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Zurzuvae	2020
Zydelig	2023
Zykadia	2026

Abirtega, Zytiga



Prior Authorization Guideline

Guideline ID	GL-356191
Guideline Name	Abirtega, Zytiga
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland 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 Virginia Medicaid - Community & State Indiana Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	9/1/2025

1 . Criteria

Product Name: Brand Zytiga, Brand Abirtega, generic abiraterone	
Diagnosis	Prostate Cancer

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of prostate cancer AND 2 - ONE of the following: 2.1 Disease is metastatic OR 2.2 Disease is regional node positive (Any T, N1, M0) OR 2.3 Patient is in a very-high-risk group receiving external beam radiation therapy (EBRT) OR 2.4 Positive pelvic persistence/recurrence after prostatectomy AND 3 - Used in combination with prednisone or dexamethasone AND 4 - ONE of the following:	

4.1 Used in combination with a gonadotropin-releasing hormone (GnRH) analog [e.g., Lupron (leuprolide), Zoladex (goserelin), Trelstar (triptorelin), Vantas (histrelin), Firmagon (degarelix)]

OR

4.2 Patient has had bilateral orchiectomy

AND

5 - If the request is for the 500 mg (milligram) tablet, the prescriber provides a reason or special circumstance the patient cannot take abiraterone 250 mg

Product Name: Brand Zytiga, Brand Abirtega, generic abiraterone	
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 the requested therapy AND 2 - If the request is for the 500 mg tablet, the prescriber provides a reason or special circumstance the patient cannot take abiraterone 250 mg	

Product Name: Brand Zytiga, Brand Abirtega, generic abiraterone	
Diagnosis	Salivary Gland Tumor
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of salivary gland tumor

AND

2 - Used in combination with prednisone

AND

3 - Androgen receptor positive recurrent disease

AND

4 - If the request is for the 500mg tablet, the prescriber provides a reason or special circumstance the patient cannot take abiraterone 250mg

Product Name:Brand Zytiga, Brand Abirtega, generic abiraterone	
Diagnosis	Salivary Gland Tumor
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 the requested therapy AND 2 - If the request is for the 500mg tablet, the prescriber provides a reason or special circumstance the patient cannot take abiraterone 250mg	

Product Name:Brand Zytiga, Brand Abirtega, generic abiraterone	
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 AND 2 - If the request is for the 500 mg tablet, the prescriber provides a reason or special circumstance the patient cannot take abiraterone 250 mg	

Product Name:Brand Zytiga, Brand Abirtega, generic abiraterone	
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 the requested therapy AND 2 - If the request is for the 500 mg tablet, the prescriber provides a reason or special circumstance the patient cannot take abiraterone 250 mg	

2 . Revision History

Date	Notes
7/31/2025	Updated formularies to add IN

ACE Inhibitors



Prior Authorization Guideline

Guideline ID	GL-144369
Guideline Name	ACE Inhibitors
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2024

1 . Criteria

Product Name: Brand Epaned, generic enalapril oral solution	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is under 12 years of age OR	

2 - Patient is unable to swallow tablets

Product Name:Qbreliis

Approval Length 12 month(s)

Guideline Type Prior Authorization

Approval Criteria

1 - Patient is 6 years of age or older AND less than 12 years of age

OR

2 - Patient is unable to swallow tablets

2 . Revision History

Date	Notes
3/14/2024	Separated criteria for Qbreliis

Acne Agents



Prior Authorization Guideline

Guideline ID	GL-480214
Guideline Name	Acne Agents
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name: Brand Absorica, Aklief, Amnesteem, Claravis, generic isotretinoin, Zenatane, adapalene/benzoyl peroxide, Epiduo, Epiduo Forte, benzoyl peroxide (all formulations and brands), Panoxyl, Benzac AC, Medpura, Benzepro, PR Benzoyl Peroxide, Effaclar Duo, Epsolay, Benzefoam, Zaclir, Benzepro Foaming Cloths, Brand Retin-A, generic tretinoin, Brand Atralin, Altreno, Brand Retin-A Micro and pump, generic tretinoin microsphere and pump, clindamycin/tretinoin, Ziana, clindamycin soln/swab, generic clindamycin foam/gel/lotn, Clindacin, Brand Clindagel, Brand Cleocin-T, Clindacin ETZ, Clindacin-P, Cabtreo, clindamycin/benzoyl peroxide, Acanya, Onexton, Benzamycin, erythromycin/benzoyl peroxide, Brand Aczone, generic dapsone, erythromycin soln, generic erythromycin gel, Ery, Ovace, generic sodium sulfacetamide, Plexion NS, sodium sulfacetamide/sulfur (all formulations and brands), Sumadan, Plexion, Avar, Sulfacleanse, Clenia Plus, SSS, Sumaxin, Brand Klaron, Lintera, Brand Evoclin	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Patient is 25 years of age or under

OR

1.2 BOTH of the following:

1.2.1 Patient is 26 years of age or older

AND

1.2.2 Patient has tried and failed therapy with an OTC (over-the-counter) acne product

AND

2 - If the request is non-preferred*, the patient must have had a 14-day trial each of at least 2 preferred* medications

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name: Twyneo	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Patient is 25 years of age or under	

OR

1.2 BOTH of the following:

1.2.1 Patient is 26 years of age or older

AND

1.2.2 Patient has tried and failed therapy with an OTC (over-the-counter) acne product

AND

2 - BOTH of the following:

2.1 The patient must have trial and failure of concomitant use of individual components for at least 30 days

AND

2.2 There is rationale for use of requested medication over separate individual components

Product Name: adapalene, generic adapalene, Brand Differin, Differin	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Patient is 25 years of age or under and has tried a preferred topical tretinoin product* OR	

1.2 Patient is 26 years of age or older and BOTH of the following:

1.2.1 Patient has tried and failed therapy with an OTC (over-the-counter) acne product

AND

1.2.2 Patient has tried a preferred topical tretinoin product*

AND

2 - If the request is non-preferred*, the patient must have had a 14-day trial each of at least 2 preferred* medications

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

2 . Revision History

Date	Notes
12/17/2025	Updated GPIs and product names.

Actimmune



Prior Authorization Guideline

Guideline ID	GL-127783
Guideline Name	Actimmune
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	9/1/2023

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	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	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	Chronic Granulomatous Disease (CGD), Osteopetrosis, 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 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

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

Aemcolo



Prior Authorization Guideline

Guideline ID	GL-249218
Guideline Name	Aemcolo
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 Indiana Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2025

1 . Criteria

Product Name:Aemcolo	
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of travelers' diarrhea

AND

2 - ONE of the following:

2.1 Failure of ONE of the following confirmed by claims history or submitted medical records:

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

OR

2.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

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

2 . Revision History

Date	Notes
4/30/2025	Combined formularies. No changes to clinical criteria.

Afinitor, Torpenz



Prior Authorization Guideline

Guideline ID	GL-354232
Guideline Name	Afinitor, Torpenz
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland 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 Virginia Medicaid - Community & State Washington Medicaid - Community & State Indiana Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	9/1/2025

1 . Criteria

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO	
Diagnosis	Neuroendocrine tumors
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ALL of the following: 1.1 Diagnosis of ONE of the following: • Neuroendocrine tumors of gastrointestinal origin • Neuroendocrine tumors of lung origin • Neuroendocrine tumors of thymic origin AND 1.2 ONE of the following: • Disease is unresectable • Disease is locally advanced • Disease is metastatic AND 1.3 If the request is for Torpenz, ONE of the following: • Failure to everolimus (generic Afinitor) as confirmed by claims history or submission of medical records • History of contraindication or intolerance to everolimus (generic Afinitor) (please specify contraindication or intolerance) OR 2 - ALL of the following:	

2.1 Diagnosis of neuroendocrine tumors of pancreatic origin

AND

2.2 ONE of the following:

- Used for the management of recurrent, locoregional advanced and/or metastatic disease
- Used for management to stabilize glucose levels of locoregional insulinoma

AND

2.3 If the request is for Torpenz, ONE of the following:

- Failure to everolimus (generic Afinitor) as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to everolimus (generic Afinitor) (please specify contraindication or intolerance)

OR

3 - ALL of the following:

3.1 Diagnosis of well-differentiated, grade 3 neuroendocrine tumor

AND

3.2 ONE of the following:

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

AND

3.3 Tumor has favorable biology (e.g., relatively low Ki-67 [

AND

3.4 If the request is for Torpenz, ONE of the following:

- Failure to everolimus (generic Afinitor) as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to everolimus (generic Afinitor) (please specify contraindication or intolerance)

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO	
Diagnosis	Kidney Cancer
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 kidney cancer • Disease is relapsed or stage IV OR 1.2 Diagnosis of tuberous sclerosis complex (TSC)-associated renal cell carcinoma AND 2 - If the request is for Torpenz, ONE of the following:	

- Failure to everolimus (generic Afinitor) as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to everolimus (generic Afinitor) (please specify contraindication or intolerance)

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO

Diagnosis	Central Nervous System Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of subependymal giant cell astrocytoma (SEGA)

AND

1.2 Used as adjuvant treatment

AND

1.3 If the request is for Torpenz, ONE of the following:

- Failure to everolimus (generic Afinitor) as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to everolimus (generic Afinitor) (please specify contraindication or intolerance)

OR

2 - ALL of the following:

2.1 Diagnosis of meningioma

AND

2.2 Disease is recurrent or progressive

AND

2.3 Surgery and/or radiation is not possible

AND

2.4 ONE of the following:

- Used in combination with bevacizumab (Avastin, Mvasi, etc.)
- Used in combination with octreotide acetate LAR

AND

2.5 If the request is for Torpenz, ONE of the following:

- Failure to everolimus (generic Afinitor) as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to everolimus (generic Afinitor) (please specify contraindication or intolerance)

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO	
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 Torpenz, ONE of the following:

- Failure to everolimus (generic Afinitor) as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to everolimus (generic Afinitor) (please specify contraindication or intolerance)

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO

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:

- Disease is recurrent
- Disease is metastatic

AND

3 - ONE of the following:

- Disease is hormone receptor positive (HR+) [i.e., estrogen-receptor-positive (ER+) or progesterone-receptor-positive (PR+)]
- Breast cancer is considered inflammatory

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 - Used in combination with ONE of the following:

- Exemestane if progressed within 12 months or on a non-steroidal aromatase inhibitor [e.g., Arimidex (anastrozole), Femara (letrozole)]
- Fulvestrant
- Tamoxifen

AND

7 - If the request is for Torpenz, ONE of the following:

- Failure to everolimus (generic Afinitor) as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to everolimus (generic Afinitor) (please specify contraindication or intolerance)

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO

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

Approval Criteria

1 - Diagnosis of classic Hodgkin lymphoma

AND

2 - Disease is relapsed or refractory

AND

3 - Patient is not a candidate for autologous stem cell rescue/high-dose therapy (ASCR/HDT)

AND

4 - If the request is for Torpenz, ONE of the following:

- Failure to everolimus (generic Afinitor) as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to everolimus (generic Afinitor) (please specify contraindication or intolerance)

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO

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 soft tissue sarcoma subtypes:

- Locally advanced unresectable or metastatic malignant perivascular epithelioid cell tumor (PEComa)
- Recurrent angiomyolipoma
- Lymphangioleiomyomatosis

AND

2 - If the request is for Torpenz, ONE of the following:

- Failure to everolimus (generic Afinitor) as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to everolimus (generic Afinitor) (please specify contraindication or intolerance)

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO

Diagnosis	Thymomas and Thymic Carcinomas
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:

- First-line therapy as a single agent for those who cannot tolerate first-line combination regimens
- Second-line therapy as a single agent

AND

3 - If the request is for Torpenz, ONE of the following:

- Failure to everolimus (generic Afinitor) as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to everolimus (generic Afinitor) (please specify contraindication or intolerance)

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO	
Diagnosis	Thyroid 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 - Oncocytic 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 - If the request is for Torpenz, ONE of the following: - Failure to everolimus (generic Afinitor) as confirmed by claims history or submission of medical records	

- History of contraindication or intolerance to everolimus (generic Afinitor) (please specify contraindication or intolerance)

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO

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

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of endometrial carcinoma

AND

1.2 Used in combination with letrozole

AND

1.3 If the request is for Torpenz, ONE of the following:

- Failure to everolimus (generic Afinitor) as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to everolimus (generic Afinitor) (please specify contraindication or intolerance)

OR

2 - ALL of the following:

2.1 Diagnosis of Uterine Sarcoma

AND

2.2 Disease is perivascular epithelioid cell tumor (PEComa)

AND

2.3 Used as second-line or subsequent therapy

AND

2.4 If the request is for Torpenz, ONE of the following:

- Failure to everolimus (generic Afinitor) as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to everolimus (generic Afinitor) (please specify contraindication or intolerance)

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO	
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 Torpenz, ONE of the following:

- Failure to everolimus (generic Afinitor) as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to everolimus (generic Afinitor) (please specify contraindication or intolerance)

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO

Diagnosis	Bone Cancer - Osteosarcoma

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of osteosarcoma

AND

2 - Disease is ONE of the following:

- Relapsed/Refractory
- Metastatic

AND

3 - Used as second-line therapy

AND

4 - Used in combination with Nexavar (sorafenib)

AND

5 - If the request is for Torpenz, ONE of the following:

- Failure to everolimus (generic Afinitor) as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to everolimus (generic Afinitor) (please specify contraindication or intolerance)

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO

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

Approval Criteria

1 - Diagnosis of ONE of the following

- Rosai-Dorfman Disease
- Langerhans Cell Histiocytosis
- Erdheim-Chester Disease

AND

2 - Presence of phosphatidylinositol-4,5-bisphosphate 3-kinase catalytic subunit alpha (PIK3CA) mutation

AND

3 - If the request is for Torpenz, ONE of the following:

- Failure to everolimus (generic Afinitor) as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to everolimus (generic Afinitor) (please specify contraindication or intolerance)

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO	
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 - Disease is one of the following: • Unresectable primary • Recurrent/Metastatic • Gross residual (R2 resection) • Tumor rupture AND 3 - Disease has progressed after single agent therapy with ALL of the following: • imatinib (generic Gleevec) • sunitinib (generic Sutent) • Stivarga (regorafenib) • Qinlock (ripretinib)	

AND

4 - Used in combination with ONE of the following:

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

AND

5 - If the request is for Torpenz, ONE of the following:

- Failure to everolimus (generic Afinitor) as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to everolimus (generic Afinitor) (please specify contraindication or intolerance)

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO

Diagnosis	Neuroendocrine Tumors, Kidney Cancer, Central Nervous System Cancer, Waldenström's Macroglobulinemia or Lymphoplasmacytic Lymphoma, Breast Cancer, Hodgkin Lymphoma, Soft Tissue Sarcoma, Thymomas and Thymic Carcinomas, Thyroid Carcinoma, Uterine Neoplasm, Tuberous Sclerosis Complex associated Partial-Onset Seizures, Bone Cancer - Osteosarcoma, Histiocytic Neoplasms, Gastrointestinal Stromal Tumor (GIST)

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: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO

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	

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO	
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
8/4/2025	Updated formularies to add IN

Agents for the Treatment of Opioid Use Disorder



Prior Authorization Guideline

Guideline ID	GL-545241
Guideline Name	Agents for the Treatment of Opioid Use Disorder
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Buprenorphine sublingual tablet, Zubsolv, buprenorphine/naloxone sublingual tablet, Brand Suboxone, generic buprenorphine/naloxone sublingual film	
Diagnosis	Age Limit Exception*
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Both of the following: 1.1 Documentation that other age and diagnosis-appropriate agents available have been	

tried for an adequate period of time and been deemed ineffective in the treatment of the patient's disease or medical condition

AND

1.2 If the patient is outside of FDA (Food and Drug Administration)-established age limits, clinical support or rationale for safety and efficacy has been provided (i.e. clinical literature in conjunction with patient attributes and/or characteristics of the drug) for the requested drug and dose

OR

2 - Both of the following:

2.1 History of the requested agent for at least 90 days within the past 120 days, confirmed by claims history or chart documentation

AND

2.2 Patient previously received an authorization for age limit exception for the requested agent

OR

3 - All of the following:

3.1 History of the requested agent for at least 90 days within the past 120 days, confirmed by claims history or chart documentation

AND

3.2 One of the following:

- The requested agent has newly implemented age limits which did not previously apply to the patient
- The request is for continuation of therapy from another plan or following inpatient therapy

AND

3.3 One of the following:

3.3.1 Documentation that other age and diagnosis-appropriate agents available have been tried for an adequate period of time and been deemed ineffective in the treatment of the patient's disease or medical condition

OR

3.3.2 The prescriber has provided valid medical justification for use of the requested agent outside of FDA or plan-established age limits over the use of other diagnosis-appropriate agents within FDA or plan-established age limits (please document justification)

AND

3.4 If the patient is outside of FDA-established age limits, clinical support or rationale for safety and efficacy has been provided (i.e., clinical literature in conjunction with patient attributes and/or characteristics of the drug) for the requested drug and dose

Notes

*This criteria comes from the Non-Drug Specific PA policy

Product Name: Buprenorphine sublingual tablet, Zubsolv, buprenorphine/naloxone sublingual tablet, Brand Suboxone, generic buprenorphine/naloxone sublingual film

Diagnosis

Non-Preferred*

Approval Length

12 month(s)

Guideline Type

Prior Authorization

Approval Criteria

1 - If the request is for a non-preferred medication**, one of the following:

1.1 History of failure to at least THREE preferred alternatives 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

1.2 History of contraindication or intolerance to THREE preferred alternatives (please specify contraindication or intolerance). 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

Notes

*This criteria comes from the Non-Preferred Drugs Policy
 **PDL link: <https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html>

Product Name: Brixadi

Approval Length 12 month(s)

Therapy Stage Initial Authorization

Guideline Type Prior Authorization

Approval Criteria

1 - The patient is 18 years of age or older

AND

2 - Prescriber has submitted medical justification as to why oral agents for opioid use disorder are unsuitable for the patient

AND

3 - One of the following:

3.1 Request is for Brixadi (buprenorphine) weekly and weekly dose does not exceed a total of 32 mg (milligram)/week

OR

3.2 Request is for Brixadi (buprenorphine) monthly and monthly dose does not exceed a total of 128 mg/month

AND

4 - The patient is not using other injectable products (e.g., Sublocade) for opioid use disorder concurrently

Product Name: Brixadi

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Request is for Brixadi (buprenorphine) weekly and both of the following:

1.1.1 History of the request agent for 14 days of the past 21 days, confirmed by claims history or chart documentation

AND

1.1.2 Weekly dose does not exceed a total of 32 mg (milligram)/week

OR

1.2 Request is for Brixadi (buprenorphine) monthly and both of the following:

1.2.1 History of the requested agent in the past 45 days, confirmed by claims history or chart documentation

AND

1.2.2 Monthly dose does not exceed a total of 128 mg/month

AND

2 - The patient is not using other injectable products (e.g., Sublocade) for opioid use disorder concurrently

Product Name:Sublocade	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - The patient is 18 years of age or older AND 2 - Prescriber has submitted medical justification as to why oral agents for opioid use disorder are unsuitable for the patient AND 3 - Dose requested does not exceed the following: - Initiation phase: Two 300 mg (milligram) injections per 60 days - Maintenance phase: 100 mg/month AND 4 - The patient is not using other injectable products (e.g., Brixadi) for opioid use disorder concurrently	

Product Name:Sublocade	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested agent in the past 45 days, confirmed by claims history or chart documentation AND 2 - Dose requested does not exceed 100 mg/month (milligrams per month) AND 3 - The patient is not using other injectable products (e.g., Brixadi) for opioid use disorder concurrently	

2 . Revision History

Date	Notes
3/11/2026	Updated step 3.3.2 of Age Limit Exception to populate free text box.

Agents for Thrombocytopenia and Related Conditions



Prior Authorization Guideline

Guideline ID	GL-475187
Guideline Name	Agents for Thrombocytopenia and Related Conditions
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Alvaiz	
Approval Length	6 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 persistent immune thrombocytopenia (ITP) (lasting between 3 and 12 months) or chronic ITP (lasting longer than 12 months) whose degree of thrombocytopenia and clinical condition increases the risk of bleeding

AND

1.1.2 Submission of medical records, including therapy(ies) trialed, confirming patient has had an insufficient response to corticosteroids, immunoglobulins, or splenectomy

AND

1.1.3 Patient is 6 years of age or older

AND

1.1.4 Dose requested does not exceed 54 mg/day (milligrams per day)

OR

1.2 All of the following:

1.2.1 Diagnosis of thrombocytopenia in members with chronic hepatitis C requiring initiation and/or maintenance of interferon-based therapy

AND

1.2.2 Prescriber attests to both of the following:

- Patient is currently on interferon-based therapy or will be initiated on interferon-based therapy
- Prescriber will discontinue Alvaiz (eltrombopag choline) if interferon-based therapy is terminated

AND

1.2.3 Patient is 18 years of age or older

AND

1.2.4 Dose requested does not exceed 72 mg/day (milligrams per day)

OR

1.3 All of the following:

1.3.1 Diagnosis of severe aplastic anemia

AND

1.3.2 Submission of medical records, including therapy(ies) trialed, confirming patient has had an insufficient response to immunosuppressive therapy (e.g., anti-thymocyte globulin, cyclosporine)

AND

1.3.3 Patient is 18 years of age or older

AND

1.3.4 Dose requested does not exceed 108 mg/day (milligrams per day)

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

1 - History of requested agent within the past 90 days, as confirmed by claims history, chart documentation, or provider attestation including dates of trial

AND

2 - Submission of medical records supporting positive clinical response to Alvaiz (eltrombopag choline) therapy (e.g., complete blood count from before initiation of therapy and post initiation of therapy, decrease in frequency of bleeding episodes, etc.)

AND

3 - Dose requested does not exceed one of the following:

- For persistent immune thrombocytopenia (ITP) (lasting between 3 and 12 months) or chronic ITP (lasting longer than 12 months) indication: 54 mg/day (milligrams per day)
- For thrombocytopenia in members with chronic hepatitis C requiring interferon-based therapy: 72 mg/day
- For severe aplastic anemia: 108 mg/day

Product Name:Doptelet tablets	
Diagnosis	Thrombocytopenia in patients with chronic liver disease who are scheduled to undergo a procedure
Approval Length	30 Day(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of thrombocytopenia AND 2 - Patient has chronic liver disease and is scheduled to undergo a procedure (please document date of procedure)	

AND

3 - Patient is 18 years of age or older

AND

4 - Dose requested does not exceed 60 mg/day (milligrams per day)

AND

5 - The request does not exceed 15 tablets total for a 5-day course

Product Name:Doptelet tablets	
Diagnosis	Immune thrombocytopenia (ITP)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of persistent immune thrombocytopenia (ITP) (lasting between 3 and 12 months) or chronic ITP (lasting longer than 12 months) AND 2 - Submission of medical records, including therapy(ies) trialed, confirming patient has had an insufficient response to corticosteroids, immunoglobulins, or splenectomy AND 3 - Patient is 1 year of age or older	

AND

4 - Dose requested does not exceed one of the following:

- Patient is less than 6 years of age, 20 mg/day (milligrams per day)
- Patient is 6 years of age or older, 40 mg/day

Product Name:Doptelet tablets	
Diagnosis	Immune thrombocytopenia (ITP)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of persistent immune thrombocytopenia (ITP) (lasting between 3 and 12 months) or chronic ITP (lasting longer than 12 months) AND 2 - History of requested agent within the past 90 days, as confirmed by claims history, chart documentation, or provider attestation including dates of trial AND 3 - Submission of medical records supporting positive clinical response to Doptelet (avatrombopag) therapy (e.g., complete blood count from before initiation of therapy and post initiation of therapy, decrease in frequency of bleeding episodes, etc.) AND 4 - Patient is 1 year of age or older	

AND

5 - Dose requested does not exceed one of the following:

- Patient is less than 6 years of age: 20 mg/day (milligrams per day)
- Patient is 6 years of age or older: 40 mg/day

Product Name:Doptelet sprinkle capsules

Approval Length	6 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of persistent immune thrombocytopenia (ITP) (lasting between 3 and 12 months) or chronic ITP (lasting longer than 12 months)

AND

2 - Submission of medical records, including therapy(ies) trialed, confirming patient has had an insufficient response to corticosteroids, immunoglobulins, or splenectomy

AND

3 - Patient is at least 1 year of age to less than 6 years of age

AND

4 - Dose requested does not exceed 20 mg/day (milligrams per day)

Product Name:Doptelet sprinkle capsules

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of requested agent within the past 90 days, as confirmed by claims history, chart documentation, or provider attestation including dates of trial AND 2 - Submission of medical records supporting positive clinical response to Doptelet (avatrombopag) therapy (e.g., complete blood count from before initiation of therapy and post initiation of therapy, decrease in frequency of bleeding episodes, etc.) AND 3 - Patient is at least 1 year of age to less than 6 years of age AND 4 - Dose requested does not exceed 20 mg/day (milligrams per day)	

Product Name: Mulpleta	
Approval Length	30 Day(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of thrombocytopenia AND	

2 - Patient has chronic liver disease and is scheduled to undergo a procedure (please document date of procedure)

AND

3 - Patient is 18 years of age or older

AND

4 - Dose requested does not exceed 3 mg/day (milligrams per day)

Product Name: Brand Promacta powder pack for suspension, generic eltrombopag powder pack for suspension

Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of persistent immune thrombocytopenia (ITP) (lasting between 3 and 12 months) or chronic ITP (lasting longer than 12 months) whose degree of thrombocytopenia and clinical condition increases the risk of bleeding

AND

2 - Submission of medical records, including therapy(ies) trialed, confirming patient has had an insufficient response to corticosteroids, immunoglobulins, or splenectomy

AND

3 - Patient is 1 year of age or older

AND

4 - Dose requested does not exceed 75 mg/day (milligrams per day)

AND

5 - If the patient is 12 years of age or older, provider has submitted medical records supporting the patient's inability to swallow the tablet formulation

Product Name: Brand Promacta powder pack for suspension, generic eltrombopag powder pack for suspension

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

Approval Criteria

1 - History of requested agent within the past 90 days, as confirmed by claims history, chart documentation, or provider attestation including dates of trial

AND

2 - Submission of medical records supporting positive clinical response to the requested therapy (e.g., complete blood count from before initiation of therapy and post initiation of therapy, decrease in frequency of bleeding episodes, etc.)

AND

3 - Dose requested does not exceed 75 mg/day (milligrams per day)

AND

4 - If the patient is 12 years of age or older, provider has submitted medical records supporting the patient's inability to swallow the tablet formulation

Product Name: Brand Promacta tablets, generic eltrombopag olamine tablets	
Approval Length	6 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 persistent immune thrombocytopenia (ITP) (lasting between 3 and 12 months) or chronic ITP (lasting longer than 12 months) whose degree of thrombocytopenia and clinical condition increases the risk of bleeding AND 1.1.2 Submission of medical records, including therapy(ies) trialed, confirming patient has had an insufficient response to corticosteroids, immunoglobulins, or splenectomy AND 1.1.3 Patient is 1 year of age or older AND 1.1.4 Dose requested does not exceed 75 mg/day (milligrams per day) OR 1.2 All of the following:	

1.2.1 Diagnosis of thrombocytopenia in members with chronic hepatitis C requiring initiation and/or maintenance of interferon-based therapy

AND

1.2.2 Prescriber attests to both of the following:

- Patient is currently on interferon-based therapy or will be initiated on interferon-based therapy
- Prescriber will discontinue the requested medication if interferon-based therapy is terminated

AND

1.2.3 Patient is 18 years of age or older

AND

1.2.4 Dose requested does not exceed 100 mg/day (milligrams per day)

OR

1.3 All of the following:

1.3.1 Diagnosis of severe aplastic anemia

AND

1.3.2 One of the following:

1.3.2.1 Patient is 2 years of age or older and will be using Promacta (eltrombopag olamine) in combination with standard immunosuppressive therapy (e.g., anti-thymocyte globulin, cyclosporine)

OR

1.3.2.2 Patient is 18 years of age or older, will be using Promacta (eltrombopag olamine) as monotherapy, and provider has submitted medical records, including therapy(ies) trialed, confirming patient has had an insufficient response to immunosuppressive therapy (e.g., anti-thymocyte globulin, cyclosporine)

AND

1.3.3 Dose requested does not exceed 150 mg/day (milligrams per day)

Product Name: Brand Promacta tablets, generic eltrombopag olamine tablets	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of requested agent within the past 90 days, as confirmed by claims history, chart documentation, or provider attestation including dates of trial AND 2 - Submission of medical records supporting positive clinical response to the requested therapy (e.g., complete blood count from before initiation of therapy and post initiation of therapy, decrease in frequency of bleeding episodes, etc.) AND 3 - Dose requested does not exceed one of the following: - For persistent immune thrombocytopenia (ITP) (lasting between 3 and 12 months) or chronic ITP (lasting longer than 12 months) indication: 75 mg/day (milligrams per day) - For thrombocytopenia in members with chronic hepatitis C requiring interferon-based therapy: 100 mg/day - For severe aplastic anemia: 150 mg/day	

Product Name:Wayrilz	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of persistent immune thrombocytopenia (ITP) (lasting between 3 and 12 months) or chronic ITP (lasting longer than 12 months) AND 2 - Submission of medical records, including therapy(ies) trialed, confirming patient has had an insufficient response to corticosteroids, immunoglobulins, or splenectomy AND 3 - Patient is 18 years of age or older AND 4 - Dose requested does not exceed 400 mg (milligrams) twice daily	

Product Name:Wayrilz	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of requested agent within the past 90 days, as confirmed by claims history, chart documentation, or provider attestation including dates of trial	

AND

2 - Submission of medical records supporting positive clinical response to Wayrilz (rilzabrutinib) therapy (e.g., complete blood count from before initiation of therapy and post initiation of therapy, decrease in frequency of bleeding episodes, etc.)

AND

3 - Dose requested does not exceed 400 mg (milligrams) twice daily

2 . Revision History

Date	Notes
12/18/2025	New guideline

Akeega



Prior Authorization Guideline

Guideline ID	GL-562212
Guideline Name	Akeega
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia Medicaid - Community & State Washington

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Akeega

Diagnosis	Prostate Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following: - Metastatic castration-resistant prostate cancer (mCRPC) - Metastatic castration-sensitive prostate cancer (mCSPC) AND 2 - Deleterious or suspected deleterious BRCA-mutated (BRCAm) AND 3 - Used in combination with prednisone	

Product Name:Akeega	
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 Akeega therapy	

Product Name:Akeega	
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:Akeega	
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 Akeega therapy	

2 . Revision History

Date	Notes
4/2/2026	Added IN.

Alecensa



Prior Authorization Guideline

Guideline ID	GL-354240
Guideline Name	Alecensa
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 Virginia Medicaid - Community & State Indiana Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	9/1/2025

1 . Criteria

Product Name:Alecensa	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of non-small cell lung cancer (NSCLC) AND 2 - Disease is anaplastic lymphoma kinase (ALK)-positive AND 3 - One of the following: 3.1 Disease is one of the following: • Recurrent • Advanced • Metastatic OR 3.2 Used as adjuvant treatment following tumor resection	

Product Name:Alecensa	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of symptomatic Erdheim-Chester Disease

AND

2 - Used as targeted therapy anaplastic lymphoma kinase (ALK)-fusion

AND

3 - Disease is ONE of the following:

- Relapsed
- Refractory

Product Name:Alecensa	
Diagnosis	T-Cell Lymphomas
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of anaplastic large cell lymphoma (ALCL) AND 2 - Used as initial palliative intent therapy or second-line and subsequent therapy AND 3 - Disease is ONE of the following: • Relapsed	

- Refractory

AND

4 - Anaplastic lymphoma kinase (ALK)-positive

Product Name:Alecensa	
Diagnosis	B-Cell Lymphomas
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of large B-Cell lymphoma AND 2 - Disease is ONE of the following: • Relapsed • Refractory AND 3 - Anaplastic lymphoma kinase (ALK)-positive	

Product Name:Alecensa	
Diagnosis	Central Nervous System (CNS) Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following:

- Metastatic brain cancer from NSCLC
- Pediatric diffuse high-grade glioma

AND

2 - Tumor is anaplastic lymphoma kinase (ALK)-positive

Product Name:Alecensa	
Diagnosis	Soft Tissue Sarcoma/Uterine Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of inflammatory myofibroblastic tumor (IMT) AND 2 - Presence of anaplastic lymphoma kinase (ALK) translocation	

Product Name:Alecensa	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC), Histiocytic Neoplasms, T-Cell Lymphomas, B-Cell Lymphomas, Central Nervous System (CNS) Cancers, Soft Tissue Sarcoma/Uterine Neoplasms
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 Alecensa therapy

Product Name:Alecensa

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:Alecensa

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 Alecensa therapy

2 . Revision History

Date	Notes
8/4/2025	Added pediatric diffuse high-grade gliomas to CNS cancers criteria

Allergy-Specific Immunotherapy



Prior Authorization Guideline

Guideline ID	GL-252188
Guideline Name	Allergy-Specific Immunotherapy
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/15/2025

1 . Criteria

Product Name:Grastek	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of grass-pollen induced allergic rhinitis	

AND

2 - Documentation of a positive skin test or in vitro test for Timothy Grass or cross-reactive grass pollens

AND

3 - Patient must be at least 5 years of age and no more than 65 years of age

AND

4 - Prescribed by, or in consultation with, an allergist or immunologist

AND

5 - ONE of the following:

5.1 Previous trial and failure (inadequate response) to at least 90 days of drug therapy with ALL of the following:

- Intranasal corticosteroid
- Leukotriene inhibitor
- Antihistamine agent

OR

5.2 Prescriber has provided documentation of contraindication to or intolerance of intranasal corticosteroids, leukotriene inhibitors, and/or antihistamine agents

AND

6 - ONE of the following:

6.1 Previous trial and failure of injectable immunotherapy (allergy shots)

OR

6.2 Prescriber has provided documentation of contraindication to injectable immunotherapy

AND

7 - The patient does NOT have any of the following contraindications:

- Severe, unstable, or uncontrolled asthma
- Current oral inflammation or wound from previous pollen-specific sublingual immunotherapy

AND

8 - Requested dose does not exceed 1 tablet (2,800 BAU) daily

Product Name:Odactra	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of house dust mite-induced allergic rhinitis AND 2 - Documentation of a positive skin test or in vitro test for IgE (immunoglobulin E) antibodies to house dust mites (dermatophagoides farinae or dermatophagoides pteronyssinus) AND	

3 - Patient must be at least 5 years of age and no more than 65 years of age

AND

4 - Prescribed by, or in consultation with, an allergist or immunologist

AND

5 - ONE of the following:

5.1 Previous trial and failure (inadequate response) to at least 90 days of drug therapy with ALL of the following: intranasal corticosteroid, leukotriene inhibitor, antihistamine agent

- Intranasal corticosteroid
- Leukotriene inhibitor
- Antihistamine agent

OR

5.2 Prescriber has provided documentation of contraindication to or intolerance of intranasal corticosteroids, leukotriene inhibitors, and/or antihistamine agents

AND

6 - ONE of the following:

6.1 Previous trial and failure of injectable immunotherapy (allergy shots)

OR

6.2 Prescriber has provided documentation of contraindication to injectable immunotherapy

AND

7 - The patient does NOT have any of the following contraindications:

- Severe, unstable, or uncontrolled asthma
- Current oral inflammation or wound from previous pollen-specific sublingual immunotherapy

AND

8 - Requested dose does not exceed 1 tablet (12 SQ-HDM) daily

Product Name: Oralair	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of grass pollen-induced allergic rhinitis AND 2 - Documentation of a positive skin test or in vitro test for any of the five grass species: Sweet Vernal, Orchard, Perennial Rye, Timothy or Kentucky Blue Grass AND 3 - Patient must be at least 5 years of age and no more than 65 years of age AND 4 - Prescribed by, or in consultation with, an allergist or immunologist AND	

5 - ONE of the following:

5.1 Previous trial and failure (inadequate response) to at least 90 days of drug therapy with ALL of the following:

- Intranasal corticosteroid
- Leukotriene inhibitor
- Antihistamine agent

OR

5.2 Prescriber has provided documentation of contraindication to or intolerance of intranasal corticosteroids, leukotriene inhibitors, and/or antihistamine agents

AND

6 - ONE of the following:

6.1 Previous trial and failure of injectable immunotherapy (allergy shots)

OR

6.2 Prescriber has provided documentation of contraindication to injectable immunotherapy

AND

7 - The patient does NOT have any of the following contraindications:

- Severe, unstable, or uncontrolled asthma
- Current oral inflammation or wound from previous pollen-specific sublingual immunotherapy

AND

8 - Requested dose does not exceed either of the following:

- For patients 5 to 17 years of age: Three 100mg tablets maximum per month for induction therapy

- 1 tablet (300mg) daily

Product Name: Palforzia	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of peanut allergy AND 2 - Patient is at least 1 years of age and no more than 17 years of age AND 3 - Prescribed by, or in consultation with, an allergist or immunologist AND 4 - The patient does NOT have any of the following contraindications: • Severe, unstable, or uncontrolled asthma • Severe or life-threatening anaphylaxis reaction in the past 60 days • History of eosinophilic esophagitis or other eosinophilic GI (gastrointestinal) disease AND 5 - Requested dose does not exceed either of the following: • If requesting the starter pack: Not exceeding 1 pack every 90 days • Dose does not exceed 300mg daily	

Product Name:Ragwitek	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of short ragweed pollen-induced allergic rhinitis AND 2 - Documentation of a positive skin test or in vitro test for short ragweed pollen AND 3 - Patient is at least 5 years of age and no more than 65 years of age AND 4 - Prescribed by, or in consultation with, an allergist or immunologist AND 5 - ONE of the following: 5.1 Previous trial and failure (inadequate response) to at least 90 days of drug therapy with ALL of the following: • Intranasal corticosteroid • Leukotriene inhibitor • Antihistamine agent	

OR

5.2 Prescriber has provided documentation of contraindication to or intolerance of intranasal corticosteroids, leukotriene inhibitors, and/or antihistamine agents

AND

6 - ONE of the following:

6.1 Previous trial and failure of injectable immunotherapy (allergy shots)

OR

6.2 Prescriber has provided documentation of contraindication to injectable immunotherapy

AND

7 - The patient does NOT have any of the following contraindications:

- Severe, unstable, or uncontrolled asthma
- Current oral inflammation or wound from previous pollen-specific sublingual immunotherapy

AND

8 - Requested dose does not exceed 1 tablet (12 Amb a 1-U) daily

Product Name: Grastek, Odactra, Oralair, Palforzia, Ragwitek	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - History of the requested medication within the past 90 days

2 . Revision History

Date	Notes
4/29/2025	Updated GL-252187 to add dosing criteria.

Alunbrig



Prior Authorization Guideline

Guideline ID	GL-562213
Guideline Name	Alunbrig
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Alunbrig	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of non-small cell lung cancer (NSCLC) AND 2 - Disease is ONE of the following: • Metastatic • Recurrent • Advanced AND 3 - Tumor is anaplastic lymphoma kinase (ALK)-positive	

Product Name:Alunbrig	
Diagnosis	Soft Tissue Sarcoma/Uterine Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of inflammatory myofibroblastic tumor (IMT) AND 2 - Presence of ALK (anaplastic lymphoma kinase) translocation	

Product Name:Alunbrig	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of symptomatic Erdheim-Chester Disease AND 2 - Used as targeted therapy for (anaplastic lymphoma kinase) ALK-fusion AND 3 - Disease is ONE of the following: • Relapsed • Refractory	

Product Name:Alunbrig	
Diagnosis	Central Nervous System (CNS) Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of metastatic brain cancer from non-small cell lung cancer (NSCLC)	

AND

2 - Tumor is anaplastic lymphoma kinase (ALK)-positive

Product Name:Alunbrig

Diagnosis	Anaplastic Large Cell Lymphoma

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of anaplastic large cell lymphoma

AND

2 - Tumor is anaplastic lymphoma kinase (ALK)-positive

AND

3 - Disease is relapsed or refractory

AND

4 - Used as palliative intent therapy or second-line and subsequent therapy

Product Name:Alunbrig

Diagnosis	Non-Small Cell Lung Cancer (NSCLC), Soft Tissue Sarcoma/Uterine Neoplasms, Histiocytic Neoplasms, Central Nervous System (CNS) Cancers, Anaplastic Large Cell Lymphoma

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 Alunbrig therapy	

Product Name:Alunbrig	
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 is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	

Product Name:Alunbrig	
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 Alunbrig therapy	

2 . Revision History

UnitedHealthcare Community Plan of Indiana Clinical Pharmacy Program Guidelines

Date	Notes
4/2/2026	Added IN. Expanded on NSCLC abbreviation under CNS cancers, with no changes to clinical intent.

Alzheimer's and Dementia Agents



Prior Authorization Guideline

Guideline ID	GL-505196
Guideline Name	Alzheimer's and Dementia Agents
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:galantamine oral solution	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is unable to swallow tablet formulation, as supported by chart documentation	

Product Name:Brand Namzaric	
Approval Length	12 month(s)

Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., charts, labs, progress notes, etc.) supporting separate components are not suitable for use OR 2 - History of the requested medication for 90 of the past 120 days (as supported by claims history or chart documentation)	

Product Name:Generic memantine/donepezil^	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., charts, labs, progress notes, etc.) supporting separate components are not suitable for use	
Notes	^Generic memantine/donepezil needs to be reviewed by clinician for generic over brand review

Product Name:Zunveyl	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following: Trial and failure of galantamine (any formulation) (as supported by claims history or chart documentation)	

- Prescriber has provided medical justification for use (please document justification)

OR

2 - History of the requested medication for 90 of the past 120 days (as supported by claims history or chart documentation)

2 . Revision History

Date	Notes
1/22/2026	Deleted required value from step 2 of Zunveyl.

Amyloid Beta-Directed Antibodies



Prior Authorization Guideline

Guideline ID	GL-436472
Guideline Name	Amyloid Beta-Directed Antibodies
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	12/1/2025

1 . Criteria

Product Name:Leqembi IQLIK	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - History of Leqembi or Leqembi Iqlik within the past 60 days AND	

2 - ONE of the following:

- Patient has received at least 18 months of consistent Leqembi intravenous formulation, as confirmed by claims history or chart documentation noting dates of infusions
- Patient has been previously approved for Leqembi Iqlik

AND

3 - Submission of documentation showing clinical improvement or stabilization when compared to previous Clinical Dementia Rating (CDR) global score, Memory Box score, Mini-Mental State Examination (MMSE) score, or Wechsler-Memory Scale-IV Logical Memory II (subscale) (WMS-IV LMII)

AND

4 - Dose does not exceed 360 mg every week

AND

5 - Submission of documentation showing decreases (or at a minimum, no increases) in amyloid beta plaque levels, as compared to baseline, confirmed by either an amyloid-positron emission tomography (PET) scan OR amyloid protein concentrations in Cerebral Spinal Fluid (CSF) obtained from a lumbar puncture performed at the following frequencies (Note – the method of measuring amyloid beta plaque levels should be consistent for each re-evaluation period; documentation of results from each of the following, with respective infusion dates/dates of administration, must be submitted):

- After the seventh dose of medication
- At 18 months after initiating therapy
- Every 18 months thereafter

AND

6 - Prescriber attests the patient remains a candidate for treatment, indicating that they have NOT developed any of the following exclusionary conditions:

- Risk factors for intracerebral hemorrhage (i.e., vasogenic edema, evidence of cerebral contusion, aneurysm, vascular malformation, infective lesions, multiple lacunar infarcts

or stroke involving a major vascular territory, severe small vessel or white matter disease)

- History of antithrombotic agent, other than aspirin or clopidogrel, with plans to use concurrently with Legembi
- Any neurological and/or psychiatric condition that may be contributing to cognitive impairment above and beyond that caused by the patient's Alzheimer's disease

2 . Revision History

Date	Notes
10/30/2025	New program

Angiotensin Receptor Blocker Combinations



Prior Authorization Guideline

Guideline ID	GL-124995
Guideline Name	Angiotensin Receptor Blocker Combinations
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	7/1/2023

1 . Criteria

Product Name:telmisartan/amlodipine, Brand Exforge, generic amlodipine/valsartan, Brand Exforge HCT, generic amlodipine/valsartan/hydrochlorothiazide, Brand Tribenzor, generic olmesartan/amlodipine/hydrochlorothiazide, Brand Azor, generic amlodipine/olmesartan	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Trial and failure of the individual components	

2 . Revision History

Date	Notes
4/25/2023	New

Angiotensin Receptor Blockers (ARBs)



Prior Authorization Guideline

Guideline ID	GL-542270
Guideline Name	Angiotensin Receptor Blockers (ARBs)
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name: Valsartan oral solution, Arbli suspension	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is unable to swallow tablets	

2 . Revision History

UnitedHealthcare Community Plan of Indiana Clinical Pharmacy Program Guidelines

Date	Notes
3/9/2026	Added Arbli

Antidepressant Agents - MAO-I



Prior Authorization Guideline

Guideline ID	GL-505197
Guideline Name	Antidepressant Agents - MAO-I
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Emsam, Marplan, Brand Nardil, phenelzine, Brand Parnate, generic tranylcypromine	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following: • Patient has previous trial and failure of one SSRI (selective serotonin reuptake inhibitor) and one SNRI (serotonin-norepinephrine reuptake inhibitor) agent for at least 4 weeks each (as supported by claims history or chart documentation)	

- Prescriber has provided medical justification for use of the requested medication (please document justification)

OR

2 - History of requested medication for 90 of the past 120 days (as supported by claims history or chart documentation)

2 . Revision History

Date	Notes
1/22/2026	New guideline

Antidepressant Agents - Misc



Prior Authorization Guideline

Guideline ID	GL-505198
Guideline Name	Antidepressant Agents - Misc
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:bupropion ER 450 mg (generic Forfivo)	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Prescriber has provided medical justification for use of the requested medication over preferred bupropion agents* (please document justification) OR	

2 - History of the requested medication for 90 of the past 120 days (as supported by claims history or chart documentation)

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:Exxua

Approval Length 12 month(s)

Guideline Type Prior Authorization

Approval Criteria

1 - Patient is 18 years of age or older

AND

2 - ONE of the following:

- Patient has trial and failure of two preferred antidepressant agents for at least 4 weeks each* (as supported by claims history or chart documentation)
- History of the requested medication for 90 of the past 120 days (as supported by claims history or chart documentation)

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:Raldesy

Approval Length 12 month(s)

Guideline Type Prior Authorization

Approval Criteria

1 - Patient is less than 12 years of age

OR

2 - Patient is 12 years of age or older AND unable to swallow tablet formulation, as supported by chart documentation

OR

3 - History of the requested medication for 90 of the past 120 days (as supported by claims history or chart documentation)

2 . Revision History

Date	Notes
1/22/2026	New guideline

Antidepressant Agents - TCA's



Prior Authorization Guideline

Guideline ID	GL-505200
Guideline Name	Antidepressant Agents - TCA's
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:nortriptyline oral soln	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is less than 12 years of age OR	

2 - Patient is 12 years of age or older AND unable to swallow capsule formulation, as supported by chart documentation

OR

3 - History of the requested medication for 90 of the past 120 days (as supported by claims history or chart documentation)

Product Name: trimipramine capsule

Approval Length 12 month(s)

Guideline Type Prior Authorization

Approval Criteria

1 - Patient has trial and failure of all preferred tricyclic antidepressants* (as supported by claims history or chart documentation)

OR

2 - Prescriber has provided medical justification for the use of the requested medication over all preferred tricyclic antidepressants* (please document justification)

Notes *PDL link: <https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html>

2 . Revision History

Date	Notes
1/23/2026	New guideline

Antiemetic, Antivertigo Agents



Prior Authorization Guideline

Guideline ID	GL-485192
Guideline Name	Antiemetic, Antivertigo Agents
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name: Anzemet, granisetron, Brand Posfree, generic palonosetron	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has previous trial of ondansetron (any formulation), as supported by claims history or chart documentation AND	

2 - Prescriber has provided medical justification for use of the requested agent over ondansetron (please document)

AND

3 - If the request is for Brand Posfrea, both of the following:

- Previous trial of generic palonosetron within the past 90 days
- Prescriber has provided medical justification for use of the Brand Posfrea over generic palonosetron injection (please document)

Product Name:Sancuso, Sustol

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - Prescriber has provided medical justification for use of the requested agent over generic granisetron tablet and injectable formulations (please document)

Product Name:Emend suspension

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has tried Emend oral capsules

OR

2 - Patient is unable to swallow or tolerate the capsule formulation

Product Name: Akynzeo	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has tried and failed combination therapy with preferred* agents of the same classes OR 2 - Prescriber has provided medical justification for use of the combination product (please document)	
Notes	* PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

2 . Revision History

Date	Notes
12/18/2025	Added Anzemet, granisetron, Posfrea (palonosetron) and Sustol. Updated Sancuso and Akynzeo criteria.

Antihistamine-Decongestant Combinations - 2nd Generation Antihistamines



Prior Authorization Guideline

Guideline ID	GL-548199
Guideline Name	Antihistamine-Decongestant Combinations - 2nd Generation Antihistamines
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:All OTC Products per label name included for cetirizine 5 mg OTC tabs	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is less than 18 years of age	

Product Name:All OTC Products per label name included for loratadine/pseudoephedrine 12-hour OTC and 24-hour OTC	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient had a trial and failure of a preferred single-agent 2nd generation antihistamine*	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:All OTC and RX Products per label name included for cetirizine 1 mg/ml solution, All OTC Products per label name included for loratadine 1 mg/ml solution	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Patient is less than 12 years of age OR 1.2 Patient is unable to swallow tablet formulation AND 2 - Patient is less than or equal to 18 years of age	

Product Name:generic levocetirizine soln	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has tried BOTH of the following within past 90 days:

- loratadine solution (OTC)
- cetirizine solution (Rx or OTC)

Product Name: Brand Clarinex tabs, generic desloratadine RX tabs, desloratadine RX ODT tabs

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Patient has tried BOTH of the following within 90 days:

- cetirizine
- loratadine

OR

1.2 Patient has previous approval for the requested medication

Product Name: Clarinex-D RX tabs

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - Patient had a trial and failure of loratadine/pseudoephedrine 12-hour OTC tab

Product Name:Desloratadine solution	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has tried BOTH of the following within 90 days: • Cetirizine • Loratadine	

Product Name:All OTC Products per label name included for fexofenadine 30 mg/5 mL suspension	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Patient is less than 12 years of age OR 1.2 Patient is unable to swallow tablet formulation AND 2 - Patient is less than or equal to 18 years of age AND	

3 - Patient has tried BOTH of the following within 90 days:

- Cetirizine solution (Rx or OTC)
- Loratadine solution (OTC)

2 . Revision History

Date	Notes
3/12/2026	Criteria updated

Antimicrobials for Treatment of Vaginal Infections



Prior Authorization Guideline

Guideline ID	GL-132649
Guideline Name	Antimicrobials for Treatment of Vaginal Infections
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	10/1/2023

1 . Criteria

Product Name: Brexafemme	
Approval Length	30 days for acute infection. 6 months for recurrent infection
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following: 1.1 Diagnosis of acute vulvovaginal candidiasis and the request does not exceed 4 tablets per treatment course	

OR

1.2 Diagnosis of recurrent vulvovaginal candidiasis (defined as 3 or more episodes of vulvovaginal candidiasis within a year) and the request does not exceed 24 tablets per treatment course

AND

2 - ONE of the following:

2.1 Patient is 18 years of age or older

OR

2.2 Patient is less than 18 years of age AND provider attests member is postmenarchal

AND

3 - For those of childbearing potential, documentation of a negative pregnancy test within the past 30 days

AND

4 - ONE of the following:

4.1 Patient has tried and failed oral fluconazole within the past year

OR

4.2 Provider has submitted medical rationale supporting the use of Brexafemme over oral fluconazole

Product Name: Vivjoa

Approval Length

12 Week(s)

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of recurrent vulvovaginal candidiasis (defined as 3 or more episodes of vulvovaginal candidiasis within a year) AND 2 - Patient is 18 years of age or older AND 3 - Provider attests patient is not considered to be of reproductive potential AND 4 - ONE of the following: 4.1 Patient has tried and failed oral fluconazole within the past year OR 4.2 Provider has submitted medical rationale supporting the use of Vivjoa over oral fluconazole AND 5 - Request does not exceed 18 tablets per treatment course	

2 . Revision History

Date	Notes

9/6/2023	Clarified pregnancy requirement for Brexafemme only include those of childbearing potential

Antimigraine Agents



Prior Authorization Guideline

Guideline ID	GL-560236
Guideline Name	Antimigraine Agents
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:generic sumatriptan/naproxen	
Approval Length	1 year(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records or claims history confirming trial and failure of BOTH of the following*: • One preferred rizatriptan product • One preferred sumatriptan product	

AND	
2 - Prescriber has provided medical justification for use of sumatriptan/naproxen (please document)	
Notes	*IN PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name: Symbravo	
Approval Length	1 year(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records or claims history confirming trial and failure of sumatriptan/naproxen AND 2 - Prescriber has provided medical justification for use of Symbravo (please document)	

Product Name: Aimovig	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of migraine with or without aura requiring prophylaxis AND	

2 - Patient is 18 years of age or older

AND

3 - One of the following:

3.1 Previous trial and failure of an agent listed within ONE of the following categories:

- angiotensin receptor blockers (candesartan)
- antidepressants (venlafaxine)
- antiseizure agents (topiramate)
- beta-blockers (atenolol, metoprolol, propranolol, or timolol)
- tricyclic antidepressants (amitriptyline)
- valproic acid and derivatives (divalproex or valproic acid)

OR

3.2 Documented intolerance or contraindication to ALL of the following:

- candesartan
- venlafaxine
- amitriptyline
- divalproex
- valproate
- topiramate
- atenolol
- metoprolol
- propranolol
- timolol

AND

4 - Dose requested does not exceed 140mg (milligrams) per month

Product Name:Aimovig	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - History of Aimovig for at least 90 days within the past 120 days, confirmed by claims history or submission of medical records

AND

2 - Dose requested does not exceed 140mg (milligrams) per month

Product Name:Ajovy

Approval Length	1 year(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of migraine with or without aura requiring prophylaxis

AND

1.2 Patient is 18 years of age or older

AND

1.3 One of the following:

1.3.1 Previous trial and failure of an agent listed within ONE of the following categories:

- angiotensin receptor blockers (candesartan)
- antidepressants (venlafaxine)
- antiseizure agents (topiramate)
- beta-blockers (atenolol, metoprolol, propranolol, or timolol)

- tricyclic antidepressants (amitriptyline)
- valproic acid and derivatives (divalproex or valproic acid)

OR

1.3.2 Documented intolerance or contraindication to ALL of the following:

- candesartan
- venlafaxine
- amitriptyline
- divalproex
- valproate
- topiramate
- atenolol
- metoprolol
- propranolol
- timolol

AND

1.4 Dose requested does not exceed 225mg (milligrams) per month or 675mg per 3 months

OR

2 - ALL of the following:

2.1 Diagnosis of episodic migraine requiring prophylaxis

AND

2.2 Patient is 6 years of age or older and less than 18 years of age

AND

2.3 Patient weighs 45 kg (kilograms) or more

AND

2.4 ONE of the following (if member is 12 years of age or older and less than 18 years of age):

- At least 90 days of therapy with topiramate (any formulation)
- Medical justification for use of Ajovy (fremanezumab-vfrm) over topiramate (please document justification)

AND

2.5 Dose requested does not exceed 225mg per month

Product Name:Ajovy	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of Ajovy for at least 90 days within the past 120 days, confirmed by claims history or submission of medical records AND 2 - ONE of the following: • Dose requested does not exceed 225mg (milligrams) per month or 675mg per 3 months for diagnosis of migraine with or without aura requiring prophylaxis • Dose requested does not exceed 225mg per month for diagnosis of episodic migraine requiring prophylaxis	

Product Name:Elyxyb	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of migraine with or without aura requiring acute treatment

AND

2 - Patient is 18 years of age or older

AND

3 - ONE of the following:

- Previous trial and failure of one triptan agent
- Medical justification for use over triptan agents (please document justification)

AND

4 - Quantity requested does not exceed 6 bottles (4.8 milliliters/bottle) per 30 days

Product Name:Elyxyb	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of Elyxyb within the past 90 days, confirmed by claims history or submission of medical records AND 2 - Quantity requested does not exceed 6 bottles (4.8 milliliters/bottle) per 30 days	

Product Name:Emgality	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ALL of the following: 1.1 Diagnosis of migraine with or without aura requiring prophylaxis AND 1.2 Patient is 18 years of age or older AND 1.3 One of the following: 1.3.1 Previous trial and failure of an agent listed within ONE of the following categories: • angiotensin receptor blockers (candesartan) • antidepressants (venlafaxine) • antiseizure agents (topiramate) • beta-blockers (atenolol, metoprolol, propranolol, or timolol) • tricyclic antidepressants (amitriptyline) • valproic acid and derivatives (divalproex or valproic acid) OR 1.3.2 Documented intolerance or contraindication to ALL of the following: • candesartan • venlafaxine • amitriptyline • divalproex • valproate	

- topiramate
- atenolol
- metoprolol
- propranolol
- timolol

AND

1.4 The requested dose does not exceed 240mg (milligrams) loading dose, then 120mg per month

OR

2 - ALL of the following

2.1 Diagnosis of episodic cluster headache

AND

2.2 Patient is 18 years of age or older

AND

2.3 The requested dose does not exceed 300mg per month for duration of headache

Product Name:Emgality	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of Emgality for at least 90 days within the past 120 days, confirmed by claims history or submission of medical record	

AND

2 - ONE of the following:

- Dose requested does not exceed 120mg (milligrams) per month for diagnosis of migraine with or without aura
- Dose requested does not exceed 300mg per month for diagnosis of episodic cluster headache

Product Name:Nurtec ODT*	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ALL of the following: 1.1 Diagnosis of migraine with or without aura requiring acute treatment AND 1.2 Patient is 18 years of age or older AND 1.3 ONE of the following: • Previous trial and failure of two triptan agents • Medical justification for use over triptan agents (please document justification) OR	

2 - ALL of the following:

2.1 Diagnosis of episodic migraine requiring prophylaxis

AND

2.2 Patient is 18 years of age or older

AND

2.3 ONE of the following:

2.3.1 At least 60 days of therapy each with any TWO of the following preferred injectable prophylaxis agents:

- Aimovig (erenumab-aooe)
- Ajovy (fremanezumab-vfrm)
- Emgality (galcanezumab-gnlm)

OR

2.3.2 Medical justification for use over ALL of the following preferred injectable prophylaxis agents (please document justification for each):

- Aimovig (erenumab-aooe)
- Ajovy (fremanezumab-vfrm)
- Emgality (galcanezumab-gnlm)

Notes	*Nurtec ODT is hard-coded with a quantity of 8 tablets per 26 days. If criteria are met for a diagnosis of episodic migraine requiring prophylaxis, please enter a quality limit override of #16 tablets per 26 days for 1 year. IN PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:Nurtec ODT*	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - All of the following:

1.1 There is a previous PA approval for the diagnosis of migraine requiring acute treatment

AND

1.2 History of Nurtec ODT within the past 90 days, confirmed by claims history or submission of medical records

AND

1.3 ONE of the following:

- Prior history of at least one triptan agent
- Medical justification for use over triptan agents (please document justification)

OR

2 - All of the following:

2.1 There is a previous PA approval for the diagnosis of episodic migraine requiring prophylaxis

AND

2.2 History of Nurtec ODT for at least 90 days within the past 120 days, confirmed by claims history or submission of medical records

AND

2.3 ONE of the following:

- Prior history of at least one preferred* injectable prophylaxis agent

Medical justification for use over preferred* injectable prophylaxis agents (please document justification)	
Notes	*Nurtec ODT is hard-coded with a quantity of 8 tablets per 26 days. If criteria are met for a diagnosis of episodic migraine requiring prophylaxis, please enter a quality limit override of #16 tablets per 26 days for 1 year. IN PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name: Qulipta	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - All of the following:

1.1 Diagnosis of episodic migraine requiring prophylaxis

AND

1.2 Patient is 18 years of age or older

AND

1.3 ONE of the following:

1.3.1 At least 60 days of therapy each with any TWO of the following preferred injectable prophylaxis agents:

- Aimovig (erenumab-aooe)
- Ajovy (fremanezumab-vfrm)
- Emgality (galcanezumab-gnlm)

OR

1.3.2 Medical justification for use over ALL of the following preferred injectable prophylaxis agents (please document justification for each):

- Aimovig (erenumab-aooe)
- Ajovy (fremanezumab-vfrm)
- Emgality (galcanezumab-gnlm)

AND

1.4 Quantity requested does not exceed 1 tablet per day of 10 mg (milligram), 30 mg, or 60 mg strengths

OR

2 - All of the following:

2.1 Diagnosis of migraine with or without aura requiring prophylaxis

AND

2.2 Patient is 18 years of age or older

AND

2.3 ONE of the following:

2.3.1 At least 60 days of therapy each with any TWO of the following preferred injectable prophylaxis agents:

- Aimovig (erenumab-aooe)
- Ajovy (fremanezumab-vfrm)
- Emgality (galcanezumab-gnlm)

OR

2.3.2 Medical justification for use over ALL of the following preferred injectable prophylaxis agents (please document justification for each):

- Aimovig (erenumab-aooe)
- Ajovy (fremanezumab-vfrm)
- Emgality (galcanezumab-gnlm)

AND

2.4 Quantity requested does not exceed 1 tablet per day of 30 mg or 60 mg strengths

Notes	IN PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/in-diana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name: Qulipta	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of Qulipta for at least 90 days within the past 120 days, confirmed by claims history or submission of medical records AND 2 - ONE of the following: • Prior history of at least one preferred* injectable prophylaxis agent • Medical justification for use over preferred* injectable prophylaxis agents (please document justification) AND 3 - ONE of the following: • Quantity requested does not exceed 1 tablet per day of 10 mg (milligram), 30 mg, or 60 mg strengths for diagnosis of episodic migraine requiring prophylaxis	

Quantity requested does not exceed 1 tablet per day of 30 mg, or 60 mg strengths for diagnosis of migraine with or without aura requiring prophylaxis	
Notes	*IN PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:Reyvow	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of migraine with or without aura requiring acute treatment AND 2 - Patient is 18 years of age or older AND 3 - ONE of the following: - Previous trial and failure of ALL preferred* acute migraine treatments - Medical justification for use over ALL preferred* acute migraine treatments (please document justification) AND 4 - One of the following: 4.1 Dose requested does not exceed 4 tablets per 30 days (50mg tablet or 100mg tablet) OR	

4.2 BOTH of the following:

- Quantity requested does not exceed eight 100mg (milligram) tablets per 30 days (200mg per dose)
- Patient has previously tried 100mg dose and has provided documented tolerability of 100mg dose (heart rate, concomitant therapies that can decrease heart rate, etc.)

Notes	*IN PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:Reyvow	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - History of Reyvow within the past 90 days, confirmed by claims history or submission of medical records

AND

2 - ONE of the following:

- Prior history of ALL preferred* acute migraine treatments
- Medical justification for use over ALL preferred* acute migraine treatments (please document justification)

AND

3 - One of the following:

3.1 Dose requested does not exceed 4 tablets per 30 days (50mg tablet or 100mg tablet)

OR

3.2 BOTH of the following:

- Quantity requested does not exceed eight 100mg (milligram) tablets per 30 days (200mg per dose)
- Member has previously tried 100mg dose and has provided documented tolerability of 100mg dose (heart rate, concomitant therapies that can decrease heart rate, etc.)

Notes	*IN PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:Ubrelvy	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of migraine with or without aura requiring acute treatment AND 2 - Patient is 18 years of age or older AND 3 - ONE of the following: • Previous trial and failure of two triptan agents • Medical justification for use over triptan agents (please document justification) AND 4 - BOTH of the following: • Quantity requested does not exceed 10 tablets per 20 days	

- Dose requested does not exceed 100mg (milligram) per dose (50mg for patients with hepatic or renal impairment and those patients on high CYP3A4 inhibitors)

Product Name:Ubrelvy	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of Ubrelvy within the past 90 days, confirmed by claims history or submission of medical records AND 2 - ONE of the following: • Prior history of at least one triptan agent • Medical justification for use over triptan agents (please document justification) AND 3 - BOTH of the following: • Quantity requested does not exceed 10 tablets per 20 days • Dose requested does not exceed 100mg (milligram) per dose (50mg for patients with hepatic or renal impairment and those patients on high CYP3A4 inhibitors)	
Notes	*IN PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:Vyepiti	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of migraine with or without aura requiring prophylaxis AND 2 - Patient is 18 years of age or older AND 3 - ONE of the following: 3.1 At least 60 days of therapy each with ALL of the following: • Aimovig (erenumab-aooe) • Ajovy (fremanezumab-vfrm) • Emgality (galcanezumab-gnlm) OR 3.2 Medical justification for use over ALL of the following (please document justification for each): • Aimovig (erenumab-aooe) • Ajovy (fremanezumab-vfrm) • Emgality (galcanezumab-gnlm) AND 4 - Dose requested does not exceed 300mg (milligrams) per 3 months	

Product Name:Vyepiti	
Approval Length	1 year(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested medication for at least 90 days within the past 120 days, confirmed by claims history or submission of medical records AND 2 - ONE of the following: • Prior history of at least ONE preferred* injectable prophylaxis agent • Medical justification for use over ALL preferred* injectable prophylaxis agents (please document justification) AND 3 - Dose requested does not exceed 300mg (milligrams) per 3 months	
Notes	*IN PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:Zavzpret	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of migraine with or without aura requiring acute treatment AND 2 - Patient is 18 years of age or older	

AND

3 - ONE of the following:

- Previous trial and failure of ALL preferred* acute migraine treatments
- Medical justification for use over ALL preferred* acute migraine treatments (please document justification)

AND

4 - Dose requested does not exceed 6 nasal spray devices per 22 days

Notes	*IN PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:Zavzpret

Approval Length 1 year(s)

Therapy Stage Reauthorization

Guideline Type Prior Authorization

Approval Criteria

1 - History of Zavzpret within the past 90 days, confirmed by claims history or submission of medical records

AND

2 - ONE of the following:

- Prior history of ALL preferred* acute migraine treatments
- Medical justification for use over ALL preferred* acute migraine treatments (please document justification)

AND

3 - Dose requested does not exceed 6 nasal spray devices per 22 days	
Notes	*IN PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

2 . Revision History

Date	Notes
3/31/2026	Added sumatriptan/naproxen and Symbravo. Updated chart documentation language

Antipsychotics



Prior Authorization Guideline

Guideline ID	GL-545242
Guideline Name	Antipsychotics
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	3/14/2026

1 . Criteria

Product Name: Prochlorperazine tabs and inj*	
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of nausea and vomiting** OR	

2 - ONE of the following: - The patient has had metabolic monitoring labs (e.g. HbA1c test, Lipids test, Glucose test) obtained within the past 12 months (with a 6-months grace period) (Please document date metabolic monitoring was performed) - The patient is new to antipsychotic therapy and will be obtaining baseline metabolic labs within 4 months of initiating therapy**	
Notes	*For all psychiatry-based diagnoses utilize applicable criteria (e.g., Duplicate Therapy, Age Limit Exception) **Approval length – 4 months for diagnosis of nausea and vomiting OR patients new to antipsychotic therapy; otherwise 6 months for initial approval and not new to antipsychotic therapy

Product Name: Prochlorperazine tabs and inj*	
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of nausea and vomiting** OR 2 - BOTH of the following**: - History of the requested agent(s) for 90 of the past 120 days, as confirmed by claims history, chart documentation, or provider attestation including dates of therapy administration - The patient has had metabolic monitoring labs (e.g. HbA1c test, Lipids test, Glucose test) obtained within the past 12 months (with a 6-months grace period) (Please document date metabolic monitoring was performed)	
Notes	*For all psychiatry-based diagnoses utilize applicable criteria (e.g., Duplicate Therapy, Age Limit Exception) **Approval length – 4 months for diagnosis of nausea and vomiting; otherwise, 12 months

Product Name:Lybalvi *	
Diagnosis	DDI: Lybalvi + Opioid
Approval Length	12 month(s)
Guideline Type	Drug Utilization Review
Approval Criteria 1 - ALL of the following: • Patient is not using opiate agonists (including buprenorphine) concurrently with Lybalvi • Patient has not used short-acting opiates within the past 7 days prior to initiating Lybalvi therapy • Patient has not used long-acting opiates within the past 14 days prior to initiating Lybalvi therapy	
Notes	*Additional criteria may apply (e.g., Duplicate Therapy, Age Limit Exception)

Product Name:Brand Abilify, Generic aripiprazole (tabs, oral solution, ODT), Abilify Mycite, Generic asenapine, Brand Saphris, Vraylar, Generic clozapine (tab, ODT), Brand Clozaril, Brand Latuda, Generic lurasidone, Brand Zyprexa, Generic olanzapine, Brand Zyprexa Zydis, Generic olanzapine ODT, Generic paliperidone ER, Brand Invega, Brand Seroquel, Generic quetiapine, Brand Seroquel XR, Generic quetiapine ER, Brand Risperdal, Generic risperidone (tabs, oral solution, ODT), Brand Geodon, Generic ziprasidone, Caplyta, chlorpromazine (tabs, oral conc), fluphenazine (tabs, oral conc, elixir), haloperidol (tabs, oral conc), loxapine, molindone, perphenazine, perphenazine/amitriptyline, pimozide, thioridazine, thiothixene, trifluoperazine, Fanapt, Generic olanzapine/fluoxetine, Brand Symbyax, Rexulti, Lybalvi, prochlorperazine tabs, Opipza, Abilify Asimtufii, Abilify Maintena, Aristada, Aristada Initio, Brand Zyprexa inj, generic olanzapine inj, Zyprexa Relprevv, Erzofri, Invega Sustenna, prochlorperazine inj, Brand Risperdal Consta, generic risperidone ER inj, Rykindo, Perseris, Uzedy, Secuado, chlorpromazine inj, fluphenazine inj, fluphenazine decanoate, Brand Haldol decanoate, Generic haloperidol decanoate, haloperidol lactate inj, Generic ziprasidone mesylate injection, Brand Geodon injection, Invega Trinza, Invega Hafyera	
Diagnosis	Duplicate Therapy with Another Antipsychotic
Therapy Stage	Initial Authorization
Guideline Type	Drug Utilization Review
Approval Criteria	

1 - One of the following:

1.1 The patient will be utilizing the requested antipsychotic as monotherapy

OR

1.2 The patient will be utilizing the requested antipsychotic agent as part of a duplicate antipsychotic regimen and ONE of the following:

1.2.1 Evidence of duplication of therapy with the requested antipsychotic agents for 90 of the past 120 days, confirmed by claims history or chart documentation

OR

1.2.2 All of the following:

- Diagnosis of psychosis
- Both antipsychotics involved in the therapeutic duplication are prescribed by or in consultation with a psychiatrist or psychiatric specialist
- History of at least 4 weeks of single-agent therapy at an adequate dose (See Table 1) for 2 different antipsychotics
- History of at least 4 weeks of therapy with clozapine (unless contraindication, allergy, or intolerance to clozapine therapy)

OR

1.3 All of the following:

1.3.1 Diagnosis of depressed mood disorder

AND

1.3.2 BOTH of the following:

- At least one of the antipsychotics in the duplicate therapy regimen has an indication for depressed mood disorder
- The patient will be utilizing an antidepressant concurrently with the requested antipsychotic regimen

AND

1.3.3 Both antipsychotics involved in the therapeutic duplication are prescribed by or in consultation with a psychiatrist or psychiatric specialist

AND

1.3.4 History of at least 4 weeks of single-agent therapy at an adequate dose (See Table 1) for 2 different antipsychotics

OR

1.4 ALL of the following:

1.4.1 Diagnosis of ONE of the following:

- Bipolar affective disorder
- Unspecified episodic mood disorder

AND

1.4.2 Both antipsychotics involved in the therapeutic duplication are prescribed by or in consultation with a psychiatrist or psychiatric specialist

AND

1.4.3 History of at least 4 weeks of single-agent therapy at an adequate dose (See Table 1) for 2 different antipsychotics

OR

1.5 The agents involved in the therapeutic duplication are being cross tapered *

AND

2 - Patient is not utilizing more than 2 antipsychotics concurrently

Notes

*Approval Length – 90 days for cross taper; otherwise 6 months

Product Name: Brand Abilify, Generic aripiprazole (tabs, oral solution, ODT), Abilify Mycite, Generic asenapine, Brand Saphris, Vraylar, Generic clozapine (tab, ODT), Brand Clozaril, Brand Latuda, Generic lurasidone, Brand Zyprexa, Generic olanzapine, Brand Zyprexa Zydis, Generic olanzapine ODT, Generic paliperidone ER, Brand Invega, Brand Seroquel, Generic quetiapine, Brand Seroquel XR, Generic quetiapine ER, Brand Risperdal, Generic risperidone (tabs, oral solution, ODT), Brand Geodon, Generic ziprasidone, Caplyta, chlorpromazine (tabs, oral conc), fluphenazine (tabs, oral conc, elixir), haloperidol (tabs, oral conc), loxapine, molindone, perphenazine, perphenazine/amitriptyline, pimozide, thioridazine, thiothixene, trifluoperazine, Fanapt, Generic olanzapine/fluoxetine, Brand Symbyax, Rexulti, Lybalvi, prochlorperazine tabs, Opipza, Abilify Asimtufii, Abilify Maintena, Aristada, Aristada Initio, Brand Zyprexa inj, generic olanzapine inj, Zyprexa Relprevv, Erzofri, Invega Sustenna, prochlorperazine inj, Brand Risperdal Consta, generic risperidone ER inj, Rykindo, Perseris, Uzedy, Secuado, chlorpromazine inj, fluphenazine inj, fluphenazine decanoate, Brand Haldol decanoate, Generic haloperidol decanoate, haloperidol lactate inj, Generic ziprasidone mesylate injection, Brand Geodon injection, Invega Trinza, Invega Hafyera

Diagnosis

Duplicate Therapy with Another Antipsychotic

Approval Length

12 month(s)

Therapy Stage

Reauthorization

Guideline Type

Drug Utilization Review

Approval Criteria

1 - One of the following:

1.1 The patient will be utilizing the requested antipsychotic as monotherapy

OR

1.2 The patient will be utilizing the requested antipsychotic agent as part of a duplicate antipsychotic regimen and there is evidence of duplication of therapy with the requested antipsychotic agents for 90 of the past 120 days, confirmed by claims history or chart documentation

AND

2 - Patient is not utilizing more than 2 antipsychotics concurrently

Product Name: Brand Abilify, Generic aripiprazole (tabs, oral solution, ODT), Abilify Mycite, Generic asenapine, Brand Saphris, Vraylar, Generic clozapine (tab, ODT), Brand Clozaril, Cobenfy, Brand Latuda, Generic lurasidone, Brand Zyprexa, Generic olanzapine, Brand Zyprexa Zydis, Generic olanzapine ODT, Generic paliperidone ER, Brand Invega, Brand Seroquel, Generic quetiapine, Brand Seroquel XR, Generic quetiapine ER, Brand Risperdal, Generic risperidone (tabs, oral solution, ODT), Brand Geodon, Generic ziprasidone, Caplyta, chlorpromazine (tabs, oral conc), fluphenazine (tabs, oral conc, elixir), haloperidol (tabs, oral conc), loxapine, molindone, perphenazine, perphenazine/amitriptyline, pimozide, thioridazine, thiothixene, trifluoperazine, Fanapt, Generic olanzapine/fluoxetine, Brand Symbyax, Rexulti, Lybalvi, prochlorperazine tabs, Opipza, Versacloz, Abilify Asimtufii, Abilify Maintena, Aristada, Aristada Initio, Brand Zyprexa inj, generic olanzapine inj, Zyprexa Relprevv, Erzofri, Invega Sustenna, prochlorperazine inj, Brand Risperdal Consta, generic risperidone ER inj, Rykindo, Perseris, Uzedly, Secuado, chlorpromazine inj, fluphenazine inj, fluphenazine decanoate, Brand Haldol decanoate, Generic haloperidol decanoate, haloperidol lactate inj, Generic ziprasidone mesylate injection, Brand Geodon injection, Invega Trinza, Invega Hafyera

Diagnosis	Age Limit Exception*
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - All of the following:

1.1 Documentation that other age and diagnosis-appropriate agents available have been tried for an adequate period of time and been deemed ineffective in the treatment of the patient's disease or medical condition

AND

1.2 If the patient is outside of FDA-established age limits, clinical support or rationale for safety and efficacy has been provided (i.e. clinical literature in conjunction with patient attributes and/or characteristics of the drug) for the requested drug and dose

OR

2 - All of the following:

2.1 History of the requested agent for at least 90 days within the past 120 days, confirmed by claims history or chart documentation

AND

2.2 Patient previously received an authorization for age limit exception for the requested agent

OR

3 - All of the following:

3.1 History of the requested agent for at least 90 days within the past 120 days, confirmed by claims history or chart documentation

AND

3.2 ONE of the following:

- The requested agent has newly implemented age limits which did not previously apply to the patient
- The request is for continuation of therapy from another plan or following inpatient therapy

AND

3.3 One of the following:

3.3.1 Documentation that other age and diagnosis-appropriate agents available have been tried for an adequate period of time and been deemed ineffective in the treatment of the patient's disease or medical condition

OR

3.3.2 The prescriber has provided valid medical justification for use of the requested agent outside of FDA or plan-established age limits over the use of other diagnosis-appropriate agents within FDA or plan-established age limits (please document justification)

AND

3.4 If the patient is outside of FDA-established age limits, clinical support or rationale for safety and efficacy has been provided (i.e., clinical literature in conjunction with patient attributes and/or characteristics of the drug) for the requested drug and dose

Notes	*This criteria applies to the Non- Drug Specific PA policy

Product Name: Brand Symbyax, Generic olanzapine/fluoxetine	

Diagnosis	Duplicate Therapy with Another SSRI/SNRI*

Therapy Stage	Initial Authorization

Guideline Type	Drug Utilization Review

Approval Criteria

1 - Agents involved in therapeutic duplication are being cross tapered**

OR

2 - The SSRI/SNRI agent in the patient's history is being discontinued or there are plans to discontinue**

OR

3 - Prescriber has provided medical rationale supporting duplication of therapy** (please document rationale)

Notes	*This criteria applies to the SSRI and SNRI Duplicate Therapy Policy **Approval Duration – Cross-taper or discontinuation: 90 days; Initial approval: 6 months

Product Name: Brand Symbyax, Generic olanzapine/fluoxetine	

Diagnosis	Duplicate Therapy with Another SSRI/SNRI*

Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Drug Utilization Review
Approval Criteria 1 - Evidence of duplication of therapy with the requested SSRI/SNRI agents for 90 of the past 120 days	
Notes	*This criteria applies to the SSRI and SNRI Duplicate Therapy Policy

Product Name:Cobenfy	
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of schizophrenia AND 2 - One of the following: 2.1 Cobenfy (xanomeline and trospium chloride) will be used as single-agent antipsychotic therapy OR 2.2 Patient will be cross-tapering from a different antipsychotic agent to Cobenfy (xanomeline and trospium chloride) as single-agent antipsychotic therapy* AND 3 - One of the following**:	

- Patient has trial and failure history with one preferred antipsychotic agent within the past year (supported by claims history and chart documentation)
- Prescriber has provided medical justification for use of the requested medication over all preferred antipsychotic agents (please document justification)

AND

4 - Prescriber attests that member does NOT have any one of the following:

- Gastric retention
- Hepatic impairment (Child-Pugh Class B or C)
- Untreated narrow-angle glaucoma
- Urinary retention

Notes	*Approval Length - 90 days for cross-taper from a different antipsychotic agent; otherwise, 6 months **PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:Cobenfy	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of requested agent for 90 days in the past 120 days, as confirmed by claims history, chart documentation, or provider attestation including dates of therapy administration AND 2 - Prescriber attests patient has been and will continue to use Cobenfy (xanomeline and trospium chloride) as single-agent antipsychotic therapy AND	

3 - Prescriber attests that member does NOT have any one of the following:

- Gastric retention
- Hepatic impairment (Child-Pugh Class B or C)
- Untreated narrow-angle glaucoma
- Urinary retention

Product Name: Brand Risperdal oral soln, generic risperidone oral soln, risperidone ODT, aripiprazole ODT, aripiprazole oral soln

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is less than 12 years of age

OR

2 - Patient is 12 years of age or older AND unable to swallow tablet formulation, as supported by chart documentation

OR

3 - History of the requested medication for 90 of the past 120 days (as supported by claims history or chart documentation)

Product Name: clozapine ODT

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - BOTH of the following:

- Patient has tried and failed clozapine tablet (as supported by claims history or chart documentation)
- Prescriber has provided medical justification for the use of the requested medication over clozapine tablet (please document justification)

OR

2 - History of requested medication for 90 days in the past 120 days (as supported by claims history or chart documentation)

Product Name:lithium solution

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is less than 12 years of age

OR

2 - Patient is 12 years of age or older AND unable to swallow capsule/tablet formulation, as supported by chart documentation

Product Name:pimozide

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has tried and failed TWO of the following for 4 weeks each, as supported by claims history or chart documentation:

- aripiprazole
- haloperidol
- risperidone

OR

2 - History of requested medication for 90 days in the past 120 days (as supported by claims history or chart documentation)

Product Name:Fanapt	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has tried and failed one preferred antipsychotic agent* (as supported by claims history or chart documentation) OR 2 - Prescriber has provided medical justification for the use of the requested medication over all preferred agents* (please document justification) OR 3 - History of requested medication for 90 days in the past 120 days (as supported by claims history or chart documentation)	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

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

Approval Criteria

1 - BOTH of the following:

- Patient has tried and failed aripiprazole tablet (as supported by claims history or chart documentation)
- Prescriber has provided medical justification for the use of the requested medication over aripiprazole (please document justification)

OR

2 - History of requested medication for 90 days in the past 120 days (as supported by claims history or chart documentation)

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:Versacloz	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is unable to swallow tablet formulation, as supported by chart documentation	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

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

1 - BOTH of the following:

- Patient has a trial and failure of asenapine SL (sublingual) (as supported by claims history or chart documentation)
- Prescriber has provided medical justification for the use of requested medication over asenapine SL (please document justification)

OR

2 - History of the requested medication for 90 of the past 120 days (as supported by claims history or chart documentation)

Product Name: Brand Abilify, Generic aripiprazole (tabs), Abilify Mycite, Generic asenapine, Brand Saphris, Vraylar, Generic clozapine (tab), Brand Clozaril, Brand Latuda, Generic lurasidone, Brand Zyprexa, Generic olanzapine, Brand Zyprexa Zydis, Generic olanzapine ODT, Generic paliperidone ER, Brand Invega, Brand Seroquel, Generic quetiapine, Brand Seroquel XR, Generic quetiapine ER, Brand Risperdal (tabs), Generic risperidone (tabs), Brand Geodon, Generic ziprasidone, Caplyta, chlorpromazine (tabs, oral conc), fluphenazine (tabs, oral conc, elixir), haloperidol (tabs, oral conc), loxapine, molindone, perphenazine, perphenazine/amitriptyline, thioridazine, thiothixene, trifluoperazine, Generic olanzapine/fluoxetine, Brand Symbyax, Rexulti, Lybalvi, Abilify Asimtufii, Abilify Maintena, Aristada, Aristada Initio, Brand Zyprexa inj, generic olanzapine inj, Zyprexa Relprevv, Erzofri, Invega Sustenna, Brand Risperdal Consta, generic risperidone ER inj, Rykindo, Perseris, Uzedy, chlorpromazine inj, fluphenazine inj, fluphenazine decanoate, Brand Haldol decanoate, Generic haloperidol decanoate, haloperidol lactate inj, Generic ziprasidone mesylate injection, Brand Geodon injection, Invega Trinza, Invega Hafyera

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 The patient has had metabolic monitoring labs (e.g. HbA1c test, Lipids test, Glucose test) obtained within the past 12 months (with a 6-months grace period) (Please document date metabolic monitoring was performed)

OR

1.2 The patient is new to antipsychotic therapy and will be obtaining baseline metabolic labs within 4 months of initiating therapy*

AND

2 - If the request is non-preferred**, 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

OR

2.3 ALL of the following:

2.3.1 One of the following:

2.3.1.1 Both of the following:

2.3.1.1.1 One of the following:

- History of failure to at least THREE preferred alternatives 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.
- History of contraindication or intolerance to THREE preferred alternatives (please specify contraindication or intolerance).* 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

AND

2.3.1.1.2 One of the following:

2.3.1.1.2.1 If the request is for a multi-source brand medication, OR a branded medication with an authorized generic, one of the following:

- The brand is being requested because of an adverse reaction, allergy or sensitivity to a generic/authorized generic equivalent (specify the adverse reaction, allergy, or sensitivity)
- The brand is being requested due to an incomplete response with a generic/authorized generic equivalent, as documented by submission of medical records
- The brand is being requested because transition to a generic/authorized generic equivalent could result in destabilization of the patient
- Special clinical circumstances exist that preclude the use of a generic/authorized generic equivalent of the brand medication for the patient (document special clinical circumstances)

OR

2.3.1.1.2.2 If the request is for a generic when there is a brand available and brand is either preferred over the generic OR both are non-preferred and the brand is required, one of the following:

- The generic is being requested because of an adverse reaction, allergy or sensitivity to the brand (specify the adverse reaction, allergy, or sensitivity)
- The generic is being requested due to an incomplete response with the brand, as documented by submission of medical records
- The generic is being requested because transition to the brand could result in destabilization of the patient
- Special clinical circumstances exist that preclude the use of the brand equivalent of the generic medication for the patient (document special clinical circumstances)

OR

2.3.1.2 There are no preferred formulary alternatives for the requested drug

AND

2.3.2 One of the following:

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

OR

2.3.2.2 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 (USP-NF)

AND

2.3.3 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	*Approval Length – 4 months for patients new to antipsychotic therapy , 6 months for initial approval and not new to antipsychotic therapy **IN PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html. 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.

Product Name: Brand Abilify, Generic aripiprazole (tabs), Abilify Mycite, Generic asenapine, Brand Saphris, Vraylar, Generic clozapine (tab), Brand Clozaril, Brand Latuda, Generic lurasidone, Brand Zyprexa, Generic olanzapine, Brand Zyprexa Zydis, Generic olanzapine ODT, Generic paliperidone ER, Brand Invega, Brand Seroquel, Generic quetiapine, Brand Seroquel XR, Generic quetiapine ER, Brand Risperdal (tabs), Generic risperidone (tabs), Brand Geodon, Generic ziprasidone, Caplyta, chlorpromazine (tabs, oral conc), fluphenazine (tabs, oral conc, elixir), haloperidol (tabs, oral conc), loxapine, molindone, perphenazine, perphenazine/amitriptyline, thioridazine, thiothixene, trifluoperazine, Generic olanzapine/fluoxetine, Brand Symbyax, Rexulti, Lybalvi, Abilify Asimtufii, Abilify Maintena, Aristada, Aristada Initio, Brand Zyprexa inj, generic olanzapine inj, Zyprexa Relprevv, Erzofri, Invega Sustenna, Brand Risperdal Consta, generic risperidone ER inj, Rykindo, Perseris, Uzedy, chlorpromazine inj, fluphenazine inj, fluphenazine decanoate, Brand Haldol decanoate, Generic haloperidol decanoate, haloperidol lactate inj, Generic ziprasidone mesylate injection, Brand Geodon injection, Invega Trinza, Invega Hafyera

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

Approval Criteria

1 - History of the requested agent(s) for 90 of the past 120 days, as confirmed by claims history, chart documentation, or provider attestation including dates of therapy administration

AND

2 - The patient has had metabolic monitoring labs (e.g. HbA1c test, Lipids test, Glucose test) obtained within the past 12 months (with a 6-months grace period) (Please document date metabolic monitoring was performed)

2 . Background

Benefit/Coverage/Program Information

Table 1 - Adequate Dose

Description	Adequate Dose
ARIPRAZOLE	≥ 5 mg/day
ASENAPINE	≥ 10 mg/day
BREXPIRAZOLE	≥ 2 mg/day
CARIPRAZINE	≥ 1.5 mg/day
CHLORPROMAZINE HCL	≥ 30 mg/day
CLOZAPINE	≥ 300 mg/day
FLUPHENAZINE HCL	≥ 1 mg/day
HALOPERIDOL	≥ 1 mg/day
HALOPERIDOL LACTATE	≥ 1 mg/day
ILOPERIDONE	≥ 12 mg/day
LOXAPINE SUCCINATE	≥ 20 mg/day
LUMATEPERONE	≥ 42 mg/day
LURASIDONE HCL	≥ 40 mg/day
MOLINDONE	≥ 15 mg/day
OLANZAPINE	≥ 10 mg/day
OLANZAPINE + FLUOXETINE	$\geq 6/25$ mg/day
OLANZAPINE + SAMIDORPHAN	$\geq 10/10$ mg/day
PALIPERIDONE	≥ 3 mg/day
PERPHENAZINE	≥ 12 mg/day
PERPHENAZINE/AMITRIPTYLINE	≥ 12 mg/day (perphenazine component)
PIMOZIDE	≥ 1 mg/day
PROCHLORPERAZINE EDISYLATE/MALEATE	≥ 15 mg/day
QUETIAPINE	≥ 300 mg/day

	RISPERIDONE	>=2 mg/day	
	THIORIDAZINE HCL	>= 150 mg/day	
	THIOTHIXENE	>= 6 mg/day	
	TRIFLUOPERAZINE HCL	>= 2 mg/day	
	ZIPRASIDONE	>= 80 mg/day	

3 . Revision History

Date	Notes
3/13/2026	Updated guideline name. Added injectable antipsychotics, updated D UR criteria and added prior authorization initial and reauth sections.

Antiseizure Agents



Prior Authorization Guideline

Guideline ID	GL-531188
Guideline Name	Antiseizure Agents
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name: Briviact tab/soln, Elepsia XR, generic carbamazepine susp, generic carbamazepine ER cap/tab, Brand Depakote DR/ER tablet, Brand Aptiom, generic eslicarbazepine, Brand Zarontin caps/soln, generic felbamate tab/soln, generic gabapentin soln, Brand Gabapentin Tinytabs, generic lacosamide soln, Brand Vimpat tab/soln, Brand Lamictal tab/chewable/ODT, generic lamotrigine kits, Subvenite, Brand Lamictal XR, Libervant, Motpoly XR, Brand Keppra, Brand Trileptal, Brand Fycompa, generic perampanel, Phenytek caps, Brand Mysoline, generic oxcarbazepine XR, generic rufinamide tab/susp, Brand Banzel tab/susp, generic tiagabine, Brand Topamax tab, Brand Topamax sprinkle, generic topiramate ER capsule (generic Trokendi), Brand Sabril tablets, generic vigabatrin, Vigadrone tablets, Xcopri, Brand Zonegran, Spritam, Levetiracetam disintegrating tablet, generic pregabalin soln	
Diagnosis	Non-Preferred*
Approval Length	1 year(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria 1 - If the request is non-preferred*, ONE of the following: 1.1 Patient has a diagnosis of seizures AND history of a preferred* antiseizure medication for at least 14 days in the past 90 days OR 1.2 For a non-seizure diagnosis ONE of the following: - History of one preferred* antiseizure medication - Prescriber has provided medical justification for the use of the requested medication over ALL of the preferred* antiseizure medications (e.g., preferred agents do not have FDA-approved or approved compendia indication for member's diagnosis, member has contraindication or intolerance to preferred agents with appropriate indications, etc.) (please document justification)	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name: Briviact tab/soln, Elepsia XR, generic carbamazepine susp, generic carbamazepine ER cap/tab, Brand Depakote DR/ER tablet, Brand Aptiom, generic eslicarbazepine, Brand Zarontin caps/soln, generic felbamate tab/soln, generic gabapentin soln, Brand Gabapentin Tinytabs, generic lacosamide soln, Brand Vimpat tab/soln, Brand Lamictal tab/chewable/ODT, generic lamotrigine kits, Subvenite, Brand Lamictal XR, Libervant, Motpoly XR, Brand Keppra, Brand Trileptal, Brand Fycompa, generic perampanel, Phenytek caps, Brand Mysoline, generic oxcarbazepine XR, generic rufinamide tab/susp, Brand Banzel tab/susp, generic tiagabine, Brand Topamax tab, Brand Topamax sprinkle, generic topiramate ER capsule (generic Trokendi), Brand Sabril tablets, generic vigabatrin, Vigadrone tablets, Xcopri, Brand Zonegran, Spritam, Levetiracetam disintegrating tablet, generic pregabalin soln

Diagnosis	Non-Preferred*
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - If the request is non-preferred*, ONE of the following:

1.1 Diagnosis of seizure disorder AND history of the requested medication for 30 of the past 60 days confirmed by claims history or chart documentation

OR

1.2 For a non-seizure diagnosis BOTH of the following:

1.2.1 History of the requested medication for 30 of the past 60 days confirmed by claims history or chart documentation

AND

1.2.2 ONE of the following:

- History of one preferred* antiseizure medication
- Prescriber has provided medical justification for the use of the requested medication over ALL of the preferred* antiseizure medications (e.g., preferred agents do not have FDA-approved or approved compendia indication for member's diagnosis, member has contraindication or intolerance to preferred agents with appropriate indications, etc.) (please document justification)

Notes

*PDL link: <https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html>

Product Name: Brand Sabril powder packs, Vigadrone powder packs, Vigpoder	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of seizure disorder	

AND

2 - Patient has tried and failed generic vigabatrin packets (powder for oral solution) for 90 of the past 120 days, as confirmed by claims history, chart documentation, or provider attestation including dates of trial

AND

3 - Prescriber has provided medical justification for use of the requested medication over generic vigabatrin packets (powder for oral solution) (please document justification)

Product Name: Vigafyde	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of seizure disorder

AND

2 - ONE of the following:

2.1 Patient has tried and failed vigabatrin packets (powder for oral solution) for 90 of the past 120 days, as confirmed by claims history, chart documentation, or provider attestation including dates of trial

OR

2.2 Prescriber has provided medical justification for use of the requested medication over vigabatrin packets (powder for oral solution) (please document justification)

Product Name:Brand Sabril powder packs, Vigadrone powder packs, Vigpoder, Vigafyde	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of seizure disorder AND 2 - Patient has history of the requested medication for 30 of the past 60 days, confirmed by claims history or chart documentation	

Product Name:Diacomit	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of seizures associated with ONE of the following: • Dravet Syndrome • SCN1A (gene) mutation	

Product Name:Epidiolex	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of seizures associated with ONE of the following:

- Lennox-Gastaut syndrome
- Dravet syndrome
- Tuberous sclerosis complex (TSC)

OR

2 - BOTH of the following:

2.1 Diagnosis of refractory epilepsy

AND

2.2 ONE of the following:

- Trial and failure of 2 other antiseizure medications
- Prescriber has provided medical justification for use of Epidiolex (please document justification)

Product Name: Brand Eprontia, generic topiramate oral soln	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Patient is less than 18 years of age	

OR

1.2 BOTH of the following:

1.2.1 Patient is 18 years of age or older

AND

1.2.2 Prescriber has provided rationale justifying use over other oral formulations (e.g., capsule, sprinkle capsules, tablets, etc.) (please document rationale)

AND

2 - Dose does not exceed 400 milligrams/day (16 milliliters/day)

Product Name:Fintepla	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following: 1.1 Diagnosis of seizures associated with of Dravet syndrome AND 1.2 ONE of the following: 1.2.1 Trial and failure of Epidiolex and Diacomit	

OR

1.2.2 Prescriber has provided medical justification for use of Fintepla (please document justification)

OR

2 - BOTH of the following:

2.1 Diagnosis of seizures associated with Lennox-Gastaut syndrome

AND

2.2 ONE of the following:

2.2.1 Trial and failure of Epidiolex

OR

2.2.2 Prescriber has provided medical justification for use of Fintepla (please document justification)

Product Name:Zonisade	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is less than 18 years of age OR	

2 - BOTH of the following:

2.1 Patient is 18 years of age or older

AND

2.2 Prescriber has provided rationale justifying use over other oral formulations (e.g., capsule) (please document rationale)

Product Name: Ztalmy	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of seizure disorder associated with cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder

AND

2 - ONE of the following:

2.1 Trial and failure of at least 2 other medications (e.g., clobazam, levetiracetam, valproic acid, vigabatrin)

OR

2.2 Prescriber has provided medical justification for use of Ztalmy (please document justification)

AND

3 - Dose does not exceed 36 milliliters/day

Product Name:Diacomit, Epidiolex, Fintepla, Ztalmy	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested medication for 30 of the past 60 days confirmed by claims history or chart documentation AND 2 - If the request is for Ztalmy, the dose does not exceed 36 milliliters/day	

Product Name:Brand Eprontia, generic topiramate oral soln, Zonisade	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested medication for 30 of the past 60 days confirmed by claims history or chart documentation AND 2 - ONE of the following: 2.1 Patient is less than 18 years of age OR	

2.2 BOTH of the following:

2.2.1 Patient is 18 years of age or older

AND

2.2.2 Prescriber has provided rationale justifying use over other oral formulations (e.g., capsule, sprinkle capsules, tablets, etc.) (please document rationale)

AND

3 - If the request is for Eprontia (topiramate) oral solution, dose does not exceed 400 milligrams/day (16 milliliters/day)

Product Name:topiramate ER sprinkle cap	
Approval Length	1 year(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is 2 years of age or older AND less than 12 years of age OR 2 - Patient is 12 years of age or older AND unable to swallow capsules	

Product Name:Gabarone	
Approval Length	1 year(s)
Guideline Type	Prior Authorization
Approval Criteria	

1 - Prescriber has provided medical justification for use of the requested medication over preferred gabapentin capsules* (please document justification)	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name: Sympazan	
Approval Length	1 year(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has trial and failure of clobazam tablet or suspension (as supported by claims history or chart documentation) AND 2 - Prescriber has provided medical justification for use of the requested medication over clobazam tablet and suspension (please document justification)	

2 . Revision History

Date	Notes
2/25/2026	Update Spritam GPI and added Levetiracetam disintegrating tablet

Antiulcer Agents



Prior Authorization Guideline

Guideline ID	GL-137617
Guideline Name	Antiulcer Agents
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name:Brand Carafate suspension	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following: 1.1 Patient is 1 year of age or older	

AND

1.2 Patient is less than 12 years of age

OR

2 - Patient is unable to swallow tablets

2 . Revision History

Date	Notes
12/11/2023	Updated guideline name and criteria.

