance to Depen (penicillamine) or Cuprimine (penicillamine)

Product Name: Brand Syprine, generic trientine, generic Clovique	
Diagnosis	Wilson's disease (i.e., hepatolenticular degeneration)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Syprine (trientine) therapy	

2 . Revision History

Date	Notes
11/6/2023	Added new GPI for trientine

Corlanor



Prior Authorization Guideline

Guideline ID	GL-140635
Guideline Name	Corlanor
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2020

1 . Criteria

Product Name:Corlanor	
Diagnosis	Chronic Heart Failure
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Worsening heart failure in a diagnosis of stable, symptomatic chronic (e.g. New York Heart Association (NYHA) class II, III or IV) heart failure	

AND

2 - Patient has a left ventricular ejection fraction (EF) less than or equal to 35%

AND

3 - The patient is in sinus rhythm

AND

4 - Patient has a resting heart rate greater than or equal to 70 beats per minute

AND

5 - ONE of the following:

5.1 Patient is on maximum tolerated doses of beta blockers (e.g., carvedilol, metoprolol succinate, bisoprolol)

OR

5.2 Patient has a contraindication or intolerance to beta-blocker therapy

Product Name:Corlanor	
Diagnosis	Heart Failure due to Dilated Cardiomyopathy (DCM)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of stable symptomatic heart failure due to dilated cardiomyopathy (DCM)

AND

2 - Patient is in sinus rhythm

AND

3 - Patient has an elevated heart rate

Product Name: Corlanor

Diagnosis	Chronic Heart Failure, Heart Failure due to Dilated Cardiomyopathy (DCM)

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Corlanor therapy

2 . Revision History

Date	Notes
3/31/2020	Bulk Copy C&S New York to C&S Arizona for effective date of 5/1

Cosentyx (secukinumab)



Prior Authorization Guideline

Guideline ID	GL-603194
Guideline Name	Cosentyx (secukinumab)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Cosentyx SC	
Diagnosis	Plaque Psoriasis (PsO)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) or verification of paid claims documenting ALL of the following:	

1.1 Diagnosis of moderate to severe plaque psoriasis (PsO)

AND

1.2 Greater than or equal to 3 percent body surface area involvement, palmoplantar, facial, or genital involvement, or severe scalp psoriasis

AND

1.3 History of failure to ONE of the following topical therapies, unless contraindicated or clinically significant adverse effects are experienced:

- corticosteroids (e.g., betamethasone, clobetasol, desonide)
- vitamin D analogs (e.g., calcitriol, calcipotriene)
- tazarotene
- calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)

AND

1.4 History of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

1.5 History of failure, contraindication, or intolerance to ONE of the following topical therapies:

- Vtama
- Zoryve 0.3% cream

AND

1.6 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred^ adalimumab biosimilar or Enbrel (etanercept)
- Infliximab (Janssen manufacturer)
- Otezla (apremilast)

- A preferred^ ustekinumab biosimilar

AND

2 - Patient is 6 years of age or older

AND

3 - Prescribed by or in consultation with a dermatologist

Notes	^PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC CP

Product Name:Cosentyx SC

Diagnosis	Hidradenitis Suppurativa (HS)

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Submission of medical records (e.g., chart notes) confirming a diagnosis of moderate to severe hidradenitis suppurativa (HS)

AND

1.2 Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure, contraindication, or intolerance to a preferred^ adalimumab biosimilar

AND

1.3 Patient is 12 years of age or older

AND	
2 - Prescribed by or in consultation with a dermatologist	
Notes	^PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name: Cosentyx SC	
Diagnosis	Plaque Psoriasis (PsO), Hidradenitis Suppurativa (HS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy AND 2 - Prescribed by or in consultation with a dermatologist	

Product Name: Cosentyx SC	
Diagnosis	Enthesitis-Related Arthritis (ERA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) or verification of paid claims documenting BOTH of the following:	

1.1 Diagnosis of active enthesitis-related arthritis (ERA)

AND

1.2 Trial and failure, contraindication, or intolerance to TWO preferred^ non-steroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen, naproxen)

AND

2 - Patient is 4 years of age or older

AND

3 - Prescribed by or in consultation with a rheumatologist

Notes	^PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name: Cosentyx SC	
Diagnosis	Enthesitis-Related Arthritis (ERA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of a positive clinical response to therapy as evidenced by at least ONE of the following: - Reduction in the total active (swollen and tender) joint count from baseline - Improvement in symptoms (e.g., pain, stiffness, inflammation) from baseline AND	

2 - Prescribed by or in consultation with a rheumatologist

Product Name:Cosentyx SC

Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) or verification of paid claims documenting ALL of the following:

1.1 Diagnosis of active psoriatic arthritis (PsA)

AND

1.2 History of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

1.3 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred^ adalimumab biosimilar or Enbrel (etanercept)
- Infliximab (Janssen manufacturer)
- Orencia (abatacept)
- Otezla (apremilast)
- Xeljanz (tofacitinib) oral tablet (IR or XR)
- A preferred^ ustekinumab biosimilar

AND

2 - Patient is 2 years of age or older

AND	
3 - Prescribed by or in consultation with ONE of the following: • Rheumatologist • Dermatologist	
Notes	^PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name: Cosentyx SC	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy AND 2 - Prescribed by or in consultation with ONE of the following: • Rheumatologist • Dermatologist	

Product Name: Cosentyx SC	
Diagnosis	Ankylosing Spondylitis (AS), Non-Radiographic Axial Spondyloarthritis (nr-axSpA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) or verification of paid claims documenting ALL of the following: 1.1 ONE of the following diagnoses: • Active ankylosing spondylitis (AS) • Active non-radiographic axial spondyloarthritis (nr-axSpA) AND 1.2 History of failure to TWO NSAIDs (non-steroidal anti-inflammatory drugs) (e.g., ibuprofen, naproxen) at maximally indicated doses, each used for at least 4 weeks within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced AND 1.3 History of failure, contraindication, or intolerance to ALL of the following: • A preferred^ adalimumab biosimilar or Enbrel (etanercept) • Infliximab (Janssen manufacturer) • Xeljanz (tofacitinib) oral tablet (IR or XR) AND 2 - Prescribed by or in consultation with a rheumatologist	
Notes	^PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name: Cosentyx SC	
Diagnosis	Ankylosing Spondylitis (AS), Non-Radiographic Axial Spondyloarthritis (nr-axSpA)
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy AND 2 - Prescribed by or in consultation with a rheumatologist	

2 . Revision History

Date	Notes
5/6/2026	Added age criterion to HS indication due to expanded age approval.

Cough and Cold Products



Prior Authorization Guideline

Guideline ID	GL-140671
Guideline Name	Cough and Cold Products
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Hydromet, generic Tussionex, Z-Tuss AC, Tuzistra XR, Tussicaps, generic Tussionex, M-END PE, Poly-Tussin AC, Capcof, Pro-Red AC, Histex-AC, Maxi-Tuss, generic promethazine w/codeine, generic promethazine-phenylephrine-codeine, Rydex, Mar-Cof BP/Mar-Cof GG, Ninjacof-XG, Coditussin AC/Coditussin DAC, generic guaifenesin-codeine, generic pseudoephedrine w/codeine-guaifenesin, Tuxarin ER	
Diagnosis	Under the Age of 18 Years for Cough and Cold Products
Approval Length	30 Day(s)
Guideline Type	Prior Authorization
Approval Criteria	

1 - Prescriber attests they are aware of Food and Drug Administration (FDA) labeled contraindications regarding use of opioid containing cough and cold products in patients less than 18 years of age and feels the treatment with the requested product is medically necessary (Document rationale for use)

AND

2 - Patient does not have a comorbid condition that may impact respiratory depression (e.g., asthma or other chronic lung disease, sleep apnea, body mass index greater than 30)

AND

3 - Patient has tried and failed at least one non-opioid containing cough and cold remedy

Product Name:Hydromet, generic Tussionex, Z-Tuss AC, Tuzistra XR, Tussicaps, generic Tussionex, M-END PE, Poly-Tussin AC, Capcof, Pro-Red AC, Histex-AC, Maxi-Tuss, generic promethazine w/codeine, generic promethazine-phenylephrine-codeine, Rydex, Mar-Cof BP/Mar-Cof GG, Ninjacof-XG, Coditussin AC/Coditussin DAC, generic guaifenesin-codeine, generic pseudoephedrine w/codeine-guaifenesin, Tuxarin ER

Diagnosis	Quantity Limit
Approval Length	30 Day(s)
Guideline Type	Quantity Limit*

Approval Criteria

1 - Prescriber attests that a larger quantity is medically necessary

AND

2 - The requested dose is within the Food and Drug Administration (FDA) maximum dose per day, where an FDA maximum dose per day exists (See table in background section)

Notes	*Authorization will be issued for up to 30 days. The authorization should be entered for the quantity requested.

2 . Background

Benefit/Coverage/Program Information	
CDC Recommended Opioid Maximum Morphine Milligram Equivalents per Day*	
Active Ingredient	FDA Label Max Daily Doses
Morphine	None
Hydromorphone	None
Hydrocodone	None
Tapentadol	600mg IR products
Oxymorphone	None
Oxycodone	None
Codeine	360mg
Pentazocine	None
Tramadol	400mg IR products
Meperidine	600mg
Butorphanol nasal	None
Opium	4 suppositories/day Deodorized tincture: 24mg/day Camphorated tincture: 16mg/day
Acetaminophen	4g/day
Aspirin	2080mg/day
Ibuprofen	3200mg/day
Benzhydrocodone**	None

3 . Revision History

UnitedHealthcare Community Plan of Arizona Clinical Pharmacy Program Guidelines

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Coverage of Off-Label Non-FDA Approved Indications



Prior Authorization Guideline

Guideline ID	GL-212195
Guideline Name	Coverage of Off-Label Non-FDA Approved Indications
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	4/1/2025

1 . Criteria

Product Name:A drug (non-anti-cancer chemotherapeutic regimen) used for an off-label indication or non-FDA approved indication	
Diagnosis	Off-label non-cancer indication
Approval Length	12 month(s)
Guideline Type	Administrative
Approval Criteria 1 - The use of this drug is supported by information from ONE of the following appropriate compendia of current literature: Published practice guidelines and treatment protocols Comparative data evaluating the efficacy, type and frequency of side effects and	

potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes

Drug Facts and Comparisons

American Hospital Formulary Service Drug Information

United States Pharmacopeia – Drug Information

DRUGDEX Information System

UpToDate

MicroMedex

Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies

Other drug reference resources

AND

2 - If the request is for a non-preferred* medication, ONE of the following:

2.1 Submission of medical records or paid claims confirming history of trial resulting in a therapeutic failure, contraindication, or intolerance to at least THREE preferred* alternatives alternatives must sufficiently demonstrate that the formulary/PDL alternatives are either ineffective or inappropriate at the time of the request)

or

2.2 Submission of medical records from prescribing clinician supporting the medical necessity of the Non-Preferred Drug over the Preferred Drug for the patient

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP Off-label use may be reviewed for medical necessity and denied as such if the off-label criteria are not met. Please refer to drug specific PA guideline for off-label criteria if available.

Product Name:A drug or biological in an anti-cancer chemotherapeutic regimen	
Diagnosis	Off-label cancer indication
Approval Length	12 month(s)
Guideline Type	Administrative

Approval Criteria

1 - ONE of the following:

1.1 Diagnosis is supported as a use in AHFS DI

OR

1.2 Diagnosis is supported as a use in the National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1, 2A, or 2B (see NCCN Categories of Evidence and Consensus table in Background section) [A]

OR

1.3 Diagnosis is supported in the FDA Uses/Non-FDA Uses section in DRUGDEX Evaluation with a Strength of Recommendation rating of Class I, Class IIa, or Class IIb (see DRUGDEX Strength of Recommendation table in Background section)

OR

1.4 Diagnosis is supported as an indication in Clinical Pharmacology

OR

1.5 Off-label use is supported in ONE of the published, peer-reviewed medical literature listed below: [B]

- American Journal of Medicine
- Annals of Internal Medicine
- Annals of Oncology
- Annals of Surgical Oncology
- Biology of Blood and Marrow Transplantation
- Blood
- Bone Marrow Transplantation
- British Journal of Cancer
- British Journal of Hematology
- British Medical Journal
- Cancer

- Clinical Cancer Research
- Drugs
- European Journal of Cancer (formerly the European Journal of Cancer and Clinical Oncology)
- Gynecologic Oncology
- International Journal of Radiation, Oncology, Biology, and Physics
- The Journal of the American Medical Association
- Journal of Clinical Oncology
- Journal of the National Cancer Institute
- Journal of the National Comprehensive Cancer Network (NCCN)
- Journal of Urology
- Lancet
- Lancet Oncology
- Leukemia
- The New England Journal of Medicine
- Radiation Oncology

OR

1.6 Diagnosis is supported as a use in Wolters Kluwer Lexi-Drugs rated as "Evidence Level A" with a "Strong" recommendation (see Lexi-Drugs Strength of Recommendation table in Background section)

AND

2 - If the request is for a non-preferred* medication, ONE of the following:

2.1 Submission of medical records (e.g., chart notes) or paid claims confirming history of trial resulting in a therapeutic failure, contraindication, or intolerance to at least THREE preferred* alternatives (if available) (Prior trials of formulary/preferred drug list (PDL) alternatives must sufficiently demonstrate that the formulary/PDL alternatives are either ineffective or inappropriate at the time of the request)

OR

2.2 Submission of medical records (e.g., chart notes) from prescribing clinician supporting the medical necessity of the Non-Preferred Drug over the Preferred Drug for the patient

Notes

*PDL link: <https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP>

Off-label use may be reviewed for medical necessity and denied as su

	ch if the off-label criteria are not met. Please refer to drug specific PA guideline for off-label criteria if available.

2 . Background

Clinical Practice Guidelines

DRUGDEX Strength of Recommendation

Class	Recommendation	Description
Class I	Recommended	The given test or treatment has been proven useful, and should be performed or administered.
Class IIa	Recommended, In Most Cases	The given test or treatment is generally considered to be useful, and is indicated in most cases.
Class IIb	Recommended, in Some Cases	The given test or treatment may be useful, and is indicated in some, but not most, cases.
Class III	Not Recommended	The given test or treatment is not useful, and should be avoided
Class Indeterminate	Evidence Inconclusive	

NCCN Categories of Evidence and Consensus [A]

Category	Level of Consensus

1	Based upon high-level evidence, there is uniform NCCN consensus that the intervention is appropriate.	
2A	Based upon lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate.	
2B	Based upon lower-level evidence, there is NCCN consensus that the intervention is appropriate.	
3	Based upon any level of evidence, there is major NCCN disagreement that the intervention is appropriate.	

Lexi-Drugs: Strength of Recommendation for Inclusion in Lexi-Drugs for Oncology Off-Label Use and Level of Evidence Scale for Oncology Off-Label Use

Strength of Recommendation for Inclusion

Strong (for proposed off-label use)	The evidence persuasively supports the off-label use (ie, Level of Evidence A).
Equivocal (for proposed off-label use)	The evidence to support the off-label use is of uncertain clinical significance (ie, Level of Evidence B, C). Additional studies may be necessary to further define the role of this medication

	for the off-label use.
Against proposed off-label use	The evidence either advocates against the off-label use or suggests a lack of support for the off-label use (independent of Level of Evidence). Additional studies are necessary to define the role of this medication for the off-label use.

Level of Evidence Scale for Oncology Off-Label Use

A	Consistent evidence from well-performed randomized, controlled trials or overwhelming evidence of some other form (eg, results of the introduction of penicillin treatment) to support off-label use. Further research is unlikely to change confidence in the estimate of benefit.
B	Evidence from randomized, controlled trials with important limitations (eg, inconsistent results, methodologic flaws, indirect, imprecise); or very strong evidence of some other research design. Further research

	(if performed) is likely to have an impact on confidence in the estimate of benefit and risk and may change the estimate.
C	Evidence from observational studies (eg, retrospective case series/reports providing significant impact on patient care); unsystematic clinical experience; or potentially flawed randomized, controlled trials (eg, when limited options exist for condition). Any estimate of effect is uncertain.
G	Use has been substantiated by inclusion in at least one evidence-based or consensus-based clinical practice guideline.

3 . Endnotes

- A. NCCN Categories of Evidence and Consensus. Category 1: The recommendation is based on high-level evidence (i.e., high-powered randomized clinical trials or meta-analyses), and the NCCN Guideline Panel has reached uniform consensus that the recommendation is indicated. In this context, uniform means near unanimous positive support with some possible neutral positions. Category 2A: The recommendation is based on lower level evidence, but despite the absence of higher level studies, there is uniform consensus that the recommendation is appropriate. Lower level evidence is interpreted broadly, and runs the gamut from phase II to large cohort studies to case series to individual practitioner experience. Importantly, in many instances, the retrospective studies are derived from clinical experience of treating large numbers of patients at a member institution, so NCCN Guideline Panel Members have first-hand knowledge of the data. Inevitably, some recommendations must address clinical situations for which limited or no data exist. In these instances the congruence of experience-based judgments provides an informed if not confirmed direction for optimizing patient care. These recommendations carry the implicit recognition that they may be superseded as higher level evidence becomes available or as outcomes-based information becomes more prevalent. Category 2B: The recommendation is based on lower level evidence, and there is nonuniform consensus that the recommendation should be made. In these instances, because the evidence is not conclusive, institutions take different approaches to the management of a particular clinical scenario. This nonuniform consensus does not represent a major disagreement, rather it recognizes that given imperfect information, institutions may adopt different approaches. A Category 2B designation should signal to the user that more than one approach can be inferred from the existing data. Category 3: Including the recommendation has engendered a major disagreement among the NCCN Guideline Panel Members. The level of evidence

is not pertinent in this category, because experts can disagree about the significance of high level trials. Several circumstances can cause major disagreements. For example, if substantial data exist about two interventions but they have never been directly compared in a randomized trial, adherents to one set of data may not accept the interpretation of the other side's results. Another situation resulting in a Category 3 designation is when experts disagree about how trial data can be generalized. An example of this is the recommendation for internal mammary node radiation in postmastectomy radiation therapy. One side believed that because the randomized studies included this modality, it must be included in the recommendation. The other side believed, based on the documented additional morbidity and the role of internal mammary radiation therapy in other studies, that this was not necessary. A Category 3 designation alerts users to a major interpretation issue in the data and directs them to the manuscript for an explanation of the controversy.

- B. Abstracts (including meeting abstracts) are excluded from consideration. When evaluating peer-reviewed medical literature, the following (among other things) should be considered: 1) Whether the clinical characteristics of the beneficiary and the cancer are adequately represented in the published evidence 2) Whether the administered chemotherapy regimen is adequately represented in the published evidence. 3) Whether the reported study outcomes represent clinically meaningful outcomes experienced by patients. 4) Whether the study is appropriate to address the clinical question. The following should be considered: a) Whether the experimental design, in light of the drugs and conditions under investigation, is appropriate to address the investigative question. (For example, in some clinical studies, it may be unnecessary or not feasible to use randomization, double blind trials, placebos, or crossover.); b) That non-randomized clinical trials with a significant number of subjects may be a basis for supportive clinical evidence for determining accepted uses of drugs; and c) That case reports are generally considered uncontrolled and anecdotal information and do not provide adequate supportive clinical evidence for determining accepted uses of drugs.

4 . Revision History

Date	Notes
3/7/2025	For both non-anti-cancer and anti-cancer criteria sections, added criterion pertaining to non-preferred medication requests and added PD L link in notes sections. Removed FDA approved indications option for compendia support from non-anti-cancer criteria section. Removed references section. Minor spelling/cosmetic updates.

Crenessity (crinecerfont)



Prior Authorization Guideline

Guideline ID	GL-363195
Guideline Name	Crenessity (crinecerfont)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	9/1/2025

1 . Criteria

Product Name:Crenessity	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of classic 21-hydroxylase deficiency congenital adrenal hyperplasia	

AND

2 - Patient is 4 years of age or older

AND

3 - Submission of medical records (e.g., chart notes) or paid claims documenting patient is receiving chronic treatment with glucocorticoid (GC) replacement therapy (e.g., dexamethasone, hydrocortisone, methylprednisolone) for adrenal insufficiency as one of the following:

3.1 Both of the following:

- Patient is 4 to 17 years old
- Daily GC dose is greater than 12 mg/m²/day in hydrocortisone dose equivalents

OR

3.2 Both of the following:

- Patient is 18 years of age or older
- Daily GC dose is greater than 13 mg/m²/day in hydrocortisone dose equivalents

AND

4 - Prescribed by an endocrinologist

Product Name:Crenessity	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Submission of medical records (e.g., chart notes) documenting that patient demonstrates positive clinical response to therapy (e.g., lowered androgen levels, reduced daily dose of steroids)

AND

2 - Submission of medical records (e.g., chart notes) or paid claims documenting patient continues to receive chronic treatment with glucocorticoid (GC) replacement therapy (e.g., dexamethasone, hydrocortisone, methylprednisolone)

AND

3 - Prescribed by or in consultation with an endocrinologist

2 . Revision History

Date	Notes
8/11/2025	Added GPI for new 25mg caps.

Cuvrior (trientine hydrochloride)



Prior Authorization Guideline

Guideline ID	GL-140984
Guideline Name	Cuvrior (trientine hydrochloride)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	8/1/2023

1 . Criteria

Product Name:Cuvrior	
Diagnosis	Wilson's disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Wilson's disease (i.e., hepatolenticular degeneration)	

AND

2 - Documentation of ONE of the following:

- Presence of Kayser-Fleisher rings
- Serum ceruloplasmin (CPN) less than 20 mg/dL (milligrams/deciliter)
- 24-hour urinary copper excretion greater than 100 mcg (micrograms)
- Liver biopsy with copper dry weight greater than 250 mcg/g (gram)
- ATP7B mutation via genetic testing

AND

3 - Trial and failure, contraindication, or intolerance to generic penicillamine capsules

AND

4 - Prescribed by or in consultation with ONE of the following:

- Gastroenterologist
- Hepatologist

Product Name:Cuvrior	
Diagnosis	Wilson's disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of a positive clinical response to therapy	

2 . Revision History

UnitedHealthcare Community Plan of Arizona Clinical Pharmacy Program Guidelines

Date	Notes
7/7/2023	Updated guideline name and all criteria, indications, and auth durations.

Cystaran, Cystadrops



Prior Authorization Guideline

Guideline ID	GL-140858
Guideline Name	Cystaran, Cystadrops
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	1/1/2021

1 . Criteria

Product Name:Cystaran, Cystadrops	
Diagnosis	Cystinosis
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of cystinosis	

2 . Revision History

Date	Notes
11/23/2020	Added Cystadrops

Daliresp (roflumilast)



Prior Authorization Guideline

Guideline ID	GL-140761
Guideline Name	Daliresp (roflumilast)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	1/1/2023

1 . Criteria

Product Name: Brand Daliresp, generic roflumilast	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of severe to very severe chronic obstructive pulmonary disease (COPD) [i.e., FEV1 (forced expiratory volume over 1 second) less than or equal to 50% of predicted]	

AND

2 - COPD is associated with chronic bronchitis

AND

3 - History of COPD exacerbation(s)

Product Name:Brand Daliresp, generic roflumilast	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to the requested therapy	

2 . Revision History

Date	Notes
12/12/2022	Updated guideline name, updated GPI and product name lists, added generic roflumilast, cleaned up criteria.

Daraprim



Prior Authorization Guideline

Guideline ID	GL-140895
Guideline Name	Daraprim
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Brand Daraprim, generic pyrimethamine	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Medical record documentation (e.g. chart notes) of one of the following: 1.1 Treatment of severe acquired toxoplasmosis, including toxoplasmic encephalitis	

OR

1.2 Treatment of congenital toxoplasmosis

OR

1.3 Secondary prophylaxis of toxoplasmic encephalitis

OR

1.4 ALL of the following:

1.4.1 Primary Pneumocystis pneumonia (PCP) prophylaxis in human immunodeficiency virus (HIV)-infected patients or as secondary prophylaxis in HIV-infected patients who have been treated for an acute episode of Pneumocystis pneumonia

AND

1.4.2 Patient has experienced intolerance to prior prophylaxis with trimethoprim-sulfamethoxazole (TMP-SMX)

AND

1.4.3 ONE of the following:

1.4.3.1 Patient has been re-challenged with trimethoprim-sulfamethoxazole (TMP-SMX) using a desensitization protocol and is still unable to tolerate

OR

1.4.3.2 Evidence of moderately severe or life threatening-reaction to trimethoprim-sulfamethoxazole (TMP-SMX) in the past (e.g. toxic epidermal necrolysis (TEN), Stevens-Johnson syndrome)

OR

1.5 ALL of the following:

1.5.1 Primary prophylaxis of toxoplasmic encephalitis

AND

1.5.2 Toxoplasma immunoglobulin G (IgG) positive

AND

1.5.3 CD4 (cluster of differentiation 4) less than or equal to 100 cells per mm³ if initiating prophylaxis or CD4 100-200 cells per mm³ if reinstituting prophylaxis

AND

1.5.4 Will be used in combination with dapsone or atovaquone

AND

1.5.5 Patient has experienced intolerance to prior prophylaxis with trimethoprim-sulfamethoxazole (TMP-SMX)

AND

1.5.6 ONE of the following:

1.5.6.1 Patient has been re-challenged with trimethoprim-sulfamethoxazole (TMP-SMX) using a desensitization protocol and is still unable to tolerate

OR

1.5.6.2 Evidence of moderately severe or life threatening-reaction to trimethoprim-

sulfamethoxazole (TMP-SMX) in the past (e.g. toxic epidermal necrolysis (TEN), Stevens-Johnson syndrome)	
Notes	*Consider discontinuation of primary prophylaxis if CD4 greater than 200 cells/mm ³ for greater than 3 months after institution of combination antiretroviral therapy.

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Daybue (trofinetide)



Prior Authorization Guideline

Guideline ID	GL-510404
Guideline Name	Daybue (trofinetide)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name:Daybue, Daybue Stix	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Rett syndrome	

AND

2 - ONE of the following:

2.1 Submission of medical records (e.g., chart notes) confirming presence of ALL of the following clinical signs and symptoms:

2.1.1 A pattern of development, regression, then recovery or stabilization

AND

2.1.2 Partial or complete loss of purposeful hand skills, such as grasping with fingers, reaching for things, or touching things on purpose

AND

2.1.3 Partial or complete loss of spoken language

AND

2.1.4 Repetitive hand movements, such as wringing the hands, washing, squeezing, clapping, or rubbing

AND

2.1.5 Gait abnormalities, including walking on toes or with an unsteady, wide-based, stiff-legged gait

OR

2.2 Submission of medical records (e.g., chart notes) documenting molecular genetic testing confirms mutations in the MECP2 gene

AND

3 - Patient is 2 years of age or older

AND

4 - Prescribed by or in consultation with ONE of the following:

- Geneticist
- Neurologist

Product Name:Daybue, Daybue Stix	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy	

2 . Revision History

Date	Notes
2/5/2026	Added Daybue Stix products as targets. Updated product name lists and GPI tables accordingly. No changes to clinical criteria.

DDAVP, Desmoda (desmopressin)



Prior Authorization Guideline

Guideline ID	GL-565277
Guideline Name	DDAVP, Desmoda (desmopressin)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name: Brand DDAVP tablets, generic desmopressin tablets, generic desmopressin nasal spray, Desmoda	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Diagnosis of central diabetes insipidus	

OR	
1.2 Diagnosis of polyuria and/or polydipsia following head trauma or surgery in the pituitary region	
OR	
1.3 Diagnosis of primary nocturnal enuresis	
AND	
2 - For Brand DDAVP ONLY: Trial and failure to generic desmopressin tablets (verified via paid pharmacy claims or submission of medical records)	
AND	
3 - For Desmoda ONLY: Trial and failure to BOTH of the following (verified via paid pharmacy claims or submission of medical records):	
• generic desmopressin tablets • generic desmopressin nasal spray	
Notes	Plan setup requires use of generic desmopressin tablets before Brand DDAVP.

2 . Revision History

Date	Notes
4/6/2026	Updated guideline name. Added Desmoda and desmopressin nasal spray as targets. Updated criteria to add prerequisite requirement for Desmoda.

Declomycin



Prior Authorization Guideline

Guideline ID	GL-140714
Guideline Name	Declomycin
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:demeclocycline*	
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Diagnosis of ONE of the following: - Rocky Mountain spotted fever, typhus fever and the typhus group, Q fever, rickettsialpox and tick fevers caused by rickettsiae - Respiratory tract infections caused by Mycoplasma pneumoniae	

- Lymphogranuloma venereum due to *Chlamydia trachomatis*
- Psittacosis (Ornithosis) due to *Chlamydia psittaci*
- Trachoma due to *Chlamydia trachomatis*
- Inclusion conjunctivitis caused by *Chlamydia trachomatis*
- Nongonococcal urethritis in adults caused by *Ureaplasma urealyticum* or *Chlamydia trachomatis*
- Relapsing fever due to *Borrelia recurrentis*
- Chancroid caused by *Haemophilus ducreyi*
- Plague due to *Yersinia pestis*
- Tularemia due to *Francisella tularensis*
- Cholera caused by *Vibrio cholerae*
- *Campylobacter fetus* infections caused by *Campylobacter fetus*
- Brucellosis due to *Brucella* species (in conjunction with streptomycin)
- Bartonellosis due to *Bartonella bacilliformis*
- Granuloma inguinale caused by *Calymmatobacterium granulomatis*
- Infection due to *Escherichia coli*
- Infection due to *Enterobacter aerogenes*
- Infection due to *Shigella* species
- Infection due to *Acinetobacter* species
- Respiratory tract infections caused by *Haemophilus influenza*
- Respiratory tract and urinary tract infections caused by *Klebsiella* species
- Upper respiratory infections caused by *Streptococcus pneumoniae*
- Skin and skin structure infections caused by *Staphylococcus aureus*.
- Uncomplicated urethritis in men due to *Neisseria gonorrhoeae*, and for the treatment of other uncomplicated gonococcal infections
- Infections in women caused by *Neisseria gonorrhoeae*
- Syphilis caused by *Treponema pallidum* subspecies *pallidum*
- Yaws caused by *Treponema pallidum* subspecies *pertenue*
- Listeriosis due to *Listeria monocytogenes*
- Anthrax due to *Bacillus anthracis*
- Vincent's infection caused by *Fusobacterium fusiforme*
- Actinomycosis caused by *Actinomyces israelii*
- Clostridial diseases caused by *Clostridium* species
- Acute intestinal amebiasis, as adjunctive therapy
- Severe acne, as adjunctive therapy

OR

1.2 The medication is being prescribed by or in consultation with an Infectious Disease specialist

Notes

*Approval duration: 6 months

2 . Revision History

UnitedHealthcare Community Plan of Arizona Clinical Pharmacy Program Guidelines

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Dificid (fidaxomicin)



Prior Authorization Guideline

Guideline ID	GL-390203
Guideline Name	Dificid (fidaxomicin)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2025

1 . Criteria

Product Name: Brand Dificid tablets, generic fidaxomicin tablets, Dificid suspension	
Approval Length	10 Day(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Clostridioides difficile-associated diarrhea (CDAD) [previously known as Clostridium difficile- associated diarrhea] AND	

2 - BOTH of the following:

2.1 ONE of the following:

2.1.1 History of failure, contraindication, or intolerance to generic vancomycin oral solution

OR

2.1.2 For continuation of prior therapy

AND

2.2 If the request is for generic fidaxomicin tablets or Difcid suspension, trial and failure or intolerance to Brand Difcid tablets

2 . Revision History

Date	Notes
9/16/2025	Updated guideline name. Added generic fidaxomicin tablets and Difcid suspension as targets. Updated product name list and GPI table accordingly. Updated criteria.

Dofetilide



Prior Authorization Guideline

Guideline ID	GL-140682
Guideline Name	Dofetilide
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:: Brand Tikosyn, generic dofetilide	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following: - Atrial fibrillation - Atrial flutter	

AND

2 - Patient requires ONE of the following:

- Conversion to normal sinus rhythm
- Maintenance of normal sinus rhythm

AND

3 - Verification that the patient has already started on dofetilide while in the hospital for a minimum of 3 days

AND

4 - Patient does NOT have severe renal impairment [Creatinine Clearance (CrCl) less than 20 milliliters per minute]

AND

5 - Patient does NOT have congenital or acquired long QT syndromes

AND

6 - Patient is NOT concurrently using cimetidine, hydrochlorothiazide, ketoconazole, megestrol, prochlorperazine, trimethoprim, dolutegravir or verapamil

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Dojolvi (triheptanoin)



Prior Authorization Guideline

Guideline ID	GL-140753
Guideline Name	Dojolvi (triheptanoin)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	12/1/2022

1 . Criteria

Product Name:Dojolvi	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) showing diagnosis of a long-chain fatty acid oxidation disorder (LC-FAOD) has been confirmed by at least TWO of the following: Disease specific elevation of acyl-carnitines on a newborn blood spot or in plasma	

- Low enzyme activity in cultured fibroblasts
- One or more known pathogenic mutations in CPT2, ACADVL, HADHA, or HADHB

AND

2 - Not used with any other medium-chain triglyceride (MCT) product

AND

3 - Prescribed by or in consultation with a clinical specialist knowledgeable in appropriate disease-related dietary management (e.g., geneticist, cardiologist, gastroenterologist, etc.)

Product Name:Dojolvi	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Prescriber attests to continued need of therapy AND 2 - Not used with any other medium-chain triglyceride (MCT) product AND 3 - Prescribed by or in consultation with a clinical specialist knowledgeable in appropriate disease-related dietary management (e.g., geneticist, cardiologist, gastroenterologist, etc.)	

2 . Revision History

UnitedHealthcare Community Plan of Arizona Clinical Pharmacy Program Guidelines

Date	Notes
11/7/2022	New guideline following FFS.

DPP-4 Inhibitors



Prior Authorization Guideline

Guideline ID	GL-448215
Guideline Name	DPP-4 Inhibitors
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	12/1/2025

1 . Criteria

Product Name:alogliptin, alogliptin/metformin, alogliptin/pioglitazone, Brynovin, Janumet, Janumet XR, Januvia, Jentadueto, Jentadueto XR, Brand Kombiglyze XR, generic saxagliptin/metformin ER, Brand Onglyza, generic saxagliptin, Tradjenta, Zituvio, sitagliptin, Zituvimet, sitagliptin/metformin, Zituvimet XR, sitagliptin/metformin ER	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - The patient has a diagnosis of type 2 diabetes mellitus	

AND

2 - ONE of the following:

2.1 History of failure to metformin at a minimum dose of 1500 milligrams daily for 90 days

OR

2.2 Contraindication or intolerance to metformin

AND

3 - If the request is non-preferred*, ONE of the following:

3.1 History of failure for 90 days to THREE preferred* alternatives

OR

3.2 Intolerance or contraindication to THREE preferred* alternatives

AND

4 - Provider attests that the requested medication will not be used concurrently with a GLP-1 receptor agonist or combination agent [e.g., Victoza (liraglutide), Byetta (exenatide), Xultophy (insulin degludec-liraglutide)], or a plan has been developed to address concomitant use

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC CP

2 . Revision History

Date	Notes

11/10/2025	Added sitagliptin/metformin ER products as targets. Updated product name list and GPI table accordingly. No changes to clinical criteria.

Dry Eye Disease



Prior Authorization Guideline

Guideline ID	GL-392196
Guideline Name	Dry Eye Disease
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2025

1 . Criteria

Product Name: Xiidra	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Tear deficiency associated with ocular inflammation due to ONE of the following: Moderate to severe keratoconjunctivitis sicca	

- Moderate to severe dry eye disease

AND

2 - Submission of medical records (e.g., chart notes) confirming diagnosis by ONE of the following diagnostic tests:

- Schirmer test
- Ocular surface dye staining (e.g., rose bengal, fluorescein, lissamine green)
- Tear function index/fluorescein clearance test
- Tear break up time
- Tear film osmolarity
- Slit lamp lid evaluation
- Lacrimal gland function

AND

3 - Medication is NOT being prescribed to manage dry eyes peri-operative elective eye surgery (e.g., LASIK)

AND

4 - Submission of medical records (e.g., chart notes) or paid claims confirming trial and failure, contraindication, or intolerance to at least ONE over-the-counter (OTC) ocular lubricant (e.g., artificial tears, lubricating gels/ointments) in the past 60 days

AND

5 - Prescribed by or in consultation with ONE of the following:

- Ophthalmologist
- Optometrist
- Rheumatologist

AND

6 - Submission of medical records (e.g., chart notes) or paid claims confirming a minimum trial of 60 days of Brand Restasis single dose vials, unless contraindicated

Product Name: Cequa, generic cyclosporine emulsion, Miebo, Restasis MultiDose, Tryptyr, Tyrvaya, Vevye	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Tear deficiency associated with ocular inflammation due to ONE of the following: • Moderate to severe keratoconjunctivitis sicca • Moderate to severe dry eye disease AND 2 - Submission of medical records (e.g., chart notes) confirming diagnosis by ONE of the following diagnostic tests: • Schirmer test • Ocular surface dye staining (e.g., rose bengal, fluorescein, lissamine green) • Tear function index/fluorescein clearance test • Tear break up time • Tear film osmolarity • Slit lamp lid evaluation • Lacrimal gland function AND 3 - Medication is NOT being prescribed to manage dry eyes peri-operative elective eye surgery (e.g., LASIK) AND 4 - Submission of medical records (e.g., chart notes) or paid claims confirming trial and failure, contraindication, or intolerance to at least ONE over-the-counter (OTC) ocular lubricant (e.g., artificial tears, lubricating gels/ointments) in the past 60 days	

AND

5 - Prescribed by or in consultation with ONE of the following:

- Ophthalmologist
- Optometrist
- Rheumatologist

AND

6 - Submission of medical records (e.g., chart notes) or paid claims confirming a minimum trial of 60 days of BOTH of the following, unless contraindicated:

- Brand Restasis single dose vials
- Xiidra*

Notes	*PA may be required.

Product Name: Cequa, generic cyclosporine emulsion, Miebo, Restasis MultiDose, Tryptyr, Tyrvaya, Vevye, Xiidra	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient demonstrates positive clinical response to therapy (e.g., increased tear production or improvement in dry eye symptoms)	

2 . Revision History

Date	Notes

9/10/2025	Added Tryptyr as a target to the guideline. Updated GPI tables and product name lists accordingly. No changes to clinical criteria.

Duexis and Vimovo



Prior Authorization Guideline

Guideline ID	GL-140716
Guideline Name	Duexis and Vimovo
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Duexis	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following risk factors for NSAID (non-steroidal anti-inflammatory drug) induced adverse GI (gastrointestinal) events: • Patient is greater than or equal to 65 years of age • Prior history of peptic, gastric, or duodenal ulcer • History of NSAID-related ulcer	

- History of clinically significant GI bleeding
- Untreated or active H. Pylori gastritis
- Concurrent use of oral corticosteroids (eg, prednisone, prednisolone, dexamethasone)
- Concurrent use of anticoagulants (eg, warfarin, heparin)
- Concurrent use of antiplatelets (eg, aspirin including low-dose, clopidogrel)

AND

2 - Documentation of history of failure, contraindication, or intolerance to **THREE** combinations of preferred NSAIDS taken with preferred H2 (histamine 2)-receptor antagonists. (Provide name and date preferred products were tried)*

AND

3 - Physician has provided rationale for needing to use fixed-dose combination therapy with Duexis instead of taking individual products in combination.

Notes	*Please reference background section for preferred products table

Product Name: Brand Vimovo, generic naproxen-esomeprazole	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following risk factors for NSAID (non-steroidal anti-inflammatory drug) induced adverse GI (gastrointestinal) events: • Patient is greater than or equal to 65 years of age • Prior history of peptic, gastric, or duodenal ulcer • History of NSAID-related ulcer • History of clinically significant GI bleeding • Untreated or active H. Pylori gastritis • Concurrent use of oral corticosteroids (eg, prednisone, prednisolone, dexamethasone) • Concurrent use of anticoagulants (eg, warfarin, heparin) • Concurrent use of antiplatelets (eg, aspirin including low-dose, clopidogrel) AND	

2 - Documentation of history of failure, contraindication, or intolerance to THREE combinations of preferred NSAIDS taken with preferred proton pump inhibitors (PPIs). (Provide name and date preferred products were tried)*

AND

3 - Physician has provided rationale for needing to use fixed-dose combination therapy with Vimovo instead of taking individual products in combination.

Notes

*Please reference background section for preferred products table

2 . Background

Benefit/Coverage/Program Information		
Preferred Table		
NSAIDS	Proton Pump Inhibitors (PPIs)	H2 (histamine 2)-receptor antagonists
Diclofenac DR (Generic Voltaren)	esomeprazole (Generic Nexium)	Famotidine (Generic Pepcid)
Diclofenac ER (Generic Voltaren ER)	lansoprazole (Generic Prevacid)	Nizatidine (Generic Axid)
Etodolac (Generic Lodine)	omeprazole (Generic Prilosec)	Ranitidine (Generic Zantac)
Etodolac ER (Generic Lodine ER)	pantoprazole sodium (Generic Protonix)	
Fenoprofen (Generic Nalfon)		
Flurbiprofen (Generic Ansaid)		

Ibuprofen		
Indomethacin (Generic Indocin)		
Ketorolac (Generic Toradol)		
Mefenamic (Generic Ponstel)		
Meloxicam (Generic Mobic)		
Nabumetone (Generic Relafen)		
Nabumetone DS (Generic Relafen DS)		
Naproxen (Generic Anaprox)		
Naproxen DR (Generic Anaprox DR)		
Naproxen EC (Generic Anaprox EC)		
Oxaprozin (Generic Daypro)		

Piroxicam (Generic Feldene)		
Sulindac (Generic Clinoril)		

3 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Dupixent (dupilumab)



Prior Authorization Guideline

Guideline ID	GL-603197
Guideline Name	Dupixent (dupilumab)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name: Dupixent	
Diagnosis	Atopic Dermatitis
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of documentation (e.g., chart notes) or verification of paid claims confirming ALL of the following:	

1.1 Diagnosis of moderate to severe chronic atopic dermatitis

AND

1.2 ONE of the following:

1.2.1 BOTH of the following:

1.2.1.1 Patient is 12 years of age and older

AND

1.2.1.2 History of failure, contraindication, or intolerance to ALL of the following (document drug, date of trial, and/or contraindication to medication)*:

- One topical calcineurin inhibitor [e.g., Elidel (pimecrolimus), Protopic (tacrolimus)]
- Eucrisa (crisaborole)
- Opzelura (ruxolitinib)
- Vtama (tapinarof)
- Zoryve (roflumilast) 0.15% cream
- Adbry (tralokinumab-ldrm)

OR

1.2.2 BOTH of the following:

1.2.2.1 Patient is less than 12 years of age

AND

1.2.2.2 History of failure, contraindication, or intolerance to ALL of the following (document drug, date of trial, and/or contraindication to medication)*:

- One topical calcineurin inhibitor [e.g., Elidel (pimecrolimus), Protopic (tacrolimus)]
- Eucrisa (crisaborole)
- One topical corticosteroid [e.g., mometasone furoate, fluocinolone acetonide (generic Synalar), fluocinonide]
- Vtama (tapinarof)
- Zoryve (roflumilast) 0.15% cream

AND	
2 - Patient is NOT receiving Dupixent in combination with another biologic medication [e.g., Xolair (omalizumab), Rituxan (rituximab), Enbrel (etanercept), Remicade/Inflectra (infliximab)]	
AND	
3 - Prescribed by ONE of the following:	
• Dermatologist • Allergist • Immunologist	
Notes	*Claims history may be used in conjunction as documentation of drug, date, and/or contraindication to medication.

Product Name: Dupixent	
Diagnosis	Atopic Dermatitis
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of documentation (e.g., chart notes) or verification of paid claims confirming ALL of the following: 1.1 Positive clinical response to therapy AND 1.2 ONE of the following: 1.2.1 BOTH of the following: 1.2.1.1 Patient is 12 years of age and older	

AND

1.2.1.2 History of failure, contraindication, or intolerance to ALL of the following (document drug, date of trial, and/or contraindication to medication)*:

- One topical calcineurin inhibitor [e.g., Elidel (pimecrolimus), Protopic (tacrolimus)]
- Eucrisa (crisaborole)
- Opzelura (ruxolitinib)
- Vtama (tapinarof)
- Zoryve (roflumilast) 0.15% cream
- Adbry (tralokinumab-ldrm)

OR

1.2.2 BOTH of the following:

1.2.2.1 Patient is less than 12 years of age

AND

1.2.2.2 History of failure, contraindication, or intolerance to ALL of the following (document drug, date of trial, and/or contraindication to medication)*:

- One topical calcineurin inhibitor [e.g., Elidel (pimecrolimus), Protopic (tacrolimus)]
- Eucrisa (crisaborole)
- One topical corticosteroid [e.g., mometasone furoate, fluocinolone acetonide (generic Synalar), fluocinonide]
- Vtama (tapinarof)
- Zoryve (roflumilast) 0.15% cream

AND

2 - Patient is NOT receiving Dupixent in combination with another biologic medication [e.g., Xolair (omalizumab), Rituxan (rituximab), Enbrel (etanercept), Remicade/Inflectra (infliximab)]

AND

3 - Prescribed by ONE of the following:

• Dermatologist • Allergist • Immunologist	
Notes	*Claims history may be used in conjunction as documentation of drug, date, and/or contraindication to medication.

Product Name:Dupixent	
Diagnosis	Asthma
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is 6 years of age or older AND 2 - Submission of documentation (e.g., chart notes) confirming diagnosis of moderate-to-severe asthma AND 3 - Classification of asthma as uncontrolled or inadequately controlled as defined by at least ONE of the following: • Poor symptom control (e.g., Asthma Control Questionnaire [ACQ] score consistently greater than 1.5 or Asthma Control Test [ACT] score consistently less than 20) • Two or more bursts of systemic corticosteroids for at least 3 days each in the previous 12 months • Asthma-related emergency treatment (e.g., emergency room visit, hospital admission, or unscheduled physician's office visit for nebulizer or other urgent treatment) • Airflow limitation (e.g., after appropriate bronchodilator withhold forced expiratory volume in 1 second [FEV1] less than 80% predicted [in the face of reduced FEV1/forced vital capacity [FVC] defined as less than the lower limit of normal])	

- Patient is currently dependent on oral corticosteroids for the treatment of asthma

AND

4 - Dupixent will be used in combination with ONE of the following:

4.1 ONE high-dose (appropriately adjusted for age) combination inhaled corticosteroid (ICS)/long-acting beta2 agonist (LABA) [e.g., Advair/AirDuo Respiclick (fluticasone propionate/salmeterol), Symbicort (budesonide/formoterol), Breo Ellipta (fluticasone furoate/vilanterol)] (see Table 1 in Background section)

OR

4.2 Combination therapy including BOTH of the following:

4.2.1 ONE high-dose (appropriately adjusted for age) ICS product [e.g., ciclesonide (Alvesco), mometasone furoate (Asmanex), beclomethasone dipropionate (QVAR)] (see Table 1 in Background section)

AND

4.2.2 ONE additional asthma controller medication [e.g., LABA - olodaterol (Striverdi) or indacaterol (Arcapta); leukotriene receptor antagonist – montelukast (Singulair); theophylline]

AND

5 - ONE of the following:

5.1 Submission of medical records (e.g., chart notes, laboratory values, etc.) documenting that asthma is an eosinophilic phenotype as defined by a baseline (pre-dupilumab treatment) peripheral blood eosinophil level greater than or equal to 150 cells/microliter within the past 6 weeks

OR

5.2 Patient is currently dependent on oral corticosteroids for the treatment of asthma

AND

6 - Paid claims or submission of documentation (e.g., chart notes) demonstrating history of failure, contraindication, or intolerance to BOTH of the following:

- Xolair (omalizumab)
- Fasenra (benralizumab)

AND

7 - Patient is NOT receiving Dupixent in combination with ONE of the following:

- Anti-interleukin-5 therapy [e.g., Nucala (mepolizumab), Cinqair (reslizumab), Fasenra (benralizumab)]
- Anti-IgE (immunoglobulin E) therapy [e.g., Xolair (omalizumab)]

AND

8 - Prescribed by ONE of the following:

- Pulmonologist
- Allergist
- Immunologist

Product Name: Dupixent	
Diagnosis	Asthma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of documentation (e.g., chart notes) confirming positive clinical response to Dupixent therapy as demonstrated by at least ONE of the following:	

- Reduction in the frequency of exacerbations
- Decreased utilization of rescue medications
- Increase in percent predicted forced expiratory volume in 1 second (FEV1) from pretreatment baseline
- Reduction in severity or frequency of asthma-related symptoms (e.g., wheezing, shortness of breath, coughing, etc.)
- Reduction in oral corticosteroid requirements

AND

2 - Dupixent is being used in combination with an inhaled corticosteroid (ICS)-containing controller medication (see Table 1 in Background section)

AND

3 - Paid claims or submission of documentation (e.g., chart notes) demonstrating history of failure, contraindication, or intolerance to BOTH of the following:

- Xolair (omalizumab)
- Fasenra (benralizumab)

AND

4 - Patient is NOT receiving Dupixent in combination with ONE of the following:

- Anti-interleukin-5 therapy [e.g., Nucala (mepolizumab), Cinqair (reslizumab), Fasenra (benralizumab)]
- Anti-IgE (immunoglobulin E) therapy [e.g., Xolair (omalizumab)]

AND

5 - Prescribed by ONE of the following:

- Pulmonologist
- Allergist
- Immunologist

Product Name:Dupixent	
Diagnosis	Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is 12 years of age or older AND 2 - Submission of documentation (e.g., chart notes) confirming ALL of the following: 2.1 Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP) defined by ALL of the following: 2.1.1 TWO or more of the following symptoms for greater than or equal to 12 weeks duration: • Mucopurulent discharge • Nasal obstruction and congestion • Decreased or absent sense of smell • Facial pressure or pain AND 2.1.2 ONE of the following: • Evidence of inflammation on paranasal sinus examination or computed tomography (CT) • Evidence of purulence coming from paranasal sinuses or ostiomeatal complex AND 2.1.3 The presence of nasal polyps	

AND

2.2 ONE of the following:

- Patient has required prior sino-nasal surgery
- Patient has required systemic corticosteroids in the previous 2 years

AND

2.3 Patient has been unable to obtain symptom relief after trial of ALL of the following agents/classes of agents:

- Nasal saline irrigations
- Intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone, etc.)
- Antileukotriene agents (e.g., montelukast, zafirlukast, zileuton)

AND

3 - Patient will receive Dupixent as add-on maintenance therapy in combination with intranasal corticosteroids

AND

4 - Paid claims or submission of documentation (e.g., chart notes) demonstrating history of failure, contraindication, or intolerance to Xolair (omalizumab)

AND

5 - Patient is NOT receiving Dupixent in combination with another biologic medication [e.g., Xolair (omalizumab), Nucala (mepolizumab), Cinqair (reslizumab), Fasenra (benralizumab)]

AND

6 - Prescribed by ONE of the following:

- Otolaryngologist
- Allergist
- Immunologist

Product Name:Dupixent	
Diagnosis	Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of documentation (e.g., chart notes) confirming positive clinical response to Dupixent therapy AND 2 - Patient will continue to receive Dupixent as add-on maintenance therapy in combination with intranasal corticosteroids AND 3 - Paid claims or submission of documentation (e.g., chart notes) demonstrating history of failure, contraindication, or intolerance to Xolair (omalizumab) AND 4 - Patient is NOT receiving Dupixent in combination with another biologic medication [e.g., Xolair (omalizumab), Nucala (mepolizumab), Cinqair (reslizumab), Fasenra (benralizumab)] AND	

5 - Prescribed by ONE of the following:

- Otolaryngologist
- Allergist
- Immunologist

Product Name: Dupixent	
Diagnosis	Eosinophilic Esophagitis (EoE)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - BOTH of the following:

- Patient is at least 1 year of age
- Patient weighs at least 15 kg (kilograms)

AND

2 - Submission of documentation (e.g., chart notes) confirming diagnosis of eosinophilic esophagitis (EoE)

AND

3 - Patient has symptoms of esophageal dysfunction [e.g., dysphagia, food impaction, gastroesophageal reflux disease (GERD)/heartburn symptoms, chest pain, abdominal pain]

AND

4 - Submission of documentation (e.g., chart notes, lab values) confirming patient has at least 15 intraepithelial eosinophils per high power field (HPF)

AND

5 - Other causes of esophageal eosinophilia have been excluded

AND

6 - Paid claims or submission of documentation (e.g., chart notes) confirming trial and failure, contraindication, or intolerance to at least an 8-week trial of ONE of the following:

- Proton pump inhibitors (e.g., pantoprazole, omeprazole)
- Topical (esophageal) corticosteroids (e.g., budesonide, fluticasone)

AND

7 - Prescribed by ONE of the following:

- Gastroenterologist
- Allergist
- Immunologist

Product Name:Dupixent	
Diagnosis	Eosinophilic Esophagitis (EoE)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of documentation (e.g., chart notes) confirming positive clinical response to therapy as evidenced by improvement of at least ONE of the following from baseline: • Symptoms (e.g., dysphagia, food impaction, heartburn, chest pain) • Histologic measures (e.g., esophageal intraepithelial eosinophil count)	

- Endoscopic measures (e.g., edema, furrows, exudates, rings, strictures)

AND

2 - Prescribed by ONE of the following:

- Gastroenterologist
- Allergist
- Immunologist

Product Name:Dupixent

Diagnosis	Prurigo Nodularis (PN)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is 18 years of age or older

AND

2 - Submission of documentation (e.g., chart notes) confirming diagnosis of prurigo nodularis (PN)

AND

3 - Patient has at least 20 nodular lesions

AND

4 - Trial and failure, contraindication, or intolerance to one previous PN treatment [e.g., topical corticosteroids, topical calcineurin inhibitors (pimecrolimus, tacrolimus), topical capsaicin]

AND

5 - Prescribed by ONE of the following:

- Dermatologist
- Allergist
- Immunologist

Product Name:Dupixent

Diagnosis	Prurigo Nodularis (PN)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of documentation (e.g., chart notes) confirming positive clinical response to therapy as evidenced by improvement of at least ONE of the following:

- Reduction in the number of nodular lesions from baseline
- Improvement in symptoms (e.g., pruritus, inflammation) from baseline

AND

2 - Prescribed by ONE of the following:

- Dermatologist
- Allergist
- Immunologist

Product Name:Dupixent

Diagnosis	Chronic Obstructive Pulmonary Disease (COPD)
Approval Length	6 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is 18 years of age or older AND 2 - Submission of medical records (e.g., chart notes) confirming diagnosis of chronic obstructive pulmonary disease (COPD) AND 3 - Submission of medical records (e.g., chart notes) confirming the presence of Type 2 inflammation evidenced by blood eosinophils greater than or equal to 300 cells per microliter at baseline AND 4 - Paid claims or submission of medical records (e.g., chart notes) confirming the patient is receiving ONE of the following therapies at maximally tolerated doses: • Triple therapy [i.e., an inhaled corticosteroid (ICS), a long-acting muscarinic antagonist (LAMA), and a long-acting beta agonist (LABA)] • If ICS are contraindicated, a LAMA and a LABA AND 5 - Patient must have post-bronchodilator forced expiratory volume [FEV1] / forced vital capacity [FVC] ratio less than 0.70 AND 6 - Patient has had BOTH of the following within the past 12 months:	

6.1 At least two exacerbations where systemic corticosteroids [intramuscular, intravenous, or oral (e.g., prednisone)] were required at least once

AND

6.2 A COPD-related hospitalization

AND

7 - Submission of medical records (e.g., chart notes) confirming the patient experiences dyspnea during everyday activities (e.g., needs to stop for breath when walking on level ground)

Product Name:Dupixent	
Diagnosis	Chronic Obstructive Pulmonary Disease (COPD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming a positive clinical response to therapy (e.g., improved lung function, a reduction in COPD exacerbations) AND 2 - Paid claims or submission of medical records (e.g., chart notes) confirming the patient continues to receive ONE of the following therapies: • Triple therapy [i.e., an inhaled corticosteroid (ICS), a long-acting muscarinic antagonist (LAMA), and a long-acting beta agonist (LABA)] • If ICS are contraindicated, a LAMA and a LABA	

Product Name:Dupixent	
Diagnosis	Chronic Spontaneous Urticaria (CSU)
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of documentation (e.g., chart notes) confirming diagnosis of chronic spontaneous urticaria (CSU) AND 2 - Persistent symptoms (itching and hives) for at least 4 consecutive weeks despite titrating to an optimal dose with a second generation H1 antihistamine (e.g., cetirizine, fexofenadine), unless there is a contraindication or intolerance to H1 antihistamines AND 3 - Paid claims or submission of documentation (e.g., chart notes) confirming concurrent use with an H1 antihistamine, unless there is a contraindication or intolerance to H1 antihistamines AND 4 - Paid claims or submission of documentation (e.g., chart notes) confirming patient has tried and had an inadequate response or intolerance to at least TWO of the following additional therapies: • Doxepin • H1 antihistamine • H2 antagonist (e.g., famotidine, cimetidine) • Hydroxyzine • Leukotriene receptor antagonist (e.g., montelukast) AND	

5 - Paid claims or submission of documentation (e.g., chart notes) demonstrating history of failure, contraindication, or intolerance to Xolair (omalizumab)

AND

6 - Prescribed by ONE of the following:

- Allergist/Immunologist
- Dermatologist

Product Name:Dupixent	
Diagnosis	Chronic Spontaneous Urticaria (CSU)
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient's disease status has been re-evaluated since the last authorization to confirm the patient's condition warrants continued treatment AND 2 - Submission of documentation (e.g., chart notes) confirming patient has experienced at least ONE of the following: • Reduction in itching severity from baseline • Reduction in the number of hives from baseline AND 3 - Paid claims or submission of documentation (e.g., chart notes) demonstrating history of failure, contraindication, or intolerance to Xolair (omalizumab)	

Product Name:Dupixent	
Diagnosis	Bullous Pemphigoid (BP)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of bullous pemphigoid (BP) as confirmed by skin biopsy or serology AND 2 - Will be used in combination with a tapering course of oral corticosteroids (e.g., prednisone) until disease control has occurred AND 3 - Prescribed by or in consultation with ONE of the following: • Allergist/Immunologist • Dermatologist	

Product Name:Dupixent	
Diagnosis	Bullous Pemphigoid (BP)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient demonstrates positive clinical response to therapy (e.g., decreased pruritus severity from baseline, no new lesions or worsening of old lesions)	

Product Name:Dupixent	
Diagnosis	Allergic Fungal Rhinosinusitis (AFRS)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming diagnosis of allergic fungal rhinosinusitis (AFRS) AND 2 - Patient is 6 years of age or older AND 3 - Submission of medical records (e.g., chart notes) confirming patient has a history of sino-nasal surgery AND 4 - Submission of medical records (e.g., chart notes) confirming that unless contraindicated, the patient has had an inadequate response to a trial (of a minimum 30-day supply) of appropriate post-operative management for AFRS [e.g., systemic glucocorticoids (e.g., prednisone), intranasal glucocorticoids (e.g., budesonide)] AND 5 - Patient is NOT receiving Dupixent in combination with another biologic medication [e.g., Xolair (omalizumab), Nucala (mepolizumab), Cinqair (reslizumab), Fasenra (benralizumab)]	

AND

6 - Prescribed by or in consultation with one of the following:

- Allergist/Immunologist
- Otolaryngologist
- Pulmonologist

Product Name:Dupixent	
Diagnosis	Allergic Fungal Rhinosinusitis (AFRS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of documentation (e.g., chart notes) confirming positive clinical response to Dupixent therapy (e.g., reduction in sinus opacification) AND 2 - Patient is NOT receiving Dupixent in combination with another biologic medication [e.g., Xolair (omalizumab), Nucala (mepolizumab), Cinqair (reslizumab), Fasenra (benralizumab)] AND 3 - Prescribed by or in consultation with one of the following: • Allergist/Immunologist • Otolaryngologist • Pulmonologist	

2 . Background

Benefit/Coverage/Program Information			
Table 1: Low, medium and high daily doses of inhaled corticosteroids Adults and adolescents (12 years of age and older)			
Drug	Daily dose (mcg)		
	Low	Medium	High
Beclomethasone dipropionate (CFC)	200-500	>500-1000	>1000
Beclomethasone dipropionate (HFA)	100-200	>200-400	>400
Budesonide DPI	200-400	>400-800	>800
Ciclesonide (HFA)	80-160	>160-320	>320
Fluticasone furoate (DPI)	100	N/A	200
Fluticasone propionate (DPI)	100-250	>250-500	>500
Fluticasone propionate (HFA)	100-250	>250-500	>500
Mometasone furoate	110-220	>220-440	>440
Triamcinolone acetonide	400-1000	>1000-2000	>2000

3 . Revision History

Date	Notes
5/6/2026	Added criteria for new AFRS indication

Durezol



Prior Authorization Guideline

Guideline ID	GL-140718
Guideline Name	Durezol
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Durezol	
Approval Length	2 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - History of failure, contraindication, or intolerance to BOTH of the following: • prednisolone 1% • dexamethasone ophthalmic drops and/or ointment.	

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Duvyzat (givinostat)



Prior Authorization Guideline

Guideline ID	GL-603198
Guideline Name	Duvyzat (givinostat)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Duvyzat	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of Duchenne muscular dystrophy (DMD)	

AND

2 - Submission of medical records (e.g., chart notes) documenting ONE of the following:

2.1 Patient has a confirmed mutation of the dystrophin gene

OR

2.2 Muscle biopsy confirmed an absence of dystrophin protein

AND

3 - Patient is 6 years of age or older

AND

4 - Submission of medical records including results of baseline North Star Ambulatory Assessment (NSAA) confirming patient is ambulatory without needing an assistive device (e.g., without side-by-side assist, cane, walker, wheelchair) as evidenced by NSAA scoring prior to initiating Duvyatz

AND

5 - Submission of medical records (e.g., chart notes) documenting BOTH of the following:

- Baseline platelet count at least $150 \times 10^9/L$
- Triglyceride level drawn prior to therapy initiation (document baseline TG level)

AND

6 - Submission of medical records (e.g., chart notes) or paid claims confirming requested drug will be used concomitantly with a corticosteroid regimen (e.g., prednisone/prednisolone, Emflaza [deflazacort], Agamree)

AND

7 - Patient will not receive Duvyzat in combination with Elevidys (delandistrogene moxeparvovec-rokl) or exon-skipping therapies for DMD [e.g., Amondys (casimersen), Exondys 51 (eteplirsen), Viltepso (viltolarsen), Vyondys 53 (golodirsen)]

AND

8 - Prescribed by or in consultation with a pediatric neurologist with expertise in treating DMD

Product Name:Duvyzat	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming patient has experienced a benefit from therapy (e.g., improvement in preservation of muscle strength) AND 2 - Submission of medical records including results of recent North Star Ambulatory Assessment (NSAA) confirming patient is maintaining ambulatory status without needing an assistive device (e.g., without side-by-side assist, cane, walker, wheelchair) as evidenced by NSAA scoring AND 3 - Submission of medical records (e.g., chart notes) or paid claims confirming patient continues to receive concomitant corticosteroid regimen (e.g., prednisone/prednisolone, Emflaza [deflazacort], Agamree)	

AND

4 - Patient will not receive Duvyzat in combination with Elevidys (delandistrogene moxeparvovec-rokl) or exon-skipping therapies for DMD [e.g., Amondys (casimersen), Exondys 51 (eteplirsen), Viltepso (viltolarsen), Vyondys 53 (golodirsen)]

2 . Revision History

Date	Notes
5/6/2026	Updated concomitant use criterion to include Elevidys

Ebglyss (lebrikizumab-lbkz)



Prior Authorization Guideline

Guideline ID	GL-163804
Guideline Name	Ebglyss (lebrikizumab-lbkz)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	2/1/2025

1 . Criteria

Product Name:Ebglyss	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming ALL of the following: 1.1 Diagnosis of moderate to severe atopic dermatitis	

AND

1.2 ONE of the following:

- Involvement of at least 10% body surface area (BSA)
- SCORing Atopic Dermatitis (SCORAD) index value of at least 25

AND

1.3 BOTH of the following:

- Patient is 12 years of age or older
- Patient weighs at least 40 kg (kilograms)

AND

1.4 History of failure, contraindication, or intolerance to ALL of the following (document drug, date of trial, and/or contraindication to medication)*:

- One topical calcineurin inhibitor [e.g., Elidel (pimecrolimus), Protopic (tacrolimus)]
- Eucrisa (crisaborole) ointment
- Adbry (tralokizumab-ldrm)
- Dupixent (dupilumab)

AND

2 - Prescribed by or in consultation with ONE of the following:

- Dermatologist
- Allergist
- Immunologist

Notes	*Claims history may be used in conjunction as documentation of drug, date, and/or contraindication to medication.

Product Name:Ebglyss	
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of documentation (e.g., chart notes) demonstrating positive clinical response to therapy as evidenced by at least ONE of the following: • Reduction in body surface area involvement from baseline • Reduction in SCORing Atopic Dermatitis (SCORAD) index value from baseline AND 2 - Prescribed by or in consultation with ONE of the following: • Dermatologist • Allergist • Immunologist	

2 . Revision History

Date	Notes
1/21/2025	New program.

Ecoza (econazole)



Prior Authorization Guideline

Guideline ID	GL-140712
Guideline Name	Ecoza (econazole)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Ecoza, Generic econazole	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - History of failure, contraindication, or intolerance to ALL of the following: • butenafine • ciclopirox • clotrimazole • clotrimazole w/ betamethasone	

- ketoconazole
- miconazole
- nystatin
- terbinafine
- tolnaftate

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Eculizumab (Soliris, Bkempv, Epysqli)



Prior Authorization Guideline

Guideline ID	GL-545233
Guideline Name	Eculizumab (Soliris, Bkempv, Epysqli)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Epysqli	
Diagnosis	Paroxysmal Nocturnal Hemoglobinuria (PNH)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of paroxysmal nocturnal hemoglobinuria (PNH)	

AND

2 - BOTH of the following:

2.1 Flow cytometry analysis confirming presence of PNH clones

AND

2.2 Laboratory results, signs, and/or symptoms attributed to PNH (e.g., abdominal pain, anemia, dyspnea, extreme fatigue, smooth muscle dystonia, unexplained/unusual thrombosis, hemolysis/hemoglobinuria, kidney disease, pulmonary hypertension, etc.)

AND

3 - Patient is treatment naïve with eculizumab therapy

AND

4 - Requested medication is dosed according to the United States Food and Drug Administration (FDA) labeled dosing for PNH

AND

5 - Prescribed by, or in consultation with, **ONE** of the following:

- Hematologist
- Oncologist

Product Name:Epysqli	
Diagnosis	Paroxysmal Nocturnal Hemoglobinuria (PNH)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) demonstrating a positive clinical response from baseline (e.g., increased or stabilization of hemoglobin levels, reduction in transfusions, improvement in hemolysis, decrease in lactate dehydrogenase [LDH], increased reticulocyte count, etc.)

AND

2 - Requested medication is dosed according to the United States Food and Drug Administration (FDA) labeled dosing for paroxysmal nocturnal hemoglobinuria (PNH)

AND

3 - Prescribed by, or in consultation with, ONE of the following:

- Hematologist
- Oncologist

Product Name:Epysqli	
Diagnosis	Atypical Hemolytic Uremic Syndrome (aHUS)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) supporting a diagnosis of atypical hemolytic uremic syndrome (aHUS) by ruling out BOTH of the following: • Shiga toxin E. coli-related hemolytic uremic syndrome (STEC-HUS)* • Thrombotic thrombocytopenia purpura (TTP) (e.g., rule out ADAMTS13 deficiency)	

AND

2 - Laboratory results, signs, and/or symptoms attributed to aHUS (e.g., thrombocytopenia, microangiopathic hemolysis, thrombotic microangiopathy, acute renal failure, etc.)

AND

3 - Patient is treatment naïve with eculizumab therapy

AND

4 - Requested medication is dosed according to the United States Food and Drug Administration (FDA) labeled dosing for aHUS

AND

5 - Prescribed by, or in consultation with, a hematologist or nephrologist

Product Name:Epysqli	
Diagnosis	Atypical Hemolytic Uremic Syndrome (aHUS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) demonstrating a positive clinical response from baseline (e.g., reduction of plasma exchanges, reduction of dialysis, increased platelet count, reduction of hemolysis) AND	

2 - Requested medication is dosed according to the United States Food and Drug Administration (FDA) labeled dosing for atypical hemolytic uremic syndrome (aHUS)

AND

3 - Prescribed by, or in consultation with, a hematologist or nephrologist

Product Name:Epysqli

Diagnosis	Generalized Myasthenia Gravis (gMG)

Approval Length	6 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming ALL of the following:

1.1 Diagnosis of generalized myasthenia gravis (gMG)

AND

1.2 Patient has not failed a previous course of eculizumab therapy

AND

1.3 Positive serologic test for anti-acetylcholine receptor (AChR) antibodies

AND

1.4 ONE of the following:

- History of abnormal neuromuscular transmission test demonstrated by single-fiber electromyography (SFEMG) or repetitive nerve stimulation
- History of positive anticholinesterase test (e.g., edrophonium chloride test)

- Patient has demonstrated improvement in myasthenia gravis (MG) signs on oral cholinesterase inhibitors, as assessed by the treating neurologist

AND

1.5 Patient has a Myasthenia Gravis Foundation of America (MGFA) Clinical Classification of class II, III, or IV at initiation of therapy

AND

1.6 Patient has a Myasthenia Gravis-specific Activities of Daily Living scale (MG-ADL) total score greater than or equal to 6 at initiation of therapy

AND

2 - Patient is 6 years of age or older

AND

3 - ONE of the following:

3.1 For patients between 6 and 17 years of age, trial and failure, contraindication, or intolerance to ONE of the following:

- Immunosuppressive therapy (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus)
- Chronic plasmapheresis or plasma exchange (PE)
- Intravenous immunoglobulin (IVIG)

OR

3.2 For patients 18 years of age or older, BOTH of the following:

- History of failure of at least TWO immunosuppressive agents over the course of at least 12 months (e.g., azathioprine, methotrexate, cyclosporine, mycophenolate, etc.)
- Patient has required TWO or more courses of plasmapheresis/plasma exchanges and/or intravenous immune globulin for at least the previous 12 months without symptom control

AND

4 - Patient is currently on a stable therapeutic dose (at least 3 to 6 months) of immunosuppressive therapy

AND

5 - Requested medication is initiated and titrated according to the United States Food and Drug Administration (FDA) labeled dosing for gMG: up to a maximum of 1200 milligrams every 2 weeks

AND

6 - Prescribed by, or in consultation, with a neurologist

Product Name:Epysqli	
Diagnosis	Generalized Myasthenia Gravis (gMG)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) demonstrating a positive clinical response from baseline as evidenced by ALL of the following: 1.1 Improvement and/or maintenance of at least a 3 point improvement (reduction in score) in the Myasthenia Gravis Activities of Daily Living (MG-ADL) score from pre-treatment baseline AND 1.2 Reduction in signs and symptoms of myasthenia gravis	

AND

1.3 Maintenance, reduction, or discontinuation of dose(s) of baseline immunosuppressive therapy (IST) prior to starting eculizumab therapy (Note: Add on, dose escalation of IST, or additional rescue therapy from baseline to treat myasthenia gravis or exacerbation of symptoms while on eculizumab therapy will be considered as treatment failure)

AND

2 - Requested medication is dosed according to the United States Food and Drug Administration (FDA) labeled dosing for generalized myasthenia gravis (gMG): up to a maximum of 1200 milligrams every 2 weeks

AND

3 - Prescribed by, or in consultation, with a neurologist

Product Name:Epysqli	
Diagnosis	Neuromyelitis Optica Spectrum Disorder (NMOSD)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming ALL of the following: 1.1 Diagnosis of neuromyelitis optica spectrum disorder (NMOSD) AND 1.2 Past medical history of ONE of the following: • Optic neuritis	

- Acute myelitis
- Area postrema syndrome: Episode of otherwise unexplained hiccups or nausea and vomiting
- Acute brainstem syndrome
- Symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic MRI lesions
- Symptomatic cerebral syndrome with NMOSD-typical brain lesions

AND

1.3 Positive serologic test for anti-aquaporin-4 immunoglobulin G (AQP4-IgG)/NMO-IgG antibodies

AND

1.4 Diagnosis of multiple sclerosis or other diagnoses have been ruled out

AND

2 - Patient has not failed a previous course of eculizumab therapy

AND

3 - History of failure of, contraindication, or intolerance to rituximab (Ruxience, Truxima) therapy

AND

4 - ONE of the following:

4.1 History of at least two relapses during the previous 12 months prior to initiating eculizumab therapy

OR

4.2 History of at least three relapses during the previous 24 months, at least one relapse occurring within the past 12 months prior to initiating eculizumab therapy

AND

5 - Requested medication is initiated and titrated according to the United States Food and Drug Administration (FDA) labeled dosing for NMOSD, up to a maximum of 1200 milligrams every 2 weeks

AND

6 - Prescribed by, or in consultation with, a neurologist

Product Name:Epysqli	
Diagnosis	Neuromyelitis Optica Spectrum Disorder (NMOSD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) demonstrating a positive clinical response from baseline as evidenced by BOTH of the following:

1.1 Reduction in the number and/or severity of relapses or signs and symptoms of neuromyelitis optica spectrum disorder (NMOSD)

AND

1.2 Maintenance, reduction, or discontinuation of dose(s) of any baseline immunosuppressive therapy (IST) prior to starting eculizumab therapy. (Note: Add on, dose escalation of IST, or additional rescue therapy from baseline to treat NMOSD or exacerbation of symptoms while on eculizumab therapy will be considered as treatment failure)

AND

2 - Requested medication is dosed according to the United States Food and Drug

Administration (FDA) labeled dosing for NMOSD: up to a maximum of 1200 milligrams every 2 weeks

AND

3 - Prescribed by, or in consultation with, a neurologist

Product Name:Non-Preferred*: Soliris, Bkembv, and newly launched eculizumab products	
Approval Length	Requests for non-preferred products are not approved at this time
Guideline Type	Prior Authorization
Approval Criteria 1 - Per your health plan's criteria, the non-preferred drug is not approved for coverage because the plan's preferred product is Epysqli (eculizumab-aagh)	
Notes	*Patients must use preferred eculizumab biosimilar.

2 . Revision History

Date	Notes
3/10/2026	Updated guideline name. Added section for Soliris, Bkembv, and newly launched eculizumab products to indicate these NP products are not approved for coverage as the plan's preferred product is Epysqli.

Effient (prasugrel)



Prior Authorization Guideline

Guideline ID	GL-524216
Guideline Name	Effient (prasugrel)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name:Brand Effient, generic prasugrel	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of acute coronary syndrome (ACS) [e.g., unstable angina (UA), non-ST elevation myocardial infarction (NSTEMI) or ST-segment elevation myocardial infarction (STEMI)]	

AND

2 - The patient must be managed with percutaneous coronary intervention (PCI)

2 . Revision History

Date	Notes
2/12/2026	Updated guideline name. Removed Brand Brilinta/generic ticagrelor products as targets. Corrected spelling from "prasurgrel" to "prasugrel" in product name list.

Egrifta



Prior Authorization Guideline

Guideline ID	GL-140863
Guideline Name	Egrifta
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2021

1 . Criteria

Product Name:Egrifta SV	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of human immunodeficiency virus (HIV)-associated lipodystrophy	

2 . Revision History

UnitedHealthcare Community Plan of Arizona Clinical Pharmacy Program Guidelines

Date	Notes
3/8/2021	Updated GPI's and product name list.

Elaprase



Prior Authorization Guideline

Guideline ID	GL-140845
Guideline Name	Elaprase
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2020

1 . Criteria

Product Name:Elaprase	
Diagnosis	Hunter syndrome
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Hunter syndrome (Mucopolysaccharidosis II, MPS II)	

2 . Revision History

Date	Notes
3/11/2020	C&S Implementation

Elevidys (delandistrogene moxeparvovec-rokl)



Prior Authorization Guideline

Guideline ID	GL-602206
Guideline Name	Elevidys (delandistrogene moxeparvovec-rokl)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Elevidys	
Approval Length	1 Time Authorization in Lifetime
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting ALL of the following: 1.1 Diagnosis of Duchenne Muscular Dystrophy (DMD)	

AND

1.2 Mutation in the DMD gene has been confirmed

AND

1.3 No deletion in exon 8 or exon 9 in the DMD gene is present

AND

1.4 Patient is 4 through 5 years of age (at least 4 years 0 days and less than 6 years old)

AND

1.5 Results of baseline North Star Ambulatory Assessment (NSAA) confirming the patient is ambulatory without needing an assistive device (e.g., without side-by-side assist, cane, walker, wheelchair) as evidenced by NSAA scoring

AND

1.6 Anti-AAVrh74 total binding antibody titers are less than 1:400

AND

1.7 Patient has been on a stable dose of a corticosteroid, unless contraindicated or intolerance, prior to start of therapy and will be used concomitantly with a corticosteroid regimen pre- and post- infusion

AND

1.8 Results of ALL of the following laboratory values in the 30 days prior to therapy:

- Liver function (i.e., clinical exam, GGT, total bilirubin)

- Platelet counts
- Troponin-I

AND

1.9 Patient has a left ventricular ejection fraction of greater than or equal to 40 percent (%)

AND

1.10 Patient does NOT have clinical signs or symptoms of infection

AND

1.11 Patient will NOT receive Duvyzat (givinostat) or exon-skipping therapies for DMD [e.g., Amondys (casimersen), Exondys 51 (eteplirsen), Viltepso (viltolarsen), Vyondys 53 (golodirsen)] concomitantly or following Elevidys treatment

AND

1.12 Patient has never received Elevidys treatment in their lifetime

AND

2 - Provider attests that patient does NOT have preexisting liver impairment, chronic hepatic condition, or acute liver disease

AND

3 - Provider attests that liver function (clinical exam, GGT, and total bilirubin) will be monitored weekly for the first 3 months following Elevidys infusion and monitoring will be continued thereafter if clinically indicated as per FDA (Food and Drug Administration)-approved recommendations in the labeling

AND

4 - Provider attests that these laboratory values will be monitored after administration according to the FDA-approved recommendations in the labeling:

- Platelet counts
- Troponin-I

AND

5 - Prescribed by a neurologist with expertise in the treatment of DMD at an authorized treatment center with expertise in gene therapy

2 . Revision History

Date	Notes
5/6/2026	Updated concomitant use criterion to include Duvyzat

Elidel (pimecrolimus) cream, tacrolimus ointment



Prior Authorization Guideline

Guideline ID	GL-502196
Guideline Name	Elidel (pimecrolimus) cream, tacrolimus ointment
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name: Brand Elidel, generic pimecrolimus, tacrolimus 0.1%, tacrolimus 0.03%	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - The drug is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plan's program*	

AND

2 - ONE of the following:

- For Brand Elidel, generic pimecrolimus, or tacrolimus 0.03% ointment: Patient is at least 2 years of age
- For tacrolimus 0.1% ointment: Patient is at least 16 years of age (for patients under age 16 yo, refer to off-label PA criteria)

AND

3 - ONE of the following:

3.1 History of failure, contraindication, or intolerance to ONE topical corticosteroid in the past 90 days

OR

3.2 Drug is being prescribed for the facial or groin area

Notes	*Note: Medications used for anti-obesity/weight loss, cosmetic (e.g., alopecia, actinic keratosis, vitiligo), erectile dysfunction, and sexual dysfunction purposes are NOT medically accepted indications and are NOT recognized as a covered benefit. Erectile dysfunction drugs (Cialis/Tadalafil) are covered for clinical diagnoses other than ED.

Product Name: Brand Elidel, generic pimecrolimus, tacrolimus 0.1%, tacrolimus 0.03%	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - The drug is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plan's program*	

AND	
2 - Patient demonstrates positive clinical response to therapy	
Notes	*Note: Medications used for anti-obesity/weight loss, cosmetic (e.g., alopecia, actinic keratosis, vitiligo), erectile dysfunction, and sexual dysfunction purposes are NOT medically accepted indications and are NOT recognized as a covered benefit. Erectile dysfunction drugs (Cialis/Tadalafil) are covered for clinical diagnoses other than ED.

2 . Revision History

Date	Notes
1/14/2026	Added criterion/note regarding approved/excluded use (cosmetic, vitiligo)

Elmiron



Prior Authorization Guideline

Guideline ID	GL-140637
Guideline Name	Elmiron
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2020

1 . Criteria

Product Name:Elmiron	
Diagnosis	Bladder pain or discomfort associated with interstitial cystitis
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has a documented diagnosis of bladder pain or discomfort associated with interstitial cystitis	

2 . Revision History

Date	Notes
3/31/2020	Bulk Copy C&S New York to C&S Arizona for effective date of 5/1

Emflaza and Deflazacort Products



Prior Authorization Guideline

Guideline ID	GL-518207
Guideline Name	Emflaza and Deflazacort Products
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name: Brand Emflaza, generic deflazacort, Jaythari, Kymbee, Pyquvi	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Duchenne muscular dystrophy	

AND

2 - Patient is 2 years of age or older

AND

3 - History of failure, contraindication, or intolerance to ONE of the following for the treatment of Duchenne muscular dystrophy:

- Prednisone
- Prednisolone

AND

4 - Prescribed by or in consultation with a neurologist

AND

5 - If the request is for generic deflazacort, Jaythari, Kymbee, or Pyquvi, patient must have tried and failed Brand Emflaza

Product Name: Brand Emflaza, generic deflazacort, Jaythari, Kymbee, Pyquvi	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Physician attestation that the patient has had a positive clinical response to therapy AND	

2 - If the request is for generic deflazacort, Jaythari, Kymbee, or Pyquvi, patient must have tried and failed Brand Emflaza

2 . Revision History

Date	Notes
2/10/2026	Added Jaythari susp

Empaveli (pegcetacoplan)



Prior Authorization Guideline

Guideline ID	GL-403220
Guideline Name	Empaveli (pegcetacoplan)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	11/1/2025

1 . Criteria

Product Name:Empaveli	
Diagnosis	Paroxysmal Nocturnal Hemoglobinuria (PNH)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of paroxysmal nocturnal hemoglobinuria (PNH)	

AND

2 - Prescribed by or in consultation with ONE of the following:

- Hematologist
- Oncologist

Product Name:Empaveli

Diagnosis	Paroxysmal Nocturnal Hemoglobinuria (PNH)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy (e.g., improvement in hemoglobin level, hemoglobin stabilization, decrease in the number of red blood cell transfusions)

Product Name:Empaveli

Diagnosis	Complement 3 Glomerulopathy (C3G) or Primary Immune-Complex Membranoproliferative Glomerulonephritis (IC-MPGN)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following diagnoses:

- Complement 3 glomerulopathy (C3G)

- Primary immune-complex membranoproliferative glomerulonephritis (IC-MPGN)

AND

2 - For primary IC-MPGN, patient has NOT had a kidney transplant

AND

3 - Used to reduce proteinuria

AND

4 - Patient is 12 years of age or older

AND

5 - Patient is currently being treated with a maximally tolerated dose of ONE of the following for at least 12 weeks prior to initiating treatment:

- Angiotensin-converting enzyme inhibitors (e.g., benazepril, lisinopril)
- Angiotensin receptor blockers (e.g., losartan, valsartan)
- Sodium-glucose cotransporter-2 (SGLT2) inhibitors (e.g., Farxiga [dapagliflozin], Jardiance [empagliflozin])

AND

6 - Prescribed by or in consultation with a nephrologist

Product Name:Empaveli	
Diagnosis	Complement 3 Glomerulopathy (C3G) or Primary Immune-Complex Membranoproliferative Glomerulonephritis (IC-MPGN)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy (e.g., reduction in urine protein-to-creatinine ratio [UPCR], stable or improved estimated glomerular filtration rate [eGFR] compared to baseline)

AND

2 - For primary IC-MPGN, patient has NOT had a kidney transplant

AND

3 - Patient continues to be treated with a maximally tolerated dose of ONE of the following:

- Angiotensin-converting enzyme inhibitors (e.g., benazepril, lisinopril)
- Angiotensin receptor blockers (e.g., losartan, valsartan)
- Sodium-glucose cotransporter-2 (SGLT2) inhibitors (e.g., Farxiga [dapagliflozin], Jardiance [empagliflozin])

2 . Revision History

Date	Notes
10/2/2025	New program for ACUAZ/ACUAZEC.

Emrosi (minocycline)



Prior Authorization Guideline

Guideline ID	GL-164975
Guideline Name	Emrosi (minocycline)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	3/1/2025

1 . Criteria

Product Name:Emrosi	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Medication will be used for treatment of inflammatory lesions (papules and pustules) of rosacea AND	

2 - History of failure to generic minocycline 50 mg capsules

2 . Revision History

Date	Notes
2/11/2025	New program.

Enbrel



Prior Authorization Guideline

Guideline ID	GL-143527
Guideline Name	Enbrel
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	3/1/2024

1 . Criteria

Product Name:Enbrel	
Diagnosis	Moderately to Severely Active Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderately to severely active Rheumatoid Arthritis (RA)	

AND

2 - History of failure to a 3 month trial of ONE non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] at maximally indicated doses within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced (document drug, date, and duration of trial)*

AND

3 - Prescribed by or in consultation with a rheumatologist

Notes	*Note: Claims history may be used in conjunction as documentation of drug, date, and duration of trial

Product Name:Enbrel	
Diagnosis	Moderately to Severely Active Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Enbrel therapy AND 2 - Prescribed by or in consultation with a rheumatologist	

Product Name:Enbrel	
Diagnosis	Moderately to Severely Active Polyarticular Juvenile Idiopathic Arthritis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis AND 2 - Patient is 2 years of age or older AND 3 - Prescribed by or in consultation with a rheumatologist	

Product Name:Enbrel	
Diagnosis	Moderately to Severely Active Polyarticular Juvenile Idiopathic Arthritis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Enbrel therapy AND 2 - Prescribed by or in consultation with a rheumatologist	

Product Name:Enbrel	
Diagnosis	Active Psoriatic Arthritis

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of active psoriatic arthritis AND 2 - History of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced (document drug, date, and duration of trial)* AND 3 - Prescribed by or in consultation with ONE of the following: • Rheumatologist • Dermatologist	
Notes	*Note: Claims history may be used in conjunction as documentation of drug, date, and duration of trial

Product Name:Enbrel	
Diagnosis	Active Psoriatic Arthritis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Enbrel therapy	

AND

2 - Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Dermatologist

Product Name:Enbrel

Diagnosis	Moderate to Severe Chronic Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe chronic plaque psoriasis

AND

2 - Greater than or equal to 3% body surface area involvement, palmoplantar, facial, or genital involvement, or severe scalp psoriasis

AND

3 - Both of the following:

3.1 History of failure to one of the following topical therapies, unless contraindicated or clinically significant adverse effects are experienced (document drug, date, and duration of trial):*

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Anthralin

Coal tar	
AND	
3.2 History of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced (document drug, date, and duration of trial)*	
AND	
4 - Prescribed by or in consultation with a dermatologist	
Notes	*Note: Claims history may be used in conjunction as documentation of drug, date, and duration of trial

Product Name:Enbrel	
Diagnosis	Moderate to Severe Chronic Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Enbrel therapy AND 2 - Prescribed by or in consultation with a dermatologist	

Product Name:Enbrel	
Diagnosis	Ankylosing spondylitis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of active ankylosing spondylitis

AND

2 - History of failure to two non-steroidal anti-inflammatory drugs (NSAIDs: e.g., ibuprofen, naproxen) at maximally indicated doses, each used for at least 4 weeks within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced (document drug, date, and duration of trials)*

AND

3 - Prescribed by or in consultation with a rheumatologist

Notes	*Note: Claims history may be used in conjunction as documentation of drug, date, and duration of trial

Product Name:Enbrel	
Diagnosis	Ankylosing Spondylitis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Enbrel therapy AND 2 - Prescribed by or in consultation with a rheumatologist	

2 . Revision History

Date	Notes
2/23/2024	Added age criteria for PJIA . Removed concomitant use criterion from all sections.

Endari



Prior Authorization Guideline

Guideline ID	GL-140638
Guideline Name	Endari
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2020

1 . Criteria

Product Name:Endari	
Diagnosis	Sickle cell disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following: • Diagnosis of sickle cell disease	

- Used to reduce acute complications of sickle cell disease

AND

2 - ONE of the following:

- Patient is using Endari with concurrent hydroxyurea therapy
- Patient is unable to take hydroxyurea due to a contraindication or intolerance

AND

3 - Patient has had 2 or more painful sickle cell crises within the past 12 months

Product Name:Endari	
Diagnosis	Sickle cell disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Endari therapy	

2 . Revision History

Date	Notes
3/31/2020	Bulk Copy C&S New York to C&S Arizona for effective date of 5/1

Enspryng



Prior Authorization Guideline

Guideline ID	GL-461329
Guideline Name	Enspryng
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State New Jersey Medicaid - Community & State New York Medicaid - Community & State New York EPP Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Arizona Medicaid - Community & State New Mexico Medicaid - Community & State Pennsylvania

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Enspryng	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of neuromyelitis optica spectrum disorder (NMOSD) AND 2 - Patient has a positive serologic test for anti-aquaporin-4 (AQP4) antibodies AND 3 - History of failure, contraindication, or intolerance to rituximab therapy AND 4 - ONE of the following: • History of one or more relapses that required rescue therapy during the previous 12 months • History of two or more relapses that required rescue therapy during the previous 24 months AND 5 - Prescribed by, or in consultation with, a neurologist AND 6 - Patient is NOT receiving Enspryng in combination with any of the following for the treatment of the same indication: • Disease modifying therapies for the treatment of multiple sclerosis [e.g., Gilenya (fingolimod), Tecfidera (dimethyl fumarate), Ocrevus (ocrelizumab), etc.]	

- Complement inhibitors [e.g., eculizumab, Ultomiris (ravulizumab), etc.]
- Anti-IL6 (anti-interleukin-6) therapy [e.g., Actemra (tocilizumab)]
- B-cell depletion therapy [e.g., rituximab, Uplizna (inebilizumab)]

Product Name: Enspryng	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Enspryng therapy

AND

2 - Prescribed by, or in consultation with, a neurologist

AND

3 - Patient is NOT receiving Enspryng in combination with any of the following for the treatment of the same indication:

- Disease modifying therapies for the treatment of multiple sclerosis [e.g., Gilenya (fingolimod), Tecfidera (dimethyl fumarate), Ocrevus (ocrelizumab), etc.]
- Complement inhibitors [e.g., eculizumab, Ultomiris (ravulizumab), etc.]
- Anti-IL6 (anti-interleukin-6) therapy [e.g., Actemra (tocilizumab)]
- B-cell depletion therapy [e.g., rituximab, Uplizna (inebilizumab)]

2 . Revision History

Date	Notes

12/5/2025	Combined formularies. Updated statement for concomitant use and updated examples of complement inhibitors in both initial and reauth sections. Minor cosmetic updates.

Entocort EC



Prior Authorization Guideline

Guideline ID	GL-140639
Guideline Name	Entocort EC
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2020

1 . Criteria

Product Name: Brand Entocort EC, generic budesonide	
Diagnosis	Crohn's Disease
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Entocort EC is being used for the treatment of Crohn's disease	

2 . Revision History

Date	Notes
3/31/2020	Bulk Copy C&S New York to C&S Arizona for effective date of 5/1

Entyvio (vedolizumab)



Prior Authorization Guideline

Guideline ID	GL-336193
Guideline Name	Entyvio (vedolizumab)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	8/1/2025

1 . Criteria

Product Name:Entyvio SC	
Approval Length	14 Week(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 ALL of the following:	

1.1.1 Submission of medical records (e.g., chart notes) confirming a diagnosis of ONE of the following:

- Moderately to severely active Crohn's disease
- Moderately to severely active ulcerative colitis

AND

1.1.2 Paid claims or submission of medical records (e.g., chart notes) confirming ONE of the following:

1.1.2.1 Will be used as a maintenance dose following two doses of Entyvio IV for induction

OR

1.1.2.2 Patient is currently established on Entyvio IV

AND

1.1.3 Prescribed by or in consultation with a gastroenterologist

OR

1.2 Patient has received 2 doses of Entyvio IV for induction

Product Name:Entyvio SC	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient demonstrates positive clinical response to therapy as evidenced by at least ONE of the following:	

- Improvement in intestinal inflammation (e.g., mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline
- Reversal of high fecal output state

2 . Revision History

Date	Notes
7/16/2025	Updated GPI entry for Entyvio pen formulation. No changes to criteria.

Eohilia (budesonide)



Prior Authorization Guideline

Guideline ID	GL-147109
Guideline Name	Eohilia (budesonide)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	6/1/2024

1 . Criteria

Product Name:Eohilia	
Diagnosis	Eosinophilic Esophagitis (EoE)
Approval Length	12 Week(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of eosinophilic esophagitis (EoE)	

AND

2 - Patient has symptoms of esophageal dysfunction (e.g., dysphagia, food impaction, heartburn, abdominal pain)

AND

3 - Patient has at least 15 intraepithelial eosinophils per high power field (HPF)

AND

4 - Other causes of esophageal eosinophilia have been excluded

AND

5 - Patient is 11 years of age or older

AND

6 - Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure (of a minimum 8-week duration), contraindication, or intolerance to a proton pump inhibitor (e.g., pantoprazole, omeprazole)

AND

7 - Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure (of a minimum 8-week duration), or intolerance to a topical (esophageal) corticosteroid (e.g., budesonide, fluticasone)

AND

8 - Prescribed by or in consultation with ONE of the following:

- Allergist/Immunologist
- Gastroenterologist

2 . Revision History

Date	Notes
5/6/2024	New program.

Epaned



Prior Authorization Guideline

Guideline ID	GL-140683
Guideline Name	Epaned
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Epaned	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Patient is less than 8 years of age	

OR

1.2 BOTH of the following:

1.2.1 ONE of the following diagnoses:

- Hypertension
- Heart failure
- Asymptomatic left ventricular dysfunction, defined as left ventricular ejection fraction less than or equal to 35%

AND

1.2.2 ONE of the following:

1.2.2.1 History of failure, contraindication, or intolerance to TWO formulary oral anti-hypertensives (e.g., angiotensin-converting enzyme (ACE) inhibitor, ACE inhibitor combination, angiotensin-receptor blockers (ARB), ARB combination, thiazide diuretic)

OR

1.2.2.2 Patient is unable to ingest a solid dosage form (e.g. an oral tablet or capsule) due to ONE of the following:

- Oral/motor difficulties
- Dysphagia

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Epinephrine Products



Prior Authorization Guideline

Guideline ID	GL-286216
Guideline Name	Epinephrine Products
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	7/1/2025

1 . Criteria

Product Name:Epinephrine Pens (Non-Mylan Manufacturer)*, Neffy	
Approval Length	6 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - There is a shortage on Epinephrine Pens manufactured by Mylan.	
Notes	*Only approve other rebatable epinephrine autoinjectors if both the branded EpiPen and authorized generic are on the FDA shortage list.

Product Name:Epinephrine Pens (Mylan Manufacturer)	
Approval Length	6 month(s)
Guideline Type	Quantity Limit
Approval Criteria 1 - Medication has been used or lost or the member is going on vacation.*	
Notes	*Only approve other rebatable epinephrine autoinjectors if both the branded EpiPen and authorized generic are on the FDA shortage list.

2 . Revision History

Date	Notes
6/3/2025	Added new Neffy GPI

Eplerenone



Prior Authorization Guideline

Guideline ID	GL-140684
Guideline Name	Eplerenone
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name: Brand Inspira, generic eplerenone	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of one of the following: 1.1 Symptomatic heart failure with reduced ejection fraction (HFrEF) after an acute myocardial infarction	

OR

1.2 Hypertension

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Epsolay (benzoyl peroxide) cream



Prior Authorization Guideline

Guideline ID	GL-140678
Guideline Name	Epsolay (benzoyl peroxide) cream
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Epsolay	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of rosacea AND	

2 - Patient has inflammatory lesions

AND

3 - Trial and failure (of a minimum 30-day supply), contraindication or intolerance to one preferred topical product for rosacea (e.g., metronidazole cream/gel/lotion) (verified via paid pharmacy claims)

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Ergot Alkaloids



Prior Authorization Guideline

Guideline ID	GL-565278
Guideline Name	Ergot Alkaloids
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name: Brekya, Brand Migranal, generic dihydroergotamine mesylate nasal spray, Trudhesa	
Diagnosis	Migraines
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of migraine headaches with or without aura	

AND

2 - Will be used for the acute treatment of migraine

AND

3 - Patient is 18 years of age or older

AND

4 - History of failure, contraindication, or intolerance to TWO preferred 5-HT₁ (5-hydroxytryptamine-1) receptor agonist (triptan) alternatives [e.g., Imitrex (sumatriptan), Maxalt or Maxalt-MLT (rizatriptan)]

Product Name: Brekiya, Brand Migranal, generic dihydroergotamine mesylate nasal spray, Trudhesa

Diagnosis	Migraines
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has experienced a positive response to therapy (e.g., reduction in pain, photophobia, phonophobia, nausea)

Product Name: Brekiya

Diagnosis	Cluster Headaches
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of cluster headache

AND

2 - Patient is 18 years of age or older

AND

3 - Trial and failure, contraindication, or intolerance to sumatriptan injection

Product Name: Brekiya

Diagnosis	Cluster Headaches
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity

2 . Revision History

Date	Notes
4/6/2026	Updated guideline name. Added Brekiya and Trudhesa as targets. Updated GPI tables and product name lists accordingly. For migraines, added a reauth section and additional criteria added to initial auth section. Added new criteria for Brekiya for cluster headache.

Erythropoietic Agents



Prior Authorization Guideline

Guideline ID	GL-334242
Guideline Name	Erythropoietic Agents
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	8/1/2025

1 . Criteria

Product Name: Aranesp, Epogen, Procrit, Retacrit, newly launched erythropoietin stimulating agents	
Diagnosis	Anemia Due to Chronic Kidney Disease (CKD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chronic kidney disease (CKD)	

AND

2 - Hematocrit is less than 30% at initiation of therapy

AND

3 - ONE of the following:

3.1 Patient is on dialysis

OR

3.2 ALL of the following:

3.2.1 Patient is NOT on dialysis

AND

3.2.2 The rate of hematocrit decline indicates the likelihood of requiring a red blood cell (RBC) transfusion

AND

3.2.3 Reducing the risk of alloimmunization and/or other RBC transfusion-related risks is a goal

AND

4 - If the request is non-preferred*, history of failure to ALL preferred* erythropoietin stimulating agents

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name: Aranesp, Epogen, Procrit, Retacrit, newly launched erythropoietin stimulating agents	
Diagnosis	Anemia Due to Chronic Kidney Disease (CKD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chronic kidney disease (CKD) AND 2 - ONE of the following: 2.1 BOTH of the following: 2.1.1 Patient is on dialysis AND 2.1.2 Most recent or average Hct (hematocrit) over 3 months is 33% or less [Hgb (hemaglobin) 11 g/dL (grams/deciliter) or less] OR 2.2 ALL of the following: 2.2.1 Patient is NOT on dialysis AND 2.2.2 Most recent or average (avg) Hct over 3 months is 30% or less (Hgb 10 g/dL or less)	

AND

2.2.3 Reducing the risk of alloimmunization and/or other RBC transfusion-related risks is a goal

OR

2.3 BOTH of the following:

2.3.1 Request is for a pediatric patient

AND

2.3.2 Most recent or average Hct over 3 months is 36% or less (Hgb 12 g/dL or less)

AND

3 - ONE of the following:

3.1 Decrease in the need for blood transfusion

OR

3.2 Hgb increased greater than or equal to 1 g/dL from pre-treatment level

Product Name:Aranesp, Epogen, Procrit, Retacrit, newly launched erythropoietin stimulating agents	
Diagnosis	Anemia Associated with Zidovudine Treatment in HIV-Infected Patients
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is receiving zidovudine administered at less than or equal to 4200 milligrams per week

AND

2 - Endogenous serum erythropoietin level is less than or equal to 500 milliunits per milliliter

AND

3 - Hematocrit is less than 30% at initiation of therapy

AND

4 - If the request is non-preferred*, history of failure to ALL preferred* erythropoietin stimulating agents

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name: Aranesp, Epogen, Procrit, Retacrit, newly launched erythropoietin stimulating agents

Diagnosis	Anemia Due to Cancer Chemotherapy
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Hematocrit less than 30% at initiation of therapy

AND

2 - There is a minimum of two additional months of planned chemotherapy

AND	
3 - If the request is non-preferred*, history of failure to ALL preferred* erythropoietin stimulating agents	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name: Aranesp, Epogen, Procrit, Retacrit, newly launched erythropoietin stimulating agents	
Diagnosis	Preoperative Use for Reduction of Allogeneic Blood Transfusions in Surgery Patients
Approval Length	1 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Perioperative hematocrit is greater than 30% and less than or equal to 39% AND 2 - Patient is at high risk for blood loss during surgery AND 3 - Patient is unable or unwilling to donate autologous blood AND 4 - Surgery procedure is elective, non-cardiac, and non-vascular	

AND	
5 - If the request is non-preferred*, history of failure to ALL preferred* erythropoietin stimulating agents	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name: Aranesp, Epogen, Procrit, Retacrit, newly launched erythropoietin stimulating agents	
Diagnosis	Anemia Associated with Myelodysplastic Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of myelodysplastic disease (MDS) AND 2 - ONE of the following: - Serum erythropoietin level less than or equal to 500 milliunits per milliliter - Hematocrit is less than or equal to 30% at the initiation of therapy AND 3 - If the request is non-preferred*, history of failure to ALL preferred* erythropoietin stimulating agents	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name: Aranesp, Epogen, Procrit, Retacrit, newly launched erythropoietin stimulating agents	
Diagnosis	Anemia Associated with Myelodysplastic Disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Hematocrit remains less than 36% OR 1.2 Patient has demonstrated a response to therapy	

Product Name: Aranesp, Epogen, Procrit, Retacrit, newly launched erythropoietin stimulating agents	
Diagnosis	Anemia in Patients with Hepatitis C with Ribavirin and Interferon Therapy
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of hepatitis C virus (HCV) infection AND 2 - Patient is receiving ribavirin and interferon therapy	

AND	
3 - Hematocrit is less than or equal to 30% at initiation of therapy	
AND	
4 - If the request is non-preferred*, history of failure to ALL preferred* erythropoietin stimulating agents	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name: Aranesp, Epogen, Procrit, Retacrit, newly launched erythropoietin stimulating agents^	
Diagnosis	Anemia in Patients with Hepatitis C with Ribavirin and Interferon Therapy
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Hematocrit remains less than 36% OR 1.2 Patient has demonstrated a response to therapy	
Notes	^Authorization will be issued for 12 months or if patient has demonstrated response to therapy, authorization will be issued for the full course of ribavirin therapy.

Product Name: Aranesp, Epogen, Procrit, Retacrit, newly launched erythropoietin stimulating agents^

Diagnosis	Erythropoietin Stimulating Agents - Off-Label Uses
Guideline Type	Prior Authorization
Approval Criteria 1 - Off-label requests will be evaluated on a case-by-case basis by a clinical pharmacist AND 2 - Requests for coverage in patients with hemoglobin (Hgb) greater than 10 grams per deciliter or hematocrit (Hct) greater than 30% will not be approved AND 3 - If the request is non-preferred*, history of failure to ALL preferred* erythropoietin stimulating agents	
Notes	^If the request is deemed medically necessary, the authorization will be issued for requested length of therapy. *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

2 . Revision History

Date	Notes
7/22/2025	Updates to product name lists and to all criteria sections. Updated GPI tables where applicable.

Esbriet, Jascayd, Ofev



Prior Authorization Guideline

Guideline ID	GL-609197
Guideline Name	Esbriet, Jascayd, Ofev
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name: Brand Esbriet, generic pirfenidone, Jascayd, Brand Ofev, generic nintedanib^	
Diagnosis	Idiopathic Pulmonary Fibrosis (IPF)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of idiopathic pulmonary fibrosis (IPF) as documented by BOTH of the following criteria:	

1.1 Exclusion of other known causes of interstitial lung disease (e.g. domestic and occupational environmental exposures, connective tissue disease, and drug toxicity), as documented by the following:

- ICD-10 Code J84.112 (Idiopathic pulmonary fibrosis)

AND

1.2 ONE of the following:

1.2.1 In patients NOT subjected to surgical lung biopsy, the presence of a usual interstitial pneumonia (UIP) pattern on high-resolution computed tomography (HRCT) revealing IPF or probable IPF

OR

1.2.2 In patients subjected to a lung biopsy, both HRCT and surgical lung biopsy pattern reveal IPF or probable IPF

AND

2 - Requested agent is NOT being used in combination with another agent for IPF [e.g., Esbriet (pirfenidone), Jascayd, or Ofev (nintedanib)]

AND

3 - Prescribed by or in consultation with a pulmonologist

AND

4 - If the request is non-preferred*, patient has tried and failed, or has intolerance to BOTH of the following:

- generic pirfenidone 267 mg capsules
- generic nintedanib (Sandoz manufacturer)

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP ^Please approve generic nintedanib at NDC level.

Product Name: Brand Esbriet, generic pirfenidone, Jascayd, Brand Ofev, generic nintedanib^	
Diagnosis	Idiopathic Pulmonary Fibrosis (IPF)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy AND 2 - Requested agent is NOT being used in combination with another agent for IPF [e.g., Esbriet (pirfenidone), Jascayd, or Ofev (nintedanib)] AND 3 - Prescribed by or in consultation with a pulmonologist AND 4 - If the request is non-preferred*, patient has tried and failed, or has intolerance to BOTH of the following: - generic pirfenidone 267 mg capsules - generic nintedanib (Sandoz manufacturer)	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

	^Please approve generic nintedanib at NDC level.

Product Name: Brand Ofev, generic nintedanib^	
Diagnosis	Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of systemic sclerosis-associated interstitial lung disease (SSc-ILD) as documented by BOTH of the following: 1.1 ONE of the following: 1.1.1 Skin thickening of the fingers of both hands extending proximal to the metacarpophalangeal joints OR 1.1.2 TWO of the following: • Skin thickening of the fingers (e.g., puffy fingers, sclerodactyly of the fingers) • Fingertip lesions (e.g., digital tip ulcers, fingertip pitting scars) • Telangiectasia • Abnormal nailfold capillaries • Pulmonary arterial hypertension • Raynaud's phenomenon • SSc-related autoantibodies (e.g., anticentromere, anti-topoisomerase I, anti-RNA polymerase III) AND 1.2 Presence of interstitial lung disease as determined by finding evidence of pulmonary fibrosis on high-resolution computed tomography (HRCT), involving at least 10 percent of the lungs	

AND	
2 - Prescribed by or in consultation with a pulmonologist	
AND	
3 - If the request is non-preferred*, patient has tried and failed, or has intolerance to generic nintedanib (Sandoz manufacturer)	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP ^Please approve generic nintedanib at NDC level.

Product Name:Brand Ofev, generic nintedanib^	
Diagnosis	Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy AND 2 - Prescribed by or in consultation with a pulmonologist AND 3 - If the request is non-preferred*, patient has tried and failed, or has intolerance to generic nintedanib (Sandoz manufacturer)	

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP ^Please approve generic nintedanib at NDC level.

Product Name:Jascayd, Brand Ofev, generic nintedanib^	
Diagnosis	Chronic fibrosing interstitial lung disease (ILD), Progressive Pulmonary Fibrosis (PPF)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following: - Chronic fibrosing interstitial lung disease (ILD) - Progressive pulmonary fibrosis (PPF) AND 2 - Patient does NOT have idiopathic pulmonary fibrosis AND 3 - BOTH of the following: 3.1 Presence of fibrotic ILD as determined by finding evidence of pulmonary fibrosis on HRCT (high-resolution computed tomography), involving at least 10 percent of the lungs AND 3.2 Patient is presenting with clinical signs of progression as defined by ONE of the following in the previous 24 months: 3.2.1 Forced vital capacity (FVC) decline of greater than 10 percent	

OR

3.2.2 TWO of the following:

- FVC decline of greater than or equal to 5 percent, but less than 10 percent
- Patient is experiencing worsening respiratory symptoms
- Patient is exhibiting increasing extent of fibrotic changes on chest imaging

AND

4 - Prescribed by or in consultation with a pulmonologist

AND

5 - If the request is non-preferred*, patient has tried and failed, or has intolerance to generic nintedanib (Sandoz manufacturer)

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP ^Please approve generic nintedanib at NDC level.

Product Name:Jascayd, Brand Ofev, generic nintedanib^	
Diagnosis	Chronic fibrosing interstitial lung disease (ILD), Progressive Pulmonary Fibrosis (PPF)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy	

AND	
2 - Prescribed by or in consultation with a pulmonologist	
AND	
3 - If the request is non-preferred*, patient has tried and failed, or has intolerance to generic nintedanib (Sandoz manufacturer)	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP ^Please approve generic nintedanib at NDC level.

2 . Revision History

Date	Notes
5/12/2026	Added generic nintedanib products as targets. In IPF criteria sections , updated prerequisites in embedded step criterion and updated concomitant use criterion. For SSc-ILD, ILD, and PPF criteria sections, added embedded step requirement. Updated notes section throughout guideline.

Estrogens



Prior Authorization Guideline

Guideline ID	GL-140685
Guideline Name	Estrogens
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Femring	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderate to severe vasomotor symptoms due to menopause OR	

2 - Diagnosis of moderate to severe vulvar and vaginal atrophy due to menopause

Product Name:Premarin	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of atrophic vaginitis and kraurosis vulvae	

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Eucrisa



Prior Authorization Guideline

Guideline ID	GL-140765
Guideline Name	Eucrisa
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	1/1/2023

1 . Criteria

Product Name:Eucrisa	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following: 1.1 History of failure, contraindication, or intolerance to ONE topical corticosteroid [e.g., mometasone furoate, fluocinolone acetonide (generic Synalar), fluocinonide]	

AND

1.2 ONE of the following:

1.2.1 Patient is less than 2 years of age

OR

1.2.2 Patient is greater than or equal to 2 years of age and has history of failure, contraindication, or intolerance to ONE topical calcineurin inhibitor [e.g., pimecrolimus (generic Elidel), tacrolimus (generic Protopic)]

2 . Revision History

Date	Notes
12/13/2022	Updated guideline type.

Evrysdi (risdiplam)



Prior Authorization Guideline

Guideline ID	GL-231251
Guideline Name	Evrysdi (risdiplam)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2025

1 . Criteria

Product Name:Evrysdi	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of spinal muscular atrophy (SMA)	

AND

2 - Submission of medical records (e.g., chart notes, laboratory values) confirming the mutation or deletion of genes in chromosome 5q resulting in ONE of the following:

2.1 Homozygous gene deletion or mutation of SMN1 gene (e.g., homozygous deletion of exon 7 at locus 5q13)

OR

2.2 Compound heterozygous mutation of SMN1 gene [e.g., deletion of SMN1 exon 7 (allele 1) and mutation of SMN1 (allele 2)]

AND

3 - Patient is not dependent on invasive ventilation or tracheostomy

AND

4 - Patient is not dependent on the use of non-invasive ventilation beyond use for naps and nighttime sleep

AND

5 - Patient is not receiving concomitant chronic survival motor neuron (SMN)-modifying therapy [e.g., Spinraza (nusinersen)]

AND

6 - Patient has not previously received gene replacement therapy for the treatment of SMA [e.g., Zolgensma (onasemnogene abeparvovec-xioi)]

AND

7 - Submission of medical records (e.g., chart notes, laboratory values) documenting the baseline assessment of at least ONE of the following exams (based on patient age and motor ability) to establish baseline motor ability (baseline motor function analysis could include assessments evaluated prior to receipt of previous chronic SMN-modifying therapy if transitioning therapy)*:

- Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND)
- Hammersmith Infant Neurological Exam Part 2 (HINE-2)
- Hammersmith Functional Motor Scale Expanded (HFMSE)
- Upper Limb Module (ULM) Test
- Motor Function Measure 32 (MFM-32) Scale

AND

8 - Prescribed by a neurologist with expertise in the treatment of SMA

Notes	*Baseline assessments for patients less than 2 months of age requesting Evrysdi are not necessary in order not to delay access to initial therapy in recently diagnosed infants. Initial assessments shortly post-therapy can serve as baseline with respect to efficacy reauthorization assessment.

Product Name:Evrysdi	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes, laboratory values) with the most recent results documenting a positive clinical response to Evrysdi compared to pretreatment baseline status [inclusive of baseline assessments prior to receipt of previous chronic survival motor neuron (SMN)-modifying therapy] as demonstrated by at least ONE of the following exams: 1.1 Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND) with ONE of the following: 1.1.1 Improvement or maintenance of previous improvement of at least a 4-point increase in score from pretreatment baseline	

OR

1.1.2 Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so

OR

1.2 Hammersmith Infant Neurological Exam Part 2 (HINE-2) with ONE of the following:

1.2.1 Improvement or maintenance of previous improvement of at least a 2-point (or maximal score) increase in ability to kick

OR

1.2.2 Improvement or maintenance of previous improvement of at least a 1-point increase in any other HINE-2 milestone (e.g., head control, rolling, sitting, crawling, etc.), excluding voluntary grasp

OR

1.2.3 The patient exhibited improvement, or maintenance of previous improvement, in more HINE motor milestones than worsening, from pretreatment baseline (net positive improvement)

OR

1.2.4 Patient has achieved and maintained any new motor milestones when they would otherwise be unexpected to do so

OR

1.3 Hammersmith Functional Motor Scale Expanded (HFMSE) with ONE of the following:

1.3.1 Improvement or maintenance of previous improvement of at least a 3-point increase in score from pretreatment baseline

OR

1.3.2 Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so

OR

1.4 Upper Limb Module (ULM) with ONE of the following:

1.4.1 Improvement or maintenance of previous improvement of at least a 2-point increase in score from pretreatment baseline

OR

1.4.2 Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so

OR

1.5 Motor Function Measure 32 (MFM-32) with ONE of the following:

1.5.1 Improvement or maintenance of previous improvement of at least a 3-point increase in score from pretreatment baseline

OR

1.5.2 Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so

AND

2 - Patient is not dependent on invasive ventilation or tracheostomy

AND

3 - Patient is not dependent on the use of non-invasive ventilation beyond use for naps and nighttime sleep

AND

4 - Patient is not receiving concomitant chronic SMN-modifying therapy [e.g., Spinraza (nusinersen)]

AND

5 - Patient has not previously received gene replacement therapy for the treatment of spinal muscular atrophy (SMA) [e.g., Zolgensma (onasemnogene abeparvovec-xioi)]

AND

6 - Prescribed by a neurologist with expertise in the treatment of SMA

2 . Revision History

Date	Notes
3/31/2025	Added new GPI for Evrysdi tablet. Removed indication/diagnosis.