Antiviral Monoclonal Antibodies



Prior Authorization Guideline

Guideline ID	GL-156483
Guideline Name	Antiviral Monoclonal Antibodies
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name:Synagis*	
Diagnosis	Patients less than 12 months of age at start of RSV season
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following: 1.1 Patient was born before 29 weeks, 0 days' gestation	

OR

1.2 BOTH of the following:

- Patient was born before 32 weeks, 0 days' gestation
- Patient has chronic lung disease (CLD) necessitating more than 21% oxygen for at least the first 28 days of life

OR

1.3 Patient has hemodynamically significant heart disease (e.g., acyanotic heart disease receiving medication to control congestive heart failure [CHF] and will require cardiac surgical procedures, or those with moderate to severe pulmonary hypertension)

OR

1.4 Patient has congenital airway abnormality or neuromuscular disease that impairs the ability to clear secretions

OR

1.5 Patient has cystic fibrosis with clinical evidence of CLD and/or nutritional compromise

OR

1.6 The patient is or will be considered to be profoundly immunocompromised (Submission of chart notes or medical records that explicitly state how the member is or will be considered to be profoundly immunocompromised during the RSV season is required), including members undergoing cardiac transplantation during current RSV season

OR

1.7 BOTH of the following:

- Patient was born before 32 weeks, 0 days' gestation

- Patient required at least 28 days of supplemental oxygen after birth and continued to require supplemental oxygen, chronic systemic corticosteroid therapy, diuretic, or bronchodilator therapy within 6 months of the start of the second RSV season

OR

1.8 Patient has cystic fibrosis with manifestations of severe lung disease (previous hospitalization for pulmonary exacerbation in the first year of life or abnormalities on chest imaging that persist when stable) or weight-for-length less than 10th percentile

AND

2 - Prescriber has provided medical justification for the use of Synagis (palivizumab) over Beyfortus (nirsevimab) (Please document)

AND

3 - Patient has not received Beyfortus (nirsevimab) within the same RSV season

AND

4 - The number of doses requested do not exceed a maximum quantity of 5 per season

AND

5 - Administered during RSV season

AND

6 - The patient is not hospitalized for RSV disease

Notes	*Approval duration will be up to a maximum of 5 doses or through the end of the defined RSV season, whichever comes first.

Product Name: Synagis*

Diagnosis	Patients less than 24 months of age at start of RSV season
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following: 1.1 The patient is or will be considered to be profoundly immunocompromised (Submission of chart notes or medical records that explicitly state how the member is or will be considered to be profoundly immunocompromised during the RSV season is required), including members undergoing cardiac transplantation during current RSV season OR 1.2 BOTH of the following: • Patient was born before 32 weeks, 0 days' gestation • Patient required at least 28 days of supplemental oxygen after birth and continued to require supplemental oxygen, chronic systemic corticosteroid therapy, diuretic, or bronchodilator therapy within 6 months of the start of the second RSV season OR 1.3 Patient has cystic fibrosis with manifestations of severe lung disease (previous hospitalization for pulmonary exacerbation in the first year of life or abnormalities on chest imaging that persist when stable) or weight-for-length less than 10th percentile AND 2 - Prescriber has provided medical justification for the use of Synagis (palivizumab) over Beyfortus (nirsevimab) (Please document) AND 3 - Patient has not received Beyfortus (nirsevimas) within the same RSV season	

AND	
4 - The number of doses requested do not exceed a maximum quantity of 5 per season	
AND	
5 - Administered during RSV season	
AND	
6 - The patient is not hospitalized for RSV disease	
Notes	*Approval duration will be up to a maximum of 5 doses or through the end of the defined RSV season, whichever comes first.

2 . Revision History

Date	Notes
9/30/2024	Removed URL referencing RSV seasons.

Antivirals - Anti-herpetic



Prior Authorization Guideline

Guideline ID	GL-154699
Guideline Name	Antivirals - Anti-herpetic
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name:generic valacyclovir	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has a diagnosis of HIV OR	

2 - Patient has tried and failed acyclovir

OR

3 - Medical justification for use over acyclovir

2 . Revision History

Date	Notes
9/10/2024	Added "for use over acyclovir" to medical justification step

Apokyn



Prior Authorization Guideline

Guideline ID	GL-511321
Guideline Name	Apokyn
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Pennsylvania Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name: Brand Apokyn, generic apomorphine hcl

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Parkinson's disease AND 2 - Apokyn 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 - ONE of the following:	

6.1 Failure to TWO anti-Parkinson's disease therapies from the following adjunctive pharmacotherapy classes (trial must be from two different classes) confirmed by claims history or submitted medical records:

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

OR

6.2 History of contraindication or intolerance to TWO anti-Parkinson's disease therapies from the following adjunctive pharmacotherapy classes (contraindication/intolerance must be from two different classes; please specify intolerance or contraindication):

- 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:Brand Apokyn, generic apomorphine hcl	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to the requested therapy AND 2 - Patient will continue to receive treatment with a carbidopa/levodopa-containing medication	

2 . Revision History

Date	Notes

2/4/2026	Combined formularies. No changes to clinical criteria.

Arikayce



Prior Authorization Guideline

Guideline ID	GL-434341
Guideline Name	Arikayce
Formulary	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 EPP Medicaid - Community & State New York Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Nevada

Guideline Note:

Effective Date:	1/1/2026

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) documenting respiratory cultures positive for MAC within the previous 6 months AND 3 - Submission of medical records (e.g., chart notes, laboratory values) or prescription 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: • 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

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 a 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 prescription claims history documenting that the patient continues to receive a multidrug background regimen containing at least TWO of the following agents:

- 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

2 . Revision History

Date	Notes
11/4/2025	Added Nevada Formulary. LKC

Arikayce



Prior Authorization Guideline

Guideline ID	GL-434341
Guideline Name	Arikayce
Formulary	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 EPP Medicaid - Community & State New York Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Nevada

Guideline Note:

Effective Date:	1/1/2026

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) documenting respiratory cultures positive for MAC within the previous 6 months AND 3 - Submission of medical records (e.g., chart notes, laboratory values) or prescription 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: • 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

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 a 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 prescription claims history documenting that the patient continues to receive a multidrug background regimen containing at least TWO of the following agents:

- 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

2 . Revision History

Date	Notes
11/4/2025	Added Nevada Formulary. LKC

Augtyro



Prior Authorization Guideline

Guideline ID	GL-457196
Guideline Name	Augtyro
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia Medicaid - Community & State Washington

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name: Augtyro

Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of non-small cell lung cancer (NSCLC) AND 2 - Disease is ONE of the following: • Advanced • Metastatic • Recurrent AND 3 - Disease is ROS1-positive	

Product Name:Augtyro	
Diagnosis	Solid Tumors
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Presence of solid tumor(s) AND	

2 - Disease is positive for neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1, etc.)

AND

3 - Disease is ONE of the following:

- Locally advanced
- Metastatic
- Unresectable

Product Name:Augtyro

Diagnosis	Non-Small Cell Lung Cancer (NSCLC), Solid Tumors
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 Augtyro therapy

Product Name:Augtyro

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:Augtyro	
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 Augtyro therapy	

2 . Revision History

Date	Notes
11/19/2025	Combined formularies to include IN for eff 1/1/26.

Avmapki Fakzynja Co-Pack



Prior Authorization Guideline

Guideline ID	GL-459190
Guideline Name	Avmapki Fakzynja Co-Pack
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia Medicaid - Community & State Washington

Guideline Note:

Effective Date:	12/1/2025

1 . Criteria

Product Name:Avmapki Fakzynja Co-Pack

Diagnosis	Ovarian Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of recurrent low-grade serous ovarian cancer (LGSOC) AND 2 - Tumor is KRAS-mutated AND 3 - Patient has received prior systemic therapy	

Product Name:Avmapki Fakzynja Co-Pack	
Diagnosis	Ovarian 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 therapy	

Product Name:Avmapki Fakzynja Co-Pack	
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:Avmapki Fakzynja Co-Pack	
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
11/19/2025	Removed ACUMI from markets in scope. No changes to clinical criteria.

Ayvakit



Prior Authorization Guideline

Guideline ID	GL-398225
Guideline Name	Ayvakit
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 Virginia Medicaid - Community & State New Mexico Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	10/1/2025

1 . Criteria

Product Name:Ayvakit	
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 - ONE of the following: 2.1 Submission of medical records or claims history confirming patient has unresectable, recurrent, or metastatic disease after failure on approved therapies (e.g., imatinib, sunitinib, regorafenib, ripretinib) OR 2.2 BOTH of the following: 2.2.1 Disease is ONE of the following: • Unresectable • Resectable with significant morbidity • Metastatic • Recurrent • Limited progression • Gross residual disease (R2 resection) • Residual disease with significant morbidity AND 2.2.2 Presence of a platelet-derived growth factor receptor alpha (PDGFRA) exon mutation, including 18 D842V mutation	

Product Name:Ayvakit	
Diagnosis	Myeloid/Lymphoid Neoplasms

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of myeloid/lymphoid neoplasms with eosinophilia AND 2 - Presence of a FIP1L1-PDGFRα (platelet-derived growth factor receptor alpha) rearrangement AND 3 - Presence of a PDGFRα D842V mutation	

Product Name:Ayvakit	
Diagnosis	Systemic Mastocytosis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following: • Advanced systemic mastocytosis • Aggressive systemic mastocytosis • Systemic mastocytosis with an associated hematological neoplasm • Mast cell leukemia • Indolent systemic mastocytosis	

AND

2 - Platelet count is greater than or equal to $50 \times 10^9/\text{liter}$

Product Name:Ayvakit

Diagnosis	Gastrointestinal Stromal Tumor (GIST), Myeloid/Lymphoid Neoplasms, Systemic Mastocytosis

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 Ayvakit therapy

Product Name:Ayvakit

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:Ayvakit

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 Ayvakit therapy

2 . Revision History

Date	Notes
9/17/2025	Added IN.

Balversa



Prior Authorization Guideline

Guideline ID	GL-363188
Guideline Name	Balversa
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 Virginia Medicaid - Community & State Indiana Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	9/1/2025

1 . Criteria

Product Name: Balversa	
Diagnosis	Urothelial Carcinoma

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of urothelial carcinoma AND 2 - Disease is ONE of the following: - Locally advanced - Metastatic AND 3 - Presence of FGFR3 genetic alterations AND 4 - Disease has progressed on or after at least one line of prior systemic therapy [e.g., platinum-based chemotherapy (e.g., cisplatin, carboplatin), immune checkpoint inhibitor (e.g., pembrolizumab, nivolumab, avelumab)] AND 5 - ONE of the following: - Patient has received prior systemic therapy containing an immune checkpoint inhibitor (e.g., pembrolizumab, nivolumab, avelumab) - Patient is not eligible for immune checkpoint inhibitor therapy (e.g., pembrolizumab, nivolumab, avelumab)	

Product Name:Balversa	
Diagnosis	Salivary Gland Tumor
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of salivary gland tumor AND 2 - Disease is ONE of the following: • Recurrent • Unresectable • Metastatic AND 3 - Presence of FGFR genetic alterations AND 4 - Disease has progressed on or after at least one line of prior systemic therapy [e.g., platinum-based chemotherapy (e.g., cisplatin, carboplatin)]	

Product Name:Balversa	
Diagnosis	Pancreatic Adenocarcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of pancreatic adenocarcinoma

AND

2 - Disease is ONE of the following:

- Locally advanced
- Metastatic
- Recurrent

AND

3 - Presence of FGFR genetic alterations

Product Name:Balversa

Diagnosis	Non-Small Cell Lung Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of non-small cell lung cancer

AND

2 - Disease is metastatic

AND

3 - Presence of FGFR genetic alterations

Product Name:Balversa

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

Approval Criteria

1 - Diagnosis of invasive breast cancer

AND

2 - Disease is metastatic

AND

3 - Presence of FGFR1-3 genetic alterations

Product Name:Balversa

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

Approval Criteria

1 - Diagnosis of cholangiocarcinoma

AND

2 - Disease is ONE of the following:

- Unresectable
- Metastatic

AND

3 - Presence of FGFR2 genetic alterations

AND

4 - Disease has progressed on or after BOTH of the following:

- Lytgobi (futibatinib)
- Pemazyre (pemigatinib)

Product Name:Balversa	
Diagnosis	Urothelial Carcinoma, Salivary Gland Tumor, Pancreatic Adenocarcinoma, Non-Small Cell Lung Cancer, Breast Cancer, Cholangiocarcinoma
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 Balversa therapy	

Product Name:Balversa	
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	

Product Name:Balversa	
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 Balversa therapy	

2 . Revision History

Date	Notes
8/11/2025	Updated formularies to add IN

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-373479
Guideline Name	Benlysta
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 Indiana Medicaid - Community & State Nebraska Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	10/1/2025

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 currently receiving standard immunosuppressive therapy [e.g., hydroxychloroquine, chloroquine, prednisone, azathioprine, methotrexate] AND 3 - Patient does NOT have severe active central nervous system lupus AND 4 - Patient is NOT receiving Benlysta in combination with any of the following: • Targeted Immunomodulator [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Kineret (anakinra)] • Lupkynis (voclosporin) • Saphnelo (anifrolumab-fnia)	

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

AND

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

AND

4 - Patient is NOT receiving Benlysta in combination with any of the following:

- Targeted Immunomodulator [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Kineret (anakinra)]
- Lupkynis (voclosporin)
- Saphnelo (anifrolumab-fnia)

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 any of the following:

- Targeted Immunomodulator [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Kineret (anakinra)]
- Lupkynis (voclosporin)
- Saphnelo (anifrolumab-fnia)

2 . Revision History

Date	Notes
8/26/2025	Combined formularies. No changes to clinical criteria.

Berinert



Prior Authorization Guideline

Guideline ID	GL-249325
Guideline Name	Berinert
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 Indiana Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2025

1 . Criteria

Product Name: Berinert	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
	Approval Criteria 1 - Diagnosis of hereditary angioedema (HAE) as 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 variant(s) in the gene(s) for factor XII, angiotensin-converting enzyme 1, plasminogen-1, kininogen-1, myoferlin, or heparan sulfate-glucosaminase 3-O-sulfotransferase 6 • Recurring angioedema attacks that are refractory to high-dose antihistamines with confirmed family history of angioedema • Recurring angioedema attacks that are refractory to high-dose antihistamines with unknown background de-novo mutation(s) (i.e., no family history) (HAE-unknown) AND 2 - Prescribed for the acute treatment of HAE attacks AND 3 - Not used in combination with other products indicated for the acute treatment of HAE attacks (e.g., Firazyr, Ruconest) AND 4 - ONE of the following: 4.1 Failure of Ruconest as confirmed by claims history or submission of medical records

OR

4.2 History of intolerance or contraindication to Ruconest (please specific intolerance or contraindication)

OR

4.3 Patient is currently on Berinert therapy as confirmed by claims history or submission of medical records

AND

5 - Prescribed by ONE of the following:

- Immunologist
- Allergist

Product Name: Berinert	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Berinert therapy AND 2 - Prescribed for the acute treatment of HAE (hereditary angioedema) attacks AND	

3 - Not used in combination with other products indicated for the acute treatment of HAE attacks (e.g., Firazyr, Ruconest)

AND

4 - Prescribed by ONE of the following:

- Immunologist
- Allergist

2 . Revision History

Date	Notes
5/1/2025	Combined formularies. No changes to clinical criteria.

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.

Beta Adrenergic and Anticholinergic Combinations



Prior Authorization Guideline

Guideline ID	GL-421293
Guideline Name	Beta Adrenergic and Anticholinergic Combinations
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	11/1/2025

1 . Criteria

Product Name:Spiriva Respimat 2.5 mcg	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Trial and failure of Spiriva Handihaler for at least 14 days	

2 . Revision History

UnitedHealthcare Community Plan of Indiana Clinical Pharmacy Program Guidelines

Date	Notes
10/15/2025	Removed 1.25mcg strength

Beta Adrenergic Blockers



Prior Authorization Guideline

Guideline ID	GL-421292
Guideline Name	Beta Adrenergic Blockers
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	11/1/2025

1 . Criteria

Product Name:Hemangeol	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is 5 weeks of age or older AND less than or equal to 1 year of age	

Product Name:Sotylize	
Approval Length	12 month(s)

Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following: 1.1 Patient is under 12 years of age OR 1.2 Patient is unable to swallow tablets/capsules	

Product Name:Lopressor soln	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records documenting the patient is unable to swallow tablet formulation	

2 . Revision History

Date	Notes
10/15/2025	Added Lopressor criteria

Beta Adrenergics and Corticosteroids



Prior Authorization Guideline

Guideline ID	GL-599198
Guideline Name	Beta Adrenergics and Corticosteroids
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name: Trelegy Ellipta	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Both of the following: 1.1 Diagnosis of Asthma	

AND

1.2 Patient has tried and failed a beta adrenergic/corticosteroid combination inhaler for at least 90 days of the past 120 days

OR

2 - Both of the following:

2.1 Diagnosis of COPD

AND

2.2 Patient has tried and failed Anoro Ellipta therapy for at least 90 of the past 120 days

Product Name:Breztri Aerosphere	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has tried and failed Anoro Ellipta therapy for at least 90 of the past 120 days	

Product Name:Airsupra	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is at least 18 years of age	

AND

2 - Submission of medical records documenting trial and failure with Dulera and Symbicort as reliever therapy

2 . Revision History

Date	Notes
4/28/2026	Updated T/F for Trelegy Ellipta asthma diagnosis. Clarified "All of the following" to "Both of the following" in Trelegy Ellipta section.

Beta-Agonists - Short Acting



Prior Authorization Guideline

Guideline ID	GL-125103
Guideline Name	Beta-Agonists - Short Acting
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	7/1/2023

1 . Criteria

Product Name:Xopenex HFA	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has tried albuterol HFA in the past 90 days	

2 . Revision History

UnitedHealthcare Community Plan of Indiana Clinical Pharmacy Program Guidelines

Date	Notes
4/27/2023	New

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

Bone Formation Stimulating Agents



Prior Authorization Guideline

Guideline ID	GL-354277
Guideline Name	Bone Formation Stimulating Agents
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	9/1/2025

1 . Criteria

Product Name:Evenity	
Approval Length	1 Year*
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is 18 years of age or older	

AND

2 - Patient has experienced menopause and is currently post-menopausal

AND

3 - Diagnosis of osteoporosis

AND

4 - ONE of the following:

- Trial and failure of bisphosphonate
- Documentation of a medical justification against use of bisphosphonate
- Patient has been determined to be a high-risk patient as demonstrated by the World Health Organization (WHO) Fracture Risk Assessment Model

AND

5 - ONE of the following:

- Previous trial and failure of Forteo (teriparatide)
- Documentation of a medical justification for use over Forteo (teriparatide)

AND

6 - Prescriber attests that the patient does NOT have any of the following conditions:

- Myocardial infarction or stroke within the previous year
- Osteonecrosis of the jaw
- Pre-existing hypocalcemia

Notes

*Up to 1 year approval duration; approval duration should not exceed the maximum allowable lifetime duration of 1 year (12 monthly doses) of total therapy with Evenity. **PDL Link: <https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html>

Product Name:Evenity	
Approval Length	1 Year*
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of Evenity (romosozumab) for at least 90 days within the past 120 days, confirmed by claims history or chart documentation AND 2 - Prescriber attests that the patient remains a candidate for treatment, by indicating that they have NOT developed any of the following conditions: • Myocardial infarction or stroke within the previous year • Osteonecrosis of the jaw • Pre-existing hypocalcemia AND 3 - ONE of the following*: • Total length of therapy has not exceeded 1 year • Documentation of a medical justification for continued use beyond 1 year	
Notes	*Up to 1 year approval duration; approval duration should not exceed the maximum allowable lifetime duration of 1 year (12 monthly doses) of total therapy with Evenity unless medical rationale for continued use beyond 1 year has been provided.

Product Name:Tymlos	
Approval Length	1 Year*
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is 18 years of age or older

AND

2 - Diagnosis of osteoporosis

AND

3 - ONE of the following:

- Trial and failure of bisphosphonate
- Documentation of a medical justification against use of bisphosphonate
- Patient has been determined to be a high-risk patient as demonstrated by the World Health Organization (WHO) Fracture Risk Assessment Model

AND

4 - ONE of the following:

- Previous trial and failure of Forteo (teriparatide)
- Documentation of a medical justification for use over Forteo (teriparatide)

AND

5 - Prescriber attests to BOTH of the following:

5.1 The patient does NOT have any of the following conditions:

- Bone metastases or skeletal malignancies
- Increased baseline risk for osteosarcoma
- Metabolic bone disease other than osteoporosis
- Paget's disease of bone
- Pre-existing hypercalcemia (Calcium greater than 12mg/dL)

AND	
5.2 The patient has NOT undergone prior radiation therapy	
Notes	*Up to 1 year approval duration; approval duration should not exceed the maximum allowable lifetime duration of 2 years of total combined therapy with Forteo, teriparatide, Bonsity, and/or Tymlos. **PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name: Brand Forteo, generic teriparatide, Brand Teriparatide, Bonsity	
Approval Length	1 Year*
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is 18 years of age or older AND 2 - Diagnosis of osteoporosis AND 3 - ONE of the following: • Trial and failure of bisphosphonate • Documentation of a medical justification against use of bisphosphonate • Patient has been determined to be a high-risk patient as demonstrated by the World Health Organization (WHO) Fracture Risk Assessment Model AND 4 - Prescriber attests to BOTH of the following:	

4.1 The patient does NOT have any of the following conditions:

- Bone metastases or skeletal malignancies
- Increased baseline risk for osteosarcoma
- Metabolic bone disease other than osteoporosis
- Paget's disease of bone
- Pre-existing hypercalcemia (Calcium greater than 12mg/dL)

AND

4.2 The patient has NOT undergone prior radiation therapy

AND

5 - If the request is for generic teriparatide, Brand Teriparatide, or Bonsity, the prescriber has submitted medical justification for use of the requested product over brand Forteo

Notes	*Up to 1 year approval duration; approval duration should not exceed the maximum allowable lifetime duration of 2 years of total combined therapy with Forteo, teriparatide, Bonsity, and/or Tymlos. **PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name: Brand Forteo, generic teriparatide, Brand Teriparatide, Bonsity, Tymlos	
Approval Length	1 Year*
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested medication for at least 90 days within the past 120 days, confirmed by claims history or chart documentation AND 2 - Prescriber attests that the patient remains a candidate for treatment, by indicating BOTH of the following:	

2.1 The patient does NOT have any of the following conditions:

- Bone metastases or skeletal malignancies
- Increased baseline risk for osteosarcoma
- Metabolic bone disease other than osteoporosis
- Paget's disease of bone
- Pre-existing hypercalcemia (Calcium greater than 12mg/dL)

AND

2.2 The patient has NOT undergone prior radiation therapy

AND

3 - ONE of the following*:

- Total length of therapy has not exceeded 2 years
- Documentation of a medical justification for continued use beyond 2 years

Notes	*Up to 1 year approval duration; approval duration should not exceed the maximum allowable lifetime duration of 2 years of total combined therapy with Forteo, teriparatide, Bonsity, and/or Tymlos unless medical rationale for continued use beyond 2 years has been provided. **PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

2 . Revision History

Date	Notes
8/7/2025	Updated GPIs. Added Bonsity. Added brand over generic language for teriparatide products

Bone Resorption Inhibitors



Prior Authorization Guideline

Guideline ID	GL-560235
Guideline Name	Bone Resorption Inhibitors
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:Brand Actonel, generic risedronate	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has tried alendronate within the past 90 days	

Product Name:alendronate oral solution	
Approval Length	12 month(s)

Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following: 1.1 Patient is 5 years of age or older AND 1.2 Patient is less than 12 years of age OR 2 - Patient is unable to swallow tablets	

Product Name:Brand Miacalcin, generic calcitonin salmon inj	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Trial and failure of calcitonin-salmon nasal OR 2 - Medical justification for use over the preferred calcitonin agent (please document justification)	

Product Name:Bildyos, Bosaya, Connexence, Jubbonti, Prolia, Stoboclo, Enoby	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following indications: 1.1 Androgen deprivation therapy-induced bone loss in males with prostate cancer and patient is determined to be a high-risk per the World Health Organization Fracture Risk Assessment Model OR 1.2 Aromatase inhibitor-induced bone loss in females with breast cancer and patient is determined to be a high-risk per the World Health Organization Fracture Risk Assessment Model OR 1.3 Glucocorticoid-induced osteoporosis and all of the following: • Patient is initiating or continuing systemic glucocorticoids equivalent to prednisone 7.5 mg/day (milligrams per day) or greater and expected to remain on glucocorticoids for at least 6 months • Patient is determined to be a high-risk per the World Health Organization Fracture Risk Assessment Model • Trial and failure of, or intolerance to, a bisphosphonate agent OR 1.4 Osteoporosis treatment in males or prophylaxis/treatment in postmenopausal females and one of the following: • Trial and failure of, or intolerance to, an oral bisphosphonate agent • Trial and failure of zoledronic acid for those that cannot utilize oral bisphosphonates • Patient is determined to be a high-risk per the World Health Organization Fracture Risk Assessment Model AND	

2 - Patient is 18 years of age or older

AND

3 - Requested dose does not exceed 60 mg every 6 months

AND

4 - Patient is not hypocalcemic

AND

5 - Patient will be receiving calcium and vitamin D supplementation daily while on requested therapy

AND

6 - If the request is for Bosaya, Conexxence, Enoby, Jubbonti, Prolia or Stoboclo, both of the following:

- Previous trial of Bildyos (denosumab-nxxp) (confirmed by claims history or submission of medical records)
- Prescriber has submitted valid medical justification for the use of the requested denosumab product over preferred Bildyos (denosumab-nxxp)

Product Name: Bildyos, Bosaya, Conexxence, Jubbonti, Prolia, Stoboclo, Enoby	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested agent within the past 365 days	

AND

2 - Requested dose does not exceed 60 mg (milligrams) every 6 months

AND

3 - If the request is for Bosaya, Conexence, Enoby, Jubbonti, Prolia or Stoboclo, both of the following:

- Previous trial of Biltyos (denosumab-nxxp) (confirmed by claims history or submission of medical records)
- Prescriber has submitted valid medical justification for the use of the requested denosumab product over preferred Biltyos (denosumab-nxxp)

Product Name:Aukelso, Bilprevda, Bomynta, Osenvelt, Wyost, Xgeva, Xtrenbo	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following indications: 1.1 Prevention of skeletal-related events associated with bone metastases from solid tumors and both of the following: • Patient is 18 years of age or older • Requested dose does not exceed 120 mg (milligrams) every 4 weeks OR 1.2 Prevention of skeletal-related events associated with multiple myeloma and all of the following: • Patient is 18 years of age or older	

- Trial and failure of, or intolerance to, zoledronic acid
- Requested dose does not exceed 120 mg every 4 weeks

OR

1.3 Treatment of giant cell bone tumor that is unresectable or where surgical resection is likely to result in severe morbidity and both of the following:

- Patient is 12 years of age or older
- Requested dose does not exceed 120mg at days 0, 8, 15, and 29 initially, then 120mg every 4 weeks thereafter

OR

1.4 Treatment of hypercalcemia of malignancy and all of the following:

- Patient is 18 years of age or older
- Trial and failure of, or intolerance to, ibandronate, pamidronate, or zoledronic acid
- Requested dose does not exceed 120mg at days 0, 8, 15, and 29 initially, then 120mg every 4 weeks thereafter

AND

2 - If the request is for Aukelso, Bomynta, Osenvelt, Wyost, Xtrenbo, or Xgeva, both of the following:

- Previous trial of Bilprevda (denosumab-nxxp) (confirmed by claims history or submission of medical records)
- Prescriber has submitted valid medical justification for the use of the requested denosumab product over preferred Bilprevda (denosumab-nxxp)

Product Name:Aukelso, Bilprevda, Bomynta, Osenvelt, Wyost, Xgeva, Xtrenbo	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - History of the requested agent within the past 365 days

AND

2 - Requested dose does not exceed 120 mg (milligrams) every 4 weeks

AND

3 - If the request is for Aukelso, Bomynta, Osenvelt, Wyost, Xtrenbo, or Xgeva, both of the following:

- Previous trial of Bilprevda (denosumab-nxxp) (confirmed by claims history or submission of medical records)
- Prescriber has submitted valid medical justification for the use of the requested denosumab product over preferred Bilprevda (denosumab-nxxp)

2 . Revision History

Date	Notes
3/31/2026	Added Bosaya and Aukelso. Added language for free text box to document justification for Miacalcin (calcitonin salmon). Clarified submission and claims history language.

Bosulif



Prior Authorization Guideline

Guideline ID	GL-228219
Guideline Name	Bosulif
Formulary	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

Guideline Note:

Effective Date:	5/1/2025

1 . Criteria

Product Name: Bosulif	
Diagnosis	Chronic Myelogenous/Myeloid Leukemia

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient must have a diagnosis of chronic myeloid leukemia AND 2 - One of the following: 2.1 Patient is not a candidate for imatinib as attested by physician OR 2.2 Patient is currently on Bosulif therapy	

Product Name:Bosulif	
Diagnosis	Philadelphia Chromosome-Positive Acute Lymphoblastic Leukemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient must have a diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia	

Product Name:Bosulif	
Diagnosis	Myeloid/Lymphoid Neoplasms
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient must have a diagnosis of myeloid/lymphoid neoplasms with eosinophilia AND 2 - Presence of ABL1 (gene) rearrangement	

Product Name:Bosulif	
Diagnosis	Chronic Myelogenous/Myeloid Leukemia, Philadelphia Chromosome-Positive Acute Lymphoblastic Leukemia, Myeloid/Lymphoid Neoplasms
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 Bosulif therapy	

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

1 - Bosulif will be approved for uses supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name:Bosulif	
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 Bosulif therapy	

2 . Revision History

Date	Notes
3/26/2025	Updated formularies

Bosulif



Prior Authorization Guideline

Guideline ID	GL-228219
Guideline Name	Bosulif
Formulary	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

Guideline Note:

Effective Date:	5/1/2025

1 . Criteria

Product Name: Bosulif	
Diagnosis	Chronic Myelogenous/Myeloid Leukemia

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient must have a diagnosis of chronic myeloid leukemia AND 2 - One of the following: 2.1 Patient is not a candidate for imatinib as attested by physician OR 2.2 Patient is currently on Bosulif therapy	

Product Name:Bosulif	
Diagnosis	Philadelphia Chromosome-Positive Acute Lymphoblastic Leukemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient must have a diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia	

Product Name:Bosulif	
Diagnosis	Myeloid/Lymphoid Neoplasms
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient must have a diagnosis of myeloid/lymphoid neoplasms with eosinophilia AND 2 - Presence of ABL1 (gene) rearrangement	

Product Name:Bosulif	
Diagnosis	Chronic Myelogenous/Myeloid Leukemia, Philadelphia Chromosome-Positive Acute Lymphoblastic Leukemia, Myeloid/Lymphoid Neoplasms
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 Bosulif therapy	

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

1 - Bosulif will be approved for uses supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Bosulif	
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 Bosulif therapy	

2 . Revision History

Date	Notes
3/26/2025	Updated formularies

BPH Agents



Prior Authorization Guideline

Guideline ID	GL-286213
Guideline Name	BPH Agents
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	7/1/2025

1 . Criteria

Product Name:Brand Jalyn, generic dutasteride/tamsulosin	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation that the separate components are not suitable for use	

Product Name:Brand Rapaflo, generic silodosin	
Approval Length	12 month(s)

Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has had a trial of BOTH of the following: • Alfuzosin ER • Tamsulosin OR 2 - Medical justification for use of silodosin	

Product Name: Brand Cialis 2.5mg and 5mg, generic tadalafil 2.5mg and 5mg*	
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following: 1.1 Documentation of a trial and failure of ALL of the following: • A nonselective alpha-blocker • A selective alpha-blocker • A 5-alpha reductase inhibitor • A combination product for the treatment of BPH OR 1.2 A medically justifiable reason why ALL of the following are not suitable for use: • A nonselective alpha-blocker • A selective alpha-blocker • A 5-alpha reductase inhibitor • A combination product for the treatment of BPH	

Notes	*Approval Duration: 26 weeks when being requested in combination with finasteride, 12 months for all other approvals

2 . Revision History

Date	Notes
6/3/2025	Removed Entadfi

Braftovi



Prior Authorization Guideline

Guideline ID	GL-354249
Guideline Name	Braftovi
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 Virginia Medicaid - Community & State Indiana Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	9/1/2025

1 . Criteria

Product Name: Braftovi	
Diagnosis	Melanoma

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of melanoma AND 2 - Presence of BRAF V600E mutation AND 3 - Disease is one of the following: • Unresectable • Metastatic AND 4 - Used in combination with Mektovi (binimetinib) AND 5 - ONE of the following: 5.1 Patient has a contraindication or history of intolerance to ONE of the following regimens (please specify contraindication or intolerance) • Tafinlar (dabrafenib) plus Mekinist (trametinib) • Zelboraf (vemurafenib) plus Cotellic (cobimetinib) OR	

5.2 Provider attests that the patient is not an appropriate candidate for either of the following regimens

- Tafinlar (dabrafenib) plus Mekinist (trametinib)
- Zelboraf (vemurafenib) plus Cotellic (cobimetinib)

OR

5.3 For continuation of prior Braftovi therapy

Product Name: Braftovi	
Diagnosis	Melanoma
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 Braftovi therapy AND 2 - Used in combination with Mektovi (binimetinib)	

Product Name: Braftovi	
Diagnosis	Colon/Rectal Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of colon or rectal cancer

AND

2 - Presence of BRAF V600E mutation

AND

3 - Disease is ONE of the following:

- Advanced
- Metastatic

AND

4 - ONE of the following:

4.1 BOTH of the following:

- Patient has received prior therapy with an oxaliplatin-based regimen (e.g., FOLFOX, CAPEOX)
- Used in combination with Erbitux (cetuximab) or Vectibix (panitumumab)

OR

4.2 BOTH of the following:

4.2.1 Patient has NOT received prior therapy with an oxaliplatin-based regimen (e.g., FOLFOX, CAPEOX)

AND

4.2.2 Used in combination with BOTH of the following:

- Erbitux (cetuximab) or Vectibix (panitumumab)
- FOLFOX (fluorouracil, leucovorin, and oxaliplatin)

Product Name: Braftovi	
Diagnosis	Colon/Rectal 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 Braftovi therapy AND 2 - Used in combination with ONE of the following: • Erbitux (cetuximab) • Vectibix (panitumumab) • Erbitux (cetuximab) and FOLFOX (fluorouracil, leucovorin, and oxaliplatin) • Vectibix (panitumumab) and FOLFOX	

Product Name: Braftovi	
Diagnosis	Non-Small Cell Lung Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of non-small cell lung cancer (NSCLC) AND 2 - Presence of BRAF V600E mutation	

AND

3 - Disease is one of the following:

- Advanced
- Recurrent
- Metastatic

AND

4 - Used in combination with Mektovi (binimetinib)

AND

5 - ONE of the following:

5.1 Patient has a contraindication or history of intolerance to the following regimen (please specify contraindication or intolerance):

- Tafinlar (dabrafenib) plus Mekinist (trametinib)

OR

5.2 Provider attests that the patient is not an appropriate candidate for the following regimen:

- Tafinlar (dabrafenib) plus Mekinist (trametinib)

OR

5.3 For continuation of prior Braftovi therapy

Product Name: Braftovi	
Diagnosis	Non-Small Cell Lung 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 Braftovi therapy AND 2 - Used in combination with Mektovi (binimetinib)	

Product Name: Braftovi	
Diagnosis	NCCN Recommended Regimen
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: Braftovi	
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 Braftovi therapy	

2 . Revision History

Date	Notes
8/5/2025	Combined colon and rectal cancer sections and updated criteria

Brekiya, Migranal, Trudhesa



Prior Authorization Guideline

Guideline ID	GL-572189
Guideline Name	Brekiya, Migranal, Trudhesa
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name: Brand Migranal, generic dihydroergotamine mesylate nasal spray, Trudhesa	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of migraine headaches with or without aura AND	

2 - ONE of the following:

2.1 Failure to THREE preferred 5-HT₁ receptor agonist (triptan) alternatives (e.g., sumatriptan, rizatriptan, or naratriptan) confirmed by claims history or submission of medical records

OR

2.2 History of contraindication or intolerance to THREE preferred 5-HT₁ receptor agonist (triptan) alternatives (e.g., sumatriptan, rizatriptan, or naratriptan) (please specify intolerance or contraindication)

Product Name: Brand Migranal, generic dihydroergotamine mesylate nasal spray, Trudhesa

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 - Currently receiving prophylactic therapy with at least ONE of the following:

- A beta-blocker (i.e., atenolol, metoprolol, nadolol*, propranolol, or timolol*)
- Candesartan (generic Atacand)*
- A calcitonin gene-related peptide receptor*** (CGRP) antagonist or inhibitor for preventive treatment of migraine [i.e., Aimovig (erenumab), Ajovy* (fremanezumab), Emgality (galcanezumab), Qulipta* (atogepant), Vyepti** (eptinezumab-jjmr)]
- Divalproex sodium (Depakote/Depakote ER)

- OnabotulinumtoxinA (Botox)**
- A serotonin-norepinephrine reuptake inhibitor [i.e., duloxetine (Cymbalta), venlafaxine (Effexor/Effexor XR)]
- Topiramate (Topamax)
- A tricyclic antidepressant [i.e., amitriptyline (Elavil), nortriptyline (Pamelor)]

AND

4 - BOTH of the following:

4.1 ONE of the following:

4.1.1 Higher dose or quantity is supported by the manufacturer's prescribing information

OR

4.1.2 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 (USP-NF)

OR

4.1.3 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 (FDA) for the diagnosis indicated

AND

4.2 Physician acknowledges that the potential benefit outweighs the risk associated with the higher dose or quantity

Notes	*This is non-preferred and should not be included in denial to provider **This is a medical benefit and should not be included in denial to provider. ***Requires a prior authorization.

Product Name: Brekiya	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following: • Migraine headaches with or without aura • Cluster headaches AND 2 - BOTH of the following: 2.1 ONE of the following: • Failure (after at least 3 migraine episodes and a minimum of a 30-day trial) to dihydroergotamine (generic D.H.E.) injection as confirmed by claims history or submission of medical records • History of contraindication or intolerance to dihydroergotamine (generic D.H.E.) injection (please specify contraindication or intolerance) AND 2.2 ONE of the following: • Failure to three preferred 5-HT₁ receptor agonist (triptan) alternatives (e.g., sumatriptan, rizatriptan, or naratriptan), one of which must be sumatriptan subcutaneous injection, confirmed by claims history or submission of medical records • History of contraindication or intolerance to three preferred 5-HT₁ receptor agonist (triptan) alternatives (e.g., sumatriptan, rizatriptan, or naratriptan), one of which must be sumatriptan subcutaneous injection (please specify intolerance or contraindication)	

Product Name: Brekiya	
Approval Length	12 month(s)
Guideline Type	Quantity Limit

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of migraine headaches with or without aura

AND

1.2 Prescribed by, or in consultation with, ONE of the following:

- Neurologist
- Pain management specialist

AND

1.3 Currently receiving prophylactic therapy with at least ONE of the following:

- A beta-blocker (i.e., atenolol, metoprolol, nadolol*, propranolol, or timolol*)
- Candesartan (generic Atacand)*
- A calcitonin gene-related peptide receptor*** (CGRP) antagonist or inhibitor for preventive treatment of migraine [i.e., Aimovig (erenumab), Ajovy* (fremanezumab), Emgality (galcanezumab), Qulipta* (atogepant), Vyepti** (eptinezumab-jjmr)]
- Divalproex sodium (Depakote/Depakote ER)
- OnabotulinumtoxinA (Botox)**
- A serotonin-norepinephrine reuptake inhibitor [i.e., duloxetine (Cymbalta), venlafaxine (Effexor/Effexor XR)]
- Topiramate (Topamax)
- A tricyclic antidepressant [i.e., amitriptyline (Elavil), nortriptyline (Pamelor)]

AND

1.4 BOTH of the following:

1.4.1 ONE of the following:

1.4.1.1 Higher dose or quantity is supported by the manufacturer's prescribing information

OR

1.4.1.2 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 (USP-NF)

OR

1.4.1.3 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 (FDA) for the diagnosis indicated

AND

1.4.2 Physician acknowledges that the potential benefit outweighs the risk associated with the higher dose or quantity

OR

2 - ALL of the following:

2.1 Diagnosis of cluster headaches

AND

2.2 Prescribed by or in consultation with a neurologist or pain management specialist

AND

2.3 BOTH of the following:

2.3.1 ONE of the following:

2.3.1.1 Higher dose or quantity is supported by the manufacturer's prescribing information

OR

2.3.1.2 Higher dose or quantity is supported by ONE of following compendia:

- American Hospital Formulary Service Drug Information
- Thomson Micromedex DrugDex
- Clinical pharmacology
- United States Pharmacopoeia-National Formulary (USP-NF)

OR

2.3.1.3 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

2.3.2 Physician acknowledges that the potential benefit outweighs the risk associated with the higher dose or quantity

Notes	*This is non-preferred and should not be included in denial to provider . **This is a medical benefit and should not be included in denial to provider. ***Requires a prior authorization.

2 . Revision History

Date	Notes
4/9/2026	Updated title. Added Brekiya

Brinsupri



Prior Authorization Guideline

Guideline ID	GL-568197
Guideline Name	Brinsupri
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 Indiana Medicaid - Community & State Nebraska Medicaid - Community & State Nevada Medicaid - Community & State New Mexico Medicaid - Community & State Pennsylvania Medicaid - Community & State Virginia Medicaid - Community & State Washington

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Brinsupri	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has a diagnosis of non-cystic fibrosis bronchiectasis AND 2 - Patient has ALL of the following signs and symptoms associated with bronchiectasis: • Cough most days of the week lasting greater than 3 months • Production of mucopurulent sputum most days of the week lasting greater than 3 months • Recurrent respiratory tract infections AND 3 - Chest computed tomography (CT) is positive for bronchiectasis AND 4 - Cystic fibrosis has been ruled out by ONE of the following: • Sweat chloride test is negative • Mutation analysis of the cystic fibrosis transmembrane conductance regulator (CFTR) gene is negative for cystic fibrosis AND 5 - ONE of the following:	

5.1 If the patient is 12 to 17 years of age, patient has experienced one or more pulmonary exacerbation(s) requiring systemic antimicrobial therapy in the previous 12 months

OR

5.2 If the patient is 18 years of age or older, patient has experienced two or more pulmonary exacerbations requiring systemic antimicrobial therapy in the previous 12 months

AND

6 - ONE of the following:

6.1 Patient does not have co-existing chronic obstructive pulmonary disease (COPD) or asthma

OR

6.2 Patient has co-existing COPD, AND patient is currently being treated with ONE of the following therapies at maximally tolerated doses unless there is a contraindication or intolerance to these medications:

- Dual therapy with a long-acting muscarinic antagonist (LAMA) (e.g., tiotropium, umeclidinium) AND a long-acting beta agonist (LABA) (e.g., salmeterol, arformoterol, formoterol)
- Triple therapy [LAMA plus LABA combined with an inhaled corticosteroid (ICS) (e.g., budesonide, fluticasone propionate)]

OR

6.3 Patient has co-existing asthma, AND the patient is currently being treated with ONE of the following therapies at maximally tolerated doses unless there is a contraindication or intolerance to these medications:

- Inhaled corticosteroid (ICS) (e.g., fluticasone propionate)
- Dual therapy with a LABA (e.g., salmeterol, arformoterol, formoterol) AND ICS (e.g., budesonide, fluticasone propionate)
- Triple therapy with a LAMA (e.g., tiotropium, umeclidinium) plus LABA (e.g., salmeterol, arformoterol, formoterol) combined with an ICS (e.g., budesonide, fluticasone propionate)]

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 - Documentation of a positive clinical response (e.g., the patient has not had an increase in the number of annual pulmonary exacerbations requiring treatment with systemic antibiotics, patient has not initiated therapy with long-term maintenance systemic or inhaled antibiotics since starting Brinsupri)

AND

2 - ONE of the following:

2.1 Patient does not have co-existing chronic obstructive pulmonary disease (COPD) or asthma

OR

2.2 Patient has co-existing COPD, AND continues to be treated with ONE of the following therapies at maximally tolerated doses unless there is a contraindication or intolerance to these medications:

- Dual therapy with a long-acting muscarinic antagonist (LAMA) (e.g., tiotropium, umeclidinium) AND a long-acting beta agonist (LABA) (e.g., salmeterol, arformoterol, formoterol)
- Triple therapy [LAMA plus LABA combined with an inhaled corticosteroid (ICS) (e.g., budesonide, fluticasone propionate)]

OR

2.3 Patient has co-existing asthma, AND continues to be treated with ONE of the following therapies at maximally tolerated doses unless there is a contraindication or intolerance to these medications:

- Inhaled corticosteroid (ICS) (e.g., fluticasone propionate)
- Dual therapy with a LABA (e.g., salmeterol, arformoterol, formoterol) AND ICS (e.g., budesonide, fluticasone propionate)
- Triple therapy with a LAMA (e.g., tiotropium, umeclidinium) plus LABA (e.g., salmeterol, arformoterol, formoterol) combined with an ICS (e.g., budesonide, fluticasone propionate)]

AND

3 - Prescribed by or in consultation with a pulmonologist

2 . Revision History

Date	Notes
4/8/2026	Removed MI

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

Brukinsa



Prior Authorization Guideline

Guideline ID	GL-562239
Guideline Name	Brukinsa
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name: Brukinsa	
Diagnosis	B-Cell Lymphomas

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ALL of the following: 1.1 Diagnosis of follicular lymphoma (FL) AND 1.2 Disease is relapsed, refractory, or progressive AND 1.3 Patient has received at least two or more lines of systemic therapy AND 1.4 Brukinsa will be used in combination with obinutuzumab OR 2 - ALL of the following: 2.1 Diagnosis of ONE of the following: • Extranodal marginal zone lymphoma (EMZL) of the stomach • Extranodal marginal zone lymphoma of nongastric sites (noncutaneous) • Nodal marginal zone lymphoma AND 2.2 Disease is relapsed, refractory, or progressive	

AND

2.3 Patient has received at least one anti-CD20-based regimen (e.g., rituximab, obinutuzumab)

OR

3 - ALL of the following:

3.1 Diagnosis of splenic marginal zone lymphoma

AND

3.2 Disease is relapsed or refractory

AND

3.3 Patient has received at least one anti-CD20-based regimen (e.g., rituximab, obinutuzumab)

OR

4 - Diagnosis of mantle cell lymphoma (MCL)

Product Name:Brukinsa	
Diagnosis	Waldenström's Macroglobulinemia (WM)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of Waldenström's macroglobulinemia (WM)

Product Name:Brukinsa

Diagnosis	Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma (CLL/SLL)

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)

Product Name:Brukinsa

Diagnosis	Hairy Cell Leukemia

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of hairy cell leukemia

AND

2 - Disease is relapsed, refractory, or progressive

Product Name:Brukinsa

Diagnosis	Central Nervous System Lymphoma

Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of primary central nervous system lymphoma AND 2 - Disease is relapsed or refractory	

Product Name:Brukinsa	
Diagnosis	B-Cell Lymphomas, Waldenström's Macroglobulinemia (WM), Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma (CLL/SLL), Hairy Cell Leukemia, Central Nervous System Lymphoma
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 Brukinsa therapy	

Product Name:Brukinsa	
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:Brukinsa

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 Brukinsa therapy

2 . Revision History

Date	Notes

4/7/2026	Added IN.

Bucapsol



Prior Authorization Guideline

Guideline ID	GL-507578
Guideline Name	Bucapsol
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Bucapsol	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has previous trial and failure of buspirone IR tablet (as supported by claims history or chart documentation) AND	

2 - Prescriber has provided rationale for use of the requested medication over buspirone IR tablet (please document rationale)

2 . Revision History

Date	Notes
1/27/2026	Renamed guideline to Bucapsol and removed meprobamate (meprobamate included in Sedative-Hypnotics and Benzodiazepines guideline).

Bylvay



Prior Authorization Guideline

Guideline ID	GL-413208
Guideline Name	Bylvay
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Pennsylvania

Guideline Note:

Effective Date:	11/1/2025

1 . Criteria

Product Name:Bylvay	
Diagnosis	Progressive Familial Intrahepatic Cholestasis

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Confirmed 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 moderate to severe pruritus associated with PFIC AND 4 - Patient has a serum bile acid concentration above the upper limit of the normal reference range for the reporting laboratory AND 5 - Patient has had an inadequate response to at least TWO other conventional treatments for the symptomatic relief of pruritus (e.g., ursodeoxycholic acid, diphenhydramine, cholestyramine, rifampin, naltrexone, sertraline) AND 6 - Prescribed by a gastroenterologist or hepatologist	

Product Name:Bylvay

Diagnosis	Progressive Familial Intrahepatic Cholestasis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Bylvay therapy (e.g., reduced serum bile acids, improved pruritis, and less sleep disturbance) AND 2 - Prescribed by a gastroenterologist or hepatologist	

Product Name:Bylvay	
Diagnosis	Alagille Syndrome
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Alagille syndrome (ALGS) AND 2 - Confirmation of diagnosis by presence of the JAG1 or Notch2 gene mutation AND 3 - Patient has a serum bile acid concentration above the upper limit of the normal reference range for the reporting laboratory	

AND

4 - Patient is experiencing moderate to severe pruritis associated with ALGS

AND

5 - Patient has had an inadequate response to at least TWO other conventional treatments for the symptomatic relief of pruritus (e.g., ursodeoxycholic acid, diphenhydramine, cholestyramine, rifampin, naltrexone, sertraline).

AND

6 - Prescribed by a gastroenterologist or hepatologist

Product Name:Bylvay	
Diagnosis	Alagille Syndrome
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Bylvay therapy (e.g., reduced serum bile acids, improved pruritis) AND 2 - Prescribed by a gastroenterologist or hepatologist	

2 . Revision History

UnitedHealthcare Community Plan of Indiana Clinical Pharmacy Program Guidelines

Date	Notes
10/8/2025	Combined formularies. Minor update made to add "of" verbiage in dx check criterion for ALGS (initial auth section), with no changes to clinical intent.

Bylvay



Prior Authorization Guideline

Guideline ID	GL-413208
Guideline Name	Bylvay
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Pennsylvania

Guideline Note:

Effective Date:	11/1/2025

1 . Criteria

Product Name:Bylvay	
Diagnosis	Progressive Familial Intrahepatic Cholestasis

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Confirmed 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 moderate to severe pruritus associated with PFIC AND 4 - Patient has a serum bile acid concentration above the upper limit of the normal reference range for the reporting laboratory AND 5 - Patient has had an inadequate response to at least TWO other conventional treatments for the symptomatic relief of pruritus (e.g., ursodeoxycholic acid, diphenhydramine, cholestyramine, rifampin, naltrexone, sertraline) AND 6 - Prescribed by a gastroenterologist or hepatologist	

Product Name:Bylvay

Diagnosis	Progressive Familial Intrahepatic Cholestasis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Bylvay therapy (e.g., reduced serum bile acids, improved pruritis, and less sleep disturbance) AND 2 - Prescribed by a gastroenterologist or hepatologist	

Product Name:Bylvay	
Diagnosis	Alagille Syndrome
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Alagille syndrome (ALGS) AND 2 - Confirmation of diagnosis by presence of the JAG1 or Notch2 gene mutation AND 3 - Patient has a serum bile acid concentration above the upper limit of the normal reference range for the reporting laboratory	

AND

4 - Patient is experiencing moderate to severe pruritis associated with ALGS

AND

5 - Patient has had an inadequate response to at least TWO other conventional treatments for the symptomatic relief of pruritus (e.g., ursodeoxycholic acid, diphenhydramine, cholestyramine, rifampin, naltrexone, sertraline).

AND

6 - Prescribed by a gastroenterologist or hepatologist

Product Name:Bylvay	
Diagnosis	Alagille Syndrome
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Bylvay therapy (e.g., reduced serum bile acids, improved pruritis) AND 2 - Prescribed by a gastroenterologist or hepatologist	

2 . Revision History

UnitedHealthcare Community Plan of Indiana Clinical Pharmacy Program Guidelines

Date	Notes
10/8/2025	Combined formularies. Minor update made to add "of" verbiage in dx check criterion for ALGS (initial auth section), with no changes to clinical intent.

C&S Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Clinical Review



Prior Authorization Guideline

Guideline ID	GL-511290
Guideline Name	C&S Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Clinical Review
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Florida MMA Medicaid - Community & State Louisiana Medicaid - Community & State Indiana Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State Michigan Medicaid - Community & State Nebraska Medicaid - Community & State Nevada Medicaid - Community & State New Mexico Medicaid - Community & State New Jersey Medicaid - Community & State Pennsylvania Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	2/3/2026

Note:

EPSDT does not apply to drugs listed in Table 1.

1 . Criteria

Diagnosis	Exception to Policy Limitations for Medicaid Patients Less Than 21 Years of Age^
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 The use of the requested medication is for an indicated diagnosis that is supported by the Food and Drug Administration (FDA) OR 1.2 The use of the requested medication 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 use of the requested medication is NOT for experimental or investigational purposes AND 3 - Prescriber attests that the requested medication is medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition (health problem)	

AND

4 - Prescriber attests the requested medication is an accepted method for treatment (medical practice)

AND

5 - Prescriber attests the requested medication is the least costly treatment of equally effective choices

AND

6 - Prescriber attests the requested medication is safe and effective

AND

7 - Submission of medical records (e.g. chart notes, assessments, treatment plans, monitoring plans, etc.) confirming previous and current treatments used to treat diagnosis (Must include regimen, duration, treatment goals, and response to treatment)

AND

8 - The requested medication is prescribed within the dosing guidelines from ONE of the following:

8.1 The manufacturer's published dosing guidelines

OR

8.2 ONE of the following compendia:

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex
- Clinical pharmacology

United States Pharmacopoeia-National Formulary	
Notes	^ This criteria does not apply to CSFLD and ACUFLEC. Note: ACUFL EC does not have Rx benefits. ^ This criteria does NOT apply to ACUNE/ ACUNEEL1

2 . Background

Benefit/Coverage/Program Information	
Table 1: EPSDT does not apply to the following drugs	
Abecma	
Acthar	
Acthar gel	
Agamree	
Beqvez	
Casgevy	
Cortrophin	
Crenessity	
Egrifta SV	
Egrifta WR	
Elevidys	
Encelto	
Epclusa	
Evrysdi	
Genotropin	
Genotropin Miniquick	
Hemgenix	

Humatrope
Humira
Increlex
Kebilidi
Ledipasvir/sofosbuvir
Lenmeldy
Leqembi
Luxturna
Lyfgenia
Mavyret
Ngenla
Norditropin Flexpro
Nutropin AQ Nuspin 10
Nutropin AQ Nuspin 20
Nutropin AQ Nuspin 5
Omnitrope
Onpattro
Papzimeos
Ribavirin
Roctavian
Saizen
Serostim
Skysona
Skytrofa
Sofosbuvir/velpatasvir

Sogroya
Solvadi
Spinraza
Stelara
Strensiq
Synagis
Tabloid
Tecelra
Vosevi
Voxzogo
Vyjuvek
Yescarta
Zepatier
Zolgensma
Zomacton
Zorbtive
Zynteglo

3 . Revision History

Date	Notes
2/3/2026	Corrected the go-live date to 2/3/26

Cabliivi



Prior Authorization Guideline

Guideline ID	GL-434348
Guideline Name	Cabliivi
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 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:Cablivi	
Diagnosis	Acquired thrombotic thrombocytopenic purpura (aTTP)
Approval Length	2 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of acquired thrombotic thrombocytopenic purpura (aTTP) AND 2 - Cablivi was initiated as a bolus intravenous injection administered by a healthcare provider in combination with plasma exchange therapy AND 3 - Cablivi will be used in combination with immunosuppressive therapy (e.g., corticosteroids) AND 4 - Total treatment duration will be limited to 58 days beyond the last therapeutic plasma exchange	

Product Name:Cablivi	
Diagnosis	Acquired thrombotic thrombocytopenic purpura (aTTP)
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)

2 . Revision History

Date	Notes
11/4/2025	Added Nevada Formulary

Cabometyx



Prior Authorization Guideline

Guideline ID	GL-457194
Guideline Name	Cabometyx
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name: Cabometyx	
Diagnosis	Kidney cancer

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following: • Advanced renal cell carcinoma (RCC) • Relapsed renal cell carcinoma (RCC) • Hereditary leiomyomatosis and RCC (HLRCC)	

Product Name: Cabometyx	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of non-small cell lung cancer (NSCLC) AND 2 - Positive for RET gene rearrangements AND 3 - Disease is ONE of the following: • Recurrent • Advanced • Metastatic	

AND

4 - Used as subsequent therapy following progression on ONE of the following:

- Gavreto (pralsetinib)
- Retevmo (selpercatinib)

Product Name:Cabometyx

Diagnosis	Hepatocellular Carcinoma

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of hepatocellular carcinoma

AND

2 - Used as subsequent-line systemic therapy

Product Name:Cabometyx

Diagnosis	Bone cancer

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following:

- Dedifferentiated chondrosarcoma
- Ewing Sarcoma
- High-grade undifferentiated pleomorphic sarcoma (UPS)
- Mesenchymal chondrosarcoma
- Osteosarcoma
- Primary round cell tumor of the bone (e.g., CIC::DUX4, BCOR::CCNB3)

AND

2 - Disease is ONE of the following:

- Relapsed/refractory
- Metastatic

AND

3 - Used as second line therapy

Product Name: Cabometyx	
Diagnosis	Gastrointestinal Stromal Tumors (GIST)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of gastrointestinal stromal tumors (GIST) AND 2 - Patient has ONE of the following: • Gross residual disease (R2 resection) • Unresectable primary disease • Tumor rupture	

- Recurrent/metastatic disease

AND

3 - Disease has progressed on ALL of the following:

- imatinib (generic Gleevec)
- sunitinib (generic Sutent)
- Stivarga (regorafenib)
- Standard dose Qinlock (ripretinib)

Product Name: Cabometyx	
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 as second-line or subsequent treatment	

Product Name: Cabometyx	
Diagnosis	Thyroid Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of differentiated thyroid cancer (DTC)

AND

2 - Disease is locally advanced or metastatic

AND

3 - Disease has progressed following prior VEGFR-targeted therapy

AND

4 - Disease is radioactive iodine-refractory or ineligible

Product Name: Cabometyx

Diagnosis	Soft Tissue Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following

1.1 Diagnosis of ONE of the following soft tissue sarcoma subtypes:

- Extremity/body wall
- Head/neck
- Pleomorphic Rhabdomyosarcoma (RMS)
- Retroperitoneal/intraabdominal

AND

1.2 Disease is advanced/metastatic

AND

1.3 Used as subsequent line of therapy

OR

2 - Diagnosis of ONE of the following soft tissue sarcoma subtypes:

- Alveolar soft part sarcoma (ASPS)
- Epithelioid hemangioendothelioma
- Extraskkeletal myxoid chondrosarcoma

Product Name: Cabometyx	
Diagnosis	Neuroendocrine and Adrenal 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: • Well-differentiated pancreatic neuroendocrine tumor (pNET) • Well-differentiated extra-pancreatic neuroendocrine tumor (epNET) AND 2 - Disease is ONE of the following: • Locally advanced • Metastatic	

- Unresectable

Product Name: Cabometyx	
Diagnosis	Kidney Cancer, Non-Small Cell Lung Cancer (NSCLC), Hepatocellular Carcinoma, Bone Cancer, Gastrointestinal Stromal Tumors (GIST), Endometrial Carcinoma, Thyroid Cancer, Soft Tissue Sarcoma, Neuroendocrine and Adrenal Tumors
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 Cabometyx therapy	

Product Name: Cabometyx	
Diagnosis	NCCN Recommended Regimen
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: Cabometyx	
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 Cabometyx therapy

2 . Revision History

Date	Notes
11/19/2025	Combined formularies to include IN for eff 1/1/26

Calcium Channel Blockers



Prior Authorization Guideline

Guideline ID	GL-150095
Guideline Name	Calcium Channel Blockers
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	8/1/2024

1 . Criteria

Product Name:Norliqva	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is unable to swallow tablets	

Product Name:Nymalize	
Approval Length	12 month(s)

Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is 18 years of age or older AND 2 - Patient is unable to swallow capsules	

Product Name:Katerzia	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following: 1.1 Patient is 6 years of age or older AND less than 12 years of age OR 1.2 Patient is unable to swallow tablets AND 2 - One of the following: 2.1 Previous trial and failure of Norliqva OR 2.2 Medical rational for use of Katerzia	

Product Name:Brand Caduet, generic amlodipine/atorvastatin	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation that separate components are not suitable for use	

2 . Revision History

Date	Notes
7/22/2024	Removed age limit for Norliqva

Calquence



Prior Authorization Guideline

Guideline ID	GL-329214
Guideline Name	Calquence
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	8/1/2025

1 . Criteria

Product Name: Calquence	
Diagnosis	Mantle Cell Lymphoma (MCL)

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of mantle cell lymphoma (MCL) AND 2 - ONE of the following: 2.1 ALL of the following: • Patient has not received prior therapy (e.g., bortezomib, rituximab) for MCL • Patient is ineligible for autologous hematopoietic stem cell transplantation (HSCT) • Used in combination with bendamustine and rituximab OR 2.2 Patient has received at least one prior therapy for MCL (e.g., bortezomib, rituximab)	

Product Name:Calquence	
Diagnosis	Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chronic lymphocytic leukemia/small lymphocytic lymphoma	

Product Name:Calquence

Diagnosis	B-Cell Lymphomas
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following: • Nodal Marginal Zone Lymphoma • Extranodal Marginal Zone Lymphoma (EMZL) of the stomach • Splenic Marginal Zone Lymphoma • Extranodal Marginal Zone Lymphoma of Nongastric Sites (Non-cutaneous) AND 2 - Disease is recurrent, relapsed, refractory, or progressive	

Product Name: Calquence	
Diagnosis	Waldenström Macroglobulinemia/Lymphoplasmacytic Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Waldenström Macroglobulinemia/Lymphoplasmacytic Lymphoma AND 2 - ONE of the following: • Patient did not respond to primary therapy	

- Disease is relapsed or progressive

Product Name:Calquence	
Diagnosis	Mantle Cell Lymphoma (MCL), Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma, B-Cell Lymphomas, Waldenström Macroglobulinemia/Lymphoplasmacytic Lymphoma
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 Calquence therapy	

Product Name:Calquence	
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 is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	

Product Name:Calquence	
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 Calquence therapy

2 . Revision History

Date	Notes
7/14/2025	Updated formularies to add ACUIN for eff 8/1/2025. Minor grammatical/cosmetic updates, with no changes to clinical intent.

Caprelsa



Prior Authorization Guideline

Guideline ID	GL-458210
Guideline Name	Caprelsa
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name: Caprelsa	
Diagnosis	Thyroid Carcinoma

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ALL of the following: 1.1 Diagnosis of medullary thyroid cancer (MTC) AND 1.2 ONE of the following: • Unresectable locoregional disease that is symptomatic or progressing • Asymptomatic recurrent or persistent distant metastatic disease if unresectable and progressing • Recurrent or persistent distant metastases if symptomatic disease or progression OR 2 - ALL of the following: 2.1 ONE of the following diagnoses: • Follicular Carcinoma • Papillary Carcinoma AND 2.2 ONE of the following: • Unresectable locoregional recurrent • Persistent disease • Distant metastatic disease AND	

2.3 ONE of the following:

- Patient has symptomatic disease
- Patient has progressive disease

AND

2.4 Disease is refractory to radioactive iodine treatment

OR

3 - ALL of the following:

3.1 Diagnosis of Oncocytic Carcinoma

AND

3.2 ONE of the following:

- Unresectable locoregional recurrent
- Persistent disease
- Distant metastatic disease

AND

3.3 ONE of the following:

- Patient has symptomatic disease
- Patient has progressive disease

Product Name:Caprelsa	
Diagnosis	Thyroid 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 Caprelsa therapy

Product Name:Caprelsa

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:Caprelsa

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 Caprelsa therapy

2 . Revision History

Date	Notes

11/21/2025	Combined formularies. Updated criteria for oncocytic, papillary, and follicular carcinoma per NCCN.

Cardiac Agents



Prior Authorization Guideline

Guideline ID	GL-154931
Guideline Name	Cardiac Agents
Formulary	Medicaid - Community & State Indiana Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name:Brand Corlanor tablets, generic ivabradine tablet	
Diagnosis	Heart failure due to dilated cardiomyopathy
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of stable, symptomatic heart failure due to dilated cardiomyopathy	

AND

2 - Documentation of all of the following:

- Left ventricular ejection fraction is less than or equal to 45%
- Patient is in sinus rhythm
- Resting heart rate is elevated

AND

3 - Both of the following:

3.1 Patient is 6 months through 17 years of age

AND

3.2 Patient weighs greater than or equal to 40 kilograms (kg)

AND

4 - Both of the following:

4.1 Requested dose does not exceed 15mg/day (milligrams/day)

AND

4.2 Requested dose does not exceed 2 tablets/day

Product Name:Brand Corlanor tablets, generic ivabradine tablet	
Diagnosis	Heart failure due to dilated cardiomyopathy
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - History of the requested agent for a least 90 days of the past 120 days, confirmed by claims history or chart documentation

AND

2 - Both of the following:

2.1 Patient is 6 months through 17 years of age

AND

2.2 Patient weighs greater than 40 kilograms (kg)

AND

3 - Both of the following:

3.1 Requested dose does not exceed 15mg/day (milligrams per day)

AND

3.2 Requested dose does not exceed 2 tablets/day

Product Name: Brand Corlanor tablets, generic ivabradine tablet	
Diagnosis	Heart failure NOT due to dilated cardiomyopathy
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of heart failure

AND

2 - Patient is 18 years of age or older

AND

3 - Documentation of both of the following:

- Left ventricular ejection fraction is less than or equal to 35%
- Resting heart rate is greater than or equal to 70 beats per minute

AND

4 - One of the following:

- Patient is currently maximized on beta-blocker therapy
- Patient has contraindication to beta-blocker use

AND

5 - Both of the following:

5.1 Requested dose does not exceed 15mg/day (milligrams per day)

AND

5.2 Requested dose does not exceed 2 tablets/day

Product Name: Brand Corlanor tablets, generic ivabradine tablet	
Diagnosis	Heart failure NOT due to dilated cardiomyopathy
Approval Length	1 year(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested agent for a least 90 days of the past 120 days, confirmed by claims history or chart documentation AND 2 - Patient is 18 years of age or older AND 3 - One of the following: • Patient continues to be maximized on concurrent beta-blocker therapy • Patient has contraindication to beta-blocker use AND 4 - Both of the following: 4.1 Requested dose does not exceed 15mg/day (milligrams/day) AND 4.2 Requested dose does not exceed 2 tablets/day	

Product Name:Brand Corlanor tablets, generic ivabradine tablet	
Diagnosis	Inappropriate sinus tachycardia
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of inappropriate sinus tachycardia

AND

2 - Patient is 18 years of age or older

AND

3 - One of the following:

- Patient is currently maximized on beta-blocker therapy
- Patient has contraindication to beta-blocker use

AND

4 - Both of the following:

4.1 Requested dose does not exceed 15mg/day (milligrams per day)

AND

4.2 Requested dose does not exceed 2 tablets/day

Product Name: Brand Corlanor tablets, generic ivabradine tablet	
Diagnosis	Inappropriate sinus tachycardia
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - History of the requested agent for a least 90 days of the past 120 days, confirmed by claims history or chart documentation

AND

2 - Patient is 18 years of age or older

AND

3 - One of the following:

- Patient continues to be maximized on concurrent beta-blocker therapy
- Patient has contraindication to beta-blocker use

AND

4 - Both of the following:

4.1 Requested dose does not exceed 15mg/day (milligrams per day)

AND

4.2 Requested dose does not exceed 2 tablets/day

Product Name:Corlanor oral solution	
Diagnosis	Heart failure due to dilated cardiomyopathy
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of stable, symptomatic heart failure due to dilated cardiomyopathy	

AND

2 - Documentation of all of the following:

- Left ventricular ejection fraction is less than or equal to 45%
- Patient is in sinus rhythm
- Resting heart rate is elevated

AND

3 - Patient is 6 months through 17 years of age

AND

4 - One of the following:

4.1 Patient weighs less than 40 kilograms and one of the following:

4.1.1 If patient is 6 months through less than 1 year of age, the requested dose does not exceed 0.2 mg/kg/dose (milligrams per kilograms per dose) twice daily

OR

4.1.2 If patient is 1 year of age through 17 years of age, the requested dose does not exceed 0.3 mg/kg/dose twice daily, maximum of 15 milliliters per day (15 milligrams per day)

OR

4.2 Patient weighs greater than or equal to 40 kilograms and one of the following:

4.2.1 If patient is 6 months through 11 years of age, the requested dose does not exceed 15 milliliters per day (15 milligrams per day)

OR

4.2.2 If patient is 12 years of age through 17 years of age, both of the following:

- The requested dose does not exceed 15 milliliters per day (15 milligrams per day)
- Submission of medical records (e.g., chart notes) confirming patient cannot swallow tablets

Product Name: Corlanor oral solution	
Diagnosis	Heart failure due to dilated cardiomyopathy
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - History of the requested agent for a least 90 days of the past 120 days, confirmed by claims history or chart documentation

AND

2 - Patient is 6 months through 17 years of age

AND

3 - One of the following:

3.1 Patient weighs less than 40 kilograms and one of the following:

3.1.1 If patient is 6 months through less than 1 year of age, the requested dose does not exceed 0.2 mg/kg/dose (milligrams per kilograms per dose) twice daily

OR

3.1.2 If patient is 1 year of age through 17 years of age, the requested dose does not exceed 0.3 mg/kg/dose twice daily, maximum of 15 milliliters per day (15 milligrams per day)

OR

3.2 Patient weighs greater than or equal to 40 kilograms and one of the following:

3.2.1 If patient is 6 months through 11 years of age, the requested dose does not exceed 15 milliliters per day (15 milligrams per day)

OR

3.2.2 If patient is 12 years of age through 17 years of age, both of the following:

- The requested dose does not exceed 15 milliliters per day (15 milligrams per day)
- Submission of medical records (e.g., chart notes) confirming patient cannot swallow tablets

Product Name:Corlanor oral solution	
Diagnosis	Heart failure NOT due to dilated cardiomyopathy
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of heart failure AND 2 - Patient is 18 years of age or older AND 3 - Documentation of both of the following:	

- Left ventricular ejection fraction is less than or equal to 35%
- Resting heart rate is greater than or equal to 70 beats per minute

AND

4 - One of the following:

- Patient is currently maximized on beta-blocker therapy
- Patient has contraindication to beta-blocker use

AND

5 - Requested dose does not exceed 15 milliliters per day (15 milligrams per day)

AND

6 - Submission of medical records (e.g., chart notes) confirming patient cannot swallow tablets

Product Name:Corlanor oral solution	
Diagnosis	Heart failure NOT due to dilated cardiomyopathy
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested agent for a least 90 days of the past 120 days, confirmed by claims history or chart documentation AND 2 - Patient is 18 years of age or older	

AND

3 - One of the following:

- Patient continues to be maximized on concurrent beta-blocker therapy
- Patient has contraindication to beta-blocker use

AND

4 - Requested dose does not exceed 15 milliliters per day (15 milligrams per day)

AND

5 - Submission of medical records (e.g., chart notes) confirming patient cannot swallow tablets

Product Name:Corlanor oral solution	
Diagnosis	Inappropriate sinus tachycardia
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of inappropriate sinus tachycardia AND 2 - Patient is 18 years of age or older AND	

3 - One of the following:

- Patient is currently maximized on beta-blocker therapy
- Patient has contraindication to beta-blocker use

AND

4 - Requested dose does not exceed 15 milliliters per day (15 milligrams per day)

AND

5 - Submission of medical records (e.g., chart notes) confirming patient cannot swallow tablets

Product Name:Corlanor oral solution	
Diagnosis	Inappropriate sinus tachycardia
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested agent for a least 90 days of the past 120 days, confirmed by claims history or chart documentation AND 2 - Patient is 18 years of age or older AND 3 - One of the following:	

- Patient continues to be maximized on concurrent beta-blocker therapy
- Patient has contraindication to beta-blocker use

AND

4 - Requested dose does not exceed 15 milliliters per day (15 milligrams per day)

AND

5 - Submission of medical records (e.g., chart notes) confirming patient cannot swallow tablets

Product Name:Entresto tablet	
Approval Length	1 year(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following: 1.1 Patient is not using an angiotensin converting enzyme (ACE) inhibitors or angiotensin II receptor blockers (ARBs) concurrently with Entresto OR 1.2 The provider has submitted valid medical justification for the use of an angiotensin converting enzyme (ACE) inhibitors or angiotensin II receptor blockers (ARBs) concurrently with Entresto	

Product Name:Entresto sprinkle	
Approval Length	1 year(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Patient is not using angiotensin converting enzyme (ACE) inhibitors or angiotensin II receptor blockers (ARBs) concurrently with Entresto

OR

1.2 The provider has submitted valid medical justification for the use of an angiotensin converting enzyme (ACE) inhibitors or angiotensin II receptor blockers (ARBs) concurrently with Entresto

AND

2 - One of the following:

2.1 One of the following:

- Patient is less than 12 years of age
- Patient weighs less than 50kg

OR

2.2 ALL of the following:

- Patient is 12 years of age or older
- Patient weighs at least 50kg
- Submission of medical records (e.g., chart notes) confirming patient cannot swallow tablets

Product Name: Verquvo	
Approval Length	1 year(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 Diagnosis of stable, symptomatic heart failure

AND

1.3 Documentation of left ventricular ejection fraction less than or equal to 45%

AND

1.4 One of the following:

- Patient has been hospitalized within the past 180 days for symptomatic heart failure
- Patient has received outpatient treatment with IV diuretics within the past 90 days

AND

1.5 Both of the following:

1.5.1 Requested dose does not exceed 10 mg/day (milligrams per day)

AND

1.5.2 Requested dose does not exceed 1 tablet/day

AND

1.6 For women of childbearing age, documentation of a negative pregnancy test within the past 60 days

Product Name:Verquvo	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested agent for a least 90 days of the past 120 days, confirmed by claims history or chart documentation AND 2 - Both of the following: 2.1 Requested dose does not exceed 10 mg/day (milligrams per day) AND 2.2 Requested dose does not exceed 1 tablet/day AND 3 - For women of childbearing age, documentation of a negative pregnancy test within the past 60 days	

Product Name:Camzyos	
Approval Length	1 year(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 Diagnosis of symptomatic obstructive hypertrophic cardiomyopathy (HCM)

AND

1.3 Documentation of both of the following:

- Left ventricular ejection fraction that is greater than or equal to 55%
- Left ventricular outflow tract (LVOT) gradient of 50 mmHg or greater

AND

1.4 One of the following:

- At least 90 days of drug therapy with a beta-adrenergic blocker or non-dihydropyridine calcium channel blocker
- Prescriber has provided valid medical rationale for the use of Camzyos over beta-adrenergic blocker and non-dihydropyridine calcium channel blocker therapy

AND

1.5 Patient is enrolled in the Camzyos/mavacamten REMS (Risk Evaluation and Mitigation Strategy) program

AND

1.6 Both of the following:

1.6.1 Requested dose does not exceed 15 mg/day (milligrams per day)

AND

1.6.2 Requested dose does not exceed 1 capsule/day

Product Name:Camzyos	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested agent for a least 90 days of the past 120 days, confirmed by claims history or chart documentation AND 2 - Both of the following: 2.1 Requested dose does not exceed 15 mg/day (milligrams per day) AND 2.2 Requested dose does not exceed 1 capsule/day	

2 . Revision History

Date	Notes
9/17/2024	Added generic ivabradine. Added criteria for Entresto sprinkle.

Carisoprodol Agents



Prior Authorization Guideline

Guideline ID	GL-126509
Guideline Name	Carisoprodol Agents
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	7/1/2023

1 . Criteria

Product Name:generic carisoprodol, Brand Soma, Brand Vanadom	
Approval Length	90 Day(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient must have diagnosis of an acute musculoskeletal condition in the past 60 days AND	

2 - Patient is between 16 and 65 years of age

AND

3 - No history of meprobamate use in the past 90 days

AND

4 - ONE of the following*:

4.1 Trial and failure of ALL of the preferred non-liquid oral agents

OR

4.2 Documented history of intolerance to ALL of the preferred non-liquid oral agents

OR

4.3 Valid medical justification for the use of carisoprodol over the preferred non-liquid oral agents

AND

5 - Patient will not use concurrently with opiates or benzodiazepines

AND

6 - The request must be no more than a 21 days' supply, to be used within a 90-day period, every 180 days

Notes

Approvals will be granted for up to 21 days' supply, to be used within a 90-day period, every 180 days.
*PDL link: <https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html>

2 . Revision History

Date	Notes
6/9/2023	Updated guideline name, updated GPI and product name lists, removed carisoprodol/asa/codeine, updated criteria and note.

Cayston



Prior Authorization Guideline

Guideline ID	GL-228223
Guideline Name	Cayston
Formulary	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

Guideline Note:

Effective Date:	5/1/2025

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) AND 2 - ONE of the following: 2.1 Failure to tobramycin solution for inhalation (generic Bethkis) confirmed by claims history or submission of medical records OR 2.2 History of intolerance or contraindication to tobramycin solution for inhalation (generic Bethkis) (please specify intolerance or contraindication)	

2 . Revision History

Date	Notes
3/27/2025	Updated formularies

Cerdelga and Zavesca



Prior Authorization Guideline

Guideline ID	GL-435249
Guideline Name	Cerdelga and Zavesca
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 Nevada Medicaid - Community & State Virginia Medicaid - Community & State Indiana Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name: Cerdelga

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Gaucher disease type 1 AND 2 - Patient is ONE of the following as detected by an FDA-cleared test: • CYP2D6 extensive metabolizer • CYP2D6 intermediate metabolizer • CYP2D6 poor metabolizer	

Product Name: Brand Zavesca, generic miglustat, Yargesa	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ALL of the following: 1.1 Diagnosis of mild to moderate type 1 Gaucher disease AND 1.2 Patient is unable to receive enzyme replacement therapy due to ONE of the following conditions: • Allergy or hypersensitivity to enzyme replacement therapy • Poor venous access	

- Unavailability of enzyme replacement therapy (e.g., Cerezyme, VPRIV)

OR

2 - ALL of the following:

- Diagnosis of Niemann-Pick disease type C (NPC)
- Diagnosis has been genetically confirmed by mutation analysis of NPC1 and NPC2 genes
- Provider attests patient presents with neurological manifestations of NPC

Product Name:Cerdelga, Brand Zavesca, generic miglustat, Yargesa	
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
11/4/2025	Added NV formulary. No clinical updates.

Cholbam



Prior Authorization Guideline

Guideline ID	GL-351201
Guideline Name	Cholbam
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 Indiana Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	9/1/2025

1 . Criteria

Product Name:Cholbam	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following: 1.1 Diagnosis of a bile acid synthesis disorder AND 1.2 Bile acid synthesis disorder is due to single enzyme defects (SEDs) OR 2 - ALL of the following: 2.1 Diagnosis of a peroxisomal disorder including Zellweger spectrum disorders AND 2.2 Patient exhibits manifestations of liver disease, steatorrhea, or complications from decreased fat soluble vitamin absorption AND 2.3 Cholbam is being used as adjunctive treatment	

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

Approval Criteria

1 - Documentation of positive clinical response to Cholbam therapy as evidenced by BOTH of the following:

1.1 Improvement in liver function (e.g., aspartate aminotransferase [AST], alanine aminotransferase [ALT])

AND

1.2 Absence of complete biliary obstruction

2 . Revision History

Date	Notes
7/30/2025	Combined formularies. No changes to clinical criteria.

Cholbam



Prior Authorization Guideline

Guideline ID	GL-351201
Guideline Name	Cholbam
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 Indiana Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	9/1/2025

1 . Criteria

Product Name:Cholbam	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following: 1.1 Diagnosis of a bile acid synthesis disorder AND 1.2 Bile acid synthesis disorder is due to single enzyme defects (SEDs) OR 2 - ALL of the following: 2.1 Diagnosis of a peroxisomal disorder including Zellweger spectrum disorders AND 2.2 Patient exhibits manifestations of liver disease, steatorrhea, or complications from decreased fat soluble vitamin absorption AND 2.3 Cholbam is being used as adjunctive treatment	

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

Approval Criteria

1 - Documentation of positive clinical response to Cholbam therapy as evidenced by BOTH of the following:

1.1 Improvement in liver function (e.g., aspartate aminotransferase [AST], alanine aminotransferase [ALT])

AND

1.2 Absence of complete biliary obstruction

2 . Revision History

Date	Notes
7/30/2025	Combined formularies. No changes to clinical criteria.

Cipro Suspension and Levaquin Solution



Prior Authorization Guideline

Guideline ID	GL-123771
Guideline Name	Cipro Suspension and Levaquin Solution
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	7/1/2023

1 . Criteria

Product Name: Brand Cipro suspension, generic ciprofloxacin suspension	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Both of the following: 1.1 Patient is 12 years of age or older	

AND

1.2 Patient is unable to swallow tablet formulation

OR

2 - Both of the following:

2.1 Patient is less than 12 years of age

AND

2.2 Patient has one of the following diagnoses:

- Anthrax
- Cystic fibrosis
- Community acquired pneumonia
- Shigella dysentery type 1
- Urinary tract infection (complicated) or pyelonephritis
- Tularemia

Product Name: Brand Cipro suspension, generic ciprofloxacin suspension	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Both of the following: 1.1 Patient is 12 years of age or older AND	

1.2 Patient has history of use of ciprofloxacin suspension

OR

2 - Both of the following:

2.1 Patient is less than 12 years of age

AND

2.2 Medical rationale for continued use of the requested medication

Product Name:Levofloxacin solution	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Both of the following: 1.1 Patient is 12 years of age or older AND 1.2 Patient is unable to swallow tablet formulation OR 2 - Both of the following: 2.1 Patient is less than 12 years of age	

AND

2.2 Patient has one of the following diagnoses:

- Anthrax
- Community acquired pneumonia
- Acute bacterial rhinosinusitis
- Tularemia
- Pneumonic plague

Product Name:Levofloxacin solution	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Both of the following: 1.1 Patient is 12 years of age or older AND 1.2 Patient has history of use of levofloxacin solution OR 2 - Both of the following: 2.1 Patient is less than 12 years of age AND	

2.2 Medical rationale for continued use of the requested medication

2 . Revision History

Date	Notes
4/7/2023	SPDL eff 7.1.23

Clonidine, Guanfacine



Prior Authorization Guideline

Guideline ID	GL-539234
Guideline Name	Clonidine, Guanfacine
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name: Brand Catapres, generic clonidine transdermal patches, clonidine ER 0.1 mg tablets, clonidine IR tablets	
Approval Length	*If patient using concurrently with guanfacine, approval length is 4 months; otherwise, approval length is 12 months
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following:	

- Patient is not using concurrently with guanfacine
- Prescriber has provided valid medical justification for the concurrent use of clonidine and guanfacine* (please document justification)

AND

2 - Request does not exceed quantity limit (see Table 1 in Background)

Product Name:Nexiclon XR, Clonidine ER 0.17 mg tablets	
Approval Length	*If patient using concurrently with guanfacine, approval length is 4 months; otherwise, approval length is 12 months
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of hypertension AND 2 - ONE of the following: • Patient is not using concurrently with guanfacine • Prescriber has provided valid medical justification for the concurrent use of clonidine and guanfacine* (please document justification) AND 3 - Request does not exceed quantity limit (see Table 1 in Background)	

Product Name:Brand Catapres, generic clonidine transdermal patches, clonidine ER 0.1 mg tablets, clonidine IR tablets, Nexiclon XR, Clonidine ER 0.17 mg tablets	
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested agent for at least 90 days within the past 120 days, confirmed by claims history or chart documentation AND 2 - ONE of the following: 2.1 Patient is not using concurrently with guanfacine OR 2.2 BOTH of the following: • Patient has been previously approved for concurrent therapy with guanfacine • Prescriber has submitted chart documentation obtained within the past 3 months demonstrating monitoring of vitals (blood pressure/heart rate) while utilizing clonidine and guanfacine concurrently AND 3 - Request does not exceed quantity limit (see Table 1 in Background)	

Product Name:Onyda XR	
Approval Length	*If patient using concurrently with guanfacine, approval length is 4 months; otherwise, approval length is 12 months
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - ONE of the following:

1.1 Patient is less than 12 years of age

OR

1.2 Patient is 12 years of age or older and there is chart documentation to support patient is unable to swallow tablet formulation

AND

2 - ONE of the following:

- Patient is not using concurrently with guanfacine
- Prescriber has provided valid medical justification for the concurrent use of clonidine and guanfacine* (please document justification)

AND

3 - Request does not exceed quantity limit (see Table 1 in Background)

Product Name: Onyda XR	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested agent for at least 90 days within the past 120 days, confirmed by claims history or chart documentation AND 2 - ONE of the following:	

2.1 Patient is less than 12 years of age

OR

2.2 Patient is 12 years of age or older and there is chart documentation to support patient is unable to swallow tablet formulation

AND

3 - ONE of the following:

3.1 Patient is not using concurrently with guanfacine

OR

3.2 BOTH of the following:

- Patient has been previously approved for concurrent therapy with guanfacine
- Prescriber has submitted chart documentation obtained within the past 3 months demonstrating monitoring of vitals (blood pressure/heart rate) while utilizing clonidine and guanfacine concurrently

AND

4 - Request does not exceed quantity limit (see Table 1 in Background)

Product Name: Brand Intuniv, generic guanfacine ER tablets, guanfacine IR tablets	
Approval Length	*If patient using concurrently with clonidine, approval length is 4 months; otherwise, approval length is 12 months
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - ONE of the following:

- Patient is not using concurrently with clonidine
- Prescriber has provided valid medical justification for the concurrent use of clonidine and guanfacine* (please document justification)

AND

2 - Request does not exceed quantity limit (see Table 1 in Background)

Product Name: Brand Intuniv, generic guanfacine ER tablets, guanfacine IR tablets	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested agent for at least 90 days within the past 120 days, confirmed by claims history or chart documentation AND 2 - ONE of the following: 2.1 Patient is not using concurrently with clonidine OR 2.2 BOTH of the following: • Patient has been previously approved for concurrent therapy with clonidine • Prescriber has submitted chart documentation obtained within the past 3 months demonstrating monitoring of vitals (blood pressure/heart rate) while utilizing clonidine and guanfacine concurrently	

AND

3 - Request does not exceed quantity limit (see Table 1 in Background)

Product Name: Javadin

Approval Length	*If patient using concurrently with guanfacine, approval length is 4 months; otherwise, approval length is 12 months

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of hypertension

AND

2 - Patient is 18 years of age or older

AND

3 - There is chart documentation to support patient is unable to swallow tablet formulation

AND

4 - ONE of the following:

- Patient is not using concurrently with guanfacine
- Prescriber has provided valid medical justification for the concurrent use of clonidine and guanfacine* (please document justification)

AND

5 - Request does not exceed quantity limit (see Table 1 in Background)

Product Name: Javadin	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested agent for at least 90 days within the past 120 days, confirmed by claims history or chart documentation AND 2 - There is chart documentation to support patient is unable to swallow tablet formulation AND 3 - ONE of the following: 3.1 Patient is not using concurrently with guanfacine OR 3.2 BOTH of the following: • Patient has been previously approved for concurrent therapy with guanfacine • Prescriber has submitted chart documentation obtained within the past 3 months demonstrating monitoring of vitals (blood pressure/heart rate) while utilizing clonidine and guanfacine concurrently AND 4 - Request does not exceed quantity limit (see Table 1 in Background)	

2 . Background

Benefit/Coverage/Program Information			
Table 1			
AGENT	AGE LIMIT	MDD (same chemical entity -all formulations)^	QUANTITY LIMIT
Catapres (clonidine) TD	≥ 18	1.2 mg/day	• 0.1 mg/24 hr patch – 1 patch/week* • 0.2 mg/24 hr patch – 2 patches/week* • 0.3 mg/24 hr patch – 2 patches/week*
	< 18	0.4 mg/day	
Clonidine ER tablets	≥ 18	1.2 mg/day	• 0.1 mg – 4 tablets/day
	< 18	0.4 mg/day	
Clonidine IR tablets	≥ 18	1.2 mg/day	• 0.1 mg – 12 tablets/day • 0.2 mg – 6 tablets/day • 0.3 mg – 4 tablets/day
	< 18	0.4 mg/day	
Guanfacine IR tablets	All ages	7 mg/day	• 1 mg – 3 tablets/day • 2 mg – 3 tablets/day
Intuniv ER (guanfacine) tablets	All ages	7 mg/day	• 1 mg – 1 tablet/day • 2 mg – 1 tablet/day • 3 mg – 1 tablet/day • 4 mg – 1 tablet/day
Javadin (clonidine) solution	≥ 18	1.2 mg/day	• 0.02 mg/mL – 1.2 mg (6 mL) day
Nexiclon XR (clonidine) tablets	≥ 18	1.2 mg/day	• 0.17 mg – 3 tablets/day
Onyda XR (clonidine) suspension	≥ 18	1.2 mg/day	• 0.1 mg/mL – 0.4 mg (4 mL)/day
	< 18	0.4 mg/day	
MDD = max daily dose; TD = transdermal; ER = extended release; IR = immediate release; XR = extended release			

*Note: Requests to exceed quantity limits due to variable absorption in pediatric members will be considered on a case-by-case basis

^Requests for doses exceeding MDD will be reviewed on a case-by-case basis

3 . Revision History

Date	Notes
3/5/2026	Added Javadin

Cometriq



Prior Authorization Guideline

Guideline ID	GL-356192
Guideline Name	Cometriq
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	9/1/2025

1 . Criteria

Product Name:Cometriq	
Diagnosis	Thyroid Carcinoma

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of medullary carcinoma OR 2 - ALL of the following: 2.1 Diagnosis of ONE of the following: - Follicular carcinoma - Oncocytic cell carcinoma - Papillary carcinoma AND 2.2 Disease is progressive after treatment with ONE of the following as confirmed by claims history or submission of medical records: - Lenvima (lenvatinib) - Nexavar (sorafenib) AND 2.3 Disease is at least ONE of the following: - Symptomatic iodine-refractory - Unresectable locoregional recurrent or persistent disease - Distant metastatic disease	

Product Name:Cometriq	
Diagnosis	Thyroid 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 Cometriq therapy	

Product Name:Cometriq	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of non-small cell lung cancer (NSCLC) AND 2 - Positive for RET gene rearrangements	

Product Name:Cometriq	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
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 Cometriq therapy	

Product Name:Cometriq	
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:Cometriq	
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 Cometriq therapy	

2 . Revision History

Date	Notes
7/31/2025	Combined formularies. No changes to clinical criteria.

Complement Inhibitor Agents



Prior Authorization Guideline

Guideline ID	GL-436474
Guideline Name	Complement Inhibitor Agents
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	12/1/2025

1 . Criteria

Product Name:Empaveli	
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, laboratory values, etc.) documenting the diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) as confirmed by high sensitivity flow cytometry	

AND

2 - Patient is 18 years of age or older

AND

3 - Prescribed by, or in consultation with, a hematologist

AND

4 - Prescriber attests to all of the following:

- Patient does not have unresolved serious infection caused by encapsulated bacteria including *S. pneumoniae*, *N. meningitidis*, and *H. influenzae* type B
- Prescriber is enrolled in the Empaveli (pegcetacoplan) REMS (Risk Evaluation and Mitigation Strategy) program
- Patient will not be using Empaveli (pegcetacoplan) in combination with another complement inhibitor

AND

5 - One of the following:

5.1 Dose requested does not exceed 1,080 milligrams twice weekly (40 milliliters per week)

OR

5.2 For patients with lactate dehydrogenase (LDH) more than 2 times the upper limit of normal, dose does not exceed 1,080 milligrams every 3 days

Product Name:Empaveli	
Diagnosis	C3 glomerulopathy (C3G), Primary immune-complex membranoproliferative glomerulonephritis (IC-MPGN)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records documenting the diagnosis of C3 glomerulopathy (C3G) or primary immune-complex membranoproliferative glomerulonephritis (IC-MPGN), confirmed by one of the following: 1.1 Patients 18 years of age and older: renal biopsy OR 1.2 Patients 12 to 17 years of age, ONE of the following: • Renal biopsy • Plasma sC5b-9 level above the upper limit of normal • Serum C3 below the lower limit of normal • Presence of active urine sediment • Presence of C3 nephritic factor obtained within the past 6 months (must provide documentation) AND 2 - Submission of medical records documenting ALL of the following: • eGFR 30 mL/min/1.73 m² or greater • Proteinuria 1 g/day or greater • Urine protein-to-creatinine ratio (UPCR) 1g/g or greater AND 3 - Patient is 12 years of age or older AND 4 - ONE of the following:	

- Patient has utilized angiotensin-converting enzyme inhibitor (ACE-I) or angiotensin receptor blocker (ARB) therapy at a maximally tolerated dose for 90 of the past 120 days (supported by claims history or chart documentation) and will continue ACE-I or ARB therapy while using Empaveli
- Prescriber has submitted valid medical justification for the use of Empaveli (pegcetacoplan) without the concomitant use of max tolerated dose of an ACE-I or ARB agent (document rationale)

AND

5 - Prescriber attests to all of the following:

- Patient does not have unresolved serious infection caused by encapsulated bacteria including *S. pneumoniae*, *N. meningitidis*, and *H. influenzae* type B
- Prescriber is enrolled in the Empaveli (pegcetacoplan) REMS (Risk Evaluation and Mitigation Strategy) program
- Patient will not be using Empaveli (pegcetacoplan) in combination with another complement inhibitor

AND

6 - Dose requested does not exceed 1,080 milligrams twice weekly (40 milliliters per week)

Product Name:Empaveli	
Diagnosis	Paroxysmal nocturnal hemoglobinuria (PNH), C3 glomerulopathy (C3G), Primary immune-complex membranoproliferative glomerulonephritis (IC-MPGN)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of requested agent for 90 of the past 120 days, as confirmed by claims history, chart documentation, or prescriber attestation including trial dates	

AND

2 - Prescriber attests to all of the following:

- Patient does not have unresolved serious infection caused by encapsulated bacteria including *S. pneumoniae*, *N. meningitidis*, and *H. influenzae* type B
- Patient will not be using Empaveli (pegcetacoplan) in combination with another complement inhibitor
- Patient continues to show positive clinical response (may vary based on disease state) to Empaveli (pegcetacoplan) as confirmed by chart documentation (e.g., increased hemoglobin level/stabilization, decreased need for transfusions, normalized lactate dehydrogenase levels, improved fatigue, eGFR and UPCR have stabilized and/or improved)

AND

3 - One of the following:

3.1 Dose requested does not exceed 1,080 milligrams twice weekly (40 milliliters per week)

OR

3.2 For patients with paroxysmal nocturnal hemoglobinuria with lactate dehydrogenase (LDH) more than 2 times the upper limit of normal, dose does not exceed 1,080 milligrams every 3 days

Product Name: Fabhalta	
Diagnosis	Paroxysmal nocturnal hemoglobinuria
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, etc.) documenting the	

diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) as confirmed by high sensitivity flow cytometry

AND

2 - Prescribed by, or in consultation with, a hematologist

AND

3 - Patient is 18 years of age or older

AND

4 - Prescriber attests to all of the following:

- Patient does not have unresolved serious infection caused by encapsulated bacteria including *S. pneumoniae*, *N. meningitidis*, and *H. influenzae* type B
- Prescriber is enrolled in the Fabhalta (iptacopan) REMS (Risk Evaluation and Mitigation Strategy) program
- Patient will not be using Fabhalta (iptacopan) in combination with another complement inhibitor

AND

5 - Dose requested does not exceed 200 milligrams twice daily

Product Name:Fabhalta	
Diagnosis	Proteinuria associated with immunoglobulin A nephropathy
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of proteinuria associated with immunoglobulin A nephropathy (IgAN), confirmed by submission of medical records (e.g., chart notes, laboratory values, etc.) of renal biopsy

AND

2 - Submission of medical records (e.g., chart notes, laboratory values, etc.) documenting the urine protein-to-creatinine ratio (UPCR) greater than or equal to 1.5 g/g (grams per gram)

AND

3 - Submission of medical records (e.g., chart notes, laboratory values, etc.) documenting eGFR (estimated glomerular filtration rate) greater than or equal to 20 mL/min/1.73 m²

AND

4 - One of the following:

4.1 Patient has had previous trial and failure of at least 90 days of drug therapy with Filspari (sparsentan)

OR

4.2 Both of the following:

4.2.1 Prescriber has submitted valid medical justification for the use of Fabhalta (iptacopan) over Filspari (sparsentan)

AND

4.2.2 One of the following:

- Patient has had previous trial and failure of at least 90 days of drug therapy with a maximally tolerated angiotensin-converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) agent
- Prescriber has submitted valid medical justification for the use of Fabhalta (iptacopan) over ACE inhibitors and/or ARB agents

AND

5 - One of the following:

- Patient will continue adjunct ACE inhibitor or ARB agent with Fabhalta (iptacopan)
- Prescriber has submitted valid medical justification for the use of Fabhalta (iptacopan) as single-agent therapy

AND

6 - Patient is 18 years of age or older

AND

7 - Prescriber attests to all of the following:

- Patient does not have unresolved serious infection caused by encapsulated bacteria including *S. pneumoniae*, *N. meningitidis*, and *H. influenzae* type B
- Prescriber is enrolled in the Fabhalta (iptacopan) REMS (Risk Evaluation and Mitigation Strategy) program
- Patient will not be using Fabhalta (iptacopan) in combination with another complement inhibitor

AND

8 - Dose requested does not exceed 200 milligrams twice daily

Product Name:Fabhalta	
Diagnosis	Complement 3 glomerulopathy (C3G)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of complement 3 glomerulopathy (C3G) confirmed by submission of medical records (e.g., chart notes, laboratory values, etc.) of renal biopsy

AND

2 - Submission of medical records (e.g., chart notes, laboratory values, etc.) supporting the urine protein-to-creatinine ratio (UPCR) greater than or equal to 1.0 g/g (grams per gram)

AND

3 - Submission of medical records (e.g., chart notes, laboratory values, etc.) documenting eGFR (estimated glomerular filtration rate) greater than or equal to 30 mL/min/1.73 m²

AND

4 - One of the following:

- Patient has utilized angiotensin-converting enzyme inhibitor (ACE-I) or angiotensin receptor blocker (ARB) therapy at a maximally tolerated dose for 90 of the past 120 days (supported by claims history or chart documentation) and will continue ACE-I or ARB therapy while using Fabhalta
- Prescriber has submitted valid medical justification for the use of Fabhalta without the concomitant use of max tolerated dose of an ACE-I or ARB agent (document rationale)

AND

5 - Patient is 18 years of age or older

AND

6 - Prescriber attests to all of the following:

- Patient does not have history of kidney transplant
- Patient does not have unresolved serious infection caused by encapsulated bacteria including *S. pneumoniae*, *N. meningitidis*, and *H. influenzae* type B
- Prescriber is enrolled in the Fabhalta (iptacopan) REMS (Risk Evaluation and Mitigation Strategy) program

- Patient will not be using Fabhalta (iptacopan) in combination with another complement inhibitor

AND

7 - Dose requested does not exceed 200 milligrams twice daily

Product Name: Fabhalta	
Diagnosis	Paroxysmal nocturnal hemoglobinuria, Proteinuria associated with immunoglobulin A nephropathy, Complement 3 glomerulopathy (C3G)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - History of requested agent for 90 of the past 120 days, as confirmed by claims history, chart documentation, or prescriber attestation including trial dates

AND

2 - Prescriber attests to all of the following:

- Patient does not have unresolved serious infection caused by encapsulated bacteria including *S. pneumoniae*, *N. meningitidis*, and *H. influenzae* type B
- Patient will not be using Fabhalta (iptacopan) in combination with another complement inhibitor
- Patient continues to show positive clinical response (may vary based on disease state) to Fabhalta (iptacopan) as confirmed by chart documentation (e.g., increased hemoglobin level/stabilization, decreased need for transfusions, normalized lactate dehydrogenase levels, improved fatigue, eGFR and UPCR have stabilized and/or improved)

AND

3 - Dose requested does not exceed 200 milligrams twice daily

2 . Revision History

Date	Notes
10/30/2025	Added glomerulopathy for Empaveli. Updated C3G criteria for Fabhal ta

Compounds and Bulk Powders



Prior Authorization Guideline

Guideline ID	GL-534191
Guideline Name	Compounds and Bulk Powders
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 Florida MMA Medicaid - Community & State Michigan Medicaid - Community & State New Mexico Medicaid - Community & State North Carolina Medicaid - Community & State Virginia Medicaid - Community & State Washington Medicaid - Community & State Indiana Medicaid - Community & State Nebraska Medicaid - Community & State Pennsylvania

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Compounds or Bulk Powders	
Approval Length	12 month(s)
Guideline Type	Administrative
Approval Criteria 1 - The request is for compounded oral budesonide for the treatment of eosinophilic esophagitis* OR 2 - ALL of the following: 2.1 The requested drug component is a covered medication AND 2.2 ONE of the following: 2.2.1 The requested drug component is to be administered for an FDA (Food and Drug Administration)-approved indication OR 2.2.2 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 (USP-NF)	

AND

2.3 If a drug included in the compound requires prior authorization and/or step therapy, all drug specific clinical criteria must also be met

AND

2.4 If the drug component is no longer available commercially, it must not have been withdrawn for safety reasons

AND

2.5 ONE of the following:

- A unique vehicle is required
- 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
- 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
- There is a shortage of the commercially available product per the FDA Drug Shortage database or the ASHP (American Society of Health-System Pharmacists) Current Drug Shortages tracking log

AND

2.6 Coverage for compounds and bulk powders will NOT be approved for any of the following:

2.6.1 For topical compound preparations (e.g., creams, ointments, lotions, or gels to be applied to the skin for transdermal, transcutaneous, or any other topical route), if the requested compound contains any FDA approved ingredient that is not FDA approved for TOPICAL use (see Table 1 in Background section)

OR

2.6.2 If the requested compound contains topical fluticasone, topical fluticasone will NOT be approved unless both of the following are met:

2.6.2.1 Topical fluticasone is intended to treat a dermatologic condition (scar treatments are considered cosmetic and will not be covered)

AND

2.6.2.2 Patient has a contraindication to all commercially available topical fluticasone formulations

OR

2.6.3 Requested compound contains any ingredients when used for cosmetic purposes (see Table 2 in Background section)

OR

2.6.4 Requested compound contains any ingredient(s) which are on the FDA's Do Not Compound List (see Table 3 in Background section)

Notes

*All other indications for budesonide refer to criteria in step 2

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) Valdecocib

(62) Zomepirac sodium

3 . Revision History

Date	Notes
2/25/2026	Removed LA from formularies.