Exdensur (depemokimab-ulaa)



Prior Authorization Guideline

Guideline ID	GL-545208
Guideline Name	Exdensur (depemokimab-ulaa)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Exdensur	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of documentation (e.g., chart notes) confirming diagnosis of severe asthma	

AND

2 - Submission of documentation (e.g., chart notes, lab values) confirming asthma is an eosinophilic phenotype as defined by a baseline (pre-treatment) peripheral blood eosinophil level greater than or equal to 150 cells per microliter

AND

3 - ONE of the following:

3.1 Patient has had at least two or more asthma exacerbations requiring systemic corticosteroids (e.g., prednisone) within the past 12 months

OR

3.2 Prior asthma-related hospitalization within the past 12 months

AND

4 - Patient is 12 years of age or older

AND

5 - Patient is currently being treated with ONE of the following unless there is a contraindication or intolerance to these medications (verified via paid pharmacy claims):

5.1 BOTH of the following:

- High-dose inhaled corticosteroid (ICS) (e.g., greater than 500 mcg fluticasone propionate equivalent/day)
- Additional asthma controller medication (e.g., leukotriene receptor antagonist [LTRA] [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], long-acting muscarinic antagonist [LAMA] [e.g., tiotropium])

OR

5.2 One maximally-dosed combination ICS/LABA product (e.g., Advair [fluticasone propionate 500 mcg/salmeterol 50 mcg], Symbicort [budesonide 160 mcg/formoterol 4.5 mcg], Breo Ellipta [fluticasone 200 mcg/vilanterol 25 mcg])

AND

6 - Paid claims or submission of documentation (e.g., chart notes) demonstrating history of failure, contraindication, or intolerance to BOTH of the following:

- Xolair (omalizumab)
- Fasenra (benralizumab)

AND

7 - Prescribed by or in consultation with ONE of the following:

- Pulmonologist
- Allergist/Immunologist

Product Name:Exdensur

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a positive clinical response to therapy (e.g., reduction in clinically significant exacerbations requiring systemic corticosteroids)

AND

2 - Paid claims or submission of documentation (e.g., chart notes) confirming patient continues to be treated with an inhaled corticosteroid (ICS) (e.g., fluticasone, budesonide) with or without additional asthma controller medication (e.g., leukotriene receptor antagonist)

[LTRA] [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], long-acting muscarinic antagonist [LAMA] [e.g., tiotropium]) unless there is a contraindication or intolerance to these medications

AND

3 - Prescribed by or in consultation with ONE of the following:

- Pulmonologist
- Allergist/Immunologist

2 . Background

Clinical Practice Guidelines

The Global Initiative for Asthma Global Strategy for Asthma Management and Prevention: Table 1. Low, medium and high daily doses of inhaled corticosteroids in adolescents and adults 12 years and older

Inhaled corticosteroid	Total Daily ICS Dose (mcg)		
	Low	Medium	High
Beclometasone dipropionate (pMDI, standard particle, HFA)	200-500	> 500-1000	> 1000
Beclometasone dipropionate (DPI or pMDI, extrafine particle*, HFA)	100-200	> 200-400	> 400
Budesonide (DPI, or pMDI, standard particle, HFA)	200-400	> 400-800	> 800
Ciclesonide (pMDI, extrafine particle*, HFA)	80-160	> 160-320	> 320
Fluticasone furoate (DPI)	100		200
Fluticasone propionate (DPI)	100-250	> 250-500	> 500
Fluticasone propionate (pMDI, standard particle, HFA)	100-250	> 250-500	> 500

Mometasone furoate (DPI)	Depends on DPI device – see product information	
Mometasone furoate (pMDI, standard particle, HFA)	200-400	> 400
DPI: dry powder inhaler; HFA: hydrofluoroalkane propellant; ICS: inhaled corticosteroid; N/A: not applicable; pMDI: pressurized metered dose inhaler (non-chlorofluorocarbon formulations); ICS by pMDI should be preferably used with a spacer *See product information. <i>This is not a table of equivalence</i>, but instead, suggested total daily doses for the 'low', 'medium' and 'high' dose ICS options for adults/adolescents, based on available studies and product information. Data on comparative potency are not readily available and therefore this table does NOT imply potency equivalence. Doses may be country -specific depending on local availability, regulatory labelling and clinical guidelines. For new preparations, including generic ICS, the manufacturer's information should be reviewed carefully; products containing the same molecule may not be clinically equivalent.		

3 . Revision History

Date	Notes
3/9/2026	New program for ACUAZ/ACUAZEC.

Exondys 51 (eteplirsen)



Prior Authorization Guideline

Guideline ID	GL-539213
Guideline Name	Exondys 51 (eteplirsen)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Exondys 51	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming BOTH of the following: • Diagnosis of Duchenne muscular dystrophy (DMD)	

- Disease is confirmed by the presence of a mutation of the dystrophin gene amenable to exon 51 skipping

AND

2 - Patient is 7 years of age or older

AND

3 - Prescribed by or in consultation with a neurologist with expertise in the treatment of DMD

AND

4 - Dose will not exceed 30 milligrams per kilogram of body weight once weekly

AND

5 - Submission of medical records including results of baseline North Star Ambulatory Assessment (NSAA) confirming the patient is ambulatory without needing an assistive device (e.g., without side-by-side assist, cane, walker, wheelchair) as evidenced by NSAA scoring

AND

6 - Patient will not receive Exondys 51 in combination with Duvyzat (givinostat) or other exon-skipping therapies for DMD [e.g., Amondys 45 (casimersen), Vilepso (viltolarsen), Vyondys 53 (golodirsen)]

Product Name:Exondys 51	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Patient is tolerating therapy

AND

2 - Prescribed by or in consultation with a neurologist with expertise in the treatment of DMD

AND

3 - Dose will not exceed 30 milligrams per kilogram of body weight once weekly

AND

4 - Submission of medical records including results of recent North Star Ambulatory Assessment (NSAA) confirming patient is maintaining ambulatory status without needing an assistive device (e.g., without side-by-side assist, cane, walker, wheelchair) as evidenced by NSAA scoring

AND

5 - Patient will not receive Exondys 51 in combination with Duvyzat (givinostat) or other exon-skipping therapies for DMD [e.g., Amondys 45 (casimersen), Viltepso (viltolarsen), Vyondys 53 (golodirsen)]

2 . Revision History

Date	Notes
3/5/2026	Added submission of NSAA testing for confirmation of ambulatory status

Ezallor Sprinkle (rosuvastatin)



Prior Authorization Guideline

Guideline ID	GL-140812
Guideline Name	Ezallor Sprinkle (rosuvastatin)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2023

1 . Criteria

Product Name:Ezallor	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 BOTH of the following: 1.1.1 Patient is less than 10 years of age	

AND

1.1.2 Prescribed by or in consultation with a cardiologist

OR

1.2 BOTH of the following:

1.2.1 Medication is being used for ONE of the following:

1.2.1.1 To reduce the risk of ONE of the following:

- Myocardial infarction (MI), stroke, revascularization procedures, and angina in adults with multiple risk factors for coronary heart disease (CHD) but without clinically evident CHD
- MI and stroke in adults with type 2 diabetes mellitus with multiple risk factors for CHD but without clinically evident CHD
- Non-fatal MI, fatal and non-fatal stroke, revascularization procedures, hospitalization for congestive heart failure, and angina in adults with clinically evident CHD

OR

1.2.1.2 As an adjunct to diet to reduce low-density lipoprotein cholesterol (LDL-C) in ONE of the following:

- Adults with primary hyperlipidemia
- Adults and pediatric patients aged 10 years and older with heterozygous familial hypercholesterolemia (HeFH)

OR

1.2.1.3 As an adjunct to other LDL-C-lowering therapies, or alone if such treatments are unavailable, to reduce LDL-C in adults and pediatric patients aged 7 years and older with homozygous familial hypercholesterolemia (HoFH)

OR

1.2.1.4 As an adjunct to diet for the treatment of adults with ONE of the following:

- Primary dysbetalipoproteinemia
- Hypertriglyceridemia

AND

1.2.2 ONE of the following:

1.2.2.1 Trial and failure, contraindication, or intolerance to generic rosuvastatin tablets (verified via paid pharmacy claims or submitted chart notes)

OR

1.2.2.2 Patient is unable to swallow oral tablets

2 . Revision History

Date	Notes
9/11/2023	New Program

Fabhalta (iptacopan)



Prior Authorization Guideline

Guideline ID	GL-403228
Guideline Name	Fabhalta (iptacopan)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	11/1/2025

1 . Criteria

Product Name:Fabhalta	
Diagnosis	Paroxysmal Nocturnal Hemoglobinuria (PNH)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of paroxysmal nocturnal hemoglobinuria (PNH)	

AND

2 - Hemoglobin level of less than 10 g/dL (grams per deciliter)

AND

3 - Prescribed by or in consultation with a hematologist/oncologist

Product Name:Fabhalta	
Diagnosis	Paroxysmal Nocturnal Hemoglobinuria (PNH)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient demonstrates positive clinical response to therapy (e.g., hemoglobin stabilization, decrease in the number of red blood cell transfusions)	

Product Name:Fabhalta	
Diagnosis	Immunoglobulin A nephropathy (IgAN)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of primary immunoglobulin A nephropathy (IgAN) as confirmed by a kidney biopsy	

AND

2 - Patient is at risk of rapid disease progression [e.g., generally a urine protein-to-creatinine ratio (UPCR) greater than or equal to 1.5 g/g (gram), or by other criteria such as clinical risk scoring using the International IgAN Prediction Tool]

AND

3 - Used to reduce proteinuria

AND

4 - Patient has an estimated glomerular filtration rate (eGFR) of greater than or equal to 20 mL/min/1.73 m² (milliliters/minute/1.73 square meters)

AND

5 - Patient has been on a minimum 90-day trial of a maximally tolerated dose of ONE of the following:

- An angiotensin-converting enzyme (ACE) inhibitor (e.g., benazepril, lisinopril)
- An angiotensin II receptor blocker (ARB) (e.g., losartan, valsartan)

AND

6 - Prescribed by or in consultation with a nephrologist

Product Name: Fabhalta	
Diagnosis	Immunoglobulin A nephropathy (IgAN)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates a positive clinical response to therapy as demonstrated by a decrease in urine protein-to-creatinine ratio (UPCR) from baseline

Product Name:Fabhalta	
Diagnosis	Complement 3 Glomerulopathy (C3G)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of kidney complement 3 glomerulopathy (C3G) AND 2 - Used to reduce proteinuria AND 3 - Patient is on a maximally tolerated renin-angiotensin system (RAS) inhibitor (e.g., benazepril, lisinopril, losartan, valsartan) AND 4 - Patient has NOT had a kidney transplant AND 5 - Prescribed by or in consultation with a nephrologist	

Product Name:Fabhalta	
Diagnosis	Complement 3 Glomerulopathy (C3G)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient demonstrates a positive clinical response to therapy (e.g., reduction in 24-hour UPCR, stable or improved eGFR compared to baseline) AND 2 - Patient is on a maximally tolerated renin-angiotensin system (RAS) inhibitor (e.g., benazepril, lisinopril, losartan, valsartan) AND 3 - Patient has NOT had a kidney transplant	

2 . Revision History

Date	Notes
10/2/2025	New program for ACUAZ/ACUAZEC.

Fabry Disease Agents



Prior Authorization Guideline

Guideline ID	GL-140996
Guideline Name	Fabry Disease Agents
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	9/1/2023

1 . Criteria

Product Name:Fabrazyme	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Fabry disease	

AND

2 - Patient is 2 years of age or older

AND

3 - Submission of medical records (e.g., chart notes) confirming ONE of the following:

3.1 Detection of pathogenic mutations in the GLA gene by molecular genetic testing

OR

3.2 Deficiency in alpha-galactosidase A (alpha-Gal A) enzyme activity in plasma, isolated leukocytes, or dried blood spots (DBS)

OR

3.3 Significant clinical manifestations (e.g., neuropathic pain, cardiomyopathy, renal insufficiency, angiokeratomas, cornea verticillata)

AND

4 - Will not be used in combination with Galafold (migalastat)

Product Name: Fabrazyme	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy	

2 . Revision History

Date	Notes
8/9/2023	Updated guideline name, updated all criteria.

Fasenra (benralizumab)



Prior Authorization Guideline

Guideline ID	GL-397217
Guideline Name	Fasenra (benralizumab)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2025

1 . Criteria

Product Name:Fasenra	
Diagnosis	Severe Asthma
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of documentation (e.g., chart notes) confirming diagnosis of severe asthma	

AND

2 - Submission of documentation (e.g., chart notes, lab values) confirming asthma is an eosinophilic phenotype as defined by a baseline (pre-treatment) peripheral blood eosinophil level greater than or equal to 150 cells per microliter

AND

3 - ONE of the following:

3.1 Patient has had at least two or more asthma exacerbations requiring systemic corticosteroids (e.g., prednisone) within the past 12 months

OR

3.2 Prior asthma-related hospitalization within the past 12 months

AND

4 - ONE of the following:

4.1 BOTH of the following:

4.1.1 Patient is 6 years of age or older but less than 12 years of age

AND

4.1.2 Paid claims or submission of medical records (e.g., chart notes) confirming patient is currently being treated with ONE of the following unless there is a contraindication or intolerance to these medications:

4.1.2.1 BOTH of the following:

- Medium-dose inhaled corticosteroid (e.g., greater than 100 – 200 mcg fluticasone propionate equivalent/day)

- Additional asthma controller medication (e.g., leukotriene receptor antagonist [LTRA] [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], long-acting muscarinic antagonist [LAMA] [e.g., tiotropium])

OR

4.1.2.2 One maximally-dosed combination ICS/LABA product (e.g., Advair [fluticasone propionate/salmeterol], Symbicort [budesonide/formoterol], Breo Ellipta [fluticasone/vilanterol])

OR

4.2 BOTH of the following:

4.2.1 Patient is 12 years of age or older

AND

4.2.2 Paid claims or submission of medical records (e.g., chart notes) confirming patient is currently being treated with ONE of the following unless there is a contraindication or intolerance to these medications:

4.2.2.1 BOTH of the following:

- High-dose inhaled corticosteroid (ICS) (e.g., greater than 500 mcg fluticasone propionate equivalent/day)
- Additional asthma controller medication (e.g., leukotriene receptor antagonist [LTRA] [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], long-acting muscarinic antagonist [LAMA] [e.g., tiotropium])

OR

4.2.2.2 One maximally-dosed combination ICS/LABA product (e.g., Advair [fluticasone propionate/salmeterol], Symbicort [budesonide/formoterol], Breo Ellipta [fluticasone/vilanterol])

AND

5 - Prescribed by or in consultation with ONE of the following:

- Pulmonologist

- Allergist/Immunologist

Product Name:Fasenra	
Diagnosis	Severe Asthma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a positive clinical response to therapy as evidenced by ONE of the following:

- A reduction in asthma exacerbations
- Improvement in forced expiratory volume in 1 second [FEV1] from baseline

AND

2 - Paid claims or submission of documentation (e.g., chart notes) confirming patient continues to be treated with an inhaled corticosteroid (ICS) (e.g., fluticasone, budesonide) with or without additional asthma controller medication (e.g., leukotriene receptor antagonist [LTRA] [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], long-acting muscarinic antagonist [LAMA] [e.g., tiotropium]) unless there is a contraindication or intolerance to these medications

AND

3 - Prescribed by or in consultation with ONE of the following:

- Pulmonologist
- Allergist/Immunologist

Product Name:Fasenra	
Diagnosis	Eosinophilic Granulomatosis with Polyangiitis

Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA) AND 2 - Submission of medical records (e.g., chart notes) confirming patient's disease has relapsed or is refractory to standard of care therapy (i.e., corticosteroid treatment with or without immunosuppressive therapy) AND 3 - Submission of medical records (e.g., chart notes) confirming patient is currently receiving corticosteroid therapy (e.g., prednisolone, prednisone) unless there is a contraindication or intolerance to corticosteroid therapy AND 4 - Prescribed by or in consultation with ONE of the following: • Pulmonologist • Rheumatologist • Allergist/Immunologist	

Product Name:Fasenra	
Diagnosis	Eosinophilic Granulomatosis with Polyangiitis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming positive clinical response to therapy (e.g., increase in remission time)

AND

2 - Prescribed by or in consultation with ONE of the following:

- Pulmonologist
- Rheumatologist
- Allergist/Immunologist

2 . Background

Clinical Practice Guidelines

The Global Initiative for Asthma Global Strategy for Asthma Management and Prevention: Table 1. Low, medium and high daily doses of inhaled corticosteroids in adolescents and adults 12 years and older

Inhaled corticosteroid	Total Daily ICS Dose (mcg)		
	Low	Medium	High
Beclometasone dipropionate (pMDI, standard particle, HFA)	200-500	> 500-1000	> 1000
Beclometasone dipropionate (DPI or pMDI, extrafine particle*, HFA)	100-200	> 200-400	> 400
Budesonide (DPI, or pMDI, standard particle, HFA)	200-400	> 400-800	> 800
Ciclesonide (pMDI, extrafine particle*, HFA)	80-160	> 160-320	> 320
Fluticasone furoate (DPI)	100		200

Fluticasone propionate (DPI)	100-250	> 250-500	> 500
Fluticasone propionate (pMDI, standard particle, HFA)	100-250	> 250-500	> 500
Mometasone furoate (DPI)	Depends on DPI device – see product information		
Mometasone furoate (pMDI, standard particle, HFA)	200-400		> 400
DPI: dry powder inhaler; HFA: hydrofluoroalkane propellant; ICS: inhaled corticosteroid; N/A: not applicable; pMDI: pressurized metered dose inhaler (non-chlorofluorocarbon formulations); ICS by pMDI should be preferably used with a spacer *See product information. <i>This is not a table of equivalence</i>, but instead, suggested total daily doses for the 'low', 'medium' and 'high' dose ICS options for adults/adolescents, based on available studies and product information. Data on comparative potency are not readily available and therefore this table does NOT imply potency equivalence. Doses may be country -specific depending on local availability, regulatory labelling and clinical guidelines. For new preparations, including generic ICS, the manufacturer's information should be reviewed carefully; products containing the same molecule may not be clinically equivalent.			

The Global Initiative for Asthma Global Strategy for Asthma Management and Prevention: Table 2. Low, medium and high daily doses of inhaled corticosteroids in children 6 – 11 years

Inhaled corticosteroid	Total Daily ICS Dose (mcg)		
	Low	Medium	High
Beclometasone dipropionate (pMDI, standard particle, HFA)	100-200	> 200-400	> 400
Beclometasone dipropionate (pMDI, extrafine particle, HFA)	50-100	> 100-200	> 200
Budesonide (DPI, or pMDI, standard particle, HFA)	100-200	> 200-400	> 400
Budesonide (nebulers)	250-500	>500-1000	>1000

Ciclesonide (pMDI, extrafine particle*, HFA)	80	>80-160	>160
Fluticasone furoate (DPI)	50		n.a.
Fluticasone propionate (DPI)	50-100	> 100-200	> 200
Fluticasone propionate (pMDI, standard particle, HFA)	50-100	> 100-200	> 200
Mometasone furoate (pMDI, standard particle, HFA)	100		200
DPI: dry powder inhaler; HFA: hydrofluoroalkane propellant; ICS: inhaled corticosteroid; N/A: not applicable; pMDI: pressurized metered dose inhaler (non-chlorofluorocarbon formulations); ICS by pMDI should be preferably used with a spacer *See product information. <i>This is not a table of equivalence</i>, but instead, suggested total daily doses for the ‘low’, ‘medium’ and ‘high’ dose ICS options for adults/adolescents, based on available studies and product information. Data on comparative potency are not readily available and therefore this table does NOT imply potency equivalence. Doses may be country -specific depending on local availability, regulatory labelling and clinical guidelines. For new preparations, including generic ICS, the manufacturer’s information should be reviewed carefully; products containing the same molecule may not be clinically equivalent.			

3 . Revision History

Date	Notes
9/15/2025	Updated criteria in initial authorization section for severe asthma.

Fecal Microbiota Agents



Prior Authorization Guideline

Guideline ID	GL-140807
Guideline Name	Fecal Microbiota Agents
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	9/1/2023

1 . Criteria

Product Name:Vowst	
Approval Length	14 Day(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of documentation (e.g., chart notes) confirming diagnosis of recurrent clostridioides difficile infection (CDI) as defined by BOTH of the following: 1.1 Presence of diarrhea defined as a passage of 3 or more loose bowel movements within a 24-hour period for 2 consecutive days	

AND

1.2 A positive stool test for *C. difficile* toxin or toxigenic *C. difficile*

AND

2 - Patient is 18 years of age or older

AND

3 - Patient has a history of two or more recurrent episodes of CDI within 12 months

AND

4 - Submission of medical records (e.g., chart notes) confirming ALL of the following:

4.1 Patient has completed at least 10 consecutive days of ONE of the following antibiotic therapies 2-4 days prior to initiating Vowst*:

- Oral vancomycin
- Dificid (fidaxomicin)

AND

4.2 Patient has completed the recommended course of magnesium citrate the day before and at least 8 hours prior to initiating Vowst

AND

4.3 Previous episode of CDI is under control [e.g., less than 3 unformed/loose (i.e., Bristol Stool Scale type 6-7) stools/day for 2 consecutive days]

AND

5 - Prescribed by or in consultation with ONE of the following:

- Gastroenterologist
- Infectious disease specialist

Notes	*Trial requirements may be verified via paid pharmacy claims or submission of medical records/chart notes.

2 . Revision History

Date	Notes
8/9/2023	New guideline.

Fentanyl IR



Prior Authorization Guideline

Guideline ID	GL-140699
Guideline Name	Fentanyl IR
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Fentanyl citrate lozenges (generic Actiq)	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records demonstrating use is for the management of breakthrough pain associated with a cancer diagnosis (cancer diagnosis must be documented) AND	

2 - Patient must have at least a one week history of ONE of the following medications to demonstrate tolerance to opioids (Document drug and date of trial):

- Morphine sulfate at a doses of greater than or equal to 60 milligrams per day
- Fentanyl transdermal patch at a dose of greater than or equal to 25 micrograms per hour
- Oxycodone at a dose of greater than or equal to 30 milligrams per day
- Oral hydromorphone at a dose of greater than or equal to 8 milligrams per day
- Oral oxymorphone at a dose of greater than or equal to 25 milligrams per day
- An alternative opioid at an equianalgesic dose (e.g., oral methadone greater than or equal to 20 milligrams per day)

AND

3 - The patient is currently taking a long-acting opioid around the clock for cancer pain (Document drug)

AND

4 - ONE of the following:

4.1 The patient is not concurrently receiving an alternative fentanyl transmucosal product

OR

4.2 BOTH of the following:

4.2.1 The patient is currently receiving an alternative transmucosal fentanyl product

AND

4.2.2 The prescriber is requesting the termination of all current authorizations for alternative transmucosal fentanyl products in order to begin treatment with the requested medication (Only one transmucosal fentanyl product will be approved at a time. If previous authorizations cannot be terminated, the PA request will be denied)

Product Name: Abstral, Brand Actiq, Brand Fentora, generic fentanyl citrate buccal tablet, Lazanda, Subsys

Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records demonstrating use is for the management of breakthrough pain associated with a cancer diagnosis (cancer diagnosis must be documented) AND 2 - Patient must have at least a one week history of ONE of the following medications to demonstrate tolerance to opioids (Document drug and date of trial): • Morphine sulfate at a doses of greater than or equal to 60 milligrams per day • Fentanyl transdermal patch at a dose of greater than or equal to 25 micrograms per hour • Oxycodone at a dose of greater than or equal to 30 milligrams per day • Oral hydromorphone at a dose of greater than or equal to 8 milligrams per day • Oral oxymorphone at a dose of greater than or equal to 25 milligrams per day • An alternative opioid at an equianalgesic dose (e.g., oral methadone greater than or equal to 20 milligrams per day) AND 3 - The patient is currently taking a long-acting opioid around the clock for cancer pain (Document drug) AND 4 - ONE of the following: 4.1 The patient is not concurrently receiving an alternative fentanyl transmucosal product OR 4.2 BOTH of the following: 4.2.1 The patient is currently receiving an alternative transmucosal fentanyl product	

AND

4.2.2 The prescriber is requesting the termination of all current authorizations for alternative transmucosal fentanyl products in order to begin treatment with the requested medication (Only one transmucosal fentanyl product will be approved at a time. If previous authorizations cannot be terminated, the PA request will be denied)

AND

5 - History of failure, contraindication, or intolerance to Fentanyl citrate lozenges (generic Actiq) [Document date of trial]

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Fexmid (cyclobenzaprine 7.5mg)



Prior Authorization Guideline

Guideline ID	GL-140686
Guideline Name	Fexmid (cyclobenzaprine 7.5mg)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name: Brand Fexmid 7.5mg, generic cyclobenzaprine 7.5mg	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of muscle spasm associated with acute, painful musculoskeletal conditions AND	

2 - Reason or special circumstance the patient cannot use cyclobenzaprine 5 milligram (mg) or 10mg tablet

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Filspari (sparsentan)



Prior Authorization Guideline

Guideline ID	GL-163797
Guideline Name	Filspari (sparsentan)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	2/1/2025

1 . Criteria

Product Name:Filspari	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting diagnosis of primary immunoglobulin A nephropathy (IgAN) as confirmed by a kidney biopsy	

AND

2 - Patient is at risk of rapid disease progression (e.g., proteinuria greater than 0.75 - 1 g/day [gram per day], or by other criteria such as clinical risk scoring using the International IgAN Prediction Tool)

AND

3 - Used to slow kidney function decline

AND

4 - Patient has an estimated glomerular filtration rate (eGFR) of greater than or equal to 30 mL/min/1.73 m² (milliliters/minute/1.73 square meters)

AND

5 - Submission of medical records (e.g., chart notes) demonstrating patient has been on a minimum 90-day trial of a maximally tolerated dose of ONE of the following (paid pharmacy claims may be used to confirm appropriate trial):

- An angiotensin-converting enzyme (ACE) inhibitor (e.g., benazepril, lisinopril)
- An angiotensin II receptor blocker (ARB) (e.g., losartan, valsartan)

AND

6 - Medication will NOT be used in combination with any of the following:

- Angiotensin receptor blockers or angiotensin receptor-neprilysin inhibitor (ARNI) (e.g., Entresto [sacubitril/valsartan])
- Endothelin receptor antagonists (ERAs) (e.g., Letairis [ambrisentan], Tracleer [bosentan], Opsumit [macitentan])
- Tekturna (aliskiren)

AND

7 - Prescribed by or in consultation with a nephrologist

AND

8 - Prescriber is certified/enrolled in the Filspari REMS (Risk Evaluation and Mitigation Strategy) Program

Product Name:Filspari

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting a positive clinical response to therapy as demonstrated by a decrease in urine protein-to-creatinine ratio (UPCR) from baseline

AND

2 - Medication is NOT taken in combination with any of the following:

- Angiotensin receptor blockers or angiotensin receptor-neprilysin inhibitor (ARNI) (e.g., Entresto [sacubitril/valsartan])
- Endothelin receptor antagonists (ERAs) (e.g., Letairis [ambrisentan], Tracleer [bosentan], Opsumit [macitentan])
- Tekturna (aliskiren)

AND

3 - Prescriber is certified/enrolled in the Filspari REMS (Risk Evaluation and Mitigation Strategy) Program

2 . Revision History

UnitedHealthcare Community Plan of Arizona Clinical Pharmacy Program Guidelines

Date	Notes
1/14/2025	Updated initial and reauth criteria.

Filsuvez (birch triterpenes)



Prior Authorization Guideline

Guideline ID	GL-147110
Guideline Name	Filsuvez (birch triterpenes)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	6/1/2024

1 . Criteria

Product Name:Filsuvez	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following: Dystrophic epidermolysis bullosa (DEB)	

- Junctional epidermolysis bullosa (JEB)

AND

2 - Disease is confirmed by ONE of the following:

2.1 Genetic testing confirms mutation in ONE of the following genes:

2.1.1 For dystrophic epidermolysis bullosa (DEB), collagen type VII (COL7A1)

OR

2.1.2 For junctional epidermolysis bullosa (JEB), ONE of the following:

- ITGA6
- ITGB4
- collagen type XVII (COL17A1)
- LAMA3
- LAMB3
- LAMC2
- ITGA3
- LAMA3A

OR

2.2 Skin biopsy

AND

3 - Patient is 6 months of age or older

AND

4 - Medication is being used for the treatment of wounds

AND

5 - DEB or JEB associated wounds are present for at least 21 days

AND

6 - Patient does not have signs of infection for wound being treated

AND

7 - Patient has no evidence or history of basal or squamous cell carcinoma for wound being treated

AND

8 - Patient does not have history of stem cell transplant

AND

9 - Medication is not being used concurrently with other FDA (Food and Drug Administration) approved therapies (e.g., Vyjuvek) for the treatment of epidermolysis bullosa

AND

10 - Standard wound care management not adequate in healing wounds (e.g., daily wound dressings, pain management, controlling infections)

AND

11 - Prescribed by or in consultation with a specialist with expertise in wound care

Product Name:Filsuvez	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy as evidenced by wound is healing but not completely closed

AND

2 - Patient does not have signs of infection for wound being treated

AND

3 - Patient has no evidence or history of basal or squamous cell carcinoma for wound being treated

AND

4 - Prescribed by or in consultation with a specialist with expertise in wound care

2 . Revision History

Date	Notes
5/6/2024	New program.

Firdapse



Prior Authorization Guideline

Guideline ID	GL-140948
Guideline Name	Firdapse
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	12/1/2022

1 . Criteria

Product Name:Firdapse	
Diagnosis	Lambert-Eaton myasthenic syndrome (LEMS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has a diagnosis of Lambert-Eaton myasthenic syndrome (LEMS)	

AND

2 - Patient is not receiving Firdapse in combination with similar potassium channel blockers [e.g., Ampyra (dalfampridine), Ruzurgi (amiframpridine)]

AND

3 - Patient is 6 years of age or older

Product Name:Firdapse	
Diagnosis	Lambert-Eaton myasthenic syndrome (LEMS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Firdapse therapy AND 2 - Patient is not receiving Firdapse in combination with similar potassium channel blockers [e.g., Ampyra (dalfampridine), Ruzurgi (amifampridine)]	

2 . Revision History

Date	Notes
11/7/2022	Added age requirement.

Flucytosine



Prior Authorization Guideline

Guideline ID	GL-140700
Guideline Name	Flucytosine
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name: Brand Ancobon, generic flucytosine	
Approval Length	2 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following: 1.1 Diagnosis of septicemia, endocarditis or a urinary system infection caused by Candida species	

OR

1.2 Diagnosis of meningitis or a pulmonary infection caused by *Cryptococcus* species

AND

2 - If the patient is being treated for a systemic infection, flucytosine is being used in combination with amphotericin B

Product Name: Brand Ancobon, generic flucytosine*	
Diagnosis	Infectious Diseases Society of America (IDSA) Recommended Regimens
Guideline Type	Prior Authorization
Approval Criteria 1 - The medication is being prescribed by or in consultation with an infectious disease specialist.	
Notes	*Approval duration based on provider recommended treatment durations, up to 12 months.

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Forteo and Teriparatide Products, Prolia and Denosumab 60mg Products, Tymlos



Prior Authorization Guideline

Guideline ID	GL-571201
Guideline Name	Forteo and Teriparatide Products, Prolia and Denosumab 60mg Products, Tymlos
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:Brand Forteo	
Diagnosis	Patients with osteoporosis at high risk for fracture
Approval Length	12 Months**
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of osteoporosis	

AND

2 - ONE of the following:

2.1 Bone Mineral Density (BMD) T-score less than or equal to -3.5 based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site). [NOTE: Provider must submit patient specific BMD T-score]

OR

2.2 BOTH of the following:

2.2.1 BMD T-score between -2.5 and -3.5 (BMD T-score greater than -3.5 and less than or equal to -2.5) based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site). [NOTE: Provider must submit patient specific BMD T-score]

AND

2.2.2 ONE of the following:

2.2.2.1 History of ONE of the following resulting from minimal trauma:

- Vertebral compression fracture
- Fracture of the hip
- Fracture of the distal radius
- Fracture of the pelvis
- Fracture of the proximal humerus

OR

2.2.2.2 History of failure, contraindication, or intolerance to ONE conventional osteoporosis therapy [e.g., bisphosphonate or selective estrogen receptor modulator (SERM)] (Document drug, date, and duration of trial)*

OR

2.3 ALL of the following:

2.3.1 BMD T-score between -1 and -2.5 (BMD T-score greater than -2.5 and less than or equal to -1) based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site). [NOTE: Provider must submit patient specific BMD T-score]

AND

2.3.2 ONE of the following:

2.3.2.1 History of ONE of the following resulting from minimal trauma:

- Vertebral compression fracture
- Fracture of the hip
- Fracture of the distal radius
- Fracture of the pelvis
- Fracture of the proximal humerus

OR

2.3.2.2 ONE of the following Fracture Risk Assessment Tool (FRAX) 10-year fracture probabilities:

- Major osteoporotic fracture at 20 percent or more
- Hip fracture at 3 percent or more

AND

2.3.3 History of failure, contraindication, or intolerance to ONE conventional osteoporosis therapy [e.g., bisphosphonate or selective estrogen receptor modulator (SERM)] (Document drug, date, and duration of trial)*

AND

3 - Treatment duration has not exceeded a total of 24 months** of cumulative use of parathyroid hormone analogs (e.g., Teriparatide Injection, Forteo, Tymlos) during the patient's lifetime

Notes	*Claims history may be used in conjunction as documentation of drug, date, and duration of trial.

	**Duration of coverage will be limited to 24 months of cumulative parathyroid hormone analog therapy (e.g., Forteo, Tymlos) in the patient's lifetime.

Product Name: Bonsity, generic teriparatide, Brand Teriparatide, Tymlos	
Diagnosis	Patients with osteoporosis at high risk for fracture
Approval Length	12 Months**
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of osteoporosis AND 2 - ONE of the following: 2.1 Bone Mineral Density (BMD) T-score less than or equal to -3.5 based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site). [NOTE: Provider must submit patient specific BMD T-score] OR 2.2 BOTH of the following: 2.2.1 BMD T-score between -2.5 and -3.5 (BMD T-score greater than -3.5 and less than or equal to -2.5) based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site). [NOTE: Provider must submit patient specific BMD T-score] AND 2.2.2 ONE of the following: 2.2.2.1 History of ONE of the following resulting from minimal trauma:	

- Vertebral compression fracture
- Fracture of the hip
- Fracture of the distal radius
- Fracture of the pelvis
- Fracture of the proximal humerus

OR

2.2.2.2 History of failure, contraindication, or intolerance to ALL of the following (Document drug, date, and duration of trial)*:

- bisphosphonate (e.g., alendronate, ibandronate)
- selective estrogen receptor modulator (SERM) (e.g., raloxifene)
- Bldyos (denosumab-nxxp)
- Brand Forteo (teriparatide)

OR

2.3 ALL of the following:

2.3.1 BMD T-score between -1 and -2.5 (BMD T-score greater than -2.5 and less than or equal to -1) based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site). [NOTE: Provider must submit patient specific BMD T-score]

AND

2.3.2 ONE of the following:

2.3.2.1 History of ONE of the following resulting from minimal trauma:

- Vertebral compression fracture
- Fracture of the hip
- Fracture of the distal radius
- Fracture of the pelvis
- Fracture of the proximal humerus

OR

2.3.2.2 ONE of the following Fracture Risk Assessment Tool (FRAX) 10-year fracture probabilities:

- Major osteoporotic fracture at 20 percent or more
- Hip fracture at 3 percent or more

AND

2.3.3 History of failure, contraindication, or intolerance to ALL of the following (Document drug, date, and duration of trial)*:

- bisphosphonate (e.g., alendronate, ibandronate)
- selective estrogen receptor modulator (SERM) (e.g., raloxifene)
- Bldyos (denosumab-nxxp)
- Brand Forteo (teriparatide)

AND

3 - Treatment duration has not exceeded a total of 24 months** of cumulative use of parathyroid hormone analogs (e.g., Teriparatide Injection, Forteo, Tymlos) during the patient's lifetime

Notes	*Claims history may be used in conjunction as documentation of drug, date, and duration of trial. **Duration of coverage will be limited to 24 months of cumulative parathyroid hormone analog therapy (e.g., Forteo, Tymlos) in the patient's lifetime.

Product Name: Bonsity, Brand Forteo, generic teriparatide, Brand Teriparatide, Tymlos	
Diagnosis	Patients with osteoporosis at high risk for fracture
Approval Length	12 Months*
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient demonstrates positive clinical response to therapy	

AND

2 - Treatment duration has not exceeded a total of 24 months* of cumulative use of parathyroid hormone analogs (e.g., Teriparatide Injection, Forteo, Tymlos) during the patient's lifetime

Notes

*Duration of coverage will be limited to 24 months of cumulative parathyroid hormone analog therapy (e.g., Forteo, Tymlos) in the patient's lifetime.

Product Name: Bıldıyos

Diagnosis	Patients with osteoporosis at high risk for fracture

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of osteoporosis

AND

2 - ONE of the following:

2.1 Bone Mineral Density (BMD) T-score less than or equal to -3.5 based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site). [NOTE: Provider must submit patient specific BMD T-score]

OR

2.2 BOTH of the following:

2.2.1 BMD T-score between -2.5 and -3.5 (BMD T-score greater than -3.5 and less than or equal to -2.5) based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site). [NOTE: Provider must submit patient specific BMD T-score]

AND

2.2.2 ONE of the following:

2.2.2.1 History of ONE of the following resulting from minimal trauma:

- Vertebral compression fracture
- Fracture of the hip
- Fracture of the distal radius
- Fracture of the pelvis
- Fracture of the proximal humerus

OR

2.2.2.2 History of failure, contraindication, or intolerance to ONE conventional osteoporosis therapy [e.g., bisphosphonate or selective estrogen receptor modulator (SERM)] (Document drug, date, and duration of trial)*

OR

2.3 ALL of the following:

2.3.1 BMD T-score between -1 and -2.5 (BMD T-score greater than -2.5 and less than or equal to -1) based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site). [NOTE: Provider must submit patient specific BMD T-score]

AND

2.3.2 ONE of the following:

2.3.2.1 History of ONE of the following resulting from minimal trauma:

- Vertebral compression fracture
- Fracture of the hip
- Fracture of the distal radius
- Fracture of the pelvis
- Fracture of the proximal humerus

OR

2.3.2.2 ONE of the following Fracture Risk Assessment Tool (FRAX) 10-year fracture probabilities:

- Major osteoporotic fracture at 20 percent or more
- Hip fracture at 3 percent or more

AND

2.3.3 History of failure, contraindication, or intolerance to ONE conventional osteoporosis therapy [e.g., bisphosphonate or selective estrogen receptor modulator (SERM)] (Document drug, date, and duration of trial)*

Notes	*Claims history may be used in conjunction as documentation of drug, date, and duration of trial.

Product Name: Bosaya, Conexence, Enoby, Jubbonti, Ospomyv, Prolia, Stoboclo	
Diagnosis	Patients with osteoporosis at high risk for fracture
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of osteoporosis AND 2 - ONE of the following: 2.1 Bone Mineral Density (BMD) T-score less than or equal to -3.5 based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site). [NOTE: Provider must submit patient specific BMD T-score]	

OR

2.2 BOTH of the following:

2.2.1 BMD T-score between -2.5 and -3.5 (BMD T-score greater than -3.5 and less than or equal to -2.5) based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site). [NOTE: Provider must submit patient specific BMD T-score]

AND

2.2.2 ONE of the following:

2.2.2.1 History of ONE of the following resulting from minimal trauma:

- Vertebral compression fracture
- Fracture of the hip
- Fracture of the distal radius
- Fracture of the pelvis
- Fracture of the proximal humerus

OR

2.2.2.2 History of failure, contraindication, or intolerance to ALL of the following (Document drug, date, and duration of trial)*:

- bisphosphonate (e.g., alendronate, ibandronate)
- selective estrogen receptor modulator (SERM) (e.g., raloxifene)
- Bildyos (denosumab-nxxp)
- Brand Forteo (teriparatide)

OR

2.3 ALL of the following:

2.3.1 BMD T-score between -1 and -2.5 (BMD T-score greater than -2.5 and less than or equal to -1) based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site). [NOTE: Provider must submit patient specific BMD T-score]

AND

2.3.2 ONE of the following:

2.3.2.1 History of ONE of the following resulting from minimal trauma:

- Vertebral compression fracture
- Fracture of the hip
- Fracture of the distal radius
- Fracture of the pelvis
- Fracture of the proximal humerus

OR

2.3.2.2 ONE of the following Fracture Risk Assessment Tool (FRAX) 10-year fracture probabilities:

- Major osteoporotic fracture at 20 percent or more
- Hip fracture at 3 percent or more

AND

2.3.3 History of failure, contraindication, or intolerance to ALL of the following (Document drug, date, and duration of trial)*:

- bisphosphonate (e.g., alendronate, ibandronate)
- selective estrogen receptor modulator (SERM) (e.g., raloxifene)
- Bieldys (denosumab-nxyp)
- Brand Forteo (teriparatide)

Notes	*Claims history may be used in conjunction as documentation of drug, date, and duration of trial.

Product Name: Bieldys, Bosaya, Connexence, Enoby, Jubbonti, Ospomyv, Prolia, Stoboclo	
Diagnosis	Patients with osteoporosis at high risk for fracture
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy

2 . Revision History

Date	Notes
4/10/2026	Updated guideline name. Added Bosaya as a target to the guideline (added to same criteria sections as Conexence, Enoby, Jubbonti, Os pomyv, Prolia, Stoboclo). No changes to clinical criteria.

Forzinity (elamipretide)



Prior Authorization Guideline

Guideline ID	GL-501223
Guideline Name	Forzinity (elamipretide)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Forzinity	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of Barth syndrome	

AND

2 - Disease is confirmed by the presence of a mutation in the Tafazzin gene

AND

3 - Patient's weight is greater than or equal to 30 kg (kilograms)

AND

4 - Prescribed by or in consultation with ONE of the following:

- Geneticist
- Cardiologist
- Neurologist
- Specialist focused on the treatment of metabolic disorders

Product Name:Forzinity	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient demonstrates positive clinical response to therapy (e.g., improvement in knee extensor muscle strength or 6 minute walking test, quality of life)	

2 . Revision History

Date	Notes
1/15/2026	New program for ACUAZ/ACUAZEC.

Fotivda



Prior Authorization Guideline

Guideline ID	GL-317191
Guideline Name	Fotivda
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State New Jersey Medicaid - Community & State New York Medicaid - Community & State New York EPP Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Arizona Medicaid - Community & State New Mexico Medicaid - Community & State Virginia Medicaid - Community & State Washington

Guideline Note:

Effective Date:	8/1/2025

1 . Criteria

Product Name:Fotivda

Diagnosis	Renal Cell Carcinoma (RCC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of advanced renal cell carcinoma (RCC) AND 2 - ONE of the following: • Disease has relapsed • Disease is refractory AND 3 - Patient has received two or more prior systemic therapies	

Product Name:Fotivda	
Diagnosis	Renal Cell Carcinoma (RCC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient does not show evidence of progressive disease while on Fotivda therapy	

Product Name:Fotivda	
Diagnosis	NCCN Recommended Regimens

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	

Product Name:Fotivda	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Fotivda therapy	

2 . Revision History

Date	Notes
7/2/2025	Combined formularies. Added RCC abbreviation in dx header section s. No changes to clinical criteria.

Fotivda



Prior Authorization Guideline

Guideline ID	GL-317191
Guideline Name	Fotivda
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State New Jersey Medicaid - Community & State New York Medicaid - Community & State New York EPP Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Arizona Medicaid - Community & State New Mexico Medicaid - Community & State Virginia Medicaid - Community & State Washington

Guideline Note:

Effective Date:	8/1/2025

1 . Criteria

Product Name:Fotivda

Diagnosis	Renal Cell Carcinoma (RCC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of advanced renal cell carcinoma (RCC) AND 2 - ONE of the following: • Disease has relapsed • Disease is refractory AND 3 - Patient has received two or more prior systemic therapies	

Product Name:Fotivda	
Diagnosis	Renal Cell Carcinoma (RCC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient does not show evidence of progressive disease while on Fotivda therapy	

Product Name:Fotivda	
Diagnosis	NCCN Recommended Regimens

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	

Product Name:Fotivda	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Fotivda therapy	

2 . Revision History

Date	Notes
7/2/2025	Combined formularies. Added RCC abbreviation in dx header section s. No changes to clinical criteria.

Furosemide Injection Products



Prior Authorization Guideline

Guideline ID	GL-510409
Guideline Name	Furosemide Injection Products
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name:Furoscix	
Approval Length	3 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting diagnosis of ONE of the following: • Chronic heart failure • Chronic kidney disease	

AND

2 - Patient weighs at least 43 kg (kilograms)

AND

3 - Patient is currently on maintenance oral diuretic therapy (e.g., bumetanide, furosemide, torsemide)

AND

4 - Provider attests that patient will be closely monitored for fluid, electrolyte, and metabolic abnormalities throughout therapy (e.g., hypokalemia, hypovolemia, hyponatremia)

AND

5 - Submission of medical records (e.g., chart notes) or paid claims documenting ONE of the following:

5.1 History of failure to intravenous furosemide (Lasix IV)

OR

5.2 Provider has submitted clinical rationale for why intravenous furosemide is inappropriate

Product Name:Lasix Onyu	
Approval Length	3 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting diagnosis of chronic heart failure	

AND

2 - Medication will be used for the treatment of edema

AND

3 - Patient is currently on maintenance oral diuretic therapy (e.g., bumetanide, furosemide, torsemide)

AND

4 - Provider attests that patient will be closely monitored for fluid, electrolyte, and metabolic abnormalities throughout therapy (e.g., hypokalemia, hypovolemia, hyponatremia)

AND

5 - Submission of medical records (e.g., chart notes) or paid claims documenting ONE of the following:

5.1 History of failure to intravenous furosemide (Lasix IV)

OR

5.2 Provider has submitted clinical rationale for why intravenous furosemide is inappropriate

2 . Revision History

Date	Notes
2/5/2026	Updated guideline name. Added weight requirement to Furoscix criteria section. Added criteria for new target drug, Lasix Onyu.

Galafold



Prior Authorization Guideline

Guideline ID	GL-140847
Guideline Name	Galafold
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2020

1 . Criteria

Product Name:Galafold	
Diagnosis	Fabry disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Fabry disease	

AND

2 - Patient has an amenable galactosidase alpha gene (GLA) variant based on in vitro assay data

AND

3 - Patient is not receiving Galafold in combination with Fabrazyme (agalsidase beta)

Product Name:Galafold	
Diagnosis	Fabry disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Galafold therapy AND 2 - Patient is not receiving Galafold in combination with Fabrazyme (agalsidase beta)	

2 . Revision History

Date	Notes
3/31/2020	Bulk copy C&S New York SP to C&S Arizona SP for 5/1 effective

Gamifant (emapalumab-lzsg)



Prior Authorization Guideline

Guideline ID	GL-403227
Guideline Name	Gamifant (emapalumab-lzsg)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	11/1/2025

1 . Criteria

Product Name:Gamifant	
Diagnosis	Primary Hemophagocytic Lymphohistiocytosis (HLH)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of primary hemophagocytic lymphohistiocytosis (HLH)	

AND

2 - Submission of medical records (e.g., chart notes) or paid claims confirming ONE of the following:

2.1 Disease is ONE of the following:

- Refractory
- Recurrent
- Progressive

OR

2.2 Trial and failure, contraindication, or intolerance to conventional HLH therapy (e.g., etoposide, dexamethasone, cyclosporine A, intrathecal methotrexate)

AND

3 - Prescribed by or in consultation with a hematologist/oncologist

AND

4 - Patient has NOT received hematopoietic stem cell transplantation (HSCT)

Product Name:Gamifant	
Diagnosis	Primary Hemophagocytic Lymphohistiocytosis (HLH)
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) demonstrating a positive clinical	

response to therapy (e.g., improvement in hemoglobin/lymphocyte/platelet counts, afebrile, normalization of inflammatory factors/markers)

AND

2 - Patient has NOT received HSCT

Product Name: Gamifant	
Diagnosis	Hemophagocytic Lymphohistiocytosis (HLH)/Macrophage Activation Syndrome (MAS) in Still's disease
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting BOTH of the following: 1.1 Diagnosis of active hemophagocytic lymphohistiocytosis (HLH)/macrophage activation syndrome (MAS) AND 1.2 Disease occurs in known or suspected Still's disease [e.g., systemic Juvenile Idiopathic Arthritis (sJIA), adult onset Still's disease (AOSD)] AND 2 - Submission of medical records (e.g., chart notes) or paid claims confirming ONE of the following: 2.1 Trial and failure, contraindication, or intolerance to high-dose corticosteroids (e.g., methylprednisolone, prednisone) OR	

2.2 Patient experiences recurrent MAS

AND

3 - Prescribed by or in consultation with a rheumatologist/hematologist

Product Name:Gamifant	
Diagnosis	Hemophagocytic Lymphohistiocytosis (HLH)/Macrophage Activation Syndrome (MAS) in Still's disease
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) demonstrating a positive clinical response to therapy (e.g., improvement in leukocyte/platelet counts, afebrile, normalization of inflammatory factors/markers)	

2 . Revision History

Date	Notes
10/2/2025	New program for ACUAZ/ACUAZEC.

Gattex (teduglutide)



Prior Authorization Guideline

Guideline ID	GL-141007
Guideline Name	Gattex (teduglutide)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	12/1/2023

1 . Criteria

Product Name: Gattex	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming all of the following: 1.1 Diagnosis of short bowel syndrome	

AND

1.2 Patient is 1 year of age and older

AND

1.3 Documentation that the patient is dependent on parenteral nutrition/intravenous (PN/IV) support for at least 12 consecutive months

AND

2 - Prescribed by or in consultation with a gastroenterologist

Product Name:Gattex	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting that the patient has had a reduction in weekly parenteral nutrition/intravenous (PN/IV) support from baseline while on Gattex therapy AND 2 - Prescribed by or in consultation with a gastroenterologist	

2 . Revision History

Date	Notes

11/7/2023	Updated guideline name and criteria to match AZM

Gaucher Disease Agents



Prior Authorization Guideline

Guideline ID	GL-555233
Guideline Name	Gaucher Disease Agents
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	4/12/2026

1 . Criteria

Product Name:Cerdelga	
Diagnosis	Type 1 Gaucher Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Type 1 Gaucher disease	

AND

2 - Patient is ONE of the following as detected by a Food and Drug Administration (FDA)-cleared test:

- CYP2D6 extensive metabolizer
- CYP2D6 intermediate metabolizer
- CYP2D6 poor metabolizer

AND

3 - Submission of medical records (e.g., chart notes) or paid claims confirming a history of failure or intolerance to generic miglustat (AG [authorized generic] is preferred)

Product Name: Elelyso, Vpriv	
Diagnosis	Type 1 Gaucher Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Type 1 Gaucher disease AND 2 - If the request is for Vpriv, submission of medical records (e.g., chart notes) or paid claims confirming a history of failure or intolerance to BOTH of the following: • generic miglustat (AG [authorized generic] preferred) • Elelyso	

Product Name:Yargesa, Brand Zavesca, generic miglustat, miglustat (authorized generic of Zavesca)	
Diagnosis	Type 1 Gaucher Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of mild to moderate Type 1 Gaucher disease AND 2 - If the request is non-preferred*, submission of medical records (e.g., chart notes) or paid claims confirming a history of failure or intolerance to generic miglustat (AG [authorized generic] is preferred)	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:Cerdelga, Elelyso, Vpriv, Yargesa, Brand Zavesca, generic miglustat, miglustat (authorized generic of Zavesca)	
Diagnosis	Type 1 Gaucher Disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy	

Product Name:Cerezyme	
Diagnosis	Type 1 Gaucher Disease

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Type 1 Gaucher disease that results in one or more of the following conditions: • Anemia • Thrombocytopenia • Bone disease • Hepatomegaly or splenomegaly AND 2 - Submission of medical records (e.g., chart notes) or paid claims confirming a history of failure or intolerance to BOTH of the following: • generic miglustat (AG [authorized generic] preferred) • Elelyso	

Product Name:Cerezyme	
Diagnosis	Type 3 Gaucher Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Type 3 Gaucher disease AND	

2 - Presence of a non-central nervous system (CNS) manifestation (e.g., moderate to severe anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly)

Product Name:Cerezyme

Diagnosis	Type 1 Gaucher Disease, Type 3 Gaucher Disease

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

2 . Revision History

Date	Notes
3/20/2026	Updated guideline name. Added new criteria for Type 3 Gaucher Disease for Cerezyme. Added Yargesa as a target. Updated dx check criterion and embedded step criterion in initial auth sections, where applicable. Updated product name lists and GPI tables. Added PDL link in notes section, where applicable.

Global Quantity Limits



Prior Authorization Guideline

Guideline ID	GL-140667
Guideline Name	Global Quantity Limits
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	12/15/2020

1 . Criteria

Product Name:Quantity Limit, Prescription Limit	
Diagnosis	Quantity limit review (General)
Approval Length	12 month(s)
Guideline Type	Administrative
Approval Criteria 1 - ONE of the following: 1.1 The requested drug must be used for an FDA-approved indication or	

1.2 The use of this drug is supported by information from ONE of the following appropriate compendia of current literature:

American Hospital Formulary Service Drug Information

National Comprehensive Cancer Network Drugs and Biologics Compendium

Thomson Micromedex DrugDex

Clinical pharmacology

United States Pharmacopoeia-National Formulary

AND

2 - The drug is being prescribed within the manufacturer's published dosing guidelines or falls within dosing guidelines found in ONE of the following compendia of current literature:

American Hospital Formulary Service Drug Information

National Comprehensive Cancer Network Drugs and Biologics Compendium

Thomson Micromedex DrugDex

Clinical pharmacology

United States Pharmacopoeia-National Formulary

AND

3 - The requested dosage cannot be achieved using the plan accepted quantity limit of a different dose or formulation.

AND

4 - The drug is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plans' program.

Product Name:Quantity Limit, Prescription Limit	
Diagnosis	Quantity limit review for the treatment of gender dysphoria*
Approval Length	12 month(s)
Guideline Type	Administrative

Approval Criteria 1 - The use of this drug is supported by information from ONE of the following appropriate compendia of current literature: American Hospital Formulary Service Drug Information National Comprehensive Cancer Network Drugs and Biologics Compendium Thomson Micromedex DrugDex Clinical pharmacology United States Pharmacopoeia-National Formulary AND 2 - The drug is being prescribed for an indication that is recognized as a covered benefit by the applicable health plans' program.	
Notes	* If the above criteria are not met, then refer for clinical review by an appropriate trained professional (physician or pharmacist) based on the applicable regulatory requirement.

Product Name:Quantity Limit, Prescription Limit	
Diagnosis	Monthly prescription limit review for migraine therapy, benzodiazepines, or muscle relaxants
Approval Length	1 month(s)
Guideline Type	Administrative
Approval Criteria 1 - Medical necessity rationale provided for why the member requires 5 or more fills of the same drug or drug class within a month.	
Notes	*If deemed medically necessary, longer authorization duration is permitted

Product Name:Quantity Limit, Prescription Limit	
Diagnosis	Topical products exceeding the allowable package size per fill OR the allowable quantity per month
Approval Length	12 month(s)

Guideline Type	Administrative
Approval Criteria 1 - The physician attests that a larger quantity is needed for treatment of a larger surface area.	

2 . Revision History

Date	Notes
1/10/2022	Bulk Copy C&S New York to C&S Arizona for effective date of 5/1

GLP-1 Agonists



Prior Authorization Guideline

Guideline ID	GL-519192
Guideline Name	GLP-1 Agonists
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name:Trulicity, Brand Victoza, generic liraglutide, Exenatide	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming BOTH of the following: • Diagnosis of type 2 diabetes mellitus • Baseline A1C greater than or equal to 6.5%	

AND

2 - Submission of medical records (e.g., chart notes) or paid claims documenting ONE of the following:

2.1 History of failure to metformin at a minimum dose of 1500 milligrams (mg) daily for 90 days

OR

2.2 Contraindication or intolerance to metformin

AND

3 - Patient is 10 years of age or older

AND

4 - Drug is not being used for weight loss

AND

5 - Provider attests that the requested medication will not be used concurrently with a DPP-4 inhibitor-containing agent [e.g., Januvia (sitagliptin), Jentadueto (linagliptin-metformin), Tradjenta (linagliptin)] or a plan has been developed to address concomitant use

Product Name:Mounjaro, Ozempic	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming BOTH of the following:	

- Diagnosis of type 2 diabetes mellitus
- Baseline A1C greater than or equal to 6.5%

AND

2 - Submission of medical records (e.g., chart notes) or paid claims documenting ONE of the following:

2.1 History of failure to metformin at a minimum dose of 1500 milligrams (mg) daily for 90 days

OR

2.2 Contraindication or intolerance to metformin

AND

3 - Submission of medical records (e.g., chart notes) or paid claims documenting a history of a 90 day trial resulting in a therapeutic failure, contraindication, or intolerance to ALL of the following:

- Trulicity
- Brand Victoza or generic liraglutide
- Exenatide

AND

4 - ONE of the following:

4.1 If the request is for Mounjaro, patient is 10 years of age or older

OR

4.2 If the request is for Ozempic, patient is 18 years of age or older

AND

5 - Drug is not being used for weight loss

AND

6 - Provider attests that the requested medication will not be used concurrently with a DPP-4 inhibitor-containing agent [e.g., Januvia (sitagliptin), Jentadueto (linagliptin-metformin), Tradjenta (linagliptin)] or a plan has been developed to address concomitant use

Product Name:Rybelsus

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming BOTH of the following:

- Diagnosis of type 2 diabetes mellitus
- Baseline A1C greater than or equal to 6.5%

AND

2 - Submission of medical records (e.g., chart notes) or paid claims documenting ONE of the following:

2.1 History of failure to metformin at a minimum dose of 1500 milligrams (mg) daily for 90 days

OR

2.2 Contraindication or intolerance to metformin

AND

3 - ONE of the following:

3.1 Submission of medical records (e.g., chart notes) or paid claims documenting a history of a 90 day trial resulting in a therapeutic failure, contraindication, or intolerance to ALL of the following:

- Trulicity
- Brand Victoza or generic liraglutide
- Exenatide

OR

3.2 BOTH of the following:

3.2.1 Submission of medical records (e.g., chart notes) confirming that the patient is unable to self-inject due to ONE of the following:

- Physical impairment
- Visual impairment
- Lipohypertrophy
- Documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-5 for specific phobia diagnostic criteria)

AND

3.2.2 Submission of medical records (e.g., chart notes) or paid claims documenting a history of a 90 day trial resulting in a therapeutic failure, contraindication, or intolerance to ALL of the following:

- Farxiga
- Jardiance
- Synjardy
- Xigduo XR

AND

4 - Patient is 18 years of age or older

AND

5 - Drug is not being used for weight loss

AND

6 - Provider attests that the requested medication will not be used concurrently with a DPP-4 inhibitor-containing agent [e.g., Januvia (sitagliptin), Jentadueto (linagliptin-metformin), Tradjenta (linagliptin)] or a plan has been developed to address concomitant use

2 . Revision History

Date	Notes
2/9/2026	Updated age criterion for Mounjaro.

Glycopyrrolate Products



Prior Authorization Guideline

Guideline ID	GL-140733
Guideline Name	Glycopyrrolate Products
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Dartisla ODT, Brand Cuvposa, Brand Robinul, Brand Robinul Forte	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting requested drug is being used for a Food and Drug Administration (FDA)-approved indication AND	

2 - Trial and failure or intolerance to generic glycopyrrolate tablets or oral solution (verified via pharmacy paid claims or submission of medical records/chart notes)

Gonadotropin-Releasing Hormone Agonists



Prior Authorization Guideline

Guideline ID	GL-609189
Guideline Name	Gonadotropin-Releasing Hormone Agonists
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Fensolvi, Lupron Depot-Ped, Triptodur	
Diagnosis	Central Precocious Puberty (CPP)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of central precocious puberty (idiopathic or neurogenic)	

AND

2 - Onset of secondary sexual characteristics in ONE of the following:

2.1 Females less than or equal to 8 years of age

OR

2.2 Males less than or equal to 9 years of age

AND

3 - Confirmation of diagnosis as defined by ONE of the following:

3.1 Pubertal basal level of luteinizing hormone (based on laboratory reference ranges)

OR

3.2 A pubertal luteinizing hormone response to a gonadotropin releasing hormone (GnRH) stimulation test

OR

3.3 Bone age advanced one year beyond the chronological age

AND

4 - If the request is non-preferred*, history of failure, contraindication, or intolerance to ONE of the following:

- Fensolvi
- Lupron Depot-Ped (1-Month): 7.5 mg, 11.25 mg, or 15 mg

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:Fensolvi, Lupron Depot-Ped, Triptodur	
Diagnosis	Central Precocious Puberty (CPP)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is currently receiving therapy for central precocious puberty AND 2 - Documentation of positive clinical response to therapy AND 3 - Patient is ONE of the following (younger than the appropriate time point for the onset of puberty): 3.1 Female younger than 11 years of age OR 3.2 Male younger than 12 years of age AND 4 - If the request is non-preferred*, ONE of the following: 4.1 If the request is for Lupron Depot-Ped (3-Month) or Lupron Depot-Ped (6-Month), continuation of prior therapy	

OR

4.2 History of failure, contraindication, or intolerance to ONE of the following:

- Fensolvi
- Lupron Depot-Ped (1-Month): 7.5 mg, 11.25 mg, or 15 mg

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC CP

Product Name:Lupron Depot 3.75 mg, Lupron Depot (3-Month) 11.25 mg	
Diagnosis	Endometriosis
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of endometriosis or endometriosis is suspected AND 2 - ONE of the following: 2.1 History of failure, contraindication, or intolerance to BOTH of the following: 2.1.1 Oral contraceptives or depot medroxyprogesterone (e.g., Depo- Provera) AND 2.1.2 Non-steroidal anti-inflammatory drugs (NSAIDs)	

OR

2.2 Patient has had surgical ablation to prevent recurrence

AND

3 - If the request is non-preferred*, history of failure, contraindication, or intolerance to Lupron Depot 3.75 mg

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:Lupron Depot 3.75 mg, Lupron Depot (3-Month) 11.25 mg

Diagnosis	Endometriosis
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of endometriosis or endometriosis is suspected

AND

2 - Recurrence of symptoms following an initial course of therapy

AND

3 - Concurrently to be used with add-back therapy (e.g., progestin, estrogen, or bone sparing agents)

AND	
4 - If the request is non-preferred*, history of failure, contraindication, or intolerance to Lupron Depot 3.75 mg	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:Lupron Depot 3.75 mg, Lupron Depot (3-Month) 11.25 mg	
Diagnosis	Uterine Leiomyomata (Fibroids)
Approval Length	3 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 ALL of the following: 1.1.1 For the treatment of uterine leiomyomata-related anemia AND 1.1.2 Patient did not respond to iron therapy of 1 month duration AND 1.1.3 For use prior to surgery OR 1.2 For use prior to surgery to reduce the size of fibroids to facilitate a surgical procedure (e.g., myomectomy, hysterectomy)	

AND	
2 - If the request is non-preferred*, history of failure, contraindication, or intolerance to Lupron Depot 3.75 mg	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:Fensolvi, Lupron Depot, Lupron Depot-Ped, leuprolide acetate inj kit 5 mg/mL, Lutrate Depot, Triptodur	
Diagnosis	Gender dysphoria in adolescents
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of gender dysphoria, according to the current Diagnostic and Statistical Manual of Mental Disorders (i.e., DSM-5) criteria, by a mental health professional with expertise in child and adolescent psychiatry AND 2 - Medication is prescribed by or in consultation with an endocrinologist or a medical provider experienced in gender dysphoria hormone therapy AND 3 - Patient has experienced puberty development to at least Tanner stage 2 AND	

4 - ONE of the following laboratory tests, based upon the laboratory reference range, confirming:

- Pubertal levels of estradiol in females
- Pubertal levels of testosterone in males
- Pubertal basal level of luteinizing hormone (based on laboratory reference ranges)
- A pubertal luteinizing hormone response to a gonadotropin-releasing hormone (GnRH) stimulation test

AND

5 - A letter from the prescriber and/or formal documentation stating ALL of the following:

5.1 Patient has experienced pubertal changes that have resulted in an increase of their gender dysphoria that has significantly impaired psychological or social functioning

AND

5.2 Coexisting psychiatric and medical comorbidities or social problems that may interfere with the diagnostic procedures or treatment have been addressed or removed

AND

5.3 BOTH of the following:

5.3.1 Current enrollment, attendance, and active participation in psychological and social support treatment program

AND

5.3.2 Patient will continue enrollment, attendance and active participation in psychological and social support throughout the course of treatment

AND

5.4 Patient demonstrates knowledge and understanding of the expected outcomes of treatment and related transgender therapies

AND

6 - If the request is non-preferred*, history of failure, contraindication, or intolerance to ONE of the following:

- Fensolvi
- Leuprolide acetate inj kit 5 mg/mL
- Lupron Depot 3.75 mg or 7.5 mg
- Lupron Depot-Ped (1-Month): 7.5 mg, 11.25 mg, or 15 mg

Notes

*PDL link: <https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP>

Product Name:Fensolvi, Lupron Depot, Lupron Depot-Ped, leuprolide acetate inj kit 5 mg/mL, Lutrate Depot, Triptodur

Diagnosis	Gender dysphoria in adolescents

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

- Documentation (within the last 6 months) of appropriate luteinizing hormone (LH) suppression
- Change in dosing

AND

2 - Documented diagnosis of gender dysphoria, according to the current Diagnostic and Statistical Manual of Mental Disorders (i.e., DSM-5) criteria, by a mental health professional with expertise in child and adolescent psychiatry

AND

3 - Medication is prescribed by or in consultation with an endocrinologist or a medical provider experienced in gender dysphoria hormone therapy

AND

4 - A letter from the prescriber and/or formal documentation stating ALL of the following:

4.1 Patient continues to meet their individual goals of therapy for gender dysphoria

AND

4.2 Patient continues to have a strong affinity for the desired (opposite of natal) gender

AND

4.3 Discontinuation of treatment and subsequent pubertal development would interfere with or impair psychological functioning and well-being

AND

4.4 Coexisting psychiatric and medical comorbidities or social problems that may interfere with treatment continue to be addressed or removed

AND

4.5 BOTH of the following:

4.5.1 Current enrollment, attendance, and active participation in psychological and social support treatment program

AND

4.5.2 Patient will continue enrollment, attendance and active participation in psychological and social support throughout the course of treatment

AND

4.6 Patient demonstrates knowledge and understanding of the expected outcomes of treatment and related transgender therapies

AND

5 - If the request is non-preferred*, ONE of the following:

5.1 If the request is for Lupron Depot (6-Month), Lupron Depot-Ped (3-Month), or Lupron Depot-Ped (6-Month), continuation of prior therapy

OR

5.2 History of failure, contraindication, or intolerance to ONE of the following:

- Fensolvi
- Leuprolide acetate inj kit 5 mg/mL
- Lupron Depot 3.75 mg or 7.5 mg
- Lupron Depot-Ped (1-Month): 7.5 mg, 11.25 mg, or 15 mg

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:Fensolvi, Lupron Depot, Lupron Depot-Ped, leuprolide acetate inj kit 5 mg/mL, Lutrate Depot, Triptodur	
Diagnosis	Adjunct for Gender-Affirming Hormonal Therapy for Transgender Adults
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of gender dysphoria, according to the current Diagnostic and Statistical Manual of Mental Disorders (i.e., DSM-5) criteria, by a mental health professional

AND

2 - Medication is prescribed by or in consultation with an endocrinologist or a medical provider experienced in transgender hormone therapy

AND

3 - Gonads (i.e., testes, ovaries) have not been removed and are functional (e.g., hormone producing)

AND

4 - Patient is currently receiving hormonal therapy (e.g., testosterone, estrogens, progesterones) to achieve the desired (e.g., non-natal) gender

AND

5 - Inability of cross sex hormone therapy to inhibit natal secondary sex characteristics, luteinizing hormone (LH), or gonadotropins (e.g., menses, testosterone)

AND

6 - A letter from the prescriber and/or formal documentation stating ALL of the following:

6.1 Transgender patient has identified goals of gender-affirming hormone therapy

AND

6.2 Coexisting psychiatric and medical comorbidities or social problems that may interfere with the diagnostic procedures or treatment have been addressed or removed

AND

6.3 BOTH of the following:

6.3.1 Current enrollment, attendance, and active participation in psychological and social support treatment program

AND

6.3.2 Patient will continue enrollment, attendance and active participation in psychological and social support throughout the course of treatment

AND

6.4 Patient demonstrates knowledge and understanding of the expected outcomes of treatment and related transgender therapies

AND

7 - If the request is non-preferred*, history of failure, contraindication, or intolerance to ONE of the following:

- Fensolvi
- Leuprolide acetate inj kit 5 mg/mL
- Lupron Depot 3.75 mg or 7.5 mg
- Lupron Depot-Ped (1-Month): 7.5 mg, 11.25 mg, or 15 mg

Notes

*PDL link: <https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP>

Product Name: Fensolvi, Lupron Depot, Lupron Depot-Ped, leuprolide acetate inj kit 5 mg/mL, Lutrate Depot, Triptodur

Diagnosis	Adjunct for Gender-Affirming Hormonal Therapy for Transgender Adults
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: • Documentation (within the last 6 months) of appropriate luteinizing hormone (LH) suppression • Change in dosing AND 2 - Documented diagnosis of gender dysphoria, according to the current Diagnostic and Statistical Manual of Mental Disorders (i.e., DSM-5) criteria, by a mental health professional AND 3 - Medication is prescribed by or in consultation with an endocrinologist or a medical provider experienced in transgender hormone therapy AND 4 - Gonads (i.e., testes, ovaries) are intact AND 5 - Patient is currently receiving hormonal therapy (e.g., testosterone, estrogens, progesterones) to achieve the desired (e.g., non-natal) gender AND	

6 - Inability of cross sex hormone therapy to inhibit natal secondary sex characteristics, luteinizing hormone (LH), or gonadotropins (e.g., menses, testosterone)

AND

7 - A letter from the prescriber and/or formal documentation stating ALL of the following:

7.1 Transgender patient continues to meet goals of gender-affirming hormone therapy

AND

7.2 Coexisting psychiatric and medical comorbidities or social problems that may interfere with the diagnostic procedures or treatment continue to be addressed or removed

AND

7.3 BOTH of the following:

7.3.1 Current enrollment, attendance, and active participation in psychological and social support treatment program

AND

7.3.2 Patient will continue enrollment, attendance and active participation in psychological and social support throughout the course of treatment

AND

7.4 Patient demonstrates knowledge and understanding of the expected outcomes of treatment and related transgender therapies

AND

8 - If the request is non-preferred*, ONE of the following:

8.1 If the request is for Lupron Depot (6-Month), Lupron Depot-Ped (3-Month), or Lupron Depot-Ped (6-Month), continuation of prior therapy

OR

8.2 History of failure, contraindication, or intolerance to ONE of the following:

- Fensolvi
- Leuprolide acetate inj kit 5 mg/mL
- Lupron Depot 3.75 mg or 7.5 mg
- Lupron Depot-Ped (1-Month): 7.5 mg, 11.25 mg, or 15 mg

Notes

*PDL link: <https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP>

Product Name: Fensolvi, Lupron Depot, Lupron Depot-Ped, leuprolide acetate inj kit 5 mg/mL, Lutrate Depot, Triptodur

Diagnosis	Fertility Preservation

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - For use in pre-menopausal women

AND

2 - Patient is receiving a cytotoxic agent that is associated with causing primary ovarian insufficiency (premature ovarian failure) [e.g., Cytosan (cyclophosphamide), procarbazine, vinblastine, cisplatin]

AND

3 - If the request is non-preferred*, history of failure, contraindication, or intolerance to ONE of the following:

- Fensolvi
- Leuprolide acetate inj kit 5 mg/mL
- Lupron Depot 3.75 mg or 7.5 mg
- Lupron Depot-Ped (1-Month): 7.5 mg, 11.25 mg, or 15 mg

Notes

*PDL link: <https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP>

Product Name: Fensolvi, Lupron Depot, Lupron Depot-Ped, leuprolide acetate inj kit 5 mg/mL, Lutrate Depot, Triptodur

Diagnosis Fertility Preservation

Approval Length 12 month(s)

Therapy Stage Reauthorization

Guideline Type Prior Authorization

Approval Criteria

1 - Patient is currently receiving gonadotropin-releasing hormone (GnRH) analog therapy for the purpose of fertility preservation

AND

2 - Patient continues to receive a cytotoxic agent that is associated with causing primary ovarian insufficiency (premature ovarian failure) [e.g., Cytoxan (cyclophosphamide), procarbazine, vinblastine, cisplatin]

AND

3 - If the request is non-preferred*, ONE of the following:

3.1 If the request is for Lupron Depot (6-Month), Lupron Depot-Ped (3-Month), or Lupron Depot-Ped (6-Month), continuation of prior therapy

OR

3.2 History of failure, contraindication, or intolerance to ONE of the following:

- Fensolvi
- Leuprolide acetate inj kit 5 mg/mL
- Lupron Depot 3.75 mg or 7.5 mg
- Lupron Depot-Ped (1-Month): 7.5 mg, 11.25 mg, or 15 mg

Notes

*PDL link: <https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP>

Product Name: Eligard, Lupron Depot 7.5 mg and 22.5 mg and 30 mg and 45 mg, leuprolide acetate inj kit 5 mg/mL, Lutrate Depot, Leuprolide acetate inj (3 Month) 22.5 mg, Vabrinty

Diagnosis	Advanced or Metastatic Prostate Cancer

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of advanced or metastatic prostate cancer

AND

2 - If the request is non-preferred*, ONE of the following:

2.1 If the request is for Lupron Depot (6-Month), continuation of prior therapy

OR

2.2 History of failure, contraindication, or intolerance to ONE of the following:

- Eligard
- Leuprolide acetate inj (3 Month) 22.5 mg
- Leuprolide acetate inj kit 5 mg/mL

Lupron Depot 7.5 mg	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC CP

2 . Revision History

Date	Notes
5/11/2026	For prostate cancer section, added Leuprolide acetate inj (3 Month) 22.5 mg as a target and updated criteria to include Eligard and Leuprolide acetate inj (3 Month) 22.5 mg as prerequisite options.

Gralise, Horizant



Prior Authorization Guideline

Guideline ID	GL-500224
Guideline Name	Gralise, Horizant
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Brand Gralise, generic gabapentin (once-daily)	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of postherpetic neuralgia (PHN) AND	

2 - Trial and failure or intolerance to generic immediate-release gabapentin (generic for Neurontin)

AND

3 - If the request is for generic gabapentin (once-daily), trial and failure or intolerance to Brand Gralise

Product Name:Horizant

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 BOTH of the following:

1.1.1 Diagnosis of postherpetic neuralgia (PHN)

AND

1.1.2 Trial and failure or intolerance to generic immediate-release gabapentin (generic for Neurontin)

OR

1.2 Diagnosis of restless legs syndrome

2 . Revision History

Date	Notes

1/16/2026	Added new GPIs for generic gabapentin (once-daily) as targets. No changes to criteria.

Growth Hormone, Growth Stimulating Agents



Prior Authorization Guideline

Guideline ID	GL-449224
Guideline Name	Growth Hormone, Growth Stimulating Agents
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	12/1/2025

1 . Criteria

Product Name: Genotropin cartridge, Genotropin Miniquick, Humatrope, Omnitrope, Saizen, Serostim, Increlex, Zomacton, Zorbtive, Nutropin AQ Nuspin, Norditropin Flexpro, Sogroya, Ngenla, Skytrofa	
Diagnosis	Idiopathic Short Stature (ISS)
Approval Length	N/A - Requests for non-approvable diagnoses should not be approved
Guideline Type	Prior Authorization
Approval Criteria 1 - Requests for coverage for diagnosis of Idiopathic Short Stature (ISS) are not authorized and will not be approved	

Notes	Approval Length: N/A - Requests for Idiopathic Short Stature (ISS) should not be approved. Deny as a benefit exclusion.

Product Name:Humatrope, Omnitrope, Saizen, Zomacton, Nutropin AQ Nuspin, Sogroya, Ngenla, Skytrofa	
Diagnosis	Non-Preferred Review
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) or paid claims documenting history of failure to ALL preferred products listed below: • Genotropin Miniquick or Genotropin cartridge • Norditropin	

Product Name:Genotropin cartridge, Genotropin Miniquick, Humatrope, Omnitrope, Saizen, Zomacton, Nutropin AQ Nuspin, Norditropin Flexpro, Sogroya, Ngenla, Skytrofa	
Diagnosis	Pediatric Growth Hormone Deficiency (GHD)*
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 ONE of the following: 1.1.1 All of the following: • Infant is less than 4 months of age • Infant has growth deficiency • Prescribed by an endocrinologist	

OR

1.1.2 BOTH of the following:

- History of neonatal hypoglycemia associated with pituitary disease
- Prescribed by an endocrinologist

OR

1.1.3 BOTH of the following:

- Diagnosis of panhypopituitarism
- Prescribed by an endocrinologist

OR

1.2 ALL of the following:

1.2.1 Diagnosis of pediatric growth hormone (GH) deficiency as confirmed by ONE of the following:

1.2.1.1 Projected height (as determined by extrapolating pre-treatment growth trajectory along current channel to 18-20 year mark) is greater than 2.0 standard deviations (SD) below midparental height utilizing age and gender growth charts related to height

OR

1.2.1.2 Height is greater than 2.25 SD below population mean (below the 1.2 percentile for age and gender) utilizing age and gender growth charts related to height

OR

1.2.1.3 Growth velocity is greater than 2 SD below mean for age and gender

OR

1.2.1.4 Delayed skeletal maturation of greater than 2 SD below mean for age and gender (e.g., delayed greater than 2 years compared with chronological age)

AND

1.2.2 ONE of the following:

1.2.2.1 BOTH of the following:

- Patient is male
- Bone age less than 16 years

OR

1.2.2.2 BOTH of the following:

- Patient is female
- Bone age less than 14 years

AND

1.2.3 Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following:

1.2.3.1 BOTH of the following:

1.2.3.1.1 Patient has undergone TWO of the following provocative GH stimulation tests:

- Arginine
- Clonidine
- Glucagon
- Insulin
- Levodopa
- Growth hormone releasing hormone

AND

1.2.3.1.2 BOTH GH response values are less than 10 micrograms per liter

OR

1.2.3.2 BOTH of the following:

1.2.3.2.1 Patient is less than 1 year of age

AND

1.2.3.2.2 ONE of the following is below the age and gender adjusted normal range as provided by the physician's lab:

- Insulin-like Growth Factor 1 (IGF-1/Somatomedin-C)
- Insulin Growth Factor Binding Protein-3 (IGFBP-3)

AND

1.2.4 ONE of the following:

1.2.4.1 Request does not exceed a maximum supply limit of 0.3 milligrams per kilogram per week

OR

1.2.4.2 BOTH of the following:

- Tanner Stage 3 or greater
- Request does not exceed a maximum supply limit of 0.7 milligrams per kilogram per week

AND

1.2.5 Prescribed by an endocrinologist

Notes

*Includes children who have undergone brain radiation. If patient is a Transition Phase Adolescent or Adult who had childhood onset GH deficiency, utilize criteria for Transition Phase Adolescent or Adult GH D efficiency.

Product Name: Genotropin cartridge, Genotropin Miniquick, Humatrope, Omnitrope, Saizen, Zomacton, Nutropin AQ Nuspin, Norditropin Flexpro, Sogroya, Ngenla, Skytrofa	
Diagnosis	Pediatric Growth Hormone Deficiency (GHD)*
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Height increase of at least 2 centimeters per year over the previous year documented by BOTH of the following:** • Previous height and date obtained • Current height and date obtained AND 2 - BOTH of the following:** • Expected adult height not attained • Documentation of expected adult height goal (e.g., genetic potential) AND 3 - Calculated height (growth) velocity over the past 12 months AND 4 - ONE of the following: 4.1 BOTH of the following: • Patient is male • Bone age less than 16 years OR	

4.2 BOTH of the following:

- Patient is female
- Bone age less than 14 years

AND

5 - ONE of the following:

5.1 Request does not exceed a maximum supply limit of 0.3 milligrams per kilogram per week

OR

5.2 BOTH of the following:

- Tanner Stage 3 or greater
- Request does not exceed a maximum supply limit of 0.7 milligrams per kilogram per week

AND

6 - Prescribed by an endocrinologist

Notes	*Includes children who have undergone brain radiation. If patient is a Transition Phase Adolescent or Adult who had childhood onset GH deficiency, utilize criteria for Transition Phase Adolescent or Adult GH D deficiency. **Documentation of previous height, current height and goal expected adult height will be required for renewal.

Product Name: Genotropin cartridge, Genotropin Miniquick, Humatrope, Omnitrope, Saizen, Zomacton, Nutropin AQ Nuspin, Norditropin Flexpro, Sogroya, Ngenla, Skytrofa	
Diagnosis	Prader-Willi Syndrome
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Prader-Willi Syndrome

AND

2 - Prescribed by an endocrinologist

Product Name: Genotropin cartridge, Genotropin Miniquick, Humatrope, Omnitrope, Saizen, Zomacton, Nutropin AQ Nuspun, Norditropin Flexpro, Sogroya, Ngenla, Skytrofa

Diagnosis	Prader-Willi Syndrome
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following criteria:

1.1 BOTH of the following:

1.1.1 Evidence of positive response to therapy (e.g., increase in total lean body mass, decrease in fat mass)

AND

1.1.2 Prescribed by an endocrinologist

OR

1.2 ALL of the following:

1.2.1 Height increase of at least 2 centimeters per year over the previous year of treatment as documented by BOTH of the following:

- Previous height and date obtained
- Current height and date obtained

AND

1.2.2 BOTH of the following:

- Expected adult height not attained
- Documentation of expected adult height goal

AND

1.2.3 Prescribed by an endocrinologist

Product Name: Genotropin cartridge, Genotropin Miniquick, Humatrope, Omnitrope, Saizen, Zomacton, Nutropin AQ Nuspin, Norditropin Flexpro, Sogroya, Ngenla, Skytrofa

Diagnosis	Growth Failure in Children Small for Gestational Age (SGA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of small for gestational age (SGA) based on demonstration of catch up growth failure in the first 24 months of life using a 0-36 month growth chart as confirmed by documentation that ONE of the following is below the third percentile for gestational age [more than 2 standard deviations (SD) below population mean]:

- Birth weight
- Birth length

AND

2 - Documentation that height remains less than or equal to the third percentile (more than 2 SD below population mean)

AND

3 - Prescribed by an endocrinologist

Product Name: Genotropin cartridge, Genotropin Miniquick, Humatrope, Omnitrope, Saizen, Zomacton, Nutropin AQ Nuspin, Norditropin Flexpro, Sogroya, Ngenla, Skytrofa

Diagnosis	Growth Failure in Children Small for Gestational Age (SGA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Height increase of at least 2 centimeters per year over the previous year documented by BOTH of the following:*

- Previous height and date obtained
- Current height and date obtained

AND

2 - Documentation of BOTH of the following:*

- Expected adult height not attained
- Expected adult height goal

AND

3 - Prescribed by an endocrinologist

Notes	*Documentation of previous height, current height, and goal expected adult height will be required for renewal.

Product Name: Genotropin cartridge, Genotropin Miniquick, Humatrope, Omnitrope, Saizen, Zomacton, Nutropin AQ Nuspin, Norditropin Flexpro, Sogroya, Ngenla, Skytrofa

Diagnosis	Turner Syndrome or Noonan Syndrome
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of pediatric growth failure associated with ONE of the following: 1.1 BOTH of the following: 1.1.1 Turner Syndrome (Gonadal Dysgenesis) AND 1.1.2 BOTH of the following: • Patient is female • Bone age less than 14 years OR 1.2 BOTH of the following: 1.2.1 Noonan Syndrome AND 1.2.2 ONE of the following: 1.2.2.1 BOTH of the following: • Patient is male • Bone age less than 16 years OR	

1.2.2.2 BOTH of the following:

- Patient is female
- Bone age less than 14 years

AND

2 - Height is below the fifth percentile on growth charts for age and gender

AND

3 - Prescribed by an endocrinologist

Product Name: Genotropin cartridge, Genotropin Miniquick, Humatrope, Omnitrope, Saizen, Zomacton, Nutropin AQ Nuspin, Norditropin Flexpro, Sogroya, Ngenla, Skytrofa

Diagnosis	Turner Syndrome or Noonan Syndrome
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Height increase of at least 2 centimeters per year over the previous year documented by BOTH of the following:*

- Previous height and date obtained
- Current height and date obtained

AND

2 - Documentation of BOTH of the following:*

- Expected adult height not attained
- Expected adult height goal

AND	
3 - Prescribed by an endocrinologist	
Notes	*Documentation of previous height, current height and goal expected adult height will be required for renewal.

Product Name: Genotropin cartridge, Genotropin Miniquick, Humatrope, Omnitrope, Saizen, Zomacton, Nutropin AQ Nuspin, Norditropin Flexpro, Sogroya, Ngenla, Skytrofa	
Diagnosis	Short-Stature Homeobox (SHOX) Gene Deficiency
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of pediatric growth failure with short-stature homeobox (SHOX) gene deficiency as confirmed by genetic testing AND 2 - ONE of the following: 2.1 BOTH of the following: • Patient is male • Bone age less than 16 years OR 2.2 BOTH of the following: • Patient is female • Bone age less than 14 years	

AND

3 - Prescribed by an endocrinologist

Product Name: Genotropin cartridge, Genotropin Miniquick, Humatrope, Omnitrope, Saizen, Zomacton, Nutropin AQ Nuspin, Norditropin Flexpro, Sogroya, Ngenla, Skytrofa

Diagnosis	Short-Stature Homeobox (SHOX) Gene Deficiency
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Height increase of at least 2 centimeters per year over the previous year documented by BOTH of the following:*

- Previous height and date obtained
- Current height and date obtained

AND

2 - Documentation of BOTH of the following:*

- Expected adult height not attained
- Expected adult height goal

AND

3 - Prescribed by an endocrinologist

Notes	*Documentation of previous height, current height, and goal expected adult height will be required for renewal.

Product Name: Genotropin cartridge, Genotropin Miniquick, Humatrope, Omnitrope, Saizen, Zomacton, Nutropin AQ Nuspin, Norditropin Flexpro, Sogroya, Ngenla, Skytrofa

Diagnosis	Growth Failure associated with Chronic Renal Insufficiency
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of pediatric growth failure associated with chronic renal insufficiency AND 2 - ONE of the following: 2.1 BOTH of the following: • Patient is male • Bone age less than 16 years OR 2.2 BOTH of the following: • Patient is female • Bone age less than 14 years AND 3 - Prescribed by ONE of the following: • Endocrinologist • Nephrologist	

Product Name: Genotropin cartridge, Genotropin Miniquick, Humatrope, Omnitrope, Saizen, Zomacton, Nutropin AQ Nuspin, Norditropin Flexpro, Sogroya, Ngenla, Skytrofa

Diagnosis	Growth Failure associated with Chronic Renal Insufficiency

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Height increase of at least 2 centimeters per year over the previous year documented by BOTH of the following:* • Previous height and date obtained • Current height and date obtained AND 2 - Documentation of BOTH of the following:* • Expected adult height not attained • Expected adult height goal AND 3 - Prescribed by ONE of the following: • Endocrinologist • Nephrologist	
Notes	*Documentation of previous height, current height, and goal expected adult height will be required for renewal.

Product Name: Genotropin cartridge, Genotropin Miniquick, Humatrope, Omnitrope, Saizen, Zomacton, Nutropin AQ Nuspin, Norditropin Flexpro, Sogroya, Ngenla, Skytrofa	
Diagnosis	Adult Growth Hormone Deficiency
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of adult growth hormone deficiency (GHD) as a result of ONE of the following:

1.1 Clinical records supporting a diagnosis of childhood-onset GHD

OR

1.2 BOTH of the following:

1.2.1 Adult-onset GHD

AND

1.2.2 Clinical records documenting that hormone deficiency is a result of hypothalamic-pituitary disease from organic or known causes (e.g., damage from surgery, cranial irradiation, head trauma, or subarachnoid hemorrhage)

AND

2 - Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following:

2.1 BOTH of the following:

2.1.1 Patient has undergone ONE of the following GH (growth hormone) stimulation tests to confirm adult GH deficiency:

- Insulin tolerance test (ITT)
- ARG (Arginine) and GHRH (growth hormone releasing hormone)
- Glucagon
- ARG

AND

2.1.2 ONE of the following peak GH values:

2.1.2.1 ITT less than or equal to 5 micrograms per liter

OR

2.1.2.2 GHRH and ARG of ONE of the following:

- Less than or equal to 11 micrograms per liter (mcg/L) if body mass index (BMI) is less than 25 kilograms per square meter (kg/m^2)
- Less than or equal to 8 mcg/L if BMI is greater than or equal to 25 and less than 30 kg/m^2
- Less than or equal to 4 mcg/L if BMI is greater than or equal to 30 kg/m^2

OR

2.1.2.3 Glucagon less than or equal to 3 mcg/L

OR

2.1.2.4 ARG less than or equal to 0.4 mcg/L

OR

2.2 BOTH of the following:

2.2.1 Submission of medical records (e.g., chart notes, laboratory values) documenting deficiency of THREE of the following anterior pituitary hormones:

- Prolactin
- ACTH (adrenocorticotrophic hormone)
- TSH (thyroid stimulating hormone)
- FSH/LH (follicle-stimulating hormone/luteinizing hormone)

AND

2.2.2 Insulin-like Growth Factor 1 (IGF-1)/Somatomedin-C level is below the age and gender adjusted normal range as provided by the physician's lab

AND

3 - ONE of the following:

3.1 Diagnosis of panhypopituitarism

OR

3.2 Other diagnosis and NOT used in combination with any of the following:

- Aromatase inhibitors [e.g., Arimidex (anastrozole), Femara (letrozole)]
- Androgens [e.g., Delatestryl (testosterone enanthate), Depo-Testosterone (testosterone cypionate)]

AND

4 - Request does not exceed a maximum supply limit of 0.3 milligrams per kilogram per week

AND

5 - Prescribed by an endocrinologist

Product Name: Genotropin cartridge, Genotropin Miniquick, Humatrope, Omnitrope, Saizen, Zomacton, Nutropin AQ Nuspin, Norditropin Flexpro, Sogroya, Ngenla, Skytrofa

Diagnosis	Adult Growth Hormone Deficiency
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of Insulin-like Growth Factor 1 (IGF-1)/Somatomedin C level within the past 12 months

AND

2 - ONE of the following:

2.1 Diagnosis of panhypopituitarism

OR

2.2 Other diagnosis and NOT used in combination with any of the following:

- Aromatase inhibitors [e.g., Arimidex (anastrozole), Femara (letrozole)]
- Androgens [e.g., Delatestryl (testosterone enanthate), Depo-Testosterone (testosterone cypionate)]

AND

3 - Request does not exceed a maximum supply limit of 0.3 milligrams per kilogram per week

AND

4 - Prescribed by an endocrinologist

Product Name: Genotropin cartridge, Genotropin Miniquick, Humatrope, Omnitrope, Saizen, Zomacton, Nutropin AQ Nuspin, Norditropin Flexpro, Sogroya, Ngenla, Skytrofa

Diagnosis	Transition Phase Adolescent Patients
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Request does not exceed a maximum supply limit of 0.3 milligrams per kilogram per week

AND

2 - Documentation of ONE of the following:

- Attained expected adult height
- Closed epiphyses on bone radiograph

AND

3 - Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following:

3.1 BOTH of the following:

3.1.1 Documentation of high risk of growth hormone (GH) deficiency due to GH deficiency in childhood from ONE of the following:

3.1.1.1 Embryopathic/congenital defects

OR

3.1.1.2 Genetic mutations

OR

3.1.1.3 Irreversible structural hypothalamic-pituitary disease

OR

3.1.1.4 Panhypopituitarism

OR

3.1.1.5 Deficiency of THREE of the following anterior pituitary hormones:

- ACTH (adrenocorticotrophic hormone)
- TSH (thyroid stimulating hormone)
- Prolactin
- FSH/LH (follicle-stimulating hormone/luteinizing hormone)

AND

3.1.2 ONE of the following:

3.1.2.1 Insulin-like Growth Factor 1 (IGF-1)/Somatomedin-C level is below the age and gender adjusted normal range as provided by the physician's lab

OR

3.1.2.2 ALL of the following:

3.1.2.2.1 Patient does not have a low IGF-1/Somatomedin C level

AND

3.1.2.2.2 Discontinued GH therapy for at least 1 month

AND

3.1.2.2.3 Patient has undergone ONE of the following GH stimulation tests after discontinuation of therapy for at least 1 month:

- Insulin tolerance test (ITT)
- ARG (Arginine) and GHRH (growth hormone releasing hormone)
- ARG
- Glucagon

AND

3.1.2.2.4 ONE of the following peak GH values:

3.1.2.2.4.1 ITT less than or equal to 5 micrograms per liter (mcg/L)

OR

3.1.2.2.4.2 GHRH and ARG of ONE of the following:

- Less than or equal to 11 mcg/L if body mass index (BMI) is less than 25 kilograms per square meter (kg/m^2)
- Less than or equal to 8 mcg/L if BMI is greater than or equal to 25 and less than 30 kg/m^2
- Less than or equal to 4 mcg/L if BMI is greater than or equal to 30 kg/m^2

OR

3.1.2.2.4.3 Glucagon less than or equal to 3 mcg/L

OR

3.1.2.2.4.4 ARG less than or equal to 0.4 mcg/L

OR

3.2 ALL of the following:

3.2.1 At low risk of severe GH deficiency (e.g., due to isolated and/or idiopathic GH deficiency)

AND

3.2.2 Discontinued GH therapy for at least 1 month

AND

3.2.3 BOTH of the following:

3.2.3.1 Patient has undergone ONE of the following GH stimulation tests after discontinuation of therapy for at least 1 month:

- ITT

- GHRH and ARG
- ARG
- Glucagon

AND

3.2.3.2 ONE of the following peak GH values:

3.2.3.2.1 ITT less than or equal to 5 mcg/L

OR

3.2.3.2.2 GHRH and ARG of ONE of the following:

- Less than or equal to 11 mcg/L if BMI is less than 25 kg/m²
- Less than or equal to 8 mcg/L if BMI is greater than or equal to 25 and less than 30 kg/m²
- Less than or equal to 4 mcg/L if BMI is greater than or equal to 30 kg/m²

OR

3.2.3.2.3 Glucagon less than or equal to 3 mcg/L

OR

3.2.3.2.4 ARG less than or equal to 0.4 mcg/L

AND

4 - Prescribed by an endocrinologist

Product Name: Genotropin cartridge, Genotropin Miniquick, Humatrope, Omnitrope, Saizen, Zomacton, Nutropin AQ Nuspin, Norditropin Flexpro, Sogroya, Ngenla, Skytrofa	
Diagnosis	Transition Phase Adolescent Patients
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive response to therapy [e.g., increase in total lean body mass, exercise capacity or IGF-1 (Insulin-like Growth Factor 1) and IGFBP-3 (Insulin-like growth factor binding protein 3) levels] AND 2 - Request does not exceed a maximum supply limit of 0.3 milligrams per kilogram per week AND 3 - Prescribed by an endocrinologist	

Product Name:Serostim	
Diagnosis	Human Immunodeficiency Virus (HIV)-associated wasting syndrome or cachexia
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of human immunodeficiency virus (HIV)-associated wasting syndrome or cachexia AND 2 - Documentation of ONE of the following: 2.1 Unintentional weight loss of greater than 10 percent over the last 12 months	

OR

2.2 Unintentional weight loss of greater than 7.5 percent over the last 6 months

OR

2.3 Loss of 5 percent body cell mass (BCM) within 6 months

OR

2.4 Body mass index (BMI) less than 20 kilograms per square meter (kg/m^2)

OR

2.5 ONE of the following:

2.5.1 ALL of the following:

- Patient is male
- BCM less than 35 percent of total body weight
- BMI less than 27 kg/m^2

OR

2.5.2 ALL of the following:

- Patient is female
- BCM less than 23 percent of total body weight
- BMI less than 27 kg/m^2

AND

3 - A nutritional evaluation has been completed since onset of wasting first occurred

AND

4 - Patient has not had weight loss as a result of other underlying treatable conditions (e.g., depression, mycobacterium avium complex, chronic infectious diarrhea, or malignancy with the exception of Kaposi's sarcoma limited to skin or mucous membranes)

AND

5 - Patient's anti-retroviral therapy has been optimized to decrease the viral load

Product Name:Serostim

Diagnosis	Human Immunodeficiency Virus (HIV)-associated wasting syndrome or cachexia
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Evidence of positive response to therapy [i.e., greater than or equal to 2 percent increase in body weight and/or body cell mass (BCM)]

AND

2 - ONE of the following targets or goals has not been achieved:

- Weight
- BCM
- Body Mass Index (BMI)

Product Name:Zorbtive*

Diagnosis	Short Bowel Syndrome

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Short Bowel Syndrome AND 2 - Patient is currently receiving specialized nutritional support (e.g., intravenous parenteral nutrition, fluid, and micronutrient supplements) AND 3 - Patient has not previously received 4 weeks of treatment with Zorbtive*	
Notes	*Treatment with Zorbtive will not be authorized beyond 4 weeks. Administration for more than 4 weeks has not been adequately studied.

Product Name:Increlex	
Diagnosis	Severe Primary IGF-1 Deficiency/Growth Hormone Gene Deletion
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Documentation of ALL of the following: 1.1.1 Diagnosis of severe primary Insulin-like Growth Factor 1 (IGF-1) deficiency AND	

1.1.2 Height standard deviation score less than or equal to -3.0

AND

1.1.3 Basal IGF-1 standard deviation score less than or equal to -3.0

AND

1.1.4 Normal or elevated growth hormone levels

AND

1.1.5 Documentation of open epiphyses on last bone radiograph

AND

1.1.6 The patient will not be treated with concurrent growth hormone therapy

AND

1.1.7 Prescribed by an endocrinologist

OR

1.2 ALL of the following:

1.2.1 Diagnosis of growth hormone gene deletion and has developed neutralizing antibodies to growth hormone

AND

1.2.2 Documentation of open epiphyses on last bone radiograph

AND

1.2.3 The patient will not be treated with concurrent growth hormone therapy

AND

1.2.4 Prescribed by an endocrinologist

Product Name:Increlex	
Diagnosis	Severe Primary IGF-1 Deficiency/Growth Hormone Gene Deletion
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Height increase of at least 2 centimeters per year over the previous year of treatment as documented by BOTH of the following:* • Previous height and date obtained • Current height and date obtained AND 2 - Documentation of BOTH of the following:* • Expected adult height not obtained • Expected adult height goal AND 3 - Patient is not treated with concurrent growth hormone therapy	

AND

4 - Prescribed by an endocrinologist

Notes	*Documentation of previous height, current height, and goal expected adult height will be required for renewal.

2 . Revision History

Date	Notes
11/13/2025	Added new GPIs for Skytrofa. Removed Saizenprep as a target since it is obsolete. No changes to criteria.

HCG



Prior Authorization Guideline

Guideline ID	GL-140654
Guideline Name	HCG
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	11/1/2020

1 . Criteria

Product Name:Novarel, Ovidrel, Brand Pregnyl, generic chorionic gonadotropin	
Diagnosis	Prepubertal Cryptorchidism
Approval Length	6 Week(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of prepubertal cryptorchidism not due to anatomical obstruction	

Hemangeol



Prior Authorization Guideline

Guideline ID	GL-503189
Guideline Name	Hemangeol
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	1/17/2026

1 . Criteria

Product Name:Hemangeol	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Patient is 10 years of age or younger	

OR

1.2 ALL of the following:

1.2.1 Patient is greater than 10 years of age

AND

1.2.2 Diagnosis of proliferating infantile hemangioma

AND

1.2.3 Prescriber provides a reason or special circumstance the patient cannot use generic propranolol oral solution

2 . Revision History

Date	Notes
1/14/2026	Updated criteria where diagnosis check and rationale for cannot use generic propranolol oral solution applies to patients greater than 10 years of age.

Hemophilia Clotting Factors



Prior Authorization Guideline

Guideline ID	GL-449222
Guideline Name	Hemophilia Clotting Factors
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	12/1/2025

1 . Criteria

Product Name:Corifact	
Diagnosis	Congenital Factor XIII Deficiency (i.e., Fibrin Stabilizing Factor Deficiency)
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of congenital factor XIII deficiency	

AND

2 - ONE of the following:

- Routine prophylactic treatment of bleeding
- Peri-operative management of surgical bleeding
- Treatment of bleeding episodes

Product Name:Tretten

Diagnosis	Congenital Factor XIII Deficiency (i.e., Fibrin Stabilizing Factor Deficiency)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of congenital factor XIII A-subunit deficiency

AND

2 - ONE of the following:

- Routine prophylactic treatment of bleeding
- Peri-operative management of surgical bleeding
- Treatment of bleeding episodes

Product Name:Humate-P

Diagnosis	Von Willebrand Disease (VWD)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Diagnosis of severe von Willebrand disease

OR

1.2 BOTH of the following:

- Diagnosis of mild or moderate von Willebrand disease
- History of failure, contraindication or intolerance to treatment with desmopressin

AND

2 - ONE of the following:

- Treatment of bleeding episodes
- Peri-operative management of surgical bleeding

Product Name:Alphanate	
Diagnosis	Von Willebrand Disease (VWD)
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of mild or moderate von Willebrand disease AND 2 - Used for peri-operative management of surgical bleeding	

AND

3 - History of failure, contraindication or intolerance to treatment with desmopressin

Product Name:Wilate, Vonvendi	
Diagnosis	Von Willebrand Disease (VWD)
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of von Willebrand disease AND 2 - ONE of the following: • Treatment of bleeding episodes • Peri-operative management of surgical bleeding • Routine prophylactic treatment	

Product Name:NovoSeven RT	
Diagnosis	Congenital Factor VII Deficiency
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of congenital factor VII deficiency	

AND

2 - ONE of the following:

- Treatment of bleeding episodes
- Routine prophylactic treatment of bleeding

Product Name: Advate, Alphanate, Humate-P, Hemofil M, KoAte, KoAte-DVI, Kogenate FS, Kovaltry, NovoEight, Nuwiq, Recombinate, Xyntha, Xyntha Solofuse

Diagnosis	Hemophilia A (i.e., Factor VIII Deficiency, Classical Hemophilia)

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of hemophilia A

AND

2 - ONE of the following:

- Routine prophylactic treatment of bleeding
- Peri-operative management of surgical bleeding
- Treatment of bleeding episodes

Product Name: Eloctate

Diagnosis	Hemophilia A (i.e., Factor VIII Deficiency, Classical Hemophilia)

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of hemophilia A

AND

2 - ONE of the following:

- Routine prophylactic treatment of bleeding
- Peri-operative management of surgical bleeding
- Treatment of bleeding episodes

AND

3 - Patient is not a suitable candidate for treatment with shorter half-life Factor VIII (recombinant) products [e.g., Advate, Kogenate FS, Kovaltry, Novoeight, Nuwiq, or Recombinate] as attested by the prescribing physician

AND

4 - ONE of the following:

4.1 BOTH of the following:

- Dose does not exceed 50 IU/kg
- Infusing no more frequently than every 4 days

OR

4.2 Requested dosage regimen does not exceed 12.5 IU/kg/day

OR

4.3 BOTH of the following:

4.3.1 Patient is less than 6 years of age

AND

4.3.2 ONE of the following:

- Pharmacokinetic (PK) testing results suggest that dosing more intensive than 50 IU/kg is required
- PK testing results suggest that dosing more frequently than every 3 to 5 days is required
- PK testing results suggest that dosing more intensive than 14.5 IU/kg/day is required

Product Name: Jivi	
Diagnosis	Hemophilia A (i.e., Factor VIII Deficiency, Classical Hemophilia)
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of hemophilia A AND 2 - ONE of the following: • Peri-operative management of surgical bleeding • Routine prophylactic treatment of bleeding • Treatment of bleeding episodes AND 3 - Patient has previously received Factor VIII replacement therapy AND	

4 - Patient is 7 years of age or older

AND

5 - Patient is not a candidate for treatment with shorter acting half-life Factor VIII (recombinant) products [e.g., Advate, Kogenate FS, Kovaltry, Novoeight, Nuwiq, or Recombinate] as attested by the prescribing physician

AND

6 - Patient is not to receive routine infusions more than 2 times per week

Product Name: Afstyl ^a	
Diagnosis	Hemophilia A (i.e., Factor VIII Deficiency, Classical Hemophilia)
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of hemophilia A AND 2 - ONE of the following: • Routine prophylactic treatment of bleeding • Peri-operative management of surgical bleeding • Treatment of bleeding episodes AND 3 - Patient is not a suitable candidate for treatment with shorter acting half-life Factor VIII (recombinant) products [e.g., Advate, Kogenate FS, Kovaltry, Novoeight, Nuwiq, Recombinate] as attested by the prescribing physician	

AND

4 - ONE of the following:

4.1 Patient is not to receive routine infusions more frequently than 3 times per week

OR

4.2 BOTH of the following:

- Patient is less than 12 years of age
- Pharmacokinetic (PK) testing results suggest that more frequently than 3 times per week dosing is required

Product Name:Hemlibra	
Diagnosis	Hemophilia A (i.e., Factor VIII Deficiency, Classical Hemophilia)
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 ALL of the following: 1.1.1 Diagnosis of severe hemophilia A AND 1.1.2 Documentation of endogenous factor VIII level less than 1% of normal factor VIII (< 0.01 IU/mL) AND	

1.1.3 Physician attestation that the patient is not to receive extended half-life factor VIII replacement products (e.g., Eloctate, Adynovate, Afstyla, Jivi) for the treatment of breakthrough bleeding episodes

OR

1.2 ALL of the following:

1.2.1 ONE of the following:

1.2.1.1 BOTH of the following:

- Diagnosis of moderate hemophilia A
- Documentation of endogenous factor VIII level greater than or equal to 1% to less than 5% (greater than or equal to 0.01 IU/mL to less than 0.05 IU/mL)

OR

1.2.1.2 BOTH of the following:

- Diagnosis of mild hemophilia A
- Documentation of endogenous factor VIII level greater than or equal to 5% (greater than 0.05 IU/mL)

AND

1.2.2 Submission of medical records (e.g., chart notes, laboratory values) documenting a failure to meet clinical goals (e.g., continuation of spontaneous bleeds, inability to achieve appropriate trough level, previous history of inhibitors) after a trial of prophylactic factor VIII replacement products

AND

1.2.3 Physician attestation that the patient is not to receive extended half-life factor VIII replacement products (e.g., Eloctate, Adynovate, Afstyla, Jivi) for the treatment of breakthrough bleeding episodes

OR

1.3 BOTH of the following:

- Diagnosis of hemophilia A
- Patient has developed high-titer factor VIII inhibitors (greater than or equal to 5 Bethesda units [BU])

AND

2 - Prescribed for the prevention of bleeding episodes (i.e., routine prophylaxis)

Product Name:FEIBA	
Diagnosis	Hemophilia A
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of hemophilia A AND 2 - Documentation of inhibitors (e.g., Bethesda inhibitor assay) AND 3 - ONE of the following: • Routine prophylactic treatment of bleeding • Peri-operative management of surgical bleeding • Treatment of bleeding episodes	

Product Name:NovoSeven RT, Obizur	
Diagnosis	Acquired factor VIII Hemophilia

Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of acquired factor VIII hemophilia (e.g., acquired hemophilia A, Factor VIII deficiency) AND 2 - Treatment or prevention of bleeding episodes	

Product Name:Adynovate	
Diagnosis	Hemophilia A (i.e., Factor VIII Deficiency, Classical Hemophilia)
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of hemophilia A AND 2 - ONE of the following: • Routine prophylactic treatment of bleeding • Peri-operative management of surgical bleeding • Treatment of bleeding episodes AND 3 - Patient is not a suitable candidate for treatment with shorter acting half-life Factor VIII (recombinant) products [Advate, Kogenate FS, Kovaltry, Novoeight, Nuwiq, or Recombinate] as attested by the prescribing physician	

AND

4 - ONE of the following:

4.1 BOTH of the following:

- Patient is not to receive routine infusions more frequently than 2 times per week
- Patient is not to receive a routine dose greater than 50 IU/kg

OR

4.2 ALL of the following:

- Patient is less than 12 years of age
- Patient is not to receive routine infusions more frequently than 2 times per week
- Patient is not to receive a routine dose greater than 70 IU/kg

Product Name:Esperoct	
Diagnosis	Hemophilia A (i.e., Factor VIII Deficiency, Classical Hemophilia)
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of hemophilia A AND 2 - ONE of the following: • Routine prophylactic treatment of bleeding • Peri-operative management of surgical bleeding • Treatment of bleeding episodes	

AND

3 - ONE of the following:

3.1 Patient is not to receive routine infusions more frequently than 2 times per week

OR

3.2 BOTH of the following:

- Patient is less than 12 years of age
- Pharmacokinetic (PK) testing results suggest that more frequent than 2 times per week dosing is required

Product Name:Wilate	
Diagnosis	Hemophilia A (i.e., Factor VIII Deficiency, Classical Hemophilia)
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of hemophilia A AND 2 - ONE of the following: 2.1 Routine prophylactic treatment of bleeding OR 2.2 Treatment of bleeding episodes	

Product Name:NovoSeven RT, SevenFACT	
Diagnosis	Hemophilia A (i.e., Factor VIII Deficiency, Classical Hemophilia)
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of hemophilia A AND 2 - Documentation of inhibitors (e.g., Bethesda inhibitor assay) AND 3 - ONE of the following: • Peri-operative management of surgical bleeding • Treatment of bleeding episodes	

Product Name:Altuviiio	
Diagnosis	Hemophilia A (i.e., Factor VIII Deficiency, Classical Hemophilia)
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of hemophilia A AND 2 - ONE of the following:	

- Treatment of bleeding episodes
- Prevention of bleeding in surgical interventions or invasive procedures (e.g., surgical prophylaxis)
- Prevention of bleeding episodes (i.e., routine prophylaxis)

AND

3 - Patient is not a suitable candidate for treatment with shorter acting half-life Factor VIII (recombinant) products [e.g., Advate, Kogenate FS, Kovaltry, Novoeight, Nuwiq, or Recombinate] as attested by the prescribing physician

AND

4 - BOTH of the following:

- Dose does not exceed 50 IU/kg
- Patient is infusing no more frequently than every 7 days

Product Name:AlphaNine SD, Profilnine	
Diagnosis	Hemophilia B (i.e., Congenital Factor IX Deficiency, Christmas Disease)
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of hemophilia B AND 2 - ONE of the following: • Routine prophylactic treatment • Treatment of bleeding episodes	

Product Name:BeneFIX, Rixubis, Alprolix, Idelvion, Ixinity, Rebinyn	
Diagnosis	Hemophilia B (i.e., Congenital Factor IX Deficiency, Christmas Disease)
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of hemophilia B AND 2 - ONE of the following: • Routine prophylactic treatment • Peri-operative management of surgical bleeding • Treatment of bleeding episodes	

Product Name:FEIBA	
Diagnosis	Hemophilia B (i.e., Congenital Factor IX Deficiency, Christmas Disease)
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of hemophilia B AND 2 - Documentation of inhibitors (e.g., Bethesda inhibitor assay)	

AND

3 - ONE of the following:

- Routine prophylactic treatment of bleeding
- Peri-operative management of surgical bleeding
- Treatment of bleeding episodes

Product Name:NovoSeven RT, SevenFACT

Diagnosis	Hemophilia B (i.e., Congenital Factor IX Deficiency, Christmas Disease)

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of hemophilia B

AND

2 - Documentation of inhibitors (e.g., Bethesda inhibitor assay)

AND

3 - ONE of the following:

- Peri-operative management of surgical bleeding
- Treatment of bleeding episodes

Product Name:Fibryga, RiaSTAP

Diagnosis	Fibrinogen Deficiency (i.e., Factor I deficiency)

Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of congenital fibrinogen deficiency, including afibrinogenemia and hypofibrinogenemia AND 2 - Treatment of bleeding episodes	

Product Name:NovoSeven RT	
Diagnosis	Glanzmann Thrombasthenia
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Glanzmann's thrombasthenia AND 2 - Refractory to platelet transfusions AND 3 - ONE of the following: • Treatment of bleeding episodes • Peri-operative management of surgical bleeding	

Product Name:Coagadex	
Diagnosis	Congenital Factor X Deficiency
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of congenital Factor X deficiency AND 2 - ONE of the following: • Treatment of bleeding episodes • Peri-operative management of surgical bleeding • Routine prophylactic treatment	

Product Name:Hypnavor	
Diagnosis	Hemophilia A, Hemophilia B
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following: • hemophilia A (congenital factor VIII deficiency) without factor VIII inhibitors • hemophilia B (congenital factor IX deficiency) without factor IX inhibitors AND 2 - Patient is 12 years of age or older	

AND

3 - Drug will be used for prophylaxis to prevent or reduce the frequency of bleeding episodes

Product Name:Alhemo

Diagnosis	Hemophilia A, Hemophilia B

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following:

- hemophilia A (congenital factor VIII deficiency) with or without factor VIII inhibitors
- hemophilia B (congenital factor IX deficiency) with or without factor IX inhibitors

AND

2 - Patient is 12 years of age or older

AND

3 - Drug will be used for prophylaxis to prevent or reduce the frequency of bleeding episodes

Product Name:Qfitlia

Diagnosis	Hemophilia A, Hemophilia B

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following:

- hemophilia A (congenital factor VIII deficiency) with or without factor VIII inhibitors
- hemophilia B (congenital factor IX deficiency) with or without factor IX inhibitors

AND

2 - Patient is 12 years of age or older

AND

3 - Drug will be used for prophylaxis to prevent or reduce the frequency of bleeding episodes

2 . Revision History

Date	Notes
11/13/2025	Added new GPI for Fibryga 2 gm strength. Removed GPI for Koate-DVI 500 unit strength (obsolete). Updated criteria for Alhemo.

Hepatitis C



Prior Authorization Guideline

Guideline ID	GL-392223
Guideline Name	Hepatitis C
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2025

Note:

Preferred drugs Mavyret and Brand Sofosbuvir-velpatasvir will be approved without requiring prior authorization ONE time per lifetime. Requests for retreatment or non-preferred drugs will require PA

1 . Criteria

Product Name: Brand Sofosbuvir-velpatasvir*, Mavyret*	
Diagnosis	Hepatitis C Retreatment
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of Hepatitis C infection status which has been confirmed by detectable serum hepatitis C virus (HCV) RNA (ribonucleic acid) by quantitative assay completed within the past 90 days from the date of the prior authorization request

AND

2 - Age of the patient is Food and Drug Administration (FDA) approved for the specific HCV DAA (Direct Acting Antiviral) product

AND

3 - The prescribing provider assesses the patient's ability to adhere to the HCV DAA treatment plan and attests the assessment has been documented within the clinical record. For patients that would benefit from adherence aids, the treating provider shall refer the patient to a treatment adherence program

AND

4 - Patient agrees to adhere to the proposed course of treatment, including taking medications as prescribed, attending follow-up appointments, and, if applicable, participating in a treatment adherence program

AND

5 - ONE of the following:

5.1 Patient has been screened for Hepatitis A and B and has received one Hepatitis A and one Hepatitis B vaccine prior to requesting treatment

OR

5.2 Patient demonstrates laboratory evidence of immunity to Hepatitis A and B

AND

6 - The Prescriber must submit the following information with the request for HCV DAA medications to be considered:

6.1 HCV treatment history and responses to treatment

AND

6.2 Current medication list

AND

6.3 Laboratory results for ALL of the following:

- HCV screen test results
- Genotype and current baseline HCV viral load
- Total bilirubin
- Albumin level
- International Normalized Ratio (INR)
- Creatinine Clearance (CrCl) or Glomerular Filtration Rate (GFR)
- Liver Function Tests (LFTs)
- Complete Blood Count (CBC)
- Viral resistance status (when applicable)
- Hepatic status (Child Pugh Score)

AND

7 - If the HCV DAA product is being used in combination with ribavirin, the prescribing provider attests to monitoring hemoglobin levels periodically

AND

8 - The prescribing provider attests to monitoring HCV RNA levels obtained at 12- and 24-weeks post therapy completion to demonstrate the Sustained Virologic Response (SVR)

AND

9 - DAA HCV treatment coverage is NOT provided for ANY of the following:

9.1 DAA dosages greater than the FDA approved maximum dosage

OR

9.2 Patients currently using a potent P-gp inducer drug (St. John's wart, rifampin, carbamazepine, ritonavir, tipranavir, etc.)

OR

9.3 Lost or stolen medication absent of good cause

OR

9.4 Fraud, waste, or misuse of HCV DAA medications

Notes	Approval length: Mavyret = 8-16 Week(s), Brand Sofosbuvir-velpatasvir = 12-24 Week(s). *Preferred drugs Mavyret and Brand Sofosbuvir-velpatasvir will be approved without requiring prior authorization ONE time per lifetime. Requests for retreatment or non-preferred drugs will require PA. Refer to AASLD for specific approval durations AASLD: https://www.hcvguidelines.org/contents

Product Name: Brand Epclusa, Brand Harvoni, Brand Ledipasvir-sofosbuvir, Sovaldi, Zepatier	
Diagnosis	Hepatitis C
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Patient was adherent to previous DAA therapy as evidenced by submission of medical records and/or pharmacy prescription claims	

OR

1.2 If prior therapy was discontinued due to adverse effects from the DAA, the medical record shall be provided which documents these adverse effects and recommendation of discontinuation by treatment provider

AND

2 - The patient's ability to adhere to the planned course of retreatment has been assessed by the treating provider and documented within the clinical record

AND

3 - Resistance-associated polymorphism testing, when applicable, has been completed and submitted with the prior authorization request when BOTH of the following are true:

- Required for regimens whereby the FDA (Food and Drug Administration) requires such testing prior to treatment to ensure clinical appropriateness
- Deemed medically necessary by the clinical reviewer prior to approval of the requested regimen

AND

4 - HCV retreatment with a DAA shall NOT be approved for ANY of the following:

4.1 Is considered an experimental service

OR

4.2 Monotherapy of Sofosbuvir (Sovaldi)

OR

4.3 DAA dosages greater than the FDA approved maximum dosage

OR

4.4 Grazoprevir/elbasvir (Zepatier) if the NS5A polymorphism testing has not been completed and submitted with the prior authorization request

OR

4.5 Patients currently using a potent P-gp inducer drug (St. John's wart, rifampin, carbamazepine, ritonavir, tipranavir, etc.)

OR

4.6 Lost or stolen medication absent of good cause

OR

4.7 Fraudulent use of HCV DAA medications

AND

5 - If the request is for brand Epclusa or brand Harvoni, BOTH of the following:

5.1 The patient has a therapeutic failure, contraindication, or intolerance to the generic as evidenced by submission of medical records or claims history

AND

5.2 The prescriber must submit the FDA MedWatch form

Notes

The approval length should be as recommended per AASLD. Refer to AASLD for specific approval durations. AASLD: <https://www.hcvguidelines.org/contents>

Product Name: Brand Harvoni, Brand Ledipasvir-sofosbuvir

Diagnosis	Hepatitis C Retreatment
Approval Length	24 Week(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chronic hepatitis C infection AND 2 - Patient has decompensated cirrhosis (e.g., Child-Pugh Class B or C) AND 3 - ONE of the following: 3.1 Patient is ribavirin ineligible OR 3.2 BOTH of the following: - Prior failure (defined as viral relapse, breakthrough while on therapy, or non-responder therapy) to Sovaldi or NS5A-based therapy - Used in combination with ribavirin AND 4 - Not used in combination with another HCV direct acting antiviral agent [e.g., Sovaldi (sofosbuvir)]	

Product Name: Vosevi, Viekira Pak	
Diagnosis	Hepatitis C
Approval Length	12 Week(s)

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chronic hepatitis C infection AND 2 - ONE of the following: 2.1 Patient is a previous relapser to an NS5A-based regimen [e.g., Daklinza (daclatasvir); Epclusa (sofosbuvir/velpatasvir); Harvoni (ledipasvir/sofosbuvir); Mavyret (glecaprevir/pibrentasvir); Technivie (ombitasvir/paritaprevir/ritonavir); Viekira (ombitasvir/paritaprevir/ritonavir & dasabuvir); Zepatier (elbasvir/grazoprevir)] OR 2.2 Patient is a previous relapser to a sofosbuvir-based regimen without an NS5A inhibitor AND 3 - Patient is without decompensated liver disease (e.g., Child-Pugh Class B or C) AND 4 - Not used in combination with another HCV direct acting antiviral agent [e.g., Harvoni (ledipasvir/sofosbuvir), Zepatier (elbasvir/grazoprevir)]	

Product Name: Vosevi, Viekira Pak	
Diagnosis	Hepatitis C: Prior Failure to Vosevi/Viekira Pak
Approval Length	24 Week(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic hepatitis C infection

AND

2 - BOTH of the following:

2.1 Patient had a prior treatment failure with Vosevi or Viekira

AND

2.2 Used in combination with ribavirin

AND

3 - Patient is without decompensated liver disease (e.g., Child-Pugh Class B or C)

AND

4 - Not used in combination with another HCV direct acting antiviral agent [e.g., Harvoni (ledipasvir/sofosbuvir), Zepatier (elbasvir/grazoprevir)]

Product Name:Pegasys	
Diagnosis	Hepatitis C
Approval Length	48 Week(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chronic hepatitis C infection	

AND	
2 - Patient without decompensated liver disease (defined as Child-Pugh Class B or C)	
AND	
3 - Will be used as part of a combination antiviral treatment regimen	

Product Name: Ribavirin tablets and capsules	
Diagnosis	Hepatitis C
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chronic hepatitis C infection AND 2 - Used in combination with a direct-acting agent	

2 . Revision History

Date	Notes
9/12/2025	For Brand Sofosbuvir-velpatasvir and Mavyret, removed "chronic" verbiage in diagnosis check criterion.

Hereditary Angioedema (HAE) Agents



Prior Authorization Guideline

Guideline ID	GL-546227
Guideline Name	Hereditary Angioedema (HAE) Agents
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	4/12/2026

1 . Criteria

Product Name:Andembry, Cinryze, Dawnzera, Haegarda, Orladeyo, Takhzyro	
Diagnosis	Prophylaxis of HAE attacks
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting diagnosis of hereditary angioedema (HAE) confirmed by ONE of the following:	

1.1 C1 inhibitor (C1-INH) deficiency or dysfunction (Type I or II HAE) as documented by ONE of the following (per laboratory standard):

- C1-INH antigenic level below the lower limit of normal
- C1-INH functional level below the lower limit of normal

OR

1.2 HAE with normal C1 inhibitor levels and ONE of the following:

- Confirmed presence of a FXII (factor XII), angiopoietin-1, or plasminogen gene mutation
- Recurring angioedema attacks that are refractory to high-dose antihistamines with confirmed family history of angioedema

AND

2 - For prophylaxis against HAE attacks

AND

3 - ONE of the following:

- If the request is for Orladeyo pellets or Takhzyro, patient is 2 years of age or older
- If the request is for Cinryze or Haegarda, patient is 6 years of age or older
- If the request is for Andembry, Dawnzera, or Orladeyo capsules, patient is 12 years of age or older

AND

4 - Prescribed by or in consultation with ONE of the following:

- Immunologist
- Allergist

AND

5 - If the request is for Andembry, Dawnzera, Orladeyo, or Takhzyro, ONE of the following:

5.1 Submission of medical records documenting a history of failure, contraindication, or intolerance to Cinryze or Haegarda

OR

5.2 Submission of medical records documenting that the patient is currently on Andembry, Dawnzera, Orladeyo, or Takhzyro therapy

Notes

Please note: Preferred agents are Cinryze and Haegarda.

Product Name: Berinert, Cinryze (off-label), Ekterly, Brand Firazyr, generic icatibant, Kalbitor, Ruconest, Sajazir

Diagnosis	Treatment of acute HAE attacks

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting diagnosis of hereditary angioedema (HAE) confirmed by ONE of the following:

1.1 C1 inhibitor (C1-INH) deficiency or dysfunction (Type I or II HAE) as documented by ONE of the following (per laboratory standard):

- C1-INH antigenic level below the lower limit of normal
- C1-INH functional level below the lower limit of normal

OR

1.2 HAE with normal C1 inhibitor levels and ONE of the following:

- Confirmed presence of a FXII, angiopoietin-1, or plasminogen gene mutation
- Recurring angioedema attacks that are refractory to high-dose antihistamines with confirmed family history of angioedema

AND

2 - For the treatment of acute HAE attacks

AND

3 - NOT used in combination with other approved treatments for acute HAE attacks

AND

4 - ONE of the following:

- If the request is for Cinryze, patient is 6 years of age or older
- If the request is for Ekterly or Kalbitor, patient is 12 years of age or older
- If the request is for Brand Firazyr, generic icatibant, or Sajazir, patient is 18 years of age or older

AND

5 - Prescribed by or in consultation with ONE of the following:

- Immunologist
- Allergist

AND

6 - If the request is for Ekterly, Brand Firazyr, Ruconest, or Sajazir, ONE of the following:

6.1 Submission of medical records documenting a history of failure, contraindication, or intolerance to ALL of the following preferred HAE agents:

- Berinert
- Cinryze
- generic icatibant
- Kalbitor

OR

6.2 Submission of medical records or paid claims documenting that the patient is currently on Ekterly, Brand Firazyr, Ruconest, or Sajazir therapy

Notes	Please note: Preferred HAE agents are Berinert, Cinryze, generic icatibant, and Kalbitor.

2 . Revision History

Date	Notes
3/12/2026	Added GPIs for Orladeyo pellet formulation as targets. Updated age criterion to specify Oraldeyo pellets applies to 2 years or older and Orladeyo capsules applies to 12 years or older. Updated embedded step criterion to reflect Haegarda moving to preferred status. Updated notes section, where applicable.

Hetlitz, Hetlitz LQ (tasimelton)



Prior Authorization Guideline

Guideline ID	GL-150117
Guideline Name	Hetlitz, Hetlitz LQ (tasimelton)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	8/1/2024

1 . Criteria

Product Name: Brand Hetlitz capsule, generic tasimelton capsule	
Diagnosis	Non-24-Hour Sleep-Wake Disorder (Non-24)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting diagnosis of non-24-hour sleep-wake disorder (also known as free-running disorder, free-running or non-entrained type	

circadian rhythm sleep disorder, or hypernyctthemeral syndrome) confirmed by meeting ONE of the following conditions:

1.1 Assessment of at least one physiologic circadian phase marker [e.g., measurement of urinary melatonin levels, dim light melatonin onset (as measured in blood or saliva), assessment of core body temperature]

OR

1.2 If assessment of at least one physiologic circadian phase marker cannot be done, the diagnosis must be confirmed by actigraphy performed for at least 1 week plus evaluation of sleep logs recorded for at least 1 month

AND

2 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting patient is totally blind (has no light perception)*

AND

3 - Patient is 18 years of age or older

AND

4 - Patient has received at least 3 months of continuous therapy (i.e., 3 consecutive months of daily treatment) under the guidance of a physician who specializes in the treatment of sleep disorders of BOTH of the following:

- Melatonin
- Rozerem (ramelteon)

AND

5 - Prescribed by or in consultation with ONE of the following:

- Specialist in sleep disorders
- Neurologist

AND

6 - If the request is for Brand Hetlioz capsules, history of failure, intolerance, or contraindication to generic tasimelteon

Notes	*Requests for patients who are sighted (non-blinded) will be reviewed on a case-by-case basis

Product Name:Brand Hetlioz capsule, generic tasimelteon capsule

Diagnosis	Non-24-Hour Sleep-Wake Disorder (Non-24)

Approval Length	6 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting positive clinical response to therapy (e.g., entrainment, clinically meaningful or significant increases in nighttime sleep, clinically meaningful or significant decreases in daytime sleep)

AND

2 - Submission of patient's sleep log demonstrating positive clinical response to therapy

AND

3 - If the request is for Brand Hetlioz capsules, history of failure, intolerance, or contraindication to generic tasimelteon

Product Name:Brand Hetlioz capsule, generic tasimelteon capsule

Diagnosis	Smith-Magenis Syndrome (SMS)

Approval Length	6 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of Smith-Magenis Syndrome (SMS)

AND

2 - Submission of test results confirming patient has microdeletion of the chromosome band 17p11.2 by fluorescent in situ hybridization (FISH) analysis

AND

3 - Patient is 16 years of age or older

AND

4 - Patient is experiencing nighttime sleep disturbances (i.e., difficulty falling asleep, frequent nighttime waking and early waking)

AND

5 - Patient has received at least 3 months of continuous therapy (i.e., 3 consecutive months of daily treatment) under the guidance of a physician who specializes in the treatment of sleep disorders of BOTH of the following:

- Melatonin
- Rozerem (ramelteon) (unless contraindicated due to patient age)

AND

6 - Prescribed by or in consultation with ONE of the following:

- Specialist in sleep disorders
- Neurologist

AND

7 - If the request is for Brand Hetlioz capsules, history of failure, intolerance, or contraindication to generic tasimelteon

Product Name:Hetlioz LQ suspension

Diagnosis	Smith-Magenis Syndrome (SMS)

Approval Length	6 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of Smith-Magenis Syndrome (SMS)

AND

2 - Submission of test results confirming patient has microdeletion of the chromosome band 17p11.2 by fluorescent in situ hybridization (FISH) analysis

AND

3 - Patient is 3 through 15 years of age

AND

4 - Patient is experiencing nighttime sleep disturbances (i.e., difficulty falling asleep, frequent nighttime waking and early waking)

AND

5 - Patient has received at least 3 months of continuous therapy (i.e., 3 consecutive months of

daily treatment) of melatonin under the guidance of a physician who specializes in the treatment of sleep disorders

AND

6 - Prescribed by or in consultation with ONE of the following:

- Specialist in sleep disorders
- Neurologist

Product Name: Brand Hetlioz capsule, generic tasimelteon capsule, Hetlioz LQ suspension	
Diagnosis	Smith-Magenis Syndrome (SMS)
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting positive clinical response to therapy (i.e., improvement in nighttime total sleep time, improvement in nighttime sleep quality) AND 2 - Submission of patient's sleep log demonstrating positive clinical response to therapy AND 3 - If the request is for Brand Hetlioz capsules, history of failure, intolerance, or contraindication to generic tasimelteon	

2 . Revision History

UnitedHealthcare Community Plan of Arizona Clinical Pharmacy Program Guidelines

Date	Notes
7/22/2024	Added generic tasimelteon capsules as a target to the guideline. Added embedded step, where applicable, where Brand Hetlioz capsule requests must step through generic tasimelteon. Updated product name lists and GPI tables accordingly.

High Cost Oral Atypical Antipsychotics (Caplyta, Cobenfy, Fanapt, Lybalvi, Rexulti, Vraylar)



Prior Authorization Guideline

Guideline ID	GL-519189
Guideline Name	High Cost Oral Atypical Antipsychotics (Caplyta, Cobenfy, Fanapt, Lybalvi, Rexulti, Vraylar)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name:Caplyta, Fanapt, Lybalvi, Rexulti, Vraylar	
Diagnosis	Schizophrenia
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of schizophrenia	

AND

2 - ONE of the following:

2.1 If the request is for Rexulti or Vraylar, patient is 13 years of age or older

OR

2.2 If the request is for Caplyta, Fanapt, or Lybalvi, patient is 18 years of age or older

AND

3 - ONE of the following:

3.1 Inadequate response (minimum 30 day trial) or adverse reaction to TWO of the following:

- Aripiprazole
- Clozapine
- Olanzapine
- Quetiapine
- Risperidone
- Ziprasidone

OR

3.2 Contraindication to ALL of the following:

- Aripiprazole
- Clozapine
- Olanzapine
- Quetiapine
- Risperidone
- Ziprasidone

OR

3.3 The patient has been receiving treatment with the requested medication and is new to the plan (enrollment effective date within the past 90 days)

OR

3.4 The patient is currently receiving treatment with the requested medication in the hospital and must continue upon discharge

AND

4 - If the request is for Lybalvi, ONE of the following:

4.1 Patient has a body mass index (BMI) of 30 kg/m² or greater

OR

4.2 Patient has a BMI of 27 kg/m² or greater with a weight-related comorbidity (e.g., dyslipidemia, hypertension, type 2 diabetes, sleep apnea)

OR

4.3 Patient has a documented history of weight gain of greater than or equal to 10% of their baseline weight after initiating antipsychotic medication

OR

4.4 Physician has provided clinical rationale for requiring samidorphan in addition to olanzapine therapy

Product Name:Cobenfy	
Diagnosis	Schizophrenia
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of schizophrenia

AND

2 - ONE of the following:

2.1 BOTH of the following:

2.1.1 Inadequate response (minimum 30 day trial), adverse reaction, or contraindication to aripiprazole

AND

2.1.2 ONE of the following:

2.1.2.1 Inadequate response (minimum 30 day trial) or adverse reaction to ONE of the following:

- Clozapine
- Olanzapine
- Quetiapine
- Risperidone
- Ziprasidone

OR

2.1.2.2 Contraindication to ALL of the following:

- Clozapine
- Olanzapine
- Quetiapine
- Risperidone
- Ziprasidone

OR

2.2 The patient has been receiving treatment with the requested medication and is new to the plan (enrollment effective date within the past 90 days)

OR

2.3 The patient is currently receiving treatment with the requested medication in the hospital and must continue upon discharge

Product Name: Fanapt, Lybalvi, Vraylar

Diagnosis	Bipolar I Disorder

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of bipolar I disorder

AND

2 - ONE of the following:

2.1 If the request is for Vraylar, patient is 10 years of age or older

OR

2.2 If the request is for Fanapt or Lybalvi, patient is 18 years of age or older

AND

3 - ONE of the following:

3.1 Inadequate response (minimum 30 day trial) or adverse reaction to THREE of the following:

- Aripiprazole
- Lamotrigine
- Lithium

- Lurasidone
- Olanzapine
- Risperidone
- Valproate

OR

3.2 Contraindication to ALL of the following:

- Aripiprazole
- Lamotrigine
- Lithium
- Lurasidone
- Olanzapine
- Risperidone
- Valproate

OR

3.3 The patient has been receiving treatment with the requested medication and is new to the plan (enrollment effective date within the past 90 days)

OR

3.4 The patient is currently receiving treatment with the requested medication in the hospital and must continue upon discharge

AND

4 - If the request is for Lybalvi, ONE of the following:

4.1 Patient has a body mass index (BMI) of 30 kg/m² or greater

OR

4.2 Patient has a BMI of 27 kg/m² or greater with a weight-related comorbidity (e.g., dyslipidemia, hypertension, type 2 diabetes, sleep apnea)

OR

4.3 Patient has a documented history of weight gain of greater than or equal to 10% of their baseline weight after initiating antipsychotic medication

OR

4.4 Physician has provided clinical rationale for requiring samidorphan in addition to olanzapine therapy

Product Name: Caplyta, Vraylar

Diagnosis	Bipolar Depression

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of bipolar depression

AND

2 - ONE of the following:

2.1 Inadequate response (minimum 30 day trial) or adverse reaction to **THREE** of the following:

- Lurasidone
- Quetiapine
- Olanzapine plus fluoxetine
- Valproate monotherapy
- Combination Therapy (i.e., lithium plus lamotrigine/valproate, lurasidone plus lithium/valproate, quetiapine plus lithium/valproate)

OR

2.2 Contraindication to ALL of the following:

- Lurasidone
- Quetiapine
- Olanzapine plus fluoxetine
- Valproate monotherapy
- Combination Therapy (i.e., lithium plus lamotrigine/valproate, lurasidone plus lithium/valproate, quetiapine plus lithium/valproate)

OR

2.3 The patient has been receiving treatment with the requested medication and is new to the plan (enrollment effective date within the past 90 days)

OR

2.4 The patient is currently receiving treatment with the requested medication in the hospital and must continue upon discharge

Product Name:Caplyta, Rexulti, Vraylar	
Diagnosis	Major Depressive Disorder (MDD)
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Diagnosis of major depressive disorder (MDD) OR 1.2 If the request is for Vraylar, diagnosis of treatment resistant depression	

AND

2 - ONE of the following:

2.1 BOTH of the following:

2.1.1 Inadequate response (minimum 30 day trial) or adverse reaction to TWO different antidepressants from the following classes (antidepressants MUST be from TWO different classes):

- Selective Serotonin Reuptake Inhibitors (SSRIs)
- Serotonin Norepinephrine Reuptake Inhibitors (SNRIs)
- New Generation Antidepressants (e.g., bupropion, mirtazapine, etc)
- Tricyclic Antidepressants (TCAs)

AND

2.1.2 Inadequate response (minimum 30 day trial) or adverse reaction to TWO of the following:

- Aripiprazole
- Quetiapine ER
- Risperidone
- Augmented Therapy (e.g., addition of lithium, another antidepressant from a different class, thyroid hormone to current antidepressant regimen)

OR

2.2 The patient has been receiving treatment with the requested medication and is new to the plan (enrollment effective date within the past 90 days)

OR

2.3 The patient is currently receiving treatment with the requested medication in the hospital and must continue upon discharge

Product Name:Rexulti	
Diagnosis	Agitation Associated with Dementia Due to Alzheimer's Disease

Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - The requested medication is being used for treatment of agitation associated with dementia due to Alzheimer's disease	

Product Name:Caplyta, Cobenfy, Fanapt, Lybalvi, Rexulti, Vraylar	
Approval Length	12 month(s)
Guideline Type	Quantity Limit
Approval Criteria 1 - ONE of the following: 1.1 The requested drug must be used for a Food and Drug Administration-approved indication or 1.2 The use of this drug is supported by information from one of the following appropriate compendia of current literature: Food and Drug Administration approved indications and limits Published practice guidelines and treatment protocols Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits, and potential patient outcomes Drug Facts and Comparisons American Hospital Formulary Service Drug Information United States Pharmacopeia - Drug Information DRUGDEX Information System UpToDate MicroMedex Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data, and pharmacoeconomic studies	

Other drug reference resources

AND

2 - ONE of the following:

2.1 The drug is being prescribed within the manufacturer's published dosing guidelines

or

2.2 The requested dose falls within dosing guidelines found in ONE of the following compendia of current literature:

Food and Drug Administration approved indications and limits

Published practice guidelines and treatment protocols

Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits, and potential patient outcomes

Drug Facts and Comparisons

American Hospital Formulary Service Drug Information

United States Pharmacopeia - Drug Information

DRUGDEX Information System

UpToDate

MicroMedex

Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data, and pharmacoeconomic studies

Other drug reference resources

AND

3 - The requested dosage cannot be achieved using the plan accepted quantity limit of a different dose or formulation

AND

4 - The drug is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plans' program

AND

5 - Physician has provided rationale for needing to exceed the quantity limit of ONE of the following:

For Caplyta requests, QL of 1 capsule/day

For Cobenfy capsule requests, QL of 2 capsules/day

For Cobenfy starter pack requests, QL of 2 packs/365 days

For Fanapt tablet requests, QL of 2 tablets/day

For Fanapt titration pack requests, QL of 1 pack/180 days

For Lybalvi requests, QL of 1 tablet/day

For Rexulti requests, QL of 1 tablet/day

For Vraylar 1.5 mg and 3 mg requests, QL of 2 capsules/day

For Vraylar 4.5 mg and 6 mg requests, QL of 1 capsule/day

For Vraylar therapy pack requests, 2 packs/365 days

2 . Revision History

Date	Notes
2/9/2026	For certain target drugs, added age restriction for schizophrenia and bipolar I disorder. Updated formatting in MDD section with no changes to clinical intent.

HIV (Fuzeon, Selzentry)



Prior Authorization Guideline

Guideline ID	GL-162015
Guideline Name	HIV (Fuzeon, Selzentry)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	1/15/2025

1 . Criteria

Product Name: Brand Selzentry tablets, generic maraviroc tablets, Selzentry oral solution	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following: 1.1 All of the following: 1.1.1 Diagnosis of CCR5-tropic HIV-1 infection as confirmed by a highly sensitive tropism assay	

AND

1.1.2 Patient is currently taking or will be prescribed an optimized background antiretroviral therapy regimen

AND

1.1.3 Prescribed by or in consultation with a clinician with HIV expertise

OR

1.2 For continuation of prior therapy

AND

2 - If the request is for Brand Selzentry tablets or Selzentry oral solution, history of failure or intolerance to generic maraviroc tablets

Product Name:Fuzeon	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following: 1.1 All of the following: 1.1.1 Patient has been diagnosed with multidrug-resistant HIV-1 infection AND	

1.1.2 Patient is currently taking or will be prescribed an optimized background antiretroviral therapy regimen

AND

1.1.3 Prescribed by or in consultation with a clinician with HIV expertise

OR

1.2 For continuation of prior therapy

2 . Revision History

Date	Notes
12/12/2024	Updated embedded step where Brand Selzentry tablets and Selzentry oral solution now require step through generic maraviroc tablets.

Hydroxychloroquine



Prior Authorization Guideline

Guideline ID	GL-140651
Guideline Name	Hydroxychloroquine
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2020

1 . Criteria

Product Name: Brand Plaquenil, generic hydroxychloroquine	
Guideline Type	Quantity Limit
Approval Criteria 1 - ONE of the following: 1.1 Treatment of chronic discoid lupus erythematosus or systemic lupus erythematosus OR	

1.2 Treatment of rheumatoid arthritis

OR

1.3 Prophylaxis of malaria in geographic areas where chloroquine resistance is not reported

OR

1.4 Treatment of uncomplicated malaria

Notes	Authorization will be issued for 6 months up to a quantity of 120 tablets per 30 days.

2 . Revision History

Date	Notes
4/6/2020	C&S Implementation

Hyftor (sirolimus) topical gel



Prior Authorization Guideline

Guideline ID	GL-140739
Guideline Name	Hyftor (sirolimus) topical gel
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	12/1/2022

1 . Criteria

Product Name:Hyftor	
Approval Length	4 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of facial angiofibroma associated with tuberous sclerosis complex	

AND	
2 - Patient is 6 years of age or older	
AND	
3 - Patient is not a candidate for laser therapy or surgical treatments	
AND	
4 - Prescribed by or in consultation with a dermatologist	

Product Name:Hyftor	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy (e.g., improvement in size or redness of facial angiofibroma)	

2 . Revision History

Date	Notes
10/21/2022	new GL

Icotyde (icotrokinra)



Prior Authorization Guideline

Guideline ID	GL-605193
Guideline Name	Icotyde (icotrokinra)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Icotyde	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of moderate to severe plaque psoriasis (PsO)	

AND

2 - BOTH of the following:

- Patient is 12 years of age or older
- Patient weighs at least 40 kg (kilograms)

AND

3 - ONE of the following:

- Greater than or equal to 3% body surface area involvement
- Severe scalp psoriasis
- Palmoplantar (i.e., palms, soles), facial, or genital involvement

AND

4 - Paid claims or submission of medical records (e.g., chart notes) confirming a trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to **ONE** of the following topical therapies:

- corticosteroids (e.g., betamethasone, clobetasol)
- vitamin D analogs (e.g., calcitriol, calcipotriene)
- tazarotene
- calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)

AND

5 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming **ALL** of the following:

5.1 History of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

5.2 History of failure, contraindication, or intolerance to ONE of the following topical therapies:

- Vtama
- Zoryve 0.3% cream

AND

5.3 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred^ adalimumab biosimilar or Enbrel (etanercept)
- infliximab
- Otezla (apremilast)
- A preferred^ ustekinumab biosimilar

AND

6 - Prescribed by or in consultation with a dermatologist

Notes	^PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC CP

Product Name: Icotyde	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient demonstrates positive clinical response to therapy as evidenced by ONE of the following: • Reduction in the body surface area (BSA) involvement from baseline • Improvement in symptoms (e.g., pruritus, inflammation) from baseline AND	

2 - Prescribed by or in consultation with a dermatologist

2 . Revision History

Date	Notes
5/6/2026	New program.

Igalmi (dexmedetomidine)



Prior Authorization Guideline

Guideline ID	GL-140740
Guideline Name	Igalmi (dexmedetomidine)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	12/1/2022

1 . Criteria

Product Name:Igalmi	
Approval Length	14 Day(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following diagnoses: - Schizophrenia - Bipolar I or II disorder	

AND

2 - For the treatment of acute agitation

AND

3 - Trial and failure, contraindication or intolerance to at least two preferred products used in acute agitation (e.g., olanzapine, ziprasidone)

AND

4 - Patient is currently being managed with maintenance medication for their underlying disorder (e.g., aripiprazole, olanzapine, quetiapine, lithium, valproic acid)

2 . Revision History

Date	Notes
10/24/2022	New

Ilaris (canakinumab)



Prior Authorization Guideline

Guideline ID	GL-324202
Guideline Name	Ilaris (canakinumab)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	8/1/2025

1 . Criteria

Product Name:Ilaris	
Diagnosis	Periodic Fever Syndromes [Cryopyrin-Associated Periodic Syndromes (CAPS), Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS), Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency(MKD), Familial Mediterranean Fever(FMF)]
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of ONE of the following periodic fever syndromes:

- Cryopyrin-associated periodic syndromes (CAPS), including familial cold autoinflammatory syndrome (FCAS) and Muckle-Wells syndrome (MWS)
- Tumor necrosis factor (TNF) receptor associated periodic syndrome (TRAPS)
- Hyperimmunoglobulin D (Hyper-IgD) syndrome (HIDS/mevalonate kinase deficiency (MKD))
- Familial Mediterranean Fever (FMF)

AND

2 - Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Immunologist

AND

3 - BOTH of the following:

- Patient is not receiving concomitant treatment with Tumor Necrosis Factor (TNF) inhibitors (e.g., Enbrel [etanercept], Humira [adalimumab], Remicade [infliximab])
- Patient is not receiving concomitant treatment with Interleukin-1 inhibitor (e.g., Arcalyst [rilonacept], Kineret [anakinra])

AND

4 - Patients diagnosed with Familial Mediterranean Fever (FMF) have a history of failure, contraindication, or intolerance to colchicine (applies to diagnosis of FMF ONLY)

Product Name: Ilaris	
Diagnosis	Periodic Fever Syndrome [CAPS, TRAPS, HIDS/MKD, FMF]
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy [defined as a decrease in frequency or severity of attacks, or a decrease in index disease flare or normalization of CRP (C-reactive protein)]

AND

2 - BOTH of the following:

- Patient is not receiving concomitant treatment with Tumor Necrosis Factor (TNF) inhibitors (e.g., Enbrel [etanercept], Humira [adalimumab], Remicade [infliximab])
- Patient is not receiving concomitant treatment with Interleukin-1 inhibitor (e.g., Arcalyst [rilonacept], Kineret [anakinra])

Product Name:Ilaris	
Diagnosis	Systemic Juvenile Idiopathic Arthritis (SJIA)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of active systemic juvenile idiopathic arthritis (SJIA) AND 2 - Paid claims or submission of medical records (e.g., chart notes) confirming a trial and failure, contraindication, or intolerance to ONE of the following conventional therapies at maximally tolerated doses: • Minimum duration of a 3-month trial and failure of methotrexate	

- Minimum duration of a 1-month trial of a nonsteroidal anti-inflammatory drug (NSAID) (e.g., ibuprofen, naproxen)
- Minimum duration of a 2-week trial of a systemic glucocorticoid (e.g., prednisone)

AND

3 - Paid claims or submission of medical records (e.g., chart notes) confirming a trial and failure, contraindication, or intolerance to a preferred[^] tocilizumab biosimilar

AND

4 - BOTH of the following:

- Patient is not receiving concomitant treatment with Tumor Necrosis Factor (TNF) inhibitors (e.g., Enbrel [etanercept], Humira [adalimumab], Remicade [infliximab])
- Patient is not receiving concomitant treatment with Interleukin-1 inhibitor (e.g., Arcalyst [rilonacept], Kineret [anakinra])

AND

5 - Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Immunologist

Notes	[^] PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC CP

Product Name: Ilaris	
Diagnosis	Systemic Juvenile Idiopathic Arthritis (SJIA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Documentation of positive clinical response to therapy as evidenced by at least ONE of the following:

- Reduction in the total active (swollen and tender) joint count from baseline
- Improvement in clinical features or symptoms (e.g., pain, fever, inflammation, rash, lymphadenopathy, serositis) from baseline

AND

2 - BOTH of the following:

- Patient is not receiving concomitant treatment with Tumor Necrosis Factor (TNF) inhibitors (e.g., Enbrel [etanercept], Humira [adalimumab], Remicade [infliximab])
- Patient is not receiving concomitant treatment with Interleukin-1 inhibitor (e.g., Arcalyst [rilonacept], Kineret [anakinra])

Product Name: Ilaris	
Diagnosis	Still's Disease
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of Still's Disease, including Adult-Onset Still's Disease (AOSD) AND 2 - Paid claims or submission of medical records (e.g., chart notes) confirming a trial and failure, contraindication, or intolerance to ONE of the following: • Corticosteroids (e.g., prednisone) • Methotrexate • Nonsteroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen, naproxen)	

AND

3 - BOTH of the following:

- Patient is not receiving concomitant treatment with Tumor Necrosis Factor (TNF) inhibitors (e.g., Enbrel [etanercept], Humira [adalimumab], Remicade [infliximab])
- Patient is not receiving concomitant treatment with Interleukin-1 inhibitor (e.g., Arcalyst [rilonacept], Kineret [anakinra])

AND

4 - Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Immunologist

Product Name: Ilaris

Diagnosis	Still's Disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - BOTH of the following:

- Patient is not receiving concomitant treatment with Tumor Necrosis Factor (TNF) inhibitors (e.g., Enbrel [etanercept], Humira [adalimumab], Remicade [infliximab])
- Patient is not receiving concomitant treatment with Interleukin-1 inhibitor (e.g., Arcalyst [rilonacept], Kineret [anakinra])

Product Name: Ilaris	
Diagnosis	Gout Flares
Approval Length	12 Week(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of gout flares

AND

2 - Paid claims or submission of medical records (e.g., chart notes) confirming a trial and failure, contraindication, or intolerance to ALL of the following:

- Nonsteroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen, naproxen)
- Colchicine
- Corticosteroids (e.g., prednisone)

AND

3 - Patient has not received Ilaris in the last 12 weeks

AND

4 - Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Nephrologist

2 . Revision History

Date	Notes

7/15/2025	In initial auth section for SJIA, added embedded step through preferred tocilizumab biosimilar and added PDL link in notes section. Minor cosmetic updates.

Ilumya (tildrakizumab-asmn)



Prior Authorization Guideline

Guideline ID	GL-155408
Guideline Name	Ilumya (tildrakizumab-asmn)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name:Ilumya	
Diagnosis	Chronic Moderate to Severe Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 ALL of the following:	

1.1.1 Diagnosis of chronic moderate to severe plaque psoriasis

AND

1.1.2 Greater than or equal to 3 percent body surface area involvement, palmoplantar, facial, genital involvement, or severe scalp psoriasis

AND

1.1.3 Submission of medical records (e.g., chart notes) or paid claims documenting history of failure, to ONE of the following topical therapies, unless contraindicated or clinically significant adverse effects are experienced:

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Anthralin
- Coal tar

AND

1.1.4 Submission of medical records (e.g., chart notes) or paid claims documenting history of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

1.1.5 Submission of medical records (e.g., chart notes) or paid claims documenting history of failure, contraindication, or intolerance to ALL of the following preferred biologic products:

- A preferred* adalimumab biosimilar
- Enbrel (etanercept)
- Otezla (apremilast)

AND

1.1.6 Patient is NOT receiving Ilumya in combination with ONE of the following:

- Biologic DMARD (disease modifying anti-rheumatic drug) [e.g., Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab), Cosentyx (secukinumab), Orencia (abatacept)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g. Otezla (apremilast)]

AND

1.1.7 Prescribed by or in consultation with a dermatologist

OR

1.2 ALL of the following:

1.2.1 Submission of medical records (e.g., chart notes) or paid claims documenting patient is currently on the requested therapy

AND

1.2.2 Diagnosis of chronic moderate to severe plaque psoriasis

AND

1.2.3 Patient is NOT receiving Ilumya in combination with ONE of the following:

- Biologic DMARD [e.g., Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab), Cosentyx (secukinumab), Orencia (abatacept)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g. Otezla (apremilast)]

AND

1.2.4 Prescribed by or in consultation with a dermatologist

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:Ilumya	
Diagnosis	Chronic Moderate to Severe Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Ilumya therapy AND 2 - Patient is NOT receiving Ilumya in combination with ONE of the following: • Biologic DMARD (disease modifying anti-rheumatic drug) [e.g., Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab), Cosentyx (secukinumab), Orencia (abatacept)] • Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)] • Phosphodiesterase 4 (PDE4) inhibitor [e.g. Otezla (apremilast)] AND 3 - Prescribed by or in consultation with a dermatologist	

2 . Revision History

Date	Notes
9/23/2024	Update to guideline name; Added submission of medical records or p aid claims verbiage; Updated embedded steps and notes section.

Iluvien (fluocinolone implant)



Prior Authorization Guideline

Guideline ID	GL-382212
Guideline Name	Iluvien (fluocinolone implant)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2025

1 . Criteria

Product Name:Iluvien	
Diagnosis	Uveitis
Approval Length	3 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming ONE of the following diagnoses: Intermediate uveitis	

- Posterior uveitis
- Panuveitis

AND

2 - Inflammation is chronic

AND

3 - Inflammation is NOT due to an infection

Product Name: Iluvien	
Diagnosis	Diabetic Macular Edema
Approval Length	3 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of diabetic macular edema AND 2 - Patient has previously been treated with a course of corticosteroids AND 3 - Patient has NOT had a clinically significant rise in intraocular pressure	

2 . Revision History

Date	Notes

9/5/2025	New program for ACUAZ/ACUAZEC.

Imaavy (nipocalimab)



Prior Authorization Guideline

Guideline ID	GL-500227
Guideline Name	Imaavy (nipocalimab)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name: Imaavy	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of generalized myasthenia gravis (gMG)	

AND

2 - Submission of medical records (e.g., chart notes) or verification of paid claims documenting ONE of the following:

2.1 BOTH of the following:

2.1.1 Patient is anti-acetylcholine receptor (AChR) antibody positive

AND

2.1.2 ONE of the following:

2.1.2.1 Trial and failure, contraindication, or intolerance to TWO immunosuppressive therapies (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus)

OR

2.1.2.2 BOTH of the following:

2.1.2.2.1 Trial and failure, contraindication, or intolerance to ONE immunosuppressive therapy (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus)

AND

2.1.2.2.2 Trial and failure, contraindication, or intolerance to ONE of the following:

- Chronic plasmapheresis or plasma exchange (PE)
- Intravenous immunoglobulin (IVIG)

OR

2.2 BOTH of the following:

2.2.1 Patient is anti-muscle-specific tyrosine kinase (MuSK) antibody positive

AND

2.2.2 ONE of the following:

2.2.2.1 Trial and failure, contraindication, or intolerance to TWO immunosuppressive therapies (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus)

OR

2.2.2.2 BOTH of the following:

2.2.2.2.1 Trial and failure, contraindication, or intolerance to ONE immunosuppressive therapy (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus)

AND

2.2.2.2.2 Trial and failure, contraindication, or intolerance to ONE of the following:

- Chronic plasmapheresis or plasma exchange (PE)
- Intravenous immunoglobulin (IVIG)
- Rituximab

AND

3 - Patient is 12 years of age or older

AND

4 - Prescribed by or in consultation with a neurologist

Product Name: Imaavy	
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Patient demonstrates positive clinical response to therapy	

2 . Revision History

Date	Notes
1/16/2026	New program for ACUAZ/ACUAZEC.

Imcivree (setmelanotide)



Prior Authorization Guideline

Guideline ID	GL-164787
Guideline Name	Imcivree (setmelanotide)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	3/1/2025

1 . Criteria

Product Name:Imcivree	
Diagnosis	POMC, PCSK1, LEPR Deficiency
Guideline Type	Prior Authorization
Approval Criteria 1 - Requests for POMC, PCSK1, LEPR Deficiency is excluded and is to be denied as a benefit exclusion	

Product Name:Imcivree

Diagnosis	Bardet-Biedl syndrome (BBS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting ALL of the following:

1.1 BOTH of the following:

- Diagnosis of Bardet-Biedl syndrome (BBS)
- Molecular genetic testing to confirm homozygous variants in a BBS gene that are interpreted as pathogenic or likely pathogenic (results of genetic testing must be submitted)

AND

1.2 ONE of the following:

1.2.1 Patient has at least THREE of the following primary features of the disease:

- Rod-cone dystrophy
- Polydactyly
- Learning disabilities
- Hypogonadotropic hypogonadism and/or genitourinary anomalies
- Renal anomalies

OR

1.2.2 BOTH of the following:

1.2.2.1 Patient has at least TWO of the following primary features of the disease:

- Rod-cone dystrophy
- Polydactyly
- Learning disabilities
- Hypogonadotropic hypogonadism and/or genitourinary anomalies
- Renal anomalies

AND

1.2.2.2 Patient has at least TWO of the following secondary features of the disease:

- Speech disorder/delay
- Strabismus/cataracts/astigmatism
- Brachydactyly/syndactyly
- Developmental delay
- Ataxia/poor coordination/imbalance
- Mild spasticity (especially lower limbs)
- Diabetes mellitus
- Dental crowding/hypodontia/small roots/high arched palate
- Left ventricular hypertrophy/congenital heart disease
- Hepatic fibrosis

AND

1.3 Patient has been diagnosed with obesity defined by ONE of the following:

- BMI greater than or equal to 30 kg/m² for adults 18 years of age or older
- Weight greater than or equal to 95th percentile using growth chart assessments for pediatric patients

AND

1.4 Patient is 2 years of age or older

AND

1.5 Other causes or types of obesity have been ruled out (e.g., obesity due to suspected POMC, PCSK1, or LEPR deficiency with POMC, PCSK1, or LEPR variants classified as benign or likely benign; obesity associated with other genetic syndromes; polygenic obesity)

AND

2 - Prescribed by or in consultation with an endocrinologist

Product Name:Imcivree	
Diagnosis	Bardet-Biedl syndrome (BBS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting BOTH of the following: 1.1 Patient has been on therapy for 12 months or more AND 1.2 Weight loss of greater than or equal to 5% of baseline body weight or BMI	

2 . Revision History

Date	Notes
2/5/2025	Update to guideline name. Updated age criterion for BBS indication due to expanded approval. Minor cosmetic updates.

Immune Globulins



Prior Authorization Guideline

Guideline ID	GL-552230
Guideline Name	Immune Globulins
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	4/12/2026

1 . Criteria

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify	
Diagnosis	Asthma (severe, persistent, high-dose steroid-dependent)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following diagnoses:	

- Severe asthma
- Persistent asthma
- High-dose steroid-dependent asthma

AND

2 - Submission of medical records (e.g., chart notes) documenting BOTH of the following:

- History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable
- Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested

AND

3 - Patient is receiving optimal conventional asthma therapy (e.g., high-dose inhaled glucocorticoids, short- and long-acting inhaled β agonists)

AND

4 - History of failure, contraindication, or intolerance to at least TWO of the following:

- Anti-IgE therapy [e.g., Xolair (omalizumab)]
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Anti-interleukin 5 therapy [e.g., Nucala (mepolizumab), Cinqair (reslizumab), Fasenra (benralizumab)]

AND

5 - Patient has required continuous oral glucocorticoid therapy for a minimum of 2 months prior to the decision to initiate immune globulin therapy

AND

6 - For long term treatment, documentation of titration to the minimum dose and frequency needed to maintain a sustained clinical effect

AND

7 - Prescribed by or in consultation with a pulmonologist or allergist or immunologist

AND

8 - If the request is for a non-preferred* product, there must be a history of failure, contraindication, or intolerance to ALL the following products:

- Bivigam
- Cutaquig
- Flebogamma
- Gammagard Liquid
- Gammagard S-D
- Gammaked
- Gammaplex
- Gamunex-C
- Hizentra
- Octagam
- Privigen
- Xembify

Notes

*PDL link: <https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC CP>

Product Name: HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify

Diagnosis	Asthma (severe, persistent, high-dose steroid-dependent)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to immune globulin therapy

AND

2 - Statement of expected frequency and duration of proposed immune globulin treatment

AND

3 - For long term treatment, documentation of titration to the minimum effective dose and frequency needed to maintain a sustained clinical response

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify

Diagnosis	Autoimmune Bullous Disease [pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, mucous membrane (cicatricial) pemphigoid, epidermolysis bullosa acquisita, pemphigoid gestationis, linear IgA bullous dermatosis]
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Autoimmune Bullous Disease [pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, mucous membrane (cicatricial) pemphigoid, epidermolysis bullosa acquisita, pemphigoid gestationis, linear IgA bullous dermatosis]

AND

2 - Submission of medical records (e.g., chart notes) documenting BOTH of the following:

- History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable
- Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested

AND

3 - Extensive and debilitating disease

AND

4 - History of failure, contraindication, or intolerance to systemic corticosteroids with concurrent immunosuppressive treatment (e.g., azathioprine, cyclophosphamide, mycophenolate mofetil)

AND

5 - Intravenous immunoglobulin (IVIG) dose does not exceed 1,000 to 2,000 milligrams (mg) per kilogram (kg) per month divided into 3 equal doses, each given over 3 consecutive days or 400 mg per kg per day given over 5 consecutive days per month. IVIG administration may be repeated monthly as needed for patients requiring maintenance therapy. Dosing interval may need to be adjusted in patients with severe comorbidities

AND

6 - For long term treatment, documentation of titration to the minimum dose and frequency needed to maintain a sustained clinical effect

AND

7 - If the request is for a non-preferred* product, there must be a history of failure, contraindication, or intolerance to ALL the following products:

- Bivigam
- Cutaquig
- Flebogamma
- Gammagard Liquid
- Gammagard S-D
- Gammaked
- Gammaplex
- Gamunex-C
- Hizentra
- Octagam
- Privigen

Xembify	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify	
Diagnosis	Autoimmune Bullous Disease [pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, mucous membrane (cicatricial) pemphigoid, epidermolysis bullosa acquisita, pemphigoid gestationis, linear IgA bullous dermatosis]
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to immune globulin therapy AND 2 - Statement of expected frequency and duration of proposed immune globulin treatment AND 3 - For long term treatment, documentation of titration to the minimum effective dose and frequency needed to maintain a sustained clinical response	

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify	
Diagnosis	Bone Marrow Transplant (BMT)
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following uses: • Prevention of acute graft vs. host disease (GVHD) • Prevention of infection AND 2 - Submission of medical records (e.g., chart notes) documenting BOTH of the following: • History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable • Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested AND 3 - Confirmed allogeneic bone marrow transplant within the last 100 days AND 4 - Documented severe hypogammaglobulinemia [Immunoglobulin (IgG) less than 400 milligrams (mg) per deciliter (dL)] AND 5 - Intravenous immunoglobulin (IVIG) dose does not exceed 500 mg per kilogram (kg) once weekly for the first 90 days of therapy, then monthly up to 360 days after transplantation AND	

6 - If the request is for a non-preferred* product, there must be a history of failure, contraindication, or intolerance to ALL the following products:

- Bivigam
- Cutaquig
- Flebogamma
- Gammagard Liquid
- Gammagard S-D
- Gammaked
- Gammaplex
- Gamunex-C
- Hizentra
- Octagam
- Privigen
- Xembify

Notes

*PDL link: <https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP>

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify

Diagnosis	Bone Marrow Transplant (BMT)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to immune globulin therapy

AND

2 - Statement of expected frequency and duration of proposed immune globulin treatment

AND

3 - For long term treatment, documentation of titration to the minimum effective dose and frequency needed to maintain a sustained clinical response

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify

Diagnosis	Chronic Inflammatory Demyelinating Polyneuropathy
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic inflammatory demyelinating polyneuropathy as confirmed by ALL of the following:

1.1 Progressive symptoms present for at least 2 months

AND

1.2 Symptomatic polyradiculoneuropathy as indicated by progressive or relapsing motor or sensory impairment of more than one limb

AND

1.3 Electrodiagnostic findings [consistent with European Federation of Neurological Societies/Peripheral Nerve Society (EFNS/PNS) guidelines for definite chronic inflammatory demyelinating polyradiculoneuropathy (CIDP)] indicating at least ONE of the following criteria are present:

- Motor distal latency prolongation in 2 nerves
- Reduction of motor conduction velocity in 2 nerves
- Prolongation of F-wave latency in 2 nerves
- Absence of F-waves in at least 1 nerve
- Partial motor conduction block of at least 1 motor nerve
- Abnormal temporal dispersion in at least 2 nerves
- Distal compound muscle action potential (CMAP) duration increase in at least 1 nerve

AND

2 - Submission of medical records (e.g., chart notes) documenting BOTH of the following:

- History and physical examination documenting the severity of the condition, including frequency and severity of infections where
- Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested

AND

3 - Prescribed by or in consultation with a neurologist

AND

4 - Intravenous immunoglobulin (IVIG) dose does not exceed 2,000 milligrams (mg) per kilogram (kg) per month given over 2 to 5 consecutive days administered in up to six monthly infusions. Dosing interval may need to be adjusted in patients with severe comorbidities.

AND

5 - If the request is for a non-preferred* product, there must be a history of failure, contraindication, or intolerance to ALL the following products:

- Bivigam
- Cutaquig
- Flebogamma
- Gammagard Liquid
- Gammagard S-D
- Gammaked
- Gammaplex
- Gamunex-C
- Hizentra
- Octagam
- Privigen
- Xembify

Notes

*PDL link: <https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP>

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify	
Diagnosis	Chronic Inflammatory Demyelinating Polyneuropathy
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy as measured by an objective scale [e.g., Rankin, Modified Rankin, Medical Research Council (MRC) scale] AND 2 - For long term treatment, documentation of titration to the minimum effective dose and frequency needed to maintain a sustained clinical response AND 3 - Prescribed by or in consultation with a neurologist AND 4 - Intravenous immunoglobulin (IVIG) dose does not exceed 2,000 milligrams (mg) per kilogram (kg) per month given over 2 to 5 consecutive days. IVIG administration may be repeated monthly as needed to prevent exacerbation. Dosing interval may need to be adjusted in patients with severe comorbidities.	

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify	
Diagnosis	Prevention of infection in B-cell Chronic Lymphocytic Leukemia (CLL)
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of B-cell chronic lymphocytic leukemia (CLL) AND 2 - Submission of medical records (e.g., chart notes) documenting BOTH of the following: - History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable - Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested AND 3 - ONE of the following: - Documented hypogammaglobulinemia [Immunoglobulin (IgG) less than 500 milligrams (mg) per deciliter (dL)] - History of bacterial infection(s) associated with B-cell CLL AND 4 - Intravenous immunoglobulin (IVIG) dose does not exceed 400 milligrams (mg) per kilogram (kg) every 3 to 4 weeks AND 5 - If the request is for a non-preferred* product, there must be a history of failure, contraindication, or intolerance to ALL the following products: - Bivigam - Cutaquig - Flebogamma - Gammagard Liquid	

• Gammagard S-D • Gammaked • Gammaplex • Gamunex-C • Hizentra • Octagam • Privigen • Xembify	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify	
Diagnosis	Prevention of infection in B-cell Chronic Lymphocytic Leukemia (CLL)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to immune globulin therapy AND 2 - Statement of expected frequency and duration of proposed immune globulin treatment AND 3 - For long term treatment, documentation of titration to the minimum effective dose and frequency needed to maintain a sustained clinical response	

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify

Diagnosis	Dermatomyositis or polymyositis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of dermatomyositis or polymyositis AND 2 - Submission of medical records (e.g., chart notes) documenting BOTH of the following: • History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable • Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested AND 3 - History of failure, contraindication, or intolerance to immunosuppressive therapy (e.g., azathioprine, corticosteroids, cyclophosphamide, methotrexate) AND 4 - Intravenous immunoglobulin (IVIG) dose does not exceed 2,000 milligrams (mg) per kilogram (kg) per month given over 2 to 5 consecutive days administered as monthly infusions. Dosing interval may need to be adjusted in patients with severe comorbidities AND 5 - For long term treatment, documentation of titration to the minimum dose and frequency needed to maintain a sustained clinical effect	

AND

6 - If the request is for a non-preferred* product, there must be a history of failure, contraindication, or intolerance to ALL the following products:

- Bivigam
- Cutaquig
- Flebogamma
- Gammagard Liquid
- Gammagard S-D
- Gammaked
- Gammaplex
- Gamunex-C
- Hizentra
- Octagam
- Privigen
- Xembify

Notes

*PDL link: <https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP>

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify

Diagnosis	Dermatomyositis or polymyositis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to immune globulin therapy

AND

2 - Statement of expected frequency and duration of proposed immune globulin treatment

AND

3 - For long term treatment, documentation of titration to the minimum effective dose and frequency needed to maintain a sustained clinical response

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify

Diagnosis	Diabetes Mellitus
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is newly diagnosed with insulin dependent (type 1) diabetes mellitus

AND

2 - Submission of medical records (e.g., chart notes) documenting BOTH of the following:

- History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable
- Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested

AND

3 - Patient is not a candidate for or is refractory to insulin therapy

AND

4 - If the request is for a non-preferred* product, there must be a history of failure, contraindication, or intolerance to ALL the following products:

• Bivigam • Cutaquig • Flebogamma • Gammagard Liquid • Gammagard S-D • Gammaked • Gammaplex • Gamunex-C • Hizentra • Octagam • Privigen • Xembify	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC CP

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify	
Diagnosis	Diabetes Mellitus
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to immune globulin therapy AND 2 - Statement of expected frequency and duration of proposed immune globulin treatment AND 3 - For long term treatment, documentation of titration to the minimum effective dose and frequency needed to maintain a sustained clinical response	

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify	
Diagnosis	Feto-neonatal Alloimmune Thrombocytopenia (AIT)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 For pregnant women, ALL of the following: 1.1.1 Diagnosis of feto-neonatal alloimmune thrombocytopenia (AIT) AND 1.1.2 ONE of the following: • Previously affected pregnancy • Family history of the disease • Platelet alloantibodies found on screening AND 1.1.3 ONE of the following: 1.1.3.1 Intravenous immunoglobulin (IVIG) dose does not exceed 1,000 milligrams (mg) per kilogram (kg) once weekly until delivery OR 1.1.3.2 BOTH of the following:	

- Fetus or newborn is considered to be at high risk for developing intracranial hemorrhage or other severe complication of AIT
- IVIG dose does not exceed 2,000 mg/kg once weekly until delivery

OR

1.2 For newborns BOTH of the following:

1.2.1 Diagnosis of feto-neonatal alloimmune thrombocytopenia

AND

1.2.2 Thrombocytopenia that persists after transfusion of antigen-negative compatible platelets

AND

2 - Submission of medical records (e.g., chart notes) documenting BOTH of the following:

- History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable
- Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested

AND

3 - If the request is for a non-preferred* product, there must be a history of failure, contraindication, or intolerance to ALL the following products:

- Bivigam
- Cutaquig
- Flebogamma
- Gammagard Liquid
- Gammagard S-D
- Gammaked
- Gammaplex
- Gamunex-C
- Hizentra
- Octagam
- Privigen

Xembify	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify	
Diagnosis	Feto-neonatal Alloimmune Thrombocytopenia (AIT)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to immune globulin therapy AND 2 - Statement of expected frequency and duration of proposed immune globulin treatment AND 3 - For long term treatment, documentation of titration to the minimum effective dose and frequency needed to maintain a sustained clinical response	

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify	
Diagnosis	Graves' ophthalmopathy Guillain-Barré syndrome (GBS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Guillain-Barré Syndrome

AND

2 - Submission of medical records (e.g., chart notes) documenting BOTH of the following:

- History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable
- Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested

AND

3 - Severe disease requiring aid to walk

AND

4 - Onset of neuropathic symptoms within the last four weeks

AND

5 - Prescribed by or in consultation with a neurologist

AND

6 - Intravenous immunoglobulin (IVIG) dose does not exceed 2,000 milligrams (mg) per kilogram (kg) per month given over 2 to 5 consecutive days. IVIG administration may be repeated in up to three monthly infusions. Dosing interval may need to be adjusted in patients with severe comorbidities

AND

7 - For long term treatment, documentation of titration to the minimum dose and frequency needed to maintain a sustained clinical effect

AND

8 - If the request is for a non-preferred* product, there must be a history of failure, contraindication, or intolerance to ALL the following products:

- Bivigam
- Cutaquig
- Flebogamma
- Gammagard Liquid
- Gammagard S-D
- Gammaked
- Gammaplex
- Gamunex-C
- Hizentra
- Octagam
- Privigen
- Xembify

Notes

*PDL link: <https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP>

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify

Diagnosis	Graves' ophthalmopathy Guillain-Barré syndrome (GBS)

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to immune globulin therapy

AND

2 - Statement of expected frequency and duration of proposed immune globulin treatment

AND

3 - For long term treatment, documentation of titration to the minimum effective dose and frequency needed to maintain a sustained clinical response

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify

Diagnosis	Prevention of bacterial infection in pediatric HIV
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of HIV disease

AND

2 - Submission of medical records (e.g., chart notes) documenting BOTH of the following:

- History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable
- Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested

AND

3 - Patient age less than or equal to 13 years of age

AND

4 - ONE of the following:

- Documented hypogammaglobulinemia [Immunoglobulin (IgG) less than 400 milligrams (mg) per deciliter (dL)]
- Functional antibody deficiency as demonstrated by either poor specific antibody titers or recurrent bacterial infections

AND

5 - Intravenous immunoglobulin (IVIG) dose does not exceed 400 mg per kilogram (kg) every 28 days

AND

6 - If the request is for a non-preferred* product, there must be a history of failure, contraindication, or intolerance to ALL the following products:

- Bivigam
- Cutaquig
- Flebogamma
- Gammagard Liquid
- Gammagard S-D
- Gammaked
- Gammaplex
- Gamunex-C
- Hizentra
- Octagam
- Privigen
- Xembify

Notes

*PDL link: <https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP>

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify

Diagnosis

Prevention of bacterial infection in pediatric HIV

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to immune globulin therapy AND 2 - Statement of expected frequency and duration of proposed immune globulin treatment AND 3 - For long term treatment, documentation of titration to the minimum effective dose and frequency needed to maintain a sustained clinical response	

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify	
Diagnosis	Immune thrombocytopenia [Idiopathic thrombocytopenic purpura (ITP)]
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 ALL of the following: • Diagnosis of acute thrombocytopenic purpura (ITP) • Documented platelet count less than 50×10^9 per Liter (L) (obtained within the past 30 days)	

- Intravenous immunoglobulin (IVIG) dose does not exceed 1,000 milligrams (mg) per kilogram(kg) per day for 1 to 2 days

OR

1.2 ALL of the following:

1.2.1 Diagnosis of chronic thrombocytopenic purpura (ITP)

AND

1.2.2 History of failure, contraindication, or intolerance to at least ONE of the following:

- Corticosteroids
- Splenectomy

AND

1.2.3 IVIG dose does not exceed 2,000 mg per kg per month given over 2 to 5 consecutive days. IVIG administration may be repeated monthly as needed to prevent exacerbation. Dosing interval should be adjusted depending upon response and titrated to the minimum effective dose that can be given at maximum intervals to maintain safe platelet levels.

AND

2 - Submission of medical records (e.g., chart notes) documenting BOTH of the following:

- History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable
- Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested

AND

3 - If the request is for a non-preferred* product, there must be a history of failure, contraindication, or intolerance to ALL the following products:

- Bivigam
- Cutaquig

• Flebogamma • Gammagard Liquid • Gammagard S-D • Gammaked • Gammaplex • Gamunex-C • Hizentra • Octagam • Privigen • Xembify	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify	
Diagnosis	Immune thrombocytopenia [Idiopathic thrombocytopenic purpura (ITP)]
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to immune globulin therapy AND 2 - Statement of expected frequency and duration of proposed immune globulin treatment AND 3 - For long term treatment, documentation of titration to the minimum effective dose and frequency needed to maintain a sustained clinical response	

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify	
Diagnosis	Kawasaki Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Kawasaki disease AND 2 - Submission of medical records (e.g., chart notes) documenting BOTH of the following: - History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable - Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested AND 3 - Intravenous immunoglobulin (IVIG) dose does not exceed 4,000 milligrams (mg) per kilograms (kg) for five consecutive days or a single dose of 2,000 mg per kg AND 4 - If the request is for a non-preferred* product, there must be a history of failure, contraindication, or intolerance to ALL the following products: - Bivigam - Cutaquig - Flebogamma - Gammagard Liquid - Gammagard S-D - Gammaked - Gammaplex	

• Gamunex-C • Hizentra • Octagam • Privigen • Xembify	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify	
Diagnosis	Kawasaki Disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to immune globulin therapy AND 2 - Statement of expected frequency and duration of proposed immune globulin treatment AND 3 - For long term treatment, documentation of titration to the minimum effective dose and frequency needed to maintain a sustained clinical response	

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify	
Diagnosis	Lambert-Eaton Myasthenic Syndrome (LEMS)
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Lambert-Eaton myasthenic syndrome (LEMS) AND 2 - Submission of medical records (e.g., chart notes) documenting BOTH of the following: - History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable - Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested AND 3 - History of failure, contraindication, or intolerance to immunomodulator monotherapy (e.g., azathioprine, corticosteroids) AND 4 - Concomitant immunomodulator therapy (e.g., azathioprine, corticosteroids), unless contraindicated, will be used for long-term management of LEMS AND 5 - Prescribed by or in consultation with a neurologist AND 6 - Intravenous Immunoglobulin (IVIG) dose does not exceed 2,000 milligrams (mg) per kilogram (kg) per month given over 2 to 5 consecutive days. IVIG administration may be repeated monthly as needed to prevent exacerbation. Dosing interval may need to be adjusted in patients with severe comorbidities	

AND

7 - For long term treatment, documentation of titration to the minimum dose and frequency needed to maintain a sustained clinical effect

AND

8 - If the request is for a non-preferred* product, there must be a history of failure, contraindication, or intolerance to ALL the following products:

- Bivigam
- Cutaquig
- Flebogamma
- Gammagard Liquid
- Gammagard S-D
- Gammaked
- Gammaplex
- Gamunex-C
- Hizentra
- Octagam
- Privigen
- Xembify

Notes

*PDL link: <https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP>

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify

Diagnosis	Lambert-Eaton Myasthenic Syndrome (LEMS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to immune globulin therapy

AND

2 - Statement of expected frequency and duration of proposed immune globulin treatment

AND

3 - For long term treatment, documentation of titration to the minimum effective dose and frequency needed to maintain a sustained clinical response

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify

Diagnosis	Lennox Gastaut Syndrome

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - History of failure, contraindication or intolerance to initial treatment with traditional anti-epileptic pharmacotherapy (e.g., lamotrigine, phenytoin, valproic acid)

AND

2 - Submission of medical records (e.g., chart notes) documenting BOTH of the following:

- History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable
- Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested

AND

3 - Prescribed by or in consultation with a neurologist

AND

4 - Intravenous immunoglobulin (IVIG) dose does not exceed 400 milligrams (mg) per kilogram (kg) per day given for 4 to 5 consecutive days. IVIG administration may be repeated monthly as needed in patients requiring maintenance therapy. Dosing interval may need to be adjusted in patients with severe comorbidities

AND

5 - For long term treatment, documentation of titration to the minimum dose and frequency needed to maintain a sustained clinical effect

AND

6 - If the request is for a non-preferred* product, there must be a history of failure, contraindication, or intolerance to ALL the following products:

- Bivigam
- Cutaquig
- Flebogamma
- Gammagard Liquid
- Gammagard S-D
- Gammaked
- Gammaplex
- Gamunex-C
- Hizentra
- Octagam
- Privigen
- Xembify

Notes

*PDL link: <https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP>

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify

Diagnosis

Lennox Gastaut Syndrome

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to immune globulin therapy AND 2 - Statement of expected frequency and duration of proposed immune globulin treatment AND 3 - For long term treatment, documentation of titration to the minimum effective dose and frequency needed to maintain a sustained clinical response	

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify	
Diagnosis	Multifocal Motor Neuropathy (MMN)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of multifocal motor neuropathy as confirmed by ALL of the following: • Weakness with slowly progressive or stepwise progressive course over at least one month • Asymmetric involvement of two or more nerves • Absence of motor neuron signs and bulbar signs	

AND

2 - Submission of medical records (e.g., chart notes) documenting BOTH of the following:

- History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable
- Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested

AND

3 - Prescribed by or in consultation with a neurologist

AND

4 - Intravenous immunoglobulin (IVIG) dose does not exceed 2,400 milligram (mg) per kilogram (kg) per month given over 2 to 5 consecutive days. IVIG administration may be repeated monthly as needed to prevent exacerbation. Dosing interval may need to be adjusted in patients with severe comorbidities.

AND

5 - If the request is for a non-preferred* product, there must be a history of failure, contraindication, or intolerance to ALL the following products:

- Bivigam
- Cutaquig
- Flebogamma
- Gammagard Liquid
- Gammagard S-D
- Gammaked
- Gammaplex
- Gamunex-C
- Hizentra
- Octagam
- Privigen
- Xembify

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify	
Diagnosis	Multifocal Motor Neuropathy (MMN)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy as measured by an objective scale [e.g., Rankin, Modified Rankin, Medical Research Council (MRC) scale] AND 2 - Prescribed by or in consultation with a neurologist AND 3 - Intravenous immunoglobulin (IVIG) dose does not exceed 2,400 milligram (mg) per kilogram (kg) per month given over 2 to 5 consecutive days. Dosing interval may need to be adjusted in patients with severe comorbidities AND 4 - For long term treatment, documentation of titration to the minimum dose and frequency needed to maintain a sustained clinical effect	

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify

Diagnosis	Prevention of infection in Multiple Myeloma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of multiple myeloma AND 2 - Submission of medical records (e.g., chart notes) documenting BOTH of the following: - History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable - Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested AND 3 - ONE of the following: - Documented hypogammaglobulinemia [immunoglobulin (IgG) less than 500 milligrams (mg) per deciliter (dL)] - History of bacterial infection(s) associated with multiple myeloma AND 4 - Intravenous immunoglobulin (IVIG) dose does not exceed 400 mg per kilogram (kg) every 3 to 4 weeks AND 5 - If the request is for a non-preferred* product, there must be a history of failure, contraindication, or intolerance to ALL the following products:	

• Bivigam • Cutaquig • Flebogamma • Gammagard Liquid • Gammagard S-D • Gammaked • Gammaplex • Gamunex-C • Hizentra • Octagam • Privigen • Xembify	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify	
Diagnosis	Prevention of infection in Multiple Myeloma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to immune globulin therapy AND 2 - Statement of expected frequency and duration of proposed immune globulin treatment AND 3 - For long term treatment, documentation of titration to the minimum effective dose and frequency needed to maintain a sustained clinical response	

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify	
Diagnosis	Relapsing Multiple Sclerosis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of relapsing forms of multiple sclerosis (MS) (e.g., relapsing-remitting MS, secondary- progressive MS with relapses, progressive-relapsing MS with relapses) AND 2 - Submission of medical records (e.g., chart notes) documenting BOTH of the following: • History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable • Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested AND 3 - Documentation of an MS exacerbation or progression (worsening) of the patient's clinical status from the visit prior to the one prompting the decision to initiate immune globulin therapy AND 4 - History of failure, contraindication, or intolerance to at least TWO of the following agents: • Avonex • Briumvi • Brand Copaxone • generic dalfampridine • generic dimethyl fumarate	

- generic fingolimod
- Kesimpta
- Ocrevus/Ocrevus Zunovo
- Rebif
- generic teriflunomide
- Tysabri

AND

5 - Prescribed by or in consultation with a neurologist

AND

6 - Induction, when indicated, does not exceed a dose of 400 milligrams (mg) per kilogram (kg) daily for up to five days

AND

7 - If the request is for a non-preferred* product, there must be a history of failure, contraindication, or intolerance to ALL the following products:

- Bivigam
- Cutaquig
- Flebogamma
- Gammagard Liquid
- Gammagard S-D
- Gammaked
- Gammaplex
- Gamunex-C
- Hizentra
- Octagam
- Privigen
- Xembify

Notes

*PDL link: <https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP>

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify

Diagnosis	Relapsing Multiple Sclerosis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Medical records, including findings of interval examination including neurological deficits incurred and assessment of disability [e.g., Expanded Disability Status Scale (EDSS), Functional Systems Score (FSS), Multiple Sclerosis Functional Composite (MSFC), Disease Steps (DS)] AND 2 - Stable or improved disability score (e.g., EDSS, FSS, MSFC, DS) AND 3 - Documentation of decreased number of relapses since starting immune globulin therapy AND 4 - Diagnosis continues to be the relapsing forms of multiple sclerosis (MS) AND 5 - Prescribed by or in consultation with a neurologist AND 6 - Intravenous immunoglobulin (IVIG) dose does not exceed 1,000 milligram (mg) per kilogram (kg) monthly	

AND

7 - For long term treatment, documentation of titration to the minimum dose and frequency needed to maintain a sustained clinical effect

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify

Diagnosis	Myasthenia Gravis - Exacerbation
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of generalized myasthenia gravis

AND

2 - Submission of medical records (e.g., chart notes) documenting BOTH of the following:

- History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable
- Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested

AND

3 - Evidence of myasthenia exacerbation, defined by at least ONE of the following symptoms in the last month

- Difficulty swallowing
- Acute respiratory failure
- Major functional disability responsible for the discontinuation of physical activity

- Recent immunotherapy treatment with a checkpoint inhibitor [e.g., Keytruda (pembrolizumab), Opdivo (nivolumab), Tecentriq (atezolizumab)]

AND

4 - ONE of the following:

- History of failure, contraindication, or intolerance to immunomodulator therapy (e.g., azathioprine, mycophenolate mofetil, cyclosporine) for long-term management of myasthenia gravis
- Currently receiving immunomodulator therapy (e.g., azathioprine, mycophenolate mofetil, cyclosporine) for long-term management of myasthenia gravis

AND

5 - Prescribed by or in consultation with a neurologist

AND

6 - Intravenous immunoglobulin (IVIG) dose does not exceed 2,000 milligrams (mg) per kilogram (kg) per month given over 2 to 5 days administered in up to three monthly infusions. Dosing interval may need to be adjusted in patients with severe comorbidities.

AND

7 - If the request is for a non-preferred* product, there must be a history of failure, contraindication, or intolerance to ALL the following products:

- Bivigam
- Cutaquig
- Flebogamma
- Gammagard Liquid
- Gammagard S-D
- Gammaked
- Gammaplex
- Gamunex-C
- Hizentra
- Octagam
- Privigen
- Xembify

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify	
Diagnosis	Refractory Myasthenia Gravis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of refractory generalized myasthenia gravis by or in consultation with a physician or center with expertise in management of myasthenia gravis AND 2 - Submission of medical records (e.g., chart notes) documenting BOTH of the following: - History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable - Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested AND 3 - Documentation that the disease status is unchanged or worsening (persistent or worsening symptoms that limit functioning) despite failure, contraindication, or intolerance to BOTH of the following (used in adequate doses and duration): - Corticosteroids - Two immunomodulator therapies (e.g., azathioprine, mycophenolate mofetil, cyclosporine, methotrexate, tacrolimus) AND	

4 - Currently receiving immunomodulator therapy (e.g., corticosteroids, azathioprine, mycophenolate mofetil, cyclosporine, methotrexate, tacrolimus), used in adequate doses, for long-term management of myasthenia gravis

AND

5 - Prescribed by or in consultation with a neurologist

AND

6 - Intravenous immunoglobulin (IVIG) dose does not exceed 2,000 milligrams (mg) per kilogram (kg) per month given over 2 to 5 days administered in up to three monthly infusions. Dosing interval may need to be adjusted in patients with severe comorbidities.

AND

7 - If the request is for a non-preferred* product, there must be a history of failure, contraindication, or intolerance to ALL the following products:

- Bivigam
- Cutaquig
- Flebogamma
- Gammagard Liquid
- Gammagard S-D
- Gammaked
- Gammaplex
- Gamunex-C
- Hizentra
- Octagam
- Privigen
- Xembify

Notes

*PDL link: <https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP>

Product Name: HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify

Diagnosis

Myasthenia Gravis –Exacerbation and Refractory Myasthenia Gravis

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to immune globulin therapy AND 2 - Statement of expected frequency and duration of proposed immune globulin treatment AND 3 - For long term treatment, documentation of titration to the minimum effective dose and frequency needed to maintain a sustained clinical response	

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify	
Diagnosis	Neuromyelitis Optica
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes, laboratory values, etc.) to support the diagnosis of neuromyelitis optica spectrum disorder (NMOSD) by a neurologist confirming ALL of the following: 1.1 Serologic testing for anti-aquaporin-4 immunoglobulin G (AQP4-IgG) or Neuromyelitis optica immunoglobulin G (NMO-IgG) antibodies has been performed	

AND

1.2 ONE of the following:

1.2.1 If AQP4-IgG/NMO-IgG positive, past medical history of ONE of the following:

- Optic neuritis
- Acute myelitis
- Area postrema syndrome: episode of otherwise unexplained hiccups or nausea and vomiting
- Symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic MRI lesions
- Symptomatic cerebral syndrome with NMOSD-typical brain lesions

OR

1.2.2 If AQP4-IgG/NMO-IgG negative, past medical history of TWO of the following:

- Optic neuritis
- Acute myelitis
- Area postrema syndrome: episode of otherwise unexplained hiccups or nausea and vomiting
- Acute brainstem syndrome
- Symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic MRI lesions
- Symptomatic cerebral syndrome with NMOSD-typical brain lesions

AND

1.3 Diagnosis of multiple sclerosis or other diagnoses have been ruled out

AND

2 - Submission of medical records (e.g., chart notes) documenting BOTH of the following:

- History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable
- Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested

AND

3 - History of failure, contraindication, or intolerance to at least TWO of the following:

- Azathioprine
- Corticosteroids
- Mycophenolate mofetil
- Rituximab
- Soliris (eculizumab)

AND

4 - Patient is not receiving immune globulin in combination with either of the following:

- Rituximab
- Soliris (eculizumab)

AND

5 - Prescribed by or in consultation with a neurologist

AND

6 - Intravenous immunoglobulin (IVIG) dose does not exceed 2,000 milligram (mg) per kilogram (kg) per month given over 2 to 5 days administered in up to six monthly infusions. Dosing interval may need to be adjusted in patients with severe comorbidities.

AND

7 - If the request is for a non-preferred* product, there must be a history of failure, contraindication, or intolerance to ALL the following products:

- Bivigam
- Cutaquig
- Flebogamma
- Gammagard Liquid
- Gammagard S-D
- Gammaked
- Gammaplex

• Gamunex-C • Hizentra • Octagam • Privigen • Xembify	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify	
Diagnosis	Neuromyelitis Optica
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has previously been treated with immune globulin AND 2 - Submission of medical records (e.g., chart notes, laboratory tests) to demonstrate a positive clinical response from baseline as demonstrated by BOTH of the following: 2.1 Reduction in the number and or severity of relapses or signs and symptoms of neuromyelitis optica spectrum disorder (NMOSD) AND 2.2 Maintenance, reduction, or discontinuation of dose(s) of any baseline immunosuppressive therapy (IST) prior to starting immune globulin. (NOTE: Add on, dose escalation of IST, or additional rescue therapy from baseline to treat NMOSD or exacerbation of symptoms while on immune globulin therapy will be considered as treatment failure.)	

AND

3 - Patient is not receiving immune globulin in combination with either of the following:

- Rituximab
- Soliris (eculizumab)

AND

4 - Prescribed by or in consultation with a neurologist

AND

5 - Intravenous immunoglobulin (IVIG) dose does not exceed 2,000 milligrams (mg) per kilogram (kg) per month given over 2 to 5 days administered in up to six monthly infusions. Dosing interval may need to be adjusted in patients with severe comorbidities

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify

Diagnosis	Posttransfusion Purpura
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of posttransfusion purpura

AND

2 - Submission of medical records (e.g., chart notes) documenting BOTH of the following:

- History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable
- Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested

AND

3 - Intravenous immunoglobulin (IVIG) dose does not exceed 1,000 milligrams (mg) per kilogram (kg) for 2 days

AND

4 - If the request is for a non-preferred* product, there must be a history of failure, contraindication, or intolerance to ALL the following products:

- Bivigam
- Cutaquig
- Flebogamma
- Gammagard Liquid
- Gammagard S-D
- Gammaked
- Gammaplex
- Gamunex-C
- Hizentra
- Octagam
- Privigen
- Xembify

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify	
Diagnosis	Posttransfusion Purpura
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to immune globulin therapy

AND

2 - Statement of expected frequency and duration of proposed immune globulin treatment

AND

3 - For long term treatment, documentation of titration to the minimum effective dose and frequency needed to maintain a sustained clinical response

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify

Diagnosis	Post B-Cell Targeted Therapies
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation confirming previous treatment of B-cell targeted therapy within the last 100 days [e.g., CAR-T (e.g., Kymriah), Rituxan (rituximab), Besponsa (inotuzumab ozogamicin)]

AND

2 - Submission of medical records (e.g., chart notes) documenting BOTH of the following:

- History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable

- Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested

AND

3 - BOTH of the following:

- Documented hypogammaglobulinemia [immunoglobulin (IgG) less than 500 milligrams (mg) per deciliter (dL)]
- History of bacterial infection(s) associated with B-cell depletion

AND

4 - Intravenous immunoglobulin (IVIG) dose does not exceed 400 mg per kilogram (kg) every 4 weeks, up to 360 days after discontinuation of B-cell depleting therapy

AND

5 - If the request is for a non-preferred* product, there must be a history of failure, contraindication, or intolerance to ALL the following products:

- Bivigam
- Cutaquig
- Flebogamma
- Gammagard Liquid
- Gammagard S-D
- Gammaked
- Gammaplex
- Gamunex-C
- Hizentra
- Octagam
- Privigen
- Xembify

Notes

*PDL link: <https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP>

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify

Diagnosis	Post B-Cell Targeted Therapies
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to immune globulin therapy AND 2 - Statement of expected frequency and duration of proposed immune globulin treatment AND 3 - For long term treatment, documentation of titration to the minimum effective dose and frequency needed to maintain a sustained clinical response	

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify	
Diagnosis	Primary Immunodeficiency Syndromes
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of primary immunodeficiency AND	

2 - Submission of medical records (e.g., chart notes) documenting BOTH of the following:

- History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable
- Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested

AND

3 - Clinically significant functional deficiency of humoral immunity as evidenced by ONE of the following:

- Documented failure to produce antibodies to specific antigens
- History of significant recurrent infections

AND

4 - Initial intravenous immunoglobulin (IVIG) dose is 200 to 800 milligrams (mg) per kilogram (kg) every 3 to 4 weeks, based on product prescribing information, and titrated based upon patient response (For subcutaneous immune globulin (SCIG) products, FDA-labeled dosing and conversion guidelines will be used to determine benefit coverage.)

AND

5 - If the request is for a non-preferred* product, there must be a history of failure, contraindication, or intolerance to ALL the following products:

- Bivigam
- Cutaquig
- Flebogamma
- Gammagard Liquid
- Gammagard S-D
- Gammaked
- Gammaplex
- Gamunex-C
- Hizentra
- Octagam
- Privigen
- Xembify

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify	
Diagnosis	Primary Immunodeficiency Syndromes
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to immune globulin therapy AND 2 - Statement of expected frequency and duration of proposed immune globulin treatment AND 3 - For long term treatment, documentation of titration to the minimum effective dose and frequency needed to maintain a sustained clinical response	

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify	
Diagnosis	Rasmussen Syndrome
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of ONE of the following demonstrating that:

- Short term amelioration of encephalitis is needed prior to definitive surgical therapy
- Disease symptoms (e.g., seizures) persist despite surgical treatment
- The patient is not a candidate for surgical treatment

AND

2 - Submission of medical records (e.g., chart notes) documenting BOTH of the following:

- History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable
- Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested

AND

3 - Intravenous immunoglobulin (IVIG) dose does not exceed 2,000 milligrams (mg) per kilogram (kg) per month given over 2 to 5 days

AND

4 - If the request is for a non-preferred* product, there must be a history of failure, contraindication, or intolerance to ALL the following products:

- Bivigam
- Cutaquig
- Flebogamma
- Gammagard Liquid
- Gammagard S-D
- Gammaked
- Gammaplex
- Gamunex-C
- Hizentra
- Octagam
- Privigen
- Xembify

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify	
Diagnosis	Rasmussen Syndrome
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to immune globulin therapy AND 2 - Statement of expected frequency and duration of proposed immune globulin treatment AND 3 - For long term treatment, documentation of titration to the minimum effective dose and frequency needed to maintain a sustained clinical response	

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify	
Diagnosis	Stiff-Person Syndrome
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of stiff-person syndrome

AND

2 - Submission of medical records (e.g., chart notes) documenting BOTH of the following:

- History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable
- Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested

AND

3 - History of failure, contraindication or intolerance to GABAergic (gamma-aminobutyric acid analogs) medication (e.g., baclofen, benzodiazepines)

AND

4 - Prescribed by or in consultation with a neurologist

AND

5 - Intravenous immunoglobulin (IVIG) dose does not exceed 2,000 milligrams (mg) per kilogram (kg) per month given over 2 to 5 days. IVIG administration may be repeated monthly as needed for patients requiring maintenance therapy. Dosing interval may need to be adjusted in patients with severe comorbidities

AND

6 - If the request is for a non-preferred* product, there must be a history of failure, contraindication, or intolerance to ALL the following products:

- Bivigam
- Cutaquig

• Flebogamma • Gammagard Liquid • Gammagard S-D • Gammaked • Gammaplex • Gamunex-C • Hizentra • Octagam • Privigen • Xembify	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify	
Diagnosis	Stiff-Person Syndrome
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of a positive clinical improvement from baseline AND 2 - Prescribed by or in consultation with a neurologist AND 3 - Intravenous immunoglobulin (IVIG) dose does not exceed 2,000 milligrams (mg) per kilogram (kg) per month given over 2 to 5 days. IVIG administration may be repeated monthly as needed for patients requiring maintenance therapy. Dosing interval may need to be adjusted in patients with severe comorbidities	

AND

4 - For long term treatment, documentation of titration to the minimum dose and frequency needed to maintain a sustained clinical effect

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify

Diagnosis	Thrombocytopenia, secondary to Hepatitis C Virus (HCV), Human Immunodeficiency Virus (HIV), or pregnancy
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 BOTH of the following:

- Diagnosis of thrombocytopenia secondary to Hepatitis C Virus (HCV) infection
- Patient is receiving concurrent antiviral therapy, unless contraindicated

OR

1.2 BOTH of the following:

- Diagnosis of thrombocytopenia secondary Human Immunodeficiency Virus (HIV) infection
- Patient is receiving concurrent antiviral therapy, unless contraindicated

OR

1.3 Diagnosis of thrombocytopenia secondary to pregnancy

AND

2 - Submission of medical records (e.g., chart notes) documenting BOTH of the following:

- History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable
- Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested

AND

3 - Documented platelet count less than 50×10^9 per liter (L) (obtained within the past 30 days)

AND

4 - Intravenous immunoglobulin (IVIG) dose does not exceed 1,000 milligrams (mg) per kilogram (kg) per day for 1 to 2 days

AND

5 - If the request is for a non-preferred* product, there must be a history of failure, contraindication, or intolerance to ALL the following products:

- Bivigam
- Cutaquig
- Flebogamma
- Gammagard Liquid
- Gammagard S-D
- Gammaked
- Gammaplex
- Gamunex-C
- Hizentra
- Octagam
- Privigen
- Xembify

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify	
Diagnosis	Thrombocytopenia, secondary to Hepatitis C Virus (HCV), Human Immunodeficiency Virus (HIV), or pregnancy
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 BOTH of the following: • Diagnosis of thrombocytopenia secondary to Hepatitis C Virus (HCV) infection • Patient is receiving concurrent antiviral therapy, unless contraindicated OR 1.2 BOTH of the following: • Diagnosis of thrombocytopenia secondary Human Immunodeficiency Virus (HIV) infection • Patient is receiving concurrent antiviral therapy, unless contraindicated OR 1.3 Diagnosis of thrombocytopenia secondary to pregnancy AND 2 - Intravenous immunoglobulin (IVIG) dose does not exceed 2,000 milligram (mg) per	

kilogram (kg) per month given over 2 to 5 consecutive days. IVIG administration may be repeated monthly as needed to prevent exacerbation. Dosing interval should be adjusted depending upon response and titrated to the minimum effective dose that can be given at maximum intervals to maintain safe platelet levels.

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify

Diagnosis	All other indications
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following diagnoses:

- Autoimmune Uveitis
- Cytomegalovirus (CMV) induced pneumonitis in solid organ transplants
- Enteroviral Meningoencephalitis
- IgM antimyelin-associated glycoprotein paraprotein-associated peripheral neuropathy
- Lymphoproliferative disease (treatment of bacterial infections)
- Monoclonal gammopathy
- Paraproteinemic neuropathy
- Renal transplantation (prevention or treatment of acute humoral rejection)
- Severe Rheumatoid arthritis
- Rotaviral enterocolitis
- Staphylococcal toxic shock
- Toxic epidermal necrolysis or Stevens-Johnson syndrome
- Urticaria (delayed pressure)

AND

2 - Submission of medical records (e.g., chart notes) documenting BOTH of the following:

- History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable
- Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested

AND

3 - If the request is for a non-preferred* product, there must be a history of failure, contraindication, or intolerance to ALL the following products:

- Bivigam
- Cutaquig
- Flebogamma
- Gammagard Liquid
- Gammagard S-D
- Gammaked
- Gammaplex
- Gamunex-C
- Hizentra
- Octagam
- Privigen
- Xembify

Notes

*PDL link: <https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP>

Product Name:HyQvia, Gammagard S-D, Gammagard liquid, Gammagard liquid ERC, Cuvitru, Gamastan, Gamunex-C, Privigen, Hizentra, Bivigam, Flebogamma Dif, Gammaplex, Octagam, Panzyga, Gammaked, Qivigy, Xembify

Diagnosis	All other indications
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to immune globulin therapy

AND

2 - Statement of expected frequency and duration of proposed immune globulin treatment

AND

3 - For long term treatment, documentation of titration to the minimum effective dose and frequency needed to maintain a sustained clinical response

2 . Revision History

Date	Notes
3/18/2026	For all indications (initial auth section), added Cutaquig and Gammaplex to list of prerequisites in the embedded step criterion, and added PDL link in notes sections. Added Gammagard liquid ERC and Qivigy as targets. Updated GPI tables and product name lists.

Inbrija



Prior Authorization Guideline

Guideline ID	GL-140661
Guideline Name	Inbrija
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	3/1/2021

1 . Criteria

Product Name:Inbrija	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Parkinson's disease	

AND

2 - Inbrija will be used as intermittent treatment for OFF episodes

AND

3 - Prescribed by, or in consultation with, a neurologist or specialist in the treatment of Parkinson's disease

AND

4 - Patient is currently on a stable dose of a carbidopa/levodopa-containing medication and will continue receiving treatment with a carbidopa/levodopa-containing medication while on therapy

AND

5 - Patient continues to experience greater than or equal to 2 hours of OFF time per day despite optimal management of carbidopa/levodopa therapy including BOTH of the following:

- Taking carbidopa/levodopa on an empty stomach or at least one half-hour or more before or one hour after a meal or avoidance of high protein diet
- Dose and dosing interval optimization

AND

6 - History of failure, contraindication, or intolerance to TWO anti-Parkinson's disease therapies from the following adjunctive pharmacotherapy classes (trial must be from two different classes):

- Dopamine agonists (e.g., pramipexole, ropinirole)
- Catechol-O-methyl transferase (COMT) inhibitors (e.g., entacapone)
- Monoamine oxidase (MAO) B inhibitors (e.g., selegiline)

Product Name: Inbrija

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Inbrija therapy AND 2 - Patient will continue to receive treatment with a carbidopa/levodopa-containing medication	

2 . Revision History

Date	Notes
1/27/2021	Updated criteria for initial authorization. Copied from 79944

Infliximab Products



Prior Authorization Guideline

Guideline ID	GL-369224
Guideline Name	Infliximab Products
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	9/1/2025

1 . Criteria

Product Name:Zymfentra	
Diagnosis	Crohn's Disease (CD)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of moderately to severely active Crohn's disease (CD)	

AND

2 - ONE of the following:

- Frequent diarrhea and abdominal pain
- At least 10% weight loss
- Complications such as obstruction, fever, abdominal mass
- Abnormal lab values (e.g., C-reactive protein [CRP])
- CD Activity Index (CAI) greater than 220

AND

3 - Prescribed by or in consultation with a gastroenterologist

AND

4 - Paid claims or submission of medical records (e.g., chart notes) confirming a trial and failure, contraindication, or intolerance to ONE of the following conventional therapies:

- 6-mercaptopurine
- Methotrexate
- Azathioprine
- Corticosteroids (e.g., prednisone)

Product Name:Zymfentra	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of moderately to severely active ulcerative colitis (UC)	

AND

2 - ONE of the following:

- Greater than 6 stools per day
- Frequent blood in the stools
- Frequent urgency
- Presence of ulcers
- Abnormal lab values (e.g., hemoglobin, ESR, CRP)
- Dependent on, or refractory to, corticosteroids

AND

3 - Prescribed by or in consultation with a gastroenterologist

AND

4 - Paid claims or submission of medical records (e.g., chart notes) confirming a trial and failure, contraindication, or intolerance to ONE of the following conventional therapies:

- 6-mercaptopurine
- Aminosalicylate (e.g., mesalamine, olsalazine, sulfasalazine)
- Azathioprine
- Corticosteroids (e.g., prednisone)

Product Name:Zymfentra	
Diagnosis	Crohn's Disease (CD), Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy as evidenced by at least ONE of the following:	

- Improvement in intestinal inflammation [e.g., mucosal healing, improvement of lab values (platelet counts, erythrocyte sedimentation rate, C-reactive protein level)] from baseline
- Reversal of high fecal output state

2 . Revision History

Date	Notes
8/14/2025	Updated initial auth criteria for CD and UC.

Ingrezza (valbenazine)



Prior Authorization Guideline

Guideline ID	GL-157491
Guideline Name	Ingrezza (valbenazine)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	11/1/2024

1 . Criteria

Product Name:Ingrezza*	
Diagnosis	Moderate to Severe Tardive Dyskinesia
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderate to severe tardive dyskinesia (TD) secondary to a centrally acting dopamine receptor blocking agent (DRBA)	

AND

2 - Prescribed by or in consultation with a psychiatrist or neurologist

AND

3 - Patient is 18 years of age or older

AND

4 - Patient has an Abnormal Involuntary Movement Scale (AIMS) score of 3 or 4 on any one of the AIMS items 1 through 9

AND

5 - Ingrezza is not prescribed concurrently with Austedo or tetrabenazine

AND

6 - Dose does not exceed 80 mg per day

Notes	*Patients will be approved for ONE strength of Ingrezza ONLY: Approve ALL requests at GPI-14. Confirm there is only 1 active PA on file for ALL Ingrezza products. End-date/Retire all other active PA's for Ingrezza products.

Product Name:Ingrezza*	
Diagnosis	Moderate to Severe Tardive Dyskinesia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria 1 - Patient is responding positively to therapy as evidenced by a reduction in the baseline AIMS score in any one of the AIMS items 1 through 9 AND 2 - Ingrezza is not prescribed concurrently with Austedo or tetrabenazine AND 3 - Dose does not exceed 80 mg per day	
Notes	*Patients will be approved for ONE strength of Ingrezza ONLY: Approve ALL requests at GPI-14. Confirm there is only 1 active PA on file for ALL Ingrezza products. End-date/Retire all other active PA's for Ingrezza products.

Product Name:Ingrezza*	
Diagnosis	Chorea Associated with Huntington's Disease
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chorea in patients with Huntington's disease AND 2 - Prescribed by or in consultation with a neurologist AND 3 - Patient is 18 years of age or older	

AND	
4 - Dose does not exceed 80 mg per day	
Notes	*Patients will be approved for ONE strength of Ingrezza ONLY: Approve ALL requests at GPI-14. Confirm there is only 1 active PA on file for ALL Ingrezza products. End-date/Retire all other active PA's for Ingrezza products.

Product Name:Ingrezza*	
Diagnosis	Chorea Associated with Huntington's Disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy AND 2 - Dose does not exceed 80 mg per day	
Notes	*Patients will be approved for ONE strength of Ingrezza ONLY: Approve ALL requests at GPI-14. Confirm there is only 1 active PA on file for ALL Ingrezza products. End-date/Retire all other active PA's for Ingrezza products.

2 . Revision History

Date	Notes
10/15/2024	Added note regarding only one strength of Ingrezza can be approved at a time. No changes to clinical criteria.

Inhaled Corticosteroids



Prior Authorization Guideline

Guideline ID	GL-605215
Guideline Name	Inhaled Corticosteroids
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Alvesco, Brand Arnuity Ellipta, generic fluticasone furoate ellipta, Asmanex HFA/Twisthaler, Qvar Redihaler, Beclomethasone Dipropionate HFA	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of asthma AND	

2 - If the request is non-preferred*, history of failure, contraindication, or intolerance to a majority (not more than 3) of the following preferred inhaled corticosteroids:

- Brand Arnuity Ellipta
- Asmanex HFA/Twisthaler (mometasone)
- Brand or generic Flovent Diskus (fluticasone)
- Brand or generic Flovent HFA (fluticasone)
- Pulmicort Flexhaler (budesonide)
- budesonide respule (generic)
- Qvar Redihaler (beclomethasone)

AND

3 - If the request is for generic fluticasone furoate ellipta, trial and failure or intolerance to Brand Arnuity Ellipta

AND

4 - If the request is for Beclomethasone Dipropionate HFA, trial and failure or intolerance to Qvar Redihaler

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

2 . Revision History

Date	Notes
5/8/2026	Added Beclomethasone Dipropionate HFA (MSC N) products as targets. Updated product name list and GPI table, accordingly. Updated criteria.

Injectable Oncology Agents



Prior Authorization Guideline

Guideline ID	GL-503313
Guideline Name	Injectable Oncology Agents
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name: Abecma, Aucatzyl, Breyanzi, Carvykti, Kymriah, Tecartus, Yescarta	
Diagnosis	Cancer Indications
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - The drug is being used as indicated by National Comprehensive Cancer Network (NCCN) guidelines with a Category of Evidence and Consensus of 1, 2A, or 2B	

2 . Revision History

Date	Notes
1/20/2026	Removed Synribo (obsolete) and Beizray (medical) products as targets. Updated product name list and GPI table accordingly. No changes to criteria.

Inqovi



Prior Authorization Guideline

Guideline ID	GL-219310
Guideline Name	Inqovi
Formulary	Medicaid - Community & State Arizona Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Indiana Medicaid - Community & State Maryland Medicaid - Community & State New Jersey Medicaid - Community & State New Mexico Medicaid - Community & State New York Medicaid - Community & State New York EPP Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Virginia Medicaid - Community & State Washington

Guideline Note:

Effective Date:	5/1/2025

1 . Criteria

Product Name:Inqovi	
Diagnosis	Myelodysplastic Syndrome (MDS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of myelodysplastic syndrome (e.g., previously treated and untreated, de novo and secondary MDS with the following French-American-British subtypes {refractory anemia, refractory anemia with ringed sideroblasts, refractory anemia with excess blasts, and chronic myelomonocytic leukemia [CMML]}) AND 2 - Patient is intermediate-1, intermediate-2, or high-risk per the International Prognostic Scoring System (IPSS)	

Product Name:Inqovi	
Diagnosis	Myelodysplastic Syndrome (MDS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient does not show evidence of progressive disease while on Inqovi therapy	

Product Name:Inqovi	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	

Product Name:Inqovi	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Inqovi therapy	

2 . Revision History

Date	Notes
3/20/2025	Updated formularies. Removed CMML as it would fall under MDS

Insulin Pen Needles and Syringes



Prior Authorization Guideline

Guideline ID	GL-512232
Guideline Name	Insulin Pen Needles and Syringes
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State New Jersey Medicaid - Community & State New York Medicaid - Community & State New York EPP Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Arizona Medicaid - Community & State Virginia Medicaid - Community & State Washington Medicaid - Community & State Kansas Medicaid - Community & State Pennsylvania Medicaid - Community & State Nebraska Medicaid - Community & State Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Nevada

Guideline Note:

Effective Date:	2/2/2026

1 . Criteria

Product Name:Non-preferred insulin pen needles and insulin syringes	
Diagnosis	Non-Preferred
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - If the request is non-preferred*, history of failure to a preferred* Embecta insulin pen needle or syringe as confirmed by claims history or submission of medical records OR 2 - If the request is non-preferred*, physician has provided documentation as to why the patient is unable to use a preferred* Embecta product (document rationale)	
Notes	*PDL links are listed in Background.

Product Name:All insulin pen needles and insulin syringes	
Diagnosis	Requests exceeding 6 pen needles or syringes per day*
Approval Length	12 month(s)
Guideline Type	Quantity Limit
Approval Criteria 1 - Physician confirmation that the patient requires a greater quantity because of more frequent delivery of insulin	
Notes	*The quantity limit for both pen needles and syringes is 6 of each per day.

2 . Background

Benefit/Coverage/Program Information
PDL links CO: https://www.uhcprovider.com/en/health-plans-by-state/colorado-health-plans/co-comm-plan-home/co-cp-pharmacy.html HI: https://www.uhcprovider.com/en/health-plans-by-state/hawaii-health-plans/hi-comm-plan-home/hi-cp-pharmacy.html MD: https://www.uhcprovider.com/en/health-plans-by-state/maryland-health-plans/md-comm-plan-home/md-cp-pharmacy.html NJ: https://www.uhcprovider.com/en/health-plans-by-state/new-jersey-health-plans/nj-comm-plan-home/nj-cp-pharmacy.html NY/NY EPP: https://www.uhcprovider.com/en/health-plans-by-state/new-york-health-plans/ny-comm-plan-home/ny-cp-pharmacy.html PA: https://www.uhcprovider.com/en/health-plans-by-state/pennsylvania-health-plans/pa-comm-plan-home/pa-cp-pharmacy.html?rfid=UHCCP RI: https://www.uhcprovider.com/en/health-plans-by-state/rhode-island-health-plans/ri-comm-plan-home/ri-cp-pharmacy.html AZ: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHCCP KS: https://www.uhcprovider.com/en/health-plans-by-state/kansas-health-plans/ks-comm-plan-home/ks-cp-pharmacy.html NM: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html VA: https://www.uhcprovider.com/en/health-plans-by-state/virginia-health-plans/va-comm-plan-home/va-cp-pharmacy.html WA: https://www.uhcprovider.com/en/health-plans-by-state/washington-health-plans/wa-comm-plan-home/wa-cp-pharmacy.html NE: https://www.uhcprovider.com/en/health-plans-by-state/nebraska-health-plans/ne-comm-plan-home/ne-cp-pharmacy.html

plan-home/ne-cp-pharmacy.html

IN: <https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html>

NV: <https://myhpnmedicaid.com/member/pharmacy-benefits>

3 . Revision History

Date	Notes
2/2/2026	Updated NV PDL Link

Insulins, Concentrated



Prior Authorization Guideline

Guideline ID	GL-164485
Guideline Name	Insulins, Concentrated
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	3/1/2025

1 . Criteria

Product Name:Humulin R U-500 kwikpen and vial	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - History of failure, intolerance, or contraindication to ALL of the following: • Insulin aspart or insulin lispro • Lantus	

OR

2 - There is a reason or special circumstance the patient needs to use a concentrated insulin product

2 . Revision History

Date	Notes
1/29/2025	Updated embedded step requirement.

Iqirvo (elafibranor)



Prior Authorization Guideline

Guideline ID	GL-155011
Guideline Name	Iqirvo (elafibranor)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name:Iqirvo	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of primary biliary cholangitis (PBC) (also known as primary biliary cirrhosis)	

AND

2 - Submission of medical records (e.g., chart notes) documenting ONE of the following:

2.1 BOTH of the following:

2.1.1 Patient has failed to achieve an alkaline phosphatase (ALP) level of less than 1.67 times the upper limit of normal (ULN) after at least 12 consecutive months of treatment with ursodeoxycholic acid (UDCA) (e.g., Urso, Urso Forte, ursodiol)

AND

2.1.2 Used in combination with ursodeoxycholic acid (UDCA)

OR

2.2 History of contraindication or intolerance to ursodeoxycholic acid (UDCA)

AND

3 - Requested drug will NOT be used in combination with Ocaliva (obeticholic acid)

AND

4 - Prescribed by or in consultation with ONE of the following:

- Hepatologist
- Gastroenterologist

Product Name:Iqirvo	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy (e.g., ALP level less than 1.67 times ULN, total bilirubin less than or equal to ULN, ALP decrease greater than or equal to 15% from baseline)

AND

2 - Requested drug will NOT be used in combination with Ocaliva (obeticholic acid)

2 . Revision History

Date	Notes
9/16/2024	New program.

Iron Chelators



Prior Authorization Guideline

Guideline ID	GL-140886
Guideline Name	Iron Chelators
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name: Brand Exjade, Brand Jadenu, generic deferasirox	
Diagnosis	Chronic Iron Overload due to Blood Transfusion
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chronic iron overload (e.g., sickle cell anemia, thalassemia, etc.) due to blood transfusion	

Product Name: Brand Exjade, Brand Jadenu, generic deferasirox	
Diagnosis	Chronic Iron Overload due to Blood Transfusion
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy	

Product Name: Brand Ferriprox, generic deferiprone	
Diagnosis	Chronic Iron Overload due to Blood Transfusion
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following 1.1 Diagnosis of transfusional iron overload due to thalassemia syndromes AND 1.2 Current chelation therapy is inadequate [e.g., Desferal (deferoxamine), Exjade (deferasirox)]	

Product Name: Brand Ferriprox, generic deferiprone	
Diagnosis	Chronic Iron Overload due to Blood Transfusion
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

- 1 - Documentation of positive clinical response to therapy

Product Name:Brand Exjade, Brand Jadenu, generic deferasirox	
Diagnosis	Chronic Iron Overload in Non-Transfusion Dependent Thalassemia Syndrome
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ALL of the following: 1.1 Diagnosis of chronic iron overload in non-transfusion dependent thalassemia syndrome AND 1.2 Patient has liver iron (Fe) concentration (LIC) levels consistently greater than or equal to 5 mg Fe per gram of dry weight prior to initiation of treatment with Exjade or Jadenu AND 1.3 Patient has serum ferritin levels consistently greater than 300 micrograms per liter prior to initiation of treatment with Exjade or Jadenu	

Product Name:Brand Exjade, Brand Jadenu, generic deferasirox	
Diagnosis	Chronic Iron Overload in Non-Transfusion Dependent Thalassemia Syndrome
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy	

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Irritable Bowel Syndrome-Diarrhea



Prior Authorization Guideline

Guideline ID	GL-140687
Guideline Name	Irritable Bowel Syndrome-Diarrhea
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Brand Lotronex, generic alosetron	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of severe diarrhea-predominant irritable bowel syndrome (IBS)	

AND

2 - Symptoms for at least 6 months

AND

3 - Patient was female at birth

AND

4 - Age greater than or equal to 18 years

AND

5 - History of failure, contraindication, or intolerance to TWO of the following:

- Antispasmodic agent (e.g. dicyclomine)
- Antidiarrheal agents (e.g. loperamide)
- Tricyclic antidepressant (e.g. amitriptyline)

Product Name:Brand Lotronex, generic alosetron	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Lotronex therapy	

Product Name:Viberzi	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of irritable bowel syndrome with diarrhea (IBS-D) AND 2 - History of failure, contraindication, or intolerance to TWO of the following: • Antispasmodic agent (e.g. dicyclomine) • Antidiarrheal agents (e.g. loperamide) • Tricyclic antidepressant (e.g. amitriptyline)	

Product Name:Viberzi	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Viberzi therapy	

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Isotretinoin



Prior Authorization Guideline

Guideline ID	GL-288262
Guideline Name	Isotretinoin
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	7/1/2025

1 . Criteria

Product Name: Brand Absorica, Absorica LD, Accutane, Amnesteem, Claravis, generic isotretinoin caps, Zenatane	
Diagnosis	Oncology Uses (Off Label)
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Used for an oncology indication meeting National Comprehensive Cancer Network with a Category of Evidence and Consensus of 1, 2A, or 2B or	

2 - Used for an oncology indication from ONE of the following appropriate compendia of current literature:

American Hospital Formulary Service Drug Information

Thomson Micromedex DrugDex

Clinical Pharmacology

Product Name: Brand Absorica, Absorica LD, Accutane, Amnesteem, Claravis, generic isotretinoin caps, Zenatane

Approval Length	5 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Diagnosis of severe recalcitrant nodular acne unresponsive to conventional therapy

OR

1.2 Diagnosis of treatment resistant acne

AND

2 - History of failure, contraindication, or intolerance to an adequate trial on TWO of the following conventional therapy regimens:

- Topical retinoid or retinoid-like agent [e.g., Retin-A/Retin-A Micro (tretinoin)]
- Oral antibiotic [e.g., Ery-Tab (erythromycin), Biaxin (clarithromycin), Minocin (minocycline)]
- Topical antibiotic with or without benzoyl peroxide [e.g., Cleocin-T (clindamycin), erythromycin, BenzaClin (benzoyl peroxide/clindamycin), Benzamycin (benzoyl peroxide/erythromycin)]

AND	
3 - If the request is non-preferred*, there must be a reason or special circumstance that the patient must be treated with a non-preferred medication	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:Brand Absorica, Absorica LD, Accutane, Amnesteem, Claravis, generic isotretinoin caps, Zenatane	
Diagnosis	Persistent or Recurring Acne After 2 Months Off Therapy
Approval Length	5 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - After greater than or equal to 2 months OFF therapy, persistent or recurring severe recalcitrant nodular acne is still present	
Notes	Authorization will be given only by clinical pharmacist review for up to 5 months.

Product Name:Brand Absorica, Absorica LD, Accutane, Amnesteem, Claravis, generic isotretinoin caps, Zenatane	
Diagnosis	Dose Titration
Approval Length	1 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Confirmation that the cumulative dose is less than 150 mg/kg (milligrams/kilogram) (there is little therapeutic benefit to be gained by increasing the cumulative dose beyond 150 mg/kg)*	

Notes	Authorization will be given only by clinical pharmacist review for 1 month to allow for titration up to the target dose. *See Background for dosing regimens.

2 . Background

Benefit/Coverage/Program Information				
Dosing by Body Weight (based on administration with food):				
Body Weight		Daily Dose		
Kg	Lbs	0.5 mg/kg/day	1 mg/kg/day	2 mg/kg/day
40	88	20	40	80
50	110	25	50	100
60	132	30	60	120
70	154	35	70	140
80	176	40	80	160
90	198	45	90	180
100	220	50	100	200

3 . Revision History

Date	Notes
6/4/2025	Added new GPI for Amnesteem 30 mg strength. Removed Myorisan products as targets (obsolete). Updated product name lists and GPI tables accordingly. Minor cosmetic/spelling updates.

Isturisa (osilodrostat)



Prior Authorization Guideline

Guideline ID	GL-286217
Guideline Name	Isturisa (osilodrostat)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	7/1/2025

1 . Criteria

Product Name:Isturisa	
Diagnosis	Cushing's Syndrome
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Cushing's syndrome	

AND

2 - Used for treatment of endogenous hypercortisolemia

AND

3 - One of the following:

- Patient is not a candidate for surgery (e.g., adrenalectomy, transsphenoidal surgery)
- Surgery has not been curative for the patient

Product Name:Isturisa	
Diagnosis	Cushing's Syndrome
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient demonstrates positive clinical response to therapy (e.g., a clinically meaningful reduction in 24-hour urinary free cortisol levels, improvement in signs or symptoms of the disease)	

Product Name:Isturisa	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Isturisa will be approved for uses supported by The National Comprehensive Cancer	

Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1, 2A, or 2B.

2 . Revision History

Date	Notes
6/3/2025	Updated title. Updated Cushing's syndrome criteria due to revised indication, removed reauth for NCCN approved indications section (NCCN auth is 12 months)

Jesduvroq (daprodustat)



Prior Authorization Guideline

Guideline ID	GL-144070
Guideline Name	Jesduvroq (daprodustat)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	4/1/2024

1 . Criteria

Product Name:Jesduvroq	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chronic kidney disease (CKD)	

AND

2 - Patient has been on dialysis for at least 4 months

AND

3 - Adequate iron stores confirmed by BOTH of the following:

- Patient's ferritin level is greater than 100 mcg/L (micrograms per liter)
- Patient's transferrin saturation (TSAT) is greater than 20%

AND

4 - Hemoglobin level is less than 11 g/dL (grams per deciliter)

AND

5 - Trial and failure, contraindication, or intolerance to ONE of the following:

- Epogen
- Procrit
- Retacrit

AND

6 - Prescribed by or in consultation with ONE of the following:

- Hematologist
- Nephrologist

AND

7 - Patient is NOT on concurrent treatment with an erythropoietin stimulating agent [ESA] (e.g., Aranesp, Epogen, Procrit)

Product Name:Jesduvroq	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient demonstrates positive clinical response to therapy (e.g., increase in hemoglobin) AND 2 - Hemoglobin level does not exceed 12 g/dL (grams per deciliter) AND 3 - Adequate iron stores confirmed by BOTH of the following: • Patient's ferritin level is greater than 100 mcg/L (micrograms per liter) • Patient's transferrin saturation (TSAT) is greater than 20% AND 4 - Patient is NOT on concurrent treatment with an erythropoietin stimulating agent [ESA] (e.g., Aranesp, Epogen, Procrit)	

2 . Revision History

Date	Notes
3/7/2024	New program - C&S to align with AZM.

Joenja (leniolisib)



Prior Authorization Guideline

Guideline ID	GL-140985
Guideline Name	Joenja (leniolisib)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	8/1/2023

1 . Criteria

Product Name:Joenja	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes, laboratory values) documenting ALL of the following: 1.1 Diagnosis of activated phosphoinositide 3-kinase delta syndrome (APDS)	

AND

1.2 Molecular genetic testing confirms mutations in the PIK3CD or PIK3R1 gene

AND

1.3 BOTH of the following:

1.3.1 Presence of nodal and/or extranodal proliferation (e.g., lymphadenopathy, splenomegaly, hepatomegaly)

AND

1.3.2 Presence of other clinical findings and manifestations consistent with APDS (e.g., recurrent sino-pulmonary infections, bronchiectasis, enteropathy)

AND

1.4 Trial and failure, contraindication, or intolerance to at least ONE standard of care treatment for APDS [e.g., immunoglobulin replacement therapy, antimicrobial prophylaxis (e.g., azithromycin, bactrim), rituximab, tacrolimus, etc.]

AND

2 - Patient is 12 years of age or older

AND

3 - Patient weighs greater than or equal to 45 kg (kilograms)

AND

4 - Prescribed by or in consultation with ONE of the following:

- Hematologist
- Immunologist

Product Name: Joenja	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy (e.g., reduced lymph node size, increased naive B-cell percentage, decreased severity or frequency of infections/hospitalizations)	

2 . Revision History

Date	Notes
7/7/2023	New guideline.

Journavx (suzetrigine)



Prior Authorization Guideline

Guideline ID	GL-523188
Guideline Name	Journavx (suzetrigine)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name: Journavx	
Approval Length	14 Days (PTD of 28 tablets per 14 days)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is 18 years of age or older AND	

2 - Patient is experiencing a new episode of moderate to severe pain

AND

3 - The request is NOT for chronic pain

AND

4 - ONE of the following:

4.1 Patient does NOT have severe hepatic impairment (Child-Pugh Class C)

OR

4.2 BOTH of the following:

- Patient has moderate hepatic impairment
- A lower dose will be prescribed

AND

5 - BOTH of the following:

- Treatment duration request is for no longer than 14 days
- Requested quantity does NOT exceed 28 tablets

AND

6 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming patient has tried and failed ALL of the following, at maximum doses, in the past 30 days:

- celecoxib
- diclofenac sodium or diclofenac potassium
- ketorolac

AND

7 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming patient has tried and failed ONE of the following, at maximum doses, in the past 30 days:

- ibuprofen
- fenoprofen
- ketoprofen
- naproxen sodium

AND

8 - Medication will NOT be used in combination with opioid products (e.g., oxycodone, hydrocodone)

AND

9 - Medication will NOT be used in combination with strong CYP3A inhibitors (e.g., clarithromycin, itraconazole, ketoconazole, mifepristone, ritonavir, darunavir)

AND

10 - For female patients with reproductive potential (aged 14-44 years), prescriber attests to BOTH of the following:

- Patient is NOT pregnant prior to initiation of therapy
- Patients taking concomitant hormonal contraceptives containing progestins other than levonorgestrel and norethindrone have been advised to use alternative contraceptives during Journavx treatment and for 28 days after discontinuation of therapy

2 . Revision History

Date	Notes
2/11/2026	Updated approval length section. Updated criteria pertaining to medication use. Updated embedded step requirements. Added examples of CYP3A4 inhibitors, where applicable.

Juxtapid



Prior Authorization Guideline

Guideline ID	GL-603200
Guideline Name	Juxtapid
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Juxtapid	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of homozygous familial hypercholesterolemia (HoFH) as confirmed by BOTH of the following:* 1.1 ONE of the following:	

- Pre-treatment low density lipoprotein cholesterol (LDL-C) greater than 500 milligrams per deciliter
- Treated LDL-C greater than 300 milligrams per deciliter

AND

1.2 ONE of the following:

- Xanthoma before 10 years of age
- Evidence of heterozygous familial hypercholesterolemia (HeFH) in both parents

AND

2 - Used as an adjunct to a low-fat diet and exercise

AND

3 - Patient is receiving other lipid-lowering therapy (e.g., statin, ezetimibe, LDL apheresis)

AND

4 - Prescribed by ONE of the following:

- Cardiologist
- Endocrinologist
- Lipid specialist

AND

5 - Patient has tried, failed or intolerant to Repatha and Praluent

AND

6 - Not used in combination with a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor

Notes	Results of prior genetic testing can be submitted as confirmation of diagnosis of HoFH.

Product Name:Juxtapid	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is continuing a low-fat diet and exercise regimen AND 2 - Patient continues to receive other lipid-lowering therapy (e.g., statin, low density lipoprotein [LDL] apheresis) AND 3 - Submission of medical records (e.g. chart notes, laboratory values) documenting low density lipoprotein cholesterol (LDL-C) reduction while on Juxtapid therapy AND 4 - Prescribed by ONE of the following: • Cardiologist • Endocrinologist • Lipid specialist AND 5 - Not used in combination with a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor	

2 . Revision History

Date	Notes
5/6/2026	Updated title. Added GPI for new 2mg strength

Jynarque (tolvaptan)



Prior Authorization Guideline

Guideline ID	GL-369225
Guideline Name	Jynarque (tolvaptan)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	9/1/2025

1 . Criteria

Product Name:Brand Jynarque, generic tolvaptan	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of autosomal dominant polycystic kidney disease (ADPKD)	

AND

2 - If the request is for generic tolvaptan, trial and failure, or intolerance to Brand Jynarque (verified via paid pharmacy claims or submitted chart notes)

Product Name:Brand Jynarque, generic tolvaptan	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy AND 2 - If the request is for generic tolvaptan, trial and failure, or intolerance to Brand Jynarque (verified via paid pharmacy claims or submitted chart notes)	

2 . Revision History

Date	Notes
8/15/2025	Update to guideline name. Added generic tolvaptan products as targets. Added embedded step where generic tolvaptan requests are to step through Brand Jynarque.

Kalydeco (ivacaftor)



Prior Authorization Guideline

Guideline ID	GL-141011
Guideline Name	Kalydeco (ivacaftor)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	12/1/2023

1 . Criteria

Product Name:Kalydeco tabs/packet	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of cystic fibrosis (CF)	

AND

2 - Submission of laboratory results confirming that patient has ONE of the mutations in the cystic fibrosis transmembrane conductance regulator (CFTR) gene (see table in Background)

AND

3 - Prescribed by, or in consultation with, a specialist affiliated with a CF care center

Product Name:Kalydeco tabs/packet	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Provider attests that the patient has achieved a clinically meaningful response while on Kalydeco therapy to ONE of the following: • Lung function as demonstrated by percent predicted expiratory volume in 1 second (ppFEV1) • Body mass index (BMI) • Pulmonary exacerbations • Quality of life as demonstrated by Cystic Fibrosis Questionnaire-Revised (CFQ-R) respiratory domain score AND 2 - Prescribed by, or in consultation with, a specialist affiliated with a cystic fibrosis (CF) care center	

2 . Background

Benefit/Coverage/Program Information				
CFTR Gene Mutations that are Responsive to Kalydeco				
List of CFTR Gene Mutations that Produce CFTR Protein and are Responsive to KALYDECO				
711+3A→G *	F311del	I148T	R75Q	S589N
2789+5G→A *	F311L	I175V	R117C *	S737F
3272-26A→G *	F508C	I807M	R117G	S945L *
3849+10kbC→T *	F508C;S1251N †	I1027T	R117H *	S977F *
A120T	F1052V	I1139V	R117L	S1159F
A234D	F1074L	K1060T	R117P	S1159P
A349V	G178E	L206W *	R170H	S1251N *
A455E *	G178R *	L320V	R347H *	S1255P *
A1067T	G194R	L967S	R347L	T338I
D110E	G314E	L997F	R352Q *	T1053I
D110H	G551D *	L1480P	R553Q	V232D
D192G	G551S *	M152V	R668C	V562I
D579G *	G576A	M952I	R792G	V754M
D924N	G970D	M952T	R933G	V1293G
D1152H *	G1069R	P67L *	R1070Q	W1282R
D1270N	G1244E *	Q237E	R1070W *	Y1014C
E56K	G1249R	Q237H	R1162L	Y1032C
E193K	G1349D *	Q359R	R1283M	
E822K	H939R	Q1291R	S549N *	
E831X *	H1375P	R74W	S549R *	
* Clinical data exist for these mutations.				
† Complex/compound mutations where a single allele of the CFTR gene has multiple mutations; these exist independent of the presence of mutations on the other allele.				