Continuous Glucose Monitors



Prior Authorization Guideline

Guideline ID	GL-551233
Guideline Name	Continuous Glucose Monitors
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:Non-preferred Continuous Glucose Monitors, sensors, and transmitters (includes all brands except Dexcom G6 and Dexcom G7^)	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - If the request is non-preferred*, one of the following: 1.1 The non-preferred continuous glucose monitor (CGM) exclusively integrates with the member's pre-existing or IHCP (Indiana Health Coverage Programs) authorized insulin infusion device (please document name of insulin infusion device)	

OR

1.2 A documented, medically justifiable reason that the non-preferred product should be used instead of the preferred product is provided

Notes	^Dexcom G7 15 day sensors are non-preferred and follow this criteria *PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

2 . Revision History

Date	Notes
3/18/2026	Added Dexcom G7 15 day and note.

Copiktra



Prior Authorization Guideline

Guideline ID	GL-363190
Guideline Name	Copiktra
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland 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 Virginia Medicaid - Community & State Indiana Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	9/1/2025

1 . Criteria

Product Name:Copiktra

Diagnosis	Chronic Lymphocytic Leukemia (CLL) / Small Lymphocytic Lymphoma (SLL)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL) AND 2 - Disease is relapsed or refractory AND 3 - ONE of the following: 3.1 Failure to at least TWO prior therapies for CLL/SLL confirmed by claims history or submitted medical records. Examples include, but not limited to, regimens consisting of: [Leukeran (chlorambucil), Gazyva (obinutuzumab), Arzerra (ofatumumab), Bendeka (bendamustine), Imbruvica (ibrutinib), Calquence (acalabrutinib), Venclexta (venetoclax), etc.] OR 3.2 History of intolerance or contraindication to at least TWO prior therapies for CLL/SLL. Examples include, but not limited to, regimens consisting of: [Leukeran (chlorambucil), Gazyva (obinutuzumab), Arzerra (ofatumumab), Bendeka (bendamustine), Imbruvica (ibrutinib), Calquence (acalabrutinib), Venclexta (venetoclax), etc.] (please specify intolerance or contraindication)	

Product Name: Copiktra	
Diagnosis	T-cell Lymphomas
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria 1 - For diagnosis of Hepatosplenic T-cell lymphoma, ALL of the following: 1.1 Disease is relapsed or refractory AND 1.2 ONE of the following: • Failure to at least two prior systemic therapies confirmed by claims history or submitted medical records • History of intolerance or contraindication to at least two prior systemic therapies (please specify intolerance or contraindication) OR 2 - For diagnosis of Breast implant-associated anaplastic large cell lymphoma, ALL of the following: • Disease is relapsed or refractory • Used as second-line and subsequent therapy OR 3 - For diagnosis of Peripheral T-cell lymphoma, ONE of the following: • Used as initial palliative intent therapy • Used as second-line and subsequent therapy	

Product Name: Copiktra	
Diagnosis	Chronic Lymphocytic Leukemia (CLL) / Small Lymphocytic Lymphoma (SLL), T-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 Copiktra therapy	

Product Name:Copiktra	
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:Copiktra	
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 Copiktra therapy	

2 . Revision History

UnitedHealthcare Community Plan of Indiana Clinical Pharmacy Program Guidelines

Date	Notes
8/11/2025	Updated formularies to add IN

Copper Chelating Agents



Prior Authorization Guideline

Guideline ID	GL-354250
Guideline Name	Copper Chelating Agents
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 Virginia Medicaid - Community & State Pennsylvania Medicaid - Community & State Nebraska Medicaid - Community & State Indiana Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	9/1/2025

1 . Criteria

Product Name:Brand Depen Titratabs, 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 Titratabs, 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 therapy	

Product Name:Brand Depen Titratabs, generic penicillamine tablets	
Diagnosis	Wilson's disease, Cystinuria
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following diagnoses: - Wilson's disease (i.e., hepatolenticular degeneration) - Cystinuria	

Product Name: Brand Cuprimine, generic penicillamine capsules	
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 - ONE of the following: 2.1 Failure to BOTH of the following as confirmed by claims history or submission of medical records: • penicillamine tablets (generic Depen Titratabs) • trientine 250 mg capsules (generic Syprine) OR 2.2 History of intolerance to BOTH of the following (please specify intolerance): • penicillamine tablets (generic Depen Titratabs) • trientine 250 mg capsules (generic Syprine)	

Product Name: Brand Cuprimine, generic penicillamine capsules	
Diagnosis	Cystinuria, Severe active rheumatoid arthritis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following diagnoses:

- Cystinuria
- Severe active rheumatoid arthritis

AND

2 - ONE of the following:

2.1 Failure to penicillamine tablets (generic Depen Titratabs) as confirmed by claims history or submission of medical records

OR

2.2 History of intolerance to penicillamine tablets (generic Depen Titratabs) (please specify intolerance)

Product Name: Brand Cuprimine, generic penicillamine capsules	
Diagnosis	Wilson's disease, 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 therapy	

Product Name: Brand Syprine, generic trientine hcl 250 mg capsules	
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)	

Product Name:Brand Syprine, generic trientine hcl 250 mg capsules	
Diagnosis	Wilson's 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:trientine hcl 500 mg capsules	
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 - ONE of the following:	

2.1 Failure to BOTH of the following as confirmed by claims history or submission of medical records:

- penicillamine tablets (generic Depen Titratabs)
- trientine 250 mg capsules (generic Syprine)

OR

2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- penicillamine tablets (generic Depen Titratabs)
- trientine 250 mg capsules (generic Syprine)

Product Name:trientine hcl 500 mg capsules	
Diagnosis	Wilson's 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
8/6/2025	Updated formularies

Cotellic



Prior Authorization Guideline

Guideline ID	GL-578223
Guideline Name	Cotellic
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Cotellic	
Diagnosis	Melanoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of melanoma	

AND

2 - ONE of the following:

2.1 Patient has unacceptable toxicities to Tafinlar (dabrafenib)/Mekinist (trametinib) on the basis of agent side-effect profile

OR

2.2 Disease is one of the following:

- Relapsed greater than 3 months after treatment discontinuation
- Unresectable
- Metastatic

AND

3 - Disease is positive for ONE of the following mutations:

- BRAF V600E
- BRAF V600K

AND

4 - Used in combination with Zelboraf (vemurafenib)

Product Name:Cotellic	
Diagnosis	Central Nervous System (CNS) Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - One of the following:

- Circumscribed glioma
- Glioblastoma

AND

2 - Disease is positive for one of the following mutations:

- BRAF V600E
- BRAF V600K

AND

3 - Used in combination with Zelboraf (vemurafenib)

Product Name:Cotellic	
Diagnosis	Melanoma, Central Nervous System (CNS) Cancers
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 Cotellic therapy AND 2 - Used in combination with Zelboraf (vemurafenib)	

Product Name:Cotellic	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of one of the following histiocytic neoplasms: • Langerhans cell histiocytosis • Erdheim-Chester disease • Rosai-Dorfman Disease	

Product Name:Cotellic	
Diagnosis	Histiocytic Neoplasms
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 Cotellic therapy	

Product Name:Cotellic	
Diagnosis	NCCN Recommended Regimen
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:Cotellic	
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 Cotellic therapy	

2 . Revision History

Date	Notes
4/13/2026	Updated criteria for CNS cancers and histiocytic neoplasms

Crenessity



Prior Authorization Guideline

Guideline ID	GL-439190
Guideline Name	Crenessity
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 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:Crenessity	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of classic congenital adrenal hyperplasia (CAH) due to 21-hydroxylase deficiency AND 2 - Diagnosis confirmed by one of the following: • Pretreatment serum 17-hydroxyprogesterone (17-OHP) level > 3,000 ng/dL • Cosyntropin stimulation 17OHP level > 10,000 ng/dL • Genetic variant in CYP21A2 gene AND 3 - Patient is 4 years of age or older AND 4 - Chronic treatment with a supraphysiologic glucocorticoid (GC) regimen (e.g., dexamethasone, hydrocortisone, methylprednisolone, prednisone, prednisolone) defined as ONE of the following: 4.1 BOTH of the following: • Patient is 4 to 17 years old • Daily glucocorticoid dose > 12 mg/m² in hydrocortisone dose equivalents	

OR

4.2 BOTH of the following:

- Patient is at least 18 years old
- Daily glucocorticoid dose > 13 mg/m²/day in hydrocortisone dose equivalents

AND

5 - Prescribed by an endocrinologist

AND

6 - If the request is for Crenessity oral solution, ONE of the following:

6.1 Patient is unable to ingest a solid dosage form (e.g., an oral tablet or capsule) due to ONE of the following:

- Age
- Oral-motor difficulties
- Dysphagia

OR

6.2 Patient utilizes a feeding tube for medication administration

Product Name:Crenessity	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Crenessity therapy (e.g., reduction in total glucocorticoid daily dose, decreased androstenedione levels)	

AND

2 - Patient will continue to receive concomitant glucocorticoid replacement (e.g., dexamethasone, hydrocortisone, methylprednisolone, prednisone, prednisolone)

AND

3 - Prescribed by an endocrinologist

AND

4 - If the request is for Crenessity oral solution, ONE of the following:

4.1 Patient is unable to ingest a solid dosage form (e.g., an oral tablet or capsule) due to ONE of the following:

- Age
- Oral-motor difficulties
- Dysphagia

OR

4.2 Patient utilizes a feeding tube for medication administration

2 . Revision History

Date	Notes
11/5/2025	Added Nevada Formulary

Crenessity



Prior Authorization Guideline

Guideline ID	GL-439190
Guideline Name	Crenessity
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 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:Crenessity	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of classic congenital adrenal hyperplasia (CAH) due to 21-hydroxylase deficiency AND 2 - Diagnosis confirmed by one of the following: • Pretreatment serum 17-hydroxyprogesterone (17-OHP) level > 3,000 ng/dL • Cosyntropin stimulation 17OHP level > 10,000 ng/dL • Genetic variant in CYP21A2 gene AND 3 - Patient is 4 years of age or older AND 4 - Chronic treatment with a supraphysiologic glucocorticoid (GC) regimen (e.g., dexamethasone, hydrocortisone, methylprednisolone, prednisone, prednisolone) defined as ONE of the following: 4.1 BOTH of the following: • Patient is 4 to 17 years old • Daily glucocorticoid dose > 12 mg/m² in hydrocortisone dose equivalents	

OR

4.2 BOTH of the following:

- Patient is at least 18 years old
- Daily glucocorticoid dose > 13 mg/m²/day in hydrocortisone dose equivalents

AND

5 - Prescribed by an endocrinologist

AND

6 - If the request is for Crenessity oral solution, ONE of the following:

6.1 Patient is unable to ingest a solid dosage form (e.g., an oral tablet or capsule) due to ONE of the following:

- Age
- Oral-motor difficulties
- Dysphagia

OR

6.2 Patient utilizes a feeding tube for medication administration

Product Name:Crenessity	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Crenessity therapy (e.g., reduction in total glucocorticoid daily dose, decreased androstenedione levels)	

AND

2 - Patient will continue to receive concomitant glucocorticoid replacement (e.g., dexamethasone, hydrocortisone, methylprednisolone, prednisone, prednisolone)

AND

3 - Prescribed by an endocrinologist

AND

4 - If the request is for Crenessity oral solution, ONE of the following:

4.1 Patient is unable to ingest a solid dosage form (e.g., an oral tablet or capsule) due to ONE of the following:

- Age
- Oral-motor difficulties
- Dysphagia

OR

4.2 Patient utilizes a feeding tube for medication administration

2 . Revision History

Date	Notes
11/5/2025	Added Nevada Formulary

Ctexli



Prior Authorization Guideline

Guideline ID	GL-532222
Guideline Name	Ctexli
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 Indiana Medicaid - Community & State Michigan Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Ctexli	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of cerebrotendinous xanthomatosis (cholestanol storage disease) AND 2 - Disease is confirmed by the presence of pathogenic variant(s) in the CYP27A1 gene AND 3 - Prescribed by or in consultation with ONE of the following: • Endocrinologist • Geneticist • Neurologist	

Product Name:Ctexli	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Ctexli therapy AND 2 - Prescribed by or in consultation with ONE of the following: • Endocrinologist	

- Geneticist
- Neurologist

2 . Revision History

Date	Notes
3/2/2026	Removed VA

Cushing's Syndrome Agents



Prior Authorization Guideline

Guideline ID	GL-531190
Guideline Name	Cushing's Syndrome Agents
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Isturisa	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of endogenous hypercortisolemia in patients with Cushing's syndrome for whom surgery is not an option or has not been curative	

AND

2 - Patient is 18 years of age or older

AND

3 - Requested dose does not exceed 60 mg/day (milligrams per day)

Product Name:Isturisa	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested agent in the past 90 days AND 2 - Requested dose does not exceed 60 mg/day (milligrams per day)	

Product Name:Brand Korlym, generic mifepristone 300 mg	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of hyperglycemia secondary to hypercortisolism in patients with endogenous	

Cushing's syndrome who have type 2 diabetes mellitus or glucose intolerance and have failed surgery or are not candidates for surgery

AND

2 - Patient is 18 years of age or older

AND

3 - For women of childbearing potential, must have a negative pregnancy test in the past 30 days and prescriber has counseled patient on risks associated with conceiving while utilizing mifepristone and appropriate methods of non-hormonal contraception

AND

4 - Prescriber attests the patient does not have any of the following contraindications:

- Concomitant use of any of the following: simvastatin, lovastatin, CYP3A substrates with narrow therapeutic ranges (e.g. cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozide, quinidine, sirolimus, tacrolimus, etc.), systemic corticosteroids being utilized for life-saving purposes (e.g., immunosuppression following organ transplant)
- Endometrial carcinoma
- Endometrial hyperplasia with atypia
- History of unexplained vaginal bleeding

AND

5 - Requested dose does not exceed 1200 mg/day (milligrams per day)

Product Name: Brand Korlym, generic mifepristone 300 mg	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - History of the requested agent in the past 90 days

AND

2 - Requested dose does not exceed 1200 mg/day (milligrams per day)

Product Name:Lysodren

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following indications for use:

- Cushing's syndrome
- Inoperable adrenocortical cancer

AND

2 - Patient is 18 years of age or older

AND

3 - For women of childbearing potential, must have a negative pregnancy test in the past 30 days

AND

4 - Requested dose does not exceed 12 g/day (grams per day)

Product Name:Lysodren

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested agent in the past 90 days AND 2 - Requested dose does not exceed 12 g/day (grams per day)	

Product Name:Metopirone	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following: 1.1 Patient is 18 years of age or older and has one of the following indications for use: • Cushing's syndrome • Pituitary-dependent hypercortisolism OR 1.2 Patient requires diagnostic testing of hypothalamic-pituitary-adrenocorticotrophic (HPA) hormone function AND	

2 - Prescriber attests that patient does not have adrenal cortical insufficiency

AND

3 - Requested dose does not exceed 6 g/day (grams per day)

Product Name:Metopirone

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - History of the requested agent in the past 90 days

AND

2 - Requested dose does not exceed 6 g/day (grams per day)

Product Name:Recorlev

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 - Diagnosis of endogenous hypercortisolemia in patients with Cushing's syndrome for whom surgery is not an option or has not been curative

AND

3 - Prescriber attests the patient does not have any of the following contraindications:

- A prior history of drug induced liver injury due to ketoconazole or any azole antifungal therapy that required discontinuation of treatment
- Acute liver disease or poorly controlled liver disease
- Baseline AST or ALT greater than 3 times the upper limit of normal
- Baseline QTcF interval greater than 470 msec
- Cirrhosis
- Concomitant use of medications that cause QT prolongation associated with ventricular arrhythmias (including torsades de pointes)
- Concomitant use with certain sensitive substrates of CYP3A4 or CYP3A4 and P-g
- Extensive metastatic liver disease
- History of torsades de pointes, ventricular tachycardia/fibrillation, or prolonged QT syndrome
- Recurrent symptomatic cholelithiasis

AND

4 - Requested dose does not exceed 1.2 g/day (grams per day)

Product Name:Recorlev	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested agent in the past 90 days AND	

2 - Requested dose does not exceed 1.2 g/day (grams per day)

Product Name:Signifor	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Cushing's syndrome in patients for whom pituitary surgery is not an option or has not been curative AND 2 - Patient is 18 years of age or older AND 3 - Requested dose does not exceed 2.4 mg/day (milligrams per day)	

Product Name:Signifor	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested agent in the past 90 days AND	

2 - Requested dose does not exceed 2.4 mg/day (milligrams per day)

Product Name:Signifor LAR	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following: • Diagnosis of Cushing's syndrome in patients for whom pituitary surgery is not an option or has not been curative • Diagnosis of acromegaly in patients who have had an inadequate response to surgery or for whom surgery is not an option AND 2 - Patient is 18 years of age or older AND 3 - One of the following: • Requested dose does not exceed 40 mg every 4 weeks for the diagnosis of Cushing's syndrome • Requested dose does not exceed 60 mg every 4 weeks for the diagnosis of acromegaly	

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

Approval Criteria

1 - History of the requested agent within the past 90 days

AND

2 - One of the following:

- Requested dose does not exceed 40 mg every 4 weeks for the diagnosis of Cushing's syndrome
- Requested dose does not exceed 60 mg every 4 weeks for the diagnosis of acromegaly

2 . Revision History

Date	Notes
2/25/2026	New guideline

Cuvrior



Prior Authorization Guideline

Guideline ID	GL-224221
Guideline Name	Cuvrior
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Indiana Medicaid - Community & State Maryland Medicaid - Community & State Michigan 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 CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	5/1/2025

1 . Criteria

Product Name:Cuvrior	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Wilson's disease

AND

2 - Patient is de-coppered [i.e., serum non-ceruloplasmin copper (NCC) level greater than or equal to 25 and less than or equal to 150 mcg/L (micrograms/liter)]

AND

3 - Patient is tolerant to penicillamine

AND

4 - Prescriber provides a reason or special circumstance why the patient cannot use penicillamine tablets (generic Depen Titratabs)

AND

5 - ONE of the following:

5.1 Failure to trientine 250 mg capsules (generic Syprine) as confirmed by claims history or submission of medical records

OR

5.2 History of intolerance to trientine 250 mg capsules (generic Syprine) (please specify intolerance)

AND

6 - Prescribed by a hepatologist

Product Name:Cuvrior

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Cuvrior therapy (e.g., increased 24-hour urinary copper excretion from baseline, normalization of serum free copper, prevention of or improvement in symptoms)

AND

2 - Prescribed by a hepatologist

2 . Revision History

Date	Notes
3/24/2025	Combined formularies. No changes to clinical criteria.

Cystaran, Cystadrops



Prior Authorization Guideline

Guideline ID	GL-439195
Guideline Name	Cystaran, Cystadrops
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 Virginia Medicaid - Community & State Nebraska Medicaid - Community & State New Mexico Medicaid - Community & State Indiana Medicaid - Community & State Pennsylvania Medicaid - Community & State Nevada

Guideline Note:

Effective Date:	1/1/2026

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
11/5/2025	Added Nevada Formulary

Danziten, nilotinib D-tartrate, Tasigna



Prior Authorization Guideline

Guideline ID	GL-578225
Guideline Name	Danziten, nilotinib D-tartrate, Tasigna
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland 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 Virginia Medicaid - Community & State New Mexico Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name: Brand Tasigna, generic nilotinib, Nilotinib D-tartrate, Danziten	
Diagnosis	Chronic Myeloid Leukemia

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chronic myeloid leukemia AND 2 - ONE of the following: 2.1 Patient is not a candidate for imatinib as attested by physician OR 2.2 Patient is currently on nilotinib (i.e., Brand Tasigna, generic nilotinib, Nilotinib D-tartrate, or Danziten) therapy AND 3 - If the request is for Nilotinib d-tartrate or brand Tasigna, prescriber provides a reason or special circumstance the patient cannot use nilotinib (generic Tasigna) (please document rationale)	

Product Name:Brand Tasigna, generic nilotinib, Nilotinib D-tartrate, Danziten	
Diagnosis	Gastrointestinal Stromal Tumor (GIST)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of progressive gastrointestinal stromal tumor (GIST)

AND

2 - ONE of the following:

2.1 Failure to ALL of the following, as confirmed by claims history or submission of medical records:

- Imatinib (generic Gleevec)
- Sunitinib (generic Sutent)
- Stivarga (regorafenib)
- Qinlock (ripretinib)

OR

2.2 History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- Imatinib (generic Gleevec)
- Sunitinib (generic Sutent)
- Stivarga (regorafenib)
- Qinlock (ripretinib)

AND

3 - If the request is for Nilotinib d-tartrate or brand Tasigna, prescriber provides a reason or special circumstance the patient cannot use nilotinib (generic Tasigna) (please document rationale)

Product Name: Brand Tasigna, generic nilotinib, Nilotinib D-tartrate, Danziten	
Diagnosis	Acute Lymphoblastic Leukemia (Ph+B-ALL)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Philadelphia chromosome-positive B-cell acute lymphoblastic leukemia (Ph+B-ALL)

AND

2 - If the request is for Nilotinib d-tartrate or brand Tasigna, prescriber provides a reason or special circumstance the patient cannot use nilotinib (generic Tasigna) (please document rationale)

Product Name: Brand Tasigna, generic nilotinib, Nilotinib D-tartrate, Danziten

Diagnosis	Myeloid/Lymphoid Neoplasms with Eosinophilia and Tyrosine Kinase Fusion Genes
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of myeloid, lymphoid or mixed lineage neoplasms with eosinophilia and ABL1 (gene) rearrangement

AND

2 - Neoplasm is in blast or chronic phase

AND

3 - If the request is for Nilotinib d-tartrate or brand Tasigna, prescriber provides a reason or special circumstance the patient cannot use nilotinib (generic Tasigna) (please document rationale)

Product Name: Brand Tasigna, generic nilotinib, Nilotinib D-tartrate, Danziten

Diagnosis	Melanoma: Cutaneous

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of metastatic or unresectable melanoma cutaneous tumors with activating mutations of KIT AND 2 - Used as second-line or subsequent therapy for disease progression, intolerance, and or projected risk of progression with BRAF-targeted therapy AND 3 - If the request is for Nilotinib d-tartrate or brand Tasigna, prescriber provides a reason or special circumstance the patient cannot use nilotinib (generic Tasigna) (please document rationale)	

Product Name:Brand Tasigna, generic nilotinib, Nilotinib D-tartrate, Danziten	
Diagnosis	Soft Tissue Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of pigmented villonodular synovitis/tenosynovial giant cell tumor AND 2 - If the request is for Nilotinib d-tartrate or brand Tasigna, prescriber provides a reason or	

special circumstance the patient cannot use nilotinib (generic Tassigna) (please document rationale)

Product Name:Brand Tassigna, generic nilotinib, Nilotinib D-tartrate, Danziten	
Diagnosis	Chronic Myeloid Leukemia, Gastrointestinal Stromal Tumor (GIST), Acute Lymphoblastic Leukemia (Ph+B-ALL), Myeloid/Lymphoid Neoplasms with Eosinophilia and Tyrosine Kinase Fusion Genes, Melanoma: Cutaneous, Soft Tissue 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 therapy	

Product Name:Brand Tassigna, generic nilotinib, Nilotinib D-tartrate, Danziten	
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:Brand Tassigna, generic nilotinib, Nilotinib D-tartrate, Danziten	
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
4/14/2026	Added Indiana. Updated GPIs and product names throughout to accommodate new MSC N for Nilotinib d-tartrate

Daurismo



Prior Authorization Guideline

Guideline ID	GL-578229
Guideline Name	Daurismo
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 New Mexico Medicaid - Community & State Virginia Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Daurismo	
Diagnosis	Acute Myeloid Leukemia

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of newly-diagnosed acute myeloid leukemia (AML) AND 2 - Daurismo therapy to be given in combination with low-dose cytarabine AND 3 - ONE of the following: 3.1 Patient is 75 years of age or older OR 3.2 Patient has significant comorbidities that preclude the use of intensive induction chemotherapy [e.g., severe cardiac disease, Eastern Cooperative Oncology Group (ECOG) performance status greater than or equal to 2, baseline creatinine greater than 1.3 milligrams/deciliter]	

Product Name:Daurismo	
Diagnosis	Acute Myeloid 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 Daurismo therapy

Product Name:Daurismo

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:Daurismo

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 Daurismo therapy

2 . Revision History

Date	Notes

4/14/2026	Added Indiana

Daybue



Prior Authorization Guideline

Guideline ID	GL-595189
Guideline Name	Daybue
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Daybue, Daybue Stix	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following: • Patient is 2 years of age or older	

- Patient weighs 9 kg (kilograms) or more

AND

2 - Diagnosis of Rett Syndrome (RTT) with BOTH of the following:

2.1 Submission of medical records confirming genetic analysis demonstrating mutation(s) in the methyl-CpG binding protein-2 (MECP2) gene

AND

2.2 Diagnosis of Typical or Classic Rett syndrome with a period of regression followed by recovery or stabilization, confirmed by ALL of the following:

- Partial or complete loss of acquired purposeful hand skills
- Partial or complete loss of acquired spoken language
- Gait abnormalities: impaired or absence of ability to walk
- Hand wringing/squeezing/clapping/tapping, mouthing, and/or washing/rubbing that seems habitual or uncontrollable

AND

3 - Prescribed by, or in consultation with, a neurologist or specialist with expertise in the management of RTT

AND

4 - Prescriber attests that patient does NOT have either of the following:

- Brain injury secondary to trauma (peri-or postnatally), neurometabolic disease, or severe infection that causes neurological problems
- Severe renal impairment (eGFR [estimated Glomerular Filtration Rate] less 30 milliliters/minute/1.73 m²)

AND

5 - Requested quantity does NOT exceed one of the following:

- Daybue oral solution: 120 mL (milliliter) per day or 8 bottles (450 mL) per 30 days

- Daybue STIX 5,000 mg (milligram) packet: 4 packets/day or 120 packets/30 days
- Daybue STIX 6,000 mg packet: 4 packets/day or 120 packets/30 days
- Daybue STIX 8,000 mg packet: 2 packets/day or 60 packets/30 days

Product Name:Daybue, Daybue Stix	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested agent for at least 90 days within the past 120 days, confirmed by claims history or submission of medical records AND 2 - Submission of medical records demonstrating ONE of the following: • Patient has achieved disease stability • Patient has achieved clinically significant improvement in core symptoms • Patient has experienced less than expected decline in disease progression AND 3 - Prescriber attests that patient does NOT have either of the following: • Brain injury secondary to trauma (peri-or postnatally), neurometabolic disease, or severe infection that causes neurological problems • Severe renal impairment (eGFR [estimated Glomerular Filtration Rate] less 30 milliliters/minute/1.73 m²) AND 4 - Requested quantity does NOT exceed one of the following: • Daybue oral solution: 120 mL (milliliter) per day or 8 bottles (450 mL) per 30 days	

- Daybue STIX 5,000 mg (milligram) packet: 4 packets/day or 120 packets/30 days
- Daybue STIX 6,000 mg packet: 4 packets/day or 120 packets/30 days
- Daybue STIX 8,000 mg packet: 2 packets/day or 60 packets/30 days

2 . Revision History

Date	Notes
4/24/2026	Updated criteria from matching CORE to align with state policy.

Descovy



Prior Authorization Guideline

Guideline ID	GL-202203
Guideline Name	Descovy
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Indiana Medicaid - Community & State Maryland Medicaid - Community & State New Mexico Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island

Guideline Note:

Effective Date:	4/1/2025

1 . Criteria

Product Name:Descovy	
Diagnosis	Human Immunodeficiency Virus-1 (HIV-1)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of human immunodeficiency virus-1 (HIV-1)

AND

2 - ONE of the following:

2.1 Submission of medical records documenting a history of adverse event or intolerance to prior use of emtricitabine/tenofovir disoproxil fumarate (generic Truvada)

OR

2.2 Patient is currently on Descovy therapy

OR

2.3 Submission of medical records documenting an estimated GFR (glomerular filtration rate) below 90 mL/min (milliliters/minute)

OR

2.4 Submission of medical records documenting a diagnosis of osteoporosis as defined by a BMD (bone mineral density) T-score 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) [Provider must submit patient specific BMD T-score]

OR

2.5 Submission of medical records documenting a prior low-trauma or non-traumatic fracture

OR

2.6 Patient is less than 20 years of age

OR

2.7 Submission of medical records documenting a diagnosis of osteopenia as defined by a 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) [Provider must submit patient specific BMD T-scores] with evidence of progressive bone loss on serial DEXA (dual-energy X-ray absorptiometry) scan

Product Name:Descovy

Diagnosis	Post-Exposure Prophylaxis (PEP)

Approval Length	4 Week(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of post-exposure prophylaxis (PEP)

Product Name:Descovy 200/25 mg

Diagnosis	HIV-1 Pre-Exposure Prophylaxis (PrEP)

Approval Length	Authorization will be issued for 12 months at GPI-14 level to approve only the 200/25mg strength

Guideline Type	Prior Authorization

Approval Criteria

1 - Request is for 200/25 mg strength

AND

2 - Used for HIV-1 pre-exposure prophylaxis (PrEP)

AND

3 - ONE of the following:

3.1 Submission of medical records documenting a history of adverse event or intolerance to prior use of emtricitabine/tenofovir disoproxil fumarate (generic Truvada)

OR

3.2 Submission of medical records documenting an estimated GFR (glomerular filtration rate) below 90 mL/min (milliliters/minute)

OR

3.3 Submission of medical records documenting a diagnosis of osteoporosis as defined by a BMD (bone mineral density) T-score 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) [Provider must submit patient specific BMD T-score]

OR

3.4 Submission of medical records documenting a prior low-trauma or non-traumatic fracture

OR

3.5 Patient is less than 20 years of age

OR

3.6 Submission of medical records documenting a diagnosis of osteopenia as defined by a 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) [Provider must submit patient specific BMD T-scores] with evidence of progressive bone loss on serial DEXA (dual-energy X-ray absorptiometry) scan

2 . Revision History

Date	Notes
2/27/2025	Combined formularies, but removed NY and NY EPP from markets in scope as Descovy moving to open access for these markets. No changes to criteria.

Dificid



Prior Authorization Guideline

Guideline ID	GL-443195
Guideline Name	Dificid
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	12/1/2025

1 . Criteria

Product Name:Brand Dificid, generic fidaxomicin^	
Approval Length	1 year(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of clostridium difficile infection (CDI) AND	

2 - Patient is 6 months of age or older

AND

3 - One of the following:

3.1 Patient has an initial episode of CDI and one of the following:

- Patient is at increased risk of CDI recurrence
- Provider has submitted documentation supporting diagnosis of vancomycin-resistant pseudomembranous colitis

OR

3.2 Patient has a recurrent episode of CDI

Notes	^Generic fidaxomicin needs to be reviewed by clinician for generic over brand review

2 . Revision History

Date	Notes
11/6/2025	Added generic fidaxomicin. Added note regarding generic over brand review.

Direct Oral Anticoagulants



Prior Authorization Guideline

Guideline ID	GL-465218
Guideline Name	Direct Oral Anticoagulants
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name: Brand Xarelto suspension, generic rivaroxaban suspension	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is under 12 years of age OR	

2 - Patient is unable to swallow tablets

Product Name:Savaysa

Approval Length 12 month(s)

Guideline Type Prior Authorization

Approval Criteria

1 - Patient has tried Eliquis and Xarelto

OR

2 - Documentation of medical justification for use of Savaysa over Eliquis and Xarelto

Product Name:Pradaxa Pak

Approval Length 12 month(s)

Guideline Type Prior Authorization

Approval Criteria

1 - Patient is under 8 years of age

OR

2 - Patient is unable to swallow capsules

OR

3 - Documentation of medical rationale for use of pellet formulation

Product Name:Eliquis sprinkle capsules	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is less than 18 years of age AND 2 - Patient weighs 2.6 kilograms (kg) to less than 4 kg	

Product Name:Eliquis tablet for oral suspension	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is less than 18 years of age AND 2 - Patient weighs 4 kilograms (kg) to less than 35 kg	

2 . Revision History

Date	Notes
12/12/2025	Removed generic dabigatran products as targets. Added generic riva roxaban susp as a target. Updated criteria for Savaysa. Corrected spelling of "rationale" in criteria section for Pradaxa Pak. Added criteria

	for new target drugs, Eliquis sprinkle cap and Eliquis tab for oral susp .

Disposable Insulin Delivery Devices



Prior Authorization Guideline

Guideline ID	GL-422563
Guideline Name	Disposable Insulin Delivery Devices
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	11/1/2025

1 . Criteria

Product Name:Omnipod Dash (Gen 4), Omnipod 5, V-Go 20, V-Go 30, V-Go 40, CeQur Simplicity, Modd1	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Type I or Type II diabetes mellitus requiring insulin treatment AND	

2 - Patient's total daily insulin dosing requirements are less than the requested disposable insulin delivery device's capacity

AND

3 - One of the following:

3.1 Patient has difficulty maintaining stable blood glucose levels (hyperglycemia or hypoglycemia) despite intensive insulin therapy and blood glucose monitoring (3 or more injections and blood glucose readings per day)

OR

3.2 Patient is less than 18 years of age and requires intensive insulin therapy and blood glucose monitoring (3 or more injections and blood glucose readings per day)

OR

3.3 Patient has physical impairments resulting in difficulty with self-injection of insulin

OR

3.4 Patient is pregnant

OR

3.5 Prescriber has provided other valid medical justification for use of a disposable insulin delivery device (document rationale)

AND

4 - For all requests other than CeQur Simplicity, other long-acting insulins/insulin analogs will be discontinued

Product Name:Omnipod Dash (Gen 4), Omnipod 5, V-Go 20, V-Go 30, V-Go 40, CeQur Simplicity, Modd1	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested product within the past 90 days AND 2 - Patient's total daily insulin dosing requirements are less than the requested disposable insulin delivery device's capacity AND 3 - For all requests other than CeQur Simplicity, other long-acting insulins/insulin analogs will be discontinued	

2 . Revision History

Date	Notes
10/22/2025	Added Modd and Omnipod 5. Removed Omnipod Go and Omnipod Classic. Added reauth criteria

Dojolvi



Prior Authorization Guideline

Guideline ID	GL-439199
Guideline Name	Dojolvi
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 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:Dojolvi	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records confirming the diagnosis of long-chain fatty acid oxidation disorders (LC-FAOD) with at least two of the following diagnostic criteria: • Disease specific elevation of acyl-carnitines on a newborn blood spot or in plasma • Low enzyme activity in cultured fibroblasts • Genetic testing demonstrating one or more pathogenic mutations in a gene associated with long-chain fatty acid oxidation disorders (e.g., CPT2, ACADVL, HADHA, or HADHB) AND 2 - Patient is not receiving Dojolvi in combination with any other medium-chain triglyceride (MCT) products AND 3 - Prescribed by a board-certified medical geneticist experienced in the treatment of long-chain fatty acid oxidation disorders (LC-FAOD) AND 4 - Target recommended daily dosage does not exceed 35% of the patient's total prescribed daily caloric intake (DCI) AND	

5 - Patient is receiving disease related dietary management

AND

6 - If not diagnosed by newborn screening, patient has a history of clinical manifestations of long-chain fatty acid oxidation disorders LC-FAOD (e.g., rhabdomyolysis)

Product Name:Dojolvi

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Dojolvi therapy (e.g., increased cardiac efficiency, decreased left ventricular wall mass, decreased incidence of rhabdomyolysis, etc.)

AND

2 - Patient is not receiving Dojolvi in combination with any other medium-chain triglyceride (MCT) product

AND

3 - Prescribed by a board-certified medical geneticist experienced in the treatment of long-chain fatty acid oxidation disorders (LC-FAOD)

AND

4 - Target recommended daily dosage does not exceed 35% of the patient's total prescribed daily caloric intake (DCI)

AND

5 - Patient is receiving disease related dietary management

2 . Revision History

Date	Notes
11/5/2025	Added Nevada Formulary

DPP4 Inhibitors and Combination Agents



Prior Authorization Guideline

Guideline ID	GL-478210
Guideline Name	DPP4 Inhibitors and Combination Agents
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Januvia, Tradjenta, Janumet, Jentadueto, Jentadueto XR, sitagliptin/metformin ER	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following: 1.1 Patient has tried metformin for 90 days of the past 120 days	

OR

1.2 Prescriber has provided a medical justification for use (please document)

AND

2 - Patient is not on concomitant GLP-1 receptor agonist and/or combination therapy (i.e., history of use of GLP-1 RA and/or combination therapy within the past 45 days)

Product Name: Brand Alogliptin, Brand Onglyza, generic saxagliptin, Sitagliptin, Zituvio	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following: 1.1 Patient has tried a preferred* medication for 90 days of the past 120 days OR 1.2 Prescriber has provided a medical justification for use (please document) AND 2 - Patient is not on concomitant GLP-1 receptor agonist and/or combination therapy (i.e., history of use of GLP-1 RA and/or combination therapy within the past 45 days)	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name: Brand Alogliptin/Metformin, Brand Kombiglyze XR, generic saxagliptin/metformin ER, Sitagliptin/Metformin, Zituvimet, Zituvimet XR, Janumet XR

Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following: 1.1 Patient has tried a preferred* combination medication for 90 days of the past 120 days OR 1.2 Prescriber has provided a medical justification for use (please document) AND 2 - Patient is not on concomitant GLP-1 receptor agonist and/or combination therapy (i.e., history of use of GLP-1 RA and/or combination therapy within the past 45 days)	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name: Brand Alogliptin/Pioglitazone	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following: 1.1 Patient has tried and failed combination therapy with preferred* medications of the same classes for 90 days of the past 120 days OR 1.2 Prescriber has provided a medical justification for use (please document)	

AND	
2 - Patient is not on concomitant GLP-1 receptor agonist and/or combination therapy (i.e., history of use of GLP-1 RA and/or combination therapy within the past 45 days)	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name: Brynovin	
Approval Length	12 month(s)
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, assessments) confirming that patient is unable to swallow AND 3 - Patient is not on concomitant GLP-1 receptor agonist and/or combination therapy (i.e., history of use of GLP-1 RA and/or combination therapy within the past 45 days)	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

2 . Revision History

Date	Notes

12/16/2025	Updated drug list to account for PDL changes. Added Brynovin. Added criteria for no concomitant GLP usage.

Dronabinol



Prior Authorization Guideline

Guideline ID	GL-126573
Guideline Name	Dronabinol
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	7/1/2023

1 . Criteria

Product Name: Brand Marinol, Generic dronabinol	
Diagnosis	Malignant cancer
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of malignant cancer	

AND

2 - History of an antineoplastic or radiation therapy in the past 45 days

AND

3 - One of the following:

3.1 Patient has tried and failed ONE of the following in the past 6 months:

- An oral selective 5HT3 receptor antagonist
- A substance P/NK-1 receptor antagonist

OR

3.2 Medical justification for use of dronabinol over BOTH of the following:

- Selective 5-HT3 receptor antagonists
- Substance P/NK-1 receptor antagonists

AND

4 - Patient is NOT currently receiving megestrol acetate suspension

Product Name: Brand Marinol, Generic dronabinol	
Diagnosis	Malignant cancer
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has a history of the requested agent	

AND	
2 - Diagnosis of malignant cancer	
AND	
3 - History of an antineoplastic or radiation therapy in the past 45 days	
AND	
4 - Patient is NOT currently receiving megestrol acetate suspension	

Product Name: Brand Marinol, Generic dronabinol	
Diagnosis	HIV/AIDS
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of HIV/AIDS with ONE of the following concurrent diagnoses in the past 2 years: • Cachexia • Anorexia • Failure to thrive AND 2 - Patient is 18 years of age or older AND	

3 - Patient is NOT currently receiving megestrol acetate suspension

AND

4 - ONE of the following:

- Member has tried and failed megestrol acetate suspension in the past six months
- Medical justification for use of dronabinol over megestrol acetate suspension

Product Name: Brand Marinol, Generic dronabinol	
Diagnosis	HIV/AIDS
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has a history of the requested agent AND 2 - Diagnosis of HIV/AIDS with ONE of the following concurrent diagnoses in the past 2 years: • Cachexia • Anorexia • Failure to thrive AND 3 - Patient is NOT currently receiving megestrol acetate suspension	

Product Name: Brand Marinol, Generic dronabinol

Diagnosis	Failure to thrive
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of failure to thrive AND 2 - Patient is 18 years of age or older AND 3 - One of the following: • Patient has tried and failed megestrol acetate suspension in the past six months • Medical justification for use of dronabinol over megestrol acetate suspension AND 4 - Patient is NOT currently receiving megestrol acetate suspension	

Product Name: Brand Marinol, Generic dronabinol	
Diagnosis	Failure to thrive
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Patient has a history of the requested medication

AND

2 - Diagnosis of failure to thrive

AND

3 - Patient is NOT currently receiving megestrol acetate suspension

2 . Revision History

Date	Notes
6/12/2023	Removed Syndros from the criteria

Dry Eye Disease or Keratoconjunctivitis Agents



Prior Authorization Guideline

Guideline ID	GL-479226
Guideline Name	Dry Eye Disease or Keratoconjunctivitis Agents
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Cequa	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of keratoconjunctivitis sicca (dry eye disease)	

AND

2 - ONE of the following:

2.1 Previous trial and failure of BOTH Restasis single-dose vials and Xiidra, as confirmed by claims history, chart documentation, or provider attestation including dates of trial

OR

2.2 Prescriber has provided valid medical justification for the use of Cequa over Restasis single-dose vials and Xiidra

AND

3 - Quantity requested does NOT exceed 60 vials (6 pouches containing 10 vials) per 30 days

Product Name:Miebo	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of dry eye disease AND 2 - ONE of the following: 2.1 Previous trial and failure of BOTH Restasis single-dose vials and Xiidra, as confirmed by claims history, chart documentation, or provider attestation including dates of trial	

OR

2.2 Prescriber has provided valid medical justification for the use of Miebo over Restasis single-dose vials and Xiidra

AND

3 - Quantity requested does NOT exceed 4 bottles per 30 days

Product Name:Restasis MultiDose	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of keratoconjunctivitis sicca (dry eye disease) AND 2 - ONE of the following: 2.1 Previous trial and failure of BOTH Restasis single-dose vials and Xiidra, as confirmed by claims history, chart documentation, or provider attestation including dates of trial OR 2.2 Prescriber has provided valid medical justification for the use of Restasis MultiDose over Restasis single-dose vials and Xiidra AND	

3 - Quantity requested does NOT exceed 1 bottle per 25 days

Product Name:Brand Restasis single-dose vials, generic cyclosporine single-dose vials

Approval Length 1 year(s)

Therapy Stage Initial Authorization

Guideline Type Prior Authorization

Approval Criteria

1 - Diagnosis of keratoconjunctivitis sicca (dry eye disease)

AND

2 - Trial of artificial tears within the past 90 days, as confirmed by claims history, chart documentation, or provider attestation including dates of trial

AND

3 - Quantity requested does NOT exceed 2 vials per day total

Product Name:Tryptyr

Approval Length 1 year(s)

Therapy Stage Initial Authorization

Guideline Type Prior Authorization

Approval Criteria

1 - Diagnosis of dry eye disease

AND

2 - ONE of the following:

2.1 Previous trial and failure of BOTH Restasis single-dose vials and Xiidra, as confirmed by claims history, chart documentation, or provider attestation including dates of trial

OR

2.2 Prescriber has provided valid medical justification for the use of Tryptyr over Restasis single-dose vials and Xiidra

AND

3 - Quantity requested does NOT exceed 1 box (60 single-dose vials) per 30 days

Product Name: Tyrvaya	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of dry eye disease AND 2 - ONE of the following: 2.1 Previous trial and failure of BOTH Restasis single-dose vials and Xiidra, as confirmed by claims history, chart documentation, or provider attestation including dates of trial OR 2.2 Prescriber has provided valid medical justification for the use of Tyrvaya over Restasis single-dose vials and Xiidra	

AND

3 - Quantity requested does NOT exceed 2 spray bottles (8.4 mL total) per 30 days

Product Name: Verkazia

Approval Length 1 year(s)

Therapy Stage Initial Authorization

Guideline Type Prior Authorization

Approval Criteria

1 - Diagnosis of vernal keratoconjunctivitis

AND

2 - ONE of the following:

2.1 Trial and failure of TWO of the following for at least 15 days (per agent), as confirmed by claims history, chart documentation, or provider attestation including dates of trial:

- Artificial tears
- Ophthalmic antihistamines (e.g., olopatadine, azelastine, ketotifen)
- Ophthalmic corticosteroids (e.g., dexamethasone, fluorometholone, loteprednol, prednisolone)
- Ophthalmic mast cell stabilizers (e.g., cromolyn sodium)

OR

2.2 Prescriber has provided valid medical justification for the use of Verkazia over artificial tears, ophthalmic antihistamines, corticosteroids, and mast cell stabilizers

AND

3 - Quantity requested does NOT exceed 120 vials per 30 days total

Product Name:Vevye	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of keratoconjunctivitis sicca (dry eye disease) AND 2 - ONE of the following: 2.1 Previous trial and failure of BOTH Restasis single-dose vials and Xiidra, as confirmed by claims history, chart documentation, or provider attestation including dates of trial OR 2.2 Prescriber has provided valid medical justification for the use of Vevye over Restasis single-dose vials and Xiidra AND 3 - Quantity requested does NOT exceed 3 bottles (6 mL total) per 30 days	

Product Name:Xiidra	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of dry eye disease

AND

2 - Trial of artificial tears within the past 90 days, as confirmed by claims history, chart documentation, or provider attestation including dates of trial

AND

3 - Quantity requested does NOT exceed 60 vials (12 pouches containing 5 vials) per 30 days

Product Name:Eysuvis

Approval Length 14 Day(s)

Therapy Stage Initial Authorization

Guideline Type Prior Authorization

Approval Criteria

1 - Diagnosis of dry eye disease

AND

2 - Requested duration of therapy does NOT exceed 14 days

AND

3 - ONE of the following:

3.1 Previous trial and failure of BOTH Restasis single-dose vials and Xiidra, as confirmed by claims history, chart documentation, or provider attestation including dates of trial

OR

3.2 Prescriber has provided valid medical justification for the use of Eysuvis over Restasis single-dose vials and Xiidra

AND

4 - Quantity requested does NOT exceed 2 bottles for a maximum of 14 days at a time and 1 approval every 90 days

Product Name: Cequa, Miebo, Restasis MultiDose, Tryptyr, Tyrvaya, Vevye

Approval Length	1 year(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - History of the requested agent in the past 180 days, as confirmed by claims history, chart documentation, or provider attestation including dates of trial

AND

2 - ONE of the following:

2.1 Previous trial and failure of BOTH Restasis single-dose vials and Xiidra, as confirmed by claims history, chart documentation, or provider attestation including dates of trial

OR

2.2 Prescriber has provided valid medical justification for the use of the requested drug over Restasis single-dose vials and Xiidra

AND

3 - ONE of the following:

- If the request is for Cequa, quantity requested does NOT exceed 60 vials (6 pouches containing 10 vials) per 30 days
- If the request is for Miebo, quantity requested does NOT exceed 4 bottles per 30 days
- If the request is for Restasis MultiDose, quantity requested does NOT exceed 1 bottle per 25 days
- If the request is for Tryptyr, quantity requested does NOT exceed 1 box (60 single-dose vials) per 30 days
- If the request is for Tyrvaya, quantity requested does NOT exceed 2 spray bottles (8.4 mL total) per 30 days
- If the request is for Vevye, quantity requested does NOT exceed 3 bottles (6 mL total) per 30 days

Product Name:Brand Restasis single-dose vials, generic cyclosporine single-dose vials, Verkazia, Xiidra	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested agent in the past 180 days, as confirmed by claims history, chart documentation, or provider attestation including dates of trial AND 2 - ONE of the following: • If the request is for Brand Restasis single-dose vials/generic cyclosporine single-dose vials, quantity requested does NOT exceed 2 vials per day total • If the request is for Verkazia, quantity requested does NOT exceed 120 vials per 30 days total • If the request is for Xiidra, quantity requested does NOT exceed 60 vials (12 pouches containing 5 vials) per 30 days	

Product Name:Eysuvis	
Approval Length	14 Day(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested agent, as confirmed by claims history, chart documentation, or provider attestation including dates of trial AND 2 - Requested duration of therapy does NOT exceed 14 days AND 3 - ONE of the following: 3.1 Previous trial and failure of BOTH Restasis single-dose vials and Xiidra, as confirmed by claims history, chart documentation, or provider attestation including dates of trial OR 3.2 Prescriber has provided valid medical justification for the use of Eysuvis over Restasis single-dose vials and Xiidra AND 4 - Prescriber has performed an ophthalmic evaluation under magnification AND an examination of intraocular pressure and has determined that Eysuvis is an appropriate treatment AND 5 - Quantity requested does NOT exceed 2 bottles for a maximum of 14 days at a time and 1 approval every 90 days	

2 . Revision History

Date	Notes
12/16/2025	Added criteria for new target drug, Tryptyr. Removed Cyclosporine in Klarity as a target. Updated initial and reauth sections for all other target drugs. Cleaned up GPI list, where applicable. Minor cosmetic and formatting updates throughout guideline.

Duopa



Prior Authorization Guideline

Guideline ID	GL-426232
Guideline Name	Duopa
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	11/1/2025

1 . Criteria

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 experiences a wearing “off” phenomenon that cannot be managed by increasing the dose of oral levodopa AND 3 - Has undergone or has planned placement of a procedurally-placed tube AND 4 - Prescribed by or in consultation with a neurologist	

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

2 . Revision History

UnitedHealthcare Community Plan of Indiana Clinical Pharmacy Program Guidelines

Date	Notes
10/20/2025	Combined formularies. No changes to clinical criteria.

Egrifta



Prior Authorization Guideline

Guideline ID	GL-438202
Guideline Name	Egrifta
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 Nevada Medicaid - Community & State Virginia Medicaid - Community & State Indiana Medicaid - Community & State Nebraska Medicaid - Community & State New Mexico Medicaid - Community & State Pennsylvania

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Egrifta SV, Egrifta WR	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of human immunodeficiency virus (HIV)-associated lipodystrophy	

2 . Revision History

Date	Notes
11/5/2025	Added Egrifta WR. Added NV formulary.

Ekterly



Prior Authorization Guideline

Guideline ID	GL-572192
Guideline Name	Ekterly
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 New Mexico Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Ekterly	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of hereditary angioedema (HAE) as 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 variant(s) in the gene(s) for factor XII, angiotensin-1, plasminogen-1, kininogen-1, myoferlin, or heparan sulfate-glucosamine 3-O-sulfotransferase 6 • Recurring angioedema attacks that are refractory to high-dose antihistamines with confirmed family history of angioedema • Recurring angioedema attacks that are refractory to high-dose antihistamines with unknown background de-novo mutation(s) (i.e., no family history) (HAE-unknown) AND 2 - Prescribed for the acute treatment of HAE attacks AND 3 - Not used in combination with other products indicated for the acute treatment of HAE attacks (e.g., Berinert, Firazyr, icatibant, Kalbitor, Ruconest, Sajazir) AND 4 - ONE of the following: • Patient is less than 18 years of age	

- Failure of icatibant (generic Firazyr) as confirmed by claims history or submission of medical records
- History of intolerance or contraindication to icatibant (generic Firazyr) (please specify intolerance or contraindication)
- Patient is currently on Ekterly therapy as confirmed by claims history or submission of medical records

AND

5 - Prescribed by ONE of the following:

- Immunologist
- Allergist

Product Name:Ekterly	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Ekterly therapy AND 2 - Prescribed for the acute treatment of HAE (hereditary angioedema) attacks AND 3 - Not used in combination with other products indicated for the acute treatment of HAE attacks (e.g., Berinert, Firazyr, icatibant, Kalbitor, Ruconest, Sajazir) AND	

4 - Prescribed by ONE of the following:

- Immunologist
- Allergist

2 . Revision History

Date	Notes
4/9/2026	Added IN. Removed NV

Electrolyte Depleters



Prior Authorization Guideline

Guideline ID	GL-144364
Guideline Name	Electrolyte Depleters
Formulary	Medicaid - Community & State Indiana Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2024

1 . Criteria

Product Name:Fosrenol Powder Packets	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is under 18 years of age	

OR

2 - Patient is unable to swallow tablets

Product Name:Xphozah

Approval Length 12 month(s)

Guideline Type Prior Authorization

Approval Criteria

1 - Patient has tried and failed preferred phosphate binders

OR

2 - Medical rationale for use of requested medication over all preferred phosphate binders

Notes PDL Link: <https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html>

2 . Revision History

Date	Notes
3/14/2024	Added SP formulary and Xphozah criteria.

Elevidys



Prior Authorization Guideline

Guideline ID	GL-542261
Guideline Name	Elevidys
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Elevidys	
Approval Length	12 weeks (one treatment course per lifetime)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is 4 years of age or older AND	

2 - Submission of medical records (e.g., chart notes, laboratory tests/values, assessments) confirming diagnosis of Duchenne muscular dystrophy (DMD) with mutation of the DMD gene

AND

3 - Submission of medical records (e.g., chart notes, laboratory tests/values, assessments) confirming patient is ambulatory

AND

4 - Submission of genetic testing confirming patient does NOT have deletion(s) in exon 8 and/or exon 9 in the DMD gene

AND

5 - Submission of ELISA assay indicates anti-AAVrh74 total binding antibody titers less than 1:400

AND

6 - Patient does not have history of prior gene therapy

AND

7 - Prescriber attests to ALL of the following:

7.1 Lab values were assessed and will continue to be monitored post infusion, if applicable:

- Liver function tests (clinical exam, liver enzymes, total bilirubin, gamma-glutamyltransferase (GGT)) prior to infusion and weekly for 12 weeks post-infusion
- Platelet counts prior to infusion and weekly for 2 weeks post-infusion
- Troponin-I prior to infusion and weekly for 4 weeks post-infusion

AND

7.2 Patient is infection free prior to infusion (and up to date on recommended vaccinations)

AND

7.3 Patient does not have uncontrolled acute liver disease

AND

7.4 Patient will be prescribed a systemic corticosteroid regimen prior to initiation of therapy and will be continued on therapy for at least 60 days unless early tapering is indicated

2 . Revision History

Date	Notes
3/6/2026	New

Elmiron



Prior Authorization Guideline

Guideline ID	GL-97793
Guideline Name	Elmiron
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2022

1 . Criteria

Product Name:Elmiron	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records showing diagnosis of bladder pain or discomfort associated with interstitial cystitis	

OR

2 - Submission of medical records showing diagnosis of hemorrhagic cystitis in a patient who previously received pelvic irradiation or chemotherapy with cyclophosphamide

Product Name:Elmiron	
Approval Length	3 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has history of the requested medication within the past 90 days AND 2 - Documentation of symptom improvement (i.e., pain relief)	

2 . Revision History

Date	Notes
11/3/2021	Updated all criteria to match state policy.

Emverm



Prior Authorization Guideline

Guideline ID	GL-461328
Guideline Name	Emverm
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Emverm	
Diagnosis	Enterobius vermicularis (pinworm)
Approval Length	1 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Enterobius vermicularis (pinworm)	

Product Name:Emverm

Diagnosis	Echinococcosis (Tapeworm)
Approval Length	6 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Hydatid Disease [Echinococcosis (Tapeworm)]	

Product Name:Emverm	
Diagnosis	Ancylostoma/Necatoriasis (Hookworm)
Approval Length	1 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Ancylostoma/Necatoriasis (Hookworm)	

Product Name:Emverm	
Diagnosis	Ascariasis (Roundworm)
Approval Length	1 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Ascariasis (Roundworm)	

Product Name:Emverm	
Diagnosis	Toxocariasis (Roundworm)
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Toxocariasis (Roundworm)

Product Name:Emverm

Diagnosis	Trichinellosis

Approval Length	1 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Trichinellosis

Product Name:Emverm

Diagnosis	Trichuriasis (Whipworm)

Approval Length	1 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Trichuriasis (Whipworm)

Product Name:Emverm

Diagnosis	Capillariasis

Approval Length	1 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Capillariasis

Product Name:Emverm

Diagnosis Baylisascaris

Approval Length 1 month(s)

Guideline Type Prior Authorization

Approval Criteria

1 - Diagnosis of Baylisascaris

2 . Revision History

Date	Notes
12/4/2025	Removed embedded step requirement in Enterobius vermicularis (pinworm) section.

Endari



Prior Authorization Guideline

Guideline ID	GL-557195
Guideline Name	Endari
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 Indiana Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name: Brand Endari, generic l-glutamine powd pack	
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 the requested therapy with concurrent hydroxyurea therapy • Patient is unable to take hydroxyurea due to a contraindication or intolerance (please specify contraindication or intolerance) AND 3 - Patient has had 2 or more painful sickle cell crises within the past 12 months	

Product Name:Brand Endari, generic l-glutamine powd pack	
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 the requested therapy	

2 . Revision History

UnitedHealthcare Community Plan of Indiana Clinical Pharmacy Program Guidelines

Date	Notes
3/25/2026	Rearranged order of formularies. Replaced "Endari" verbiage with "the requested therapy" verbiage, where applicable (no changes to clinical intent).

Ensacove



Prior Authorization Guideline

Guideline ID	GL-375187
Guideline Name	Ensacove
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 Virginia Medicaid - Community & State New Mexico Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	9/1/2025

1 . Criteria

Product Name: Ensacove	
Diagnosis	Non-small cell lung cancer (NSCLC)

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of non-small cell lung cancer (NSCLC) AND 2 - Tumor is anaplastic lymphoma kinase (ALK)-positive AND 3 - Disease is ONE of the following: • Advanced • Metastatic • Recurrent AND 4 - One of the following: 4.1 Patient has not previously received an ALK-inhibitor [e.g., Alecensa (alectinib), Alunbrig (brigatinib), Lorbrena (lorlatinib), Xalkori (crizotinib), Zykadia (ceritinib)] OR 4.2 Patient is intolerant to or experiences disease progression on Xalkori (crizotinib)	

Product Name: Ensacove	
Diagnosis	Non-small cell lung cancer (NSCLC)
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 Ensacove therapy	

Product Name:Ensacove	
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:Ensacove	
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 Ensacove therapy	

2 . Revision History

UnitedHealthcare Community Plan of Indiana Clinical Pharmacy Program Guidelines

Date	Notes
8/19/2025	Removed AZ from formularies - see AZ state specific Oral Oncology Agents GL-363219 for Ensacove. No clinical changes to guideline.

Enspryng



Prior Authorization Guideline

Guideline ID	GL-459275
Guideline Name	Enspryng
Formulary	Medicaid - Community & State Indiana

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 - 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

4 - Prescribed by, or in consultation with, a neurologist

AND

5 - 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
12/3/2025	Updated statement for concomitant use and updated examples of complement inhibitors in both initial and reauth sections. Minor cosmetic updates.

Epidermolysis Bullosa Agents



Prior Authorization Guideline

Guideline ID	GL-531198
Guideline Name	Epidermolysis Bullosa Agents
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

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

AND

2 - Diagnosis of dystrophic or junctional epidermolysis bullosa (DEB or JEB)

AND

3 - Submission of medical records (e.g., charts, labs, progress notes, etc.) verifying one of the following:

- Genetic analysis demonstrating mutation(s) in any of the following: COL7A1, LAMA3, LAMB3, LAMC2, COL17A1, ITGA6, ITGB4, ITGA3 genes
- Skin biopsy of a mechanically induced blister confirming diagnosis utilizing immunofluorescence mapping (IFM) and/or transmission electron microscopy (TEM)

AND

4 - Patient has at least one open wound with both of the following:

- Wound has been present for at least 21 days
- Wound is 10 cm² to 50 cm² in size

AND

5 - Prescribed by, or in consultation with, a dermatologist or wound care specialist with expertise in the management of DEB or JEB

AND

6 - Prescriber attests to all of the following:

- Patient does not have current evidence or a history of squamous cell carcinoma in the area that will undergo treatment
- Patient does not have evidence of active infection in the area that will undergo treatment
- Patient is not currently receiving chemotherapy or immunotherapy
- Patient has not received a skin graft in the past 3 months

- Patient will not be using Filsuvez (birch triterpenes) with Vyjuvek (beremagene geperpavec-svdt)

AND

7 - Requested quantity does not exceed 19 tubes every 30 days

Product Name:Filsuvez	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - History of the requested agent for at least 90 days within the past 120 days, confirmed by claims history or chart documentation

AND

2 - Submission of medical records (e.g., charts, labs, progress notes, etc.) demonstrating both of the following:

- Patient continues to have open wounds secondary to DEB or JEB
- Patient is receiving clinical benefit as demonstrated by closure of previously treated wound(s) (incomplete wound closure will be assessed on a case-by-case basis)

AND

3 - Prescriber attests to all of the following:

- Patient does not have current evidence or a history of squamous cell carcinoma in the area that will undergo treatment
- Patient is not currently receiving chemotherapy or immunotherapy
- Patient has not received a skin graft in the past 3 months
- Patient has not and will not be using Filsuvez (birch triterpenes) with Vyjuvek (beremagene geperpavec-svdt)

AND

4 - Requested quantity does not exceed 19 tubes every 30 days

2 . Revision History

Date	Notes
2/25/2026	New guideline

Erivedge



Prior Authorization Guideline

Guideline ID	GL-468192
Guideline Name	Erivedge
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia Medicaid - Community & State Washington

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Erivedge

Diagnosis	Basal Cell Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of metastatic basal cell carcinoma OR 2 - BOTH of the following: 2.1 Diagnosis of locally advanced basal cell carcinoma AND 2.2 ONE of the following: • Cancer has recurred following surgery • Patient is not a candidate for surgery • Patient is not a candidate for radiation	

Product Name:Erivedge	
Diagnosis	Medulloblastoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of medulloblastoma	

AND

2 - Patient has mutations in the sonic hedgehog pathway

AND

3 - Patient has failed prior chemotherapy

Product Name:Erivedge	
Diagnosis	Basal Cell Carcinoma, Medulloblastoma
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 Erivedge therapy	

Product Name:Erivedge	
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:Erivedge

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 Erivedge therapy	

2 . Revision History

Date	Notes
12/10/2025	Combined formularies. No changes to clinical criteria.

Erleada



Prior Authorization Guideline

Guideline ID	GL-581190
Guideline Name	Erleada
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Erleada	
Diagnosis	Prostate Cancer

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of prostate cancer AND 2 - ONE of the following: 2.1 BOTH of the following: • Disease is castration-resistant or recurrent • Disease is non-metastatic OR 2.2 BOTH of the following: • Disease is castration-sensitive or naïve • Disease is metastatic AND 3 - ONE of the following: 3.1 Used in combination with a gonadotropin-releasing hormone (GnRH) analog [e.g., Lupron (leuprolide), Zoladex (goserelin), Trelstar (triptorelin), Vantas (histrelin), Firmagon (degarelix)] OR 3.2 Patient has had bilateral orchiectomy	

Product Name:Erleada

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 Erleada therapy	

Product Name:Erleada	
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:Erleada	
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 Erleada therapy	

2 . Revision History

Date	Notes
4/14/2026	Combined formularies. Minor cosmetic updates.

Esbriet, Ofev



Prior Authorization Guideline

Guideline ID	GL-363193
Guideline Name	Esbriet, Ofev
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	9/1/2025

1 . Criteria

Product Name: Brand Esbriet, generic pirfenidone, Ofev	
Diagnosis	Idiopathic Pulmonary Fibrosis
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: 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 an ICD-10 Code of J84.112 (idiopathic pulmonary fibrosis)

AND

1.2 ONE of the following:

1.2.1 If the patient was 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 If the patient was subjected to a lung biopsy, both HRCT and surgical lung biopsy pattern reveal IPF or probable IPF

AND

2 - The prescriber is a pulmonologist

Product Name: Brand Esbriet, generic pirfenidone, Ofev

Diagnosis	Idiopathic Pulmonary Fibrosis

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to the requested therapy

Product Name: Ofev

Diagnosis	Systemic Sclerosis-Associated Interstitial Lung Disease

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 At least 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 (ribonucleic acid) 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% of the lungs AND 2 - The prescriber is a pulmonologist	

Product Name:Ofev	
Diagnosis	Chronic Fibrosing Interstitial Lung Disease with a Progressive Phenotype
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chronic fibrosing interstitial lung disease (ILD) with a progressive phenotype as documented by BOTH of the following: 1.1 Presence of fibrotic ILD as determined by finding evidence of pulmonary fibrosis on HRCT (high-resolution computed tomography), involving at least 10% of the lungs AND 1.2 Patient is presenting with clinical signs of progression as defined by ONE of the following in the previous 24 months: 1.2.1 Forced vital capacity (FVC) decline of greater than 10% OR 1.2.2 TWO of the following: - FVC decline of greater than or equal to 5%, but less than 10% - Patient is experiencing worsening respiratory symptoms - Patient is exhibiting increasing extent of fibrotic changes on chest imaging AND 2 - The prescriber is a pulmonologist	

Product Name:Ofev	
Diagnosis	Systemic Sclerosis-Associated Interstitial Lung Disease, Chronic Fibrosing Interstitial Lung Disease with a Progressive Phenotype
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Ofev therapy

2 . Revision History

Date	Notes
8/11/2025	Clarified ALL to BOTH in initial auth. Removed prescriber check from reauthorization section.

Fentanyl IR



Prior Authorization Guideline

Guideline ID	GL-126579
Guideline Name	Fentanyl IR
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	7/1/2023

1 . Criteria

Product Name: Brand Actiq, generic fentanyl citrate lozenge, Fentora, fentanyl citrate buccal tabs	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of cancer or diagnosis within approved compendia	

AND

2 - Member is enrolled in the TIRF REMS (Transmucosal Immediate Release Fentanyl Risk Evaluation and Mitigation Strategy) Access program and prescriber is monitoring in accordance with REMS requirements

AND

3 - Patient is currently utilizing a long-acting opioid medication around the clock

AND

4 - Patient must be tolerant to opioids, as defined by at least one week without adequate pain relief using ONE of the following:

- Greater than or equal to 60 milligrams (mg) oral morphine per day
- Greater than or equal to 25 micrograms per hour (mcg/hr) transdermal fentanyl
- Greater than or equal to 30 mg oral oxycodone per day
- Greater than or equal to 8 mg oral hydromorphone per day
- Greater than or equal to 25 mg oral oxymorphone per day
- Equianalgesic dose of another opioid

AND

5 - ONE of the following:

- If the request is for Actiq (fentanyl citrate lozenge) the patient is 16 years of age or older
- If the request is for Fentora (fentanyl citrate buccal tab) or Subsys the patient is 18 years of age or older

AND

6 - No concurrent claims for buprenorphine/naloxone or buprenorphine therapy, excluding buprenorphine patches (Butrans) and sublingual buprenorphine indicated for the treatment of pain (Belbuca), within the past 45 days*

AND

7 - Patient is not using concurrently with a carisoprodol-containing product

AND

8 - No concurrent claims for Lybalvi (olanzapine/samidorphan) within the past 45 days

AND

9 - Fewer than 5 different prescribers of opiates in the past 60 days

AND

10 - One of the following:

10.1 Member is not using the recommended medication concurrently with a benzodiazepine (claim within the past 30 days)

OR

10.2 Both of the following:

- Days' supply for the requested opioid is 7 days or less
- Including the days' supply for the requested agent, the patient will not exceed 7 days of concurrent opiate/benzodiazepine therapy in the past 180 days

OR

10.3 Patient has utilized concurrent benzodiazepine/opiate therapy, including any cross-tapered or discontinued agents, for at least 90 of the past 120 days

OR

10.4 ALL of the following for concurrent opiate/benzodiazepine therapy exceeding 7 days in the past 180 days:

10.4.1 Indications provided for both the benzodiazepine agent(s) and the opioid agent(s)

AND

10.4.2 Documentation of previous therapies attempted for the given indications

AND

10.4.3 Prescriber attests to ALL of the following:

- The patient's INSPECT report has been evaluated and continues to be evaluated on a regular basis
- The patient has been educated in regard to the risks of concurrent utilization of opioid and benzodiazepine therapy, and the patient accepts these risks
- The prescriber has consulted any other prescribers involved in concurrent therapy and all prescribers agree to pursue concurrent opioid and benzodiazepine therapy for the patient, if applicable
- The prescriber acknowledges the risk of adverse event(s), including respiratory depression, coma, and death, associated with concurrent utilization

Notes	*Unless faxed documentation has been received from the opioid prescriber with approval for opioid therapy from the buprenorphine or buprenorphine/naloxone prescriber.

Product Name: Brand Actiq, generic fentanyl citrate lozenge, Fentora, fentanyl citrate buccal tabs	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested agent within the past 45 days	

AND

2 - If the request is for Actiq (fentanyl citrate lozenge), one of the following:

- Patient is maintaining the same strength and not exceeding 4 units of a single strength per day
- Patient is increasing strength and does not exceed 6 units of a single strength per day

AND

3 - No concurrent claims for buprenorphine/naloxone or buprenorphine therapy, excluding buprenorphine patches (Butrans) and sublingual buprenorphine indicated for the treatment of pain (Belbuca), within the past 45 days*

AND

4 - Patient is not using concurrently with a carisoprodol-containing product

AND

5 - No concurrent claims for Lybalvi (olanzapine/samidorphan) within the past 45 days

AND

6 - Fewer than 5 different prescribers of opiates in the past 60 days

AND

7 - One of the following:

7.1 Member is not using the recommended medication concurrently with a benzodiazepine (claim within the past 30 days)

OR

7.2 Both of the following:

- Days' supply for the requested opioid is 7 days or less
- Including the days' supply for the requested agent, the patient will not exceed 7 days of concurrent opiate/benzodiazepine therapy in the past 180 days

OR

7.3 Patient has utilized concurrent benzodiazepine/opiate therapy, including any cross-tapered or discontinued agents, for at least 90 of the past 120 days

OR

7.4 ALL of the following for concurrent opiate/benzodiazepine therapy exceeding 7 days in the past 180 days:

7.4.1 Indications provided for both the benzodiazepine agent(s) and the opioid agent(s)

AND

7.4.2 Documentation of previous therapies attempted for the given indications

AND

7.4.3 Prescriber attests to ALL of the following:

- The patient's INSPECT report has been evaluated and continues to be evaluated on a regular basis
- The patient has been educated in regard to the risks of concurrent utilization of opioid and benzodiazepine therapy, and the patient accepts these risks
- The prescriber has consulted any other prescribers involved in concurrent therapy and all prescribers agree to pursue concurrent opioid and benzodiazepine therapy for the patient, if applicable
- The prescriber acknowledges the risk of adverse event(s), including respiratory depression, coma, and death, associated with concurrent utilization

Notes	*Unless faxed documentation has been received from the opioid prescriber with approval for opioid therapy from the buprenorphine or buprenorphine/naloxone prescriber.

2 . Revision History

Date	Notes
6/14/2023	Removed Subsys, updated initial criteria and DUR criteria. Added Re-auth box.

Firazyr, Sajazir



Prior Authorization Guideline

Guideline ID	GL-581194
Guideline Name	Firazyr, Sajazir
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 Indiana Medicaid - Community & State Michigan Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name: Brand Sajazir, Brand Firazyr, generic icatibant	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of hereditary angioedema (HAE) as 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 variant(s) in the gene(s) for factor XII, angiopoietin-1, plasminogen-1, kininogen-1, myoferlin, or heparan sulfate-glucosamine 3-O-sulfotransferase 6 • Recurring angioedema attacks that are refractory to high-dose antihistamines with confirmed family history of angioedema • Recurring angioedema attacks that are refractory to high-dose antihistamines with unknown background de-novo mutation(s) (i.e., no family history) (HAE-unknown) AND 2 - Prescribed for the acute treatment of HAE attacks AND 3 - Not used in combination with other products indicated for the acute treatment of HAE attacks (e.g., Berinert, Ekterly, Kalbitor, or Ruconest) AND 4 - Prescribed by ONE of the following:	

- Immunologist
- Allergist

Product Name: Brand Sajazir, Brand Firazy, generic icatibant	
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 for the acute treatment of hereditary angioedema (HAE) attacks AND 3 - Not used in combination with other products indicated for the acute treatment of HAE attacks (e.g., Berinert, Ekterly, Kalbitor, or Ruconest) AND 4 - Prescribed by ONE of the following: • Immunologist • Allergist	

2 . Revision History

Date	Notes

4/14/2026	Added IN.

Firdapse



Prior Authorization Guideline

Guideline ID	GL-564240
Guideline Name	Firdapse
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 Indiana Medicaid - Community & State Nebraska Medicaid - Community & State Nevada Medicaid - Community & State New Mexico Medicaid - Community & State Pennsylvania Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Firdapse	
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 - Diagnosis confirmed by ONE of the following: 2.1 Increased compound muscle action potential (CMAP) amplitude after exercise or with high-frequency repetitive nerve stimulation (RNS) OR 2.2 A high titer P/Q-type voltage-gated calcium channels (VGCC) antibody AND 3 - Prescribed by or in consultation with a specialist in the treatment of LEMS (e.g., neurologist or oncologist)	

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

1 - Documentation of positive clinical response to Firdapse therapy (e.g., improved muscle strength, improved mobility)

2 . Revision History

Date	Notes
4/6/2026	Added IN.

Forzinity



Prior Authorization Guideline

Guideline ID	GL-578253
Guideline Name	Forzinity
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 Indiana Medicaid - Community & State Nebraska Medicaid - Community & State Nevada Medicaid - Community & State New Mexico Medicaid - Community & State Pennsylvania Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Forzinity	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Barth syndrome AND 2 - Diagnosis has been confirmed by the presence of a pathogenic variant in the TAFAZZIN gene identified by molecular genetic testing AND 3 - Patient weight is greater than or equal to 30 kg (kilograms) AND 4 - Prescribed by or in consultation with ONE of the following: • Cardiologist • Geneticist • Metabolic specialist • Neurologist	

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

Approval Criteria

1 - Documentation of positive clinical response to Forzinity therapy (e.g., improvement or stabilization in 6-minute walk test, improvement or stabilization in knee extensor muscle strength)

AND

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

- Cardiologist
- Geneticist
- Metabolic specialist
- Neurologist

2 . Revision History

Date	Notes
4/15/2026	Updated formularies to add ACUIN and ACUPA for eff 6/1/2026. No clinical changes.

Fruzaqla



Prior Authorization Guideline

Guideline ID	GL-571193
Guideline Name	Fruzaqla
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Fruzaqla	
Diagnosis	Colorectal Cancer

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of colorectal cancer AND 2 - Disease is ONE of the following: • Advanced • Metastatic AND 3 - Patient has been previously treated with ALL of the following: • Fluoropyrimidine-based chemotherapy (e.g., capecitabine, 5-FU) • Oxaliplatin-based chemotherapy (e.g., CAPEOX, FOLFOX) • Irinotecan-based chemotherapy (e.g., FOLFIRI, FOLFIRINOX) • Anti-VEGF therapy (e.g., aflibercept, bevacizumab, ramucirumab) AND 4 - ONE of the following: 4.1 BOTH of the following: 4.1.1 Disease is RAS wild-type AND 4.1.2 Patient has been previously treated with an anti-EGFR therapy (e.g., cetuximab, panitumumab)	

OR

4.2 Disease is not RAS wild-type

Product Name:Fruzaqla	
Diagnosis	Appendiceal Neoplasms and Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following diagnoses:

- Appendiceal adenocarcinoma (AA)
- Goblet cell adenocarcinoma (GCA)
- Undifferentiated carcinoma not otherwise specified (UC-NOS)

AND

2 - Patient has been previously treated with ALL of the following:

- Fluoropyrimidine-based chemotherapy (e.g., capecitabine, 5-FU)
- Oxaliplatin-based chemotherapy (e.g., CAPEOX, FOLFOX)
- Irinotecan-based chemotherapy (e.g., FOLFIRI, FOLFIRINOX)
- Anti-VEGF therapy (e.g., aflibercept, bevacizumab, ramucirumab)

AND

3 - ONE of the following:

3.1 BOTH of the following:

- Disease is RAS wild-type

- Patient has been previously treated with an anti-EGFR therapy (e.g., cetuximab, panitumumab)

OR

3.2 Disease is not RAS wild-type

Product Name:Fruzaqla	
Diagnosis	Colorectal Cancer, Appendiceal Neoplasms and Cancers
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 Fruzaqla therapy	

Product Name:Fruzaqla	
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:Fruzaqla	
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 Fruzaqla therapy	

2 . Revision History

Date	Notes
4/9/2026	Added IN.

Galafold



Prior Authorization Guideline

Guideline ID	GL-136357
Guideline Name	Galafold
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2024

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) or Elfabrio (pegunigalsidase alfa-iwxj)

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) or Elfabrio (pegunigalsidase alfa-iwxj)	

2 . Revision History

Date	Notes
11/15/2023	Added Elfabrio as a drug to not be used in combination

Gastroprotective Agents



Prior Authorization Guideline

Guideline ID	GL-458426
Guideline Name	Gastroprotective Agents
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Vyscoxa	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following: 1.1 Patient is 2 years of age or older	

AND

1.2 Patient is less than 12 years of age

OR

2 - Patient is unable to swallow capsules

2 . Revision History

Date	Notes
12/8/2025	New program.

Gattex



Prior Authorization Guideline

Guideline ID	GL-439208
Guideline Name	Gattex
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 Indiana Medicaid - Community & State Nebraska Medicaid - Community & State New Mexico Medicaid - Community & State Pennsylvania Medicaid - Community & State Virginia Medicaid - Community & State Nevada

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Gattex	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Short Bowel Syndrome (SBS) AND 2 - Dependent on parenteral support	

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

2 . Revision History

Date	Notes
11/5/2025	Added Nevada Formulary

Gavreto



Prior Authorization Guideline

Guideline ID	GL-578230
Guideline Name	Gavreto
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 New Mexico Medicaid - Community & State Virginia Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Gavreto	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has a diagnosis of non-small cell lung cancer (NSCLC) AND 2 - Disease is ONE of the following: • Recurrent • Advanced • Metastatic AND 3 - There is presence of RET rearrangement positive tumors	

Product Name:Gavreto	
Diagnosis	Thyroid Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ALL of the following: 1.1 Diagnosis of ONE of the following: • Follicular carcinoma • Papillary carcinoma	

AND

1.2 ONE of the following:

- Unresectable locoregional recurrent disease
- Persistent disease
- Metastatic disease

AND

1.3 Disease is RET gene fusion positive

AND

1.4 Disease is not amenable to radioactive iodine therapy

OR

2 - ALL of the following:

2.1 Diagnosis of oncocytic carcinoma

AND

2.2 ONE of the following:

- Unresectable locoregional recurrent disease
- Persistent disease
- Metastatic disease

AND

2.3 Disease is RET gene fusion positive

OR

3 - ALL of the following:

3.1 Diagnosis of medullary carcinoma

AND

3.2 ONE of the following:

- Unresectable locoregional disease that is symptomatic or progressing
- Disease is recurrent
- Disease is with persistent distant metastases

AND

3.3 Disease is RET-mutation positive

OR

4 - ALL of the following:

4.1 Diagnosis of anaplastic carcinoma

AND

4.2 ONE of the following:

- Disease is stage IVA or IVB (locoregional)
- Disease is metastatic

AND

4.3 Disease is RET gene fusion positive

Product Name:Gavreto	
Diagnosis	Biliary Tract Cancers
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: 1.1.1 Diagnosis of gallbladder cancer AND 1.1.2 Disease is ONE of the following: • Resectable locoregionally advanced • Unresectable • Resected gross residual (R2) • Metastatic OR 1.2 BOTH of the following: 1.2.1 Diagnosis of cholangiocarcinoma AND 1.2.2 Disease is ONE of the following: • Unresectable • Resected gross residual (R2) • Metastatic	

AND

2 - Disease is positive for RET gene fusion mutation

Product Name:Gavreto

Diagnosis	Non-Small Cell Lung Cancer (NSCLC), Thyroid Carcinoma, Biliary Tract Cancers

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 Gavreto therapy

Product Name:Gavreto

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:Gavreto

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 Gavreto therapy

2 . Revision History

Date	Notes
4/14/2026	Added Indiana

Gilotrif



Prior Authorization Guideline

Guideline ID	GL-356190
Guideline Name	Gilotrif
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	9/1/2025

1 . Criteria

Product Name:Gilotrif	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of metastatic non-small cell lung cancer (NSCLC) AND 2 - ONE of the following: - Squamous disease progressing after previous platinum-based chemotherapy - Tumors are positive for non-resistant epidermal growth factor receptor (EGFR) mutations	

Product Name:Gilotrif	
Diagnosis	Non-Nasopharyngeal Head and Neck Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of advanced, non-nasopharyngeal head and neck cancer AND 2 - Disease has progressed on or after platinum-containing chemotherapy	

Product Name:Gilotrif	
Diagnosis	Brain Metastases

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of brain metastasis due to EGFR (epidermal growth factor receptor)-sensitizing mutation positive non-small cell lung cancer	

Product Name:Gilotrif	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC), Non-Nasopharyngeal Head and Neck Cancer, Brain Metastases
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 Gilotrif therapy	

Product Name:Gilotrif	
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:Gilotrif	
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 Gilotrif therapy	

2 . Revision History

Date	Notes
7/31/2025	Combined formularies. Minor updates to dx headers and updated verbiage in NCCN initial auth section, with no changes to clinical intent.

GLP-1 RA-GIP-Combinations



Prior Authorization Guideline

Guideline ID	GL-588199
Guideline Name	GLP-1 RA-GIP-Combinations
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	5/10/2026

Note:

Guideline does not apply to Wegovy HD.

1 . Criteria

Product Name: Ozempic	
Diagnosis	Type 2 diabetes
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 type 2 diabetes mellitus with or without cardiovascular disease and/or chronic kidney disease, as confirmed by submission of medical records or claims history

AND

3 - One of the following:

3.1 Previous trial of metformin for at least 90 days within the past 120 days, as confirmed by claims history, submission of medical records, or prescriber documents dates of trial

OR

3.2 Documented intolerance or contraindication to metformin therapy

AND

4 - Prescriber has submitted baseline HbA1c (hemoglobin A1c) lab documentation, obtained within the past 90 days, prior to initiating the requested medication

AND

5 - One of the following:

5.1 Patient is not on concomitant DPP-4 inhibitor-containing agent

OR

5.2 Patient will be transitioning from DPP-4 inhibitor-containing therapy to GLP-1 RA-containing therapy within the next 45 days

AND

6 - Patient will not be utilizing the requested agent concurrently with another GLP-1 RA or combination product

AND

7 - Dose requested does not exceed 2 mg/week

Product Name:Ozempic

Diagnosis	Type 2 diabetes

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of type 2 diabetes mellitus with or without cardiovascular disease and/or chronic kidney disease, as confirmed by submission of medical records or claims history

AND

2 - BOTH of the following:

2.1 Submission of HbA1c lab documentation, obtained within one of the following timeframes:

- Patients who have been on requested therapy for less than 1 year: within the past 90 days (document date and A1c)
- Patients who have been on requested therapy for at least 1 year: within the past 180 days (document date and A1c)

AND

2.2 ONE of the following:

2.2.1 Submitted HbA1c demonstrates a reduction in HbA1c from the baseline value obtained prior to initiating the requested agent (must submit documentation of baseline HbA1c or provide value of baseline HbA1c, including date and time of collection)

OR

2.2.2 Submitted HbA1c demonstrates a reduction or trend towards stabilization over the past year

OR

2.2.3 BOTH of the following:

- Submitted HbA1c does NOT demonstrate a reduction in HbA1c from the baseline value obtained prior to initiating the requested agent (must submit documentation of baseline HbA1c or provide value of baseline HbA1c, including date and time of collection) OR does NOT demonstrate a reduction or trend towards stabilization in HbA1c over the past year
- Prescriber has submitted medical justification for continued use, supported by documentation within submitted chart notes

AND

3 - History of the requested medication for at least 84 days within the past 112 days, confirmed by claims history, submission of medical records, or prescriber documents dates of trial

AND

4 - Patient is not on concomitant DPP-4 inhibitor-containing therapy

AND

5 - Patient is not utilizing the requested agent concurrently with another GLP-1 RA or combination product

AND

6 - Dose requested does not exceed 2 mg/week

Product Name: Ozempic

Diagnosis	Metabolic dysfunction-associated steatohepatitis (MASH), Metabolic dysfunction-associated steatotic liver disease (MASLD)

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 - One of the following diagnosis:

- Metabolic dysfunction-associated steatohepatitis (MASH)
- Metabolic dysfunction-associated steatotic liver disease (MASLD)

AND

3 - One of the following confirming the diagnosis (submission of medical records required):

3.1 Liver biopsy obtained within the past 2 years illustrating one of the following scores:

3.1.1 For MASH indication, both of the following:

- Non-alcoholic fatty liver disease activity score (NAS) of greater than or equal to 4 with a score of at least 1 in each of the following NAS components: steatosis, ballooning degeneration, and lobular inflammation
- METAVIR stage of F1-F3 fibrosis

OR

3.1.2 For MASLD indication: score of at least 1 in steatosis category

OR

3.2 Vibration-controlled transient elastography (e.g., Fibroscan) obtained within the past 6 months illustrating one of the following scores:

3.2.1 For MASH indication: results with a liver stiffness measurement (LSM) greater than or equal to 6.43 kPa (kilopascal) and controlled attenuation parameter (CAP) greater than or equal to 238 dB/m (decibels per meter)

OR

3.2.2 For MASLD indication: controlled attenuation parameter (CAP) greater than or equal to 238 dB/m

AND

4 - Prescribed by, or in consultation with, an endocrinologist, gastroenterologist, or hepatologist

AND

5 - One of the following:

5.1 Patient is not on concomitant DPP-4 inhibitor-containing agent

OR

5.2 Patient will be transitioning from DPP-4 inhibitor-containing therapy to GLP-1 RA-containing therapy within the next 45 days

AND

6 - Patient will not be utilizing the requested agent concurrently with another GLP-1 RA or combination product

AND

7 - Dose requested does not exceed 2 mg/week

Product Name:Ozempic

Diagnosis	Metabolic dysfunction-associated steatohepatitis (MASH), Metabolic dysfunction-associated steatotic liver disease (MASLD)

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of metabolic dysfunction-associated steatohepatitis (MASH) OR metabolic dysfunction-associated steatotic liver disease (MASLD), as confirmed by submission of medical records or claims history

AND

2 - Submission of medical records documenting current clinical status, including one of the following:

- Liver biopsy results within the past year demonstrating improvement or stabilization in fibrosis staging and NAS score from baseline
- Fibroscan results within the past year demonstrating improvement or stabilization in CAP and LSM scores

AND

3 - History of the requested medication for at least 84 days within the past 112 days, confirmed by claims history, submission of medical records, or prescriber documents dates of trial

AND

4 - Patient is not on concomitant DPP-4 inhibitor-containing therapy

AND

5 - Patient is not utilizing the requested agent concurrently with another GLP-1 RA or combination product

AND

6 - Dose requested does not exceed 2 mg/week

Product Name:Soliqua	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of type 2 diabetes mellitus, as confirmed by submission of medical records or claims history AND 2 - Patient is 18 years of age or older AND 3 - Prescriber has submitted baseline HbA1c (hemoglobin A1c) lab documentation, obtained within the past 90 days, prior to initiating the requested medication	

AND

4 - One of the following:

4.1 Patient is not on concomitant DPP-4 inhibitor-containing agent

OR

4.2 Patient will be transitioning from DPP-4 inhibitor-containing therapy to GLP-1 RA-containing therapy within the next 45 days

AND

5 - Patient will not be utilizing the requested agent concurrently with another GLP-1 RA or combination product

AND

6 - Previous trial with ONE of the following for at least 90 days in the past 120 days:

- A preferred* non-insulin injectable hypoglycemic
- A preferred* long-acting insulin

AND

7 - Dose requested does not exceed 60 units insulin glargine/20 mcg lixisenatide per day

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

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

Approval Criteria

1 - Diagnosis of type 2 diabetes mellitus, as confirmed by submission of medical records or claims history

AND

2 - History of the requested medication for at least 90 days within the past 120 days, confirmed by claims history, submission of medical records, or prescriber documents dates of trial

AND

3 - BOTH of the following:

3.1 Submission of HbA1c lab documentation, obtained within one of the following timeframes:

- Patients who have been on requested therapy for less than 1 year: within the past 90 days (document date and A1c)
- Patients who have been on requested therapy for at least 1 year: within the past 180 days (document date and A1c)

AND

3.2 ONE of the following:

3.2.1 Submitted HbA1c demonstrates a reduction in HbA1c from the baseline value obtained prior to initiating the requested agent (must submit documentation of baseline HbA1c or provide value of baseline HbA1c, including date and time of collection)

OR

3.2.2 Submitted HbA1c demonstrates a reduction or trend towards stabilization over the past year

OR

3.2.3 BOTH of the following:

- Submitted HbA1c does NOT demonstrate a reduction in HbA1c from the baseline value obtained prior to initiating the requested agent (must submit documentation of baseline HbA1c or provide value of baseline HbA1c, including date and time of collection) OR does NOT demonstrate a reduction or trend towards stabilization in HbA1c over the past year
- Prescriber has submitted medical justification for continued use, supported by documentation within submitted chart notes

AND

4 - Patient is not on concomitant DPP-4 inhibitor-containing therapy

AND

5 - Patient is not utilizing the requested agent concurrently with another GLP-1 RA or combination product

AND

6 - Dose requested does not exceed 60 units insulin glargine/20 mcg lixisenatide per day

Product Name:Trulicity	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of type 2 diabetes mellitus with or without cardiovascular disease or cardiovascular disease risk factors, as confirmed by submission of medical records or claims history	

AND

2 - Patient is 10 years of age or older

AND

3 - Prescriber has submitted baseline HbA1c (hemoglobin A1c) lab documentation, obtained within the past 90 days, prior to initiating the requested medication

AND

4 - One of the following:

4.1 Patient is not on concomitant DPP-4 inhibitor-containing agent

OR

4.2 Patient will be transitioning from DPP-4 inhibitor-containing therapy to GLP-1 RA-containing therapy within the next 45 days

AND

5 - Patient will not be utilizing the requested agent concurrently with another GLP-1 RA or combination product

AND

6 - One of the following:

6.1 Previous trial of metformin for at least 90 days within the past 120 days, as confirmed by claims history, submission of medical records, or prescriber documents dates of trial

OR

6.2 Documented intolerance or contraindication to metformin therapy

AND

7 - Dose requested does not exceed ONE of the following:

- 0.75 mg injection: 2 injections/week
- 1.5 mg, 3 mg, or 4.5 mg injection: 1 injection/week

Product Name:Trulicity	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of type 2 diabetes mellitus with or without cardiovascular disease or cardiovascular disease risk factors, as confirmed by submission of medical records or claims history AND 2 - History of the requested medication for at least 84 days within the past 112 days, confirmed by claims history, submission of medical records, or prescriber documents dates of trial AND 3 - BOTH of the following: 3.1 Submission of HbA1c lab documentation, obtained within one of the following timeframes: • Patients who have been on requested therapy for less than 1 year: within the past 90 days (document date and A1c)	

- Patients who have been on requested therapy for at least 1 year: within the past 180 days (document date and A1c)

AND

3.2 ONE of the following:

3.2.1 Submitted HbA1c demonstrates a reduction in HbA1c from the baseline value obtained prior to initiating the requested agent (must submit documentation of baseline HbA1c or provide value of baseline HbA1c, including date and time of collection)

OR

3.2.2 Submitted HbA1c demonstrates a reduction or trend towards stabilization over the past year

OR

3.2.3 BOTH of the following:

- Submitted HbA1c does NOT demonstrate a reduction in HbA1c from the baseline value obtained prior to initiating the requested agent (must submit documentation of baseline HbA1c or provide value of baseline HbA1c, including date and time of collection) OR does NOT demonstrate a reduction or trend towards stabilization in HbA1c over the past year
- Prescriber has submitted medical justification for continued use, supported by documentation within submitted chart notes

AND

4 - Patient is not on concomitant DPP-4 inhibitor-containing therapy

AND

5 - Patient is not utilizing the requested agent concurrently with another GLP-1 RA or combination product

AND

6 - Dose requested does not exceed ONE of the following:

- 0.75 mg injection: 2 injections/week
- 1.5 mg, 3 mg, or 4.5 mg injection: 1 injection/week

Product Name: Brand Victoza, generic liraglutide

Diagnosis	Type 2 diabetes

Approval Length	6 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is 10 years of age or older

AND

2 - Diagnosis of Type 2 diabetes mellitus with or without cardiovascular disease, as confirmed by submission of medical records or claims history

AND

3 - One of the following:

3.1 Previous trial of metformin for at least 90 days within the past 120 days, as confirmed by claims history, submission of medical records, or prescriber documents dates of trial

OR

3.2 Documented intolerance or contraindication to metformin therapy

AND

4 - Prescriber has submitted baseline HbA1c (hemoglobin A1c) lab documentation, obtained within the past 90 days, prior to initiating the requested medication

AND

5 - One of the following:

5.1 Patient is not on concomitant DPP-4 inhibitor-containing agent

OR

5.2 Patient will be transitioning from DPP-4 inhibitor-containing therapy to GLP-1 RA-containing therapy within the next 45 days

AND

6 - Patient will not be utilizing the requested agent concurrently with another GLP-1 RA or combination product

AND

7 - Dose requested does not exceed 1.8 mg/day

Product Name:Brand Victoza, generic liraglutide	
Diagnosis	Type 2 diabetes
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of type 2 diabetes mellitus with or without cardiovascular disease, as confirmed by submission of medical records or claims history

AND

2 - History of the requested medication for at least 90 days within the past 120 days, confirmed by claims history, submission of medical records, or prescriber documents dates of trial

AND

3 - BOTH of the following:

3.1 Submission of HbA1c lab documentation, obtained within one of the following timeframes:

- Patients who have been on requested therapy for less than 1 year: within the past 90 days (document date and A1c)
- Patients who have been on requested therapy for at least 1 year: within the past 180 days (document date and A1c)

AND

3.2 ONE of the following:

3.2.1 Submitted HbA1c demonstrates a reduction in HbA1c from the baseline value obtained prior to initiating the requested agent (must submit documentation of baseline HbA1c or provide value of baseline HbA1c, including date and time of collection)

OR

3.2.2 Submitted HbA1c demonstrates a reduction or trend towards stabilization over the past year

OR

3.2.3 BOTH of the following:

- Submitted HbA1c does NOT demonstrate a reduction in HbA1c from the baseline value obtained prior to initiating the requested agent (must submit documentation of baseline HbA1c or provide value of baseline HbA1c, including date and time of collection) OR does NOT demonstrate a reduction or trend towards stabilization in HbA1c over the past year
- Prescriber has submitted medical justification for continued use, supported by documentation within submitted chart notes

AND

4 - Patient is not on concomitant DPP-4 inhibitor-containing therapy

AND

5 - Patient is not utilizing the requested agent concurrently with another GLP-1 RA or combination product

AND

6 - Dose requested does not exceed 1.8 mg/day

Product Name: Brand Victoza, generic liraglutide	
Diagnosis	Polycystic ovary syndrome
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is 10 years of age or older AND	

2 - Diagnosis of Polycystic ovary syndrome, as confirmed by submission of medical records or claims history

AND

3 - One of the following:

3.1 Previous trial of metformin for at least 90 days within the past 120 days, as confirmed by claims history, submission of medical records, or prescriber documents dates of trial

OR

3.2 Documented intolerance or contraindication to metformin therapy

AND

4 - One of the following:

4.1 Patient is not on concomitant DPP-4 inhibitor-containing agent

OR

4.2 Patient will be transitioning from DPP-4 inhibitor-containing therapy to GLP-1 RA-containing therapy within the next 45 days

AND

5 - Patient will not be utilizing the requested agent concurrently with another GLP-1 RA or combination product

AND

6 - Dose requested does not exceed 1.8 mg/day

Product Name:Brand Victoza, generic liraglutide	
Diagnosis	Polycystic ovary syndrome
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of polycystic ovary syndrome, as confirmed by submission of medical records or claims history AND 2 - History of the requested medication for at least 90 days within the past 120 days, confirmed by claims history, submission of medical records, or prescriber documents dates of trial AND 3 - Patient is not on concomitant DPP-4 inhibitor-containing therapy AND 4 - Patient is not utilizing the requested agent concurrently with another GLP-1 RA or combination product AND 5 - Dose requested does not exceed 1.8 mg/day	

Product Name:Brand Victoza, generic liraglutide	
Diagnosis	Metabolic-dysfunction associated steatotic liver disease (MASLD), Metabolic dysfunction associated steatohepatitis (MASH)
Approval Length	6 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is 10 years of age or older AND 2 - One of the following diagnosis: • Metabolic dysfunction associated steatohepatitis (MASH) • Metabolic dysfunction-associated steatotic liver disease (MASLD) AND 3 - One of the following confirming the diagnosis (submission of medical records required): 3.1 Liver biopsy obtained within the past 2 years illustrating one of the following scores: 3.1.1 For MASH indication, both of the following: • Non-alcoholic fatty liver disease activity score (NAS) of greater than or equal to 4 with a score of at least 1 in each of the following NAS components: steatosis, ballooning degeneration, and lobular inflammation • METAVIR stage of F1-F3 fibrosis OR 3.1.2 For MASLD indication: score of at least 1 in steatosis category OR 3.2 Vibration-controlled transient elastography (e.g., Fibroscan) obtained within the past 6 months illustrating one of the following scores: 3.2.1 For MASH indication: results with a liver stiffness measurement (LSM) greater than or	

equal to 6.43 kPa (kilopascal) and controlled attenuation parameter (CAP) greater than or equal to 238 dB/m (decibels per meter)

OR

3.2.2 For MASLD indication: controlled attenuation parameter (CAP) greater than or equal to 238 dB/m

AND

4 - Prescribed by, or in consultation with, an endocrinologist, gastroenterologist, or hepatologist

AND

5 - One of the following:

5.1 Patient is not on concomitant DPP-4 inhibitor-containing agent

OR

5.2 Patient will be transitioning from DPP-4 inhibitor-containing therapy to GLP-1 RA-containing therapy within the next 45 days

AND

6 - Patient will not be utilizing the requested agent concurrently with another GLP-1 RA or combination product

AND

7 - Dose requested does not exceed 1.8 mg/day

Product Name: Brand Victoza, generic liraglutide

Diagnosis	Metabolic-dysfunction associated steatotic liver disease (MASLD), Metabolic dysfunction associated steatohepatitis (MASH)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of metabolic dysfunction associated steatohepatitis (MASH) OR metabolic dysfunction-associated steatotic liver disease (MASLD), as confirmed by submission of medical records or claims history AND 2 - Submission of medical records documenting current clinical status, including one of the following: • Liver biopsy results within the past year demonstrating improvement or stabilization in fibrosis staging and NAS score from baseline • Fibroscan results within the past year demonstrating improvement or stabilization in CAP and LSM scores AND 3 - History of the requested medication for at least 90 days within the past 120 days, confirmed by claims history, submission of medical records, or prescriber documents dates of trial AND 4 - Patient is not on concomitant DPP-4 inhibitor-containing therapy AND 5 - Patient is not utilizing the requested agent concurrently with another GLP-1 RA or combination product	

AND

6 - Dose requested does not exceed 1.8 mg/day

Product Name: Zepbound

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 - Diagnosis of moderate to severe obstructive sleep apnea (OSA) in individuals with obesity AND all of the following:

2.1 Submission of clinical documentation (e.g., chart notes) of BOTH of the following within the past 3 months:

- BMI (body mass index) of greater than or equal to 30 kg/m² (kilograms per square meter) before initiating Zepbound
- Baseline weight before initiating Zepbound

AND

2.2 One of the following:

2.2.1 Patient has an apnea hypopnea index (AHI) of greater than or equal to 15 events/hour, as measured on polysomnography (PSG) or home sleep apnea test (HSAT) that has been reviewed and interpreted by a sleep medicine-certified physician, confirmed by submission of clinical documentation from a PSG or HSAT obtained within the past year

OR

2.2.2 Both of the following:

- Patient has an apnea hypopnea index (AHI) of greater than or equal to 15 events/hour, as measured on polysomnography (PSG) or home sleep apnea test (HSAT) that has been reviewed and interpreted by a sleep medicine-certified physician, confirmed by submission of clinical documentation (e.g., chart notes)
- Prescriber has submitted documentation confirming patient has been utilizing positive airway pressure (PAP) therapy (e.g., CPAP, BiPAP) with documented adherence from within the past 90 days (adherence defined as at least 4 hours of use per night for at least 70 percent of all nights within a 30-day period, supported by submitted PAP therapy report or chart note documentation)

AND

2.3 Patient does NOT have Type 1 or Type 2 diabetes mellitus

AND

2.4 Patient's hemoglobin A1c is less than 6.5% confirmed by submission of clinical documentation (e.g., chart notes) from within the past 3 months

AND

3 - Prescriber attests to ALL of the following:

- Patient does not have diagnosis of central or mixed sleep apnea with percent of mixed or central apneas/hypopneas greater than or equal to 50%
- Patient will use Zepbound (tirzepatide) in combination with reduced calorie diet and increased physical activity
- Patient will NOT use the requested medication concurrently with another GLP-1 RA or combination product (including tirzepatide-containing products)

AND

4 - Dose requested does not exceed 15 mg/week (milligrams per week)

Product Name:Zepbound	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of requested medication for at least 84 days within the past 112 days, as confirmed by claims history or submission of medical records AND 2 - If the request is for the first reauthorization (patient has been on requested therapy for > 1 year and < 2 years), patient demonstrates a documented reduction in apnea hypopnea index (AHI) from baseline study (e.g., polysomnography [PSG] or home sleep apnea test [HSAT] that was reviewed and interpreted by a sleep medicine-certified physician, CPAP or BiPAP sleep data) obtained within the past 3 months AND 3 - Patient demonstrates a meaningful weight loss from baseline (defined as a weight loss of at least 5% from baseline) AND 4 - Prescriber attests to BOTH of the following: • Patient does not have Type 1 or Type 2 diabetes mellitus • Patient has not been diagnosed with central or mixed sleep apnea AND 5 - Dose requested does not exceed 15 mg/week (milligrams per week)	

AND

6 - Patient will NOT use the requested medication concurrently with another GLP-1 RA or combination product (including tirzepatide-containing products)

Product Name:Exenatide	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of type 2 diabetes mellitus, as confirmed by submission of medical records or claims history AND 2 - Patient is 18 years of age or older AND 3 - Prescriber has submitted baseline HbA1c (hemoglobin A1c) lab documentation, obtained within the past 90 days, prior to initiating the requested medication AND 4 - One of the following: 4.1 Patient is not on concomitant DPP-4 inhibitor-containing agent OR	

4.2 Patient will be transitioning from DPP-4 inhibitor-containing therapy to GLP-1 RA-containing therapy within the next 45 days

AND

5 - Patient will not be utilizing the requested agent concurrently with another GLP-1 RA or combination product

AND

6 - One of the following:

6.1 Both of the following:

6.1.1 History of at least 90 days at an optimized dose*, supported by claims history, submission of medical records, or prescriber documents dates of trial, to TWO different preferred GLP-1 RA agents, at least one of the two preferred GLP-1 RA trials must consist of either Ozempic (semaglutide) or Trulicity (dulaglutide)

AND

6.1.2 Prescriber has submitted laboratory reports (e.g., HbA1c) with respective collection dates and times illustrating insufficient response to each of the two preferred agents trialed

OR

6.2 Medical justification for use of the requested medication over Ozempic (semaglutide), Trulicity (dulaglutide), AND Victoza (liraglutide) (any medical justification regarding intolerance or adverse effects must be supported by documentation within submitted chart notes. Gastrointestinal adverse effects are not considered an intolerance as they are expected class effects)

AND

7 - Dose requested does not exceed 20 mcg/day

Notes	*See Table 1 in Background section **PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name: Exenatide	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of type 2 diabetes mellitus, as confirmed by submission of medical records or claims history AND 2 - One of the following: 2.1 Both of the following: 2.1.1 History of at least 90 days at an optimized dose*, supported by claims history, submission of medical records, or prescriber documents dates of trial, to TWO different preferred GLP-1 RA agents, at least one of the two preferred GLP-1 RA trials must consist of either Ozempic (semaglutide) or Trulicity (dulaglutide) (documents agents and trial dates of each) AND 2.1.2 Prescriber has submitted laboratory reports (e.g., HbA1c) with respective collection dates and times illustrating insufficient response to each of the two preferred agents trialed OR 2.2 Medical justification for use of the requested medication over Ozempic (semaglutide), Trulicity (dulaglutide), AND Victoza (liraglutide) (any medical justification regarding intolerance or adverse effects must be supported by documentation within submitted chart notes.	