3 . Revision History

Date	Notes
11/7/2023	Added GPI for 5.8 mg packs

Kerendia (finerenone)



Prior Authorization Guideline

Guideline ID	GL-421259
Guideline Name	Kerendia (finerenone)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	11/1/2025

1 . Criteria

Product Name:Kerendia	
Diagnosis	Chronic Kidney Disease Associated with Type 2 Diabetes
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chronic kidney disease (CKD) associated with type 2 diabetes (T2D)	

AND

2 - Urinary albumin-to-creatinine ratio (UACR) greater than or equal to 30 mg/g (milligrams/gram)

AND

3 - Estimated glomerular filtration rate (eGFR) greater than or equal to 25 mL/min/1.73 m² (milliliters/minute/1.73 square meter)

AND

4 - Serum potassium level less than or equal to 5.0 mEq/L (milliequivalents/liter) prior to initiating treatment

AND

5 - ONE of the following:

5.1 Minimum 30-day supply trial of a maximally tolerated dose and will continue therapy with ONE of the following:

- Generic angiotensin-converting enzyme (ACE) inhibitor (e.g., benazepril, lisinopril)
- Generic angiotensin II receptor blocker (ARB) (e.g., losartan, valsartan)

OR

5.2 Patient has a contraindication or intolerance to ACE inhibitors and ARBs

AND

6 - ONE of the following:

6.1 Patient is on a stable dose and will continue therapy with a sodium-glucose cotransporter-2 (SGLT2) inhibitor (e.g., Farxiga [dapagliflozin], Jardiance [empagliflozin])

OR

6.2 Patient has a contraindication or intolerance to an SGLT2 inhibitor (e.g., Farxiga [dapagliflozin], Jardiance [empagliflozin])

Product Name:Kerendia	
Diagnosis	Chronic Kidney Disease Associated with Type 2 Diabetes
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient demonstrates positive clinical response to therapy AND 2 - ONE of the following: 2.1 Patient continues to be on a maximally tolerated dose of ACE inhibitor or ARB OR 2.2 Patient has a contraindication or intolerance to ACE inhibitors and ARBs AND 3 - ONE of the following: 3.1 Patient continues to be on an SGLT2 inhibitor (e.g., Farxiga [dapagliflozin], Jardiance [empagliflozin])	

OR

3.2 Patient has a contraindication or intolerance to an SGLT2 inhibitor (e.g., Farxiga [dapagliflozin], Jardiance [empagliflozin])

Product Name:Kerendia	
Diagnosis	Heart Failure with Left Ventricular Ejection Fraction (LVEF) $\geq$ 40%
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of heart failure AND 2 - Patient has left ventricular ejection fraction (LVEF) greater than or equal to 40% AND 3 - Patient has New York Heart Association (NYHA) Class II, III, or IV symptoms AND 4 - Estimated glomerular filtration rate (eGFR) greater than or equal to 25 mL/min/1.73 m² (milliliters/minute/1.73 square meter) AND	

5 - Serum potassium level less than or equal to 5.0 mEq/L (milliequivalents/liter) prior to initiating treatment

AND

6 - BOTH of the following:

6.1 Patient is on diuretic treatment (e.g., bumetanide, furosemide) for the management of symptoms of heart failure for at least 30 days prior to initiating treatment

AND

6.2 Patient is NOT receiving drug in combination with spironolactone or eplerenone

AND

7 - ONE of the following:

7.1 Patient is on a stable dose and will continue therapy with a sodium-glucose cotransporter-2 (SGLT2) inhibitor (e.g., Farxiga [dapagliflozin], Jardiance [empagliflozin])

OR

7.2 Patient has a contraindication or intolerance to an SGLT2 inhibitor (e.g., Farxiga [dapagliflozin], Jardiance [empagliflozin])

AND

8 - Prescribed by or in consultation with a cardiologist

Product Name:Kerendia	
Diagnosis	Heart Failure with Left Ventricular Ejection Fraction (LVEF) $\geq$ 40%
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Patient demonstrates positive clinical response to therapy AND 2 - ONE of the following: 2.1 Patient continues to be on an SGLT2 inhibitor (e.g., Farxiga [dapagliflozin], Jardiance [empagliflozin]) OR 2.2 Patient has a contraindication or intolerance to an SGLT2 inhibitor (e.g., Farxiga [dapagliflozin], Jardiance [empagliflozin])	

2 . Revision History

Date	Notes
10/14/2025	Added criteria for new HF indication, added new strength. Added step through SGLT2 for CKD indication

Keveyis



Prior Authorization Guideline

Guideline ID	GL-140848
Guideline Name	Keveyis
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2020

1 . Criteria

Product Name:Keveyis	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Diagnosis of primary hyperkalemic periodic paralysis or related variant	

OR

1.2 Diagnosis of primary hypokalemic periodic paralysis or related variant

Product Name:Keveyis	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Keveyis therapy	

2 . Revision History

Date	Notes
3/31/2020	Bulk copy C&S New York SP to C&S Arizona SP for 5/1 effective

Kevzara (sarilumab)



Prior Authorization Guideline

Guideline ID	GL-324210
Guideline Name	Kevzara (sarilumab)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	8/1/2025

1 . Criteria

Product Name:Kevzara	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) or verification of paid claims documenting ALL of the following:	

1.1 Diagnosis of moderately to severely active rheumatoid arthritis (RA)

AND

1.2 History of failure to a 3 month trial of ONE non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] at maximally indicated doses within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

1.3 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred^ adalimumab biosimilar or Enbrel (etanercept)
- infliximab
- Orencia (abatacept)
- Xeljanz (tofacitinib) oral tablet (IR or XR)
- A preferred^ tocilizumab biosimilar

AND

2 - Prescribed by or in consultation with a rheumatologist

Notes	^PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC CP

Product Name:Kevzara	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy as evidenced by at least ONE of the following:

- Reduction in the total active (swollen and tender) joint count from baseline
- Improvement in symptoms (e.g., pain, stiffness, inflammation) from baseline

AND

2 - Prescribed by or in consultation with a rheumatologist

Product Name:Kevzara	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (PJIA)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of active polyarticular juvenile idiopathic arthritis (PJIA) AND 2 - Patient weighs at least 63 kg (kilograms) AND 3 - Prescribed by or in consultation with a rheumatologist AND 4 - Paid claims or submission of medical records (e.g., chart notes) confirming a minimum duration of a 6-week trial and failure, contraindication, or intolerance to ONE of the following conventional therapies at maximally tolerated doses:	

- leflunomide
- methotrexate

AND

5 - Paid claims or submission of medical records (e.g., chart notes) confirming a trial and failure, contraindication, or intolerance to ALL of the following:

- A preferred^ adalimumab biosimilar or Enbrel (etanercept)
- Orencia (abatacept)
- Xeljanz (tofacitinib) oral tablet
- A preferred^ tocilizumab biosimilar

Notes	^PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:Kevzara	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (PJIA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy as evidenced by at least ONE of the following: • Reduction in the total active (swollen and tender) joint count from baseline • Improvement in symptoms (e.g., pain, stiffness, inflammation) from baseline AND 2 - Prescribed by or in consultation with a rheumatologist	

Product Name:Kevzara

Diagnosis	Polymyalgia Rheumatica (PMR)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of polymyalgia rheumatica (PMR) AND 2 - ONE of the following: 2.1 Patient has had an inadequate response to corticosteroids (e.g., prednisone) OR 2.2 Patient cannot tolerate tapering of corticosteroids (e.g., prednisone) AND 3 - Prescribed by or in consultation with a rheumatologist	

Product Name:Kevzara	
Diagnosis	Polymyalgia Rheumatica (PMR)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy as evidenced by at least ONE of the following:

- Improvement in symptoms (e.g., pain, stiffness) or lab values (e.g., C-reactive protein) from baseline
- Reduced need for corticosteroids (e.g., prednisone)

AND

2 - Prescribed by or in consultation with a rheumatologist

2 . Revision History

Date	Notes
7/16/2025	Updates to initial auth sections for RA and PJIA.

Kineret (anakinra)



Prior Authorization Guideline

Guideline ID	GL-324214
Guideline Name	Kineret (anakinra)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	8/1/2025

1 . Criteria

Product Name:Kineret	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming ALL of the following:	

1.1 Diagnosis of moderately to severely active rheumatoid arthritis (RA)

AND

1.2 History of failure to a 3 month trial of ONE non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] at maximally indicated doses within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

1.3 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred^ adalimumab biosimilar or Enbrel (etanercept)
- infliximab
- Orencia (abatacept)
- Xeljanz (tofacitinib) oral tablet (IR or XR)
- A preferred^ tocilizumab biosimilar

AND

2 - Prescribed by or in consultation with a rheumatologist

Notes	^PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC CP

Product Name:Kineret	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy	

AND

2 - Prescribed by or in consultation with a rheumatologist

Product Name:Kineret

Diagnosis	Systemic Juvenile Idiopathic Arthritis (SJIA)

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming the diagnosis of active systemic juvenile idiopathic arthritis

AND

2 - Prescribed by or in consultation with a rheumatologist

AND

3 - Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure, contraindication, or intolerance to ONE of the following:

- Nonsteroidal anti-inflammatory drug (NSAID) (e.g., Motrin [ibuprofen], Naprosyn [naproxen])
- Systemic glucocorticoid (e.g., prednisone)

AND

4 - Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure, contraindication, or intolerance to a preferred[^] tocilizumab biosimilar

Notes	^PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:Kineret	
Diagnosis	Systemic Juvenile Idiopathic Arthritis (SJIA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy AND 2 - Prescribed by or in consultation with a rheumatologist	

Product Name:Kineret	
Diagnosis	Neonatal-Onset Multisystem Inflammatory Disease (NOMID)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming the diagnosis of neonatal-onset multisystem inflammatory disease (NOMID) AND 2 - Diagnosis of NOMID has been confirmed by ONE of the following:	

2.1 NLRP-3 (nucleotide-binding domain, leucine rich family (NLR), pyrin domain containing 3-gene (also known as Cold-Induced Auto-inflammatory Syndrome-1 [CIAS1]) mutation

OR

2.2 BOTH of the following:

2.2.1 TWO of the following clinical symptoms:

- Urticaria-like rash
- Cold/stress triggered episodes
- Sensorineural hearing loss
- Musculoskeletal symptoms (e.g., arthralgia, arthritis, myalgia)
- Chronic aseptic meningitis
- Skeletal abnormalities (e.g., epiphyseal overgrowth, frontal bossing)

AND

2.2.2 Elevated acute phase reactants (e.g., erythrocyte sedimentation rate [ESR], C-reactive protein [CRP], serum amyloid A [SAA])

AND

3 - Prescribed by or in consultation with ONE of the following:

- Allergist/Immunologist
- Rheumatologist
- Pediatrician

Product Name:Kineret	
Diagnosis	Neonatal-Onset Multisystem Inflammatory Disease (NOMID)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

Product Name:Kineret

Diagnosis	Deficiency of Interleukin-1 Receptor Antagonist (DIRA)

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming the diagnosis of deficiency of interleukin-1 receptor antagonist (DIRA)

2 . Revision History

Date	Notes
7/15/2025	Updated formatting of criteria sections. Updated initial and reauth sections for RA and SJIA.

Korlym



Prior Authorization Guideline

Guideline ID	GL-140849
Guideline Name	Korlym
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2020

1 . Criteria

Product Name:Korlym	
Diagnosis	Endogenous Cushing's Syndrome
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ALL of the following:	

1.1 Diagnosis of Endogenous Cushing's Syndrome (i.e., hypercortisolism is not a result of chronic administration of high dose glucocorticoids)

AND

1.2 ONE of the following:

- Diagnosis of type 2 diabetes mellitus
- Diagnosis of glucose intolerance

AND

1.3 ONE of the following:

- Patient has failed surgery
- Patient is not a candidate for surgery

Product Name:Korlym	
Diagnosis	Endogenous Cushing's Syndrome
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of ONE of the following: • Patient has improved glucose tolerance while on Korlym therapy • Patient has stable glucose tolerance while on Korlym therapy	

2 . Revision History

UnitedHealthcare Community Plan of Arizona Clinical Pharmacy Program Guidelines

Date	Notes
3/31/2020	Bulk copy C&S New York SP to C&S Arizona SP for 5/1 effective

LAMA-LABA



Prior Authorization Guideline

Guideline ID	GL-288260
Guideline Name	LAMA-LABA
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	7/1/2025

1 . Criteria

Product Name: Brand Anoro Ellipta, Brand Umeclidinium-Vilanterol Ellipta, Bevespi Aerosphere, Stiolto Respimat	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chronic obstructive pulmonary disease (COPD) AND	

2 - ONE of the following:

2.1 History of failure, contraindication, or intolerance to treatment with a 30 day trial of a long-acting beta-agonist (e.g., Foradil, Serevent, Striverdi, Arcapta)

OR

2.2 History of failure, contraindication, or intolerance to treatment with a 30 day trial of an orally inhaled anticholinergic agent (e.g., Spiriva, Atrovent, Combivent, Tudorza)

AND

3 - If the request is for Bevespi Aerosphere, history of failure, contraindication, or intolerance to treatment with a 30 day trial of both of the following preferred drugs:

- Brand Anoro Ellipta
- Stiolto Respimat

AND

4 - If the request is for Brand Umeclidinium-Vilanterol Ellipta, history of failure or intolerance to Brand Anoro Ellipta

2 . Revision History

Date	Notes
6/4/2025	Added Brand Umeclidinium-Vilanterol Ellipta as a target. Updated product name list and GPI table accordingly. Updated embedded step requirements in criteria section. Minor cosmetic updates.

Lantidra (donislecel-jujn)



Prior Authorization Guideline

Guideline ID	GL-141015
Guideline Name	Lantidra (donislecel-jujn)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name:Lantidra	
Approval Length	30 Day(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting ALL of the following: 1.1 Diagnosis of Type 1 diabetes	

AND

1.2 Patient is insulin dependent

AND

1.3 Patient is unable to approach target HbA1c (Hemoglobin A1c) because of current repeated episodes of severe hypoglycemia despite intensive diabetes management and education

AND

1.4 Patient has reduced awareness of hypoglycemia, as defined by the absence of adequate autonomic symptoms at glucose levels of less than 54 mg/dL (milligrams per deciliter)

AND

1.5 Patient has had at least one episode of severe hypoglycemia in the past 3 years with both of the following:

1.5.1 Patient required assistance of another person

AND

1.5.2 One of the following:

1.5.2.1 Symptoms were associated with a blood glucose level less than 50 mg/dL

OR

1.5.2.2 Prompt recovery after oral carbohydrate, intravenous glucose, or glucagon administration

AND

1.6 Patient will be on concomitant immunosuppression (e.g., daclizumab, sirolimus, tacrolimus, etanercept, mycophenolate mofetil, etc.)

AND

2 - Prescribed by or in consultation with an endocrinologist

AND

3 - Patient has not had more than three infusions of Lantidra in their lifetime*

Notes	*There are no data regarding the effectiveness or safety for patients receiving more than three infusions.

Product Name:Lantidra	
Approval Length	30 Day(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting that patient has not achieved independence from exogenous insulin within one year of infusion or within one year after losing independence from exogenous insulin after previous infusion AND 2 - Patient has not had more than three infusions of Lantidra in their lifetime*	
Notes	*There are no data regarding the effectiveness or safety for patients receiving more than three infusions.

2 . Revision History

UnitedHealthcare Community Plan of Arizona Clinical Pharmacy Program Guidelines

Date	Notes
12/6/2023	New guideline

Leqvio (inclisiran)



Prior Authorization Guideline

Guideline ID	GL-605194
Guideline Name	Leqvio (inclisiran)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Leqvio	
Diagnosis	Heterozygous Familial Hypercholesterolemia (HeFH), Atherosclerotic Cardiovascular Disease (ASCVD)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting ONE of the following diagnoses:	

1.1 Heterozygous familial hypercholesterolemia (HeFH) as confirmed by ONE of the following:

1.1.1 BOTH of the following:

1.1.1.1 Untreated/pre-treatment LDL-cholesterol (LDL-C) greater than 190 mg/dL

AND

1.1.1.2 ONE of the following:

- Family history of myocardial infarction in first-degree relative less than 60 years of age
- Family history of myocardial infarction in second-degree relative less than 50 years of age
- Family history of LDL-C greater than 190 mg/dL in first- or second-degree relative
- Family history of familial hypercholesterolemia in first- or second-degree relative
- Family history of tendinous xanthomata and/or arcus cornealis in first- or second-degree relative

OR

1.1.2 BOTH of the following:

1.1.2.1 Untreated/pre-treatment LDL-cholesterol (LDL-C) greater than 190 mg/dL

AND

1.1.2.2 ONE of the following:

- Functional mutation in the LDL receptor, ApoB, or PCSK9 gene
- Tendinous xanthomata
- Arcus cornealis before age 45

OR

1.2 Atherosclerotic cardiovascular disease (ASCVD) as confirmed by ONE of the following:

- Acute coronary syndromes
- History of myocardial infarction
- Stable or unstable angina

- Coronary or other arterial revascularization
- Stroke
- Transient ischemic attack
- Peripheral arterial disease presumed to be of atherosclerotic origin

AND

2 - ONE of the following:

- For diagnosis of HeFH: Patient is 12 years of age or older
- For diagnosis of ASCVD: Patient is 18 years of age or older

AND

3 - ONE of the following:

3.1 Patient has been receiving at least 12 consecutive weeks of HIGH-INTENSITY statin therapy [i.e., atorvastatin 40-80 mg, rosuvastatin 20-40 mg] and will continue to receive a HIGH-INTENSITY statin at maximally tolerated dose

OR

3.2 BOTH of the following:

3.2.1 Patient is unable to tolerate high-intensity statin as evidenced by ONE of the following intolerable and persistent (i.e., more than 2 weeks) symptoms:

- Myalgia (muscle symptoms without CK elevations)
- Myositis (muscle symptoms with CK elevations less than 10 times upper limit of normal [ULN])

AND

3.2.2 ONE of the following:

- Patient has been receiving at least 12 consecutive weeks of MODERATE-INTENSITY statin therapy [i.e., atorvastatin 10-20 mg, rosuvastatin 5-10 mg, simvastatin 20-40 mg, pravastatin 40-80 mg, lovastatin 40 mg, Lescol XL (fluvastatin XL) 80 mg, fluvastatin 40 mg twice daily, or Livalo (pitavastatin) 2-4 mg] and will continue to receive a MODERATE-INTENSITY statin at maximally tolerated dose

- Patient has been receiving at least 12 consecutive weeks of LOW-INTENSITY statin therapy [i.e., simvastatin 10 mg, pravastatin 10-20 mg, lovastatin 20 mg, fluvastatin 20-40 mg, Livalo (pitavastatin) 1 mg] and will continue to receive a LOW-INTENSITY statin at maximally tolerated dose

OR

3.3 Patient is unable to tolerate low- or moderate-, and high-intensity statins as evidenced by ONE of the following intolerable and persistent (i.e., more than 2 weeks) symptoms for low- or moderate-, and high-intensity statins:

- Myalgia (muscle symptoms without CK elevations)
- Myositis (muscle symptoms with CK elevations less than 10 times ULN)

OR

3.4 Patient has a labeled contraindication to all statins

OR

3.5 Patient has experienced rhabdomyolysis or muscle symptoms with statin treatment with CK elevations greater than 10 times ULN

AND

4 - ONE of the following:

4.1 Patient has been receiving at least 12 consecutive weeks of ezetimibe (Zetia) therapy as adjunct to maximally tolerated statin therapy

OR

4.2 Patient has a history of contraindication or intolerance to ezetimibe

AND

5 - Patient is unable to maintain adherence to proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor therapy

AND

6 - Submission of medical records (e.g., chart notes) documenting ONE of the following LDL-C values while on maximally tolerated lipid lowering therapy within the last 120 days:

- LDL-C greater than or equal to 55 mg/dL for diagnosis of ASCVD
- LDL-C greater than or equal to 100 mg/dL for diagnosis of HeFH

AND

7 - Prescribed by or in consultation with ONE of the following:

- Cardiologist
- Endocrinologist
- Lipid specialist

AND

8 - Medication will NOT be used in combination with PCSK9 inhibitor therapy

Product Name:Leqvio	
Diagnosis	Heterozygous Familial Hypercholesterolemia (HeFH), Atherosclerotic Cardiovascular Disease (ASCVD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting LDL-C reduction from baseline while on therapy	

AND

2 - ONE of the following:

2.1 Patient continues to receive other lipid-lowering therapy (e.g., statins, ezetimibe) at the maximally tolerated dose

OR

2.2 Patient has a documented inability to take other lipid-lowering therapy (e.g., statins, ezetimibe)

AND

3 - Medication will NOT be used in combination with PCSK9 inhibitor therapy

Product Name:Leqvio	
Diagnosis	Homozygous Familial Hypercholesterolemia (HoFH)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of homozygous familial hypercholesterolemia (HoFH) as confirmed by ONE of the following: 1.1 Genetic confirmation of 2 mutations in the LDL receptor, ApoB, PCSK9, or LDL receptor adaptor protein 1 (i.e., LDLRAP1 or ARH) OR 1.2 BOTH of the following:	

1.2.1 Untreated/pre-treatment LDL-cholesterol (LDL-C) greater than 400 mg/dL

AND

1.2.2 ONE of the following:

- Xanthoma before 20 years of age
- Evidence of heterozygous familial hypercholesterolemia in both parents

AND

2 - Patient is 12 years of age or older

AND

3 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming ONE of the following:

3.1 Patient is receiving other lipid-lowering therapy (e.g., statins, ezetimibe)

OR

3.2 Patient has a documented inability to take other lipid-lowering therapy (e.g., statins, ezetimibe)

AND

4 - Prescribed by or in consultation with ONE of the following:

- Cardiologist
- Endocrinologist
- Lipid specialist

Product Name:Leqvio	
Diagnosis	Homozygous Familial Hypercholesterolemia (HoFH)

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting LDL-C reduction from baseline while on therapy AND 2 - ONE of the following: 2.1 Patient continues to receive other lipid-lowering therapy (e.g., statins, ezetimibe) OR 2.2 Patient has a documented inability to take other lipid-lowering therapy (e.g., statins, ezetimibe)	

2 . Revision History

Date	Notes
5/6/2026	Added new criteria for HoFH indication. For HeFH/ASCVD, added age requirement in initial auth section and updated submission of records verbiage, where applicable.

Leucovorin



Prior Authorization Guideline

Guideline ID	GL-449199
Guideline Name	Leucovorin
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	12/1/2025

1 . Criteria

Product Name:Leucovorin tablets	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Methotrexate toxicity prophylaxis	

OR

1.2 Treatment of hematologic toxicity from folic acid antagonists (i.e., pyrimethamine toxicity treatment or trimethoprim toxicity treatment)

OR

1.3 Submission of medical records (e.g., chart notes) documenting a diagnosis of cerebral folate deficiency (CFD)

2 . Revision History

Date	Notes
11/11/2025	Updated guideline name. Minor update to product name section. Added diagnosis of cerebral folate deficiency as an option.

Libervant, Nayzilam, Valtoco



Prior Authorization Guideline

Guideline ID	GL-292192
Guideline Name	Libervant, Nayzilam, Valtoco
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	7/1/2025

1 . Criteria

Product Name:Libervant, Nayzilam, Valtoco	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of epilepsy	

AND

2 - Requested medication is being prescribed for the acute treatment of intermittent, stereotypic episodes of frequent seizure activity that are distinct from a patient's usual seizure pattern

Product Name:Libervant, Nayzilam, Valtoco	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy	

Product Name:Nayzilam, Valtoco	
Diagnosis	Requests Exceeding Quantity Limit
Approval Length	12 month(s)
Guideline Type	Quantity Limit
Approval Criteria 1 - One of the following*: - For Nayzilam: Physician has provided rationale for needing to exceed the quantity limit of 2 boxes per 30 days - For Valtoco: Physician has provided rationale for needing to exceed the quantity limit of 1 box per 30 days AND	

2 - The requested dose is within the FDA (Food and Drug Administration) maximum dose per day	
Notes	*Nayzilam QL is 2 boxes (containing 2 doses each box) per 30 days. Valtoco QL is 1 box (containing 5 doses) per 30 days

2 . Revision History

Date	Notes
6/5/2025	Updated QL for Valtoco, added note for clarification.

Lidoderm (lidocaine) 5% patches



Prior Authorization Guideline

Guideline ID	GL-140762
Guideline Name	Lidoderm (lidocaine) 5% patches
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	1/1/2023

1 . Criteria

Product Name:Brand Lidoderm patch, generic lidocaine 5% patch	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following: 1.1 The requested drug must be used for a Food and Drug Administration-approved indication or	

1.2 The use of this drug is supported by information from ONE of the following appropriate compendia of current literature:

- Food and Drug Administration approved indications and limits
- Published practice guidelines and treatment protocols
- Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes
- Drug Facts and Comparisons
- American Hospital Formulary Service Drug Information
- United States Pharmacopeia - Drug Information
- DRUGDEX Information System
- UpToDate
- MicroMedex
- Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies
- Other drug reference resources

2 . Revision History

Date	Notes
12/12/2022	New guideline

Livdelzi (seladelpar)



Prior Authorization Guideline

Guideline ID	GL-159587
Guideline Name	Livdelzi (seladelpar)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	12/1/2024

1 . Criteria

Product Name:Livdelzi	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of primary biliary cholangitis (PBC) (also known as primary biliary cirrhosis)	

AND

2 - Submission of medical records (e.g., chart notes) or paid claims documenting ONE of the following:

2.1 BOTH of the following:

2.1.1 Patient has failed to achieve an alkaline phosphatase (ALP) level of less than 1.67 times the upper limit of normal (ULN) after at least 12 consecutive months of treatment with ursodeoxycholic acid (UDCA) (e.g., Urso, Urso Forte, ursodiol)

AND

2.1.2 Used in combination with ursodeoxycholic acid (UDCA)

OR

2.2 History of contraindication or intolerance to ursodeoxycholic acid (UDCA)

AND

3 - Requested drug will NOT be used in combination with Ocaliva (obeticholic acid) or Iqirvo (elafibranor)

AND

4 - Prescribed by or in consultation with ONE of the following:

- Hepatologist
- Gastroenterologist

Product Name:Livdelzi	
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy (e.g., ALP level less than 1.67 times ULN, total bilirubin less than or equal to ULN, ALP decrease greater than or equal to 15% from baseline) AND 2 - Requested drug will NOT be used in combination with Ocaliva (obeticholic acid) or Iqirvo (elafibranor)	

2 . Revision History

Date	Notes
11/7/2024	New program.

Livmarli (maralixibat)



Prior Authorization Guideline

Guideline ID	GL-287354
Guideline Name	Livmarli (maralixibat)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	7/1/2025

1 . Criteria

Product Name:Livmarli	
Diagnosis	Alagille Syndrome (ALGS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming BOTH of the following: 1.1 Diagnosis of Alagille syndrome (ALGS)	

AND

1.2 Molecular genetic testing confirms mutations in the JAG1 or NOTCH2 gene

AND

2 - Documentation of ONE of the following:

- Total serum bile acid > 3x the upper limit of normal (ULN)
- Conjugated bilirubin > 1 mg/dL (milligrams/deciliter)
- Fat soluble vitamin deficiency otherwise unexplainable
- Gammaglutamyl transpeptidase (GGT) > 3x ULN

AND

3 - Patient is experiencing moderate to severe cholestatic pruritus

AND

4 - Patient has had an inadequate response to at least TWO of the following treatments used for the relief of pruritus:

- Ursodeoxycholic acid (e.g., Ursodiol)
- Antihistamines (e.g., diphenhydramine, hydroxyzine)
- Rifampin
- Bile acid sequestrants (e.g., Questran, Colestid, Welchol)

AND

5 - Patient is 3 months of age or older

AND

6 - Prescribed by or in consultation with a hepatologist

Product Name:Livmarli	
Diagnosis	Progressive Familial Intrahepatic Cholestasis (PFIC)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming BOTH of the following: 1.1 Diagnosis of progressive familial intrahepatic cholestasis (PFIC) AND 1.2 Molecular genetic testing confirms mutations in the ATP8B1, ABCB11, ABCB4, TJP2, NR1H4, or MYO5B gene AND 2 - Patient is experiencing BOTH of the following: • Moderate to severe pruritus • Patient has a serum bile acid concentration above the upper limit of the normal reference for the reporting laboratory AND 3 - Patient is 12 months of age or older AND 4 - Patient has had an inadequate response to at least TWO of the following treatments used for the relief of pruritus: • Ursodeoxycholic acid (e.g., Ursodiol) • Antihistamines (e.g., diphenhydramine, hydroxyzine)	

- Rifampin
- Bile acid sequestrants (e.g., Questran, Colestid, Welchol)

AND

5 - Prescribed by or in consultation with ONE of the following:

- Hepatologist
- Gastroenterologist

Product Name:Livmarli	
Diagnosis	Alagille Syndrome (ALGS), Progressive Familial Intrahepatic Cholestasis (PFIC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy (e.g., reduced bile acids, reduced pruritus severity score)	

2 . Revision History

Date	Notes
6/4/2025	Added GPIs for new tablet formulations

Livtency



Prior Authorization Guideline

Guideline ID	GL-140947
Guideline Name	Livtency
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	12/1/2022

1 . Criteria

Product Name:Livtency	
Diagnosis	CMV infection/disease
Approval Length	8 Week(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of cytomegalovirus (CMV) infection/disease as confirmed by one of the following methods: quantitative polymerase chain reaction (qPCR)	

- CMV pp65 antigenemia

AND

2 - Patient is a recipient of one of the following:

- Hematopoietic stem cell transplant
- Solid organ transplant

AND

3 - Trial and failure of a minimum 2 weeks duration, contraindication, or intolerance to one of the following therapies at an appropriately indicated dose:

- Intravenous (IV) ganciclovir
- Oral valganciclovir
- IV foscarnet
- IV cidofovir

AND

4 - Patient is 12 years of age or older

AND

5 - Patient weighs greater than or equal to 35kg

AND

6 - Prescribed by or in consultation with a provider who specializes in one of the following areas:

- Transplant
- Infectious Disease

2 . Revision History

Date	Notes
10/28/2022	Removed references and end note, no changes to clinical criteria.

Lodoco (colchicine)



Prior Authorization Guideline

Guideline ID	GL-140826
Guideline Name	Lodoco (colchicine)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	12/1/2023

1 . Criteria

Product Name:Lodoco	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of cardiovascular disease (CV)	

AND

2 - Used for the secondary prevention of CV disease

AND

3 - Patient is on guideline therapy management for multiple risk factors (e.g., dyslipidemia, hypertension, hyperglycemia) associated with CV disease

AND

4 - Submission of medical records (e.g., chart notes) or paid claims documenting trial and failure or intolerance to colchicine 0.6 mg tablets

Product Name:Lodoco	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient demonstrates positive clinical response to therapy(e.g., reduced risk of cardiovascular death, myocardial infarction, ischemia-driven coronary revascularization)	

2 . Revision History

Date	Notes
11/7/2023	New GL

Long-Acting Opioid Products



Prior Authorization Guideline

Guideline ID	GL-562225
Guideline Name	Long-Acting Opioid Products
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:generic morphine sulfate ER tabs, Brand MS Contin, morphine sulfate ER caps, morphine sulfate beads caps ER, fentanyl patches, generic hydrocodone ER tabs, Brand Hysingla ER, oxymorphone ER, Tapentadol ER, oxycodone ER, Oxycontin, Conzip, tramadol ER biphasic release caps, tramadol ER biphasic release tabs, tramadol ER tabs (non-biphasic release), generic methadone tabs/concentrate/soln/tabs for oral susp, Brand Methadose, hydromorphone ER, hydrocodone ER caps	
Diagnosis	PA REQUIRED for use of MAT and other Opioids
Guideline Type	DUR
Approval Criteria	

1 - Provider attests to notify the prescriber of the MAT (medication assisted treatment) therapy and the prescriber of the MAT therapy approves the concurrent opioid therapy

AND

2 - The days supply does not exceed 14 days for a surgical procedure

AND

3 - The days supply does not exceed 5 days for all other requests

AND

4 - There has not been a previous approval in the last 6 months

Notes	Approval Length: 14 Days for surgical procedure, 5 Days for all other requests

Product Name:generic morphine sulfate ER tabs, fentanyl patches 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr, 100 mcg/hr, tramadol ER tabs (non-biphasic release), Oxycontin, generic methadone tabs/concentrate/soln/tabs for oral susp

Diagnosis	Cancer related pain/Hospice care/end-of-life care*
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Patient is being treated for cancer

OR

1.2 Patient is receiving hospice or end-of-life care

Notes	*If the patient is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be issued and a maximum 30 day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment.

Product Name: Brand MS Contin, morphine sulfate ER caps, morphine sulfate beads caps ER, fentanyl patches 37.5mcg/hr, 62.5mcg/hr, and 87.5mcg/hr, generic hydrocodone ER tabs, Brand Hysingla ER, oxymorphone ER, Tapentadol ER, oxycodone ER, Brand Methadose, hydromorphone ER, hydrocodone ER caps	
Diagnosis	Cancer related pain/Hospice care/end-of-life care*
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Patient is being treated for cancer OR 1.2 Patient is receiving hospice or end-of-life care AND 2 - BOTH of the following: 2.1 ONE of the following: 2.1.1 The patient has a history of failure, contraindication, or intolerance to a trial of at least THREE of the following (Document drugs and date of trials):* • morphine sulfate controlled release tablets (specifically generic MS Contin) • preferred fentanyl transdermal (12 mcg, 25 mcg, 50 mcg, 75 mcg, 100 mcg)** • Brand Butrans (buprenorphine) transdermal • Brand Oxycontin • tramadol extended release tablets (non-biphasic release tablets)	

- generic methadone tablets/concentrate/soln/tablets for oral susp

OR

2.1.2 Patient is established on pain therapy with the requested medication for cancer, hospice care, or end-of-life care pain, and the medication is not a new regimen for treatment of cancer, hospice care, or end-of-life care pain (Document date regimen was started)

AND

2.2 Prescriber attests to the following: the information provided is true and accurate to the best of their knowledge and they understand that a routine audit may be performed and the medical information necessary to verify the accuracy of the information provided may be requested

Notes	*If the patient is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be issued and a maximum 30-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. *If the request is for a non-preferred product and the patient is currently taking the requested long-acting opioid for at least 30 days and has met the medical necessity authorization criteria requirements for treatment with an opioid, but has not tried the preferred alternatives a denial should be issued and a maximum 30-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. *Claims history may be used in conjunction as documentation of drug, date, and duration of trial. **Fentanyl transdermal 37.5mcg/hr, 62.5mcg/hr, and 87.5mcg/hr are non-preferred.

Product Name:Conzip, tramadol ER biphasic release caps, tramadol ER biphasic release tabs	
Diagnosis	Cancer related pain/Hospice care/end-of-life care*
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria	

1 - ONE of the following:

1.1 Patient is being treated for cancer

OR

1.2 Patient is receiving hospice or end-of-life care

AND

2 - BOTH of the following:

2.1 ONE of the following:

2.1.1 The patient has a history of failure, contraindication or intolerance to a trial of BOTH of the following (Document drugs and date of trials):*

- tramadol immediate release (IR)
- tramadol extended release tablets (non-biphasic release tablets)

OR

2.1.2 Patient is established on pain therapy with the requested medication for cancer, hospice care, or end-of-life care pain, and the medication is not a new regimen for treatment of cancer, hospice care, or end-of-life care pain (Document date regimen was started)

AND

2.2 Prescriber attests to the following: the information provided is true and accurate to the best of their knowledge and they understand that a routine audit may be performed and the medical information necessary to verify the accuracy of the information provided may be requested

Notes

*If the patient is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be issued and a maximum 30-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment.
*Claims history may be used in conjunction as documentation of drug, date, and duration of trial.

Product Name:generic morphine sulfate ER tabs, fentanyl patches 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr, 100 mcg/hr, tramadol ER tabs (non-biphasic release), Oxycontin, generic methadone tabs/concentrate/soln/tabs for oral susp	
Diagnosis	Non-cancer pain/Non-hospice care/Non-end-of-life care pain*
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Prescriber attests to ALL of the following:

- The information provided is true and accurate to the best of their knowledge and they understand that a routine audit may be performed and the medical information necessary to verify the accuracy of the information provided may be requested
- Treatment goals are defined, including estimated duration of treatment
- Treatment plan includes the use of a non-opioid analgesic and/or non-pharmacologic intervention
- Patient has been screened for substance abuse/opioid dependence
- If used in patients with medical comorbidities or if used concurrently with a benzodiazepine or other drugs that could potentially cause drug-drug interactions, the prescriber has acknowledged that they have completed an assessment of increased risk for respiratory depression
- Pain is moderate to severe and expected to persist for an extended period of time
- Pain is chronic
- Pain is not postoperative (unless the patient is already receiving chronic opioid therapy prior to surgery, or if the postoperative pain is expected to be moderate to severe and persist for an extended period of time)
- Pain management is required around the clock with a long-acting opioid

AND

2 - ONE of the following:

2.1 Prior to the start of therapy with the long-acting opioid, the patient has failed an adequate (minimum of 2 week) trial of a short-acting opioid within the last 30 days [Document drug(s) and date of trial]*

OR

2.2 The patient is already receiving chronic opioid therapy prior to surgery for postoperative pain

OR

2.3 Postoperative pain is expected to be moderate to severe and persist for an extended period of time

AND

3 - If the request for neuropathic pain (examples of neuropathic pain include neuralgias, neuropathies, fibromyalgia), BOTH of the following:

3.1 Unless it is contraindicated, the patient has not exhibited an adequate response to 8 weeks of treatment with gabapentin titrated to a therapeutic dose (Document date of trial)*

AND

3.2 Unless it is contraindicated, the patient has not exhibited an adequate response to at least 6 weeks of treatment with a tricyclic antidepressant titrated to the maximum tolerated dose (Document drug and date of trial)*

Notes	*If the patient is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be issued and a maximum 30-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. *Claims history may be used in conjunction as documentation of drug, date, and duration of trial. **Fentanyl transdermal 37.5mcg/hr, 62.5mcg/hr, and 87.5 mcg/hr are non-preferred.

Product Name: Brand MS Contin, morphine sulfate ER caps, morphine sulfate beads caps ER, fentanyl patches 37.5mcg/hr, 62.5mcg/hr, and 87.5mcg/hr, generic hydrocodone ER tabs, Brand Hysingla ER, oxycodone ER, Tapentadol ER, oxycodone ER, Brand Methadose, hydromorphone ER, hydrocodone ER caps

Diagnosis	Non-cancer pain/Non-hospice care/Non-end-of-life care pain*
Approval Length	6 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Prescriber attests to ALL of the following: • The information provided is true and accurate to the best of their knowledge and they understand that a routine audit may be performed and the medical information necessary to verify the accuracy of the information provided may be requested • Treatment goals are defined, including estimated duration of treatment • Treatment plan includes the use of a non-opioid analgesic and/or non-pharmacologic intervention • Patient has been screened for substance abuse/opioid dependence • If used in patients with medical comorbidities or if used concurrently with a benzodiazepine or other drugs that could potentially cause drug-drug interactions, the prescriber has acknowledged that they have completed an assessment of increased risk for respiratory depression • Pain is moderate to severe and expected to persist for an extended period of time • Pain is chronic • Pain is not postoperative (unless the patient is already receiving chronic opioid therapy prior to surgery, or if the postoperative pain is expected to be moderate to severe and persist for an extended period of time) • Pain management is required around the clock with a long-acting opioid AND 2 - ONE of the following: 2.1 Prior to the start of therapy with the long-acting opioid, the patient has failed an adequate (minimum of 2 week) trial of a short-acting opioid within the last 30 days [Document drug(s) and date of trial]* OR 2.2 The patient is already receiving chronic opioid therapy prior to surgery for postoperative pain OR	

2.3 Postoperative pain is expected to be moderate to severe and persist for an extended period of time

AND

3 - The patient has a history of failure, contraindication, or intolerance to at least THREE of the following (Document drugs and date of trials):*

- morphine sulfate controlled release tablets (specifically generic MS Contin)
- preferred fentanyl transdermal (12 mcg, 25 mcg, 50 mcg, 75 mcg, 100 mcg)**
- Brand Butrans (buprenorphine) transdermal
- Brand Oxycontin
- tramadol extended release tablets (non-biphasic release tablets)
- generic methadone tablets/concentrate/soln/tablets for oral susp

AND

4 - If the request for neuropathic pain (examples of neuropathic pain include neuralgias, neuropathies, fibromyalgia), BOTH of the following:

4.1 Unless it is contraindicated, the patient has not exhibited an adequate response to 8 weeks of treatment with gabapentin titrated to a therapeutic dose (Document date of trial)*

AND

4.2 Unless it is contraindicated, the patient has not exhibited an adequate response to at least 6 weeks of treatment with a tricyclic antidepressant titrated to the maximum tolerated dose (Document drug and date of trial)*

Notes	*If the patient is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be issued and a maximum 30-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. *If the request is for a non-preferred product and the patient is currently taking the requested long-acting opioid for at least 30 days and has met the medical necessity authorization criteria requirements for treatment with an opioid, but has not tried the preferred alternatives a denial should be issued and a maximum 30-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. *Claims history may be used in conjunction as documentation of drug,

	date, and duration of trial. **Fentanyl transdermal 37.5mcg/hr, 62.5mcg/hr, and 87.5 mcg/hr are non-preferred.

Product Name:Conzip, tramadol ER biphasic release caps, tramadol ER biphasic release tabs	
Diagnosis	Non-cancer pain/Non-hospice care/Non-end-of-life care pain*
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Prescriber attests to ALL of the following: • The information provided is true and accurate to the best of their knowledge and they understand that a routine audit may be performed and the medical information necessary to verify the accuracy of the information provided may be requested • Treatment goals are defined, including estimated duration of treatment • Treatment plan includes the use of a non-opioid analgesic and/or non-pharmacologic intervention • Patient has been screened for substance abuse/opioid dependence • If used in patients with medical comorbidities or if used concurrently with a benzodiazepine or other drugs that could potentially cause drug-drug interactions, the prescriber has acknowledged that they have completed an assessment of increased risk for respiratory depression • Pain is moderate to severe and expected to persist for an extended period of time • Pain is chronic • Pain is not postoperative (unless the patient is already receiving chronic opioid therapy prior to surgery, or if the postoperative pain is expected to be moderate to severe and persist for an extended period of time) • Pain management is required around the clock with a long-acting opioid AND 2 - ONE of the following: 2.1 Prior to the start of therapy with the long-acting opioid, the patient has failed an adequate (minimum of 2 week) trial of a short-acting opioid within the last 30 days [Document drug(s) and date of trial]*	

OR

2.2 The patient is already receiving chronic opioid therapy prior to surgery for postoperative pain

OR

2.3 Postoperative pain is expected to be moderate to severe and persist for an extended period of time

AND

3 - If the request for neuropathic pain (examples of neuropathic pain include neuralgias, neuropathies, fibromyalgia), BOTH of the following:

3.1 Unless it is contraindicated, the patient has not exhibited an adequate response to 8 weeks of treatment with gabapentin titrated to a therapeutic dose (Document date of trial)*

AND

3.2 Unless it is contraindicated, the patient has not exhibited an adequate response to at least 6 weeks of treatment with a tricyclic antidepressant titrated to the maximum tolerated dose (Document drug and date of trial)*

AND

4 - The patient has a history of failure, contraindication, or intolerance to BOTH of the following (Document drugs and date of trials):*

- tramadol immediate release (IR)**
- tramadol extended release tablets (non-biphasic release tablets)**

Notes

*If the patient is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be issued and a maximum 30-day authorization may be authorized one time for the requested drug/strength combination up to the requested q

	quantity for transition to an alternative treatment. *If the request is for tramadol extended release capsules or tramadol extended release biphasic release tablets and the patient is currently taking the requested long-acting opioid for at least 30 days and has met the medical necessity authorization criteria requirements for treatment with an opioid, but has not tried the preferred alternatives a denial should be issued and a maximum 30-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. *Claims history may be used in conjunction as documentation of drug, date, and duration of trial. **Drug may require prior authorization.

Product Name:generic morphine sulfate ER tabs, Brand MS Contin, morphine sulfate ER caps, morphine sulfate beads caps ER, fentanyl patches**, generic hydrocodone ER tabs, Brand Hysingla ER, oxymorphone ER, Tapentadol ER, oxycodone ER, Oxycontin, Conzip, tramadol ER biphasic release caps, tramadol ER biphasic release tabs, tramadol ER tabs (non-biphasic release), generic methadone tabs/concentrate/soln/tabs for oral susp, Brand Methadose, hydromorphone ER, hydrocodone ER caps	
Diagnosis	Non-cancer pain/Non-hospice care/Non-end-of-life care pain*
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient demonstrates meaningful improvement in pain and function (Document improvement in function or pain score improvement) AND 2 - Identify rationale for not tapering and discontinuing opioid (Document rationale) AND 3 - Prescriber attests to ALL of the following:	

• The information provided is true and accurate to the best of their knowledge and they understand that a routine audit may be performed and the medical information necessary to verify the accuracy of the information provided may be requested • Treatment goals are defined, including estimated duration of treatment • Treatment plan includes the use of a non-opioid analgesic and/or non-pharmacologic intervention • Patient has been screened for substance abuse/opioid dependence • If used in patients with medical comorbidities or if used concurrently with a benzodiazepine or other drugs that could potentially cause drug-drug interactions, the prescriber has acknowledged that they have completed an assessment of increased risk for respiratory depression • Pain is moderate to severe and expected to persist for an extended period of time • Pain is chronic • Pain is not postoperative (unless the patient is already receiving chronic opioid therapy prior to surgery, or if the postoperative pain is expected to be moderate to severe and persist for an extended period of time) • Pain management is required around the clock with a long-acting opioid	
Notes	*If the patient is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be issued and a maximum 30-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. *If the request is for a non-preferred product and the patient is currently taking the requested long-acting opioid for at least 30 days and has met the medical necessity authorization criteria requirements for treatment with an opioid, but has not tried the preferred alternatives a denial should be issued and a maximum 30-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. **Fentanyl transdermal 37.5mcg/hr, 62.5mcg/hr, and 87.5mcg/hr are non-preferred.

Product Name:generic morphine sulfate ER tabs, Brand MS Contin, morphine sulfate ER caps, morphine sulfate beads caps ER, fentanyl patches, generic hydrocodone ER tabs, Brand Hysingla ER, oxymorphone ER, Tapentadol ER, oxycodone ER, Oxycontin, Conzip, tramadol ER biphasic release caps, tramadol ER biphasic release tabs, tramadol ER tabs (non-biphasic release), generic methadone tabs/concentrate/soln/tabs for oral susp, Brand Methadose, hydromorphone ER, hydrocodone ER caps	
Guideline Type	Quantity Limit
Approval Criteria	

1 - The requested dose cannot be achieved by moving to a higher strength of the product

AND

2 - The requested dose is within the Food and Drug Administration (FDA) maximum dose per day, where an FDA maximum dose per day exists (see Table 1 in the Background section)

Notes	Authorization will be issued for: • Cancer pain/hospice/end-of-life related pain: 12 months • All Tramadol ER requests: 6 months • Non-cancer pain/non-hospice/non-end-of-life related pain: 6 months

Product Name:generic morphine sulfate ER tabs, Brand MS Contin, morphine sulfate ER caps, morphine sulfate beads caps ER, fentanyl patches, generic hydrocodone ER tabs, Brand Hysingla ER, oxymorphone ER, Tapentadol ER, oxycodone ER, Oxycontin, Conzip, tramadol ER biphasic release caps, tramadol ER biphasic release tabs, tramadol ER tabs (non-biphasic release), generic methadone tabs/concentrate/soln/tabs for oral susp, Brand Methadose, hydromorphone ER, hydrocodone ER caps

Diagnosis	Doses Exceeding the Cumulative MME of 90 mg - Cancer/Hospice/End-of-Life/Palliative Care/Skilled Nursing Facility/Traumatic Injury Related Pain*
Approval Length	12 month(s)
Guideline Type	Morphine Milligram Equivalent (MME) MME 90.00 exceeded; PA REQUIRED; Dosage Above MEDD Limit

Approval Criteria

1 - Doses exceeding the cumulative morphine milligram equivalent (MME) of 90 milligrams will be approved up to the requested amount for ALL opioid products if the patient has one of the following conditions:

- Active oncology diagnosis
- Hospice care
- End-of-life care (other than hospice)
- Palliative care
- Skilled nursing facility care
- Traumatic injury, including burns and excluding post-surgical procedure

AND

2 - Provider attests patient has been prescribed naloxone (may also be verified via paid pharmacy claims)	
Notes	*Authorization will be issued for 12 months for one of the above conditions. The authorization should be entered for an MME of 9999 so as to prevent future disruptions in therapy if the patient's dose is increased.

Product Name:generic morphine sulfate ER tabs, Brand MS Contin, morphine sulfate ER caps, morphine sulfate beads caps ER, fentanyl patches, generic hydrocodone ER tabs, Brand Hysingla ER, oxymorphone ER, Tapentadol ER, oxycodone ER, Oxycontin, Conzip, tramadol ER biphasic release caps, tramadol ER biphasic release tabs, tramadol ER tabs (non-biphasic release), generic methadone tabs/concentrate/soln/tabs for oral susp, Brand Methadose, hydromorphone ER, hydrocodone ER caps	
Diagnosis	Doses Exceeding the Cumulative MME of 90 mg - Non-cancer/non-hospice/non-end-of-life/non-palliative care/non-skilled nursing facility/non-traumatic injury related pain*
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Morphine Milligram Equivalent (MME) MME 90.00 exceeded; PA REQUIRED; Dosage Above MEDD Limit
Approval Criteria 1 - Prescriber attests to ALL of the following: • The information provided is true and accurate to the best of their knowledge and they understand that a routine audit may be performed and the medical information necessary to verify the accuracy of the information provided may be requested • Treatment goals are defined, including estimated duration of treatment • Treatment plan includes the use of a non-opioid analgesic and/or non-pharmacologic intervention • Patient has been screened for substance abuse/opioid dependence • if used in patients with medical comorbidities or if used concurrently with a benzodiazepine or other drugs that could potentially cause drug-drug interactions, the prescriber has acknowledged that they have completed an assessment of increased risk for respiratory depression AND 2 - BOTH of the following:	

2.1 Patient has tried and failed non-opioid pain medication (document drug name and date of trial)

AND

2.2 Opioid medication doses of less than 90 morphine milligram equivalent (MME) have been tried and did not adequately control pain (document drug regimen or MME and dates of therapy)

AND

3 - Provider attests patient has been prescribed naloxone (may also be verified via paid pharmacy claims)

Notes	*If the patient has been established on the requested MME dose for at least 30 days and does not meet the medical necessity authorization criteria requirements, a denial should be issued and a maximum 30-day authorization may be authorized one time for the requested MME dose. **Authorization will be issued for 6 months for non-cancer/non-hospice/non-end-of-life/non-palliative care/non-skilled nursing facility/non-traumatic injury related pain up to the current requested MME plus 90 MME.

Product Name:generic morphine sulfate ER tabs, Brand MS Contin, morphine sulfate ER caps, morphine sulfate beads caps ER, fentanyl patches, generic hydrocodone ER tabs, Brand Hysingla ER, oxymorphone ER, Tapentadol ER, oxycodone ER, Oxycontin, Conzip, tramadol ER biphasic release caps, tramadol ER biphasic release tabs, tramadol ER tabs (non-biphasic release), generic methadone tabs/concentrate/soln/tabs for oral susp, Brand Methadose, hydromorphone ER, hydrocodone ER caps

Diagnosis	Doses Exceeding the Cumulative MME of 90 mg - Non-cancer/non-hospice/non-end-of-life/non-palliative care/non-skilled nursing facility/non-traumatic injury related pain*
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Morphine Milligram Equivalent (MME)** MME 90.00 exceeded; PA REQUIRED; Dosage Above MEDD Limit

Approval Criteria

1 - Prescriber attests to ALL of the following:

- The information provided is true and accurate to the best of their knowledge and they understand that a routine audit may be performed and the medical information necessary to verify the accuracy of the information provided may be requested
- Treatment goals are defined, including estimated duration of treatment
- Treatment plan includes the use of a non-opioid analgesic and/or non-pharmacologic intervention
- Patient has been screened for substance abuse/opioid dependence
- if used in patients with medical comorbidities or if used concurrently with a benzodiazepine or other drugs that could potentially cause drug-drug interactions, the prescriber has acknowledged that they have completed an assessment of increased risk for respiratory depression

AND

2 - Identify rationale for not tapering and discontinuing opioid (Document rationale)

AND

3 - Patient demonstrates meaningful improvement in pain and function (Document improvement in function or pain score improvement)

AND

4 - Provider attests patient has been prescribed naloxone (may also be verified via paid pharmacy claims)

Notes	*If the patient has been established on the requested MME dose for at least 30 days and does not meet the medical necessity authorization criteria requirements, a denial should be issued and a maximum 30-day authorization may be authorized one time for the requested MME dose. **Authorization will be issued for 6 months for non-cancer/non-hospice/non-end-of-life/non-palliative care/non-skilled nursing facility/non-traumatic injury related pain up to the current requested MME plus 90 MME.

2 . Background

Benefit/Coverage/Program Information**Table 1. CDC Recommended Morphine Milligram Equivalents per Day***

Active Ingredient	FDA Label Max Daily Doses	90 MME Equivalent (mg/day) (non treatment naïve)
Morphine	None	90mg
Morphine and naltrexone	None	90mg
Hydromorphone	None	22.5mg
Fentanyl transdermal, mcg/hr	None	37.5 mcg/hr
Hydrocodone	None	90mg
Methadone	None	Conversion factor is variable based upon dose
Tapentadol	500mg ER products	225mg
Oxymorphone	None	30mg
Tramadol	300mg ER products	900mg

*Doses are not considered equianalgesic and table does not represent a dose conversion chart.

Max MME is the maximum dose per day based on morphine milligram equivalents allowed without consultation or prescription by a pain specialist. Max MME is based upon the CDC guidelines and adjusted for currently available product strengths. Fentanyl is dosed in mcg/hr rather than mg/day.

3 . Revision History

Date	Notes
4/7/2026	Added Tapentadol ER products as targets. Removed Nucynta ER products as targets. Updated product name lists, where applicable. Cleaned up GPI tables, where applicable.

Lucemyra (lofexidine)



Prior Authorization Guideline

Guideline ID	GL-157266
Guideline Name	Lucemyra (lofexidine)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	11/1/2024

1 . Criteria

Product Name:Brand Lucemyra, generic lofexidine	
Approval Length	14 Day(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - For symptoms of abrupt opioid withdrawal AND	

2 - Opioids have been discontinued

AND

3 - History of failure, contraindication, or intolerance to clonidine as verified by recent clonidine claims history in the past 180 days

AND

4 - Prescriber must verify patient has been screened for hepatic and renal impairment and that dosing is appropriate for the patient's degree of hepatic and renal function

AND

5 - Prescriber must verify patient's vital signs have been monitored and that the patient is capable of and has been instructed on self-monitoring for hypotension, orthostasis, bradycardia, and associated symptoms

AND

6 - Patient does NOT have severe coronary insufficiency, a recent myocardial infarction, cerebrovascular disease, chronic renal failure, or marked bradycardia

AND

7 - Patient does NOT have congenital long QT syndrome

AND

8 - If the request is for Brand Lucemyra, history of failure or intolerance to generic lofexidine

2 . Revision History

UnitedHealthcare Community Plan of Arizona Clinical Pharmacy Program Guidelines

Date	Notes
10/9/2024	Updated guideline name. Added generic lofexidine as a target. Updated product name list and GPI table accordingly. Removed inpatient setting bypass. For Brand Lucemyra, added step through generic lofexidine. Minor cosmetic updates.

Lumizyme



Prior Authorization Guideline

Guideline ID	GL-140652
Guideline Name	Lumizyme
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	
P&T Approval Date:	
P&T Revision Date:	

1 . Criteria

Product Name:Lumizyme	
Diagnosis	Pompe disease
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Pompe disease (acid alpha-glucosidase [GAA] deficiency)	

2 . Revision History

Date	Notes
4/27/2020	Removed Myozyme from title

Lupkynis (voclosporin)



Prior Authorization Guideline

Guideline ID	GL-157422
Guideline Name	Lupkynis (voclosporin)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	11/1/2024

1 . Criteria

Product Name:Lupkynis	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of active lupus nephritis	

AND

2 - Provider attests to ONE of the following:

- Diagnosis is biopsy proven
- Biopsy is contraindicated in the patient

AND

3 - Prescribed in combination with a background immunosuppressive therapy regimen (e.g., mycophenolate mofetil and corticosteroids)

AND

4 - Patient is NOT receiving Lupkynis in combination with either of the following:

- Cyclophosphamide
- Benlysta (belimumab)

AND

5 - Prescribed by ONE of the following:

- Nephrologist
- Rheumatologist

Product Name:Lupkynis	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Documentation of positive clinical response to Lupkynis therapy

AND

2 - Prescribed in combination with a background immunosuppressive therapy regimen (e.g., mycophenolate mofetil and corticosteroids)

AND

3 - Patient is NOT receiving Lupkynis in combination with either of the following:

- Cyclophosphamide
- Benlysta (belimumab)

AND

4 - Prescribed by ONE of the following:

- Nephrologist
- Rheumatologist

AND

5 - ONE of the following:

5.1 Patient has been on Lupkynis therapy for less than 12 months

OR

5.2 BOTH of the following:

5.2.1 Patient has completed 12 or more months of Lupkynis therapy

AND

5.2.2 The provider attests that the benefit of continuation of therapy exceeds the risk in light of the patient’s treatment response and risk of worsening nephrotoxicity

2 . Revision History

Date	Notes
10/14/2024	Replaced CORE criteria with FFS/state criteria.

Luxturna



Prior Authorization Guideline

Guideline ID	GL-141005
Guideline Name	Luxturna
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name:Luxturna	
Approval Length	45 Day(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is greater than 12 months of age AND	

2 - Diagnosis of a confirmed biallelic RPE65 mutation-associated retinal dystrophy [e.g., Leber's congenital amaurosis (LCA), retinitis pigmentosa (RP), early onset severe retinal dystrophy (EOSRD), etc.]

AND

3 - Genetic testing documenting biallelic mutations of the RPE65 gene

AND

4 - Sufficient viable retinal cells as determined by optical coherence tomography (OCT) confirming an area of retina within the posterior pole of greater than 100 micrometers thickness

AND

5 - Prescribed and administered by ophthalmologist or retinal surgeon with experience providing sub-retinal injections

AND

6 - Patient has not previously received Luxturna treatment in the intended eye

AND

7 - Must not exceed more than 1 treatment per lifetime per eye

Notes	Authorization will be issued for no more than 1 treatment per lifetime per eye and for no longer than 45 days from approval.

2 . Revision History

Date	Notes

UnitedHealthcare Community Plan of Arizona Clinical Pharmacy Program Guidelines

10/30/2023	Updated guideline name, updated approval length, added once per lifetime criteria and note.

Lyfgenia (lovotibeglogene autotemcel)



Prior Authorization Guideline

Guideline ID	GL-459191
Guideline Name	Lyfgenia (lovotibeglogene autotemcel)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	12/1/2025

1 . Criteria

Product Name:Lyfgenia	
Approval Length	1 Time Authorization in Lifetime*
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of sickle cell disease (SCD) confirmed by patient genotype including betaS/betaS, betaS/beta0, or betaS/beta+	

AND

2 - Patient is 12 years of age or older

AND

3 - Submission of medical records (e.g., chart notes) or paid claims confirming a history of failure or intolerance to hydroxyurea (defined as being unable to take hydroxyurea per health care professional judgement) at any point in the past

AND

4 - Provider attests that patient is clinically stable and eligible to undergo hematopoietic stem cell transplant (HSCT)

AND

5 - Submission of medical records (e.g., chart notes) documenting ONE of the following:

5.1 Patient has a history of at least 4 vaso-occlusive events (VOEs) in the past 24 months defined by ONE of following scenarios:

- an episode of acute pain with no medically determined cause other than vaso-occlusion, lasting more than 2 hours
- acute chest syndrome (ACS)
- acute hepatic sequestration
- acute splenic sequestration
- VOE requiring a hospitalization or multiple visits to an emergency department/urgent care over 72 hours and receiving intravenous medications at each visit
- priapism requiring any level of medical attention

OR

5.2 Patient is currently receiving chronic transfusion therapy for recurrent Vaso-Occlusive Events (VOEs)

AND

6 - Prescribed by a provider at a SCD treatment center with expertise in gene therapy

AND

7 - Prescribed by or in consultation with a board-certified hematologist with SCD expertise

AND

8 - Patient has never received any previous sickle cell gene therapy treatment in their lifetime (i.e., Casgevy, Lyfgenia)

Notes	*Per prescribing information, Lyfgenia is for one-time, single dose intravenous use only.

2 . Revision History

Date	Notes
11/20/2025	New program for ACUAZ/ACUAZEC; Disregard GL-449197.

Lyrica



Prior Authorization Guideline

Guideline ID	GL-140672
Guideline Name	Lyrica
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Brand Lyrica	
Diagnosis	Seizure Disorder
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of seizure disorder	

AND

2 - History of failure, contraindication, or intolerance to generic pregabalin immediate-release capsules or generic pregabalin solution

Product Name:Brand Lyrica	
Diagnosis	Neuropathic Pain Associated with Spinal Cord Injury
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of neuropathic pain associated with spinal cord injury AND 2 - One of the following: - History of failure to generic pregabalin immediate-release capsules or solution at a minimum dose of 300mg daily for 4 weeks - Contraindication or intolerance to generic pregabalin immediate-release capsules or solution	

Product Name:Brand Lyrica	
Diagnosis	Fibromyalgia
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of fibromyalgia	

AND

2 - One of the following:

- History of failure to generic pregabalin immediate-release capsules or solution at a minimum dose of 300mg daily for 4 weeks
- Contraindication or intolerance to generic pregabalin immediate-release capsules or solution

Product Name:Brand Lyrica	
Diagnosis	Diabetic peripheral neuropathy (DPN)
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of diabetic peripheral neuropathy (DPN) AND 2 - One of the following: • History of failure to generic pregabalin immediate-release capsules or solution at a minimum dose of 300mg daily for 4 weeks • Contraindication or intolerance to generic pregabalin immediate-release capsules or solution	

Product Name:Brand Lyrica	
Diagnosis	Post herpetic neuralgia (PHN)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of post herpetic neuralgia (PHN)

AND

2 - One of the following:

- History of failure to generic pregabalin immediate-release capsules or solution at a minimum dose of 300mg daily for 4 weeks
- Contraindication or intolerance to generic pregabalin immediate-release capsules or solution

Product Name: Lyrica CR

Diagnosis	Diabetic peripheral neuropathy (DPN)

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of diabetic peripheral neuropathy (DPN)

AND

2 - History of failure, contraindication, or intolerance to gabapentin (generic Neurontin) at a minimum dose of 1800 milligrams daily for 4 weeks

AND

3 - History of failure, contraindication, or intolerance to treatment with ONE of the following:

- Tricyclic antidepressant at the maximum tolerated dose for 6 to 8 weeks, or intolerance to a tricyclic antidepressant

- Serotonin and norepinephrine reuptake inhibitor (SNRI) antidepressant (i.e. duloxetine, venlafaxine)

AND

4 - History of failure, contraindication, or intolerance to generic pregabalin immediate-release capsules or generic pregabalin solution

Product Name:Lyrica CR	
Diagnosis	Post herpetic neuralgia (PHN)
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of post herpetic neuralgia (PHN) AND 2 - History of failure, contraindication, or intolerance to gabapentin (generic Neurontin) at a minimum dose of 1800 milligrams daily for 4 weeks AND 3 - History of failure, contraindication, or intolerance to a tricyclic antidepressant at the maximum tolerated dose for 6 to 8 weeks AND 4 - History of failure, contraindication, or intolerance to generic pregabalin immediate-release capsules or generic pregabalin solution	

2 . Revision History

UnitedHealthcare Community Plan of Arizona Clinical Pharmacy Program Guidelines

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Lysteda



Prior Authorization Guideline

Guideline ID	GL-140641
Guideline Name	Lysteda
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2020

1 . Criteria

Product Name:Brand Lysteda, generic tranexamic acid	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of cyclic heavy menstrual bleeding	

2 . Revision History

UnitedHealthcare Community Plan of Arizona Clinical Pharmacy Program Guidelines

Date	Notes
3/31/2020	Bulk Copy C&S New York to C&S Arizona for effective date of 5/1

Makena



Prior Authorization Guideline

Guideline ID	GL-140949
Guideline Name	Makena
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	12/1/2022

1 . Criteria

Product Name:Brand Makena*, generic hydroxyprogesterone caproate*	
Guideline Type	Prior Authorization
Approval Criteria 1 - Current singleton pregnancy AND 2 - History of a prior spontaneous preterm birth of a singleton pregnancy	

AND

3 - Treatment is initiated between 16 weeks, 0 days of gestation and 20 weeks, 6 days of gestation

AND

4 - Administration is to continue weekly until week 37 (through 36 weeks, 6 days) of gestation or delivery, whichever occurs first

AND

5 - If the request is for generic hydroxyprogesterone caproate, the patient has a history of failure, contraindication or intolerance to Brand Makena

Notes	*Approval duration is up to 21 weeks; approval duration should take in to account gestation week when Makena will be started and only auth orized up to week 37.

2 . Revision History

Date	Notes
11/7/2022	Updated gestational days for drug initiation to align w PI

Marinol (dronabinol)



Prior Authorization Guideline

Guideline ID	GL-397200
Guideline Name	Marinol (dronabinol)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2025

1 . Criteria

Product Name:Brand Marinol	
Diagnosis	Chemotherapy-induced nausea and vomiting
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is receiving cancer chemotherapy	

AND

2 - History of failure, contraindication, or intolerance to preferred generic dronabinol

AND

3 - History of failure, contraindication, or intolerance to a 5HT-3 (5-hydroxytryptamine) receptor antagonist [e.g., Anzemet (dolasetron), Kytril (granisetron), or Zofran (ondansetron)]

AND

4 - History of failure, contraindication, or intolerance to ONE of the following:

- Ativan (lorazepam)
- Compazine (prochlorperazine)
- Decadron (dexamethasone)
- Haldol (haloperidol)
- Phenergan (promethazine)
- Reglan (metoclopramide)
- Zyprexa (olanzapine)

Product Name:generic dronabinol	
Diagnosis	Chemotherapy-induced nausea and vomiting
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is receiving cancer chemotherapy AND	

2 - History of failure, contraindication, or intolerance to a 5HT-3 (5-hydroxytryptamine) receptor antagonist [e.g., Anzemet (dolasetron), Kytril (granisetron), or Zofran (ondansetron)]

AND

3 - History of failure, contraindication, or intolerance to ONE of the following:

- Ativan (lorazepam)
- Compazine (prochlorperazine)
- Decadron (dexamethasone)
- Haldol (haloperidol)
- Phenergan (promethazine)
- Reglan (metoclopramide)
- Zyprexa (olanzapine)

Product Name: Brand Marinol	
Diagnosis	Anorexia in patients with AIDS
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of anorexia with weight loss in patients with AIDS (acquired immunodeficiency syndrome) AND 2 - Patient is on antiretroviral therapy AND 3 - ONE of the following: 3.1 Patient is 65 years of age or greater	

OR

3.2 BOTH of the following:

- Patient is less than 65 years of age
- History of failure, contraindication, or intolerance to Megace (megestrol)

AND

4 - History of failure, contraindication, or intolerance to preferred generic dronabinol

Product Name:generic dronabinol	
Diagnosis	Anorexia in patients with AIDS
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of anorexia with weight loss in patients with AIDS (acquired immunodeficiency syndrome) AND 2 - Patient is on antiretroviral therapy AND 3 - ONE of the following: 3.1 Patient is 65 years of age or greater OR	

3.2 BOTH of the following:

- Patient is less than 65 years of age
- History of failure, contraindication, or intolerance to Megace (megestrol)

2 . Revision History

Date	Notes
9/15/2025	Updated guideline name. Removed Syndros as a target. Updated product name lists and GPI tables accordingly. Updated embedded step criterion for Brand Marinol, where applicable. Minor cosmetic updates.

Mepron



Prior Authorization Guideline

Guideline ID	GL-140689
Guideline Name	Mepron
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name: Brand Mepron, generic atovaquone	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 BOTH of the following: 1.1.1 The patient has a diagnosis (e.g. human immunodeficiency virus [HIV]) warranting Pneumocystis jirovecii pneumonia (PCP) infection prophylaxis	

AND

1.1.2 The patient has a documented intolerance or contraindication to trimethoprim-sulfamethoxazole (TMP-SMX) and dapsone

OR

1.2 BOTH of the following:

1.2.1 The patient has a diagnosis of mild to moderate pneumonia caused by *P. jirovecii*

AND

1.2.2 The patient has a documented intolerance, contraindication, or history of treatment failure to TMP-SMX

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Metformin Products



Prior Authorization Guideline

Guideline ID	GL-140741
Guideline Name	Metformin Products
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	12/1/2022

1 . Criteria

Product Name:generic metformin 625 mg immediate-release tablets	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - History of greater than or equal to 12 week trial of preferred metformin immediate-release products	

Product Name:generic metformin extended-release (generic for Fortamet and generic for Glumetza)	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ALL of the following: 1.1 History of greater than or equal to 12 week trial of metformin extended-release (generic Glucophage XR) AND 1.2 ONE of the following: 1.2.1 Submission of medical records (e.g. chart notes, laboratory values) documenting an inadequate response to metformin extended-release (generic Glucophage XR), in diabetic patients, as evidenced by the hemoglobin A1c level being above the patient's goal OR 1.2.2 Submission of medical records (e.g. chart notes, laboratory values) documenting an intolerance to metformin extended-release (generic Glucophage XR) which is unable to be resolved with attempts to minimize the adverse effects where appropriate (e.g. dose reduction) AND 1.3 History of greater than or equal to 12 week trial of metformin immediate-release AND 1.4 One of the following: 1.4.1 Submission of medical records (e.g. chart notes, laboratory values) documenting an	

inadequate response to metformin immediate-release, in diabetic patients, as evidenced by the hemoglobin A1c level being above the patient's goal

OR

1.4.2 Submission of medical records (e.g. chart notes, laboratory values) documenting an intolerance to metformin immediate-release which is unable to be resolved with attempts to minimize the adverse effects where appropriate (e.g. dose reduction)

Product Name: Brand Glumetza, Brand Fortamet

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 History of greater than or equal to 12 week trial of metformin extended-release (generic Glucophage XR)

AND

1.2 ONE of the following:

1.2.1 Submission of medical records (e.g. chart notes, laboratory values) documenting an inadequate response to metformin extended-release (generic Glucophage XR), in diabetic patients, as evidenced by the hemoglobin A1c level being above the patient's goal

OR

1.2.2 Submission of medical records (e.g. chart notes, laboratory values) documenting an intolerance to metformin extended-release (generic Glucophage XR) which is unable to be resolved with attempts to minimize the adverse effects where appropriate (e.g. dose reduction)

AND

1.3 History of greater than or equal to 12 week trial of metformin extended-release (generic Fortamet)

AND

1.4 One of the following:

1.4.1 Submission of medical records (e.g. chart notes, laboratory values) documenting an inadequate response to metformin extended-release (generic Fortamet), in diabetic patients, as evidenced by the hemoglobin A1c level being above the patient's goal

OR

1.4.2 Submission of medical records (e.g. chart notes, laboratory values) documenting an intolerance to metformin extended-release (generic Fortamet) which is unable to be resolved with attempts to minimize the adverse effects where appropriate (e.g. dose reduction)

AND

1.5 History of greater than or equal to 12 week trial of metformin immediate-release

AND

1.6 One of the following:

1.6.1 Submission of medical records (e.g. chart notes, laboratory values) documenting an inadequate response to metformin immediate-release, in diabetic patients, as evidenced by the hemoglobin A1c level being above the patient's goal

OR

1.6.2 Submission of medical records (e.g. chart notes, laboratory values) documenting an intolerance to metformin immediate-release which is unable to be resolved with attempts to minimize the adverse effects where appropriate (e.g. dose reduction)

AND

1.7 Submission of article(s) published in the peer-reviewed medical literature showing that the requested drug is likely to be more efficacious to this patient than metformin extended-release (generic Glucophage XR)

Miplyffa (arimoclomol)



Prior Authorization Guideline

Guideline ID	GL-254203
Guideline Name	Miplyffa (arimoclomol)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	6/1/2025

1 . Criteria

Product Name:Miplyffa	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of Niemann-Pick disease type C (NPC)	

AND

2 - Submission of medical records (e.g., chart notes) confirming diagnosis by ONE of the following:

2.1 Genetically confirmed (deoxyribonucleic acid [DNA] sequence analysis) by mutations in both alleles of NPC1 or NPC2

OR

2.2 Mutation in only one allele of NPC1 or NPC2 plus either positive filipin staining or elevated cholestane triol/oxysterols (>2 x upper limit of normal)

AND

3 - Patient has at least one neurological symptom of the disease (e.g., hearing loss, vertical supranuclear gaze palsy, ataxia, dementia, dystonia, seizures, dysarthria, or dysphagia)

AND

4 - Patient is 2 years of age or older

AND

5 - Requested drug will be used in combination with miglustat

AND

6 - Requested drug will NOT be used in combination with Aqneursa (levacetylleucine)*

AND

7 - Prescribed by or in consultation with a specialist knowledgeable in the treatment of Niemann-Pick disease type C

Notes	*The use of both Miplyffa and Aqneursa concomitantly is not covered due to lack of evidence to support the use of both products at the same time and the lack of a Miplyffa and Aqneursa head-to-head study.

Product Name:Miplyffa	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient demonstrates positive clinical response to therapy (e.g., slowing of disease progression, improvement in neurological symptoms of the disease) AND 2 - Requested drug will be used in combination with miglustat AND 3 - Requested drug will NOT be used in combination with Aqneursa (levacetylleucine)*	
Notes	*The use of both Miplyffa and Aqneursa concomitantly is not covered due to lack of evidence to support the use of both products at the same time and the lack of a Miplyffa and Aqneursa head-to-head study.

2 . Revision History

Date	Notes
5/8/2025	Added note regarding concomitant use with Aqneursa, no change to clinical criteria.

Mitapivat Products



Prior Authorization Guideline

Guideline ID	GL-537202
Guideline Name	Mitapivat Products
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Pyrukynd	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting ALL of the following: 1.1 Diagnosis of hemolytic anemia confirmed by the presence of chronic hemolysis (e.g.,	

increased indirect bilirubin, elevated lactated dehydrogenase [LDH], decreased haptoglobin, increased reticulocyte count)

AND

1.2 Diagnosis of pyruvate kinase deficiency confirmed by molecular testing of ALL the following mutations on the PKLR gene:

- Presence of at least 2 variant alleles in the pyruvate kinase liver and red blood cell (PKLR) gene, of which at least 1 was a missense variant
- Patient is NOT homozygous for the c.1436G>A (p.R479H) variant
- Patient does NOT have 2 non-missense variants (without the presence of another missense variant) in the PKLR gene

AND

1.3 Hemoglobin is less than or equal to 10 g/dL

AND

1.4 Patient has symptomatic anemia or is transfusion dependent

AND

1.5 Exclusion of other causes of hemolytic anemias (e.g., infections, toxins, drugs)

AND

2 - Prescribed by or in consultation with a hematologist

Product Name:Pyrukynd	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy [e.g., hemoglobin greater than or equal to 1.5 g/dL from baseline, reduction in transfusions of greater than or equal to 33% in the number of red blood cell units transfused during the fixed dose period compared with the patient's historical transfusion burden, improvement in markers of hemolysis from baseline (e.g., bilirubin, lactated dehydrogenase [LDH], haptoglobin, reticulocyte count)]

AND

2 - Prescribed by or in consultation with a hematologist

Notes	If the member does not meet the medical necessity reauthorization criteria requirements, a denial should be issued and a 1-month authorization should be issued one time for Pyrukynd gradual therapy discontinuation.

Product Name:Aqvesme

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting ALL of the following:

1.1 Diagnosis of anemia with alpha or beta-thalassemia

AND

1.2 Hemoglobin is less than or equal to 10 g/dL

AND

1.3 Patient has symptomatic anemia or is transfusion dependent

AND

1.4 Patient does NOT have liver disease (e.g., cirrhosis - Child Pugh Class A, B, or C, Hepatitis B virus [HBV], Hepatitis C virus [HCV], Human Immunodeficiency virus [HIV-1 or HIV-2])

AND

1.5 BOTH of the following:

- Patient has NOT had prior exposure to gene therapy (e.g., Casgevy [exagamglogene autotemcel], Zynteglo [betibeglogene autotemcel])
- Patient has NOT had prior bone marrow or stem cell transplantation

AND

2 - Prescribed by or in consultation with ONE of the following:

- Hematologist
- Hepatologist

AND

3 - Patient is NOT on concurrent treatment with any of the following:

- Reblozyl (luspatercept-aamt)
- Hematopoietic stimulating agents (e.g., Epogen [epoetin alfa], Aranesp [darbepoetin alfa])
- Pyrukynd (mitapivat)

Product Name:Aqvesme	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy (e.g., reduction in RBC transfusion burden, improvement in fatigue, increase in Hb concentration greater than or equal to 1 g/dL from baseline)

AND

2 - Prescribed by or in consultation with ONE of the following:

- Hematologist
- Hepatologist

AND

3 - Patient is NOT on concurrent treatment with any of the following:

- Reblozyl (luspatercept-aamt)
- Hematopoietic stimulating agents (e.g., Epogen [epoetin alfa], Aranesp [darbepoetin alfa])
- Pyrukynd (mitapivat)

2 . Revision History

Date	Notes
3/3/2026	Updated guideline name. Updated initial/reauth criteria sections for P yrukynd. Added criteria for new target drug, Aqvesme.

Molluscum Contagiosum Agents



Prior Authorization Guideline

Guideline ID	GL-560217
Guideline Name	Molluscum Contagiosum Agents
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:Ycanth	
Approval Length	12 Week(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of molluscum contagiosum AND	

2 - Patient is 2 years of age or older

AND

3 - Patient has single or multiple, 2- to 5-mm-diameter, flesh-colored to translucent, dome-shaped papules, some with central umbilication

AND

4 - ONE of the following:

- Patient has eczema (e.g., atopic dermatitis)
- Patient is immunocompromised
- Patient has extensive involvement or experiences bleeds, secondary infections or discomfort from the lesions

AND

5 - Lesions have NOT resolved within six months of diagnosis

AND

6 - Trial and failure, contraindication, or intolerance to ALL of the following:

- imiquimod
- topical salicylic acid
- topical tretinoin
- podofilox (e.g., Condylox gel, podofilox solution)
- cimetidine
- Tea Tree oil preparations

AND

7 - ONE of the following:

7.1 Patient is treating new lesions that have NOT previously been treated with Ycanth

OR

7.2 Lesions have previously been treated with Ycanth and will NOT exceed a total of 4 treatments of Ycanth

AND

8 - Medication is NOT being used concurrently with other FDA approved therapies (e.g., Zelsuvmi) on the same lesion for the treatment of molluscum contagiosum

AND

9 - Prescribed by or in consultation with a dermatologist

Product Name:Zelsuvmi	
Approval Length	12 Week(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of molluscum contagiosum AND 2 - Patient is 1 year of age or older AND 3 - Patient has single or multiple, 2- to 5-mm-diameter, flesh-colored to translucent, dome-shaped papules, some with central umbilication	

AND

4 - ONE of the following:

- Patient has eczema (e.g., atopic dermatitis)
- Patient is immunocompromised
- Patient has extensive involvement or experiences bleeds, secondary infections or discomfort from the lesions

AND

5 - Lesions have NOT resolved within six months of diagnosis

AND

6 - Trial and failure, contraindication, or intolerance to ALL of the following:

- imiquimod
- topical salicylic acid
- topical tretinoin
- podofilox (e.g., Condylox gel, podofilox solution)
- cimetidine
- Tea Tree oil preparations

AND

7 - Patient is treating new lesions that have NOT previously been treated with Zelsuvmi

AND

8 - Medication is NOT being used concurrently with other FDA approved therapies (e.g., Ycanth) on the same lesion for the treatment of molluscum contagiosum

AND

9 - Prescribed by or in consultation with a dermatologist

2 . Revision History

Date	Notes
3/30/2026	Removed cantharidin as prerequisite

Monoclonal Antibody Agents for Alzheimer's Disease



Prior Authorization Guideline

Guideline ID	GL-420275
Guideline Name	Monoclonal Antibody Agents for Alzheimer's Disease
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	11/1/2025

1 . Criteria

Product Name:Aduhelm	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following: 1.1 Based on the National Institute on Aging and the Alzheimer's Association (NIA-AA) criteria, ONE of the following:	

- Diagnosis of mild cognitive impairment due to Alzheimer's disease
- Diagnosis of probable Alzheimer's disease dementia

AND

1.2 Submission of medical records (e.g., chart notes) confirming BOTH of the following:

- Clinical Dementia Rating-Global (CDR-G) score of 0.5 or Clinical Dementia Rating Sum of Boxes (CDR-SB) score of 0.5-4
- Mini-Mental State Examination score of 24-30

AND

2 - Submission of medical records (e.g., chart notes) confirming the presence of beta-amyloid protein deposition, as evidenced by ONE of the following:

2.1 Positive amyloid positron emission tomography (PET) scan

OR

2.2 BOTH of the following:

- Attestation that the patient does not have access to amyloid PET scanning
- Cerebrospinal fluid (CSF) biomarker or blood testing documents abnormalities suggestive of beta-amyloid accumulation (e.g., A β 42 level, A β 42:A β 40 ratio)

AND

3 - Provider attests that the patient's ApoE e4 carrier status is known prior to initiating treatment and a shared decision-making conversation regarding the results has been completed

AND

4 - Other differential diagnoses (e.g., dementia with Lewy bodies (DLB), frontotemporal dementia (FTD), vascular dementia, pseudodementia due to mood disorder, vitamin B12 deficiency, encephalopathy, etc.) have been ruled out

AND

5 - BOTH of the following:

- Patient is not currently taking an anticoagulant or antiplatelet agent (unless aspirin 325 mg/day or less)
- Patient has no history of transient ischemic attack (TIA) or stroke within previous year prior to initiating treatment

AND

6 - Counseling has been provided on the risk of amyloid-related imaging abnormalities (ARIA-E and ARIA-H) and patient and/or caregiver are aware to monitor for headache, dizziness, visual disturbances, nausea, and vomiting

AND

7 - Submission of medical records (e.g., chart notes) confirming a baseline brain magnetic resonance imaging (MRI) has been completed within 12 months prior to initiating treatment

AND

8 - Not used in combination with other A β monoclonal antibodies (mAbs) for Alzheimer's disease (e.g., Leqembi)

AND

9 - Prescribed by a neurologist, geriatrician, or geriatric psychiatrist

Product Name:Aduhelm	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is benefitting from therapy as defined by BOTH of the following:

1.1 Based on the National Institute on Aging and the Alzheimer's Association (NIA-AA) criteria, ONE of the following:

- Patient continues to have a diagnosis of mild cognitive impairment due to Alzheimer's disease
- Patient continues to have a diagnosis of probable Alzheimer's disease dementia

AND

1.2 Submission of medical records (e.g., chart notes) confirming BOTH of the following:

- Clinical Dementia Rating-Global (CDR-G) score of 0.5 or Clinical Dementia Rating Sum of Boxes (CDR-SB) score of 0.5-4
- Mini-Mental State Examination score of 24-30

AND

2 - Submission of medical records (e.g., chart notes) confirming follow-up brain magnetic resonance imaging (MRI) has been completed after the initiation of therapy prior to the 5th infusion treatment to show ONE of the following:

2.1 BOTH of the following:

- Less than 10 new incident microhemorrhages
- 2 or less focal areas of superficial siderosis

OR

2.2 If 10 or more new incident microhemorrhages or greater than 2 focal areas of superficial siderosis are present, then BOTH of the following:

- Patient has been clinically evaluated for ARIA related signs or symptoms (e.g., dizziness, visual disturbances)
- Follow-up MRI demonstrates radiographic stabilization (i.e., no increase in size or number of ARIA-H)

AND

3 - Not used in combination with other A β monoclonal antibodies (mAbs) for Alzheimer's disease (e.g., Leqembi)

AND

4 - Prescribed by a neurologist, geriatrician, or geriatric psychiatrist

Product Name:Leqembi IQLIK subcutaneous solution

Approval Length	6 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - BOTH of the following:

1.1 Diagnosis of ONE of the following, based on the National Institute on Aging and the Alzheimer's Association (NIA-AA) criteria:

- Mild cognitive impairment due to Alzheimer's disease
- Mild dementia due to Alzheimer's disease

AND

1.2 Submission of medical records (e.g., chart notes) confirming ALL of the following:

- Global Clinical Dementia Rating (CDR) score of 0.5 or 1.0
- CDR Memory Box score of 0.5 or greater
- Mini-Mental State Examination score of 22 or greater

AND

2 - Submission of medical records (e.g., chart notes) confirming the presence of beta-amyloid protein deposition, as evidenced by ONE of the following:

- Positive amyloid positron emission tomography (PET) scan
- Attestation that patient does not have access to amyloid PET scanning and cerebrospinal fluid (CSF) biomarker testing documents abnormalities suggestive of beta-amyloid accumulation (e.g., A β 42 level, A β 42:A β 40 ratio, Tau, p-Tau)

AND

3 - BOTH of the following:

- Provider attests that testing regarding the patient's ApoE e4 (apolipoproteinE e4) carrier status has been performed prior to initiating treatment
- Prior to testing, a shared decision-making conversation has occurred, regarding the risk of amyloid-related imaging abnormalities (ARIA), across genotypes, and the implications of genetic testing results

AND

4 - Submission of medical records (e.g., chart notes) confirming a baseline brain magnetic resonance imaging (MRI) has been completed within 12 months prior to initiating treatment

AND

5 - Other differential diagnoses (e.g., dementia with Lewy bodies (DLB), frontotemporal dementia (FTD), vascular dementia, pseudodementia due to mood disorder, vitamin B12 deficiency, encephalopathy) have been ruled out

AND

6 - BOTH of the following:

- Patient is not currently taking an anticoagulant (e.g., warfarin, dabigatran)
- Patient has no history of intracerebral hemorrhage (e.g., transient ischemic attack [TIA], stroke) prior to initiating treatment

AND

7 - Not used in combination with other A β monoclonal antibodies (mAbs) for Alzheimer's disease (e.g., Aduhelm, Kisunla)

AND

8 - Counseling has been provided on the risk of amyloid-related imaging abnormalities (ARIA-E and ARIA-H) and patient and/or caregiver are aware to monitor for headache, confusion, dizziness, visual changes, nausea, and gait difficulty

AND

9 - Provider will enroll patient in a registry [e.g., Alzheimer's Network for Treatment and Diagnostics (ALZ-Net)]

AND

10 - Patient is not being treated with Leqembi as part of a clinical trial

AND

11 - Will be used as a maintenance dose following completion of 18 months with the intravenous initiation phase

AND

12 - Prescribed by a neurologist, geriatrician, or geriatric psychiatrist

Product Name:Leqembi IQLIK subcutaneous solution	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - BOTH of the following:

1.1 Patient continues to have ONE of the following diagnoses based on the National Institute on Aging and the Alzheimer's Association (NIA-AA) criteria:

- Mild cognitive impairment due to Alzheimer's disease
- Mild dementia due to Alzheimer's disease

AND

1.2 Submission of medical records (e.g., chart notes) confirming ALL of the following:

- Global Clinical Dementia Rating (CDR) score of 0.5 or 1.0
- CDR Memory Box score of 0.5 or greater
- Mini-Mental State Examination score of 22 or greater

AND

2 - Submission of medical records (e.g., chart notes) confirming follow-up brain magnetic resonance imaging (MRI) has been completed after the initiation of therapy prior to the 5th and 7th infusion treatment to show ONE of the following radiographic evidence of amyloid related imaging abnormalities (i.e., ARIA-E, ARIA-H):

- Patient has mild radiographic severity of ARIA-E on MRI and is asymptomatic
- Patient has mild radiographic severity of ARIA-E on MRI and has mild clinical symptoms
- Patient has mild radiographic severity of ARIA-H on MRI and is asymptomatic
- ARIA (i.e., ARIA E, ARIA H) has not been observed on MRI

AND

3 - Not used in combination with other A β monoclonal antibodies (mAbs) for Alzheimer's disease (e.g., Aduhelm, Kisunla)

AND

4 - Patient is not being treated with Leqembi as part of a clinical trial

AND

5 - Prescribed by a neurologist, geriatrician, or geriatric psychiatrist

2 . Revision History

Date	Notes
10/15/2025	New program for Leqembi IQLIK. Of note, Aduhelm is now part of this class guideline with different criteria (no longer stand-alone guideline).

Monurol



Prior Authorization Guideline

Guideline ID	GL-140675
Guideline Name	Monurol
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name: Monurol	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - The provider has submitted labs showing the culture and sensitivity is positive for Monural and negative to Ciprofloxacin or Nitrofurantoin OR	

2 - Trial and failure, contraindication, or intolerance to ONE of the following:

- Ciprofloxacin
- Nitrofurantoin

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Mozobil



Prior Authorization Guideline

Guideline ID	GL-140850
Guideline Name	Mozobil
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2020

1 . Criteria

Product Name:Mozobil	
Approval Length	4 Days*
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: Patients with non-Hodgkin's lymphoma (NHL) who will be undergoing autologous hematopoietic stem cell (HSC) transplantation	

Patients with multiple myeloma (MM) who will be undergoing autologous HSC transplantation	
AND	
2 - Used in combination with granulocyte-colony stimulating factor (G-CSF) [e.g., Zarxio (filgrastim)]	
AND	
3 - Prescribed by, or in consultation with, a hematologist/oncologist	
Notes	*Authorization will be issued for 1 course of therapy (up to four days of therapy).

2 . Revision History

Date	Notes
3/31/2020	Bulk copy C&S New York SP to C&S Arizona SP for 5/1 effective

MS Agents



Prior Authorization Guideline

Guideline ID	GL-519197
Guideline Name	MS Agents
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name:Brand Gilenya, generic fingolimod, Brand Copaxone, generic glatiramer, Glatopa, Avonex, Rebif, Betaseron, Extavia, Vumerity, Bafiertam, Kesimpta, Brand Tecfidera, generic dimethyl fumarate, Plegridy, Brand Aubagio, generic teriflunomide, Mayzent, Tascenso ODT, Brand Ampyra, generic dalfampridine, Brand Mavenclad, generic cladribine tabs, Ponvory	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of multiple sclerosis (MS)

AND

2 - If the request is non-preferred, ONE of the following:**

2.1 Patient has a history of failure, contraindication, or intolerance to a trial of at least TWO preferred^^ alternatives (Verified via paid claims or submission of medical records)

OR

2.2 Patient is currently established on requested medication as documented by claims history or medical records (document drug, date, and duration of therapy)

Notes	**PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC CCP *Preferred drugs may require PA. ^Preferred drugs include medical benefit drugs Briumvi, Ocrevus/Ocrevus Zunovo, and Tysabri.

Product Name: Brand Gilenya, generic fingolimod, Brand Copaxone, generic glatiramer, Glatopa, Avonex, Rebif, Betaseron, Extavia, Vumerity, Bafiertam, Kesimpta, Brand Tecfidera, generic dimethyl fumarate, Plegridy, Brand Aubagio, generic teriflunomide, Mayzent, Tascenso ODT, Brand Ampyra, generic dalfampridine, Brand Mavenclad, generic cladribine tabs, Ponvory

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy (e.g., stability in radiologic disease activity, clinical relapses, disease progression)

2 . Revision History

UnitedHealthcare Community Plan of Arizona Clinical Pharmacy Program Guidelines

Date	Notes
2/9/2026	Added generic cladribine tabs as targets. Updated GPI tables and product name lists, accordingly. No changes to clinical criteria.

Multaq



Prior Authorization Guideline

Guideline ID	GL-140642
Guideline Name	Multaq
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2020

1 . Criteria

Product Name:Multaq	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 All of the following: 1.1.1 Diagnosis of ONE of the following:	

- Paroxysmal Atrial Fibrillation (AF)
- Persistent AF defined as AF less than 6 months duration

AND

1.1.2 ONE of the following:

- Patient is in sinus rhythm
- Patient is planned to undergo cardioversion to sinus rhythm

AND

1.1.3 Patient does not have New York Heart Association (NYHA) Class IV heart failure

AND

1.1.4 Patient does not have symptomatic heart failure with recent decompensation requiring hospitalization

OR

1.2 For continuation of current therapy

2 . Revision History

Date	Notes
3/31/2020	Bulk Copy C&S New York to C&S Arizona for effective date of 5/1

Myalept



Prior Authorization Guideline

Guideline ID	GL-140898
Guideline Name	Myalept
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Myalept	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following: Congenital generalized lipodystrophy associated with leptin deficiency	

- Acquired generalized lipodystrophy associated with leptin deficiency

AND

2 - Used as an adjunct to diet modification

AND

3 - Prescribed by an endocrinologist

AND

4 - Documentation demonstrates that patient has at least ONE of the following:

4.1 Diabetes mellitus or insulin resistance with persistent hyperglycemia (hemoglobin A1C greater than 7.0%) despite BOTH of the following:

- Dietary intervention
- Optimized insulin therapy at maximum tolerated doses

OR

4.2 Persistent hypertriglyceridemia (triglycerides greater than 250 milligrams per deciliter) despite BOTH of the following:

- Dietary intervention
- Optimized therapy with at least two triglyceride-lowering agents from different classes (e.g., fibrates, statins) at maximum tolerated doses

Product Name: Myalept	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Myalept therapy

AND

2 - Used as an adjunct to diet modification

AND

3 - Prescribed by an endocrinologist

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Myfembree, Oriahnn



Prior Authorization Guideline

Guideline ID	GL-140770
Guideline Name	Myfembree, Oriahnn
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	3/1/2023

1 . Criteria

Product Name:Oriahnn, Myfembree	
Diagnosis	Heavy Menstrual Bleeding Associated With Uterine Leiomyomas (Fibroids)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of heavy menstrual bleeding associated with uterine leiomyomas (fibroids)	

AND

2 - Patient is premenopausal

AND

3 - One of the following:

3.1 History of inadequate control of bleeding following a trial of at least 3 months, or history of intolerance or contraindication to one of the following:

- Combination (estrogen/progestin) contraceptive
- Progestins
- Tranexamic acid

OR

3.2 Patient has had a previous interventional therapy to reduce bleeding

AND

4 - Treatment duration of therapy has not exceeded a total of 24 months

Product Name:Oriahnn, Myfembree

Diagnosis	Heavy Menstrual Bleeding Associated With Uterine Leiomyomas (Fibroids)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has improvement in bleeding associated with uterine leiomyomas (fibroids) (e.g., significant/sustained reduction in menstrual blood loss per cycle, improved quality of life, etc.)

AND

2 - Treatment duration of therapy has not exceeded a total of 24 months

Product Name: Myfembree

Diagnosis	Pain Associated With Endometriosis

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe pain associated with endometriosis

AND

2 - Patient is premenopausal

AND

3 - One of the following:

3.1 History of inadequate pain control response following a trial of 30 days, or history of intolerance or contraindication to one of the following:

- Danazol
- Combination (estrogen/progestin) contraceptive
- Progestins

OR

3.2 Patient has had surgical ablation to prevent recurrence

AND

4 - Treatment duration of Myfembree has not exceeded a total of 24 months

Product Name:Myfembree	
Diagnosis	Pain Associated With Endometriosis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has improvement in pain associated with endometriosis (e.g., improvement in dysmenorrhea and nonmenstrual pelvic pain) AND 2 - Treatment duration of Myfembree has not exceeded a total of 24 months	

2 . Revision History

Date	Notes
2/9/2023	Moved guideline to standard formulary. Added Oriahnn. Added criteria for Myfembree - for Endometriosis pain.

Myqorzo (aficamten)



Prior Authorization Guideline

Guideline ID	GL-557209
Guideline Name	Myqorzo (aficamten)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:Myqorzo	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of obstructive hypertrophic cardiomyopathy (HCM)	

AND

2 - Patient has New York Heart Association (NYHA) Class II or III symptoms (e.g., shortness of breath, chest pain)

AND

3 - BOTH of the following were measured prior to Myqorzo therapy:

3.1 Patient had a left ventricular ejection fraction of greater than or equal to 55%

AND

3.2 Patient had a Valsalva left ventricular outflow tract (LVOT) peak gradient greater than or equal to 50 mmHg at rest or with provocation

AND

4 - Trial and inadequate response, contraindication, or intolerance to ONE of the following at a maximally tolerated dose:

- Non-vasodilating beta blocker (e.g., bisoprolol, propranolol)
- Calcium channel blocker (e.g., verapamil, diltiazem)

AND

5 - Requested drug will NOT be used in combination with another cardiac myosin inhibitor (e.g., Camzyos)

AND

6 - Prescribed by or in consultation with a cardiologist

Product Name: Myqorzo

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy (e.g., improved symptom relief) AND 2 - Patient has a left ventricular ejection fraction of greater than or equal to 50% AND 3 - Requested drug will NOT be used in combination with another cardiac myosin inhibitor (e.g., Camzyos) AND 4 - Prescribed by or in consultation with a cardiologist	

2 . Revision History

Date	Notes
3/27/2026	New program.

Mytesi



Prior Authorization Guideline

Guideline ID	GL-140643
Guideline Name	Mytesi
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2020

1 . Criteria

Product Name:Mytesi	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS) associated diarrhea	

2 . Revision History

UnitedHealthcare Community Plan of Arizona Clinical Pharmacy Program Guidelines

Date	Notes
3/31/2020	Bulk Copy C&S New York to C&S Arizona for effective date of 5/1

Nadolol



Prior Authorization Guideline

Guideline ID	GL-140731
Guideline Name	Nadolol
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:generic nadolol	
Diagnosis	PA required for patients 18 years of age or older
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - History of failure, contraindication, or intolerance to 3 of the following: • atenolol • atenolol/chlorthalidone	

- bisoprolol fumarate
- bisoprolol/hydrochlorothiazide
- carvedilol
- labetalol HCl
- metoprolol succinate
- metoprolol tartrate
- metoprolol/hydrochlorothiazide
- propranolol HCl
- propranolol/hydrochlorothiazide
- sotalol HCl

2 . Revision History

Date	Notes
8/10/2022	C&S to match AZM 10.1.22

Namzaric (memantine/donepezil)



Prior Authorization Guideline

Guideline ID	GL-164736
Guideline Name	Namzaric (memantine/donepezil)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	3/1/2025

1 . Criteria

Product Name: Brand Namzaric, generic memantine/donepezil	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following: 1.1 History of BOTH of the following: 1.1.1 Memantine (generic Namenda)	

AND	
1.1.2 Donepezil (generic Aricept)	
AND	
1.2 Patient is stabilized on 10mg of donepezil once daily	

2 . Revision History

Date	Notes
2/5/2025	Update to guideline name. Added generic memantine/donepezil as a target. Updated product name list and GPI table accordingly.

Natpara



Prior Authorization Guideline

Guideline ID	GL-140851
Guideline Name	Natpara
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2020

1 . Criteria

Product Name:Natpara	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ALL of the following: 1.1 Diagnosis of hypocalcemia resulting from chronic hypoparathyroidism	

AND

1.2 25-hydroxy vitamin D level is above the lower limit of the normal laboratory reference range

AND

1.3 Patient is currently on active vitamin D (calcitriol) therapy

AND

1.4 Total serum calcium level (albumin corrected) is above 7.5 milligrams per deciliter

AND

2 - ONE of the following:

2.1 Patient is currently on calcium supplementation of 1-2 grams per day of elemental calcium in divided doses

OR

2.2 Patient has a contraindication to calcium supplementation

AND

3 - Prescribed by ONE of the following:

- Endocrinologist
- Nephrologist

Product Name:Natpara

Approval Length

12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Total serum calcium level (albumin corrected) within the lower half of the normal range (approximately 8 to 9 milligrams per deciliter) AND 2 - Patient continues to take concomitant calcium supplementation that is sufficient to meet daily requirements AND 3 - Prescribed by ONE of the following: • Endocrinologist • Nephrologist	

2 . Revision History

Date	Notes
3/31/2020	Bulk copy C&S New York SP to C&S Arizona SP for 5/1 effective

Nemluvio (nemolizumab-ilto)



Prior Authorization Guideline

Guideline ID	GL-210194
Guideline Name	Nemluvio (nemolizumab-ilto)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	4/1/2025

1 . Criteria

Product Name:Nemluvio	
Diagnosis	Prurigo Nodularis (PN)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming diagnosis of prurigo nodularis (PN)	

AND

2 - Patient has at least 20 nodular lesions

AND

3 - Prescribed by or in consultation with ONE of the following:

- Dermatologist
- Allergist
- Immunologist

AND

4 - Submission of medical records (e.g., chart notes) or paid claims confirming trial and failure, contraindication, or intolerance to BOTH of the following*:

- One medium or higher potency topical corticosteroid
- Dupixent (dupilumab)^

Notes	*Claims history may be used in conjunction as documentation of drug, date, and/or contraindication to medication. ^PA may be required.

Product Name:Nemluvio	
Diagnosis	Prurigo Nodularis (PN)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting that patient demonstrates a positive clinical response to therapy as evidenced by at least ONE of the following:	

- Reduction in the number of nodular lesions from baseline
- Improvement in symptoms (e.g., pruritus, inflammation) from baseline

AND

2 - Prescribed by or in consultation with ONE of the following:

- Dermatologist
- Allergist
- Immunologist

Product Name:Nemluvio	
Diagnosis	Atopic Dermatitis (AD)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming diagnosis of moderate to severe atopic dermatitis (AD)

AND

2 - One of the following:

- Involvement of at least 10% body surface area (BSA)
- SCORing Atopic Dermatitis (SCORAD) index value of at least 25

AND

3 - Patient is 12 years of age or older

AND

4 - Will be used in combination with topical corticosteroids and/or calcineurin inhibitors (e.g., tacrolimus ointment)

AND

5 - Submission of medical records (e.g., chart notes) or paid claims confirming history of failure, contraindication, or intolerance to ALL of the following*:

- One topical calcineurin inhibitor [e.g., Elidel (pimecrolimus), Protopic (tacrolimus)]
- Eucrisa (crisaborole)
- Adbry (tralokinumab-ldrm)
- Opzelura (ruxolitinib)

AND

6 - Prescribed by or in consultation with one of the following:

- Dermatologist
- Allergist
- Immunologist

Notes	*Claims history may be used in conjunction as documentation of drug, date, and/or contraindication to medication.

Product Name:Nemluvio	
Diagnosis	Atopic Dermatitis (AD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Submission of medical records (e.g., chart notes) documenting that patient demonstrates a positive clinical response to therapy as evidenced by at least ONE of the following:

- Reduction in body surface area involvement from baseline
- Reduction in SCORing Atopic Dermatitis (SCORAD) index value from baseline

AND

2 - Prescribed by or in consultation with ONE of the following:

- Dermatologist
- Allergist
- Immunologist

2 . Background

Benefit/Coverage/Program Information

Table 1: Relative potencies of topical corticosteroids

Class	Drug	Dosage Form	Strength (%)
Very high potency	Augmented betamethasone dipropionate	Ointment	0.05
	Clobetasol propionate	Cream, foam, ointment	0.05
	Diflorasone diacetate	Ointment	0.05
	Halobetasol propionate	Cream, ointment	0.05
High Potency	Amcinonide	Cream, lotion, ointment	0.1
	Augmented betamethasone dipropionate	Cream	0.05

	Betamethasone dipropionate	Cream, foam, ointment, solution	0.05
	Desoximetasone	Cream, ointment	0.25
	Desoximetasone	Gel	0.05
	Diflorasone diacetate	Cream	0.05
	Fluocinonide	Cream, gel, ointment, solution	0.05
	Halcinonide	Cream, ointment	0.1
	Mometasone furoate	Ointment	0.1
	Triamcinolone acetonide	Cream, ointment	0.5
Medium potency	Betamethasone valerate	Cream, foam, lotion, ointment	0.1
	Clocortolone pivalate	Cream	0.1
	Desoximetasone	Cream	0.05
	Fluocinolone acetonide	Cream, ointment	0.025
	Flurandrenolide	Cream, ointment	0.05
	Fluticasone propionate	Cream	0.05
	Fluticasone propionate	Ointment	0.005
	Mometasone furoate	Cream	0.1
	Triamcinolone acetonide	Cream, ointment	0.1
Lower-medium potency	Hydrocortisone butyrate	Cream, ointment, solution	0.1
	Hydrocortisone probutate	Cream	0.1
	Hydrocortisone valerate	Cream, ointment	0.2
	Prednicarbate	Cream	0.1
Low potency	Alclometasone dipropionate	Cream, ointment	0.05
	Desonide	Cream, gel, foam, ointment	0.05

	Fluocinolone acetonide	Cream, solution	0.01
Lowest potency	Dexamethasone	Cream	0.1
	Hydrocortisone	Cream, lotion, ointment, solution	0.25, 0.5, 1
	Hydrocortisone acetate	Cream, ointment	0.5-1

3 . Revision History

Date	Notes
3/6/2025	Added criteria for new AD indication. Updated notes.

Nexiclon XR (clonidine ER)



Prior Authorization Guideline

Guideline ID	GL-140801
Guideline Name	Nexiclon XR (clonidine ER)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	7/1/2023

1 . Criteria

Product Name:Nexiclon XR, Brand Clonidine ER 24HR 0.17 mg tabs	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Requested medication is being used for treatment of hypertension AND	

2 - Trial and failure, contraindication, or intolerance to ONE of the following (verified via paid pharmacy claims or submitted chart notes):

- generic clonidine oral tablet
- generic clonidine topical patch

2 . Revision History

Date	Notes
6/7/2023	Added brand clonidine ER 24Hr GPI and product name, updated criteria.

Nexletol (bempedoic acid) and Nexlizet (bempedoic acid-ezetimibe)



Prior Authorization Guideline

Guideline ID	GL-148465
Guideline Name	Nexletol (bempedoic acid) and Nexlizet (bempedoic acid-ezetimibe)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name:Nexletol, Nexlizet	
Diagnosis	Heterozygous familial hypercholesterolemia (HeFH) or primary hyperlipidemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following diagnoses:	

- Heterozygous familial hypercholesterolemia (HeFH)
- Primary Hyperlipidemia

AND

2 - ONE of the following:

- Patient has been receiving at least 12 consecutive weeks of highest tolerable dose of statin therapy
- Patient is statin intolerant as evidenced by an inability to tolerate at least two statins, with at least one started at the lowest starting daily dose, due to intolerable symptoms or clinically significant biomarker changes of liver function or muscle function (e.g., creatine kinase)
- Patient has an FDA (Food and Drug Administration) labeled contraindication to all statins

AND

3 - ONE of the following LDL-C (low-density lipoprotein cholesterol) values while on maximally tolerated statin therapy within the last 120 days:

- LDL-C greater than or equal to 55 mg/dL (milligrams/deciliter) with ASCVD (atherosclerotic cardiovascular disease)
- LDL-C greater than or equal to 100 mg/dL without ASCVD

AND

4 - ONE of the following:

4.1 For Nexletol, ONE of the following:

- Patient has been receiving at least 12 consecutive weeks of generic ezetimibe therapy as adjunct to maximally tolerated statin therapy
- Patient has a history of contraindication or intolerance to ezetimibe

OR

4.2 For Nexlizet, patient has been receiving at least 12 consecutive weeks of generic ezetimibe therapy as adjunct to maximally tolerated statin therapy

Product Name:Nexletol, Nexlizet	
Diagnosis	Heterozygous familial hypercholesterolemia (HeFH) or primary hyperlipidemia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient demonstrates positive clinical response to therapy as evidenced by a reduction in LDL-C (low-density lipoprotein cholesterol) levels from baseline while on therapy AND 2 - ONE of the following: • Patient continues to receive other lipid-lowering therapy (e.g., statins, ezetimibe) at the maximally tolerated dose • Patient has a documented inability to take other lipid-lowering therapy (e.g., statins, ezetimibe)	

Product Name:Nexletol, Nexlizet	
Diagnosis	Established cardiovascular disease (CVD) or high risk for a CVD event but without established CVD
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following diagnoses: • Established cardiovascular disease (CVD) (e.g., coronary artery disease, symptomatic peripheral arterial disease, cerebrovascular atherosclerotic disease)	

- A high risk for a CVD event but without established CVD [e.g., diabetes mellitus (type 1 or type 2) in females over 65 years of age or males over 60 years of age]

AND

2 - ONE of the following:

- Patient is statin intolerant as evidenced by an inability to tolerate at least two statins, with at least one started at the lowest starting daily dose, due to intolerable symptoms or clinically significant biomarker changes of liver function or muscle function (e.g., creatine kinase)
- Patient has an FDA (Food and Drug Administration) labeled contraindication to all statins

AND

3 - ONE of the following LDL-C (low-density lipoprotein cholesterol) values within the last 120 days:

- LDL-C greater than or equal to 55 mg/dL (milligrams/deciliter) with ASCVD (atherosclerotic cardiovascular disease)
- LDL-C greater than or equal to 100 mg/dL without ASCVD

AND

4 - ONE of the following:

4.1 For Nexletol, ONE of the following:

- Patient has been receiving at least 12 consecutive weeks of generic ezetimibe therapy
- Patient has a history of contraindication or intolerance to ezetimibe

OR

4.2 For Nexlizet, patient has been receiving at least 12 consecutive weeks of generic ezetimibe therapy

Product Name:Nexletol, Nexlizet

Diagnosis	Established cardiovascular disease (CVD) or high risk for a CVD event but without established CVD
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient demonstrates positive clinical response to therapy	

2 . Revision History

Date	Notes
6/14/2024	Updated criteria due to indication updates in prescribing information. Added criteria for the new FDA approved indication.

Nitisinone Products



Prior Authorization Guideline

Guideline ID	GL-572200
Guideline Name	Nitisinone Products
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:Nityr, Brand Orfadin caps, generic nitisinone caps, Orfadin susp	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of hereditary tyrosinemia type 1 (HT-1)	

AND

2 - Diagnosis confirmed by the presence of succinylacetone in the plasma or urine

AND

3 - Used in combination with dietary restriction of tyrosine and phenylalanine

AND

4 - Prescribed by or in consultation with ONE of the following:

- Gastroenterologist
- Hepatologist
- Other specialist with experience in treating inborn errors of metabolism

AND

5 - If the request is for Nityr, trial and intolerance to Orfadin (nitisinone) capsules or suspension

Product Name:Nityr, Brand Orfadin caps, generic nitisinone caps, Orfadin susp	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient demonstrates a positive clinical response to therapy AND	

2 - If the request is for Nityr, trial and intolerance to Orfadin (nitisinone) capsules or suspension

Product Name:Harliku

Approval Length 12 month(s)

Therapy Stage Initial Authorization

Guideline Type Prior Authorization

Approval Criteria

1 - Diagnosis of alkaptonuria (AKU)

AND

2 - Used for the reduction of urine homogentisic acid (HGA)

AND

3 - Disease is confirmed by ONE of the following:

- Presence of a mutation in the homogentisate 1,2-dioxygenase (HGD) gene
- Presence of elevated homogentisic acid (HGA) levels in urine greater than 0.4 g/24h

AND

4 - Trial (of a minimum 30-day supply) or intolerance to generic nitisinone 2 mg capsules

AND

5 - Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Geneticist

- Specialist experienced in the treatment of inborn errors of metabolism

Product Name:Harliku	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient demonstrates positive clinical response to therapy [e.g., reduced levels of urinary homogentisic acid (HGA)] AND 2 - Trial (of a minimum 30-day supply) or intolerance to generic nitisinone 2 mg capsules	

2 . Revision History

Date	Notes
4/10/2026	Updated guideline name. Added Nityr products as targets to this class guideline (Nityr will no longer be a standalone GL). Updated criteria for Nityr and Orfadin (nitisinone) caps/susp products. Added criteria for new target drug, Harliku.

Nocdurna



Prior Authorization Guideline

Guideline ID	GL-140663
Guideline Name	Nocdurna
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2021

1 . Criteria

Product Name:Nocdurna	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of nocturia due to nocturnal polyuria (as defined by nighttime urine production that exceeds one-third of the 24-hour urine production)	

AND

2 - Patient wakes at least twice per night on a reoccurring basis to void

AND

3 - Documented serum sodium level is currently within normal limits of the normal laboratory reference range and has been within normal limits over the previous six months

AND

4 - The patient has been evaluated for other medical causes and has either not responded to, tolerated, or has a contraindication to treatments for identifiable medical causes [e.g., overactive bladder, benign prostatic hyperplasia/lower urinary tract symptoms (BPH/LUTS), elevated post-void residual urine, and heart failure]

AND

5 - Prescriber attests that the risks have been assessed and benefits outweigh the risks

Product Name:Nocdurna	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy AND 2 - Patient has routine monitoring for serum sodium levels	

AND

3 - Prescriber attests that the risks of hyponatremia have been assessed and benefits outweigh the risks

2 . Revision History

Date	Notes
3/1/2021	Noctiva removed from the guideline

Non-hormonal Therapies for Vasomotor Symptoms



Prior Authorization Guideline

Guideline ID	GL-519203
Guideline Name	Non-hormonal Therapies for Vasomotor Symptoms
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name:Lynkuet, Veozah	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderate to severe vasomotor symptoms due to menopause	

AND

2 - Submission of medical records (e.g., chart notes, paid claims history) documenting trial and failure, contraindication, or intolerance to BOTH of the following (document drug, date, and duration of trial):

- Menopausal hormone therapy (e.g., Premarin, Bijuva, Estrogel, etc.)
- Non-hormonal therapy (e.g., paroxetine mesylate, venlafaxine, clonidine, etc.)

Product Name:Lynkuet, Veozah	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy (e.g., decrease in frequency and severity of vasomotor symptoms from baseline, etc.)	

2 . Revision History

Date	Notes
2/10/2026	Updated guideline name. Added Lynkuet as a target to the guideline. No changes to clinical criteria.

Non-Preferred Drugs



Prior Authorization Guideline

Guideline ID	GL-231255
Guideline Name	Non-Preferred Drugs
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2025

1 . Criteria

Product Name:Non-Preferred Drugs	
Approval Length	12 months*
Guideline Type	Administrative
Approval Criteria 1 - ALL of the following: 1.1 ONE of the following**: 1.1.1 If there are at least three preferred alternatives, history of trial per patient's pharmacy claims resulting in a therapeutic failure, contraindication, or intolerance to at	

least THREE preferred alternatives [Prior trials of formulary/preferred drug list alternatives must sufficiently demonstrate that the formulary/PDL alternatives are either ineffective or inappropriate at the time of the request]

or

1.1.2 If there are fewer than three preferred alternatives, the patient must have a history of trial per patient's pharmacy claims resulting in a therapeutic failure, contraindication, or intolerance to ALL of the preferred products

or

1.1.3 There are no preferred formulary alternatives for the requested drug

AND

1.2 If the request is for a multi-source brand medication, ONE of the following:

1.2.1 BOTH of the following:

1.2.1.1 The brand is being requested because of an adverse reaction, allergy, or sensitivity to the generic and the prescriber must attest to submitting the FDA MedWatch Form for allergic reactions to the medications

AND

1.2.1.2 The patient has tried three generic formulations of the requested brand product

or

1.2.2 ONE of the following:

The brand is being requested due to a therapeutic failure with the generic

The brand is being requested because transition to the generic could result in destabilization of the patient

Special clinical circumstances exist that preclude the use of the generic equivalent of the multi-source brand medication for the patient

AND

1.3 ONE of the following:

1.3.1 The requested drug must be used for an FDA-approved indication

or

1.3.2 The use of this drug is supported by information from ONE of the following appropriate compendia of current literature:

The requested drug must be used for an FDA-approved indication

FDA approved indications and limits

Published practice guidelines and treatment protocols

Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits, and potential patient outcomes

Drug Facts and Comparisons

American Hospital Formulary Service Drug Information

United States Pharmacopeia - Drug Information

DRUGDEX Information System

UpToDate

MicroMedex

Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data, and pharmacoeconomic studies

Other drug reference resources

AND

1.4 The drug is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plan's program***

or

2 - If the requested medication is a behavioral health medication, ONE of the following:
The patient has been receiving treatment with the requested non-preferred behavioral health medication and is new to the plan

The patient is currently receiving treatment with the requested non-preferred behavioral health medication in the hospital and must continue upon discharge	
Notes	*Anti-infectives: Approve for the requested time frame, or if duration is not specified approve the request for 30 days. *Controlled Substances shall be approved for the requested time. If there is not a requested time period and it is not clear in the directions, approve for one time only. *Other medications: Approved for the requested time frame, or if duration is not specified, approve for 12 months. **PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC ***Medications used to treat anti-obesity/weight loss, cosmetic (e.g., alopecia, actinic keratosis, vitiligo), erectile dysfunction, or sexual dysfunction purposes are NOT medically accepted indications and are NOT recognized as a covered benefit. Erectile dysfunction drugs (Cialis/Tadalafil) are covered for clinical diagnoses other than ED.

2 . Revision History

Date	Notes
4/1/2025	Updated note section regarding cosmetic/excluded use.

Non-Preferred Prenatal Vitamins



Prior Authorization Guideline

Guideline ID	GL-140705
Guideline Name	Non-Preferred Prenatal Vitamins
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Non-Preferred Prenatal Vitamins	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - History of failure, contraindication, or intolerance to ALL of the following preferred products:*	
Notes	*Please refer to the background table for the alternatives

2 . Background

Benefit/Coverage/Program Information			
Preferred Products:			
GPI-14	Product ID	Product Label	GPI-14 Description
785120000003 15	7331710500 9	PRENATVITE TA B RX	*PRENATAL MULTIVITAMINS & MINERALS W/IRON & FA TAB 0.8 MG***
785120100003 30	6954302679 0	PNV TABS TAB 29-1MG	*PRENATAL VIT W/ IRON CARBONYL-FA TAB 29-1 MG***
785120100003 30	6025801930 9	PRENATABS RX TAB	*PRENATAL VIT W/ IRON CARBONYL-FA TAB 29-1 MG***
785120100003 30	4293707051 0	PRENATAL+FE T AB 29-1MG	*PRENATAL VIT W/ IRON CARBONYL-FA TAB 29-1 MG***
785120100003 30	4293707051 6	PRENATAL+FE T AB 29-1MG	*PRENATAL VIT W/ IRON CARBONYL-FA TAB 29-1 MG***
785120100003 30	4293707051 8	PRENATAL+FE T AB 29-1MG	*PRENATAL VIT W/ IRON CARBONYL-FA TAB 29-1 MG***
785120100003 30	5865701339 0	THRIVITE RX TAB 29-1MG	*PRENATAL VIT W/ IRON CARBONYL-FA TAB 29-1 MG***
785120100003 30	7118600192 4	VIL-RX TAB 29-1MG	*PRENATAL VIT W/ IRON CARBONYL-FA TAB 29-1 MG***
785120100003 30	1381105169 0	VOL-TAB RX TAB	*PRENATAL VIT W/ IRON CARBONYL-FA TAB 29-1 MG***
785120100003 52	1381100271 0	ELITE-OB TAB	*PRENATAL VIT W/ IRON CARBONYL-FA TAB 50-1.25 MG***
785120100003 52	6802500101 0	OB COMPLETE TAB	*PRENATAL VIT W/ IRON CARBONYL-FA TAB 50-1.25 MG***
785120150003 24	5865701700 1	M-NATAL PLUS TAB	*PRENATAL VIT W/ FE FUMARATE-FA TAB 27-1 MG***
785120150003 24	1283008000 1	M-VIT TAB 27- 1MG	*PRENATAL VIT W/ FE FUMARATE-FA TAB 27-1 MG***

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785120150003 24	7089802200 1	NEONATAL TAB COMPLTE	*PRENATAL VIT W/ FE FUMARATE-FA TAB 27-1 MG***
785120150003 24	7089801150 1	NEONATAL PLS TAB 27-1MG	*PRENATAL VIT W/ FE FUMARATE-FA TAB 27-1 MG***
785120150003 24	7583400500 1	NIVA-PLUS TAB	*PRENATAL VIT W/ FE FUMARATE-FA TAB 27-1 MG***
785120150003 24	0081393160 1	O-CAL FA TAB	*PRENATAL VIT W/ FE FUMARATE-FA TAB 27-1 MG***
785120150003 24	7139962460 9	ONE VITE TAB 1MG PLUS	*PRENATAL VIT W/ FE FUMARATE-FA TAB 27-1 MG***
785120150003 24	3932801061 0	PRENATAL TAB 27-1MG	*PRENATAL VIT W/ FE FUMARATE-FA TAB 27-1 MG***
785120150003 24	3932801065 0	PRENATAL TAB 27-1MG	*PRENATAL VIT W/ FE FUMARATE-FA TAB 27-1 MG***
785120150003 24	6304401500 1	PRENATAL VIT TAB LOW IRON	*PRENATAL VIT W/ FE FUMARATE-FA TAB 27-1 MG***
785120150003 24	6304401500 5	PRENATAL VIT TAB LOW IRON	*PRENATAL VIT W/ FE FUMARATE-FA TAB 27-1 MG***
785120150003 24	6954302581 0	PREPLUS TAB 27-1MG	*PRENATAL VIT W/ FE FUMARATE-FA TAB 27-1 MG***
785120150003 24	6954302585 0	PREPLUS TAB 27-1MG	*PRENATAL VIT W/ FE FUMARATE-FA TAB 27-1 MG***
785120150003 24	6711201010 0	TRICARE TAB PRENATAL	*PRENATAL VIT W/ FE FUMARATE-FA TAB 27-1 MG***
785120150003 24	1713908003 0	VITATHELY TAB	*PRENATAL VIT W/ FE FUMARATE-FA TAB 27-1 MG***
785120150003 24	1381105191 0	VOL-PLUS TAB	*PRENATAL VIT W/ FE FUMARATE-FA TAB 27-1 MG***
785120150003 24	1381105195 0	VOL-PLUS TAB	*PRENATAL VIT W/ FE FUMARATE-FA TAB 27-1 MG***
785120150003 24	6936702670 1	WESTAB PLUS TAB 27- 1MG	*PRENATAL VIT W/ FE FUMARATE-FA TAB 27-1 MG***

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785120150003 29	6025801920 1	TRINATE TAB	*PRENATAL VIT W/ FE FUMARATE-FA TAB 28-1 MG***
785120150003 29	1381105141 0	VOL-NATE TAB	*PRENATAL VIT W/ FE FUMARATE-FA TAB 28-1 MG***
785120150003 32	1026722700 1	CO-NATAL FA TAB 29-1MG	*PRENATAL VIT W/ FE FUMARATE-FA TAB 29-1 MG***
785120150003 32	7331782860 1	NEONATAL TAB COMPLETE	*PRENATAL VIT W/ FE FUMARATE-FA TAB 29-1 MG***
785120150003 32	6954302591 0	PRETAB TAB 29-1MG	*PRENATAL VIT W/ FE FUMARATE-FA TAB 29-1 MG***
785120150003 60	1381100071 0	TRINATAL RX TAB 1	*PRENATAL VIT W/ FE FUMARATE-FA TAB 60-1 MG***
785120150003 60	5199105660 1	VINATE ONE TAB	*PRENATAL VIT W/ FE FUMARATE-FA TAB 60-1 MG***
785120150003 66	5860708112 0	MYNATAL PLUS TAB	*PRENATAL VIT W/ FE FUMARATE-FA TAB 65-1 MG***
785120150003 66	5860701056 5	MYNATAL-Z TAB	*PRENATAL VIT W/ FE FUMARATE-FA TAB 65-1 MG***
785120150003 66	0064200791 2	VITAFOL-OB TAB 65-1MG	*PRENATAL VIT W/ FE FUMARATE-FA TAB 65-1 MG***
785120150005 30	1381100149 0	COMPLETENATE CHW	*PRENATAL VIT W/ FE FUMARATE-FA CHEW TAB 29-1 MG***
785120150005 30	4293707071 0	PRENATAL 19 CHW 29-1MG	*PRENATAL VIT W/ FE FUMARATE-FA CHEW TAB 29-1 MG***
785120150005 30	4293707071 6	PRENATAL 19 CHW 29-1MG	*PRENATAL VIT W/ FE FUMARATE-FA CHEW TAB 29-1 MG***
785120150005 30	4293707071 8	PRENATAL 19 CHW 29-1MG	*PRENATAL VIT W/ FE FUMARATE-FA CHEW TAB 29-1 MG***

785120150005 30	6025801970 1	PRENATAL 19 CHW TAB	*PRENATAL VIT W/ FE FUMARATE-FA CHEW TAB 29-1 MG***
785120150005 30	1392501170 1	SE-NATAL 19 CHW	*PRENATAL VIT W/ FE FUMARATE-FA CHEW TAB 29-1 MG***
785120160001 30	1381100493 0	ULTIMATECARE CAP ONE	*PRENATAL VIT W/ FE CBN-FE ASP GLYC-FA-OMEGA 3 CAP 27- 1MG***
7851201800011 6	2335901053 0	C-NATE DHA CAP 28-1- 200	*PRENATAL VIT W/ FE FUM-FA- OMEGA 3 CAP 28-1-200 MG***
7851201800011 6	2335902003 0	RELNATE DHA CAP	*PRENATAL VIT W/ FE FUM-FA- OMEGA 3 CAP 28-1-200 MG***
7851201800011 6	6954303703 0	VIRT-NATE CAP DHA	*PRENATAL VIT W/ FE FUM-FA- OMEGA 3 CAP 28-1-200 MG***
7851201800011 6	6466100803 0	VIVA DHA CAP	*PRENATAL VIT W/ FE FUM-FA- OMEGA 3 CAP 28-1-200 MG***
785120220003 20	6954302419 0	VIRT-PN TAB	*PRENATAL VIT W/ FE FUM- METHYLFOLATE-FA TAB 27-0.6- 0.4 MG***
785120460003 30	5549501250 1	ATABEX OB TAB 29-1MG	*PRENATAL VIT W/ FE BISGLYCINATE CHELATE-FA TAB 29-1 MG***
785120460003 30	5199101780 1	VINATE II TAB	*PRENATAL VIT W/ FE BISGLYCINATE CHELATE-FA TAB 29-1 MG***
785120510003 27	0017808589 0	CITRANATAL TA B RX	*PRENATAL W/O A W/ FE CARBONYL-FE GLUC-DSS-FA TAB 27-1MG***
785120580001 50	5274706203 0	CONCEPT OB CAP	*PRENATAL W/O A W/FE FUM-FE POLY-FA CAP 130-92.4-1 MG***
785120580001 50	1381105353 0	FOLIVANE- OB CAP	*PRENATAL W/O A W/FE FUM-FE POLY-FA CAP 130-92.4-1 MG***

785120600003 25	5199101550 1	VINATE M TAB	*PRENATAL VIT W/ SEL-FE FUMARATE-FA TAB 27-1 MG***
785120700003 30	4293707061 0	PRENATAL 19 TAB 29-1MG	*PRENATAL VIT W/ DSS-FE FUMARATE-FA TAB 29-1 MG***
785120700003 30	4293707061 6	PRENATAL 19 TAB 29-1MG	*PRENATAL VIT W/ DSS-FE FUMARATE-FA TAB 29-1 MG***
785120700003 30	4293707061 8	PRENATAL 19 TAB 29-1MG	*PRENATAL VIT W/ DSS-FE FUMARATE-FA TAB 29-1 MG***
785120700003 30	1392501160 1	SE-NATAL 19 TAB	*PRENATAL VIT W/ DSS-FE FUMARATE-FA TAB 29-1 MG***
785120910001 35	5274706213 0	CONCEPT DHA CAP	*PRENATAL W/FE FUM-FE POLY - FA-OMEGA 3 CAP 53.5-38-1 MG***
785120910001 35	5865701213 0	DOTHELLE DHA CAP	*PRENATAL W/FE FUM-FE POLY - FA-OMEGA 3 CAP 53.5-38-1 MG***
785120910001 35	1381105363 0	TARON-C DHA CAP	*PRENATAL W/FE FUM-FE POLY - FA-OMEGA 3 CAP 53.5-38-1 MG***
785120910001 35	7643903313 0	VIRT-C DHA CAP	*PRENATAL W/FE FUM-FE POLY - FA-OMEGA 3 CAP 53.5-38-1 MG***
785160200063 30	0064200763 0	VITAFOL-OB PAK +DHA	*PRENATAL MV W/FE FUM-FA TAB 65-1 MG & DHA CAP 250 MG PACK *
785160320001 30	0064200703 0	VITAFOL- ONE CAP	*PRENATAL MV W/ FE POLYSAC CMPLX-FA-DHA CAP 29-1-200 MG***
785160320063 25	0064200753 0	SELECT- OB+ PAK DHA	*PRENATAL MV W/FE POLY-FA CHW 29-1 MG & DHA CAP 250 MG PAK *

3 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Non-Solid Oral Dosage Forms



Prior Authorization Guideline

Guideline ID	GL-602209
Guideline Name	Non-Solid Oral Dosage Forms
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	6/1/2026

Note:

The purpose of this guideline is to target high-cost oral solution formulations that are duplicative in clinical nature. For oral solutions without preferred alternatives available, patient may receive the requested drug if they demonstrate inability to swallow. For oral solutions with preferred alternatives that only exist in solid oral dosage formulations (e.g., capsules, tablets), patients will be asked to try the preferred solid oral dosage formulation unless they have an inability to swallow. Not all oral solutions that fit the criteria below will be added to this PA guideline. Certain oral solutions may have drug-specific PA criteria applied if the drug-specific PA criteria can provide more tailored and/or robust clinical review.

1 . Criteria

Product Name:Subvenite oral suspension	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Requested drug is FDA (Food and Drug Administration)-approved for the condition being treated

OR

1.2 If requested for an off-label indication, the off-label guideline approval criteria have been met

AND

2 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming ONE of the following:

2.1 Trial and failure, or intolerance to generic lamotrigine tablet or lamotrigine ODT

OR

2.2 Patient is unable to swallow a solid dosage form (e.g., oral tablet, capsule) due to ONE of the following:

- Age
- Physical impairment (e.g., difficulties with motor or oral coordination)
- Dysphagia
- Patient is using a feeding tube or nasal gastric tube

OR

2.3 For continuation of prior therapy defined as no more than a 45-day gap in therapy

Product Name:Arbli, Atmeksi, Atorvaliq, Butalbital/APAP/Caffeine solution, Eliquis sprinkle capsules, Eliquis tablet for oral suspension, Gloperba, Inzirgo, Javadin, Katerzia, Likmez, Lopressor oral solution, Norliqva, Ontralfy, Sdamlo, Tezruly, Tonmya, Vyscoxa

Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Requested drug is FDA (Food and Drug Administration)-approved for the condition being treated OR 1.2 If requested for an off-label indication, the off-label guideline approval criteria have been met AND 2 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming ONE of the following: 2.1 Trial and failure, or intolerance to a generic equivalent of the requested drug in a solid dosage form OR 2.2 Patient is unable to swallow a solid dosage form (e.g., oral tablet, capsule) due to ONE of the following: • Age • Physical impairment (e.g., difficulties with motor or oral coordination) • Dysphagia • Patient is using a feeding tube or nasal gastric tube AND 3 - If the request is for Norliqva or Sdamlo, trial and failure, contraindication, or intolerance to Katerzia (verified via paid pharmacy claims or submitted chart notes)	

2 . Revision History

Date	Notes
5/7/2026	Added Atmeski

Northera



Prior Authorization Guideline

Guideline ID	GL-140900
Guideline Name	Northera
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Northera	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of symptomatic neurogenic orthostatic hypotension (nOH) as defined by ONE of the following when an upright position is assumed or when using a head-up tilt-table testing at an angle of at least 60 degrees:	

- At least a 20 millimeters of mercury (mm Hg) fall in systolic pressure
- At least a 10 mm Hg fall in diastolic pressure

AND

2 - nOH caused by ONE of the following:

- Primary autonomic failure (e.g., Parkinson's disease, multiple system atrophy, and pure autonomic failure)
- Dopamine beta-hydroxylase deficiency
- Non-diabetic autonomic neuropathy

AND

3 - Diagnostic evaluation has excluded other causes associated with orthostatic hypotension (e.g., congestive heart failure, fluid restriction, malignancy)

AND

4 - The patient has tried at least TWO of the following non-pharmacologic interventions:

- Discontinuation of drugs which can cause orthostatic hypotension [e.g., diuretics, antihypertensive medications (primarily sympathetic blockers), anti-anginal drugs (nitrates), alpha-adrenergic antagonists, and antidepressants]
- Raising the head of the bed 10 to 20 degrees
- Compression garments to the lower extremities or abdomen
- Physical maneuvers to improve venous return (e.g., regular modest-intensity exercise)
- Increased salt and water intake, if appropriate
- Avoiding precipitating factors (e.g., overexertion in hot weather, arising too quickly from supine to sitting or standing)

AND

5 - No previous diagnosis of supine hypertension

AND

6 - Prescribed by, or in consultation with, ONE of the following specialists:

- Cardiologist
- Neurologist
- Nephrologist

AND

7 - History of failure (after a trial of at least 30 days), contraindication or intolerance to BOTH of the following medications:

- Florinef (fludrocortisone)
- ProAmatine (midodrine)

Product Name:Northera	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Northera therapy AND 2 - Physiological countermeasures for neurogenic orthostatic hypotension (nOH) continue to be employed	

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Nourianz



Prior Authorization Guideline

Guideline ID	GL-140644
Guideline Name	Nourianz
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2020

1 . Criteria

Product Name:Nourianz	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Parkinson's disease	

AND

2 - Used as adjunctive treatment to levodopa/carbidopa in patients experiencing “off” episodes

AND

3 - History of failure, contraindication, or intolerance to TWO anti-Parkinson’s disease therapies from the following adjunctive pharmacotherapy classes (trial must be from two different classes):

- Dopamine agonists (e.g., pramipexole, ropinirole)
- Catechol-O-methyl transferase (COMT) inhibitors (e.g., entacapone)
- Monoamine oxidase (MAO) B inhibitors (e.g., rasagiline, selegiline)

Product Name:Nourianz	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Nourianz therapy AND 2 - Patient will continue to receive treatment with a carbidopa/levodopa-containing medication	

2 . Revision History

Date	Notes

3/31/2020	Bulk Copy C&S New York to C&S Arizona for effective date of 5/1

Nucala (mepolizumab)



Prior Authorization Guideline

Guideline ID	GL-398242
Guideline Name	Nucala (mepolizumab)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2025

1 . Criteria

Product Name:Nucala	
Diagnosis	Severe Asthma
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is 6 years of age or older	

AND

2 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of severe asthma

AND

3 - Asthma is an eosinophilic phenotype as defined by ONE of the following:

- Baseline (pre-treatment) peripheral blood eosinophil level is greater than or equal to 150 cells/microliter
- Peripheral blood eosinophil levels were greater than or equal to 300 cells/microliter within the past 12 months

AND

4 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting ONE of the following:

4.1 Patient has had at least two or more asthma exacerbations requiring systemic corticosteroids (e.g., prednisone) within the past 12 months

OR

4.2 Prior asthma-related hospitalization within the past 12 months

AND

5 - Patient is currently being treated with ONE of the following unless there is a contraindication or intolerance to these medications (verified via paid pharmacy claims):

5.1 BOTH of the following:

- High-dose inhaled corticosteroid (ICS) (e.g., greater than 500 mcg fluticasone propionate equivalent/day)
- Additional asthma controller medication (e.g., leukotriene receptor antagonist [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], tiotropium)

OR

5.2 One maximally-dosed combination ICS/LABA product (e.g., Advair [fluticasone propionate/salmeterol], Symbicort [budesonide/formoterol], Breo Ellipta [fluticasone/vilanterol])

AND

6 - Paid claims or submission of documentation (e.g., chart notes) demonstrating history of failure, contraindication, or intolerance to BOTH of the following:

- Xolair (omalizumab)
- Fasenra (benralizumab)

AND

7 - Prescribed by or in consultation with ONE of the following:

- Pulmonologist
- Allergist/Immunologist

Product Name:Nucala	
Diagnosis	Severe Asthma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting positive clinical response to therapy (e.g., reduction in exacerbations, improvement in forced expiratory volume in 1 second [FEV1], decreased use of rescue medications) AND	

2 - Patient continues to be treated with an inhaled corticosteroid (ICS) (e.g., fluticasone, budesonide) with or without additional asthma controller medication (e.g., leukotriene receptor antagonist [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], tiotropium) unless there is a contraindication or intolerance to these medications (verified via paid pharmacy claims)

AND

3 - Paid claims or submission of documentation (e.g., chart notes) demonstrating history of failure, contraindication, or intolerance to BOTH of the following:

- Xolair (omalizumab)
- Fasenra (benralizumab)

AND

4 - Prescribed by or in consultation with ONE of the following:

- Pulmonologist
- Allergist/Immunologist

Product Name:Nucala	
Diagnosis	Chronic rhinosinusitis with nasal polyps (CRSwNP)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is 18 years of age or older AND 2 - Submission of documentation (e.g., chart notes) confirming ALL of the following:	

2.1 Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP) defined by ALL of the following:

2.1.1 TWO or more of the following symptoms for greater than or equal to 12 weeks duration:

- Mucopurulent discharge
- Nasal obstruction and congestion
- Decreased or absent sense of smell
- Facial pressure or pain

AND

2.1.2 ONE of the following:

- Evidence of inflammation on paranasal sinus examination or computed tomography (CT)
- Evidence of purulence coming from paranasal sinuses or ostiomeatal complex

AND

2.1.3 The presence of nasal polyps

AND

2.2 ONE of the following:

- Patient has required prior sino-nasal surgery
- Patient has required systemic corticosteroids in the previous 2 years

AND

2.3 Patient has been unable to obtain symptom relief after trial of ALL of the following agents/classes of agents:

- Nasal saline irrigations
- Intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone, etc.)
- Antileukotriene agents (e.g., montelukast, zafirlukast, zileuton)

AND

3 - Paid claims or submission of documentation (e.g., chart notes) demonstrating history of failure, contraindication, or intolerance to Xolair (omalizumab)

AND

4 - Patient will receive Nucala as add-on maintenance therapy in combination with intranasal corticosteroids

AND

5 - Patient is NOT receiving Nucala in combination with another biologic medication [e.g., Xolair (omalizumab), Dupixent (dupilumab)]

AND

6 - Prescribed by or in consultation with ONE of the following:

- Otolaryngologist
- Allergist
- Pulmonologist

Product Name:Nucala	
Diagnosis	Chronic rhinosinusitis with nasal polyps (CRSwNP)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of documentation (e.g., chart notes) confirming positive clinical response to Nucala therapy	

AND

2 - Paid claims or submission of documentation (e.g., chart notes) demonstrating history of failure, contraindication, or intolerance to Xolair (omalizumab)

AND

3 - Patient will continue to receive Nucala as add-on maintenance therapy in combination with intranasal corticosteroids

AND

4 - Patient is NOT receiving Nucala in combination with another biologic medication [e.g., Xolair (omalizumab), Dupixent (dupilumab)]

AND

5 - Prescribed by or in consultation with ONE of the following:

- Otolaryngologist
- Allergist
- Pulmonologist

Product Name:Nucala	
Diagnosis	Eosinophilic Granulomatosis with Polyangiitis (EGPA)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA)

AND

2 - Patient's disease has relapsed or is refractory to standard of care therapy (i.e., corticosteroid treatment with or without immunosuppressive therapy)

AND

3 - Paid claims or submission of documentation (e.g., chart notes) demonstrating history of failure, contraindication, or intolerance to Fasenra (benralizumab)

AND

4 - Patient is currently receiving corticosteroid therapy (e.g., prednisolone, prednisone)

AND

5 - Prescribed by or in consultation with ONE of the following:

- Pulmonologist
- Rheumatologist
- Allergist/Immunologist

Product Name:Nucala	
Diagnosis	Eosinophilic Granulomatosis with Polyangiitis (EGPA)
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting positive clinical response to therapy (e.g., increase in remission time)

AND

2 - Paid claims or submission of documentation (e.g., chart notes) demonstrating history of failure, contraindication, or intolerance to Fasenra (benralizumab)

Product Name:Nucala

Diagnosis	Hypereosinophilic Syndrome (HES)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of hypereosinophilic syndrome (HES)

AND

2 - Patient has been diagnosed for at least 6 months

AND

3 - Verification that other non-hematologic secondary causes have been ruled out (e.g., drug hypersensitivity, parasitic helminth infection, HIV infection, non-hematologic malignancy)

AND

4 - Patient is Fip1-like1-platelet-derived growth factor receptor alpha (FIP1L1-PDGFRα)-negative

AND

5 - Patient has uncontrolled HES defined as BOTH of the following:

- History of 2 or more flares within the past 12 months
- Pre-treatment blood eosinophil count greater than or equal to 1000 cells/microliter

AND

6 - Trial and failure, contraindication, or intolerance to ONE of the following:

- Corticosteroid therapy (e.g., prednisone)
- Cytotoxic/immunosuppressive therapy (e.g., hydroxyurea, cyclosporine, imatinib)

AND

7 - Prescribed by or in consultation with ONE of the following:

- Allergist/Immunologist
- Hematologist

Product Name:Nucala	
Diagnosis	Hypereosinophilic Syndrome (HES)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting positive clinical response to therapy (e.g., reduction in flares, decreased blood eosinophil count, reduction in corticosteroid dose)	

Product Name:Nucala	
Diagnosis	Chronic Obstructive Pulmonary Disease (COPD)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is 18 years of age or older AND 2 - Submission of medical records (e.g., chart notes) confirming diagnosis of chronic obstructive pulmonary disease (COPD) AND 3 - Submission of medical records (e.g., chart notes) confirming the presence of Type 2 inflammation evidenced by blood eosinophils greater than or equal to 300 cells per microliter at baseline AND 4 - Paid claims or submission of medical records (e.g., chart notes) confirming the patient is receiving ONE of the following therapies at maximally tolerated doses: • Triple therapy [i.e., an inhaled corticosteroid (ICS), a long-acting muscarinic antagonist (LAMA), and a long-acting beta agonist (LABA)] • If ICS are contraindicated, a LAMA and a LABA AND 5 - Patient must have post-bronchodilator forced expiratory volume [FEV1] / forced vital capacity [FVC] ratio less than 0.70	

AND

6 - Patient has had BOTH of the following within the past 12 months:

6.1 At least two exacerbations where systemic corticosteroids [intramuscular, intravenous, or oral (e.g., prednisone)] were required at least once

AND

6.2 A COPD-related hospitalization

AND

7 - Submission of medical records (e.g., chart notes) confirming the patient experiences dyspnea during everyday activities (e.g., needs to stop for breath when walking on level ground)

Product Name:Nucala	
Diagnosis	Chronic Obstructive Pulmonary Disease (COPD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming a positive clinical response to therapy (e.g., improved lung function, a reduction in COPD exacerbations) AND 2 - Paid claims or submission of medical records (e.g., chart notes) confirming the patient continues to receive ONE of the following therapies:	

- Triple therapy [i.e., an inhaled corticosteroid (ICS), a long-acting muscarinic antagonist (LAMA), and a long-acting beta agonist (LABA)]
- If ICS are contraindicated, a LAMA and a LABA

2 . Background

Clinical Practice Guidelines

The Global Initiative for Asthma Global Strategy for Asthma Management and Prevention: Table 1. Low, medium and high daily doses of inhaled corticosteroids in adolescents and adults 12 years and older

Inhaled corticosteroid	Total Daily ICS Dose (mcg)		
	Low	Medium	High
Beclometasone dipropionate (pMDI, standard particle, HFA)	200-500	> 500-1000	> 1000
Beclometasone dipropionate (pMDI, extrafine particle*, HFA)	100-200	> 200-400	> 400
Budesonide (DPI)	200-400	> 400-800	> 800
Ciclesonide (pMDI, extrafine particle*, HFA)	80-160	> 160-320	> 320
Fluticasone furoate (DPI)	100		200
Fluticasone propionate (DPI)	100-250	> 250-500	> 500
Fluticasone propionate (pMDI, standard particle, HFA)	100-250	> 250-500	> 500
Mometasone furoate (DPI)	200		400
Mometasone furoate (pMDI, standard particle, HFA)	200-400		> 400
DPI: dry powder inhaler; HFA: hydrofluoroalkane propellant; ICS: inhaled corticosteroid; N/A: not applicable; pMDI: pressurized metered dose inhaler			

(non-chlorofluorocarbon formulations); ICS by pMDI should be preferably used with a spacer *See product information.

This is not a table of equivalence, but instead, suggested total daily doses for the 'low', 'medium' and 'high' dose ICS options for adults/adolescents, based on available studies and product information. Data on comparative potency are not readily available and therefore this table does NOT imply potency equivalence. Doses may be country -specific depending on local availability, regulatory labelling and clinical guidelines.

For new preparations, including generic ICS, the manufacturer's information should be reviewed carefully; products containing the same molecule may not be clinically equivalent.

3 . Revision History

Date	Notes
9/17/2025	Added back GPI 4460405500E520. Updated initial and reauth criteria sections for severe asthma, CRSwNP, and EGPA. Added new criteria for COPD.

Nuedexta



Prior Authorization Guideline

Guideline ID	GL-140645
Guideline Name	Nuedexta
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2020

1 . Criteria

Product Name:Nuedexta	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of pseudobulbar affect (PBA)	

2 . Revision History

UnitedHealthcare Community Plan of Arizona Clinical Pharmacy Program Guidelines

Date	Notes
3/31/2020	Bulk Copy C&S New York to C&S Arizona for effective date of 5/1

Nuplazid



Prior Authorization Guideline

Guideline ID	GL-140646
Guideline Name	Nuplazid
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2020

1 . Criteria

Product Name:Nuplazid	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Parkinson's disease	

AND

2 - Patient is currently experiencing hallucinations and delusions associated with Parkinson's disease psychosis (i.e., hallucination and delusion symptoms started after Parkinson's disease diagnosis)

Product Name:Nuplazid	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Nuplazid therapy	

2 . Revision History

Date	Notes
3/31/2020	Bulk Copy C&S New York to C&S Arizona for effective date of 5/1

Nuzyra



Prior Authorization Guideline

Guideline ID	GL-140701
Guideline Name	Nuzyra
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Nuzyra	
Diagnosis	Community-Acquired Bacterial Pneumonia
Approval Length	14 Day(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 For continuation of therapy upon hospital discharge	

OR

1.2 As continuation of therapy when transitioning from intravenous antibiotics that are shown to be sensitive to the cultured organism for the requested indication

OR

1.3 ALL of the following:

1.3.1 Diagnosis of community-acquired bacterial pneumonia (CABP)

AND

1.3.2 Infection caused by an organism that is confirmed to be or likely to be susceptible to treatment with Nuzyra

AND

1.3.3 History of failure, contraindication, or intolerance to THREE of the following antibiotics or antibiotic regimens:

- Amoxicillin
- A macrolide
- Doxycycline
- A fluoroquinolone
- Combination therapy with amoxicillin/clavulanate or cephalosporin AND a macrolide or doxycycline

Product Name:Nuzyra	
Diagnosis	Acute Bacterial Skin and Skin Structure Infections
Approval Length	14 Day(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 For continuation of therapy upon hospital discharge

OR

1.2 As continuation of therapy when transitioning from intravenous antibiotics that are shown to be sensitive to the cultured organism for the requested indication

OR

1.3 ALL of the following:

1.3.1 ONE of the following diagnoses:

1.3.1.1 BOTH of the following:

- Acute bacterial skin and skin structure infections
- Infection caused by methicillin-resistant *Staphylococcus aureus* (MRSA) documented by culture and sensitivity report

OR

1.3.1.2 BOTH of the following:

- Empirical treatment of patients with acute bacterial skin and skin structure infections
- Presence of MRSA infection is likely

AND

1.3.2 History of failure, contraindication, or intolerance to linezolid (generic Zyvox)

AND

1.3.3 History of failure, contraindication, or intolerance to ONE of the following antibiotics:

- Sulfamethoxazole-trimethoprim (SMZ-TMP)

- A tetracycline
- Clindamycin

OR

1.4 ALL of the following:

1.4.1 Diagnosis of acute bacterial skin and skin structure infections

AND

1.4.2 Infection caused by an organism that is confirmed to be or likely to be susceptible to treatment with Nuzyra

AND

1.4.3 History of failure, contraindication, or intolerance to THREE of the following antibiotics:

- A penicillin
- A cephalosporin
- A tetracycline
- Sulfamethoxazole-trimethoprim (SMZ-TMP)
- Clindamycin

Product Name: Nuzyra	
Diagnosis	Off-Label Uses*
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 For continuation of therapy upon hospital discharge OR	

1.2 As continuation of therapy when transitioning from intravenous antibiotics that are shown to be sensitive to the cultured organism for the requested indication

OR

1.3 The medication is being prescribed by or in consultation with an infectious disease specialist.

Notes	*Note: Authorization duration based on provider treatment durations, not to exceed 6 months.

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

OAB - Overactive Bladder Agents



Prior Authorization Guideline

Guideline ID	GL-546244
Guideline Name	OAB - Overactive Bladder Agents
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	4/12/2026

1 . Criteria

Product Name: darifenacin ER, Brand Detrol, Brand Detrol LA, Brand Ditropan XL, flavoxate, Gelnique, Gemtesa, Brand Myrbetriq tabs, generic mirabegron ER tabs, Myrbetriq granules, generic oxybutynin 2.5 mg IR tabs, Oxytrol (Rx), trospium, trospium ER, Brand Toviaz, Brand Vesicare, Vesicare LS	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - The patient has a history of failure, contraindication, or intolerance to a trial of THREE preferred products:	

- fesoterodine ER
- oxybutynin (generic Ditropan) 5 mg tablet or oxybutynin 5mg/5mL oral solution
- oxybutynin ER (generic Ditropan XL)
- solifenacin (generic Vesicare)
- tolterodine
- tolterodine ER

2 . Revision History

Date	Notes
3/16/2026	Added Brand Detrol, Brand Detrol LA, and Brand Toviaz as targets. Removed generic solifenacin and oxybutynin oral soln as targets. Updated prerequisites in step requirement. Updated product name list and GPI table accordingly.

Ocaliva



Prior Authorization Guideline

Guideline ID	GL-140901
Guideline Name	Ocaliva
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Ocaliva	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of primary biliary cholangitis (aka primary biliary cirrhosis)	

AND

2 - ONE of the following:

2.1 BOTH of the following:

2.1.1 Patient has failed to achieve an alkaline phosphatase (ALP) level of less than 1.67 times the upper limit of normal after at least 12 consecutive months of treatment with ursodeoxycholic acid(e.g., Urso, ursodiol)

AND

2.1.2 Used in combination with ursodeoxycholic acid (e.g., Urso, ursodiol)

OR

2.2 History of contraindication or intolerance to ursodeoxycholic acid (e.g., Urso, ursodiol)

AND

3 - Prescribed by ONE of the following:

- Hepatologist
- Gastroenterologist

Product Name:Ocaliva	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., laboratory values) documenting a reduction in	

alkaline phosphatase (ALP) level from pre-treatment baseline (i.e., prior to Ocaliva therapy) while on Ocaliva therapy

AND

2 - Prescribed by ONE of the following:

- Hepatologist
- Gastroenterologist

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Octreotide Products



Prior Authorization Guideline

Guideline ID	GL-140960
Guideline Name	Octreotide Products
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	3/1/2023

1 . Criteria

Product Name: Brand Sandostatin, generic octreotide, octreotide	
Diagnosis	Acromegaly
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of acromegaly	

AND

2 - ONE of the following:

2.1 Inadequate response to ONE of the following:

- Surgery
- Pituitary irradiation

OR

2.2 Not a candidate for surgical resection or pituitary irradiation

AND

3 - Trial and failure, contraindication, or intolerance to a dopamine agonist (e.g., bromocriptine or cabergoline) at maximally tolerated doses

AND

4 - If the request is for Brand Sandostatin, trial and failure, or intolerance to generic octreotide

Product Name: Mycapssa	
Diagnosis	Acromegaly
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of acromegaly	

AND

2 - ONE of the following:

2.1 Inadequate response to ONE of the following:

- Surgery
- Pituitary irradiation

OR

2.2 Not a candidate for surgical resection or pituitary irradiation

AND

3 - Patient has responded to and tolerated treatment with generic octreotide or lanreotide

Product Name:Brand Sandostatin, generic octreotide, octreotide, Mycapssa	
Diagnosis	Acromegaly
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy [e.g., reduction or normalization of IGF-1/GH (insulin-like growth factor-1/growth hormone) level for same age and sex, reduction in tumor size]	

Product Name:Brand Sandostatin, generic octreotide, octreotide	
Diagnosis	Carcinoid Tumors, for Symptomatic Treatment of Diarrhea or Flushing
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of metastatic carcinoid tumor requiring symptomatic treatment of severe diarrhea or flushing episodes AND 2 - If the request is for Brand Sandostatin, trial and failure, or intolerance to generic octreotide	

Product Name:Brand Sandostatin, generic octreotide, octreotide	
Diagnosis	Carcinoid Tumors, for Symptomatic Treatment of Diarrhea or Flushing
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of an improvement in the number of diarrhea or flushing episodes	

Product Name:Brand Sandostatin, generic octreotide, octreotide	
Diagnosis	Vasoactive Intestinal Peptide Tumors, for Symptomatic Treatment of Diarrhea
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of vasoactive intestinal peptide tumor requiring treatment of profuse watery diarrhea	

AND

2 - If the request is for Brand Sandostatin, trial and failure, or intolerance to generic octreotide

Product Name: Brand Sandostatin, generic octreotide, octreotide	
Diagnosis	Vasoactive Intestinal Peptide Tumors, for Symptomatic Treatment of Diarrhea
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of an improvement in the number of diarrhea episodes	

2 . Revision History

Date	Notes
2/7/2023	Updated product name lists, spelled out acronym, and updated T/F c riteria.

Ohtuvayre (ensifentrine)



Prior Authorization Guideline

Guideline ID	GL-157290
Guideline Name	Ohtuvayre (ensifentrine)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	11/1/2024

1 . Criteria

Product Name:Ohtuvayre	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chronic obstructive pulmonary disease (COPD)	

AND

2 - Submission of medical records (e.g., chart notes) documenting BOTH of the following:

- Post-bronchodilator FEV1 % predicted greater than or equal to 30% and less than 80%
- Post-bronchodilator forced expiratory volume (FEV1) / forced vital capacity (FVC) ratio less than 0.7

AND

3 - ONE of the following:

3.1 BOTH of the following:

3.1.1 Patient is on a stabilized dose and receiving concomitant therapy with ONE of the following (document name):

- A long-acting beta-agonist [LABA (e.g., Serevent Diskus)]
- A long-acting antimuscarinic agent [LAMA (e.g., Spiriva Respimat/HandiHaler)]
- A LABA/LAMA (e.g., Anoro Ellipta, Bevespi Aerosphere, Stiolto Respimat)
- An ICS/LABA/LAMA (i.e., Breztri Aerosphere, Trelegy Ellipta)

AND

3.1.2 ONE of the following:

3.1.2.1 ALL of the following:

- FEV1 less than 50% of predicted
- History of chronic bronchitis
- History of failure, contraindication, or intolerance to a selective phosphodiesterase 4 (PDE4) inhibitor [i.e., roflumilast (Daliresp)]

OR

3.1.2.2 FEV1 is less than 80% of predicted but greater than or equal to 50% of predicted

OR

3.2 BOTH of the following:

3.2.1 Patient has a failure, contraindication, or intolerance to ALL of the following (document name and date tried):

- A long-acting beta-agonist [LABA (e.g., Serevent Diskus)]
- A long-acting antimuscarinic agent [LAMA (e.g., Spiriva Respimat/HandiHaler)]
- A LABA/LAMA (e.g., Anoro Ellipta, Bevespi Aerosphere, Stiolto Respimat)
- An ICS/LABA/LAMA (i.e., Breztri Aerosphere, Trelegy Ellipta)

AND

3.2.2 ONE of the following:

3.2.2.1 ALL of the following:

- FEV1 less than 50% of predicted
- History of chronic bronchitis
- History of failure, contraindication, or intolerance to a selective phosphodiesterase 4 (PDE4) inhibitor [i.e., roflumilast (Daliresp)]

OR

3.2.2.2 FEV1 is less than 80% of predicted but greater than or equal to 50% of predicted

OR

3.3 ALL of the following:

3.3.1 Patient is unable to use a metered-dose, dry powder, or slow mist inhaler (e.g. Spiriva Respimat) to control their COPD due to ONE of the following:

- Cognitive or physical impairment limiting coordination of handheld devices (e.g., cognitive decline, arthritis in the hands) (Document impairment)
- Patient is unable to generate adequate inspiratory force (e.g., peak inspiratory flow rate [PIFR] resistance is < 60 L/min)

AND

3.3.2 Patient requires the use of BOTH of the following (document date):

- A nebulized LABA [i.e., arformoterol (generic Brovana), formoterol (generic Perforomist)]
- A nebulized long-acting antimuscarinic agent [LAMA (i.e.,Yupelri)]

AND

3.3.3 ONE of the following:

3.3.3.1 ALL of the following:

- FEV1 less than 50% of predicted
- History of chronic bronchitis
- History of failure, contraindication, or intolerance to a selective phosphodiesterase 4 (PDE4) inhibitors [i.e., roflumilast (Daliresp)]

OR

3.3.3.2 FEV1 is less than 80% of predicted but greater than or equal to 50% of predicted

AND

4 - Patient experiences dyspnea during everyday activities (e.g., short of breath when walking up a slight hill)

AND

5 - Prescribed by or in consultation with a pulmonologist

Product Name:Ohtuvayre	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

- 1 - Documentation of positive clinical response to Ohtuvayre therapy demonstrated by BOTH of the following:
- Improved COPD symptoms (e.g., dyspnea)
 - Improved FEV1

2 . Revision History

Date	Notes
10/11/2024	New program.

Ojjaara (mometotinib)



Prior Authorization Guideline

Guideline ID	GL-141017
Guideline Name	Ojjaara (mometotinib)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name:Ojjaara	
Diagnosis	Myelofibrosis
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting all of the following: 1.1 Diagnosis of one of the following:	

- Primary myelofibrosis
- Post-polycythemia vera myelofibrosis
- Post-essential thrombocythemia myelofibrosis

AND

1.2 Disease is intermediate or high risk

AND

1.3 Patient has anemia

Product Name:Ojjaara	
Diagnosis	Myelofibrosis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy (e.g., symptom improvement, spleen volume reduction)	

2 . Revision History

Date	Notes
12/6/2023	New guideline

Olumiant (baricitinib)



Prior Authorization Guideline

Guideline ID	GL-324206
Guideline Name	Olumiant (baricitinib)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	8/1/2025

1 . Criteria

Product Name:Olumiant 1 mg and 2 mg	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming ALL of the following:	

1.1 Diagnosis of moderately to severely active rheumatoid arthritis (RA)

AND

1.2 History of failure to a 3 month trial of ONE non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] at maximally indicated doses within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

1.3 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred^ adalimumab biosimilar or Enbrel (etanercept)
- infliximab
- Orencia (abatacept)
- Xeljanz (tofacitinib) oral tablet (IR or XR)
- A preferred^ tocilizumab biosimilar

AND

2 - Prescribed by or in consultation with a rheumatologist

Notes	^PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name: Olumiant 1 mg and 2 mg	
Diagnosis	Rheumatoid Arthritis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy	

AND

2 - Prescribed by or in consultation with a rheumatologist

Product Name:Olumiant

Diagnosis	Coronavirus Disease 2019 (COVID-19)

Approval Length	14 Day(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of COVID-19

AND

2 - Patient is hospitalized*

AND

3 - Patient requires ONE of the following:

- Supplemental oxygen
- Non-invasive mechanical ventilation
- Invasive mechanical ventilation
- Extracorporeal membrane oxygenation (ECMO)

Notes	*Olumiant is only FDA approved when used for COVID-19 patients in an inpatient setting.

Product Name:Olumiant

Diagnosis	Alopecia Areata

Guideline Type	Prior Authorization

Approval Criteria

1 - Request for coverage for diagnosis of alopecia areata is excluded and is to be denied as a benefit exclusion

2 . Revision History

Date	Notes
7/15/2025	Updated initial and reauth sections for RA.

Omnipod 5, Twiist



Prior Authorization Guideline

Guideline ID	GL-588187
Guideline Name	Omnipod 5, Twiist
Formulary	Medicaid - Community & State Arizona Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Michigan Medicaid - Community & State New Jersey Medicaid - Community & State New Mexico Medicaid - Community & State New York Medicaid - Community & State New York EPP Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name: Omnipod 5, Twiist	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: • For Omnipod 5 product: Diagnosis of diabetes • For Twist product: Diagnosis of Type 1 diabetes AND 2 - ALL of the following: 2.1 Patient has done ONE of the following for at least 8 weeks: • Regularly tests blood glucose at least 4 times/day • Utilizes a continuous glucose monitor (CGM) AND 2.2 Patient has completed a diabetes management program AND 2.3 Patient injects insulin at least 3 times/day AND 3 - BOTH of the following: 3.1 Patient or caregiver is motivated to assume responsibility for self-care and insulin management AND	

3.2 Patient or caregiver demonstrates knowledge of importance of nutrition including carbohydrate counting and meal planning

AND

4 - Prescriber attests that there is a reason or special circumstance the patient cannot use external insulin pumps obtained on the medical benefit

Notes	If patient meets criteria, approve using NDC List OMNIPOD5

Product Name:Omnipod 5, Twiist

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response

Notes	If patient meets criteria, approve using NDC List OMNIPOD5

Product Name:Omnipod 5 pods

Approval Length	12 month(s)

Guideline Type	Quantity Limit

Approval Criteria

1 - Physician confirmation that the patient requires a greater quantity

Notes	Authorization for quantity limit overrides should be entered at the NDC level for the requested Omnipod 5 pods, for the requested quantity.

2 . Revision History

UnitedHealthcare Community Plan of Arizona Clinical Pharmacy Program Guidelines

Date	Notes
4/20/2026	Updated GPIs

OmvoH (mirikizumab-mrkz)



Prior Authorization Guideline

Guideline ID	GL-518208
Guideline Name	OmvoH (mirikizumab-mrkz)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name:OmvoH SC	
Diagnosis	Crohn's disease (CD)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of moderately to severely active Crohn's disease (CD)	

AND

2 - Will be used as a maintenance dose following the intravenous induction doses

AND

3 - Prescribed by or in consultation with a gastroenterologist

Product Name:Omvox SC	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of moderately to severely active ulcerative colitis AND 2 - Will be used as a maintenance dose following the intravenous induction doses AND 3 - Prescribed by or in consultation with a gastroenterologist	

Product Name:Omvox SC	
Diagnosis	Crohn's disease (CD), Ulcerative Colitis (UC)
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: - Improvement in intestinal inflammation (e.g., mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline - Reversal of high fecal output state	

2 . Revision History

Date	Notes
2/10/2026	Updated GPIs

Onureg



Prior Authorization Guideline

Guideline ID	GL-521222
Guideline Name	Onureg
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State New Jersey Medicaid - Community & State New York Medicaid - Community & State New York EPP Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Arizona Medicaid - Community & State Nebraska Medicaid - Community & State New Mexico Medicaid - Community & State Virginia Medicaid - Community & State Washington

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name:Onureg	
Diagnosis	Acute Myeloid Leukemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of acute myeloid leukemia AND 2 - Achieved first complete remission (CR) or complete remission with incomplete blood count recovery (CRi) following intensive induction chemotherapy AND 3 - Patient is not able to complete intensive curative therapy (e.g., transplant-ineligible)	

Product Name:Onureg	
Diagnosis	Peripheral T-cell Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following T-cell lymphomas: • Angioimmunoblastic T-cell lymphoma (AITL) • Nodal peripheral T-cell lymphoma with TFH phenotype (PTCL, TFH) • Follicular T-cell lymphoma (FTCL)	

AND

2 - ONE of the following:

- Used as initial palliative intent therapy
- Used as second-line and subsequent therapy

Product Name:Onureg	
Diagnosis	Acute Lymphoblastic Leukemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of T-cell acute lymphoblastic leukemia/lymphoma (T-ALL/T-LBL) AND 2 - Used with Venclexta (venetoclax) – containing regimens as part of relapsed/refractory therapy	

Product Name:Onureg	
Diagnosis	Acute Myeloid Leukemia, Peripheral T-cell Lymphoma, Acute Lymphoblastic Leukemia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Patient does not show evidence of progressive disease while on Onureg therapy

Product Name:Onureg

Diagnosis	NCCN Recommended Regimens

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name:Onureg

Diagnosis	NCCN Recommended Regimens

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - There is documentation of positive clinical response to Onureg therapy

2 . Revision History

Date	Notes
2/12/2026	Added criteria for acute lymphoblastic leukemia. Minor cosmetic update to diagnosis header for NCCN sections, with no changes to clinical intent.

Opfolda



Prior Authorization Guideline

Guideline ID	GL-143582
Guideline Name	Opfolda
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	3/17/2024

1 . Criteria

Product Name:Opfolda	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting all of the following: 1.1 Diagnosis of late-onset Pompe disease (lysosomal acid alpha-glucosidase [GAA] deficiency)	

AND

1.2 Disease is confirmed by one of the following:

- Absence or deficiency (less than 40% of the lab specific normal mean) of GAA enzyme activity in lymphocytes, fibroblasts, or muscle tissues as confirmed by an enzymatic assay
- Molecular genetic testing confirms mutations in the GAA gene

AND

1.3 Presence of clinical signs and symptoms of the disease (e.g., respiratory distress, skeletal muscle weakness, etc.)

AND

1.4 Medication is used in combination with Pombiliti (cipaglucosidase alfa-atga)

AND

1.5 Patient's weight is greater than or equal to 40 kg

AND

2 - Opfolda is not substituted with other miglustat products (i.e., Zavesca, Yargesa)

Product Name:Opfolda	
Approval Length	24 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Patient demonstrates positive clinical response to therapy (e.g., improvement in FVC, improvement in 6-minute walk distance [6MWD])

AND

2 - Medication is used in combination with Pombiliti (cipaglucosidase alfa-atga)

AND

3 - Opfolda is not substituted with other miglustat products (i.e., Zavesca, Yargesa)

2 . Revision History

Date	Notes
2/26/2024	New

Ophthalmic Antihistamine



Prior Authorization Guideline

Guideline ID	GL-479209
Guideline Name	Ophthalmic Antihistamine
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State New Jersey Medicaid - Community & State New York Medicaid - Community & State New York EPP Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Arizona Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name: azelastine ophth soln	
Approval Length	12 month(s)
Guideline Type	Step Therapy

Approval Criteria

1 - Failure to Pataday OTC (over-the-counter), as confirmed by claims history or submission of medical records

OR

2 - History of contraindication or intolerance to Pataday OTC (please specify contraindication or intolerance)

Product Name: olopatadine ophth soln (Rx formulation)

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Failure to Pataday OTC (over-the-counter), as confirmed by claims history or submission of medical records

OR

1.2 History of contraindication or intolerance to Pataday OTC (please specify contraindication or intolerance)

AND

2 - ONE of the following:

2.1 Failure to ONE of the following, as confirmed by claims history or submission of medical records:

- Azelastine ophthalmic solution
- Ketotifen

- Cromolyn

OR

2.2 History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- Azelastine ophthalmic solution
- Ketotifen
- Cromolyn

2 . Revision History

Date	Notes
12/15/2025	Combined formularies. Cleaned up GPI list. No changes to clinical criteria.

Opzelura (ruxolitinib)



Prior Authorization Guideline

Guideline ID	GL-443209
Guideline Name	Opzelura (ruxolitinib)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	12/1/2025

1 . Criteria

Product Name:Opzelura	
Diagnosis	Atopic Dermatitis
Approval Length	12 Week(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of mild to moderate atopic dermatitis	

AND

2 - ONE of the following:

- Greater than or equal to 3% body surface area (BSA) involvement
- Involvement of sensitive body areas (e.g., face, hands, feet, scalp, groin)

AND

3 - Patient is 2 years of age or older

AND

4 - Prescribed by or in consultation with ONE of the following:

- Dermatologist
- Allergist/Immunologist

AND

5 - Trial and failure of a minimum 30-day supply of non-pharmacologic topical therapies (e.g., moisturizers)

AND

6 - Trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to at least TWO of the following:

- Medium or higher potency topical corticosteroid
- Elidel (pimecrolimus) cream*
- Tacrolimus ointment
- Eucrisa (crisaborole) ointment*

AND

7 - Patient is NOT receiving Opzelura in combination with a potent immunosuppressant (e.g., azathioprine or cyclosporine)

AND

8 - Opzelura will only be used for short-term and/or non-continuous chronic treatment

Notes

*Product may require step therapy.

Product Name:Opzelura

Diagnosis	Atopic Dermatitis

Approval Length	6 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of a positive clinical response to therapy as evidenced by at least ONE of the following:

- Reduction in body surface area involvement from baseline
- Reduction in pruritus severity from baseline
- Improvement in quality of life from baseline

AND

2 - Patient is NOT receiving Opzelura in combination with a potent immunosuppressant (e.g., azathioprine or cyclosporine)

AND

3 - Opzelura will only be used for short-term and/or non-continuous chronic treatment

Product Name:Opzelura

Diagnosis	Nonsegmental Vitiligo
Guideline Type	Prior Authorization
Approval Criteria 1 - Request for coverage for diagnosis of nonsegmental vitiligo is excluded and is to be denied as a benefit exclusion	

2 . Background

Clinical Practice Guidelines			
Table 1. Relative potencies of topical corticosteroids			
Class	Drug	Dosage Form	Strength (%)
Very high potency	Augmented betamethasone dipropionate	Ointment, gel	0.05
	Clobetasol propionate	Cream, foam, ointment	0.05
	Diflorasone diacetate	Ointment	0.05
	Halobetasol propionate	Cream, ointment	0.05
High Potency	Amcinonide	Cream, lotion, ointment	0.1
	Augmented betamethasone dipropionate	Cream, lotion	0.05
	Betamethasone dipropionate	Cream, foam, ointment, solution	0.05
	Desoximetasone	Cream, ointment	0.25
	Desoximetasone	Gel	0.05
	Diflorasone diacetate	Cream	0.05
	Fluocinonide	Cream, gel, ointment, solution	0.05

	Halcinonide	Cream, ointment	0.1
	Mometasone furoate	Ointment	0.1
	Triamcinolone acetonide	Cream, ointment	0.5
Medium potency	Betamethasone valerate	Cream, foam, lotion, ointment	0.1
	Clocortolone pivalate	Cream	0.1
	Desoximetasone	Cream	0.05
	Fluocinolone acetonide	Cream, ointment	0.025
	Flurandrenolide	Cream, ointment, lotion	0.05
	Fluticasone propionate	Cream	0.05
	Fluticasone propionate	Ointment	0.005
	Mometasone furoate	Cream, lotion	0.1
	Triamcinolone acetonide	Cream, ointment, lotion	0.1
Lower-medium potency	Hydrocortisone butyrate	Cream, ointment, solution	0.1
	Hydrocortisone probutate	Cream	0.1
	Hydrocortisone valerate	Cream, ointment	0.2
	Prednicarbate	Cream	0.1
Low potency	Alclometasone dipropionate	Cream, ointment	0.05
	Desonide	Cream, gel, foam, ointment	0.05
	Fluocinolone acetonide	Cream, solution	0.01
Lowest potency	Dexamethasone	Cream	0.1
	Hydrocortisone	Cream, lotion, ointment, solution	0.25, 0.5, 1
	Hydrocortisone acetate	Cream, ointment	0.5-1

3 . Revision History

UnitedHealthcare Community Plan of Arizona Clinical Pharmacy Program Guidelines

Date	Notes
11/7/2025	Updated age criterion in initial auth section for AD.

Oral Oncology Agents



Prior Authorization Guideline

Guideline ID	GL-605201
Guideline Name	Oral Oncology Agents
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name: Brand Gleevec, generic imatinib, Imkeldi	
Diagnosis	Cancer Indications
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - The drug is being used as indicated by National Comprehensive Cancer Network (NCCN) guidelines with a Category of Evidence and Consensus of 1, 2A, or 2B	

AND

2 - If the request is for the non-preferred Brand (Brand Gleevec or Imkeldi), patient must have tried and failed the preferred generic counterpart (generic imatinib)

Product Name: Abirtega, Akeega, Alecensa, Alunbrig, Augtyro, Avmapki Fakzynja Co-pack, Ayvakit, Balversa, Bosulif, Braftovi, Brukinsa, Cabometyx, Calquence, Caprelsa, Cometriq, Copiktra, Cotellic, Danziten, Daurismo, Ensacove, Erivedge, Erleada, etoposide capsules, Fruzaqla, Gavreto, Gilotrif, Brand Gleostine, generic lomustine, Gomekli, Hernexeos, Hycamtin capsules, Hyrnuo, Ibrance, Ibtrozi, Iclusig, Idhifa, Imbruvica, Inluriyo, Inlyta, Inrebic, Brand Iressa, generic gefitinib, Itovebi, Iwifin, Jakafi, Jaypirca, Jylamvo, Kisqali, Kisqali-Femara Co-pack, Komzifti, Koselugo, Koselugo Sprinkle, Krazati, Lazcluze, Lenvima, Lifyorli, Lonsurf, Lorbrena, Lumakras, Lynparza, Lytgobi, Mekinist, Mektovi, Modeyso, Nerlynx, Brand Nexavar, generic sorafenib, Ninlaro, Nubeqa, Odomzo, Ogsiveo, Ojemda, Orserdu, Pemazyre, Phyrago, Piqray, Brand Pomalyst, generic pomalidomide, Brand Purixan, generic mercaptopurine suspension, Qinlock, Retevmo, Brand Revlimid, generic lenalidomide, Revuforj, Rezlidhia, Romvimza, Rozlytrek, Rubraca, Rydapt, Scemblix, Brand Sprycel, generic dasatinib, Stivarga, Tabrecta, Tabloid, Tafenlar, Tagrisso, Talzenna, Brand Tarceva, generic erlotinib, Brand Tassigna, generic nilotinib, Nilotinib, Tazverik, temozolomide capsules, Tepmetko, Tibsovo, Truqap, Tukysa, Turalio, Brand Tykerb, generic lapatinib, Vanflyta, Venclexta, Verzenio, Vitrakvi, Vizimpro, Voranigo, Brand Votrient, generic pazopanib, Welireg, Xalkori, Xatmep, Brand Xeloda, generic capecitabine, Xospata, Xpovio, Xtandi, Yonsa, Zejula, Zelboraf, Zolanza, Zydelig, Zykadia, Brand Zytiga, generic abiraterone

Diagnosis	Cancer Indications
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The drug is being used as indicated by National Comprehensive Cancer Network (NCCN) guidelines with a Category of Evidence and Consensus of 1, 2A, or 2B

2 . Revision History

Date	Notes

5/7/2026	Added Lifyorli products as targets. Updated GPI entries for Nilotinib (MSC N) products. No changes to clinical criteria.

Orencia (abatacept)



Prior Authorization Guideline

Guideline ID	GL-141021
Guideline Name	Orencia (abatacept)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Orencia Clickject, Orencia prefilled syringe	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderately to severely active rheumatoid arthritis	

AND

2 - Prescribed by or in consultation with a rheumatologist

AND

3 - Trial and failure, contraindication, or intolerance to ONE nonbiologic disease-modifying antirheumatic drug (DMARD) [e.g., methotrexate (Rheumatrex/Trexall), Arava (leflunomide), Azulfidine (sulfasalazine)]

Product Name: Orenzia Clickject, Orenzia prefilled syringe

Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

Product Name: Orenzia Clickject, Orenzia prefilled syringe

Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (PJIA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis

AND

2 - Prescribed by or in consultation with a rheumatologist

AND

3 - Trial and failure, contraindication, or intolerance to ONE of the following nonbiologic disease modifying anti-rheumatic drugs (DMARDs):

- leflunomide (Arava)
- methotrexate (Rheumatrex/Trexall)

Product Name:Orencia Clickject, Orencia prefilled syringe	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (PJIA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy	

Product Name:Orencia Clickject, Orencia prefilled syringe	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of active psoriatic arthritis (PsA)

AND

2 - Patient is 2 years of age or older

AND

3 - Prescribed by or in consultation with one of the following:

- Dermatologist
- Rheumatologist

Product Name: Ocrencia Clickject, Ocrencia prefilled syringe	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy	

2 . Revision History

Date	Notes
12/7/2023	Added age criterion to PsA indication.

Orgovyx



Prior Authorization Guideline

Guideline ID	GL-219253
Guideline Name	Orgovyx
Formulary	Medicaid - Community & State Arizona Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State New Jersey Medicaid - Community & State New Mexico Medicaid - Community & State New York EPP Medicaid - Community & State New York Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Virginia Medicaid - Community & State Washington

Guideline Note:

Effective Date:	5/1/2025

1 . Criteria

Product Name:Orgovyx

Diagnosis	Prostate Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of advanced prostate cancer	

Product Name:Orgovyx	
Diagnosis	Prostate Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient does not show evidence of progressive disease while on Orgovyx therapy	

Product Name:Orgovyx	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	

Product Name:Orgovyx	

Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Orgovyx therapy	

2 . Revision History

Date	Notes
3/14/2025	Combined formularies. Updated initial auth criteria section for prostate cancer and minor update in reauth section for prostate cancer.

Orilissa



Prior Authorization Guideline

Guideline ID	GL-140726
Guideline Name	Orilissa
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Orilissa 150 mg	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderate to severe pain associated with endometriosis	

AND

2 - Patient is premenopausal

AND

3 - History of trial and failure (e.g., inadequate pain relief), contraindication or intolerance after a three month trial of TWO analgesics (e.g., ibuprofen, meloxicam, naproxen)

AND

4 - History of trial and failure, contraindication, or intolerance after a three month trial to ONE of the following:

- Hormonal contraceptives
- Progestins [e.g., norethindrone (generic Aygestin)]

AND

5 - Prescribed by or in consultation with ONE of the following:

- Obstetrics/Gynecologist (OB/GYN)
- Reproductive endocrinologist

Product Name:Orilissa 150 mg	
Approval Length	6 months*
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy	

AND	
2 - Impact to bone mineral density has been considered	
AND	
3 - Treatment duration has not exceeded a total of 24 months**	
Notes	*NOTE: Authorization for Orilissa 150 mg will be issued for 6 months up to a maximum of 24 months. **NOTE: Orilissa 150 mg once daily is indicated for a maximum of 24 months.

Product Name:Orilissa 200 mg	
Approval Length	6 months*
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderate to severe pain associated with endometriosis AND 2 - Patient is premenopausal AND 3 - History of trial and failure (e.g., inadequate pain relief), contraindication or intolerance after a three month trial of TWO analgesics (e.g., ibuprofen, meloxicam, naproxen) AND	

4 - History of trial and failure, contraindication, or intolerance after a three month trial to ONE of the following:

- Hormonal contraceptives
- Progestins [e.g., norethindrone (generic Aygestin)]

AND

5 - Prescribed by or in consultation with ONE of the following:

- Obstetrics/Gynecologist (OB/GYN)
- Reproductive endocrinologist

Notes	*NOTE: Orilissa 200 mg twice daily is indicated for a maximum of 6 months.

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Orkambi



Prior Authorization Guideline

Guideline ID	GL-140950
Guideline Name	Orkambi
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	12/1/2022

1 . Criteria

Product Name:Orkambi	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of cystic fibrosis (CF)	

AND

2 - Submission of laboratory results confirming that patient is homozygous for the F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene

AND

3 - The patient is 1 year of age or older

AND

4 - Prescribed by, or in consultation with, a specialist affiliated with a CF care center

Product Name:Orkambi	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Provider attests that the patient has achieved a clinically meaningful response while on Orkambi therapy to ONE of the following: • Lung function as demonstrated by percent predicted expiratory volume in 1 second (ppFEV1) • Body mass index (BMI) • Pulmonary exacerbations • Quality of life as demonstrated by Cystic Fibrosis Questionnaire-Revised (CFQ-R) respiratory domain score AND 2 - Prescribed by, or in consultation with, a specialist affiliated with a cystic fibrosis (CF) care center	

2 . Revision History

Date	Notes
11/7/2022	Updated age requirement, added new GPI

Orlynvah (sulopenem etzadroxil and probenecid)



Prior Authorization Guideline

Guideline ID	GL-502209
Guideline Name	Orlynvah (sulopenem etzadroxil and probenecid)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Orlynvah	
Approval Length	5 Day(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of an uncomplicated urinary tract infection (uUTI) AND	

2 - Patient is 18 years of age or older

AND

3 - Trial and inadequate response, contraindication, or resistance to one alternative oral antibacterial treatment option (e.g., trimethoprim-sulfamethoxazole, ciprofloxacin)

AND

4 - Infection caused by ONE of the following:

- Escherichia coli
- Klebsiella pneumoniae
- Proteus mirabilis

2 . Revision History

Date	Notes
1/14/2026	Updated criterion 4 "infection with" to "infection caused by", no change to clinical intent.

Osphena



Prior Authorization Guideline

Guideline ID	GL-140630
Guideline Name	Osphena
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2020

1 . Criteria

Product Name:Osphena	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Treatment of moderate to severe vaginal dryness, a symptom of vulvar and vaginal atrophy (VVA), due to menopause*	

AND

2 - History of failure, contraindication, or intolerance to BOTH of the following:

- Estradiol vaginal cream
- Estradiol vaginal tablet

Notes

*Treatment of dyspareunia is a benefit exclusion.

Product Name: Osphena

Approval Length 12 month(s)

Therapy Stage Reauthorization

Guideline Type Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

2 . Revision History

Date

Notes

3/16/2020

New program

Otezla (apremilast)



Prior Authorization Guideline

Guideline ID	GL-448293
Guideline Name	Otezla (apremilast)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	12/1/2025

1 . Criteria

Product Name:Otezla, Otezla XR	
Diagnosis	Psoriatic Arthritis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of active psoriatic arthritis	

AND

2 - Patient is 6 years of age or older

AND

3 - ONE of the following:

- If the request is for Otezla, patient weighs at least 20 kg (kilograms)
- If the request is for Otezla XR, patient weighs at least 50 kg

AND

4 - History of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced (document drug, date, and duration of trial)*

AND

5 - Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Dermatologist

Notes	*Claims history may be used in conjunction as documentation of drug, date, and duration of trial.

Product Name:Otezla, Otezla XR	
Diagnosis	Behcet's Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Behcet's Disease

AND

2 - Patient has active oral ulcers

AND

3 - History of failure, contraindication, or intolerance to one non-biologic (e.g., corticosteroids, colchicine) within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced (document drug, date, and duration of trial)*

AND

4 - Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Dermatologist

Notes

*Claims history may be used in conjunction as documentation of drug, date, and duration of trial.

Product Name: Otezla, Otezla XR

Diagnosis	Psoriatic Arthritis, Behcet's Disease

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Dermatologist

Product Name: Otezla, Otezla XR

Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of plaque psoriasis

AND

2 - Patient is 6 years of age or older

AND

3 - ONE of the following:

- If the request is for Otezla, patient weighs at least 20 kg (kilograms)
- If the request is for Otezla XR, patient weighs at least 50 kg

AND

4 - BOTH of the following:

4.1 History of failure to ONE of the following topical therapies, unless contraindicated or clinically significant adverse effects are experienced (document drug, date, and duration of trial):*

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)

AND

4.2 History of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced (document drug, date, and duration of trial)*

AND

5 - Prescribed by or in consultation with a dermatologist

Notes	*Claims history may be used in conjunction as documentation of drug, date, and duration of trial.

Product Name: Otezla, Otezla XR	
Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy AND 2 - Prescribed by or in consultation with a dermatologist	

2 . Revision History

Date	Notes
11/12/2025	Added Otezla XR as a target to all indications. Updated weight requirements in PsA and PsO initial auth sections to account for Otezla XR . Updated embedded step criterion for PsO (initial auth section). Removed reference to "Otezla" in reauth sections for PsA and PsO.

Oxervate (cenegermin-bkbj)



Prior Authorization Guideline

Guideline ID	GL-572201
Guideline Name	Oxervate (cenegermin-bkbj)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name: Oxervate	
Approval Length	8 Weeks (maximum of 8 weeks per eye per lifetime)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Stage 2 or 3 neurotrophic keratitis AND	

2 - History of failure to at least one OTC ocular artificial tear product (e.g., Systane Ultra, Akwa Tears, Refresh Optive, Soothe XP)

AND

3 - Prescribed by or in consultation with ONE of the following:

- Ophthalmologist
- Optometrist

Notes	Authorization maximum coverage is limited to one 8-week approval per eye.

2 . Revision History

Date	Notes
4/10/2026	Updated approval length and notes sections.

Palforzia [Peanut (Arachis hypogaea)]



Prior Authorization Guideline

Guideline ID	GL-231253
Guideline Name	Palforzia [Peanut (Arachis hypogaea)]
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2025

1 . Criteria

Product Name:Palforzia	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis and clinical history of peanut allergy as documented by BOTH of the following: 1.1 A serum peanut-specific IgE level of greater than or equal to 0.35 kUA/L (kilo units of allergen per liter)	

AND

1.2 A mean wheal diameter that is at least 3mm (millimeters) larger than the negative control on skin-prick testing for peanut

AND

2 - ONE of the following:

2.1 BOTH of the following:

- Patient is 1 to 17 years of age
- Patient is in the initial dose escalation phase of therapy

OR

2.2 BOTH of the following:

- Patient is 1 year of age or older
- Patient is in the up-dosing or maintenance phase of therapy

AND

3 - Used in conjunction with a peanut-avoidant diet

AND

4 - Patient does not have one of the following:

- History of eosinophilic esophagitis (EoE) or eosinophilic gastrointestinal disease
- History of severe or life-threatening episode(s) of anaphylaxis or anaphylactic shock within the past 2 months
- Severe or poorly controlled asthma

AND

5 - Prescribed by or in consultation with an allergist or immunologist

AND

6 - Prescriber is certified/enrolled in the Palforzia REMS (Risk Evaluation and Mitigation Strategy) Program

Product Name:Palforzia

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Palforzia therapy

AND

2 - Used in conjunction with a peanut-avoidant diet

AND

3 - Prescribed by or in consultation with an allergist or immunologist

AND

4 - Prescriber is certified/enrolled in the Palforzia REMS (Risk Evaluation and Mitigation Strategy) Program

2 . Revision History

UnitedHealthcare Community Plan of Arizona Clinical Pharmacy Program Guidelines

Date	Notes
4/1/2025	Added new GPIs.

Palsonify (paltusotine)



Prior Authorization Guideline

Guideline ID	GL-501224
Guideline Name	Palsonify (paltusotine)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Palsonify	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of acromegaly	

AND

2 - ONE of the following:

2.1 Patient has an inadequate response to surgery

OR

2.2 Patient is NOT a candidate for surgery

AND

3 - Patient has responded to and tolerated treatment with generic octreotide or lanreotide

AND

4 - Prescribed by or in consultation with an endocrinologist

Product Name:Palsonify	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient demonstrates positive clinical response to therapy [e.g., clinically significant reduction in IGF-1/GH (insulin-like growth factor-1/growth hormone) levels, reduction in Total Acromegaly Symptoms Diary (ASD) score]	

2 . Revision History

UnitedHealthcare Community Plan of Arizona Clinical Pharmacy Program Guidelines

Date	Notes
1/15/2026	New program for ACUAZ/ACUAZEC.

Palynziq (pegvaliase-pqpz)



Prior Authorization Guideline

Guideline ID	GL-560216
Guideline Name	Palynziq (pegvaliase-pqpz)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:Palynziq	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of phenylketonuria (PKU)	

AND

2 - Patient is 12 years of age or older

AND

3 - Patient is actively on a phenylalanine-restricted diet

AND

4 - Physician attestation that the patient will not be receiving Palynziq in combination with Kuvan (sapropterin dihydrochloride)

AND

5 - Submission of medical records (e.g. chart notes, laboratory values) documenting that the patient has a blood phenylalanine concentration greater than 600 micromoles per liter

Product Name:Palynziq	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is actively on a phenylalanine-restricted diet AND 2 - ONE of the following:	

2.1 Submission of medical records (e.g. chart notes, laboratory values) documenting that the patient has a blood phenylalanine concentration less than 600 micromoles per liter

OR

2.2 Submission of medical records (e.g. chart notes, laboratory values) documenting that the patient has achieved a 20% reduction in blood phenylalanine concentration from pre-treatment baseline

OR

2.3 BOTH of the following:

2.3.1 Patient is in initial titration/maintenance phase of dosing regimen (week 1-33)

AND

2.3.2 Patient will receive maximum labeled dosage of 40 milligrams (mg) once daily if response has not been obtained after 24 weeks of 20 mg once daily maintenance dosing

AND

3 - Submission of medical records (e.g. chart notes, laboratory values) documenting that the patient is not receiving Palynziq in combination with Kuvan (sapropterin dihydrochloride) [Prescription claim history that does not show any concomitant Kuvan claim within 60 days of reauthorization request may be used as documentation]

2 . Revision History

Date	Notes
3/30/2026	Updated title. Added age to initial auth

Panretin



Prior Authorization Guideline

Guideline ID	GL-140695
Guideline Name	Panretin
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Panretin	
Diagnosis	AIDS-related Kaposi's Sarcoma (KS)
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of acquired immunodeficiency syndrome (AIDS)-related Kaposi's Sarcoma (KS)	

AND

2 - Patient is not receiving systemic anti-KS treatment

Product Name:Panretin	
Diagnosis	NCCN Recommended Regimen
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Panretin will be approved for uses supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1, 2A, or 2B.	

Product Name:Panretin	
Diagnosis	NCCN Recommended Regimen
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Panretin therapy	

2 . Revision History

Date	Notes

8/4/2022	C&S to match AZM as of 10.1.22

Pediculicides



Prior Authorization Guideline

Guideline ID	GL-140732
Guideline Name	Pediculicides
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Brand Natroba, generic spinosad, Sklice	
Diagnosis	Head lice
Approval Length	30 Day(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of topical treatment of head lice infestations	

AND

2 - For Brand Natroba requests ONLY: Trial and failure to generic spinosad suspension (verified via paid pharmacy claims or submission of medical records/chart notes)

2 . Revision History

Date	Notes
8/10/2022	C&S to match AZM 10.1.22

Phexxi



Prior Authorization Guideline

Guideline ID	GL-555342
Guideline Name	Phexxi
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State New Jersey Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Arizona Medicaid - Community & State Nebraska Medicaid - Community & State Pennsylvania Medicaid - Community & State Virginia Medicaid - Community & State Nevada

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:Phexxi, Phexx	
Approval Length	12 month(s)

Guideline Type	Prior Authorization
Approval Criteria 1 - Used for the prevention of pregnancy AND 2 - ONE of the following: 2.1 Failure to ALL of the following methods of contraception as confirmed by claims history or submission of medical records: • Injection (e.g., Depo-Provera) • Oral Contraceptive [e.g., norethindrone (generic Micronor), Yaz] • Transdermal Patch (e.g., Twirla, Xulane) • Vaginal Contraceptive Ring (e.g., Annovera, NuvaRing) • Diaphragm • Cervical Cap (e.g., FemCap) • Female Condom OR 2.2 History of intolerance or contraindication to ALL of the following methods of contraception (please document intolerance or contraindication): • Injection (e.g., Depo-Provera) • Oral Contraceptive [e.g., norethindrone (generic Micronor), Yaz] • Transdermal Patch (e.g., Twirla, Xulane) • Vaginal Contraceptive Ring (e.g., Annovera, NuvaRing) • Diaphragm • Cervical Cap (e.g., FemCap) • Female Condom AND 3 - ONE of the following: 3.1 Failure to nonoxynol-9 based spermicide as confirmed by claims history or submission of medical records	

OR

3.2 History of intolerance or contraindication to nonoxynol-9 based spermicide (please document intolerance or contraindication)

AND

4 - Provider attests they have counseled the patient regarding higher rate of pregnancy prevention with the use of other methods of contraception (e.g., injection, oral contraception, transdermal patch, vaginal ring) compared to Phexxi/Phexx

2 . Revision History

Date	Notes
3/24/2026	Removed NY. Add Phexx

Pivya (pivmecillinam)



Prior Authorization Guideline

Guideline ID	GL-557208
Guideline Name	Pivya (pivmecillinam)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:Pivya	
Approval Length	7 Day(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of uncomplicated urinary tract infection (uUTI) AND	

2 - Infection is susceptible to pivmecillinam

AND

3 - Patient is 18 years of age or older

AND

4 - Trial and inadequate response, contraindication, or resistance to ONE alternative oral antibacterial treatment option (e.g., trimethoprim-sulfamethoxazole, ciprofloxacin)

AND

5 - Infection is caused by ONE of the following:

- Escherichia coli
- Proteus mirabilis
- Staphylococcus saprophyticus

2 . Revision History

Date	Notes
3/27/2026	New program.

Pombiliti



Prior Authorization Guideline

Guideline ID	GL-143526
Guideline Name	Pombiliti
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	3/17/2024

1 . Criteria

Product Name:Pombiliti	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting all of the following: 1.1 Diagnosis of late-onset Pompe disease (lysosomal acid alpha-glucosidase [GAA] deficiency)	

AND

1.2 Disease is confirmed by one of the following:

- Absence or deficiency (less than 40% of the lab specific normal mean) of GAA enzyme activity in lymphocytes, fibroblasts, or muscle tissues as confirmed by an enzymatic assay
- Molecular genetic testing confirms mutations in the GAA gene

AND

1.3 Presence of clinical signs and symptoms of the disease (e.g., respiratory distress, skeletal muscle weakness, etc.)

AND

1.4 Medication is used in combination with Opfolda (miglustat)

AND

1.5 Patient's weight is greater than or equal to 40 kg

AND

2 - Pombiliti will not to be used in combination with other miglustat products (i.e., Zavesca, Yargesa)

Product Name:Pombiliti	
Approval Length	24 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy (e.g., improvement in FVC, improvement in 6-minute walk distance [6MWD])

AND

2 - Medication is used in combination with Opfolda (miglustat)

AND

3 - Pombiliti will not to be used in combination with other miglustat products (i.e., Zavesca, Yargesa)

2 . Revision History

Date	Notes
2/26/2024	New

Pradaxa Pellet Packs



Prior Authorization Guideline

Guideline ID	GL-140822
Guideline Name	Pradaxa Pellet Packs
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	11/1/2023

1 . Criteria

Product Name:Pradaxa Pellet Packs	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is 8 years of age or younger OR	

2 - ALL of the following:

2.1 Patient is between 9 and 12 years of age

AND

2.2 Requested medication is being used for ONE of the following diagnoses:

- Treatment of venous thromboembolic events (VTE) in patients who have been treated with a parenteral anticoagulant for at least 5 days
- To reduce the risk of recurrence of VTE in patients who have been previously treated

AND

2.3 ONE of the following:

- Trial and failure, contraindication, or intolerance to Brand Pradaxa capsules (verified via paid pharmacy claims or submitted chart notes)
- Patient is unable to swallow oral tablets/capsules

2 . Revision History

Date	Notes
10/3/2023	New

Praluent



Prior Authorization Guideline

Guideline ID	GL-140811
Guideline Name	Praluent
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2023

1 . Criteria

Product Name:Praluent	
Diagnosis	Primary Hyperlipidemia [Including Heterozygous Familial Hypercholesterolemia (HeFH), Atherosclerotic Cardiovascular Disease (ASCVD), and Secondary Prevention of Cardiovascular Events in Patients with ASCVD]
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of ONE of the following:

1.1 Heterozygous familial hypercholesterolemia (HeFH) as confirmed by ONE of the following*:

1.1.1 BOTH of the following:

1.1.1.1 Pre-treatment low density lipoprotein cholesterol (LDL-C) of ONE of the following:

- Greater than 190 milligrams per deciliter (mg/dL)
- Greater than 155 mg/dL if less than 16 years of age

AND

1.1.1.2 ONE of the following:

- Family history of myocardial infarction in first-degree relative less than 60 years of age
- Family history of myocardial infarction in second-degree relative less than 50 years of age
- Family history of LDL-C greater than 190 mg/dL in first- or second-degree relative
- Family history of heterozygous or homozygous familial hypercholesterolemia in first- or second-degree relative
- Family history of tendinous xanthomata and/or arcus cornealis in first- or second degree relative

OR

1.1.2 BOTH of the following:

1.1.2.1 Pre-treatment LDL-C of ONE of the following:

- Greater than 190 mg/dL
- Greater than 155 mg/dL if less than 16 years of age

AND

1.1.2.2 Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following:

- Functional mutation in LDL (low density lipoprotein), apoB (apolipoprotein B), or PCSK9 (proprotein convertase subtilisin/kexin type 9) gene*
- Tendinous xanthomata

- Arcus cornealis before age 45

OR

1.2 Atherosclerotic cardiovascular disease (ASCVD) as confirmed by ONE of the following:

- Acute coronary syndromes
- History of myocardial infarction
- Stable or unstable angina
- Coronary or other arterial revascularization
- Stroke
- Transient ischemic attack
- Peripheral arterial disease presumed to be of atherosclerotic origin

AND

2 - Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following [prescription claims history may be used in conjunction as documentation of medication use, dose, and duration]:

2.1 Patient has been receiving at least 12 consecutive weeks of high-intensity statin therapy [i.e. atorvastatin 40-80 milligrams (mg), rosuvastatin 20-40mg] and will continue to receive high intensity statin at maximally tolerated dose

OR

2.2 BOTH of the following:

2.2.1 Patient is unable to tolerate high-intensity statin as evidenced by one of the following intolerable and persistent (i.e. more than 2 weeks) symptoms:

- Myalgia (muscle symptoms without creatine kinase [CK] elevations)
- Myositis (muscle symptoms with CK elevations less than 10 times upper limit of normal [ULN])

AND

2.2.2 ONE of the following:

2.2.2.1 Patient has been receiving at least 12 consecutive weeks of moderate-intensity statin [i.e. atorvastatin 10-20 mg, rosuvastatin 5-10 mg, simvastatin greater than or equal to

20 mg, pravastatin greater than or equal to 40 mg, lovastatin 40 mg, Lescol XL (fluvastatin XL) 80 mg, fluvastatin 40 mg twice daily or Livalo (pitavastatin) greater than or equal to 2 mg] and will continue to receive a moderate-intensity statin at maximally tolerated dose

OR

2.2.2.2 Patient has been receiving at least 12 consecutive weeks of low-intensity statin [i.e. simvastatin 10 mg, pravastatin 10-20 mg, lovastatin 20 mg, fluvastatin 20-40 mg, or Livalo (pitavastatin) 1 mg] therapy and will continue to receive a low-intensity statin at maximally tolerated dose

OR

2.3 Patient is unable to tolerate low or moderate-, and high-intensity statins as evidenced by ONE of the following:

2.3.1 ONE of the following intolerable and persistent (i.e. more than 2 weeks) symptoms for low or moderate-, and high-intensity statins:

- Myalgia (muscle symptoms without CK elevations)
- Myositis (muscle symptoms with CK elevations less than 10 times upper limit of normal [ULN])

OR

2.3.2 Patient has a labeled contraindication to all statins as documented in medical records

OR

2.3.3 Patient has experienced rhabdomyolysis or muscle symptoms with statin treatment with CK elevations greater than 10 times ULN

AND

3 - ONE of the following:

3.1 Submission of medical records (e.g., laboratory values) documenting ONE of the following LDL-C values while on maximally tolerated lipid lowering therapy for a minimum of at least 12 weeks within the last 120 days:

- LDL-C greater than or equal to 100 mg/dL with ASCVD
- LDL-C greater than or equal to 130 mg/dL without ASCVD

OR

3.2 BOTH of the following:

3.2.1 Submission of medical records (e.g., laboratory values) documenting ONE of the following LDL-C values while on maximally tolerated lipid lowering therapy for a minimum of at least 12 weeks within the last 120 days:

- LDL-C between 55 mg/dL and 99 mg/dL with ASCVD
- LDL-C between 100 mg/dL and 129 mg/dL without ASCVD

AND

3.2.2 Submission of medical records (e.g., laboratory values) documenting ONE of the following [prescription claims history may be used in conjunction as documentation of medication use, dose, and duration]:

3.2.2.1 Patient has been receiving at least 12 consecutive weeks of ezetimibe (Zetia) therapy as adjunct to maximally tolerated statin therapy

OR

3.2.2.2 Patient has a history of contraindication or intolerance to ezetimibe

AND

4 - Used as an adjunct to a low-fat diet and exercise

AND

5 - Prescribed by ONE of the following:

- Cardiologist
- Endocrinologist

Lipid specialist	
AND	
6 - Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor (e.g., Repatha (evolocumab))	
Notes	*Note: Results of prior genetic testing can be submitted as confirmation of diagnosis of HeFH.

Product Name: Praluent	
Diagnosis	Primary Hyperlipidemia [Including Heterozygous Familial Hypercholesterolemia (HeFH), Atherosclerotic Cardiovascular Disease (ASCVD), and Secondary Prevention of Cardiovascular Events in Patients with ASCVD]
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient continues to receive statin at maximally tolerated dose (unless patient has documented inability to take statins) AND 2 - Patient is continuing a low-fat diet and exercise regimen AND 3 - Prescribed by ONE of the following: - Cardiologist - Endocrinologist - Lipid specialist	

AND

4 - Submission of medical records (e.g. chart notes, laboratory values) documenting low density lipoprotein cholesterol (LDL-C) reduction while on Praluent therapy

AND

5 - Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor (e.g., Repatha (evolocumab))

Product Name:Praluent	
Diagnosis	Homozygous Familial Hypercholesterolemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of homozygous familial hypercholesterolemia (HoFH) as confirmed by submission of medical records (e.g., chart notes, laboratory values) documenting BOTH of the following:* 1.1 ONE of the following: • Pre-treatment LDL-C (low-density lipoprotein cholesterol) greater than 500 mg/dL (milligrams per deciliter) • Treated LDL-C greater than 300 mg/dL AND 1.2 ONE of the following: • Xanthoma before 10 years of age • Evidence of heterozygous familial hypercholesterolemia (HeFH) in both parents	

AND	
2 - Used as an adjunct to a low-fat diet and exercise	
AND	
3 - Patient is receiving other lipid-lowering therapy (e.g., statin, ezetimibe, LDL [low-density lipoprotein] apheresis)	
AND	
4 - Prescribed by ONE of the following:	
• Cardiologist • Endocrinologist • Lipid specialist	
AND	
5 - Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor (e.g., Repatha (evolocumab))	
Notes	*Results of prior genetic testing can be submitted as confirmation of diagnosis of HoFH.

Product Name:Praluent	
Diagnosis	Homozygous Familial Hypercholesterolemia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient continues to receive other lipid-lowering therapy (e.g., statin, LDL apheresis)	

AND

2 - Patient is continuing a low-fat diet and exercise regimen

AND

3 - Prescribed by ONE of the following:

- Cardiologist
- Endocrinologist
- Lipid specialist

AND

4 - Submission of medical records (e.g. chart notes, laboratory values) documenting low density lipoprotein cholesterol (LDL-C) reduction while on Praluent therapy

AND

5 - Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor (e.g., Repatha (evolocumab))

2 . Revision History

Date	Notes
9/11/2023	Updated SP to standard formulary. Update to account for 2022 ACC recommendations of a lower LDL threshold of 55mg/dl for patients with ASCVD at very high risk.

Preferred Drugs



Prior Authorization Guideline

Guideline ID	GL-382219
Guideline Name	Preferred Drugs
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2025

1 . Criteria

Product Name: Preferred Drugs	
Diagnosis	Prior Authorization Administrative Guideline for Preferred Drugs Without Drug-Specific Criteria
Approval Length	12 month(s)
Guideline Type	Administrative
Approval Criteria 1 - ALL of the following: 1.1 ONE of the following:	

1.1.1 The requested drug must be used for a Food and Drug Administration-approved indication

or

1.1.2 The use of this drug is supported by information from ONE of the following appropriate compendia of current literature:

American Hospital Formulary Service Drug Information

National Comprehensive Cancer Network Drugs and Biologics Compendium

Thomson Micromedex DrugDex

Clinical pharmacology

AND

1.2 The drug is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plans' program*

AND

1.3 If the patient is less than FDA minimum age, the prescriber attests they are aware of FDA labeling and feels the treatment with the requested product is medically necessary.

Notes

*Medications used for anti-obesity/weight loss, cosmetic (e.g., alopecia, actinic keratosis, vitiligo), erectile dysfunction, and sexual dysfunction purposes are NOT medically accepted indications and are NOT recognized as a covered benefit. Erectile dysfunction drugs (Cialis/Tadalafil) are covered for clinical diagnoses other than ED.

2 . Revision History

Date	Notes
9/5/2025	Updated guideline name. Updated notes section. Updated Product Name section. Added asterisk to criterion 1.2.

Preferred Non-Solid Dosage Forms



Prior Authorization Guideline

Guideline ID	GL-545275
Guideline Name	Preferred Non-Solid Dosage Forms
Formulary	Medicaid - Community & State Arizona Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State Michigan Medicaid - Community & State New Jersey Medicaid - Community & State New Mexico Medicaid - Community & State North Carolina Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Pennsylvania Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/12/2026

1 . Criteria

Diagnosis	Requests for Non-Solid Dosage Forms

Approval Length	12 month(s)
Guideline Type	Administrative
Approval Criteria 1 - ONE of the following: 1.1 Requested drug must be used for an FDA-approved indication or 1.2 The use of this drug is supported by information from ONE of the following appropriate compendia of current literature: American Hospital Formulary Service Drug Information National Comprehensive Cancer Network Drugs and Biologics Compendium Thomson Micromedex DrugDex Clinical pharmacology United States Pharmacopeia-National Formulary AND 2 - The drug is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plans' program AND 3 - ONE of the following: 3.1 BOTH of the following: 3.1.1 The patient is able to swallow a solid dosage form AND 3.1.2 ONE of the following: 3.1.2.1 History of failure to at least THREE preferred* solid oral dosage forms as confirmed by claims history or submission of medical records. NOTE: In instances where	

there are fewer than three preferred alternatives, the patient must have a history of failure to ALL of the preferred products.

or

3.1.2.2 History of contraindication or intolerance to THREE preferred* solid oral dosage forms. NOTE: In instances where there are fewer than three preferred alternatives, the patient must have a history of contraindication or intolerance to ALL of the preferred products.

or

3.1.2.3 There are no preferred formulary alternatives for the requested drug

or

3.2 Patient is unable to swallow a solid dosage form

or

3.3 Patient utilizes a feeding tube for medication administration

or

3.4 Request is for a nebulized formulation of an inhaled medication for a patient who has an inability to effectively utilize an agent in an inhaler formulation due to neuromuscular or cognitive disability, or other evidence of lack of response to the inhaled formulation supported by clinical documentation

Notes

*See Table 1 in Background for PDL links. Prior trials of formulary/PDL alternatives must sufficiently demonstrate that the formulary/PDL alternatives are either ineffective or inappropriate at the time of the request.

2 . Background

Benefit/Coverage/Program Information**Table 1. PDL Links**

Arizona	https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHCCP
Colorado	https://www.uhcprovider.com/en/health-plans-by-state/colorado-health-plans/co-comm-plan-home/co-cp-pharmacy.html
Hawaii	https://www.uhcprovider.com/en/health-plans-by-state/hawaii-health-plans/hi-comm-plan-home/hi-cp-pharmacy.html
Indiana	https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html
Maryland	https://www.uhcprovider.com/en/health-plans-by-state/maryland-health-plans/md-comm-plan-home/md-cp-pharmacy.html
Michigan	https://www.uhcprovider.com/en/health-plans-by-state/michigan-health-plans/mi-comm-plan-home/mi-cp-pharmacy.html
New Jersey	https://www.uhcprovider.com/en/health-plans-by-state/new-jersey-health-plans/nj-comm-plan-home/nj-cp-pharmacy.html
New Mexico	https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html
North Carolina	https://www.uhcprovider.com/en/health-plans-by-state/north-carolina-health-plans/nc-comm-plan-home/nc-cp-pharmacy.html
Pennsylvania CAID/CHIP	https://www.uhcprovider.com/en/health-plans-by-state/pennsylvania-health-plans/pa-comm-plan-home/pa-cp-pharmacy.html?rfid=UHCCP

3 . Revision History

Date	Notes
3/13/2026	Removed NV from formularies and PDL link in background. No other updates to guideline. (See GL-545274 for NV specific guideline).

Presbyopia Agents



Prior Authorization Guideline

Guideline ID	GL-560214
Guideline Name	Presbyopia Agents
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:Qlosi, Vizz, Brand Vuity, generic pilocarpine 1.25% ophth soln, Yuvezzi	
Approval Length	1 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of presbyopia	

AND	
2 - History of failure or intolerance to a preferred* generic pilocarpine ophthalmic preparation	
AND	
3 - Prescribed by or in consultation with ONE of the following:	
• Ophthalmologist • Optometrist	
AND	
4 - Provider confirms valid clinical rationale, which excludes lifestyle choice, as to why patient is unable to use corrective lenses (e.g., eyeglasses or contact lenses)	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name: Qlosi, Vizz, Brand Vuity, generic pilocarpine 1.25% ophth soln, Yuvezzi	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient demonstrates positive clinical response to therapy (e.g., improvement in near vision in low light conditions without loss of distance vision) AND 2 - History of failure or intolerance to a preferred* generic pilocarpine ophthalmic preparation	

AND

3 - Prescribed by or in consultation with ONE of the following:

- Ophthalmologist
- Optometrist

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC CP

2 . Revision History

Date	Notes
3/30/2026	Added Yuvezzi

Pretomanid



Prior Authorization Guideline

Guideline ID	GL-140653
Guideline Name	Pretomanid
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	7/1/2020

1 . Criteria

Product Name:Pretomanid	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following: 1.1 Diagnosis of pulmonary extensively drug resistant (XDR) tuberculosis (TB)	

OR

1.2 Treatment-intolerant or nonresponsive multidrug-resistant (MDR) tuberculosis (TB)

AND

2 - Pretomanid will be used in combination with bedaquiline and linezolid

2 . Revision History

Date	Notes
5/12/2020	New program

Prevymis (letermovir)



Prior Authorization Guideline

Guideline ID	GL-449195
Guideline Name	Prevymis (letermovir)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	12/1/2025

1 . Criteria

Product Name:Prevymis tablets/pellets	
Diagnosis	CMV Prophylaxis in Hematopoietic Stem Cell Transplant (HSCT) Recipients
Approval Length	6 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following: • Patient is 6 months of age or older	

- Patient weighs at least 6 kg (kilograms)

AND

2 - Patient is a recipient of an allogeneic hematopoietic stem cell transplant

AND

3 - Patient is cytomegalovirus (CMV) seropositive (R+)

AND

4 - Provider attests to BOTH of the following:

4.1 Prevymis will be initiated between Day 0 and Day 28 post-transplantation (before or after engraftment), and continued through Day 100 post-transplant (in patients at risk for late CMV infection and disease, may continue through Day 200 post-transplant)

AND

4.2 Prevymis is being prescribed as prophylaxis and not treatment of CMV infection

Product Name:Prevymis tablets/pellets	
Diagnosis	CMV Prophylaxis in Kidney Transplant Recipients
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following: • Patient is 12 years of age or older • Patient weighs at least 40 kg (kilograms)	

AND

2 - Patient is a recipient of a kidney transplant

AND

3 - Patient is cytomegalovirus (CMV) seronegative [Donor CMV seropositive/Recipient CMV seronegative (D+/R-)]

AND

4 - Provider attests to BOTH of the following:

4.1 Prevymis will be initiated between Day 0 and Day 7 post-transplantation, and continued through Day 200 post-transplant

AND

4.2 Prevymis is being prescribed as prophylaxis and not treatment of CMV infection

2 . Revision History

Date	Notes
11/11/2025	Updated attestation criterion, where applicable.

Primary Hyperoxaluria (PH1) Agents [Oxlumo (lumasiran), Rivfloza (nedosiran)]



Prior Authorization Guideline

Guideline ID	GL-256195
Guideline Name	Primary Hyperoxaluria (PH1) Agents [Oxlumo (lumasiran), Rivfloza (nedosiran)]
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	6/1/2025

1 . Criteria

Product Name:Oxlumo	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of primary hyperoxaluria type 1 (PH1)	

AND

2 - Submission of medical records (e.g., chart notes) documenting diagnosis has been confirmed by BOTH of the following:

2.1 ONE of the following:

- Elevated urinary oxalate excretion
- Elevated plasma oxalate concentration
- Spot urinary oxalate to creatinine molar ratio greater than normal for age

AND

2.2 ONE of the following:

- Genetic testing demonstrating a mutation in the alanine:glyoxylate aminotransferase (AGXT) gene
- Liver biopsy demonstrating absence or reduced alanine:glyoxylate aminotransferase (AGT) activity

AND

3 - Patient has NOT received a liver transplant

AND

4 - Prescribed by or in consultation with ONE of the following:

- Hepatologist
- Nephrologist
- Urologist
- Geneticist
- Specialist with expertise in the treatment of PH1

Product Name: Rivfloza	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of primary hyperoxaluria type 1 (PH1) AND 2 - Submission of medical records (e.g., chart notes) documenting diagnosis has been confirmed by BOTH of the following: 2.1 ONE of the following: • Elevated urinary oxalate excretion • Elevated plasma oxalate concentration • Spot urinary oxalate to creatinine molar ratio greater than normal for age AND 2.2 ONE of the following: • Genetic testing demonstrating a mutation in the alanine:glyoxylate aminotransferase (AGXT) gene • Liver biopsy demonstrating absence or reduced alanine:glyoxylate aminotransferase (AGT) activity AND 3 - Patient is 2 years of age or older AND 4 - Patient has preserved kidney function [e.g., estimated glomerular filtration rate (eGFR) greater than or equal to 30 mL/min/1.73 m²]	

AND

5 - Patient has NOT received a liver transplant

AND

6 - Prescribed by or in consultation with ONE of the following:

- Hepatologist
- Nephrologist
- Urologist
- Geneticist
- Specialist with expertise in the treatment of PH1

Product Name:Oxlumo, Rivfloza

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming positive clinical response to therapy (e.g., decreased urinary oxalate excretion, decreased plasma oxalate concentration)

AND

2 - Patient has NOT received a liver transplant

AND

3 - Prescribed by or in consultation with ONE of the following:

- Hepatologist

- Nephrologist
- Urologist
- Geneticist
- Specialist with expertise in the treatment of PH1

2 . Revision History

Date	Notes
5/6/2025	Updated min age for Rivfloza

Procysbi



Prior Authorization Guideline

Guideline ID	GL-140934
Guideline Name	Procysbi
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Procysbi	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of nephropathic cystinosis	

AND	
2 - Patient is 1 year of age or older	
AND	
3 - History of failure or intolerance to Cystagon (immediate-release cysteamine bitartrate)*	
Notes	*Frequency of dosing and/or lack of compliance to dosing regimens is not generally considered an indication of medical necessity.

Product Name:Procysbi	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Procysbi therapy	

2 . Revision History

Date	Notes
8/10/2022	C&S to match AZM 10.1.22

Progesterone - Non-Oral



Prior Authorization Guideline

Guideline ID	GL-140647
Guideline Name	Progesterone - Non-Oral
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2020

1 . Criteria

Product Name:Crinone, Endometrin	
Approval Length	6 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Treatment is for non-infertility use (e.g., secondary amenorrhea, reduce the risk of recurrent spontaneous preterm birth)	

2 . Revision History

UnitedHealthcare Community Plan of Arizona Clinical Pharmacy Program Guidelines

Date	Notes
3/31/2020	Bulk Copy C&S New York to C&S Arizona for effective date of 5/1

Progesterone - Oral



Prior Authorization Guideline

Guideline ID	GL-442204
Guideline Name	Progesterone - Oral
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State New Jersey Medicaid - Community & State New York Medicaid - Community & State New York EPP Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Arizona Medicaid - Community & State New Mexico Medicaid - Community & State Nebraska Medicaid - Community & State Nevada

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name: Brand Prometrium, generic progesterone caps	
Approval Length	12 month(s)

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following: • Amenorrhea • Endometrial hyperplasia or prevention of endometrial hyperplasia • Abnormal uterine or vaginal bleeding • History of preterm birth • Prevention of preterm delivery for current pregnancy	

2 . Revision History

Date	Notes
11/6/2025	Added Nevada Formulary

Proton Pump Inhibitors (PPIs)



Prior Authorization Guideline

Guideline ID	GL-255208
Guideline Name	Proton Pump Inhibitors (PPIs)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	6/1/2025

1 . Criteria

Product Name:generic lansoprazole ODT, Brand Nexium granules/suspension packets, generic esomeprazole granules/suspension packets, Brand Protonix suspension packets, generic pantoprazole suspension packets	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Patient is less than 18 years of age	

OR

1.2 ALL of the following:

1.2.1 Patient is 18 years of age or older

AND

1.2.2 Patient is unable to swallow solid oral dosage forms (e.g., tablets) in the past 30 days

AND

1.2.3 History of failure to lansoprazole ODT (DOES NOT APPLY TO REQUESTS FOR LANSOPRAZOLE ODT)

AND

2 - If the request is for Brand Nexium granules/suspension packets, history of failure or intolerance to generic esomeprazole granules/suspension packets

2 . Revision History

Date	Notes
5/8/2025	Added step through generic esomeprazole granules/suspension packets for Brand Nexium granules/suspension packets requests. Update to product name section.

Provigil, Nuvigil



Prior Authorization Guideline

Guideline ID	GL-451228
Guideline Name	Provigil, Nuvigil
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	12/1/2025

1 . Criteria

Product Name: Brand Provigil, generic modafinil, Brand Nuvigil, generic armodafinil	
Diagnosis	Narcolepsy, Obstructive Sleep Apnea, Shift Work Disorder, Idiopathic Hypersomnia (off label)
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following diagnoses: Narcolepsy	

- Excessive sleepiness due to obstructive sleep apnea
- Excessive sleepiness due to shift work disorder (circadian rhythm sleep disorder, shift work type)
- Idiopathic hypersomnia

AND

2 - If the request is for Brand Provigil or Brand Nuvigil, the patient has a history of failure, contraindication, or intolerance to its preferred generic counterpart (i.e., generic modafinil or generic armodafinil)

AND

3 - Patient is 18 years of age or older

Product Name: Brand Provigil, generic modafinil, Brand Nuvigil, generic armodafinil	
Diagnosis	Fatigue due to Multiple Sclerosis (off-label)
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of multiple sclerosis (MS) AND 2 - Patient is experiencing fatigue AND 3 - If the request is for Brand Provigil or Brand Nuvigil, the patient has a history of failure, contraindication, or intolerance to its preferred generic counterpart (i.e., generic modafinil or generic armodafinil)	

AND

4 - Patient is 18 years of age or older

Product Name: Brand Provigil, generic modafinil, Brand Nuvigil, generic armodafinil

Diagnosis	Adjunctive Therapy for the Treatment of Major Depressive Disorder or Bipolar Depression (off-label)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Treatment-resistant depression, defined as BOTH of the following:

1.1 Diagnosis of ONE of the following:

- Major depressive disorder (MDD)
- Bipolar depression

AND

1.2 History of failure, contraindication, or intolerance to at least TWO antidepressants from different classes (e.g., SSRIs [selective serotonin reuptake inhibitors], SNRIs [serotonin-norepinephrine reuptake inhibitors], bupropion)

AND

2 - Used as adjunctive therapy

AND

3 - If the request is for Brand Provigil or Brand Nuvigil, the patient has a history of failure,

contraindication, or intolerance to its preferred generic counterpart (i.e., generic modafinil or generic armodafinil)

AND

4 - Patient is 18 years of age or older

Product Name: Brand Provigil, generic modafinil, Brand Nuvigil, generic armodafinil	
Diagnosis	Adjunctive Therapy for the Treatment of Major Depressive Disorder or Bipolar Depression (off-label)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy AND 2 - Used as adjunctive therapy AND 3 - If the request is for Brand Provigil or Brand Nuvigil, the patient has a history of failure, contraindication, or intolerance to its preferred generic counterpart (i.e., generic modafinil or generic armodafinil) AND 4 - Patient is 18 years of age or older	

2 . Revision History

Date	Notes
11/13/2025	Added age criteria to all sections

Pulmonary Arterial Hypertension (PAH) Agents



Prior Authorization Guideline

Guideline ID	GL-546236
Guideline Name	Pulmonary Arterial Hypertension (PAH) Agents
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	4/12/2026

1 . Criteria

Product Name:Brand Adcirca, generic tadalafil 20 mg (PAH), Adempas, Alyq, Brand Letairis, generic ambrisentan, Opsumit, Opsynvi, Orenitram, Remodulin 0.4 mg/mL, Brand Revatio tabs, generic sildenafil 20 mg tabs, generic sildenafil susp, Tadliq, Brand Tracleer tabs, generic bosentan tabs, Brand Tracleer tab for oral susp, generic bosentan tab for oral susp, Tyvaso, Tyvaso DPI, Upravi tabs, Ventavis, Yutrepia	
Diagnosis	Pulmonary Arterial Hypertension
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of pulmonary arterial hypertension

AND

2 - Pulmonary arterial hypertension is symptomatic

AND

3 - ONE of the following:

3.1 Diagnosis of pulmonary arterial hypertension was confirmed by right heart catheterization

OR

3.2 Patient is currently on any therapy for the diagnosis of pulmonary arterial hypertension

AND

4 - Prescribed by or in consultation with ONE of the following:

- Pulmonologist
- Cardiologist

AND

5 - If the request is non-preferred*, patient has a history of failure, contraindication, or intolerance to BOTH of the following:

- A preferred* endothelin receptor antagonist (ERA) [e.g., generic ambrisentan, Tracleer tablet for oral suspension]
- A preferred* phosphodiesterase 5 inhibitor (PDE5i) [e.g., Alyq or tadalafil 20 mg (PAH), generic sildenafil tablet (generic for Revatio tablet), generic sildenafil suspension]

AND

6 - If the request is for Brand Adcirca, patient must have tried and failed generic tadalafil 20 mg (PAH) or Alyq

AND

7 - If the request is for Opsynvi, patient must have tried and failed BOTH of the following as separate products:

- generic tadalafil 20 mg (PAH)
- Opsumit^

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP ^Drug may require PA.

Product Name:Brand Adcirca, generic tadalafil 20 mg (PAH), Adempas, Alyq, Brand Letairis, generic ambrisentan, Opsumit, Opsynvi, Orenitram, Remodulin 0.4 mg/mL, Brand Revatio tabs, generic sildenafil 20 mg tabs, generic sildenafil susp, Tadliq, Brand Tracleer tabs, generic bosentan tabs, Brand Tracleer tab for oral susp, generic bosentan tab for oral susp, Tyvaso, Tyvaso DPI, Upravi tabs, Ventavis, Yutrepia

Diagnosis	Pulmonary Arterial Hypertension
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

Product Name:Adempas

Diagnosis	Chronic Thromboembolic Pulmonary Hypertension (CTEPH)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 BOTH of the following:

1.1.1 Diagnosis of inoperable or persistent/recurrent chronic thromboembolic pulmonary hypertension (CTEPH)

AND

1.1.2 CTEPH is symptomatic

OR

1.2 Patient is currently on any therapy for the diagnosis of CTEPH

AND

2 - Prescribed by or in consultation with ONE of the following:

- Pulmonologist
- Cardiologist

Product Name:Adempas	
Diagnosis	Chronic Thromboembolic Pulmonary Hypertension (CTEPH)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Documentation of positive clinical response to therapy

Product Name:Winrevair

Approval Length 6 month(s)

Therapy Stage Initial Authorization

Guideline Type Prior Authorization

Approval Criteria

1 - Diagnosis of pulmonary arterial hypertension

AND

2 - Pulmonary arterial hypertension is symptomatic

AND

3 - Patient is currently on at least TWO therapies indicated for the treatment of pulmonary arterial hypertension from the following different mechanisms of action, unless there is a contraindication or intolerance:

- Endothelin receptor antagonists [e.g., bosentan, ambrisentan or macitentan]
- Phosphodiesterase 5 inhibitors [e.g., tadalafil or sildenafil]

AND

4 - Prescribed by or in consultation with ONE of the following:

- Pulmonologist
- Cardiologist

Product Name:Winrevair

Approval Length 12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient demonstrates positive clinical response to therapy	

2 . Revision History

Date	Notes
3/12/2026	Removed obsolete GPI 40170080002970 for Tyvaso DPI. Under Win revair (initial auth section), updated verbiage from "i.e." to "e.g." in regards to ERA and PDE5i agents.

Pulmozyme



Prior Authorization Guideline

Guideline ID	GL-140864
Guideline Name	Pulmozyme
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2021

1 . Criteria

Product Name:Pulmozyme	
Diagnosis	Cystic Fibrosis
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Cystic Fibrosis	

2 . Revision History

Date	Notes
3/8/2021	Added product name list.

Qbrexza



Prior Authorization Guideline

Guideline ID	GL-369194
Guideline Name	Qbrexza
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	9/1/2025

1 . Criteria

Product Name:Qbrexza	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of primary axillary hyperhidrosis AND	

2 - ONE of the following:

2.1 Failure to Xerac-AC as confirmed by claims history or submission of medical records

OR

2.2 History of contraindication or intolerance to Xerac-AC (please specify contraindication or intolerance)

2 . Revision History

Date	Notes
8/13/2025	AZ stand-alone guideline created with Qbrexa only as target. No changes to criteria.

Qutenza (capsaicin)



Prior Authorization Guideline

Guideline ID	GL-140808
Guideline Name	Qutenza (capsaicin)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	9/1/2023

1 . Criteria

Product Name:Qutenza	
Diagnosis	Neuropathic pain associated with postherpetic neuralgia (PHN)
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming diagnosis of neuropathic pain associated with postherpetic neuralgia (PHN)	

AND

2 - Submission of medical records (e.g., chart notes, paid claims history) documenting trial and failure, contraindication, or intolerance to ALL of the following:

- gabapentin
- pregabalin
- minimum 60-day trial of a tricyclic antidepressant (e.g., amitriptyline, nortriptyline, desipramine)
- generic lidocaine 5% patch
- topical capsaicin cream

Product Name: Qutenza	
Diagnosis	Neuropathic pain associated with diabetic peripheral neuropathy (DPN) of the feet
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming diagnosis of neuropathic pain associated with diabetic peripheral neuropathy (DPN) of the feet AND 2 - Submission of medical records (e.g., chart notes, paid claims history) documenting trial and failure, contraindication, or intolerance to ALL of the following: • gabapentin • pregabalin • minimum 60-day trial of a tricyclic antidepressant (e.g., amitriptyline, nortriptyline, desipramine) • generic lidocaine 5% patch • topical capsaicin cream • duloxetine	

Product Name:Qutenza	
Diagnosis	Neuropathic pain associated with PHN, Neuropathic pain associated with DPN of the feet
Approval Length	3 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - It has been at least 3 months since the last application/administration AND 2 - Patient experienced pain relief with a prior course of therapy AND 3 - Patient is experiencing a return of neuropathic pain	

2 . Revision History

Date	Notes
8/9/2023	New guideline

Radicava (edaravone)



Prior Authorization Guideline

Guideline ID	GL-140940
Guideline Name	Radicava (edaravone)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	12/1/2022

1 . Criteria

Product Name:Radicava ORS	
Diagnosis	Amyotrophic Lateral Sclerosis (ALS)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of documentation (e.g., chart notes) confirming diagnosis of “definite” or “probable” amyotrophic lateral sclerosis (ALS) per the revised EL Escorial and Airlie House diagnostic criteria	

AND

2 - Prescribed by or in consultation with a neurologist with expertise in the diagnosis of ALS

AND

3 - Patient has scores greater than or equal to 2 in all items of the ALS Functional Rating Scale-Revised (ALSFRS-R) criteria at the start of treatment

AND

4 - Patient has a percent forced vital capacity (%FVC) greater than or equal to 80% at the start of treatment

Product Name:Radicava ORS

Diagnosis	Amyotrophic Lateral Sclerosis (ALS)

Approval Length	6 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of documentation (e.g., chart notes) confirming positive clinical response to therapy (e.g., slowing in the decline of functional abilities)

AND

2 - Patient is not dependent on invasive ventilation or tracheostomy

2 . Revision History

UnitedHealthcare Community Plan of Arizona Clinical Pharmacy Program Guidelines

Date	Notes
10/21/2022	Removed the Radicava-solution (Medical benefit)

Ranolazine products



Prior Authorization Guideline

Guideline ID	GL-140748
Guideline Name	Ranolazine products
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	12/1/2022

1 . Criteria

Product Name: Brand Ranexa, generic ranolazine	
Approval Length	12 month(s)
Guideline Type	Step Therapy
Approval Criteria 1 - History of ONE of the following standard anti-angina treatments: 1.1 One beta-blocker [e.g. Lopressor (metoprolol), Inderal (propranolol)]	

OR

1.2 One calcium channel blocker [e.g. Procardia XL (nifedipine ER), Cardizem LA/Cardizem CD (diltiazemER)]

OR

1.3 One long acting nitrate therapy [e.g. Imdur (isosorbide mononitrate), Isordil (isosorbide dinitrate), Nitro-Time/Nitro-Dur/Nitro-Bid (nitroglycerin ER)]

AND

2 - For Brand Ranexa requests ONLY: Trial and failure to generic ranolazine (verified via paid pharmacy claims or submission of medical records/chart notes)

Product Name:Aspruzo Sprinkle

Approval Length	12 month(s)

Guideline Type	Step Therapy

Approval Criteria

1 - History of ONE of the following standard anti-angina treatments:

1.1 One beta-blocker [e.g. Lopressor (metoprolol), Inderal (propranolol)]

OR

1.2 One calcium channel blocker [e.g. Procardia XL (nifedipine ER), Cardizem LA/Cardizem CD (diltiazemER)]

OR

1.3 One long acting nitrate therapy [e.g. Imdur (isosorbide mononitrate), Isordil (isosorbide dinitrate), Nitro-Time/Nitro-Dur/Nitro-Bid (nitroglycerin ER)]

AND

2 - One of the following:

2.1 Trial and failure to generic ranolazine (verified via paid pharmacy claims or submission of medical records/chart notes)

OR

2.2 One of the following:

- Patient is 8 years of age or younger
- Patient is unable to swallow the oral tablet (solid formulation) due to swallowing difficulties

2 . Revision History

Date	Notes
10/26/2022	Added Aspruzyo Sprinkle as target. Updated guideline name to Ranolazine Products

Rayos



Prior Authorization Guideline

Guideline ID	GL-382217
Guideline Name	Rayos
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2025

1 . Criteria

Product Name:Rayos	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 The requested drug must be used for a Food and Drug Administration-approved indication or	

1.2 The use of this drug is supported by information from ONE of the following appropriate compendia of current literature:

American Hospital Formulary Service Drug Information

National Comprehensive Cancer Network Drugs and Biologics Compendium

Thomson Micromedex DrugDex

Clinical pharmacology

United States Pharmacopoeia-National Formulary

AND

2 - The drug is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plan's program*

AND

3 - Submission of medical records or claims history documenting an intolerance to generic prednisone tablets which is unable to be resolved with attempts to minimize the adverse effects where appropriate

AND

4 - History of failure, contraindication, or intolerance to TWO the following:

Dexamethasone tablet, oral solution

Hydrocortisone tablet

Methylprednisolone tablet

Prednisolone tablet, oral solution

Notes

*Medications used for anti-obesity/weight loss, cosmetic (e.g., alopecia, actinic keratosis, vitiligo), erectile dysfunction, and sexual dysfunction purposes are NOT medically accepted indications and are NOT recognized as a covered benefit. Erectile dysfunction drugs (Cialis/Tadalafil) are covered for clinical diagnoses other than ED.

2 . Revision History

Date	Notes

9/5/2025	Updated notes section to remove "solely" verbiage.