Gastrointestinal adverse effects are not considered an intolerance as they are expected class effects)

AND

3 - Patient has a history of the requested medication for at least 90 days within the past 120 days, confirmed by claims history, submission of medical records, or prescriber documents dates of trial

AND

4 - BOTH of the following:

4.1 Submission of HbA1c lab documentation, obtained within one of the following timeframes:

- Patients who have been on requested therapy for less than 1 year: within the past 90 days (document date and A1c)
- Patients who have been on requested therapy for at least 1 year: within the past 180 days (document date and A1c)

AND

4.2 ONE of the following:

4.2.1 Submitted HbA1c demonstrates a reduction in HbA1c from the baseline value obtained prior to initiating the requested agent (must submit documentation of baseline HbA1c or provide value of baseline HbA1c, including date and time of collection)

OR

4.2.2 Submitted HbA1c demonstrates a reduction or trend towards stabilization over the past year

OR

4.2.3 BOTH of the following:

- Submitted HbA1c does NOT demonstrate a reduction in HbA1c from the baseline value obtained prior to initiating the requested agent (must submit documentation of

baseline HbA1c or provide value of baseline HbA1c, including date and time of collection) OR does NOT demonstrate a reduction or trend towards stabilization in HbA1c over the past year	
• Prescriber has submitted medical justification for continued use, supported by documentation within submitted chart notes	
AND	
5 - Patient is not on concomitant DPP-4 inhibitor-containing therapy	
AND	
6 - Patient is not utilizing the requested agent concurrently with another GLP-1 RA or combination product	
AND	
7 - Dose requested does not exceed 20 mcg/day	
Notes	*See Table 1 in Background section **PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:Mounjaro	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of type 2 diabetes mellitus, as confirmed by submission of medical records or claims history AND 2 - Patient is 10 years of age or older	

AND

3 - Prescriber has submitted baseline HbA1c (hemoglobin A1c) lab documentation, obtained within the past 90 days, prior to initiating the requested medication

AND

4 - One of the following:

4.1 Patient is not on concomitant DPP-4 inhibitor-containing agent

OR

4.2 Patient will be transitioning from DPP-4 inhibitor-containing therapy to GLP-1 RA-containing therapy within the next 45 days

AND

5 - Patient will not be utilizing the requested agent concurrently with another GLP-1 RA or combination product

AND

6 - One of the following:

6.1 Both of the following:

6.1.1 History of at least 90 days at an optimized dose*, supported by claims history, submission of medical records, or prescriber documents dates of trial, to TWO different preferred GLP-1 RA agents, at least one of the two preferred GLP-1 RA trials must consist of either Ozempic (semaglutide) or Trulicity (dulaglutide), as applicable based on FDA (Food and Drug Administration) approved age limit

AND

6.1.2 Prescriber has submitted laboratory reports (e.g., HbA1c) with respective collection dates and times illustrating insufficient response to each of the two preferred agents trialed

OR

6.2 Medical justification for use of Mounjaro (tirzepatide) over Ozempic (semaglutide), Trulicity (dulaglutide), AND Victoza (liraglutide), as applicable based on FDA approved age limit (any medical justification regarding intolerance or adverse effects must be supported by documentation within submitted chart notes. Gastrointestinal adverse effects are not considered an intolerance as they are expected class effects)

AND

7 - ONE of the following:

- Patient is 18 years of age or older: dose requested does not exceed 15 mg/week
- Patient is less than 18 years of age: dose requested does not exceed 10mg/week

Notes

*See Table 1 in Background section

**PDL Link: <https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html>

Product Name:Mounjaro

Approval Length 12 month(s)

Therapy Stage Reauthorization

Guideline Type Prior Authorization

Approval Criteria

1 - Diagnosis of type 2 diabetes mellitus, as confirmed by submission of medical records or claims history

AND

2 - One of the following:

2.1 Both of the following:

2.1.1 History of at least 90 days at an optimized dose*, supported by claims history, submission of medical records, or prescriber documents dates of trial, to TWO different preferred GLP-1 RA agents, at least one of the two preferred GLP-1 RA trials must consist of either Ozempic (semaglutide) or Trulicity (dulaglutide), as applicable based on FDA (Food and Drug Administration) approved age limit

AND

2.1.2 Prescriber has submitted laboratory reports (e.g., HbA1c) with respective collection dates and times illustrating insufficient response to each of the two preferred agents trialed

OR

2.2 Medical justification for use of Mounjaro (tirzepatide) over Ozempic (semaglutide), Trulicity (dulaglutide), AND Victoza (liraglutide), as applicable based on FDA approved age limit (any medical justification regarding intolerance or adverse effects must be supported by documentation within submitted chart notes. Gastrointestinal adverse effects are not considered an intolerance as they are expected class effects)

AND

3 - History of the requested medication for at least 84 days within the past 112 days, confirmed by claims history, submission of medical records, or prescriber documents dates of trial

AND

4 - BOTH of the following:

4.1 Submission of HbA1c lab documentation, obtained within one of the following timeframes:

- Patients who have been on requested therapy for less than 1 year: within the past 90 days (document date and A1c)
- Patients who have been on requested therapy for at least 1 year: within the past 180 days (document date and A1c)

AND

4.2 ONE of the following:

4.2.1 Submitted HbA1c demonstrates a reduction in HbA1c from the baseline value obtained prior to initiating the requested agent (must submit documentation of baseline HbA1c or provide value of baseline HbA1c, including date and time of collection)

OR

4.2.2 Submitted HbA1c demonstrates a reduction or trend towards stabilization over the past year

OR

4.2.3 BOTH of the following:

- Submitted HbA1c does NOT demonstrate a reduction in HbA1c from the baseline value obtained prior to initiating the requested agent (must submit documentation of baseline HbA1c or provide value of baseline HbA1c, including date and time of collection) OR does NOT demonstrate a reduction or trend towards stabilization in HbA1c over the past
- Prescriber has submitted medical justification for continued use, supported by documentation within submitted chart notes

AND

5 - Patient is not on concomitant DPP-4 inhibitor-containing therapy

AND

6 - Patient is not utilizing the requested agent concurrently with another GLP-1 RA or combination product

AND

7 - ONE of the following:

• Patient is 18 years of age or older: dose requested does not exceed 15 mg/week • Patient is less than 18 years of age: dose requested does not exceed 10mg/week	
Notes	*See Table 1 in Background section **PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:Rybelsus	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of type 2 diabetes mellitus, as confirmed by submission of medical records or claims history AND 2 - Patient is 18 years of age or older AND 3 - Prescriber has submitted baseline HbA1c (hemoglobin A1c) lab documentation, obtained within the past 90 days, prior to initiating the requested medication AND 4 - One of the following: 4.1 Patient is not on concomitant DPP-4 inhibitor-containing agent OR	

4.2 Patient will be transitioning from DPP-4 inhibitor-containing therapy to GLP-1 RA-containing therapy within the next 45 days

AND

5 - Patient will not be utilizing the requested agent concurrently with another GLP-1 RA or combination product

AND

6 - One of the following:

6.1 Both of the following:

6.1.1 History of at least 90 days at an optimized dose*, supported by claims history, submission of medical records, or prescriber documents dates of trial, to TWO different preferred GLP-1 RA agents, at least one of the two preferred GLP-1 RA trials must consist of either Ozempic (semaglutide) or Trulicity (dulaglutide)

AND

6.1.2 Prescriber has submitted laboratory reports (e.g., HbA1c) with respective collection dates and times illustrating insufficient response to each of the two preferred agents trialed

OR

6.2 Medical justification for use of Rybelsus (semaglutide) over Ozempic (semaglutide), Trulicity (dulaglutide), AND Victoza (liraglutide) (any medical justification regarding intolerance or adverse effects must be supported by documentation within submitted chart notes. Gastrointestinal adverse effects are not considered an intolerance as they are expected class effects)

AND

7 - Dose requested does not exceed 1 tablet/day

Notes	*See Table 1 in Background section **PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:Rybelsus	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of type 2 diabetes mellitus, as confirmed by submission of medical records or claims history AND 2 - One of the following: 2.1 Both of the following: 2.1.1 History of at least 90 days at an optimized dose*, supported by claims history, submission of medical records, or prescriber documents dates of trial, to TWO different preferred GLP-1 RA agents, at least one of the two preferred GLP-1 RA trials must consist of either Ozempic (semaglutide) or Trulicity (dulaglutide) AND 2.1.2 Prescriber has submitted laboratory reports (e.g., HbA1c) with respective collection dates and times illustrating insufficient response to each of the two preferred agents trialed OR 2.2 Medical justification for use of Rybelsus (semaglutide) over Ozempic (semaglutide), Trulicity (dulaglutide), AND Victoza (liraglutide) (any medical justification regarding intolerance or adverse effects must be supported by documentation within submitted chart notes. Gastrointestinal adverse effects are not considered an intolerance as they are expected class effects)	

AND

3 - History of the requested medication for at least 90 days within the past 120 days, confirmed by claims history, submission of medical records, or prescriber documents dates of trial

AND

4 - BOTH of the following:

4.1 Submission of HbA1c lab documentation, obtained within one of the following timeframes:

- Patients who have been on requested therapy for less than 1 year: within the past 90 days (document date and A1c)
- Patients who have been on requested therapy for at least 1 year: within the past 180 days (document date and A1c)

AND

4.2 ONE of the following:

4.2.1 Submitted HbA1c demonstrates a reduction in HbA1c from the baseline value obtained prior to initiating the requested agent (must submit documentation of baseline HbA1c or provide value of baseline HbA1c, including date and time of collection)

OR

4.2.2 Submitted HbA1c demonstrates a reduction or trend towards stabilization over the past year

OR

4.2.3 BOTH of the following:

- Submitted HbA1c does NOT demonstrate a reduction in HbA1c from the baseline value obtained prior to initiating the requested agent (must submit documentation of baseline HbA1c or provide value of baseline HbA1c, including date and time of

collection) OR does NOT demonstrate a reduction or trend towards stabilization in HbA1c over the past year • Prescriber has submitted medical justification for continued use, supported by documentation within submitted chart notes AND 5 - Patient is not on concomitant DPP-4 inhibitor-containing therapy AND 6 - Patient is not utilizing the requested agent concurrently with another GLP-1 RA or combination product AND 7 - Dose requested does not exceed 1 tablet/day	
Notes	*See Table 1 in Background section **PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:Wegovy inj	
Diagnosis	Cardiovascular disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is 45 years of age or older AND	

2 - Diagnosis of cardiovascular disease (CVD) in an obese or overweight patient who needs risk reduction of major adverse cardiovascular events (MACE) and all of the following:

2.1 Submission of clinical documentation (e.g., chart notes) of patient having a BMI (body mass index) of greater than or equal to 27 kg/m² (kilograms per square meter) within the past 3 months

AND

2.2 Submission of clinical documentation (e.g., chart notes) of patient having one of the following within the past year:

2.2.1 Prior myocardial infarction (MI)

OR

2.2.2 Prior stroke (ischemic or hemorrhagic)

OR

2.2.3 Symptomatic peripheral arterial disease (PAD) as evidenced by one of the following:

- Amputation due to atherosclerotic disease
- History of peripheral arterial revascularization procedure
- Intermittent claudication with ankle-brachial index (ABI) less than 0.85 (at rest)

AND

2.3 One of the following:

2.3.1 Submission of clinical documentation (e.g., chart notes) or confirmation by claims history that patient is optimized on guideline directed-therapy, including beta-blockers and/or renin-angiotensin system (RAS) inhibitors AND lipid-lowering agents

OR

2.3.2 Prescriber has provided medical justification as to why patient cannot use beta-

blockers, RAS inhibitors, AND lipid-lowering therapies (please document justification and if applicable, dates of trial)

AND

2.4 Prescriber attests to all of the following:

- Patient does not have Type 1 or Type 2 diabetes
- Patient will use Wegovy (semaglutide) in combination with reduced calorie diet and increased physical activity
- Patient will not use with other semaglutide products or with any other GLP-1 Receptor Agonists or combination products

AND

3 - Dose requested does not exceed 2.4 mg/week (milligrams per week)

Product Name:Wegovy inj	
Diagnosis	Cardiovascular disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of requested medication for at least 84 days within the past 112 days, as confirmed by claims history or submission of medical records AND 2 - Diagnosis of cardiovascular disease (CVD) in an obese or overweight patient who needs risk reduction of major adverse cardiovascular events (MACE) and both of the following: 2.1 Prescriber attests to all of the following: • Patient does not have Type 1 or Type 2 diabetes	

- Patient will continue to use Wegovy (semaglutide) in combination with reduced calorie diet and increased physical activity
- Patient will not use with other semaglutide products or with any other GLP-1 RA or combination agents

AND

2.2 One of the following:

2.2.1 Submission of clinical documentation (e.g., chart notes) or confirmation by claims history that patient continues to utilize optimized on guideline directed-therapy, including beta-blockers and/or renin-angiotensin system (RAS) inhibitors AND lipid-lowering agents

OR

2.2.2 Prescriber has provided medical justification as to why patient cannot use beta-blockers, RAS inhibitors, AND lipid-lowering therapies (please document justification and if applicable, dates of trial)

AND

3 - Dose requested does not exceed 2.4 mg/week (milligrams per week)

Product Name:Wegovy inj	
Diagnosis	Metabolic dysfunction-associated steatohepatitis (MASH)
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 medical records documenting diagnosis of metabolic dysfunction-associated steatohepatitis (MASH) confirmed by ONE of the following methods:

2.1 Liver biopsy obtained within the past 2 years illustrating the following scores:

- Non-alcoholic fatty liver disease activity score (NAS) of at least 4 with a score of at least 1 in each of the following NAS components: steatosis, ballooning degeneration, and lobular inflammation
- METAVIR stage of F2-F3 fibrosis and no evidence of cirrhosis

OR

2.2 Vibration-controlled transient elastography (e.g., Fibroscan) obtained within the past 6 months illustrating the following scores:

- Results with a liver stiffness measurement (LSM) at least 9.1 kPa
- Controlled attenuation parameter (CAP) at least 280 dB/m

AND

3 - Prescribed by, or in consultation with, an endocrinologist, gastroenterologist, or hepatologist

AND

4 - ONE of the following:

- Patient will NOT be using Wegovy concurrently with Rezdiffra
- Prescriber has provided valid medical justification for the concurrent use of Wegovy and Rezdiffra (document rationale)

AND

5 - ONE of the following:

5.1 Patient does not have Type 2 diabetes (T2D)

OR

5.2 BOTH of the following:

- Patient has concomitant T2D with MASH and has utilized Ozempic at 2 mg/week consistently for at least 18 months (confirmed by claims history or submission of medical records)
- Patient has demonstrated inadequate reduction in fibrosis and/or steatosis, confirmed by liver biopsy and/or non-invasive tests (baseline reports must be submitted along with testing documentation collected within the past 6 months)

AND

6 - Patient will not use the requested agent concurrently with another GLP-1 RA or combination product (including semaglutide-containing products)

AND

7 - Patient will use Wegovy (semaglutide) in combination with reduced calorie diet and increased physical activity

AND

8 - Dose requested does not exceed 2.4 mg/week (milligrams per week)

Product Name:Wegovy inj	
Diagnosis	Metabolic dysfunction-associated steatohepatitis (MASH)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of requested medication for at least 84 days within the past 112 days, as confirmed by claims history or submission of medical records	

AND

2 - Diagnosis of metabolic dysfunction-associated steatohepatitis (MASH)

AND

3 - Submission of medical records documenting current clinical status, including one of the following:

- Liver biopsy results within the past year demonstrating improvement or stabilization in fibrosis staging and NAS score from baseline
- Fibroscan results within the past year demonstrating improvement or stabilization in CAP and LSM scores

AND

4 - Patient is not utilizing the requested agent concurrently with another GLP-1 RA or combination product (including semaglutide-containing products)

AND

5 - Patient will continue to use Wegovy (semaglutide) in combination with reduced calorie diet and increased physical activity

AND

6 - Dose requested does not exceed 2.4 mg/week (milligrams per week)

Product Name:Wegovy tabs	
Diagnosis	Cardiovascular disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is 45 years of age or older

AND

2 - Diagnosis of cardiovascular disease (CVD) in an obese or overweight patient who needs risk reduction of major adverse cardiovascular events (MACE) and all of the following:

2.1 Submission of clinical documentation (e.g., chart notes) of patient having a BMI (body mass index) of greater than or equal to 27 kg/m² (kilograms per square meter) within the past 3 months

AND

2.2 Submission of clinical documentation (e.g., chart notes) of patient having one of the following within the past year:

2.2.1 Prior myocardial infarction (MI)

OR

2.2.2 Prior stroke (ischemic or hemorrhagic)

OR

2.2.3 Symptomatic peripheral arterial disease (PAD) as evidenced by one of the following:

- Amputation due to atherosclerotic disease
- History of peripheral arterial revascularization procedure
- Intermittent claudication with ankle-brachial index (ABI) less than 0.85 (at rest)

AND

2.3 One of the following:

2.3.1 Submission of clinical documentation (e.g., chart notes) or confirmation by claims history that patient is optimized on guideline directed-therapy, including beta-blockers and/or renin-angiotensin system (RAS) inhibitors AND lipid-lowering agents

OR

2.3.2 Prescriber has provided medical justification as to why patient cannot use beta-blockers, RAS inhibitors, AND lipid-lowering therapies (please document justification and if applicable, dates of trial)

AND

2.4 Prescriber attests to all of the following:

- Patient does not have Type 1 or Type 2 diabetes
- Patient will use Wegovy (semaglutide) in combination with reduced calorie diet and increased physical activity
- Patient will not use with other semaglutide products or with any other GLP-1 Receptor Agonists or combination products

AND

3 - Submission of medical records (e.g., chart notes) justifying the use of Wegovy oral formulation over Wegovy subcutaneous injection

AND

4 - BOTH of the following:

- Dose requested does NOT exceed 25 mg/day
- Dose requested does NOT exceed 1 tablet/day

Product Name:Wegovy tabs	
Diagnosis	Cardiovascular disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
	Approval Criteria 1 - History of requested medication for at least 90 days within the past 120 days, as confirmed by claims history or submission of medical records AND 2 - Diagnosis of cardiovascular disease (CVD) in an obese or overweight patient who needs risk reduction of major adverse cardiovascular events (MACE) and both of the following: 2.1 Prescriber attests to all of the following: • Patient does not have Type 1 or Type 2 diabetes • Patient will continue to use Wegovy (semaglutide) in combination with reduced calorie diet and increased physical activity • Patient will not use with other semaglutide products or with any other GLP-1 RA or combination agents AND 2.2 One of the following: 2.2.1 Submission of clinical documentation (e.g., chart notes) or confirmation by claims history that patient continues to utilize optimized on guideline directed-therapy, including beta-blockers and/or renin-angiotensin system (RAS) inhibitors AND lipid-lowering agents OR 2.2.2 Prescriber has provided medical justification as to why patient cannot use beta-blockers, RAS inhibitors, AND lipid-lowering therapies (please document justification and if applicable, dates of trial) AND 3 - Submission of medical records (e.g., chart notes) justifying the use of Wegovy oral formulation over Wegovy subcutaneous injection

AND

4 - BOTH of the following:

- Dose requested does NOT exceed 25 mg/day
- Dose requested does NOT exceed 1 tablet/day

Product Name:Xultophy	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of type 2 diabetes mellitus, as confirmed by submission of medical records or claims history AND 2 - Patient is 18 years of age or older AND 3 - Prescriber has submitted baseline HbA1c (hemoglobin A1c) lab documentation, obtained within the past 90 days, prior to initiating the requested medication AND 4 - One of the following: 4.1 Patient is not on concomitant DPP-4 inhibitor-containing agent	

OR

4.2 Patient will be transitioning from DPP-4 inhibitor-containing therapy to GLP-1 RA-containing therapy within the next 45 days

AND

5 - Patient will not be utilizing the requested agent concurrently with another GLP-1 RA or combination product

AND

6 - One of the following:

6.1 Trial and failure of Soliqua as confirmed claims history, submission of medical records, or prescriber documents dates of trial

OR

6.2 Both of the following:

6.2.1 Medical justification for use of Xultophy over Soliqua (document justification)

AND

6.2.2 Patient has had a previous trial of ONE of the following for at least 90 days in the past 120 days, as confirmed by claims history, submission of medical records, or provider documents dates of trial:

- A preferred* non-insulin injectable hypoglycemic
- A preferred* long-acting insulin

AND

7 - Dose requested does not exceed 50 units insulin degludec/1.8 mg liraglutide per day

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:Xultophy	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of type 2 diabetes mellitus, as confirmed by submission of medical records or claims history AND 2 - One of the following: 2.1 Patient has a prior history of Soliqua, as confirmed claims history, submission of medical records, or prescriber documents dates of trial OR 2.2 Medical justification for the use of Xultophy over Soliqua (document justification) AND 3 - History of the requested medication for at least 90 days within the past 120 days, confirmed by claims history, submission of medical records, or prescriber documents dates of trial AND 4 - BOTH of the following: 4.1 Submission of HbA1c lab documentation, obtained within one of the following timeframes:	

- Patients who have been on requested therapy for less than 1 year: within the past 90 days (document date and A1c)
- Patients who have been on requested therapy for at least 1 year: within the past 180 days (document date and A1c)

AND

4.2 ONE of the following:

4.2.1 Submitted HbA1c demonstrates a reduction in HbA1c from the baseline value obtained prior to initiating the requested agent (must submit documentation of baseline HbA1c or provide value of baseline HbA1c, including date and time of collection)

OR

4.2.2 Submitted HbA1c demonstrates a reduction or trend towards stabilization over the past year

OR

4.2.3 BOTH of the following:

- Submitted HbA1c does NOT demonstrate a reduction in HbA1c from the baseline value obtained prior to initiating the requested agent (must submit documentation of baseline HbA1c or provide value of baseline HbA1c, including date and time of collection) OR does NOT demonstrate a reduction or trend towards stabilization in HbA1c over the past year
- Prescriber has submitted medical justification for continued use, supported by documentation within submitted chart notes

AND

5 - Patient is not on concomitant DPP-4 inhibitor-containing therapy

AND

6 - Patient is not utilizing the requested agent concurrently with another GLP-1 RA or combination product

AND

7 - Dose requested does not exceed 50 units insulin degludec/1.8 mg liraglutide per day

2 . Background

Benefit/Coverage/Program Information

Table 1: Optimized Dose

AGENT	OPTIMIZED DOSE
Ozempic (semaglutide)	2 mg weekly
Trulicity (dulaglutide)	4.5 mg weekly
Victoza (liraglutide)	1.8 mg daily

3 . Revision History

Date	Notes
4/22/2026	Updated guideline name. Added note stating guideline does not apply to Wegovy HD. Updated Zepbound GPIs and added Wegovy tablets. Updated HbA1c reauth criteria for Type 2 diabetes. Updated Mounjaro min age. Updated T/F language for Mounjaro, Exenatide and Rybelsus. Updated submission language throughout.

Gomekli



Prior Authorization Guideline

Guideline ID	GL-267197
Guideline Name	Gomekli
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 Virginia Medicaid - Community & State Washington Medicaid - Community & State Indiana Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2025

1 . Criteria

Product Name:Gomekli

Diagnosis	Neurofibromatosis Type 1
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of neurofibromatosis type 1 AND 2 - Patient has plexiform neurofibromas (PN) that are both of the following: • Symptomatic • Not amenable to complete resection	

Product Name:Gomekli	
Diagnosis	Neurofibromatosis Type 1
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 Gomekli therapy	

Product Name:Gomekli	
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:Gomekli	
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 Gomekli therapy	

2 . Revision History

Date	Notes
5/14/2025	Updated formularies to add IN

Gonadotropin-Releasing Hormone Agonists



Prior Authorization Guideline

Guideline ID	GL-577245
Guideline Name	Gonadotropin-Releasing Hormone Agonists
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Fensolvi, leuprolide acetate inj kit 5 mg/mL, Lupron Depot-Ped, Supprelin LA, 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 for Triptodur or Lupron-Depot Ped (6-month), ONE of the following:

4.1 Failure to Fensolvi as confirmed by claims history or submission of medical records

OR

4.2 History of intolerance or contraindication to Fensolvi (please specify intolerance or contraindication)

Product Name:Fensolvi, leuprolide acetate inj kit 5 mg/mL, Lupron Depot-Ped, Supprelin LA, 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 (e.g., decrease in height velocity, cessation of menses, arrest pubertal progression, reduction in bone age advancement)

AND

3 - Patient is currently younger than the appropriate time point for the onset of puberty, as ONE of the following:

3.1 Female younger than 11 years of age

OR

3.2 Male younger than 12 years of age

Product Name:Lupron Depot 3.75 mg and 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 Failure to BOTH of the following classes as confirmed by claims history or submission of medical records: • Oral contraceptives or depot medroxyprogesterone (e.g., Depo-Provera) • Non-steroidal anti-inflammatory drugs (NSAIDs) OR 2.2 History of intolerance or contraindication to BOTH of the following classes (please specify intolerance or contraindication): • Oral contraceptives or depot medroxyprogesterone (e.g., Depo-Provera) • Non-steroidal anti-inflammatory drugs (NSAIDs) OR 2.3 Patient has had surgical ablation to prevent recurrence	

Product Name:Lupron Depot 3.75 mg and 3-month 11.25 mg	
Diagnosis	Endometriosis
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 - Treatment duration has not exceeded a total of 12 months, as confirmed by claims history or submission of medical records

Notes	Approval Length - Authorization will be issued for 6 months. Duration of both the initial and recurrent course of therapies is no longer than 12 months total.

Product Name:Lupron Depot 3.75 mg and 3-month 11.25 mg	
Diagnosis	Uterine Leiomyomata (Fibroids)
Approval Length	3 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ALL of the following: 1.1 For the treatment of uterine leiomyomata-related anemia AND 1.2 Patient did not respond to iron therapy of 1 month duration	

AND

1.3 For use prior to surgery

OR

2 - For use prior to surgery to reduce the size of fibroids to facilitate a surgical procedure (e.g., myomectomy, hysterectomy)

Product Name:Lupron Depot 7.5 mg, 22.5 mg, 30 mg, and 45 mg, leuprolide acetate inj kit 5 mg/mL, Leuprolide acetate (3 month) 22.5 mg inj, Lutrate Depot

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

Approval Criteria

1 - Diagnosis of advanced or metastatic prostate cancer

Product Name:Lupron Depot 7.5 mg, 22.5 mg, 30 mg, and 45 mg, leuprolide acetate inj kit 5 mg/mL, Leuprolide acetate (3 month) 22.5 mg inj, Lutrate Depot

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 therapy

Product Name:Lupron Depot, Lupron Depot-Ped, Fensolvi, Supprelin LA, Triptodur, leuprolide acetate inj kit 5 mg/mL, Leuprolide acetate (3 month) 22.5 mg inj, Lutrate Depot	
Diagnosis	Gender Dysphoria in Adolescents*
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 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 - Submission of medical records (e.g., chart notes, laboratory values) documenting the medication is prescribed by or in consultation with an endocrinologist or a medical provider experienced in gender dysphoria hormone therapy AND 3 - Submission of medical records (e.g., chart notes, laboratory values) documenting the patient has experienced puberty development to at least Tanner stage 2 (stage 2 through 4) AND 4 - Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following laboratory tests, based upon the laboratory reference range, confirming: • Pubertal levels of estradiol in a female • Pubertal levels of testosterone in a male • 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 - Submission of medical records (e.g., chart notes, laboratory values) documenting 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

Notes	*Please verify gender dysphoria is a coverable benefit for the patient.

Product Name:Lupron Depot, Lupron Depot-Ped, Fensolvi, Supprelin LA, Triptodur, leuprolide acetate inj kit 5 mg/mL, Leuprolide acetate (3 month) 22.5 mg inj, Lutrate Depot

Diagnosis	Gender Dysphoria in Adolescents*

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) documenting ONE of the following within the last 6 months: • LH (luteinizing hormone) suppression assessing for appropriate suppression • Change in dosing AND 2 - Submission of medical records (e.g., chart notes, laboratory values) documenting 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 - Submission of medical records (e.g., chart notes, laboratory values) documenting the medication is prescribed by or in consultation with an endocrinologist or a medical provider experienced in gender dysphoria hormone therapy AND 4 - Submission of medical records (e.g., chart notes, laboratory values) documenting 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

Notes	*Please verify gender dysphoria is a coverable benefit for the patient.

Product Name:Lupron Depot, Lupron Depot-Ped, Fensolvi, Supprelin LA, Triptodur, leuprolide acetate inj kit 5 mg/mL, Leuprolide acetate (3 month) 22.5 mg inj, Lutrate Depot

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 - Submission of medical records (e.g., chart notes, laboratory values) documenting a 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 - Submission of medical records (e.g., chart notes, laboratory values) documenting the medication is prescribed by or in consultation with an endocrinologist or a medical provider experienced in transgender hormone therapy

AND

3 - Submission of medical records (e.g., chart notes, laboratory values) documenting the gonads (i.e., testes, ovaries) have not been removed and are functional (e.g., hormone producing)

AND

4 - Submission of medical records (e.g., chart notes, laboratory values) documenting the patient is currently receiving hormonal therapy (e.g., testosterone, estrogens, progesterones) to achieve the desired (e.g., non-natal) gender

AND

5 - Submission of medical records (e.g., chart notes, laboratory values) documenting inability of cross sex hormone therapy to inhibit natal secondary sex characteristics, luteinizing hormone (LH), or gonadotropins (e.g., menses, testosterone)

AND

6 - Submission of medical records (e.g., chart notes, laboratory values) documenting 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

Notes	*Please verify gender dysphoria is a coverable benefit for the patient

Product Name:Lupron Depot, Lupron Depot-Ped, Fensolvi, Supprelin LA, Triptodur, leuprolide acetate inj kit 5 mg/mL, Leuprolide acetate (3 month) 22.5 mg inj, Lutrate Depot

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 - Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following within the last 6 months:

- Luteinizing hormone (LH) suppression assessing for appropriate suppression
- Change in dosing

AND

2 - Submission of medical records (e.g., chart notes, laboratory values) documenting a 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 - Submission of medical records (e.g., chart notes, laboratory values) documenting the medication is prescribed by or in consultation with an endocrinologist or a medical provider experienced in transgender hormone therapy

AND

4 - Submission of medical records (e.g., chart notes, laboratory values) documenting the gonads (i.e., testes, ovaries) are intact

AND

5 - Submission of medical records (e.g., chart notes, laboratory values) documenting the patient is currently receiving hormonal therapy (e.g., testosterone, estrogens, progestones) to achieve the desired (e.g., non-natal) gender

AND

6 - Submission of medical records (e.g., chart notes, laboratory values) documenting inability of cross sex hormone therapy to inhibit natal secondary sex characteristics, luteinizing hormone (LH), or gonadotropins (e.g., menses, testosterone)

AND

7 - Submission of medical records (e.g., chart notes, laboratory values) documenting 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

Notes	*Please verify gender dysphoria is a coverable benefit for the patient

Product Name:Lupron Depot, Lupron Depot-Ped, Fensolvi, Supprelin LA, Triptodur, leuprolide acetate inj kit 5 mg/mL, Leuprolide acetate (3 month) 22.5 mg inj, Lutrate Depot

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]

Product Name:Lupron Depot, Lupron Depot-Ped, Fensolvi, Supprelin LA, Triptodur, leuprolide acetate inj kit 5 mg/mL, Leuprolide acetate (3 month) 22.5 mg inj, Lutrate Depot

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., Cytosan (cyclophosphamide), procarbazine, vinblastine, cisplatin]

Product Name:leuprolide acetate inj kit 5 mg/mL

Diagnosis	Salivary Gland Tumors
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of salivary gland tumor AND 2 - Disease is one of the following: • Recurrent • Unresectable • Metastatic AND 3 - Disease is androgen receptor positive (AR+)	

Product Name:leuprolide acetate inj kit 5 mg/mL	
Diagnosis	Salivary Gland Tumors
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:leuprolide acetate inj kit 5 mg/mL	
Diagnosis	Uterine Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of one of the following: • Low-grade endometrial stromal sarcoma (ESS) • Adenosarcoma without sarcomatous overgrowth • Estrogen receptor/progesterone receptor positive (ER/PR+) uterine sarcoma	

Product Name:leuprolide acetate inj kit 5 mg/mL	
Diagnosis	Uterine 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 therapy	

Product Name:Lupron Depot, Lupron Depot-Ped, leuprolide acetate inj kit 5 mg/mL	
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:Lupron Depot, Lupron Depot-Ped, leuprolide acetate inj kit 5 mg/mL	
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
4/14/2026	Added Supprelin LA into the CPP, GD in adolescents, Adjunct for gender-affirming for transgender adults and Fertility preservation sections. Added Lutrate Depot to prostate cancer, GD in adolescents, Adjunct for gender-affirming for transgender adults and Fertility preservation sections. Clarified Tanner Stage 2 through 4 in GD in adolescents section.

Gralise, Horizant, and Lyrica CR



Prior Authorization Guideline

Guideline ID	GL-132243
Guideline Name	Gralise, Horizant, and Lyrica CR
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	10/1/2023

1 . Criteria

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

AND

2 - Diagnosis of postherpetic neuralgia (PHN)

AND

3 - One of the following:

3.1 Previous trial and failure of immediate-release gabapentin for 90 days in the past 180 days

OR

3.2 Medical rationale for use of Gralise (gabapentin ER) over immediate-release gabapentin (Document medical rationale)

AND

4 - Both of the following:

4.1 The dose requested does not exceed 1800 mg/day

AND

4.2 The dose requested does not exceed one of the following:

- 300 mg strength - max of 1 tablet/day
- 450 mg strength - max of 1 tablet/day
- 600 mg strength -max of 2 tablets/day
- 750 mg strength - max of 2 tablets/day
- 900 mg strength - max of 2 tablets/day
- Titration pack - 1 pack/90 days

Product Name:Gralise

Approval Length	1 year(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested medication for at least 90 days within the past 120 days, confirmed by claims history or chart documentation AND 2 - Both of the following: 2.1 The dose requested does not exceed 1800 mg/day AND 2.2 The dose requested does not exceed one of the following: • 300 mg strength - max of 1 tablet/day • 450 mg strength - max of 1 tablet/day • 600 mg strength -max of 2 tablets/day • 750 mg strength - max of 2 tablets/day • 900 mg strength - max of 2 tablets/day • Titration pack - 1 pack/90 days	

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

AND

2 - One of the following:

2.1 All of the following:

2.1.1 Diagnosis of postherpetic neuralgia (PHN)

AND

2.1.2 One of the following:

- Previous trial and failure of immediate-release gabapentin for 90 days in the past 180 days
- Medical rationale for use of Horizant (gabapentin ER) over immediate-release gabapentin (Document medical rationale)

OR

2.2 All of the following:

2.2.1 Diagnosis of moderate-to-severe primary restless legs syndrome (RLS)

AND

2.2.2 One of the following:

- Previous trial and failure of gabapentin IR, pramipexole, ropinirole or rotigotine patches for 90 days in the past 180 days
- Medical rationale for use of Horizant (gabapentin ER) over gabapentin IR, pramipexole, ropinirole and rotigotine patches (Document medical rationale)

AND

3 - Both of the following:

3.1 Dose requested does not exceed 1200 mg/day

AND

3.2 Dose requested does not exceed one of the following:

- 300 mg strength - max of 2 tablets/day
- 600 mg strength - max of 2 tablets/day

Product Name:Horizant	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested medication for at least 90 days within the past 120 days, confirmed by claims history or chart documentation AND 2 - Both of the following: 2.1 Dose requested does not exceed 1200 mg/day AND 2.2 Dose requested does not exceed one of the following: • 300 mg strength - max of 2 tablets/day • 600 mg strength - max of 2 tablets/day	

Product Name:Brand Lyrica CR, generic pregabalin ER	
Approval Length	1 year(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is 18 years of age or older AND 2 - One of the following: 2.1 All of the following: 2.1.1 Diagnosis of diabetic peripheral neuropathy (DPN) AND 2.1.2 Both of the following: 2.1.2.1 Dose requested does not exceed 330 mg/day AND 2.1.2.2 Dose requested does not exceed one of the following: • 82.5 mg strength - max of 3 tablets/day • 165 mg strength - max of 1 tablet/day • 330 mg strength - max of 1 tablet/day OR 2.2 All of the following: 2.2.1 Diagnosis of postherpetic neuralgia (PHN) AND	

2.2.2 Both of the following:

2.2.2.1 Dose requested does not exceed 660 mg/day

AND

2.2.2.2 Dose requested does not exceed one of the following:

- 82.5 mg strength - max of 3 tablets/day
- 165 mg strength - max of 3 tablets/day
- 330 mg strength - max of 2 tablets/day

AND

3 - One of the following:

3.1 Previous trial and failure of immediate-release pregabalin for 90 days in the past 180 days

OR

3.2 Medical rationale for use of Lyrica CR (pregabalin ER) over immediate-release pregabalin (Document medical rationale)

Product Name: Brand Lyrica CR, generic pregabalin ER	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested medication for at least 90 days within the past 120 days, confirmed by claims history or chart documentation	

AND

2 - One of the following:

2.1 All of the following:

2.1.1 Diagnosis of diabetic peripheral neuropathy (DPN)

AND

2.1.2 Both of the following:

2.1.2.1 Dose requested does not exceed 330 mg/day

AND

2.1.2.2 Dose requested does not exceed one of the following:

- 82.5 mg strength - max of 3 tablets/day
- 165 mg strength - max of 1 tablet/day
- 330 mg strength - max of 1 tablet/day

OR

2.2 All of the following:

2.2.1 Diagnosis of postherpetic neuralgia (PHN)

AND

2.2.2 Both of the following:

2.2.2.1 Dose requested does not exceed 660 mg/day

AND

2.2.2.2 Dose requested does not exceed one of the following:

- 82.5 mg strength - max of 3 tablets/day
- 165 mg strength - max of 3 tablets/day
- 330 mg strength - max of 2 tablets/day

2 . Revision History

Date	Notes
9/1/2023	Updated T/F for Horizant RLS to include gabapentin IR and look back of 90 in the last 180 days

Growth Hormones



Prior Authorization Guideline

Guideline ID	GL-480211
Guideline Name	Growth Hormones
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ Nuspin, Omnitrope, Serostim, Zomacton	
Diagnosis	Pediatric Patients (Less than 18 Years of Age)
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following:	

1.1 ONE of the following diagnoses (submission of biochemical evidence or other applicable testing supporting the diagnosis is required):

1.1.1 Growth-hormone deficiency

OR

1.1.2 BOTH of the following:

- Noonan syndrome
- The request is for Norditropin

OR

1.1.3 Prader-Willi syndrome

OR

1.1.4 BOTH of the following:

- Renal function impairment associated with growth failure
- The request is for Nutropin AQ Nuspin

OR

1.1.5 BOTH of the following:

- Short stature homeobox-containing gene (SHOX) deficiency
- The request is for Humatrope or Zomacton

OR

1.1.6 Small for gestational age (SGA)

OR

1.1.7 Turner syndrome

OR

1.2 ALL of the following:

1.2.1 Diagnosis of idiopathic short stature

AND

1.2.2 Submission of growth chart confirming BOTH of the following:

- Height measurement of more than 2.0 standard deviations below population mean for given age
- Growth rate of 5 cm (centimeters)/year or less prior to starting growth hormone therapy

AND

2 - Submission of a radiology report showing BOTH of the following:

- Bone age of 14-15 or less in patients assigned female at birth, 16-17 or less in patients assigned male at birth
- If patient is nearing or at puberty (estimated age range 10-17 years of age), open epiphyses

AND

3 - Prescriber attestation that they have performed all necessary testing to ensure there are no expanding intracranial lesions or tumors prior to initiating growth hormone therapy

AND

4 - If the request is non-preferred*, ONE of the following:

4.1 Medication is requested for a product-specific indication**

OR

4.2 Prescriber has provided valid medical justification for the use of the non-preferred medication over a preferred medication

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html **Humatrope and Zomactan are non-preferred unless the patient has a diagnosis of SHOX deficiency, Nutropin AQ is non-preferred unless patient has a diagnosis of growth failure associated with chronic renal insufficiency.

Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ Nuspin, Omnitrope, Serostim, Zomacton

Diagnosis	Pediatric Patients (Less than 18 Years of Age)
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has ONE of the following diagnoses:

- Growth-hormone deficiency
- Noonan syndrome (Norditropin only)
- Prader-Willi syndrome
- Renal function impairment associated with growth failure (Nutropin AQ only)
- Short stature homeobox-containing gene (SHOX) deficiency (Humatrope or Zomacton only)
- Small for gestational age (SGA)
- Turner syndrome

AND

2 - Patient has a history of the requested medication for at least 90 days within the past 120 days, confirmed by claims history or chart documentation

AND

3 - Submission of a radiology report showing BOTH of the following:

- Bone age of 14-15 or less in patients assigned female at birth, 16-17 or less in patients assigned male at birth
- If patient is nearing or at puberty (estimated age range 10-17 years of age) open epiphyses

AND

4 - Prescriber attestation that they are continuing to monitor the patient for intracranial tumor recurrence, progression of underlying disease, or malignant transformation of skin lesions, if appropriate

AND

5 - ONE of the following:

5.1 Growth rate of 2 to 2.5 cm/year or more with growth hormone therapy

OR

5.2 BOTH of the following:

- The patient's diagnosis is idiopathic short stature
- The provider has documented valid medical justification for continued use

AND

6 - If the request is non-preferred*, ONE of the following:

6.1 Medication is requested for a product-specific indication**

OR

6.2 Prescriber has provided valid justification for the use of the non-preferred medication over a preferred medication

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html **Humatrope and Zomactan are non-preferred unless the patient has a diagnosis of SHOX deficiency, Nutropin AQ is non-preferred unless patient has a diagnosis of growth failure associated with chronic renal insufficiency.

Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ Nuspin, Omnitrope, Serostim, Zomacton

Diagnosis	Adult Patients (18 Years of Age or Older) or Patients with Closed Epiphyses
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Patient is transitioning from pediatric growth hormone therapy, and ALL of the following:

1.1.1 Patient has reached adult height

AND

1.1.2 Patient stopped growth hormone therapy for at least 1 month before re-evaluation of the need for continued therapy

AND

1.1.3 Prescriber has determined that the patient will experience growth hormone deficiency into adulthood and would receive clinical benefit from continued growth hormone therapy

OR

1.2 BOTH of the following:

1.2.1 Patient has a diagnosis of adult growth-hormone deficiency

AND

1.2.2 Biochemical evidence or other applicable testing supporting the diagnosis

AND

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

2.1 Medication is requested for a product-specific indication**

OR

2.2 Prescriber has provided valid justification for the use of the non-preferred medication over a preferred medication

AND

3 - Prescriber attestation that they have performed all necessary testing to ensure there are no expanding intracranial lesions or tumors prior to initiating growth hormone therapy

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html **Humatrope and Zomactan are non-preferred unless the patient has a diagnosis of SHOX deficiency, Nutropin AQ is non-preferred unless patient has a diagnosis of growth failure associated with chronic renal insufficiency.

Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ Nuspin, Omnitrope, Serostim, Zomacton

Diagnosis	Adult Patients (18 Years of Age or Older) or Patients with Closed Epiphyses
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Patient has previously been transitioned from pediatric growth hormone therapy OR 1.2 Patient has a diagnosis of adult growth hormone deficiency AND 2 - Patient has a history of growth hormone therapy for at least 90 days within the past 120 days, confirmed by claims history or chart documentation AND 3 - If the request is non-preferred*, ONE of the following: 3.1 Medication is requested for a product-specific indication** OR 3.2 Prescriber has provided valid justification for the use of the non-preferred medication over a preferred medication AND 4 - Prescriber attestation that they are continuing to monitor the patient for intracranial tumor	

recurrence, progression of underlying disease, or malignant transformation of skin lesions, if appropriate	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html **Humatrope and Zomactan are non-preferred unless the patient has a diagnosis of SHOX deficiency, Nutropin AQ is non-preferred unless patient has a diagnosis of growth failure associated with chronic renal insufficiency.

Product Name:Serostim	
Diagnosis	HIV-Associated Wasting or Cachexia
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of HIV (human immunodeficiency virus)-associated wasting or cachexia AND 2 - Patient has failed one other therapy for HIV-associated wasting or cachexia (e.g., anabolic steroids, or for adults 18 years or older: dronabinol, megestrol) AND 3 - Patient must be on AIDS (acquired immunodeficiency syndrome)/HIV anti-retroviral therapy AND 4 - Patient must have ONE of the following: • Involuntary weight loss of greater than 10% of baseline total body weight • Body cell mass of less than 30%	

AND

5 - Patient must have a quantitative measurement of lean body mass using dual energy X-ray absorptiometry (DEXA) or bioelectric impedance analysis (BIA) prior to initiation of therapy

AND

6 - Prescriber attestation that they have performed all necessary testing to ensure there are no expanding intracranial lesions or tumors prior to initiating growth hormone therapy

Product Name:Serostim	
Diagnosis	HIV-Associated Wasting or Cachexia
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of HIV (human immunodeficiency virus)-associated wasting or cachexia AND 2 - History of the requested medication for at least 90 days within the past 120 days, confirmed by claims history or chart documentation AND 3 - Documentation stating patient is continuing to utilize AIDS (acquired immunodeficiency syndrome)/HIV antiretroviral therapy AND 4 - Documentation of the patient's current total body weight or lean body mass, showing total	

body weight or lean body mass has increased from treatment baseline during treatment period

AND

5 - Prescriber attestation that they are continuing to monitor the patient for intracranial tumor recurrence, progression of underlying disease, or malignant transformation of skin lesions, if appropriate

Product Name:Increlex

Approval Length	1 year(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Documented diagnosis of growth failure due to ONE of the following:

- Severe primary insulin-like growth factor-1 deficiency (primary IGFD)
- Growth hormone (GH) gene deletion with acquired neutralizing antibodies to GH

AND

2 - Submission of radiology report confirming open epiphyses

AND

3 - Patient is greater than or equal to 2 years of age and less than 18 years of age

AND

4 - Documentation of baseline height and weight

Product Name:Increlex

Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested medication for at least 90 days within the past 120 days, confirmed by claims history or chart documentation AND 2 - Patient is less than 18 years of age AND 3 - Submission of radiology report confirming open epiphyses AND 4 - ONE of the following: • Documentation of improvement in annualized growth velocity (AGV) • Provider has documented valid medical justification for continued use	

Product Name:Ngenla	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of growth failure due to growth hormone deficiency (documentation of biochemical evidence or other applicable testing supporting the diagnosis is required)

AND

2 - BOTH of the following:

- Patient is at least 3 years of age
- Patient is less than 18 years of age

AND

3 - Submission of a radiology report showing BOTH of the following:

- Bone age of 14-15 or less in females, 16-17 or less in males
- If patient is nearing or at puberty (estimated age range 10-17 years of age), open epiphyses

AND

4 - Prescriber attestation that they have performed all necessary testing to ensure there are no expanding intracranial lesions or tumors prior to initiating growth hormone therapy

AND

5 - ONE of the following:

5.1 Trial and failure of Skytrofa (lonapegsomatropin), confirmed by claims history or chart documentation

OR

5.2 Prescriber has documented valid medical justification as to why Skytrofa (lonapegsomatropin) is unsuitable for use

Product Name:Ngenla

Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested medication for at least 90 days within the past 120 days, confirmed by claims history or chart documentation AND 2 - Patient is less than 18 years of age AND 3 - Submission of a radiology report showing BOTH of the following: - Bone age of 14-15 or less in females, 16-17 or less in males - If patient is nearing or at puberty (estimated age range 10-17 years of age), open epiphyses AND 4 - Prescriber attestation that they are continuing to monitor the patient for intracranial tumor recurrence, progression of underlying disease, or malignant transformation of skin lesions, if appropriate	

Product Name:Skytrofa	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - One of the following:

1.1 Patient is 1 year of age or older and less than 18 years of age, weighing 11.5 kg (kilograms) or greater AND all of the following:

- Diagnosis of growth failure due to growth hormone deficiency (submission of biochemical evidence or other applicable testing supporting the diagnosis is required)
- Submission of radiology report showing bone age of 14-15 or less in females, 16-17 or less in males
- If patient is nearing or at puberty (estimated age range 10-17 years of age), submission of radiology report showing open epiphyses

OR

1.2 Patient is 18 years of age or older AND has a diagnosis of adult growth hormone deficiency (submission of biochemical evidence or other applicable testing supporting the diagnosis is required)

AND

2 - Prescriber attestation that they have performed all necessary testing to ensure there are no expanding intracranial lesions or tumors prior to initiating growth hormone therapy

AND

3 - ONE of the following:

- Trial and failure of ONE preferred* somatropin product, confirmed by claims history or chart documentation
- Prescriber has documented valid medical justification as to why the available preferred* somatropin agent(s) are unsuitable for use

Notes

*PDL link: <https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html>

Product Name: Skytrofa

Approval Length

1 year(s)

Therapy Stage

Reauthorization

Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested medication for at least 90 days within the past 120 days, confirmed by claims history or chart documentation AND 2 - One of the following: 2.1 Patient is less than 18 years of age AND both of the following: • Submission of radiology report showing bone age of 14-15 or less in females, 16-17 or less in males • If patient is nearing or at puberty (estimated age range 10-17 years of age), submission of radiology report showing open epiphyses OR 2.2 Patient is 18 years of age or older AND 3 - Prescriber attestation that they are continuing to monitor the patient for intracranial tumor recurrence, progression of underlying disease, or malignant transformation of skin lesions, if appropriate	

Product Name:Sogroya	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - ALL of the following:

1.1 Diagnosis of growth failure due to growth hormone deficiency (submission of biochemical evidence or other applicable testing supporting the diagnosis is required)

AND

1.2 BOTH of the following:

- Patient is at least 2.5 years of age
- Patient is less than 18 years of age

AND

1.3 Submission of a radiology report showing BOTH of the following:

- Bone age of 14-15 or less in females, 16-17 or less in males
- If patient is nearing or at puberty (estimated age range 10-17 years of age), open epiphyses

AND

1.4 Prescriber attestation that they have performed all necessary testing to ensure there are no expanding intracranial lesions or tumors prior to initiating growth hormone therapy

AND

1.5 ONE of the following:

- Trial and failure of Skytrofa (lonapegsomatropin), confirmed by claims history or chart documentation
- Prescriber has documented valid medical justification as to why Skytrofa (lonapegsomatropin) is unsuitable for use

OR

2 - ALL of the following:

2.1 Diagnosis of adult growth hormone deficiency (documentation of biochemical evidence or other applicable testing supporting the diagnosis is required)

AND

2.2 Patient is 18 years of age or older

AND

2.3 Prescriber attestation that they have performed all necessary testing to ensure there are no expanding intracranial lesions or tumors prior to initiating growth hormone therapy

AND

2.4 ONE of the following:

- Trial and failure of Skytrofa (lonapegsomatropin), confirmed by claims history or chart documentation
- Prescriber has documented valid medical justification as to why all Skytrofa (lonapegsomatropin) is unsuitable for use

Notes

*PDL link: <https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html>

Product Name:Sogroya	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested medication for at least 90 days within the past 120 days, confirmed by claims history or chart documentation	

AND

2 - ONE of the following:

2.1 Patient is less than 18 years of age and BOTH of the following:

2.1.1 Submission of a radiology report showing a bone age of 14-15 or less in females, 16-17 or less in males

AND

2.1.2 If patient is nearing or at puberty (estimated age range 10-17 years of age), submission of a radiology report showing open epiphyses

OR

2.2 Patient is 18 years of age or older

AND

3 - Prescriber attestation that they are continuing to monitor the patient for intracranial tumor recurrence, progression of underlying disease, or malignant transformation of skin lesions, if appropriate

Product Name:Voxzogo	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documented diagnosis of achondroplasia	

AND

2 - Submission of radiology report confirming open epiphyses

AND

3 - Patient is less than 18 years of age

AND

4 - Documentation of baseline height and weight

Product Name:Voxzogo	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested medication for at least 90 days within the past 120 days, confirmed by claims history or chart documentation AND 2 - Patient is less than 18 years of age AND 3 - Submission of radiology report confirming open epiphyses	

AND

4 - ONE of the following:

- Documentation of improvement in annualized growth velocity (AGV) of 1.5 cm/year
- Provider has documented valid medical justification for continued use

2 . Revision History

Date	Notes
12/17/2025	Updated Skytrofa GPIs. Removed step through Sogroya for Ngenla. Updated age criteria for Skytrofa. Updated step through to Skytrofa f or Sogroya.

H2 Receptor Antagonists



Prior Authorization Guideline

Guideline ID	GL-137625
Guideline Name	H2 Receptor Antagonists
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name:famotidine susp	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is under 12 years of age OR	

2 - Patient is unable to swallow tablets

2 . Revision History

Date	Notes
12/11/2023	Updated age requirement in criteria.

Harliku



Prior Authorization Guideline

Guideline ID	GL-578231
Guideline Name	Harliku
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 Nebraska Medicaid - Community & State Nevada Medicaid - Community & State New Mexico Medicaid - Community & State Pennsylvania Medicaid - Community & State Virginia Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name: Harliku	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has a diagnosis of alkaptonuria AND 2 - Patient is 18 years of age or older AND 3 - Submission of medical records (e.g., chart notes, laboratory values) confirming ONE of the following: • Urinary homogentisic acid (HGA) excretion greater than 0.4 grams per 24 hours • Biallelic mutation in homogentisate 1,2-dioxygenase (HGD) gene confirmed by genetic testing AND 4 - Harliku will not be used in combination with any of the following: • Generic nitisinone • Nityr • Orfadin AND 5 - Prescribed by or in consultation with a geneticist, metabolic disease specialist, or rheumatologist	

Product Name:Harliku	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Harliku therapy (e.g., reduced urinary HGA levels, improvement in joint symptoms) AND 2 - Harliku will not be used in combination with any of the following: • Generic nitisinone • Nityr • Orfadin AND 3 - Prescribed by or in consultation with a geneticist, metabolic disease specialist, or rheumatologist	

2 . Revision History

Date	Notes
4/14/2026	Added Indiana

HCG



Prior Authorization Guideline

Guideline ID	GL-509215
Guideline Name	HCG
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State New Jersey Medicaid - Community & State New York Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Indiana Medicaid - Community & State Nevada Medicaid - Community & State New Mexico Medicaid - Community & State Pennsylvania Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Novarel, Chorionic Gonadotropin, Ovidrel, Pregnyl	
Diagnosis	Prepubertal Cryptorchidism

Approval Length	6 Week(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of prepubertal cryptorchidism not due to anatomical obstruction	

2 . Revision History

Date	Notes
1/26/2026	Combined formularies. Removed GPI for Novarel 10000 Unit (obsolete). No changes to clinical criteria.

Hematinic Agents



Prior Authorization Guideline

Guideline ID	GL-124339
Guideline Name	Hematinic Agents
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	7/1/2023

1 . Criteria

Product Name: Aranesp	
Approval Length	6 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has anemia with ONE of the following: - Chronic kidney disease (CKD) - Myelodysplastic syndrome (MDS)	

OR

2 - BOTH of the following:

2.1 Patient has chemotherapy-induced anemia with non-myeloid malignancies/neoplastic disease

AND

2.2 Patient has at least 2 additional months of chemotherapy planned

Product Name:Epogen	
Approval Length	6 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Patient has anemia with ONE of the following: • Chronic kidney disease • Congestive heart failure • Hepatitis C for a patient receiving ribavirin with interferon alfa or ribavirin with peginterferon alfa • HIV (human immunodeficiency virus)-infected patient receiving zidovudine • Multiple myeloma • Myelodysplastic syndrome (MDS) • Myelofibrosis • Neoplastic disease not associated with chemotherapy • Rheumatoid arthritis • Transfusion-dependent beta thalassemia OR 1.2 Patient has anemia associated with radiation therapy	

OR

1.3 Patient has anemia due to trauma or postsurgical event, transfusion refusal (e.g., Jehovah's Witness)

OR

1.4 Patient has anemia of prematurity

OR

1.5 Request is for blood unit collection in preparation for autotransfusion

OR

1.6 BOTH of the following:

1.6.1 Patient has chemotherapy-induced anemia with non-myeloid malignancies/neoplastic disease

AND

1.6.2 Patient has at least 2 additional months of chemotherapy planned

OR

1.7 Patient has chronic anemia in neoplastic disease not associated with chemotherapy

OR

1.8 Request is for iron overload transfusion

OR

1.9 Patient has post-partum anemia (during the puerperium)

OR

1.10 Request is for reduction in allogenic blood transfusions in an anemic surgical patient (e.g., elective noncardiac, nonvascular surgeries) at high risk for perioperative blood loss

Product Name:Mircera	
Approval Length	6 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has anemia with chronic kidney disease AND 2 - ONE of the following: 2.1 Trial and failure of all preferred* agents OR 2.2 Prescriber has submitted valid medical rationale for the use of Mircera over all preferred* agents	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:Procrit	
Approval Length	6 month(s)

Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Patient has anemia with ONE of the following: • Chronic kidney disease • Congestive heart failure • Hepatitis C for a patient receiving ribavirin with interferon alfa or ribavirin with peginterferon alfa • HIV (human immunodeficiency virus)-infected patient receiving zidovudine • Multiple myeloma • Myelodysplastic syndrome (MDS) • Myelofibrosis • Neoplastic disease not associated with chemotherapy • Rheumatoid arthritis • Transfusion-dependent beta thalassemia OR 1.2 Patient has anemia associated with radiation therapy OR 1.3 Patient has anemia due to trauma or postsurgical event, transfusion refusal (e.g., Jehovah's Witness) OR 1.4 Patient has anemia of prematurity OR 1.5 Request is for blood unit collection in preparation for autotransfusion	

OR

1.6 BOTH of the following:

1.6.1 Patient has chemotherapy-induced anemia with non-myeloid malignancies/neoplastic disease

AND

1.6.2 Patient has at least 2 additional months of chemotherapy planned

OR

1.7 Patient has chronic anemia in neoplastic disease not associated with chemotherapy

OR

1.8 Request is for iron overload transfusion

OR

1.9 Patient has post-partum anemia (during the puerperium)

OR

1.10 Request is for reduction in allogenic blood transfusions in an anemic surgical patient (e.g., elective noncardiac, nonvascular surgeries) at high risk for perioperative blood loss

AND

2 - ONE of the following:

2.1 Trial and failure of all preferred* agents

OR

2.2 Prescriber has submitted valid medical rationale for the use of Procrit over all preferred* agents

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:Retacrit

Approval Length	6 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has anemia with ONE of the following:

- Chronic kidney disease
- Congestive heart failure
- Hepatitis C for a patient receiving ribavirin with interferon alfa or ribavirin with peginterferon alfa
- HIV (human immunodeficiency virus)-infected patient receiving zidovudine
- Multiple myeloma
- Myelodysplastic syndrome (MDS)
- Myelofibrosis
- Neoplastic disease not associated with chemotherapy
- Rheumatoid arthritis
- Transfusion-dependent beta thalassemia

OR

2 - Patient has anemia associated with radiation therapy

OR

3 - Patient has anemia due to trauma or postsurgical event, transfusion refusal (e.g., Jehovah's Witness)

OR

4 - Patient has anemia of prematurity

OR

5 - Request is for blood unit collection in preparation for autotransfusion

OR

6 - BOTH of the following:

6.1 Patient has chemotherapy-induced anemia with non-myeloid malignancies/neoplastic disease

AND

6.2 Patient has at least 2 additional months of chemotherapy planned

OR

7 - Patient has chronic anemia in neoplastic disease not associated with chemotherapy

OR

8 - Request is for iron overload transfusion

OR

9 - Patient has post-partum anemia (during the puerperium)

OR

10 - Request is for reduction in allogenic blood transfusions in an anemic surgical patient (e.g., elective noncardiac, nonvascular surgeries) at high risk for perioperative blood loss

2 . Revision History

Date	Notes
4/17/2023	Removed NP language from Epogen to match policy.

Hepatitis B Agents



Prior Authorization Guideline

Guideline ID	GL-146287
Guideline Name	Hepatitis B Agents
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2024

1 . Criteria

Product Name:Vemlidy	
Approval Length	Lifetime approval
Guideline Type	Prior Authorization
Approval Criteria 1 - The patient has a diagnosis of chronic viral hepatitis type B with documentation of ALL of the following: • Compensated liver disease • Negative HIV status	

- Creatinine clearance greater than 15 mL/minute (milliliters per minute)

AND

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

- Gastroenterologist
- Hepatologist
- Infectious disease specialist

AND

3 - Patient is 6 years of age or older

AND

4 - Patient weighs at least 25 kilograms (kg)

AND

5 - ONE of the following:

- Previous trial and failure of entecavir at a maximum indication-based dose
- Prescriber has submitted valid medical rationale for the use of Vemlidy (tenofovir alafenamide) over entecavir

2 . Revision History

Date	Notes
4/29/2024	Updated minimum age requirement and added weight requirement; F ormatting updates.

Hernexeos



Prior Authorization Guideline

Guideline ID	GL-458209
Guideline Name	Hernexeos
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Hernexeos	
Diagnosis	Non-Small Cell Lung Cancer

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of non-small cell lung cancer AND 2 - Disease is ONE of the following: • Recurrent • Advanced • Metastatic • Unresectable AND 3 - Presence of ERBB2 (HER2) mutation AND 4 - Patient has received prior systemic therapy	

Product Name:Hernexeos	
Diagnosis	Non-Small Cell Lung 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 Hernexeos therapy

Product Name:Hernexeos

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:Hernexeos

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 Hernexeos therapy

2 . Revision History

Date	Notes

11/21/2025	New Program.

Hetlitz



Prior Authorization Guideline

Guideline ID	GL-527195
Guideline Name	Hetlitz
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name: Brand Hetlitz capsules, generic tasimelteon capsules	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following: 1.1 Diagnosis of non-24-hour sleep-wake disorder and all of the following:	

1.1.1 Submission of medical records (e.g., charts, labs, progress notes, etc.) confirming patient has total blindness

AND

1.1.2 Submission of medical records (e.g., charts, labs, progress notes, etc.) confirming at least 3 months of persistent non-24 hours sleep-wake disorder symptoms (e.g., difficulty sleeping at night, difficulty initiating or staying asleep, etc.)

AND

1.1.3 Prescriber attests that patient's symptoms are not better explained by another current sleep, medical, neurologic, mental, or substance use disorder, or from medication use

AND

1.1.4 Patient is 18 years of age or older

AND

1.1.5 Requested dose does not exceed 20 mg (milligrams/day)

OR

1.2 Diagnosis of nighttime sleep disturbances in patients with Smith-Magenis syndrome and all of the following:

1.2.1 Prescriber has submitted medical records (e.g., charts, labs, progress notes, etc.) of genetic testing confirming Smith-Magenis syndrome

AND

1.2.2 Prescriber has submitted medical records (e.g., charts, progress notes, etc.) supporting nighttime sleep disturbances experienced by patient (e.g., frequent nighttime awakenings, shortened and fragmented sleep cycles, etc.)

AND

1.2.3 Patient is 16 years of age or older

AND

1.2.4 Requested dose does not exceed 20 mg (milligrams)/day

Product Name:Brand Hetlioz capsules, generic tasimelteon capsules	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of requested agent for at least 90 days within the past 120 days, confirmed by claims history or chart documentation AND 2 - Prescriber has submitted medical records (charts, progress notes, etc.) explicitly supporting positive response or stabilization in sleep-wake disorder or sleep disturbances AND 3 - Requested dose does not exceed 20 mg (milligrams)/day	

Product Name:Hetlioz LQ	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of nighttime sleep disturbances in patients with Smith-Magenis syndrome

AND

2 - Prescriber has submitted medical records (e.g., charts, labs, progress notes, etc.) of genetic testing confirming Smith-Magenis syndrome

AND

3 - Prescriber has submitted medical records (e.g., charts, progress notes, etc.) supporting nighttime sleep disturbances experienced by patient (e.g., frequent nighttime awakenings, shortened and fragmented sleep cycles, etc.)

AND

4 - Patient is 3 years of age or older and less than 16 years of age AND one of the following:

- Patient weighs less than or equal to 28 kilograms: requested dose does not exceed 0.7 mg/kg/day (milligrams/kilogram/day)
- Patient weighs greater than 28 kg: requested dose does not exceed 20 mg/day

Product Name:Hetlloz LQ	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of requested agent for at least 90 days within the past 120 days, confirmed by claims history or chart documentation	

AND

2 - Prescriber has submitted medical records (charts, progress notes, etc.) explicitly supporting positive response or stabilization in sleep disturbances

AND

3 - Patient is 3 years of age or older and less than 16 years of age AND one of the following:

- Patient weighs less than or equal to 28 kilograms: requested dose does not exceed 0.7 mg/kg/day (milligrams/kilogram/day)
- Patient weighs greater than 28 kg: requested dose does not exceed 20 mg/day

2 . Revision History

Date	Notes
2/24/2026	Removed note referencing generic tasimelteon capsules need to be reviewed by clinician for generic over brand review.

HIV



Prior Authorization Guideline

Guideline ID	GL-578232
Guideline Name	HIV
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Maryland Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State New Mexico Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name: Brand Viread, generic tenofovir disoproxil fumarate	
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following diagnoses:	

• HIV (human immunodeficiency virus) • Hepatitis B • HIV post-exposure prophylaxis (PEP)	
Notes	Approval Duration: 12 months for HIV and hepatitis B; 4 weeks for PEP.

Product Name: Brand Truvada, generic emtricitabine/tenofovir disoproxil fumarate*	
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following diagnoses: • HIV (human immunodeficiency virus) • Pre-exposure prophylaxis (PrEP) • HIV post-exposure prophylaxis (PEP)	
Notes	Approval Duration: 12 months for HIV and PrEP; 4 weeks for PEP. *This criteria only applies to brand Truvada for Maryland. Emtricitabine/tenofovir disoproxil fumarate (generic Truvada) is open access for Maryland.

Product Name: Stribild	
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Diagnosis of post-exposure prophylaxis (PEP) OR	

1.2 BOTH of the following:

1.2.1 Diagnosis of HIV (human immunodeficiency virus)

AND

1.2.2 ONE of the following:

1.2.2.1 Provider gives a reason or special circumstance as to why the patient is not an appropriate candidate for three preferred* products, one of which must be Genvoya (please specify why the patient is not a candidate)

OR

1.2.2.2 Continuation of current therapy

Notes	Approval Duration: 12 months for HIV; 4 weeks for PEP. *See Table 1 in Background for PDL links.

Product Name:(All other HIV medications which do not have criteria above) Brand Selzentry, generic maraviroc, Fuzeon, Tivicay, Tivicay PD, Isentress, Isentress HD, Brand Reyataz, generic atazanavir, Brand Prezista, generic darunavir, Brand Lexiva, generic fosamprenavir, Brand Norvir, generic ritonavir, Brand Ziagen, generic abacavir, Brand Emtriva, generic emtricitabine, Brand Epivir, generic lamivudine, Brand Retrovir, generic zidovudine, Pifeltro, Brand Sustiva, generic efavirenz, Brand Intelence, generic etravirine, Edurant, Edurant Ped, Tybost, Brand Epzicom, generic abacavir/lamivudine, Evotaz, Dovato, Prezcobix, Cimduo, generic lamivudine/zidovudine, Brand Kaletra, generic lopinavir/ritonavir, Triumeq, Triumeq PD, Delstrigo, efavirenz/emtricitabine/tenofovir, Brand Symfi Lo, Brand Symfi, generic efavirenz/lamivudine/tenofovir, Odefsey, Symtuza, Juluca, Biktarvy, Brand Complera, generic emtricitabine/rilpivirine/tenofovir disoproxil fumarate, Genvoya, Aptivus, Viracept, nevirapine, nevirapine ER

Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 If the request is for a preferred* medication, ONE of the following diagnoses:	

- HIV (human immunodeficiency virus)
- HIV post-exposure prophylaxis (PEP)

OR

1.2 If the request is for a non-preferred* medication, ONE of the following:

1.2.1 Diagnosis of post-exposure prophylaxis (PEP)

OR

1.2.2 BOTH of the following:

1.2.2.1 Diagnosis of HIV (human immunodeficiency virus)

AND

1.2.2.2 ONE of the following:

1.2.2.2.1 Provider gives a reason or special circumstance as to why the patient is not an appropriate candidate for three preferred* products (please specify why the patient is not a candidate)

OR

1.2.2.2.2 Continuation of current therapy

Notes	This guideline does NOT include Descovy and Rukobia. These medications have drug specific guidelines. Approval Duration: 12 months for HIV; 4 weeks for PEP. *See Table 1 in Background for PDL links.

2 . Background

Benefit/Coverage/Program Information

Table 1: PDL Links

CO: <https://www.uhcprovider.com/en/health-plans-by-state/colorado-health-plans/co-comm-plan-home/co-cp-pharmacy.html>

MD: <https://www.uhcprovider.com/en/health-plans-by-state/maryland-health-plans/md-comm-plan-home/md-cp-pharmacy.html>

PA CHIP: <https://www.uhcprovider.com/en/health-plans-by-state/pennsylvania-health-plans/pa-comm-plan-home/pa-cp-pharmacy.html?rfid=UHCCP>

NM: <https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html>

IN: <https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html>

3 . Revision History

Date	Notes
4/14/2026	Added Indiana

HMG CoA Reductase Inhibitors



Prior Authorization Guideline

Guideline ID	GL-132806
Guideline Name	HMG CoA Reductase Inhibitors
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	10/1/2023

1 . Criteria

Product Name:Atorvaliq	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is 10 years of age or older AND less than 12 years of age OR	

2 - Patient is unable to swallow tablets

2 . Revision History

Date	Notes
9/8/2023	New

Hycamtin



Prior Authorization Guideline

Guideline ID	GL-589192
Guideline Name	Hycamtin
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 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: Brand Hycamtin, generic topotecan

Diagnosis	Small Cell Lung Cancer (SCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of small cell lung cancer (SCLC) AND 2 - Patient has experienced a relapse of disease after initial first-line chemotherapy (e.g., cisplatin with etoposide)	

Product Name:Brand Hycamtin, generic topotecan	
Diagnosis	Merkel Cell Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Merkel cell carcinoma AND 2 - Patient has a contraindication to or disease has progressed on anti-PD-L1 or anti-PD-1 therapy AND 3 - ONE of the following:	

- Disease is regional N+
- Disease is M1 disseminated

Product Name:Brand Hycamtin, generic topotecan	
Diagnosis	Small Cell Lung Cancer (SCLC), Merkel Cell 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 the requested therapy	

Product Name:Brand Hycamtin, generic topotecan	
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:Brand Hycamtin, generic topotecan	
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 the requested therapy

2 . Revision History

Date	Notes
4/21/2026	Updated formularies to add ACUIN for eff 6/1/2026.

Hyrnuo



Prior Authorization Guideline

Guideline ID	GL-581187
Guideline Name	Hyrnuo
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Hyrnuo	
Diagnosis	Non-Small Cell Lung Cancer

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of non-small cell lung cancer (NSCLC) AND 2 - Disease is ONE of the following: • Advanced • Metastatic • Recurrent • Unresectable AND 3 - Presence of ERBB2 [human epidermal growth factor receptor 2 (HER2)] mutation AND 4 - Patient has received prior systemic therapy	

Product Name:Hyrnuo	
Diagnosis	Non-Small Cell Lung Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria	

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

Product Name:Hyrnuo

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:Hyrnuo

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 Hyrnuo therapy

2 . Revision History

Date	Notes

4/13/2026	Added IN.

Ibrance



Prior Authorization Guideline

Guideline ID	GL-570209
Guideline Name	Ibrance
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 New Mexico Medicaid - Community & State Virginia Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Ibrance	
Diagnosis	Breast Cancer

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of advanced, recurrent, or metastatic breast cancer AND 2 - Disease is hormone-receptor (HR)-positive AND 3 - Disease is human epidermal growth factor receptor 2 (HER2)-negative AND 4 - ONE of the following: • Used in combination with an aromatase inhibitor (e.g., anastrozole, letrozole, exemestane) • Used in combination with Faslodex (fulvestrant) AND 5 - For PIK3CA activating mutation-negative disease, BOTH of the following: 5.1 Disease is ONE of the following: 5.1.1 Recurrent unresectable (local or regional) OR 5.1.2 Stage IV (M1)	

AND

5.2 ONE of the following:

5.2.1 ONE of the following:

- Failure to Verzenio (abemaciclib) confirmed by claims history or submission of medical records
- History of contraindication or intolerance to Verzenio (abemaciclib) (please specify intolerance or contraindication)

OR

5.2.2 Patient is currently on Ibrance therapy

Product Name:Ibrance	
Diagnosis	Well-Differentiated/Dedifferentiated Liposarcoma (WD-DDLS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of unresectable retroperitoneal WD-DDLS (well-differentiated/dedifferentiated liposarcoma)	

Product Name:Ibrance	
Diagnosis	Uterine Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of endometrial carcinoma

AND

1.2 Disease is recurrent or metastatic

AND

1.3 Used in combination with letrozole

OR

2 - ALL of the following:

2.1 Diagnosis of uterine sarcoma

AND

2.2 Positive for cyclin-dependent kinase (CDK) 4 gene amplification

AND

2.3 Disease is ONE of the following:

- Advanced
- Inoperable
- Recurrent/metastatic

Product Name: Ibrance

Diagnosis	Breast Cancer, Well-Differentiated/Dedifferentiated Liposarcoma (WD-DDLS), Uterine Neoplasms
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 Ibrance therapy	

Product Name:Ibrance	
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:Ibrance	
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 Ibrance therapy	

2 . Revision History

Date	Notes
4/8/2026	Added IN back.

Ibrance



Prior Authorization Guideline

Guideline ID	GL-570209
Guideline Name	Ibrance
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 New Mexico Medicaid - Community & State Virginia Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Ibrance	
Diagnosis	Breast Cancer

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of advanced, recurrent, or metastatic breast cancer AND 2 - Disease is hormone-receptor (HR)-positive AND 3 - Disease is human epidermal growth factor receptor 2 (HER2)-negative AND 4 - ONE of the following: • Used in combination with an aromatase inhibitor (e.g., anastrozole, letrozole, exemestane) • Used in combination with Faslodex (fulvestrant) AND 5 - For PIK3CA activating mutation-negative disease, BOTH of the following: 5.1 Disease is ONE of the following: 5.1.1 Recurrent unresectable (local or regional) OR 5.1.2 Stage IV (M1)	

AND

5.2 ONE of the following:

5.2.1 ONE of the following:

- Failure to Verzenio (abemaciclib) confirmed by claims history or submission of medical records
- History of contraindication or intolerance to Verzenio (abemaciclib) (please specify intolerance or contraindication)

OR

5.2.2 Patient is currently on Ibrance therapy

Product Name:Ibrance	
Diagnosis	Well-Differentiated/Dedifferentiated Liposarcoma (WD-DDLS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of unresectable retroperitoneal WD-DDLS (well-differentiated/dedifferentiated liposarcoma)	

Product Name:Ibrance	
Diagnosis	Uterine Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of endometrial carcinoma

AND

1.2 Disease is recurrent or metastatic

AND

1.3 Used in combination with letrozole

OR

2 - ALL of the following:

2.1 Diagnosis of uterine sarcoma

AND

2.2 Positive for cyclin-dependent kinase (CDK) 4 gene amplification

AND

2.3 Disease is ONE of the following:

- Advanced
- Inoperable
- Recurrent/metastatic

Product Name:Ibrance

Diagnosis	Breast Cancer, Well-Differentiated/Dedifferentiated Liposarcoma (WD-DDLS), Uterine Neoplasms
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 Ibrance therapy	

Product Name:Ibrance	
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:Ibrance	
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 Ibrance therapy	

2 . Revision History

Date	Notes
4/8/2026	Added IN back.

Ibtrozi



Prior Authorization Guideline

Guideline ID	GL-461209
Guideline Name	Ibtrozi
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia Medicaid - Community & State Washington

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Ibtrozi

Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of non-small cell lung cancer (NSCLC) AND 2 - Disease is ONE of the following: • Metastatic • Advanced AND 3 - Tumor is ROS1-positive	

Product Name:Ibuprofen	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
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 Ibuprofen therapy	

Product Name:Ibuprofen	
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:Ibuprofen	
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 Ibuprofen therapy	

2 . Revision History

Date	Notes
11/20/2025	Updated formularies to include IN for eff 1/1/26.

Iclusig



Prior Authorization Guideline

Guideline ID	GL-578237
Guideline Name	Iclusig
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 New Mexico Medicaid - Community & State Indiana Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Iclusig	
Diagnosis	Chronic Myelogenous / Myeloid Leukemia (CML)

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chronic myelogenous/ myeloid leukemia (CML) AND 2 - ONE of the following: 2.1 BOTH of the following: 2.1.1 Disease is in the chronic phase AND 2.1.2 ONE of the following: • Patient with resistance or intolerance to two or more tyrosine kinase inhibitor (TKI) therapies [e.g., imatinib mesylate, Sprycel (dasatinib), or Tassigna (nilotinib)] • Patient has no identifiable BCR::ABL1 mutations OR 2.2 Confirmed documentation of T315I mutation OR 2.3 BOTH of the following: • Disease is in the accelerated or blast phase • No other kinase inhibitors are indicated	

Product Name:Iclusig	
Diagnosis	Philadelphia Chromosome-Positive Acute Lymphoblastic Leukemia (Ph+ALL)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ALL)	

Product Name:Iclusig	
Diagnosis	Myeloid/Lymphoid Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of lymphoid, myeloid, or mixed lineage neoplasms with eosinophilia AND 2 - ONE of the following: 2.1 Patient has a FGFR1 (fibroblast growth factor receptor 1) rearrangement OR 2.2 Patient has an ABL1 (gene) rearrangement	

Product Name:Iclusig

Diagnosis	Gastrointestinal Stromal Tumors (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 - Disease is ONE of the following: • Gross residual disease (R2 resection) • Unresectable primary disease • Tumor rupture • Recurrent/metastatic disease after progression on approved therapies (e.g. imatinib, sunitinib, regorafenib, and standard dose ripretinib)	

Product Name:Iclusig	
Diagnosis	Chronic Myelogenous / Myeloid Leukemia (CML), Philadelphia Chromosome-Positive Acute Lymphoblastic Leukemia (Ph+ALL), Myeloid/Lymphoid Neoplasms, Gastrointestinal Stromal Tumors (GIST)
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 Iclusig therapy	

Product Name:Iclusig

Diagnosis	NCCN Recommended Regimen
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:Iclusig	
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 Iclusig therapy	

2 . Revision History

Date	Notes
4/14/2026	Added Indiana

Idhifa



Prior Authorization Guideline

Guideline ID	GL-444202
Guideline Name	Idhifa
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia Medicaid - Community & State Washington

Guideline Note:

Effective Date:	12/1/2025

1 . Criteria

Product Name:Idhifa

Diagnosis	Acute Myeloid Leukemia (AML)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of acute myeloid leukemia (AML) AND 2 - AML is IDH2 (isocitrate dehydrogenase 2) mutation-positive AND 3 - ONE of the following: 3.1 Disease is relapsed or refractory OR 3.2 Used as low-intensity treatment induction when not a candidate for intensive induction therapy OR 3.3 Used for consolidation therapy as continuation of low-intensity regimen used for induction OR 3.4 Used as follow-up after induction therapy following response to previous lower intensity therapy with the same regimen	

Product Name:Idhifa	
Diagnosis	Acute Myeloid Leukemia (AML)
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 Idhifa therapy	

Product Name:Idhifa	
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:Idhifa	
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 Idhifa therapy	

2 . Revision History

Date	Notes
11/7/2025	Combined formularies. No changes to clinical criteria.

Igalmi



Prior Authorization Guideline

Guideline ID	GL-148844
Guideline Name	Igalmi
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name:Igalmi	
Approval Length	5 Day(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of one of the following: - Bipolar I or II disorder - Schizophrenia	

AND

2 - Member is 18 years of age and older

AND

3 - Prescriber attests to both of the following:

3.1 Patient is currently or will be maintained on maintenance psychotropic therapy

AND

3.2 Medication will be administered under the supervision of a healthcare provider

AND

4 - Dose requested does not exceed 2 sublingual films per 30-day period

2 . Revision History

Date	Notes
6/26/2024	New guideline

Imbruvica



Prior Authorization Guideline

Guideline ID	GL-457319
Guideline Name	Imbruvica
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name: Imbruvica	
Diagnosis	B-Cell Lymphoma

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following: 1.1 Diagnosis of mantle cell lymphoma (MCL) AND 1.2 ONE of the following: 1.2.1 Patient has received at least one prior therapy for MCL OR 1.2.2 Used in pre-treatment therapy in combination with Rituxan (rituximab) to limit the number of cycles with RHyperCVAD (rituximab, cyclophosphamide, vincristine, doxorubicin, and dexamethasone) regimen OR 2 - Diagnosis of ONE of the following: • Chronic Lymphocytic Leukemia (CLL) • Small Lymphocytic Lymphoma (SLL) OR 3 - BOTH of the following: 3.1 Diagnosis of ONE of the following: • Diffuse large B-cell lymphoma (non-germinal center DLBCL) • Human Immunodeficiency Virus (HIV)-related B-cell lymphoma	

- Post-transplant lymphoproliferative disorders
- Hairy cell leukemia
- Nodal or splenic marginal zone lymphoma (MZL)
- Extranodal marginal zone lymphoma (EMZL) of the stomach
- Extranodal marginal zone lymphoma (EMZL) of nongastric sites (noncutaneous)
- High grade B-cell lymphoma

AND

3.2 Used as second-line or a subsequent therapy

Product Name:Imbruvica	
Diagnosis	Waldenström's Macroglobulinemia/Lymphoplasmacytic Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Waldenström's Macroglobulinemia/Lymphoplasmacytic Lymphoma	

Product Name:Imbruvica	
Diagnosis	Primary CNS Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of primary central nervous system (CNS) lymphoma AND	

2 - ONE of the following:

2.1 Used as second-line or a subsequent therapy

OR

2.2 Used as induction therapy if the patient is unsuitable or intolerant to high-dose methotrexate

Product Name:Imbruvica	
Diagnosis	B-Cell Lymphoma, Waldenström's Macroglobulinemia/Lymphoplasmacytic Lymphoma, Primary CNS Lymphoma
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 Imbruvica therapy	

Product Name:Imbruvica	
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 - History of failure of at least one other systemic therapy (e.g., corticosteroids, mycophenolate, etc.) as confirmed by claims history or submission of medical records

Product Name:Imbruvica	
Diagnosis	Chronic Graft Versus Host Disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient shows evidence of positive clinical response while on Imbruvica therapy	

Product Name:Imbruvica	
Diagnosis	NCCN Recommended Regimen
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:Imbruvica	
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 Imbruvica therapy	

2 . Revision History

Date	Notes
12/5/2025	Combined formularies. Updated initial criteria for B-Cell Lymphoma. Updated GPI list.

Immunoglobulin A Nephropathy (IgAN) Agents



Prior Authorization Guideline

Guideline ID	GL-597187
Guideline Name	Immunoglobulin A Nephropathy (IgAN) Agents
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Filspari	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - The patient is 18 years of age or older	

AND

2 - Diagnosis of proteinuria associated with immunoglobulin A nephropathy (IgAN) confirmed by renal biopsy (must submit evidence of biopsy)

AND

3 - Prescriber has submitted a baseline urine protein-creatinine ratio based on 24-hour urine collection (uPCR-24h) and estimated glomerular filtration rate (eGFR) collected within the past 6 months

AND

4 - ONE of the following:

4.1 The patient has had at least 90 days of drug therapy with an ACE (angiotensin converting enzyme) inhibitor or ARB (angiotensin receptor blocker) agent at maximally tolerated doses and demonstrates continued disease progression (i.e., proteinuria of greater than or equal to 0.5 g/day [grams/day] obtained after 90 days of ACE inhibitor or ARB therapy)

OR

4.2 BOTH of the following:

- Submission of medical records confirming proteinuria of greater than or equal to 0.5 g/day collected within the past 6 months
- Prescriber has submitted valid medical justification for the use of the requested medication without historical use of an ACE inhibitor or ARB agent

AND

5 - The patient is enrolled in the Filspari (sparsentan) REMS program and prescriber is monitoring in accordance with REMS requirements

AND

6 - The patient will not be using concomitantly with any of the following: ACE inhibitors, ARB agents, endothelin receptor antagonists (ERAs), aliskiren

AND

7 - Requested quantity does not exceed 1 tablet/day (200 mg or 400 mg strength tablets)

Product Name: Filspari

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - History of the requested agent for at least 90 days within the past 120 days, confirmed by claims history or submission of medical records

AND

2 - Prescriber has submitted a urine protein-creatinine ratio based on 24-hour urine collection (uPCR-24h) and estimated glomerular filtration rate (eGFR) demonstrating a reduction from baseline or trend towards stabilization (lab documentation collected within the past year must be submitted)

AND

3 - The patient will not be using concomitantly with any of the following: ACE inhibitors, ARB agents, endothelin receptor antagonists (ERAs), aliskiren

AND

4 - Requested quantity does not exceed 1 tablet/day (200 mg or 400 mg strength tablets)

Product Name: Tarpeyo	
Approval Length	Up to a maximum of 9 months
Guideline Type	Prior Authorization
Approval Criteria 1 - The patient is 18 years of age or older AND 2 - Diagnosis of proteinuria associated with immunoglobulin A nephropathy (IgAN) confirmed by renal biopsy (must submit evidence of biopsy) AND 3 - ONE of the following: 3.1 The patient has had at least 90 days of drug therapy with an ACE (angiotensin converting enzyme) inhibitor or ARB (angiotensin receptor blocker) agent at maximally tolerated doses and demonstrates continued disease progression (i.e., proteinuria of greater than or equal to 0.5 g/day [grams/day] obtained after 90 days of ACE inhibitor or ARB therapy) OR 3.2 BOTH of the following: • Submission of medical records confirming proteinuria of greater than or equal to 0.5 g/day collected within the past 6 months • Prescriber has submitted valid medical justification for the use of the requested medication without historical use of an ACE inhibitor or ARB agent AND 4 - ONE of the following: • Prescriber attests that member will continue concomitant ACE inhibitor or ARB agent while taking the requested medication	

- Prescriber has submitted valid medical justification for the use of the requested medication without the concomitant use of ACE inhibitor or ARB agent

AND

5 - Requested quantity does not exceed 4 capsules/day

AND

6 - Requested length of therapy does not exceed 9 months total

Product Name: Vanrafia	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - The patient is 18 years of age or older AND 2 - Diagnosis of proteinuria associated with immunoglobulin A nephropathy (IgAN) confirmed by renal biopsy (must submit evidence of biopsy) AND 3 - Prescriber has submitted a baseline urine protein-creatinine ratio based on 24-hour urine collection (uPCR-24h) and estimated glomerular filtration rate (eGFR) collected within the past 6 months AND	

4 - ONE of the following:

4.1 The patient has had at least 90 days of drug therapy with Filspari (sparsentan) and demonstrates continued disease progression (i.e., proteinuria of greater than or equal to 0.5 g/day [grams/day] obtained after 90 days of Filspari (sparsentan) therapy)

OR

4.2 BOTH of the following:

- Submission of medical records confirming proteinuria of greater than or equal to 0.5 g/day collected within the past 6 months
- Prescriber has submitted valid medical justification for the use of the requested medication over Filspari (sparsentan)

AND

5 - ONE of the following:

- Prescriber attests that member will continue concomitant ACE (angiotensin converting enzyme) inhibitor or ARB (angiotensin receptor blocker) agent while taking the requested medication
- Prescriber has submitted valid medical justification for the use of the requested medication without the concomitant use of ACE inhibitor or ARB agent

AND

6 - The patient will not be using the requested medication concomitantly with Filspari (sparsentan)

AND

7 - For those patients of childbearing potential, submission of medical records (chart notes, laboratory tests/values, etc.) confirming a negative pregnancy test has been obtained within the past 30 days

AND

8 - Requested quantity does not exceed 1 tablet/day

Product Name:Vanrafia

Approval Length 12 month(s)

Therapy Stage Reauthorization

Guideline Type Prior Authorization

Approval Criteria

1 - History of the requested agent for at least 90 days within the past 120 days, confirmed by claims history or submission of medical records

AND

2 - Prescriber has submitted a urine protein-creatinine ratio based on 24-hour urine collection (uPCR-24h) and estimated glomerular filtration rate (eGFR) demonstrating a reduction from baseline or trend towards stabilization (lab documentation collected within the past year must be submitted)

AND

3 - ONE of the following:

- Patient continues concomitant ACE (angiotensin converting enzyme) inhibitor or ARB (angiotensin receptor blocker) agent while taking the requested medication
- Prescriber has submitted valid medical justification for the use of the requested medication without the concomitant use of ACE inhibitor or ARB agent

AND

4 - The patient will not be using the requested medication concomitantly with Filspari (sparsentan)

AND

5 - Requested quantity does not exceed 1 tablet/day

Product Name:Voyxact

Approval Length 12 month(s)

Therapy Stage Initial Authorization

Guideline Type Prior Authorization

Approval Criteria

1 - The patient is 18 years of age or older

AND

2 - Diagnosis of proteinuria associated with immunoglobulin A nephropathy (IgAN) confirmed by renal biopsy (must submit evidence of biopsy)

AND

3 - Prescriber has submitted a baseline urine protein-creatinine ratio based on 24-hour urine collection (uPCR-24h) and estimated glomerular filtration rate (eGFR) collected within the past 6 months

AND

4 - ONE of the following:

4.1 The patient has had at least 90 days of drug therapy with an ACE (angiotensin converting enzyme) inhibitor or ARB (angiotensin receptor blocker) agent at maximally tolerated doses and demonstrates continued disease progression (i.e., proteinuria of greater than or equal to 0.5 g/day [grams/day] obtained after 90 days of ACE inhibitor or ARB therapy)

OR

4.2 BOTH of the following:

- Submission of medical records confirming proteinuria of greater than or equal to 0.5 g/day collected within the past 6 months
- Prescriber has submitted valid medical justification for the use of the requested medication without historical use of an ACE inhibitor or ARB agent

AND

5 - ONE of the following:

- Prescriber attests that member will continue concomitant ACE inhibitor or ARB agent while taking the requested medication
- Prescriber has submitted valid medical justification for the use of the requested medication without the concomitant use of ACE inhibitor or ARB agent

AND

6 - Requested quantity does not exceed 400 mg (milligrams) every 4 weeks

Product Name: Voyxact	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested agent for at least 84 days within the past 112 days, confirmed by claims history or submission of medical records AND 2 - Prescriber has submitted a urine protein-creatinine ratio based on 24-hour urine collection (uPCR-24h) and estimated glomerular filtration rate (eGFR) demonstrating a reduction from baseline or trend towards stabilization (lab documentation collected within the past year must be submitted)	

AND

3 - ONE of the following:

- Patient continues concomitant ACE (angiotensin converting enzyme) inhibitor or ARB (angiotensin receptor blocker) agent while taking the requested medication
- Prescriber has submitted valid medical justification for the use of the requested medication without the concomitant use of ACE inhibitor or ARB agent

AND

4 - Requested quantity does not exceed 400 mg (milligrams) every 4 weeks

2 . Revision History

Date	Notes
4/27/2026	Added Voyxact. Updated T/F language and UPCR requirements throughout and history of the requested agent in reauth.