Recorlev (levoketoconazole)



Prior Authorization Guideline

Guideline ID	GL-140883
Guideline Name	Recorlev (levoketoconazole)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name: Recorlev	
Diagnosis	Cushing's Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Both of the following: 1.1 Diagnosis of Cushing's disease	

AND

1.2 ONE of the following:

- Patient is not a candidate for pituitary surgery
- Pituitary surgery has not been curative

Product Name:Recorlev	
Diagnosis	Cushing's Disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive response to therapy	

Product Name:Recorlev	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Recorlev will be approved for uses supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1, 2A, or 2B.	

Product Name:Recorlev

Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy	

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Rectiv



Prior Authorization Guideline

Guideline ID	GL-140648
Guideline Name	Rectiv
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2020

1 . Criteria

Product Name:Rectiv	
Diagnosis	Pain Associated with Chronic Anal Fissures
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderate to severe pain associated with chronic anal fissures	

2 . Revision History

UnitedHealthcare Community Plan of Arizona Clinical Pharmacy Program Guidelines

Date	Notes
3/31/2020	Bulk Copy C&S New York to C&S Arizona for effective date of 5/1

Redemplo (plozasiran)



Prior Authorization Guideline

Guideline ID	GL-510403
Guideline Name	Redemplo (plozasiran)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name:Redemplo	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of familial chylomicronemia syndrome (FCS) (type 1 hyperlipoproteinemia)	

AND

2 - Submission of medical records (e.g., chart notes) documenting ONE of the following:

2.1 Genetic confirmation of biallelic pathogenic variants in FCS-causing genes (i.e., LPL, GPIHBP1, APOA5, APOC2, or LMF1)

OR

2.2 A North American FCS (NAFCS) score of greater than or equal to 45

OR

2.3 A Moulin score greater than 10

AND

3 - Submission of medical records (e.g., chart notes) documenting BOTH of the following:

3.1 ONE of the following:

3.1.1 Patient has tried or will receive treatment with standard of care triglyceride lowering therapy (i.e., prescription omega-3 fatty acid and a fibrate)

OR

3.1.2 Patient has an intolerance to standard of care triglyceride lowering therapy (i.e., prescription omega-3 fatty acid and a fibrate)

AND

3.2 Baseline fasting triglyceride levels are greater than or equal to 880 mg/dL prior to treatment with requested drug

AND

4 - Requested drug will be used as adjunct to a low-fat diet

AND

5 - Requested drug will NOT be used in combination with Tryngolza (olezarsen)

AND

6 - Prescribed by or in consultation with ONE of the following:

- Cardiologist
- Endocrinologist
- Gastroenterologist
- Lipid specialist (lipidologist)

Product Name:Redemplo	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy (e.g., reduction in triglyceride levels from baseline) AND 2 - Requested drug will NOT be used in combination with Tryngolza (olezarsen)	

2 . Revision History

Date	Notes
2/5/2026	New program.

Regranex



Prior Authorization Guideline

Guideline ID	GL-140670
Guideline Name	Regranex
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name: Regranex	
Approval Length	6 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has a lower extremity diabetic neuropathic ulcer	

2 . Revision History

UnitedHealthcare Community Plan of Arizona Clinical Pharmacy Program Guidelines

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Relyvrio (sodium phenylbutyrate and taurursodiol)



Prior Authorization Guideline

Guideline ID	GL-140963
Guideline Name	Relyvrio (sodium phenylbutyrate and taurursodiol)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	3/1/2023

1 . Criteria

Product Name:Relyvrio	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting diagnosis of amyotrophic lateral sclerosis (ALS)	

AND

2 - Diagnosis of ALS is further supported by neurogenic changes in electromyography (EMG)

AND

3 - Patient has had ALS symptoms for less than or equal to 18 months

AND

4 - Patient has a percent (%) forced vital capacity (FVC) or slow vital capacity (SVC) greater than or equal to 60% at the start of treatment

AND

5 - Patient does not require permanent noninvasive ventilation or invasive ventilation

AND

6 - Prescribed by or in consultation with a neurologist with expertise in the diagnosis of ALS

Product Name:Relyvrio	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting slowed disease progression from baseline	

AND

2 - Prescribed by or in consultation with a neurologist with expertise in the diagnosis of ALS

2 . Revision History

Date	Notes
2/8/2023	New guideline

Repatha



Prior Authorization Guideline

Guideline ID	GL-140814
Guideline Name	Repatha
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2023

1 . Criteria

Product Name: Repatha	
Diagnosis	Heterozygous familial hypercholesterolemia (HeFH), Atherosclerotic cardiovascular disease (ASCVD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following diagnoses:	

1.1 Heterozygous familial hypercholesterolemia (HeFH) as confirmed by ONE of the following*:

1.1.1 BOTH of the following:

1.1.1.1 Pre-treatment LDL-C (low-density lipoprotein cholesterol) greater than 190 milligrams per deciliter (mg/dL) (greater than 155 mg/dL if less than 16 years of age)

AND

1.1.1.2 ONE of the following:

- Family history of myocardial infarction in first degree relative less than 60 years of age
- Family history of myocardial infarction in second degree relative less than 50 years of age
- Family history of LDL-C greater than 190 mg/dL in first or second degree relative
- Family history of heterozygous or homozygous familial hypercholesterolemia in first or second degree relative
- Family history of tendinous xanthomata and or arcus cornealis in first or second degree relative

OR

1.1.2 BOTH of the following:

1.1.2.1 Pre-treatment LDL-C greater than 190 mg/dL (greater than 155 mg/dL if less than 16 years of age)

AND

1.1.2.2 Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following:

- Functional mutation in LDL (low-density lipoprotein), apoB (Apolipoprotein B), or PCSK9 (Proprotein convertase subtilisin/kexin type 9) gene*
- Tendinous xanthomata
- Arcus cornealis before age 45

OR

1.2 Atherosclerotic cardiovascular disease (ASCVD) as confirmed by ONE of the following:

- Acute coronary syndromes
- History of myocardial infarction
- Stable or unstable angina
- Coronary or other arterial revascularization
- Stroke
- Transient ischemic attack
- Peripheral arterial disease presumed to be of atherosclerotic origin

AND

2 - Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following (prescription claims history may be used in conjunction as documentation of medication use, dose, and duration):

2.1 Patient has been receiving at least 12 consecutive weeks of high-intensity statin therapy (i.e. atorvastatin 40-80 mg, rosuvastatin 20-40 mg) and will continue to receive high-intensity statin at maximally tolerated dose

OR

2.2 BOTH of the following:

2.2.1 Patient is unable to tolerate high-intensity statin as evidenced by ONE of the following intolerable and persistent (i.e. more than 2 weeks) symptoms:

- Myalgia (muscle symptoms without CK elevations)
- Myositis (muscle symptoms with CK elevations less than 10 times upper limit of normal [ULN])

AND

2.2.2 ONE of the following:

2.2.2.1 Patient has been receiving at least 12 consecutive weeks of moderate-intensity statin [i.e. atorvastatin 10-20 mg, rosuvastatin 5-10 mg, simvastatin greater than or equal to 20 mg, pravastatin greater than or equal to 40 mg, lovastatin 40 mg, Lescol XL (fluvastatin XL) 80 mg, fluvastatin 40 mg twice daily or Livalo (pitavastatin) greater than or equal to 2 mg] and will continue to receive a moderate-intensity statin at maximally tolerated dose

OR

2.2.2.2 Patient has been receiving at least 12 consecutive weeks of low-intensity statin [i.e. simvastatin 10 mg, pravastatin 10-20 mg, lovastatin 20 mg, fluvastatin 20-40 mg, or Livalo (pitavastatin) 1 mg] therapy and will continue to receive a low-intensity statin at maximally tolerated dose

OR

2.3 Patient is unable to tolerate low or moderate, and high intensity statins as evidenced by ONE of the following:

2.3.1 ONE of the following intolerable and persistent (i.e. more than 2 weeks) symptoms for low or moderate, and high intensity statins:

- Myalgia (muscle symptoms without CK elevations)
- Myositis (muscle symptoms with CK elevations less than 10 times upper limit of normal [ULN])

OR

2.3.2 Patient has a labeled contraindication to all statins as documented in medical records

OR

2.3.3 Patient has experienced rhabdomyolysis or muscle symptoms with statin treatment with CK elevations greater than 10 times ULN

AND

3 - ONE of the following:

3.1 Submission of medical records (e.g., laboratory values) documenting ONE of the following LDL-C values while on maximally tolerated lipid lowering therapy for a minimum of at least 12 weeks within the last 120 days:

- LDL-C greater than or equal to 100 mg/dL with ASCVD

- LDL-C greater than or equal to 130 mg/dL without ASCVD

OR

3.2 BOTH of the following:

3.2.1 Submission of medical records (e.g., laboratory values) documenting ONE of the following LDL-C values while on maximally tolerated lipid lowering therapy for a minimum of at least 12 weeks within the last 120 days:

- LDL-C between 55 mg/dL and 99 mg/dL with ASCVD
- LDL-C between 100 mg/dL and 129 mg/dL without ASCVD

AND

3.2.2 Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following [prescription claims history may be used in conjunction as documentation of medication use, dose, and duration]:

- Patient has been receiving at least 12 consecutive weeks of ezetimibe (Zetia) therapy as adjunct to maximally tolerated statin therapy
- Patient has a history of contraindication or intolerance to ezetimibe

AND

4 - Used as an adjunct to a low-fat diet and exercise

AND

5 - Prescribed by ONE of the following:

- Cardiologist
- Endocrinologist
- Lipid specialist

AND

6 - Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor (e.g., Praluent (alirocumab))

Notes	*Results of prior genetic testing can be submitted as confirmation of diagnosis of HeFH .

Product Name: Repatha	
Diagnosis	Heterozygous familial hypercholesterolemia (HeFH), Atherosclerotic cardiovascular disease (ASCVD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient continues to receive statin at maximally tolerated dose (unless patient has documented inability to take statins) AND 2 - Patient is continuing a low-fat diet and exercise regimen AND 3 - Prescribed by ONE of the following: • Cardiologist • Endocrinologist • Lipid specialist AND 4 - Submission of medical records (e.g. chart notes, laboratory values) documenting LDL-C (low-density lipoprotein cholesterol) reduction while on Repatha therapy AND	

5 - Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor (e.g., Praluent (alirocumab))

Product Name: Repatha

Diagnosis	Homozygous Familial Hypercholesterolemia (HoFH)

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of homozygous familial hypercholesterolemia (HoFH) as confirmed by submission of medical records (e.g., chart notes, laboratory values) documenting BOTH of the following:*

1.1 ONE of the following:

- Pre-treatment LDL-C (low-density lipoprotein cholesterol) greater than 500 mg/dL (milligrams per deciliter)
- Treated LDL-C greater than 300 mg/dL

AND

1.2 ONE of the following:

- Xanthoma before 10 years of age
- Evidence of heterozygous familial hypercholesterolemia (HeFH) in both parents

AND

2 - Used as an adjunct to a low-fat diet and exercise

AND

3 - Patient is receiving other lipid-lowering therapy (e.g., statin, ezetimibe, LDL [low-density lipoprotein] apheresis)

AND

4 - Prescribed by ONE of the following:

- Cardiologist
- Endocrinologist
- Lipid specialist

AND

5 - Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor (e.g., Praluent (alirocumab))

Notes	*Results of prior genetic testing can be submitted as confirmation of diagnosis of HoFH.

Product Name: Repatha	
Diagnosis	Homozygous Familial Hypercholesterolemia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is continuing a low-fat diet and exercise regimen AND 2 - Patient continues to receive other lipid-lowering therapy (e.g., statin, LDL apheresis) AND 3 - Submission of medical records (e.g. chart notes, laboratory values) documenting LDL-C (low-density lipoprotein cholesterol) reduction while on Repatha therapy	

AND

4 - Prescribed by ONE of the following:

- Cardiologist
- Endocrinologist
- Lipid Specialist

AND

5 - Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor (e.g., Praluent (alirocumab))

2 . Revision History

Date	Notes
9/11/2023	Updated SP to standard formulary. Update to account for 2022 ACC recommendations of a lower LDL threshold of 55mg/dl for patients with ASCVD at very high risk.

Respiratory Syncytial Virus (RSV) Vaccines



Prior Authorization Guideline

Guideline ID	GL-603202
Guideline Name	Respiratory Syncytial Virus (RSV) Vaccines
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Abrysvo, Arexvy, mResvia	
Approval Length	14 days (1 injection per 2 years)
Guideline Type	Prior Authorization
Approval Criteria 1 - Vaccine is being used for the prevention of lower respiratory tract disease (LRTD) caused by respiratory syncytial virus (RSV) AND	

2 - Patient has NOT received an RSV vaccine (i.e., Abrysvo, Arexvy, mResvia) in the previous 2 years

AND

3 - ONE of the following:

3.1 ONE of the following:

- If the request is for Abrysvo: Age greater than or equal to 60 years
- If the request is for Arexvy: Age greater than or equal to 50 years
- If the request is for mResvia: Age greater than or equal to 60 years

OR

3.2 ONE of the following:

3.2.1 BOTH of the following (applies to Abrysvo only):

- Will be used for active immunization of pregnant individuals at 32 through 36 weeks gestational age
- Will also be used for the prevention of severe LRTD caused by RSV in infants from birth through 6 months of age

OR

3.2.2 BOTH of the following:

- Patient is 18 to 59 years of age
- Patient is at increased risk for LRTD caused by RSV

2 . Revision History

Date	Notes
5/6/2026	Arexvy expanded indication: Updated criterion 3.2.2 (removed designation specific to Mresvia and Abrysvo only note). Updated formatting

Revcovi



Prior Authorization Guideline

Guideline ID	GL-140857
Guideline Name	Revcovi
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	8/14/2020

1 . Criteria

Product Name:Revcovi	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of severe combined immunodeficiency disease (SCID)	

AND

2 - Deficiency of adenosine deaminase is confirmed by one of the following:

- Deficiency or absence of adenosine deaminase (ADA) in plasma, lysed erythrocytes, fibroblasts (cultured from amniotic fluid), or chorionic villus
- Increase in deoxyadenosine triphosphate (dATP) levels in erythrocyte lysates compared to laboratory standard
- Decrease in ATP (Adenosine triphosphate) concentration in erythrocytes
- Molecular genetic confirmation of mutations in both alleles of the ADA1 gene
- Positive screening by T cell receptor excision circles (TRECs)

AND

3 - One of the following:

- Patient is not a suitable candidate for hematopoietic cell transplantation (HCT)
- Patient has failed HCT
- Patient is awaiting HCT

AND

4 - Dosing is in accordance with the United States Food and Drug Administration approved labeling

Product Name: Revcovi	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has previously received treatment with Revcovi (elapegamase) therapy	

AND

2 - Patient has experienced a positive clinical response to therapy (e.g., normalization of plasma ADA activity, erythrocyte dATP levels, improvement of disease symptoms, etc.)

AND

3 - Dosing is in accordance with the United States Food and Drug Administration approved labeling

2 . Revision History

Date	Notes
7/14/2020	2020 Implementation

Reyvow



Prior Authorization Guideline

Guideline ID	GL-140711
Guideline Name	Reyvow
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Reyvow	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderate to severe migraine headaches with or without aura	

AND

2 - Used for acute treatment of migraine

AND

3 - Patient is 18 years of age or older

AND

4 - Documentation of a one month trial resulting in therapeutic failure, contraindication, or intolerance to THREE of the following:

- naratriptan tablets
- rizatriptan tablets/ODT (oral disintegrating tablets)
- sumatriptan tablets/auto injection/cartridge or Imitrex nasal spray (Brand only)
- zolmitriptan tablets/ODT

AND

5 - Prescribed by or in consultation with one of the following specialists with expertise in the acute treatment of migraine:

- Neurologist
- Pain Specialist
- Headache Specialist*

AND

6 - Prescriber attests to ALL of the following:

- Patient has been informed the use of Reyvow may result in significant CNS impairment, and may impact the patient's ability to drive or operate machinery for 8 hours after each dose
- If used concurrently with a benzodiazepine or other drugs that could potentially cause central nervous system (CNS) depression, the prescriber has acknowledged that they have completed an assessment of increased risk for sedation and other cognitive and/or neuropsychiatric adverse events

- The information provided is true and accurate to the best of their knowledge and they understand that OptumRx may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided

AND

7 - Both of the following:

7.1 One of the following

7.1.1 The patient must have a history of therapeutic failure, contraindication, or intolerance to **THREE** of the following:

- Amitriptyline (Elavil)**
- A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol)**
- Divalproex sodium [Depakote/Depakote ER (extended-release)]**
- Topiramate (Topamax)**
- VENLAFAXINE [EFFEXOR/EFFEXOR XR (EXTENDED-RELEASE)]**

OR

7.1.2 The patient must be currently treated with one of the following prophylactic therapies unless there is a contraindication or intolerance to **ALL**:

- Amitriptyline (Elavil)**
- A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol)**
- Divalproex sodium [Depakote/Depakote ER (extended-release)]**
- Topiramate (Topamax)**
- Venlafaxine [Effexor/Effexor XR (extended-release)]**

AND

7.2 Both of the Following

7.2.1 History of a therapeutic failure after 3 month trial, contraindication, or intolerance to two of the following biologic calcitonin gene-related peptide receptor (CGRP) antagonists for preventive treatment of migraine

- Ajovy (fremanezumab)
- Emgality (galcanezumab)
- Aimovig (erenumab)

AND	
7.2.2 History of a therapeutic failure, contraindication, or intolerance to Ubrelvy	
Notes	*Headache specialists are physicians certified by the United Council f or Neurologic Subspecialties (UCNS) **Drugs may require PA

Product Name:Reyvow	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy AND 2 - Prescribed by or in consultation with one of the following specialists with expertise in the acute treatment of migraine: • Neurologist • Pain Specialist • Headache Specialist*	
Notes	*Headache specialists are physicians certified by the United Council f or Neurologic Subspecialties (UCNS)

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Rezdiffra (resmetirom)



Prior Authorization Guideline

Guideline ID	GL-155257
Guideline Name	Rezdiffra (resmetirom)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name:Rezdiffra	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of metabolic dysfunction-associated steatohepatitis (MASH), formerly known as nonalcoholic steatohepatitis (NASH)	

AND

2 - Patient does NOT have cirrhosis (e.g., decompensated cirrhosis)

AND

3 - Submission of medical records (e.g., chart notes) confirming diagnosis has been confirmed by ONE of the following:

- FibroScan-aspartate aminotransferase (FAST)
- MRI-aspartate aminotransferase (MAST)
- Liver biopsy

AND

4 - Submission of medical records (e.g., chart notes) confirming disease is fibrosis stage F2 or F3 as confirmed by ONE of the following:

- FibroScan
- Fibrosis-4 index (FIB-4)
- Magnetic Resonance Elastography (MRE)

AND

5 - Presence of greater than or equal to 3 metabolic risk factors (e.g., Type 2 diabetes, hypertension, obesity)

AND

6 - Submission of medical records (e.g., chart notes) confirming drug is used as an adjunct to lifestyle modification (e.g., dietary or caloric restriction, exercise, behavioral support, community based program)

AND

7 - Prescribed by or in consultation with ONE of the following:

- Gastroenterologist
- Hepatologist

Product Name:Rezdiffra	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient demonstrates positive response to therapy (e.g., NASH resolution, fibrosis stage improvement, etc.) AND 2 - Submission of medical records (e.g., chart notes) confirming drug will continue to be used as an adjunct to lifestyle modification (e.g., dietary or caloric restriction, exercise, behavioral support, community based program) AND 3 - Submission of medical records (e.g., chart notes) confirming patient has NOT progressed to cirrhosis	

2 . Revision History

Date	Notes
9/18/2024	Replaced CORE criteria with FFS/state criteria.

Rezurock (belumosudil)



Prior Authorization Guideline

Guideline ID	GL-140885
Guideline Name	Rezurock (belumosudil)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Rezurock	
Diagnosis	Chronic graft-versus-host disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chronic graft-versus-host disease	

AND

2 - Trial and failure of two or more lines of systemic therapy (e.g., corticosteroids, mycophenolate, etc.)

AND

3 - Prescribed by or in consultation with one of the following:

- Hematologist
- Oncologist
- Physician experienced in the management of transplant patients

Product Name:Rezurock	
Diagnosis	Chronic graft-versus-host disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient does not show evidence of progressive disease while on therapy	

Product Name:Rezurock	
Diagnosis	Chronic graft-versus-host disease - Twice daily (BID) Therapy
Approval Length	12 month(s)
Guideline Type	Quantity Limit
Approval Criteria 1 - Patient is using medication concomitantly with one of the following:	

- Strong CYP3A inducer (e.g., carbamazepine, phenobarbital, phenytoin, rifampin)
- Proton pump inhibitor (e.g., omeprazole, pantoprazole, lansoprazole)

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Rhapsido (remibrutinib)



Prior Authorization Guideline

Guideline ID	GL-501225
Guideline Name	Rhapsido (remibrutinib)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Rhapsido	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of documentation (e.g., chart notes) confirming diagnosis of chronic spontaneous urticaria	

AND

2 - Persistent symptoms (itching and hives) for at least 4 consecutive weeks despite titrating to an optimal dose with a second generation H1 antihistamine (e.g., cetirizine, fexofenadine), unless there is a contraindication or intolerance to H1 antihistamines

AND

3 - Paid claims or submission of documentation (e.g., chart notes) confirming concurrent use with an H1 antihistamine, unless there is a contraindication or intolerance to H1 antihistamines

AND

4 - Paid claims or submission of documentation (e.g., chart notes) confirming patient has tried and had an inadequate response or intolerance to at least TWO of the following additional therapies:

- Doxepin
- H1 antihistamine
- H2 antagonist (e.g., famotidine, cimetidine)
- Hydroxyzine
- Leukotriene receptor antagonist (e.g., montelukast)

AND

5 - Paid claims or submission of documentation (e.g., chart notes) demonstrating history of failure, contraindication, or intolerance to Xolair (omalizumab)

AND

6 - Prescribed by ONE of the following:

- Allergist/Immunologist
- Dermatologist

Product Name: Rhapsido	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient's disease status has been re-evaluated since the last authorization to confirm the patient's condition warrants continued treatment

AND

2 - Submission of documentation (e.g., chart notes) confirming patient has experienced at least ONE of the following:

- Reduction in itching severity from baseline
- Reduction in the number of hives from baseline

AND

3 - Paid claims or submission of documentation (e.g., chart notes) demonstrating history of failure, contraindication, or intolerance to Xolair (omalizumab)

2 . Revision History

Date	Notes
1/15/2026	New program for ACUAZ/ACUAZEC.

Rhofade



Prior Authorization Guideline

Guideline ID	GL-140692
Guideline Name	Rhofade
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Rhofade	
Diagnosis	Persistent erythema associated with rosacea
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of persistent erythema associated with rosacea	

AND

2 - ONE of the following:

2.1 History of a 30 day or longer trial and failure of one of the following:

- metronidazole cream, gel, or lotion
- azelaic acid gel

OR

2.2 Contraindication or intolerance to both of the following:

- metronidazole cream, gel, or lotion
- azelaic acid gel

Product Name: Rhofade	
Diagnosis	Persistent erythema associated with rosacea
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of a positive clinical response to Rhofade therapy	

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Rinvoq (upadacitinib)



Prior Authorization Guideline

Guideline ID	GL-329202
Guideline Name	Rinvoq (upadacitinib)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	8/1/2025

1 . Criteria

Product Name:Rinvoq	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of moderately to severely active rheumatoid arthritis (RA)	

AND

2 - Prescribed by or in consultation with a rheumatologist

AND

3 - Submission of medical records (e.g., chart notes) or paid claims documenting BOTH of the following:**

3.1 History of failure to a 3 month trial of ONE non-biologic disease modifying anti-rheumatic drug (DMARD) (e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine) at maximally indicated doses within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced*

AND

3.2 History of failure, contraindication, or intolerance to ALL of the following.***

- A preferred adalimumab biosimilar or Enbrel (etanercept)
- infliximab
- Orencia (abatacept)
- Xeljanz (tofacitinib) oral tablet (IR or XR)
- A preferred tocilizumab biosimilar

AND

4 - Not used in combination with other Janus kinase (JAK) inhibitors, biologic DMARDs, or potent immunosuppressants (e.g., azathioprine or cyclosporine)*

Notes	*Rinvoq may be used with concomitant methotrexate, topical or inhaled corticosteroids, and/or low stable dosages of oral corticosteroids (equivalent to 10 mg or less of prednisone daily). **PA may be required. PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHCCP ***Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from manufacturer sponsor

	nsored programs shall be required to meet initial authorization criteria as if patient were new to therapy.

Product Name:Rinvoq	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy AND 2 - Not used in combination with other JAK inhibitors, biologic DMARDs, or potent immunosuppressants (e.g., azathioprine or cyclosporine)* AND 3 - Prescribed by or in consultation with a rheumatologist	
Notes	*Rinvoq may be used with concomitant methotrexate, topical or inhaled corticosteroids, and/or low stable dosages of oral corticosteroids (equivalent to 10 mg or less of prednisone daily).

Product Name:Rinvoq, Rinvoq LQ	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (PJIA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of active polyarticular juvenile idiopathic arthritis (PJIA)

AND

2 - Prescribed by or in consultation with a rheumatologist

AND

3 - Submission of medical records (e.g., chart notes) or paid claims documenting BOTH of the following:**

3.1 Minimum duration of a 6-week trial and failure, contraindication, or intolerance to ONE of the following conventional therapies at maximally tolerated doses:*

- methotrexate
- leflunomide

AND

3.2 History of failure, contraindication, or intolerance to ALL of the following:***

- A preferred adalimumab biosimilar or Enbrel (etanercept)
- Orencia (abatacept)
- Xeljanz (tofacitinib) oral tablet
- A preferred tocilizumab biosimilar

AND

4 - Not used in combination with other JAK inhibitors, biologic DMARDs, or potent immunosuppressants (e.g., azathioprine or cyclosporine)*

Notes

*Rinvoq may be used with concomitant methotrexate, topical or inhaled corticosteroids, and/or low stable dosages of oral corticosteroids (equivalent to 10 mg or less of prednisone daily).

**PA may be required. PDL link: <https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHCCP>

	***Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from manufacturer sponsored programs shall be required to meet initial authorization criteria as if patient were new to therapy.

Product Name:Rinvoq, Rinvoq LQ	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (PJIA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy AND 2 - Not used in combination with other JAK inhibitors, biologic DMARDs, or potent immunosuppressants (e.g., azathioprine or cyclosporine)* AND 3 - Prescribed by or in consultation with a rheumatologist	
Notes	*Rinvoq may be used with concomitant methotrexate, topical or inhaled corticosteroids, and/or low stable dosages of oral corticosteroids (equivalent to 10 mg or less of prednisone daily).

Product Name:Rinvoq, Rinvoq LQ	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of active psoriatic arthritis (PsA)

AND

2 - Prescribed by or in consultation with ONE of the following:

- Dermatologist
- Rheumatologist

AND

3 - Submission of medical records (e.g., chart notes) or paid claims documenting BOTH of the following:**

3.1 History of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced*

AND

3.2 History of failure, contraindication, or intolerance to ALL of the following:***

- A preferred adalimumab biosimilar or Enbrel (etanercept)
- infliximab
- Orencia (abatacept)
- Otezla (apremilast)
- Xeljanz (tofacitinib) oral tablet (IR or XR)
- A preferred ustekinumab biosimilar

AND

4 - Not used in combination with other JAK inhibitors, biologic DMARDs, or potent immunosuppressants (e.g., azathioprine or cyclosporine)*

Notes	*Rinvoq may be used with concomitant methotrexate, topical or inhaled corticosteroids, and/or low stable dosages of oral corticosteroids (equivalent to 10 mg or less of prednisone daily). **PA may be required. PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHCCP ***Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from manufacturer sponsored programs shall be required to meet initial authorization criteria as if patient were new to therapy.

Product Name:Rinvoq, Rinvoq LQ	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy AND 2 - Not used in combination with other JAK inhibitors, biologic DMARDs, or potent immunosuppressants (e.g., azathioprine or cyclosporine)* AND 3 - Prescribed by or in consultation with ONE of the following: • Dermatologist • Rheumatologist	

Notes	*Rinvoq may be used with concomitant methotrexate, topical or inhaled corticosteroids, and/or low stable dosages of oral corticosteroids (equivalent to 10 mg or less of prednisone daily).

Product Name:Rinvoq	
Diagnosis	Ankylosing Spondylitis (AS), Non-radiographic Axial Spondyloarthritis (nr-axSpA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming ONE of the following diagnoses: • Active ankylosing spondylitis (AS) • Active non-radiographic axial spondyloarthritis (nr-axSpA) AND 2 - Prescribed by or in consultation with a rheumatologist AND 3 - Submission of medical records (e.g., chart notes) or paid claims documenting BOTH of the following:** 3.1 Trial and failure, contraindication, or intolerance to TWO nonsteroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen, naproxen) AND 3.2 History of failure, contraindication, or intolerance to ALL of the following:*** • A preferred adalimumab biosimilar or Enbrel (etanercept) • infliximab	

- Xeljanz (tofacitinib) oral tablet (IR or XR)

AND

4 - Not used in combination with other JAK inhibitors, biologic DMARDs, or potent immunosuppressants (e.g., azathioprine or cyclosporine)*

Notes	*Rinvoq may be used with concomitant methotrexate, topical or inhaled corticosteroids, and/or low stable dosages of oral corticosteroids (equivalent to 10 mg or less of prednisone daily). **PA may be required. PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHCCP ***Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from manufacturer sponsored programs shall be required to meet initial authorization criteria as if patient were new to therapy.

Product Name: Rinvoq	
Diagnosis	Ankylosing Spondylitis (AS), Non-radiographic Axial Spondyloarthritis (nr-axSpA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy AND 2 - Not used in combination with other JAK inhibitors, biologic DMARDs, or potent immunosuppressants (e.g., azathioprine or cyclosporine)*	

AND

3 - Prescribed by or in consultation with a rheumatologist

Notes	*Rinvoq may be used with concomitant methotrexate, topical or inhaled corticosteroids, and/or low stable dosages of oral corticosteroids (equivalent to 10 mg or less of prednisone daily).

Product Name: Rinvoq

Diagnosis	Atopic Dermatitis (AD)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of moderate to severe atopic dermatitis (AD)

AND

2 - Patient is 12 years of age or older

AND

3 - Submission of medical records (e.g., chart notes) documenting ONE of the following:

- Involvement of at least 10% body surface area (BSA)
- SCORing Atopic Dermatitis (SCORAD) index value of at least 25

AND

4 - Prescribed by or in consultation with ONE of the following:

- Dermatologist
- Allergist/Immunologist

AND

5 - Submission of medical records (e.g., chart notes) or paid claims history documenting ALL of the following:**

5.1 History of failure, contraindication, or intolerance to ALL of the following topical therapies.***

- One topical calcineurin inhibitor [e.g., Elidel (pimecrolimus), Protopic (tacrolimus)]
- Eucrisa (crisaborole)
- Opzelura (ruxolitinib) cream
- Vtama (tapinarof) cream
- Zoryve (roflumilast) 0.15% cream

AND

5.2 Submission of medical records (e.g., chart notes) or paid claims history documenting trial and failure of a minimum 12-week supply of Dupixent (dupilumab)***

AND

5.3 Submission of medical records (e.g., chart notes) or paid claims history documenting trial and failure of a minimum 12-week supply of Adbry (tralokinumab-ldrm)***

AND

6 - Not used in combination with other JAK inhibitors, biologic immunomodulators (e.g., Dupixent, Adbry), or other immunosuppressants (e.g., azathioprine, cyclosporine)*

Notes	*Rinvoq may be used with concomitant methotrexate, topical or inhaled corticosteroids, and/or low stable dosages of oral corticosteroids (equivalent to 10 mg or less of prednisone daily). **PA may be required. PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHCCPA

	***Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from manufacturer sponsored programs shall be required to meet initial authorization criteria as if patient were new to therapy.

Product Name:Rinvoq	
Diagnosis	Atopic Dermatitis (AD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy as evidenced by at least ONE of the following: • Reduction in body surface area involvement from baseline • Reduction in SCORing Atopic Dermatitis (SCORAD) index value from baseline AND 2 - Prescribed by or in consultation with ONE of the following: • Dermatologist • Allergist/Immunologist AND 3 - Not used in combination with other JAK inhibitors, biologic immunomodulators (e.g., Dupixent, Adbry), or other immunosuppressants (e.g., azathioprine, cyclosporine)*	
Notes	*Rinvoq may be used with concomitant methotrexate, topical or inhaled corticosteroids, and/or low stable dosages of oral corticosteroids (equivalent to 10 mg or less of prednisone daily).

Product Name:Rinvoq

Diagnosis	Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of moderately to severely active ulcerative colitis (UC) AND 2 - Prescribed by or in consultation with a gastroenterologist AND 3 - Submission of medical records (e.g., chart notes) or paid claims documenting BOTH of the following:** 3.1 Trial and failure, contraindication, or intolerance to ONE of the following conventional therapies: • 6-mercaptopurine • Aminosalicylate (e.g., mesalamine, olsalazine, sulfasalazine) • Azathioprine • Corticosteroids (e.g., prednisone) AND 3.2 History of failure, contraindication, or intolerance to ALL of the following.*** • A preferred adalimumab biosimilar • infliximab • Xeljanz (tofacitinib) oral tablet (IR or XR) • A preferred ustekinumab biosimilar AND	

4 - Not used in combination with other JAK inhibitors, biological therapies for UC, or with potent immunosuppressants (e.g., azathioprine, cyclosporine)*	
Notes	*Rinvoq may be used with concomitant methotrexate, topical or inhaled corticosteroids, and/or low stable dosages of oral corticosteroids (equivalent to 10 mg or less of prednisone daily). **PA may be required. PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHCCP ***Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from manufacturer sponsored programs shall be required to meet initial authorization criteria as if patient were new to therapy.

Product Name:Rinvoq	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy AND 2 - Prescribed by or in consultation with a gastroenterologist AND 3 - Not used in combination with other JAK inhibitors, biological therapies for UC, or with potent immunosuppressants (e.g., azathioprine, cyclosporine)*	

Notes	*Rinvoq may be used with concomitant methotrexate, topical or inhaled corticosteroids, and/or low stable dosages of oral corticosteroids (equivalent to 10 mg or less of prednisone daily).

Product Name: Rinvoq	
Diagnosis	Crohn's Disease (CD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of moderately to severely active Crohn's disease (CD) AND 2 - Prescribed by or in consultation with a gastroenterologist AND 3 - Submission of medical records (e.g., chart notes) or paid claims documenting BOTH of the following:** 3.1 Trial and failure, contraindication, or intolerance to ONE of the following conventional therapies: • 6-mercaptopurine • Azathioprine • Methotrexate • Corticosteroids (e.g., prednisone) AND 3.2 History of failure, contraindication, or intolerance to ALL of the following.*** • A preferred adalimumab biosimilar	

- infliximab
- A preferred ustekinumab biosimilar

AND

4 - Not used in combination with other JAK inhibitors, biological therapies for CD, or with potent immunosuppressants (e.g., azathioprine, cyclosporine)*

Notes	*Rinvoq may be used with concomitant methotrexate, topical or inhaled corticosteroids, and/or low stable dosages of oral corticosteroids (equivalent to 10 mg or less of prednisone daily). **PA may be required. PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHCCP ***Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from manufacturer sponsored programs shall be required to meet initial authorization criteria as if patient were new to therapy.

Product Name:Rinvoq	
Diagnosis	Crohn's Disease (CD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy as evidenced by at least ONE of the following: • Improvement in intestinal inflammation (e.g., mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline • Reversal of high fecal output state AND	

2 - Prescribed by or in consultation with a gastroenterologist

AND

3 - Not used in combination with other JAK inhibitors, biological therapies for CD, or with potent immunosuppressants (e.g., azathioprine, cyclosporine)*

Notes

*Rinvoq may be used with concomitant methotrexate, topical or inhaled corticosteroids, and/or low stable dosages of oral corticosteroids (equivalent to 10 mg or less of prednisone daily).

Product Name: Rinvoq

Diagnosis	Giant Cell Arteritis (GCA)

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of giant cell arteritis (GCA)

AND

2 - Prescribed by or in consultation with a rheumatologist

AND

3 - Paid claims or submission of medical records (e.g., chart notes) confirming a trial and failure, contraindication, or intolerance to BOTH of the following:

- A glucocorticoid (e.g., prednisone)
- A preferred** tocilizumab biosimilar

AND	
4 - Not used in combination with other JAK inhibitors, biological therapies, or with potent immunosuppressants (e.g., azathioprine, cyclosporine)*	
Notes	*Rinvoq may be used with concomitant methotrexate, topical or inhaled corticosteroids, and/or low stable dosages of oral corticosteroids (equivalent to 10 mg or less of prednisone daily). **PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC

Product Name:Rinvoq	
Diagnosis	Giant Cell Arteritis (GCA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy AND 2 - Prescribed by or in consultation with a rheumatologist AND 3 - Not used in combination with other JAK inhibitors, biological therapies, or with potent immunosuppressants (e.g., azathioprine, cyclosporine)*	
Notes	*Rinvoq may be used with concomitant methotrexate, topical or inhaled corticosteroids, and/or low stable dosages of oral corticosteroids (equivalent to 10 mg or less of prednisone daily).

2 . Background

Clinical Practice Guidelines			
Table 1. Relative potencies of topical corticosteroids			
Class	Drug	Dosage Form	Strength (%)
Very high potency	Augmented betamethasone dipropionate	Ointment, gel	0.05
	Clobetasol propionate	Cream, foam, ointment	0.05
	Diflorasone diacetate	Ointment	0.05
	Halobetasol propionate	Cream, ointment	0.05
High Potency	Amcinonide	Cream, lotion, ointment	0.1
	Augmented betamethasone dipropionate	Cream, lotion	0.05
	Betamethasone dipropionate	Cream, foam, ointment, solution	0.05
	Desoximetasone	Cream, ointment	0.25
	Desoximetasone	Gel	0.05
	Diflorasone diacetate	Cream	0.05
	Fluocinonide	Cream, gel, ointment, solution	0.05
	Halcinonide	Cream, ointment	0.1
	Mometasone furoate	Ointment	0.1
	Triamcinolone acetonide	Cream, ointment	0.5
Medium potency	Betamethasone valerate	Cream, foam, lotion, ointment	0.1
	Clocortolone pivalate	Cream	0.1

	Desoximetasone	Cream	0.05
	Fluocinolone acetonide	Cream, ointment	0.025
	Flurandrenolide	Cream, ointment, lotion	0.05
	Fluticasone propionate	Cream	0.05
	Fluticasone propionate	Ointment	0.005
	Mometasone furoate	Cream, lotion	0.1
	Triamcinolone acetonide	Cream, ointment, lotion	0.1
Lower-medium potency	Hydrocortisone butyrate	Cream, ointment, solution	0.1
	Hydrocortisone probutate	Cream	0.1
	Hydrocortisone valerate	Cream, ointment	0.2
	Prednicarbate	Cream	0.1
Low potency	Alclometasone dipropionate	Cream, ointment	0.05
	Desonide	Cream, gel, foam, ointment	0.05
	Fluocinolone acetonide	Cream, solution	0.01
Lowest potency	Dexamethasone	Cream	0.1
	Hydrocortisone	Cream, lotion, ointment, solution	0.25, 0.5, 1
	Hydrocortisone acetate	Cream, ointment	0.5-1

3 . Revision History

Date	Notes
7/18/2025	Updates to criteria for all indications. Added new criteria for GCA indication.

Ryaltris



Prior Authorization Guideline

Guideline ID	GL-140754
Guideline Name	Ryaltris
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	12/1/2022

1 . Criteria

Product Name:Ryaltris	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Trial and failure to BOTH of the following as separate agents: • generic mometasone nasal spray • azelastine or olopatadine nasal spray	

2 . Revision History

Date	Notes
11/7/2022	New guideline following FFS.

Samsca



Prior Authorization Guideline

Guideline ID	GL-140869
Guideline Name	Samsca
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	9/1/2021

1 . Criteria

Product Name:Brand Samsca, generic tolvaptan	
Approval Length	30 Day(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following: • Diagnosis of clinically significant euvolemic hyponatremia • Diagnosis of clinically significant hypervolemic hyponatremia	

AND

2 - Patient has not responded to fluid restriction

AND

3 - Treatment has been initiated or re-initiated in a hospital setting prior to discharge

Sapropterin Products



Prior Authorization Guideline

Guideline ID	GL-501227
Guideline Name	Sapropterin Products
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name: Brand Javygtor, Brand Kuvan, generic sapropterin, Zelvysia	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of phenylketonuria (PKU) AND	

2 - If the request is for Brand Javygtor, Brand Kuvan, or Zelvysia, patient must have tried and failed generic sapropterin

2 . Revision History

Date	Notes
1/16/2026	Added embedded step requirement where requests for Brand Javygtor, Brand Kuvan, and Zelvysia are to step through generic sapropterin.

Sedative Hypnotics



Prior Authorization Guideline

Guideline ID	GL-235212
Guideline Name	Sedative Hypnotics
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2025

1 . Criteria

Product Name:Brand Rozerem	
Approval Length	12 month(s)
Guideline Type	Step Therapy
Approval Criteria 1 - History of failure, contraindication, or intolerance to a trial of at least TWO of the following preferred agents: • Eszopiclone (Generic Lunesta) • Zolpidem/Zolpidem ER (Generic Ambien/Ambien CR)	

- Temazepam 15/30 mg (milligram) capsules (Generic Restoril)

Product Name: Brand Ambien, Brand Ambien CR, zolpidem SL, Edluar, Zolpimist, Belsomra, estazolam, Brand Lunesta, flurazepam, triazolam, Brand Halcion, Brand Restoril, generic temazepam 7.5 mg and 22.5 mg, generic ramelteon, generic doxepin, Brand Silenor, zaleplon, Quviviq, Dayvigo

Diagnosis	Non-Preferred
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - History of failure, contraindication, or intolerance to a trial of at least TWO of the following preferred agents:

- Eszopiclone (Generic Lunesta)
- Zolpidem/Zolpidem ER (Generic Ambien/Ambien CR)
- Temazepam 15/30 mg (milligram) capsules (Generic Restoril)

AND

2 - If the request is for generic ramelteon, patient must have tried and failed Brand Rozerem

Product Name: Brand Ambien, generic zolpidem, Brand Ambien CR, generic zolpidem ER, zolpidem SL, Edluar, Zolpimist, Belsomra, estazolam, generic eszopiclone, Brand Lunesta, flurazepam, triazolam, Brand Halcion, Brand Restoril, generic temazepam, generic ramelteon, Brand Rozerem, generic doxepin, Brand Silenor, zaleplon, Quviviq, Dayvigo

Diagnosis	Greater than 1 hypnotic in 30 days
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The requested medication is being used to adjust the dose of the drug

OR

2 - The requested medication will be used in place of the previously prescribed drug, and not in addition to it

OR

3 - The requested medication dosage form will be used in place of the previously prescribed medication dosage form, and not in addition to it

OR

4 - The physician attests they are aware of the multiple sedative hypnotics prescribed to the patient and feels treatment with both medications is medically necessary (Document rationale for use)

Product Name: Brand Ambien, generic zolpidem, Brand Ambien CR, generic zolpidem ER, zolpidem SL, Edluar, Zolpimist, Belsomra, estazolam, generic eszopiclone, Brand Lunesta, flurazepam, triazolam, Brand Halcion, Brand Restoril, generic temazepam, generic ramelteon, Brand Rozerem, generic doxepin, Brand Silenor, zaleplon, Quviviq, Dayvigo

Diagnosis	Requests for Patients less than 6 years of age
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient is unresponsive to other treatment modalities, unless contraindicated (i.e., other medications or behavioral modification attempted)

AND

2 - The physician attests that the requested medication is medically necessary (Document rationale for use)

2 . Revision History

Date	Notes
4/7/2025	Moved Brand Rozerem from NP section to its own ST criteria section . Updated verbiage in criterion 2 for NP section with no changes to clinical intent. Updated GPI entries for flurazepam due to update in product name.

Sensipar



Prior Authorization Guideline

Guideline ID	GL-442214
Guideline Name	Sensipar
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State New Jersey Medicaid - Community & State New York Medicaid - Community & State New York EPP Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Arizona Medicaid - Community & State Michigan Medicaid - Community & State Virginia Medicaid - Community & State Pennsylvania Medicaid - Community & State Nebraska Medicaid - Community & State Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Nevada

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Sensipar, generic cinacalcet	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Prescribed by or in consultation with an oncologist, endocrinologist, or nephrologist AND 2 - ONE of the following: 2.1 BOTH of the following: • Diagnosis of secondary hyperparathyroidism with chronic kidney disease • Patient is on dialysis OR 2.2 Diagnosis of hypercalcemia with parathyroid carcinoma OR 2.3 ALL of the following: • Diagnosis of primary hyperparathyroidism (HPT) • Severe hypercalcemia [serum calcium level greater than 12.5 mg/dL (milligrams/deciliter)] due to primary HPT • Patient is unable to undergo parathyroidectomy	

Product Name:Brand Sensipar, generic cinacalcet

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has experienced a reduction in serum calcium from baseline	

2 . Revision History

Date	Notes
11/6/2025	Added Nevada Formulary

Sephience (sepiapterin)



Prior Authorization Guideline

Guideline ID	GL-502215
Guideline Name	Sephience (sepiapterin)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Sephience	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of phenylketonuria (PKU)	

AND

2 - Used in conjunction with a phenylalanine (Phe)-restricted diet

AND

3 - Patient will have Phe blood levels measured within 2 weeks of therapy (new starts to therapy only) and periodically for up to 3 months of therapy to determine response

AND

4 - Trial and failure, contraindication, or intolerance to generic sapropterin

Product Name:Sephience	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has had an objective response to therapy, defined as a 15% or greater reduction in phenylalanine (Phe) blood levels from baseline AND 2 - Used in conjunction with a phenylalanine (Phe)-restricted diet AND 3 - Patient will continue to have blood Phe levels measured periodically during therapy	

2 . Revision History

Date	Notes
1/15/2026	Added step through generic sapropterin

Serevent Diskus



Prior Authorization Guideline

Guideline ID	GL-140779
Guideline Name	Serevent Diskus
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	3/19/2023

1 . Criteria

Product Name:Serevent Diskus	
Diagnosis	Asthma
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of asthma	

AND	
2 - Patient is 4 years of age or older	
AND	
3 - Patient is also receiving treatment with an inhaled corticosteroid	

Product Name:Serevent Diskus	
Diagnosis	Exercise-Induced Bronchospasm
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of exercise-induced bronchospasm (EIB) AND 2 - Being used for prevention AND 3 - Patient is 4 years of age or older	

Product Name:Serevent Diskus	
Diagnosis	Bronchospasm associated with chronic obstructive pulmonary disease (COPD)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of bronchospasm associated with chronic obstructive pulmonary disease (COPD)

2 . Revision History

Date	Notes
2/9/2023	Removed TD criteria section.

SGLT-2 Inhibitors



Prior Authorization Guideline

Guideline ID	GL-604198
Guideline Name	SGLT-2 Inhibitors
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Brand Farxiga, generic dapagliflozin	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 ALL of the following: • Patient is 10 years of age or older • Diagnosis of type 2 diabetes mellitus	

- History of failure to metformin at a minimum dose of 1500 mg daily for 90 days, or contraindication or intolerance to metformin

OR

1.2 ONE of the following:

- Diagnosis of chronic kidney disease (CKD)
- Diagnosis of heart failure (NYHA class II-IV) with reduced ejection fraction
- Diagnosis of heart failure (NYHA class II-IV) with preserved ejection fraction

AND

2 - If the request is for generic dapagliflozin, history of failure, intolerance, or contraindication to Brand Farxiga

Product Name: Jardiance	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ALL of the following: • Patient is 10 years of age or older • Diagnosis of type 2 diabetes mellitus • History of failure to metformin at a minimum dose of 1500 mg daily for 90 days, or contraindication or intolerance to metformin OR 2 - BOTH of the following: • Requested medication is being used to reduce the risk of cardiovascular death in adults with type 2 diabetes mellitus and established cardiovascular disease • History of failure to metformin at a minimum dose of 1500 mg daily for 90 days, or contraindication or intolerance to metformin	

OR

3 - Requested medication is being used for ONE of the following:

- To reduce the risk of cardiovascular death and hospitalization for heart failure in adults with heart failure
- To reduce the risk of sustained decline in eGFR, end-stage kidney disease, cardiovascular death, and hospitalization in adults with chronic kidney disease at risk of progression

Product Name:Synjardy, Synjardy XR	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ALL of the following: • Patient is 10 years of age or older • Diagnosis of type 2 diabetes mellitus • History of failure to metformin at a minimum dose of 1500 mg daily for 90 days, or contraindication or intolerance to metformin AND 2 - If the request is for Synjardy XR, history of failure, intolerance, or contraindication to BOTH of the following: • Brand Farxiga • Jardiance	

Product Name:Invokana, Invokamet, Invokamet XR, Segluromet, Steglatro, Trijardy XR	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of type 2 diabetes mellitus

AND

2 - History of failure to metformin at a minimum dose of 1500 mg daily for 90 days, or contraindication or intolerance to metformin

AND

3 - History of failure, intolerance, or contraindication to BOTH of the following:

- Brand Farxiga
- Jardiance

AND

4 - If the request is for Invokana, Invokamet, or Invokamet XR, patient is 10 years of age or older

Product Name: Brand Xigduo XR, generic dapagliflozin-metformin ER	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 ALL of the following: • Patient is 10 years of age or older • Diagnosis of type 2 diabetes mellitus	

- History of failure to metformin at a minimum dose of 1500 mg daily for 90 days, or contraindication or intolerance to metformin

OR

1.2 ONE of the following:

- Diagnosis of chronic kidney disease (CKD)
- Diagnosis of heart failure (NYHA class II-IV) with reduced ejection fraction

AND

2 - If the request is for generic dapagliflozin-metformin, history of failure, intolerance, or contraindication to Brand Xigduo XR

Product Name: Brand Bexagliflozin, Brenzavvy, Glyxambi, Qtern, Dapagliflozin-Saxagliptin, Steglujan

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of type 2 diabetes mellitus

AND

2 - History of failure to metformin at a minimum dose of 1500 mg daily for 90 days, or contraindication or intolerance to metformin

AND

3 - History of failure, intolerance, or contraindication to ALL of the following:

- Janumet or Janumet XR
- Januvia
- Jentadueto

- Onglyza
- Tradjenta
- Trijardy XR
- Brand Farxiga
- Jardiance

Product Name: Inpefa	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Requested medication is being used to reduce the risk of cardiovascular death, hospitalization for heart failure, and urgent heart failure visit in adults with ONE of the following: • Heart failure • Type 2 diabetes mellitus, chronic kidney disease, and other cardiovascular risk factors AND 2 - History of failure, intolerance, or contraindication to Brand Farxiga	

2 . Revision History

Date	Notes
5/7/2026	Added Dapagliflozin-Saxagliptin (MSC N) as a target (same criteria section as Qtern). Updated GPI entries for Farxiga/dapagliflozin and Xigduo XR/dapagliflozin-metformin ER products. Updated prerequisite from "Farxiga" to "Brand Farxiga" throughout guideline, where applicable. Minor cosmetic updates.

Shingrix (zoster vaccine recombinant, adjuvanted)



Prior Authorization Guideline

Guideline ID	GL-140755
Guideline Name	Shingrix (zoster vaccine recombinant, adjuvanted)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	12/1/2022

1 . Criteria

Product Name:Shingrix	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Vaccine is being used for prevention of herpes zoster (shingles) AND	

2 - BOTH of the following:

2.1 Patient is between 18 to 49 years of age*

AND

2.2 Patient is or will be at increased risk of herpes zoster due to immunodeficiency or immunosuppression caused by known disease or therapy

Notes	*Prior authorization is not required for patients 50 years of age and older.

2 . Revision History

Date	Notes
11/7/2022	New guideline following FFS.

Short-Acting Opioid Products



Prior Authorization Guideline

Guideline ID	GL-562228
Guideline Name	Short-Acting Opioid Products
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:butorphanol nasal soln, codeine sulfate, acetaminophen/codeine soln/tabs, generic butalbital/acetaminophen/caffeine/codeine, Brand Fioricet/codeine, Ascomp/codeine, butalbital/aspirin/caffeine/codeine, morphine sulfate oral soln/supp/tabs, hydrocodone/acetaminophen soln, hydrocodone/acetaminophen tabs, hydrocodone/ibuprofen, Brand Dilaudid liqd/tabs, generic hydromorphone liqd/supp/tabs, oxycodone caps/conc/soln/tabs, Brand Roxicodone, Nalocet, oxycodone/acetaminophen tabs/soln, Endocet, Brand Percocet, Prolate tabs/soln, oxymorphone, tramadol tabs, Synapryn Fusepaq, tramadol/acetaminophen, generic tapentadol, meperidine tabs/oral soln, levorphanol tabs, generic acetaminophen/caffeine/dihydrocodeine, Brand Trezix, belladonna/opium supp, opium tinc, pentazocine/naloxone, Qdolo, tramadol soln, Seglantis, Roxybond, oxycodone abuse deterrent tabs, Xyvona	
Diagnosis	PA REQUIRED for use of MAT and other Opioids
Guideline Type	DUR

Approval Criteria

1 - Provider attests to notify the prescriber of the MAT (medication-assisted treatment) therapy and the prescriber of the MAT therapy approves the concurrent opioid therapy

AND

2 - The days supply does not exceed 14 days for a surgical procedure

AND

3 - The days supply does not exceed 5 days for all other requests

AND

4 - There has not been a previous approval in the last 6 months

Notes	Approval Length: 14 Days for surgical procedure, 5 Days for all other requests

Product Name:butorphanol nasal soln, codeine sulfate, generic butalbital/acetaminophen/caffeine/codeine, Brand Fioricet/codeine, Ascomp/codeine, butalbital/aspirin/caffeine/codeine, morphine sulfate 20 mg/mL oral soln, morphine sulfate supp, hydrocodone/acetaminophen 10-300 mg soln, hydrocodone/ibuprofen, Brand Dilaudid liqd/tabs, generic hydromorphone liqd/supp, oxycodone caps/conc, Brand Roxicodone, Nalocet, Brand Percocet, Prolate tabs/soln, oxymorphone, tramadol 25 mg and 75 mg and 100 mg tablets, Synapryn Fusepaq, generic tapentadol, meperidine tabs/oral soln, levorphanol tabs, generic acetaminophen/caffeine/dihydrocodeine, Brand Trezix, belladonna/opium supp, opium tinc, pentazocine/naloxone, Qdolo, tramadol soln, Seglentis, Roxybond, oxycodone abuse deterrent tabs, oxycodone/acetaminophen 10-300 mg soln, Xyvona

Diagnosis	Non-Preferred
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - If the request is for a non-preferred* medication, the patient must have a history of failure, contraindication, or intolerance to a trial of at least FIVE of the following preferred short-acting opioids:

- hydromorphone tablets (generic Dilaudid)
- morphine sulfate IR
- oxycodone IR
- tramadol 50 mg tablets or tramadol-acetaminophen tablets
- oxycodone w/acetaminophen (generic Percocet)
- acetaminophen w/codeine
- hydrocodone-acetaminophen

Notes

*PDL link: <https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP>

Product Name: butorphanol nasal soln, codeine sulfate, acetaminophen/codeine soln/tabs, generic butalbital/acetaminophen/caffeine/codeine, Brand Fioricet/codeine, Ascomp/codeine, butalbital/aspirin/caffeine/codeine, morphine sulfate oral soln/supp/tabs, hydrocodone/acetaminophen soln, hydrocodone/acetaminophen tabs, hydrocodone/ibuprofen, Brand Dilaudid liqd/tabs, generic hydromorphone liqd/supp/tabs, oxycodone caps/conc/soln/tabs, Brand Roxicodone, Nalocet, oxycodone/acetaminophen tabs/soln, Endocet, Brand Percocet, Prolate tabs/soln, oxymorphone, tramadol tabs, Synapryn Fusepaq, tramadol/acetaminophen, generic tapentadol, meperidine tabs/oral soln, levorphanol tabs, generic acetaminophen/caffeine/dihydrocodeine, Brand Trezix, belladonna/opium supp, opium tinc, pentazocine/naloxone, Qdolo, tramadol soln, Seglentis, Roxybond, oxycodone abuse deterrent tabs, Xyvona

Diagnosis

PA Required for > 2 Short Acting Opioids

Guideline Type

Prior Authorization

Approval Criteria

1 - One of the following:

1.1 The requested medication is being used to adjust the dose of the previously prescribed drug

OR

1.2 The requested medication will be used in place of the previously prescribed drug, and not in addition to it

OR

1.3 The requested medication dosage form will be used in place of the previously prescribed medication dosage form, and not in addition to it

OR

1.4 The physician attests they are aware of the multiple short-acting opioids prescribed to the patient and feels treatment with all medications is medically necessary (Document rationale for use)

Notes	Authorization will be issued for the requested duration, not to exceed 12 months.

Product Name:butorphanol nasal soln, codeine sulfate, acetaminophen/codeine soln/tabs, generic butalbital/acetaminophen/caffeine/codeine, Brand Fioricet/codeine, Ascomp/codeine, butalbital/aspirin/caffeine/codeine, morphine sulfate oral soln/supp/tabs, hydrocodone/acetaminophen soln, hydrocodone/acetaminophen tabs, hydrocodone/ibuprofen, Brand Dilaudid liqd/tabs, generic hydromorphone liqd/supp/tabs, oxycodone caps/conc/soln/tabs, Brand Roxicodone, Nalocet, oxycodone/acetaminophen tabs/soln, Endocet, Brand Percocet, Prolate tabs/soln, oxymorphone, tramadol tabs, Synapryn Fusepaq, tramadol/acetaminophen, generic tapentadol, meperidine tabs/oral soln, levorphanol tabs, generic acetaminophen/caffeine/dihydrocodeine, Brand Trezix, belladonna/opium supp, opium tinc, pentazocine/naloxone, Qdolo, tramadol soln, Seglantis, Roxybond, oxycodone abuse deterrent tabs, Xyvona

Approval Length	12 month(s)
Guideline Type	Quantity Limit

Approval Criteria

1 - The requested dose cannot be achieved by moving to a higher strength of the product

AND

2 - The requested dose is within FDA (Food and Drug Administration) approved maximum dose per day, where an FDA maximum dose per day exists (See Table 1 in background section)

Product Name:butorphanol nasal soln, codeine sulfate, acetaminophen/codeine soln/tabs, generic butalbital/acetaminophen/caffeine/codeine, Brand Fioricet/codeine, Ascomp/codeine, butalbital/aspirin/caffeine/codeine, morphine sulfate oral soln/supp/tabs, hydrocodone/acetaminophen soln, hydrocodone/acetaminophen tabs, hydrocodone/ibuprofen, Brand Dilaudid liqd/tabs, generic hydromorphone liqd/supp/tabs, oxycodone caps/conc/soln/tabs, Brand Roxicodone, Nalocet, oxycodone/acetaminophen tabs/soln, Endocet, Brand Percocet, Prolate tabs/soln, oxymorphone, tramadol tabs, Synapryn Fusepaq, tramadol/acetaminophen, generic tapentadol, meperidine tabs/oral soln, levorphanol tabs, generic acetaminophen/caffeine/dihydrocodeine, Brand Trezix, belladonna/opium supp, opium tinc, pentazocine/naloxone, Qdolo, tramadol soln, Seglantis, Roxybond, oxycodone abuse deterrent tabs, Xyvona

Diagnosis	Greater than 5 day supply requests for patients 18 years of age and older
Guideline Type	Quantity Limit
Approval Criteria 1 - ONE of the following conditions or care instances: • Active oncology diagnosis • Hospice care • End-of-life care (other than hospice) • Palliative care • Skilled nursing facility care • Traumatic injury, excluding post-surgical procedures • Chronic conditions for which the provider has received PA (prior authorization) approval • Post-surgical procedures	
Notes	Approvals are for 6 months for all of the listed conditions with the exception of post-surgical procedures which can be approved for a 14 day supply. Adults may obtain additional fills without PA if the refill is requested within 60 days from the initial fill.

Product Name:butorphanol nasal soln, codeine sulfate, acetaminophen/codeine soln/tabs, generic butalbital/acetaminophen/caffeine/codeine, Brand Fioricet/codeine, Ascomp/codeine, butalbital/aspirin/caffeine/codeine, morphine sulfate oral soln/supp/tabs,

hydrocodone/acetaminophen soln, hydrocodone/acetaminophen tabs, hydrocodone/ibuprofen, Brand Dilaudid liqd/tabs, generic hydromorphone liqd/supp/tabs, oxycodone caps/conc/soln/tabs, Brand Roxicodone, Nalocet, oxycodone/acetaminophen tabs/soln, Endocet, Brand Percocet, Prolate tabs/soln, oxymorphone, tramadol tabs, Synapryn Fusepaq, tramadol/acetaminophen, generic tapentadol, meperidine tabs/oral soln, levorphanol tabs, generic acetaminophen/caffeine/dihydrocodeine, Brand Trezix, belladonna/opium supp, opium tinc, pentazocine/naloxone, Qdolo, tramadol soln, Seglantis, Roxybond, oxycodone abuse deterrent tabs, Xyvona	
Diagnosis	Greater than 5 day supply requests for patients under 18 years of age
Guideline Type	Quantity Limit
Approval Criteria 1 - ONE of the following conditions or care instances: • Active oncology diagnosis • Hospice care • End-of-life care (other than hospice) • Palliative care • Children on opioid wean at time of hospital discharge • Skilled nursing facility care • Traumatic injury, excluding post-surgical procedures • Chronic conditions for which the provider has received PA (prior authorization) approval • Post-surgical procedures	
Notes	Approvals are for 6 months for all of the listed conditions with the exception of post-surgical procedures which can be approved for a 14 day supply. Children and adolescents may obtain additional fills without P A for 5 days supply unless the submitted PA supports a longer duration for use.

Product Name:butorphanol nasal soln, codeine sulfate, acetaminophen/codeine soln/tabs, generic butalbital/acetaminophen/caffeine/codeine, Brand Fioricet/codeine, Ascomp/codeine, butalbital/aspirin/caffeine/codeine, morphine sulfate oral soln/supp/tabs, hydrocodone/acetaminophen soln, hydrocodone/acetaminophen tabs, hydrocodone/ibuprofen, Brand Dilaudid liqd/tabs, generic hydromorphone liqd/supp/tabs, oxycodone caps/conc/soln/tabs, Brand Roxicodone, Nalocet, oxycodone/acetaminophen tabs/soln, Endocet, Brand Percocet, Prolate tabs/soln, oxymorphone, tramadol tabs, Synapryn Fusepaq, tramadol/acetaminophen, generic tapentadol, meperidine tabs/oral soln, levorphanol tabs, generic acetaminophen/caffeine/dihydrocodeine, Brand Trezix, belladonna/opium supp, opium tinc, pentazocine/naloxone, Qdolo, tramadol soln, Seglantis, Roxybond, oxycodone abuse deterrent tabs, Xyvona

Diagnosis	Cancer/Hospice/End of Life/Palliative Care/Skilled Nursing Facility/Traumatic Injury Related Pain Exceeding the 90 MME Cumulative Threshold*
Approval Length	12 month(s)
Guideline Type	Morphine Milligram Equivalents (MME) Reviews* (MME 90.00 exceeded; PA REQUIRED; Dosage Above MEDD Limit)
Approval Criteria 1 - ONE of the following conditions: • Active oncology diagnosis • Hospice • End-of-life care (other than hospice) • Palliative care • Skilled nursing facility care • Traumatic injury, including burns and excluding post-surgical procedures	
Notes	*The authorization should be entered for an MME of 9999 so as to prevent future disruptions in therapy if the patient's dose is increased.

Product Name:butorphanol nasal soln, codeine sulfate, acetaminophen/codeine soln/tabs, generic butalbital/acetaminophen/caffeine/codeine, Brand Fioricet/codeine, Ascomp/codeine, butalbital/aspirin/caffeine/codeine, morphine sulfate oral soln/supp/tabs, hydrocodone/acetaminophen soln, hydrocodone/acetaminophen tabs, hydrocodone/ibuprofen, Brand Dilaudid liqd/tabs, generic hydromorphone liqd/supp/tabs, oxycodone caps/conc/soln/tabs, Brand Roxicodone, Nalocet, oxycodone/acetaminophen tabs/soln, Endocet, Brand Percocet, Prolate tabs/soln, oxymorphone, tramadol tabs, Synapryn Fusepaq, tramadol/acetaminophen, generic tapentadol, meperidine tabs/oral soln, levorphanol tabs, generic acetaminophen/caffeine/dihydrocodeine, Brand Trezix, belladonna/opium supp, opium tinc, pentazocine/naloxone, Qdolo, tramadol soln, Seglantis, Roxybond, oxycodone abuse deterrent tabs, Xyvona	
Diagnosis	Non-cancer/non-hospice/non-end of life/non-palliative care/non-skilled nursing facility/non-traumatic injury related pain Exceeding the 90 MME Cumulative Threshold*
Therapy Stage	Initial Authorization
Guideline Type	Morphine Milligram Equivalents (MME) Reviews** (MME 90.00 exceeded; PA REQUIRED; Dosage Above MEDD Limit)

Approval Criteria

1 - Prescriber attests to ALL of the following:

1.1 The information provided is true and accurate to the best of their knowledge and they understand that a routine audit may be performed and the medical information necessary to verify the accuracy of the information provided may be requested

AND

1.2 Treatment goals are defined, including estimated duration of treatment

AND

1.3 Treatment plan includes the use of a non-opioid analgesic and/or non-pharmacologic intervention

AND

1.4 Patient has been screened for substance abuse/opioid dependence

AND

1.5 If used in patients with medical comorbidities or if used concurrently with a benzodiazepine or other drugs that could potentially cause drug-drug interactions, the prescriber has acknowledged that they have completed an assessment of increased risk for respiratory depression

AND

2 - BOTH of the following:

- Patient has tried and failed non-opioid pain medication (document drug name and date of trial)
- Opioid medication doses of less than 90 morphine milligram equivalent (MME) have been tried and did not adequately control pain (document drug regimen or MME and dates of therapy)**

Notes	*Authorization will be issued for 6 months for non-cancer/non-hospice/non-end-of-life/non-palliative care/non-skilled nursing facility/non-traumatic injury related pain related pain up to the current requested MME plus 90 MME. **If the member has been established on the requested MME dose for at least 30 days and does not meet the medical necessity authorization criteria requirements, a denial should be issued and a maximum 30-day authorization may be authorized one time for the requested MME dose.

Product Name:butorphanol nasal soln, codeine sulfate, acetaminophen/codeine soln/tabs, generic butalbital/acetaminophen/caffeine/codeine, Brand Fioricet/codeine, Ascomp/codeine, butalbital/aspirin/caffeine/codeine, morphine sulfate oral soln/supp/tabs, hydrocodone/acetaminophen soln, hydrocodone/acetaminophen tabs, hydrocodone/ibuprofen, Brand Dilaudid liqd/tabs, generic hydromorphone liqd/supp/tabs, oxycodone caps/conc/soln/tabs, Brand Roxicodone, Nalocet, oxycodone/acetaminophen tabs/soln, Endocet, Brand Percocet, Prolate tabs/soln, oxymorphone, tramadol tabs, Synapryn Fusepaq, tramadol/acetaminophen, generic tapentadol, meperidine tabs/oral soln, levorphanol tabs, generic acetaminophen/caffeine/dihydrocodeine, Brand Trezix, belladonna/opium supp, opium tinc, pentazocine/naloxone, Qdolo, tramadol soln, Seglensis, Roxybond, oxycodone abuse deterrent tabs, Xyvona	
Diagnosis	Non-cancer/non-hospice/non-end of life/non-palliative care/non-skilled nursing facility/non-traumatic injury related pain Exceeding the 90 MME Cumulative Threshold*
Therapy Stage	Reauthorization
Guideline Type	Morphine Milligram Equivalents (MME) Reviews** (MME 90.00 exceeded; PA REQUIRED; Dosage Above MEDD Limit)
Approval Criteria 1 - Prescriber attests to ALL of the following: 1.1 The information provided is true and accurate to the best of their knowledge and they understand that a routine audit may be performed and the medical information necessary to verify the accuracy of the information provided may be requested AND 1.2 Treatment goals are defined, including estimated duration of treatment	

AND

1.3 Treatment plan includes the use of a non-opioid analgesic and/or non-pharmacologic intervention

AND

1.4 Patient has been screened for substance abuse/opioid dependence

AND

1.5 If used in patients with medical comorbidities or if used concurrently with a benzodiazepine or other drugs that could potentially cause drug-drug interactions, the prescriber has acknowledged that they have completed an assessment of increased risk for respiratory depression

AND

2 - Identify rationale for not tapering and discontinuing opioid (Document rationale)

AND

3 - Patient demonstrates meaningful improvement in pain and function (Document improvement in function or pain score improvement)**

Notes	*Authorization will be issued for 6 months for non-cancer/non-hospice/non-end-of-life/non-palliative care/non-skilled nursing facility/non-traumatic injury related pain related pain up to the current requested MME plus 90 MME. **If the member has been established on the requested MME dose for at least 30 days and does not meet the medical necessity authorization criteria requirements, a denial should be issued and a maximum 30-day authorization may be authorized one time for the requested MME dose.

2 . Background

Benefit/Coverage/Program Information**Table 1. CDC Recommended Opioid Maximum Morphine Milligram Equivalents per Day***

Active Ingredient	FDA Label Max Daily Doses	90 MME Equivalent (mg/day) (non treatment naïve)
Morphine	None	90mg
Hydromorphone	None	22.5mg
Hydrocodone	None	90mg
Tapentadol	600mg IR products	225mg
Oxymorphone	None	30mg
Oxycodone	None	60mg
Codeine	360mg	600mg
Pentazocine	None	243mg
Tramadol	400mg IR products	900mg
Meperidine	600mg	900mg
Butorphanol	None	12.86mg
Opium	4 suppositories/day Deodorized tincture: 24mg/day Camphorated tincture: 16mg/day	90mg
Levorphanol	None	8.18mg
Acetaminophen	4000 mg	N/A

*Doses are not considered equianalgesic and table does not represent a dose conversion chart.

3 . Revision History

Date	Notes
4/7/2026	Added generic tapentadol products as targets. Removed Brand Nucynta products as targets. Updated product name lists and GPI tables throughout guideline.

Signifor



Prior Authorization Guideline

Guideline ID	GL-140853
Guideline Name	Signifor
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2020

1 . Criteria

Product Name:Signifor	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Both of the following: 1.1 Diagnosis of endogenous Cushing's disease (i.e., hypercortisolism is not a result of chronic administration of high dose glucocorticoids)	

AND

1.2 One of the following:

- Pituitary surgery has not been curative for the patient
- Patient is not a candidate for pituitary surgery

Product Name:Signifor	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Signifor therapy	

2 . Revision History

Date	Notes
3/31/2020	Bulk copy C&S New York SP to C&S Arizona SP for 5/1 effective

Simponi (golimumab)



Prior Authorization Guideline

Guideline ID	GL-452192
Guideline Name	Simponi (golimumab)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	12/1/2025

1 . Criteria

Product Name:Simponi SC	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) or verification of paid claims documenting ALL of the following:	

1.1 Diagnosis of moderately to severely active rheumatoid arthritis (RA)

AND

1.2 ONE of the following:

1.2.1 Patient is receiving concurrent therapy with methotrexate (e.g., Rheumatrex, Trexall)

OR

1.2.2 History of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

1.3 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred^ adalimumab biosimilar or Enbrel (etanercept)
- Infliximab (Janssen manufacturer)
- Oencia (abatacept)
- Xeljanz (tofacitinib) oral tablet (IR or XR)
- A preferred^ tocilizumab biosimilar

AND

2 - Prescribed by or in consultation with a rheumatologist

Notes	^PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name: Simponi SC	
Diagnosis	Ankylosing Spondylitis (AS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) or verification of paid claims documenting ALL of the following:

1.1 Diagnosis of active ankylosing spondylitis (AS)

AND

1.2 History of failure to TWO NSAIDs (non-steroidal anti-inflammatory drugs) (e.g., ibuprofen, naproxen) at maximally indicated doses, each used for at least 4 weeks within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced

AND

1.3 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred^ adalimumab biosimilar or Enbrel (etanercept)
- Infliximab (Janssen manufacturer)
- Xeljanz (tofacitinib) oral tablet (IR or XR)

AND

2 - Prescribed by or in consultation with a rheumatologist

Notes	^PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name: Simponi SC	
Diagnosis	Rheumatoid Arthritis (RA), Ankylosing Spondylitis (AS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) demonstrating positive clinical response to therapy

AND

2 - Prescribed by or in consultation with a rheumatologist

Product Name: Simponi SC

Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) or verification of paid claims documenting ALL of the following:

1.1 Diagnosis of active psoriatic arthritis (PsA)

AND

1.2 History of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

1.3 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred^ adalimumab biosimilar or Enbrel (etanercept)

- Infliximab (Janssen manufacturer)
- Orencia (abatacept)
- Otezla (apremilast)
- Xeljanz (tofacitinib) oral tablet (IR or XR)
- A preferred^ ustekinumab biosimilar

AND

2 - Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Dermatologist

Notes

^PDL link: <https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP>

Product Name: Simponi SC

Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) demonstrating positive clinical response to therapy

AND

2 - Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Dermatologist

Product Name: Simponi SC

Diagnosis	Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) or verification of paid claims documenting ALL of the following: 1.1 Diagnosis of moderately to severely active ulcerative colitis (UC) AND 1.2 Patient weighs at least 15 kg (kilograms) AND 1.3 ONE of the following: 1.3.1 Patient is corticosteroid dependent (i.e., an inability to successfully taper corticosteroids without a return of the symptoms of UC) OR 1.3.2 History of failure to ONE of the following conventional therapies at maximally indicated doses within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced: • Corticosteroids (e.g., prednisone, methylprednisolone, budesonide) • 6-mercaptopurine (Purinethol) • Azathioprine (Imuran) • Aminosalicylates (e.g., mesalamine, sulfasalazine) AND 1.4 History of failure, contraindication, or intolerance to ALL of the following:	

• A preferred^ adalimumab biosimilar • Infliximab (Janssen manufacturer) • Xeljanz (tofacitinib) oral tablet (IR or XR) • A preferred^ ustekinumab biosimilar AND 2 - Prescribed by or in consultation with a gastroenterologist	
Notes	^PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name: Simponi SC	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) demonstrating positive clinical response to therapy AND 2 - Prescribed by or in consultation with a gastroenterologist	

2 . Revision History

Date	Notes
11/18/2025	Added weight requirement to initial auth section for UC. Moved prescriber requirement to it's own separate criterion in initial auth section for all indications.

Sivextro (tedizolid)



Prior Authorization Guideline

Guideline ID	GL-256197
Guideline Name	Sivextro (tedizolid)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	6/1/2025

1 . Criteria

Product Name:Sivextro tablets	
Diagnosis	Skin and Skin Structure Infections
Approval Length	6 Day(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 For continuation of therapy upon hospital discharge	

OR

1.2 As continuation of therapy when transitioning from intravenous antibiotics that are shown to be sensitive to the cultured organism for the requested indication.

OR

1.3 ALL of the following:

1.3.1 Diagnosis of acute bacterial skin and skin structure infection (including diabetic foot infections)

AND

1.3.2 BOTH of the following:

- Patient is at least 26 weeks gestational age
- Patient weighs at least 1 kg (kilogram)

AND

1.3.3 ONE of the following diagnoses:

1.3.3.1 BOTH of the following:

- Acute bacterial skin and skin structure infections
- Infection caused by methicillin-resistant *Staphylococcus aureus* (MRSA) documented by culture and sensitivity report

OR

1.3.3.2 BOTH of the following:

- Empirical treatment of patients with acute bacterial skin and skin structure infections
- Presence of MRSA infection is likely

AND

1.3.4 History of failure, contraindication, or intolerance to linezolid (generic Zyvox)

AND

1.3.5 History of failure, contraindication, or intolerance to ONE of the following antibiotics:

- Sulfamethoxazole-trimethoprim (SMX-TMP)
- A tetracycline
- Clindamycin

OR

1.4 ALL of the following:

1.4.1 Diagnosis of acute bacterial skin and skin structure infection(including diabetic foot infections)

AND

1.4.2 BOTH of the following:

- Patient is at least 26 weeks gestational age
- Patient weighs at least 1 kg

AND

1.4.3 Infection caused by an organism that is confirmed to be or likely to be susceptible to treatment with Sivextro

AND

1.4.4 History of failure, contraindication, or intolerance to linezolid (generic Zyvox)

AND

1.4.5 History of failure, contraindication, or intolerance to TWO of the following antibiotics:

- Dicloxacillin
- A cephalosporin
- A tetracycline
- Amoxicillin/clavulanate
- Clindamycin
- Sulfamethoxazole-trimethoprim (SMX-TMP)
- A fluoroquinolone

Product Name:Sivextro tablets	
Diagnosis	Off-Label Uses
Approval Length	60 Day(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following: 1.1 For continuation of therapy upon hospital discharge OR 1.2 As continuation of therapy when transitioning from intravenous antibiotics that are shown to be sensitive to the cultured organism for the requested indication OR 1.3 BOTH of the following: 1.3.1 The medication is being prescribed by or in consultation with an infectious disease specialist	

AND

1.3.2 History of failure, contraindication, or intolerance to linezolid (generic Zyvox), if culture and susceptibility confirm susceptibility.

2 . Revision History

Date	Notes
5/7/2025	Updated guideline name and product names. Added age and weight criteria to Skin and Skin Structure Infections section.

Skyclarys



Prior Authorization Guideline

Guideline ID	GL-145462
Guideline Name	Skyclarys
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2024

1 . Criteria

Product Name:Skyclarys	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting BOTH of the following: • Diagnosis of Friedreich's ataxia	

- Confirmed presence of a mutation in the frataxin (FXN) gene

AND

2 - Prescribed by or in consultation with ONE of the following:

- Neurologist
- Neurogeneticist
- Physiatrist (Physical Medicine and Rehabilitation Specialist)

Product Name:Skyclarys	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy (e.g., slowed disease progression, improvement in or stabilization of speech or swallowing, upper/lower limb coordination, upright stability) AND 2 - Prescribed by or in consultation with ONE of the following: • Neurologist • Neurogeneticist • Physiatrist (Physical Medicine and Rehabilitation Specialist)	

2 . Revision History

Date	Notes

4/5/2024	Updated criteria to remove mFARS scoring. Addition of specialist for re-auth.

Skyrizi (risankizumab-rzaa)



Prior Authorization Guideline

Guideline ID	GL-324228
Guideline Name	Skyrizi (risankizumab-rzaa)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	8/1/2025

1 . Criteria

Product Name:Skyrizi SC 150 mg*	
Diagnosis	Plaque Psoriasis (PsO)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) or verification of paid claims documenting ALL of the following:	

1.1 Diagnosis of moderate to severe plaque psoriasis (PsO)

AND

1.2 Greater than or equal to 3 percent body surface area involvement, palmoplantar, facial, or genital involvement, or severe scalp psoriasis

AND

1.3 Minimum duration of a 4-week trial and failure, contraindication, or intolerance to ONE of the following topical therapies:

- corticosteroids (e.g., betamethasone, clobetasol, desonide)
- vitamin D analogs (e.g., calcitriol, calcipotriene)
- tazarotene
- calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)

AND

1.4 History of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

1.5 History of failure, contraindication, or intolerance to ONE of the following topical therapies:

- Vtama
- Zoryve 0.3% cream

AND

1.6 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred^ adalimumab biosimilar or Enbrel (etanercept)
- infliximab
- Otezla (apremilast)

A preferred^ ustekinumab biosimilar	
AND	
2 - Prescribed by or in consultation with a dermatologist	
Notes	*If patient meets criteria above, please approve at GPI-14. ^PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:Skyrizi SC 150 mg*	
Diagnosis	Plaque Psoriasis (PsO)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy AND 2 - Prescribed by or in consultation with a dermatologist	
Notes	*If patient meets criteria above, please approve at GPI-14.

Product Name:Skyrizi SC 150 mg*	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) or verification of paid claims documenting ALL of the following:

1.1 Diagnosis of active psoriatic arthritis (PsA)

AND

1.2 History of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

1.3 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred^ adalimumab biosimilar or Enbrel (etanercept)
- infliximab
- Orenia (abatacept)
- Otezla (apremilast)
- Xeljanz (tofacitinib) oral tablet (IR or XR)
- A preferred^ ustekinumab biosimilar

AND

2 - Prescribed by or in consultation with ONE of the following:

- Dermatologist
- Rheumatologist

Notes	*If patient meets criteria above, please approve at GPI-14. ^PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:Skyrizi SC 150 mg*

Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy AND 2 - Prescribed by or in consultation with ONE of the following: • Dermatologist • Rheumatologist	
Notes	*If patient meets criteria above, please approve at GPI-14.

Product Name:Skyrizi SC 180 mg*, 360 mg*	
Diagnosis	Crohn's Disease (CD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) or verification of paid claims documenting ALL of the following: 1.1 Diagnosis of moderately to severely active Crohn's disease (CD) AND	

1.2 History of failure, contraindication, or intolerance to ONE of the following conventional therapies:

- 6-mercaptopurine
- Azathioprine
- Methotrexate
- Corticosteroid (e.g., prednisone)

AND

1.3 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred^ adalimumab biosimilar
- infliximab
- A preferred^ ustekinumab biosimilar

AND

2 - Will be used as a maintenance dose following the intravenous induction doses

AND

3 - Prescribed by or in consultation with a gastroenterologist

Notes	*If patient meets criteria above, please approve at GPI-14. ^PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:Skyrizi SC 180 mg*, 360 mg*	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) or verification of paid claims documenting ALL of the following:

1.1 Diagnosis of moderately to severely active ulcerative colitis (UC)

AND

1.2 History of failure, contraindication, or intolerance to ONE of the following conventional therapies:

- 6-mercaptopurine
- Azathioprine
- Corticosteroid (e.g., prednisone)
- Aminosalicylate (e.g., mesalamine, olsalazine, sulfasalazine)

AND

1.3 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred^ adalimumab biosimilar
- infliximab
- Xeljanz (tofacitinib) oral tablet (IR or XR)
- A preferred^ ustekinumab biosimilar

AND

2 - Will be used as a maintenance dose following the intravenous induction doses

AND

3 - Prescribed by or in consultation with a gastroenterologist

Notes	*If patient meets criteria above, please approve at GPI-14. ^PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:Skyrizi SC 180 mg*, 360 mg*	
Diagnosis	Crohn's Disease (CD), Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy as evidenced by at least ONE of the following: - Improvement in intestinal inflammation (e.g., mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline - Reversal of high fecal output state AND 2 - Prescribed by or in consultation with a gastroenterologist	
Notes	*If patient meets criteria above, please approve at GPI-14.

2 . Revision History

Date	Notes
7/15/2025	Updates to initial and reauth sections for all indications.

Skysona (elivaldogene autotemcel)



Prior Authorization Guideline

Guideline ID	GL-448216
Guideline Name	Skysona (elivaldogene autotemcel)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	12/1/2025

1 . Criteria

Product Name:Skysona	
Approval Length	1 Time Authorization in Lifetime
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming diagnosis of early, active cerebral adrenoleukodystrophy (CALD) AND	

2 - Submission of medical records (e.g., chart notes) documenting molecular genetic testing confirms mutation in the ABCD1 gene

AND

3 - Submission of medical records (e.g., chart notes) confirming ALL of the following:

- Patient has elevated very long chain fatty acid (VLCFA) levels
- Loes score between 0.5 and 9 (inclusive) based on brain magnetic resonance imaging (MRI) assessment
- Brain MRI utilizes Gadolinium enhancement (GdE +) and demonstrates demyelinating lesions
- Neurologic function score (NFS) less than or equal to 1

AND

4 - BOTH of the following:

- Patient is male sex
- Patient is 4 to 17 years of age

AND

5 - Patient does NOT have an available human leukocyte antigen (HLA)-matched donor for allogeneic hematopoietic stem cell transplant

AND

6 - Submission of medical records (e.g., chart notes) confirming patient has obtained a negative test result for ALL of the following prior to cell collection:

- Hepatitis B virus (HBV)
- Hepatitis C virus (HCV)
- Human T-lymphotropic virus 1 and 2 (HTLV-1/HTLV-2)
- Human immunodeficiency virus (HIV)

AND

7 - Patient does NOT have CALD secondary to head trauma

AND

8 - Discontinue prophylactic anti-retroviral medications (e.g., Truvada, Descovy) for at least one month prior to initiating medications for stem cell mobilization and until all cycles of apheresis are completed

AND

9 - Prescribed by a stem cell transplant physician from a qualified treatment center

AND

10 - Provider is aware of hematologic malignancy risk and attests they will complete adequate baseline hematologic assessments [e.g., complete blood count with differential, hematopathology review of peripheral blood smear, and bone marrow biopsy (core and aspirate) with flow cytometry] and monitoring as indicated in prescribing information

AND

11 - Patient has never received Skysona treatment in their lifetime

2 . Revision History

Date	Notes
11/10/2025	New program for ACUAZ/ACUAZEC.

Sodium Oxybate Products (Lumryz, Xyrem, Xywav)



Prior Authorization Guideline

Guideline ID	GL-164853
Guideline Name	Sodium Oxybate Products (Lumryz, Xyrem, Xywav)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	3/1/2025

1 . Criteria

Product Name:Lumryz, Xyrem, Brand Sodium Oxybate, Xywav	
Diagnosis	Narcolepsy with Cataplexy (i.e., Narcolepsy Type 1)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g. chart notes, laboratory values) documenting a diagnosis of narcolepsy with cataplexy (i.e., Narcolepsy Type 1) with BOTH of the following:	

1.1 The patient has daily periods of irrepressible need to sleep or daytime lapses into sleep occurring for at least three months

AND

1.2 A mean sleep latency of less than or equal to 8 minutes and two or more sleep onset rapid eye movement (REM) periods (SOREMPs) on a Multiple Sleep Latency Test (MSLT) performed according to standard techniques following a normal overnight polysomnogram. A SOREMP (within 15 minutes of sleep onset) on the preceding nocturnal polysomnogram may replace one of the SOREMPs on the MSLT

AND

2 - Physician attestation to BOTH of the following:

2.1 Patient has experienced cataplexy defined as more than one episode of sudden loss of muscle tone with retained consciousness

AND

2.2 Other causes of sleepiness have been ruled out or treated (including but not limited to obstructive sleep apnea, insufficient sleep syndrome, shift work, the effects of substances or medications, or other sleep disorders)

AND

3 - Prescribed by ONE of the following:

- Neurologist
- Psychiatrist
- Sleep Medicine Specialist

AND

4 - Patient is 7 years of age or older

Product Name:Lumryz, Xyrem, Brand Sodium Oxybate, Xywav	
Diagnosis	Narcolepsy with Cataplexy (i.e., Narcolepsy Type 1)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting a reduction in frequency of cataplexy attacks associated with therapy OR 2 - Documentation demonstrating reduction in symptoms of excessive daytime sleepiness associated with therapy	

Product Name:Lumryz, Xyrem, Brand Sodium Oxybate, Xywav	
Diagnosis	Narcolepsy without Cataplexy (i.e., Narcolepsy Type 2)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g. chart notes, lab values) documenting a diagnosis of narcolepsy without cataplexy (i.e., Narcolepsy Type 2) with BOTH of the following: 1.1 The patient has daily periods of irrepressible need to sleep or daytime lapses into sleep occurring for at least three months AND 1.2 A mean sleep latency of less than or equal to 8 minutes and two or more sleep onset rapid eye movement (REM) periods (SOREMPs) are found on a Multiple Sleep Latency Test	

(MSLT) performed according to standard techniques following a normal overnight polysomnogram. A SOREMP (within 15 minutes of sleep onset) on the preceding nocturnal polysomnogram may replace one of the SOREMPs on the MSLT

AND

2 - Physician attestation to BOTH of the following:

2.1 Cataplexy is absent

AND

2.2 Other causes of sleepiness have been ruled out or treated (including but not limited to obstructive sleep apnea, insufficient sleep syndrome, shift work, the effects of substances or medications or their withdrawal, sleep phase disorder, or other sleep disorders)

AND

3 - History of failure, contraindication, or intolerance of ALL of the following (MUST be verified via paid pharmacy claims or submission of medical records):

3.1 ONE of the following:

- Amphetamine based stimulant (e.g., amphetamine, dextroamphetamine)
- Methylphenidate based stimulant

AND

3.2 Armodafanil (Nuvigil)

AND

3.3 Sunosi (solriamfetol)

AND

4 - Prescribed by ONE of the following:

- Neurologist
- Psychiatrist
- Sleep Medicine Specialist

AND

5 - Patient is 7 years of age or older

Product Name:Lumryz, Xyrem, Brand Sodium Oxybate, Xywav

Diagnosis	Narcolepsy without Cataplexy (i.e., Narcolepsy Type 2)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting reduction in symptoms of excessive daytime sleepiness associated with therapy

Product Name:Xywav

Diagnosis	Idiopathic Hypersomnia (IH)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of idiopathic hypersomnia (IH) confirmed by ALL of the following:

1.1 Patient has experienced daily periods of irrepressible need for sleep or daytime lapses into sleep (i.e., excessive daytime sleepiness) for at least 3 months

AND

1.2 A multiple sleep latency test (MSLT) documents fewer than two sleep-onset rapid eye movement periods (SOREMPs), or no SOREMPs if the REM sleep latency on the preceding polysomnogram was less than or equal to 15 minutes

AND

1.3 The presence of at least ONE of the following:

- MSLT shows a mean sleep latency of less than or equal to 8 minutes
- Total 24-hour sleep time is greater than or equal to 660 minutes (typically 12 to 14 hours) on 24-hour polysomnography or by wrist actigraphy in association with a sleep log

AND

2 - Physician attestation to BOTH of the following:

2.1 Cataplexy is absent

AND

2.2 Other causes of sleepiness have been ruled out or treated (including but not limited to obstructive sleep apnea, insufficient sleep syndrome, shift work, the effects of substances or medications or their withdrawal, sleep phase disorder, or other sleep disorders)

AND

3 - Prescribed by ONE of the following:

- Neurologist
- Psychiatrist
- Sleep Medicine Specialist

AND

4 - History of failure, contraindication, or intolerance of ALL of the following (MUST be verified via paid pharmacy claims or submission of medical records):

- An amphetamine or methylphenidate based stimulant
- Modafinil
- Armodafinil

Product Name:Xywav	
Diagnosis	Idiopathic Hypersomnia (IH)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting reduction in symptoms of excessive daytime sleepiness associated with therapy	

2 . Revision History

Date	Notes
2/6/2025	Updated prescriber requirement verbiage for IH in initial auth section.

Sofdra (sofpironium)



Prior Authorization Guideline

Guideline ID	GL-369192
Guideline Name	Sofdra (sofpironium)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	9/1/2025

1 . Criteria

Product Name:Sofdra	
Approval Length	6 Week(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of primary axillary hyperhidrosis	

AND

2 - Patient has experienced symptoms of disease for a duration of at least 6 months

AND

3 - Patient is 9 years of age or older

AND

4 - Provider attests other causes of axillary hyperhidrosis have been ruled out (e.g., menopause, medications)

AND

5 - Disease frequently interferes with daily activities (e.g., lower productivity at work, lower psychosocial wellbeing)

AND

6 - Trial and failure (minimum 6 weeks supply), contraindication, or intolerance to a topical prescription strength drying agent [e.g., Drysol, Xerac AC (aluminum chloride hexahydrate)]

AND

7 - Trial and failure, contraindication, or intolerance to Botox

AND

8 - Prescribed by or in consultation with a dermatologist

Product Name:Sofdra

Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient demonstrates positive clinical response to therapy (e.g., improvement in productivity, improvement in psychosocial wellbeing)	

2 . Revision History

Date	Notes
8/13/2025	Removed Qbrexza as a prerequisite in initial auth section.

Sohonos (palovarotene)



Prior Authorization Guideline

Guideline ID	GL-141019
Guideline Name	Sohonos (palovarotene)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name:Sohonos	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting ALL of the following: 1.1 Diagnosis of Fibrodysplasia Ossificans Progressiva (FOP)	

AND

1.2 Molecular genetic testing confirms mutation in the ACVR1 gene

AND

1.3 One of the following:

1.3.1 Both of the following:

- Patient is female
- Patient is 8 years of age or older

OR

1.3.2 Both of the following:

- Patient is male
- Patient is 10 years of age or older

AND

2 - Prescribed by or in consultation with one of the following:

- Geneticist
- Orthopedic physician
- Rheumatologist
- Endocrinologist

Product Name:Sohonos	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that patient demonstrates positive clinical response to therapy (e.g., reduction of volume in new abnormal bone growth)

2 . Revision History

Date	Notes
12/6/2023	New guideline

Somavert



Prior Authorization Guideline

Guideline ID	GL-140854
Guideline Name	Somavert
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2020

1 . Criteria

Product Name:Somavert	
Diagnosis	Acromegaly
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - All of the following: 1.1 Diagnosis of acromegaly by ONE of the following:	

- Serum GH (growth hormone) level greater than 1 ng/mL (nanograms per milliliter) after a 2 hour oral glucose tolerance test (OGTT) at time of diagnosis
- Elevated serum IGF-1 (Insulin-like growth factor-1) levels (above the age and gender adjusted normal range as provided by the physician's lab) at time of diagnosis

AND

1.2 One of the following:

1.2.1 Inadequate response to one of the following:

- Surgery
- Radiation therapy
- Dopamine agonist (e.g., bromocriptine, cabergoline) therapy

OR

1.2.2 Not a candidate for all of the following:

- Surgery
- Radiation therapy
- Dopamine agonist (e.g., bromocriptine, cabergoline) therapy

AND

1.3 Inadequate response, intolerance, or contraindication to one of the following somatostatin analogs:

- Sandostatin (octreotide) or Sandostatin LAR
- Somatuline Depot (lanreotide)

OR

2 - Patient is currently on Somavert therapy for acromegaly

Product Name: Somavert	
Diagnosis	Acromegaly

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Somavert therapy	

2 . Revision History

Date	Notes
3/31/2020	Bulk copy C&S New York SP to C&S Arizona SP for 5/1 effective

Soriatane



Prior Authorization Guideline

Guideline ID	GL-140693
Guideline Name	Soriatane
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Brand Soriatane, Generic acitretin	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of severe psoriasis	

AND

2 - Prescribed or recommended by a dermatologist

AND

3 - One of the following:

3.1 Patient is unresponsive to other therapies (e.g., topical corticosteroids, topical vitamin D analogs, tazarotene, methotrexate)

OR

3.2 Other therapies are contraindicated based on the patient's clinical condition

AND

4 - One of the following:

- Greater than or equal to 10% body surface area involvement
- Palmoplantar, facial, or genital involvement
- Severe scalp psoriasis

Product Name:Brand Soriatane, Generic acitretin	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Soriatane therapy	

AND

2 - Prescribed or recommended by a dermatologist

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Sotyktu (deucravacitinib)



Prior Authorization Guideline

Guideline ID	GL-605191
Guideline Name	Sotyktu (deucravacitinib)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Sotyktu	
Diagnosis	Plaque Psoriasis (PsO)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming ALL of the following:	

1.1 Diagnosis of moderate to severe plaque psoriasis (PsO)

AND

1.2 Greater than or equal to 3% body surface area involvement, palmoplantar, facial, or genital involvement, or severe scalp psoriasis

AND

1.3 History of failure to ONE of the following topical therapies, unless contraindicated or clinically significant adverse effects are experienced:

- corticosteroids (e.g., betamethasone, clobetasol)
- vitamin D analogs (e.g., calcitriol, calcipotriene)
- tazarotene
- calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)

AND

1.4 History of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

1.5 History of failure, contraindication, or intolerance to ONE of the following topical therapies:

- Vtama
- Zoryve 0.3% cream

AND

1.6 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred^ adalimumab biosimilar or Enbrel (etanercept)
- infliximab
- Otezla (apremilast)

- A preferred^ ustekinumab biosimilar

AND

2 - Prescribed by or in consultation with a dermatologist

AND

3 - NOT used in combination with other potent immunosuppressants [e.g., azathioprine, cyclosporine, biologic DMARDs (disease-modifying antirheumatic drugs)]*

Notes	*Sotyktu may be used with concomitant methotrexate, topical or inhaled corticosteroids, and/or low stable dosages of oral corticosteroids. ^PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:Sotyktu	
Diagnosis	Plaque Psoriasis (PsO)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming positive clinical response to therapy as evidenced by ONE of the following: • Reduction in the body surface area (BSA) involvement from baseline • Improvement in symptoms (e.g., pruritus, inflammation) from baseline AND 2 - Prescribed by or in consultation with a dermatologist	

AND

3 - NOT used in combination with other potent immunosuppressants [e.g., azathioprine, cyclosporine, biologic DMARDs (disease-modifying antirheumatic drugs)]*

Notes

*Sotyktu may be used with concomitant methotrexate, topical or inhaled corticosteroids, and/or low stable dosages of oral corticosteroids.

Product Name:Sotyktu

Diagnosis Psoriatic Arthritis (PsA)

Approval Length 6 month(s)

Therapy Stage Initial Authorization

Guideline Type Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming ALL of the following:

1.1 Diagnosis of active psoriatic arthritis (PsA)

AND

1.2 ONE of the following:

- Actively inflamed joints
- Dactylitis
- Enthesitis
- Axial disease
- Active skin and/or nail involvement

AND

1.3 History of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

1.4 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred^ adalimumab biosimilar or Enbrel (etanercept)
- infliximab
- Orenzia (abatacept)
- Otezla (apremilast)
- Xeljanz (tofacitinib) oral tablet (IR or XR)
- A preferred^ ustekinumab biosimilar

AND

2 - Prescribed by or in consultation with ONE of the following:

- Dermatologist
- Rheumatologist

AND

3 - NOT used in combination with other potent immunosuppressants [e.g., azathioprine, cyclosporine, biologic DMARDs (disease-modifying antirheumatic drugs)]*

Notes	*Sotyktu may be used with concomitant methotrexate, topical or inhaled corticosteroids, and/or low stable dosages of oral corticosteroids. ^PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:Sotyktu	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming positive clinical response to therapy as evidenced by at least ONE of the following:

- Reduction in the total active (swollen and tender) joint count from baseline
- Improvement in symptoms (e.g., pain, stiffness, pruritus, inflammation) from baseline
- Reduction in the body surface area (BSA) involvement from baseline

AND

2 - Prescribed by or in consultation with ONE of the following:

- Dermatologist
- Rheumatologist

AND

3 - NOT used in combination with other potent immunosuppressants [e.g., azathioprine, cyclosporine, biologic DMARDs (disease-modifying antirheumatic drugs)]*

Notes

*Sotyktu may be used with concomitant methotrexate, topical or inhaled corticosteroids, and/or low stable dosages of oral corticosteroids.

2 . Revision History

Date	Notes
5/6/2026	Added criteria for new PsA indication. For PsO (initial and reauth sections): Added dx header, updated concomitant use criterion, and updated notes section. Minor grammatical update in reauth section for PsO.

Spevigo (spesolimab-sbzo)



Prior Authorization Guideline

Guideline ID	GL-390202
Guideline Name	Spevigo (spesolimab-sbzo)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2025

1 . Criteria

Product Name:Spevigo SC	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming diagnosis of generalized pustular psoriasis (GPP) as defined by BOTH of the following:	

- Primary, sterile, macroscopically visible pustules on non-acral skin (excluding cases where pustulation is restricted to psoriatic plaques)
- Disease is relapsing (> 1 episode) or persistent (> 3 months)

AND

2 - Subcutaneous formulation will NOT be used to treat GPP flare

AND

3 - BOTH of the following:

- Patient is 12 years of age or older
- Patient weighs at least 40 kg (kilograms)

AND

4 - Prescribed by or in consultation with a dermatologist

Product Name:Spevigo SC	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy (e.g., reduction in number of flares)	

2 . Revision History

Date	Notes

9/9/2025	Added new GPI for Spevigo SC syringe. No changes to clinical criteria.

Spinraza



Prior Authorization Guideline

Guideline ID	GL-603205
Guideline Name	Spinraza
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Spinraza	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of spinal muscular atrophy (SMA) type I, II, or III made by, or in consultation with, a neurologist with expertise in the diagnosis of SMA	

AND

2 - Submission of medical records (e.g., chart notes, laboratory values) confirming both of the following:

2.1 The mutation or deletion of genes in chromosome 5q resulting in one of the following:

- Homozygous gene deletion or mutation (e.g., homozygous deletion of exon 7 at locus 5q13)
- Compound heterozygous mutation (e.g., deletion of SMN1 exon 7 [allele 1] and mutation of SMN1 [allele 2])

AND

2.2 Patient has at least 2 copies of SMN2

AND

3 - Patient is not dependent on invasive ventilation or tracheostomy

AND

4 - Patient is not dependent on use of non-invasive ventilation beyond use for naps and nighttime sleep

AND

5 - Submission of medical records (e.g., chart notes, laboratory values) or claims history of the baseline exam of one of the following exams (based on patient age and motor ability) to establish baseline motor ability:

- Hammersmith Infant Neurological Exam Part 2 (HINE-2) (infant to early childhood)
- Hammersmith Functional Motor Scale Expanded (HFMSE)
- Upper Limb Module (ULM) Test (Non ambulatory)
- Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND)

AND

6 - Prescribed by, or in consultation with, a neurologist with expertise in the treatment of SMA

AND

7 - One of the following:

7.1 Patient has not previously received gene replacement therapy for the treatment of SMA

OR

7.2 One of the following:

7.2.1 Both of the following:

7.2.1.1 Patient recently received gene replacement therapy within the previous 6 months

AND

7.2.1.2 Patient has experienced a declination in clinical status since receipt of gene replacement therapy

OR

7.2.2 Both of the following:

7.2.2.1 Patient has previously received gene replacement therapy

AND

7.2.2.2 Patient has experienced a declination in clinical status that represents a potential abatement of gene therapy efficacy

AND

8 - Spinraza is to be administered intrathecally by, or under the direction of, healthcare professionals experienced in performing lumbar punctures

AND

9 - Spinraza dosing for SMA is within accordance with the United States Food and Drug Administration approved labeling: maximum dosing of 12 milligrams for each loading dose

Product Name:Spinraza	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of spinal muscular atrophy (SMA) type I, II, or III made by, or in consultation with, a neurologist with expertise in the diagnosis of SMA AND 2 - Submission of medical records (e.g., chart notes, laboratory values) or claims history confirming both of the following: 2.1 The mutation or deletion of genes in chromosome 5q resulting in one of the following: • Homozygous gene deletion or mutation (e.g., homozygous deletion of exon 7 at locus 5q13) • Compound heterozygous mutation (e.g., deletion of SMN1 exon 7 [allele 1] and mutation of SMN1 [allele 2]) AND 2.2 Patient has at least 2 copies of SMN2	

AND

3 - Patient is not dependent on invasive ventilation or tracheostomy

AND

4 - Patient is not dependent on use of non-invasive ventilation beyond use for naps and nighttime sleep

AND

5 - One of the following:

5.1 Patient has not previously received gene replacement therapy for the treatment of SMA

OR

5.2 Both of the following:

5.2.1 Patient has previously received gene replacement therapy

AND

5.2.2 Patient has experienced a declination in clinical status that represented a potential failure or abatement of gene therapy efficacy

AND

6 - Submission of medical records (e.g., chart notes, laboratory values) or claims history with the most recent results (less than 1 month prior to request) documenting a positive clinical response from pretreatment baseline status to Spinraza therapy as demonstrated by one of the following exams:

6.1 Both of the following for Hammersmith Infant Neurological Exam Part 2 (HINE-2) milestones:

6.1.1 One of the following:

- Improvement or maintenance of previous improvement of at least 2 point (or maximal score) increase in ability to kick
- Improvement or maintenance of previous improvement of at least 1 point increase in any other HINE-2 milestone (e.g., head control, rolling, sitting, crawling, etc.), excluding voluntary grasp

AND

6.1.2 One of the following:

- The patient exhibited improvement or maintenance of previous improvement in more HINE motor milestones than worsening, from pretreatment baseline (net positive improvement)
- Achieved and maintained any new motor milestones when they would otherwise be unexpected to do so (e.g., sit unassisted, stand, walk)

OR

6.2 One of the following for Hammersmith Functional Motor Scale Expanded (HFMSE):

- Improvement or maintenance of previous improvement of at least a 3 point increase in score from pretreatment baseline
- Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so

OR

6.3 One of the following for Upper Limb Module (ULM):

- Improvement or maintenance of previous improvement of at least a 2 point increase in score from pretreatment baseline
- Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so

OR

6.4 One of the following for Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND):

6.4.1 Improvement or maintenance of previous improvement of at least a 4 point increase in score from pretreatment baseline

OR

6.4.2 Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so

OR

6.4.3 Both of the following:

- Patient was prescribed Spinraza due to clinical declination after receipt of gene therapy
- Patients clinical status has stabilized after receipt of Spinraza therapy

AND

7 - Prescribed by, or in consultation with, a neurologist with expertise in the treatment of SMA

AND

8 - Spinraza is to be administered intrathecally by, or under the direction of, healthcare professionals experienced in performing lumbar punctures

AND

9 - Spinraza dosing for SMA is within accordance with the United States Food and Drug Administration approved labeling: maximum dosing of 12 milligrams every 4 months, starting 4 months after the last loading dose

2 . Revision History

Date	Notes

5/6/2026	Added new GPIs

Spravato, ketamine



Prior Authorization Guideline

Guideline ID	GL-415189
Guideline Name	Spravato, ketamine
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	11/1/2025

1 . Criteria

Product Name:Spravato, ketamine	
Diagnosis	Major Depressive Disorder (Treatment-Resistant)
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has a confirmed diagnosis of major depressive disorder as defined by the DSM-V (Diagnostic and Statistical Manual of Mental Disorders) criteria and is treatment resistant	

AND

2 - Patient is 18 years of age or older

AND

3 - Requested medication is prescribed by, or in consultation with, a psychiatric provider

AND

4 - ONE of the following:

4.1 Patient does not have an active substance use disorder (SUD)

OR

4.2 BOTH of the following:

- Patient has an active substance use disorder
- Patient is currently receiving treatment

AND

5 - ONE of the following:

5.1 Patient has experienced an inadequate response during the current depressive episode with BOTH of the following therapies:

5.1.1 TWO antidepressants from at least TWO different classes [must include one of each AHCCCS (Arizona Health Care Cost Containment System) preferred agents: SSRI (selective serotonin reuptake inhibitor), SNRI (serotonin-norepinephrine reuptake inhibitor), or bupropion] having different mechanisms of action at the maximally tolerated labeled dose, each used for at least 4-6 weeks

AND

5.1.2 At least TWO augmentation therapies below for at least 4 weeks:

- SSRI or SNRI, and a second-generation antipsychotic used concomitantly (aripiprazole, quetiapine, risperidone, olanzapine)
- SSRI or SNRI, and lithium used concomitantly
- SSRI or SNRI, and liothyronine (T3) used concomitantly
- SSRI or SNRI, and mirtazapine
- SSRI and bupropion and buspirone

OR

5.2 Patient has active suicidal ideation and urgent symptom control is necessary

AND

6 - Requested medication is used in combination with an oral antidepressant (e.g., duloxetine, escitalopram, sertraline, venlafaxine)

AND

7 - Requested medication is administered under the direct supervision of a healthcare provider

AND

8 - Provider is certified in the Spravato REMS (Risk Evaluation and Mitigation Strategy) program (Applies to Spravato requests ONLY)

AND

9 - Patient must be monitored by a health care provider for at least 2 hours after administration

Product Name: Spravato, ketamine	
Diagnosis	Major Depressive Disorder (Treatment-Resistant)

Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Provider attests that the patient has documented improvement or sustained improvement in depressive symptoms from baseline AND 2 - Patient use of requested medication is in combination with an oral antidepressant AND 3 - Patient administers requested medication under the direct supervision of a healthcare provider AND 4 - Provider is certified in the Spravato REMS (risk evaluation and mitigation strategy) program (applies to Spravato requests ONLY) AND 5 - Patient must continue to be monitored by a health care provider for at least 2 hours after administration	

Product Name: Spravato, ketamine	
Diagnosis	Requests for Patients less than 6 years of age
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient is unresponsive to other treatment modalities, unless contraindicated (i.e., other medications or behavioral modification attempted)

AND

2 - The physician attests that the requested medication is medically necessary. (Document rationale for use)

Product Name: Spravato, ketamine

Diagnosis	Depressive symptoms in an adult with major depressive disorder (MDD) with acute suicidal ideation or behavior

Approval Length	1 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of major depressive disorder according to the current Diagnostic and Statistical Manual of Mental Disorders (DSM) (i.e., DSM-5) criteria

AND

2 - Patient is experiencing an acute suicidal ideation or behavior

AND

3 - Patient is receiving newly initiated or optimized oral antidepressant

AND

4 - Provider and/or the provider's healthcare setting is certified in the Spravato REMS (Risk Evaluation and Mitigation Strategy) program (Applies to Spravato requests ONLY)

2 . Revision History

Date	Notes
10/6/2025	Removed GPI 7040002010E561 for ketamine inj as it is medical. No changes to clinical criteria.

Strensiq



Prior Authorization Guideline

Guideline ID	GL-140903
Guideline Name	Strensiq
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Strensiq	
Diagnosis	perinatal/infantile or juvenile-onset hypophosphatasia (HPP)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - All of the following:	

1.1 Diagnosis of perinatal/infantile or juvenile-onset hypophosphatasia based on all of the following:

1.1.1 One of the following:

- Onset of clinical signs and symptoms of hypophosphatasia prior to age 18 years (e.g., respiratory insufficiency, vitamin B6 responsive seizures, hypotonia, failure to thrive, delayed walking, waddling gait, dental abnormalities, low trauma fractures)
- Radiographic evidence supporting the diagnosis of hypophosphatasia at the age of onset prior to age 18 years (e.g., craniosynostosis, infantile rickets, non-traumatic fractures)

AND

1.1.2 One of the following:

1.1.2.1 Both of the following:

- Patient has low level activity of serum alkaline phosphatase (ALP) evidenced by an ALP level below the age-adjusted normal range
- Patient has an elevated level of tissue non-specific alkaline phosphatase (TNSALP) substrate (e.g. serum pyridoxal 5'-phosphate [PLP] level, serum or urine phosphoethanolamine [PEA] level, urinary inorganic pyrophosphate [PPi level])

OR

1.1.2.2 Confirmation of tissue-nonspecific alkaline phosphatase (TNSALP) gene mutation by ALPL genomic DNA testing*

AND

1.2 Prescribed by one of the following:

- Endocrinologist
- A specialist experienced in the treatment of metabolic bone disorders

AND

1.3 One of the following:

1.3.1 Both of the following:

- Diagnosis of perinatal/infantile-onset hypophosphatasia
- Coverage will be provided up to a maximum supply limit of 9 mg/kg/week

OR

1.3.2 Both of the following:

- Diagnosis of juvenile-onset hypophosphatasia
- Coverage will be provided up to a maximum supply limit of 6 mg/kg/week

AND

1.4 One of the following:

1.4.1 Patient is prescribed Strensiq 18 mg/0.45 mL, Strensiq 28 mg/0.7 mL, or Strensiq 40 mg/mL vials

OR

1.4.2 Both of the following:

- Patient is prescribed Strensiq 80 mg/0.8 mL vial
- Patient's weight is greater than or equal to 40 kg

AND

1.5 Prescriber attests to the following: the information provided is true and accurate to the best of their knowledge and they understand that UnitedHealthcare may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided

Notes	*Results of prior genetic testing can be submitted as confirmation of diagnosis of HPP, however please note that the provider should confirm coverage status of any new genetic testing under the patient's United Healthcare plan prior to ordering

Product Name:Strensiq

Diagnosis	perinatal/infantile or juvenile-onset hypophosphatasia (HPP)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - All of the following: 1.1 Clinically relevant decrease from baseline in tissue non-specific alkaline phosphatase (TNSALP) substrate (e.g. serum pyridoxal 5'-phosphate [PLP] level, serum or urine phosphoethanolamine [PEA] level, urinary inorganic pyrophosphate [PPi level]) AND 1.2 Prescribed by one of the following: • Endocrinologist • A specialist experienced in the treatment of metabolic bone diseases AND 1.3 One of the following: 1.3.1 Both of the following: • Diagnosis of perinatal/infantile-onset hypophosphatasia • Coverage will be provided up to a maximum supply limit of 9 mg/kg/week OR 1.3.2 Both of the following: • Diagnosis of juvenile-onset hypophosphatasia • Coverage will be provided up to a maximum supply limit of 6 mg/kg/week	

AND

1.4 One of the following:

1.4.1 Patient is prescribed Strensiq 18 mg/0.45 mL, Strensiq 28 mg/0.7 mL, or Strensiq 40 mg/mL vials

OR

1.4.2 Both of the following

- Patient is prescribed Strensiq 80 mg/0.8 mL vials
- Patient's weight is greater than or equal to 40 kg

AND

1.5 Prescriber attests to the following: the information provided is true and accurate to the best of their knowledge and they understand that UnitedHealthcare may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Sublingual Immunotherapy (SLIT)



Prior Authorization Guideline

Guideline ID	GL-235209
Guideline Name	Sublingual Immunotherapy (SLIT)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2025

1 . Criteria

Product Name:Grastek, Oralair, Ragwitek, Odactra	
Diagnosis	Patients 21 years of age and older
Approval Length	N/A - All requests for patients 21 years of age and older should be DENIED as benefit exclusion
Guideline Type	Prior Authorization
Approval Criteria 1 - Requests for patients 21 years of age and older are not covered	
Notes	Approval Length: N/A - All requests for patients 21 years of age and older should be denied as a benefit exclusion.