Inbrija



Prior Authorization Guideline

Guideline ID	GL-216281
Guideline Name	Inbrija
Formulary	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

Guideline Note:

Effective Date:	5/1/2025

1 . Criteria

Product Name: Inbrija	
Approval Length	12 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 - ONE of the following: 6.1 Failure to TWO anti-Parkinson's disease therapies from the following adjunctive	

pharmacotherapy classes confirmed by claims history or submission of medical records (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)

OR

6.2 History of contraindication or intolerance to ALL anti-Parkinson's disease therapies from the following adjunctive pharmacotherapy classes (please specify intolerance or contraindication):

- 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

3/18/2025	Combined formularies. Minor update to required value section in criterion 5, but no changes to clinical criteria.

Inluriyo



Prior Authorization Guideline

Guideline ID	GL-581188
Guideline Name	Inluriyo
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia Medicaid - Community & State Washington

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Inluriyo

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 - Breast cancer is ALL of the following: • Estrogen receptor-positive (ER+) • Human epidermal growth factor receptor 2-negative (HER2-) • Estrogen receptor 1 (ESR1)-mutated AND 3 - Disease is advanced or metastatic AND 4 - Disease progression has occurred following at least one line of endocrine therapy	

Product Name: Inluriyo	
Diagnosis	Breast 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 Inluriyo therapy

Product Name:Inluriyo

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:Inluriyo

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 Inluriyo therapy

2 . Revision History

Date	Notes
4/13/2026	Added IN.

Inlyta



Prior Authorization Guideline

Guideline ID	GL-457327
Guideline Name	Inlyta
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name: Inlyta	
Diagnosis	Renal Cell Carcinoma

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following: 1.1 Diagnosis of advanced renal cell carcinoma AND 1.2 ONE of the following: • Patient has failed one prior systemic therapy • The requested medication will be used in combination with Bavencio (avelumab) or Keytruda (pembrolizumab) OR 2 - Diagnosis of relapsed or stage IV renal cell carcinoma	

Product Name:Inlyta	
Diagnosis	Thyroid Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following diagnoses: • Follicular Carcinoma • Oncocytic Carcinoma	

- Papillary Carcinoma

AND

2 - Disease is ONE of the following:

- Recurrent and unresectable
- Persistent
- Metastatic

AND

3 - Disease is not amenable to radioactive iodine treatment

Product Name:Inlyta	
Diagnosis	Salivary Gland Tumor
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of salivary gland tumor AND 2 - Disease is ONE of the following: • Recurrent and unresectable • Metastatic	

Product Name:Inlyta	
Diagnosis	Soft Tissue Sarcoma

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of alveolar soft part sarcoma (ASPS) AND 2 - The requested medication will be used in combination with Keytruda (pembrolizumab)	

Product Name:Inlyta	
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 - ONE of the following: - Used as first-line therapy for those who cannot tolerate first-line combination regimens - Used as second-line therapy AND 3 - The requested medication will be used in combination with Bavencio (avelumab)	

Product Name:Inlyta	
Diagnosis	Renal Cell Carcinoma, Thyroid Carcinoma, Salivary Gland Tumor, Soft Tissue Sarcoma, 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 Inlyta therapy	

Product Name:Inlyta	
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:Inlyta	
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 Inlyta therapy	

2 . Revision History

Date	Notes
12/5/2025	Updated formularies to include IN for eff 1/1/26.

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

Inrebic



Prior Authorization Guideline

Guideline ID	GL-479200
Guideline Name	Inrebic
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Inrebic	
Diagnosis	Myelofibrosis

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of intermediate-2 or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis AND 2 - ONE of the following: 2.1 Failure to Jakafi (ruxolitinib) confirmed by claims history or submitted medical records OR 2.2 History of intolerance or contraindication to Jakafi (ruxolitinib) (please specify intolerance or contraindication) OR 2.3 Patient is currently on Inrebic therapy	

Product Name:Inrebic	
Diagnosis	Myelofibrosis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Documentation that the patient has evidence of symptom improvement or reduction in spleen volume while on Inrebic

Product Name:Inrebic

Diagnosis	Myeloid/Lymphoid Neoplasms

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of lymphoid, myeloid, or mixed lineage neoplasms with eosinophilia

AND

2 - Patient has a JAK2 (Janus kinase 2) rearrangement

AND

3 - ONE of the following:

3.1 Failure to Jakafi (ruxolitinib) confirmed by claims history or submitted medical records

OR

3.2 History of intolerance or contraindication to Jakafi (ruxolitinib) (please specify intolerance or contraindication)

OR

3.3 Patient is currently on Inrebic therapy

Product Name:Inrebic	
Diagnosis	Myeloid/Lymphoid Neoplasms
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 Inrebic therapy	

Product Name:Inrebic	
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:Inrebic	
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 Inrebic therapy	

2 . Revision History

Date	Notes
12/12/2025	Combined formularies. No changes to clinical criteria. Minor cosmetic update.

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

Iqirvo



Prior Authorization Guideline

Guideline ID	GL-444203
Guideline Name	Iqirvo
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia Medicaid - Community & State Washington

Guideline Note:

Effective Date:	12/1/2025

1 . Criteria

Product Name:Iqirvo

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of primary biliary cholangitis AND 2 - Patient does not have decompensated cirrhosis AND 3 - ONE of the following: 3.1 BOTH of the following: 3.1.1 Used in combination with ursodeoxycholic acid (e.g., Urso, ursodiol) AND 3.1.2 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) OR 3.2 History of contraindication or intolerance to ursodeoxycholic acid (e.g., Urso, ursodiol) [please specify contraindication or intolerance] AND 4 - Patient is not receiving Iqirvo in combination with Livdelzi (seladelpar) or Ocaliva (obeticholic acid)	

AND

5 - Prescribed by 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., laboratory values) documenting a reduction in alkaline phosphatase (ALP) level from pre-treatment baseline (i.e., prior to Iqirvo therapy)

AND

2 - Patient does not have decompensated cirrhosis

AND

3 - Patient is not receiving Iqirvo in combination with Livdelzi (seladelpar) or Ocaliva (obeticholic acid)

AND

4 - Prescribed by ONE of the following:

- Hepatologist
- Gastroenterologist

2 . Revision History

Date	Notes
11/8/2025	Combined formularies. No changes to clinical criteria. Minor cosmetic updates.

Iron Chelators



Prior Authorization Guideline

Guideline ID	GL-439211
Guideline Name	Iron Chelators
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 Michigan Medicaid - Community & State Virginia 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 Exjade, Brand Jadenu, generic deferasirox	
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 OR 2 - ALL of the following: • Diagnosis of chronic iron overload in non-transfusion dependent thalassemia (NTDT) syndrome • 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 the requested medication • Patient has serum ferritin levels consistently greater than 300 micrograms per liter prior to initiation of treatment with the requested medication	

Product Name: Brand Ferriprox, generic deferiprone	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of transfusional iron overload due to thalassemia syndromes, sickle cell disease or other anemias AND	

2 - Requested medication will NOT be used for the treatment of transfusional iron overload due to myelodysplastic syndrome or Diamond Blackfan anemia

Product Name: Brand Exjade, Brand Jadenu, generic deferasirox, Brand Ferriprox, generic deferiprone

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
11/5/2025	Added Nevada Formulary

Irritable Bowel Syndrome - Diarrhea



Prior Authorization Guideline

Guideline ID	GL-208216
Guideline Name	Irritable Bowel Syndrome - Diarrhea
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Indiana 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

Guideline Note:

Effective Date:	4/1/2025

1 . Criteria

Product Name:generic alosetron, Brand Lotronex	
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) with symptoms for at least six months AND 2 - Patient was female at birth AND 3 - ONE of the following: 3.1 Failure to a tricyclic antidepressant (e.g., amitriptyline) as confirmed by claims history or submitted medical records OR 3.2 History of intolerance or contraindication to a tricyclic antidepressant (e.g., amitriptyline) (please specify intolerance or contraindication) AND 4 - Anatomic or biochemical abnormalities of the GI (gastrointestinal) tract have been excluded	

Product Name:generic alosetron, Brand Lotronex	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to the requested 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 - ONE of the following: 2.1 Failure to a tricyclic antidepressant (e.g., amitriptyline) as confirmed by claims history or submitted medical records OR 2.2 History of intolerance or contraindication to a tricyclic antidepressant (e.g., amitriptyline) (please specify intolerance or contraindication)	

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
3/5/2025	Updated formularies

Itovebi



Prior Authorization Guideline

Guideline ID	GL-164670
Guideline Name	Itovebi
Formulary	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

Guideline Note:

Effective Date:	3/1/2025

1 . Criteria

Product Name:Itovebi	
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 - Disease is one of the following: • Locally advanced • Metastatic AND 3 - Disease is hormone receptor (HR)-positive AND 4 - Disease is human epidermal growth factor receptor 2 (HER2)-negative AND 5 - Disease is PIK3CA-mutation positive AND 6 - Used following recurrence on or after completing adjuvant endocrine therapy AND	

7 - Used in combination with both of the following:

- Ibrance (palbociclib)
- Fulvestrant

Product Name:Itovebi

Diagnosis Breast 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 Itovebi therapy

Product Name:Itovebi

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:Itovebi

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 Itovebi therapy

2 . Revision History

Date	Notes
2/4/2025	New guideline

Iwifin



Prior Authorization Guideline

Guideline ID	GL-220213
Guideline Name	Iwifin
Formulary	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 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:Iwifin

Diagnosis	High-Risk Neuroblastoma (HRNB)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of high-risk neuroblastoma (HRNB) AND 2 - Patient has shown at least a partial response to prior multiagent, multimodality therapy AND 3 - Prior therapy included anti-GD2 immunotherapy [e.g., Danyelza (naxitamab-gqgk), Unituxin (dinutuximab)]	

Product Name:lwilfin	
Diagnosis	High-Risk Neuroblastoma (HRNB)
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 lwilfin therapy	

Product Name:lwilfin	
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:lwilfin	
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 lwilfin therapy	

2 . Revision History

Date	Notes
3/13/2025	Combined formularies. Minor update to bracket punctuations in criteri on 3 of HRNB initial auth section, with no changes to clinical intent.

Jakafi



Prior Authorization Guideline

Guideline ID	GL-578238
Guideline Name	Jakafi
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 New Mexico Medicaid - Community & State Virginia Medicaid - Community & State Washington Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Jakafi

Diagnosis	Myelofibrosis
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following: 1.1 Symptomatic lower-risk myelofibrosis OR 1.2 Intermediate or higher-risk myelofibrosis OR 1.3 Post-polycythemia vera myelofibrosis OR 1.4 Post-essential thrombocythemia myelofibrosis OR 2 - ALL of the following: 2.1 Diagnosis of myelofibrosis-associated anemia AND 2.2 Presence of symptomatic splenomegaly and/or constitutional symptoms	

AND

2.3 Given in combination with ONE of the following:

- Reblozyl (luspatercept)
- Erythropoietin stimulating agent (ESA) if serum EPO (Erythropoietin) less than 500 mU/mL (milliunits per milliliter)
- Danazol

Product Name: Jakafi	
Diagnosis	Polycythemia Vera
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of low-risk polycythemia vera AND 2 - ONE of the following: 2.1 Failure to ONE of the following as confirmed by claims history or submission of medical records: • Hydroxyurea • Interferon therapy [e.g., Besremi (ropeginterferon alfa-2b), Intron A (interferon alfa-2b), Pegasys (peginterferon alfa-2a)] OR 2.2 History of contraindication or intolerance to BOTH of the following (please specify contraindication or intolerance):	

- Hydroxyurea
- Interferon therapy [e.g., Besremi (ropeginterferon alfa-2b), Intron A (interferon alfa-2b), Pegasys (peginterferon alfa-2a)]

Product Name:Jakafi	
Diagnosis	Essential Thrombocythemia
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of essential thrombocythemia AND 2 - Inadequate response or loss of response to ONE of the following: • Hydroxyurea • Pegasys (peginterferon alfa-2a) • Agrylin (Anagrelide)	

Product Name:Jakafi	
Diagnosis	Myeloproliferative Neoplasms
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of accelerated/blast phase myeloproliferative neoplasm	

AND

2 - Used for splenomegaly or other disease-related symptoms

Product Name: Jakafi	
Diagnosis	Myelofibrosis, Polycythemia Vera, Essential Thrombocythemia, Myeloproliferative Neoplasms
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation that patient has evidence of symptom improvement or reduction in spleen volume while on Jakafi*	
Notes	*If documentation does not provide evidence of symptom improvement or reduction in spleen volume while on Jakafi, authorization will be issued for 2 months to allow for dose titration with discontinuation of the therapy.

Product Name: Jakafi	
Diagnosis	Graft versus host disease (GVHD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following: 1.1 Diagnosis of acute graft versus host disease (GVHD)	

AND	
1.2 Disease is steroid refractory	
OR	
2 - BOTH of the following:	
2.1 Diagnosis of chronic GVHD	
AND	
2.2 Failure of one or two lines of systemic therapy	

Product Name: Jakafi	
Diagnosis	Graft versus host disease (GVHD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of symptom improvement while on Jakafi	

Product Name: Jakafi	
Diagnosis	Myeloid/Lymphoid Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of lymphoid, myeloid, or mixed lineage neoplasms with eosinophilia

AND

2 - Patient has a Janus Associated Kinase (JAK) 2 rearrangement

Product Name: Jakafi

Diagnosis	Myelodysplastic Syndromes

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - BOTH of the following:

1.1 Diagnosis of chronic myelomonocytic leukemia (CMML)-2

AND

1.2 Used in combination with a hypomethylating agent (e.g., azacitidine, decitabine)

OR

2 - BOTH of the following:

2.1 Diagnosis of myelodysplastic/myeloproliferative neoplasm (MDS/MPN) with neutrophilia

AND

2.2 Disease is positive for Colony Stimulating Factor 3 Receptor (CSF3R) or Janus Associated Kinase (JAK) 2 mutation

Product Name:Jakafi

Diagnosis T-Cell Lymphomas

Approval Length 12 month(s)

Therapy Stage Initial Authorization

Guideline Type Prior Authorization

Approval Criteria

1 - BOTH of the following:

1.1 Diagnosis of peripheral T-cell lymphoma

AND

1.2 Used as initial palliative intent therapy or second-line and subsequent therapy for relapsed/refractory disease

OR

2 - BOTH of the following:

2.1 ONE of the following diagnoses:

- T-cell large granular lymphocytic leukemia
- T-cell prolymphocytic leukemia
- Breast implant-associated anaplastic large cell lymphoma (ALCL)

AND

2.2 Used as second-line or subsequent therapy

OR

3 - BOTH of the following:

3.1 Diagnosis of hepatosplenic T-cell lymphoma

AND

3.2 Used for refractory disease after two first-line therapy regimens

Product Name:Jakafi	
Diagnosis	Pediatric Acute Lymphoblastic Leukemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of pediatric acute lymphoblastic leukemia	

Product Name:Jakafi	
Diagnosis	Myeloid/Lymphoid Neoplasms, Myelodysplastic Syndromes, T-Cell Lymphomas, Pediatric 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 Jakafi therapy	

Product Name:Jakafi	
Diagnosis	Immunotherapy-Related Toxicities
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following: 1.1 Diagnosis of Chimeric Antigen Receptor (CAR)-T induced G4 cytokine release syndrome AND 1.2 Disease is refractory to high-dose corticosteroids and anti-IL-6 therapy (e.g., Actemra [tocilizumab]) OR 2 - BOTH of the following: 2.1 Diagnosis of immunotherapy-related toxicities AND 2.2 ONE of the following: - Used in combination with Orencia (abatacept) for the management of concomitant myositis and myocarditis - Used as additional therapy for hemophagocytic lymphohistiocytosis-like syndrome if no response to corticosteroids after 5 days	

Product Name:Jakafi	
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:Jakafi	
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 Jakafi therapy	

2 . Revision History

Date	Notes
4/14/2026	Added Indiana

Jaypirca



Prior Authorization Guideline

Guideline ID	GL-578239
Guideline Name	Jaypirca
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 Virginia Medicaid - Community & State Indiana Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name: Jaypirca	
Diagnosis	B-Cell Lymphoma

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following: • Extranodal marginal zone lymphoma of nongastric sites (noncutaneous) • Extranodal marginal zone lymphoma of the stomach • Mantle cell lymphoma (MCL) • Nodal marginal zone lymphoma • Splenic marginal zone lymphoma AND 2 - Disease is relapsed, refractory, or progressive AND 3 - Patient has received at least two prior systemic therapies [e.g., chemotherapy], one of which is a Bruton Tyrosine Kinase (BTK) inhibitor therapy [e.g., Imbruvica (ibrutinib), Calquence (acalabrutinib), Brukinsa (zanubrutinib)]	

Product Name: Jaypirca	
Diagnosis	Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chronic lymphocytic leukemia or small lymphocytic lymphoma	

AND

2 - Patient has been previously treated with a covalent Bruton Tyrosine Kinase (BTK) inhibitor therapy [e.g., Imbruvica (ibrutinib), Calquence (acalabrutinib), Brukinsa (zanubrutinib)]

Product Name:Jaypirca	
Diagnosis	Waldenström Macroglobulinemia/Lymphoplasmacytic Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Waldenström Macroglobulinemia/Lymphoplasmacytic Lymphoma which has been previously treated	

Product Name:Jaypirca	
Diagnosis	B-Cell Lymphoma, Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma, Waldenström Macroglobulinemia/Lymphoplasmacytic Lymphoma
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 Jaypirca therapy	

Product Name:Jaypirca	
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: Jaypirca	
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 Jaypirca therapy	

2 . Revision History

Date	Notes
4/14/2026	Added Indiana

Jesduvroq (daprodustat)



Prior Authorization Guideline

Guideline ID	GL-137548
Guideline Name	Jesduvroq (daprodustat)
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name:Jesduvroq	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of anemia due to chronic kidney disease	

AND

2 - Patient has been receiving dialysis for at least four months

AND

3 - Patient is 18 years of age or older

AND

4 - ONE of the following

- Patient has tried and failed one erythropoiesis-stimulating agent (ESA) (e.g., Aranesp, Epogen, Retacrit, Mircera, Procrit), confirmed by claims history or chart documentation
- Prescriber has submitted valid medical justification for the use of Jesduvroq (daprodustat) over all ESA agents listed above

AND

5 - Documentation patient has a pretreatment hemoglobin of less than 11 grams per deciliter (g/dL)

AND

6 - Prescribed by, or in consultation with, a nephrologist

AND

7 - Prescriber attests that patient will not be utilizing Jesduvroq (daprodustat) concomitantly with an ESA agent (e.g., Aranesp, Epogen, Retacrit, Mircera, Procrit)

Product Name: Jesduvroq

Approval Length

6 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested agent within the past 90 days, confirmed by claims history or chart documentation AND 2 - ONE of the following: • Patient has tried and failed an erythropoiesis-stimulating agent (ESA) (e.g., Aranesp, Epogen, Retacrit, Mircera, Procrit), confirmed by claims history or chart documentation • Prescriber has submitted valid medical justification for the use of Jesduvroq (daprodustat) over all ESA agents listed above AND 3 - Prescriber attests that patient is not/will not be utilizing Jesduvroq (daprodustat) concomitantly with an ESA agent (e.g., Aranesp, Epogen, Retacrit, Mircera, Procrit)	

2 . Revision History

Date	Notes
12/11/2023	Updated patient to prescriber in second bullet of step 4 initial authorization.

Joenja



Prior Authorization Guideline

Guideline ID	GL-151234
Guideline Name	Joenja
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	9/1/2024

1 . Criteria

Product Name:Joenja	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of activated phosphoinositide 3-kinase delta syndrome (APDS)	

AND

2 - Diagnosis has been confirmed by the presence of an APDS-associated genetic variant in either PIK3CD or PIK3R1

AND

3 - Documentation of other clinical findings and manifestations consistent with APDS (e.g., recurrent respiratory tract infections, recurrent herpesvirus infections, lymphadenopathy, hepatosplenomegaly, autoimmune cytopenia)

AND

4 - ONE of the following:

4.1 Failure to one current standard of care for APDS (e.g., antimicrobial prophylaxis, immunoglobulin replacement therapy, immunosuppressive therapy) as confirmed by claims history or submission of medical records

OR

4.2 History of contraindication or intolerance to one current standard of care for APDS (e.g., antimicrobial prophylaxis, immunoglobulin replacement therapy, immunosuppressive therapy) (please specify intolerance or contraindication)

AND

5 - Prescribed by ONE of the following:

- Hematologist
- Immunologist

AND

6 - BOTH of the following:

- Patient is 12 years of age or older
- Patient weighs greater than or equal to 45 kg (kilograms)

Product Name:Joenja	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Joenja therapy (e.g., reduced lymph node size, increased naïve B-cell percentage, decreased frequency or severity of infections, decreased frequency of hospitalizations) AND 2 - Prescribed by ONE of the following: • Hematologist • Immunologist AND 3 - Patient weighs greater than or equal to 45 kg	

2 . Revision History

Date	Notes
8/8/2024	Updated initial authorization duration to 12 months.

Keveyis, Ormalvi



Prior Authorization Guideline

Guideline ID	GL-439216
Guideline Name	Keveyis, Ormalvi
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Indiana 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 Medicaid - Community & State Nevada

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Keveyis, generic dichlorphenamide, Brand Ormalvi	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of primary hyperkalemic periodic paralysis or related variant OR 2 - Diagnosis of primary hypokalemic periodic paralysis or related variant	

Product Name:Brand Keveyis, generic dichlorphenamide, Brand Ormalvi	
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
11/5/2025	Added Nevada Formulary

Kisqali



Prior Authorization Guideline

Guideline ID	GL-354272
Guideline Name	Kisqali
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 Virginia Medicaid - Community & State Indiana Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	9/1/2025

1 . Criteria

Product Name:Kisqali	
Diagnosis	Breast Cancer

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following: • Early stage (II or III) breast cancer at high-risk of recurrence • Advanced, recurrent, or metastatic breast cancer AND 2 - If for diagnosis of early stage (II or III) breast cancer at high-risk of recurrence, BOTH of the following: 2.1 ONE of the following: • Disease is node-positive • Disease is node-negative with tumor size > 5 cm • Disease is node-negative with tumor size 2-5 cm and Grade 2 and high genomic risk or Ki-67 at least 20% • Disease is node-negative with tumor size 2-5 cm and Grade 3 AND 2.2 Used in combination with an aromatase inhibitor (e.g., anastrozole, letrozole, exemestane) AND 3 - If for diagnosis of advanced, recurrent, or metastatic breast cancer, ONE of the following: • Used in combination with an aromatase inhibitor (e.g., anastrozole, letrozole, exemestane) • Used in combination with Faslodex (fulvestrant)	

AND

4 - BOTH of the following:

- Disease is hormone receptor (HR)-positive
- Disease is human epidermal growth factor receptor 2 (HER2)-negative

AND

5 - ONE of the following:

- Failure to Verzenio (abemaciclib) confirmed by claims history or submission of medical records
- History of contraindication or intolerance to Verzenio (abemaciclib) (please specify intolerance or contraindication)
- Patient is currently on Kisqali therapy

Product Name:Kisqali	
Diagnosis	Endometrial Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of recurrent or metastatic endometrial cancer AND 2 - Tumor is estrogen receptor (ER)-positive AND	

3 - Used in combination with letrozole

Product Name:Kisqali	
Diagnosis	Breast Cancer, Endometrial 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 Kisqali therapy	

Product Name:Kisqali	
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:Kisqali	
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 Kisqali therapy

2 . Revision History

Date	Notes
8/7/2025	Updated breast cancer criteria

Kisqali Femara Co-Pack



Prior Authorization Guideline

Guideline ID	GL-354273
Guideline Name	Kisqali Femara Co-Pack
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 Virginia Medicaid - Community & State Indiana Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	9/1/2025

1 . Criteria

Product Name:Kisqali Femara Co-Pack	
Diagnosis	Breast Cancer

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following: • Early stage (II or III) breast cancer at high-risk of recurrence • Advanced, recurrent, or metastatic breast cancer AND 2 - If for diagnosis of early stage (II or III) breast cancer at high-risk of recurrence, ONE of the following: • Disease is node-positive • Disease is node-negative with tumor size > 5 cm • Disease is node-negative with tumor size 2-5 cm and Grade 2 and high genomic risk or Ki-67 at least 20% • Disease is node-negative with tumor size 2-5 cm and Grade 3 AND 3 - BOTH of the following: • Disease is hormone receptor (HR)-positive • Disease is human epidermal growth factor receptor 2 (HER2)-negative AND 4 - ONE of the following: • Failure to Verzenio (abemaciclib) plus an aromatase inhibitor (e.g., anastrozole, letrozole) confirmed by claims history or submission of medical records • History of contraindication or intolerance to Verzenio (abemaciclib) plus an aromatase inhibitor (e.g., anastrozole, letrozole) (please specify intolerance or contraindication) • Patient is currently on Kisqali Femara Co-Pack therapy	

Product Name:Kisqali Femara Co-Pack	
Diagnosis	Endometrial Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of recurrent or metastatic endometrial cancer AND 2 - Tumor is estrogen receptor (ER)-positive	

Product Name:Kisqali Femara Co-Pack	
Diagnosis	Breast Cancer, Endometrial 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 Kisqali Femara Co-Pack therapy	

Product Name:Kisqali Femara Co-Pack	
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:Kisqali Femara Co-Pack	
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 Kisqali Femara Co-Pack therapy	

2 . Revision History

Date	Notes
8/7/2025	Updated breast cancer criteria

Komzifti



Prior Authorization Guideline

Guideline ID	GL-578251
Guideline Name	Komzifti
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia Medicaid - Community & State Washington

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Komzifti

Diagnosis	Acute Myeloid Leukemia (AML)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of acute myeloid leukemia (AML) AND 2 - Disease is relapsed or refractory AND 3 - Positive for nucleophosmin 1 (NPM1) mutation	

Product Name:Komzifti	
Diagnosis	Acute Myeloid Leukemia (AML)
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 Komzifti therapy	

Product Name:Komzifti	
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:Komzifti	
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 Komzifti therapy	

2 . Revision History

Date	Notes
4/15/2026	Updated formularies to add ACUIN for eff 6/1/2026. No clinical changes.

Koselugo



Prior Authorization Guideline

Guideline ID	GL-448289
Guideline Name	Koselugo
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia Medicaid - Community & State Washington

Guideline Note:

Effective Date:	12/1/2025

1 . Criteria

Product Name:Koselugo

Diagnosis	Neurofibromatosis Type 1
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of neurofibromatosis type 1 AND 2 - Patient has plexiform neurofibromas that are BOTH of the following: • Inoperable • Causing significant morbidity (e.g., disfigurement, motor dysfunction, pain, airway dysfunction, visual impairment, bladder/bowel dysfunction)	

Product Name:Koselugo	
Diagnosis	Glioma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Circumscribed glioma with presence of BRAF fusion or BRAF V600E activating mutations OR 1.2 NF-1 mutated glioma	

AND

2 - Disease is recurrent or progressive

AND

3 - Used as monotherapy

Product Name:Koselugo

Diagnosis	Langerhans Cell Histiocytosis

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Langerhans cell histiocytosis

AND

2 - ONE of the following:

- Presence of mitogen-activated protein (MAP) kinase pathway mutation
- No detectable mutation
- Genetic testing not available

AND

3 - Used as monotherapy

Product Name:Koselugo

Diagnosis	Neurofibromatosis Type 1, Glioma, Langerhans Cell Histiocytosis
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 Koselugo therapy	

Product Name:Koselugo	
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:Koselugo	
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 Koselugo therapy	

2 . Revision History

Date	Notes
11/12/2025	Combined formularies. No changes to clinical criteria. Expanded on MAP abbreviation.

Krazati



Prior Authorization Guideline

Guideline ID	GL-417192
Guideline Name	Krazati
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia Medicaid - Community & State Washington

Guideline Note:

Effective Date:	11/1/2025

1 . Criteria

Product Name:Krazati

Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of non-small cell lung cancer (NSCLC) AND 2 - Presence of KRAS G12C mutation AND 3 - Disease is ONE of the following: • Recurrent • Advanced • Metastatic AND 4 - Patient has received at least one prior systemic therapy	

Product Name:Krazati	
Diagnosis	Colorectal Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of colorectal cancer

AND

2 - Presence of KRAS G12C mutation

AND

3 - Disease is ONE of the following:

- Recurrent
- Advanced
- Metastatic

AND

4 - Patient has received at least one prior systemic therapy

Product Name:Krazati	
Diagnosis	Ampullary Adenocarcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ampullary adenocarcinoma AND 2 - Presence of KRAS G12C mutation	

AND

3 - Disease is ONE of the following:

- Recurrent
- Advanced
- Metastatic

AND

4 - Patient has received at least one prior systemic therapy

Product Name:Krazati	
Diagnosis	Pancreatic Adenocarcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of pancreatic adenocarcinoma

AND

2 - Presence of KRAS G12C mutation

AND

3 - Disease is ONE of the following:

- Recurrent
- Advanced

- Metastatic

AND

4 - Patient has received at least one prior systemic therapy

Product Name:Krazati	
Diagnosis	Biliary Tract Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following:

- Gallbladder Cancer
- Intrahepatic cholangiocarcinoma
- Extrahepatic cholangiocarcinoma

AND

2 - Presence of KRAS G12C mutation

AND

3 - Disease is ONE of the following:

- Unresectable
- Resected gross residual (R2)
- Metastatic

AND

4 - Patient has received at least one prior systemic therapy

Product Name:Krazati	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC), Colorectal Cancer, Ampullary Adenocarcinoma, Pancreatic Adenocarcinoma, Biliary Tract Cancers
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 Krazati therapy	

Product Name:Krazati	
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:Krazati	
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 Krazati therapy

2 . Revision History

Date	Notes
10/9/2025	Combined formularies. No changes to clinical criteria.

Laxatives and Cathartics



Prior Authorization Guideline

Guideline ID	GL-500220
Guideline Name	Laxatives and Cathartics
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name: Brand Amitiza, generic lubiprostone, Linzess	
Approval Length	12 month(s)
Guideline Type	Step Therapy
Approval Criteria 1 - Patient had a trial of ONE of the following: • Lactulose • Sorbitol • Polyethylene glycol	

Product Name:lbsrela, Brand Motegrity, generic prucalopride	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following: 1.1 Patient had a trial of lubiprostone and Linzess OR 1.2 BOTH of the following: 1.2.1 Patient had a trial of ONE of the following: • Lactulose • Sorbitol • Polyethylene glycol AND 1.2.2 There is medical justification for use over the preferred* medications	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:Movantik, Symproic	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient had a trial of ONE of the following:	

- Lactulose
- Sorbitol
- Polyethylene glycol

AND

2 - Diagnosis of opioid-induced constipation

AND

3 - There is medical justification for use over the preferred* medications

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

2 . Revision History

Date	Notes
1/16/2026	Removed Trulance and Relistor - no longer on PDL.

Lazcluze



Prior Authorization Guideline

Guideline ID	GL-458429
Guideline Name	Lazcluze
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Lazcluze	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of non-small cell lung cancer (NSCLC) AND 2 - Disease is ONE of the following: • Recurrent • Advanced • Metastatic AND 3 - Disease is positive for ONE of the following: • Epidermal growth factor receptor (EGFR) exon 19 deletion • EGFR exon 21 L858R mutation AND 4 - Used in combination with Rybrevant (amivantamab-vmjw)	

Product Name:Lazcluze	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
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 Lazcluze therapy

Product Name:Lazcluze

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:Lazcluze

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 Lazcluze therapy

2 . Revision History

Date	Notes
12/8/2025	Combined formularies. Minor update to dx headers for NCCN section s. No changes to clinical criteria.

Lenvima



Prior Authorization Guideline

Guideline ID	GL-578240
Guideline Name	Lenvima
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 Virginia Medicaid - Community & State New Mexico Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Lenvima	
Diagnosis	Renal Cell Cancer

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of advanced renal cell carcinoma AND 2 - ONE of the following: 2.1 BOTH of the following: 2.1.1 ONE of the following: • Failure to one prior anti-angiogenic therapy as confirmed by claims history or submission of medical records [e.g., Avastin (bevacizumab), Votrient (pazopanib), Sutent (sunitinib), Nexavar (sorafenib)] • History of intolerance or contraindication to one prior anti-angiogenic therapy [e.g., Avastin (bevacizumab), Votrient (pazopanib), Sutent (sunitinib), Nexavar (sorafenib)] (please specify contraindication or intolerance) AND 2.1.2 Used in combination with Afinitor (everolimus) OR 2.2 Used in combination with Keytruda (pembrolizumab) OR 2.3 Used as single-agent therapy for stage IV or relapsed disease as subsequent therapy for clear cell histology	

Product Name:Lenvima	
Diagnosis	Renal Cell 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 Lenvima therapy AND 2 - Used in combination with Afinitor (everolimus) or Keytruda (pembrolizumab)	

Product Name:Lenvima	
Diagnosis	Thyroid Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of differentiated thyroid cancer (DTC) AND 2 - Disease is locally recurrent, metastatic, progressive, or symptomatic AND 3 - Disease is radioactive iodine-refractory or ineligible	

Product Name:Lenvima	
Diagnosis	Hepatocellular Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of hepatocellular carcinoma	

Product Name:Lenvima	
Diagnosis	Endometrial Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of endometrial carcinoma	

Product Name:Lenvima	
Diagnosis	Adenoid Cystic Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of recurrent adenoid cystic carcinoma	

Product Name:Lenvima	
Diagnosis	Thymic Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of thymic carcinoma	

Product Name:Lenvima	
Diagnosis	Thyroid Cancer, Hepatocellular Cancer, Adenoid Cystic Carcinoma, Thymic Carcinoma, Endometrial 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 Lenvima therapy	

Product Name:Lenvima	
Diagnosis	Cutaneous Melanoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of cutaneous melanoma	

AND

2 - Disease is ONE of the following:

- Disease is unresectable
- Disease is metastatic

AND

3 - Used in combination with Keytruda (pembrolizumab)

Product Name:Lenvima	
Diagnosis	Cutaneous Melanoma
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 Lenvima therapy AND 2 - Used in combination with Keytruda (pembrolizumab)	

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

Approval Criteria

1 - Lenvima will be approved for uses supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name:Lenvima	
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 Lenvima therapy	

2 . Revision History

Date	Notes
4/14/2026	Added Indiana

Leukocyte Stimulants



Prior Authorization Guideline

Guideline ID	GL-329195
Guideline Name	Leukocyte Stimulants
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	8/1/2025

1 . Criteria

Product Name:Leukine	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following: 1.1 Patient has trial and failure of all preferred short-acting agents*	

OR

1.2 The requested medication is being used in combination with an antineoplastic monoclonal antibody (e.g., dinutuximab, naxitamab) that requires concurrent use

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

2 . Revision History

Date	Notes
7/14/2025	New guideline

Leukotriene Receptor Antagonists



Prior Authorization Guideline

Guideline ID	GL-548193
Guideline Name	Leukotriene Receptor Antagonists
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:generic montelukast granules	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation indicating tablet formulations are unsuitable for use	

2 . Revision History

UnitedHealthcare Community Plan of Indiana Clinical Pharmacy Program Guidelines

Date	Notes
3/10/2026	Removed Brand Singulair granules.

Lipotropics



Prior Authorization Guideline

Guideline ID	GL-534248
Guideline Name	Lipotropics
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Brand Vytorin, generic ezetimibe/simvastatin	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Trial history of a single-agent HMG-CoA (3-Hydroxy-3-Methylglutaryl Coenzyme A) reductase inhibitor for 90 days of the past 120 days	

Product Name:Nexletol

Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following: 1.1 Patient has tried and failed two statin agents OR 1.2 Patient has tried and failed a statin in combination with ezetimibe OR 1.3 Medical justification for use over preferred statins and ezetimibe (please document)	

Product Name:Nexlizet	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following: 1.1 Patient has tried and failed a statin in combination with ezetimibe OR 1.2 Medical justification for use over preferred statins and ezetimibe (please document)	

2 . Revision History

UnitedHealthcare Community Plan of Indiana Clinical Pharmacy Program Guidelines

Date	Notes
3/3/2026	Updated criteria wording.

Livdelzi



Prior Authorization Guideline

Guideline ID	GL-164659
Guideline Name	Livdelzi
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Indiana Medicaid - Community & State Maryland 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 Medicaid - Community & State Washington

Guideline Note:

Effective Date:	3/1/2025

1 . Criteria

Product Name:Livdelzi	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of primary biliary cholangitis AND 2 - Patient does not have decompensated cirrhosis AND 3 - One of the following: 3.1 Both of the following: • Used in combination with ursodeoxycholic acid (e.g., Urso, ursodiol) • 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) OR 3.2 History of contraindication or intolerance to ursodeoxycholic acid (e.g., Urso, ursodiol) (please specify contraindication or intolerance) AND 4 - Patient is not receiving Livdelzi in combination with Iqirvo (elafibranor) or Ocaliva (obeticholic acid)	

AND

5 - Prescribed by 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., laboratory values) documenting a reduction in alkaline phosphatase (ALP) level from pre-treatment baseline (i.e., prior to Livdelzi therapy)

AND

2 - Patient does not have decompensated cirrhosis

AND

3 - Patient is not receiving Livdelzi in combination with Iqirvo (elafibranor) or Ocaliva (obeticholic acid)

AND

4 - Prescribed by one of the following:

- Hepatologist
- Gastroenterologist

2 . Revision History

Date	Notes
2/4/2025	New program

Livdelzi



Prior Authorization Guideline

Guideline ID	GL-164659
Guideline Name	Livdelzi
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Indiana Medicaid - Community & State Maryland 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 Medicaid - Community & State Washington

Guideline Note:

Effective Date:	3/1/2025

1 . Criteria

Product Name:Livdelzi	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of primary biliary cholangitis AND 2 - Patient does not have decompensated cirrhosis AND 3 - One of the following: 3.1 Both of the following: • Used in combination with ursodeoxycholic acid (e.g., Urso, ursodiol) • 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) OR 3.2 History of contraindication or intolerance to ursodeoxycholic acid (e.g., Urso, ursodiol) (please specify contraindication or intolerance) AND 4 - Patient is not receiving Livdelzi in combination with Iqirvo (elafibranor) or Ocaliva (obeticholic acid)	

AND

5 - Prescribed by 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., laboratory values) documenting a reduction in alkaline phosphatase (ALP) level from pre-treatment baseline (i.e., prior to Livdelzi therapy)

AND

2 - Patient does not have decompensated cirrhosis

AND

3 - Patient is not receiving Livdelzi in combination with Iqirvo (elafibranor) or Ocaliva (obeticholic acid)

AND

4 - Prescribed by one of the following:

- Hepatologist
- Gastroenterologist

2 . Revision History

Date	Notes
2/4/2025	New program

Livmarli



Prior Authorization Guideline

Guideline ID	GL-457330
Guideline Name	Livmarli
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Pennsylvania

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Livmarli	
Diagnosis	Progressive Familial Intrahepatic Cholestasis (PFIC)

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - 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 (BSEP) protein AND 3 - Patient is experiencing cholestatic pruritus associated with PFIC AND 4 - Patient has a serum bile acid concentration above the upper limit of the normal reference range for the reporting laboratory AND 5 - Patient has had an inadequate response to at least two conventional treatments for the symptomatic relief of pruritus (e.g., ursodeoxycholic acid, diphenhydramine, cholestyramine, rifampin, naltrexone, and sertraline) AND 6 - Prescribed by a gastroenterologist or hepatologist	

Product Name:Livmarli

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 Livmarli therapy (e.g., reduced serum bile acids, improved pruritus and less sleep disturbance) AND 2 - Prescribed by a gastroenterologist or hepatologist	

Product Name:Livmarli	
Diagnosis	Alagille Syndrome (ALGS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Alagille syndrome (ALGS) AND 2 - Confirmation of diagnosis by presence of the JAG1 or Notch2 gene mutation AND 3 - Patient has a serum bile acid concentration above the upper limit of the normal reference range for the reporting laboratory	

AND

4 - Patient is experiencing cholestatic pruritus associated with ALGS

AND

5 - Patient has had an inadequate response to at least two conventional treatments for the symptomatic relief of pruritus (e.g., ursodeoxycholic acid, diphenhydramine, cholestyramine, rifampin, naltrexone, and sertraline)

AND

6 - Prescribed by a gastroenterologist or hepatologist

Product Name:Livmarli	
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 Livmarli therapy (e.g., reduced serum bile acids, improved pruritus) AND 2 - Prescribed by a gastroenterologist or hepatologist	

2 . Revision History

UnitedHealthcare Community Plan of Indiana Clinical Pharmacy Program Guidelines

Date	Notes
12/6/2025	Updated formularies to include IN for eff 1/1/26.

Livtensity



Prior Authorization Guideline

Guideline ID	GL-230187
Guideline Name	Livtensity
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland 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 Virginia Medicaid - Community & State Washington Medicaid - Community & State Nebraska Medicaid - Community & State New Mexico Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	5/1/2025

1 . Criteria

Product Name:Livtency	
Approval Length	2 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of post-transplant cytomegalovirus (CMV) infection or CMV disease AND 2 - CMV infection or disease is refractory to treatment (with or without genotypic resistance) to ONE of the following: • Ganciclovir • Valganciclovir • Cidofovir • Foscarnet AND 3 - Patient will not use Livtency in combination with ganciclovir or valganciclovir	

2 . Revision History

Date	Notes
3/26/2025	Combined formularies.

Lonsurf



Prior Authorization Guideline

Guideline ID	GL-267204
Guideline Name	Lonsurf
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 Virginia Medicaid - Community & State Washington Medicaid - Community & State Indiana Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2025

1 . Criteria

Product Name:Lonsurf

Diagnosis	Colorectal Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of advanced or metastatic colorectal cancer (mCRC) AND 2 - History of failure, contraindication, or intolerance to treatment with ALL of the following: • Fluoropyrimidine-based chemotherapy • Oxaliplatin-based chemotherapy • Irinotecan-based chemotherapy • Anti-vascular endothelial growth factor (VEGF) biological therapy AND 3 - ONE of the following: 3.1 Tumors is RAS mutant-type OR 3.2 BOTH of the following: • Tumor is RAS wild-type • History of failure, contraindication, or intolerance to anti-EGFR (epidermal growth factor receptor) therapy	

Product Name:Lonsurf	
Diagnosis	Gastric/Gastroesophageal Junction Adenocarcinoma
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following: • Unresectable locally advanced, recurrent, or metastatic gastric cancer • Unresectable locally advanced, recurrent, or metastatic gastroesophageal junction adenocarcinoma AND 2 - History of failure, contraindication, or intolerance to treatment with at least TWO prior lines of chemotherapy that consisted of the following agents: • Fluoropyrimidine (e.g., fluorouracil) • Platinum (e.g., carboplatin, cisplatin, oxaliplatin) • Taxane (e.g., docetaxel, paclitaxel) or irinotecan • Human epidermal growth factor receptor 2 (HER2)/neu-targeted therapy (e.g., trastuzumab) (if HER2 overexpression)	

Product Name:Lonsurf	
Diagnosis	Colorectal Cancer, Gastric/Gastroesophageal Junction Adenocarcinoma
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 Lonsurf therapy	

Product Name:Lonsurf

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:Lonsurf	
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 Lonsurf therapy	

2 . Revision History

Date	Notes
5/15/2025	Updated formularies

Lorbrena



Prior Authorization Guideline

Guideline ID	GL-583190
Guideline Name	Lorbrena
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Lorbrena	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of non-small cell lung cancer (NSCLC) AND 2 - ONE of the following: 2.1 Disease is BOTH of the following: • Recurrent, advanced, or metastatic • Anaplastic lymphoma kinase (ALK)-positive OR 2.2 BOTH of the following: 2.2.1 Disease is BOTH of the following: • Recurrent, advanced, or metastatic • ROS proto-oncogene 1 (ROS1)-positive AND 2.2.2 Disease has progressed on at least ONE of the following therapies: • Augtyro (repotrectinib) • Rozlytrek (entrectinib) • Xalkori (crizotinib) • Zykadia (ceritinib)	

Product Name:Lorbrena

Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Erdheim-Chester Disease (ECD) AND 2 - Disease is BOTH of the following: • Symptomatic, relapsed, or refractory • Anaplastic lymphoma kinase (ALK)-positive	

Product Name:Lorbrena	
Diagnosis	Soft Tissue Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of inflammatory myofibroblastic tumor (IMT) AND 2 - Disease is anaplastic lymphoma kinase (ALK)-positive	

Product Name:Lorbrena

Diagnosis	Uterine Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of uterine sarcoma AND 2 - Disease is ONE of the following: • Advanced • Recurrent/metastatic • Inoperable AND 3 - Disease is anaplastic lymphoma kinase (ALK)-positive	

Product Name:Lorbrena	
Diagnosis	Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following diagnoses: • Anaplastic large cell lymphoma (ALCL) • Large B-Cell lymphoma	

AND	
2 - Disease is relapsed or refractory	
AND	
3 - Disease is anaplastic lymphoma kinase (ALK)-positive	

Product Name:Lorbrena	
Diagnosis	Glioma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of pediatric diffuse high-grade glioma AND 2 - Disease is anaplastic lymphoma kinase (ALK)-positive	

Product Name:Lorbrena	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC), Histiocytic Neoplasms, Soft Tissue Sarcoma, Uterine Sarcoma, Lymphoma, Glioma
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 Lorbrena therapy

Product Name:Lorbrena

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:Lorbrena

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 Lorbrena therapy

2 . Revision History

Date	Notes

4/17/2026	Added IN. Expanded on ALK abbreviation where applicable, with no changes to clinical intent.

Lucemyra



Prior Authorization Guideline

Guideline ID	GL-126584
Guideline Name	Lucemyra
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	7/1/2023

1 . Criteria

Product Name:Lucemyra	
Diagnosis	First Course of Therapy (Less than or equal to 14 days of therapy within 180 days)
Approval Length	14 Day(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following:	

1.1 Patient has a history of trial and failure of a guideline-accepted alpha-2 adrenergic agonist agent, confirmed by claims history or chart documentation

OR

1.2 Prescriber has provided valid medical rational for use of Lucemyra over other guideline-accepted alpha-2 adrenergic agonist agents

AND

2 - The request does not exceed the plan limitation maximum of 14 days supply (two separate 7 day fills) within 180 days

Product Name:Lucemyra	
Diagnosis	Subsequent Course of therapy (Greater than 14 days of therapy within 180 days)
Approval Length	14 Day(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Prescriber has provided valid medical rationale for continued use of Lucemyra AND 2 - The request does not exceed the plan limitation maximum of 14 days supply (two separate 7 day fills)	

2 . Revision History

Date	Notes

6/14/2023	Added T/F language and plan limitations (Two 7-day supplies in 180 days)

Lumakras



Prior Authorization Guideline

Guideline ID	GL-425232
Guideline Name	Lumakras
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia Medicaid - Community & State Washington

Guideline Note:

Effective Date:	11/1/2025

1 . Criteria

Product Name:Lumakras

Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of non-small cell lung cancer (NSCLC) AND 2 - Disease is ONE of the following: • Recurrent • Advanced • Metastatic AND 3 - Tumor is KRAS G12C-mutation positive AND 4 - Patient has received at least one prior systemic therapy (e.g., immune checkpoint inhibitor, platinum-based chemotherapy)	

Product Name:Lumakras	
Diagnosis	Pancreatic Adenocarcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of pancreatic adenocarcinoma

AND

2 - Disease is ONE of the following:

- Recurrent
- Locally advanced
- Metastatic

AND

3 - Tumor is KRAS G12C-mutation positive

AND

4 - Patient has received at least one prior systemic therapy (e.g., immune checkpoint inhibitor, platinum-based chemotherapy)

Product Name:Lumakras	
Diagnosis	Ampullary Adenocarcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ampullary adenocarcinoma AND 2 - Disease is progressive	

AND

3 - Tumor is KRAS G12C-mutation positive

AND

4 - Patient has received at least one prior systemic therapy (e.g., immune checkpoint inhibitor, platinum-based chemotherapy)

Product Name:Lumakras

Diagnosis	Colon Cancer

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of colon cancer

AND

2 - Tumor is KRAS G12C-mutation positive

AND

3 - Patient has received at least one prior systemic therapy (e.g., immune checkpoint inhibitor, platinum-based chemotherapy)

Product Name:Lumakras

Diagnosis	Rectal Cancer

Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of rectal cancer AND 2 - Tumor is KRAS G12C-mutation positive AND 3 - Patient has received at least one prior systemic therapy (e.g., immune checkpoint inhibitor, platinum-based chemotherapy)	

Product Name:Lumakras	
Diagnosis	Central Nervous System Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of brain metastases AND 2 - Metastases from KRAS G12C-mutated positive non-small cell lung cancer	

Product Name:Lumakras

Diagnosis	Small Bowel Adenocarcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of small bowel adenocarcinoma AND 2 - Disease is ONE of the following: • Advanced • Metastatic AND 3 - Tumor is KRAS G12C-mutation positive AND 4 - Patient has received at least one prior systemic therapy (e.g., immune checkpoint inhibitor, platinum-based chemotherapy)	

Product Name:Lumakras	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC), Pancreatic Adenocarcinoma, Ampullary Adenocarcinoma, Colon Cancer, Rectal Cancer, Central Nervous System Cancers, Small Bowel Adenocarcinoma
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 Lumakras therapy

Product Name:Lumakras

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:Lumakras

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 Lumakras therapy

2 . Revision History

Date	Notes

10/21/2025	Updated formularies to include IN for eff 11/1/25. Minor cosmetic updates.

Lynparza



Prior Authorization Guideline

Guideline ID	GL-430188
Guideline Name	Lynparza
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia Medicaid - Community & State Washington

Guideline Note:

Effective Date:	11/1/2025

1 . Criteria

Product Name:Lynparza

Diagnosis	Breast Cancer (High Risk Early)
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of high risk early breast cancer AND 2 - Presence of deleterious or suspected deleterious germline breast cancer (BRCA)-mutations (gBRCAm) AND 3 - Disease is human growth factor receptor 2 (HER2)-negative AND 4 - ONE of the following: 4.1 Patient is hormone receptor (HR) negative OR 4.2 BOTH of the following: 4.2.1 Patient is hormone receptor (HR) positive AND 4.2.2 Patient is continuing concurrent treatment with endocrine therapy	

AND

5 - Patient has been treated with neoadjuvant or adjuvant chemotherapy

AND

6 - Treatment duration has not exceeded 12 months of therapy

Product Name:Lynparza

Diagnosis	Breast Cancer (Metastatic or Recurrent)

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following:

1.1 Metastatic breast cancer

OR

1.2 Recurrent breast cancer

AND

2 - Presence of deleterious or suspected deleterious germline breast cancer (BRCA)-mutations (gBRCAm)

AND

3 - ONE of the following:

3.1 BOTH of the following:

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

AND

3.1.2 ONE of the following:

3.1.2.1 Disease is hormone receptor (HR) negative

OR

3.1.2.2 BOTH of the following:

3.1.2.2.1 Disease is hormone receptor (HR) positive

AND

3.1.2.2.2 ONE of the following:

- Disease has progressed on previous endocrine therapy
- Provider attestation that treatment with endocrine therapy is inappropriate

OR

3.2 Disease is human epidermal growth factor receptor 2 (HER2)-positive

Product Name:Lynparza	
Diagnosis	Ovarian Cancer (Maintenance Therapy)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following:

- Epithelial ovarian cancer
- Fallopian tube cancer
- Primary peritoneal cancer

AND

2 - Disease is ONE of the following:

- Advanced
- Recurrent

AND

3 - ONE of the following:

3.1 Presence of deleterious or suspected deleterious germline or somatic BRCA-mutations

OR

3.2 BOTH of the following:

3.2.1 Cancer is associated with homologous recombination deficiency (HRD)-positive status defined by either a deleterious or suspected deleterious BRCA mutation or genomic instability

AND

3.2.2 Used in combination with bevacizumab (e.g., Avastin, Mvasi)

AND

4 - Patient has had a complete or partial response to platinum-based chemotherapy

AND

5 - Request is for maintenance therapy

Product Name:Lynparza

Diagnosis	Ovarian Cancer (Treatment)

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following:

- Epithelial ovarian cancer
- Fallopian tube cancer
- Primary peritoneal cancer

AND

2 - Disease is ONE of the following:

- Advanced
- Persistent
- Recurrent

AND

3 - Presence of deleterious or suspected deleterious germline BRCA (breast cancer gene)-mutation

AND

4 - Patient has been treated with two or more prior lines of chemotherapy

Product Name:Lynparza	
Diagnosis	Pancreatic Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of pancreatic adenocarcinoma AND 2 - Disease is metastatic AND 3 - Presence of deleterious or suspected deleterious germline BRCA1/2 (breast cancer gene)-mutation AND 4 - Disease has NOT progressed while receiving at least 16 weeks of a first-line platinum-based chemotherapy regimen	

Product Name:Lynparza	
Diagnosis	Prostate Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of metastatic castration-resistant prostate cancer

AND

2 - ONE of the following:

2.1 BOTH of the following:

2.1.1 Presence of deleterious or suspected deleterious germline or somatic homologous recombination repair (HRR) gene mutations

AND

2.1.2 Disease has progressed following prior treatment with ONE of the following:

- Enzalutamide (Xtandi)
- Abiraterone (e.g., Zytiga, Yonsa)

OR

2.2 ALL of the following:

2.2.1 Presence of deleterious or suspected deleterious BRCA-mutation

AND

2.2.2 Used in combination with abiraterone (e.g., Zytiga, Yonsa)

AND

2.2.3 Used in combination with steroids (e.g., methylprednisolone, prednisolone, prednisone)

AND

3 - ONE of the following:

3.1 Used in combination with a gonadotropin-releasing hormone (GnRH) analog [e.g., Lupron (leuprolide), Zoladex (goserelin), Trelstar (triptorelin), Vantas (histrelin), Firmagon (degarelix)]

OR

3.2 Patient has had bilateral orchiectomy

Product Name:Lynparza	
Diagnosis	Uterine Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of uterine sarcoma AND 2 - The requested medication is NOT used as first-line therapy	

Product Name:Lynparza	
Diagnosis	Breast Cancer (Metastatic or Recurrent), Ovarian Cancer (Maintenance or Treatment), Pancreatic Cancer, Prostate Cancer, Uterine Neoplasms
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 Lynparza therapy

Product Name:Lynparza

Diagnosis	NCCN Recommended Regimen

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:Lynparza

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 Lynparza therapy

2 . Revision History

Date	Notes

10/23/2025	Updated formularies to include IN for eff 11/1/25. Minor cosmetic updates.

Lytgobi



Prior Authorization Guideline

Guideline ID	GL-592205
Guideline Name	Lytgobi
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Lytgobi	
Diagnosis	Cholangiocarcinoma

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of cholangiocarcinoma (intrahepatic or extrahepatic) AND 2 - Disease is ONE of the following: • Unresectable • Resected gross residual (R2) • Metastatic AND 3 - Positive for fibroblast growth factor receptor 2 (FGFR2) fusions or rearrangements AND 4 - Used as second line or subsequent treatment	

Product Name:Lytgobi	
Diagnosis	Cholangiocarcinoma
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 Lytgobi therapy	

Product Name:Lytgobi	
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:Lytgobi	
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 Lytgobi therapy	

2 . Revision History

Date	Notes
4/23/2026	Combined formularies. No changes to clinical criteria.

Macrolides



Prior Authorization Guideline

Guideline ID	GL-599199
Guideline Name	Macrolides
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:generic erythromycin ethylsuccinate susp	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient must be under 12 years of age OR	

2 - Patient must be unable to swallow tablets/capsules

Product Name:Brand Eryped susp, Brand E.E.S. Granules	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient must have tried and failed generic erythromycin ethylsuccinate suspension in the past 90 days OR 2 - BOTH of the following: 2.1 ONE of the following: 2.1.1 Patient must be under 12 years of age OR 2.1.2 Patient must be unable to swallow tablets/capsules AND 2.2 There is medical justification for use over the preferred* medications (please document justification)	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

2 . Revision History

Date	Notes

4/28/2026	Added language for free text box to document justification for use over preferred medications in Brand Eryped susp, Brand E.E.S. Granules section.

MASH-MASLD



Prior Authorization Guideline

Guideline ID	GL-465212
Guideline Name	MASH-MASLD
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Rezdiffra	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of metabolic dysfunction-associated steatohepatitis (MASH) with moderate (F2) to advanced (F3) liver fibrosis, confirmed by submission of ONE of the following: 1.1 Liver biopsy obtained within the past 2 years with a non-alcoholic fatty liver disease	

activity score (NAS) of greater than or equal to 4 with a score of at least 1 in each of the following NAS components: steatosis, ballooning degeneration, and lobular inflammation AND METAVIR (Meta-analysis of histological data in viral hepatitis) stage of F2-F3 fibrosis

OR

1.2 Vibration-controlled transient elastography (e.g., Fibroscan) results with a liver stiffness measurement (LSM) greater than or equal to 8.5 kPa (kilopascal) and controlled attenuation parameter (CAP) greater than or equal to 280 dB/m (decibel-milliwatts) within the past 6 months

AND

2 - Patient is 18 years of age or older

AND

3 - Prescriber attests the patient does not have decompensated MASH cirrhosis

AND

4 - Prescribed by, or in consultation with, an endocrinologist, gastroenterologist, or hepatologist

AND

5 - The dose requested does not exceed 100 mg/day (milligrams per day)

AND

6 - The dose requested does not exceed ONE of the following:

- 60 mg strength - max of 1 tablet/day
- 80 mg strength - max of 1 tablet/day
- 100 mg strength - max of 1 tablet/day

AND

7 - ONE of the following:

7.1 Patient will not be using Rezdiffra (resmetirom) concurrently with Wegovy (semaglutide)

OR

7.2 Prescriber has provided valid medical justification for the concurrent use of Rezdiffra (resmetirom) and Wegovy (semaglutide) (document rationale)

Product Name:Rezdiffra	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of ONE of the following: 1.1 Liver biopsy results within the past year demonstrating improvement or stabilization in fibrosis staging and non-alcoholic fatty liver disease activity score (NAS) score from baseline OR 1.2 Fibroscan results within the past year demonstrating improvement or stabilization in controlled attenuation parameter (CAP) and liver stiffness measurement (LSM) scores AND 2 - Prescriber attests to BOTH of the following: • Patient does not have decompensated metabolic dysfunction-associated steatohepatitis (MASH) cirrhosis	

- Patient continues to have signs of MASH and/or contributing metabolic dysfunction factors (e.g., hyperlipidemia, hypertension, insulin resistance, obesity)

AND

3 - The dose requested does not exceed 100 mg/day (milligrams per day)

AND

4 - The dose requested does not exceed ONE of the following:

- 60 mg strength - max of 1 tablet/day
- 80 mg strength - max of 1 tablet/day
- 100 mg strength - max of 1 tablet/day

AND

5 - ONE of the following:

5.1 Patient will not be using Rezdiffra (resmetirom) concurrently with Wegovy (semaglutide)

OR

5.2 Prescriber has provided valid medical justification for the concurrent use of Rezdiffra (resmetirom) and Wegovy (semaglutide) (document rationale)

2 . Revision History

Date	Notes
12/10/2025	Added concomitant use criterion in both initial and reauth sections. Other minor verbiage/grammatical/cosmetic updates.

Mekinist



Prior Authorization Guideline

Guideline ID	GL-151758
Guideline Name	Mekinist
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	9/1/2024

1 . Criteria

Product Name:Mekinist	
Diagnosis	Melanoma
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:	

1.1.1 ONE of the following:

1.1.1.1 Unresectable melanoma

OR

1.1.1.2 Metastatic melanoma

OR

1.1.1.3 BOTH of the following:

1.1.1.3.1 Prescribed as adjuvant therapy for melanoma involving the lymph node(s)

AND

1.1.1.3.2 Used in combination with Tafinlar (dabrafenib)

AND

1.1.2 Cancer is positive for BRAF V600 (gene) mutation

OR

1.2 Distant metastatic uveal melanoma

AND

2 - If the request is for Mekinist solution, there is a reason or special circumstance why the patient is unable to use Mekinist tablets (document reason or special circumstance)

Product Name:Mekinist	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of non-small cell lung cancer (NSCLC) AND 2 - Disease is ONE of the following: • Metastatic • Advanced • Recurrent AND 3 - Cancer is positive for BRAF V600E (gene) mutation AND 4 - Used in combination with Tafenlar (dabrafenib) AND 5 - If the request is for Mekinist solution, there is a reason or special circumstance why the patient is unable to use Mekinist tablets (document reason or special circumstance)	

Product Name:Mekinist	
Diagnosis	Thyroid Cancer
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 anaplastic thyroid cancer (ATC) AND 1.1.2 Cancer is positive for BRAF V600E (gene) mutation AND 1.1.3 Used in combination with Tafenlar (dabrafenib) AND 1.1.4 ONE of the following: 1.1.4.1 Disease is ONE of the following: • Metastatic • Locally advanced • Unresectable OR 1.1.4.2 Prescribed as adjuvant therapy following resection OR 1.2 ALL of the following:	

1.2.1 ONE of the following diagnoses:

- Follicular Carcinoma
- Oncocytic Carcinoma
- Papillary Carcinoma

AND

1.2.2 ONE of the following:

- Unresectable locoregional recurrent disease
- Persistent disease
- Metastatic disease

AND

1.2.3 ONE of the following:

- Patient has symptomatic disease
- Patient has progressive disease

AND

1.2.4 Disease is refractory to radioactive iodine treatment

AND

1.2.5 Cancer is positive for BRAF V600 mutation

AND

1.2.6 Used in combination with Tafinlar (dabrafenib)

AND

2 - If the request is for Mekinist solution, there is a reason or special circumstance why the patient is unable to use Mekinist tablets (document reason or special circumstance)

Product Name: Mekinist	
Diagnosis	Central Nervous System (CNS) Cancers
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:

1.1.1 Patient has metastatic brain lesions

AND

1.1.2 Mekinist is active against the primary tumor (melanoma)

OR

1.2 Patient has a glioma

AND

2 - Cancer is positive for BRAF V600E (gene) mutation

AND

3 - Used in combination with Tafenlar (dabrafenib)

AND

4 - If the request is for Mekinist solution, there is a reason or special circumstance why the patient is unable to use Mekinist tablets (document reason or special circumstance)

Product Name:Mekinist	
Diagnosis	Epithelial Ovarian Cancer/Fallopian Tube Cancer/Primary Peritoneal Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following:

- Epithelial Ovarian Cancer
- Fallopian Tube Cancer
- Primary Peritoneal Cancer

AND

2 - ONE of the following:

- Persistent disease
- Recurrence in BRAF V600E positive tumors
- Recurrence of low-grade serous carcinoma

AND

3 - If the request is for Mekinist solution, there is a reason or special circumstance why the patient is unable to use Mekinist tablets (document reason or special circumstance)

Product Name:Mekinist

Diagnosis	Hepatobiliary Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following: • Gallbladder cancer • Extrahepatic Cholangiocarcinoma • Intrahepatic Cholangiocarcinoma AND 2 - Used as subsequent treatment after progression on or after systemic treatment AND 3 - Disease is unresectable or metastatic AND 4 - Cancer is positive for BRAF V600E (gene) mutation AND 5 - Used in combination with Tafenlar (dabrafenib) AND 6 - If the request is for Mekinist solution, there is a reason or special circumstance why the patient is unable to use Mekinist tablets (document reason or special circumstance)	

Product Name:Mekinist	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following: • Langerhans Cell Histiocytosis • Erdheim-Chester Disease • Rosai-Dorfman Disease AND 2 - ONE of the following: • Mitogen-activated protein (MAP) kinase pathway mutation • No detectable mutation • Testing not available AND 3 - If the request is for Mekinist solution, there is a reason or special circumstance why the patient is unable to use Mekinist tablets (document reason or special circumstance)	

Product Name:Mekinist	
Diagnosis	Solid Tumors
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Presence of solid tumor

AND

2 - Used as subsequent treatment after progression on or after systemic treatment

AND

3 - Disease is unresectable or metastatic

AND

4 - Cancer is positive for BRAF V600E (gene) mutation

AND

5 - Used in combination with Tafenlar (dabrafenib)

AND

6 - If the request is for Mekinist solution, there is a reason or special circumstance why the patient is unable to use Mekinist tablets (document reason or special circumstance)

Product Name:Mekinist	
Diagnosis	Pancreatic Cancer, Ambullary Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of ONE of the following:

- Pancreatic adenocarcinoma
- Ampullary adenocarcinoma

AND

2 - Disease is ONE of the following:

- Metastatic
- Locally advanced
- Unresectable

AND

3 - Cancer is positive for BRAF V600E mutation

AND

4 - Used in combination with Tafenlar (dabrafenib)

AND

5 - If the request is for Mekinist solution, there is a reason or special circumstance why the patient is unable to use Mekinist tablets (document reason or special circumstance)

Product Name:Mekinist	
Diagnosis	Hairy Cell Leukemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of hairy cell leukemia

AND

2 - Used in combination with Tafenlar (dabrafenib)

AND

3 - If the request is for Mekinist solution, there is a reason or special circumstance why the patient is unable to use Mekinist tablets (document reason or special circumstance)

Product Name: Mekinist	
Diagnosis	Salivary Gland Tumor
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of salivary gland tumor

AND

2 - Disease is one of the following:

- Recurrent and unresectable
- Metastatic

AND

3 - Cancer is positive for BRAF V600E mutation

AND

4 - Used in combination with Tafenlar (dabrafenib)

AND

5 - If the request is for Mekinist solution, there is a reason or special circumstance why the patient is unable to use Mekinist tablets (document reason or special circumstance)

Product Name:Mekinist	
Diagnosis	Gastrointestinal Stromal Tumor (GIST)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of BRAF V600E-mutated gastrointestinal stromal tumor (GIST) AND 2 - Disease is one of the following: • Gross residual disease (R2 resection) • Unresectable primary disease • Tumor rupture • Progressive • Recurrent • Metastatic AND 3 - Used in combination with Tafenlar (dabrafenib)	

AND

4 - If the request is for Mekinist solution, there is a reason or special circumstance why the patient is unable to use Mekinist tablets (document reason or special circumstance)

Product Name:Mekinist	
Diagnosis	Melanoma, NSCLC, Thyroid Cancer, CNS Cancers, Epithelial Ovarian /Fallopian Tube /Primary Peritoneal Cancers, Hepatobiliary Cancers, Histiocytic Neoplasms, Solid Tumors, Pancreatic /Ampullary Cancer , Hairy Cell Leukemia, Salivary Gland Tumor, GIST
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 Mekinist therapy	

Product Name:Mekinist	
Diagnosis	NCCN Recommended Regimen
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 AND	

2 - If the request is for Mekinist solution, there is a reason or special circumstance why the patient is unable to use Mekinist tablets (document reason or special circumstance)

Product Name:Mekinist	
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 Mekinist therapy	

2 . Revision History

Date	Notes
8/14/2024	Added criteria for hairy cell leukemia, salivary gland tumor, and GIST.

Mektovi



Prior Authorization Guideline

Guideline ID	GL-164675
Guideline Name	Mektovi
Formulary	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

Guideline Note:

Effective Date:	3/1/2025

1 . Criteria

Product Name:Mektovi	
Diagnosis	Melanoma

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ALL of the following: 1.1 Diagnosis of melanoma AND 1.2 Disease is one of the following: • Unresectable • Metastatic AND 1.3 Patient is positive for BRAFV600 mutation AND 1.4 Used in combination with Braftovi (encorafenib) AND 1.5 ONE of the following: 1.5.1 Patient has a contraindication or history of intolerance to ONE of the following regimens (please specify intolerance or contraindication): • Tafinlar (dabrafenib) plus Mekinist (trametinib) • Zelboraf (vemurafenib) plus Cotellic (cobimetinib)	

OR

1.5.2 Provider attests that the patient is not an appropriate candidate based on the patient's clinical status or comorbidities for either of the following regimens:

- Tafinlar (dabrafenib) plus Mekinist (trametinib)
- Zelboraf (vemurafenib) plus Cotellic (cobimetinib)

OR

1.5.3 For continuation of prior Mektovi therapy

OR

2 - ALL of the following:

2.1 Diagnosis of melanoma

AND

2.2 Disease is one of the following:

- Unresectable
- Metastatic

AND

2.3 Patient is positive for NRAS-mutation

AND

2.4 Progression after prior immune checkpoint inhibitor therapy

Product Name:Mektovi	
Diagnosis	Melanoma

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 Mektovi therapy AND 2 - ONE of the following: 2.1 BOTH of the following: - BRAFV600 mutation positive - Used in combination with Braftovi (encorafenib) OR 2.2 NRAS-mutated tumor	

Product Name:Mektovi	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following: - Multisystem Langerhans Cell Histiocytosis - Single-system lung Langerhans Cell Histiocytosis - Langerhans Cell Histiocytosis with CNS (central nervous system) lesions	

AND

2 - ONE of the following:

- Disease is positive for mitogen-activated protein (MAP) kinase pathway mutation
- No other detectable/actionable mutation
- Testing is not available

Product Name:Mektovi	
Diagnosis	Serous Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of low-grade serous carcinoma AND 2 - Disease is recurrent	

Product Name:Mektovi	
Diagnosis	Histiocytic Neoplasms, Serous 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 Mektovi therapy	

Product Name:Mektovi	
Diagnosis	Gastrointestinal Stromal Tumor (GIST)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of succinate dehydrogenase (SDH)-deficient gastrointestinal stromal tumor (GIST) AND 2 - Disease is ONE of the following: • Gross residual disease (R2 resection) • Unresectable primary disease • Tumor rupture • Progressive • Recurrent • Metastatic AND 3 - Used in combination with imatinib mesylate (generic Gleevec)	

Product Name:Mektovi	
Diagnosis	Gastrointestinal Stromal Tumor (GIST)
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 Mektovi therapy

AND

2 - Used in combination with imatinib mesylate (Gleevec)

Product Name:Mektovi

Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of non-small cell lung cancer (NSCLC)

AND

2 - Disease is one of the following:

- Recurrent
- Advanced
- Metastatic

AND

3 - Patient is positive for BRAFV600 mutation

AND

4 - Used in combination with Braftovi (encorafenib)

AND

5 - ONE of the following:

5.1 Patient has a contraindication or history of intolerance to Tafenlar (dabrafenib) plus Mekinist (trametinib) (please specify intolerance or contraindication)

OR

5.2 Provider attests that the patient is not an appropriate candidate based on the patient's clinical status or comorbidities for Tafenlar (dabrafenib) plus Mekinist (trametinib)

OR

5.3 For continuation of prior Mektovi therapy

Product Name:Mektovi	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
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 Mektovi therapy AND 2 - Used in combination with Braftovi (encorafenib)	

Product Name:Mektovi	
Diagnosis	NCCN Recommended Regimen

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:Mektovi	
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 Mektovi therapy	

2 . Revision History

Date	Notes
2/4/2025	Updated formularies. Updated reauth criteria

Menopausal Symptom Suppressants



Prior Authorization Guideline

Guideline ID	GL-458418
Guideline Name	Menopausal Symptom Suppressants
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Lynkuet	
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 - Patient is 18 years of age or older

AND

3 - ONE of the following:

3.1 Patient has tried and failed at least 90 days of therapy with Veozah (fezolinetant), confirmed by claims history or chart documentation

OR

3.2 BOTH of the following:

3.2.1 Patient has tried and failed at least 90 days of therapy with ONE of the following, confirmed by claims history or chart documentation:

- Hormonal agent (e.g., oral, injectable, topical, transdermal, or vaginal)
- Non-hormonal agent (e.g., gabapentin, paroxetine, venlafaxine, oxybutynin)

AND

3.2.2 Prescriber has submitted valid medical justification for the use of Lynkuet (elinzanetant) over Veozah (fezolinetant)

AND

4 - Requested dose does NOT exceed 120 mg (2 capsules) per day

Product Name:Lynkuet	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - History of the requested agent for at least 90 days of the past 120 days, confirmed by claims history or chart documentation

AND

2 - ONE of the following:

2.1 Patient has previously tried and failed at least 90 days of therapy with Veozah (fezolinetant), confirmed by claims history or chart documentation

OR

2.2 BOTH of the following:

2.2.1 Patient has previously tried and failed at least 90 days of therapy with ONE of the following, confirmed by claims history or chart documentation:

- Hormonal agent (e.g., oral, injectable, topical, transdermal, or vaginal)
- Non-hormonal agent (e.g., gabapentin, paroxetine, venlafaxine, oxybutynin)

AND

2.2.2 Prescriber has submitted valid medical justification for the use of Lynkuet (elinzanetant) over Veozah (fezolinetant)

AND

3 - Requested dose does NOT exceed 120 mg (2 capsules) per day

Product Name: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 - Patient is 18 years of age or older

AND

3 - ONE of the following:

3.1 Patient has tried and failed at least 90 days of therapy with ONE hormonal agent (e.g., oral, injectable, topical, transdermal, or vaginal), confirmed by claims history or chart documentation

OR

3.2 BOTH of the following:

3.2.1 Patient has contraindication to hormonal therapy (submission of supporting chart documentation required)

AND

3.2.2 Patient has tried and failed at least 90 days of therapy with ONE non-hormonal agent (e.g., gabapentin, paroxetine, venlafaxine, oxybutynin), confirmed by claims history or chart documentation

OR

3.3 Prescriber has submitted valid medical justification for the use of Veozah (fezolinetant) over hormonal therapy AND other non-hormonal therapy

AND

4 - Prescriber attests to ALL of the following:

- Patient does NOT have cirrhosis
- Patient does NOT have severe renal impairment or end-stage renal disease (ESRD)
- Patient is NOT currently utilizing a CYP1A2 inhibitor and will not be initiated on CYP1A2 inhibitor therapy while on concomitant Veezah (fezolinetant) therapy

AND

5 - Requested dose does NOT exceed 45 mg (1 tablet) per day

Product Name:Veezah	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested agent for at least 90 days of the past 120 days, confirmed by claims history or chart documentation AND 2 - ONE of the following: 2.1 Patient has previously tried and failed at least 90 days of therapy with ONE hormonal agent (e.g., oral, injectable, topical, transdermal, or vaginal), confirmed by claims history or chart documentation OR 2.2 Patient has contraindication to hormonal therapy and has previously tried and failed at	

least 90 days of therapy with ONE non-hormonal agent (e.g., gabapentin, paroxetine, venlafaxine, oxybutynin), confirmed by claims history or chart documentation

OR

2.3 Prescriber has submitted valid medical justification for the use of Veozah (fezolinetant) over hormonal therapy AND other non-hormonal therapy

AND

3 - Prescriber attests to ALL of the following:

- Patient does NOT have cirrhosis
- Patient does NOT have severe renal impairment or end-stage renal disease (ESRD)
- Patient is currently NOT on a CYP1A2 inhibitor and will not be initiated on a CYP1A2 inhibitor while on concomitant Veozah (fezolinetant) therapy

AND

4 - Requested dose does NOT exceed 45 mg (1 tablet) per day

2 . Revision History

Date	Notes
12/8/2025	Updated guideline name. Added criteria for new target drug, Lynkuet. Added dosing requirement in both initial and reauth sections for Veozah. Minor cosmetic updates.

Mepron



Prior Authorization Guideline

Guideline ID	GL-98050
Guideline Name	Mepron
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2022

1 . Criteria

Product Name: Brand Mepron, generic atovaquone	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ALL of the following: 1.1 Prophylaxis or treatment of Pneumocystis jirovecii pneumonia (PCP, PJP)	

AND

1.2 ONE of the following:

1.2.1 Previous trial and failure of sulfamethoxazole/trimethoprim

OR

1.2.2 Prescriber has provided valid medical justification for the use of atovaquone over sulfamethoxazole/trimethoprim

OR

2 - BOTH of the following:

2.1 Diagnosis of babesiosis

AND

2.2 Patient will be using atovaquone concurrently with azithromycin

OR

3 - Prophylaxis or treatment of toxoplasma encephalitis in an HIV (human immunodeficiency virus)-infected patient

OR

4 - Treatment for ocular toxoplasmosis in an immunocompetent patient

Product Name:Brand Mepron, generic atovaquone	
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has history of the requested medication within the past 90 days AND 2 - Documentation from prescriber indicating improvement (including stabilization) in current clinical status	

2 . Revision History

Date	Notes
11/5/2021	Updated all criteria to match state policy.

Miotics-Intraocular Pressure Reducers



Prior Authorization Guideline

Guideline ID	GL-280191
Guideline Name	Miotics-Intraocular Pressure Reducers
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	7/1/2025

1 . Criteria

Product Name:lyuzeh	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Trial and failure of latanoprost OR	

2 - Prescriber has provided medical justification for use of lyuzeh over latanoprost

2 . Revision History

Date	Notes
5/28/2025	Removed Simbrinza as a target as it's moving to preferred status.

Miscellaneous Oral Antidiabetic Agents



Prior Authorization Guideline

Guideline ID	GL-288205
Guideline Name	Miscellaneous Oral Antidiabetic Agents
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	7/1/2025

1 . Criteria

Product Name: Brand Riomet, generic metformin solution	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following: 1.1 Patient is 10 years of age or older	

AND	
1.2 Patient is less than 12 years of age	
OR	
2 - Patient is unable to swallow tablets	

Product Name: Brand Duetact, generic pioglitazone/glimepiride, Brand Actoplus Met, generic pioglitazone/metformin	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation that the separate components are unsuitable for use	

2 . Revision History

Date	Notes
5/29/2025	Removed glipizide/metformin, glyburide/metformin, and pioglitazone as targets. Removed inactive GPI for Brand Actoplusmet.

Modeyso



Prior Authorization Guideline

Guideline ID	GL-458421
Guideline Name	Modeyso
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia Medicaid - Community & State Washington

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Modeyso

Diagnosis	Central Nervous System Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following: • Diffuse midline glioma • High-grade glioma AND 2 - Disease is positive for an H3 K27M mutation AND 3 - Disease is ONE of the following: • Recurrent • Progressive	

Product Name:Modeyso	
Diagnosis	Central Nervous System Cancers
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 Modeyso therapy	

Product Name:Modeyso	
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:Modeyso	
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 Modeyso therapy	

2 . Revision History

Date	Notes
12/8/2025	New Program.

Movement Disorder Agents



Prior Authorization Guideline

Guideline ID	GL-285289
Guideline Name	Movement Disorder Agents
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	7/1/2025

1 . Criteria

Product Name:Austedo, Austedo XR, Austedo XR Patient Titration Kit	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following: 1.1 Diagnosis of chorea associated with Huntington's disease and both of the following:	

1.1.1 Patient is 18 years of age or older

AND

1.1.2 Dose does not exceed 48 mg/day

OR

1.2 Diagnosis of tardive dyskinesia and all of the following:

1.2.1 Patient is 18 years of age or older

AND

1.2.2 One of the following:

1.2.2.1 Causative agent (e.g., antipsychotic, dopamine receptor blocking drug, etc.) has been removed from the patient's medication profile

OR

1.2.2.2 Medical rationale was provided as to why the causative agent (e.g., antipsychotic, dopamine receptor blocking drug, etc.) cannot be removed from the patient's medication profile

AND

1.2.3 Dose does not exceed 48 mg/day

Product Name:Austedo, Austedo XR, Austedo XR Patient Titration Kit	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - History of the requested medication for at least 90 days within the past 120 days, confirmed by claims history or chart documentation

AND

2 - Dose does not exceed 48 mg/day

Product Name:Ingrezza

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of chorea associated with Huntington disease

AND

1.2 Patient is 18 years of age or older

AND

1.3 Dose does not exceed 80 mg/day

OR

2 - ALL of the following:

2.1 Diagnosis of tardive dyskinesia

AND

2.2 Patient is 18 years of age or older

AND

2.3 One of the following:

2.3.1 Causative agent (e.g., antipsychotic, dopamine receptor blocking drug, etc.) has been removed from the patient's medication profile

OR

2.3.2 Medical rationale was provided as to why the causative agent (e.g., antipsychotic, dopamine receptor blocking drug, etc.) cannot be removed from the patient's medication profile

AND

2.4 Dose does not exceed 80 mg/day

Product Name:Ingrezza	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested medication for at least 90 days within the past 120 days, confirmed by claims history or chart documentation	

AND

2 - One of the following:

2.1 Diagnosis of chorea associated with Huntington disease

OR

2.2 Diagnosis of tardive dyskinesia

AND

3 - Dose does not exceed 80 mg/day

Product Name:generic tetrabenazine, Brand Xenazine	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following: 1.1 Diagnosis of chorea associated with Huntington's disease and both of the following: 1.1.1 Patient is 18 years of age or older AND 1.1.2 Dose does not exceed 100 mg/day OR	

1.2 Diagnosis of tardive dyskinesia and all of the following:

1.2.1 Patient is 18 years of age or older

AND

1.2.2 One of the following:

1.2.2.1 Causative agent (e.g., antipsychotic, dopamine receptor blocking drug, etc.) has been removed from the patient's medication profile

OR

1.2.2.2 Medical rationale was provided as to why the causative agent (e.g., antipsychotic, dopamine receptor blocking drug, etc.) cannot be removed from the patient's medication profile

AND

1.2.3 Dose does not exceed 200 mg/day

OR

1.3 Both of the following:

1.3.1 Diagnosis of Tourette's syndrome

AND

1.3.2 Dose does not exceed 150 mg/day

OR

1.4 Diagnosis of other hyperkinetic movement disorder (e.g., hemiballismus, senile chorea, tic disorder) and both of the following:

1.4.1 Patient is 18 years of age or older

AND

1.4.2 Dose does not exceed 200 mg/day

Product Name:generic tetrabenazine, Brand Xenazine	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested medication for at least 90 days within the past 120 days, confirmed by claims history or chart documentation AND 2 - ONE of the following: 2.1 Both of the following: 2.1.1 Diagnosis of chorea associated with Huntington's disease AND 2.1.2 Dose does not exceed 100 mg/day OR 2.2 BOTH of the following: 2.2.1 Diagnosis of one of the following:	

- Tardive dyskinesia
- Hyperkinetic movement disorder (e.g., hemiballismus, senile chorea, tic disorder)

AND

2.2.2 Dose does not exceed 200 mg/day

OR

2.3 Both of the following:

2.3.1 Diagnosis of Tourette's syndrome

AND

2.3.2 Dose does not exceed 150 mg/day

2 . Revision History

Date	Notes
6/5/2025	Removed Austedo IR Titration Kit. Updated 1 year(s) authorization length to 12 month(s).

Mozobil



Prior Authorization Guideline

Guideline ID	GL-439226
Guideline Name	Mozobil
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Indiana 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 Medicaid - Community & State Washington Medicaid - Community & State Nevada

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Mozobil, generic plerixafor	
Diagnosis	Hematopoietic Stem Cell Mobilization
Approval Length	30 Day(s)
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	

Product Name:Brand Mozobil, generic plerixafor	
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:Brand Mozobil, generic plerixafor

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 the requested therapy

2 . Revision History

Date	Notes
11/5/2025	Added Nevada Formulary

Multaq



Prior Authorization Guideline

Guideline ID	GL-438187
Guideline Name	Multaq
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 Nevada Medicaid - Community & State Virginia Medicaid - Community & State Indiana Medicaid - Community & State Nebraska Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name: Multaq	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ALL of the following: 1.1 Diagnosis of ONE of the following: • Paroxysmal Atrial Fibrillation (AF) • Persistent AF defined as AF less than 6 months duration AND 1.2 ONE of the following: • Patient is in sinus rhythm • Patient is planned to undergo cardioversion to sinus rhythm AND 1.3 Patient does NOT have New York Heart Association (NYHA) Class IV heart failure AND 1.4 Patient does NOT have symptomatic heart failure with recent decompensation requiring hospitalization OR 2 - For continuation of current therapy	

2 . Revision History

UnitedHealthcare Community Plan of Indiana Clinical Pharmacy Program Guidelines

Date	Notes
11/5/2025	Combined formularies - added NV, VA, IN, NE, NM. No clinical changes.

Multiple Sclerosis



Prior Authorization Guideline

Guideline ID	GL-542264
Guideline Name	Multiple Sclerosis
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:generic teriflunomide, Brand Aubagio, generic fingolimod, Brand Gilenya, generic dimethyl fumarate, Brand Tecfidera, Avonex, Betaseron, generic glatiramer, Glatopa, Brand Copaxone, Rebif, Rebif Rebidose	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of multiple sclerosis	

AND

2 - Dose requested does not exceed established quantity limits in Table 1 of background

Product Name:generic dalfampridine ER

Approval Length	100 Day(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of multiple sclerosis

AND

2 - Prescribed by or in consultation with a neurologist

AND

3 - Dose requested does not exceed established quantity limits in Table 1 of background

Product Name:generic dalfampridine ER

Approval Length	1 year(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation from a neurologist indicating improvement (including stabilization) in gait

AND

2 - Dose requested does not exceed established quantity limits in Table 1 of background

Product Name:Bafiertam	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of multiple sclerosis

AND

2 - ONE of the following:

2.1 BOTH of the following:

- Patient has had a trial of at least 28 days of therapy with Vumerity (diroximel fumarate)
- Patient has had a trial of at least 28 days of therapy with ONE other preferred* agent (excluding Ampyra)

OR

2.2 Medical justification for use of Bafiertam (monomethyl fumarate) over Vumerity and ALL preferred* agents (document rationale)

AND

3 - Prescribed by or in consultation with a neurologist

AND	
4 - Dose requested does not exceed established quantity limits in Table 1 of background	
Notes	*PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name: Briumvi	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of multiple sclerosis AND 2 - Prescribed by, or in consultation with, a neurologist AND 3 - ONE of the following: 3.1 Patient has had a trial of at least 28 days of therapy with ONE preferred* agent (excluding Ampyra) OR 3.2 Medical justification for use of Briumvi over ALL preferred* agents (document rationale) AND	

4 - Dose requested does not exceed established quantity limits in Table 1 of background	
Notes	*PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:Briumvi	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of requested agent in the past 210 days AND 2 - Dose requested does not exceed established quantity limits in Table 1 of background	

Product Name:Kesimpta	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of multiple sclerosis AND 2 - ONE of the following: 2.1 Patient's multiple sclerosis is secondary progressive	

OR

2.2 Patient has had a trial of at least 28 days of therapy with ONE preferred* agent (excluding Ampyra)

OR

2.3 Medical justification for use of Kesimpta over ALL preferred* agents (document rationale)

AND

3 - Prescribed by or in consultation with a neurologist

AND

4 - Dose requested does not exceed established quantity limits in Table 1 of background

Notes

*PDL Link: <https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html>

Product Name:Plegridy

Approval Length 1 year(s)

Therapy Stage Initial Authorization

Guideline Type Prior Authorization

Approval Criteria

1 - Diagnosis of multiple sclerosis

AND

2 - ONE of the following:

2.1 BOTH of the following:

- Trial and failure of Avonex within the past 180 days
- Patient has had a trial of at least 28 days of therapy with ONE different preferred* agent (excluding Ampyra)

OR

2.2 Medical justification for use of Plegridy over ALL preferred* agents (document rationale)

AND

3 - Prescribed by or in consultation with a neurologist

AND

4 - Dose requested does not exceed established quantity limits in Table 1 of background

Notes	*PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:Ocrevus, Ocrevus Zunovo	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of multiple sclerosis AND 2 - ONE of the following: 2.1 Patient's multiple sclerosis is primary progressive	

OR

2.2 Patient has had a trial of at least 28 days of therapy with ONE preferred* agent (excluding Ampyra)

OR

2.3 Medical justification for use of Ocrevus or Ocrevus Zunovo over ALL preferred* agents (document rationale)

AND

3 - Prescribed by or in consultation with a neurologist

AND

4 - Dose requested does not exceed established quantity limits in Table 1 of background

Notes	*PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name: Ocrevus, Ocrevus Zunovo

Approval Length	1 year(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - History of requested agent in the past 210 days

AND

2 - Dose requested does not exceed established quantity limits in Table 1 of background

Product Name:Tascenso ODT	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of multiple sclerosis

AND

2 - Prescribed by or in consultation with a neurologist

AND

3 - ONE of the following:

3.1 Patient is 10 years of age or older, and less than 18 years of age

OR

3.2 Patient is 18 years of age or older and cannot swallow oral capsules [e.g., Gilenya (fingolimod) capsules]

AND

4 - Dose requested does not exceed established quantity limits in Table 1 of background

Product Name:Tascenso ODT	
Approval Length	1 year(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested medication in the past 90 days AND 2 - ONE of the following: • Patient is less than 18 years of age • Patient is 18 years of age or older and cannot swallow oral capsules [e.g., Gilenya (fingolimod) capsules] AND 3 - Dose requested does not exceed established quantity limits in Table 1 of background	

Product Name:Tysabri	
Diagnosis	Multiple Sclerosis
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of multiple sclerosis AND 2 - ONE of the following:	

2.1 Patient has had a trial of at least 28 days of therapy with ONE preferred* agent (excluding Ampyra)

OR

2.2 Medical justification for use of Tysabri over ALL preferred* agents (document rationale)

AND

3 - Prescribed by or in consultation with a neurologist

AND

4 - Dose requested does not exceed established quantity limits in Table 1 of background

Notes

*PDL Link: <https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html>

Product Name:Tysabri	
Diagnosis	Crohn's disease
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Crohn's disease AND 2 - ONE of the following: 2.1 Trial and failure of at least one targeted immunomodulator agent with a Crohn's disease	

indication (adalimumab, certolizumab, infliximab, guselkumab, mirikizumab, risankizumab, upadacitinib, ustekinumab, vedolizumab)

OR

2.2 Medical rationale supporting the use of the requested medication over all targeted immunomodulator agents (document rationale)

Product Name:Zeposia	
Diagnosis	Multiple Sclerosis
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of multiple sclerosis

AND

2 - ONE of the following:

2.1 Patient has had a trial of at least 28 days of therapy with ONE preferred* agent (excluding Ampyra)

OR

2.2 Medical justification for use of Zeposia over ALL preferred* agents (document rationale)

AND

3 - Prescribed by or in consultation with a neurologist

AND

4 - Dose requested does not exceed established quantity limits in Table 1 of background

Notes	*PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:Zeposia	
Diagnosis	Ulcerative Colitis
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderate to severe ulcerative colitis AND 2 - ONE of the following: 2.1 Trial and failure of at least one targeted immunomodulator agent with an ulcerative colitis indication (adalimumab, etrasimod, infliximab, golimumab, guselkumab, mirikizumab, risankizumab, tofacitinib, upadacitinib, ustekinumab, vedolizumab) OR 2.2 Medical rationale supporting the use of the requested medication over all targeted immunomodulator agents (document rationale)	

Product Name:Lemtrada	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of multiple sclerosis AND 2 - ONE of the following: 2.1 Patient has had a trial of at least 28 days of therapy with TWO different preferred* agents (excluding Ampyra) OR 2.2 Medical justification for use of Lemtrada over ALL preferred* agents (document rationale) AND 3 - Prescribed by or in consultation with a neurologist AND 4 - Dose requested does not exceed established quantity limits in Table 1 of background	
Notes	*PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:Lemtrada	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - History of requested agent

AND

2 - Dose requested does not exceed established quantity limits in Table 1 of background

Product Name:Mavenclad, generic cladribine^

Approval Length	4 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of multiple sclerosis or secondary progressive multiple sclerosis

AND

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

AND

3 - ONE of the following:

3.1 Patient has had trials of at least 28 days of therapy with TWO different preferred* agents (excluding Ampyra)

OR

3.2 Medical justification for use of Mavenclad (cladribine) over ALL preferred* agents (document rationale)

AND	
4 - Dose requested does not exceed established quantity limits in Table 1 of background	
Notes	*PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html ^Generic cladribine needs to be reviewed by clinician for generic over brand review

Product Name:Mavenclad, generic cladribine	
Approval Length	4 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested medication AND 2 - BOTH of the following:* • Patient has only received one initial treatment course • 43 weeks have elapsed following completion of the first treatment course AND 3 - Dose requested does not exceed established quantity limits in Table 1 of background	
Notes	*Mavenclad will be granted one reauthorization no earlier than 43 weeks following completion of first treatment course

Product Name:Mayzent	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of multiple sclerosis AND 2 - ONE of the following: 2.1 Patient's multiple sclerosis is secondary progressive OR 2.2 Patient has had trials of at least 28 days of therapy with TWO different preferred* agents (excluding Ampyra) OR 2.3 Medical justification for use of Mayzent over ALL preferred* agents (document rationale) AND 3 - Prescribed by or in consultation with a neurologist AND 4 - Dose requested does not exceed established quantity limits in Table 1 of background	
Notes	*PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:Ponvory	
Approval Length	1 year(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of multiple sclerosis AND 2 - ONE of the following: 2.1 Patient's multiple sclerosis is secondary progressive OR 2.2 Patient has had trials of at least 28 days of therapy with TWO different preferred* agents (excluding Ampyra) OR 2.3 Medical justification for use of Ponvory over ALL preferred* agents (document rationale) AND 3 - Prescribed by or in consultation with a neurologist AND 4 - Dose requested does not exceed established quantity limits in Table 1 of background	
Notes	*PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name: Tyruko

Diagnosis	Multiple Sclerosis
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of multiple sclerosis AND 2 - BOTH of the following: 2.1 Patient has had a trial of at least 28 days of therapy with ONE preferred* agent (excluding Ampyra) AND 2.2 BOTH of the following: • Previous trial of ALL preferred* natalizumab product(s) • Prescriber has provided valid medical justification for the use of the requested non-preferred natalizumab product over ALL of the preferred* natalizumab product(s) (document rationale) AND 3 - Prescribed by or in consultation with a neurologist AND 4 - Dose requested does not exceed established quantity limits in Table 1 of background	
Notes	*PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:Tyruko	
Diagnosis	Crohn's disease
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Crohn's disease AND 2 - BOTH of the following: 2.1 Trial and failure of at least one targeted immunomodulator agent with a Crohn's disease indication (adalimumab, certolizumab, infliximab, guselkumab, mirikizumab, risankizumab, upadacitinib, ustekinumab, vedolizumab) AND 2.2 BOTH of the following: • Previous trial of ALL preferred* natalizumab product(s) • Prescriber has provided valid medical justification for the use of the requested non-preferred natalizumab product over ALL of the preferred* natalizumab product(s) (document rationale)	
Notes	*PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:Tyruko	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - History of the requested medication in the past 90 days

AND

2 - Previous trial of ALL preferred* natalizumab product(s)

AND

3 - Prescriber has provided valid medical justification for the use of the requested non-preferred natalizumab product over ALL of the preferred* natalizumab product(s) (document rationale)

AND

4 - Dose requested does not exceed established quantity limits in Table 1 of background

Notes	*PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:Vumerity	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of multiple sclerosis AND	

2 - ONE of the following:

2.1 BOTH of the following:

2.1.1 Trial and failure of at least 28 days of therapy with dimethyl fumarate (generic of Tecfidera)

AND

2.1.2 Trial and failure of at least 28 days of therapy with ONE other preferred* agent (excluding Ampyra)

OR

2.2 Medical justification for use of Vumerity over dimethyl fumarate (generic of Tecfidera) and ALL other preferred* agents (document rationale)

AND

3 - Prescribed by or in consultation with a neurologist

AND

4 - Dose requested does not exceed established quantity limits in Table 1 of background

Notes	*PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:generic teriflunomide, Brand Aubagio, generic fingolimod, Brand Gilenya, Gilenya, generic dimethyl fumarate, Brand Tecfidera, Avonex, Betaseron, generic glatiramer, Glatopa, Brand Copaxone, Rebif, Rebif Rebidose, Kesimpta, Plegridy, Vumerity, Zeposia, Bafiertam, Extavia, Mayzent, Ponvory, Tysabri

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

Approval Criteria

1 - History of the requested medication in the past 90 days

AND

2 - Dose requested does not exceed established quantity limits in Table 1 of background

2 . Background

Benefit/Coverage/Program Information

Table 1: Quantity Limits

AGENT	QUANTITY LIMIT
Ampyra (dalfampridine)	2 tablets per day
Aubagio (teriflunomide)	1 tablet per day
Avonex (interferon beta-1a)	1 kit (4 vials/syringes/pens) per 28 days
Bafiertam (monomethyl fumarate)	4 tablets (380mg) per day
Betaseron (interferon beta-1b)	1 kit (14 units) per 28 days
Briumvi (ublituximab-xiiy)	150 mg at week 0; 450 mg at week 2; 450 mg at week 24; 450 mg every 24 weeks thereafter
Copaxone, Glatopa (glatiramer)	1 kit (30 units) per 30 days
Gilenya/Tascenso ODT (fingolimod)	1 capsule/orally disintegrating tablet per day
Kesimpta (ofatumumab)	20 mg at weeks 0, 1, 2, and 4; 20 mg monthly thereafter
Lemtrada (alemtuzumab)	5 vials per 365 days on year 1; 3 vials yearly thereafter
Mavenclad (cladribine)	Initial authorization (limited to 1 per lifetime): 2 tablets (20 mg) per day for a total of 10 days (includes two treatment cycles of 5 days each)

	Reauthorization (limited to 1 per lifetime): 2 tablets (20 mg) per day for 10 days (includes two treatment cycles of 5 days each)
Mayzent (siponimod)	1 tablet (1 mg or 2 mg) per day; 1 starter pack per 90 days
Ocrevus (ocrelizumab)	600 mg (20 mL) every 6 months
Ocrevus Zunovo (ocrelizumab)	920 mg (23 mL) every 6 months
Plegridy (peginterferon beta-1a)	1 kit (2 syringes) every 28 days
Ponvory (ponesimod)	1 tablet (20 mg) per day; 1 starter pack per 90 days
Rebif (interferon beta-1a)	1 kit (12 units) per 28 days
Tecfidera (dimethyl fumarate)	2 capsules per day
Tyruko (natalizumab-sztn)	1 vial per 28 days
Tysabri (natalizumab)	1 vial per 28 days
Vumerity (diroximel fumarate)	4 capsules per day
Zeposia (ozanimod)	0.92 mg per day; 1 starter pack per 90 days

3 . Revision History

Date	Notes
3/16/2026	Updated GPI for Plegridy. Removed Brand Ampyra from GL. Added generic cladribine. Added note regarding generic over brand review and updated criteria. Removed criteria for Extavia. Added criteria for Tysabri, Lemtrada, Briumvi, Ocrevus, Ocrevus Zunovo, Tyruko. Updated initial auth criteria for Zeposia. Added QL criteria, where applicable and included QL limit table under Background section. Added "document rationale" for criteria with medical justification for use. Minor cosmetic updates.