Product Name:Grastek	
Diagnosis	Grass pollen-induced allergic rhinitis for patients under 21 years of age
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderate to severe grass pollen-induced allergic rhinitis AND 2 - Diagnosis confirmed by ONE of the following: • Positive skin test to Timothy grass or cross-reactive grass pollens (e.g., Sweet Vernal, Orchard/Cocksfoot, Perennial Rye, Kentucky blue/June grass, Meadow Fescue, or Redtop) • In vitro testing for pollen-specific IgE (immunoglobulin E) antibodies for Timothy grass or cross-reactive grass pollens (e.g., Sweet Vernal, Orchard/Cocksfoot, Perennial Rye, Kentucky blue/June grass, Meadow Fescue, or Redtop) AND 3 - Treatment is started or will be started at least 12 weeks before the beginning of the grass pollen season AND 4 - History of failure, contraindication, or intolerance to TWO of the following: • Oral antihistamine [e.g., cetirizine (Zyrtec)] • Intranasal antihistamine [e.g., azelastine (Astelin)] • Intranasal corticosteroid [e.g., fluticasone (Flonase)] • Leukotriene inhibitor [e.g., montelukast (Singulair)]	

AND

5 - Not received in combination with similar cross-reactive grass pollen immunotherapy (e.g., Oralair)

AND

6 - Patient does not have unstable and/or uncontrolled asthma

AND

7 - Prescribed by or in consultation with a specialist in allergy and immunology

Product Name:Grastek	
Diagnosis	Grass pollen-induced allergic rhinitis for patients under 21 years of age
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Grastek therapy	

Product Name:Oralair	
Diagnosis	Grass pollen-induced allergic rhinitis for patients under 21 years of age
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe grass pollen-induced allergic rhinitis

AND

2 - Diagnosis confirmed by ONE of the following:

- Positive skin test to any of the five grass species contained in Oralair [(i.e., Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue grass mixed pollens) or cross-reactive grass pollens (e.g., Cocksfoot, Meadow Fescue, or Redtop)]
- In vitro testing for pollen-specific IgE antibodies for any of the five grass species contained in Oralair [(i.e., Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue grass mixed pollens) or cross-reactive grass pollens (e.g., Cocksfoot, Meadow Fescue, or Redtop)]

AND

3 - Treatment is started or will be started at least 4 months before the beginning of the grass pollen season

AND

4 - History of failure, contraindication, or intolerance to TWO of the following:

- Oral antihistamine [e.g., cetirizine (Zyrtec)]
- Intranasal antihistamine [e.g., azelastine (Astelin)]
- Intranasal corticosteroid [e.g., fluticasone (Flonase)]
- Leukotriene inhibitor [e.g., montelukast (Singulair)]

AND

5 - Not received in combination with similar cross-reactive grass pollen immunotherapy (e.g., Grastek)

AND

6 - Patient does not have unstable and/or uncontrolled asthma

AND

7 - Prescribed by or in consultation with a specialist in allergy and immunology

Product Name:Oralair

Diagnosis	Grass pollen-induced allergic rhinitis for patients under 21 years of age
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Oralair therapy

Product Name:Ragwitek

Diagnosis	Short ragweed pollen-induced allergic rhinitis for patients under 21 years of age
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe short ragweed pollen-induced allergic rhinitis

AND

2 - Diagnosis confirmed by ONE of the following:

- Positive skin test to short ragweed pollen
- In vitro testing for pollen-specific IgE antibodies for short ragweed pollen

AND

3 - Treatment is started or will be started at least 12 weeks before the beginning of the short ragweed pollen season

AND

4 - History of failure, contraindication, or intolerance to TWO of the following:

- Oral antihistamine [e.g., cetirizine (Zyrtec)]
- Intranasal antihistamine [e.g., azelastine (Astelin)]
- Intranasal corticosteroid [e.g., fluticasone (Flonase)]
- Leukotriene inhibitor [e.g., montelukast (Singulair)]

AND

5 - Patient does not have unstable and/or uncontrolled asthma

AND

6 - Prescribed by or in consultation with a specialist in allergy and immunology

Product Name:Ragwitek	
Diagnosis	Short ragweed pollen-induced allergic rhinitis for patients under 21 years of age
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Documentation of positive clinical response to Ragwitek therapy

Product Name: Odactra

Diagnosis	House dust mite (HDM)-induced allergic rhinitis for patients under 21 years of age
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of house dust mite (HDM)-induced allergic rhinitis

AND

2 - Diagnosis confirmed by ONE of the following:

- Positive skin test to licensed house dust mite allergen extracts
- In vitro testing for IgE antibodies to Dermatophagoides farinae or Dermatophagoides pteronyssinus house dust mites

AND

3 - History of failure, contraindication, or intolerance to TWO of the following:

- Oral antihistamine [e.g., cetirizine (Zyrtec)]
- Intranasal antihistamine [e.g., azelastine (Astelin)]
- Intranasal corticosteroid [e.g., fluticasone (Flonase)]
- Leukotriene inhibitor [e.g., montelukast (Singulair)]

AND

4 - Patient does not have unstable and/or uncontrolled asthma

AND

5 - Prescribed by or in consultation with a specialist in allergy and immunology

AND

6 - Patient is at least 5 years of age and not greater than 20 years of age

Product Name:Odactra	
Diagnosis	House dust mite (HDM)-induced allergic rhinitis for patients under 21 years of age
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Odactra therapy AND 2 - Patient is at least 5 years of age and not greater than 20 years of age	

2 . Revision History

Date	Notes
4/7/2025	Updated age criterion for Odactra due to expanded approval.

Sublocade, Brixadi



Prior Authorization Guideline

Guideline ID	GL-162608
Guideline Name	Sublocade, Brixadi
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	1/1/2025

1 . Criteria

Product Name:Brixadi, Sublocade	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ALL of the following: 1.1 Patient has severe Opioid Use Disorder (OUD) as defined by the DSM-5 (Diagnostic and	

Statistical Manual of Mental Disorders, Fifth Edition) OUD Diagnostic Tool and has a demonstrated history of non-adherence to oral medications

AND

1.2 Patient is currently maintained on 8mg to 24mg per day dose of oral, sublingual, or transmucosal buprenorphine product equivalent prior to initiation of Brixadi or Sublocade

AND

1.3 Patient will not receive supplemental oral, sublingual, or transmucosal buprenorphine for greater than 6 weeks after initiation of Brixadi or Sublocade

AND

1.4 Patient is receiving psychosocial interventions as part of a comprehensive medication assisted treatment (MAT) program

AND

1.5 Prescriber checks the Arizona State Board of Pharmacy Controlled Substance Prescription Monitoring Program (CSPMP) database prior to each monthly injection of Brixadi or Sublocade

AND

1.6 Dosing of Brixadi or Sublocade is in accordance with the U. S. Food and Drug Administration approved labeling

OR

2 - Brixadi or Sublocade is being requested due to circumstances other than non-adherence to oral medications. Document circumstance(s).

Product Name:Brixadi, Sublocade

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Physician documentation that the patient has experienced a positive clinical response to Brixadi or Sublocade therapy, as defined by the provider AND 2 - ONE of the following: 2.1 ALL of the following: 2.1.1 Patient will not receive supplemental oral, sublingual, or transmucosal buprenorphine for greater than 6 weeks after Brixadi or Sublocade therapy initiation AND 2.1.2 Patient is receiving psychosocial interventions as part of a comprehensive medication assisted treatment (MAT) program AND 2.1.3 Prescriber checks the Arizona State Board of Pharmacy Controlled Substance Prescription Monitoring Program (CSPMP) database prior to each monthly injection of Brixadi or Sublocade AND 2.1.4 Dosing of Brixadi or Sublocade is in accordance with the U. S. Food and Drug Administration approved labeling OR	

2.2 Brixadi or Sublocade is being requested due to circumstances other than non-adherence to oral medications. Document circumstance(s).

2 . Revision History

Date	Notes
12/31/2024	Update to guideline name. Added Sublocade back as a target. Updated criteria, product name lists, and GPI tables.

Suboxone



Prior Authorization Guideline

Guideline ID	GL-505191
Guideline Name	Suboxone
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:generic buprenorphine-naloxone film, Zubsolv *	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - The patient has a Diagnostic and Statistical Manual, Fifth Edition, Text Revision, (DSM-V-TR) diagnosis of opioid use disorder	

AND

2 - The patient must have a reason or special circumstance that they cannot use the preferred products**

- Brand Suboxone film
- buprenorphine sublingual tablet (generic Subutex)
- buprenorphine hcl/naloxone tablet (generic Suboxone tablet)
- naloxone
- naltrexone
- Narcan (naloxone)
- Sublocade (buprenorphine)
- Vivitrol (naltrexone microspheres)

Notes

*Up to 24 mg per day of Suboxone, or equivalent dosing of an alternative medication, will be authorized for the initial period.

**PDL link: <https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC>

Product Name:generic buprenorphine-naloxone film, Zubsolv *

Approval Length 12 month(s)

Therapy Stage Reauthorization

Guideline Type Prior Authorization

Approval Criteria

1 - The patient has been prescribed a buprenorphine product for the purpose of opioid use disorder maintenance therapy

AND

2 - The patient must have a reason or special circumstance that they cannot use the preferred products**

AND	
3 - Patient must have tried Suboxone film or buprenorphine-naloxone ODT tablets	
Notes	*Up to 16 mg per day of Suboxone, or equivalent dosing of an alternative medication, will be authorized for the reauthorization period. **PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name: Brand Suboxone, generic buprenorphine-naloxone film, buprenorphine/naloxone sublingual tablet, Zubsolv *	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Quantity Limit
Approval Criteria 1 - Physician has provided rationale for needing to exceed the buprenorphine daily limit AND 2 - The requested dosage cannot be achieved using the plan accepted quantity limit of a different dose or formulation	
Notes	*This criteria applies to requests exceeding 24 mg of buprenorphine or equivalent.

Product Name: Brand Suboxone, generic buprenorphine-naloxone film, buprenorphine/naloxone sublingual tablet, Zubsolv *	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Quantity Limit

Approval Criteria

1 - Physician has provided rationale for needing to exceed the buprenorphine daily limit

AND

2 - The requested dosage cannot be achieved using the plan accepted quantity limit of a different dose or formulation

Notes	*This criteria applies to requests exceeding 16 mg of buprenorphine or equivalent.

2 . Revision History

Date	Notes
1/22/2026	Update to alts list in initial auth section for generic buprenorphine-naloxone film and Zubsolv. Other minor cosmetic updates.

Sucraid



Prior Authorization Guideline

Guideline ID	GL-145460
Guideline Name	Sucraid
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2024

1 . Criteria

Product Name:Sucraid	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of congenital sucrase-isomaltase deficiency (CSID) as confirmed by one of the following:	

1.1 Duodenal biopsy showing low sucrose activity and normal amounts of other disaccharides

OR

1.2 All of the following:

- Stool pH less than 6
- Negative lactose breath test
- Increase in breath hydrogen greater than 10 ppm (parts per million) when challenged with sucrose after fasting

AND

2 - Prescribed by or in consultation with a gastroenterologist or rare disease specialist

AND

3 - Will be used with a sucrose-free, low starch diet

AND

4 - Provider attests that the requested medication will be obtained under compassionate use

Product Name: Sucraid	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Prescribed by or in consultation with a gastroenterologist or rare disease specialist	

AND

2 - Will be used with a sucrose-free, low starch diet

AND

3 - Provider attests that the patient has achieved a clinically meaningful response while on Sucraid therapy, defined as at least a 50 percent reduction in all of the following:

- Symptoms of abdominal pain, cramps, bloating, gas, vomiting
- Number of stools per day
- Watery, loose stool consistency
- Number of symptomatic days

AND

4 - Provider attests that the requested medication will be obtained under compassionate use

2 . Revision History

Date	Notes
4/5/2024	Added criterion that the drug will be obtained under compassionate use

Sunlenca (lenacapavir sodium)



Prior Authorization Guideline

Guideline ID	GL-286218
Guideline Name	Sunlenca (lenacapavir sodium)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	7/1/2025

1 . Criteria

Product Name:Sunlenca	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following: 1.1 Submission of medical records (e.g., chart notes) documenting all of the following: 1.1.1 Diagnosis of HIV-1 infection	

AND

1.1.2 Both of the following:

1.1.2.1 Patient is heavily treatment-experienced with multidrug resistance as confirmed by a resistance assay

AND

1.1.2.2 Patient is failing their current antiretroviral regimen due to ONE of the following:

- Resistance
- Intolerance
- Safety considerations

AND

1.1.3 Patient is currently taking, or will be prescribed, an active and optimized background antiretroviral therapy regimen

AND

1.1.4 Prescribed by or in consultation with a clinician with HIV expertise

OR

1.2 For continuation of prior therapy

2 . Revision History

Date	Notes
6/3/2025	Updated title and GPIs

Sunosi (solriamfetol)



Prior Authorization Guideline

Guideline ID	GL-206198
Guideline Name	Sunosi (solriamfetol)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	3/1/2025

1 . Criteria

Product Name:Sunosi	
Diagnosis	Narcolepsy
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes, lab values) documenting a diagnosis of narcolepsy with BOTH of the following:	

1.1 The patient has daily periods of irrepressible need to sleep or daytime lapses into sleep occurring for at least three months

AND

1.2 A mean sleep latency of less than or equal to 8 minutes and two or more sleep onset rapid eye movement (REM) periods (SOREMPs) are found on a multiple sleep latency test (MSLT) performed according to standard techniques following a normal overnight polysomnogram. A SOREMP (within 15 minutes of sleep onset) on the preceding nocturnal polysomnogram may replace one of the SOREMPs on the MSLT.

AND

2 - Physician attestation that other causes of sleepiness have been ruled out or treated (including but not limited to obstructive sleep apnea, insufficient sleep syndrome, shift work, the effects of substances or medications or their withdrawal, sleep phase disorder, or other sleep disorders)

AND

3 - History of failure, contraindication, or intolerance to BOTH of the following:

3.1 ONE of the following:

- Amphetamine based stimulant (e.g., amphetamine, dextroamphetamine)
- Methylphenidate based stimulant

AND

3.2 Armodafinil

AND

4 - Prescribed by ONE of the following:

- Neurologist
- Psychiatrist

- Sleep Medicine Specialist

Product Name:Sunosi	
Diagnosis	Narcolepsy
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Reduction in symptoms of excessive daytime sleepiness associated with Sunosi therapy	

Product Name:Sunosi	
Diagnosis	Obstructive Sleep Apnea
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes, lab values) documenting a diagnosis of obstructive sleep apnea with ONE of the following: 1.1 Fifteen or more obstructive respiratory events per hour of sleep confirmed by a sleep study OR 1.2 BOTH of the following: 1.2.1 Five or more obstructive respiratory events per hour of sleep confirmed by a sleep study	

AND

1.2.2 ONE or more of the following sign/symptoms are present:

- Daytime sleepiness
- Nonrestorative sleep
- Fatigue
- Insomnia
- Waking up with breath holding, gasping, or choking
- Habitual snoring noted by bed partner or other observer
- Observed apnea

AND

2 - BOTH of the following:

2.1 Standard treatments for the underlying airway obstruction (e.g., continuous positive airway pressure [CPAP], bi-level positive airway pressure [BiPAP]) have been used for one month or longer

AND

2.2 Patient is fully compliant with ongoing treatment(s) for the underlying airway obstruction

AND

3 - History of failure, contraindication, or intolerance to armodafinil

AND

4 - Prescribed by ONE of the following:

- Neurologist
- Psychiatrist
- Sleep Medicine Specialist

Product Name:Sunosi	
Diagnosis	Obstructive Sleep Apnea
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Reduction in symptoms of excessive daytime sleepiness associated with Sunosi therapy AND 2 - Patient continues to be fully compliant with ongoing treatment(s) for the underlying airway obstruction (e.g., continuous positive airway pressure [CPAP], bi-level positive airway pressure [BiPAP])	

2 . Revision History

Date	Notes
2/27/2025	Updated guideline name. For narcolepsy initial auth section, corrected logic connector between criterion 1.1 and 1.2 and updated formatting of criterion 2 with no changes to clinical intent. Minor cosmetic updates.

Sutent



Prior Authorization Guideline

Guideline ID	GL-140925
Guideline Name	Sutent
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Sutent	
Diagnosis	Gastrointestinal Stromal Tumor (GIST)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of gastrointestinal stromal tumor (GIST)	

AND

2 - History of failure, contraindication, or intolerance to Gleevec (imatinib)

Product Name:Sutent

Diagnosis	Renal Cell Carcinoma (RCC)

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of renal cell carcinoma (RCC)

AND

2 - ONE of the following:

2.1 Disease has relapsed

OR

2.2 Diagnosis of Stage IV disease

OR

2.3 BOTH of the following:

2.3.1 Used in adjuvant setting

AND

2.3.2 Patient has a high risk of recurrence following nephrectomy

Product Name:Sutent	
Diagnosis	Islet Cell Tumor / Progressive Pancreatic Neuroendocrine Tumors (pNET)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of islet cell tumor / progressive pancreatic neuroendocrine tumors (pNET) AND 2 - Disease is ONE of the following: • Unresectable, locally advanced • Metastatic	

Product Name:Sutent	
Diagnosis	Soft Tissue Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following: • Alveolar soft part sarcoma (ASPS) • Angiosarcoma	

- Solitary fibrous tumor / hemangiopericytoma

Product Name:Sutent	
Diagnosis	Thyroid Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 ALL of the following:

1.1.1 Diagnosis of ONE of the following:

- Follicular carcinoma
- Hürthle cell carcinoma
- Papillary carcinoma

AND

1.1.2 ONE of the following:

- Unresectable locoregional recurrent disease
- Persistent disease
- Metastatic disease

AND

1.1.3 ONE of the following:

- Patient has symptomatic disease
- Patient has progressive disease

AND

1.1.4 Disease is refractory to radioactive iodine treatment

OR

1.2 ALL of the following:

1.2.1 Diagnosis of medullary thyroid carcinoma

AND

1.2.2 ONE of the following:

- Patient has progressive disease
- Patient has symptomatic metastatic disease

AND

1.2.3 History of failure, contraindication, or intolerance to ONE of the following:

- Caprelsa (vandetanib)
- Cometriq (cabozantinib)

Product Name:Sutent	
Diagnosis	Chordoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of recurrent chordoma	

Product Name:Sutent	
Diagnosis	Central Nervous System Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of surgically inaccessible meningiomas AND 2 - ONE of the following: • Disease is recurrent • Disease is progressive AND 3 - Further radiation is not possible	

Product Name:Sutent	
Diagnosis	Thymic Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of thymic carcinoma	

AND

2 - Used as second-line following a failure, contraindication, or intolerance to a first-line chemotherapy regimen (e.g., carboplatin/paclitaxel)

Product Name:Sutent	
Diagnosis	Gastrointestinal Stromal Tumor (GIST), Renal Cell Carcinoma (RCC), Islet Cell Tumor / Progressive Pancreatic Neuroendocrine Tumors (pNET), Soft Tissue Sarcoma, Thyroid Carcinoma, Chordoma, Central Nervous System Cancer, Thymic Carcinoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient does not show evidence of progressive disease while on Sutent therapy	

Product Name:Sutent	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Sutent will be approved for uses supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1, 2A, or 2B.	

Product Name:Sutent	
Diagnosis	NCCN Recommended Regimens

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Sutent therapy	

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Symdeko



Prior Authorization Guideline

Guideline ID	GL-140905
Guideline Name	Symdeko
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name: Symdeko	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of cystic fibrosis (CF)	

AND

2 - Submission of laboratory result documenting ONE of the following:

2.1 The patient is homozygous for the F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene

OR

2.2 The patient has at least ONE mutation in the CFTR gene that is responsive to Symdeko (See Table in Background Section)

AND

3 - The patient is greater than or equal to 6 years of age

AND

4 - Prescribed by or in consultation with a specialist affiliated with a CF care center

Product Name:Symdeko	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Provider attests that the patient has achieved a clinically meaningful response while on Symdeko therapy to ONE of the following: • Lung function as demonstrated by percent predicted expiratory volume in 1 second (ppFEV1) • Body mass index (BMI) • Pulmonary exacerbations	

- Quality of life as demonstrated by Cystic Fibrosis Questionnaire-Revised (CFQ-R) respiratory domain score

AND

2 - Prescribed by, or in consultation with, a specialist affiliated with a cystic fibrosis (CF) care center

2 . Background

Benefit/Coverage/Program Information

Table 1 CFTR Gene Mutations

A1067T	D1270N	F1052V	R1070W	S945L	3272-26A→G
A455E	D579G	F1074L	R117C	S977F	3849+10kbC→T
D110E	E193K	K1060T	R347H		711+3A→G
D110H	E56K	L206W	R352Q		2789+5G→A
D1152H	E831X	P67L	R74W		

3 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Symlin



Prior Authorization Guideline

Guideline ID	GL-140649
Guideline Name	Symlin
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2020

1 . Criteria

Product Name: Symlin	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient must have ONE of the following diagnoses: • Type 1 diabetes • Type 2 diabetes	

AND

2 - Concurrent use of insulin therapy

2 . Revision History

Date	Notes
3/31/2020	Bulk Copy C&S New York to C&S Arizona for effective date of 5/1

Synagis



Prior Authorization Guideline

Guideline ID	GL-140953
Guideline Name	Synagis
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	1/1/2023

Note:

PA is not required for children under 2 years of age

1 . Criteria

Product Name:Synagis*	
Diagnosis	Prematurity
Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following:	

1.1 Patient is an infant born before 29 weeks, 0 days gestation

AND

1.2 Patient is less than 12 months of age at the start of RSV “season”

AND

2 - Administered during RSV season**

AND

3 - Monthly dose of Synagis does not exceed 15 milligram per kilogram per dose

AND

4 - Monthly dose of Synagis does not exceed 5 doses per single RSV “season”***

AND

5 - The patient does not meet ONE of the following situations

- Infants and children with hemodynamically insignificant heart disease (e.g., secundum atrial septal defect, small ventricular septal defect, pulmonic stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, and patent ductus arteriosus)
- Infants with congenital heart disease and cardiac lesions adequately corrected by surgery, unless they continue to require medication for congestive heart failure
- Infants with cardiomyopathy sufficiently mild that they do not require pharmacotherapy
- Routine use of prophylaxis in children with Down syndrome [unless qualifying heart disease, CLD, airway clearance issues (the inability to clear secretions from the upper airway because of ineffective cough), or prematurity (less than 29 weeks, 0 days gestation) is present]
- Routine use of prophylaxis in children with cystic fibrosis (unless indications noted in proven indications above are present)
- Administration of monthly Synagis prophylaxis after an infant or child has experienced a breakthrough RSV hospitalization during the current season if child had met criteria for palivizumab

• Prophylaxis for primary asthma prevention or to reduce subsequent episodes of wheezing in infants and children • Synagis prophylaxis for prevention of nosocomial disease • Treatment of symptomatic RSV disease	
Notes	*NOTE: Approval for up to 5 doses per single RSV “season” ** Information regarding RSV season may be found at: • Centers for Disease and Prevention (CDC) surveillance reports (http://www.cdc.gov/surveillance/nrevss/rsv/index.html) • http://uhc-cs-10.uhc.com/sites/cspm/CSSP/Pages/Synagis.aspx ***NOTE: Infants in a neonatal intensive care unit who qualify for prophylaxis may receive the first dose 48 to 72 hours before discharge to home or promptly after discharge. If the first dose is administered in the hospital, this dose will be considered the first dose of the maximum 5 dose series for the season. And any subsequent doses received in the hospital setting, are also considered as part of the maximum 5 dose series. For infants born during the RSV “season,” fewer than 5 monthly doses may be needed.

Product Name:Synagis*	
Diagnosis	Chronic Lung Disease (CLD)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 ALL of the following for patients age 0 to less than 12 months: 1.1.1 The patient is a preterm infant defined as gestational age less than 32 weeks, 0 days AND 1.1.2 Patient has developed chronic lung disease (CLD) of prematurity AND 1.1.3 There was a requirement for greater than 21% oxygen for at least the first 28 days after birth	

OR

1.2 ALL of the following for patients age greater than or equal to 12 months to less than 24 months:

1.2.1 The patient was born at less than 32 weeks, 0 days gestation

AND

1.2.2 The patient required at least 28 days of oxygen after birth

AND

1.2.3 The patient continues to require supplemental oxygen, diuretics, or chronic systemic corticosteroid therapy within 6 months of the start of the second RSV “season”

AND

2 - Administered during RSV season**

AND

3 - Monthly dose of Synagis does not exceed 15 milligram per kilogram per dose

AND

4 - Monthly dose of Synagis does not exceed 5 doses per single RSV “season”***

AND

5 - The patient does not meet ONE of the following situations

• Infants and children with hemodynamically insignificant heart disease (e.g., secundum atrial septal defect, small ventricular septal defect, pulmonic stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, and patent ductus arteriosus) • Infants with congenital heart disease and cardiac lesions adequately corrected by surgery, unless they continue to require medication for congestive heart failure • Infants with cardiomyopathy sufficiently mild that they do not require pharmacotherapy • Routine use of prophylaxis in children with Down syndrome [unless qualifying heart disease, CLD, airway clearance issues (the inability to clear secretions from the upper airway because of ineffective cough), or prematurity (less than 29 weeks, 0 days gestation) is present] • Routine use of prophylaxis in children with cystic fibrosis (unless indications noted in proven indications above are present) • Administration of monthly Synagis prophylaxis after an infant or child has experienced a breakthrough RSV hospitalization during the current season if child had met criteria for palivizumab • Prophylaxis for primary asthma prevention or to reduce subsequent episodes of wheezing in infants and children • Synagis prophylaxis for prevention of nosocomial disease • Treatment of symptomatic RSV disease	
Notes	*NOTE: Approval for up to 5 doses per single RSV “season” ** Information regarding RSV season may be found at: • Centers for Disease and Prevention (CDC) surveillance reports (http://www.cdc.gov/surveillance/nrevss/rsv/index.html) • http://uhc-cs-10.uhc.com/sites/cspm/CSSP/Pages/Synagis.aspx ***NOTE: Infants in a neonatal intensive care unit who qualify for prophylaxis may receive the first dose 48 to 72 hours before discharge to home or promptly after discharge. If the first dose is administered in the hospital, this dose will be considered the first dose of the maximum 5 dose series for the season. And any subsequent doses received in the hospital setting, are also considered as part of the maximum 5 dose series. For infants born during the RSV “season,” fewer than 5 monthly doses may be needed.

Product Name: Synagis*	
Diagnosis	Congenital Heart Disease (CHD)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 ONE of the following for patients age 0 to less than 12 months:	

1.1.1 Patient has hemodynamically significant congenital heart disease (CHD) including ONE of the following:

- Acyanotic heart disease and receiving medication to control congestive heart failure and will require cardiac surgical procedures
- Moderate to severe pulmonary hypertension
- Documentation that decisions regarding prophylaxis for infants with cyanotic heart defects were made in consultation with a pediatric cardiologist

OR

1.1.2 The patient is undergoing cardiac transplantation during the RSV “season”

OR

1.2 BOTH of the following:

1.2.1 The patient is greater than or equal to 12 months to less than 24 months of age:

AND

1.2.2 ONE of the following:

- After cardiac bypass
- At the conclusion of extracorporeal membrane oxygenation
- The patient is undergoing cardiac transplantation during the RSV “season”

AND

2 - Administered during RSV season**

AND

3 - Monthly dose of Synagis does not exceed 15 milligram per kilogram per dose

AND

4 - Monthly dose of Synagis does not exceed 5 doses per single RSV “season”***

AND

5 - The patient does not meet ONE of the following situations

- Infants and children with hemodynamically insignificant heart disease (e.g., secundum atrial septal defect, small ventricular septal defect, pulmonic stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, and patent ductus arteriosus)
- Infants with congenital heart disease and cardiac lesions adequately corrected by surgery, unless they continue to require medication for congestive heart failure
- Infants with cardiomyopathy sufficiently mild that they do not require pharmacotherapy
- Routine use of prophylaxis in children with Down syndrome [unless qualifying heart disease, CLD, airway clearance issues (the inability to clear secretions from the upper airway because of ineffective cough), or prematurity (less than 29 weeks, 0 days gestation) is present]
- Routine use of prophylaxis in children with cystic fibrosis (unless indications noted in proven indications above are present)
- Administration of monthly Synagis prophylaxis after an infant or child has experienced a breakthrough RSV hospitalization during the current season if child had met criteria for palivizumab
- Prophylaxis for primary asthma prevention or to reduce subsequent episodes of wheezing in infants and children
- Synagis prophylaxis for prevention of nosocomial disease
- Treatment of symptomatic RSV disease

Notes

*NOTE: Approval for up to 5 doses per single RSV “season”
 ** Information regarding RSV season may be found at:
 • Centers for Disease and Prevention (CDC) surveillance reports (<http://www.cdc.gov/surveillance/nrevss/rsv/index.html>)
 • <http://uhc-cs-10.uhc.com/sites/cspm/CSSP/Pages/Synagis.aspx>
 ***NOTE: Infants in a neonatal intensive care unit who qualify for prophylaxis may receive the first dose 48 to 72 hours before discharge to home or promptly after discharge. If the first dose is administered in the hospital, this dose will be considered the first dose of the maximum 5 dose series for the season. And any subsequent doses received in the hospital setting, are also considered as part of the maximum 5 dose series. For infants born during the RSV “season,” fewer than 5 monthly doses may be needed.

Product Name: Synagis*

Diagnosis	Congenital abnormalities of the airway or neuromuscular disease

Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Patient is age 0 to less than 12 months

AND

1.2 Patient has ONE of the following:

- Neuromuscular disease
- A congenital anomaly that impairs the ability to clear secretions from the lower airway because of ineffective cough

AND

2 - Administered during RSV season**

AND

3 - Monthly dose of Synagis does not exceed 15 milligram per kilogram per dose

AND

4 - Monthly dose of Synagis does not exceed 5 doses per single RSV "season"***

AND

5 - The patient does not meet ONE of the following situations

- Infants and children with hemodynamically insignificant heart disease (e.g., secundum atrial septal defect, small ventricular septal defect, pulmonic stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, and patent ductus arteriosus)
- Infants with congenital heart disease and cardiac lesions adequately corrected by surgery, unless they continue to require medication for congestive heart failure
- Infants with cardiomyopathy sufficiently mild that they do not require pharmacotherapy

• Routine use of prophylaxis in children with Down syndrome [unless qualifying heart disease, CLD, airway clearance issues (the inability to clear secretions from the upper airway because of ineffective cough), or prematurity (less than 29 weeks, 0 days gestation) is present] • Routine use of prophylaxis in children with cystic fibrosis (unless indications noted in proven indications above are present) • Administration of monthly Synagis prophylaxis after an infant or child has experienced a breakthrough RSV hospitalization during the current season if child had met criteria for palivizumab • Prophylaxis for primary asthma prevention or to reduce subsequent episodes of wheezing in infants and children • Synagis prophylaxis for prevention of nosocomial disease • Treatment of symptomatic RSV disease	
Notes	*NOTE: Approval for up to 5 doses per single RSV “season” ** Information regarding RSV season may be found at: • Centers for Disease and Prevention (CDC) surveillance reports (http://www.cdc.gov/surveillance/nrevss/rsv/index.html) • http://uhc-cs-10.uhc.com/sites/cspm/CSSP/Pages/Synagis.aspx ***NOTE: Infants in a neonatal intensive care unit who qualify for prophylaxis may receive the first dose 48 to 72 hours before discharge to home or promptly after discharge. If the first dose is administered in the hospital, this dose will be considered the first dose of the maximum 5 dose series for the season. And any subsequent doses received in the hospital setting, are also considered as part of the maximum 5 dose series. For infants born during the RSV “season,” fewer than 5 monthly doses may be needed.

Product Name:Synagis*	
Diagnosis	Immunocompromised children less than 24 months of age
Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following: 1.1 Patient is less than 24 months of age AND 1.2 The patient is immunocompromised (e.g. receiving cancer chemotherapy, undergoing hematopoietic stem cell transplantation, or solid organ transplantation)	

AND

2 - Administered during RSV season**

AND

3 - Monthly dose of Synagis does not exceed 15 milligram per kilogram per dose

AND

4 - Monthly dose of Synagis does not exceed 5 doses per single RSV “season”***

AND

5 - The patient does not meet ONE of the following situations

- Infants and children with hemodynamically insignificant heart disease (e.g., secundum atrial septal defect, small ventricular septal defect, pulmonic stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, and patent ductus arteriosus)
- Infants with congenital heart disease and cardiac lesions adequately corrected by surgery, unless they continue to require medication for congestive heart failure
- Infants with cardiomyopathy sufficiently mild that they do not require pharmacotherapy
- Routine use of prophylaxis in children with Down syndrome [unless qualifying heart disease, CLD, airway clearance issues (the inability to clear secretions from the upper airway because of ineffective cough), or prematurity (less than 29 weeks, 0 days gestation) is present]
- Routine use of prophylaxis in children with cystic fibrosis (unless indications noted in proven indications above are present)
- Administration of monthly Synagis prophylaxis after an infant or child has experienced a breakthrough RSV hospitalization during the current season if child had met criteria for palivizumab
- Prophylaxis for primary asthma prevention or to reduce subsequent episodes of wheezing in infants and children
- Synagis prophylaxis for prevention of nosocomial disease
- Treatment of symptomatic RSV disease

Notes

*NOTE: Approval for up to 5 doses per single RSV “season”

** Information regarding RSV season may be found at:

• Centers for Disease and Prevention (CDC) surveillance reports (<http://www.cdc.gov/rsv/>)

	://www.cdc.gov/surveillance/nrevss/rsv/index.html) • http://uhc-cs-10.uhc.com/sites/cspm/CSSP/Pages/Synagis.aspx ***NOTE: Infants in a neonatal intensive care unit who qualify for prophylaxis may receive the first dose 48 to 72 hours before discharge to home or promptly after discharge. If the first dose is administered in the hospital, this dose will be considered the first dose of the maximum 5 dose series for the season. And any subsequent doses received in the hospital setting, are also considered as part of the maximum 5 dose series. For infants born during the RSV "season," fewer than 5 monthly doses may be needed.

Product Name:Synagis*	
Diagnosis	Cystic fibrosis (CF)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 BOTH of the following for patients age 0 to less than 12 months: 1.1.1 Patient has cystic fibrosis AND 1.1.2 Patient has clinical evidence of at least ONE of the following: • Chronic lung disease (CLD) • Nutritional compromise • Failure to thrive defined as weight for length less than the 10th percentile on a pediatric growth chart OR 1.2 BOTH of the following: 1.2.1 Patient is greater than or equal to 12 months to less than 24 months of age	

AND

1.2.2 Patient has manifestations of severe lung disease including ONE of the following:

- Previous hospitalization for pulmonary exacerbation in the first year of life
- Abnormalities on chest radiography or chest computed tomography that persists when stable
- Weight for length less than the 10th percentile on a pediatric growth chart

AND

2 - Administered during RSV season**

AND

3 - Monthly dose of Synagis does not exceed 15 milligram per kilogram per dose

AND

4 - Monthly dose of Synagis does not exceed 5 doses per single RSV "season"***

AND

5 - The patient does not meet ONE of the following situations

- Infants and children with hemodynamically insignificant heart disease (e.g., secundum atrial septal defect, small ventricular septal defect, pulmonic stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, and patent ductus arteriosus)
- Infants with congenital heart disease and cardiac lesions adequately corrected by surgery, unless they continue to require medication for congestive heart failure
- Infants with cardiomyopathy sufficiently mild that they do not require pharmacotherapy
- Routine use of prophylaxis in children with Down syndrome [unless qualifying heart disease, CLD, airway clearance issues (the inability to clear secretions from the upper airway because of ineffective cough), or prematurity (less than 29 weeks, 0 days gestation) is present]
- Routine use of prophylaxis in children with cystic fibrosis (unless indications noted in proven indications above are present)

• Administration of monthly Synagis prophylaxis after an infant or child has experienced a breakthrough RSV hospitalization during the current season if child had met criteria for palivizumab • Prophylaxis for primary asthma prevention or to reduce subsequent episodes of wheezing in infants and children • Synagis prophylaxis for prevention of nosocomial disease • Treatment of symptomatic RSV disease	Notes *NOTE: Approval for up to 5 doses per single RSV “season” ** Information regarding RSV season may be found at: • Centers for Disease and Prevention (CDC) surveillance reports (http://www.cdc.gov/surveillance/nrevss/rsv/index.html) • http://uhc-cs-10.uhc.com/sites/cspm/CSSP/Pages/Synagis.aspx ***NOTE: Infants in a neonatal intensive care unit who qualify for prophylaxis may receive the first dose 48 to 72 hours before discharge to home or promptly after discharge. If the first dose is administered in the hospital, this dose will be considered the first dose of the maximum 5 dose series for the season. And any subsequent doses received in the hospital setting, are also considered as part of the maximum 5 dose series. For infants born during the RSV “season,” fewer than 5 monthly doses may be needed.

2 . Background

Benefit/Coverage/Program Information
Additional Information In most of North America, peak RSV activity typically occurs between November and March, usually beginning in November or December, peaking in January or February, and ending by the end of March or sometime in April. Communities in the southern United States, particularly some communities in the state of Florida, tend to experience the earliest onset of RSV. Data from the Centers for Disease Control and Prevention (CDC) have identified variations in the onset and offset of the RSV “season” in the state of Florida that could affect the timing of Synagis administration. ¹⁰ • Despite varied onsets, the RSV “season” is of the same duration (5 months) in the different regions of Florida. • On the basis of the epidemiology of RSV in Alaska, particularly in remote regions where the burden of RSV disease is significantly greater than the general US population, the selection of Alaska Native infants eligible for prophylaxis may differ from the remainder of the United States. Clinicians may wish to use RSV surveillance data generated by the state of Alaska to assist in determining onset and end of the RSV season for qualifying infants.

- Limited information is available concerning the burden of RSV disease among Native American populations. However, special consideration may be prudent for Navajo and White Mountain Apache infants in the first year of life.

For analysis of National Respiratory and Enteric Virus Surveillance System (NREVSS) reports in the CDC Morbidity and Mortality Weekly Report, season onset is defined as the first of 2 consecutive weeks during which the mean percentage of specimens testing positive for RSV antigen is $\geq 10\%$ and RSV “season” offset is defined as the last of 2 consecutive weeks during which the mean percentage of positive specimens is $\geq 10\%$. Use of specimens to determine the start of the RSV “season” requires that the number of specimens tested be statistically significant.

3 . Revision History

Date	Notes
12/8/2022	Added guideline note for PA is not required if patient is under 2 years of age.

Systane, Refresh, Gonak, Genteal, Tears Naturale



Prior Authorization Guideline

Guideline ID	GL-140708
Guideline Name	Systane, Refresh, Gonak, Genteal, Tears Naturale
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:brand Systane, brand Refresh, brand Gonak, brand Genteal, Tears Naturale	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - History of failure, contraindication, or intolerance to ALL of the following: Generic equivalents for drops, ointments and gel formulations for Systane, Refresh, Gonak, Genteal, Tears Naturale, and Generic equivalent to the requested brand product	

- sodium chloride ophthalmic ointment

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Talicia and rifabutin



Prior Authorization Guideline

Guideline ID	GL-164977
Guideline Name	Talicia and rifabutin
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	3/1/2025

1 . Criteria

Product Name:generic rifabutin	
Diagnosis	Mycobacterium Avium Complex Prophylaxis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Mycobacterium Avium Complex Prophylaxis	

AND

2 - Prescribed by or in consultation with an HIV or infectious disease specialist

AND

3 - Patient has failed azithromycin or clarithromycin or is intolerant to the medication due to significant adverse effects or both are contraindicated

AND

4 - The requested dosage does not exceed 450 mg per day

Product Name:generic rifabutin	
Diagnosis	Mycobacterium Avium Complex Prophylaxis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is responding positively to therapy	

Product Name:generic rifabutin	
Diagnosis	Mycobacterium Avium Complex Prophylaxis
Approval Length	12 month(s)
Guideline Type	Quantity Limit
Approval Criteria 1 - For doses that exceed 450 mg, the use of this drug is supported by information from ONE of the following appropriate compendia of current literature:	

Food and Drug Administration approved indications and limits
 Published practice guidelines and treatment protocols
 Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes
 Drug Facts and Comparisons
 American Hospital Formulary Service Drug Information
 United States Pharmacopeia – Drug Information
 DRUGDEX Information System
 UpToDate
 MicroMedex
 Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies
 Other drug reference resources

Product Name:generic rifabutin	
Diagnosis	Helicobacter pylori Infection (off-label)
Approval Length	14 Day(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of H. pylori infection AND 2 - Prescribed in combination with amoxicillin and a proton pump inhibitor	

Product Name:Talicia	
Diagnosis	Helicobacter pylori Infection
Approval Length	14 Day(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of H. pylori infection

AND

2 - The medication is prescribed by or in consultation with a gastroenterologist or infectious disease specialist

AND

3 - ONE of the following:

3.1 BOTH of the following:

3.1.1 Trial and failure, contraindication, or intolerance to bismuth quadruple therapy (e.g., bismuth and metronidazole and tetracycline and proton pump inhibitor [PPI])

AND

3.1.2 Trial and failure, contraindication, or intolerance to BOTH of the following suggested first line treatment regimens:

- Clarithromycin based therapy (e.g., clarithromycin based triple therapy, clarithromycin based concomitant therapy) or PCAB-clarithromycin triple therapy
- Rifabutin triple therapy

OR

3.2 BOTH of the following:

3.2.1 Culture and sensitivity report indicate resistance or lack of susceptibility of H. pylori to all first-line treatment regimens except rifabutin triple therapy

AND

3.2.2 Patient must have tried and failed rifabutin triple therapy

Product Name:generic rifabutin	
Diagnosis	Tuberculosis (off-label)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of tuberculosis infection AND 2 - Prescribed by or in consultation with an HIV or infectious disease specialist AND 3 - Current treatment with protease inhibitors or non-nucleoside reverse transcriptase inhibitors (NNRTIs) for the treatment of HIV infection	

Product Name:generic rifabutin	
Diagnosis	Tuberculosis (off-label)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is responding positively to therapy	

2 . Revision History

Date	Notes
2/11/2025	Update to guideline name. Removed Brand Mycobutin as a target (inactive). Added generic rifabutin as a target. Removed any criteria that referenced Brand Mycobutin. Updated product name lists and GPI tables accordingly. Minor cosmetic updates.

Taltz (ixekizumab)



Prior Authorization Guideline

Guideline ID	GL-329199
Guideline Name	Taltz (ixekizumab)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	8/1/2025

1 . Criteria

Product Name:Taltz	
Diagnosis	Plaque Psoriasis (PsO)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) or verification of paid claims documenting ALL of the following:	

1.1 Diagnosis of chronic moderate to severe plaque psoriasis (PsO)

AND

1.2 Greater than or equal to 3 percent body surface area involvement, palmoplantar, facial, or genital involvement, or severe scalp psoriasis

AND

1.3 History of failure to ONE of the following topical therapies, unless contraindicated or clinically significant adverse effects are experienced:

- corticosteroids (e.g., betamethasone, clobetasol, desonide)
- vitamin D analogs (e.g., calcitriol, calcipotriene)
- tazarotene
- calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)

AND

1.4 History of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

1.5 History of failure, contraindication, or intolerance to ONE of the following topical therapies:

- Vtama
- Zoryve 0.3% cream

AND

1.6 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred^ adalimumab biosimilar or Enbrel (etanercept)
- infliximab
- Otezla (apremilast)

- A preferred^ ustekinumab biosimilar

AND

2 - Prescribed by or in consultation with a dermatologist

Notes	^PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:Taltz

Diagnosis	Plaque Psoriasis (PsO)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Prescribed by or in consultation with a dermatologist

Product Name:Taltz

Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) or verification of paid claims documenting ALL of the following:

1.1 Diagnosis of active psoriatic arthritis (PsA)

AND

1.2 History of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

1.3 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred^ adalimumab biosimilar or Enbrel (etanercept)
- infliximab
- Orencia (abatacept)
- Otezla (apremilast)
- Xeljanz (tofacitinib) oral tablet (IR or XR)
- A preferred^ ustekinumab biosimilar

AND

2 - Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Dermatologist

Notes	^PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:Taltz	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Dermatologist

Product Name:Taltz	
Diagnosis	Ankylosing Spondylitis (AS), Non-Radiographic Axial Spondyloarthritis (nr-axSpA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) or verification of paid claims documenting ALL of the following: 1.1 ONE of the following diagnoses: • Active ankylosing spondylitis (AS) • Active non-radiographic axial spondyloarthritis (nr-axSpA) AND 1.2 History of failure to TWO nonsteroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen, naproxen) at maximally indicated doses, each used for at least 4 weeks within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced	

AND

1.3 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred^ adalimumab biosimilar or Enbrel (etanercept)
- infliximab
- Xeljanz (tofacitinib) oral tablet (IR or XR)

AND

2 - Prescribed by or in consultation with a rheumatologist

Notes	^PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:Taltz	
Diagnosis	Ankylosing Spondylitis (AS), Non-Radiographic Axial Spondyloarthritis (nr-axSpA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy AND 2 - Prescribed by or in consultation with a rheumatologist	

2 . Revision History

UnitedHealthcare Community Plan of Arizona Clinical Pharmacy Program Guidelines

Date	Notes
7/16/2025	Updates to initial and reauth sections for all indications. Consolidated AS and nr-axSpA criteria sections.

Targretin



Prior Authorization Guideline

Guideline ID	GL-140926
Guideline Name	Targretin
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name: Brand Targretin caps, generic bexarotene caps, Targretin gel	
Diagnosis	Cutaneous T-Cell Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of cutaneous T-cell lymphoma (CTCL)	

AND

2 - History of failure, contraindication, or intolerance to at least one prior therapy (including skin-directed therapies [e.g., corticosteroids (clobetasol, diflorasone, halobetasol, augmented betamethasone dipropionate), phototherapy, or systemic therapies [e.g. Interferons])

Product Name:Brand Targretin caps, generic bexarotene caps, Targretin gel	
Diagnosis	Cutaneous T-Cell Lymphoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has not had disease progression while on therapy	

Product Name:Brand Targretin caps, generic bexarotene caps, Targretin gel	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Targretin will be approved for uses supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1, 2A, or 2B.	

Product Name:Brand Targretin caps, generic bexarotene caps, Targretin gel	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Targretin therapy	

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Tarpeyo (budesonide)



Prior Authorization Guideline

Guideline ID	GL-140750
Guideline Name	Tarpeyo (budesonide)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	12/1/2022

1 . Criteria

Product Name: Tarpeyo	
Approval Length	9 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of primary immunoglobulin A nephropathy (IgAN) as confirmed by a kidney biopsy AND	

2 - Patient is at risk of rapid disease progression [e.g., generally a urine protein-to-creatinine ratio (UPCR) greater than or equal to 1.5 g/g (gram), or by other criteria such as clinical risk scoring using the International IgAN Prediction Tool]

AND

3 - Used to reduce proteinuria

AND

4 - Estimated glomerular filtration rate (eGFR) greater than or equal to 35 mL/min/1.73 m² (milliliters/minute/1.73 square meters)

AND

5 - One of the following:

5.1 Patient has been on a minimum 90-day trial of a maximally tolerated dose and will continue to receive therapy with one of the following:

- An angiotensin-converting enzyme (ACE) inhibitor (e.g., benazepril, lisinopril)
- An angiotensin II receptor blocker (ARB) (e.g., losartan, valsartan)

OR

5.2 Patient has a contraindication or intolerance to both ACE inhibitors and ARBs

AND

6 - Trial and failure, contraindication, or intolerance to another glucocorticoid (e.g., methylprednisolone, prednisone)

AND

7 - Prescribed by or in consultation with a nephrologist

2 . Revision History

Date	Notes
10/28/2022	Removed references and updated abbreviations, no clinical criteria changes.

Tavneos



Prior Authorization Guideline

Guideline ID	GL-580230
Guideline Name	Tavneos
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State New Jersey Medicaid - Community & State New York Medicaid - Community & State New York EPP Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Arizona Medicaid - Community & State Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Pennsylvania Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Tavneos	
Diagnosis	ANCA (Anti-Neutrophil Cytoplasmic Autoantibody)-Associated Vasculitis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of severe active ANCA (anti-neutrophil cytoplasmic autoantibody)-associated vasculitis AND 2 - Submission of medical records (e.g., chart notes, laboratory values, etc.) documenting the disease is ONE of the following types: 2.1 Granulomatosis with polyangiitis (GPA) OR 2.2 Microscopic polyangiitis (MPA) AND 3 - Patient is being treated with an initial immunosuppressive regimen to induce remission (i.e., rituximab, cyclophosphamide) AND 4 - Tavneos is being prescribed as adjunctive treatment in combination with standard therapy (e.g., prednisone, azathioprine, mycophenolate, methotrexate, rituximab, cyclophosphamide) AND	

5 - Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Nephrologist
- Pulmonologist
- Vascular Medicine Specialist

Product Name:Tavneos	
Diagnosis	ANCA (Anti-Neutrophil Cytoplasmic Autoantibody)-Associated Vasculitis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient does not show evidence of progressive disease while on Tavneos therapy AND 2 - Tavneos is being prescribed as adjunctive treatment in combination with standard therapy (e.g., prednisone, azathioprine, mycophenolate, methotrexate, rituximab, cyclophosphamide) AND 3 - Prescribed by or in consultation with ONE of the following: • Rheumatologist • Nephrologist • Pulmonologist • Vascular Medicine Specialist	

2 . Revision History

UnitedHealthcare Community Plan of Arizona Clinical Pharmacy Program Guidelines

Date	Notes
4/17/2026	Updated formularies to add ACUIN and ACUPA for eff 6/1/2026.

Tavneos



Prior Authorization Guideline

Guideline ID	GL-580230
Guideline Name	Tavneos
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State New Jersey Medicaid - Community & State New York Medicaid - Community & State New York EPP Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Arizona Medicaid - Community & State Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Pennsylvania Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Tavneos	
Diagnosis	ANCA (Anti-Neutrophil Cytoplasmic Autoantibody)-Associated Vasculitis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of severe active ANCA (anti-neutrophil cytoplasmic autoantibody)-associated vasculitis AND 2 - Submission of medical records (e.g., chart notes, laboratory values, etc.) documenting the disease is ONE of the following types: 2.1 Granulomatosis with polyangiitis (GPA) OR 2.2 Microscopic polyangiitis (MPA) AND 3 - Patient is being treated with an initial immunosuppressive regimen to induce remission (i.e., rituximab, cyclophosphamide) AND 4 - Tavneos is being prescribed as adjunctive treatment in combination with standard therapy (e.g., prednisone, azathioprine, mycophenolate, methotrexate, rituximab, cyclophosphamide) AND	

5 - Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Nephrologist
- Pulmonologist
- Vascular Medicine Specialist

Product Name:Tavneos	
Diagnosis	ANCA (Anti-Neutrophil Cytoplasmic Autoantibody)-Associated Vasculitis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient does not show evidence of progressive disease while on Tavneos therapy AND 2 - Tavneos is being prescribed as adjunctive treatment in combination with standard therapy (e.g., prednisone, azathioprine, mycophenolate, methotrexate, rituximab, cyclophosphamide) AND 3 - Prescribed by or in consultation with ONE of the following: • Rheumatologist • Nephrologist • Pulmonologist • Vascular Medicine Specialist	

2 . Revision History

UnitedHealthcare Community Plan of Arizona Clinical Pharmacy Program Guidelines

Date	Notes
4/17/2026	Updated formularies to add ACUIN and ACUPA for eff 6/1/2026.

Tecelra (afamitresgene autoleucel)



Prior Authorization Guideline

Guideline ID	GL-159332
Guideline Name	Tecelra (afamitresgene autoleucel)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	12/1/2024

1 . Criteria

Product Name:Tecelra	
Approval Length	1 Time Authorization in Lifetime
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming ALL of the following: 1.1 Diagnosis of synovial sarcoma	

AND

1.2 Disease is ONE of the following:

- Unresectable
- Metastatic

AND

1.3 BOTH of the following:

1.3.1 Patient is HLA-A*02:01P, HLA-A*02:02P, HLA-A*02:03P, or HLA-A*02:06P positive

AND

1.3.2 Patient does NOT have HLA-A*02:05P in either allele

AND

1.4 Presence of MAGE-A4 antigen as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA)

AND

2 - Submission of medical records (e.g., chart notes) or paid claims confirming patient has received prior therapy with ONE of the following:

- An anthracycline (e.g., doxorubicin)
- Ifosfamide

AND

3 - Patient is 16 years of age or older

AND

4 - Submission of medical records (e.g., chart notes) or paid claims confirming patient has never received Tecelra treatment in their lifetime

2 . Revision History

Date	Notes
11/5/2024	New program.

Tegsedi



Prior Authorization Guideline

Guideline ID	GL-140859
Guideline Name	Tegsedi
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	2/1/2021

1 . Criteria

Product Name:Tegsedi	
Diagnosis	Hereditary transthyretin-mediated (hATTR) amyloidosis with polyneuropathy
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following:	

- Diagnosis of Hereditary transthyretin-mediated (hATTR) amyloidosis with polyneuropathy
- Documentation that the patient has a pathogenic transthyretin (TTR) mutation (e.g., V30M)

AND

2 - Prescribed by or in consultation with a neurologist

AND

3 - Documentation of ONE of the following:

- Patient has a baseline polyneuropathy disability (PND) score less than or equal to IIIb
- Patient has a baseline familial amyloidotic polyneuropathy (FAP) Stage 1 or 2
- Patient has a baseline neuropathy impairment (NIS) score greater than or equal to 10 and less than or equal to 130

AND

4 - Patient has not had a liver transplant

AND

5 - Presence of clinical signs and symptoms of the disease (e.g., peripheral sensorimotor polyneuropathy, autonomic neuropathy, motor disability, etc.)

AND

6 - Patient is not receiving Tegsedi in combination with ONE of the following:

- Oligonucleotide agents [e.g., Onpattro (patisiran)]
- Tafamidis (e.g., Vyndaqel, Vyndamax)

Product Name:Tegsedi

Diagnosis	Hereditary transthyretin-mediated (hATTR) amyloidosis with polyneuropathy
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has previously received treatment with Tegsedi AND 2 - Prescribed by or in consultation with a neurologist AND 3 - Documentation of ONE of the following: • Patient continues to have a polyneuropathy disability (PND) score less than or equal to IIIb • Patient continues to have a familial amyloidotic polyneuropathy (FAP) Stage 1 or 2 • Patient continues to have a neuropathy impairment (NIS) score greater than or equal to 10 and less than or equal to 130 AND 4 - Documentation that the patient has experienced a positive clinical response to Tegsedi therapy (e.g., improved neurologic impairment, motor function, quality of life, slowing of disease progression, etc.) AND 5 - Patient is not receiving Tegsedi in combination with ONE of the following: • Oligonucleotide agents [e.g., Onpattro (patisiran)]	

- Tafamidis (e.g., Vyndaqel, Vyndamax)

2 . Revision History

Date	Notes
12/17/2020	Added examples of tafamidis products but no change to clinical intent.

Tepezza (teprotumumab-trbw)



Prior Authorization Guideline

Guideline ID	GL-415187
Guideline Name	Tepezza (teprotumumab-trbw)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	11/1/2025

1 . Criteria

Product Name:Tepezza	
Approval Length	6 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting diagnosis of thyroid eye disease (TED) AND	

2 - Prescribed by or in consultation with ONE of the following:

- Endocrinologist
- Specialist with expertise in the treatment of TED
- Ophthalmologist

AND

3 - Treatment with Tepezza has NOT exceeded a total of 8 infusions

2 . Revision History

Date	Notes
10/6/2025	New program for ACUAZ/ACUAZEC.

Test Strips



Prior Authorization Guideline

Guideline ID	GL-369221
Guideline Name	Test Strips
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	9/1/2025

1 . Criteria

Product Name:Non-preferred Test Strip Products	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - History of failure, contraindication, or intolerance to ALL preferred* products OR	

2 - Patient is on an insulin pump

OR

3 - Patient is visually impaired

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name: Preferred or Non-preferred Test Strip Products	
Approval Length	12 month(s)
Guideline Type	Quantity Limit
Approval Criteria 1 - ONE of the following: 1.1 For insulin dependent or pregnant patients, the physician must confirm the patient requires a greater quantity because of more frequent blood glucose testing (e.g., patients on intravenous insulin infusions) OR 1.2 For non-insulin dependent patients, ONE the following: 1.2.1 The patient is experiencing or is prone to hypoglycemia or hyperglycemia and requires additional testing to achieve glycemic control OR 1.2.2 The patient's physician is adjusting medications and the patient requires additional blood glucose testing during this time OR	

1.2.3 The patient's physician is adjusting MNT (medical nutrition therapy) and the patient requires additional blood glucose testing during this time

OR

1.2.4 The patient requires additional testing due to fluctuations in blood glucose due to physical activity or exercise

OR

1.2.5 Other circumstances where prescribing physician confirms that the patient requires a greater quantity because of more frequent blood glucose testing (clinical review required by reviewing pharmacist and/or medical director)

2 . Revision History

Date	Notes
8/14/2025	Replaced CORE criteria with FFS/state criteria.

Testosterone



Prior Authorization Guideline

Guideline ID	GL-421251
Guideline Name	Testosterone
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	11/1/2025

1 . Criteria

Product Name:Brand Androgel, generic testosterone gel 1% and 1.62%, Brand Testim, Brand Vogelxo, testosterone gel 2%, testosterone soln, testosterone enanthate, Depo-testosterone, testosterone cypionate, Jatenzo, Kyzatrex, Natesto, Tlando, Undecatrex, Xyosted	
Diagnosis	Hypogonadism
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting ONE of the following:

1.1 TWO pre-treatment serum total testosterone levels less than 300 ng/dL (nanograms/deciliter) [less than 10.4 nmol/L (nanomoles/liter)] or less than the reference range for the lab, taken at separate times (document lab value and date for both levels)

OR

1.2 BOTH of the following:

1.2.1 Patient has a condition that may cause altered sex-hormone binding globulin (SHBG) [e.g., thyroid disorder, HIV (human immunodeficiency virus) disease, liver disorder, diabetes, obesity]

AND

1.2.2 ONE pre-treatment calculated free or bioavailable testosterone level less than 50 pg/mL (picograms/milliliter) (less than 5 ng/dL or less than 0.17 nmol/L) or less than the reference range for the lab (This may require treatment to be temporarily held. Document lab value and date)

OR

1.3 Patient has a history of ONE of the following:

- Bilateral orchiectomy
- Panhypopituitarism
- A genetic disorder known to cause hypogonadism (e.g., congenital anorchia, Klinefelter's syndrome)

AND

2 - Patient is NOT taking any of the following growth hormones, unless diagnosed with panhypopituitarism:

- Genotropin
- Humatrope
- Norditropin FlexPro
- Nutropin AQ

- Omnitrope
- Saizen

AND

3 - Patient is NOT taking with an aromatase inhibitor [e.g., Arimidex (anastrozole), Femara (letrozole), or Aromasin (exemestane)]

AND

4 - Patient was male at birth

AND

5 - Diagnosis of hypogonadism

AND

6 - ONE of the following:

- Significant reduction in weight (less than 90 percent ideal body weight) [e.g., AIDS (acquired immunodeficiency syndrome) wasting syndrome]
- Osteopenia
- Osteoporosis
- Decreased bone density
- Decreased libido
- Organic cause of testosterone deficiency (e.g., injury, tumor, infection, or genetic defects)

AND

7 - If the request is for a non-preferred* medication, submission of medical records (e.g., chart notes) or paid claims confirming a history of failure or intolerance to generic testosterone 1.62% gel (generic for Androgel by preferred* manufacturers)

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name: Brand Androgel, generic testosterone gel 1% and 1.62%, Brand Testim, Brand Vogelxo, testosterone gel 2%, testosterone soln, testosterone enanthate, Depo-testosterone, testosterone cypionate, Jatenzo, Kyzatrex, Natesto, Tlando, Undecatrex, Xyosted

Diagnosis	Gender Dysphoria
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is using hormones to change physical characteristics

AND

2 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of gender dysphoria, as defined by the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM)

AND

3 - Patient is NOT taking any of the following growth hormones, unless diagnosed with panhypopituitarism:

- Genotropin
- Humatrope
- Norditropin FlexPro
- Nutropin AQ
- Omnitrope
- Saizen

AND

4 - Patient is NOT taking with an aromatase inhibitor [e.g., Arimidex (anastrozole), Femara (letrozole), Aromasin (exemestane)]

AND

5 - If the request is for a non-preferred* medication, submission of medical records (e.g., chart notes) or paid claims confirming a history of failure or intolerance to generic testosterone 1.62% gel (generic for Androgel by preferred* manufacturers)	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name: Brand Androgel, generic testosterone gel 1% and 1.62%, Brand Testim, Brand Vogelxo, testosterone gel 2%, testosterone soln, testosterone enanthate, Depo-testosterone, testosterone cypionate, Jatenzo, Kyzatrex, Natesto, Tlando, Undecatrex, Xyosted	
Diagnosis	Hypogonadism, Gender Dysphoria
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting ONE of the following: 1.1 Follow-up total serum testosterone level drawn within the past 12 months is within or below the normal male limits of the reporting lab (document value and date) OR 1.2 Follow-up total serum testosterone level drawn within the past 12 months is outside of upper male limits of normal for the reporting lab and the dose is adjusted (document value and date) OR 1.3 BOTH of the following: 1.3.1 Patient has a condition that may cause altered sex-hormone binding globulin (SHBG) [e.g., thyroid disorder, HIV (human immunodeficiency virus) disease, liver disorder, diabetes, obesity]	

AND

1.3.2 ONE of the following:

1.3.2.1 Follow-up calculated free or bioavailable testosterone level drawn within the past 12 months is within or below the normal male limits of the reporting lab (document lab value and date)

OR

1.3.2.2 Follow-up calculated free or bioavailable testosterone level drawn within the past 12 months is outside of upper male limits of normal for the reporting lab and the dose is adjusted (document value and date)

AND

2 - Patient is NOT taking any of the following growth hormones, unless diagnosed with panhypopituitarism:

- Genotropin
- Humatrope
- Norditropin FlexPro
- Nutropin AQ
- Omnitrope
- Saizen

AND

3 - Patient is NOT taking with an aromatase inhibitor [e.g., Arimidex (anastrozole), Femara (letrozole), Aromasin (exemestane)]

AND

4 - If the request is for a non-preferred* medication, submission of medical records (e.g., chart notes) or paid claims confirming a history of failure or intolerance to generic testosterone 1.62% gel (generic for Androgel by preferred* manufacturers)

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC CP

2 . Revision History

Date	Notes
10/13/2025	Added Xyosted as a target for all indications. Updated product name lists and GPI tables accordingly. No changes to clinical criteria.

Tezspire (tezepelumab-ekko)



Prior Authorization Guideline

Guideline ID	GL-502216
Guideline Name	Tezspire (tezepelumab-ekko)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name: Tezspire auto-inj	
Diagnosis	Asthma
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of severe asthma	

AND

2 - Patient is 12 years of age or older

AND

3 - ONE of the following:

3.1 Patient has had two or more asthma exacerbations requiring systemic corticosteroids (e.g., prednisone) within the past 12 months

OR

3.2 Prior asthma-related hospitalization within the past 12 months

AND

4 - Patient is currently being treated with ONE of the following unless there is a contraindication or intolerance to these medications:

4.1 BOTH of the following:

- High-dose inhaled corticosteroid (ICS) (i.e., greater than 500 mcg fluticasone propionate equivalent/day)
- Additional asthma controller medication (e.g., leukotriene receptor antagonist [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], tiotropium)

OR

4.2 One maximally-dosed combination ICS/LABA product (e.g., Advair [fluticasone propionate/salmeterol], Symbicort [budesonide/formoterol], Breo Ellipta [fluticasone/vilanterol])

AND

5 - Paid claims or submission of documentation (e.g., chart notes) demonstrating history of failure, contraindication, or intolerance to BOTH of the following:

- Xolair (omalizumab)
- Fasenra (benralizumab)

AND

6 - Prescribed by or in consultation with ONE of the following:

- Pulmonologist
- Allergist/Immunologist

Product Name: Tezspire auto-inj	
Diagnosis	Asthma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting positive clinical response to therapy as evidenced by ONE of the following:

- A reduction in asthma exacerbations
- Improvement in forced expiratory volume in 1 second (FEV1) from baseline

AND

2 - Patient continues to be treated with an inhaled corticosteroid (ICS) (e.g., fluticasone, budesonide) with or without additional asthma controller medication (e.g., leukotriene receptor antagonist [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], tiotropium) unless there is a contraindication or intolerance to these medications

AND

3 - Prescribed by or in consultation with ONE of the following:

- Pulmonologist
- Allergist/Immunologist

Product Name: Tezspire auto-inj

Diagnosis	Chronic rhinosinusitis with nasal polyps (CRSwNP)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is 12 years of age or older

AND

2 - Submission of documentation (e.g., chart notes) confirming ALL of the following:

2.1 Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP) defined by ALL of the following:

2.1.1 TWO or more of the following symptoms for greater than or equal to 12 weeks duration:

- Mucopurulent discharge
- Nasal obstruction and congestion
- Decreased or absent sense of smell
- Facial pressure or pain

AND

2.1.2 ONE of the following:

- Evidence of inflammation on paranasal sinus examination or computed tomography (CT)
- Evidence of purulence coming from paranasal sinuses or ostiomeatal complex

AND

2.1.3 The presence of nasal polyps

AND

2.2 ONE of the following:

- Patient has required prior sino-nasal surgery
- Patient has required systemic corticosteroids in the previous 2 years

AND

2.3 Patient has been unable to obtain symptom relief after trial of ALL of the following agents/classes of agents:

- Nasal saline irrigations
- Intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone)
- Antileukotriene agents (e.g., montelukast, zafirlukast, zileuton)

AND

3 - Paid claims or submission of documentation (e.g., chart notes) demonstrating history of failure, contraindication, or intolerance to Xolair (omalizumab)

AND

4 - Used in combination with another agent for CRSwNP (i.e., intranasal corticosteroids, nasal saline)

AND

5 - Patient is NOT receiving Tezspire in combination with another biologic medication [e.g., Nucala (mepolizumab), (Xolair (omalizumab), Dupixent (dupilumab)]

AND

6 - Prescribed by or in consultation with ONE of the following:

- Otolaryngologist
- Allergist
- Pulmonologist

Product Name: Tezspire auto-inj

Diagnosis	Chronic rhinosinusitis with nasal polyps (CRSwNP)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of documentation (e.g., chart notes) confirming positive clinical response to therapy

AND

2 - Paid claims or submission of documentation (e.g., chart notes) demonstrating history of failure, contraindication, or intolerance to Xolair (omalizumab)

AND

3 - Used in combination with another agent for CRSwNP (i.e., intranasal corticosteroids, nasal saline)

AND

4 - Patient is NOT receiving Tezspire in combination with another biologic medication [e.g., Nucala (mepolizumab), (Xolair (omalizumab), Dupixent (dupilumab)]

AND

5 - Prescribed by or in consultation with ONE of the following:

- Otolaryngologist
- Allergist
- Pulmonologist

2 . Revision History

Date	Notes
1/15/2026	Added criteria for CRSwNP indication

Thalomid



Prior Authorization Guideline

Guideline ID	GL-140927
Guideline Name	Thalomid
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Thalomid	
Diagnosis	Multiple Myeloma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of multiple myeloma	

Product Name:Thalomid	
Diagnosis	Multiple Myeloma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient does not show evidence of progressive disease while on Thalomid therapy	

Product Name:Thalomid	
Diagnosis	Erythema Nodosum Leprosum (ENL)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderate to severe erythema nodosum leprosum (ENL) AND 2 - ONE of the following: 2.1 Used for acute treatment OR 2.2 Used as maintenance therapy for prevention & suppression of cutaneous manifestations of ENL recurrence	

Product Name:Thalomid

Diagnosis	Erythema Nodosum Leprosum (ENL)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Thalomid therapy	

Product Name:Thalomid	
Diagnosis	Aphthous Stomatitis or Ulcer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of severe, recurrent aphthous stomatitis or ulcer	

Product Name:Thalomid	
Diagnosis	Aphthous Stomatitis or Ulcer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Thalomid therapy	

Product Name:Thalomid	

Diagnosis	Pyoderma Gangrenosum
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of pyoderma gangrenosum AND 2 - Used as third line treatment	

Product Name:Thalomid	
Diagnosis	Pyoderma Gangrenosum
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Thalomid therapy	

Product Name:Thalomid	
Diagnosis	Cutaneous Manifestations Systemic Lupus Erythematosus (SLE)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of cutaneous manifestations of systemic lupus erythematosus (SLE)

Product Name:Thalomid

Diagnosis	Cutaneous Manifestations Systemic Lupus Erythematosus (SLE)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Thalomid therapy

Product Name:Thalomid

Diagnosis	B-Cell Lymphomas
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Castleman's Disease (CD)

AND

2 - NOT used as first line therapy

Product Name:Thalomid

Diagnosis	B-Cell Lymphomas
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Patient does not show evidence of progressive disease while on Thalomid therapy	

Product Name:Thalomid	
Diagnosis	Myelofibrosis-Associated Anemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of primary myelofibrosis AND 2 - One of the following: 2.1 Both of the following: 2.1.1 Serum erythropoietin levels less than 500 mU/mL AND 2.1.2 History of failure, contraindication, or intolerance to erythropoietins [e.g., Procrit (epoetin alfa)] OR 2.2 Serum erythropoietin levels greater than or equal to 500 mU/mL	

Product Name:Thalomid	
Diagnosis	Myelofibrosis-Associated Anemia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation that member has evidence of symptom improvement or reduction in spleen-liver volume while on Thalomid	

Product Name:Thalomid	
Diagnosis	Acquired Immunodeficiency Syndrome (AIDS)- Related Kaposi Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Acquired Immunodeficiency Syndrome (AIDS)- Related Kaposi Sarcoma AND 2 - Patient is currently being treated with antiretroviral therapy (ART) AND 3 - Not used as first line therapy	

Product Name:Thalomid	
Diagnosis	AIDS- Related Kaposi Sarcoma

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient does not show evidence of progressive disease while on Thalomid therapy	

Product Name:Thalomid	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Thalomid will be approved for uses supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1, 2A, or 2B.	

Product Name:Thalomid	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Thalomid therapy	

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Therapeutic Duplication (Subtype A)



Prior Authorization Guideline

Guideline ID	GL-599195
Guideline Name	Therapeutic Duplication (Subtype A)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Generic arformoterol nebulizer solution, Brand Brovana nebulizer, generic formoterol nebulizer solution, Brand Perforomist nebulizer, Striverdi Respimat, Serevent Diskus, Incruse Ellipta, Brand Spiriva Handihaler, generic tiotropium, Spiriva Respimat, Tudorza Pressair, generic ipratropium inhalation solution, Atrovent HFA, Anoro Ellipta, Stiolto Respimat, Bevespi Aerosphere, Duaklir Pressair, Breztri Aerosphere, Glyxambi, Steglujan, Qtern, Trijardy XR, Brand Pulmicort suspension, generic budesonide suspension, Victoza, Adlyxin, Trulicity, Bydureon BCise, Byetta, Ozempic, Rybelsus, Januvia, Janumet, Janumet XR, Brand Onglyza, generic saxagliptin, Brand Kombiglyze XR, generic saxagliptin/metformin ER, Tradjenta, Jentadueto, Jentadueto XR, Nesina, alogliptin, Kazano, alogliptin/metformin, Oseni, alogliptin/pioglitazone, Mounjaro, Xultophy, Soliqua, Invokana, brand Farxiga, generic dapagliflozin, Jardiance, Invokamet, Invokamet XR, brand Xigduo XR, generic dapagliflozin/metformin ER, Synjardy, Synjardy XR, Steglatro, Segluromet, Zituvio, Brand Flovent HFA, Fluticasone propionate HFA, Flovent Diskus, Brand Fluticasone propionate Diskus, Brand Pulmicort Flexhaler, Alvesco, ArmonAir Digihaler, Asmanex Twisthaler, Asmanex HFA, Arnuity Ellipta, Qvar RediHaler, Lohala Magnair, Trelegy Ellipta, Brand Advair Diskus, generic fluticasone propionate/salmeterol diskus (generic Advair Diskus),

generic Wixela Inhub (generic Advair Diskus), AirDuo Respiclick, fluticasone/salmeterol (authorized generic of AirDuo), Brand Advair HFA, Brand Fluticasone/salmeterol HFA, Brand Symbicort, generic budesonide/formoterol, Breyna, AirDuo Digihaler, Dulera, Breo Ellipta, Brand fluticasone/vilanterol Ellipta, Basaglar Tempo pen, Basaglar Kwikpen, Insulin Glargine Solostar, Lantus Solostar, Toujeo Solostar, Toujeo Max Solostar, Semglee Pen Injector, Insulin Glargine-YFGN pen, Lantus vial, Insulin Glargine vial, Semglee vial, Insulin Glargine-YFGN vial, Levemir vial, Levemir Flextouch, Levemir Flexpen, Tresiba vial, Insulin Degludec vial, Tresiba Flextouch, Insulin Degludec Flextouch, Rezvoglar, Baclofen tabs, generic baclofen suspension, Brand Fleqsuvy, Brand Ozobax DS, brand Ozobax, Brand Baclofen solution, brand Lioresal intrathecal, generic baclofen intrathecal, brand Gablofen intrathecal, baclofen intrathecal solution, Lyvispah, generic carisoprodol tab, brand Soma, brand Vanadom tab, generic chlorzoxazone, brand Lorzone, generic cyclobenzaprine, brand Fexmid, generic cyclobenzaprine ER, brand Amrix, metaxalone, methocarbamol, orphenadrine CR/ER, generic tizanidine caps/tabs, brand Zanaflex caps/tabs, brand Dantrium, generic dantrolene, brand Norgesic, generic orphenadrine/aspirin/caffeine, norgesic forte, orphengesic forte, Brand Neurontin caps/tabs/soln, generic gabapentin caps/tabs/soln, gabapentin tinytabs, brand Lyrica caps/soln, generic pregabalin caps/soln, brand Gralise, brand Lyrica CR, generic pregabalin ER, Horizant, Zorvolex, brand Zipsor, generic diclofenac caps, brand Lofena, generic diclofenac tabs, diclofenac DR/ER, brand Cambia, generic diclofenac packet (migraine), etodolac cap, brand Lodine, generic etodolac tab, etodolac ER, brand Nalfon caps/tabs, generic fenoprofen caps/tabs, flurbiprofen, ibuprofen caps/tabs/chewable (includes All Manufactures), Brand Advil, ibuprofen suspension (40 mg/ml & 100 mg/5ml), indomethacin caps, indomethacin ER/SR caps, indocin susp, indocin suppository, indomethacin suppository, ketoprofen cap, ketoprofen ER cap, ketorolac tabs, meclizolamine cap, mefenamic acid, meloxicam cap/tab, brand Relafen DS, generic nabumetone, generic naproxen tab/susp/caps (includes All Manufactures), brand naprosyn tab/susp, brand Aleve, brand Anaprox DS, brand EC-Naprosyn, generic naproxen DR, generic EC-naproxen, brand Naprelan, generic naproxen CR/ER, Brand Daypro, generic oxaprozin, brand Feldene, generic piroxicam, sulindac, tolmetin, brand Celebrex, generic celecoxib, Elyxyb, brand Arthrotec, generic diclofenac sodium/misoprostol, brand Duexis, generic ibuprofen/famotidine, brand Vimovo, generic naproxen/esomeprazole, brand Advil PM, generic ibuprofen/diphenhydramine, brand Aleve PM, generic naproxen/diphenhydramine, hydrocodone/ibuprofen, brand Treximet, generic sumatriptan/naproxen, Motrin Dual Action/Tylenol, Advil Dual Action/acetaminophen, acetaminophen/ibuprofen, Naproxen/capsaicin cream (Naprotin), Inpefa, Saxenda, Wegovy inj/tab, Foundayo, Brand Brenzavvy, Brand Bexagliflozin, Zepbound, Coxanto, Zituvimet, Sitagliptin/metformin, Brand Tanlor, Dolobid, generic diflunisal, Zituvimet XR, Tresni, Fenopron, Gabarone, Addaprin, Symbravo, Exenatide, Brynovin, Vyscoxa, Tonmya, Ontralfy

Diagnosis	DUR: Therapeutic Duplication
Approval Length	12 month(s)
Guideline Type	Administrative
Approval Criteria	
1 - The requested medication will be used exclusively, and the previously prescribed medication will be discontinued	

or

2 - All of the following:

2.1 The requested medication combination is supported by information from ONE of the following appropriate compendia of current literature:

American Hospital Formulary Service Drug Information

National Comprehensive Cancer Network Drugs and Biologics Compendium

Thomson Micromedex DrugDex

Clinical pharmacology

United States Pharmacopoeia-National Formulary

AND

2.2 The drug combination is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plan's program

AND

2.3 The provider attests that they are aware that the patient is using duplicate therapy

AND

2.4 Special clinical circumstances exist that necessitate the need for duplicate therapy

AND

2.5 Provider attests that the necessity for continued concomitant therapy and safety will be periodically assessed

2 . Revision History

Date	Notes
4/28/2026	Added Foundayo

Therapeutic Duplication (Subtype B)



Prior Authorization Guideline

Guideline ID	GL-560225
Guideline Name	Therapeutic Duplication (Subtype B)
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State New Jersey Medicaid - Community & State New York Medicaid - Community & State New York EPP Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Indiana Medicaid - Community & State Kansas Medicaid - Community & State Maryland Medicaid - Community & State Nebraska Medicaid - Community & State Nevada Medicaid - Community & State New Mexico Medicaid - Community & State North Carolina Medicaid - Community & State Virginia Medicaid - Community & State Washington Medicaid - Community & State Arizona Medicaid - Community & State Texas

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:(All formulations/packaging, except for Entyvio) Entyvio Pen, Stelara, Cimzia, Abrilada, Humira, Amjevita, Idacio, Hulio, Cyltezo, Yusimry, Yuflyma, Hadlima, Hyrimoz, Adalimumab (all products), Simponi, Enbrel, Actemra, Cosentyx, Ilaris, Kineret, Kevzara, Taltz, Tremfya, Orencia, Xeljanz, Xeljanz XR, Xeljanz Solution, Siliq, Otezla, Olumiant, Ilumya, Skyrizi, Rinvoq, Sotyktu, Cibinqo, Adbry, Dupixent, brand Copaxone, generic glatiramer acetate, generic glatopa, Mavenclad, Rebif, Avonex, Betaseron, Extavia, brand Aubagio, generic teriflunomide, Plegridy, Lemtrada, Tysabri, Ocrevus, brand Tecfidera, generic dimethyl fumarate, Vumerity, brand Gilenya, generic fingolimod, Tascenso ODT, Zeposia, Mayzent, Bafiertam, Kesimpta, Ponvory, Xolair, Fasenra, Nucala, Cinqair, Tezspire, Velsipity, Bimzelx, Omvoh, Zymfentra, Simlandi, Spevigo, Tyenne, Rinvoq LQ, Nemludio, Ebglyss, Wezlana, Steqeyma, Yesintek, Pyzchiva, Otulfi, Selarsdi, Imuldosa, Ustekinumab (all products), Leqselvi, Litfulo, Avtozma, Otezla XR, Starjemza, Exdensur, Icotyde	
Diagnosis	DUR: Therapeutic Duplication
Approval Length	12 month(s)
Guideline Type	Administrative
Approval Criteria 1 - The requested medication will be used exclusively, and the previously prescribed medication will be discontinued	

2 . Revision History

Date	Notes
3/30/2026	Added Icotyde to drug list.

Thrombopoiesis Stimulating Agents



Prior Authorization Guideline

Guideline ID	GL-546252
Guideline Name	Thrombopoiesis Stimulating Agents
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	4/12/2026

1 . Criteria

Product Name:Alvaiz, Doptelet, Doptelet Sprinkle, Nplate, Brand Promacta tabs, generic eltrombopag tabs, Brand Promacta powder pack for susp, generic eltrombopag powder pack for susp, Tavalisse, Wayrilz	
Diagnosis	Chronic Immune Thrombocytopenia (ITP)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chronic immune thrombocytopenia (ITP)	

AND

2 - History of failure, contraindication, or intolerance to ONE of the following:

- Corticosteroids
- Immunoglobulins
- Splenectomy

AND

3 - If the request is non-preferred*, history of failure, contraindication, or intolerance to BOTH of the following preferred alternatives:

- generic eltrombopag tablet
- Nplate

Notes

*PDL link: <https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP>

Product Name:Alvaiz, Doptelet, Doptelet Sprinkle, Nplate, Brand Promacta tabs, generic eltrombopag tabs, Brand Promacta powder pack for susp, generic eltrombopag powder pack for susp, Tavalisse, Wayrilz

Diagnosis	Chronic Immune (idiopathic) thrombocytopenia (ITP)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - If the request is non-preferred*, history of failure, contraindication, or intolerance to BOTH of the following preferred alternatives:

- generic eltrombopag tablet
- Nplate

Notes

*PDL link: <https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP>

Product Name:Alvaiz, Brand Promacta tabs, generic eltrombopag tabs, Brand Promacta powder pack for susp, generic eltrombopag powder pack for susp

Diagnosis Severe Aplastic Anemia

Approval Length 6 month(s)

Therapy Stage Initial Authorization

Guideline Type Prior Authorization

Approval Criteria

1 - Diagnosis of severe aplastic anemia

AND

2 - ONE of the following:

2.1 Used in combination with standard immunosuppressive therapy [e.g., Atgam (antithymocyte globulin equine), Thymoglobulin (antithymocyte globulin rabbit), cyclosporine]

OR

2.2 History of failure, contraindication, or intolerance to at least one course of immunosuppressive therapy [e.g., Atgam (antithymocyte globulin equine), Thymoglobulin (antithymocyte globulin rabbit), cyclosporine]

AND

3 - If the request is non-preferred*, history of failure, contraindication, or intolerance to generic eltrombopag tablet	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC CP

Product Name:Alvaiz, Brand Promacta tabs, generic eltrombopag tabs, Brand Promacta powder pack for susp, generic eltrombopag powder pack for susp	
Diagnosis	Severe Aplastic Anemia
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy AND 2 - If the request is non-preferred*, history of failure, contraindication, or intolerance to generic eltrombopag tablet	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC CP

Product Name:Alvaiz, Brand Promacta tabs, generic eltrombopag tabs, Brand Promacta powder pack for susp, generic eltrombopag powder pack for susp	
Diagnosis	Chronic Hepatitis C-associated Thrombocytopenia
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of chronic Hepatitis C-associated thrombocytopenia

AND

2 - ONE of the following:

- Planning to initiate and maintain interferon-based treatment
- Currently receiving interferon-based treatment

AND

3 - If the request is non-preferred*, history of failure, contraindication, or intolerance to generic eltrombopag tablet

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:Alvaiz, Brand Promacta tabs, generic eltrombopag tabs, Brand Promacta powder pack for susp, generic eltrombopag powder pack for susp

Diagnosis	Chronic Hepatitis C-associated Thrombocytopenia
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Patient is currently on antiviral interferon therapy for treatment of chronic Hepatitis C

AND

3 - If the request is non-preferred*, history of failure, contraindication, or intolerance to generic eltrombopag tablet	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:Doptelet, Doptelet Sprinkle, Mulpleta	
Diagnosis	Thrombocytopenia
Approval Length	1 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of thrombocytopenia AND 2 - Patient has chronic liver disease AND 3 - Patient is scheduled to undergo a procedure	

Product Name:Nplate	
Diagnosis	Hematopoietic Syndrome of Acute Radiation Syndrome [HS-ARS]
Approval Length	6 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Hematopoietic Syndrome of Acute Radiation Syndrome [HS-ARS]	

AND

2 - Patient is receiving myelosuppressive doses of radiation

2 . Revision History

Date	Notes
3/13/2026	Replaced prerequisite "Brand Promacta" with "generic eltrombopag tablet" throughout guideline. Updated product name lists throughout guideline. In thrombocytopenia criteria section for Doptelet/Mulpleta, removed embedded step requirement and added Doptelet Sprinkle as a target.

Tobramycin Inhalation



Prior Authorization Guideline

Guideline ID	GL-140865
Guideline Name	Tobramycin Inhalation
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2021

1 . Criteria

Product Name:Brand Bethkis, Kitabis	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of cystic fibrosis (CF)	

Product Name:Brand TOBI Nebulizer Solution, generic tobramycin solution for inhalation, TOBI Podhaler

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of cystic fibrosis (CF) AND 2 - Lung infection with positive culture demonstrating Pseudomonas aeruginosa infection AND 3 - History of failure, intolerance, or contraindication to BOTH of the following • Brand Bethkis • Kitabis	

Product Name: Brand TOBI Nebulizer Solution, generic tobramycin solution for inhalation, TOBI Podhaler	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy	

2 . Revision History

UnitedHealthcare Community Plan of Arizona Clinical Pharmacy Program Guidelines

Date	Notes
3/10/2021	Added generic Bethkis. Updated product name listing of first criteria box to specify brand Bethkis and updated NP language to specify T/F must be brand Bethkis.

Tocilizumab



Prior Authorization Guideline

Guideline ID	GL-565279
Guideline Name	Tocilizumab
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:Actemra Actpen, Actemra SC, Avtozma SC, Tyenne SC, newly launched tocilizumab SC products	
Diagnosis	Rheumatoid Arthritis (RA)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) or verification of paid claims documenting ALL of the following:	

1.1 Diagnosis of moderately to severely active rheumatoid arthritis (RA)

AND

1.2 History of failure to a 3 month trial of ONE non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] at maximally indicated doses within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

2 - Prescribed by, or in consultation with, a rheumatologist

AND

3 - If the request is non-preferred*, history of failure to ALL preferred* tocilizumab biosimilars

Notes	Approval Length: 12 months. If approving a preferred tocilizumab, please enter the NDC list group authorization: AZTOCILIZU. If approving a non-preferred tocilizumab, please enter the following: 1) The NDC list group authorization: AZTOCILIZU 2) An authorization for the non-preferred tocilizumab at GPI-12 level *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name: Actemra Actpen, Actemra SC, Avtozma SC, Tyenne SC, newly launched tocilizumab SC products

Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (PJIA)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) or verification of paid claims documenting ALL of the following:

1.1 Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis (PJIA)

AND

1.2 History of failure to a minimum duration of a 6-week trial, contraindication, or intolerance to ONE of the following conventional therapies at maximally tolerated doses:

- leflunomide
- methotrexate

AND

2 - Prescribed by, or in consultation with, a rheumatologist

AND

3 - If the request is non-preferred*, history of failure to ALL preferred* tocilizumab biosimilars

Notes	Approval Length: 12 months. If approving a preferred tocilizumab, please enter the NDC list group authorization: AZTOCILIZU. If approving a non-preferred tocilizumab, please enter the following: 1) The NDC list group authorization: AZTOCILIZU 2) An authorization for the non-preferred tocilizumab at GPI-12 level *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name: Actemra Actpen, Actemra SC, Avtozma SC, Tyenne SC, newly launched tocilizumab SC products	
Diagnosis	Systemic Juvenile Idiopathic Arthritis (SJIA)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Submission of medical records (e.g., chart notes) or verification of paid claims documenting ALL of the following:

1.1 Diagnosis of active systemic juvenile idiopathic arthritis (SJIA)

AND

1.2 History of failure, contraindication, or intolerance to ONE of the following conventional therapies at maximally tolerated doses:

- Minimum duration of a 3-month trial and failure of methotrexate
- Minimum duration of a 1-month trial of nonsteroidal anti-inflammatory drug (NSAID) (e.g., ibuprofen, naproxen)
- Minimum duration of a 2-week trial of systemic glucocorticoid (e.g., prednisone)

AND

2 - Prescribed by, or in consultation with, a rheumatologist

AND

3 - If the request is non-preferred*, history of failure to ALL preferred* tocilizumab biosimilars

Notes	Approval Length: 12 months. If approving a preferred tocilizumab, please enter the NDC list group authorization: AZTOCILIZU. If approving a non-preferred tocilizumab, please enter the following: 1) The NDC list group authorization: AZTOCILIZU 2) An authorization for the non-preferred tocilizumab at GPI-12 level *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name: Actemra Actpen, Actemra SC, Avtozma SC, Tyenne SC, newly launched tocilizumab SC products	
Diagnosis	Giant Cell Arteritis (GCA)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) or verification of paid claims documenting ALL of the following:

1.1 Diagnosis of giant cell arteritis (GCA)

AND

1.2 History of failure, contraindication, or intolerance to a glucocorticoid (e.g., prednisone)

AND

2 - Prescribed by, or in consultation with, a rheumatologist

AND

3 - If the request is non-preferred*, history of failure to ALL preferred* tocilizumab biosimilars

Notes	Approval Length: 12 months. If approving a preferred tocilizumab, please enter the NDC list group authorization: AZTOCILIZU. If approving a non-preferred tocilizumab, please enter the following: 1) The NDC list group authorization: AZTOCILIZU 2) An authorization for the non-preferred tocilizumab at GPI-12 level *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name: Actemra Actpen, Actemra SC, Avtozma SC, Tyenne SC, newly launched tocilizumab SC products	
Diagnosis	Rheumatoid Arthritis (RA), Polyarticular Juvenile Idiopathic Arthritis (PJIA), Systemic Juvenile Idiopathic Arthritis (SJIA), Giant Cell Arteritis (GCA)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy

AND

2 - Prescribed by, or in consultation with, a rheumatologist

AND

3 - If the request is non-preferred*, history of failure to ALL preferred* tocilizumab biosimilars

Notes	Approval Length: 12 months. If approving a preferred tocilizumab, please enter the NDC list group authorization: AZTOCILIZU. If approving a non-preferred tocilizumab, please enter the following: 1) The NDC list group authorization: AZTOCILIZU 2) An authorization for the non-preferred tocilizumab at GPI-12 level *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC CP

Product Name: Actemra Actpen, Actemra SC, Avtozma SC, Tyenne SC, newly launched tocilizumab SC products

Diagnosis	Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of active systemic sclerosis-associated interstitial lung disease (SSc-ILD) as documented by ALL of the following:

1.1 ONE of the following:

1.1.1 Skin thickening of the fingers of both hands extending proximal to the metacarpophalangeal joints

OR

1.1.2 TWO of the following:

- Skin thickening of the fingers (e.g., puffy fingers, sclerodactyly of the fingers)
- Fingertip lesions (e.g., digital tip ulcers, fingertip pitting scars)
- Telangiectasia
- Abnormal nailfold capillaries
- Pulmonary arterial hypertension
- Raynaud's phenomenon
- SSc-related autoantibodies (e.g., anticentromere, anti-topoisomerase I, anti-RNA polymerase III)

AND

1.2 Presence of interstitial lung disease as determined by finding evidence of pulmonary fibrosis on HRCT (high-resolution computed tomography), involving at least 10% of the lungs

AND

2 - Prescribed by, or in consultation with, a pulmonologist

AND

3 - If the request is non-preferred*, history of failure to ALL preferred* tocilizumab biosimilars

Notes	Approval Length: 12 months. If approving a preferred tocilizumab, please enter the NDC list group authorization: AZTOCILIZU. If approving a non-preferred tocilizumab, please enter the following: 1) The NDC list group authorization: AZTOCILIZU 2) An authorization for the non-preferred tocilizumab at GPI-12 level *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC CP

Product Name: Actemra Actpen, Actemra SC, Avtozma SC, Tyenne SC, newly launched tocilizumab SC products	
Diagnosis	Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy AND 2 - Prescribed by, or in consultation with, a pulmonologist AND 3 - If the request is non-preferred*, history of failure to ALL preferred* tocilizumab biosimilars	
Notes	Approval Length: 12 months. If approving a preferred tocilizumab, please enter the NDC list group authorization: AZTOCILIZU. If approving a non-preferred tocilizumab, please enter the following: 1) The NDC list group authorization: AZTOCILIZU 2) An authorization for the non-preferred tocilizumab at GPI-12 level *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC CP

2 . Revision History

Date	Notes
4/6/2026	Updated guideline name. Added Avtozma SC products as targets. Updated product name lists and GPI tables accordingly.

Topical Capsaicin Products



Prior Authorization Guideline

Guideline ID	GL-140833
Guideline Name	Topical Capsaicin Products
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name:Diclareal	
Approval Length	3 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming diagnosis of osteoarthritis of the knees AND	

2 - Submission of medical records (e.g., chart notes, paid claims history) documenting history of failure to ALL of the following:

- diclofenac 1% topical gel
- diclofenac 2% topical solution
- topical capsaicin cream/patch

Product Name:Trubrex	
Approval Length	3 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming requested medication is being used for the treatment of acute and chronic pain in muscles and joints associated with muscle soreness, strains, sprains, arthritis, simple backache, muscle stiffness, etc. AND 2 - Submission of medical records (e.g., chart notes, paid claims history) documenting trial and failure, contraindication, or intolerance to ALL of the following: • diclofenac 1% topical gel • topical capsaicin cream/patch • topical lidocaine patch	

2 . Revision History

Date	Notes
12/7/2023	New guideline

Topical NSAIDs



Prior Authorization Guideline

Guideline ID	GL-140719
Guideline Name	Topical NSAIDs
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name: Brand Flector Patch, generic diclofenac epolamine 1.3% patch	
Approval Length	2 Week(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of acute pain due to minor strains, sprains, or contusions AND	

2 - ONE of the following:

2.1 The patient did not receive adequate pain relief when treated with at least three preferred non-steroidal anti-inflammatory drugs (NSAIDs) (An inadequate response to treatment is defined as pain and/or inflammatory symptoms not resolved after 14 days of therapy)

- Diclofenac DR (Generic Voltaren)
- Diclofenac ER (Generic Voltaren ER)
- Etodolac (Generic Lodine)
- Etodolac ER (Generic Lodine ER)
- Fenoprofen (Generic Nalfon)
- Flurbiprofen (Generic Ansaid)
- Ibuprofen
- Indomethacin (Generic Indocin)
- Ketorolac (Generic Toradol)
- Mefenamic (Generic Ponstel)
- Meloxicam (Generic Mobic)
- Nabumetone (Generic Relafen)
- Nabumetone DS (Generic Relafen DS)
- Naproxen (Generic Anaprox)
- Naproxen DR (Generic Anaprox DR)
- Naproxen EC (Generic Anaprox EC)
- Oxaprozin (Generic Daypro)
- Piroxicam (Generic Feldene)
- Sulindac (Generic Clinoril)

OR

2.2 The patient has one of the following risk factors for NSAID-induced adverse GI (gastrointestinal) events:

- Patient is greater than or equal to 65 years of age
- Prior history of peptic, gastric, or duodenal ulcer
- History of NSAID-related ulcer
- History of clinically significant GI (gastrointestinal) bleeding
- Untreated or active H. Pylori gastritis
- Concurrent use of oral corticosteroids (e.g. prednisone, prednisolone, dexamethasone)
- Concurrent use of anticoagulants (e.g. warfarin, heparin)
- Concurrent use of antiplatelets (e.g. aspirin including low-dose, clopidogrel)

Product Name: Pennsaid 2%, diclofenac sodium soln 1.5%

Approval Length	12 month(s)

Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has a diagnosis of pain due to osteoarthritis of the knee(s) AND 2 - ONE of the following: 2.1 The patient did not receive adequate pain relief when treated with at least three preferred non-steroidal anti-inflammatory drugs (NSAIDs) (An inadequate response to treatment is defined as pain and/or inflammatory symptoms not resolved after 14 days of therapy) • Diclofenac DR (Generic Voltaren) • Diclofenac ER (Generic Voltaren ER) • Etodolac (Generic Lodine) • Etodolac ER (Generic Lodine ER) • Fenoprofen (Generic Nalfon) • Flurbiprofen (Generic Ansaïd) • Ibuprofen • Indomethacin (Generic Indocin) • Ketorolac (Generic Toradol) • Mefenamic (Generic Ponstel) • Meloxicam (Generic Mobic) • Nabumetone (Generic Relafen) • Nabumetone DS (Generic Relafen DS) • Naproxen (Generic Anaprox) • Naproxen DR (Generic Anaprox DR) • Naproxen EC (Generic Anaprox EC) • Oxaprozin (Generic Daypro) • Piroxicam (Generic Feldene) • Sulindac (Generic Clinoril) OR 2.2 The patient has one of the following risk factors for NSAID-induced adverse GI (gastrointestinal) events: • Patient is greater than or equal to 65 years of age • Prior history of peptic, gastric, or duodenal ulcer • History of NSAID-related ulcer • History of clinically significant GI bleeding	

- Untreated or active H. Pylori gastritis
- Concurrent use of oral corticosteroids (e.g. prednisone, prednisolone, dexamethasone)
- Concurrent use of anticoagulants (e.g. warfarin, heparin)
- Concurrent use of antiplatelets (e.g. aspirin including low-dose, clopidogrel)

AND

3 - Patient has a history of failure, intolerance, or contraindication to diclofenac topical gel 1% (Rx formulation), or Voltaren OTC (over the counter)

Product Name:generic diclofenac topical gel 1% (Rx formulation), Voltaren OTC

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a diagnosis of pain due to osteoarthritis of joints amenable to topical treatment, including but not limited to the hands, knees, ankles, elbows, feet, and wrists

AND

2 - ONE of the following:

2.1 The patient did not receive adequate pain relief when treated with at least three preferred non-steroidal anti-inflammatory drugs (NSAIDs) (An inadequate response to treatment is defined as pain and/or inflammatory symptoms not resolved after 14 days of therapy)

- Diclofenac DR (Generic Voltaren)
- Diclofenac ER (Generic Voltaren ER)
- Etodolac (Generic Lodine)
- Etodolac ER (Generic Lodine ER)
- Fenoprofen (Generic Nalfon)
- Flurbiprofen (Generic Ansaid)
- Ibuprofen
- Indomethacin (Generic Indocin)
- Ketorolac (Generic Toradol)
- Mefenamic (Generic Ponstel)
- Meloxicam (Generic Mobic)
- Nabumetone (Generic Relafen)

- Nabumetone DS (Generic Relafen DS)
- Naproxen (Generic Anaprox)
- Naproxen DR (Generic Anaprox DR)
- Naproxen EC (Generic Anaprox EC)
- Oxaprozin (Generic Daypro)
- Piroxicam (Generic Feldene)
- Sulindac (Generic Clinoril)

OR

2.2 The patient has one of the following risk factors for NSAID-induced adverse GI (gastrointestinal) events:

- Patient is greater than or equal to 65 years of age
- Prior history of peptic, gastric, or duodenal ulcer
- History of NSAID-related ulcer
- History of clinically significant GI bleeding
- Untreated or active H. Pylori gastritis
- Concurrent use of oral corticosteroids (e.g. prednisone, prednisolone, dexamethasone)
- Concurrent use of anticoagulants (e.g. warfarin, heparin)
- Concurrent use of antiplatelets (e.g. aspirin including low-dose, clopidogrel)

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Tremfya (guselkumab)



Prior Authorization Guideline

Guideline ID	GL-500226
Guideline Name	Tremfya (guselkumab)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Tremfya SC 100 mg*	
Diagnosis	Plaque Psoriasis (PsO)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) or verification of paid claims documenting ALL of the following:	

1.1 Diagnosis of chronic moderate to severe plaque psoriasis (PsO)

AND

1.2 BOTH of the following:

- Patient is 6 years of age or older
- Patient weighs at least 40 kg

AND

1.3 Greater than or equal to 3% body surface area involvement, palmoplantar, facial, or genital involvement, or severe scalp psoriasis

AND

1.4 History of failure to ONE of the following topical therapies, unless contraindicated or clinically significant adverse effects are experienced:

- corticosteroids (e.g., betamethasone, clobetasol, desonide)
- vitamin D analogs (e.g., calcitriol, calcipotriene)
- tazarotene
- calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)

AND

1.5 History of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

1.6 History of failure, contraindication, or intolerance to ONE of the following topical therapies:

- Vtama
- Zoryve 0.3% cream

AND

1.7 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred^ adalimumab biosimilar or Enbrel (etanercept)
- infliximab
- Otezla (apremilast)
- A preferred^ ustekinumab biosimilar

AND

2 - Prescribed by or in consultation with a dermatologist

Notes	*If patient meets criteria above, please approve at GPI-14. ^PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:Tremfya SC 100 mg*	
Diagnosis	Plaque Psoriasis (PsO)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy AND 2 - Prescribed by or in consultation with a dermatologist	
Notes	*If patient meets criteria above, please approve at GPI-14.

Product Name:Tremfya SC 100 mg*

Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) or verification of paid claims documenting ALL of the following:

1.1 Diagnosis of active psoriatic arthritis (PsA)

AND

1.2 BOTH of the following:

- Patient is 6 years of age or older
- Patient weighs at least 40 kg

AND

1.3 History of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

1.4 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred^ adalimumab biosimilar or Enbrel (etanercept)
- infliximab
- Orencia (abatacept)
- Otezla (apremilast)
- Xeljanz (tofacitinib) oral tablet (IR or XR)
- A preferred^ ustekinumab biosimilar

AND

2 - Prescribed by or in consultation with ONE of the following: • Rheumatologist • Dermatologist	
Notes	*If patient meets criteria above, please approve at GPI-14. ^PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:Tremfya SC 100 mg*	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy AND 2 - Prescribed by or in consultation with ONE of the following: • Rheumatologist • Dermatologist	
Notes	*If patient meets criteria above, please approve at GPI-14.

Product Name:Tremfya SC	
Diagnosis	Crohn's Disease (CD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of moderately to severely active Crohn's disease (CD)

AND

2 - Prescribed by or in consultation with a gastroenterologist

AND

3 - ONE of the following:

3.1 Will be used as a maintenance dose following the intravenous induction doses

OR

3.2 ALL of the following:

3.2.1 Will be used for induction dosing

AND

3.2.2 ONE of the following:

- Frequent diarrhea and abdominal pain
- At least 10% weight loss
- Complications such as obstruction, fever, abdominal mass
- Abnormal lab values (e.g., C-reactive protein [CRP])
- CD Activity Index (CAI) greater than 220

AND

3.2.3 Submission of medical records (e.g., chart notes) or verification of paid claims documenting BOTH of the following:

3.2.3.1 Trial and failure, contraindication, or intolerance to ONE of the following conventional therapies:

- corticosteroids (e.g., prednisone, methylprednisolone, budesonide)
- 6-mercaptopurine (Purinethol)
- azathioprine (Imuran)
- methotrexate (Rheumatrex, Trexall)

AND

3.2.3.2 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred^ adalimumab biosimilar
- infliximab
- A preferred^ ustekinumab biosimilar

Notes

^PDL link: <https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP>

Product Name:Tremfya SC

Diagnosis Ulcerative Colitis (UC)

Approval Length 12 month(s)

Therapy Stage Initial Authorization

Guideline Type Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of moderately to severely active ulcerative colitis (UC)

AND

2 - Prescribed by or in consultation with a gastroenterologist

AND

3 - ONE of the following:

3.1 Will be used as a maintenance dose following the intravenous induction doses

OR

3.2 ALL of the following:

3.2.1 Will be used for induction dosing

AND

3.2.2 ONE of the following:

- Greater than 6 stools per day
- Frequent blood in the stools
- Frequent urgency
- Presence of ulcers
- Abnormal lab values (e.g., hemoglobin, erythrocyte sedimentation rate, C-reactive protein)
- Dependent on, or refractory to, corticosteroids

AND

3.2.3 Submission of medical records (e.g., chart notes) or verification of paid claims documenting BOTH of the following:

3.2.3.1 Trial and failure, contraindication, or intolerance to ONE of the following conventional therapies:

- 6-mercaptopurine
- aminosalicylate (e.g., mesalamine, olsalazine, sulfasalazine)
- azathioprine
- corticosteroids (e.g., prednisone)

AND

3.2.3.2 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred^ adalimumab biosimilar
- infliximab
- Xeljanz (tofacitinib) oral tablet (IR or XR)
- A preferred^ ustekinumab biosimilar

Notes

^PDL link: <https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP>

Product Name:Tremfya SC

Diagnosis Crohn's Disease (CD), Ulcerative Colitis (UC)

Approval Length 12 month(s)

Therapy Stage Reauthorization

Guideline Type Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy as evidenced by at least ONE of the following:

- Improvement in intestinal inflammation (e.g., mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline
- Reversal of high fecal output state

AND

2 - Prescribed by or in consultation with a gastroenterologist

2 . Revision History

Date

Notes

1/21/2026	Updated initial authorization criteria and notes section for UC and CD .

Tretinoin Capsules



Prior Authorization Guideline

Guideline ID	GL-140696
Guideline Name	Tretinoin Capsules
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Tretinoin capsules	
Diagnosis	Acute Promyelocytic Leukemia (APL)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of acute promyelocytic leukemia	

Product Name:Tretinoin capsules	
Diagnosis	Acute Promyelocytic Leukemia (APL)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to tretinoin capsules	

Product Name:Tretinoin capsules	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Tretinoin capsules will be approved for uses supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1, 2A, or 2B.	

Product Name:Tretinoin capsules	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to tretinoin capsules	

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Tretinoin Topical



Prior Authorization Guideline

Guideline ID	GL-418222
Guideline Name	Tretinoin Topical
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/11/2025

1 . Criteria

Product Name:generic tretinoin cream and gel*	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Patient is 26 years of age or less	

OR

1.2 ALL of the following:

1.2.1 Patient is greater than 26 years of age

AND

1.2.2 Diagnosis of acne vulgaris

AND

1.2.3 Patient must have a history of therapeutic failure, contraindication, or intolerance to ALL of the following:

- benzoyl peroxide
- topical clindamycin
- topical erythromycin

Notes	*Only generic covered, PA not required for patients 26 years of age or less.

2 . Revision History

Date	Notes
10/10/2025	Replaced Brand Retin-A cream/gel products with generic tretinoin cream/gel products as targets. Updated product name list, GPI table, and notes section accordingly. No changes to clinical criteria.

Trikafta (elexacaftor/tezacaftor/ivacaftor)



Prior Authorization Guideline

Guideline ID	GL-604205
Guideline Name	Trikafta (elexacaftor/tezacaftor/ivacaftor)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Trikafta	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of cystic fibrosis (CF)	

AND

2 - Submission of medical records (e.g., chart notes) or laboratory results confirming the presence of at least one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene

AND

3 - ONE of the following:

3.1 CFTR mutation is responsive based on clinical or in vitro data

OR

3.2 CFTR mutation results in the production of CFTR protein

AND

4 - ONE of the following:

4.1 For granules packets, patient is at least 2 to less than 6 years of age

OR

4.2 For tablets, patient is 6 years of age or older

AND

5 - Prescribed by, or in consultation with, a specialist affiliated with a CF care center

Product Name: Trikafta	
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Provider attests that the patient has achieved a clinically meaningful response while on Trikafta therapy to ONE of the following: • Lung function as demonstrated by percent predicted expiratory volume in 1 second (ppFEV1) • Body mass index (BMI) • Pulmonary exacerbations • Quality of life as demonstrated by Cystic Fibrosis Questionnaire-Revised (CFQ-R) respiratory domain score AND 2 - Prescribed by, or in consultation with, a specialist affiliated with a cystic fibrosis (CF) care center	

2 . Revision History

Date	Notes
5/7/2026	Combined initial auth criteria sections for tablets/granules. Updated i nitial auth criteria.

Triptans



Prior Authorization Guideline

Guideline ID	GL-494229
Guideline Name	Triptans
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	1/17/2026

1 . Criteria

Product Name: Brand Imitrex tabs, Brand Imitrex (cartridge, auto-injector), almotriptan, Brand Maxalt, Brand Maxalt MLT, Onzetra Xsail, Brand Relpax, Symbravo, Brand Treximet, generic sumatriptan-naproxen, Zembrace, Brand Zomig tabs, Brand Frova, generic frovatriptan, Tosymra	
Diagnosis	Non-preferred products
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of migraine headaches with or without aura	

AND

2 - Patient has a history of failure, contraindication, or intolerance to a trial of at least three preferred products (document drugs, duration, and date of trials)*

AND

3 - If the request is for Brand Treximet or generic sumatriptan-naproxen, BOTH of the following:

3.1 Trial, failure, contraindication or intolerance to BOTH of the following:

- naproxen
- sumatriptan

AND

3.2 Physician has provided rationale for needing to use fixed-dose combination therapy with requested medication instead of taking individual products in combination (i.e., naproxen and sumatriptan)

AND

4 - If the request is for Symbravo, BOTH of the following:

4.1 Trial, failure, contraindication or intolerance to BOTH of the following:

- meloxicam
- rizatriptan

AND

4.2 Physician has provided rationale for needing to use fixed-dose combination therapy with requested medication instead of taking individual products in combination (i.e., meloxicam and rizatriptan)

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name: Brand Imitrex (cartridge, auto-injector), generic sumatriptan (inj, cartridge, auto-injector)*	
Diagnosis	Migraine Headaches with or without Aura
Approval Length	12 month(s)
Guideline Type	Quantity Limits
Approval Criteria 1 - Diagnosis of migraine headaches with or without aura AND 2 - Prescribed by or in consultation with one of the following: Neurologist Pain management specialist AND 3 - Patient is currently receiving prophylactic therapy with at least ONE of the following: 3.1 Amitriptyline or 3.2 One of the following beta-blockers: atenolol metoprolol nadolol** propranolol timolol** or 3.3 Divalproex sodium	

or

3.4 OnabotulinumtoxinA ***

or

3.5 Topiramate

or

3.6 Venlafaxine

or

3.7 Calcitonin gene-related peptide receptor antagonists [e.g., Aimovig, Emgality]

AND

4 - One of the following:

4.1 Higher dose or quantity is supported in the dosage and administration section of the manufacturer's prescribing information

or

4.2 Higher dose or quantity is supported by one of the following compendia:

American Hospital Formulary Service Drug Information

Thomson Micromedex DrugDex

Clinical pharmacology

United States Pharmacopoeia-National Formulary

or

4.3 Physician provides evidence from published biomedical literature to support safety and additional efficacy at doses/quantities greater than those approved by the Food and Drug Administration for the diagnosis indicated

AND

5 - Physician acknowledges that the potential benefit outweighs the risk associated with the higher dose or quantity

Notes

* See "Quantity Limits" table in background section for quantity limits
 ** Nadolol and timolol are non-preferred and should not be included in denial to provider
 *** OnabotulinumtoxinA (Botox) is a medical benefit, should not be included in denial to provider

Product Name: Brand Imitrex (cartridge, auto-injector), generic sumatriptan (inj, cartridge, auto-injector)*

Diagnosis Cluster Headaches

Approval Length 12 month(s)

Guideline Type Quantity Limit

Approval Criteria

1 - Diagnosis of cluster headaches

AND

2 - Prescribed by or in consultation with one of the following:

Neurologist

Pain management specialist

AND

3 - Patient has experienced at least 2 cluster periods lasting from 7 days to 365 days, separated by pain-free periods lasting at least three months.

AND

4 - One of the following:

4.1 Higher dose or quantity is supported in the dosage and administration section of the

manufacturer's prescribing information or 4.2 Higher dose or quantity is supported by one of the following compendia: American Hospital Formulary Service Drug Information Thomson Micromedex DrugDex Clinical pharmacology United States Pharmacopoeia-National Formulary or 4.3 Physician provides evidence from published biomedical literature to support safety and additional efficacy at doses/quantities greater than those approved by the Food and Drug Administration for the diagnosis indicated AND 5 - Physician acknowledges that the potential benefit outweighs the risk associated with the higher dose or quantity	
Notes	* See "Quantity Limits" table in background section for quantity limits

Product Name:naratriptan, Brand Frova, generic frovatriptan, Brand Imitrex tabs and nasal spray, generic sumatriptan tabs and nasal spray, almotriptan, Brand Maxalt and Maxalt MLT, generic rizatriptan and rizatriptan ODT, Onzetra Xsail, Brand Relpax, generic eletriptan, Symbravo, Brand Treximet, generic sumatriptan-naproxen, Zembrace Sym Touch, Brand Zomig tabs, generic zolmitriptan tabs, zolmitriptan ODT, Brand Zomig nasal spray, generic zolmitriptan nasal spray, Tosymra *	
Approval Length	12 month(s)
Guideline Type	Quantity Limit
Approval Criteria 1 - Diagnosis of migraine headaches with or without aura AND 2 - Prescribed by or in consultation with one of the following:	

Neurologist

Pain management specialist

AND

3 - Patient is currently receiving prophylactic therapy with at least ONE of the following:

3.1 Amitriptyline

or

3.2 One of the following beta-blockers:

atenolol

metoprolol

nadolol**

propranolol

timolol**

or

3.3 Divalproex sodium

or

3.4 OnabotulinumtoxinA ***

or

3.5 Topiramate

or

3.6 Venlafaxine

or

3.7 Calcitonin gene-related peptide receptor antagonists [e.g., Aimovig, Emgality]

AND

4 - One of the following:

4.1 Higher dose or quantity is supported in the dosage and administration section of the manufacturer's prescribing information

or

4.2 Higher dose or quantity is supported by one of the following compendia:

American Hospital Formulary Service Drug Information

Thomson Micromedex DrugDex

Clinical pharmacology

United States Pharmacopoeia-National Formulary

or

4.3 Physician provides evidence from published biomedical literature to support safety and additional efficacy at doses/quantities greater than those approved by the FDA for the diagnosis indicated

AND

5 - Physician acknowledges that the potential benefit outweighs the risk associated with the higher dose or quantity

Notes	* See "Quantity Limits" table in background section for quantity limits ** Nadolol and timolol are non-preferred and should not be included in denial to provider *** OnabotulinumtoxinA (Botox) is a medical benefit, should not be included in denial to provider

Product Name: Brand Zomig nasal spray, generic zolmitriptan nasal spray	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has a history of failure, contraindication, or intolerance to sumatriptan nasal spray

2 . Background

Benefit/Coverage/Program Information

Quantity Limits

Drug Name	Strength	Quantity Limit
Generic naratriptan	1mg, 2.5mg	9 tabs/month
Brand Frova Generic frovatriptan	2.5mg	9 tabs/month
Brand Imitrex tablets Generic sumatriptan tablets	25mg, 50mg, 100mg	9 tabs/month
Brand Maxalt Generic rizatriptan	5mg, 10mg	9 tabs/month
Brand Maxalt MLT Generic rizatriptan ODT	5mg, 10mg	9 tabs/month
Generic almotriptan	6.25mg, 12.5mg	6 tabs/month
Brand Relpax Generic eletriptan	20mg, 40mg	6 tabs/month
Brand Zomig	2.5mg, 5mg	6 tabs/month

Generic zolmitriptan		
Generic zolmitriptan ODT	2.5mg, 5mg	6 tabs/month
Brand Imitrex Nasal Spray Generic sumatriptan nasal spray	5mg, 20mg	6 spray devices/month
Zomig Nasal Spray	2.5mg, 5mg	6 spray devices/month
Brand Treximet Generic sumatriptan/naproxen	85mg/500mg	9 tabs/month
Symbravo	10mg/20mg	9 tabs/month
Onzetra Xsail	11mg	1 box (8 units)/month
Zembrace SymTouch	3mg	1 box (4 units)/month
Brand Imitrex Generic Sumatriptan Autoinjector/Cartridge Refills	4mg/0.5mL 6mg/0.5mL	8 autoinjectors or cartridge refills/month (4 boxes/month)
Generic Sumatriptan Vials	6mg/0.5mL	10 vials/month (2 boxes/month)
Tosymra Nasal Spray	10mg	6 units per month

3 . Revision History

Date	Notes
1/9/2026	Added Brand Zomig nasal spray to same criteria section as generic zolmitriptan nasal spray, updated guideline type from ST to PA, and updated prerequisite to sumatriptan nasal spray.

Tryngolza (olezarsen sodium)



Prior Authorization Guideline

Guideline ID	GL-210204
Guideline Name	Tryngolza (olezarsen sodium)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	4/1/2025

1 . Criteria

Product Name:Tryngolza	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of familial chylomicronemia syndrome (FCS) (type 1 hyperlipoproteinemia)	

AND

2 - Submission of medical records (e.g., chart notes) documenting one of the following:

2.1 Genetic confirmation of biallelic pathogenic variants in FCS-causing genes (i.e., LPL, GPIHBP1, APOA5, APOC2, or LMF1)

OR

2.2 A North American FCS (NAFCS) Score of greater than or equal to 45

AND

3 - Submission of medical records (e.g., chart notes) documenting both of the following:

3.1 One of the following:

3.1.1 Patient has tried or will receive treatment with standard of care triglyceride lowering therapy (i.e., prescription omega-3 fatty acid and a fibrate)

OR

3.1.2 Patient has an intolerance to standard of care triglyceride lowering therapy (i.e., prescription omega-3 fatty acid and a fibrate)

AND

3.2 Baseline fasting triglyceride levels are greater than or equal to 880 mg/dL prior to treatment with requested drug

AND

4 - Requested drug will be used as adjunct to a low-fat diet

AND

5 - Prescribed by or in consultation with one of the following:

- Cardiologist
- Endocrinologist
- Gastroenterologist
- Lipid specialist (lipidologist)

Product Name:Tryngolza	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy (e.g., reduction in triglyceride levels from baseline)	

2 . Revision History

Date	Notes
3/6/2025	New guideline

Tryvio (aprocitentan)



Prior Authorization Guideline

Guideline ID	GL-157435
Guideline Name	Tryvio (aprocitentan)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	11/1/2024

1 . Criteria

Product Name:Tryvio	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of hypertension	

AND

2 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming patient has not achieved target blood pressure (e.g., systolic blood pressure [SBP] less than 130 mmHg) after treatment with ALL of the following antihypertensive medications from different classes for an adequate duration (minimum 4 weeks each) at a maximally tolerated dose:

2.1 ONE of the following:

- Angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril)
- Angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan)

AND

2.2 Diuretic (e.g., hydrochlorothiazide, chlorthalidone)

AND

2.3 Calcium channel blocker (e.g., amlodipine, nifedipine)

AND

2.4 Mineralocorticoid receptor antagonist (MRA) (e.g., eplerenone, spironolactone)

AND

3 - Provider attests other causes of hypertension have been excluded (e.g., secondary causes [e.g., primary hyperaldosteronism], white coat effect, medication nonadherence)

AND

4 - Used as an adjunct to lifestyle modification (e.g., dietary or caloric restriction, exercise, behavioral support, community based program)

AND

5 - Requested drug will be used in combination with at least 3 antihypertensive medications from different classes

AND

6 - Prescribed by or in consultation with a specialist experienced in the treatment of resistant hypertension (e.g., cardiologist, nephrologist)

Product Name: Tryvio

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy (e.g., systolic blood pressure [SBP] less than 130 mmHg)

AND

2 - Patient continues to use Tryvio in combination with at least 3 antihypertensive medications from different classes and is adherent to therapy

AND

3 - Requested drug will continue to be used as an adjunct to lifestyle modification (e.g., dietary or caloric restriction, exercise, behavioral support, community based program)

AND

4 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming patient has been previously treated with ALL of the following antihypertensive medications from different classes for an adequate duration (minimum 4 weeks each) at a maximally tolerated dose:

4.1 ONE of the following:

- Angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril)
- Angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan)

AND

4.2 Diuretic (e.g., hydrochlorothiazide, chlorthalidone)

AND

4.3 Calcium channel blocker (e.g., amlodipine, nifedipine)

AND

4.4 Mineralocorticoid receptor antagonist (MRA) (e.g., eplerenone, spironolactone)

2 . Revision History

Date	Notes
10/14/2024	Replaced CORE criteria with FFS/state criteria.