Muscular Dystrophy Agents



Prior Authorization Guideline

Guideline ID	GL-424200
Guideline Name	Muscular Dystrophy Agents
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	11/1/2025

1 . Criteria

Product Name: Brand Emflaza, generic deflazacort, Jaythari, Pyquvi	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records documenting diagnosis of Duchenne muscular dystrophy (DMD) confirmed by genetic testing	

AND

2 - Patient is 2 years of age or older

AND

3 - Requested dose does not exceed 0.9mg/kg/day, rounded up to the nearest possible tablet dose or nearest tenth of a milliliter of oral suspension once daily (document weight)

AND

4 - Submission of documentation of current clinical status to compare upon re-evaluations of therapy (e.g. Brooke Score, 6 minute walk test)

Product Name:Brand Emflaza, generic deflazacort, Jaythari, Pyquvi	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested agent within the past 90 days AND 2 - Documentation from prescriber indicating improvement (including stabilization) in current clinical status (e.g. Brooke Score, 6 minute walk test) AND 3 - Requested dose does not exceed 0.9mg/kg/day, rounded up to the nearest possible tablet dose or nearest tenth of a milliliter of oral suspension once daily (document weight)	

Product Name:Agamree	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records documenting diagnosis of Duchenne muscular dystrophy (DMD) confirmed by genetic testing

AND

2 - Patient is 2 years of age or older

AND

3 - ONE of the following:

- Trial and failure of at least 90 days of therapy with Emflaza (deflazacort, Jaythari, Pyquvi), as confirmed by claims history, chart documentation, or provider attestation including dates of trial
- Prescriber has provided valid medical justification for use of Agamree over Emflaza (deflazacort, Jaythari, Pyquvi) (document rationale)

AND

4 - Requested dose does not exceed 6 mg/kg/day (max: 300 mg/day or 2 bottles every 25 days), rounded to the nearest tenth of a mL of oral suspension, once daily (document weight)

AND

5 - Submission of documentation of current clinical status to compare upon re-evaluations of therapy (e.g. Brooke Score, 6 minute walk test)

Product Name:Agamree	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested agent within the past 90 days AND 2 - Documentation from prescriber indicating improvement (including stabilization) in current clinical status (e.g. Brooke Score, 6 minute walk test) AND 3 - Requested dose does not exceed 6 mg/kg/day (max: 300 mg/day or 2 bottles every 25 days), rounded to the nearest tenth of a mL of oral suspension, once daily (document weight)	

2 . Revision History

Date	Notes
10/16/2025	Added Agamree and generic Emflaza

Myalept



Prior Authorization Guideline

Guideline ID	GL-442188
Guideline Name	Myalept
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland 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 Virginia Medicaid - Community & State Nebraska Medicaid - Community & State Pennsylvania Medicaid - Community & State Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Nevada

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name: Myalept	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of congenital or acquired generalized lipodystrophy associated with leptin deficiency

AND

2 - Used as an adjunct to diet modification

AND

3 - Prescribed by an endocrinologist

AND

4 - 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 200 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
11/6/2025	Added Nevada Formulary

Myalept



Prior Authorization Guideline

Guideline ID	GL-442188
Guideline Name	Myalept
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland 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 Virginia Medicaid - Community & State Nebraska Medicaid - Community & State Pennsylvania Medicaid - Community & State Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Nevada

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name: Myalept	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of congenital or acquired generalized lipodystrophy associated with leptin deficiency AND 2 - Used as an adjunct to diet modification AND 3 - Prescribed by an endocrinologist AND 4 - 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 200 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
11/6/2025	Added Nevada Formulary

Myqorzo



Prior Authorization Guideline

Guideline ID	GL-568188
Guideline Name	Myqorzo
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 Indiana Medicaid - Community & State Nevada Medicaid - Community & State Michigan Medicaid - Community & State New Mexico Medicaid - Community & State Nebraska Medicaid - Community & State Washington Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Myqorzo	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of obstructive hypertrophic cardiomyopathy (oHCM) AND 2 - Heart failure is classified as ONE of the following: - New York Heart Association (NYHA) class II heart failure - New York Heart Association (NYHA) class III heart failure AND 3 - Patient had a left ventricular ejection fraction of greater than or equal to 55% AND 4 - Patient had a Valsalva left ventricular outflow tract (LVOT) peak gradient greater than or equal to 50 mmHg at rest or with provocation AND 5 - ONE of the following: 5.1 Failure to ONE of the following as confirmed by claims history or submission of medical records: - Non-vasodilating beta blocker (e.g., atenolol, bisoprolol, metoprolol, propranolol)	

- Nondihydropyridine calcium channel blocker (i.e., diltiazem, verapamil)

OR

5.2 History of contraindication or intolerance to BOTH of the following (please specify contraindication or intolerance):

- Non-vasodilating beta blocker (e.g., atenolol, bisoprolol, metoprolol, propranolol)
- Nondihydropyridine calcium channel blocker (i.e., diltiazem, verapamil)

AND

6 - Not used in combination with another cardiac myosin inhibitor [i.e., Camzyos (mavacamten)]

AND

7 - 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 - Documentation of positive clinical response to therapy (e.g., reduction in NYHA class, no worsening in NYHA class) AND 2 - Patient has a left ventricular ejection fraction of greater than or equal to 50%	

AND

3 - Not used in combination with another cardiac myosin inhibitor [i.e., Camzyos (mavacamten)]

AND

4 - Myqorzo is prescribed by or in consultation with a cardiologist

2 . Revision History

Date	Notes
4/8/2026	Added IN and NV. Updated criteria for a left ventricular ejection fraction and LVOT to clarify these measurements are prior to Myqorzo therapy without change to clinical intent

Mytesi



Prior Authorization Guideline

Guideline ID	GL-228221
Guideline Name	Mytesi
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Indiana 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:	5/1/2025

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

Date	Notes
3/27/2025	Combined formularies. No changes to clinical criteria.

Narcolepsy Agents



Prior Authorization Guideline

Guideline ID	GL-505190
Guideline Name	Narcolepsy Agents
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name: Brand Nuvigil, generic armodafinil	
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 - Patient has ONE of the following diagnoses:

- Narcolepsy with excessive daytime sleepiness
- Obstructive sleep apnea/hypopnea syndrome with residual excessive daytime sleepiness in conjunction with appropriate medical intervention(s)
- Shift work sleep disorder

Product Name: Brand Provigil, generic modafinil

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 - ONE of the following diagnoses:

- Idiopathic hypersomnia
- Narcolepsy with excessive daytime sleepiness
- Obstructive sleep apnea/hypopnea syndrome with residual excessive daytime sleepiness in conjunction with appropriate medical intervention(s)
- Shift work sleep disorder
- Sleep deprivation

Product Name: Brand Nuvigil, generic armodafinil, Brand Provigil, generic modafinil

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - History of the requested medication within the past 90 days

Product Name:Sunosi

Approval Length 3 month(s)

Therapy Stage Initial Authorization

Guideline Type Prior Authorization

Approval Criteria

1 - Patient is 18 years of age or older

AND

2 - ONE of the following diagnoses:

- Narcolepsy with excessive daytime sleepiness
- Obstructive sleep apnea/hypopnea syndrome with residual excessive daytime sleepiness in conjunction with appropriate medical intervention(s)

AND

3 - ONE of the following:

- Previous trial and failure of armodafinil or modafinil (supported by claims history or chart documentation)
- Prescriber has provided valid medical justification for the use of the requested medication over armodafinil and modafinil (please document justification)

Product Name:Wakix

Approval Length 3 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Patient is 6 years of age or older and less than 18 years of age with a diagnosis of narcolepsy with excessive daytime sleepiness OR 1.2 Patient is 18 years of age or older and BOTH of the following: 1.2.1 ONE of the following diagnoses: • Diagnosis of narcolepsy with cataplexy or excessive daytime sleepiness • Diagnosis of obstructive sleep apnea/hypopnea syndrome with residual excessive daytime sleepiness in conjunction with appropriate medical intervention(s) AND 1.2.2 ONE of the following: • Previous trial and failure of armodafinil or modafinil (supported by claims history or chart documentation) • Prescriber has provided valid medical justification for the use of the requested medication over armodafinil and modafinil (please document justification)	

Product Name: Brand Xyrem, generic sodium oxybate^	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Patient is 7 years of age or older

AND

2 - Patient has a diagnosis of narcolepsy with cataplexy or excessive daytime sleepiness

AND

3 - Requested dose does NOT exceed ONE of the following:

- 12 milliliters per day for patients weighing 20 kilograms (kg) to less than 30 kg
- 15 milliliters per day for patients weighing 30 kg to less than 45kg
- 18 milliliters per day for patients weighing at least 45 kg

Notes

^Generic sodium oxybate needs to be reviewed by clinician for generic over brand review

Product Name:Xywav

Approval Length

3 month(s)

Therapy Stage

Initial Authorization

Guideline Type

Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Patient is 7 years of age or older and ALL of the following:

1.1.1 Diagnosis of narcolepsy with cataplexy or excessive daytime sleepiness

AND

1.1.2 Requested dose does NOT exceed ONE of the following:

- 12 milliliters per day for patients weighing 20 kilograms (kg) to less than 30 kg
- 15 milliliters per day for patients weighing 30 kg to less than 45 kg

- 18 milliliters per day for patients weighing at least 45 kg

AND

1.1.3 ONE of the following:

- Previous trial and failure of Xyrem (sodium oxybate) (supported by claims history or chart documentation)
- Prescriber has provided valid medical justification for the use of the requested medication over Xyrem (sodium oxybate) (please document justification)

OR

1.2 Patient is 18 years of age or older and ALL of the following:

1.2.1 Diagnosis of idiopathic hypersomnia

AND

1.2.2 Requested dose does not exceed 18 milliliters per day

AND

1.2.3 ONE of the following:

- Previous trial and failure of modafinil (supported by claims history or chart documentation)
- Prescriber has provided valid medical justification for the use of the requested medication over modafinil (please document justification)

Product Name:Sunosi, Wakix, Brand Xyrem, generic sodium oxybate, Xywav	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - History of the requested medication within the past 90 days

AND

2 - Documentation from prescriber indicating continued benefit from the requested medication (reduction in frequency of cataplexy, reduction in symptoms of excessive daytime sleepiness, etc.) without significant adverse events

2 . Revision History

Date	Notes
1/22/2026	Updated Nuvigil (armodafinil) diagnoses. Updated Provigil (modafinil) diagnoses and age. Updated Sunosi and Wakix initial and reauth criteria. Added step throughs for Xywav.

Natpara



Prior Authorization Guideline

Guideline ID	GL-161410
Guideline Name	Natpara
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2025

1 . Criteria

Product Name:Natpara	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of hypocalcemia resulting from chronic hypoparathyroidism	

AND

2 - Patient is currently on adequate supplemental calcium and active vitamin D (e.g., calcitriol) therapy as evidenced by serum calcium (albumin corrected) greater than 7.5 mg/dL

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 - Documentation of positive clinical response [e.g., total serum calcium level (albumin corrected) within the lower half of the normal range (approximately 8 to 8.5 mg/dL)] 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
12/9/2024	Updated initial authorization criteria.

Nerlynx



Prior Authorization Guideline

Guideline ID	GL-422570
Guideline Name	Nerlynx
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	11/1/2025

1 . Criteria

Product Name:Nerlynx	
Diagnosis	Early-Stage or Node-Positive Breast Cancer

Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ALL of the following: 1.1 Diagnosis of early-stage breast cancer AND 1.2 Disease is human epidermal growth factor receptor 2 (HER2)-positive AND 1.3 Used as extended adjuvant therapy following adjuvant trastuzumab containing therapy (e.g., Herceptin, Kanjinti) AND 1.4 Patient will not have more than 12 months of treatment per occurrence* OR 2 - ALL of the following: 2.1 Diagnosis of node positive breast cancer AND 2.2 Disease is hormone receptor (HR)-positive and HER2-positive AND	

2.3 Used as extended adjuvant therapy following adjuvant trastuzumab containing therapy (e.g., Herceptin, Kanjinti)

AND

2.4 Patient has a perceived high risk of recurrence

AND

2.5 Patient will not have more than 12 months of treatment per occurrence*

Notes	*Duration of coverage is limited to 12 months per occurrence.

Product Name:Nerlynx	
Diagnosis	Advanced or Metastatic Breast Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ALL of the following: 1.1 Diagnosis of advanced or metastatic breast cancer AND 1.2 Disease is human epidermal growth factor receptor 2 (HER2)-positive AND 1.3 Patient has received two or more prior anti-HER2 based regimens in metastatic setting	

AND

1.4 Will be used in combination with capecitabine (generic Xeloda)

OR

2 - BOTH of the following:

2.1 Diagnosis of stage IV (M1) breast cancer

AND

2.2 ONE of the following:

2.2.1 BOTH of the following:

- Disease is hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative disease
- Patient has already received a CDK4/6 inhibitor therapy

OR

2.2.2 Triple negative disease

Product Name:Nerlynx	
Diagnosis	Breast Cancer with Brain Metastases
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of breast cancer	

AND

2 - Patient has brain metastases

AND

3 - Disease is human epidermal growth factor receptor 2 (HER2)-positive

AND

4 - Used in combination with ONE of the following:

- capecitabine (generic Xeloda)
- Paclitaxel

Product Name:Nerlynx	
Diagnosis	Cervical Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of recurrent or metastatic cervical cancer AND 2 - Disease is human epidermal growth factor receptor 2 (HER2)-positive AND	

3 - Used as second-line or subsequent therapy

Product Name:Nerlynx	
Diagnosis	Advanced or Metastatic Breast Cancer, Breast Cancer with Brain Metastases, Cervical 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 Nerlynx therapy	

Product Name:Nerlynx	
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:Nerlynx	
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 Nerlynx therapy

2 . Revision History

Date	Notes
10/22/2025	Updated formularies to include IN for eff 11/1/25. Minor cosmetic updates.

Nexavar



Prior Authorization Guideline

Guideline ID	GL-458425
Guideline Name	Nexavar
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name: Brand Nexavar, generic sorafenib	
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)	

Product Name:Brand Nexavar, generic sorafenib	
Diagnosis	Hepatocellular Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of hepatocellular carcinoma AND 2 - ONE of the following: • Disease is unresectable • Used as subsequent-line therapy	

Product Name:Brand Nexavar, generic sorafenib	
Diagnosis	Thyroid Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of ONE of the following:

- Follicular carcinoma
- Papillary carcinoma

AND

1.2 Disease is ONE of the following:

- Unresectable locoregional recurrent or persistent
- Metastatic

AND

1.3 ONE of the following:

- Patient has symptomatic disease
- Patient has progressive disease

AND

1.4 Disease is refractory to radioactive iodine treatment

OR

2 - BOTH of the following:

2.1 Diagnosis of medullary thyroid carcinoma

AND

2.2 Disease is ONE of the following:

- Recurrent
- Metastatic

Product Name:Brand Nexavar, generic sorafenib	
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: • Angiosarcoma • Desmoid tumors/aggressive fibromatosis • Solitary fibrous tumor/hemangiopericytoma	

Product Name:Brand Nexavar, generic sorafenib	
Diagnosis	Bone Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following: 1.1 Diagnosis of chordoma	

AND	
1.2 Disease is recurrent	
OR	
2 - BOTH of the following:	
2.1 ONE of the following:	
• Diagnosis of osteosarcoma • Diagnosis of dedifferentiated chondrosarcoma • Diagnosis of high-grade undifferentiated pleomorphic sarcoma (UPS)	
AND	
2.2 Not used as first-line therapy	

Product Name:Brand Nexavar, generic sorafenib	
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 (AML) AND 2 - Patient has FLT3-ITD mutation-positive disease	

AND

3 - ONE of the following:

3.1 Used for those who are post-allogeneic stem cell transplantation, in remission

OR

3.2 BOTH of the following:

- Patient has relapsed/refractory disease
- Used in combination with azacitidine or decitabine

Product Name:Brand Nexavar, generic sorafenib	
Diagnosis	Ovarian Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following: • Ovarian cancer • Fallopian tube cancer • Primary peritoneal cancer AND 2 - ONE of the following: • Patient has persistent disease • Patient has recurrent disease	

AND	
3 - Disease is platinum-resistant	
AND	
4 - Used in combination with topotecan	

Product Name:Brand Nexavar, generic sorafenib	
Diagnosis	Salivary Gland Tumor
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of salivary gland tumor AND 2 - Disease is ONE of the following: • Recurrent • Unresectable • Metastatic	

Product Name:Brand Nexavar, generic sorafenib	
Diagnosis	Myeloid/Lymphoid Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of myeloid/lymphoid neoplasm with eosinophilia

AND

2 - Presence of FLT3 gene rearrangement

Product Name: Brand Nexavar, generic sorafenib

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 tumors (GIST)

AND

2 - Disease is ONE of the following:

- Unresectable
- Progressive
- Metastatic

AND

3 - ONE of the following:

3.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- imatinib (generic for Gleevec)
- sunitinib (generic for Sutent)
- Qinlock (ripretinib)
- Stivarga (regorafenib)

OR

3.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- imatinib (generic for Gleevec)
- sunitinib (generic for Sutent)
- Qinlock (ripretinib)
- Stivarga (regorafenib)

Product Name:Brand Nexavar, generic sorafenib	
Diagnosis	Renal Cell Carcinoma (RCC), Hepatocellular Carcinoma, Thyroid Cancer, Soft Tissue Sarcoma, Bone Cancer, Acute Myeloid Leukemia, Ovarian Cancer, Salivary Gland Tumor, Myeloid/Lymphoid Neoplasms, Gastrointestinal Stromal Tumor (GIST)
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 the requested therapy	

Product Name:Brand Nexavar, generic sorafenib	
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:Brand Nexavar, generic sorafenib	
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 the requested therapy	

2 . Revision History

Date	Notes
12/8/2025	Updated formularies to include IN for eff 1/1/26.

Nexavar



Prior Authorization Guideline

Guideline ID	GL-458425
Guideline Name	Nexavar
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name: Brand Nexavar, generic sorafenib	
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)	

Product Name:Brand Nexavar, generic sorafenib	
Diagnosis	Hepatocellular Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of hepatocellular carcinoma AND 2 - ONE of the following: • Disease is unresectable • Used as subsequent-line therapy	

Product Name:Brand Nexavar, generic sorafenib	
Diagnosis	Thyroid Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of ONE of the following:

- Follicular carcinoma
- Papillary carcinoma

AND

1.2 Disease is ONE of the following:

- Unresectable locoregional recurrent or persistent
- Metastatic

AND

1.3 ONE of the following:

- Patient has symptomatic disease
- Patient has progressive disease

AND

1.4 Disease is refractory to radioactive iodine treatment

OR

2 - BOTH of the following:

2.1 Diagnosis of medullary thyroid carcinoma

AND

2.2 Disease is ONE of the following:

- Recurrent
- Metastatic

Product Name:Brand Nexavar, generic sorafenib	
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: • Angiosarcoma • Desmoid tumors/aggressive fibromatosis • Solitary fibrous tumor/hemangiopericytoma	

Product Name:Brand Nexavar, generic sorafenib	
Diagnosis	Bone Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following: 1.1 Diagnosis of chordoma	

AND	
1.2 Disease is recurrent	
OR	
2 - BOTH of the following:	
2.1 ONE of the following:	
• Diagnosis of osteosarcoma • Diagnosis of dedifferentiated chondrosarcoma • Diagnosis of high-grade undifferentiated pleomorphic sarcoma (UPS)	
AND	
2.2 Not used as first-line therapy	

Product Name:Brand Nexavar, generic sorafenib	
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 (AML) AND 2 - Patient has FLT3-ITD mutation-positive disease	

AND

3 - ONE of the following:

3.1 Used for those who are post-allogeneic stem cell transplantation, in remission

OR

3.2 BOTH of the following:

- Patient has relapsed/refractory disease
- Used in combination with azacitidine or decitabine

Product Name:Brand Nexavar, generic sorafenib	
Diagnosis	Ovarian Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following: • Ovarian cancer • Fallopian tube cancer • Primary peritoneal cancer AND 2 - ONE of the following: • Patient has persistent disease • Patient has recurrent disease	

AND	
3 - Disease is platinum-resistant	
AND	
4 - Used in combination with topotecan	

Product Name:Brand Nexavar, generic sorafenib	
Diagnosis	Salivary Gland Tumor
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of salivary gland tumor AND 2 - Disease is ONE of the following: • Recurrent • Unresectable • Metastatic	

Product Name:Brand Nexavar, generic sorafenib	
Diagnosis	Myeloid/Lymphoid Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of myeloid/lymphoid neoplasm with eosinophilia

AND

2 - Presence of FLT3 gene rearrangement

Product Name: Brand Nexavar, generic sorafenib

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 tumors (GIST)

AND

2 - Disease is ONE of the following:

- Unresectable
- Progressive
- Metastatic

AND

3 - ONE of the following:

3.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- imatinib (generic for Gleevec)
- sunitinib (generic for Sutent)
- Qinlock (ripretinib)
- Stivarga (regorafenib)

OR

3.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- imatinib (generic for Gleevec)
- sunitinib (generic for Sutent)
- Qinlock (ripretinib)
- Stivarga (regorafenib)

Product Name:Brand Nexavar, generic sorafenib	
Diagnosis	Renal Cell Carcinoma (RCC), Hepatocellular Carcinoma, Thyroid Cancer, Soft Tissue Sarcoma, Bone Cancer, Acute Myeloid Leukemia, Ovarian Cancer, Salivary Gland Tumor, Myeloid/Lymphoid Neoplasms, Gastrointestinal Stromal Tumor (GIST)
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 the requested therapy	

Product Name:Brand Nexavar, generic sorafenib	
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:Brand Nexavar, generic sorafenib	
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 the requested therapy	

2 . Revision History

Date	Notes
12/8/2025	Updated formularies to include IN for eff 1/1/26.

Niemann Pick Disease Agents



Prior Authorization Guideline

Guideline ID	GL-244337
Guideline Name	Niemann Pick Disease Agents
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/15/2025

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 (submission of genetic confirmation required)	

AND

2 - Submission of medical records (e.g., chart notes) confirming patient is experiencing neurological manifestations (e.g., ataxia, vertical supranuclear gaze palsy, dysarthria, dysphagia, dementia, movement disorders, etc.)

AND

3 - Patient weighs at least 15 kg (kilograms)

AND

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

AND

5 - Patient will not be using Aqneursa (levacetylleucine) in conjunction with Miplyffa (arimoclomol), as confirmed by chart documentation or claim history

AND

6 - Requested dose does not exceed 4 grams daily (112 packets/28 days)

Product Name:Aqneursa	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested agent for 90 of the past 120 days	

AND

2 - Submission of medical records (e.g., chart notes) confirming patient demonstrates positive clinical response to therapy (e.g., improvement/stabilization in neurological symptoms of the disease)

AND

3 - Patient continues to use Aqneursa (levacetylleucine) as monotherapy and not in conjunction with Miplyffa (arimoclomol), as confirmed by chart documentation or claim history

AND

4 - Requested dose does not exceed 4 grams daily (112 packets/28 days)

Product Name:Miplyffa	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Niemann-Pick disease type C (submission of genetic confirmation required) AND 2 - Submission of medical records (e.g., chart notes) confirming patient is experiencing neurological manifestations (e.g., ataxia, vertical supranuclear gaze palsy, dysarthria, dysphagia, dementia, movement disorders, etc.) AND	

3 - Patient is 2 years of age or older and weighs at least 8 kg (kilograms)

AND

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

AND

5 - Patient will be using Miplyffa (arimoclomol) concurrently with miglustat, as confirmed by chart documentation or claim history

AND

6 - Patient will not be using Miplyffa (arimoclomol) in conjunction with Aqneursa (levacetylleucine), as confirmed by chart documentation or claim history

AND

7 - Requested dose does not exceed 372 milligrams daily

Product Name:Miplyffa	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested agent for 90 of the past 120 days AND	

2 - Submission of medical records (e.g., chart notes) confirming patient demonstrates positive clinical response to therapy (e.g., improvement/stabilization in neurological symptoms of the disease)

AND

3 - Patient will continue to use Miplyffa (arimoclomol) in conjunction with miglustat, as confirmed by chart documentation or claim history

AND

4 - Patient continues to not use Miplyffa (arimoclomol) in conjunction with Aqneursa (levacetylleucine), as confirmed by chart documentation or claim history

AND

5 - Requested dose does not exceed 372 milligrams daily

2 . Revision History

Date	Notes
4/29/2025	New state mandated guideline

Ninlaro



Prior Authorization Guideline

Guideline ID	GL-351197
Guideline Name	Ninlaro
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia Medicaid - Community & State Washington

Guideline Note:

Effective Date:	9/1/2025

1 . Criteria

Product Name:Ninlaro

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:Ninlaro	
Diagnosis	Systemic Light Chain Amyloidosis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of relapsed or refractory systemic light chain amyloidosis	

Product Name:Ninlaro	
Diagnosis	Waldenström Macroglobulinemia/Lymphoplasmacytic Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Waldenström macroglobulinemia/lymphoplasmacytic lymphoma AND	

2 - Used in combination with rituximab and dexamethasone

Product Name:Ninlaro	
Diagnosis	Multiple Myeloma, Systemic Light Chain Amyloidosis, Waldenström Macroglobulinemia/Lymphoplasmacytic Lymphoma
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 Ninlaro therapy	

Product Name:Ninlaro	
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:Ninlaro	
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 Ninlaro therapy

2 . Revision History

Date	Notes
7/30/2025	Combined formularies. No changes to clinical criteria.

Nityr



Prior Authorization Guideline

Guideline ID	GL-442190
Guideline Name	Nityr
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 Indiana Medicaid - Community & State Nebraska Medicaid - Community & State New Mexico Medicaid - Community & State Pennsylvania Medicaid - Community & State Virginia Medicaid - Community & State Nevada

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Nityr	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of hereditary tyrosinemia type 1	

2 . Revision History

Date	Notes
11/6/2025	Added Nevada Formulary

Nocdurna



Prior Authorization Guideline

Guideline ID	GL-228222
Guideline Name	Nocdurna
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Indiana Medicaid - Community & State Maryland Medicaid - Community & State Michigan 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 Medicaid - Community & State Washington

Guideline Note:

Effective Date:	5/1/2025

1 . Criteria

Product Name:Nocdurna	
Approval Length	12 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 Nocdurna 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
3/27/2025	Combined formularies. No changes to clinical criteria.

Nocdurna



Prior Authorization Guideline

Guideline ID	GL-228222
Guideline Name	Nocdurna
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Indiana Medicaid - Community & State Maryland Medicaid - Community & State Michigan 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 Medicaid - Community & State Washington

Guideline Note:

Effective Date:	5/1/2025

1 . Criteria

Product Name:Nocdurna	
Approval Length	12 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 Nocdurna 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
3/27/2025	Combined formularies. No changes to clinical criteria.

Non-Preferred Drugs



Prior Authorization Guideline

Guideline ID	GL-577277
Guideline Name	Non-Preferred Drugs
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Non-Preferred Drugs	
Approval Length	12 month(s)
Guideline Type	Administrative
Approval Criteria 1 - If the requested medication is a behavioral health medication, ONE of the following: 1.1 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

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

OR

2 - ALL of the following:

2.1 One of the following:

2.1.1 All of the following:

2.1.1.1 One of the following:

- History of failure to at least THREE preferred alternatives 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.
- History of contraindication or intolerance to THREE preferred alternatives (please specify contraindication or intolerance).* 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.

AND

2.1.1.2 One of the following:

2.1.1.2.1 If the request is for a multi-source brand medication, OR a branded medication with an authorized generic, one of the following:

- The brand is being requested because of an adverse reaction, allergy or sensitivity to a generic/authorized generic equivalent (specify the adverse reaction, allergy, or sensitivity)
- The brand is being requested due to an incomplete response with a generic/authorized generic equivalent, as documented by submission of medical records
- The brand is being requested because transition to a generic/authorized generic equivalent could result in destabilization of the patient.

- Special clinical circumstances exist that preclude the use of a generic/authorized generic equivalent of the brand medication for the patient (document special clinical circumstances)

OR

2.1.1.2.2 If the request is for a generic when there is a brand available and brand is either preferred over the generic OR both are non-preferred and the brand is required, one of the following:

- The generic is being requested because of an adverse reaction, allergy or sensitivity to the brand (specify the adverse reaction, allergy, or sensitivity).
- The generic is being requested due to an incomplete response with the brand, as documented by submission of medical records.
- The generic is being requested because transition to the brand could result in destabilization of the patient.
- Special clinical circumstances exist that preclude the use of the brand equivalent of the generic medication for the patient (document special clinical circumstances).

AND

2.1.1.3 If the request is for an oral non-solid dosage form (e.g., suspension) when there is an equivalent solid dosage form available, one of the following:

- Patient is unable to swallow a solid dosage form
- Patient utilizes a feeding tube for medication administration
- Request is for a nebulized formulation of an inhaled agent 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

OR

2.1.2 There are no preferred formulary alternatives for the requested drug.

AND

2.2 One of the following:

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

OR

2.2.2 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 (USP-NF)

AND

2.3 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	*IN PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html . 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.

Product Name:PA Required Medications For a New Indication Not Addressed in Drug Specific Guideline	
Approval Length	12 month(s)
Guideline Type	Administrative
Approval Criteria 1 - Both of the following: 1.1 Diagnosis is consistent with an indication listed in the product's FDA-approved prescribing information (or package insert) AND 1.2 All of the following labeling requirements have been met:	

1.2.1 All requirements listed in the “Indications and Use” have been met (e.g., pre-requisite treatment, any testing requirements have been met, etc.)

AND

1.2.2 Prescribed medication is approved for the patient’s age

AND

1.2.3 “Dosage and Administration” section of the prescribing information (or package insert) has been met

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 - If the requested medication is non-preferred, patient meets the non-preferred criteria as applicable

Notes	These criteria come from PA Required Medications For a New Indication Not Addressed in Drug Specific Guideline policy.

2 . Revision History

Date	Notes
4/15/2026	Added criteria for non-solid dosage forms

Non-SUPDL Agents Prior Authorization and Step Therapy



Prior Authorization Guideline

Guideline ID	GL-599200
Guideline Name	Non-SUPDL Agents Prior Authorization and Step Therapy
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Abrysvo	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Patient is 50 years of age or older	

OR

1.2 BOTH of the following:

1.2.1 Patient is 11 years of age or older and less than 50 years of age

AND

1.2.2 Submission of medical records confirming patient is between 32 and 36 weeks gestation during the months of September through January

AND

2 - The request does NOT exceed the limit of 1 dose/lifetime

Product Name: Brand Cambia, generic diclofenac packet	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of migraine with or without aura AND 2 - ONE of the following: 2.1 Patient has had a trial and failure of at least 14 days of generic diclofenac oral tablets OR	

2.2 Prescriber has submitted valid medical justification for the use of Cambia over generic diclofenac tablets

Product Name: Brand Cambia, generic diclofenac packet

Approval Length 12 month(s)

Therapy Stage Reauthorization

Guideline Type Prior Authorization

Approval Criteria

1 - Patient has a history of the requested agent within the past 90 days, confirmed by claims history or submission of medical records

Product Name: Brand Carospir, generic spironolactone suspension

Approval Length 12 month(s)

Therapy Stage Initial Authorization

Guideline Type Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., charts, progress notes, etc.) confirming patient is unable to swallow tablet formulation

Product Name: Brand Carospir, generic spironolactone suspension

Approval Length 12 month(s)

Therapy Stage Reauthorization

Guideline Type Prior Authorization

Approval Criteria

1 - Patient has a history of the requested agent within the past 90 days, confirmed by claims history or submission of medical records

AND

2 - Submission of medical records (e.g., charts, progress notes, etc.) confirming patient is unable to swallow tablet formulation

Product Name:minocycline ER tablet

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has had a trial of the minocycline IR capsule formulation in the past 30 days

OR

2 - Prescriber has submitted valid medical justification for the use of minocycline ER over the IR capsule formulation

OR

3 - Patient has a history of the requested agent within the past 90 days, confirmed by claims history or submission of medical records

Product Name:Coxanto, Oxaprozin capsules

Approval Length	3 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Patient has had a trial of Daypro (oxaprozin) tablet in the past 30 days

OR

1.2 Prescriber has submitted valid medical justification for the use of Coxanto (Oxaprozin) capsule over Daypro (oxaprozin) tablet formulation

AND

2 - Requested dose does NOT exceed 1,200 milligrams (4 capsules) per day

Product Name:Crexont	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Patient has had previous trial and failure history of at least 90 days of therapy with generic carbidopa/levodopa extended release (ER) tablet formulation OR 1.2 Prescriber has submitted valid medical justification for the use of Crexont (carbidopa/levodopa) ER capsules over generic carbidopa/levodopa ER tablets AND 2 - Requested dose does NOT exceed 525 mg (milligrams) carbidopa/2,100 mg levodopa per day	

Product Name:Crexont	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has a history of the requested agent within the past 90 days, confirmed by claims history or submission of medical records AND 2 - Requested dose does NOT exceed 525 mg (milligrams) carbidopa/2,100 mg levodopa per day	

Product Name:DermacinRx Ribotin-E	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Prescriber has provided medical justification as to why supplementation with any or all of the following are not suitable for the patient's needs: multivitamin with minerals and iron, folic acid (please document justification) OR 2 - Submission of medical records (chart notes and lab values required) confirming history of trial and failure of supplementation with the following separate components: multivitamin with minerals and iron, folic acid OR	

3 - Patient has a history of the requested agent within the past 90 days, confirmed by claims history or submission of medical records

Product Name:Elfolate, generic L-methylfolate	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of copy of genetic testing confirming patient has a MTHFR (methylenetetrahydrofolate reductase) gene mutation resulting in diminished MTHFR enzyme function AND 2 - Patient has a diagnosis of mood disorder or depression that has been attributed to the MTHFR gene mutation	

Product Name:Elfolate, generic L-methylfolate	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has a history of the requested agent within the past 60 days, confirmed by claims history only (chart notes/prescriber attestation will not be accepted for reauthorization) AND 2 - Submission of medical records (e.g., charts, progress notes, etc.) demonstrating improvement or continued benefit in patient's clinical status	

Product Name:Eohilia	
Approval Length	12 Week(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., charts, progress notes, etc.) confirming diagnosis of eosinophilic esophagitis (documentation of histological evidence and clinical symptoms consistent with diagnosis required) AND 2 - Patient is 11 years of age or older AND 3 - Dose does NOT exceed 4 milligrams (20 milliliters) per day AND 4 - Request does NOT exceed 12 weeks of total therapy per patient's lifetime	

Product Name:Folditam	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Prescriber has provided medical justification as to why supplementation with any or all of the following are not suitable for the patient's needs: folic acid, cholecalciferol (please document justification)	

OR

2 - Submission of medical records (chart notes and lab values required) confirming history of trial and failure of supplementation with the following separate components: folic acid, cholecalciferol

OR

3 - Patient has a history of the requested agent within the past 90 days, confirmed by claims history or submission of medical records

Product Name:Folite	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Prescriber has provided medical justification as to why supplementation with any or all of the following are not suitable for the patient's needs: folic acid, cholecalciferol, magnesium, calcium (please document justification) OR 2 - Submission of medical records (chart notes and lab values required) confirming history of trial and failure of supplementation with the following separate components: folic acid, cholecalciferol, magnesium, calcium OR 3 - Patient has a history of the requested agent within the past 90 days, confirmed by claims history or submission of medical records	

Product Name:Gimoti

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 - Diagnosis of diabetic gastroparesis AND 3 - ONE of the following: • Patient has had a trial and failure of oral generic metoclopramide • Prescriber has submitted valid medical justification of the use of metoclopramide nasal spray over oral metoclopramide	

Product Name:Gimoti	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has a history of the requested agent within the past 90 days, confirmed by claims history or submission of medical records	

Product Name:generic indomethacin suspension	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., charts, progress notes, etc.) confirming patient is unable to swallow capsule formulation	

Product Name:generic indomethacin suspension	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has a history of the requested agent within the past 90 days, confirmed by claims history or submission of medical records AND 2 - Submission of medical records (e.g., charts, progress notes, etc.) confirming patient is unable to swallow capsule formulation	

Product Name:Fluad, Fluzone HD	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Patient is 65 years of age or older	

OR

1.2 BOTH of the following:

1.2.1 Patient is 18 years of age or older and less than 65 years of age

AND

1.2.2 Submission of medical records (e.g., charts, progress notes, etc.) confirming patient has had a solid organ transplant and is receiving immunosuppressive medication

Product Name:eplerenone	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has had a trial and failure of spironolactone OR 2 - Prescriber has submitted valid medical justification for the use of eplerenone over spironolactone OR 3 - Patient has a history of the requested agent within the past 90 days, confirmed by claims history or submission of medical records	

Product Name:Inzirgo	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., charts, progress notes, etc.) confirming patient is unable to swallow capsule or tablet formulations	

Product Name:Inzirqo	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has a history of the requested agent within the past 90 days, confirmed by claims history or submission of medical records AND 2 - Submission of medical records (e.g., charts, progress notes, etc.) confirming patient is unable to swallow capsule or tablet formulations	

Product Name:Journavx	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is 18 years of age or older AND	

2 - Request does NOT exceed the plan limitation maximum of 7-day supply with a subsequent claim(s) not to exceed 7-day supply (for a total of 14 days of therapy, maximum of 29 tablets) every 90 days

Product Name:Jylamvo	
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 medical records (e.g., charts, progress notes, etc.) confirming patient is unable to swallow tablet formulation	

Product Name:Jylamvo	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has a history of the requested agent within the past 90 days, confirmed by claims history or submission of medical records AND 2 - Submission of medical records (e.g., charts, progress notes, etc.) confirming patient is unable to swallow tablet formulation	

Product Name:Kerendia	
Diagnosis	Chronic kidney disease in type 2 diabetes mellitus (T2DM)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chronic kidney disease in type 2 diabetes mellitus (T2DM) with submission of medical records (e.g., charts, progress notes, labs, etc.) confirming BOTH the following, obtained within the past 6 months: • Estimated glomerular filtration rate (eGFR) of greater than or equal to 25 mL/min/1.73 m² • Persistent albuminuria with urinary albumin-to-creatinine ratio (UACR) greater than or equal to 30 mg/g (milligrams per gram) AND 2 - Submission of medical records (e.g., charts, progress notes, labs, etc.) obtained within the past 30 days confirming the patient has a serum potassium of less than or equal to 5.0 mEq/L (milliequivalents per liter) AND 3 - Patient is 18 years of age or older AND 4 - ONE of the following: 4.1 BOTH of the following: • Patient has utilized angiotensin-converting enzyme inhibitor (ACE-I) or angiotensin receptor blocker (ARB) therapy at a maximally tolerated dose for 90 of the past 120 days (confirmed by claims history or submission of medical records)	

- Patient will continue ACE-I or ARB therapy while using Kerendia (finerenone)

OR

4.2 Prescriber has submitted valid medical justification for the use of Kerendia (finerenone) without the concomitant use of max tolerated dose of an ACE-I or ARB agent

AND

5 - ONE of the following:

5.1 BOTH of the following:

- Patient has utilized sodium-glucose cotransporter-2 inhibitor (SGLT2i) for 90 of the past 120 days (confirmed by claims history or submission of medical records)
- Patient will continue SGLT2i therapy while using Kerendia (finerenone)

OR

5.2 Prescriber has submitted valid medical justification for the use of Kerendia (finerenone) without the concomitant use of an SGLT2i

AND

6 - Dose requested does not exceed 20 mg/day (milligrams per day)

Product Name:Kerendia	
Diagnosis	Chronic kidney disease in type 2 diabetes mellitus (T2DM)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chronic kidney disease in type 2 diabetes mellitus (T2DM)	

AND

2 - Patient has a history of the requested agent within the past 90 days, confirmed by claims history or submission of medical records

AND

3 - ONE of the following:

- Patient has utilized and will continue to utilize angiotensin-converting enzyme inhibitor (ACE-I) or angiotensin receptor blocker (ARB) therapy at a maximally tolerated dose while on Kerendia (finerenone) therapy
- Prescriber has submitted valid medical justification for the use of the Kerendia (finerenone) without the concomitant use of maximally tolerated dose of an ACE-I or ARB agent

AND

4 - ONE of the following:

- Patient has utilized and will continue to utilize sodium-glucose cotransporter-2 inhibitor (SGLT2i) while on Kerendia (finerenone) therapy
- Prescriber has submitted valid medical justification for the use of Kerendia (finerenone) without the concomitant use of an SGLT2i

AND

5 - Dose requested does not exceed 20 mg/day (milligrams per day)

Product Name:Kerendia	
Diagnosis	Heart failure
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of heart failure

AND

2 - BOTH of the following:

2.1 Submission of medical records (e.g., charts, progress notes, labs, etc.) of an estimated glomerular filtration rate (eGFR) AND cardiac test (e.g., ECHO) obtained within the past 6 months

AND

2.2 The submitted documentation from step 2.1 above confirms ALL of the following:

- Left ventricular ejection fraction of greater than or equal to 40%
- New York Heart Association class II-IV symptoms
- eGFR greater than or equal to 25 mL/min/1.73 m²

AND

3 - Submission of medical records (e.g., charts, progress notes, labs, etc.) obtained within the past 30 days confirming the patient has a serum potassium of less than or equal to 5.0 mEq/L (milliequivalents per liter)

AND

4 - Patient is 18 years of age or older

AND

5 - ONE of the following:

- Patient has had trial and failure history with spironolactone or eplerenone after diagnosis of heart failure with mildly reduced ejection fraction (HFmrEF) or heart

failure with preserved ejection fraction (HFpEF) (confirmed by claims history or submission of medical records)

- Prescriber has submitted valid medical justification for the use of Kerendia (finerenone) over spironolactone and eplerenone

AND

6 - ONE of the following:

6.1 BOTH of the following:

- Patient has been receiving sodium-glucose cotransporter-2 inhibitor (SGLT2i) (confirmed by claims history or submission of medical records)
- Patient will continue SGLT2i therapy while using Kerendia (finerenone)

OR

6.2 Prescriber has submitted valid medical justification for the use of Kerendia (finerenone) without the concomitant use of an SGLT2i

AND

7 - Prescriber attests that patient will not use Kerendia (finerenone) with other mineralocorticoid receptor antagonists containing therapy (e.g., eplerenone, hydrochlorothiazide/spironolactone, spironolactone)

AND

8 - Dose requested does not exceed 40 mg/day (milligrams per day)

Product Name:Kerendia	
Diagnosis	Heart failure
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of heart failure

AND

2 - Patient has a history of the requested agent within the past 90 days, confirmed by claims history or submission of medical records

AND

3 - ONE of the following:

- Patient has utilized and will continue to utilize sodium-glucose cotransporter-2 inhibitor (SGLT2i) while on Kerendia (finerenone) therapy
- Prescriber has submitted valid medical justification for the use of Kerendia (finerenone) without the concomitant use of an SGLT2i

AND

4 - Prescriber attests that patient will not use Kerendia (finerenone) with other mineralocorticoid receptor antagonists containing therapy (e.g., eplerenone, hydrochlorothiazide/spironolactone, spironolactone)

AND

5 - Dose requested does not exceed 40 mg/day (milligrams per day)

Product Name:Khindivi	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is 5 years of age or older and less than 18 years of age

AND

2 - Submission of medical records (e.g., charts, progress notes, etc.) confirming patient has a diagnosis of adrenocortical insufficiency

AND

3 - Submission of medical records (e.g., charts, progress notes, etc.) confirming ONE of the following:

3.1 Patient is unable to swallow tablet formulation

OR

3.2 Patient's dosing regimen is not conducive to utilizing whole tablet strengths that are commercially available

Product Name:Khindivi	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has a history of the requested agent within the past 90 days, confirmed by claims history or submission of medical records AND	

2 - Submission of medical records (e.g., charts, progress notes, etc.) confirming ONE of the following:

2.1 Patient is unable to swallow tablet formulation

OR

2.2 Patient's dosing regimen is not conducive to utilizing whole tablet strengths that are commercially available

Product Name:Likmez	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Patient is less than 12 years of age OR 1.2 Patient is 12 years of age or older AND submission of medical records (e.g., charts, progress notes, etc.) confirming patient is unable to swallow capsule/tablet formulation	

Product Name:Lodoco	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is 18 years of age or older	

AND

2 - Patient has established atherosclerotic disease or has multiple risk factors for cardiovascular disease

AND

3 - Prescriber is using Lodoco (colchicine) for risk reduction of myocardial infarction, stroke, coronary revascularization, and cardiovascular death

AND

4 - Requested dose does NOT exceed 1 tablet (0.5 milligram) per day

Product Name:minocycline tablet	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has had a trial of the minocycline IR capsule formulation in the past 30 days OR 2 - Prescriber has submitted valid medical justification for the use of minocycline tablet over the IR capsule formulation OR 3 - Patient has a history of the requested agent within the past 90 days, confirmed by claims history or submission of medical records	

Product Name: Myhibbin	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Previous trial of reconstituted mycophenolate suspension (generic CellCept suspension), as confirmed by claims history, submission of medical records, or provider documents dates of trial (document dates of trial, if applicable)

OR

1.2 Medical justification for use of Myhibbin (mycophenolate mofetil) suspension over reconstituted mycophenolate suspension (generic CellCept suspension) (please document justification)

AND

2 - ONE of the following:

2.1 Patient is less than 12 years of age

OR

2.2 Patient is 12 years of age or older AND submission of medical records (e.g., charts, progress notes, etc.) confirming patient is unable to swallow capsule/tablet formulation

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

Approval Criteria

1 - Patient has a history of the requested agent within the past 90 days, confirmed by claims history or submission of medical records

AND

2 - ONE of the following:

2.1 Patient is less than 12 years of age

OR

2.2 Patient is 12 years of age or older AND submission of medical records (e.g., charts, progress notes, etc.) confirming patient is unable to swallow capsule/tablet formulation

Product Name:Nuzyra

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has had a trial and failure of another tetracycline agent (minocycline, doxycycline, etc.) in the past 30 days

OR

2 - Prescriber has submitted valid medical justification for the use of Nuzyra (omadacycline) over other tetracycline agents

Product Name:Oravig

Approval Length	12 month(s)

Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has had a trial and failure of clotrimazole troches, nystatin tablets, or nystatin suspension OR 2 - Prescriber has submitted valid medical justification for the use of Oravig (miconazole buccal tab) over clotrimazole troches, nystatin tablets, and nystatin suspension	

Product Name:Rytary, Carbidopa/levodopa ER capsules^	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Patient has had previous trial and failure history of at least 90 days of therapy with generic carbidopa/levodopa extended release (ER) tablet formulation OR 1.2 Prescriber has submitted valid medical justification for the use of Rytary (carbidopa/levodopa) ER capsules over generic carbidopa/levodopa ER tablets AND 2 - Requested dose does NOT exceed 612.5 mg (milligrams) carbidopa/2,450 mg levodopa per day	

Notes	^Carbidopa/levodopa ER capsules need to be reviewed by clinician for generic over brand review

Product Name:Rytary, Carbidopa/levodopa ER capsules	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has a history of the requested agent within the past 90 days, confirmed by claims history or submission of medical records AND 2 - Requested dose does NOT exceed 612.5 mg (milligrams) carbidopa/2,450 mg levodopa per day	

Product Name:Shingrix	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Patient is 50 years of age or older OR 1.2 BOTH of the following: 1.2.1 Patient is 19 years of age or older and less than 50 years of age	

AND

1.2.2 Patient is or will be at increased risk of herpes zoster infection due to immunodeficiency or immunosuppression

Product Name:Siklos	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Patient is less than 12 years of age OR 1.2 Patient is 12 years of age or older and ONE of the following: • Submission of medical records (e.g., charts, progress notes, etc.) confirming patient is unable to swallow capsule formulation • Prescriber has submitted medical justification for the use of Siklos (hydroxyurea) tablet over hydroxyurea capsules	

Product Name:Sprix	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Prescriber has submitted valid medical justification for the use of ketorolac nasal spray over ketorolac oral tablets

AND

2 - Requested duration of therapy does not exceed 5 days

AND

3 - Requested quantity does NOT exceed 1 box per 28 days

Product Name: Sprix

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - History of the requested agent within the past 90 days, confirmed by claims history or submission of medical records

AND

2 - Requested duration of therapy does not exceed 5 days

AND

3 - Requested quantity does NOT exceed 1 box per 28 days

Product Name: Brand Tekturna, generic aliskiren

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has had a trial and failure of at least two ACE (angiotensin-converting enzyme) inhibitors and/or ARB's (angiotensin receptor blocker) in the past 90 days

OR

2 - Prescriber has submitted valid medical justification for the use of aliskiren fumarate over other ACE inhibitor/ARB agents

OR

3 - Patient has a history of the requested agent within the past 90 days, confirmed by claims history or submission of medical records

Product Name: Tezruly	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., charts, progress notes, etc.) confirming patient is unable to swallow capsule formulation	

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

Approval Criteria

1 - Patient has a history of the requested agent within the past 90 days, confirmed by claims history or submission of medical records

AND

2 - Submission of medical records (e.g., charts, progress notes, etc.) confirming patient is unable to swallow capsule formulation

Product Name:Tirosint-sol

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Patient is less than 12 years of age

OR

1.2 Patient is 12 years of age or older AND submission of medical records (e.g., charts, progress notes, etc.) confirming patient is unable to swallow capsule formulation

Product Name:Tirosint-sol

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has a history of the requested agent within the past 90 days, confirmed by claims history or submission of medical records

AND

2 - ONE of the following:

2.1 Patient is less than 12 years of age

OR

2.2 Patient is 12 years of age or older AND submission of medical records (e.g., charts, progress notes, etc.) confirming patient is unable to swallow capsule formulation

Product Name:Thyquidity	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Patient is less than 12 years of age OR 1.2 Patient is 12 years of age or older AND submission of medical records (e.g., charts, progress notes, etc.) confirming patient is unable to swallow tablet formulation	

Product Name:Thyquidity	
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has a history of the requested agent within the past 90 days, confirmed by claims history or submission of medical records AND 2 - ONE of the following: 2.1 Patient is less than 12 years of age OR 2.2 Patient is 12 years of age or older AND submission of medical records (e.g., charts, progress notes, etc.) confirming patient is unable to swallow tablet formulation	

Product Name: Tryvio	
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 medical records (e.g., charts, progress notes, etc.) confirming patient has a diagnosis of hypertension that is inadequately controlled	

AND

3 - ONE of the following:

3.1 Patient has previous trial and failure of at least four weeks of combination antihypertensive therapy at maximally tolerated doses with an agent from EACH of the following pharmacological classes: calcium channel blockers, diuretics, mineralocorticoid receptor antagonists, and renin- angiotensin-aldosterone system antagonists (e.g., ACE-inhibitors or ARBs)

OR

3.2 BOTH of the following:

- Prescriber has provided medical justification for use of Tryvio (document rationale)
- Prescriber has submitted documented contraindication or intolerance to any pharmacological class listed above that the patient has not trialed

AND

4 - For patients of childbearing potential, the prescriber must submit a negative pregnancy test obtained within the past 30 days

AND

5 - Dose requested does not exceed 12.5 mg (1 tablet) once daily

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

1 - Patient has a history of the requested agent within the past 90 days, confirmed by claims history or submission of medical records

AND

2 - Dose requested does not exceed 12.5 mg (1 tablet) once daily

Product Name:meloxicam capsules

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has had a trial and failure of at least 60 days of generic meloxicam oral tablets

OR

2 - Prescriber has submitted valid medical justification for the use of the requested agent over generic meloxicam tablets

OR

3 - Patient has a history of the requested agent within the past 90 days, confirmed by claims history or submission of medical records

Product Name:Voquezna tablets

Diagnosis	Erosive esophagitis

Approval Length	Active treatment of erosive esophagitis: 8 weeks; Maintenance of healed erosive esophagitis: 6 months

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of erosive esophagitis with gastroesophageal reflux disease (GERD) symptoms needing active treatment or maintenance of healing of erosive esophagitis and ONE of the following:

- Patient has tried and failed two standard dose proton pump inhibitors (PPI)* for a total of 8 weeks each in the past 6 months, as confirmed by claims history, submission of medical records, or provider documents dates of trial (document dates of trial, if applicable)
- Prescriber has submitted medical justification for use of Voquezna (vonoprazan) over ALL PPIs (any medical justification regarding intolerance or adverse effects must be supported by documentation within submitted chart notes)

AND

2 - Requested dose and duration of therapy will NOT exceed one of the following:

- Active treatment of erosive esophagitis: 20 mg (milligrams) once daily for 8 weeks
- Maintenance treatment of healed erosive esophagitis: 10 mg once daily for 6 months

AND

3 - Patient is 18 years of age or older

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:Voquezna tablets	
Diagnosis	Non-erosive esophagitis with gastroesophageal reflux disease (GERD)
Approval Length	4 Week(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of symptomatic non-erosive esophagitis with gastroesophageal reflux disease (GERD) requiring heartburn relief and ONE of the following:	

- Patient has tried and failed one standard dose proton pump inhibitors (PPI)* for a total of 4 weeks AND one standard dose histamine 2 receptor antagonist (h2RA) for 2 weeks, in the past 6 months, as confirmed by claims history, submission of medical records, or provider documents dates of trial (document dates of trial, if applicable)
- Prescriber has submitted medical justification for use of Voquezna (vonoprazan) over ALL PPIs and/or H2RAs (any medical justification regarding intolerance or adverse effects must be supported by documentation within submitted chart notes)

AND

2 - Requested dose and duration of therapy will NOT exceed 10 mg (milligrams) once daily for 4 weeks

AND

3 - If the request is for reauthorization, 6 months has elapsed since last course of therapy

AND

4 - Patient is 18 years of age or older

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:Xatemp

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

Approval Criteria

1 - ONE of the following:

1.1 Patient is less than 12 years of age

OR

1.2 Patient is 12 years of age or older AND submission of medical records (e.g., charts, progress notes, etc.) confirming patient is unable to swallow tablet formulation

Product Name:Xatemp	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has a history of the requested agent within the past 90 days, confirmed by claims history or submission of medical records AND 2 - ONE of the following: 2.1 Patient is less than 12 years of age OR 2.2 Patient is 12 years of age or older AND submission of medical records (e.g., charts, progress notes, etc.) confirming patient is unable to swallow tablet formulation	

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

1 - ONE of the following:

1.1 Patient is less than 12 years of age

OR

1.2 Patient is 12 years of age or older and ONE of the following:

- Submission of medical records (e.g., charts, progress notes, etc.) confirming patient is unable to swallow capsule formulation
- Prescriber has submitted medical justification for the use of Xromi (hydroxyurea) solution over hydroxyurea capsules

Product Name: Brand Zipsor, generic diclofenac capsules	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has had a trial and failure of at least 60 days of generic diclofenac oral tablets OR 2 - Prescriber has submitted valid medical justification for the use of Zipsor (diclofenac) capsules over generic diclofenac tablets OR 3 - Patient has a history of the requested agent within the past 90 days, confirmed by claims history or submission of medical records	

2 . Revision History

UnitedHealthcare Community Plan of Indiana Clinical Pharmacy Program Guidelines

Date	Notes
4/30/2026	Updated Siklos criteria. Added multiple drugs to align with policy.

Northera



Prior Authorization Guideline

Guideline ID	GL-442191
Guideline Name	Northera
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Indiana 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 Medicaid - Community & State Nevada

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name: Brand Northera, generic droxidopa	
Approval Length	12 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 - ONE of the following:

7.1 Failure (after a trial of at least 30 days) of BOTH of the following confirmed by claims history or submitted medical records:

- fludrocortisone (generic Florinef)
- midodrine (generic ProAmatine)

OR

7.2 History of contraindication or intolerance to BOTH of the following:

- fludrocortisone (generic Florinef)
- midodrine (generic ProAmatine)

Product Name: Brand Northera, generic droxidopa	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to the requested therapy

AND

2 - Physiological countermeasures for neurogenic orthostatic hypotension (nOH) continue to be employed

2 . Revision History

Date	Notes
11/6/2025	Added Nevada Formulary

Nourianz



Prior Authorization Guideline

Guideline ID	GL-164688
Guideline Name	Nourianz
Formulary	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

Guideline Note:

Effective Date:	3/1/2025

1 . Criteria

Product Name:Nourianz	
Approval Length	12 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 - ONE of the following: 3.1 Failure to TWO anti-Parkinson's disease therapies from the following adjunctive pharmacotherapy classes (trial must be from two different classes) as confirmed by claims history or submission of medical records: • Dopamine agonists (e.g., pramipexole, ropinirole) • Catechol-O-methyl transferase (COMT) inhibitors (e.g., entacapone) • Monoamine oxidase (MAO) B inhibitors (e.g., rasagiline, selegiline) OR 3.2 History of contraindication or intolerance to ALL anti-Parkinson's disease therapy from the following adjunctive pharmacotherapy classes (trial must be from all classes) (please specify intolerance or contraindication): • 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
2/4/2025	Updated formularies. Updated initial auth duration

Nourianz



Prior Authorization Guideline

Guideline ID	GL-164688
Guideline Name	Nourianz
Formulary	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

Guideline Note:

Effective Date:	3/1/2025

1 . Criteria

Product Name:Nourianz	
Approval Length	12 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 - ONE of the following:

3.1 Failure to TWO anti-Parkinson's disease therapies from the following adjunctive pharmacotherapy classes (trial must be from two different classes) as confirmed by claims history or submission of medical records:

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

OR

3.2 History of contraindication or intolerance to ALL anti-Parkinson's disease therapy from the following adjunctive pharmacotherapy classes (trial must be from all classes) (please specify intolerance or contraindication):

- 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
2/4/2025	Updated formularies. Updated initial auth duration

Nubeqa



Prior Authorization Guideline

Guideline ID	GL-423189
Guideline Name	Nubeqa
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	11/1/2025

1 . Criteria

Product Name:Nubeqa	
Diagnosis	Prostate Cancer

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of prostate cancer AND 2 - ONE of the following: 2.1 BOTH of the following: 2.1.1 Disease is non-metastatic AND 2.1.2 Disease is castration-resistant OR 2.2 BOTH of the following: 2.2.1 Disease is metastatic AND 2.2.2 Disease is castration-sensitive AND 3 - ONE of the following:	

3.1 Used in combination with a gonadotropin-releasing hormone (GnRH) analog [e.g., Lupron (leuprolide), Zoladex (goserelin), Trelstar (triptorelin), Vantas (histrelin), Firmagon (degarelix)]

OR

3.2 Patient has had a bilateral orchiectomy

Product Name:Nubeqa	
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 Nubeqa therapy	

Product Name:Nubeqa	
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:Nubeqa	
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 Nubeqa therapy	

2 . Revision History

Date	Notes
10/16/2025	Updated formularies to add ACUIN for eff 11/1/2025.

Nuedexta



Prior Authorization Guideline

Guideline ID	GL-81266
Guideline Name	Nuedexta
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2021

1 . Criteria

Product Name:Nuedexta (dextromethorphan/quinidine)	
Approval Length	1 year(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of pseudobulbar affect (PBA) AND	

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

AND

3 - Patient does not have ONE of the following:

- Lupus-like syndrome
- Thrombocytopenia or bone marrow suppression
- Heart failure, QT prolongation, AV block or history of AV block, or on other medications that can lead to QT prolongation
- Currently utilizing MAOI therapy (or within past 14 days)
- Hepatitis induced by dextromethorphan/quinidine, quinine, mefloquine, or quinidine

2 . Revision History

Date	Notes
2/18/2021	IN 4/1 implementation

Nuplazid



Prior Authorization Guideline

Guideline ID	GL-505188
Guideline Name	Nuplazid
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Nuplazid	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., charts, progress notes, etc.) confirming BOTH of the following: • Diagnosis of Parkinson's disease	

- Diagnosis of psychosis related to Parkinson's disease (e.g., hallucinations/delusions)

AND

2 - Prescriber attests to BOTH of the following:

- Patient does NOT have dementia-related psychosis due to Alzheimer's disease or Lewy body dementia that is unrelated to the diagnosis of Parkinson's disease
- Attempt has been made to adjust patient's Parkinson's disease medications to reduce psychotic symptoms without worsening motor symptoms prior to initiating Nuplazid

AND

3 - Requested dose does not exceed 34 mg (milligrams) daily

Product Name:Nuplazid	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of requested agent for at least 90 days within the past 120 days, confirmed by claims history or chart documentation AND 2 - Submission of medical records (e.g., charts, progress notes, etc.) explicitly supporting positive response or stabilization in psychotic symptoms AND 3 - Requested dose does not exceed 34 mg (milligrams) daily	

2 . Revision History

Date	Notes
1/22/2026	New guideline

Ocaliva



Prior Authorization Guideline

Guideline ID	GL-164691
Guideline Name	Ocaliva
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Indiana Medicaid - Community & State Maryland 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

Guideline Note:

Effective Date:	3/1/2025

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 AND 2 - ONE of the following: • Patient does not have cirrhosis • Patient has compensated cirrhosis without evidence of portal hypertension AND 3 - ONE of the following: 3.1 BOTH of the following: • Used in combination with ursodeoxycholic acid (e.g., Urso, ursodiol) • 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) OR 3.2 History of contraindication or intolerance to ursodeoxycholic acid (e.g., Urso, ursodiol) (please specify contraindication or intolerance) AND 4 - Patient is not receiving Ocaliva in combination with Iqirvo (elafibranor) or Livdelzi (seladelpar)	

AND

5 - 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)

AND

2 - ONE of the following:

- Patient does not have cirrhosis
- Patient has compensated cirrhosis without evidence of portal hypertension

AND

3 - Patient is not receiving Ocaliva in combination with Iqirvo (elafibranor) or Livdelzi (seladelpar)

AND

4 - Prescribed by ONE of the following:

- Hepatologist
- Gastroenterologist

2 . Revision History

Date	Notes
2/4/2025	Updated formularies. Minor formatting changes. Added concurrent use criteria

Ocaliva



Prior Authorization Guideline

Guideline ID	GL-164691
Guideline Name	Ocaliva
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Indiana Medicaid - Community & State Maryland 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

Guideline Note:

Effective Date:	3/1/2025

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 AND 2 - ONE of the following: • Patient does not have cirrhosis • Patient has compensated cirrhosis without evidence of portal hypertension AND 3 - ONE of the following: 3.1 BOTH of the following: • Used in combination with ursodeoxycholic acid (e.g., Urso, ursodiol) • 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) OR 3.2 History of contraindication or intolerance to ursodeoxycholic acid (e.g., Urso, ursodiol) (please specify contraindication or intolerance) AND 4 - Patient is not receiving Ocaliva in combination with Iqirvo (elafibranor) or Livdelzi (seladelpar)	

AND

5 - 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)

AND

2 - ONE of the following:

- Patient does not have cirrhosis
- Patient has compensated cirrhosis without evidence of portal hypertension

AND

3 - Patient is not receiving Ocaliva in combination with Iqirvo (elafibranor) or Livdelzi (seladelpar)

AND

4 - Prescribed by ONE of the following:

- Hepatologist
- Gastroenterologist

2 . Revision History

Date	Notes
2/4/2025	Updated formularies. Minor formatting changes. Added concurrent use criteria

Odomzo



Prior Authorization Guideline

Guideline ID	GL-522268
Guideline Name	Odomzo
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia Medicaid - Community & State Washington

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Odomzo

Diagnosis	Basal Cell Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of nodal metastatic basal cell carcinoma (BCC) OR 2 - Diagnosis of diffuse basal cell carcinoma (BCC) formation (e.g., Gorlin syndrome, other genetic forms of multiple BCC) OR 3 - BOTH of the following: 3.1 Diagnosis of locally advanced basal cell carcinoma AND 3.2 ONE of the following: • Cancer has recurred following surgery • Cancer has recurred following radiation • Patient is not a candidate for surgery • Patient is not a candidate for radiation	

Product Name: Odomzo	
Diagnosis	Basal Cell 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 Odomzo therapy

Product Name:Odomzo

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:Odomzo

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 Odomzo therapy

2 . Revision History

Date	Notes

2/20/2026	Combined formularies. No changes to clinical criteria.

Odomzo



Prior Authorization Guideline

Guideline ID	GL-522268
Guideline Name	Odomzo
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia Medicaid - Community & State Washington

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Odomzo

Diagnosis	Basal Cell Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of nodal metastatic basal cell carcinoma (BCC) OR 2 - Diagnosis of diffuse basal cell carcinoma (BCC) formation (e.g., Gorlin syndrome, other genetic forms of multiple BCC) OR 3 - BOTH of the following: 3.1 Diagnosis of locally advanced basal cell carcinoma AND 3.2 ONE of the following: • Cancer has recurred following surgery • Cancer has recurred following radiation • Patient is not a candidate for surgery • Patient is not a candidate for radiation	

Product Name: Odomzo	
Diagnosis	Basal Cell 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 Odomzo therapy

Product Name:Odomzo	
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:Odomzo	
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 Odomzo therapy	

2 . Revision History

Date	Notes
2/20/2026	Combined formularies. No changes to clinical criteria.

Ogsiveo



Prior Authorization Guideline

Guideline ID	GL-186193
Guideline Name	Ogsiveo
Formulary	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 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:	4/1/2025

1 . Criteria

Product Name:Ogsiveo

Diagnosis	Desmoid Tumors
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of desmoid tumor AND 2 - Disease is progressive AND 3 - Patient requires systemic treatment	

Product Name:Ogsiveo	
Diagnosis	Desmoid Tumors
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 Ogsiveo therapy	

Product Name:Ogsiveo	
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:Ogsiveo	
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 Ogsiveo therapy	

2 . Revision History

Date	Notes
2/21/2025	Combined formularies. Added new GPIs for Ogsiveo (IN previously al ready had new GPIs included). No changes to clinical criteria.

Ojemda



Prior Authorization Guideline

Guideline ID	GL-522206
Guideline Name	Ojemda
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	2/15/2026

1 . Criteria

Product Name:Ojemda	
Diagnosis	Pediatric Low-Grade Glioma

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of pediatric low-grade glioma AND 2 - Disease is relapsed or refractory AND 3 - Presence of ONE of the following genetic mutations: • BRAF fusion or rearrangement • BRAF V600 mutation	

Product Name:Ojemda	
Diagnosis	Pediatric Low-Grade Glioma
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 Ojemda therapy	

Product Name:Ojemda	
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:Ojemda	
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 Ojemda therapy	

2 . Revision History

Date	Notes
2/11/2026	Removed WA from formularies, WA moved to state mandated criteria . No other changes to guideline.

Ojjaara



Prior Authorization Guideline

Guideline ID	GL-594192
Guideline Name	Ojjaara
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia Medicaid - Community & State Washington

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Ojjaara

Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of symptomatic lower-risk myelofibrosis OR 2 - BOTH of the following: 2.1 Diagnosis of higher-risk myelofibrosis AND 2.2 ONE of the following: 2.2.1 ALL of the following: • Patient is not a transplant candidate or transplant not currently feasible • Platelets greater than or equal to $50 \times 10^9/L$ (per liter) • Presence of symptomatic splenomegaly and/or constitutional symptoms OR 2.2.2 BOTH of the following: • Patient is not a transplant candidate or transplant not currently feasible • Platelets less than $50 \times 10^9/L$ (per liter) OR 2.2.3 Patient is a transplant candidate	

OR

3 - Diagnosis of myelofibrosis-associated anemia

OR

4 - BOTH of the following:

4.1 Diagnosis of accelerated/blast phase myeloproliferative neoplasm

AND

4.2 ONE of the following:

- Used for the improvement of splenomegaly or other disease-related symptoms
- Continued treatment as a single agent near to the start of conditioning therapy in transplant candidates for the improvement of splenomegaly and other disease-related symptoms

Product Name:Ojjaara	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation that patient has evidence of symptom improvement or reduction in spleen volume while on Ojjaara*	
Notes	*If documentation does not provide evidence of symptom improvement or reduction in spleen volume while on Ojjaara, authorization will be issued for 2 months to allow for dose titration with discontinuation of therapy.

Product Name:Ojjaara	
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:Ojjaara	
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 Ojjaara therapy	

2 . Revision History

Date	Notes
4/22/2026	Added IN. Expanded on L abbreviation where applicable, with no changes to clinical intent.

Ophthalmic Antibiotics



Prior Authorization Guideline

Guideline ID	GL-144311
Guideline Name	Ophthalmic Antibiotics
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2024

1 . Criteria

Product Name:Brand Vigamox, generic moxifloxacin ophth soln	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is 30 years of age or older OR	

2 - Patient has tried at least ONE preferred* medication within the past 30 days	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

2 . Revision History

Date	Notes
3/13/2024	Removed Moxeza.

Opiates



Prior Authorization Guideline

Guideline ID	GL-594188
Guideline Name	Opiates
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Belbuca	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of pain AND	

2 - No concurrent claims for buprenorphine/naloxone or buprenorphine therapy, excluding buprenorphine patches (Butrans) and sublingual buprenorphine indicated for the treatment of pain (Belbuca), exceeding a 7-day supply every 180 days*

AND

3 - The patient is not using concurrently with a carisoprodol-containing product

AND

4 - No concurrent claims for Lybalvi (olanzapine/samidorphan) within the past 45 days

AND

5 - One of the following:

5.1 Patient is not using the requested medication concurrently with a benzodiazepine (claim within the past 30 days)

OR

5.2 BOTH of the following:

- Days' supply for the requested opioid is 7 days or less
- Including the days' supply for the requested agent, the patient will not exceed 7 days of concurrent opiate/benzodiazepine therapy in the past 180 days

OR

5.3 Patient has utilized concurrent benzodiazepine/opiate therapy, including any cross-tapered or discontinued agents, for at least 90 of the past 120 days (confirmed by claims history)

OR

5.4 All of the following for concurrent opiate/benzodiazepine therapy exceeding 7 days in the past 180 days:

5.4.1 Indications provided for both the benzodiazepine agent(s) and the opioid agent(s)

AND

5.4.2 Documentation of previous therapies attempted for the given indications

AND

5.4.3 Prescriber attests to ALL of the following:

- The patient's INSPECT report has been evaluated and continues to be evaluated on a regular basis
- The patient has been educated in regard to the risks of concurrent utilization of opioid and benzodiazepine therapy, and the patient accepts these risks
- The prescriber has consulted any other prescribers involved in concurrent therapy and all prescribers agree to pursue concurrent opioid and benzodiazepine therapy for the patient, if applicable
- The prescriber acknowledges the risk of adverse event(s), including respiratory depression, coma, and death, associated with concurrent utilization

AND

6 - Fewer than 5 different prescribers of opiates in the past 60 days

AND

7 - ONE of the following:

7.1 BOTH of the following:

7.1.1 Patient is a current utilizer of opioid therapy (at least 90 days of therapy in the past 120 days, confirmed by claims history)

AND

7.1.2 Patient is not utilizing more than one long-acting opioid agent

OR

7.2 The patient has one of the following indications for long-term opioid use:

- Cancer
- Sickle cell disease
- Palliative care
- Other terminal diagnosis associated with significant pain

AND

8 - ONE of the following:

- History of the requested agent for 90 of the past 105 days (stable therapy)
- History of a 14-day trial of Butrans (buprenorphine) patches within the past 90 days
- Prescriber has provided valid medical rationale as to why Butrans (buprenorphine patches) are unsuitable for use

Notes	*Unless faxed documentation has been received from the opioid prescriber with approval for opioid therapy from the buprenorphine or buprenorphine/naloxone prescriber.

Product Name:fentanyl patch	
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 a current utilizer of opioid therapy (at least 90 days of therapy in the past 120 days, confirmed by claims history)	

AND

1.1.2 Patient is not utilizing more than one long-acting agent

OR

1.2 The patient has one of the following indications for long-term opioid use:

- Cancer
- Sickle cell disease
- Palliative care
- Other terminal diagnosis associated with significant pain

AND

2 - One of the following:

- History of the requested agent for 90 of the past 105 days (stable therapy)
- History of dysphagia
- Submission of medical records showing patient has a history of NPO (nothing-by-mouth) within the past 6 months
- Active cancer diagnosis
- History of 1 preferred long-acting opioid agent in the past 120 days

AND

3 - The patient is not using concurrently with a carisoprodol-containing product

AND

4 - No concurrent claims for Lybalvi (olanzapine/samidorphan) within the past 45 days

AND

5 - No concurrent claims for buprenorphine/naloxone or buprenorphine therapy, excluding

buprenorphine patches (Butrans) and sublingual buprenorphine indicated for the treatment of pain (Belbuca), exceeding a 7-day supply every 180 days*

AND

6 - One of the following:

6.1 Patient is not using the requested medication concurrently with a benzodiazepine (claim within the past 30 days)

OR

6.2 BOTH of the following:

- Days' supply for the requested opioid is 7 days or less
- Including the days' supply for the requested agent, the patient will not exceed 7 days of concurrent opiate/benzodiazepine therapy in the past 180 days

OR

6.3 Patient has utilized concurrent benzodiazepine/opiate therapy, including any cross-tapered or discontinued agents, for at least 90 of the past 120 days (confirmed by claims history)

OR

6.4 All of the following for concurrent opiate/benzodiazepine therapy exceeding 7 days in the past 180 days:

6.4.1 Indications provided for both the benzodiazepine agent(s) and the opioid agent(s)

AND

6.4.2 Documentation of previous therapies attempted for the given indications

AND

6.4.3 Prescriber attests to ALL of the following:

- The patient's INSPECT report has been evaluated and continues to be evaluated on a regular basis
- The patient has been educated in regard to the risks of concurrent utilization of opioid and benzodiazepine therapy, and the patient accepts these risks
- The prescriber has consulted any other prescribers involved in concurrent therapy and all prescribers agree to pursue concurrent opioid and benzodiazepine therapy for the patient, if applicable
- The prescriber acknowledges the risk of adverse event(s), including respiratory depression, coma, and death, associated with concurrent utilization

AND

7 - Fewer than 5 different prescribers of opiates in the past 60 days

Notes	*Unless faxed documentation has been received from the opioid prescriber with approval for opioid therapy from the buprenorphine or buprenorphine/naloxone prescriber.

Product Name:brand Hysingla ER, generic hydrocodone ER tab, Oxymorphone ER	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - No concurrent claims for buprenorphine/naloxone or buprenorphine therapy, excluding buprenorphine patches (Butrans) and sublingual buprenorphine indicated for the treatment of pain (Belbuca), exceeding a 7-day supply every 180 days* AND 2 - The patient is not using concurrently with a carisoprodol-containing product AND 3 - No concurrent claims for Lybalvi (olanzapine/samidorphan) within the past 45 days	

AND

4 - One of the following:

4.1 Patient is not using the requested medication concurrently with a benzodiazepine (claim within the past 30 days)

OR

4.2 BOTH of the following:

- Days' supply for the requested opioid is 7 days or less
- Including the days' supply for the requested agent, the patient will not exceed 7 days of concurrent opiate/benzodiazepine therapy in the past 180 days

OR

4.3 Patient has utilized concurrent benzodiazepine/opiate therapy, including any cross-tapered or discontinued agents, for at least 90 of the past 120 days (confirmed by claims history)

OR

4.4 All of the following for concurrent opiate/benzodiazepine therapy exceeding 7 days in the past 180 days:

4.4.1 Indications provided for both the benzodiazepine agent(s) and the opioid agent(s)

AND

4.4.2 Documentation of previous therapies attempted for the given indications

AND

4.4.3 Prescriber attests to ALL of the following:

- The patient's INSPECT report has been evaluated and continues to be evaluated on a regular basis
- The patient has been educated in regard to the risks of concurrent utilization of opioid and benzodiazepine therapy, and the patient accepts these risks
- The prescriber has consulted any other prescribers involved in concurrent therapy and all prescribers agree to pursue concurrent opioid and benzodiazepine therapy for the patient, if applicable
- The prescriber acknowledges the risk of adverse event(s), including respiratory depression, coma, and death, associated with concurrent utilization

AND

5 - Fewer than 5 different prescribers of opiates in the past 60 days

AND

6 - ONE of the following:

6.1 BOTH of the following:

6.1.1 Patient is a current utilizer of opioid therapy (at least 90 days of therapy in the past 120 days, confirmed by claims history)

AND

6.1.2 Patient is not utilizing more than one long-acting agent

OR

6.2 The patient has one of the following indications for long-term opioid use:

- Cancer
- Sickle cell disease
- Palliative care
- Other terminal diagnosis associated with significant pain

AND

7 - One of the following:

7.1 History of the requested agent for 90 of the past 105 days (stable therapy)

OR

7.2 BOTH of the following:

- History of trial with 2 different preferred long acting medications (2 different ingredients) in the past 90 days
- History of trial with 2 different non-preferred long acting medications (2 different ingredients) in the past 90 days

Notes	*Unless faxed documentation has been received from the opioid prescriber with approval for opioid therapy from the buprenorphine or buprenorphine/naloxone prescriber. IN PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/in-diana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:Qdolo, tramadol oral soln	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - No concurrent claims for buprenorphine/naloxone or buprenorphine therapy, excluding buprenorphine patches (Butrans) and sublingual buprenorphine indicated for the treatment of pain (Belbuca), exceeding a 7-day supply every 180 days* AND 2 - The patient is not using concurrently with a carisoprodol-containing product AND	

3 - No concurrent claims for Lybalvi (olanzapine/samidorphan) within the past 45 days

AND

4 - One of the following:

4.1 Patient is not using the requested medication concurrently with a benzodiazepine (claim within the past 30 days)

OR

4.2 BOTH of the following:

- Days' supply for the requested opioid is 7 days or less
- Including the days' supply for the requested agent, the patient will not exceed 7 days of concurrent opiate/benzodiazepine therapy in the past 180 days

OR

4.3 Patient has utilized concurrent benzodiazepine/opiate therapy, including any cross-tapered or discontinued agents, for at least 90 of the past 120 days (confirmed by claims history)

OR

4.4 All of the following for concurrent opiate/benzodiazepine therapy exceeding 7 days in the past 180 days:

4.4.1 Indications provided for both the benzodiazepine agent(s) and the opioid agent(s)

AND

4.4.2 Documentation of previous therapies attempted for the given indications

AND

4.4.3 Prescriber attests to ALL of the following:

- The patient's INSPECT report has been evaluated and continues to be evaluated on a regular basis
- The patient has been educated in regard to the risks of concurrent utilization of opioid and benzodiazepine therapy, and the patient accepts these risks
- The prescriber has consulted any other prescribers involved in concurrent therapy and all prescribers agree to pursue concurrent opioid and benzodiazepine therapy for the patient, if applicable
- The prescriber acknowledges the risk of adverse event(s), including respiratory depression, coma, and death, associated with concurrent utilization

AND

5 - Fewer than 5 different prescribers of opiates in the past 60 days

AND

6 - One of the following:

6.1 Patient is an initial utilizer of opioid therapy (less than 90 days of therapy in the past 120 days, confirmed by claims history)^ and all of the following:

- Requested dose does not exceed 60mg morphine equivalents per day
- Requested days' supply does not exceed 7 days
- Including the days' supply for the current request, the member will not exceed 14 days' supply in the past 45 days

OR

6.2 Patient is a current utilizer of opioid therapy (at least 90 days of therapy in the past 120 days, confirmed by claims history)** and not using more than one short-acting opioid agent

OR

6.3 The patient has one of the following indications for long-term opioid use:

- Cancer
- Sickle cell disease
- Palliative care

- Other terminal diagnosis associated with significant pain

AND

7 - ONE of the following:

- History of the requested agent for 90 of the past 105 days (stable therapy)
- The prescriber has provided rationale as to why the tablets are not suitable for use

AND

8 - The patient is 18 years of age or older (if less than 18 years of age, please see Age Limit criteria)

Notes	*Unless faxed documentation has been received from the opioid prescriber with approval for opioid therapy from the buprenorphine or buprenorphine/naloxone prescriber. ^Patient is within plan limitation [7-day supply with a subsequent claim(s) not to exceed 7-day supply (for a total of 14 days of therapy) every 45 days] two times. **Patient has utilized the plan limitation [7-day supply with a subsequent claim(s) not to exceed 7-day supply (for a total of 14 days of therapy) every 45 days] two times. The following is only to be used on peer-to-peer and appeals reviews: Requests for durations longer than 14 days (7 days + 7 days) for members that have undergone significant surgical intervention or other severe acute injury causing significant pain will be reviewed on a case-by-case basis and will not exceed 30 days in duration without further subsequent PA review for continued use.

Product Name:Conzip, tramadol ER cap, tramadol ER tab, tramadol ER biphasic ER tab	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - No concurrent claims for buprenorphine/naloxone or buprenorphine therapy, excluding buprenorphine patches (Butrans) and sublingual buprenorphine indicated for the treatment of pain (Belbuca), exceeding a 7-day supply every 180 days*	

AND

2 - The patient is not using concurrently with a carisoprodol-containing product

AND

3 - No concurrent claims for Lybalvi (olanzapine/samidorphan) within the past 45 days

AND

4 - One of the following:

4.1 Patient is not using the requested medication concurrently with a benzodiazepine (claim within the past 30 days)

OR

4.2 BOTH of the following:

- Days' supply for the requested opioid is 7 days or less
- Including the days' supply for the requested agent, the patient will not exceed 7 days of concurrent opiate/benzodiazepine therapy in the past 180 days

OR

4.3 Patient has utilized concurrent benzodiazepine/opiate therapy, including any cross-tapered or discontinued agents, for at least 90 of the past 120 days (confirmed by claims history)

OR

4.4 All of the following for concurrent opiate/benzodiazepine therapy exceeding 7 days in the past 180 days:

4.4.1 Indications provided for both the benzodiazepine agent(s) and the opioid agent(s)

AND

4.4.2 Documentation of previous therapies attempted for the given indications

AND

4.4.3 Prescriber attests to ALL of the following:

- The patient's INSPECT report has been evaluated and continues to be evaluated on a regular basis
- The patient has been educated in regard to the risks of concurrent utilization of opioid and benzodiazepine therapy, and the patient accepts these risks
- The prescriber has consulted any other prescribers involved in concurrent therapy and all prescribers agree to pursue concurrent opioid and benzodiazepine therapy for the patient, if applicable
- The prescriber acknowledges the risk of adverse event(s), including respiratory depression, coma, and death, associated with concurrent utilization

AND

5 - Fewer than 5 different prescribers of opiates in the past 60 days

AND

6 - ONE of the following:

6.1 BOTH of the following:

6.1.1 Patient is a current utilizer of opioid therapy (at least 90 days of therapy in the past 120 days, confirmed by claims history)

AND

6.1.2 Patient is not utilizing more than one Long-acting agent

OR

6.2 The patient has one of the following indications for long-term opioid use:

- Cancer
- Sickle cell disease
- Palliative care
- Other terminal diagnosis associated with significant pain

AND

7 - ONE of the following:

- History of the requested agent for 90 of the past 105 days (stable therapy)
- History of immediate release tramadol for 90 of the past 120 days

AND

8 - The patient is 18 years of age or older (if less than 18 years of age, please see Age Limit criteria)

Notes	*Unless faxed documentation has been received from the opioid prescriber with approval for opioid therapy from the buprenorphine or buprenorphine/naloxone prescriber.

Product Name: Long-Acting Opioids: brand Butrans, generic buprenorphine patch, brand MS Contin, generic morphine sulfate ER, generic morphine sulfate CR, Oxycontin, Oxycodone ER, hydromorphone ER, methadone (tab, conc, soln, intensol, tab for oral susp, inj), methadose (conc, SF conc and tab for oral susp), generic hydrocodone ER caps

Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - No concurrent claims for buprenorphine/naloxone or buprenorphine therapy, excluding buprenorphine patches (Butrans) and sublingual buprenorphine indicated for the treatment of pain (Belbuca), exceeding a 7-day supply every 180 days*

AND

2 - The patient is not using concurrently with a carisoprodol-containing product

AND

3 - No concurrent claims for Lybalvi (olanzapine/samidorphan) within the past 45 days

AND

4 - One of the following:

4.1 Patient is not using the requested medication concurrently with a benzodiazepine (claim within the past 30 days)

OR

4.2 BOTH of the following:

- Days' supply for the requested opioid is 7 days or less
- Including the days' supply for the requested agent, the patient will not exceed 7 days of concurrent opiate/benzodiazepine therapy in the past 180 days

OR

4.3 Patient has utilized concurrent benzodiazepine/opiate therapy, including any cross-tapered or discontinued agents, for at least 90 of the past 120 days (confirmed by claims history)

OR

4.4 All of the following for concurrent opiate/benzodiazepine therapy exceeding 7 days in the past 180 days:

4.4.1 Indications provided for both the benzodiazepine agent(s) and the opioid agent(s)

AND

4.4.2 Documentation of previous therapies attempted for the given indications

AND

4.4.3 Prescriber attests to ALL of the following:

- The patient's INSPECT report has been evaluated and continues to be evaluated on a regular basis
- The patient has been educated in regard to the risks of concurrent utilization of opioid and benzodiazepine therapy, and the patient accepts these risks
- The prescriber has consulted any other prescribers involved in concurrent therapy and all prescribers agree to pursue concurrent opioid and benzodiazepine therapy for the patient, if applicable
- The prescriber acknowledges the risk of adverse event(s), including respiratory depression, coma, and death, associated with concurrent utilization

AND

5 - Fewer than 5 different prescribers of opiates in the past 60 days

AND

6 - One of the following:

6.1 BOTH of the following:

6.1.1 Patient is a current utilizer (at least 90 days of therapy in the past 120 days, confirmed by claims history)

AND

6.1.2 Patient is not utilizing more than one long-acting opioid agent

OR

6.2 The patient has one of the following indications for long-term opioid use:

- Cancer

- Sickle cell disease
- Palliative care
- Other terminal diagnosis associated with significant pain

AND

7 - If the request is for a non-preferred medication ONE of the following:

- History of at least 2 different preferred long-acting opioid products (2 different ingredients) in the past 90 days
- History of the requested agent for 90 of the past 105 days (stable therapy)

AND

8 - If the request is for a methadone product, the patient does not have a diagnosis of opioid use disorder (OUD) **

Notes	*Unless faxed documentation has been received from the opioid prescriber with approval for opioid therapy from the buprenorphine or buprenorphine/naloxone prescriber. **Methadone for the diagnosis of opioid use disorder (OUD) is not permissible for reimbursement through the pharmacy benefit. By law, only a SAMHSA-certified opioid treatment program (OTP) can dispense methadone for the treatment of OUD, as governed by 42 CFR 8. Patients taking methadone to treat OUD must receive the medication under the supervision of a practitioner at an OTP facility. The Indiana Health Coverage Programs (IHCP) requires providers to enroll under the Addiction Services/OTP provider type and to bill services as outlined in the Indiana Health Coverage Programs provider bulletin BT201755. IN PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/in-diana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:belladonna/Opium suppositories	
Approval Length	For diagnosis of pain associated with ureteral spasm: 4 weeks; All other diagnoses:12 month(s)
Guideline Type	Prior Authorization
Approval Criteria	

1 - No concurrent claims for buprenorphine/naloxone or buprenorphine therapy, excluding buprenorphine patches (Butrans) and sublingual buprenorphine indicated for the treatment of pain (Belbuca), exceeding a 7-day supply every 180 days*

AND

2 - The patient is not using concurrently with a carisoprodol-containing product

AND

3 - No concurrent claims for Lybalvi (olanzapine/samidorphan) within the past 45 days

AND

4 - One of the following:

4.1 Patient is not using the requested medication concurrently with a benzodiazepine (claim within the past 30 days)

OR

4.2 BOTH of the following:

- Days' supply for the requested opioid is 7 days or less
- Including the days' supply for the requested agent, the patient will not exceed 7 days of concurrent opiate/benzodiazepine therapy in the past 180 days

OR

4.3 Patient has utilized concurrent benzodiazepine/opiate therapy, including any cross-tapered or discontinued agents, for at least 90 of the past 120 days (confirmed by claims history)

OR

4.4 All of the following for concurrent opiate/benzodiazepine therapy exceeding 7 days in the past 180 days:

4.4.1 Indications provided for both the benzodiazepine agent(s) and the opioid agent(s)

AND

4.4.2 Documentation of previous therapies attempted for the given indications

AND

4.4.3 Prescriber attests to ALL of the following:

- The patient's INSPECT report has been evaluated and continues to be evaluated on a regular basis
- The patient has been educated in regard to the risks of concurrent utilization of opioid and benzodiazepine therapy, and the patient accepts these risks
- The prescriber has consulted any other prescribers involved in concurrent therapy and all prescribers agree to pursue concurrent opioid and benzodiazepine therapy for the patient, if applicable
- The prescriber acknowledges the risk of adverse event(s), including respiratory depression, coma, and death, associated with concurrent utilization

AND

5 - Fewer than 5 different prescribers of opiates in the past 60 days

AND

6 - One of the following:

6.1 The patient has one of the following indications for long-term opioid use:

- Cancer
- Sickle cell disease
- Palliative care
- Other terminal diagnosis associated with significant pain

OR

6.2 The patient has a diagnosis of pain associated with ureteral spasm

AND

7 - If the request is for a non-preferred medication, one of the following:

- History of at least 2 different preferred short-acting opioid products (2 different ingredients) in the past 6 months
- History of the requested medication for 90 of the past 105 days

Notes	*Unless faxed documentation has been received from the opioid prescriber with approval for opioid therapy from the buprenorphine or buprenorphine/naloxone prescriber. IN PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/in-diana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:Opium tincture	
Approval Length	For patients with non-cancer treatment-related diarrhea: 4 weeks; For patients with cancer treatment-related diarrhea: 6 month(s); All other diagnoses: 12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - No concurrent claims for buprenorphine/naloxone or buprenorphine therapy, excluding buprenorphine patches (Butrans) and sublingual buprenorphine indicated for the treatment of pain (Belbuca), exceeding a 7-day supply every 180 days* AND 2 - The patient is not using concurrently with a carisoprodol-containing product	

AND

3 - No concurrent claims for Lybalvi (olanzapine/samidorphan) within the past 45 days

AND

4 - One of the following:

4.1 Patient is not using the requested medication concurrently with a benzodiazepine (claim within the past 30 days)

OR

4.2 BOTH of the following:

- Days' supply for the requested opioid is 7 days or less
- Including the days' supply for the requested agent, the patient will not exceed 7 days of concurrent opiate/benzodiazepine therapy in the past 180 days

OR

4.3 Patient has utilized concurrent benzodiazepine/opiate therapy, including any cross-tapered or discontinued agents, for at least 90 of the past 120 days (confirmed by claims history)

OR

4.4 All of the following for concurrent opiate/benzodiazepine therapy exceeding 7 days in the past 180 days:

4.4.1 Indications provided for both the benzodiazepine agent(s) and the opioid agent(s)

AND

4.4.2 Documentation of previous therapies attempted for the given indications

AND

4.4.3 Prescriber attests to ALL of the following:

- The patient's INSPECT report has been evaluated and continues to be evaluated on a regular basis
- The patient has been educated in regard to the risks of concurrent utilization of opioid and benzodiazepine therapy, and the patient accepts these risks
- The prescriber has consulted any other prescribers involved in concurrent therapy and all prescribers agree to pursue concurrent opioid and benzodiazepine therapy for the patient, if applicable
- The prescriber acknowledges the risk of adverse event(s), including respiratory depression, coma, and death, associated with concurrent utilization

AND

5 - Fewer than 5 different prescribers of opiates in the past 60 days

AND

6 - One of the following:

6.1 The patient has one of the following indications for long-term opioid use:

- Cancer
- Sickle cell disease
- Palliative care
- Other terminal diagnosis associated with significant pain

OR

6.2 The patient has a diagnosis of diarrhea and diarrhea is one of the following:

- Non-cancer treatment related
- Cancer treatment related

AND

7 - If the request is for a non-preferred medication, one of the following:

- History of at least 2 different preferred short-acting opioid products (2 different ingredients) in the past 6 months
- History of the requested medication for 90 of the past 105 days

Notes	*Unless faxed documentation has been received from the opioid prescriber with approval for opioid therapy from the buprenorphine or buprenorphine/naloxone prescriber. IN PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/in-diana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:Antitussives: Brand Hycodan, Hydromet, hydrocodone/homatropine syrup, hydrocodone/homatropine tabs, hydrocodone polst/chlorpheniramine polst ER susp, Poly-Tussin AC, Capcof, Pro-Red AC, Histex-AC, Maxi-Tuss CD, promethazine w/codeine, Promethazine VC/codeine, promethazine-phenylephrine-codeine, Rydex, Mar-Cof BP, Ninjacof-XG, Coditussin AC, Mar-Cof GG, Trymine CG, Codeine/Guaifenesin, G Tussin AC, GuaiaTussin AC, Guaifenesin AC, Guaifenesin/Codeine, Virtussin A/C, Virtussin AC/ALC, Maxi-Tuss AC, Coditussin DAC, Virtussin DAC, Tuxarin ER

Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - No concurrent claims for buprenorphine/naloxone or buprenorphine therapy, excluding buprenorphine patches (Butrans) and sublingual buprenorphine indicated for the treatment of pain (Belbuca), exceeding a 7-day supply every 180 days*

AND

2 - The patient is not using concurrently with a carisoprodol-containing product

AND

3 - No concurrent claims for Lybalvi (olanzapine/samidorphan) within the past 45 days

AND

4 - One of the following:

4.1 Patient is not using the requested medication concurrently with a benzodiazepine (claim within the past 30 days)

OR

4.2 BOTH of the following:

- Days' supply for the requested opioid is 7 days or less
- Including the days' supply for the requested agent, the patient will not exceed 7 days of concurrent opiate/benzodiazepine therapy in the past 180 days

OR

4.3 Patient has utilized concurrent benzodiazepine/opiate therapy, including any cross-tapered or discontinued agents, for at least 90 of the past 120 days (confirmed by claims history)

OR

4.4 All of the following for concurrent opiate/benzodiazepine therapy exceeding 7 days in the past 180 days:

4.4.1 Indications provided for both the benzodiazepine agent(s) and the opioid agent(s)

AND

4.4.2 Documentation of previous therapies attempted for the given indications

AND

4.4.3 Prescriber attests to ALL of the following:

- The patient's INSPECT report has been evaluated and continues to be evaluated on a regular basis
- The patient has been educated in regard to the risks of concurrent utilization of opioid and benzodiazepine therapy, and the patient accepts these risks
- The prescriber has consulted any other prescribers involved in concurrent therapy and all prescribers agree to pursue concurrent opioid and benzodiazepine therapy for the patient, if applicable
- The prescriber acknowledges the risk of adverse event(s), including respiratory depression, coma, and death, associated with concurrent utilization

AND

5 - Fewer than 5 different prescribers of opiates in the past 60 days

AND

6 - One of the following:

6.1 Patient is an initial utilizer of opioid therapy (less than 90 days of therapy in the past 120 days, confirmed by claims history)^ and all of the following:

- Requested dose does not exceed 60mg morphine equivalents per day
- Requested days' supply does not exceed 7 days
- Including the days' supply for the current request, the member will not exceed 14 days' supply in the past 45 days

OR

6.2 Patient is a current utilizer of opioid therapy (at least 90 days of therapy in the past 120 days, confirmed by claims history)** and not using more than one short-acting opioid agent

OR

6.3 One of the following diagnoses:

- Cancer
- Palliative care
- Other terminal diagnosis with concomitant irretractable cough

AND

7 - If the request is for a non-preferred medication, one of the following:

- History of 2 different preferred antitussive products (2 different ingredients) in the past 6 months
- History of the requested medication for 90 of the past 105 days

AND

8 - The patient is 18 years of age or older (if less than 18 years of age, please see Age Limit criteria)

Notes	*Unless faxed documentation has been received from the opioid prescriber with approval for opioid therapy from the buprenorphine or buprenorphine/naloxone prescriber. ^Patient is within plan limitation [7-day supply with a subsequent claim (s) not to exceed 7-day supply (for a total of 14 days of therapy) every 45 days] two times. **Patient has utilized the plan limitation [7-day supply with a subsequent claim(s) not to exceed 7-day supply (for a total of 14 days of therapy) every 45 days] two times. IN PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/in-diana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name: Short-Acting Opioids: butorphanol, acetaminophen/codeine (soln and tabs), brand Fioricet/codeine, generic butalbital/acetaminophen/caffeine/codeine, ascomp/codeine, butalbital/aspirin/caffeine/codeine, morphine sulfate (tab, soln and supp), codeine sulfate, generic hydrocodone/acetaminophen soln, brand Xodol, generic hydrocodone/acetaminophen tab, hydrocodone/ibuprofen, brand Trezix, generic acetaminophen/caffeine/dihydrocodeine, brand dilaudid, generic hydromorphone, oxycodone cap, brand Roxicodone, brand Oxaydo, generic oxycodone tab, oxycodone conc, oxycodone soln, brand Percocet, Nalocet, Endocet, Prolate (tab and soln), Oxycodone/acetaminophen (tab and soln), generic oxycodone/acetaminophen tab, levorphanol, Xyvona, meperidine (tab and soln), oxymorphone, pentazocine/naloxone, brand Ultram, generic tramadol, brand Ultracet, generic tramadol/acetaminophen, Synapryn

Diagnosis	Prior Authorization/Opioid Naive (days supply limit)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - No concurrent claims for buprenorphine/naloxone or buprenorphine therapy, excluding buprenorphine patches (Butrans) and sublingual buprenorphine indicated for the treatment of pain (Belbuca), exceeding a 7-day supply every 180 days*

AND

2 - The patient is not using concurrently with a carisoprodol-containing product

AND

3 - No concurrent claims for Lybalvi (olanzapine/samidorphan) within the past 45 days

AND

4 - One of the following:

4.1 Patient is not using the requested medication concurrently with a benzodiazepine (claim within the past 30 days)

OR

4.2 BOTH of the following:

- Days' supply for the requested opioid is 7 days or less
- Including the days' supply for the requested agent, the patient will not exceed 7 days of concurrent opiate/benzodiazepine therapy in the past 180 days

OR

4.3 Patient has utilized concurrent benzodiazepine/opiate therapy, including any cross-tapered or discontinued agents, for at least 90 of the past 120 days (confirmed by claims history)

OR

4.4 All of the following for concurrent opiate/benzodiazepine therapy exceeding 7 days in the past 180 days:

4.4.1 Indications provided for both the benzodiazepine agent(s) and the opioid agent(s)

AND

4.4.2 Documentation of previous therapies attempted for the given indications

AND

4.4.3 Prescriber attests to ALL of the following:

- The patient's INSPECT report has been evaluated and continues to be evaluated on a regular basis
- The patient has been educated in regard to the risks of concurrent utilization of opioid and benzodiazepine therapy, and the patient accepts these risks
- The prescriber has consulted any other prescribers involved in concurrent therapy and all prescribers agree to pursue concurrent opioid and benzodiazepine therapy for the patient, if applicable
- The prescriber acknowledges the risk of adverse event(s), including respiratory depression, coma, and death, associated with concurrent utilization

AND

5 - Fewer than 5 different prescribers of opiates in the past 60 days

AND

6 - One of the following:

6.1 Patient is an initial utilizer of opioid therapy (less than 90 days of therapy in the past 120 days, confirmed by claims history)^ and all of the following:

- Requested dose does not exceed 60mg morphine equivalents per day
- Requested days' supply does not exceed 7 days

- Including the days' supply for the current request, the member will not exceed 14 days' supply in the past 45 days

OR

6.2 Patient is a current utilizer of opioid therapy (at least 90 days of therapy in the past 120 days, confirmed by claims history)** and not using more than one short-acting opioid agent

OR

6.3 The patient has one of the following indications for long-term opioid use:

- Cancer
- Sickle cell disease
- Palliative care
- Other terminal diagnosis associated with significant pain

AND

7 - If the request is for a non-preferred medication, one of the following:

- History of at least 2 different preferred short-acting opioid products (2 different ingredients) in the past 6 months
- History of the requested medication for 90 of the past 105 days

AND

8 - If the request is for a codeine-containing or tramadol-containing product, the patient is 18 years of age or older (if less than 18 years of age, please see Age Limit criteria)

Notes	*Unless faxed documentation has been received from the opioid prescriber with approval for opioid therapy from the buprenorphine or buprenorphine/naloxone prescriber. ^Patient is within plan limitation [7-day supply with a subsequent claim(s) not to exceed 7-day supply (for a total of 14 days of therapy) every 45 days] two times. **Patient has utilized the plan limitation [7-day supply with a subsequent claim(s) not to exceed 7-day supply (for a total of 14 days of therapy) every 45 days] two times. The following is only to be used on peer-t

	o-peer and appeals reviews: Requests for durations longer than 14 days (7 days + 7 days) for members that have undergone significant surgical intervention or other severe acute injury causing significant pain will be reviewed on a case-by-case basis and will not exceed 30 days in duration without further subsequent PA review for continued use. IN PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/in-diana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:fentanyl patch, brand Butrans, generic buprenorphine patch, brand MS Contin, generic morphine sulfate ER, generic morphine sulfate CR, Oxycontin, Oxycodone ER, hydromorphone ER, brand Hysingla ER, generic hydrocodone ER tab, Oxymorphone ER, brand Zohydro ER, generic hydrocodone ER cap, Conzip, tramadol ER cap, tramadol ER tab, tramadol ER biphasic ER tab, butorphanol, acetaminophen/codeine (soln and tabs), brand Fioricet/codeine, generic butalbital/acetaminophen/caffeine/codeine, ascomp/codeine, butalbital/aspirin/caffeine/codeine, morphine sulfate (tab, soln and supp), codeine sulfate, generic hydrocodone/acetaminophen soln, brand Xodol, generic hydrocodone/acetaminophen tab, hydrocodone/ibuprofen, brand Trezix, generic acetaminophen/caffeine/dihydrocodeine, brand dilaudid, generic hydromorphone, oxycodone cap, brand Roxicodone, brand Oxaydo, generic oxycodone tab, oxycodone conc, oxycodone soln, brand Percocet, Nalocet, Endocet, Prolate (tab and soln), Oxycodone/acetaminophen (tab and soln), generic oxycodone/acetaminophen tab, levorphanol, Xyvona, meperidine (tab and soln), methadone (tab, conc, soln, intensol, tab for oral susp, inj), methadose (conc, SF conc and tab for oral susp), oxymorphone, pentazocine/naloxone, brand Ultram, generic tramadol, brand Ultracet, generic tramadol/acetaminophen, Synapryn, Qdolo, tramadol oral soln, belladonna/Opium, Opium, Roxybond, Oxycodone abuse deterrent tabs, Brand Hycodan, Hydromet, hydrocodone/homatropine syrup, hydrocodone/homatropine tabs, hydrocodone polst/chlorpheniramine polst ER susp, Poly-Tussin AC, Capcof, Pro-Red AC, Histex-AC, Maxi-Tuss CD, promethazine w/codeine, Promethazine VC/codeine, promethazine-phenylephrine-codeine, Rydex, Mar-Cof BP, Ninjacof-XG, Coditussin AC, Mar-Cof GG, Trymine CG, Codeine/Guaifenesin, G Tussin AC, Guaiaitussin AC, Guaifenesin AC, Guaifenesin/Codeine, Virtussin A/C, Virtussin AC/ALC, Maxi-Tuss AC, Coditussin DAC, Virtussin DAC, Tuxarin ER *

Guideline Type	Morphine Milligram Equivalents (MME)**
Approval Criteria 1 - Diagnosis of cancer, sickle cell disease, palliative care, other terminal diagnosis associated with significant pain OR 2 - Provider has submitted a taper plan with specific doses and durations	

OR

3 - The patient has attempted a dose reduction of their opioid therapy within the past 12 months and all of the following:

- Attempt at MME reduction can be identified by chart notes or claims history
- Provider has submitted chart notes demonstrating adverse outcomes experienced with attempted taper

Notes

*Authorization will be issued for 12 months for Cancer, sickle cell disease, palliative care, and terminal diagnosis associated with significant pain. 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. Authorization for when member has attempted a dose reduction of their opioid therapy within the past 12 months will be granted for 12 months. Authorization for when a provider has submitted a taper plan with specific doses and durations will be granted for 6 months. These authorizations should be entered for the requested MME.
 **Reference Table 1 in background for MME Limits.