Twynéo (tretinoin-benzoyl peroxide 0.1-3% cream)



Prior Authorization Guideline

Guideline ID	GL-140674
Guideline Name	Twynéo (tretinoin-benzoyl peroxide 0.1-3% cream)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Twynéo	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting both of the following: 1.1 Both of the following: • Patient is 9 years of age or older	

- Diagnosis of acne vulgaris

AND

1.2 The patient must have a history of therapeutic failure, contraindication, or intolerance to ALL of the following (verified via paid pharmacy claims or submission of medical records):

- benzoyl peroxide
- topical clindamycin
- topical erythromycin
- topical tretinoin (Brand Retin-A)

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Uloric



Prior Authorization Guideline

Guideline ID	GL-140650
Guideline Name	Uloric
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2020

1 . Criteria

Product Name: Brand Uloric, generic febuxostat	
Approval Length	12 month(s)
Guideline Type	Step Therapy
Approval Criteria 1 - History of failure, contraindication or intolerance to allopurinol (generic Zyloprim)	

2 . Revision History

UnitedHealthcare Community Plan of Arizona Clinical Pharmacy Program Guidelines

Date	Notes
3/31/2020	Bulk Copy C&S New York to C&S Arizona for effective date of 5/1

Ultomiris (ravulizumab-cwvz)



Prior Authorization Guideline

Guideline ID	GL-148352
Guideline Name	Ultomiris (ravulizumab-cwvz)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name:Ultomiris	
Diagnosis	Paroxysmal Nocturnal Hemoglobinuria (PNH)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of paroxysmal nocturnal hemoglobinuria (PNH)	

AND

2 - Patient is one month of age or older

AND

3 - Prescribed by or in consultation with a hematologist/oncologist

Product Name:Ultomiris

Diagnosis	Paroxysmal Nocturnal Hemoglobinuria (PNH)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response (e.g., hemoglobin stabilization, decrease in the number of red blood cell transfusions) to therapy

Product Name:Ultomiris

Diagnosis	Atypical Hemolytic Uremic Syndrome (aHUS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of atypical hemolytic uremic syndrome (aHUS)

AND

2 - Patient is one month of age or older

AND

3 - Prescribed by or in consultation with ONE of the following:

- Hematologist
- Nephrologist

Product Name:Ultomiris	
Diagnosis	Atypical Hemolytic Uremic Syndrome (aHUS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response (e.g., hemoglobin stabilization, decrease in the number of red blood cell transfusions) to therapy	

Product Name:Ultomiris	
Diagnosis	Generalized Myasthenia Gravis (gMG)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Submission of medical records (e.g., chart notes) documenting BOTH of the following:

- Diagnosis of generalized myasthenia gravis (gMG)
- Patient is anti-acetylcholine receptor (AChR) antibody positive

AND

2 - Submission of medical records (e.g., chart notes) or paid claims documenting ONE of the following:

2.1 Trial and failure, contraindication, or intolerance to TWO preferred immunosuppressive therapies (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus)

OR

2.2 BOTH of the following:

2.2.1 Trial and failure, contraindication, or intolerance to ONE preferred immunosuppressive therapy (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus)

AND

2.2.2 Trial and failure, contraindication, or intolerance to ONE of the following:

- Chronic plasmapheresis or plasma exchange (PE)
- Intravenous immunoglobulin (IVIG)

AND

3 - Prescribed by or in consultation with a neurologist

Product Name:Ultomiris	
Diagnosis	Generalized Myasthenia Gravis (gMG)
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy	

Product Name:Ultomiris	
Diagnosis	Neuromyelitis Optica Spectrum Disorder (NMOSD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting BOTH of the following: • Diagnosis of neuromyelitis optica spectrum disorder (NMOSD) • Patient is anti-aquaporin-4 (AQP4) antibody positive AND 2 - Prescribed by or in consultation with ONE of the following: • Neurologist • Ophthalmologist	

Product Name:Ultomiris	
Diagnosis	Neuromyelitis Optica Spectrum Disorder (NMOSD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

2 . Revision History

Date	Notes
6/10/2024	Added criteria for new indication of NMOSD and added submission of records/paid claims where applicable to all initial authorization criteria.

Upneeq



Prior Authorization Guideline

Guideline ID	GL-208217
Guideline Name	Upneeq
Formulary	Medicaid - Community & State Arizona Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State Nebraska Medicaid - Community & State New Jersey Medicaid - Community & State New Mexico Medicaid - Community & State New York Medicaid - Community & State New York EPP Medicaid - Community & State Pennsylvania Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	3/1/2025

1 . Criteria

Product Name:Upneeq	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of acquired blepharoptosis AND 2 - Patient has a functional impairment related to the position of the eyelid AND 3 - ONE of the following: • Marginal reflex distance-1 (MRD-1) is less than or equal to 2 millimeters (mm) in primary gaze • Marginal reflex distance-1 (MRD-1) is less than or equal to 2 mm in down gaze • Superior visual field loss of at least 12 degrees or 24 percent AND 4 - Other treatable causes of blepharoptosis have been ruled out (e.g., recent botulinum toxin injections, myasthenia gravis)	

Product Name:Upneeq	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Documentation of a positive clinical response to therapy

2 . Revision History

Date	Notes
3/5/2025	Added PA-CAID for 4/1 go-live. No change to criteria.

Urea Cycle Disorder Agents



Prior Authorization Guideline

Guideline ID	GL-502217
Guideline Name	Urea Cycle Disorder Agents
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name: Brand Buphenyl, generic sodium phenylbutyrate, Pheburane	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following: 1.1 Diagnosis of urea cycle disorder (UCD)	

AND

1.2 ONE of the following deficiencies:

- carbamylphosphate synthetase (CPS)
- ornithine transcarbamylase (OTC)
- argininosuccinic acid synthetase (AS)

AND

2 - Molecular genetic testing confirms mutations in the CPS1, OTC, or ASS1 gene

AND

3 - If the request is for Brand Buphenyl or Pheburane, trial and failure, or intolerance to generic sodium phenylbutyrate

AND

4 - Used as an adjunct with dietary protein restriction and, in some cases, dietary supplements (e.g., essential amino acids, arginine, citrulline, protein-free calorie supplements)

AND

5 - Prescribed by or in consultation with a specialist focused on the treatment of metabolic disorders

Product Name: Olpruva, Brand Ravicti, generic glycerol phenylbutyrate	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - BOTH of the following:

1.1 Diagnosis of urea cycle disorder (UCD)

AND

1.2 ONE of the following deficiencies:

- carbamylphosphate synthetase (CPS)
- ornithine transcarbamylase (OTC)
- argininosuccinic acid synthetase (AS)

AND

2 - Molecular genetic testing confirms mutations in the CPS1, OTC, or ASS1 gene

AND

3 - Inadequate response to ONE of the following:

- Dietary protein restriction
- Amino acid supplementation

AND

4 - Trial and failure, contraindication, or intolerance to generic sodium phenylbutyrate

AND

5 - If the request is for generic glycerol phenylbutyrate, history of failure or intolerance to Brand Ravicti

AND

6 - Used as an adjunct with dietary protein restriction and, in some cases, dietary supplements (e.g., essential amino acids, arginine, citrulline, protein-free calorie supplements)

AND

7 - Prescribed by or in consultation with a specialist focused on the treatment of metabolic disorders

Product Name: Brand Buphenyl, generic sodium phenylbutyrate, Olpruva, Pheburane, Brand Ravicti, generic glycerol phenylbutyrate

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g., plasma ammonia and amino acid levels within normal limits)

AND

2 - Used as an adjunct with dietary protein restriction and, in some cases, dietary supplements (e.g., essential amino acids, arginine, citrulline, protein-free calorie supplements)

2 . Revision History

Date	Notes
1/15/2026	Added generic Ravicti

Ustekinumab



Prior Authorization Guideline

Guideline ID	GL-605200
Guideline Name	Ustekinumab
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Ustekinumab SC, Ustekinumab-aauz SC, Ustekinumab-aekn SC, Ustekinumab-ttwe SC, Imuldosa SC, Otulfi SC, Pyzchiva SC, Selarsdi SC, Starjemza SC, Stelara SC, Steqeyma SC, Wezlana SC, Yesintek SC, newly launched ustekinumab SC products	
Diagnosis	Plaque Psoriasis (PsO)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Submission of medical records (e.g., chart notes, laboratory values, prescription claims history) documenting ALL of the following:

1.1 Diagnosis of chronic moderate to severe plaque psoriasis (PsO)

AND

1.2 Greater than or equal to 3% body surface area involvement, palmoplantar, facial, or genital involvement, or severe scalp psoriasis

AND

1.3 History of failure to ONE of the following topical therapies, unless contraindicated or clinically significant adverse effects are experienced:

- corticosteroids (e.g., betamethasone, clobetasol, desonide)
- vitamin D analogs (e.g., calcitriol, calcipotriene)
- tazarotene
- calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Vtama
- Zoryve 0.3% cream

AND

1.4 Paid claims or submission of medical records (e.g., chart notes) documenting history of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

2 - Patient is 6 years of age or older

AND

3 - Prescribed by or in consultation with a dermatologist

AND	
4 - If the request is non-preferred*, history of failure to ALL preferred* ustekinumab biosimilars	
Notes	Approval Length: 12 months. If approving a preferred ustekinumab, please enter the group authorization AZUSTEKINU. If approving a non-preferred ustekinumab, please enter the following: 1) The group authorization AZUSTEKINU 2) An authorization for the non-preferred ustekinumab at GPI-12 level *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:Ustekinumab SC, Ustekinumab-aaaz SC, Ustekinumab-aekn SC, Ustekinumab-ttwe SC, Imuldosa SC, Otulfi SC, Pyzchiva SC, Selarsdi SC, Starjemza SC, Stelara SC, Steqeyma SC, Wezlana SC, Yesintek SC, newly launched ustekinumab SC products	
Diagnosis	Plaque Psoriasis (PsO)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy AND 2 - Prescribed by or in consultation with a dermatologist AND 3 - If the request is non-preferred*, history of failure to ALL preferred* ustekinumab biosimilars	
Notes	Approval Length: 12 months. If approving a preferred ustekinumab, please enter the group authorization AZUSTEKINU. If approving a non-preferred ustekinumab, please enter the following:

	1) The group authorization AZUSTEKINU 2) An authorization for the non-preferred ustekinumab at GPI-12 level *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC CP

Product Name:Ustekinumab SC, Ustekinumab-aauz SC, Ustekinumab-aekn SC, Ustekinumab-ttwe SC, Imuldosa SC, Otulfi SC, Pyzchiva SC, Selarsdi SC, Starjemza SC, Stelara SC, Steqeyma SC, Wezlana SC, Yesintek SC, newly launched ustekinumab SC products	
Diagnosis	Psoriatic Arthritis (PsA)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of active psoriatic arthritis (PsA) AND 2 - Paid claims or submission of medical records (e.g., chart notes) documenting history of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced AND 3 - Patient is 6 years of age or older AND 4 - Prescribed by or in consultation with ONE of the following: • Rheumatologist • Dermatologist	

AND	
5 - If the request is non-preferred*, history of failure to ALL preferred* ustekinumab biosimilars	
Notes	Approval Length: 12 months. If approving a preferred ustekinumab, please enter the group authorization AZUSTEKINU. If approving a non-preferred ustekinumab, please enter the following: 1) The group authorization AZUSTEKINU 2) An authorization for the non-preferred ustekinumab at GPI-12 level *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:Ustekinumab SC, Ustekinumab-aauz SC, Ustekinumab-aekn SC, Ustekinumab-ttwe SC, Imuldosa SC, Otulfi SC, Pyzchiva SC, Selarsdi SC, Starjemza SC, Stelara SC, Steqeyma SC, Wezlana SC, Yesintek SC, newly launched ustekinumab SC products	
Diagnosis	Psoriatic Arthritis (PsA)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy AND 2 - Prescribed by or in consultation with ONE of the following: • Rheumatologist • Dermatologist AND 3 - If the request is non-preferred*, history of failure to ALL preferred* ustekinumab biosimilars	

Notes	Approval Length: 12 months. If approving a preferred ustekinumab, please enter the group authorization AZUSTEKINU. If approving a non-preferred ustekinumab, please enter the following: 1) The group authorization AZUSTEKINU 2) An authorization for the non-preferred ustekinumab at GPI-12 level *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC CP

Product Name:Ustekinumab SC, Ustekinumab-aaaz SC, Ustekinumab-aekn SC, Ustekinumab-ttwe SC, Imuldosa SC, Otulfi SC, Pyzchiva SC, Selarsdi SC, Starjemza SC, Stelara SC, Steqeyma SC, Wezlana SC, Yesintek SC, newly launched ustekinumab SC products	
Diagnosis	Crohn's Disease (CD)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderately to severely active Crohn's disease (CD) AND 2 - Paid claims or submission of medical records (e.g., chart notes) documenting history of failure to ONE of the following conventional therapies at maximally indicated doses within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced: • Corticosteroids (e.g., prednisone, methylprednisolone, budesonide) • Azathioprine (Imuran) • 6-mercaptopurine (Purinethol) • Methotrexate (Rheumatrex, Trexall) AND 3 - Prescribed by or in consultation with a gastroenterologist	

AND

4 - If the request is non-preferred*, history of failure to ALL preferred* ustekinumab biosimilars

Notes	Approval Length: 12 months. If approving a preferred ustekinumab, please enter the group authorization AZUSTEKINU. If approving a non-preferred ustekinumab, please enter the following: 1) The group authorization AZUSTEKINU 2) An authorization for the non-preferred ustekinumab at GPI-12 level *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:Ustekinumab SC, Ustekinumab-aauz SC, Ustekinumab-aekn SC, Ustekinumab-ttwe SC, Imuldosa SC, Otulfi SC, Pyzchiva SC, Selarsdi SC, Starjemza SC, Stelara SC, Steqeyma SC, Wezlana SC, Yesintek SC, newly launched ustekinumab SC products

Diagnosis	Ulcerative Colitis (UC)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active ulcerative colitis (UC)

AND

2 - Paid claims or submission of medical records (e.g., chart notes) documenting history of failure to ONE of the following conventional therapies at maximally indicated doses within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced:

- Corticosteroids (e.g., prednisone, methylprednisolone, budesonide)
- 6-mercaptopurine (Purinethol)
- Azathioprine (Imuran)
- Aminosalicylates (e.g., mesalamine, sulfasalazine)

AND	
3 - Prescribed by or in consultation with a gastroenterologist	
AND	
4 - If the request is non-preferred*, history of failure to ALL preferred* ustekinumab biosimilars	
Notes	Approval Length: 12 months. If approving a preferred ustekinumab, please enter the group authorization AZUSTEKINU. If approving a non-preferred ustekinumab, please enter the following: 1) The group authorization AZUSTEKINU 2) An authorization for the non-preferred ustekinumab at GPI-12 level *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:Ustekinumab SC, Ustekinumab-aauz SC, Ustekinumab-aekn SC, Ustekinumab-ttwe SC, Imuldosa SC, Otulfi SC, Pyzchiva SC, Selarsdi SC, Starjemza SC, Stelara SC, Steqeyma SC, Wezlana SC, Yesintek SC, newly launched ustekinumab SC products	
Diagnosis	Crohn's Disease (CD), Ulcerative Colitis (UC)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy AND 2 - Prescribed by or in consultation with a gastroenterologist AND	

3 - If the request is non-preferred*, history of failure to ALL preferred* ustekinumab biosimilars	
Notes	Approval Length: 12 months. If approving a preferred ustekinumab, please enter the group authorization AZUSTEKINU. If approving a non-preferred ustekinumab, please enter the following: 1) The group authorization AZUSTEKINU 2) An authorization for the non-preferred ustekinumab at GPI-12 level *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

2 . Revision History

Date	Notes
5/6/2026	Added new GPI for Steqeyma SC 45 mg/0.5 mL soln as a target. No changes to clinical criteria.

Vafseo (vadadustat)



Prior Authorization Guideline

Guideline ID	GL-157239
Guideline Name	Vafseo (vadadustat)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	11/1/2024

1 . Criteria

Product Name:Vafseo	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) or paid claims confirming ALL of the following: 1.1 Diagnosis of chronic kidney disease (CKD)	

AND

1.2 Patient has been on dialysis for at least 3 months

AND

1.3 Adequate iron stores confirmed by BOTH of the following:

- Patient's ferritin level is greater than 100 mcg/L (micrograms per liter)
- Patient's transferrin saturation (TSAT) is greater than 20%

AND

1.4 Hemoglobin level is less than 11 g/dL (grams per deciliter)

AND

1.5 Trial and failure, contraindication, or intolerance to ONE of the following preferred erythropoietin stimulating agents (ESA):

- Epogen (epoetin alfa)
- Retacrit (epoetin alfa-epbx)

AND

2 - Prescribed by or in consultation with ONE of the following:

- Hematologist
- Nephrologist

AND

3 - Patient is NOT on concurrent treatment with an erythropoietin stimulating agent [ESA] (e.g., Aranesp, Epogen, Procrit)

Product Name:Vafseo	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) or paid claims confirming ALL of the following: 1.1 Patient demonstrates positive clinical response to therapy (e.g., increase in hemoglobin) AND 1.2 Hemoglobin level does NOT exceed 11 g/dL (grams per deciliter) AND 1.3 Adequate iron stores confirmed by BOTH of the following: • Patient's ferritin level is greater than 100 mcg/L (micrograms per liter) • Patient's transferrin saturation (TSAT) is greater than 20% AND 1.4 Trial and failure, contraindication, or intolerance to ONE of the following preferred erythropoietin stimulating agents (ESA): • Epogen (epoetin alfa) • Retacrit (epoetin alfa-epbx) AND 2 - Patient is NOT on concurrent treatment with an erythropoietin stimulating agent [ESA] (e.g., Aranesp, Epogen, Procrit)	

2 . Revision History

Date	Notes
10/9/2024	New program.

Valchlor



Prior Authorization Guideline

Guideline ID	GL-140912
Guideline Name	Valchlor
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Valchlor	
Diagnosis	Primary Cutaneous Lymphomas
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following: Chronic or smoldering T-cell leukemia-lymphoma	

- Primary cutaneous marginal zone or follicle center B-cell lymphoma
- Lymphomatoid papulosis (LyP) with extensive lesions
- Mycosis fungoides (MF)-Sezary syndrome (SS)

Product Name:Valchlor	
Diagnosis	Primary Cutaneous Lymphomas
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient does not show evidence of progressive disease while on Valchlor	

Product Name:Valchlor	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Valchlor will be approved for uses supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1, 2A, or 2B.	

Product Name:Valchlor	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Valchlor therapy

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Valsartan oral solution



Prior Authorization Guideline

Guideline ID	GL-140742
Guideline Name	Valsartan oral solution
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	12/1/2022

1 . Criteria

Product Name: Valsartan oral solution	
Diagnosis	Patients 7 years of age or older
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is 7 years of age or older	

AND

2 - Patient cannot take solid dosage forms due to swallowing issues

2 . Revision History

Date	Notes
10/21/2022	New guideline

Vanrafia (atrasentan)



Prior Authorization Guideline

Guideline ID	GL-382213
Guideline Name	Vanrafia (atrasentan)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2025

1 . Criteria

Product Name:Vanrafia	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting diagnosis of primary immunoglobulin A nephropathy (IgAN)	

AND

2 - Diagnosis has been confirmed by ALL of the following:

- Kidney biopsy
- Proteinuria of greater than or equal to 1 g/day (gram per day)
- Estimated glomerular filtration rate (eGFR) of greater than or equal to 30 mL/min/1.73 m² (milliliters/minute/1.73 square meters)

AND

3 - Patient is at risk for disease progression [e.g., generally a urine protein-to-creatinine ratio (UPCR) greater than or equal to 1.5 g/g (gram), or by other criteria such as clinical risk scoring using the International IgAN Prediction Tool]

AND

4 - Used to reduce proteinuria

AND

5 - Submission of medical records (e.g., chart notes) demonstrating patient has been on a minimum 90-day trial of a maximally tolerated dose of ONE of the following (paid pharmacy claims may be used to confirm appropriate trial):

- An angiotensin-converting enzyme (ACE) inhibitor (e.g., benazepril, lisinopril)
- An angiotensin II receptor blocker (ARB) (e.g., losartan, valsartan)

AND

6 - Prescribed by or in consultation with a nephrologist

Product Name: Vanrafia

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting a positive clinical response to therapy as demonstrated by a decrease in urine protein-to-creatinine ratio (UPCR) from baseline	

2 . Revision History

Date	Notes
9/5/2025	New program for ACUAZ/ACUAZEC.

Vecamyl



Prior Authorization Guideline

Guideline ID	GL-140855
Guideline Name	Vecamyl
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2020

1 . Criteria

Product Name:Vecamyl	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderately severe to severe essential hypertension	

OR

2 - Diagnosis of uncomplicated malignant hypertension

Product Name:Vecamyl	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of a positive clinical response to Vecamyl therapy	

2 . Revision History

Date	Notes
3/31/2020	Bulk copy C&S New York SP to C&S Arizona SP for 5/1 effective

Velphoro (sucroferric oxyhydroxide), Auryxia (ferric citrate)



Prior Authorization Guideline

Guideline ID	GL-609188
Guideline Name	Velphoro (sucroferric oxyhydroxide), Auryxia (ferric citrate)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Velphoro, Brand Auryxia, ferric citrate tablets	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: • Diagnosis of hyperphosphatemia • Diagnosis of End Stage Renal Disease	

AND

2 - ONE of the following:

2.1 If the request is for Velphoro, patient is 9 years of age or older

OR

2.2 If the request is for Brand Auryxia/ferric citrate, patient is 18 years of age or older

AND

3 - Adherence to and trial and failure to ONE of the following at maximum dosages (MUST be verified via paid pharmacy claims or submission of medical records):

- Sevelamer Carbonate at the maximum dosage – 800mg/15 per day
- Sevelamer Powder Packets at maximum dosage – 2.4gm packet 4 per day

AND

4 - If the request is for ferric citrate, history of failure or intolerance to Brand Auryxia

Notes	1. Approval will not be granted for requests based on potential side effects, i.e., constipation 2. Approval will not be granted for submitted prior authorizations based on pill burden. Velphoro and Sevelamer are both taken 3 times a day.

2 . Revision History

Date	Notes
5/11/2026	Updated naming convention for ferric citrate tabs in product name list and criteria section.

Velsipity (etrasimod)



Prior Authorization Guideline

Guideline ID	GL-324212
Guideline Name	Velsipity (etrasimod)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	8/1/2025

1 . Criteria

Product Name:Velsipity	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of moderately to severely active ulcerative colitis (UC)	

AND

2 - ONE of the following:

- Greater than 6 stools per day
- Frequent blood in the stools
- Frequent urgency
- Presence of ulcers
- Abnormal lab values (e.g., hemoglobin, ESR, CRP)
- Dependent on, or refractory to, corticosteroids

AND

3 - Paid claims or submission of medical records (e.g., chart notes) confirming a trial and failure, contraindication, or intolerance to ONE of the following conventional therapies:

- 6-mercaptopurine
- Aminosalicylate (e.g., mesalamine, olsalazine, sulfasalazine)
- Azathioprine
- Corticosteroids (e.g., prednisone)

AND

4 - Paid claims or submission of medical records (e.g., chart notes) confirming history of failure, contraindication, or intolerance to ALL of the following:

- A preferred^ adalimumab biosimilar
- infliximab
- Xeljanz (tofacitinib) oral tablet (IR or XR)
- A preferred^ ustekinumab biosimilar

AND

5 - Prescribed by or in consultation with a gastroenterologist

Notes	^PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:Velsipity	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient demonstrates positive clinical response to therapy as evidenced by at least ONE of the following: - Improvement in intestinal inflammation (e.g., mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline - Reversal of high fecal output state AND 2 - Prescribed by or in consultation with a gastroenterologist	

2 . Revision History

Date	Notes
7/15/2025	Updated initial and reauth sections.

Veltassa



Prior Authorization Guideline

Guideline ID	GL-157252
Guideline Name	Veltassa
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	11/1/2024

1 . Criteria

Product Name:Veltassa	
Diagnosis	Non-Life Threatening Hyperkalemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of non-life threatening hyperkalemia	

AND

2 - Patient is 12 years of age or older

AND

3 - Where clinically appropriate, medications known to cause hyperkalemia (e.g. angiotensin-converting enzyme inhibitor, angiotensin II receptor blocker, aldosterone antagonist, non-steroidal anti-inflammatory drugs [NSAIDs]) have been discontinued or reduced to the lowest effective dose

AND

4 - Where clinically appropriate, loop or thiazide diuretic therapy for potassium removal has failed

AND

5 - Patient follows a low potassium diet (less than or equal to 3 grams per day)

AND

6 - History of failure, intolerance, or contraindication to Lokelma

Product Name: Veltassa	
Diagnosis	Non-Life Threatening Hyperkalemia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Patient has a positive clinical response to Veltassa therapy

AND

2 - Patient continues to require treatment for hyperkalemia

AND

3 - Where clinically appropriate, medications known to cause hyperkalemia (e.g. angiotensin-converting enzyme inhibitor, angiotensin II receptor blocker, aldosterone antagonist, non-steroidal anti-inflammatory drugs [NSAIDs])) have been discontinued or reduced to the lowest effective dose

2 . Revision History

Date	Notes
10/9/2024	Added new GPI for Veltassa 1 gm strength and added age criterion i n initial auth section.

Vemlidy



Prior Authorization Guideline

Guideline ID	GL-147124
Guideline Name	Vemlidy
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	6/1/2024

1 . Criteria

Product Name:Vemlidy	
Diagnosis	Treatment-Naïve Chronic Hepatitis B Infection
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has a contraindication to entecavir therapy	

AND

2 - BOTH of the following:

- Patient is 6 years of age or older
- Patient weighs at least 25 kg (kilograms)

Product Name:Vemlidy

Diagnosis	Treatment-Experienced Chronic Hepatitis B Infection
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Patient is currently on Viread therapy

AND

1.2 ONE of the following:

- Patient has a creatinine clearance less than 60 mL (milliliters) per minute
- Patient has a diagnosis of osteoporosis

AND

1.3 BOTH of the following:

- Patient is 6 years of age or older
- Patient weighs at least 25 kg (kilograms)

OR

2 - Patient is currently on Vemlidy therapy

2 . Revision History

Date	Notes
5/7/2024	Updated age criterion and added weight requirement due to expanded indication.

Verkazia (cyclosporine ophthalmic emulsion 0.1%)



Prior Authorization Guideline

Guideline ID	GL-140673
Guideline Name	Verkazia (cyclosporine ophthalmic emulsion 0.1%)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Verkazia	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting all of the following: 1.1 Diagnosis of moderate to severe vernal keratoconjunctivitis confirmed by the presence of	

clinical signs and symptoms (e.g., itching, photophobia, giant papillae at the upper tarsal conjunctiva or at the limbus, thick mucus discharge, conjunctival hyperaemia)

AND

1.2 Trial and failure, contraindication, or intolerance to one of the following (verified via pharmacy paid claims or submission of medical records):

- Topical ophthalmic “dual-acting” mast cell stabilizer and antihistamine (e.g., olopatadine, azelastine)
- Topical ophthalmic mast cell stabilizers (e.g., cromolyn)

AND

1.3 Trial and failure, contraindication, or intolerance, for short term use (up to 2 to 3 weeks), of topical ophthalmic corticosteroids (e.g., dexamethasone, prednisolone, fluorometholone) ((verified via pharmacy paid claims or submission of medical records)

AND

2 - Prescribed by or in consultation with ONE of the following:

- Ophthalmologist
- Optometrist

Product Name: Verkazia

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting positive clinical response to therapy as evidenced by an improvement in clinical signs and symptoms (e.g., itching, photophobia, papillary hypertrophy, mucus discharge, conjunctival hyperaemia)

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Verquvo



Prior Authorization Guideline

Guideline ID	GL-274203
Guideline Name	Verquvo
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State New Jersey Medicaid - Community & State New York Medicaid - Community & State New York EPP Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Arizona Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	7/1/2025

1 . Criteria

Product Name: Verquvo	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of heart failure AND 2 - Ejection fraction is less than 45 percent AND 3 - Heart failure is classified as ONE of the following: • New York Heart Association Class II • New York Heart Association Class III • New York Heart Association Class IV AND 4 - ONE of the following: 4.1 Hospitalization for heart failure within the past six months OR 4.2 Outpatient IV (intravenous) diuretics for heart failure within the past three months AND 5 - ONE of the following: 5.1 Patient is on a stabilized dose and receiving concomitant therapy with a maximally tolerated beta-blocker (e.g., bisoprolol, carvedilol, metoprolol) confirmed by claims history or submission of medical records	

OR

5.2 Patient has a contraindication or intolerance to beta-blocker therapy (please specify intolerance or contraindication)

AND

6 - ONE of the following:

6.1 Patient is on a stabilized dose and receiving concomitant therapy with ONE of the following, confirmed by claims history or submission of medical records:

- Angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril)
- Angiotensin II receptor blocker (ARB) (e.g., losartan)
- Angiotensin receptor-neprilysin inhibitor (ARNI) (e.g., Entresto)

OR

6.2 Patient has an allergy, contraindication, or intolerance to ACE inhibitors, ARBs, and ARNIs (please specify intolerance or contraindication)

AND

7 - ONE of the following:

7.1 Patient is on a stabilized dose and receiving concomitant therapy with a maximally tolerated aldosterone antagonist (e.g., spironolactone) confirmed by claims history or submission of medical records

OR

7.2 Patient has a contraindication or intolerance to aldosterone antagonist therapy (please specify intolerance or contraindication)

AND

8 - ONE of the following:

8.1 Patient is on a stabilized dose and receiving concomitant therapy with a sodium-glucose cotransporter 2 (SGLT2) inhibitor indicated for heart failure (e.g., Farxiga) confirmed by claims history or submission of medical records

OR

8.2 Patient has a contraindication or intolerance to SGLT2 inhibitor therapy (please specify intolerance or contraindication)

AND

9 - Verquvo is prescribed by or in consultation with a cardiologist

Product Name:Verquvo	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy	

2 . Revision History

Date	Notes
5/20/2025	Combined formularies. No changes to clinical criteria. Minor cosmetic updates.

Verquvo



Prior Authorization Guideline

Guideline ID	GL-274203
Guideline Name	Verquvo
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State New Jersey Medicaid - Community & State New York Medicaid - Community & State New York EPP Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Arizona Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	7/1/2025

1 . Criteria

Product Name: Verquvo	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of heart failure AND 2 - Ejection fraction is less than 45 percent AND 3 - Heart failure is classified as ONE of the following: • New York Heart Association Class II • New York Heart Association Class III • New York Heart Association Class IV AND 4 - ONE of the following: 4.1 Hospitalization for heart failure within the past six months OR 4.2 Outpatient IV (intravenous) diuretics for heart failure within the past three months AND 5 - ONE of the following: 5.1 Patient is on a stabilized dose and receiving concomitant therapy with a maximally tolerated beta-blocker (e.g., bisoprolol, carvedilol, metoprolol) confirmed by claims history or submission of medical records	

OR

5.2 Patient has a contraindication or intolerance to beta-blocker therapy (please specify intolerance or contraindication)

AND

6 - ONE of the following:

6.1 Patient is on a stabilized dose and receiving concomitant therapy with ONE of the following, confirmed by claims history or submission of medical records:

- Angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril)
- Angiotensin II receptor blocker (ARB) (e.g., losartan)
- Angiotensin receptor-neprilysin inhibitor (ARNI) (e.g., Entresto)

OR

6.2 Patient has an allergy, contraindication, or intolerance to ACE inhibitors, ARBs, and ARNIs (please specify intolerance or contraindication)

AND

7 - ONE of the following:

7.1 Patient is on a stabilized dose and receiving concomitant therapy with a maximally tolerated aldosterone antagonist (e.g., spironolactone) confirmed by claims history or submission of medical records

OR

7.2 Patient has a contraindication or intolerance to aldosterone antagonist therapy (please specify intolerance or contraindication)

AND

8 - ONE of the following:

8.1 Patient is on a stabilized dose and receiving concomitant therapy with a sodium-glucose cotransporter 2 (SGLT2) inhibitor indicated for heart failure (e.g., Farxiga) confirmed by claims history or submission of medical records

OR

8.2 Patient has a contraindication or intolerance to SGLT2 inhibitor therapy (please specify intolerance or contraindication)

AND

9 - Verquvo is prescribed by or in consultation with a cardiologist

Product Name:Verquvo	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy	

2 . Revision History

Date	Notes
5/20/2025	Combined formularies. No changes to clinical criteria. Minor cosmetic updates.

Vijoice (alpelisib)



Prior Authorization Guideline

Guideline ID	GL-149995
Guideline Name	Vijoice (alpelisib)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	8/1/2024

1 . Criteria

Product Name:Vijoice tablets, Vijoice granules	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of PIK3CA-Related Overgrowth Spectrum (PROS)	

AND

2 - Submission of documentation of mutation in the PIK3CA gene

AND

3 - Patient is 2 years of age or older

AND

4 - Submission of documentation of severe clinical manifestations (e.g., Congenital Lipomatous Overgrowth, Vascular malformations, Epidermal nevi, Scoliosis/skeletal and spinal [CLOVES], Facial Infiltrating Lipomatosis [FIL], Klippel-Trenaunay Syndrome [KTS], Megalencephaly-Capillary Malformation Polymicrogyria [MCAP])

AND

5 - Prescribed by or in consultation with a physician who specializes in the treatment of PROS

Product Name:Vioice tablets, Vioice granules	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of documentation of positive clinical response to therapy (e.g., radiological response defined as a $\geq 20\%$ reduction from baseline in the sum of target lesion volume) AND 2 - Prescribed by or in consultation with a physician who specializes in the treatment of PROS	

2 . Revision History

Date	Notes
7/18/2024	Added new Vioice granule formulation as a target. Updated product name list and GPI table accordingly. No changes to criteria.

Viltepso (viltolarsen)



Prior Authorization Guideline

Guideline ID	GL-539215
Guideline Name	Viltepso (viltolarsen)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name: Viltepso	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting BOTH of the following: 1.1 Diagnosis of Duchenne muscular dystrophy (DMD)	

AND

1.2 Presence of a mutation of the dystrophin gene amenable to exon 53 skipping

AND

2 - Patient is 4 years of age or older

AND

3 - Prescribed by or in consultation with a neurologist with expertise in the treatment of DMD

AND

4 - Dose will NOT exceed 80 milligrams per kilogram of body weight infused once weekly

AND

5 - Submission of medical records including results of baseline North Star Ambulatory Assessment (NSAA) confirming the patient is ambulatory without needing an assistive device (e.g., without side-by-side assist, cane, walker, wheelchair) as evidenced by NSAA scoring

AND

6 - Patient will NOT receive Viltepso in combination with Duvyzat (givinostat) or other exon-skipping therapies for DMD [e.g., Amondys 45 (casimersen), Exondys 51 (eteplirsen), Vyondys 53 (golodirsen)]

Product Name:Viltepso	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is tolerating therapy

AND

2 - Dose will NOT exceed 80 milligrams per kilogram of body weight infused once weekly

AND

3 - Prescribed by or in consultation with a neurologist with expertise in the treatment of DMD

AND

4 - Submission of medical records including results of recent North Star Ambulatory Assessment (NSAA) confirming patient is maintaining ambulatory status without needing an assistive device (e.g., without side-by-side assist, cane, walker, wheelchair) as evidenced by NSAA scoring

AND

5 - Patient will NOT receive Viltepso in combination with Duvyzat (givinostat) or other exon-skipping therapies for DMD [e.g., Amondys 45 (casimersen), Exondys 51 (eteplirsen), Vyondys 53 (golodirsen)]

2 . Revision History

Date	Notes
3/5/2026	Added submission of NSAA testing for confirmation of ambulatory status

Vivjoa (oteseconazole)



Prior Authorization Guideline

Guideline ID	GL-256198
Guideline Name	Vivjoa (oteseconazole)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	6/1/2025

1 . Criteria

Product Name:Vivjoa	
Approval Length	4 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of recurrent vulvovaginal candidiasis (RVVC) AND	

2 - Patient is NOT of reproductive potential

AND

3 - Diagnosis of RVVC confirmed by one of the following:

- Positive potassium hydroxide (KOH) preparation
- Vaginal fungal culture

AND

4 - Patient has experienced 3 or more symptomatic episodes of vulvovaginal candidiasis (VVC) within the past 12 months

AND

5 - Trial and failure, contraindication, or intolerance to one intravaginal product (e.g., clotrimazole, miconazole, tioconazole, terconazole, boric acid)

AND

6 - One of the following:

- Failure of a maintenance course of oral fluconazole defined as 100-mg (milligram), 150-mg, or 200-mg taken weekly for 6 months or Inadequate response (defined as greater than or equal to 24 weeks of therapy)
- Recurrence of infection while on maintenance therapy, adverse reaction or contraindication to oral fluconazole

AND

7 - Trial and failure, contraindication or intolerance to Brexafemme (ibrexafungerp)

2 . Revision History

UnitedHealthcare Community Plan of Arizona Clinical Pharmacy Program Guidelines

Date	Notes
5/7/2025	New guideline

Vonjo (pacritinib)



Prior Authorization Guideline

Guideline ID	GL-140891
Guideline Name	Vonjo (pacritinib)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name: Vonjo	
Diagnosis	Myelofibrosis
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting ALL of the following:	

1.1 Diagnosis of ONE of the following:

- Primary myelofibrosis
- Post-polycythemia vera myelofibrosis
- Post-essential thrombocythemia myelofibrosis

AND

1.2 Disease is intermediate or high risk

AND

1.3 Pre-treatment platelet count below 50×10^9 L

AND

2 - Prescribed by or in consultation with ONE of the following:

- Hematologist
- Oncologist

Product Name: Vonjo	
Diagnosis	Myelofibrosis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting positive clinical response to therapy (e.g., symptom improvement, spleen volume reduction)	

Product Name: Vonjo

Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - This drug will be approved for uses supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1, 2A, or 2B	

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Vonoprazan Containing Agents



Prior Authorization Guideline

Guideline ID	GL-157272
Guideline Name	Vonoprazan Containing Agents
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	11/1/2024

1 . Criteria

Product Name:Voquezna Dual Pak, Voquezna Triple Pak	
Diagnosis	Helicobacter pylori (H. pylori) Infection
Approval Length	1 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Helicobacter pylori infection	

AND

2 - Trial and failure, contraindication, or intolerance to BOTH of the following first line treatment regimens:

- Clarithromycin based therapy (e.g., clarithromycin based triple therapy, clarithromycin based concomitant therapy)
- Bismuth quadruple therapy (e.g., bismuth and metronidazole and tetracycline and proton pump inhibitor [PPI])

Product Name:Voquezna 20 mg tablet

Diagnosis	Helicobacter pylori (H. pylori) Infection
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Helicobacter pylori infection

AND

2 - ONE of the following:

- Used in combination with amoxicillin and clarithromycin for the treatment of H. pylori infection
- Used in combination with amoxicillin for the treatment of H. pylori infection

AND

3 - Trial and failure, contraindication, or intolerance to BOTH of the following first line treatment regimens:

- Clarithromycin based therapy (e.g., clarithromycin based triple therapy, clarithromycin based concomitant therapy)

- Bismuth quadruple therapy (e.g., bismuth and metronidazole and tetracycline and proton pump inhibitor [PPI])

Product Name:Voquezna 20 mg tablet	
Diagnosis	Healing and Relief of Heartburn associated with Erosive Esophagitis
Approval Length	8 Week(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of erosive esophagitis AND 2 - Used for healing of all grades of erosive esophagitis and relief of heartburn associated with erosive esophagitis AND 3 - Trial (of a minimum 8-week supply) and inadequate response (within the last 365 days), contraindication, or intolerance to TWO of the following generic proton pump inhibitors (PPI's): • omeprazole • esomeprazole • pantoprazole • lansoprazole • rabeprazole • dexlansoprazole	

Product Name:Voquezna 10 mg tablet	
Diagnosis	Maintenance of Healing and Relief of Heartburn associated with Erosive Esophagitis
Approval Length	6 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Used to maintain healing and relief of heartburn associated with erosive esophagitis

AND

2 - Trial (of a minimum 8-week supply) and inadequate response (within the last 365 days), contraindication, or intolerance to TWO of the following generic proton pump inhibitors (PPI's):

- omeprazole
- esomeprazole
- pantoprazole
- lansoprazole
- rabeprazole
- dexlansoprazole

Product Name:Voquezna 10 mg tablet*

Diagnosis	Relief of Heartburn associated with Non-Erosive Gastroesophageal Reflux Disease
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of non-erosive gastroesophageal reflux disease

AND

2 - BOTH of the following:

- Patient has history of heartburn for at least 6 months
- Heartburn symptoms are present for at least 4 days during any consecutive 7-day period

AND

3 - Trial (of a minimum 8-week supply) and inadequate response (within the last 365 days), contraindication, or intolerance to TWO of the following generic proton pump inhibitors (PPI's):

- omeprazole
- esomeprazole
- pantoprazole
- lansoprazole
- rabeprazole
- dexlansoprazole

Notes	*Voquezna 20 mg tablets are not FDA approved for non-erosive gastroesophageal reflux disease.

2 . Revision History

Date	Notes
10/9/2024	Added new criteria for relief of heartburn associated with non-erosive GERD for Voquezna 10 mg tabs. Specified which strengths of Voquezna apply to which indication. Updated product name lists and GPI tables accordingly.

Voxzogo (vosoritide)



Prior Authorization Guideline

Guideline ID	GL-141023
Guideline Name	Voxzogo (vosoritide)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name:Voxzogo	
Diagnosis	Achondroplasia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has open epiphyses	

AND

2 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of achondroplasia as confirmed by one of the following:

2.1 Both of the following:

2.1.1 Patient has clinical manifestations characteristic of achondroplasia (e.g., macrocephaly, frontal bossing, midface retrusion, disproportionate short stature with rhizomelic shortening of the arms and the legs, brachydactyly, trident configuration of the hands, thoracolumbar kyphosis, and accentuated lumbar lordosis)

AND

2.1.2 Patient has radiographic findings characteristic of achondroplasia (e.g., large calvaria and narrowing of the foramen magnum region, undertubulated, shortened long bones with metaphyseal abnormalities, narrowing of the interpedicular distance of the caudal spine, square ilia and horizontal acetabula, small sacrosciatic notches, proximal scooping of the femoral metaphyses, and short and narrow chest)

OR

2.2 Molecular genetic testing confirmed c.1138G > A or c.1138G > C variant (i.e., p.Gly380Arg mutation) in the fibroblast growth factor receptor-3 (FGFR3) gene

AND

3 - Patient did not have limb-lengthening surgery in the previous 18 months and does not plan on having limb-lengthening surgery while on Voxzogo therapy

AND

4 - Prescribed by or in consultation with one of the following:

- Clinical geneticist
- Endocrinologist
- A physician who has specialized expertise in the management of achondroplasia

Notes	Requests for Idiopathic Short Stature (ISS) should not be approved. Deny as a benefit exclusion.

Product Name:Voxzogo	
Diagnosis	Achondroplasia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient continues to have open epiphyses AND 2 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting positive clinical response to therapy as evidenced by one of the following: • Improvement in annualized growth velocity (AGV) compared to baseline • Improvement in height Z-score compared to baseline AND 3 - Prescribed by or in consultation with one of the following: • Clinical geneticist • Endocrinologist • A physician who has specialized expertise in the management of achondroplasia	
Notes	Requests for Idiopathic Short Stature (ISS) should not be approved. Deny as a benefit exclusion.

2 . Revision History

Date	Notes

12/7/2023	Removed age criterion for Achondroplasia, removed ISS criteria section, added notes.

Voydeya (danicopan)



Prior Authorization Guideline

Guideline ID	GL-403218
Guideline Name	Voydeya (danicopan)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	11/1/2025

1 . Criteria

Product Name:Voydeya	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of paroxysmal nocturnal hemoglobinuria (PNH)	

AND

2 - Will be used as add-on therapy to Ultomiris (ravulizumab) or Soliris (eculizumab)

AND

3 - Hemoglobin level less than or equal to 9.5 g/dL

AND

4 - Absolute reticulocyte count greater than or equal to $120 \times 10^9/L$

AND

5 - Prescribed by or in consultation with a hematologist/oncologist

Product Name:Voydeya	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient demonstrates positive clinical response to therapy (e.g., hemoglobin stabilization, decrease in the number of red blood cell transfusions) AND 2 - Will be used as add-on therapy to Ultomiris (ravulizumab) or Soliris (eculizumab)	

2 . Revision History

Date	Notes
10/1/2025	New program.

Voyxact (sibeprenlimab-szsi)



Prior Authorization Guideline

Guideline ID	GL-534287
Guideline Name	Voyxact (sibeprenlimab-szsi)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Voyxact	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of primary immunoglobulin A nephropathy (IgAN)	

AND

2 - Patient is at risk for disease progression (e.g., proteinuria of at least 0.5 g/day [grams per day], or by other criteria such as clinical risk scoring using the International IgAN Prediction Tool)

AND

3 - Used to reduce proteinuria

AND

4 - Submission of medical records (e.g., chart notes) or verification of paid claims documenting ONE of the following:

4.1 Patient has been on a minimum 90-day trial of a maximally tolerated dose and will continue to receive therapy with ONE of the following:

- An angiotensin-converting enzyme (ACE) inhibitor (e.g., benazepril, lisinopril)
- An angiotensin II receptor blocker (ARB) (e.g., losartan, valsartan)

OR

4.2 Patient has a contraindication or intolerance to both ACE inhibitors and ARBs

AND

5 - Prescribed by or in consultation with a nephrologist

Product Name: Voyxact	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates a positive clinical response to therapy as demonstrated by a decrease in urine protein-to-creatinine ratio (UPCR) from baseline

2 . Revision History

Date	Notes
3/2/2026	New program.

Vtama (tapinarof)



Prior Authorization Guideline

Guideline ID	GL-398262
Guideline Name	Vtama (tapinarof)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2025

1 . Criteria

Product Name:Vtama	
Diagnosis	Plaque Psoriasis (PsO)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes, lab work, imaging, paid claims history) documenting a diagnosis of plaque psoriasis (PsO)	

AND

2 - Submission of medical records (e.g., chart notes, lab work, imaging, paid claims history) documenting a minimum duration of a 4 week trial and failure, contraindication, or intolerance to ONE of the following topical therapies:

- Corticosteroids (e.g., betamethasone, clobetasol)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)

AND

3 - Prescribed by or in consultation with a dermatologist

Product Name:Vtama	
Diagnosis	Plaque Psoriasis (PsO)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes, lab work, imaging, paid claims history) documenting positive clinical response to therapy as evidenced by ONE of the following: • Reduction in the body surface area (BSA) involvement from baseline • Improvement in symptoms (e.g., pruritus, inflammation) from baseline	

Product Name:Vtama	
Diagnosis	Atopic Dermatitis (AD)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of atopic dermatitis (AD) AND 2 - Patient is 2 years of age or older AND 3 - Submission of medical records (e.g., chart notes) or paid claims confirming a trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to TWO of the following: • Medium or higher potency topical corticosteroid • Elidel (pimecrolimus) cream • Tacrolimus ointment • Eucrisa (crisaborole) ointment AND 4 - Prescribed by or in consultation with ONE of the following: • Dermatologist • Allergist • Immunologist	

Product Name:Vtama	
Diagnosis	Atopic Dermatitis (AD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging, paid claims history) documenting positive clinical response to therapy as evidenced by ONE of the following:

- Reduction in the body surface area (BSA) involvement from baseline
- Reduction in pruritus severity from baseline
- Improvement in quality of life from baseline

2 . Background**Clinical Practice Guidelines****Table 1: Relative potencies of topical corticosteroids**

Class	Drug	Dosage Form	Strength (%)
Very high potency	Augmented betamethasone dipropionate	Ointment	0.05
	Clobetasol propionate	Cream, foam, ointment	0.05
	Diflorasone diacetate	Ointment	0.05
	Halobetasol propionate	Cream, ointment	0.05
High Potency	Amcinonide	Cream, lotion, ointment	0.1
	Augmented betamethasone dipropionate	Cream	0.05
	Betamethasone dipropionate	Cream, foam, ointment, solution	0.05
	Desoximetasone	Cream, ointment	0.25
	Desoximetasone	Gel	0.05
	Diflorasone diacetate	Cream	0.05
	Fluocinonide	Cream, gel, ointment, solution	0.05
	Halcinonide	Cream, ointment	0.1
	Mometasone furoate	Ointment	0.1

	Triamcinolone acetonide	Cream, ointment	0.5
Medium potency	Betamethasone valerate	Cream, foam, lotion, ointment	0.1
	Clocortolone pivalate	Cream	0.1
	Desoximetasone	Cream	0.05
	Fluocinolone acetonide	Cream, ointment	0.025
	Flurandrenolide	Cream, ointment	0.05
	Fluticasone propionate	Cream	0.05
	Fluticasone propionate	Ointment	0.005
	Mometasone furoate	Cream	0.1
	Triamcinolone acetonide	Cream, ointment	0.1
Lower-medium potency	Hydrocortisone butyrate	Cream, ointment, solution	0.1
	Hydrocortisone probutate	Cream	0.1
	Hydrocortisone valerate	Cream, ointment	0.2
	Prednicarbate	Cream	0.1
Low potency	Alclometasone dipropionate	Cream, ointment	0.05
	Desonide	Cream, gel, foam, ointment	0.05
	Fluocinolone acetonide	Cream, solution	0.01
Lowest potency	Dexamethasone	Cream	0.1
	Hydrocortisone	Cream, lotion, ointment, solution	0.25, 0.5, 1
	Hydrocortisone acetate	Cream, ointment	0.5-1

3 . Revision History

Date	Notes
9/19/2025	Updated embedded step criterion in initial auth sections for AD and P sO. Disregard GL-392214, replaced with this guideline.

Vyjuvek (beremagene geperpavec-svdt)



Prior Authorization Guideline

Guideline ID	GL-502218
Guideline Name	Vyjuvek (beremagene geperpavec-svdt)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Vyjuvek	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of dystrophic epidermolysis bullosa (DEB)	

AND

2 - Submission of medical records (e.g., chart notes) confirming patient has mutation(s) in the collagen type VII alpha 1 chain (COL7A1) gene

AND

3 - Medication is being used for the treatment of wounds

AND

4 - Medication will be applied by a healthcare professional

AND

5 - Submission of medical records (e.g., chart notes) confirming wound(s) being treated meet ALL of the following criteria:

- Adequate granulation tissue
- Excellent vascularization
- No evidence of active wound infection in the wound being treated
- No evidence or history of squamous cell carcinoma in the wound being treated

AND

6 - Prescribed by or in consultation with a dermatologist

AND

7 - Medication is NOT being used concurrently with other FDA approved therapies (e.g., Filsuvez) for the treatment epidermolysis bullosa

Product Name:Vyjuvek

Approval Length

6 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting positive clinical response (e.g., decrease in wound size, increase in granulation tissue, complete wound closure) AND 2 - Wound(s) being treated meet ALL of the following criteria: • Adequate granulation tissue • Excellent vascularization • No evidence of active wound infection in the wound being treated • No evidence or history of squamous cell carcinoma in the wound being treated AND 3 - Medication is NOT being used concurrently with other FDA approved therapies (e.g., Filsuvez) for the treatment epidermolysis bullosa	

2 . Revision History

Date	Notes
1/15/2026	Added concomitant use criterion

Vykat XR (diazoxide choline)



Prior Authorization Guideline

Guideline ID	GL-287359
Guideline Name	Vykat XR (diazoxide choline)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	7/1/2025

1 . Criteria

Product Name:Vykat XR	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of Prader-Willi syndrome (PWS)	

AND

2 - Medication is being used for hyperphagia due to PWS

AND

3 - Submission of medical records (e.g., chart notes) documenting disease is confirmed by the presence of a mutation in chromosome 15 as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA)

AND

4 - Patient is 4 years of age or older

AND

5 - Prescribed by or in consultation with one of the following:

- Endocrinologist
- Geneticist
- Specialist knowledgeable in the treatment of Prader-Willi syndrome

Product Name:Vykat XR

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) demonstrating positive clinical response to therapy (e.g., decreased hunger or thoughts about food, decreased weight or BMI)

2 . Revision History

Date	Notes
6/4/2025	New Guideline

Vyndaqel and Vyndamax



Prior Authorization Guideline

Guideline ID	GL-140932
Guideline Name	Vyndaqel and Vyndamax
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Vyndaqel, Vyndamax	
Diagnosis	Transthyretin (ATTR)-mediated amyloidosis with cardiomyopathy (ATTR-CM)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of transthyretin (ATTR)-mediated amyloidosis with cardiomyopathy (ATTR-CM)	

AND

2 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting ONE of the following:

2.1 Documentation that the patient has a pathogenic transthyretin (TTR) mutation (e.g., V30M)

OR

2.2 Cardiac or noncardiac tissue biopsy demonstrating histologic confirmation of ATTR amyloid deposits

OR

2.3 Submission of medical records (e.g., chart notes, lab work, imaging) documenting ALL of the following

2.3.1 Echocardiogram or cardiac magnetic resonance imaging suggestive of amyloidosis

AND

2.3.2 Radionuclide imaging (99mTc-DPD, 99mTc-PYP, or 99m Tc-HMDP) showing grade 2 or 3 cardiac uptake*

AND

2.3.3 Absence of monoclonal protein identified in serum, urine immunofixation (IFE), serum free light chain (sFLC) assay

AND

3 - Prescribed by, or in consultation, with a cardiologist

AND

4 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting presence of clinical signs and symptoms of cardiomyopathy (e.g., heart failure, dyspnea, edema, hepatomegaly, ascites, angina, etc.)

AND

5 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting BOTH of the following:

5.1 ONE of the following:

5.1.1 Patient has New York Heart Association (NYHA) Functional Class I or II heart failure

OR

5.1.2 BOTH of the following:

5.1.2.1 Patient has New York Heart Association (NYHA) Functional Class III heart failure

AND

5.1.2.2 Patient's cardiopulmonary functional status allows patient to ambulate 100 meters or greater in six minutes or less

AND

5.2 Patient has an N-terminal pro-B-type natriuretic peptide (NT-proBNP) level greater than or equal to 600 picograms/milliliter

AND

6 - One of the following:

6.1 Paid claims or submission of medical records (e.g., chart notes) verifying patient is not receiving Vyndaqel or Vyndamax in combination with either of the following:

- Onpattro (patisiran)
- Tegsedi (inotersen)

OR

6.2 If the patient is receiving Vyndaqel/Vyndamax in combination with Onpattro (patisiran) or Tegsedi (inotersen), the physician attests that he/she will coordinate care with other specialist(s) involved in the patient's amyloidosis treatment plan to determine optimal long term monotherapy** treatment regimen

Notes

NOTE: *May require prior authorization and notification
 ** Referring to monotherapy with Vyndaqel/Vyndamax, Onpattro, or Tegsedi

Product Name: Vyndaqel, Vyndamax

Diagnosis	Transthyretin (ATTR)-mediated amyloidosis with cardiomyopathy (ATTR-CM)

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that the patient has experienced a positive clinical response to Vyndaqel or Vyndamax (e.g., improved symptoms, quality of life, slowing of disease progression, decreased hospitalizations, etc.)

AND

2 - Prescribed by or in consultation with a cardiologist

AND

3 - Submission of medical records (e.g., chart notes) documenting that patient continues to have New York Heart Association (NYHA) Functional Class I, II, or III heart failure

AND

4 - Paid claims or submission of medical records (e.g., chart notes) verifying patient is not receiving Vyndaqel or Vyndamax in combination with either of the following:

- Onpattro (patisiran)
- Tegsedi (inotersen)

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Vyondys 53 (golodirsen)



Prior Authorization Guideline

Guideline ID	GL-539218
Guideline Name	Vyondys 53 (golodirsen)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Vyondys 53	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting BOTH of the following: 1.1 Diagnosis of Duchenne muscular dystrophy (DMD)	

AND

1.2 Confirmed mutation of the dystrophin gene amenable to exon 53 skipping

AND

2 - Patient is 6 years of age or older

AND

3 - Prescribed by or in consultation with a neurologist with expertise in the treatment of DMD

AND

4 - Dose will NOT exceed 30 milligrams per kilogram of body weight infused once weekly

AND

5 - Submission of medical records including results of baseline North Star Ambulatory Assessment (NSAA) confirming the patient is ambulatory without needing an assistive device (e.g., without side-by-side assist, cane, walker, wheelchair) as evidenced by NSAA scoring

AND

6 - Patient will NOT receive Vyondys 53 in combination with Duvyzat (givinostat) or other exon-skipping therapies for DMD [e.g., Amondys 45 (casimersen), Exondys 51 (eteplirsen), Viltepso (viltolarsen)]

Product Name:Vyondys 53	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is tolerating therapy

AND

2 - Dose will NOT exceed 30 milligrams per kilogram of body weight infused once weekly

AND

3 - Prescribed by or in consultation with a neurologist with expertise in the treatment of DMD

AND

4 - Submission of medical records including results of recent North Star Ambulatory Assessment (NSAA) confirming patient is maintaining ambulatory status without needing an assistive device (e.g., without side-by-side assist, cane, walker, wheelchair) as evidenced by NSAA scoring

AND

5 - Patient will NOT receive Vyondys 53 in combination with Duvyzat (givinostat) or other exon-skipping therapies for DMD [e.g., Amondys 45 (casimersen), Exondys 51 (eteplirsen), Vilterso (viltolarsen)]

2 . Revision History

Date	Notes
3/5/2026	Added submission of NSAA testing for confirmation of ambulatory status

Vyvgart (efgartigimod alfa-fcab)



Prior Authorization Guideline

Guideline ID	GL-539223
Guideline Name	Vyvgart (efgartigimod alfa-fcab)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Vyvgart, Vyvgart Hytrulo	
Diagnosis	Generalized myasthenia gravis (gMG)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of generalized myasthenia gravis (gMG)	

AND

2 - Patient is anti-acetylcholine receptor (AChR) antibody positive

AND

3 - Submission of medical records (e.g., chart notes) or paid claims confirming BOTH of the following:

3.1 Trial and failure, contraindication, or intolerance to TWO immunosuppressive therapies (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus)

AND

3.2 Trial and failure, contraindication, or intolerance to ONE of the following:

- Chronic plasmapheresis or plasma exchange (PE)
- Intravenous immunoglobulin (IVIG) or immunoglobulin (IG) therapy

AND

4 - Prescribed by or in consultation with a neurologist

AND

5 - Requested medication is NOT being used in combination with any of the following:

- Another neonatal Fc Receptor (FcRn) blocker (e.g., Imaavy, Rystiggo)
- Complement inhibitor (e.g., Soliris, Ultomiris, Zilbrysq)
- Immune globulin (e.g., IVIG)

Product Name:Vyvgart, Vyvgart Hytrulo

Diagnosis

Generalized myasthenia gravis (gMG)

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting positive clinical response to therapy AND 2 - Requested medication is NOT being used in combination with any of the following: • Another neonatal Fc Receptor (FcRn) blocker (e.g., Imaavy, Rystiggo) • Complement inhibitor (e.g., Soliris, Ultomiris, Zilbrysq) • Immune globulin (e.g., IVIG)	

Product Name:Vyvgart Hytrulo	
Diagnosis	Chronic inflammatory demyelinating polyneuropathy (CIDP)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) or paid pharmacy claims documenting ALL of the following: 1.1 Diagnosis of chronic inflammatory demyelinating polyneuropathy (CIDP) as confirmed by ALL of the following: 1.1.1 Progressive symptoms present for at least 2 months AND	

1.1.2 Symptomatic polyradiculoneuropathy as indicated by ONE of the following:

- Progressive or relapsing motor impairment of more than one limb
- Progressive or relapsing sensory impairment of more than one limb

AND

1.1.3 Electrophysiologic findings when THREE of the following four criteria are present:

- Partial conduction block of 1 or more motor nerve
- Reduced conduction velocity of 2 or more motor nerves
- Prolonged distal latency of 2 or more motor nerves
- Prolonged F-wave latencies of 2 or more motor nerves or the absence of F waves

AND

1.2 Trial and failure, contraindication, or intolerance to ONE of the following standard of care treatments:

- Corticosteroids (minimum 3 month trial duration)
- Immunoglobulin
- Plasma exchange

AND

2 - Prescribed by or in consultation with ONE of the following:

- Immunologist
- Neurologist
- Hematologist

AND

3 - Requested medication is NOT being used in combination with any of the following:

- Another neonatal Fc Receptor (FcRn) blocker (e.g., Imaavy, Rystiggo)
- Complement inhibitor (e.g., Soliris, Ultomiris, Zilbrysq)
- Immune globulin (e.g., IVIG)

Product Name:Vyvgart Hytrulo	
Diagnosis	Chronic inflammatory demyelinating polyneuropathy (CIDP)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting positive clinical response to therapy (e.g., improvement in INCAT or aINCAT score)

AND

2 - Prescribed by or in consultation with ONE of the following:

- Immunologist
- Neurologist
- Hematologist

AND

3 - Requested medication is NOT being used in combination with any of the following:

- Another neonatal Fc Receptor (FcRn) blocker (e.g., Imaavy, Rystiggo)
- Complement inhibitor (e.g., Soliris, Ultomiris, Zilbrysq)
- Immune globulin (e.g., IVIG)

2 . Revision History

Date	Notes
3/5/2026	Updated title to match AZM. Added concomitant use criteria to all sections

Wainua (eplontersen)



Prior Authorization Guideline

Guideline ID	GL-145433
Guideline Name	Wainua (eplontersen)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2024

1 . Criteria

Product Name:Wainua	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of hereditary transthyretin-mediated amyloidosis (hATTR amyloidosis) with polyneuropathy	

AND

2 - Submission of medical records (e.g., chart notes) confirming patient has a transthyretin (TTR) mutation (e.g., V30M)

AND

3 - Submission of medical records (e.g., chart notes) confirming ONE of the following:

- Patient has a baseline familial amyloidotic polyneuropathy (FAP) stage of 1 or 2
- Patient has a baseline neuropathy impairment score (NIS) greater than or equal to 10 and less than or equal to 130
- Patient has a baseline Karnofsky Performance Status score greater than 50%

AND

4 - Presence of clinical signs and symptoms of the disease (e.g., neuropathy, quality of life)

AND

5 - Patient has NOT had a liver transplant

AND

6 - Prescribed by or in consultation with a neurologist

Product Name:Wainua	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Submission of medical records (e.g., chart note) documenting a positive clinical response to therapy as evidenced by an improvement in clinical signs and symptoms from baseline (e.g., neuropathy, quality of life, lower serum TTR level)

AND

2 - Submission of medical records (e.g., chart notes) confirming ONE of the following:

- Patient continues to have a familial amyloidotic polyneuropathy (FAP) stage of 1 or 2
- Patient continues to have a neuropathy impairment score (NIS) greater than or equal to 10 and less than or equal to 130
- Patient continues to have a Karnofsky Performance Status score greater than 50%

AND

3 - Patient has NOT had a liver transplant

2 . Revision History

Date	Notes
4/5/2024	New program.

Wakix (pitolisant)



Prior Authorization Guideline

Guideline ID	GL-560213
Guideline Name	Wakix (pitolisant)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:Wakix	
Diagnosis	Narcolepsy with Cataplexy (i.e., Narcolepsy Type 1)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g. chart notes) documenting ALL of the following:	

1.1 Diagnosis of narcolepsy as confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible)

AND

1.2 Symptoms of cataplexy are present

AND

1.3 Symptoms of excessive daytime sleepiness (e.g., irrepressible need to sleep or daytime lapses into sleep) are present

AND

2 - Physician attestation to the following: Other causes of sleepiness have been ruled out or treated (including but not limited to obstructive sleep apnea, insufficient sleep syndrome, shift work, the effects of substances or medications or their withdrawal, sleep phase disorder, or other sleep disorders)

AND

3 - Patient is 6 years of age or older

AND

4 - Prescribed by ONE of the following:

- Neurologist
- Psychiatrist
- Sleep Medicine Specialist

Product Name:Wakix

Diagnosis	Narcolepsy without Cataplexy (i.e., Narcolepsy Type 2)
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g. chart notes) documenting ALL of the following: 1.1 Diagnosis of narcolepsy as confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible) AND 1.2 Symptoms of cataplexy are absent AND 1.3 Symptoms of excessive daytime sleepiness (e.g., irrepressible need to sleep or daytime lapses into sleep) are present AND 2 - Physician attestation to the following: Other causes of sleepiness have been ruled out or treated (including but not limited to obstructive sleep apnea, insufficient sleep syndrome, shift work, the effects of substances or medications or their withdrawal, sleep phase disorder, or other sleep disorders) AND 3 - Patient is 6 years of age or older AND 4 - Paid claims or submission of medical records (e.g., chart notes) confirming BOTH of the following: 4.1 Trial and failure, contraindication (e.g., age), or intolerance to BOTH of the following:	

- armodafinil or modafinil
- Sunosi (solriamfetol)

AND

4.2 Trial and failure, contraindication, or intolerance to an amphetamine (e.g., amphetamine, dextroamphetamine) or methylphenidate based stimulant UNLESS patient is not a candidate

AND

5 - Prescribed by ONE of the following:

- Neurologist
- Psychiatrist
- Sleep Medicine Specialist

Product Name:Wakix	
Diagnosis	Narcolepsy with Cataplexy (i.e., Narcolepsy Type 1), Narcolepsy without Cataplexy (i.e., Narcolepsy Type 2)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has a reduction in symptoms of excessive daytime sleepiness associated with therapy	

2 . Revision History

Date	Notes
3/30/2026	Age added for narcolepsy w cataplexy

Wegovy (semaglutide)



Prior Authorization Guideline

Guideline ID	GL-523190
Guideline Name	Wegovy (semaglutide)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name:Wegovy injection, Wegovy tablets	
Diagnosis	Weight Loss
Guideline Type	Prior Authorization
Approval Criteria 1 - Wegovy when used for the treatment of weight loss is excluded and is to be denied as a benefit exclusion	

Product Name:Wegovy injection, Wegovy tablets

Diagnosis	Reduction of risk of major adverse cardiovascular events
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Treatment is being requested to reduce the risk of major adverse cardiovascular events AND 2 - Patient is 45 years of age or older AND 3 - Submission of medical records (e.g., chart notes) documenting ALL the following: 3.1 BMI (body mass index) greater than or equal to 30 kg/m² (kilograms per square meter) AND 3.2 Established cardiovascular disease as evidenced by ONE of the following: 3.2.1 Prior myocardial infarction (MI) OR 3.2.2 ONE of the following diagnoses/diagnosis codes: • I25.2 Old myocardial infarction • I46.2 Cardiac arrest due to underlying cardiac condition • I46.8 Cardiac arrest due to other underlying condition • I46.9 Cardiac arrest, cause unspecified • Z95.0 Presence of cardiac pacemaker • Z95.1 Presence of aortocoronary bypass graft • Z95.2 Presence of prosthetic heart valve • Z95.3 Presence of xenogenic heart valve	

- Z95.4 Presence of other heart-valve replacement
- Z95.5 Presence of coronary angioplasty implant and graft

AND

4 - Used in combination with a reduced calorie diet and increased physical activity

AND

5 - For patients with a history of myocardial infarction, submission of medical records (e.g., chart notes) or paid claims documenting ONE of the following:

5.1 Patient is on therapy from each of the following classes (as confirmed by claims history or submission of medical records):

- Cholesterol lowering medication (e.g., statin, PCSK9i)
- Beta blocker (i.e., carvedilol, metoprolol, or bisoprolol)
- Angiotensin-converting enzyme inhibitor (ACE-I)/angiotensin II receptor blocker (ARB)/angiotensin II receptor blocker neprilysin inhibitor (ARNI)
- Antiplatelet (e.g., aspirin, clopidogrel)

OR

5.2 Patient has a history of intolerance or contraindication to ALL of the following therapeutic classes (please specify intolerance or contraindication):

- Cholesterol lowering medication (e.g., statin, PCSK9i)
- Beta blocker (i.e., carvedilol, metoprolol, or bisoprolol)
- Angiotensin-converting enzyme inhibitor (ACE-I)/angiotensin II receptor blocker (ARB)/angiotensin II receptor blocker neprilysin inhibitor (ARNI)
- Antiplatelet (e.g., aspirin, clopidogrel)

AND

6 - Patient does NOT have diagnosis of diabetes or HgA1c greater than or equal to 6.5%

AND

7 - Patient does NOT have New York Heart Association class IV heart failure

AND

8 - Patient does NOT have end-stage renal disease

Product Name:Wegovy injection, Wegovy tablets

Diagnosis	Reduction of risk of major adverse cardiovascular events
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - BMI (body mass index) greater than or equal to 30 kg/m2 (kilograms per square meter)

AND

2 - Used in combination with a reduced calorie diet and increased physical activity

AND

3 - Patient does NOT have diagnosis of diabetes or HgA1c greater than or equal to 6.5%

AND

4 - Patient does NOT have New York Heart Association class IV heart failure

AND

5 - Patient does NOT have end-stage renal disease

Product Name:Wegovy injection	
Diagnosis	Metabolic dysfunction-associated steatohepatitis (MASH)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of metabolic dysfunction-associated steatohepatitis (MASH), formerly known as nonalcoholic steatohepatitis (NASH) AND 2 - Patient does NOT have cirrhosis (e.g., decompensated cirrhosis) AND 3 - Disease is fibrosis stage F2 or F3 as confirmed by ONE of the following: - Enhanced liver fibrosis (ELF) test - Liver stiffness measurement (LSM) by vibration-controlled transient elastography (VCTE) (e.g., FibroScan) - FibroScan aspartate aminotransferase (FAST) - MRI aspartate aminotransferase (MAST) - Magnetic Resonance Elastography (MRE) combined with fibrosis-4 index (MEFIB) - Liver biopsy within the past 12 months AND 4 - Patient is 18 years of age or older AND 5 - Used as an adjunct to lifestyle modification (e.g., dietary or caloric restriction, exercise, behavioral support, community-based program)	

AND

6 - Prescribed by or in consultation with ONE of the following:

- Gastroenterologist
- Hepatologist
- Endocrinologist

AND

7 - Medication is NOT being co-administered with another GLP-1 receptor agonist (e.g., Saxenda, Trulicity, Victoza)

AND

8 - Medication will NOT be used in combination with Rezdiffra (resmetirom) for the treatment of MASH

Product Name:Wegovy injection	
Diagnosis	Metabolic dysfunction-associated steatohepatitis (MASH)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient demonstrates positive response to therapy (e.g., improvement in liver function tests [LFTs], fibrosis stage improvement, improvement from baseline on MASH-specific imaging [VCTE greater than or equal to 25%, MRE greater than or equal to 20%, etc.], etc.) AND 2 - Patient has NOT progressed to cirrhosis	

AND

3 - Used as an adjunct to lifestyle modification (e.g., dietary or caloric restriction, exercise, behavioral support, community-based program)

AND

4 - Medication is NOT being co-administered with another GLP-1 receptor agonist (e.g., Saxenda, Trulicity, Victoza)

AND

5 - Medication will NOT be used in combination with Rezdiffra (resmetirom) for the treatment of MASH

2 . Revision History

Date	Notes
2/11/2026	Moved wt loss section to top of GL. Added Wegovy tabs as targets to MACE and wt loss sections. Updated product name lists and GPI tables accordingly. Added new criteria for MASH for Wegovy inj formulation.

Xdemvy (lotilaner)



Prior Authorization Guideline

Guideline ID	GL-287355
Guideline Name	Xdemvy (lotilaner)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	7/1/2025

1 . Criteria

Product Name:Xdemvy	
Approval Length	2 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting ALL of the following: 1.1 Diagnosis of Demodex blepharitis	

AND

1.2 Patient exhibits one of the following signs of Demodex infestation:

- Collarettes
- Eyelid margin erythema
- Eyelash anomalies (e.g., eyelash misdirection)

AND

1.3 Patient is experiencing symptoms or architectural changes associated with Demodex infestation (e.g., burning, tearing, itching, foreign body sensation, eyelashes missing, eyelashes growing inward)

AND

1.4 Inadequate response to at least a 12-week trial of BOTH of the following:

- tea tree-oil
- eyelid scrub

AND

2 - Prescribed by or in consultation with one of the following:

- Ophthalmologist
- Optometrist

2 . Revision History

Date	Notes
6/4/2025	Updated step 1.4 to include 12-week trial of tea tree-oil and eyelid scrub

Xeljanz, Xeljanz XR (tofacitinib)



Prior Authorization Guideline

Guideline ID	GL-512275
Guideline Name	Xeljanz, Xeljanz XR (tofacitinib)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name:Xeljanz tablets, Xeljanz XR tablets	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderately to severely active rheumatoid arthritis (RA)	

AND

2 - Submission of medical records (e.g., chart notes) or paid claims documenting history of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

3 - Prescribed by or in consultation with a rheumatologist

Product Name: Xeljanz tablets, Xeljanz XR tablets

Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Prescribed by or in consultation with a rheumatologist

Product Name: Xeljanz tablets, Xeljanz XR tablets, Xeljanz oral solution

Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of active psoriatic arthritis (PsA)

AND

2 - If the request is for Xeljanz IR tablets or Xeljanz oral solution, patient is 2 years of age or older

AND

3 - Submission of medical records (e.g., chart notes) or paid claims documenting history of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

4 - Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Dermatologist

Product Name:Xeljanz tablets, Xeljanz XR tablets, Xeljanz oral solution	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy	

AND

2 - Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Dermatologist

Product Name: Xeljanz tablets, Xeljanz XR tablets

Diagnosis	Ulcerative Colitis (UC)

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active ulcerative colitis (UC)

AND

2 - Submission of medical records (e.g., chart notes) or paid claims documenting history of failure to ONE of the following conventional therapies at maximally indicated doses within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced:

- Corticosteroids (e.g., prednisone, methylprednisolone, budesonide)
- 6-mercaptopurine (Purinethol)
- Azathioprine (Imuran)
- Aminosalicylates (e.g., mesalamine, sulfasalazine)

AND

3 - Prescribed by or in consultation with a gastroenterologist

Product Name: Xeljanz tablets, Xeljanz XR tablets

Diagnosis	Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy AND 2 - Prescribed by or in consultation with a gastroenterologist	

Product Name:Xeljanz tablets, Xeljanz XR tablets	
Diagnosis	Ankylosing Spondylitis (AS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of active ankylosing spondylitis (AS) AND 2 - Trial and failure, contraindication, or intolerance to TWO nonsteroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen, naproxen) AND 3 - Prescribed by or in consultation with a rheumatologist	

Product Name:Xeljanz tablets, Xeljanz XR tablets	
Diagnosis	Ankylosing Spondylitis (AS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy AND 2 - Prescribed by or in consultation with a rheumatologist	

Product Name:Xeljanz tablets, Xeljanz oral solution	
Diagnosis	Polyarticular Course Juvenile Idiopathic Arthritis (pcJIA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of active polyarticular course juvenile idiopathic arthritis (pcJIA) AND 2 - Prescribed by or in consultation with a rheumatologist AND 3 - Submission of medical records (e.g., chart notes) or paid claims documenting trial and	

failure, contraindication, or intolerance to ONE of the following nonbiologic disease-modifying antirheumatic drugs (DMARDs):

- leflunomide
- methotrexate

AND

4 - If the request is for Xeljanz oral solution, submission of medical records (e.g., chart notes) or paid claims documenting history of failure, contraindication, or intolerance to ALL of the following:

- A preferred* adalimumab biosimilar
- Enbrel (etanercept)
- Xeljanz (tofacitinib) IR tablet
- Orencia (abatacept)

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:Xeljanz tablets, Xeljanz oral solution	
Diagnosis	Polyarticular Course Juvenile Idiopathic Arthritis (pcJIA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy AND 2 - Prescribed by or in consultation with a rheumatologist	

2 . Revision History

UnitedHealthcare Community Plan of Arizona Clinical Pharmacy Program Guidelines

Date	Notes
2/6/2026	In pcJIA (initial auth section), removed bypass for COT and removed Xeljanz XR as a prerequisite option.

Xenazine



Prior Authorization Guideline

Guideline ID	GL-140906
Guideline Name	Xenazine
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Brand Xenazine, generic tetrabenazine	
Diagnosis	Chorea associated with Huntington's Disease
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chorea in patients with Huntington's disease	

Product Name:Brand Xenazine, generic tetrabenazine

Diagnosis	Tardive Dyskinesia (Off Label)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of tardive dyskinesia AND 2 - One of the following: 2.1 Patient has persistent symptoms of tardive dyskinesia despite a trial of dose reduction, tapering, or discontinuation of the offending medication OR 2.2 Patient is not a candidate for a trial of dose reduction, tapering, or discontinuation of the offending medication AND 3 - Prescribed by or in consultation with one of the following: - Neurologist - Psychiatrist	

Product Name:Brand Xenazine, generic tetrabenazine	
Diagnosis	Tardive Dyskinesia (Off Label)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

- 1 - Documentation of positive clinical response to therapy

Product Name: Brand Xenazine, generic tetrabenazine

Diagnosis	Tourette's syndrome (off-label)

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

- 1 - Patient has tics associated with Tourette's syndrome

AND

- 2 - History of failure, contraindication, or intolerance to Haldol (haloperidol)

AND

- 3 - Prescribed by or in consultation with one of the following:

- Neurologist
- Psychiatrist

Product Name: Brand Xenazine, generic tetrabenazine

Diagnosis	Tourette's syndrome (off-label)

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Xenleta



Prior Authorization Guideline

Guideline ID	GL-140706
Guideline Name	Xenleta
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Xenleta	
Diagnosis	Community-acquired bacterial pneumonia
Approval Length	7 Day(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following: 1.1 For continuation of therapy upon hospital discharge	

OR

1.2 As continuation of therapy when transitioning from intravenous antibiotics that are shown to be sensitive to the cultured organism for the requested indication

OR

1.3 All of the following:

1.3.1 Diagnosis of community-acquired bacterial pneumonia (CABP)

AND

1.3.2 Infection caused by an organism that is confirmed to be or likely to be susceptible to treatment with Xenleta

AND

1.3.3 History of failure, contraindication, or intolerance to three of the following antibiotics:

- Amoxicillin
- A macrolide
- Doxycycline
- A fluoroquinolone
- Combination therapy with amoxicillin/clavulanate or cephalosporin AND a macrolide or doxycycline

Product Name:Xenleta*	
Diagnosis	Off-Label Uses
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following:	

1.1 For continuation of therapy upon hospital discharge

OR

1.2 As continuation of therapy when transitioning from intravenous antibiotics that are shown to be sensitive to the cultured organism for the requested indication

OR

1.3 The medication is being prescribed by or in consultation with an infectious disease specialist

Notes	*Approval Duration: Based on provider recommended treatment durations, not to exceed 6 months

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Xermelo



Prior Authorization Guideline

Guideline ID	GL-140907
Guideline Name	Xermelo
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Xermelo	
Diagnosis	Carcinoid Syndrome Diarrhea
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of carcinoid syndrome diarrhea	

AND

2 - Diarrhea is inadequately controlled with somatostatin analog therapy (e.g., octreotide, Sandostatin LAR, Somatuline Depot)

AND

3 - Used in combination with somatostatin analog therapy (e.g., octreotide, Sandostatin LAR, Somatuline Depot)

Product Name:Xermelo	
Diagnosis	Carcinoid Syndrome Diarrhea
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Xermelo	

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Xgeva and Denosumab 120mg Products



Prior Authorization Guideline

Guideline ID	GL-572199
Guideline Name	Xgeva and Denosumab 120mg Products
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:Xgeva, Aukelso, Bilprevda, Bomynta, Osenvelt, Wyost, Xtrenbo	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - The drug is being used as indicated by National Comprehensive Cancer Network (NCCN) guidelines with a Category of Evidence and Consensus of 1, 2A, or 2B	

2 . Revision History

UnitedHealthcare Community Plan of Arizona Clinical Pharmacy Program Guidelines

Date	Notes
4/10/2026	New program for ACUAZ/ACUAZEC.

Xhance (fluticasone nasal spray)



Prior Authorization Guideline

Guideline ID	GL-148425
Guideline Name	Xhance (fluticasone nasal spray)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name:Xhance	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following: - Chronic rhinosinusitis with nasal polyps (CRSwNP) - Chronic rhinosinusitis without nasal polyps (CRSsNP)	

AND

2 - History of failure to generic fluticasone nasal spray

2 . Revision History

Date	Notes
6/11/2024	New program.

Xolair (omalizumab)



Prior Authorization Guideline

Guideline ID	GL-147108
Guideline Name	Xolair (omalizumab)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	6/1/2024

1 . Criteria

Product Name:Xolair	
Diagnosis	Allergic Asthma
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of documentation (e.g., chart notes) confirming diagnosis of moderate to severe persistent allergic asthma	

AND

2 - Submission of documentation (e.g., chart notes, lab values) confirming a positive skin test or in vitro reactivity to a perennial aeroallergen

AND

3 - ONE of the following:

3.1 BOTH of the following:

- Patient is 12 years of age or older
- Submission of documentation (e.g., chart notes, lab values) confirming pre-treatment serum immunoglobulin (Ig)E level between 30 to 700 IU/mL

OR

3.2 BOTH of the following:

- Patient is 6 years to less than 12 years of age
- Submission of documentation (e.g. chart notes, lab values) confirming pre-treatment serum immunoglobulin (Ig)E level between 30 to 1300 IU/mL

AND

4 - Paid claims or submission of documentation (e.g., chart notes) confirming patient is currently being treated with ONE of the following, unless there is a contraindication or intolerance to these medications:

4.1 BOTH of the following:

- High-dose inhaled corticosteroid (ICS) (e.g., greater than 500 mcg fluticasone propionate equivalent/day)
- Additional asthma controller medication (e.g., leukotriene receptor antagonist [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], tiotropium)

OR

4.2 One maximally-dosed combination ICS/LABA product (e.g., Advair [fluticasone propionate/salmeterol], Symbicort [budesonide/formoterol], Breo Ellipta [fluticasone/vilanterol])

AND

5 - Prescribed by or in consultation with ONE of the following:

- Pulmonologist
- Allergist/immunologist

Product Name:Xolair

Diagnosis	Allergic Asthma

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of documentation (e.g., chart notes) confirming a positive clinical response to therapy (e.g., reduction in exacerbations, improvement in forced expiratory volume in 1 second [FEV1], decreased use of rescue medications)

AND

2 - Paid claims or submission of documentation (e.g., chart notes) confirming patient continues to be treated with an inhaled corticosteroid (ICS) (e.g., fluticasone, budesonide) with or without additional asthma controller medication (e.g., leukotriene receptor antagonist [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], tiotropium) unless there is a contraindication or intolerance to these medications

AND

3 - Prescribed by or in consultation with ONE of the following:

- Pulmonologist

- Allergist/immunologist

Product Name:Xolair	
Diagnosis	Chronic Spontaneous Urticaria (CSU)
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of documentation (e.g., chart notes) confirming diagnosis of chronic spontaneous urticaria

AND

2 - Persistent symptoms (itching and hives) for at least 4 consecutive weeks despite titrating to an optimal dose with a second generation H1 antihistamine (e.g., cetirizine, fexofenadine), unless there is a contraindication or intolerance to H1 antihistamines

AND

3 - Paid claims or submission of documentation (e.g., chart notes) confirming concurrent use with an H1 antihistamine, unless there is a contraindication or intolerance to H1 antihistamines

AND

4 - Paid claims or submission of documentation (e.g., chart notes) confirming patient has tried and had an inadequate response or intolerance to at least TWO of the following additional therapies:

- Doxepin
- H1 antihistamine
- H2 antagonist (e.g., famotidine, cimetidine)
- Hydroxyzine

- Leukotriene receptor antagonist (e.g., montelukast)

AND

5 - Prescribed by or in consultation with ONE of the following:

- Allergist/immunologist
- Dermatologist

Product Name:Xolair	
Diagnosis	Chronic Spontaneous Urticaria (CSU)
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient's disease status has been re-evaluated since the last authorization to confirm the patient's condition warrants continued treatment AND 2 - Submission of documentation (e.g., chart notes) confirming patient has experienced at least ONE of the following: • Reduction in itching severity from baseline • Reduction in the number of hives from baseline	

Product Name:Xolair	
Diagnosis	Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is 18 years of age or older

AND

2 - Submission of documentation (e.g., chart notes) confirming **ONE** of the following:

2.1 ALL of the following:

2.1.1 Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP) defined by **ALL** of the following:

2.1.1.1 **TWO** or more of the following symptoms for greater than or equal to 12 weeks duration:

- Mucopurulent discharge
- Nasal obstruction and congestion
- Decreased or absent sense of smell
- Facial pressure or pain

AND

2.1.1.2 **ONE** of the following:

- Evidence of inflammation on paranasal sinus examination or computed tomography (CT)
- Evidence of purulence coming from paranasal sinuses or ostiomeatal complex

AND

2.1.1.3 The presence of nasal polyps

AND

2.1.2 **ONE** of the following:

- Patient has required prior sino-nasal surgery

- Patient has required systemic corticosteroids in the previous 2 years

AND

2.1.3 Patient has been unable to obtain symptom relief after trial of ALL of the following agents/classes of agents:

- Nasal saline irrigations
- Intranasal corticosteroids (e.g. fluticasone, mometasone, triamcinolone, etc.)
- Antileukotriene agents (e.g. montelukast, zafirlukast, zileuton)

OR

2.2 BOTH of the following:

2.2.1 Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP)

AND

2.2.2 Patient is currently on Xolair therapy

AND

3 - Patient will receive Xolair as add-on maintenance therapy in combination with intranasal corticosteroids

AND

4 - Patient is NOT receiving Xolair in combination with another biologic medication (e.g., Dupixent [dupilumab], Nucala [mepolizumab])

AND

5 - Prescribed by or in consultation with ONE of the following:

- Otolaryngologist
- Allergist

- Pulmonologist

Product Name:Xolair	
Diagnosis	Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of documentation (e.g., chart notes, lab values) confirming a positive clinical response to Xolair therapy

AND

2 - Patient will continue to receive Xolair as add-on maintenance therapy in combination with intranasal corticosteroids

AND

3 - Patient is NOT receiving Xolair in combination with another biologic medication (e.g., Dupixent [dupilumab], Nucala [mepolizumab])

AND

4 - Prescribed by or in consultation with ONE of the following:

- Otolaryngologist
- Allergist
- Pulmonologist

Product Name:Xolair

Diagnosis	IgE-Mediated Food Allergy
Approval Length	20 Week(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Submission of documentation (e.g., chart notes, lab values) confirming BOTH of the following:

1.1.1 Diagnosis of IgE Mediated Food Allergy as evidenced by ONE of the following:

- Positive skin prick test (defined as greater than or equal to 4 millimeters wheal greater than saline control) to food
- Positive food specific IgE (greater than or equal to 6 kUA/L)
- Positive oral food challenge, defined as experiencing dose-limiting symptoms at a single dose of less than or equal to 300 mg of food protein

AND

1.1.2 Clinical history of IgE Mediated Food Allergy

OR

1.2 Submission of documentation (e.g., chart notes, lab values) confirming patient has a history of severe allergic response, including anaphylaxis, following exposure to one or more foods

AND

2 - Patient is 1 year of age or older

AND

3 - Used in conjunction with food allergen avoidance

AND

4 - Submission of documentation (e.g., chart notes, lab values) confirming BOTH of the following:

- Baseline (pre-Xolair treatment) serum total IgE level is greater than or equal to 30 IU/mL and less than or equal to 1850 IU/mL
- Dosing is according to serum total IgE levels and body weight

AND

5 - Prescribed by or in consultation with ONE of the following:

- Allergist
- Immunologist

Product Name:Xolair	
Diagnosis	IgE-Mediated Food Allergy
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of documentation (e.g., chart notes, lab values) confirming a positive clinical response to therapy (e.g., reduction of type 1 allergic reactions, including anaphylaxis, following accidental exposure to one or more foods) AND 2 - Used in conjunction with food allergen avoidance	

AND

3 - Submission of documentation (e.g., chart notes, lab values) confirming that dosing will continue to be based on body weight and pretreatment total IgE serum levels (Note: Dose should only be adjusted during therapy due to significant changes in patient body weight)

AND

4 - Prescribed by or in consultation with ONE of the following:

- Allergist
- Immunologist

2 . Background

Clinical Practice Guidelines

The Global Initiative for Asthma Global Strategy for Asthma Management and Prevention: Table 1. Low, medium and high daily doses of inhaled corticosteroids in adolescents and adults 12 years and older.

Inhaled corticosteroid	Total Daily ICS Dose (mcg)		
	Low	Medium	High
Beclometasone dipropionate (pMDI, standard particle, HFA)	200-500	> 500-1000	> 1000
Beclometasone dipropionate (DPI or pMDI, extrafine particle*, HFA)	100-200	> 200-400	> 400
Budesonide (DPI, or pMDI, standard particle, HFA)	200-400	> 400-800	> 800
Ciclesonide (pMDI, extrafine particle*, HFA)	80-160	> 160-320	> 320
Fluticasone furoate (DPI)	100		200

Fluticasone propionate (DPI)	100-250	> 250-500	> 500
Fluticasone propionate (pMDI, standard particle, HFA)	100-250	> 250-500	> 500
Mometasone furoate (DPI)	Depends on DPI device – see product information		
Mometasone furoate (pMDI, standard particle, HFA)	200-400		> 400

DPI: dry powder inhaler; HFA: hydrofluoroalkane propellant; ICS: inhaled corticosteroid; N/A: not applicable; pMDI: pressurized metered dose inhaler (non-chlorofluorocarbon formulations); ICS by pMDI should be preferably used with a spacer *See product information.

This is not a table of equivalence, but instead, suggested total daily doses for the ‘low’, ‘medium’ and ‘high’ dose ICS options for adults/adolescents, based on available studies and product information. Data on comparative potency are not readily available and therefore this table does NOT imply potency equivalence. Doses may be country -specific depending on local availability, regulatory labelling and clinical guidelines.

For new preparations, including generic ICS, the manufacturer’s information should be reviewed carefully; products containing the same molecule may not be clinically equivalent.

3 . Revision History

Date	Notes
5/16/2024	Updated criteria and GPI table.

Xolremdi (mavorixafor)



Prior Authorization Guideline

Guideline ID	GL-151359
Guideline Name	Xolremdi (mavorixafor)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	9/1/2024

1 . Criteria

Product Name:Xolremdi	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting ALL of the following: 1.1 Diagnosis of WHIM (warts, hypogammaglobulinemia, infections and myelokathexis) syndrome	

AND

1.2 Patient has genotype confirmed variant of CXCR4 as detected by an FDA (Food and Drug Administration)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA)

AND

1.3 Patient has an absolute neutrophil count (ANC) less than or equal to 500 cells/ μ L

AND

2 - Patient is 12 years of age or older

AND

3 - Prescribed by or in consultation with ONE of the following:

- Immunologist
- Hematologist
- Geneticist
- Allergist

Product Name:Xolremdi	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy (e.g., improvement in ANC, reduction in infections)	

2 . Revision History

Date	Notes
8/12/2024	New program.

Xopenex Respules



Prior Authorization Guideline

Guideline ID	GL-140660
Guideline Name	Xopenex Respules
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	3/1/2021

1 . Criteria

Product Name:Brand Xopenex inhalation soln, generic levalbuterol inhalation soln	
Approval Length	12 month(s)
Guideline Type	Step Therapy
Approval Criteria 1 - The patient has a history of failure, contraindication, or intolerance to treatment with albuterol inhalation solution	

2 . Revision History

UnitedHealthcare Community Plan of Arizona Clinical Pharmacy Program Guidelines

Date	Notes
1/26/2021	Copy NY to AZ and fix guideline name for PA CHIP

Xphozah (tenapanor)



Prior Authorization Guideline

Guideline ID	GL-143587
Guideline Name	Xphozah (tenapanor)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	3/17/2024

1 . Criteria

Product Name:Xphozah	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of hyperphosphatemia in chronic kidney disease	

AND

2 - Patient is on dialysis

AND

3 - Submission of medical records (e.g., chart notes) or paid claims confirming trial and inadequate response (minimum 30-day supply), contraindication, or intolerance to ALL of the following:

- calcium carbonate
- calcium acetate
- sevelamer carbonate

Product Name:Xphozah	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient demonstrates positive clinical response to therapy AND 2 - Trial and inadequate response (minimum 30-day supply), contraindication, or intolerance to ALL of the following: • calcium carbonate • calcium acetate • sevelamer carbonate	

2 . Revision History

Date	Notes
2/26/2024	New program.

Xromi (hydroxyurea)



Prior Authorization Guideline

Guideline ID	GL-263191
Guideline Name	Xromi (hydroxyurea)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	6/1/2025

1 . Criteria

Product Name:Xromi	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of sickle cell anemia	

AND

2 - Patient has moderate to severe painful crises

AND

3 - Patient is 6 months of age or older

AND

4 - One of the following:

4.1 Patient is unable to swallow solid oral dosage forms (e.g., oral tablet, capsule) due to one of the following:

- Age
- Physical impairment (e.g., difficulties with motor or oral coordination)
- Dysphagia
- Patient is using a feeding tube or nasal gastric tube

OR

4.2 Dosage requirements cannot be met with a solid dosage form

Product Name:Xromi	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient demonstrates positive clinical response to therapy	

2 . Revision History

Date	Notes
5/13/2025	New guideline

Xuriden



Prior Authorization Guideline

Guideline ID	GL-140856
Guideline Name	Xuriden
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2020

1 . Criteria

Product Name:Xuriden	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of a hereditary orotic aciduria	

Product Name:Xuriden

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Xuriden therapy	

2 . Revision History

Date	Notes
3/31/2020	Bulk copy C&S New York SP to C&S Arizona SP for 5/1 effective

Yeztugo (lenacapavir)



Prior Authorization Guideline

Guideline ID	GL-560212
Guideline Name	Yeztugo (lenacapavir)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:Yeztugo	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Requested drug is being used for pre-exposure prophylaxis (PrEP) to reduce the risk of sexually acquired HIV (human immunodeficiency virus)-1 infection	

AND

2 - Patient's weight is greater than or equal to 35 kg (kilograms)

AND

3 - BOTH of the following:

- Provider attests that the patient has a negative HIV-1 test prior to the initiation of Yeztugo
- Provider attests that the patient has been informed about the need for the required testing, adherence, and every 6-month injection dosing schedule with Yeztugo

AND

4 - ONE of the following:

4.1 Trial and failure, contraindication or intolerance to BOTH of the following:

- emtricitabine-tenofovir (generic Truvada)
- Descovy

OR

4.2 Submission of medical records (e.g., chart notes) from provider documenting BOTH of the following:

- Patient would benefit from long-acting injectable therapy over standard oral regimens
- Patient would be adherent to testing and dosing schedule

Product Name:Yeztugo	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Provider attests that patient is adherent to the testing appointments and scheduled injections of Yeztugo

AND

2 - BOTH of the following:

- Patient has a negative HIV-1 test
- Provider confirms that the patient will be tested for HIV-1 infection with each subsequent injection

2 . Revision History

Date	Notes
3/30/2026	Updated GPIs. Updated HIV testing requirement in both initial and re auth

Yorvipath (palopegteriparatide)



Prior Authorization Guideline

Guideline ID	GL-163670
Guideline Name	Yorvipath (palopegteriparatide)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	2/1/2025

1 . Criteria

Product Name:Yorvipath	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting ALL of the following: 1.1 Diagnosis of hypoparathyroidism	

AND

1.2 Requested drug is NOT being used in the setting of acute post-surgical hypoparathyroidism

AND

1.3 Patient has achieved albumin-corrected serum calcium of at least 7.8 mg/dL (milligrams/deciliter) using calcium and active vitamin D (e.g., calcitriol) treatment

AND

2 - Prescribed by or in consultation with an endocrinologist

Product Name:Yorvipath	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting that patient demonstrates positive clinical response to therapy as evidenced by maintenance of normalized calcium levels compared to baseline	

2 . Revision History

Date	Notes
1/13/2025	New program.

Zeposia (ozanimod)



Prior Authorization Guideline

Guideline ID	GL-390195
Guideline Name	Zeposia (ozanimod)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2025

1 . Criteria

Product Name:Zeposia	
Diagnosis	Multiple Sclerosis (MS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of multiple sclerosis (MS)	

AND

2 - If the request is non-preferred**, submission of medical records (e.g., chart notes) or verification of paid claims confirming a history of failure, contraindication, or intolerance to a trial of at least TWO preferred*^ alternatives

Notes	**PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC *Preferred drugs may require PA. ^Preferred drugs include medical benefit drugs Briumvi, Ocrevus/Ocrevus Zunovo, and Tysabri.

Product Name:Zeposia	
Diagnosis	Multiple Sclerosis (MS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient demonstrates positive clinical response to therapy (e.g., stability in radiologic disease activity, clinical relapses, disease progression)	

Product Name:Zeposia	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	12 Week(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of moderately to severely active ulcerative colitis (UC)

AND

2 - Submission of medical records (e.g., chart notes) or verification of paid claims documenting BOTH of the following*:

2.1 Trial and failure, contraindication, or intolerance to ONE of the following conventional therapies:

- 6-mercaptopurine
- Aminosalicylate (e.g., mesalamine, olsalazine, sulfasalazine)
- Azathioprine
- Corticosteroids (e.g., prednisone)

AND

2.2 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred^ adalimumab biosimilar
- infliximab
- Xeljanz (tofacitinib) oral tablet (IR or XR)
- A preferred^ ustekinumab biosimilar

AND

3 - Prescribed by or in consultation with a gastroenterologist

Notes	*PA may be required. ^PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name:Zeposia	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Prescribed by or in consultation with a gastroenterologist

2 . Revision History

Date	Notes
9/8/2025	Updated notes in initial auth section for MS. No changes to clinical criteria.

Zilbrysq (zilucoplan injection)



Prior Authorization Guideline

Guideline ID	GL-418212
Guideline Name	Zilbrysq (zilucoplan injection)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	11/1/2025

1 . Criteria

Product Name:Zilbrysq	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of generalized myasthenia gravis (gMG)	

AND

2 - Patient is anti-acetylcholine receptor (AChR) antibody positive

AND

3 - ONE of the following:

3.1 Trial and failure, contraindication, or intolerance to TWO immunosuppressive therapies (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus)

OR

3.2 BOTH of the following:

3.2.1 Trial and failure, contraindication, or intolerance to ONE immunosuppressive therapy (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus)

AND

3.2.2 Trial and failure, contraindication, or intolerance to ONE of the following:

- Chronic plasmapheresis or plasma exchange (PE)
- Intravenous immunoglobulin (IVIG)

AND

4 - BOTH of the following:

4.1 Trial and failure, contraindication, or intolerance to Epysqli (eculizumab-aagh)

AND

4.2 Trial and failure, contraindication, or intolerance to ONE of the following:

- Rystiggo
- Ultomiris
- Vyvgart
- Vyvgart Hytrulo

AND

5 - Prescribed by or in consultation with a neurologist

Product Name:Zilbrysq	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient demonstrates positive clinical response to therapy AND 2 - BOTH of the following: 2.1 Trial and failure, contraindication, or intolerance to Epysqli (eculizumab-aagh) AND 2.2 Trial and failure, contraindication, or intolerance to ONE of the following: • Rystiggo • Ultomiris • Vyvgart • Vyvgart Hytrulo	

2 . Revision History

Date	Notes
10/8/2025	Replaced CORE criteria with FFS/state criteria.

Zimhi (naloxone)



Prior Authorization Guideline

Guideline ID	GL-140747
Guideline Name	Zimhi (naloxone)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	12/1/2022

1 . Criteria

Product Name:Zimhi	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - History of failure or intolerance to preferred* naloxone products (e.g., Brand Narcan nasal spray, Kloxxado, preferred naloxone injections)	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

2 . Revision History

Date	Notes
10/24/2022	New guideline

Zokinvy



Prior Authorization Guideline

Guideline ID	GL-434311
Guideline Name	Zokinvy
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State Nevada Medicaid - Community & State New Jersey Medicaid - Community & State New York EPP Medicaid - Community & State New York Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Arizona Medicaid - Community & State Virginia Medicaid - Community & State Pennsylvania Medicaid - Community & State Nebraska Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Zokinvy	
Diagnosis	Hutchinson-Gilford Progeria Syndrome
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Hutchinson-Gilford Progeria Syndrome	

Product Name:Zokinvy	
Diagnosis	Progeroid Laminopathies
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of processing deficient Progeroid laminopathy AND 2 - Documentation of ONE of the following: - Heterozygous LMNA (gene) mutation with progerin-like protein accumulation - Homozygous or compound heterozygous ZMPSTE24 (gene) mutations	

2 . Revision History

Date	Notes
11/3/2025	Added NV formulary

Zolgensma (onasemnogene abeparvovec-xioi), Itvisma (onasemnogene abeparvovec-brve)



Prior Authorization Guideline

Guideline ID	GL-523191
Guideline Name	Zolgensma (onasemnogene abeparvovec-xioi), Itvisma (onasemnogene abeparvovec-brve)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name:Zolgensma	
Approval Length	1 Time Authorization in Lifetime
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming the mutation or deletion of genes in chromosome 5q resulting in ONE of the following: 1.1 Homozygous gene deletion or mutation of SMN1 gene (e.g., homozygous deletion of exon 7 at locus 5q13)	

OR

1.2 Compound heterozygous mutation of SMN1 gene [e.g., deletion of Survival of Motor Neuron 1 (SMN1) exon 7 (allele 1) and mutation of SMN1 (allele 2)]

AND

2 - ONE of the following:

2.1 BOTH of the following:

2.1.1 Diagnosis of symptomatic spinal muscular atrophy (SMA) confirmed by a neurologist with expertise in the diagnosis and treatment of SMA

AND

2.1.2 Patient is less than 2 years of age

OR

2.2 ALL of the following:

2.2.1 Diagnosis of SMA based on the results of SMA newborn screening

AND

2.2.2 Patient has 4 copies or less of Survival of Motor Neuron 2 (SMN 2)

AND

2.2.3 Patient is less than or equal to 6 months of age

AND

3 - Patient is NOT dependent on invasive ventilation

AND

4 - Patient is NOT dependent on the use of non-invasive ventilation beyond use for naps and nighttime sleep

AND

5 - Submission of medical records (e.g., chart notes) documenting patient's anti-AAV9 antibody titers are less than or equal to 1:50

AND

6 - BOTH of the following:

6.1 Provider attests that the patient has never received onasemnogene abeparvovec treatment in their lifetime

AND

6.2 Provider attests that the patient is NOT receiving concomitant chronic survival motor neuron (SMN) modifying therapy for the treatment of SMA (e.g., Spinraza, Evrysdi)

AND

7 - Prescribed by a neurologist with expertise in the diagnosis of SMA

Product Name:Itvisma	
Approval Length	1 Time Authorization in Lifetime
Guideline Type	Prior Authorization
Approval Criteria	

1 - BOTH of the following:

1.1 Submission of medical records (e.g., chart notes) confirming diagnosis of spinal muscular atrophy (SMA)

AND

1.2 Submission of medical records (e.g., chart notes) confirming the presence of a SMN1 gene mutation

AND

2 - Patient is 2 years of age or older and under 17 years old

AND

3 - BOTH of the following:

3.1 Provider attests that the patient has never received onasemnogene abeparvovec (e.g., Zolgensma) treatment in their lifetime

AND

3.2 Provider attests that the patient is NOT receiving concomitant chronic survival motor neuron (SMN) modifying therapy for the treatment of SMA (e.g., Spinraza, Evrysdi)

AND

4 - Patient will commence systemic corticosteroids equivalent to oral prednisolone at 1 mg per kg of body weight per day (mg/kg/day), starting one day prior to Ivisma therapy and planned for a total of 30 days

AND

5 - Submission of medical records (e.g., chart notes) confirming the absence of hepatic dysfunction [e.g., alanine aminotransferase (ALT), total bilirubin, gamma-glutamyl transferase

(GGT) or glutamate dehydrogenase (GLDH) less than or equal to the upper limit of normal (ULN)]

AND

6 - Provider attests that patient has NOT had clinical signs or symptoms of infection within 30 days prior to treatment

AND

7 - BOTH of the following:

7.1 Patient can sit independently

AND

7.2 Patient has never had the ability to walk independently

AND

8 - Submission of medical records (e.g., chart notes) confirming anti-AAV9 antibody titers are less than or equal to 1:50

AND

9 - Patient's clinical signs and symptoms onset occurred at greater than or equal to 6 months of age

AND

10 - Patient is NOT dependent on any of the following:

- Invasive ventilation
- Awake noninvasive ventilation for greater than 6 hours during a 24-hour period
- Noninvasive ventilation for greater than 12 hours during a 24-hour period

AND

11 - BOTH of the following:

11.1 Patient has NOT received surgery for scoliosis or hip fixation in the 12 months prior to approval

AND

11.2 Patient has no planned surgery for scoliosis or hip fixation within the next 64 weeks following therapy

AND

12 - Prescribed by a neurologist with expertise in the diagnosis of SMA

2 . Revision History

Date	Notes
2/12/2026	Updated guideline name. Updated criteria for Zolgensma. Added criteria for new target drug, Itvisma.

Zontivity



Prior Authorization Guideline

Guideline ID	GL-140655
Guideline Name	Zontivity
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	12/1/2020

1 . Criteria

Product Name:Zontivity	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: - History of myocardial infarction (MI) - Peripheral arterial disease (PAD)	

AND

2 - Patient does not have a history of ONE of the following:

- Stroke
- Transient ischemic attack (TIA)
- Intracranial hemorrhage (ICH)

AND

3 - Patient does not have active pathological bleeding

Zortress



Prior Authorization Guideline

Guideline ID	GL-140694
Guideline Name	Zortress
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Zortress	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Kidney transplant rejection prophylaxis in patients at low-moderate immunologic risk OR	

2 - Liver transplant rejection prophylaxis

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22

Zoryve (roflumilast)



Prior Authorization Guideline

Guideline ID	GL-448291
Guideline Name	Zoryve (roflumilast)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	12/1/2025

1 . Criteria

Product Name:Zoryve 0.3% cream, Zoryve foam	
Diagnosis	Plaque Psoriasis (PsO)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of plaque psoriasis (PsO)	

AND

2 - Submission of medical records (e.g., chart notes) or paid claims history documenting a minimum duration of a 4 week trial and failure, contraindication, or intolerance to ONE of the following topical therapies:

- Corticosteroids (e.g., betamethasone, clobetasol)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)

AND

3 - Prescribed by or in consultation with a dermatologist

Product Name:Zoryve 0.3% cream, Zoryve foam	
Diagnosis	Plaque Psoriasis (PsO)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy as evidenced by ONE of the following: • Reduction in the body surface area (BSA) involvement from baseline • Improvement in symptoms (e.g., pruritus, inflammation) from baseline	

Product Name:Zoryve 0.05% cream, Zoryve 0.15% cream	
Diagnosis	Atopic Dermatitis
Approval Length	6 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of mild to moderate atopic dermatitis

AND

2 - Patient is 2 years of age or older

AND

3 - Submission of medical records (e.g., chart notes) or paid claims history documenting trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to TWO of the following:

- Medium or higher potency topical corticosteroid
- Elidel (pimecrolimus) cream
- Tacrolimus ointment
- Eucrisa (crisaborole) ointment

AND

4 - Prescribed by or in consultation with a dermatologist

Product Name:Zoryve foam	
Diagnosis	Seborrheic Dermatitis
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of seborrheic dermatitis

AND

2 - Patient is 9 years of age or older

AND

3 - Submission of medical records (e.g., chart notes) or paid claims history documenting a minimum duration of a 4 week trial and failure, contraindication, or intolerance to TWO of the following topical therapies (trial must be from two different classes):

- Corticosteroids (e.g., betamethasone, clobetasol)
- Antifungals (e.g., ciclopirox, ketoconazole)
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)

AND

4 - Prescribed by or in consultation with a dermatologist

Product Name: Zoryve foam

Diagnosis	Seborrheic Dermatitis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy as evidenced by improvement from baseline for ONE of the following:

- Scaling
- Erythema
- Pruritis

- Body surface area (BSA) involvement

2 . Background

Clinical Practice Guidelines			
Relative potencies of topical corticosteroids			
Class	Drug	Dosage Form	Strength (%)
Very high potency	Augmented betamethasone dipropionate	Ointment	0.05
	Clobetasol propionate	Cream, foam, ointment	0.05
	Diflorasone diacetate	Ointment	0.05
	Halobetasol propionate	Cream, ointment	0.05
High Potency	Amcinonide	Cream, lotion, ointment	0.1
	Augmented betamethasone dipropionate	Cream	0.05
	Betamethasone dipropionate	Cream, foam, ointment, solution	0.05
	Desoximetasone	Cream, ointment	0.25
	Desoximetasone	Gel	0.05
	Diflorasone diacetate	Cream	0.05
	Fluocinonide	Cream, gel, ointment, solution	0.05
	Halcinonide	Cream, ointment	0.1
	Mometasone furoate	Ointment	0.1
	Triamcinolone acetonide	Cream, ointment	0.5
Medium potency	Betamethasone valerate	Cream, foam, lotion, ointment	0.1
	Clocortolone pivalate	Cream	0.1
	Desoximetasone	Cream	0.05
	Fluocinolone acetonide	Cream, ointment	0.025
	Flurandrenolide	Cream, ointment	0.05
	Fluticasone propionate	Cream	0.05
	Fluticasone propionate	Ointment	0.005
	Mometasone furoate	Cream	0.1
	Triamcinolone acetonide	Cream, ointment	0.1

Lower-medium potency	Hydrocortisone butyrate	Cream, ointment, solution	0.1
	Hydrocortisone probutate	Cream	0.1
	Hydrocortisone valerate	Cream, ointment	0.2
	Prednicarbate	Cream	0.1
Low potency	Alclometasone dipropionate	Cream, ointment	0.05
	Desonide	Cream, gel, foam, ointment	0.05
	Fluocinolone acetonide	Cream, solution	0.01
Lowest potency	Dexamethasone	Cream	0.1
	Hydrocortisone	Cream, lotion, ointment, solution	0.25, 0.5, 1
	Hydrocortisone acetate	Cream, ointment	0.5-1

3 . Revision History

Date	Notes
11/12/2025	In AD criteria section, added Zoryve 0.05% cream as a target and up dated age criterion.

Ztalmy (ganaxolone)



Prior Authorization Guideline

Guideline ID	GL-140938
Guideline Name	Ztalmy (ganaxolone)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	12/1/2022

1 . Criteria

Product Name:Ztalmy	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of documentation (e.g., chart notes) confirming diagnosis of cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder (CDD)	

AND

2 - Patient has a mutation in the CDKL5 gene

AND

3 - Patient is 2 years of age or older

AND

4 - Patient is experiencing motor seizures (e.g., bilateral tonic, generalized tonic-clonic, bilateral clonic, atonic, focal, or bilateral tonic-clonic)

AND

5 - One of the following:

5.1 Trial and failure, contraindication, or intolerance to two preferred* anticonvulsants (e.g., valproic acid, levetiracetam, lamotrigine)

OR

5.2 For continuation of prior therapy

AND

6 - Prescribed by or in consultation with a neurologist

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHC-CP

Product Name: Ztalmy	
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy as evidenced by a reduction in the frequency of seizures from baseline	

2 . Revision History

Date	Notes
10/24/2022	New guideline

Zunveyl (benzgalantamine)



Prior Authorization Guideline

Guideline ID	GL-256191
Guideline Name	Zunveyl (benzgalantamine)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	6/1/2025

1 . Criteria

Product Name: Zunveyl	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of mild to moderate dementia of the Alzheimer's type AND	

2 - Patient is 18 years of age or older

AND

3 - Trial and failure (of a minimum 30-day supply), contraindication, or intolerance to ALL of the following:

- generic galantamine
- generic rivastigmine
- generic donepezil

2 . Revision History

Date	Notes
5/6/2025	New guideline

Zurzuvae (zuranolone)



Prior Authorization Guideline

Guideline ID	GL-143585
Guideline Name	Zurzuvae (zuranolone)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	3/17/2024

1 . Criteria

Product Name:Zurzuvae	
Approval Length	14 Day(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following: 1.1 Diagnosis of severe postpartum depression (PPD)	

OR

1.2 Both of the following:

1.2.1 Diagnosis of mild to moderate postpartum depression (PPD)

AND

1.2.2 Trial and failure, contraindication or intolerance to at least one oral SSRI or SNRI (e.g., escitalopram, duloxetine)

AND

2 - Patient is 18 years of age or older

AND

3 - Onset of symptoms in the third trimester or within 4 weeks of delivery

AND

4 - Prescriber attests that the patient has been counseled and has agreed to adhere to the following: Will follow instructions to not drive or operate machinery until at least 12 hours after taking each dose of Zurzuvae for the duration of the 14-day treatment course and that patients are informed that they may not be able to assess their own driving competence or the degree of driving impairment caused by Zurzuvae

2 . Revision History

Date	Notes
2/26/2024	New program.

Zycubo (copper histidinate)



Prior Authorization Guideline

Guideline ID	GL-605187
Guideline Name	Zycubo (copper histidinate)
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Zycubo	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming BOTH of the following: 1.1 Diagnosis of Menkes disease	

AND

1.2 Molecular genetic testing confirms pathogenic variants of the ATP7A gene (copper-transporting ATPase) as detected by an FDA (Food and Drug Administration)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA)

AND

2 - Provider attests that the patient will be closely monitored for copper accumulation and related toxicity throughout therapy

AND

3 - Prescribed by or in consultation with ONE of the following:

- Pediatrician
- Neurologist
- Geneticist

Product Name:Zycubo	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient demonstrates positive clinical response to therapy AND 2 - Provider attests that the patient will continue to be monitored for copper accumulation and related toxicity throughout therapy	

AND

3 - Patient has NOT exceeded 3 years duration of treatment with Zycubo

AND

4 - Prescribed by or in consultation with ONE of the following:

- Pediatrician
- Neurologist
- Geneticist

2 . Revision History

Date	Notes
5/6/2026	New program.

Zyvox



Prior Authorization Guideline

Guideline ID	GL-140720
Guideline Name	Zyvox
Formulary	Medicaid - Community & State Arizona

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Brand Zyvox*, generic linezolid*	
Diagnosis	Labeled Uses
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following: 1.1 For continuation of therapy upon hospital discharge	

OR

1.2 As continuation of therapy when transitioning from intravenous antibiotics that are shown to be sensitive to the cultured organism for the requested indication

OR

1.3 BOTH of the following:

1.3.1 ONE of the following diagnoses:

- Nosocomial pneumonia
- Community-acquired pneumonia
- Skin and skin structure infections (complicated and uncomplicated)

AND

1.3.2 Infection caused by an organism that is confirmed to be or likely to be susceptible to treatment with Zyvox

OR

1.4 Invasive infection caused by or likely to be caused by vancomycin-resistant *Enterococcus faecium* (VRE)

Notes	*Approval Duration: For vancomycin-resistant <i>Enterococcus faecium</i> , authorization will be issued for 28 days. For osteomyelitis, authorization will be issued for the requested duration, not to exceed 6 weeks. All other approvals will be issued for 14 days.

Product Name: Brand Zyvox*, generic linezolid*	
Diagnosis	Off label Uses
Guideline Type	Prior Authorization
Approval Criteria	

1 - For continuation of therapy upon hospital discharge

OR

2 - As continuation of therapy when transitioning from intravenous antibiotics that are shown to be sensitive to the cultured organism for the requested indication

OR

3 - The medication is being prescribed by or in consultation with an Infectious Disease specialist

Notes	*Approval Duration: Based on provider recommended treatment durations, not to exceed 6 months.

2 . Revision History

Date	Notes
8/4/2022	C&S to match AZM as of 10.1.22