Product Name:acetaminophen/codeine (soln and tabs), brand Fioricet/codeine, generic butalbital/acetaminophen/caffeine/codeine, ascomp/codeine, butalbital/aspirin/caffeine/codeine, codeine sulfate, brand Trezix, generic acetaminophen/caffeine/dihydrocodeine, brand Ultram, generic tramadol, brand Ultracet, generic tramadol/acetaminophen, Qdolo, tramadol oral soln, Conzip, tramadol ER cap, tramadol ER tab, tramadol ER biphasic ER tab, hydrocodone polst/chlorpheniramine polst ER susp, Poly-Tussin AC, Capcof, Pro-Red AC, Histex-AC, Maxi-Tuss CD, promethazine w/codeine, Promethazine VC/codeine, promethazine-phenylephrine-codeine, Rydex, Mar-Cof BP, Ninjacof-XG, Coditussin AC, Mar-Cof GG, Trymine CG, Codeine/Guaifenesin, G Tussin AC, GuaiaTussin AC, Guaifenesin AC, Guaifenesin/Codeine, Virtussin A/C, Virtussin AC/ALC, Maxi-Tuss AC, Coditussin DAC, Virtussin DAC, Tuxarin ER, butorphanol

Diagnosis	Age Limit
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - All of the following:

1.1 Documentation that other age and diagnosis-appropriate agents available have been

tried for an adequate period of time and been deemed ineffective in the treatment of the patient's disease or medical condition

AND

1.2 If the member is outside of FDA-established age limits, clinical support or rationale for safety and efficacy has been provided (i.e., clinical literature in conjunction with patient attributes and/or characteristics of the drug) for the requested drug and dose

OR

2 - All of the following:

2.1 History of requested agent for at least 90 days within the past 120 days, confirmed by claims history or chart documentation

AND

2.2 Patient previously received an authorization for age limit exception for the requested agent

OR

3 - All of the following:

3.1 History of requested agent for at least 90 days within the past 120 days, confirmed by claims history or chart documentation

AND

3.2 ONE of the following:

- The requested agent has newly implemented age limits which did not previously apply to the patient
- The request is for continuation of therapy from another plan or following inpatient therapy

AND

3.3 One of the following:

3.3.1 Documentation that other age and diagnosis-appropriate agents available have been tried for an adequate period of time and been deemed ineffective in the treatment of the patient's disease or medical condition

OR

3.3.2 The prescriber has provided valid medical justification for use of the requested agent outside of FDA or plan-established age limits over the use of other diagnosis-appropriate agents within FDA or plan-established age limits

AND

3.4 If the member is outside of FDA-established age limits, clinical support or rationale for safety and efficacy has been provided (i.e., clinical literature in conjunction with patient attributes and/or characteristics of the drug) for the requested drug and dose

Notes	These criteria are from the Non-Drug-Specific Prior Authorization Criteria policy

Product Name: All Opioid Products	
Diagnosis	DDI: Lybalvi + Opioid
Approval Length	12 month(s)
Guideline Type	Drug Utilization Review
Approval Criteria 1 - The patient has not used Lybalvi (olanzapine/samidorphan) within the past 45 days	

2 . Background

Benefit/Coverage/Program Information

Table 1: Planned Taper Schedule for MME Limit Reduction

Date of Reduction	MME Daily Limit
April 1, 2026	275
July 1, 2026	250
October 1, 2026	225
January 1, 2027	210
April 1, 2027	195
July 1, 2027	180
October 1, 2027	165

3 . Revision History

Date	Notes
4/23/2026	Updated step 6 for Qdolo, tramadol oral soln/Antitussives/Short-Acting Opioids sections for denial note clarification

Orserdu



Prior Authorization Guideline

Guideline ID	GL-239261
Guideline Name	Orserdu
Formulary	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:	6/1/2025

1 . Criteria

Product Name:Orserdu

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: • Advanced • Metastatic AND 3 - Disease is estrogen receptor (ER)-positive AND 4 - Disease is human epidermal growth factor receptor 2 (HER2)-negative AND 5 - Presence of an ESR1 gene mutation AND 6 - Patient is ONE of the following: • Postmenopausal woman • Male	

- Premenopausal woman treated with ovarian ablation/suppression

AND

7 - Disease has progressed following at least one line of endocrine therapy

Product Name:Orserdu	
Diagnosis	Breast 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 Orserdu therapy	

Product Name:Orserdu	
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:Orserdu	
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 Orserdu therapy	

2 . Revision History

Date	Notes
4/16/2025	Combined formularies. No changes to clinical criteria.

Osphena



Prior Authorization Guideline

Guideline ID	GL-124497
Guideline Name	Osphena
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2023

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 - ONE of the following:

2.1 Failure to BOTH of the following as confirmed by claims history or submission of medical records:

- Estradiol vaginal cream
- Estradiol vaginal tablet

OR

2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- 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	

Oxervate



Prior Authorization Guideline

Guideline ID	GL-98032
Guideline Name	Oxervate
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2022

1 . Criteria

Product Name: Oxervate	
Diagnosis	Neurotrophic keratitis
Approval Length	8 Week(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is 2 years of age or older	

AND

2 - Diagnosis of neurotrophic keratitis

AND

3 - Prescribed by, or in consultation with, an ophthalmologist

AND

4 - Patient has not received 8 weeks or more of prior cenegermin (Oxervate) treatment for the affected eye

2 . Revision History

Date	Notes
11/4/2021	Updated all criteria to match state policy.

Pancreatic Enzymes



Prior Authorization Guideline

Guideline ID	GL-125017
Guideline Name	Pancreatic Enzymes
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	7/1/2023

1 . Criteria

Product Name:Pertzye, Viokace	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has utilized 30 cumulative days of preferred* agent therapy in the past 180 days	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

2 . Revision History

Date	Notes
4/25/2023	New

Panretin



Prior Authorization Guideline

Guideline ID	GL-164747
Guideline Name	Panretin
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 Virginia Medicaid - Community & State Washington Medicaid - Community & State Nebraska Medicaid - Community & State New Mexico Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	2/1/2025

1 . Criteria

Product Name:Panretin	
Diagnosis	Kaposi's Sarcoma
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of AIDS (acquired immunodeficiency syndrome)-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 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	

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
2/5/2025	Added IN formulary. No change to clinical criteria.

PCSK9 Inhibitors and Select Lipotropics



Prior Authorization Guideline

Guideline ID	GL-531201
Guideline Name	PCSK9 Inhibitors and Select Lipotropics
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Evkeeza	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of homozygous familial hypercholesterolemia (HoFH)	

AND

2 - Prescribed by, or in consultation with, a cardiologist or endocrinologist

AND

3 - One of the following:

3.1 Patient is 1 year of age or older and less than 7 years of age

OR

3.2 Patient is 7 years of age or older and less than 10 years of age AND one of the following:

- Trial and failure of at least 90 days of therapy with rosuvastatin 20 mg (milligram)
- Documentation of intolerance/contraindication to rosuvastatin

OR

3.3 Patient is 10 years of age or older and less than 18 years of age AND one of the following:

3.3.1 Trial and failure of Repatha (evolocumab)

OR

3.3.2 Both of the following:

- Medical justification for use of Evkeeza (evinacumab-dgnb) over Repatha (evolocumab) (please document justification)
- Patient has had trial and failure of at least 90 days of high dose rosuvastatin (20 mg/40 mg) or atorvastatin (40 mg/80 mg, if rosuvastatin intolerant) therapy concurrently with ezetimibe (or documented intolerance/contraindication to statins/ezetimibe)

OR

3.4 Patient is 18 years of age or older AND one of the following:

3.4.1 Trial and failure of Praluent (alirocumab) or Repatha (evolocumab)

OR

3.4.2 Both of the following:

- Medical justification for use of Evkeeza (evinacumab-dgnb) over Praluent (alirocumab) or Repatha (evolocumab) (please document justification)
- Patient has had trial and failure of at least 90 days of high dose rosuvastatin (20 mg/40 mg) or atorvastatin (40 mg/80 mg, if rosuvastatin intolerant) therapy concurrently with ezetimibe (or documented intolerance/contraindication to statins/ezetimibe)

AND

4 - One of the following:

- Patient will be utilizing maximally tolerated statin therapy with or without ezetimibe concurrently with Evkeeza (evinacumab-dgnb) (for those 7 years of age and older)
- Documented intolerance to statin and/or ezetimibe therapy or medical rationale against use of statin or ezetimibe therapy (please document reason)

AND

5 - Dose does not exceed 15 mg/kg (milligrams per kilogram) every 4 weeks

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

1 - History of the requested medication for at least 90 days within the past 120 days, confirmed by claims history or chart documentation

AND

2 - One of the following:

- Prior history of at least one preferred PCSK9 inhibitor*
- Valid medical rationale for the use of Evkeeza (evinacumab-dgnb) over preferred PCSK9 inhibitors* (please document rationale)

AND

3 - One of the following:

- Continued concurrent use of maximally tolerated statin therapy with or without ezetimibe (for those 7 years of age and older)
- Documented intolerance to statin and/or ezetimibe therapy or medical rationale against use of statin or ezetimibe therapy (please document reason)

AND

4 - Dose does not exceed 15 mg/kg (milligrams per kilogram) every 4 weeks

AND

5 - One of the following:

5.1 Reduction in LDL-C (low-density lipoprotein-cholesterol) from baseline

OR

5.2 Maintenance of goal LDL-C

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:Juxtapid	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is enrolled in the Juxtapid REMS (Risk Evaluation and Mitigation Strategy) program and prescriber is monitoring in accordance with REMS requirements AND 2 - The patient is 18 years of age or older AND 3 - Prescribed by, or in consultation with, a cardiologist or endocrinologist AND 4 - One of the following: 4.1 Trial and failure of Praluent or Repatha OR 4.2 BOTH of the following: • Medical rationale for use of Juxtapid over Praluent or Repatha (please document rationale) • Patient has had trial and failure of at least 90 days of high dose rosuvastatin (20 mg/40 mg) or atorvastatin (40 mg/80 mg, if rosuvastatin intolerant) therapy concurrently with ezetimibe (or documented intolerance/contraindication to statins/ezetimibe)	

AND

5 - For those of childbearing potential, documentation of a negative pregnancy test in the past 30 days and prescriber has counseled member on risks associated with conceiving while utilizing Juxtapid and appropriate methods of contraception

AND

6 - One of the following:

6.1 The patient will be utilizing maximally tolerated statin therapy with or without ezetimibe concurrently with Juxtapid

OR

6.2 Documented intolerance to statin and/or ezetimibe therapy

OR

6.3 Medical rationale against use of statin or ezetimibe therapy (please document rationale)

Product Name:Juxtapid	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of Juxtapid for at least 90 days within the past 120 days, confirmed by claims history or chart documentation AND	

2 - One of the following:

2.1 Prior history of at least one preferred PCSK9 inhibitor*

OR

2.2 Valid medical rationale for the use of Juxtapid over preferred PCSK9 inhibitors* (please document rationale)

AND

3 - One of the following:

3.1 Continued concurrent use of maximally tolerated statin therapy with or without ezetimibe

OR

3.2 Documented intolerance to statin and/or ezetimibe therapy

OR

3.3 Medical rationale against use of statin or ezetimibe therapy (please document rationale)

AND

4 - One of the following:

4.1 Reduction in LDL-C (low-density lipoprotein-cholesterol) from baseline

OR

4.2 Maintenance of goal LDL-C

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:Leqvio	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following: • Diagnosis of primary hyperlipidemia with clinical atherosclerotic cardiovascular disease (ASCVD) or at increased risk for ASCVD with a baseline LDL-C (low-density lipoprotein-cholesterol) greater than or equal to 55 mg/dL (milligrams per deciliter) • Diagnosis of heterozygous familial hypercholesterolemia (HeFH) with a baseline LDL-C greater than or equal to 70 mg/dL AND 2 - Patient is 18 years of age or older AND 3 - Prescribed by, or in consultation with, a cardiologist or endocrinologist AND 4 - One of the following: 4.1 Trial and failure of Praluent (alirocumab) or Repatha (evolocumab) OR 4.2 Both of the following: • Medical rationale for use of Leqvio (inclisiran) over Praluent (alirocumab) and Repatha (evolocumab) (please document rationale) • Patient has had trial and failure of at least 90 days of high dose rosuvastatin (20 mg/40 mg) or atorvastatin (40 mg/80 mg, if rosuvastatin intolerant) therapy	

concurrently with ezetimibe (or documented intolerance/contraindication to statins/ezetimibe)

AND

5 - One of the following:

- Patient will be utilizing maximally tolerated statin therapy with or without ezetimibe concurrently with Leqvio (inclisiran)
- Documented intolerance to statin and/or ezetimibe therapy or medical rationale against use of statin or ezetimibe therapy (please document reason)

AND

6 - Dose requested does not exceed 284 mg every 3 months for 2 doses at initiation, then 284 mg every 6 months thereafter

Product Name:Leqvio	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested medication within the past 210 days AND 2 - One of the following: • Prior history of at least one preferred PCSK9 inhibitor* • Valid medical rationale for the use of Leqvio (inclisiran) over preferred PCSK9 inhibitors* (please document rationale) AND	

3 - One of the following:

- Continued concurrent use of maximally tolerated statin therapy with or without ezetimibe
- Documented intolerance to statin and/or ezetimibe therapy or medical rationale against use of statin or ezetimibe therapy (please document reason)

AND

4 - Dose does not exceed 284 mg (milligrams) every 6 months

AND

5 - One of the following:

5.1 Reduction in LDL-C (low-density lipoprotein-cholesterol) from baseline

OR

5.2 Maintenance of goal LDL-C

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:Niacin ER (generic Niaspan)

Approval Length 12 month(s)

Therapy Stage Initial Authorization

Guideline Type Prior Authorization

Approval Criteria

1 - Diagnosis of severe hypertriglyceridemia [baseline triglycerides greater than or equal to 500 mg/dL (milligrams per deciliter)] and one of the following:

1.1 Concurrent therapy with ALL of the following for at least 90 days:

- Omega-3 fatty acid (omega-3-acid ethyl esters or icosapent ethyl)

- Fibric acid derivative
- Statin therapy

OR

1.2 Documented intolerance of omega-3 fatty acid, fibric acid derivative, AND statin therapy

OR

1.3 Medical rationale against the use of omega-3 fatty acid, fibric acid derivatives, AND statin therapy (please document rationale)

AND

2 - Patient is 17 years of age or older

Product Name:Niacin ER (generic Niaspan)	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of requested agent for at least 90 days within the past 120 days, confirmed by claims history or chart documentation	

Product Name:Praluent	
Diagnosis	ASCVD (Atherosclerotic Cardiovascular Disease)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of clinical ASCVD (atherosclerotic cardiovascular disease)

AND

2 - ONE of the following:

2.1 Patient at very high risk of future ASCVD events* requiring therapy for secondary prevention and one of the following:

2.1.1 Persistently elevated LDL-C (low-density lipoprotein cholesterol) (greater than or equal to 55 mg/dL) despite treatment with one of the following:

2.1.1.1 For patient requiring greater than 25% additional lowering, one of the following:

- At least 90 days of therapy with high intensity rosuvastatin (20 mg/40 mg) therapy
- For those intolerant to rosuvastatin, at least 90 days of therapy with high intensity atorvastatin (40 mg/80 mg) therapy

OR

2.1.1.2 For patient requiring less than or equal to 25% additional lowering, one of the following:

- At least 90 days of therapy with high intensity rosuvastatin (20 mg/40 mg) therapy with ezetimibe
- For those intolerant to rosuvastatin, at least 90 days of therapy with high intensity atorvastatin (40 mg/80 mg) therapy with ezetimibe

OR

2.1.2 Documented intolerance of both rosuvastatin and atorvastatin with or without ezetimibe OR medical rationale against the use of statin therapy with or without ezetimibe therapy (please document reason)

OR

2.2 Patient is NOT at very high risk of future ASCVD events* requiring therapy for secondary prevention and one of the following:

2.2.1 Persistently elevated LDL-C (greater than or equal to 70 mg/dL) despite treatment with one of the following:

- At least 90 days of therapy with high intensity rosuvastatin (20 mg/40 mg) therapy with ezetimibe
- For those intolerant to rosuvastatin, at least 90 days of therapy with high intensity atorvastatin (40 mg/80 mg) therapy with ezetimibe

OR

2.2.2 Documented intolerance of both rosuvastatin and atorvastatin and/or ezetimibe

OR

2.2.3 Medical rationale against the use of statin therapy and/or ezetimibe therapy (please document rationale)

OR

2.3 Patient with a baseline LDL-C greater than or equal to 190 mg/dL not due to secondary causes (see Table 3), without clinical or genetic diagnosis of familial hypercholesterolemia, requiring therapy for secondary prevention and one of the following:

2.3.1 Persistently elevated LDL-C (greater than or equal to 70 mg/dL) despite treatment with one of the following:

2.3.1.1 For patient requiring greater than 25% additional lowering, one of the following:

- At least 90 days of therapy with high intensity rosuvastatin (20 mg/40 mg) therapy
- For those intolerant to rosuvastatin, at least 90 days of therapy with high intensity atorvastatin (40 mg/80 mg) therapy

OR

2.3.1.2 For patient requiring less than or equal to 25% additional lowering, one of the following:

- At least 90 days of therapy with high intensity rosuvastatin (20 mg/40 mg) therapy with ezetimibe
- For those intolerant to rosuvastatin, at least 90 days of therapy with high intensity atorvastatin (40 mg/80 mg) therapy with ezetimibe

OR

2.3.2 Documented intolerance of both rosuvastatin and atorvastatin with or without ezetimibe
OR medical rationale against the use of statin therapy with or without ezetimibe therapy
(please document reason)

OR

2.4 Patient at very high risk of future ASCVD events* with a baseline LDL-C greater than or equal to 190 mg/dL not due to secondary causes (see Table 3), a diagnosis of familial hypercholesterolemia, and requiring treatment for secondary prevention and one of the following:

2.4.1 Persistently elevated LDL-C (greater than or equal to 55 mg/dL) despite treatment with one of the following:

2.4.1.1 For patient requiring greater than 25% additional lowering, one of the following:

- At least 90 days of therapy with high intensity rosuvastatin (20 mg/40 mg) therapy
- For those intolerant to rosuvastatin, at least 90 days of therapy with high intensity atorvastatin (40 mg/80 mg) therapy

OR

2.4.1.2 For patient requiring less than or equal to 25% additional lowering, one of the following:

- At least 90 days of therapy with high intensity rosuvastatin (20 mg/40 mg) therapy with ezetimibe
- For those intolerant to rosuvastatin, at least 90 days of therapy with high intensity atorvastatin (40 mg/80 mg) therapy with ezetimibe

OR

2.4.2 Documented intolerance of both rosuvastatin and atorvastatin with or without ezetimibe

OR medical rationale against the use of statin therapy with or without ezetimibe therapy (please document reason)

AND

3 - The patient is 18 years of age or older

AND

4 - One of the following:

4.1 The patient will be utilizing maximally tolerated statin therapy with or without ezetimibe concurrently with Praluent

OR

4.2 Documented intolerance to statin and/or ezetimibe therapy

OR

4.3 Medical rationale against use of statin or ezetimibe therapy (please document rationale)

AND

5 - One of the following:

5.1 The dose requested is 75 mg every 2 weeks

OR

5.2 The dose requested is 300 mg every 4 weeks

OR

5.3 The dose requested is 150 mg every 2 weeks and one of the following:

• Patient has homozygous familial hypercholesterolemia • Patient has heterozygous familial hypercholesterolemia and is undergoing LDL apheresis • Patient has not achieved clinically meaningful response after at least 4 weeks of dosing at 75 mg every 2 weeks or 300 mg every 4 weeks	
Notes	*Very High Risk of future ASCVD events is defined as: multiple (2 or more) major ASCVD events from Table 1 OR 1 major ASCVD event from Table 1 and multiple (2 or more) high risk conditions from Table 2

Product Name:Praluent	
Diagnosis	Primary hyperlipidemia, without clinical ASCVD (Atherosclerotic Cardiovascular Disease)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of primary hyperlipidemia, without clinical ASCVD (atherosclerotic cardiovascular disease) AND 2 - Baseline LDL-C (low-density lipoprotein cholesterol) greater than or equal to 190 mg/dL (milligrams per deciliter) not due to secondary causes (see Table 3), with or without concomitant ASCVD risk factors, requiring therapy for primary prevention AND 3 - One of the following: 3.1 Persistently elevated LDL-C (greater than or equal to 100 mg/dL) despite treatment with one of the following: 3.1.1 For patient requiring greater than 25% additional lowering, one of the following:	

- At least 90 days of therapy with high intensity rosuvastatin (20 mg/40 mg) therapy
- For those intolerant to rosuvastatin, at least 90 days of therapy with high intensity atorvastatin (40 mg/80 mg) therapy

OR

3.1.2 For patient requiring less than or equal to 25% additional lowering, one of the following:

- At least 90 days of therapy with high intensity rosuvastatin (20 mg/40 mg) therapy with ezetimibe
- For those intolerant to rosuvastatin, at least 90 days of therapy with high intensity atorvastatin (40 mg/80 mg) therapy with ezetimibe

OR

3.2 Documented intolerance of both rosuvastatin and atorvastatin with or without ezetimibe
OR medical rationale against the use of statin therapy with or without ezetimibe therapy
(please document reason)

AND

4 - The patient is 18 years of age or older

AND

5 - One of the following:

5.1 Patient will be utilizing maximally tolerated statin therapy with or without ezetimibe concurrently with Praluent

OR

5.2 Documented intolerance to statin and/or ezetimibe therapy

OR

5.3 Medical rationale against use of statin or ezetimibe therapy (please document rationale)

AND

6 - One of the following:

6.1 The dose requested is 75 mg every 2 weeks

OR

6.2 The dose requested is 300 mg every 4 weeks

OR

6.3 The dose requested is 150 mg every 2 weeks and one of the following:

- Patient has homozygous familial hypercholesterolemia
- Patient has heterozygous familial hypercholesterolemia and is undergoing LDL apheresis
- Patient has not achieved clinically meaningful response after at least 4 weeks of dosing at 75 mg every 2 weeks or 300 mg every 4 weeks

Product Name:Praluent	
Diagnosis	HoFH (Homozygous Familial Hypercholesterolemia), HeFH (Heterozygous Familial Hypercholesterolemia)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of homozygous familial hypercholesterolemia (HoFH) OR heterozygous familial hypercholesterolemia (HeFH)	

AND

2 - One of the following:

2.1 Persistently elevated LDL-C (low-density lipoprotein cholesterol) (greater than or equal to 70 mg/dL) despite treatment with one of the following:

- At least 90 days of therapy with high intensity rosuvastatin (20 mg/40 mg) therapy concurrently with ezetimibe
- For those intolerant to rosuvastatin, at least 90 days of therapy with high intensity atorvastatin (40 mg/80 mg) therapy concurrently with ezetimibe

OR

2.2 Documented intolerance of both rosuvastatin and atorvastatin and/or ezetimibe

OR

2.3 Medical rationale against the use of statin and/or ezetimibe therapy (please document rationale)

AND

3 - One of the following:

- If for a diagnosis of HeFH, patient is 8 years of age or older
- If for a diagnosis of HoFH, patient is 18 years of age or older

AND

4 - One of the following:

4.1 Patient will be utilizing maximally tolerated statin therapy with or without ezetimibe concurrently with Praluent

OR

4.2 Documented intolerance to statin and/or ezetimibe therapy

OR

4.3 Medical rationale against use of statin or ezetimibe therapy (please document rationale)

AND

5 - One of the following:

5.1 The dose requested is 75 mg every 2 weeks

OR

5.2 The dose requested is 300 mg every 4 weeks

OR

5.3 The dose requested is 150 mg every 2 weeks and one of the following:

- Patient has homozygous familial hypercholesterolemia
- Patient has heterozygous familial hypercholesterolemia and is undergoing LDL apheresis
- Patient has not achieved clinically meaningful response after at least 4 weeks of dosing at 75 mg every 2 weeks or 300 mg every 4 weeks

OR

5.4 The dose requested is 150 mg every 4 weeks and both of the following:

- Patient has heterozygous familial hypercholesterolemia
- Patient is under 18 years of age and weighs less than 50 kg

Product Name:Praluent

Diagnosis	ASCVD (Atherosclerotic Cardiovascular Disease), Primary hyperlipidemia, without clinical ASCVD, HoFH (Homozygous Familial Hypercholesterolemia), HeFH (Heterozygous Familial Hypercholesterolemia)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of Praluent for at least 90 days within the past 120 days, confirmed by claims history or chart documentation AND 2 - ONE of the following: - Continued concurrent use of maximally tolerated statin therapy with or without ezetimibe - Documented intolerance to statin and/or ezetimibe therapy OR medical rationale against the use of statin and/or ezetimibe therapy (please document reason) AND 3 - One of the following: 3.1 The dose requested is 75 mg every 2 weeks OR 3.2 The dose requested is 300 mg every 4 weeks OR 3.3 The dose requested is 150 mg every 2 weeks and one of the following: - Patient has homozygous familial hypercholesterolemia	

- Patient has heterozygous familial hypercholesterolemia and is undergoing LDL (low-density lipoprotein) apheresis
- Patient has not achieved clinically meaningful response after at least 4 weeks of dosing at 75 mg every 2 weeks or 300 mg every 4 weeks

OR

3.4 The dose requested is 150 mg every 4 weeks and both of the following:

- Patient has heterozygous familial hypercholesterolemia
- Patient is under 18 years of age and weighs less than 50 kg

AND

4 - One of the following:

4.1 Reduction in LDL-C from baseline

OR

4.2 Maintenance of goal LDL-C

Product Name: Repatha	
Diagnosis	ASCVD (Atherosclerotic Cardiovascular Disease)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of clinical ASCVD (atherosclerotic cardiovascular disease) AND 2 - ONE of the following:	

2.1 Patient is at very high risk of future ASCVD events* requiring therapy for secondary prevention and one of the following:

2.1.1 Persistently elevated LDL-C (low-density lipoprotein cholesterol) (greater than or equal to 55 mg/dL) despite treatment with one of the following:

2.1.1.1 For patient requiring greater than 25% additional lowering, one of the following:

- At least 90 days of therapy with high intensity rosuvastatin (20 mg/40 mg) therapy
- For those intolerant to rosuvastatin, at least 90 days of therapy with high intensity atorvastatin (40 mg/80 mg) therapy

OR

2.1.1.2 For patient requiring less than or equal to 25% additional lowering, one of the following:

- At least 90 days of therapy with high intensity rosuvastatin (20 mg/40 mg) therapy with ezetimibe
- For those intolerant to rosuvastatin, at least 90 days of therapy with high intensity atorvastatin (40 mg/80 mg) therapy with ezetimibe

OR

2.1.2 Documented intolerance of both rosuvastatin and atorvastatin with or without ezetimibe OR medical rationale against the use of statin therapy with or without ezetimibe therapy (please document reason)

OR

2.2 Patient is NOT at very high risk of future ASCVD events* requiring therapy for secondary prevention and one of the following:

2.2.1 Persistently elevated LDL-C (greater than or equal to 70 mg/dL) despite treatment with one of the following:

- At least 90 days of therapy with high intensity rosuvastatin (20 mg/40 mg) therapy with ezetimibe
- For those intolerant to rosuvastatin, at least 90 days of therapy with high intensity atorvastatin (40 mg/80 mg) therapy with ezetimibe

OR

2.2.2 Documented intolerance of both rosuvastatin and atorvastatin and/or ezetimibe

OR

2.2.3 Medical rationale against the use of statin therapy and/or ezetimibe therapy (please document rationale)

OR

2.3 Patient with a baseline LDL-C greater than or equal to 190 mg/dL not due to secondary causes (see Table 3), without clinical or genetic diagnosis of familial hypercholesterolemia, requiring therapy for secondary prevention and one of the following:

2.3.1 Persistently elevated LDL-C (greater than or equal to 70 mg/dL) despite treatment with one of the following:

2.3.1.1 For patient requiring greater than 25% additional lowering, one of the following:

- At least 90 days of therapy with high intensity rosuvastatin (20 mg/40 mg) therapy
- For those intolerant to rosuvastatin, at least 90 days of therapy with high intensity atorvastatin (40 mg/80 mg) therapy

OR

2.3.1.2 For patient requiring less than or equal to 25% additional lowering, one of the following:

- At least 90 days of therapy with high intensity rosuvastatin (20 mg/40 mg) therapy with ezetimibe
- For those intolerant to rosuvastatin, at least 90 days of therapy with high intensity atorvastatin (40 mg/80 mg) therapy with ezetimibe

OR

2.3.2 Documented intolerance of both rosuvastatin and atorvastatin with or without ezetimibe OR medical rationale against the use of statin therapy with or without ezetimibe therapy (please document reason)

OR

2.4 Patient is at very high risk of future ASCVD events* with a baseline LDL-C greater than or equal to 190 mg/dL not due to secondary causes (see Table 3), a diagnosis of familial hypercholesterolemia, and requiring treatment for secondary prevention and one of the following:

2.4.1 Persistently elevated LDL-C (greater than or equal to 55 mg/dL) despite treatment with one of the following:

2.4.1.1 For patient requiring greater than 25% additional lowering, one of the following:

- At least 90 days of therapy with high intensity rosuvastatin (20 mg/40 mg) therapy
- For those intolerant to rosuvastatin, at least 90 days of therapy with high intensity atorvastatin (40 mg/80 mg) therapy

OR

2.4.1.2 For patient requiring less than or equal to 25% additional lowering, one of the following:

- At least 90 days of therapy with high intensity rosuvastatin (20 mg/40 mg) therapy with ezetimibe
- For those intolerant to rosuvastatin, at least 90 days of therapy with high intensity atorvastatin (40 mg/80 mg) therapy with ezetimibe

OR

2.4.2 Documented intolerance of both rosuvastatin and atorvastatin with or without ezetimibe OR medical rationale against the use of statin therapy with or without ezetimibe therapy (please document reason)

AND

3 - The patient is 18 years of age or older

AND

4 - One of the following:

4.1 Patient will be utilizing maximally tolerated statin therapy with or without ezetimibe concurrently with Repatha

OR

4.2 Documented intolerance to statin and/or ezetimibe therapy

OR

4.3 Medical rationale against use of statin or ezetimibe therapy (please document rationale)

AND

5 - One of the following:

5.1 The dose requested is 140 mg every 2 weeks

OR

5.2 The dose requested is 420 mg once monthly

OR

5.3 Dose requested is 420 mg every 2 weeks and the patient is receiving lipid apheresis

Notes	*Very High Risk of future ASCVD events is defined as: multiple (2 or more) major ASCVD events from Table 1 OR 1 major ASCVD event from Table 1 and multiple (2 or more) high risk conditions from Table 2

Product Name: Repatha	
Diagnosis	Primary hyperlipidemia, without clinical ASCVD (Atherosclerotic Cardiovascular Disease)
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of primary hyperlipidemia, without clinical ASCVD (atherosclerotic cardiovascular disease) AND 2 - Patient with a baseline LDL-C (low-density lipoprotein cholesterol) greater than or equal to 190 mg/dL (milligrams per deciliter) not due to secondary causes (see Table 3), with or without concomitant ASCVD risk factors, requiring therapy for primary prevention AND 3 - One of the following: 3.1 Persistently elevated LDL-C (greater than or equal to 100 mg/dL) despite treatment with one of the following: 3.1.1 For patient requiring greater than 25% additional lowering, one of the following: • At least 90 days of therapy with high intensity rosuvastatin (20 mg/40 mg) therapy • For those intolerant to rosuvastatin, at least 90 days of therapy with high intensity atorvastatin (40 mg/80 mg) therapy OR 3.1.2 For patient requiring less than or equal to 25% additional lowering, one of the following: • At least 90 days of therapy with high intensity rosuvastatin (20 mg/40 mg) therapy with ezetimibe • For those intolerant to rosuvastatin, at least 90 days of therapy with high intensity atorvastatin (40 mg/80 mg) therapy with ezetimibe OR	

3.2 Documented intolerance of both rosuvastatin and atorvastatin with or without ezetimibe
OR medical rationale against the use of statin therapy with or without ezetimibe therapy
(please document reason)

AND

4 - The patient is 18 years of age or older

AND

5 - One of the following:

5.1 Patient will be utilizing maximally tolerated statin therapy with or without ezetimibe
concurrently with Repatha

OR

5.2 Documented intolerance to statin and/or ezetimibe therapy

OR

5.3 Medical rationale against use of statin or ezetimibe therapy (please document rationale)

AND

6 - One of the following:

6.1 The dose requested is 140 mg every 2 weeks

OR

6.2 The dose requested is 420 mg once monthly

OR

6.3 The dose requested is 420 mg every 2 weeks and patient is receiving lipid apheresis

Product Name: Repatha	
Diagnosis	HoFH (Homozygous Familial Hypercholesterolemia), HeFH (Heterozygous Familial Hypercholesterolemia)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of homozygous familial hypercholesterolemia (HoFH) or heterozygous familial hypercholesterolemia (HeFH)

AND

2 - One of the following:

2.1 Persistently elevated LDL-C (low-density lipoprotein cholesterol) (greater than or equal to 70 mg/dL) despite treatment with one of the following:

- At least 90 days of therapy with high intensity rosuvastatin (20 mg/40 mg) therapy concurrently with ezetimibe
- For those intolerant to rosuvastatin, at least 90 days of therapy with high intensity atorvastatin (40 mg/80 mg) therapy concurrently with ezetimibe

OR

2.2 Documented intolerance of both rosuvastatin and atorvastatin and/or ezetimibe

OR

2.3 Medical rationale against the use of statin and/or ezetimibe therapy (please document rationale)

AND

3 - The patient is 10 years of age or older

AND

4 - One of the following:

4.1 Patient will be utilizing maximally tolerated statin therapy with or without ezetimibe concurrently with Repatha

OR

4.2 Documented intolerance to statin and/or ezetimibe therapy

OR

4.3 Medical rationale against use of statin or ezetimibe therapy (please document rationale)

AND

5 - One of the following:

5.1 If the patient has a diagnosis of HoFH, one of the following:

5.1.1 The dose requested is 420 mg once monthly

OR

5.1.2 The dose requested is 420 mg every 2 weeks and one of the following:

- Patient has not achieved clinically meaningful response after at least 12 weeks at 420 mg once monthly dosing
- Patient is receiving lipid apheresis

OR

5.2 If the patient has a diagnosis of HeFH, one of the following:

5.2.1 The dose requested is 140 mg every 2 weeks

OR

5.2.2 The dose requested is 420 mg once monthly

OR

5.2.3 The dose requested is 420 mg every 2 weeks and patient is receiving lipid apheresis

Product Name: Repatha	
Diagnosis	ASCVD (Atherosclerotic Cardiovascular Disease), Primary hyperlipidemia, without clinical ASCVD, HoFH (Homozygous Familial Hypercholesterolemia), HeFH (Heterozygous Familial Hypercholesterolemia)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of Repatha for at least 90 days within the past 120 days, confirmed by claims history or chart documentation AND 2 - One of the following: Continued concurrent use of maximally tolerated statin therapy with or without ezetimibe	

- Documented intolerance to statin and/or ezetimibe therapy OR medical rationale against use of statin or ezetimibe therapy (please document reason)

AND

3 - One of the following:

3.1 If the patient has a diagnosis of HoFH (homozygous familial hypercholesterolemia), one of the following:

3.1.1 The dose requested is 420 mg once monthly

OR

3.1.2 The dose requested is 420 mg every 2 weeks and one of the following:

- Patient has not achieved clinically meaningful response after at least 12 weeks at 420 mg once monthly dosing
- Patient is receiving lipid apheresis

OR

3.2 For all other diagnoses, one of the following:

3.2.1 The dose requested is 140 mg every 2 weeks

OR

3.2.2 The dose requested is 420 mg once monthly

OR

3.2.3 The dose requested is 420 mg every 2 weeks and patient is receiving lipid apheresis

AND

4 - One of the following:

4.1 Reduction in LDL-C from baseline

OR

4.2 Maintenance of goal LDL-C

Product Name:Tryngolza	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records documenting diagnosis of familial chylomicronemia syndrome confirmed by genetic testing AND 2 - Submission of lab documentation obtained within the past 90 days documenting patient has a baseline fasting triglyceride level 880 mg/dL or greater AND 3 - Patient is 18 years of age or older AND 4 - Prescribed by, or in consultation with, a cardiologist, endocrinologist, or lipid specialist (lipidologist) AND	

5 - Prescriber attests that patient will be using the requested medication as an adjunct to low-fat diet (20 grams fat per day or less) to reduce triglycerides

Product Name:Tryngolza	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested medication for at least 90 days within the past 120 days, confirmed by claims history or chart documentation AND 2 - Submission of lab documentation obtained within the past 180 days demonstrating positive clinical response (e.g., improvement/stabilization in fasting triglyceride levels)	

2 . Background

Benefit/Coverage/Program Information					
Table 1. Major ASCVD Events <table border="1"> <tr> <td>Acute Coronary Syndrome (ACS) within the past 12 months</td> </tr> <tr> <td>History of myocardial infarction (other than recent ACS event listed above)</td> </tr> <tr> <td>History of ischemic stroke</td> </tr> <tr> <td>Peripheral artery disease (PAD) with history of claudication with ABI <0.85</td> </tr> <tr> <td>PAD with history of previous revascularization or amputation</td> </tr> </table> Table 2. High-Risk Conditions	Acute Coronary Syndrome (ACS) within the past 12 months	History of myocardial infarction (other than recent ACS event listed above)	History of ischemic stroke	Peripheral artery disease (PAD) with history of claudication with ABI <0.85	PAD with history of previous revascularization or amputation
Acute Coronary Syndrome (ACS) within the past 12 months					
History of myocardial infarction (other than recent ACS event listed above)					
History of ischemic stroke					
Peripheral artery disease (PAD) with history of claudication with ABI <0.85					
PAD with history of previous revascularization or amputation					

Age $\geq$ 65 years
Heterozygous familial hypercholesterolemia
History of prior coronary artery bypass surgery outside of major ASCVD event
History of prior percutaneous coronary intervention outside of major ASCVD event
Diabetes mellitus
Hypertension
Chronic kidney disease (eGFR 15-59 mL/min/1.73m ²)
Current smoker
Persistently elevated LDL-C ($\geq$ 100 mg/dL) despite maximally tolerated statin therapy plus ezetimibe
Congestive heart failure

Table 3. Secondary Causes of Dyslipidemia

Cholestatic Liver Disease
Chronic Renal Disease
Cigarette Smoking
Diabetes Mellitus
Excessive Alcohol Consumption
Extreme Dietary Patterns (e.g., anorexia nervosa)
Hypothyroidism
Medications (e.g., thiazide diuretics, beta blockers, oral estrogens)
Nephrotic Syndrome
Obesity

3 . Revision History

UnitedHealthcare Community Plan of Indiana Clinical Pharmacy Program Guidelines

Date	Notes
2/26/2026	Added Evkeeza and Leqvio. Updated medical justification/rationale language.

Pemazyre



Prior Authorization Guideline

Guideline ID	GL-474193
Guideline Name	Pemazyre
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia Medicaid - Community & State Washington

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name: Pemazyre

Diagnosis	Cholangiocarcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of cholangiocarcinoma AND 2 - Disease is ONE of the following: • Unresectable locally advanced • Resected gross residual (R2) • Metastatic AND 3 - Disease has presence of a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement AND 4 - Patient has been previously treated	

Product Name:Pemazyre	
Diagnosis	Myeloid/Lymphoid Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of myeloid/lymphoid/mixed lineage neoplasms with eosinophilia

AND

2 - Disease has presence of a fibroblast growth factor receptor 1 (FGFR1) rearrangement

Product Name:Pemazyre

Diagnosis	Cholangiocarcinoma, Myeloid/Lymphoid Neoplasms

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 Pemazyre therapy

Product Name:Pemazyre

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:Pemazyre

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 Pemazyre therapy	

2 . Revision History

Date	Notes
12/11/2025	Combined formularies. Updated verbiage in initial auth section for NCCN Recommended Regimens, with no changes to clinical intent.

Phenylketonuria agents



Prior Authorization Guideline

Guideline ID	GL-560237
Guideline Name	Phenylketonuria agents
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name: Brand Javygtor, Brand Kuvan, generic sapropterin, generic Zelvysia	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of hyperphenylalaninemia due to tetrahydrobiopterin-responsive phenylketonuria	

AND

2 - Submission of medical records documenting baseline blood phenylalanine levels prior to initiating therapy, obtained within the past 30 days

AND

3 - Patient is 1 month of age or older

AND

4 - Provider attests to all of the following:

- Patient is concomitantly prescribed and will adhere to a phenylalanine-restricted diet
- Patient will only be using a single sapropterin agent
- Medication will not be used in combination with Palynziq or Sepience

AND

5 - Dose requested does not exceed 20 mg/kg once daily (document weight)

AND

6 - If the request is for Javygtor or Zelvysia, ONE of the following:

- Patient tried and failed generic sapropterin
- There is medical justification for use of the requested product (document rationale)

Product Name: Brand Javygtor, Brand Kuvan, generic sapropterin, generic Zelvysia	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - History of requested agent for 60 of the past 90 days, as confirmed by claims history, submission of medical records, or prescriber attestation including trial dates (if applicable, document trial dates)

AND

2 - Submission of medical records documenting a reduction in blood phenylalanine from baseline level (documentation of blood phenylalanine levels, obtained within the past 60 days, must be submitted)

AND

3 - Provider attests to all of the following:

- Patient has been adherent to and will be maintained on a phenylalanine-restricted diet
- Patient will only be using a single sapropterin agent
- Medication will not be used in combination with Palynziq or Sephience

AND

4 - Dose requested does not exceed 20 mg/kg once daily (document weight)

AND

5 - If the request is for Javygtor or Zelvysia, ONE of the following:

- Patient tried and failed generic sapropterin
- There is medical justification for use of the requested product (document rationale)

Product Name:Palynziq	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of phenylketonuria with uncontrolled blood phenylalanine (PHE) concentrations greater than 600 micromol/L (10 mg/dL) on existing treatment AND 2 - Submission of medical records documenting baseline blood phenylalanine levels prior to initiating therapy, obtained within the past 30 days AND 3 - Patient is 18 years of age or older AND 4 - ONE of the following: • Previous trial and failure of a sapropterin product at an optimized dose of 20 mg/kg/day for at least 30 days in the past 60 days, as confirmed by claims history, submission of medical records, or provider attestation including dates of trial (if applicable, document dates of trial) • Medical justification for use of Palynziq over sapropterin products (document rationale) AND 5 - Prescriber attests to all of the following: • Prescriber is enrolled in the Palynziq REMS program • Patient will not be using Palynziq in combination with sapropterin or Sepience AND 6 - Dose requested does not exceed 20 mg once daily	

Product Name:Palynziq	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of requested agent for 90 of the past 120 days, as confirmed by claims history, submission of medical records, or prescriber attestation including trial dates (if applicable, document trial dates) AND 2 - ONE of the following: • Submission of medical records documenting a reduction in blood phenylalanine from baseline level (documentation of blood phenylalanine levels, obtained within the past 60 days, must be submitted) • Provider has submitted medical justification for continued use in patients who have not seen a reduction in blood phenylalanine levels from baseline AND 3 - Prescriber attests to all of the following: • Prescriber is enrolled in the Palynziq REMS program • Patient will not be using Palynziq in combination with sapropterin or Sephience AND 4 - Dose requested does not exceed 60 mg once daily	

Product Name:Sephience	
Approval Length	Patient is less than 2 years of age: 6 months; Patient is 2 years of age and older: 2 months

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of hyperphenylalaninemia due to sepiapterin-responsive phenylketonuria AND 2 - Submission of medical records documenting baseline blood phenylalanine levels prior to initiating therapy, obtained within the past 30 days AND 3 - Patient is 1 month of age or older AND 4 - Provider attests to all of the following: • Patient is concomitantly prescribed and will adhere to a phenylalanine-restricted diet • Patient has not been and will not be using Sephience in combination with Palynziq or a sapropterin product AND 5 - ONE of the following: • Previous trial and failure of a sapropterin product at an optimized dose of 20 mg/kg/day for at least 30 days in the past 60 days, as confirmed by claims history, submission of medical records, or provider attestation including dates of trial (if applicable, document dates of trial) • Medical justification for use of Sephience over sapropterin products (document rationale)	

AND

6 - Dose requested does not exceed 60 mg/kg/day (document weight)

Product Name:Sephience

Approval Length	6 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - History of requested agent for 45 of the past 60 days, as confirmed by claims history, submission of medical records, or prescriber attestation including trial dates (if applicable, document trial dates)

AND

2 - Submission of medical records documenting a reduction in blood phenylalanine from baseline level (documentation of blood phenylalanine levels, obtained within the past 60 days, must be submitted)

AND

3 - Provider attests to all of the following:

- Patient has been adherent to and will be maintained on a phenylalanine-restricted diet
- Patient has not been and will not be using Sephience in combination with Palynziq or a sapropterin product

AND

4 - Dose requested does not exceed 60 mg/kg/day (document weight)

2 . Revision History

Date	Notes
3/31/2026	Clarified chart documentation language.

Phosphodiesterase Inhibitors for Pulmonary Related Disorders



Prior Authorization Guideline

Guideline ID	GL-598199
Guideline Name	Phosphodiesterase Inhibitors for Pulmonary Related Disorders
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Brand Daliresp, generic roflumilast	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has severe chronic obstructive pulmonary disease (COPD) associated with chronic bronchitis	

AND

2 - Submission of medical records (e.g., charts, labs, progress notes, etc.) confirming patient has history of exacerbations

AND

3 - Submission of medical records (e.g., charts, labs, progress notes, etc.) confirming patient has an FEV-1 that is less than or equal to 50% predicted

AND

4 - One of the following:

4.1 Patient is utilizing a combination long-acting beta-agonist (LABA)/long-acting muscarinic antagonist (LAMA)/inhaled corticosteroid (ICS) therapy for at least 90 days in the past 120 days

OR

4.2 BOTH of the following:

4.2.1 Prescriber has provided medical rationale for the use of Daliresp (roflumilast) over combination LAMA/LABA/ICS therapy (please document rationale)

AND

4.2.2 One of the following:

- Patient is utilizing combination LABA/LAMA therapy for at least 90 days in the past 120 days
- Prescriber has provided medical rationale for the use of Daliresp (roflumilast) over combination LABA/LAMA therapy (please document rationale)

AND

5 - One of the following:

5.1 Prescriber attests patient will continue to utilize appropriate adjunct therapy while on Daliresp (roflumilast)

OR

5.2 Prescriber has provided medical rationale for discontinuing use of adjunct therapy (please document)

Product Name:Ohtuvayre	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has diagnosis of chronic obstructive pulmonary disease (COPD)

AND

2 - Submission of medical records (e.g., charts, labs, progress notes, etc.) confirming patient has an FEV-1/FVC ratio of less than 0.7 measured by spirometry

AND

3 - Submission of medical records (e.g., charts, labs, progress notes, etc.) confirming patient has a Modified Medical Research Council (mMRC) dyspnea score of greater than or equal to 2

AND

4 - One of the following:

4.1 Patient is utilizing a combination long-acting beta-agonist (LABA)/long-acting muscarinic antagonist (LAMA)/inhaled corticosteroid (ICS) therapy for at least 90 days in the past 120 days

OR

4.2 BOTH of the following:

4.2.1 Prescriber has provided medical rationale for the use of Ohtuvayre (ensifentrine) over combination LAMA/LABA/ICS therapy

AND

4.2.2 One of the following:

- Patient is utilizing combination LABA/LAMA therapy for at least 90 days in the past 120 days
- Prescriber has provided medical rationale for the use of Ohtuvayre (ensifentrine) over combination LABA/LAMA therapy (please document rationale)

AND

5 - One of the following:

5.1 Prescriber attests patient will continue to utilize appropriate adjunct therapy while on Ohtuvayre (ensifentrine)

OR

5.2 Prescriber has provided medical rationale for discontinuing use of adjunct therapy (please document)

Product Name: Brand Daliresp, generic roflumilast, Ohtuvayre	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - History of the requested agent for at least 90 days within the past 120 days, as confirmed by claims history, submission of medical records, or provider documents dates of trial (document dates of trial, if applicable)

AND

2 - One of the following:

2.1 Patient is continuing to utilize adjunct therapy, as applicable

OR

2.2 Medical rationale has been provided for not continuing adjunct therapy (please document rationale)

Product Name: Jascayd

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Submission of medical records (e.g., charts, labs, progress notes, etc.) verifying diagnosis of idiopathic pulmonary fibrosis confirmed by lung biopsy or high-resolution computed tomography (HRCT) demonstrating usual interstitial pneumonia (UIP) or probable UIP HRCT pattern

OR

1.2 Submission of medical records (e.g., charts, labs, progress notes, etc.) verifying

diagnosis of progressive pulmonary fibrosis confirmed by consistent decline in lung function [supported by documentation such as HCRT scan, pulmonary function tests (PFTs), etc.]

AND

2 - Patient is 18 years of age or older

AND

3 - Submission of medical records (e.g., charts, labs, progress notes, etc.) confirming patient has a forced vital capacity (FVC) greater than or equal to 45% of predicted at baseline

AND

4 - Submission of medical records (e.g., charts, labs, progress notes, etc.) confirming patient has a carbon monoxide diffusing capacity greater than or equal to 25% of predicted

AND

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

AND

6 - Requested dose does not exceed 18 mg (milligrams) twice daily

Product Name:Jascayd	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested agent for at least 90 days within the past 120 days, as confirmed	

by claims history, submission of medical records, or provider documents dates of trial (document dates of trial, if applicable)

AND

2 - Submission of medical records (e.g., charts, labs, progress notes, etc.) confirming patient demonstrates positive clinical response to therapy [e.g., improvement/stabilization in forced vital capacity FVC - documentation submitted must show trend from baseline]

AND

3 - Requested dose does not exceed 18 mg (milligrams) twice daily

2 . Revision History

Date	Notes
4/28/2026	Updated guideline name. Added Jascayd. Clarified submission and document language throughout.

Piqray



Prior Authorization Guideline

Guideline ID	GL-333264
Guideline Name	Piqray
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	8/1/2025

1 . Criteria

Product Name:Piqray	
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: • Advanced • Metastatic AND 3 - Disease is hormone receptor (HR)-positive AND 4 - Disease is human epidermal growth factor receptor 2 (HER2)-negative AND 5 - Presence of one or more PIK3CA mutations AND 6 - Used in combination with fulvestrant AND	

7 - Disease has progressed on or after an endocrine-based regimen

Product Name:Piqrax	
Diagnosis	Breast 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 Piqrax therapy	

Product Name:Piqrax	
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:Piqrax	
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 Piqray therapy

2 . Revision History

Date	Notes
7/18/2025	Combined formularies. No changes to clinical criteria.

Pomalyst



Prior Authorization Guideline

Guideline ID	GL-351194
Guideline Name	Pomalyst
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	9/1/2025

1 . Criteria

Product Name:Pomalyst	
Diagnosis	Multiple Myeloma

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of multiple myeloma AND 2 - ONE of the following: 2.1 Failure of ONE of the following, confirmed by claims history or submitted medical records: - Immunomodulatory agent [e.g., Revlimid (lenalidomide)] - Proteasome inhibitor [e.g., Velcade (bortezomib)] - Anti CD-38 therapy [e.g., Darzalex (daratumumab), Sarclisa (isatuximab)] OR 2.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication): - Immunomodulatory agent [e.g., Revlimid (lenalidomide)] - Proteasome inhibitor [e.g., Velcade (bortezomib)] - Anti CD-38 therapy [e.g., Darzalex (daratumumab), Sarclisa (isatuximab)] OR 2.3 Induction therapy for the management of POEMS (polyneuropathy, organomegaly, endocrinopathy, monoclonal protein, skin changes) syndrome	

Product Name:Pomalyst	
Diagnosis	Systemic Light Chain Amyloidosis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of systemic light chain amyloidosis AND 2 - Used in combination with dexamethasone	

Product Name:Pomalyst	
Diagnosis	Kaposi Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of HIV (human immunodeficiency virus)-negative Kaposi Sarcoma OR 2 - BOTH of the following: 2.1 Diagnosis of AIDS (acquired immunodeficiency syndrome)-related Kaposi Sarcoma AND 2.2 Patient is currently being treated with antiretroviral therapy (ART), confirmed by claims history or submitted medical records	

Product Name:Pomalyst

Diagnosis	Primary CNS Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of primary central nervous system (CNS) lymphoma AND 2 - ONE of the following: 2.1 Used as second-line or subsequent therapy OR 2.2 Used as induction therapy if patient is unsuitable for or intolerant to high-dose methotrexate	

Product Name:Pomalyst	
Diagnosis	Multiple Myeloma, Systemic Light Chain Amyloidosis, Kaposi Sarcoma, Primary CNS Lymphoma
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 Pomalyst therapy	

Product Name:Pomalyst

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:Pomalyst	
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 Pomalyst therapy	

2 . Revision History

Date	Notes
7/30/2025	Updated formularies to add IN for eff 9/1/2025.

Pomalyst



Prior Authorization Guideline

Guideline ID	GL-351194
Guideline Name	Pomalyst
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	9/1/2025

1 . Criteria

Product Name:Pomalyst	
Diagnosis	Multiple Myeloma

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of multiple myeloma AND 2 - ONE of the following: 2.1 Failure of ONE of the following, confirmed by claims history or submitted medical records: - Immunomodulatory agent [e.g., Revlimid (lenalidomide)] - Proteasome inhibitor [e.g., Velcade (bortezomib)] - Anti CD-38 therapy [e.g., Darzalex (daratumumab), Sarclisa (isatuximab)] OR 2.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication): - Immunomodulatory agent [e.g., Revlimid (lenalidomide)] - Proteasome inhibitor [e.g., Velcade (bortezomib)] - Anti CD-38 therapy [e.g., Darzalex (daratumumab), Sarclisa (isatuximab)] OR 2.3 Induction therapy for the management of POEMS (polyneuropathy, organomegaly, endocrinopathy, monoclonal protein, skin changes) syndrome	

Product Name:Pomalyst	
Diagnosis	Systemic Light Chain Amyloidosis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of systemic light chain amyloidosis AND 2 - Used in combination with dexamethasone	

Product Name:Pomalyst	
Diagnosis	Kaposi Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of HIV (human immunodeficiency virus)-negative Kaposi Sarcoma OR 2 - BOTH of the following: 2.1 Diagnosis of AIDS (acquired immunodeficiency syndrome)-related Kaposi Sarcoma AND 2.2 Patient is currently being treated with antiretroviral therapy (ART), confirmed by claims history or submitted medical records	

Product Name:Pomalyst

Diagnosis	Primary CNS Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of primary central nervous system (CNS) lymphoma AND 2 - ONE of the following: 2.1 Used as second-line or subsequent therapy OR 2.2 Used as induction therapy if patient is unsuitable for or intolerant to high-dose methotrexate	

Product Name:Pomalyst	
Diagnosis	Multiple Myeloma, Systemic Light Chain Amyloidosis, Kaposi Sarcoma, Primary CNS Lymphoma
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 Pomalyst therapy	

Product Name:Pomalyst

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:Pomalyst	
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 Pomalyst therapy	

2 . Revision History

Date	Notes
7/30/2025	Updated formularies to add IN for eff 9/1/2025.

Pompe Disease Agents



Prior Authorization Guideline

Guideline ID	GL-154706
Guideline Name	Pompe Disease Agents
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name:Opfolda	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of late-onset Pompe disease confirmed by ONE of the following (submission of documentation required): 1.1 Deficiency of acid alpha-glucosidase (GAA) enzyme	

OR

1.2 GAA genotyping or gene sequencing

AND

2 - Patient is 18 years of age or older

AND

3 - Patient weighs greater than or equal to 40 kilograms

AND

4 - Prescriber attests that patient will be using Opfolda (miglustat) and Pombiliti (cipaglucosidase alfa) concurrently

AND

5 - Prescriber attests that patient will NOT be using Opfolda (miglustat) concurrently with Lumizyme (alglucosidase alfa) or Nexvazyme (avalglucosidase alfa)

AND

6 - Prescribed by, or in consultation with, a geneticist, metabolic disorder specialist or neurologist

AND

7 - For those of childbearing potential, documentation of a negative pregnancy test from within the past 30 days and prescriber has counseled patient on risks associated with conceiving while utilizing Pombiliti/Opfolda and medically appropriate methods of contraception

AND

8 - Dose requested does not exceed 260 milligrams every other week (8 capsules/28 days)

Product Name:Opfolda

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - History of requested agent within the past 90 days, as confirmed by claims history, chart documentation, or provider attestation including dates of trial

AND

2 - Prescriber attests to ALL of the following:

2.1 Opfolda (miglustat) will continue to be used in conjunction with Pombiliti (cipaglucosidase alfa)

AND

2.2 For those of childbearing potential, patient is not currently pregnant and prescriber has counseled patient regarding medically appropriate methods of contraception

AND

2.3 Patient will NOT be using Opfolda (miglustat) concurrently with Lumizyme (alglucosidase alfa) or Nexvazyme (avalglucosidase alfa)

AND

3 - Prescriber has submitted documentation supporting improvement or stabilization in disease state (e.g., forced vital capacity, six-minute walk test)

AND

4 - Dose requested does not exceed 260 milligrams every other week (8 capsules/28 days)

2 . Revision History

Date	Notes
9/10/2024	Criteria added to not use Opfolda with Lumizyme or Nexviazyme.

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 (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 Pharmacopeia-National Formulary (USP-NF) 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 (please specify contraindication or intolerance). 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-443190
Guideline Name	Presbyopia Agents
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	12/1/2025

1 . Criteria

Product Name:Brand Vuity, generic pilocarpine 1.25%^	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of presbyopia	

AND	
2 - Patient is 18 years of age or older	
AND	
3 - Prescribed by, or in consultation with, an optometrist or ophthalmologist	
AND	
4 - Previous trial/failure/intolerance of corrective lenses (e.g., eyeglasses, contact lenses)	
AND	
5 - Requested quantity does NOT exceed 1 bottle of either 2.5 mL (milliliter) per 10 days or 5 mL per 20 days	
Notes	^Generic pilocarpine 1.25% needs to be reviewed by clinician for generic over brand review

Product Name: Brand Vuity, generic pilocarpine 1.25%	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested agent within the past 90 days AND	

2 - Requested quantity does NOT exceed 1 bottle of either 2.5 mL (milliliter) per 10 days or 5 mL per 20 days

Notes	*If patient does not meet history requirement for reauthorization criteria, please refer to initial authorization criteria.

2 . Revision History

Date	Notes
11/6/2025	Added generic pilocarpine 1.25%. Added note regarding generic over brand review.

Prevymis



Prior Authorization Guideline

Guideline ID	GL-129062
Guideline Name	Prevymis
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	10/1/2023

1 . Criteria

Product Name:Prevymis tabs	
Diagnosis	Cytomegalovirus Prophylaxis
Approval Length	9 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ALL of the following: 1.1 Patient is a recipient of an allogeneic hematopoietic stem cell transplant	

AND

1.2 Patient is cytomegalovirus (CMV)-seropositive

AND

1.3 Provider attests that Prevymsis will be initiated between Day 0 and Day 28 post-transplantation (before or after engraftment) and is being prescribed as prophylaxis and not treatment of CMV infection

OR

2 - ALL of the following:

2.1 Patient is a recipient of a kidney transplant

AND

2.2 Patient is CMV-seronegative

AND

2.3 Donor is CMV-seropositive

AND

2.4 Provider attests that Prevymsis will be initiated between Day 0 and Day 7 post-transplantation (before or after engraftment) and is being prescribed as prophylaxis and not treatment of CMV infection

Procysbi



Prior Authorization Guideline

Guideline ID	GL-442202
Guideline Name	Procysbi
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland 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 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: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 - ONE of the following*: 3.1 Failure to Cystagon as confirmed by claims history or submission of medical records OR 3.2 History of intolerance or contraindication to Cystagon (please specify intolerance or contraindication)	
Notes	*UHC generally does not consider frequency of dosing and/or lack of compliance to dosing regimens, 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
11/6/2025	Added Nevada Formulary

Procysbi



Prior Authorization Guideline

Guideline ID	GL-442202
Guideline Name	Procysbi
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland 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 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: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 - ONE of the following*: 3.1 Failure to Cystagon as confirmed by claims history or submission of medical records OR 3.2 History of intolerance or contraindication to Cystagon (please specify intolerance or contraindication)	
Notes	*UHC generally does not consider frequency of dosing and/or lack of compliance to dosing regimens, 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
11/6/2025	Added Nevada Formulary

Progesterone - Non-Oral



Prior Authorization Guideline

Guideline ID	GL-577267
Guideline Name	Progesterone - Non-Oral
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name: Brand Endometrin, generic progesterone vaginal insert	
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

Date	Notes
4/14/2026	Added generic progesterone vaginal insert.

Proton Pump Inhibitors



Prior Authorization Guideline

Guideline ID	GL-289259
Guideline Name	Proton Pump Inhibitors
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	7/1/2025

1 . Criteria

Product Name:(All Rx and OTC Products per label name included) generic omeprazole tabs, Brand Prilosec tabs, Brand Protonix tabs, Brand Prevacid caps, Nexium caps, generic rabeprazole tabs, generic dexlansoprazole caps, generic omeprazole/sodium bicarb caps, Brand Zegerid caps, Zegerid OTC, omeprazole 20.6 mg caps, omeprazole ODT, generic esomeprazole 24HR, Brand Nexium 24HR	
Diagnosis	Non-Preferred Products - NOT exceeding 90 days PPI therapy within past 180 days
Approval Length	90 Days*
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following**:

1.1 Trial and failure history of two different (chemical entities) preferred agents within the same subclass for a total duration of 4 weeks (supported by chart documentation or claims history)

OR

1.2 Prescriber has submitted medical justification for use of the requested non-preferred agent over ALL preferred agents within the same subclass

Notes	*Approval duration should not allow member to exceed 90 days of PPI therapy within 180 days **PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:(All Rx and OTC Products per label name included) generic omeprazole tabs, Brand Prilosec tabs, Brand Protonix tabs, Brand Prevacid caps, Nexium caps, generic rabeprazole tabs, generic dexlansoprazole caps, generic omeprazole/sodium bicarb caps, Brand Zegerid caps, Zegerid OTC, omeprazole 20.6 mg caps, omeprazole ODT, generic esomeprazole 24HR, Brand Nexium 24HR

Diagnosis	Non-Preferred Products - NOT exceeding 90 days PPI therapy within past 180 days
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - History of the requested agent within the past 365 days

Product Name:(All Rx and OTC Products per label name included) generic omeprazole caps, Brand Prilosec tabs, generic omeprazole tabs, generic pantoprazole tabs, Brand Protonix tabs, generic lansoprazole caps, Brand Prevacid caps, generic esomeprazole magnesium caps, Brand Nexium caps, generic rabeprazole tabs, generic dexlansoprazole caps, Brand Dexilant caps, generic omeprazole/sodium bicarb caps, Brand Zegerid caps, Zegerid OTC, omeprazole 20.6 mg caps, omeprazole ODT, generic esomeprazole 24HR, Brand Nexium 24HR

Diagnosis	Exceeding 90 days PPI therapy within past 180 days
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following: 1.1 Patient has one of the following diagnoses: • Barrett's esophagus • Abnormality of secretion of gastrin • Zollinger-Ellison syndrome • Any disease leading to hypersecretion OR 1.2 Diagnosis of duodenal/gastric/peptic ulcer that has not healed* (see notes) OR 1.3 Patient is on continuous drug therapy requiring gastroprotection (e.g. anticoagulants, corticosteroids, antiplatelet agents, NSAIDS, etc.) OR 1.4 Both of the following: 1.4.1 Diagnosis of one of the following: • Erosive esophagitis • Gastroesophageal reflux disease (GERD) AND 1.4.2 One of the following:	

- Previous trial and failure of intermittent PPI therapy (patient has experienced discontinuation of PPI therapy)
- Previous trial and failure of H2 antagonist therapy
- Previous trial and failure of antacid therapy

AND

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

2.1 Trial and failure history of two different (chemical entities) preferred agents within the same subclass for a total duration of 4 weeks (supported by chart documentation or claims history)

OR

2.2 Prescriber has submitted medical justification for use of the requested non-preferred agent over ALL preferred agents within the same subclass

Notes	*Diagnosis of duodenal/gastric/peptic ulcer that has not healed: Approve only 4 additional weeks beyond patient's previous 90 days of use (permit a total of 118 days of therapy per 180 days). **PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:(All Rx and OTC Products per label name included) Brand Prilosec susp packet, generic lansoprazole ODT, Brand Prevacid Solutab, Rabeprazole sprinkle, generic esomeprazole susp packet, generic pantoprazole susp packet, generic omeprazole/sodium bicarb powd pack, Brand Zegerid powd pack, Konvomep

Diagnosis	Non-Preferred Non-Solid Dosage Forms - NOT exceeding 90 days PPI therapy within past 180 days
Approval Length	90 Days*
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is unable to swallow tablet/capsule formulation

AND

2 - One of the following:

2.1 Trial and failure of both Brand Nexium Packets and Brand Protonix Pak for a total duration of 4 weeks (supported by chart documentation or claims history)

OR

2.2 Prescriber has submitted medical justification for use of the requested non-preferred agent over both Brand Nexium Packets and Brand Protonix Pak

Notes	*Approval duration should not allow member to exceed 90 days of PPI therapy within 180 days

Product Name:(All Rx and OTC Products per label name included) Brand Prilosec susp packet, generic lansoprazole ODT, Brand Prevacid Solutab, Rabeprazole sprinkle, generic esomeprazole susp packet, generic pantoprazole susp packet, generic omeprazole/sodium bicarb powd pack, Brand Zegerid powd pack, Konvomep

Diagnosis	Non-Preferred Non-Solid Dosage Forms - NOT exceeding 90 days PPI therapy within past 180 days

Approval Length	1 year(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - History of the requested agent within the past 365 days

Product Name:(All Rx and OTC Products per label name included) Brand Prilosec susp packet, generic lansoprazole ODT, Brand Prevacid Solutab, Rabeprazole sprinkle, generic esomeprazole susp packet, Brand Nexium packet, generic pantoprazole susp packet, Brand Protonix packet, generic omeprazole/sodium bicarb powd pack, Brand Zegerid powd pack, Konvomep

Diagnosis	Non-Solid Dosage Forms - Exceeding 90 days PPI therapy within past 180 days

Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following: 1.1 Patient has one of the following diagnoses: • Barrett's esophagus • Abnormality of secretion of gastrin • Zollinger-Ellison syndrome • Any disease leading to hypersecretion OR 1.2 Diagnosis of duodenal/gastric/peptic ulcer that has not healed* (see notes) OR 1.3 Patient is on continuous drug therapy requiring gastroprotection (e.g. anticoagulants, corticosteroids, antiplatelet agents, NSAIDS, etc.) OR 1.4 Both of the following: 1.4.1 Diagnosis of one of the following: • Erosive esophagitis • Gastroesophageal reflux disease (GERD) AND 1.4.2 One of the following:	

- Previous trial and failure of intermittent PPI therapy (patient has experienced discontinuation of PPI therapy)
- Previous trial and failure of H2 antagonist therapy
- Previous trial and failure of antacid therapy

AND

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

2.1 Patient is unable to swallow tablet/capsule formulation

AND

2.2 One of the following:

2.2.1 Trial and failure of both Brand Nexium Packets and Brand Protonix Pak for a total duration of 4 weeks (supported by chart documentation or claims history)

OR

2.2.2 Prescriber has submitted medical justification for use of the requested non-preferred agent over both Brand Nexium Packets and Brand Protonix Pak

Notes	*Diagnosis of duodenal/gastric/peptic ulcer that has not healed: Approve only 4 additional weeks beyond patient's previous 90 days of use (permit a total of 118 days of therapy per 180 days).

Product Name:(All Rx and OTC Products per label name included) generic omeprazole caps, Brand Prilosec tabs, generic omeprazole tabs, generic pantoprazole tabs, Brand Protonix tabs and susp packet, generic lansoprazole caps, Brand Prevacid caps, generic esomeprazole magnesium caps, Brand Nexium caps and susp packet, generic rabeprazole tabs, generic dexlansoprazole caps, Brand Dexilant caps, generic omeprazole/sodium bicarb caps, Brand Zegerid caps, Zegerid OTC, Brand Prilosec susp packet, generic lansoprazole ODT, Brand Prevacid Solutab, Rabeprazole sprinkle, generic esomeprazole susp packet, generic pantoprazole susp packet, generic omeprazole/sodium bicarb powd pack, Brand Zegerid powd pack, Konvomep, omeprazole 20.6 mg caps, omeprazole ODT, generic esomeprazole 24HR, Brand Nexium 24HR

Diagnosis	Quantity Limit
Approval Length	90 Days*
Guideline Type	Quantity Limit (Max Daily Dose)

Approval Criteria

1 - One of the following:

1.1 The requested drug must be used for an FDA (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 (USP-NF)

AND

2 - ONE of the following:

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

OR

2.2 The request 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 (USP-NF)

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.

Notes	These criteria are from the Quantity Limits policy. *May approve UP TO 1 year if member meets drug-specific criteria for PPI therapy in excess of 90 days per 180 days; otherwise, approval should not exceed 90 days of therapy within 180 days.

Product Name:(All Rx and OTC Products per label name included) generic omeprazole caps, Brand Prilosec tabs, generic omeprazole tabs, generic pantoprazole tabs, Brand Protonix tabs and susp packet, generic lansoprazole caps, Brand Prevacid caps, generic esomeprazole magnesium caps, Brand Nexium caps and susp packet, generic rabeprazole tabs, generic dexlansoprazole caps, Brand Dexilant caps, generic omeprazole/sodium bicarb caps, Brand Zegerid caps, Brand Prilosec susp packet, generic lansoprazole ODT, Brand Prevacid Solutab, Rabeprazole sprinkle, generic esomeprazole susp packet, generic pantoprazole susp packet, generic omeprazole/sodium bicarb powd pack, Brand Zegerid powd pack, Zegerid OTC, Konvomep, omeprazole 20.6 mg caps, omeprazole ODT, generic esomeprazole 24HR, Brand Nexium 24HR

Diagnosis	Exceeding 90 days PPI therapy within past 180 days; Non-Solid Dosage Forms - Exceeding 90 days PPI therapy within past 180 days
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has had a previous prior authorization (PA) approval to exceed 90 days of proton pump inhibitor (PPI) therapy in 180 days (i.e., PA approval to use beyond 90 days in a period of 180 days was granted for any PPI agent previously)

2 . Revision History

UnitedHealthcare Community Plan of Indiana Clinical Pharmacy Program Guidelines

Date	Notes
6/4/2025	Removed Brand Aciphex. Added new esomeprazole packet strength. Updated Zegerid GPIs and product name. Updated quantity limit section to match current format from Quantity Limits guideline. Updated reauthorization criteria for exceeding 90 days PPI therapy within past 180 days.

Pulmonary Antihypertensives



Prior Authorization Guideline

Guideline ID	GL-527192
Guideline Name	Pulmonary Antihypertensives
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Winrevair	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of pulmonary arterial hypertension (WHO Group 1)	

AND

2 - Prescribed by, or in consultation with, a pulmonologist or cardiologist

AND

3 - Patient is 18 years of age or older

AND

4 - One of the following:

4.1 Patient has previous trial and failure of at least 60 days of therapy with any agent from two of the following subcategories:

- Endothelin receptor antagonists
- Phosphodiesterase 5-inhibitors
- Prostacyclin receptor modulators
- Soluble guanylate cyclase inhibitors

OR

4.2 Prescriber has provided valid medical justification for the use of Winrevair (sotatercept-csrk) over all agents within all of the following subcategories:

- Endothelin receptor antagonists
- Phosphodiesterase 5-inhibitors
- Prostacyclin receptor modulators
- Soluble guanylate cyclase inhibitors

AND

5 - Prescriber attests to all of the following:

- Prescriber has obtained baseline hemoglobin (Hgb) and platelet count prior to initiating therapy
- Baseline platelet count is 50,000/mm³ (50 x 10⁹/L) or greater

- Prescriber will continue to monitor Hgb and platelet count and adjust dosing per the prescribing information

AND

6 - Requested dose does not exceed 0.7 milligrams per kilogram (actual body weight) every 3 weeks

Product Name:Winrevair	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested medication for at least 60 days within the past 90 days, confirmed by claims history or submission of medical records AND 2 - Prescriber has submitted documentation (e.g., current and previous chart notes) explicitly supporting improvement or stabilization in disease state (e.g., WHO Functional Class classification, 6-minute walk test, etc.) AND 3 - Requested dose does not exceed 0.7 milligrams per kilogram (actual body weight) every 3 weeks	

Product Name:Opsynvi	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of pulmonary arterial hypertension (WHO Group 1)

AND

2 - Prescribed by, or in consultation with, a pulmonologist or cardiologist

AND

3 - One of the following:

- Previous trial and failure of separate components
- Prescriber has provided valid medical rationale for the use of macitentan/tadalafil combination over separate components

AND

4 - Requested dose does not exceed 10 milligrams/40 milligrams per day

AND

5 - For those of childbearing potential, submission of documentation of a negative pregnancy test obtained within the past 30 days

AND

6 - Patient does not have an active claim for any of the following:

- Nitrate therapy
- PDE-5 inhibitor (other than the one being requested)
- Adempas (riociguat)

Product Name:Opsynvi	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested medication for at least 60 days within the past 90 days, confirmed by claims history or submission of medical records AND 2 - Requested dose does not exceed 10 milligrams/40 milligrams per day AND 3 - Patient does not have an active claim for any of the following: • Nitrate therapy • PDE-5 inhibitor (other than the one being requested) • Adempas (riociguat)	

Product Name:Brand Letairis, generic ambrisentan	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of pulmonary arterial hypertension AND	

2 - Prescribed by, or in consultation with, a pulmonologist or cardiologist

AND

3 - ONE of the following:

- Previous trial and failure of bosentan
- Prescriber has provided valid medical rationale of ambrisentan over bosentan

AND

4 - Requested dose does not exceed one of the following:

- 10 mg (milligrams)/day
- 5 mg/day if on concomitant cyclosporine therapy

AND

5 - For those of childbearing potential, submission of documentation of a negative pregnancy test obtained within the past 30 days

Product Name: Brand Letairis, generic ambrisentan	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested medication for at least 60 days within the past 90 days, confirmed by claims history or submission of medical records AND 2 - Requested dose does not exceed one of the following:	

- 10 mg/day
- 5 mg/day if on concomitant cyclosporine therapy

Product Name:Opsumit	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of pulmonary arterial hypertension AND 2 - Prescribed by, or in consultation with, a pulmonologist or cardiologist AND 3 - ONE of the following: • Previous trial and failure of bosentan • Prescriber has provided valid medical rationale for the use of macitentan over bosentan AND 4 - Requested dose does not exceed 10 mg/day AND 5 - For those of childbearing potential, submission of documentation of a negative pregnancy test obtained within the past 30 days	

Product Name:Opsumit	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested medication for at least 60 days within the past 90 days, confirmed by claims history or submission of medical records AND 2 - Requested dose does not exceed 10 mg/day	

Product Name:Brand Tracleer, generic bosentan	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of pulmonary arterial hypertension AND 2 - Prescribed by, or in consultation with, a pulmonologist or cardiologist AND 3 - ONE of the following: 3.1 For adult patients (tablet formulation), ONE of the following:	

3.1.1 Requested dose does not exceed 250 mg/day for patients weighing greater than 40 kg (kilograms)

OR

3.1.2 Requested dose does not exceed 125 mg/day for patients weighing less than or equal to 40 kg

OR

3.2 For pediatric patients 12 years of age or older (tablet formulation), ONE of the following:

3.2.1 Requested dose does not exceed 250 mg/day for patients weighing greater than 40 kg

OR

3.2.2 Requested dose does not exceed 125 mg/day for patients weighing less than or equal to 40 kg

OR

3.3 For pediatric patients less than or equal to 12 years of age (dispersible tablet formulation), ONE of the following:

3.3.1 Requested dose does not exceed 32 mg/day (1 dispersible tablet/day) for patients weighing 4 kg to 8 kg

OR

3.3.2 Requested dose does not exceed 64 mg/day (2 dispersible tablets/day) for patients weighing greater than 8 kg to 16 kg

OR

3.3.3 Requested dose does not exceed 96 mg/day (3 dispersible tablets/day) for patients weighing greater than 16 kg to 24 kg

OR

3.3.4 Requested dose does not exceed 128 mg/day (4 dispersible tablets/day) for patients weighing greater than 24 kg to 40 kg

AND

4 - Patient does not have active claims for cyclosporine-A or glyburide

AND

5 - For those of childbearing potential, submission of documentation of a negative pregnancy test obtained within the past 30 days

AND

6 - Patient is enrolled in the Tracleer/bosentan REMS program

Product Name: Brand Tracleer, generic bosentan	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested medication for at least 60 days within the past 90 days, confirmed by claims history or submission of medical records AND 2 - Patient does not have active claims for cyclosporine-A or glyburide	

AND

3 - ONE of the following:

3.1 For adult patients (tablet formulation), ONE of the following:

3.1.1 Requested dose does not exceed 250 mg/day for patients weighing greater than 40 kg (kilograms)

OR

3.1.2 Requested dose does not exceed 125 mg/day for patients weighing less than or equal to 40 kg

OR

3.2 For pediatric patients 12 years of age or older (tablet formulation), ONE of the following:

3.2.1 Requested dose does not exceed 250 mg/day for patients weighing greater than 40 kg

OR

3.2.2 Requested dose does not exceed 125 mg/day for patients weighing less than or equal to 40 kg

OR

3.3 For pediatric patients less than or equal to 12 years of age (dispersible tablet formulation), ONE of the following:

3.3.1 Requested dose does not exceed 32 mg/day (1 dispersible tablet/day) for patients weighing 4 kg to 8 kg

OR

3.3.2 Requested dose does not exceed 64 mg/day (2 dispersible tablets/day) for patients weighing greater than 8 kg to 16 kg

OR

3.3.3 Requested dose does not exceed 96 mg/day (3 dispersible tablets/day) for patients weighing greater than 16 kg to 24 kg

OR

3.3.4 Requested dose does not exceed 128 mg/day (4 dispersible tablets/day) for patients weighing greater than 24 kg to 40 kg

Product Name: Brand Revatio tablets, generic sildenafil tablets and oral suspension	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of pulmonary arterial hypertension AND 2 - Prescribed by, or in consultation with, a pulmonologist or cardiologist AND 3 - Requested dose does not exceed 60 mg/day AND	

4 - Patient does not have an active claim for any of the following:

- Nitrate therapy
- Adempas (riociguat)
- Reyataz (atazanavir)
- Prezista (darunavir)
- Lexiva (fosamprenavir)
- Crixivan (indinavir)
- Kaletra (lopinavir/ritonavir)
- Viracept (nelfinavir)
- Norvir (ritonavir)
- Invirase (saquinavir)
- Aptivus (tipranavir)
- PDE-5 inhibitor (other than the one being requested)

AND

5 - If the request is for sildenafil oral suspension, ONE of the following:

- Patient is under 12 years of age
- Patient is 12 years of age or older and unable to swallow tablet formulation of sildenafil

Product Name: Brand Revatio tablets, generic sildenafil tablets and oral suspension	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested medication for at least 60 days within the past 90 days, confirmed by claims history or submission of medical records AND 2 - Requested dose does not exceed 60 mg/day	

AND

3 - Patient does not have an active claim for any of the following:

- Nitrate therapy
- Adempas (riociguat)
- Reyataz (atazanavir)
- Prezista (darunavir)
- Lexiva (fosamprenavir)
- Crixivan (indinavir)
- Kaletra (lopinavir/ritonavir)
- Viracept (nelfinavir)
- Norvir (ritonavir)
- Invirase (saquinavir)
- Aptivus (tipranavir)
- PDE-5 inhibitor (other than the one being requested)

AND

4 - If the request is for sildenafil oral suspension, ONE of the following:

- Patient is under 12 years of age
- Patient is 12 years of age or older and unable to swallow tablet formulation of sildenafil

Product Name:Brand Adcirca, generic tadalafil, Alyq	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of pulmonary arterial hypertension AND	

2 - Prescribed by, or in consultation with, a pulmonologist or cardiologist

AND

3 - Requested dose does not exceed 40 mg/day

AND

4 - Patient does not have an active claim for any of the following:

- Nitrate therapy
- PDE5 inhibitor (other than the one being requested)
- Adempas (riociguat)

AND

5 - If the request is for Alyq, the patient has a trial and failure of generic tadalafil or medical justification for use

Product Name: Brand Adcirca, generic tadalafil, Alyq	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested medication for at least 60 days within the past 90 days, confirmed by claims history or submission of medical records AND 2 - Requested dose does not exceed 40 mg/day	

AND

3 - Patient does not have an active claim for any of the following:

- Nitrate therapy
- PDE-5 inhibitor (other than the one being requested)
- Adempas (riociguat)

Product Name:Tadliq

Approval Length	1 year(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of pulmonary arterial hypertension

AND

2 - Prescribed by, or in consultation with, a pulmonologist or cardiologist

AND

3 - ONE of the following:

- Previous trial and failure of sildenafil oral suspension
- Prescriber has provided valid medical rationale for the use of Tadliq over sildenafil oral suspension
- Patient requires Tadliq as a less frequent dosing option (supported by submission of medical records)

AND

4 - Requested dose does not exceed 40 mg/day

AND

5 - ONE of the following:

- Patient is under 12 years of age
- Patient is 12 years of age or older and unable to swallow tablet formulation of tadalafil

AND

6 - Patient does not have an active claim for any of the following:

- Nitrate therapy
- PDE-5 inhibitor (other than the one being requested)
- Adempas (riociguat)

Product Name:Tadliq

Approval Length	1 year(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - History of the requested medication for at least 60 days within the past 90 days, confirmed by claims history or submission of medical records

AND

2 - Requested dose does not exceed 40 mg/day

AND

3 - Patient does not have an active claim for any of the following:

- Nitrate therapy
- PDE-5 inhibitor (other than the one being requested)
- Adempas (riociguat)

AND

4 - ONE of the following:

- Patient is under 12 years of age
- Patient is 12 years of age or older and unable to swallow tablet formulation of tadalafil

Product Name:Orenitram, Orenitram titration kit	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of pulmonary arterial hypertension AND 2 - Prescribed by, or in consultation with, a pulmonologist or cardiologist AND 3 - Patient does not have severe hepatic impairment (Child-Pugh class C)	

Product Name:Orenitram, Orenitram titration kit	
Approval Length	1 year(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested medication for at least 60 days within the past 90 days, confirmed by claims history or submission of medical records AND 2 - Patient does not have severe hepatic impairment (Child-Pugh class C)	

Product Name:Tyvaso, Tyvaso DPI	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of pulmonary arterial hypertension or pulmonary hypertension associated with interstitial lung disease AND 2 - Prescribed by, or in consultation with, a pulmonologist or cardiologist	

Product Name:Tyvaso, Tyvaso DPI	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - History of the requested medication for at least 60 days within the past 90 days, confirmed by claims history or submission of medical records

Product Name:Uptravi, Uptravi Titration Pack

Approval Length 1 year(s)

Therapy Stage Initial Authorization

Guideline Type Prior Authorization

Approval Criteria

1 - Diagnosis of pulmonary arterial hypertension

AND

2 - Prescribed by, or in consultation with, a pulmonologist or cardiologist

AND

3 - Patient does not have an active claim for CYP2C8 (enzyme) inhibitor (e.g., gemfibrozil)

AND

4 - ONE of the following:

- Previous trial and failure of Orenitram
- Prescriber has submitted valid medical rationale for the use of Uptravi over Orenitram

Product Name:Uptravi, Uptravi Titration Pack

Approval Length 1 year(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested medication for at least 60 days within the past 90 days, confirmed by claims history or submission of medical records AND 2 - Patient does not have an active claim for CYP2C8 inhibitor (e.g., gemfibrozil)	

Product Name:Adempas	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: • Diagnosis of pulmonary arterial hypertension • Diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH) AND 2 - Prescribed by, or in consultation with, a pulmonologist or cardiologist AND 3 - Requested dose does not exceed 7.5 mg/day (patients who smoke may require further dosing evaluation)	

AND

4 - Patient does not have an active claim for any of the following:

- Nitrate therapy
- PDE-5 inhibitor
- Non-specific PDE inhibitor (dipyridamole, theophylline, aminophylline)
- Verquvo (vericiguat)

AND

5 - For those of childbearing potential, submission of documentation of a negative pregnancy test obtained within the past 30 days

AND

6 - Patient is enrolled in the Adempas REMS program (female patients only)

Product Name:Adempas	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested medication for at least 60 days within the past 90 days, confirmed by claims history or submission of medical records AND 2 - Requested dose does not exceed 7.5 mg/day (patients who smoke may require further dosing evaluation)	

AND

3 - Patient does not have an active claim for any of the following:

- Nitrate therapy
- PDE-5 inhibitor
- Non-specific PDE inhibitor (dipyridamole, theophylline, aminophylline)
- Verquvo (vericiguat)

Product Name:Yutrepia	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of pulmonary arterial hypertension or pulmonary hypertension associated with interstitial lung disease AND 2 - Prescribed by, or in consultation with, a pulmonologist or cardiologist AND 3 - ONE of the following: • Previous trial and failure of Tyvaso (treprostinil DPI) • Prescriber has provided valid medical rationale for the use of Yutrepia (treprostinil DPI) over Tyvaso (treprostinil DPI)	

Product Name:Yutrepia

Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested medication for at least 60 days within the past 90 days, confirmed by claims history or submission of medical records	

2 . Revision History

Date	Notes
2/24/2026	Updated GPIs and product names. Removed Brand Revatio oral suspension (and updated wording in Tadliq/Revatio/sildenafil section), Liqrev and Ventavis.

Pulmozyme



Prior Authorization Guideline

Guideline ID	GL-442206
Guideline Name	Pulmozyme
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Indiana 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 Medicaid - Community & State Nevada

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

2 . Revision History

Date	Notes
11/6/2025	Added Nevada Formulary

Qbrexza, Sofdra



Prior Authorization Guideline

Guideline ID	GL-369193
Guideline Name	Qbrexza, Sofdra
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 Nebraska Medicaid - Community & State New Mexico Medicaid - Community & State Pennsylvania Medicaid - Community & State Virginia Medicaid - Community & State Washington

Guideline Note:

Effective Date:	9/1/2025

1 . Criteria

Product Name:Qbrexza, Sofdra	
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	Updated guideline name. Added Sofdra as a target. Removed AZ for mulary as AZ will have it's own separate guideline with Qbrexza only.

Qinlock



Prior Authorization Guideline

Guideline ID	GL-398212
Guideline Name	Qinlock
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 Virginia Medicaid - Community & State Indiana Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	10/1/2025

1 . Criteria

Product Name:Qinlock	
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 - ONE of the following: • Gross residual disease (R2 resection) • Unresectable primary disease • Tumor rupture • Recurrent/Metastatic AND 3 - ONE of the following: 3.1 History of progression on ALL of the following as confirmed by claims history or submission of medical records: • imatinib (generic Gleevec) • sunitinib (generic Sutent) • regorafenib (generic Stivarga) OR 3.2 BOTH of the following: • History of progression on imatinib (Gleevec) as confirmed by claims history or submission of medical records • History of intolerance to sunitinib (Sutent) (please specify intolerance) as confirmed by claims history or submission of medical records	

OR

3.3 ALL of the following:

- PDGFRA exon 18 mutations that are insensitive to imatinib (Gleevec) (including PDGFRA D842V)
- History of progression on Ayvakit (avapritinib) as confirmed by claims history or submission of medical records
- History of progression on dasatinib (Sprycel) as confirmed by claims history or submission of medical records

Product Name:Qinlock	
Diagnosis	Cutaneous Melanoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of cutaneous melanoma AND 2 - Disease is unresectable or metastatic AND 3 - Disease progression, intolerance, and/or projected risk of progression with BRAF-targeted therapy AND 4 - Positive for activating mutations of KIT	

Product Name:Qinlock	
Diagnosis	Gastrointestinal Stromal Tumor (GIST), Cutaneous Melanoma
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 Qinlock therapy	

Product Name:Qinlock	
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:Qinlock	
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 Qinlock therapy	

2 . Revision History

Date	Notes
9/16/2025	Updated formularies. Updated GIST criteria

Quantity Limits



Prior Authorization Guideline

Guideline ID	GL-128960
Guideline Name	Quantity Limits
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	10/1/2023

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 (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 (USP-NF)

AND

2 - ONE of the following:

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

OR

2.2 The request 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 (USP-NF)

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 (USP-NF) 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
7/25/2023	Updated guideline name. Defined FDA and reformatted step 2 of Quantity limit review (General) section.

Radicava ORS



Prior Authorization Guideline

Guideline ID	GL-442209
Guideline Name	Radicava ORS
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland 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 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:Radicava ORS	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following: 1.1 Patient has been established on therapy with edaravone for amyotrophic lateral sclerosis (ALS) under an active UnitedHealthcare medical benefit prior authorization AND 1.2 ALL of the following: 1.2.1 Diagnosis of ALS AND 1.2.2 Prescribed by, or in consultation with, a neurologist with expertise in the diagnosis of ALS AND 1.2.3 Patient is currently receiving edaravone therapy AND 1.2.4 Patient is not dependent on invasive ventilation OR 2 - ALL of the following:	

2.1 Submission of medical records (e.g., chart notes, previous medical history, diagnostic testing including: imaging, nerve conduction studies, laboratory values) to support the diagnosis of ALS

AND

2.2 Prescribed by, or in consultation with, a neurologist with expertise in the diagnosis of ALS

AND

2.3 Submission of the most recent ALS Functional Rating Scale-Revised (ALSFRS-R) score confirming that the patient has scores greater than or equal to 2 in all items of the ALSFRS-R criteria at the start of treatment

AND

2.4 Submission of medical records (e.g., chart notes, laboratory values) confirming that the patient has a % forced vital capacity (%FVC) greater than or equal to 80% at the start of treatment

Product Name:Radicava ORS	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of amyotrophic lateral sclerosis (ALS) AND 2 - Prescribed by, or in consultation with, a neurologist with expertise in the diagnosis of ALS	

AND

3 - Patient is currently receiving Radicava ORS therapy

AND

4 - Patient is not dependent on invasive ventilation

2 . Revision History

Date	Notes
11/6/2025	Added Nevada Formulary

Rectiv



Prior Authorization Guideline

Guideline ID	GL-438188
Guideline Name	Rectiv
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 Michigan Medicaid - Community & State Nevada Medicaid - Community & State Virginia Medicaid - Community & State Indiana Medicaid - Community & State Nebraska Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Rectiv ointment, generic nitroglycerin ointment	
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

Date	Notes
11/5/2025	Combined formularies - added MI, NV, VA, IN, NE, NM. No clinical changes.

Redemplo



Prior Authorization Guideline

Guideline ID	GL-594201
Guideline Name	Redemplo
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 Indiana Medicaid - Community & State Michigan Medicaid - Community & State Nebraska Medicaid - Community & State Nevada Medicaid - Community & State New Mexico Medicaid - Community & State Virginia Medicaid - Community & State Washington

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Redemplo	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of familial chylomicronemia syndrome (FCS) (i.e., monogenic chylomicronemia, type 1 hyperlipoproteinemia) AND 2 - Diagnosis has been confirmed by BOTH of the following: 2.1 ONE of the following: 2.1.1 Genetic confirmation of FCS (e.g., homozygous, compound heterozygous, or double heterozygote for loss-of-function or otherwise inactivating mutations in genes affecting lipoprotein lipase activity including LPL, GPIHBP1, APOA5, APOC2, or LMF1) OR 2.1.2 North American FCS (NAFCS) Score greater than or equal to 45 AND 2.2 Untreated fasting triglyceride levels greater than or equal to 880 mg/dL (milligrams per deciliter) AND 3 - Prescribed by ONE of the following:	

- Cardiologist
- Endocrinologist
- Gastroenterologist
- Lipid specialist (lipidologist)

AND

4 - Not used in combination with Tryngolza (olezarsen)

Product Name:Redemplo	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Redemplo therapy (e.g., reduction in triglycerides, reduction in episodes of acute pancreatitis) AND 2 - Prescribed by ONE of the following: • Cardiologist • Endocrinologist • Gastroenterologist • Lipid specialist (lipidologist) AND 3 - Not used in combination with Tryngolza (olezarsen)	

2 . Revision History

UnitedHealthcare Community Plan of Indiana Clinical Pharmacy Program Guidelines

Date	Notes
4/23/2026	Added IN and NV. Expanded on mg/dL abbreviation, with no changes to clinical intent. Minor cosmetic updates.

Regranex



Prior Authorization Guideline

Guideline ID	GL-242213
Guideline Name	Regranex
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Indiana 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:	6/1/2025

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

Date	Notes
4/17/2025	Combined formularies. No changes to clinical criteria.

Repository Corticotropins



Prior Authorization Guideline

Guideline ID	GL-442211
Guideline Name	Repository Corticotropins
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 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: Acthar, Cortrophin

Diagnosis	Infantile spasm (i.e., West Syndrome)*
Approval Length	1 month(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	
Notes	*Acthar gel and Cortrophin gel are not medically necessary for treatment of acute exacerbations of multiple sclerosis. See Background for more information.

Product Name:Acthar, Cortrophin	
Diagnosis	Opsoclonus-myoclonus syndrome (i.e., Kinsbourne Syndrome)*
Approval Length	3 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of opsoclonus-myoclonus syndrome (i.e., Kinsbourne Syndrome)* AND 2 - If the request is for Acthar gel, provider submits documentation of reason or special circumstance patient cannot use Cortrophin Gel	
Notes	*Acthar gel and Cortrophin gel are not medically necessary for treatment of acute exacerbations of multiple sclerosis. See Background for more information.

2 . Background

Benefit/Coverage/Program Information
More Information: The Acthar Gel and Purified Cortrophin Gel package inserts have listed other conditions in which it may be used. UHCP has determined that use of Acthar Gel and Purified Cortrophin Gel is not medically necessary for treatment of the following disorders and diseases: multiple sclerosis; rheumatic; collagen; dermatologic; allergic states; ophthalmic; respiratory; and edematous state.

3 . Revision History

Date	Notes
11/6/2025	Added Nevada Formulary

Respiratory and Allergy Biologics



Prior Authorization Guideline

Guideline ID	GL-545234
Guideline Name	Respiratory and Allergy Biologics
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Cinqair	
Diagnosis	Asthma
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of asthma (eosinophilic phenotype)	

AND

2 - Patient is 18 years of age or older

AND

3 - Patient is utilizing ONE of the following inhaled asthma treatments for 90 of the past 120 days:

- Concurrent high-dose inhaled corticosteroid (ICS) AND a long-acting beta 2 agonist (LABA)
- A high-dose ICS/LABA combination product
- A high-dose ICS/LAMA/LABA combination product

AND

4 - Cinqair will be used as adjunct therapy along with the above inhaled asthma treatment

AND

5 - Patient has inadequately controlled asthma as evidenced by ONE of the following:

- Greater than or equal to 3 canisters of a short-acting beta2 agonist (SABA) in past 60 days
- Oral steroid use in the past 45 days
- ER visit with primary diagnosis of asthma in past 45 days

AND

6 - ONE of the following:

6.1 Previous trial and failure of at least TWO of the following:

- Dupixent
- Fasenra
- Nucala
- Tezspire

OR

6.2 Documented medical rationale for use of Cinqair over preferred agents* (please document rationale)

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:Cinqair	
Diagnosis	Asthma
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has a history of Cinqair within the past 90 days AND 2 - ONE of the following: • Patient is continuing to utilize adjunct therapy, if applicable • Medical rationale has been provided for not continuing adjunct therapy (please document rationale) AND 3 - Submission of medical records documenting positive clinical response to therapy (e.g., improvement/stabilization in symptoms of the respective disease from baseline)	

Product Name:Dupixent	
Diagnosis	Asthma
Approval Length	6 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of asthma (eosinophilic phenotype or corticosteroid-dependent) AND 2 - Patient is 6 years of age or older AND 3 - Patient is utilizing ONE of the following inhaled asthma treatments for 90 of the past 120 days: • High-dose inhaled corticosteroid (ICS) AND a long-acting beta 2 agonist (LABA) concurrently • High-dose ICS/LABA combination product • High-dose ICS/long acting antimuscarinic (LAMA)/LABA combination product AND 4 - Dupixent will be used as adjunct therapy along with one of the above inhaled asthma treatments AND 5 - Patient has inadequately controlled asthma as evidenced by ONE of the following: • Greater than or equal to 3 canisters of a short-acting beta 2 agonist (SABA) in past 60 days • Oral steroid use in the past 45 days • ER (emergency room) visit with primary diagnosis of asthma in past 45 days	

Product Name:Dupixent	
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 - Patient is 6 months of age or older AND 3 - Patient has had greater than or equal to 45 days of topical drug therapy with ONE of the following: • Pimecrolimus • Tacrolimus • Corticosteroids	

Product Name:Dupixent	
Diagnosis	Eosinophilic Esophagitis
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of eosinophilic esophagitis	

AND

2 - Patient is 1 year of age or older

AND

3 - Patient weighs 15 kg (kilograms) or more

AND

4 - One of the following:

4.1 Patient is 10 years of age or younger

OR

4.2 Patient has had a trial and failure of a 12-week course of Eohilia (budesonide) suspension

OR

4.3 Provider has documented valid medical justification for the use Dupixent (dupilumab) over Eohilia (budesonide) (please document)

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 - Diagnosis of inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP)

AND

2 - Patient is 12 years of age or older

AND

3 - Patient has had greater than or equal to 90 days of therapy with an intranasal corticosteroid

AND

4 - Dupixent will be used as adjunct therapy along with an intranasal corticosteroid

Product Name:Dupixent

Diagnosis	Prurigo Nodularis

Approval Length	6 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of prurigo nodularis

AND

2 - Patient is 18 years of age or older

AND

3 - Patient has had greater than or equal to 30 days of topical drug therapy with at least ONE of the following:

- Pimecrolimus
- Tacrolimus
- Corticosteroids

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 - Diagnosis of chronic obstructive pulmonary disease (COPD) with eosinophilic phenotype AND 2 - Patient is 18 years of age or older AND 3 - Patient is utilizing ICS/LAMA/LABA (inhaled corticosteroid/long acting antimuscarinic/long-acting beta 2 agonist) combination therapy for 90 of the past 120 days AND 4 - Dupixent will be used as adjunct therapy with ICS/LAMA/LABA combination therapy AND	

5 - Submission of medical records (e.g., chart notes) confirming patient has a post-bronchodilator FEV-1 of 30% to 70% predicted AND a post-bronchodilator FEV-1/FVC ratio of < 0.7 as measured by spirometry

AND

6 - Patient has documented signs and symptoms of chronic bronchitis (e.g., chronic productive cough) for at least 3 months during the past year

AND

7 - Submission of medical records (e.g., chart notes) confirming patient has inadequately controlled COPD as evidenced by one of the following:

- Two or more moderate exacerbations requiring systemic steroids or antibiotics in the past 365 days
- One or more severe exacerbations requiring hospitalization or observation for over 24 hours in the emergency department or urgent care setting in the past 365 days

Product Name:Dupixent

Diagnosis	Bullous pemphigoid

Approval Length	6 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of bullous pemphigoid

AND

2 - Patient is 18 years of age or older

AND

3 - Patient has had at least 30 days of drug therapy with at least ONE of the following:

- Topical corticosteroid therapy
- Systemic corticosteroid therapy

Product Name:Dupixent

Diagnosis	Chronic spontaneous urticaria

Approval Length	6 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic spontaneous urticaria

AND

2 - Documentation of at least 6 weeks of symptoms

AND

3 - Patient is 12 years of age or older

AND

4 - Submission of medical records documenting trial and failure for at least 14 days with a single second generation antihistamine as monotherapy (e.g., cetirizine, desloratadine, fexofenadine, levocetirizine, loratadine)

AND

5 - Submission of medical records documenting trial and failure of TWO of the following (trial history is considered as at least 14 days of each individual option):

- Two different second generation H1 receptor antagonists as concomitant therapy
- Second generation H1 receptor antagonist as monotherapy with dose advancement (e.g., four time max FDA dose/day)
- Second generation H1 receptor antagonist used concomitantly with H2-antagonist
- Second generation H1 receptor antagonist used concomitantly with leukotriene-receptor antagonist (LTRA)
- Second generation H1 receptor antagonist used concomitantly with bedtime first generation antihistamine

Product Name:Dupixent	
Diagnosis	Asthma, Atopic Dermatitis, Eosinophilic Esophagitis, Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP), Prurigo Nodularis, Chronic Obstructive Pulmonary Disease (COPD), Bullous pemphigoid, Chronic spontaneous urticaria
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has a history of Dupixent within the past 90 days AND 2 - ONE of the following: • Patient is continuing to utilize adjunct therapy, if applicable • Medical rationale has been provided for not continuing adjunct therapy (please document rationale)	

AND

3 - Submission of medical records documenting positive clinical response to therapy (e.g., improvement/stabilization in symptoms of the respective disease from baseline)

Product Name:Fasenra	
Diagnosis	Asthma
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of asthma (eosinophilic phenotype)

AND

2 - Patient is 6 years of age or older

AND

3 - Patient is utilizing ONE of the following inhaled asthma treatments for 90 of the past 120 days:

- Concurrent high-dose inhaled corticosteroid (ICS) AND a long-acting beta 2 agonist (LABA)
- A high-dose ICS/LABA combination product
- A high-dose ICS/LAMA/LABA combination product

AND

4 - Fasenra will be used as adjunct therapy along with the above inhaled asthma treatment

AND

5 - Patient has inadequately controlled asthma as evidenced by ONE of the following:

- Greater than or equal to 3 canisters of a short-acting beta2 agonist (SABA) in past 60 days
- Oral steroid use in the past 45 days
- ER visit with primary diagnosis of asthma in past 45 days

Product Name:Fasenra	
Diagnosis	Eosinophilic Granulomatosis with Polyangiitis (Churg-Strauss syndrome)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has diagnosis of eosinophilic granulomatosis with polyangiitis (Churg-Strauss Syndrome) AND 2 - Patient is 18 years of age or older AND 3 - Patient has had greater than or equal to 90 days of drug therapy with ONE of the following: • Systemic glucocorticoid • Azathioprine • Methotrexate • Cyclophosphamide	

- Mycophenolate

Product Name:Fasenra	
Diagnosis	Asthma, Eosinophilic Granulomatosis with Polyangiitis (Churg-Strauss syndrome)
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has a history of Fasenra within the past 90 days AND 2 - ONE of the following: • Patient is continuing to utilize adjunct therapy, if applicable • Medical rationale has been provided for not continuing adjunct therapy (please document rationale) AND 3 - Submission of medical records documenting positive clinical response to therapy (e.g., improvement/stabilization in symptoms of the respective disease from baseline)	

Product Name:Nucala	
Diagnosis	Asthma
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of asthma (eosinophilic phenotype)

AND

2 - Patient is 6 years of age or older

AND

3 - Patient is utilizing ONE of the following inhaled asthma treatments for 90 of the past 120 days:

- Concurrent high-dose inhaled corticosteroid (ICS) AND a long-acting beta 2 agonist (LABA)
- A high-dose ICS/LABA combination product
- A high-dose ICS/LAMA/LABA combination product

AND

4 - Nucala will be used as adjunct therapy along with the above inhaled asthma treatment

AND

5 - Patient has inadequately controlled asthma as evidenced by ONE of the following:

- Greater than or equal to 3 canisters of a short-acting beta 2 agonist (SABA) in past 60 days
- Oral steroid use in the past 45 days
- ER visit with primary diagnosis of asthma in past 45 days

Product Name:Nucala	
Diagnosis	Eosinophilic Granulomatosis with Polyangiitis (Churg-Strauss syndrome)

Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has diagnosis of eosinophilic granulomatosis with polyangiitis (Churg-Strauss Syndrome) AND 2 - Patient is 18 years of age or older AND 3 - Patient has had greater than or equal to 90 days of drug therapy with ONE of the following: • Systemic glucocorticoid • Azathioprine • Methotrexate • Cyclophosphamide • Mycophenolate	

Product Name:Nucala	
Diagnosis	Hypereosinophilic syndrome (HES)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has diagnosis of hypereosinophilic syndrome (HES)	

AND

2 - Patient is 12 years of age or older

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 has diagnosis of inadequately controlled chronic rhinosinusitis with nasal polyps (CRSwNP)

AND

2 - Patient is 18 years of age or older

AND

3 - Patient has had greater than or equal to 90 days of therapy with an intranasal corticosteroid

AND

4 - Nucala will be used as adjunct therapy along with an intranasal corticosteroid

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 - Diagnosis of chronic obstructive pulmonary disease (COPD) with eosinophilic phenotype AND 2 - Patient is 18 years of age or older AND 3 - Patient is utilizing ICS/LAMA/LABA (inhaled corticosteroid/long acting antimuscarinic/long-acting beta 2 agonist) combination therapy for 90 of the past 120 days AND 4 - Nucala will be used as adjunct therapy with ICS/LAMA/LABA combination therapy AND 5 - Submission of medical records (e.g., chart notes) confirming patient has a post-bronchodilator FEV-1 of 20% to 80% predicted AND a post-bronchodilator FEV-1/FVC ratio of < 0.7 as measured by spirometry AND 6 - Patient has documented signs and symptoms of chronic bronchitis (e.g., chronic productive cough) for at least 3 months during the past year AND	

7 - Submission of medical records (e.g., chart notes) confirming patient has inadequately controlled COPD as evidenced by one of the following:

- Two or more moderate exacerbations requiring systemic steroids or antibiotics in the past 365 days
- One or more severe exacerbations requiring hospitalization or observation for over 24 hours in the emergency department or urgent care setting in the past 365 days

Product Name:Nucala	
Diagnosis	Asthma, Eosinophilic Granulomatosis with Polyangiitis (Churg-Strauss syndrome), Hypereosinophilic syndrome (HES), Chronic Rhinosinusitis with Nasal Polyps (CRSwNP), COPD
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of Nucala within the past 90 days AND 2 - ONE of the following: • Patient is continuing to utilize adjunct therapy, if applicable • Medical rationale has been provided for not continuing adjunct therapy (please document rationale) AND 3 - Submission of medical records documenting positive clinical response to therapy (e.g., improvement/stabilization in symptoms of the respective disease from baseline)	

Product Name:Tezspire	
Diagnosis	Asthma

Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of asthma AND 2 - Patient is 12 years of age or older AND 3 - Patient is utilizing ONE of the following inhaled asthma treatments for 90 of the past 120 days: • Concurrent high-dose inhaled corticosteroid (ICS) AND a long-acting beta 2 agonist (LABA) • A high-dose ICS/LABA combination product • A high-dose ICS/LAMA/LABA combination product AND 4 - Tezspire will be used as adjunct therapy along with one of the above inhaled asthma treatments AND 5 - Patient has inadequately controlled asthma as evidenced by ONE of the following: • Greater than or equal to 3 canisters of a short-acting beta2 agonist (SABA) in past 60 days • Oral steroid use in the past 45 days • ER visit with primary diagnosis of asthma in past 45 days	

Product Name:Tezspire	
Diagnosis	Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of inadequately controlled chronic rhinosinusitis with nasal polyps (CRSwNP) AND 2 - Patient is 12 years of age or older AND 3 - At least 90 days of therapy with an intranasal corticosteroid AND 4 - Tezspire will be used as adjunct therapy along with an intranasal corticosteroid	

Product Name:Tezspire	
Diagnosis	Asthma, Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of Tezspire within the past 90 days	

AND

2 - ONE of the following:

- Patient is continuing to utilize adjunct therapy, if applicable
- Medical rationale has been provided for not continuing adjunct therapy (please document rationale)

AND

3 - Submission of medical records documenting positive clinical response to therapy (e.g., improvement/stabilization in symptoms of the respective disease from baseline)

Product Name:Xolair	
Diagnosis	Asthma
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of asthma (severe allergic asthma or nonallergic eosinophilic asthma)

AND

2 - Documentation of ONE of the following:

- A positive percutaneous allergy skin test
- In vitro reactivity to a perennial aeroallergen within the past year

AND

3 - Patient is 6 years of age or older

AND

4 - Patient is utilizing ONE of the following inhaled asthma treatments for 90 of the past 120 days:

- Concurrent high-dose inhaled corticosteroid (ICS) AND a long-acting beta 2 agonist (LABA)
- A high-dose ICS/LABA combination product
- A high-dose ICS/LAMA/LABA combination product

AND

5 - Xolair will be used as adjunct therapy along with one of the above inhaled asthma treatments

AND

6 - Patient has inadequately controlled asthma as evidenced by ONE of the following:

- Greater than or equal to 3 canisters of a short-acting beta 2 agonist (SABA) in past 60 days
- Oral steroid use in the past 45 days
- ER visit with primary diagnosis of asthma in past 45 days

Product Name:Xolair	
Diagnosis	Chronic spontaneous urticaria
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chronic spontaneous urticaria	

AND

2 - Documentation of at least 6 weeks of symptoms

AND

3 - Patient is 12 years of age or older

AND

4 - Submission of medical records documenting trial and failure for at least 14 days with a single second generation antihistamine as monotherapy (e.g., cetirizine, desloratadine, fexofenadine, levocetirizine, loratadine)

AND

5 - Submission of medical records documenting trial and failure of TWO of the following (trial history is considered as at least 14 days of each individual option):

- Two different second generation H1 receptor antagonists as concomitant therapy
- Second generation H1 receptor antagonist as monotherapy with dose advancement (e.g., four time max FDA dose/day)
- Second generation H1 receptor antagonist used concomitantly with H2-antagonist
- Second generation H1 receptor antagonist used concomitantly with leukotriene-receptor antagonist (LTRA)
- Second generation H1 receptor antagonist used concomitantly with bedtime first generation antihistamine

Product Name:Xolair	
Diagnosis	Nasal Polyps
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of inadequately controlled nasal polyps

AND

2 - Patient is 18 years of age or older

AND

3 - The patient has had at least 90 days of therapy with an intranasal corticosteroid

AND

4 - Xolair will be used as adjunct therapy along with an intranasal corticosteroid

Product Name:Xolair	
Diagnosis	IgE-Mediated Food Allergy
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of an IgE-mediated (Type 1) allergic reaction to one or more food allergens (submission of chart notes explicitly stating suspected food allergen and respective reaction experienced required) AND	

2 - Submission of documentation (chart notes, laboratory tests/values, assessments, etc.) of one of the following:

- Positive skin prick test (SPT) (greater than or equal to 4 millimeter wheal) to identified foods
- Positive IgE screening (greater than or equal to 6 kUA/L) to identified foods

AND

3 - Patient is at least 1 year of age or older

AND

4 - Prescribed by, or in consultation with, an allergist or immunologist

AND

5 - Prescriber attests that patient has been counseled to continue food allergen avoidance while utilizing Xolair (omalizumab)

Product Name:Xolair	
Diagnosis	Asthma, Chronic Spontaneous Urticaria, Nasal Polyps, IgE-Mediated Food Allergy
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of Xolair within the past 90 days AND 2 - ONE of the following:	

- Patient is continuing to utilize adjunct therapy, if applicable
- Medical rationale has been provided for not continuing adjunct therapy (please document rationale)

AND

3 - Submission of medical records documenting positive clinical response to therapy (e.g., improvement/stabilization in symptoms of the respective disease from baseline)

2 . Revision History

Date	Notes
3/10/2026	Added Cinqair and Tezspire prefilled syringe GPIs. Added Cinqair criteria and updated Tezspire criteria. Added language to populate free text box in reauthorization for rationale of not continuing adjunct therapy.

Retevmo



Prior Authorization Guideline

Guideline ID	GL-506283
Guideline Name	Retevmo
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Retevmo	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of non-small cell lung cancer (NSCLC) AND 2 - Disease is ONE of the following: • Recurrent • Advanced • Metastatic AND 3 - Presence of RET gene fusion-positive or RET rearrangement positive tumors	

Product Name:Retevmo	
Diagnosis	Thyroid Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ALL of the following: 1.1 Diagnosis of medullary thyroid cancer (MTC) AND	

1.2 Disease is ONE of the following:

- Advanced
- Metastatic

AND

1.3 Disease has presence of RET gene mutation

AND

1.4 Disease requires treatment with systemic therapy

OR

2 - ALL of the following:

2.1 Diagnosis of thyroid cancer

AND

2.2 Disease is ONE of the following:

- Advanced
- Metastatic

AND

2.3 Disease is RET gene fusion-positive

AND

2.4 Disease requires treatment with systemic therapy

AND

2.5 ONE of the following:

- Patient is radioactive iodine-refractory
- Treatment with radioactive iodine is not appropriate

Product Name:Retevmo	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following histiocytic neoplasms: • Langerhans Cell Histiocytosis • Erdheim-Chester disease • Rosai-Dorfman disease AND 2 - Used for RET fusion target as a single agent	

Product Name:Retevmo	
Diagnosis	Solid Tumors
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Presence of RET gene fusion-positive solid tumor

AND

2 - Disease is ONE of the following:

- Recurrent
- Advanced
- Metastatic

Product Name:Retevmo

Diagnosis	Non-Small Cell Lung Cancer (NSCLC), Thyroid Cancer, Histiocytic Neoplasms, Solid Tumors
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 Retevmo therapy

Product Name:Retevmo

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:Retevmo	
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 Retevmo therapy	

2 . Revision History

Date	Notes
1/24/2026	Combined formularies. No changes to clinical criteria. Minor cosmetic updates.

Revlimid



Prior Authorization Guideline

Guideline ID	GL-398199
Guideline Name	Revlimid
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 Virginia Medicaid - Community & State New Mexico Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	10/1/2025

1 . Criteria

Product Name: Brand Revlimid, generic lenalidomide	
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: Brand Revlimid, generic lenalidomide	
Diagnosis	Myelodysplastic Syndromes (MDS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of symptomatic anemia due to myelodysplastic syndrome (MDS) associated WITH a deletion 5q OR 2 - BOTH of the following: 2.1 Diagnosis of symptomatic anemia due to myelodysplastic syndrome (MDS) WITHOUT deletion 5q AND 2.2 ONE of the following: 2.2.1 BOTH of the following: 2.2.1.1 Ring sideroblasts greater than or equal to 15% (or greater than or equal to 5% with an SF3B1 mutation)	

AND

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

- Rytelo (imetelstat)
- Reblozyl (luspatercept-aamt)

OR

2.2.2 ALL of the following:

2.2.2.1 Serum erythropoietin levels less than or equal to 500 mU/mL

AND

2.2.2.2 Ring sideroblasts less than 15% (or less than 5% with an SF3B1 mutation)

AND

2.2.2.3 Used in combination with an erythropoietin stimulating agent (ESA) [e.g., Epogen, Procrit, Retacrit (epoetin alfa)] or darbepoetin alfa

OR

2.2.3 ALL of the following:

2.2.3.1 Serum erythropoietin levels greater than 500 mU/mL

AND

2.2.3.2 Ring sideroblasts less than 15% (or less than 5% with an SF3B1 mutation)

AND

2.2.3.3 History or failure, contraindication, intolerance, or a poor probability of responding to immunosuppressive therapy (e.g., azacitidine, decitabine)

OR

3 - BOTH of the following:

3.1 Diagnosis of myelodysplastic/myeloproliferative neoplasms (MDS/MPN) overlap neoplasm

AND

3.2 One of the following:

- Patient has SF3B1 mutation and thrombocytosis
- Patient has ring sideroblasts and thrombocytosis (MDS/MPN-RS-T)

Product Name: Brand Revlimid, generic lenalidomide	
Diagnosis	B-Cell Lymphomas
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following diagnoses: • Mantle cell lymphoma (MCL) • Extranodal marginal zone lymphoma of nongastric sites (noncutaneous) • Extranodal marginal zone lymphoma (EMZL) of the stomach • Classic follicular lymphoma • Nodal marginal zone lymphoma • Splenic marginal zone lymphoma OR	

2 - BOTH of the following:

2.1 ONE of the following diagnoses:

- HIV-related B-cell lymphoma
- Diffuse large B-cell lymphoma
- High-grade B-cell lymphoma
- Histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma
- Post-transplant lymphoproliferative disorders

AND

2.2 Used as second line and subsequent therapy

Product Name:Brand Revlimid, generic lenalidomide	
Diagnosis	Hodgkin Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Hodgkin lymphoma AND 2 - Used for primary refractory disease or suspected relapse AND 3 - Patient is not a candidate for high-dose therapy and autologous stem cell rescue (HDT/ASCR)	

Product Name:Brand Revlimid, generic lenalidomide

Diagnosis	Systemic Light Chain Amyloidosis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of systemic light chain amyloidosis AND 2 - Used in combination with ONE of the following: • Dexamethasone • Dexamethasone and cyclophosphamide • Dexamethasone and Ninlaro (ixazomib) • Dexamethasone and Darzalex (daratumumab)	

Product Name: Brand Revlimid, generic lenalidomide	
Diagnosis	Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL) AND 2 - Disease is relapsed or refractory	

AND

3 - Used after prior therapy with Bruton Tyrosine Kinase (BTK) inhibitor and venetoclax-based regimens

Product Name:Brand Revlimid, generic lenalidomide	
Diagnosis	T-Cell Lymphomas
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following: 1.1 Diagnosis of peripheral T-cell lymphoma AND 1.2 ONE of the following: - Used as initial palliative intent therapy - Used as second-line and subsequent therapy OR 2 - BOTH of the following: - Diagnosis of adult T-cell lymphoma - Used as second-line and subsequent therapy OR	

3 - BOTH of the following:

- Diagnosis of hepatosplenic T-cell lymphoma
- Used for refractory disease after two first-line therapy regimens

Product Name:Brand Revlimid, generic lenalidomide

Diagnosis Primary CNS Lymphoma

Approval Length 12 month(s)

Therapy Stage Initial Authorization

Guideline Type Prior Authorization

Approval Criteria
1 - Diagnosis of primary central nervous system lymphoma

Product Name:Brand Revlimid, generic lenalidomide

Diagnosis Kaposi Sarcoma

Approval Length 12 month(s)

Therapy Stage Initial Authorization

Guideline Type Prior Authorization

Approval Criteria
1 - ONE of the following:
1.1 Diagnosis of HIV-negative Kaposi Sarcoma

OR
1.2 BOTH of the following:

- Diagnosis of HIV-related Kaposi Sarcoma

- Patient is currently being treated with antiretroviral therapy (ART) confirmed by claims history or submission of medical records

AND

2 - Disease has progressed or not responded to TWO different systemic first-line therapies (e.g., liposomal doxorubicin, sirolimus, paclitaxel)

Product Name:Brand Revlimid, generic lenalidomide	
Diagnosis	Langerhans Cell Histiocytosis, Rosai-Dorfman disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following: • Langerhans cell histiocytosis • Rosai-Dorfman disease	

Product Name:Brand Revlimid, generic lenalidomide	
Diagnosis	Multicentric Castleman Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of multicentric Castleman disease	

AND

2 - One of the following:

- Progressed following treatment of relapsed/refractory disease
- Considered progressive disease

Product Name:Brand Revlimid, generic lenalidomide	
Diagnosis	Multiple Myeloma, Myelodysplastic Syndromes (MDS), B-Cell Lymphomas, Hodgkin Lymphoma, Systemic Light Chain Amyloidosis, Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma, T-Cell Lymphomas, Primary CNS Lymphomas, Kaposi Sarcoma, Langerhans Cell Histiocytosis, Rosai-Dorfman disease, Multicentric Castleman 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 Revlimid therapy	

Product Name:Brand Revlimid, generic lenalidomide	
Diagnosis	Myelofibrosis-Associated Anemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of myelofibrosis-associated anemia	

AND

2 - Presence of del(5q) mutation

AND

3 - No symptomatic splenomegaly and/or constitutional symptoms

Product Name:Brand Revlimid, generic lenalidomide	
Diagnosis	Myelofibrosis-Associated Anemia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response while on Revlimid	

Product Name:Brand Revlimid, generic lenalidomide	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Revlimid will be approved for uses supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	

Product Name:Brand Revlimid, generic lenalidomide

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 Revlimid therapy	

2 . Revision History

Date	Notes
9/15/2025	Updated criteria for Myelodysplastic Syndromes (MDS) .

Revuforj



Prior Authorization Guideline

Guideline ID	GL-597222
Guideline Name	Revuforj
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia Medicaid - Community & State Washington

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Revuforj

Diagnosis	Acute Lymphoblastic Leukemia/Acute Myeloid Leukemia
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 acute lymphoblastic leukemia (ALL) • Positive for lysine methyltransferase 2A gene (KMT2A) translocation OR 1.2 Diagnosis of acute myeloid leukemia (AML) and ONE of the following: • Positive for nucleophosmin 1 (NPM1) mutation • Positive for lysine methyltransferase 2A gene (KMT2A) translocation AND 2 - Disease is relapsed or refractory	

Product Name: Revuforj	
Diagnosis	Acute Lymphoblastic Leukemia/Acute Myeloid 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 Revuforj therapy	

Product Name:Revuforj	
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:Revuforj	
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 Revuforj therapy	

2 . Revision History

Date	Notes
4/28/2026	Added IN.

Rezlidhia



Prior Authorization Guideline

Guideline ID	GL-592213
Guideline Name	Rezlidhia
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia Medicaid - Community & State Washington

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Rezlidhia

Diagnosis	Acute Myeloid Leukemia (AML)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of acute myeloid leukemia (AML) AND 2 - Positive for a susceptible isocitrate dehydrogenase-1 (IDH1) mutation (e.g., R132C, R132H, R132G, R132S, R132L) AND 3 - ONE of the following: • Disease is relapsed or refractory • Patient is not a candidate for or declines intensive induction therapy	

Product Name:Rezlidhia	
Diagnosis	Myelodysplastic Syndrome (MDS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of myelodysplastic syndrome (MDS)	

AND

2 - Presence of IDH1 (isocitrate dehydrogenase-1) mutation

Product Name:Rezlidhia	
Diagnosis	Acute Myeloid Leukemia (AML), 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 Rezlidhia therapy	

Product Name:Rezlidhia	
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:Rezlidhia	
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 Rezlidhia therapy

2 . Revision History

Date	Notes
4/23/2026	Updated formularies to add ACUIN for eff 6/1/2026.

Rezurock



Prior Authorization Guideline

Guideline ID	GL-448298
Guideline Name	Rezurock
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 Indiana Medicaid - Community & State Michigan Medicaid - Community & State Nevada Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Rezurock	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chronic graft-versus-host disease (chronic GVHD) AND 2 - History of failure of at least TWO prior lines of systemic therapy (e.g., corticosteroids, mycophenolate, tacrolimus, etc.) confirmed by claims history or submitted medical records	

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

2 . Revision History

Date	Notes
11/12/2025	Combined formularies including NV for eff 1/1/26. No changes to clinical criteria.

Rivfloza



Prior Authorization Guideline

Guideline ID	GL-373188
Guideline Name	Rivfloza
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 Virginia Medicaid - Community & State Pennsylvania Medicaid - Community & State Nebraska Medicaid - Community & State Indiana Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	9/1/2025

1 . Criteria

Product Name:Rivfloza	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ALL of the following: 1.1 Patient has been established on therapy with Rivfloza under an active UnitedHealthcare medical benefit prior authorization for the treatment of primary hyperoxaluria type 1 (PH1) AND 1.2 Submission of medical records (e.g., chart notes, laboratory values) documenting a positive clinical response to therapy from pre-treatment baseline (e.g., decreased urinary oxalate concentrations, decreased urinary oxalate: creatinine ratio, decreased plasma oxalate concentrations) AND 1.3 Patient has NOT received a liver transplant AND 1.4 Patient has relatively preserved kidney function (e.g., eGFR [estimated glomerular filtration rate] greater than or equal to 30 mL/min/1.73 m²) AND 1.5 Patient is NOT receiving Rivfloza in combination with Oxlumio (lumasiran) AND	

1.6 Prescribed by, or in consultation with, a specialist (e.g., geneticist, nephrologist, urologist) with expertise in the treatment of PH1

OR

2 - ALL of the following:

2.1 Diagnosis of primary hyperoxaluria type 1 (PH1)

AND

2.2 Confirmation of diagnosis based on BOTH of the following:

2.2.1 Metabolic testing demonstrating ONE of the following:

2.2.1.1 Increased urinary oxalate excretion (e.g., greater than 1 mmol/1.73 m² per day [90 mg/1.73 m² per day], increased urinary oxalate: creatinine ratio relative to normative values for age)

OR

2.2.1.2 Increased plasma oxalate and glyoxylate concentrations

AND

2.2.2 Genetic testing has confirmed a mutation in the alanine: glyoxylate aminotransferase (AGT or AGXT) gene

AND

2.3 Patient has NOT received a liver transplant

AND

2.4 Patient is at least 2 years of age or older

AND

2.5 Patient has relatively preserved kidney function (e.g., eGFR [estimated glomerular filtration rate] greater than or equal to 30 mL/min/1.73 m²)

AND

2.6 Patient is NOT receiving Rivfloza in combination with Oxlumio (lumasiran)

AND

2.7 Prescribed by, or in consultation with, a specialist (e.g., geneticist, nephrologist, urologist) with expertise in the treatment of PH1

Product Name: Rivfloza	
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) documenting a positive clinical response to therapy from pre-treatment baseline (e.g., decreased urinary oxalate concentrations, decreased urinary oxalate: creatinine ratio, decreased plasma oxalate concentrations) AND 2 - Patient has NOT received a liver transplant AND	

3 - Patient has relatively preserved kidney function (e.g., eGFR [estimated glomerular filtration rate] greater than or equal to 30 mL/min/1.73 m²)

AND

4 - Patient is NOT receiving Rivfloza in combination with Oxlumio (lumasiran)

AND

5 - Prescribed by, or in consultation with, a specialist (e.g., geneticist, nephrologist, urologist) with expertise in the treatment of PH1

2 . Revision History

Date	Notes
8/19/2025	Updated formularies to add IN

Romvimza



Prior Authorization Guideline

Guideline ID	GL-267198
Guideline Name	Romvimza
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 Virginia Medicaid - Community & State Indiana Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2025

1 . Criteria

Product Name: Romvimza	
Diagnosis	Tenosynovial Giant Cell Tumor (TGCT)

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of tenosynovial giant cell tumor (TGCT) AND 2 - Surgical resection will potentially cause worsening functional limitation or severe morbidity	

Product Name: Romvimza	
Diagnosis	Tenosynovial Giant Cell Tumor (TGCT)
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 Romvimza therapy	

Product Name: Romvimza	
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: Romvimza	
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 Romvimza therapy	

2 . Revision History

Date	Notes
5/14/2025	Updated formularies to add IN

Rozlytrek



Prior Authorization Guideline

Guideline ID	GL-597250
Guideline Name	Rozlytrek
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Rozlytrek	
Diagnosis	Ampullary Adenocarcinoma

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ampullary adenocarcinoma AND 2 - Disease is positive for neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1) AND 3 - ONE of the following: • Used for metastatic disease • Used for disease progression	

Product Name: Rozlytrek	
Diagnosis	Appendiceal Neoplasms and Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following appendiceal neoplasms and cancers: • Appendiceal adenocarcinoma • Goblet cell adenocarcinoma • Undifferentiated carcinoma not otherwise specified	

AND

2 - Disease is positive for neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1)

AND

3 - Used as second-line or subsequent therapy

Product Name: Rozlytrek

Diagnosis	Biliary Tract Cancer

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of biliary tract cancer (e.g., gallbladder, cholangiocarcinoma)

AND

2 - Disease is positive for neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1)

AND

3 - Disease is ONE of the following:

- Gross Residual (R2)
- Metastatic
- Resectable locoregionally advanced
- Unresectable

Product Name: Rozlytrek	
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 - Disease is positive for neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1)

AND

3 - Disease is without a known acquired resistance mutation [e.g., TRKA G595R substitution, TRKA G667C substitution, or other recurrent kinase domain (solvent front and xDFG) mutations]

AND

4 - Disease is ONE of the following:

- Metastatic
- Recurrent unresectable
- Unresponsive to preoperative systemic therapy

Product Name: Rozlytrek	
Diagnosis	Central Nervous System Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following: • Circumscribed glioma • Glioblastoma • High-grade glioma • Brain metastases AND 2 - Disease is positive for neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1) AND 3 - Disease is ONE of the following: • Metastatic • Recurrent or progressive	

Product Name:Rozlytrek	
Diagnosis	Cervical Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of cervical cancer	

AND

2 - Disease is positive for neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1)

AND

3 - Used as second-line or subsequent therapy

Product Name:Rozlytrek

Diagnosis	Colorectal Cancers

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of colon or rectal cancer

AND

2 - Disease is positive for neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1)

AND

3 - Used as second-line or subsequent therapy

Product Name:Rozlytrek

Diagnosis	Esophageal, Esophagogastric Junction, and Gastric Cancers

Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of esophageal, esophagogastric junction, or gastric cancer AND 2 - Disease is positive for neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1) AND 3 - Disease is ONE of the following: • Metastatic • Recurrent • Unresectable locally advanced	

Product Name:Rozlytrek	
Diagnosis	Gastrointestinal Stromal Tumors
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of gastrointestinal stromal tumor AND	

2 - Disease is positive for neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1)

AND

3 - Used in ONE of the following settings:

- Neoadjuvant therapy to decrease surgical morbidity
- Gross residual disease (R2 resection)
- Unresectable primary disease
- Preoperative/intraoperative tumor rupture
- Recurrent/metastatic disease

Product Name:Rozlytrek

Diagnosis	Head and Neck Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of salivary gland tumor

AND

2 - Disease is positive for neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1)

AND

3 - Used as second-line or subsequent therapy

Product Name:Rozlytrek

Diagnosis	Hepatocellular Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of hepatocellular carcinoma AND 2 - Disease is positive for neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1) AND 3 - Disease is recurrent or metastatic	

Product Name:Rozlytrek	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of histiocytic neoplasm AND 2 - Disease is positive for neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1)	

AND

3 - Disease is ONE of the following:

- Metastatic
- Relapsed/refractory
- Symptomatic unresectable or multifocal

Product Name:Rozlytrek

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

Approval Criteria

1 - Diagnosis of cutaneous melanoma

AND

2 - Disease is positive for ONE of the following gene fusions:

- ROS1-gene fusion
- NTRK-gene fusion

AND

3 - Disease is metastatic or unresectable

Product Name:Rozlytrek

Diagnosis	Neuroendocrine and Adrenal Tumors
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of neuroendocrine tumor AND 2 - Disease is positive for neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1) AND 3 - Disease is without a known acquired resistance mutation [e.g., TRKA G595R substitution, TRKA G667C substitution, or other recurrent kinase domain (solvent front and xDFG) mutations] AND 4 - Disease is ONE of the following: • Locoregional unresectable • Metastatic	

Product Name:Rozlytrek	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of metastatic non-small cell lung cancer (NSCLC)

AND

2 - Disease is positive for ONE of the following gene fusions:

- ROS1-gene fusion
- NTRK-gene fusion

AND

3 - Disease is ONE of the following:

- Advanced
- Metastatic
- Recurrent

Product Name:Rozlytrek

Diagnosis	Occult Primary [Cancer of Unknown Primary (CUP)]
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following occult primary cancers:

- Adenocarcinoma
- Carcinoma not otherwise specified
- Squamous cell carcinoma

AND

2 - Disease is positive for neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1)

AND

3 - Disease is without a known acquired resistance mutation [e.g., TRKA G595R substitution, TRKA G667C substitution, or other recurrent kinase domain (solvent front and xDFG) mutations]

AND

4 - Used in ONE of the following settings:

- Asymptomatic patients with PS 0 and aggressive disease
- Symptomatic patients with performance status (PS) 1-2

Product Name:Rozlytrek

Diagnosis	Ovarian/Fallopian Tube/Primary Peritoneal Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following:

- Fallopian tube cancer
- Ovarian cancer
- Primary peritoneal cancer

AND

2 - Disease is positive for neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1)

AND

3 - ONE of the following histologies:

- Endometrioid
- Carcinosarcoma (Malignant Mixed Müllerian Tumors)
- Clear cell carcinoma of the ovary
- Mucinous carcinoma
- Serous carcinoma

AND

4 - Disease is persistent or recurrent

Product Name:Rozlytrek	
Diagnosis	Pancreatic Adenocarcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of pancreatic adenocarcinoma AND 2 - Disease is positive for neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1) AND 3 - Disease is ONE of the following:	

- Locally advanced
- Metastatic

Product Name:Rozlytrek	
Diagnosis	Small Bowel Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of small bowel adenocarcinoma AND 2 - Disease is positive for neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1) AND 3 - Used as second-line or subsequent therapy	

Product Name:Rozlytrek	
Diagnosis	Soft Tissue Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of soft tissue sarcoma

AND

2 - Disease is positive for neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1)

AND

3 - Disease is ONE of the following:

- Advanced
- Metastatic

Product Name:Rozlytrek

Diagnosis	Thyroid Carcinoma

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following thyroid cancers:

- Papillary carcinoma
- Follicular carcinoma
- Oncocytic carcinoma
- Anaplastic carcinoma

AND

2 - Disease is positive for neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1)

AND

3 - Disease is ONE of the following:

- Metastatic
- Persistent
- Unresectable locoregional recurrent

Product Name: Rozlytrek

Diagnosis	Uterine Neoplasm

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following uterine neoplasms:

- Endometrial carcinoma
- Uterine Sarcoma

AND

2 - Disease is positive for neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1)

AND

3 - Disease is ONE of the following:

- Advanced
- Inoperable
- Recurrent

- Metastatic

Product Name:Rozlytrek	
Diagnosis	Vaginal/Vulvar Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of vaginal or vulvar cancer AND 2 - Disease is positive for neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1) AND 3 - Used as second-line or subsequent therapy	

Product Name:Rozlytrek	
Diagnosis	Ampullary Adenocarcinoma, Appendiceal Neoplasms and Cancers, Biliary Tract Cancer, Breast Cancer, Central Nervous System Cancers, Cervical Cancer, Colorectal Cancers, Esophageal, Esophagogastric Junction, and Gastric Cancers, Gastrointestinal Stromal Tumors, Head and Neck Cancers, Hepatocellular Carcinoma, Histiocytic Neoplasms, Melanoma, Neuroendocrine and Adrenal Tumors, Non-Small Cell Lung Cancer (NSCLC), Occult Primary [Cancer of Unknown Primary (CUP)], Ovarian/Fallopian Tube/Primary Peritoneal Cancers, Pancreatic Adenocarcinoma, Small Bowel Cancer, Soft Tissue Sarcoma, Thyroid Carcinoma, Uterine Neoplasm, Vaginal/Vulvar 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 Rozlytrek therapy	

Product Name:Rozlytrek	
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:Rozlytrek	
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 Rozlytrek therapy	

2 . Revision History

Date	Notes

4/28/2026	Added IN.

Rubraca



Prior Authorization Guideline

Guideline ID	GL-257188
Guideline Name	Rubraca
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 Virginia Medicaid - Community & State Washington Medicaid - Community & State Indiana Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2025

1 . Criteria

Product Name:Rubraca

Diagnosis	Epithelial ovarian cancer, fallopian tube cancer, primary peritoneal cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following: • Epithelial ovarian cancer • Fallopian tube cancer • Primary peritoneal cancer AND 2 - BOTH of the following: 2.1 Cancer has a deleterious BRCA mutation AND 2.2 To be used as maintenance therapy in individuals who are in complete or partial response to platinum-based chemotherapy	

Product Name: Rubraca	
Diagnosis	Prostate cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of metastatic, castration-resistant prostate cancer	

AND

2 - Cancer has a deleterious BRCA mutation

AND

3 - ONE of the following:

3.1 Failure to androgen receptor-directed therapy [e.g., Zytiga (abiraterone), Xtandi (enzalutamide), Erleada (apalutamide)] as confirmed by claims history or submission of medical records

OR

3.2 Contraindication or intolerance to androgen receptor-directed therapy [e.g., Zytiga (abiraterone), Xtandi (enzalutamide), Erleada (apalutamide)] (please specify intolerance or contraindication)

AND

4 - ONE of the following:

4.1 Used in combination with a gonadotropin-releasing hormone (GnRH) analog [e.g., Lupron (leuprolide), Zoladex (goserelin), Trelstar (triptorelin), Vantas (histrelin), Firmagon (degarelix)]

OR

4.2 Patient has had bilateral orchiectomy

Product Name: Rubraca	
Diagnosis	Uterine cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of BRCA altered uterine leiomyosarcoma (uLMS)

AND

2 - Disease has progressed following prior treatment with ONE of the following:

- Gemcitabine plus docetaxel
- Doxorubicin

Product Name: Rubraca	
Diagnosis	Pancreatic cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of pancreatic adenocarcinoma AND 2 - Disease is metastatic AND 3 - Presence of ONE of the following: 3.1 Deleterious or suspected deleterious germline or somatic BRCA1/2 mutation	

OR

3.2 Deleterious or suspected deleterious germline or somatic PALB2 mutation

AND

4 - Disease has NOT progressed while receiving at least 16 weeks of a first-line platinum-based chemotherapy regimen

Product Name:Rubraca	
Diagnosis	Epithelial ovarian cancer, fallopian tube cancer, primary peritoneal cancer, Prostate cancer, Uterine cancer, Pancreatic 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 Rubraca therapy	

Product Name:Rubraca	
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	

Product Name: Rubraca	
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 Rubraca therapy	

2 . Revision History

Date	Notes
5/5/2025	Updated formularies. Removed requirement for taxane-based chemotherapy for prostate cancer

Ruconest



Prior Authorization Guideline

Guideline ID	GL-268187
Guideline Name	Ruconest
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 Indiana Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2025

1 . Criteria

Product Name:Ruconest	
Diagnosis	Hereditary Angioedema (HAE)
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of hereditary angioedema (HAE) as 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 variant(s) in the gene(s) for factor XII, angiopoietin-1, plasminogen-1, kininogen-1, myoferlin, or heparan sulfate-glucosamine 3-O-sulfotransferase 6 • Recurring angioedema attacks that are refractory to high-dose antihistamines with confirmed family history of angioedema • Recurring angioedema attacks that are refractory to high-dose antihistamines with unknown background de-novo mutation(s) (i.e., no family history) (HAE-unknown) AND 2 - Prescribed for the acute treatment of HAE attacks AND 3 - Not used in combination with other products indicated for the acute treatment of HAE attacks (e.g., Berinert, Firazyr) AND 4 - Prescribed by ONE of the following:	

- Immunologist
- Allergist

Product Name:Ruconest	
Diagnosis	Hereditary Angioedema (HAE)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Ruconest therapy AND 2 - Prescribed for the acute treatment of HAE attacks AND 3 - Not used in combination with other products indicated for the acute treatment of HAE attacks (e.g., Berinert, Firazyr) AND 4 - Prescribed by ONE of the following: • Immunologist • Allergist	

2 . Revision History

UnitedHealthcare Community Plan of Indiana Clinical Pharmacy Program Guidelines

Date	Notes
5/14/2025	Combined formularies. No changes to clinical criteria.

Rukobia



Prior Authorization Guideline

Guideline ID	GL-202202
Guideline Name	Rukobia
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Indiana Medicaid - Community & State Maryland Medicaid - Community & State New Mexico Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island

Guideline Note:

Effective Date:	4/1/2025

1 . Criteria

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

1 - Patient has been diagnosed with multidrug-resistant HIV-1 (human immunodeficiency virus type 1) infection

AND

2 - Patient is currently taking or will be prescribed an optimized background antiretroviral regimen

2 . Revision History

Date	Notes
2/27/2025	Minor update to definition of HIV-1 in criteria, with no changes to clinical intent. Removed NY and NY EPP from markets in scope as Rukobia moving to open access for these markets.

Rydapt



Prior Authorization Guideline

Guideline ID	GL-370209
Guideline Name	Rydapt
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland 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 Virginia Medicaid - Community & State Washington Medicaid - Community & State New Mexico Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	9/1/2025

1 . Criteria

Product Name:Rydapt

Diagnosis	Acute Myeloid Leukemia (AML)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of acute myeloid leukemia (AML) AND 2 - AML is FLT3 mutation-positive AND 3 - Rydapt will be used in combination with standard induction and consolidation therapy	

Product Name:Rydapt	
Diagnosis	Systemic Mastocytosis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following: - Aggressive systemic mastocytosis (ASM) - Systemic mastocytosis with associated hematologic neoplasm (SM-AHN) - Mast cell leukemia (MCL)	

Product Name:Rydapt

Diagnosis	Myeloid/Lymphoid Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of lymphoid, myeloid, or mixed lineage neoplasms with eosinophilia AND 2 - ONE of the following: • Presence of an FGFR1 rearrangement • Presence of an FLT3 rearrangement	

Product Name:Rydapt	
Diagnosis	Acute Myeloid Leukemia (AML), Systemic Mastocytosis, Myeloid/Lymphoid Neoplasms
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 Rydapt therapy	

Product Name:Rydapt	
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:Rydapt	
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 Rydapt therapy	

2 . Revision History

Date	Notes
8/15/2025	Combined formularies. Minor wording update to Myeloid/Lymphoid Neoplasms criteria.

Scemblix



Prior Authorization Guideline

Guideline ID	GL-599212
Guideline Name	Scemblix
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Scemblix	
Diagnosis	Chronic Myeloid Leukemia (CML)

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chronic myeloid leukemia (CML) AND 2 - Disease is Philadelphia chromosome (Ph+) or BCR::ABL1-positive AND 3 - ONE of the following: • Used in newly diagnosed chronic phase CML (CP-CML) • Used in previously treated chronic phase CML (CP-CML) • Used in chronic phase CML (CP-CML) positive for a T315I mutation • Used in accelerated phase CML (AP-CML) as primary treatment as a single agent	

Product Name:Scemblix	
Diagnosis	Myeloid/Lymphoid Neoplasms with Eosinophilia and ABL1 Gene Rearrangement
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of myeloid/lymphoid neoplasm with eosinophilia and ABL1 rearrangement	

AND

2 - Disease is in chronic or blast phase

Product Name:Scemblix

Diagnosis	Acute Lymphoblastic Leukemia

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of B-cell acute lymphoblastic leukemia (B-ALL)

AND

2 - Disease is Philadelphia chromosome (Ph+) or BCR:ABL1-positive

AND

3 - Disease is relapsed/refractory

AND

4 - Used in combination with dasatinib

Product Name:Scemblix

Diagnosis	Chronic Myeloid Leukemia (CML), Myeloid/Lymphoid Neoplasms with Eosinophilia and ABL1 Gene Rearrangement, 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 Scemblix therapy	

Product Name:Scemblix	
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:Scemblix	
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 Scemblix therapy	

2 . Revision History

UnitedHealthcare Community Plan of Indiana Clinical Pharmacy Program Guidelines

Date	Notes
4/29/2026	Added IN.

Sedative-Hypnotics and Benzodiazepines



Prior Authorization Guideline

Guideline ID	GL-504223
Guideline Name	Sedative-Hypnotics and Benzodiazepines
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name: Brand Ambien CR; Generic zolpidem ER; Amytal; Edluar; Generic zolpidem; Brand Lunesta; Generic eszopiclone; meprobamate; zaleplon; Brand Ambien; Generic zolpidem; pentobarbital; alprazolam ODT; Generic alprazolam; Brand Xanax; Generic alprazolam ER; Brand Xanax XR; alprazolam intensol; chlordiazepoxide; chlordiazepoxide/amitriptyline; Generic clonazepam; Brand Klonopin; clonazepam ODT; clorazepate dipotassium; Generic diazepam; Brand Valium; diazepam intensol; Brand Doral; Generic quazepam; estazolam; flurazepam; Brand Ativan; Lorazepam; Generic lorazepam; lorazepam intensol; Loreev XR; midazolam; oxazepam; Brand Restoril; Generic temazepam; Brand Halcion; Generic triazolam; Belsomra; Quviviq; Dayvigo; zolpidem caps; Brand Librax; Generic chlordiazepoxide/clidinium; Brand Onfi; Generic clobazam	
Diagnosis	Duplicate Therapy
Approval Length	12 month(s)
Guideline Type	Drug Utilization Review

Approval Criteria

1 - If the request is a clobazam product, the patient has a seizure diagnosis

OR

2 - One of the following:

2.1 The medications involved in the therapeutic duplication are being cross-tapered

OR

2.2 The sedative-hypnotic or benzodiazepine in patient's history is being discontinued or there are plans to discontinue

OR

2.3 There is medical rationale supporting duplication of therapy (please document rationale)

Product Name:alprazolam ODT; Generic alprazolam; Brand Xanax; Generic alprazolam ER; Brand Xanax XR; alprazolam intensol; chlordiazepoxide; chlordiazepoxide/amitriptyline; Generic clonazepam; Brand Klonopin; clonazepam ODT; clorazepate dipotassium; Generic diazepam; Brand Valium; diazepam intensol; Brand Doral; Generic quazepam; estazolam; flurazepam; Brand Ativan; Lorazepam; Generic lorazepam; lorazepam intensol; midazolam; oxazepam; Brand Restoril; Generic temazepam; Brand Halcion; Generic triazolam

Diagnosis	(> 15 day supply and/or > 30 day supply within 90 days)
Approval Length	6 month(s) for catatonia, 12 month(s) for all other indications
Guideline Type	Quantity Limit

Approval Criteria

1 - One of the following:

1.1 Patient has at least 90 days of benzodiazepine therapy in the past 180 days

OR

1.2 ONE of the following:

1.2.1 Diagnosis of cancer, seizure disorder, catatonia, intractable Meniere's disease, or other terminal illness

OR

1.2.2 Diagnosis of spasticity associated with a central neurological disorder (e.g. cerebral palsy, dystonia, paraplegia, etc.) and BOTH of the following:

1.2.2.1 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 Pharmacopeia-National Formulary (USP-NF)

AND

1.2.2.2 ONE of the following:

- Prescribed by, or in consultation with, a neurologist or physical medicine and rehabilitation specialist
- Previous trial and failure of at least two non-benzodiazepine muscle relaxants

OR

1.2.3 Diagnosis of akathisia and ONE of the following:

- Previous trial and failure of propranolol
- Prescriber has provided medical rationale for the use of a benzodiazepine over propranolol (please document rationale)

OR

1.3 Documentation of valid medical justification to exceed plan limitation maximum for initiation of benzodiazepine therapy [15-day supply with a subsequent claim(s) not to exceed 15-day supply (for a total of 30 days of therapy) every 90 days] (please document justification)

Product Name:Loreev XR

Diagnosis	(> 15 day supply and/or > 30 day supply within 90 days)

Approval Length	6 month(s) for catatonia, 12 month(s) for all other indications

Guideline Type	Quantity Limit

Approval Criteria

1 - One of the following:

1.1 The patient has current approval for long-term benzodiazepine therapy (1 year or greater)

OR

1.2 ONE of the following:

1.2.1 Patient has at least 90 days of benzodiazepine therapy in the past 180 days

OR

1.2.2 ONE of the following:

1.2.2.1 Diagnosis of cancer, seizure disorder, catatonia, intractable Meniere's disease, or other terminal illness

OR

1.2.2.2 Diagnosis of spasticity associated with a central neurological disorder (e.g. cerebral palsy, dystonia, paraplegia, etc.) and BOTH of the following:

1.2.2.2.1 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 Pharmacopeia-National Formulary (USP-NF)

AND

1.2.2.2.2 ONE of the following:

- Prescribed by, or in consultation with, a neurologist or physical medicine and rehabilitation specialist
- Previous trial and failure of at least two non-benzodiazepine muscle relaxants

OR

1.2.2.3 Diagnosis of akathisia and ONE of the following:

- Previous trial and failure of propranolol
- Prescriber has provided medical rationale for the use of a benzodiazepine over propranolol (please document rationale)

OR

1.3 Documentation of valid medical justification to exceed plan limitation maximum for initiation of benzodiazepine therapy [15-day supply with a subsequent claim(s) not to exceed 15-day supply (for a total of 30 days of therapy) every 90 days] (please document justification)

AND

2 - BOTH of the following:

- History of lorazepam IR formulation for at least 90 of the past 180 days
- Documentation the patient has been utilizing lorazepam IR formulation at a consistent scheduled TID (three times per day) dose within the previous 30 days

Product Name:alprazolam ODT; Generic alprazolam; Brand Xanax; Generic alprazolam ER; Brand Xanax XR; alprazolam intensol; chlordiazepoxide; chlordiazepoxide/amitriptyline; Generic clonazepam; Brand Klonopin; clonazepam ODT; clorazepate dipotassium; Generic diazepam; Brand Valium; diazepam intensol; Brand Doral; Generic quazepam; estazolam; flurazepam; Brand Ativan; Lorazepam; Generic lorazepam; lorazepam intensol; midazolam; oxazepam; Brand Restoril; Generic temazepam; Brand Halcion; Generic triazolam, Loreev XR	
Diagnosis	Concurrent benzodiazepine and opioid use
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following: 1.1 Patient is not using the requested medication concurrently with an opioid (claim within the past 30 days) OR 1.2 BOTH of the following: • Days' supply for the requested benzodiazepine is 7 days or less • Including the days' supply for the requested agent, the patient will not exceed 7 days of concurrent opiate/benzodiazepine therapy in the past 180 days OR 1.3 Patient has utilized concurrent benzodiazepine/opiate therapy, including any cross-tapered or discontinued agents, for at least 90 of the past 120 days OR 1.4 All of the following for concurrent opiate/benzodiazepine therapy exceeding 7 days in the past 180 days: 1.4.1 Indications provided for both the benzodiazepine agent(s) and the opioid agent(s)	

AND

1.4.2 Documentation of previous therapies attempted for the given indications

AND

1.4.3 Prescriber attests to ALL of the following:

- The patient's INSPECT report has been evaluated and continues to be evaluated on a regular basis
- The patient has been educated in regard to the risks of concurrent utilization of opioid and benzodiazepine therapy, and the patient accepts these risks
- The prescriber has consulted any other prescribers involved in concurrent therapy and all prescribers agree to pursue concurrent opioid and benzodiazepine therapy for the patient, if applicable
- The prescriber acknowledges the risk of adverse event(s), including respiratory depression, coma, and death, associated with concurrent utilization

Product Name: Brand Onfi*	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - If the request is non-preferred**, ONE of the following: 1.1 Patient has a diagnosis of seizures AND history of a preferred* antiseizure medication for at least 14 days in the past 90 days OR 1.2 For a non-seizure diagnosis ONE of the following: • History of one preferred** antiseizure medication	

Prescriber has provided medical justification for the use of the requested medication over ALL of the preferred** antiseizure medications (e.g., preferred agents do not have FDA-approved or approved compendia indication for member's diagnosis, member has contraindication or intolerance to preferred agents with appropriate indications, etc.) (please document justification)	
Notes	*These criteria come from the Antiseizure policy **PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name: Brand Onfi*	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - If the request is non-preferred**, ONE of the following: 1.1 Diagnosis of seizure disorder AND history of the requested medication for 30 of the past 60 days confirmed by claims history or chart documentation OR 1.2 For a non-seizure diagnosis BOTH of the following: 1.2.1 History of the requested medication for 30 of the past 60 days confirmed by claims history or chart documentation AND 1.2.2 ONE of the following: - History of one preferred** antiseizure medication - Prescriber has provided medical justification for the use of the requested medication over ALL of the preferred** antiseizure medications (e.g., preferred agents do not have FDA-approved or approved compendia indication for member's diagnosis, member	

has contraindication or intolerance to preferred agents with appropriate indications, etc.) (please document justification)	
Notes	*These criteria come from the Antiseizure policy **PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:Dayvigo, Quviviq	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has trial and failure of Belsomra (as supported by claims history or chart documentation) OR 2 - Prescriber has provided medical justification for the use of the requested medication over Belsomra (please document justification)	

Product Name:Edluar	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has trial and failure of zolpidem tablet (as supported by claims history or chart documentation) AND 2 - Prescriber has provided medical justification for the use of the requested medication over zolpidem tablet (please document justification)	

Product Name:flurazepam, Brand Doral, Generic quazepam	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has trial and failure of all preferred benzodiazepine agents for insomnia* (as supported by claims history or chart documentation) OR 2 - Prescriber has provided medical justification for the use of the requested medication over preferred benzodiazepine agents for insomnia (please document justification)	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:Zolpidem 7.5 mg capsule	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has trial and failure of zolpidem IR 5 milligram (as supported by claims history or chart documentation)	

Product Name:zolpidem 1.75 mg and 3 mg sublingual tablet	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria	

1 - Prescriber has provided medical justification for the use of the requested medication (please document justification)

AND

2 - Patient is not using concomitantly with other zolpidem strengths/formulations

Product Name:meprobamate

Approval Length 12 month(s)

Guideline Type Prior Authorization

Approval Criteria

1 - BOTH of the following:

- Patient has previous trial and failure of buspirone IR tablet and hydroxyzine (as supported by claims history or chart documentation)
- Prescriber has provided rationale for use of the requested medication over buspirone IR tablet and hydroxyzine (please document rationale)

OR

2 - History of the requested medication for 90 of the past 120 days (as supported by claims history or chart documentation)

2 . Revision History

Date	Notes
1/27/2026	Updated GPIs and product names. Moved Sympazan to Antiseizure guideline. Added language for free text box for medical justification/rationale. Added specific criteria for Dayvigo, Quviviq, Edluar, flurazepam, Brand Doral, Generic quazepam, Zolpidem 7.5 mg capsule, zolpidem 1.75 mg and 3 mg sublingual tablet and meprobamate.

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

SGLT2 Inhibitors and Combinations



Prior Authorization Guideline

Guideline ID	GL-487248
Guideline Name	SGLT2 Inhibitors and Combinations
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Qtern, Steglujan, Trijardy XR	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has tried and failed Glyxambi or combination therapy with preferred agents* of the same classes OR	

2 - Medical justification for use (please document)	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name: Inpefa	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has tried and failed ALL of the following active ingredients as monotherapy or combination product: • canagliflozin • dapagliflozin • empagliflozin OR 2 - Medical justification for use (please document)	

2 . Revision History

Date	Notes
12/23/2025	Added Inpefa. Updated Qtern, Steglujan, Trijardy XR step therapy. R emoved Glyxambi.

Sivextro



Prior Authorization Guideline

Guideline ID	GL-522256
Guideline Name	Sivextro
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Pennsylvania Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name:Sivextro tablets	
Diagnosis	Skin and Skin Structure Infections
Approval Length	1 month(s)

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 acute bacterial skin and skin structure infection (including diabetic foot infections) AND 3.2 ONE of the following: 3.2.1 Infection is caused by methicillin-resistant <i>Staphylococcus aureus</i> (MRSA) documented by culture and sensitivity report OR 3.2.2 Presence of MRSA infection is likely and empiric treatment is warranted AND 3.3 ONE of the following: 3.3.1 Failure of linezolid (generic Zyvox) confirmed by claims history or submitted medical records

OR

3.3.2 History of intolerance or contraindication to linezolid (generic Zyvox) (please specify intolerance or contraindication)

AND

3.4 ONE of the following:

3.4.1 Failure of ONE of the following confirmed by claims history or submitted medical records:

- Sulfamethoxazole-trimethoprim (SMX-TMP)
- A tetracycline
- Clindamycin

OR

3.4.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- Sulfamethoxazole-trimethoprim (SMX-TMP)
- A tetracycline
- Clindamycin

OR

4 - ALL of the following:

4.1 Diagnosis of acute bacterial skin and skin structure infection (including diabetic foot infections)

AND

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

AND

4.3 ONE of the following:

4.3.1 Failure of linezolid (generic Zyvox) confirmed by claims history or submitted medical records

OR

4.3.2 History of intolerance or contraindication to linezolid (generic Zyvox) (please specify intolerance or contraindication)

AND

4.4 ONE of the following:

4.4.1 Failure of TWO of the following confirmed by claims history or submitted medical records:

- A penicillin
- A cephalosporin
- A tetracycline
- Clindamycin
- Sulfamethoxazole-trimethoprim (SMX-TMP)
- A fluoroquinolone

OR

4.4.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- A Penicillin
- A cephalosporin
- A tetracycline
- Clindamycin
- Sulfamethoxazole-trimethoprim (SMX-TMP)
- A fluoroquinolone

Product Name:Sivextro tablets	
Diagnosis	Off-Label Uses
Approval Length	Based on provider and IDSA recommended treatment durations, up to 6 months.
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 - BOTH of the following: 3.1 The drug has been recognized for treatment of the indication by the Infectious Diseases Society of America (IDSA) AND 3.2 ONE of the following: 3.2.1 Failure of linezolid (generic Zyvox) confirmed by claims history or submitted medical records, if susceptibility is confirmed by culture OR 3.2.2 History of intolerance or contraindication to linezolid (generic Zyvox), if susceptibility is confirmed by culture (please specify intolerance or contraindication)	

2 . Revision History

Date	Notes
2/17/2026	Removed NY-CHIP and NY-EPP.

Skeletal Muscle Relaxants



Prior Authorization Guideline

Guideline ID	GL-465217
Guideline Name	Skeletal Muscle Relaxants
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:generic baclofen solution, generic baclofen suspension	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is unable to swallow tablets	

Product Name:Brand Amrix, generic cyclobenzaprine ER, Tonmya	
Approval Length	12 month(s)

Guideline Type	Prior Authorization
Approval Criteria 1 - Trial of cyclobenzaprine IR (immediate release) tablets within the past 30 days AND 2 - ONE of the following: 2.1 History of failure to at least TWO additional preferred alternatives as confirmed by claims history or submission of medical records* OR 2.2 History of contraindication or intolerance to TWO additional preferred alternatives (please specify contraindication or intolerance)*	
Notes	NOTE: In instances where there are fewer than three preferred alternatives, the patient must have a history of failure, contraindication or intolerance to all of the preferred products.

2 . Revision History

Date	Notes
12/15/2025	Updated language in criteria section for Amrix/cyclobenzaprine ER. Added Tonmya as a target (shares same criteria as Amrix/cyclobenzaprine ER). Minor cosmetic updates.

Skyclarys



Prior Authorization Guideline

Guideline ID	GL-127234
Guideline Name	Skyclarys
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	8/1/2023

1 . Criteria

Product Name:Skyclarys	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Friedreich's ataxia	

AND

2 - Confirmed presence of a mutation in the frataxin (FXN) gene

AND

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

- Neurologist
- Neurogeneticist
- Physical Medicine and Rehabilitation physician (i.e., physiatrist)

Product Name:Skyclarys	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Skyclarys therapy AND 2 - Prescribed by, or in consultation with, one of the following: • Neurologist • Neurogeneticist • Physical Medicine and Rehabilitation physician (i.e., physiatrist)	

2 . Revision History

UnitedHealthcare Community Plan of Indiana Clinical Pharmacy Program Guidelines

Date	Notes
6/28/2023	New guideline.

Smoking Deterrent Agents



Prior Authorization Guideline

Guideline ID	GL-137508
Guideline Name	Smoking Deterrent Agents
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name:nicotine transdermal patch, Nicoderm CQ, nicotine gum, Thrive, Nicorette, nicotine lozenge, Nicotrol NS, Nicotrol Inhaler	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is 10 years of age or older AND	

2 - If the request is non-preferred*, the patient had a trial and failure of THREE preferred* medications within this drug class that are indicated for the patient's diagnosis (if applicable)	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:varenicline, Apo-varenicline	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is 18 years of age or older	

2 . Revision History

Date	Notes
12/11/2023	Updated GPI and product name lists, added NP criteria and PDL link in note.

Sohonos



Prior Authorization Guideline

Guideline ID	GL-438190
Guideline Name	Sohonos
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland 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 Nevada Medicaid - Community & State Virginia Medicaid - Community & State Indiana Medicaid - Community & State Nebraska Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Sohonos	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of fibrodysplasia ossificans progressiva (FOP) AND 2 - Diagnosis has been confirmed by the presence of a mutation in the activin receptor IA (ACVR1) gene AND 3 - ONE of the following: 3.1 BOTH of the following: • Patient is female • Patient is 8 years of age or older OR 3.2 BOTH of the following: • Patient is male • Patient is 10 years of age or older AND 4 - Sohonos is being used to reduce the volume of new heterotopic ossification (HO)	

AND

5 - Prescribed by or in consultation with an FOP expert (e.g., endocrinologist, geneticist, pediatric orthopedist, pediatric rheumatologist)

Product Name:Sohonos	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response [e.g., reduction in new HO (heterotopic ossification) volume, improved CAJIS (Cumulative Analogue Joint Involvement Scale) and FOP-PFQ (Fibrodysplasia Ossificans Progressiva-Physical Function Questionnaire) scores, improved quality of life] AND 2 - Prescribed by or in consultation with an FOP expert (e.g., endocrinologist, geneticist, pediatric orthopedist, pediatric rheumatologist)	

2 . Revision History

Date	Notes
11/5/2025	Combined formularies - added NV, VA, IN, NE, NM. No clinical changes.

Solaraze



Prior Authorization Guideline

Guideline ID	GL-124376
Guideline Name	Solaraze
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	7/1/2023

1 . Criteria

Product Name: Brand Solaraze, generic diclofenac 3% (actinic keratoses) gel	
Approval Length	1 year(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of actinic keratosis	

2 . Revision History

UnitedHealthcare Community Plan of Indiana Clinical Pharmacy Program Guidelines

Date	Notes
4/7/2023	Updated GL type to PA

Somatostatin Analogs



Prior Authorization Guideline

Guideline ID	GL-531191
Guideline Name	Somatostatin Analogs
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name: Bynfezia Pen	
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 - One of the following indications for treatment:

- Acromegaly
- Metastatic carcinoid tumor-associate diarrhea and/or flushing
- Vasoactive intestinal peptide-secreting tumor-associated diarrhea (VIPoma-associated diarrhea)

Product Name:Brand Somatuline Depot, generic lanreotide	
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 - One of the following indications for treatment: • Acromegaly • Carcinoid syndrome • Unresectable gastroenteropancreatic neuroendocrine tumors	

Product Name:Brand Sandostatin, Brand Sandostatin LAR Depot, generic octreotide	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Patient is less than 18 years of age and has one of the following indications for treatment:

- Acromegaly
- Bleeding associated with esophageal varices
- Chemotherapy-induced diarrhea
- Hepatorenal syndrome
- Hyperinsulinaemic hypoglycemia
- Metastatic carcinoid tumor-associated symptoms
- Vasoactive intestinal peptide-secreting tumor-associated diarrhea (VIPoma-associated diarrhea)

OR

1.2 Patient is 18 years of age or older and has one of the following indications for treatment:

- Acromegaly
- Autosomal dominant polycystic liver or kidney disease
- Bleeding associated with esophageal varices
- Chemotherapy-induced diarrhea
- Entercutaneous fistula
- Gastrointestinal angiodysplastic lesions
- Hepatorenal syndrome
- Hyperinsulinaemic hypoglycemia
- Metastatic carcinoid tumor-associated symptoms
- Vasoactive intestinal peptide-secreting tumor-associated diarrhea (VIPoma-associated diarrhea)

Product Name: Bynfezia Pen, Brand Somatuline Depot, generic lanreotide, Brand Sandostatin, Brand Sandostatin LAR Depot, generic octreotide	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - History of the requested agent within the past 90 days

Product Name:Mycapssa

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 - Diagnosis of acromegaly

AND

3 - Submission of medical records (e.g., charts, labs, progress notes, etc.) supporting patient has responded to and tolerated treatment with lanreotide or octreotide

AND

4 - Prescriber has submitted medical justification for use of Mycapssa (octreotide) over lanreotide injection and octreotide injection

AND

5 - Dose requested does not exceed 4 capsules per day

Product Name:Mycapssa

Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested agent within the past 90 days AND 2 - Dose requested does not exceed 4 capsules per day	

Product Name:Palsonify	
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 - Diagnosis of acromegaly AND 3 - Submission of medical records (e.g., charts, labs, progress notes, etc.) supporting patient has had an inadequate response to surgery and/or patient is not a candidate for surgery AND 4 - Dose requested does not exceed 2 capsules per day	

Product Name:Palsonify	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested agent within the past 90 days AND 2 - Dose requested does not exceed 2 capsules per day	

2 . Revision History

Date	Notes
2/25/2026	Updated Sandostatin product names

Somavert



Prior Authorization Guideline

Guideline ID	GL-375410
Guideline Name	Somavert
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 Indiana Medicaid - Community & State Nebraska Medicaid - Community & State New Mexico Medicaid - Community & State Pennsylvania Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	10/1/2025

1 . Criteria

Product Name: Somavert	
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 confirmed by ONE of the following: 1.1.1 Serum GH (growth hormone) level greater than 1 ng/mL (nanogram/milliliter) after a 2-hour oral glucose tolerance test (OGTT) at time of diagnosis OR 1.1.2 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 any of the following: • Surgery • Radiation therapy • Dopamine agonist (e.g., bromocriptine, cabergoline) therapy	

AND

1.3 Inadequate response, intolerance, or contraindication to a long-acting somatostatin analog [e.g., Sandostatin LAR (octreotide), Somatuline Depot (lanreotide)]

OR

2 - Patient is currently on Somavert therapy for acromegaly

Product Name:Somavert	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Somavert therapy (e.g., age-normalized serum IGF-1 level)	

2 . Revision History

Date	Notes
8/25/2025	Combined formularies. Minor grammatical update from "2 hour" to "2-hour" in initial auth section (no changes to clinical intent). No other changes to guideline made.

Soriatane



Prior Authorization Guideline

Guideline ID	GL-98051
Guideline Name	Soriatane
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2022

1 . Criteria

Product Name:generic acitretin, Brand Soriatane	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient must meet ONE of the following indications for treatment: - Hyperkeratotic dermatitis of the palms - Lichen planus	

- Palmoplantar pustulosis
- Prophylaxis of skin cancer in a high-risk kidney transplant recipient
- Psoriasis classified as severe
- Squamous cell carcinoma
- Subcorneal pustular dermatosis (SPD; Sneddon-Wilkinson disease)

Product Name:generic acitretin, Brand Soriatane	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient must have a history of the requested medication within the past 90 days	

2 . Revision History

Date	Notes
11/5/2021	Updated all criteria to match state policy.

Spravato



Prior Authorization Guideline

Guideline ID	GL-527203
Guideline Name	Spravato
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Spravato	
Diagnosis	Major Depressive Disorder with Suicidality
Approval Length	2 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has a diagnosis of major depressive disorder (unipolar), with suicidality (supported by chart documentation or medical profile history)	

AND

2 - Patient is on concomitant oral antidepressant therapy (supported by chart documentation or medical profile history)

AND

3 - Patient is 18 years of age or older

AND

4 - Prescribed by, or in consultation with, a psychiatrist or psychiatric specialist

AND

5 - Patient is enrolled in Spravato (esketamine) REMS (Risk Evaluation and Mitigation Strategy) program

AND

6 - Prescriber attests that patient does NOT have any of the following contraindications:

- Aneurysmal vascular disease (including thoracic and abdominal aorta, intracranial, and peripheral arterial vessels)
- Arteriovenous malformation
- History of intracerebral hemorrhage

AND

7 - Prescriber attests that patient has been counseled on the increased risks (e.g., sedation) associated with concomitant benzodiazepine and Spravato (esketamine) use

AND

8 - Dose requested does NOT exceed 56 mg or 84 mg twice weekly for 4 weeks (maximum 8 kits/4 weeks)

Product Name: Spravato	
Diagnosis	Treatment Resistant Depression
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has a diagnosis of treatment resistant depression (supported by chart documentation or medical profile history)

AND

2 - Patient is 18 years of age or older

AND

3 - Prescribed by, or in consultation with, a psychiatrist or psychiatric specialist

AND

4 - Patient is enrolled in Spravato (esketamine) REMS (Risk Evaluation and Mitigation Strategy) program

AND

5 - Prescriber attests that patient does NOT have any of the following contraindications:

- Aneurysmal vascular disease (including thoracic and abdominal aorta, intracranial, and peripheral arterial vessels)
- Arteriovenous malformation

- History of intracerebral hemorrhage

AND

6 - Prescriber attests that patient has been counseled on the increased risks (e.g., sedation) associated with concomitant benzodiazepine and Spravato (esketamine) use

AND

7 - Dose requested does NOT exceed 56 mg or 84 mg twice weekly for 4 weeks (maximum 8 kits/4 weeks) for induction, and does NOT exceed 56 mg or 84 mg once weekly (maximum 4 kits/4 weeks) for maintenance

Product Name: Spravato	
Diagnosis	Treatment Resistant Depression
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has a diagnosis of treatment resistant depression (supported by chart documentation or medical profile history) AND 2 - History of the requested agent for at least 84 days within the past 112 days, confirmed by claims history or chart documentation AND 3 - Prescriber attests that patient has been counseled on the increased risks (e.g., sedation) associated with concomitant benzodiazepine and Spravato (esketamine) use	

AND

4 - Dose requested does NOT exceed 56 mg or 84 mg once weekly (maximum 4 kits/4 weeks)

2 . Revision History

Date	Notes
2/24/2026	Updated criteria to add prescriber attestation on patient counseling.

Sprycel, Phyrago



Prior Authorization Guideline

Guideline ID	GL-558223
Guideline Name	Sprycel, Phyrago
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland 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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:Brand Sprycel, generic dasatinib, Phyrago

Diagnosis	Philadelphia Chromosome-Positive or BCR-ABL1-Positive Chronic Myeloid Leukemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Philadelphia chromosome-positive or BCR-ABL1-positive chronic myeloid leukemia AND 2 - ONE of the following: 2.1 Patient is not a candidate for imatinib as attested by physician OR 2.2 Patient is currently on Phyrago or Sprycel therapy AND 3 - If the request is for Phyrago, the prescriber provides a reason or special circumstance the patient cannot use dasatinib (generic Sprycel) (please document reason/special circumstances)	

Product Name: Brand Sprycel, generic dasatinib, Phyrago	
Diagnosis	Philadelphia Chromosome-Positive Acute Lymphoblastic Leukemia (Ph+ALL)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ALL)

AND

2 - If the request is for Phyrago, the prescriber provides a reason or special circumstance the patient cannot use dasatinib (generic Sprycel) (please document reason/special circumstances)

Product Name: Brand Sprycel, generic dasatinib, Phyrago

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 - The tumor is PDGFRA exon 18 mutation positive and is unsensitive to imatinib

AND

3 - One of the following:

- Gross residual disease (R2 resection)
- Unresectable primary disease
- Preoperative/intraoperative tumor rupture
- Recurrent/metastatic disease with progression

AND

4 - If the request is for Phyrago, the prescriber provides a reason or special circumstance the patient cannot use dasatinib (generic Sprycel) (please document reason/special circumstances)

Product Name:Brand Sprycel, generic dasatinib, Phyrago	
Diagnosis	Chondrosarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of metastatic chondrosarcoma AND 2 - If the request is for Phyrago, the prescriber provides a reason or special circumstance the patient cannot use dasatinib (generic Sprycel) (please document reason/special circumstances)	

Product Name:Brand Sprycel, generic dasatinib, Phyrago	
Diagnosis	Chordoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of recurrent chordoma	

AND

2 - If the request is for Phyrago, the prescriber provides a reason or special circumstance the patient cannot use dasatinib (generic Sprycel) (please document reason/special circumstances)

Product Name:Brand Sprycel, generic dasatinib, Phyrago	
Diagnosis	Myeloid/Lymphoid Neoplasms with Eosinophilia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of lymphoid, myeloid, or mixed lineage neoplasms with eosinophilia AND 2 - Patient has an ABL1 (gene) rearrangement AND 3 - If the request is for Phyrago, the prescriber provides a reason or special circumstance the patient cannot use dasatinib (generic Sprycel) (please document reason/special circumstances)	

Product Name:Brand Sprycel, generic dasatinib, Phyrago	
Diagnosis	Philadelphia Chromosome-Positive or BCR-ABL1-Positive Chronic Myeloid Leukemia, Ph+ALL, GIST, Chondrosarcoma, Chordoma, Myeloid/Lymphoid Neoplasms with Eosinophilia
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:Brand Sprycel, generic dasatinib	
Diagnosis	Cutaneous Melanoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of cutaneous melanoma AND 2 - Tumors are metastatic or unresectable AND 3 - Contains activating mutations of KIT AND 4 - Used as second-line or subsequent therapy for disease progression, intolerance, and/or projected risk of progression with BRAF-targeted therapy	

Product Name:Brand Sprycel, generic dasatinib	
Diagnosis	Cutaneous Melanoma

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:Brand Sprycel, generic dasatinib, Phyrago	
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 AND 2 - If the request is for Phyrago, the prescriber provides a reason or special circumstance the patient cannot use dasatinib (generic Sprycel) (please document reason/special circumstances)	

Product Name:Brand Sprycel, generic dasatinib, Phyrago	
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
3/26/2026	Updated title. Added Phyrago

SSRI and SNRI



Prior Authorization Guideline

Guideline ID	GL-507563
Guideline Name	SSRI and SNRI
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name: Brand Celexa, Generic citalopram, Citalopram, Drizalma, Brand Pristiq, Generic desvenlafaxine succinate ER, Desvenlafaxine ER, Brand Cymbalta, Generic duloxetine, Brand Lexapro, Generic escitalopram, Escitalopram, Brand Prozac, Generic fluoxetine caps, Fluoxetine (tabs, soln, DR caps, PMDD tabs), fluvoxamine, Fetzima, Brand Zoloft, Generic sertraline, Savella, Venlafaxine Besylate 112.5mg ER tabs, Venlafaxine tabs, Brand Effexor XR, Generic venlafaxine ER caps, Venlafaxine ER tabs, Brand Viibryd, Generic vilazodone, Qelbree, Trintellix, Brand Strattera, Generic atomoxetine, Brand Paxil, Generic paroxetine tablets, Paroxetine oral susp, Brand Paxil CR, Generic paroxetine ER, paroxetine capsules	
Diagnosis	Duplicate Therapy with Another SSRI/SNRI
Therapy Stage	Initial Authorization
Guideline Type	Drug Utilization Review (DUR)

Approval Criteria

1 - Agents involved in therapeutic duplication are being cross tapered*

OR

2 - The SSRI/SNRI agent in the patient's history is being discontinued or there are plans to discontinue*

OR

3 - Prescriber has provided medical rationale supporting duplication of therapy* (please document rationale)

Notes	*Approval Duration – Cross-taper or discontinuation: 90 days; Initial approval: 6 months

Product Name: Brand Celexa, Generic citalopram, Citalopram, Drizalma, Brand Pristiq, Generic desvenlafaxine succinate ER, Desvenlafaxine ER, Brand Cymbalta, Generic duloxetine, Brand Lexapro, Generic escitalopram, Escitalopram, Brand Prozac, Generic fluoxetine caps, Fluoxetine (tabs, soln, DR caps, PMDD tabs), fluvoxamine, Fetzima, Brand Zoloft, Generic sertraline, Savella, Venlafaxine Besylate 112.5mg ER tabs, Venlafaxine tabs, Brand Effexor XR, Generic venlafaxine ER caps, Venlafaxine ER tabs, Brand Viibryd, Generic vilazodone, Qelbree, Trintellix, Brand Strattera, Generic atomoxetine, Brand Paxil, Generic paroxetine tablets, Paroxetine oral susp, Brand Paxil CR, Generic paroxetine ER, paroxetine capsules

Diagnosis	Duplicate Therapy with Another SSRI/SNRI
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Drug Utilization Review (DUR)

Approval Criteria

1 - Evidence of duplication of therapy with the requested SSRI/SNRI agents for 90 of the past 120 days

Product Name: Brand Celexa, Generic citalopram, Citalopram, Drizalma, Brand Pristiq, Generic desvenlafaxine succinate ER, Desvenlafaxine ER, Brand Cymbalta, Generic duloxetine, Brand Lexapro, Generic escitalopram, Escitalopram, Brand Prozac, Generic fluoxetine caps, Fluoxetine (tabs, soln, DR caps, PMDD tabs), fluvoxamine, Fetzima, Brand Zoloft, Generic sertraline, Savella, Venlafaxine Besylate 112.5mg ER tabs, Venlafaxine tabs, Brand Effexor XR, Generic venlafaxine ER caps, Venlafaxine ER tabs, Brand Viibryd, Generic vilazodone, Qelbree, Trintellix, Brand Strattera, Generic atomoxetine, Brand Paxil, Generic paroxetine tablets, Paroxetine oral susp, Brand Paxil CR, Generic paroxetine ER, paroxetine capsules

Diagnosis	Age Limit Exception*
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - All of the following:

1.1 Documentation that other age and diagnosis-appropriate agents available have been tried for an adequate period of time and been deemed ineffective in the treatment of the patient's disease or medical condition

AND

1.2 If the patient is outside of FDA-established age limits, clinical support or rationale for safety and efficacy has been provided (i.e. clinical literature in conjunction with patient attributes and/or characteristics of the drug) for the requested drug and dose

OR

2 - All of the following:

2.1 History of the requested agent for at least 90 days within the past 120 days, confirmed by claims history or chart documentation

AND

2.2 Patient previously received an authorization for age limit exception for the requested agent

OR

3 - All of the following:

3.1 History of the requested agent for at least 90 days within the past 120 days, confirmed by claims history or chart documentation

AND

3.2 ONE of the following:

- The requested agent has newly implemented age limits which did not previously apply to the patient
- The request is for continuation of therapy from another plan or following inpatient therapy

AND

3.3 One of the following:

3.3.1 Documentation that other age and diagnosis-appropriate agents available have been tried for an adequate period of time and been deemed ineffective in the treatment of the patient's disease or medical condition

OR

3.3.2 The prescriber has provided valid medical justification for use of the requested agent outside of FDA or plan-established age limits over the use of other diagnosis-appropriate agents within FDA or plan-established age limits (please document justification)

AND

3.4 If the patient is outside of FDA-established age limits, clinical support or rationale for safety and efficacy has been provided (i.e., clinical literature in conjunction with patient attributes and/or characteristics of the drug) for the requested drug and dose

Notes	*This criteria applies to the Non- Drug Specific PA policy

Product Name:citalopram oral soln, escitalopram oral soln, fluoxetine oral soln, Brand Zoloft oral conc soln, generic sertraline oral conc soln, Drizalma	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is less than 12 years of age OR 2 - Patient is 12 years of age or older AND unable to swallow capsule/tablet formulation, as supported by chart documentation OR 3 - History of the requested medication for 90 of the past 120 days (as supported by claims history or chart documentation)	

Product Name:Brand Paxil oral susp, generic paroxetine oral susp	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is unable to swallow tablet formulation, as supported by chart documentation OR 2 - History of the requested medication for 90 of the past 120 days (as supported by claims history or chart documentation)	

Product Name:Citalopram caps, Escitalopram caps, sertraline caps	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following: • Patient has trial and failure of tablet formulation of the requested medication (as supported by claims history or chart documentation) • Prescriber has provided medical justification for the use of the requested medication over its tablet formulation (please document justification) OR 2 - History of the requested medication for 90 of the past 120 days (as supported by claims history or chart documentation)	

Product Name:fluvoxamine ER caps	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following: • Patient has trial and failure of fluvoxamine IR tablet formulation (as supported by claims history or chart documentation) • Prescriber has provided medical justification for the use of the requested medication over fluvoxamine IR tablet (please document justification) OR 2 - History of the requested medication for 90 of the past 120 days (as supported by claims history or chart documentation)	

Product Name: Qelbree	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has trial and failure of a preferred ADHD medication (stimulant or non-stimulant)*, as supported by claims history or chart documentation OR 2 - History of the requested medication for 90 of the past 120 days (as supported by claims history or chart documentation)	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

2 . Revision History

Date	Notes
1/28/2026	Updated GPIs and product names. Added language for free text box for medical justification. Added drug specific criteria for citalopram/es citalopram/fluoxetine oral soln/Zoloft (sertraline)/Paxil (paroxetine) or al soln's, Drizalma, citalopram/Escitalopram/sertraline caps, fluvoxamine ER caps, and Qelbree.

Stimulants



Prior Authorization Guideline

Guideline ID	GL-507564
Guideline Name	Stimulants
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name: Brand Adzenys XR-ODT, Generic amphetamine ER ODT, Generic amphetamine, Brand Evekeo, Generic amphetamine/dextroamphetamine, Brand Adderall, generic amphetamine/dextroamphetamine ER, Brand Adderall XR^, Brand Aptensio XR, generic methylphenidate ER (XR) cap, Azstarys, Cotempla XR-ODT, Brand Daytrana, Generic methylphenidate patch, Generic dexmethylphenidate, Brand Focalin, Generic dexmethylphenidate ER, Brand Focalin XR, Dyanavel XR, Generic dextroamphetamine tabs, Brand Zenzedi, Generic dextroamphetamine ER, Brand Dexedrine ER, Generic dextroamphetamine soln, Brand Procentra, Evekeo ODT, Generic methamphetamine, Brand Desoxyn, Jornay PM, Generic methylphenidate tabs, Brand Ritalin, methylphenidate chew, methylphenidate ER tabs, Generic methylphenidate ER osmotic tabs, Brand Concerta^, Brand Relexxi^, Generic methylphenidate ER (LA) caps, Brand Ritalin LA, generic methylphenidate CD caps, Brand Metadate CD, methylphenidate ER (24 HR) tabs, Generic methylphenidate soln, Brand Methylin soln, Brand Mydayis, generic amphetamine/dextroamphetamine 3-Bead ER capsules, Quillichew ER, Quillivant XR, Brand Vyvanse, generic lisdexamfetamine, Xelstryl*

Diagnosis	Duplicate Therapy with Another Stimulant
Guideline Type	Drug Utilization Review (DUR)
Approval Criteria 1 - One of the following: 1.1 Patient is 19 years of age or younger OR 1.2 Patient has a Food and Drug Administration (FDA)-labeled or approved compendia indication (See Table 1 in Background) AND 2 - One of the following: 2.1 Evidence of duplication of therapy with the requested stimulant agents for 90 of the past 120 days OR 2.2 The request is for immediate-release dextroamphetamine tablets or immediate-release amphetamine salts in combination with Vyvanse OR 2.3 The medications involved in the therapeutic duplication are being cross tapered or discontinued	
Notes	*Approval Length: 45 days for any request involving cross-tapering or discontinuation, 6 months for all others ^Brand Adderall XR, Brand Concerta and Brand Relexxi need to be reviewed by clinician for brand over generic review

Product Name: Brand Adzenys XR-ODT, Generic amphetamine ER ODT, Generic amphetamine, Brand Evekeo, Generic amphetamine/dextroamphetamine, Brand Adderall, generic amphetamine/dextroamphetamine ER, Brand Adderall XR^, Brand Aptensio XR, generic methylphenidate ER (XR) cap, Azstarys, Cotempla XR-ODT, Brand Daytrana, Generic methylphenidate patch, Generic dexmethylphenidate, Brand Focalin, Generic dexmethylphenidate ER, Brand Focalin XR, Dyanavel XR, Generic dextroamphetamine tabs, Brand Zenzedi, Generic dextroamphetamine ER, Brand Dexedrine ER, Generic dextroamphetamine soln, Brand Procentra, Evekeo ODT, Generic methamphetamine, Brand Desoxyn, Jornay PM, Generic methylphenidate tabs, Brand Ritalin, methylphenidate chew, methylphenidate ER tabs, Generic methylphenidate ER osmotic tabs, Brand Concerta^, Brand Relexxi^, Generic methylphenidate ER (LA) caps, Brand Ritalin LA, generic methylphenidate CD caps, Brand Metadate CD, methylphenidate ER (24 HR) tabs, Generic methylphenidate soln, Brand Methylin soln, Brand Mydayis, generic amphetamine/dextroamphetamine 3-Bead ER capsules, Quillichew ER, Quillivant XR, Brand Vyvanse, generic lisdexamfetamine, Xelstryl	
Diagnosis	Single stimulant agent in adults (greater than 19 years of age)
Approval Length	6 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has a Food and Drug Administration (FDA)-labeled or approved compendia indication for the use of stimulant agents (See Table 1 in Background)	
Notes	^Brand Adderall XR, Brand Concerta and Brand Relexxi need to be reviewed by clinician for brand over generic review

Product Name: Brand Adzenys XR-ODT, Generic amphetamine ER ODT, Generic amphetamine, Brand Evekeo, Generic amphetamine/dextroamphetamine, Brand Adderall, generic amphetamine/dextroamphetamine ER, Brand Adderall XR^, Brand Aptensio XR, generic methylphenidate ER (XR) cap, Azstarys, Cotempla XR-ODT, Brand Daytrana, Generic methylphenidate patch, Generic dexmethylphenidate, Brand Focalin, Generic dexmethylphenidate ER, Brand Focalin XR, Dyanavel XR, Generic dextroamphetamine tabs, Brand Zenzedi, Generic dextroamphetamine ER, Brand Dexedrine ER, Generic dextroamphetamine soln, Brand Procentra, Evekeo ODT, Generic methamphetamine, Brand Desoxyn, Jornay PM, Generic methylphenidate tabs, Brand Ritalin, methylphenidate chew, methylphenidate ER tabs, Generic methylphenidate ER osmotic tabs, Brand Concerta^, Brand Relexxi^, Generic methylphenidate ER (LA) caps, Brand Ritalin LA, generic methylphenidate CD caps, Brand Metadate CD, methylphenidate ER (24 HR) tabs, Generic methylphenidate soln, Brand Methylin soln, Brand Mydayis, generic amphetamine/dextroamphetamine 3-Bead ER capsules, Quillichew ER, Quillivant XR, Brand Vyvanse, generic lisdexamfetamine, Xelstryl*	
Diagnosis	Age Limit Exception*

Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - All of the following: 1.1 Documentation that other age and diagnosis-appropriate agents available have been tried for an adequate period of time and been deemed ineffective in the treatment of the patient's disease or medical condition AND 1.2 If the patient is outside of FDA-established age limits, clinical support or rationale for safety and efficacy has been provided (i.e. clinical literature in conjunction with patient attributes and/or characteristics of the drug) for the requested drug and dose OR 2 - All of the following: 2.1 History of the requested agent for at least 90 days within the past 120 days, confirmed by claims history or chart documentation AND 2.2 Patient previously received an authorization for age limit exception for the requested agent OR 3 - All of the following: 3.1 History of the requested agent for at least 90 days within the past 120 days, confirmed by claims history or chart documentation	

AND

3.2 ONE of the following:

- The requested agent has newly implemented age limits which did not previously apply to the patient
- The request is for continuation of therapy from another plan or following inpatient therapy

AND

3.3 One of the following:

3.3.1 Documentation that other age and diagnosis-appropriate agents available have been tried for an adequate period of time and been deemed ineffective in the treatment of the patient's disease or medical condition

OR

3.3.2 The prescriber has provided valid medical justification for use of the requested agent outside of FDA or plan-established age limits over the use of other diagnosis-appropriate agents within FDA or plan-established age limits (please document justification)

AND

3.4 If the patient is outside of FDA-established age limits, clinical support or rationale for safety and efficacy has been provided (i.e., clinical literature in conjunction with patient attributes and/or characteristics of the drug) for the requested drug and dose

Notes	*This criteria applies to the Non- Drug Specific PA policy ^Brand Adderall XR, Brand Concerta and Brand Relexxi need to be reviewed by clinician for brand over generic review

Product Name:Generic dextroamphetamine soln, Brand Vyvanse chewable, generic lisdexamfetamine chewable	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is less than 12 years of age

OR

2 - Patient is 12 years of age or older AND unable to swallow capsule/tablet formulation, as supported by chart documentation

Product Name:Jornay, Brand Aptensio XR, generic methylphenidate ER (XR) cap

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has trial and failure of at least one preferred long-acting methylphenidate product*, as supported by claims history or chart documentation

OR

2 - Prescriber has provided medical justification for the use of the requested medication (please document justification)

OR

3 - History of the requested medication for 90 of the past 120 days (as supported by claims history or chart documentation)

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:Brand Adzenys XR-ODT, Generic amphetamine ER ODT^

Approval Length	12 month(s)

Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has trial and failure of Dyanavel XR (amphetamine) chew or suspension, as supported by claims history or chart documentation OR 2 - Prescriber has provided medical justification for the use of the requested medication over Dyanavel XR (amphetamine) (please document justification) OR 3 - History of the requested medication for 90 of the past 120 days (as supported by claims history or chart documentation)	
Notes	^Generic amphetamine ER ODT needs to be reviewed by clinician for generic over brand review

Product Name: Brand Mydayis, generic amphetamine/dextroamphetamine 3-Bead ER capsules	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has trial and failure of generic amphetamine/dextroamphetamine ER capsules (generic Adderall XR), as supported by claims history or chart documentation OR 2 - Prescriber has provided medical justification for the use of the requested medication over generic amphetamine/dextroamphetamine ER capsules (generic Adderall XR) (please document justification)	

OR

3 - History of the requested medication for 90 of the past 120 days (as supported by claims history or chart documentation)

Product Name:Cotempla XR-ODT, Brand Procentra, Relexxi [^] , Brand Zenedi	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has trial and failure of two preferred stimulants (different chemical entities)*, as supported by claims history or chart documentation OR 2 - Prescriber has provided medical justification for the use of the requested medication over all preferred agents* (please document justification) OR 3 - History of the requested medication for 90 of the past 120 days (as supported by claims history or chart documentation)	
Notes	[^]Brand Relexxi needs to be reviewed by clinician for brand over generic review *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

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

Approval Criteria

1 - Prescriber has provided medical justification for topical formulation (please document justification)

2 . Background**Benefit/Coverage/Program Information****Table 1:**

FDA-Labeled Diagnoses or Approved Compendia Diagnoses
ADHD
Narcolepsy
Binge Eating Disorder (lisdexamfetamine only)
Depression
Mania (dextroamphetamine only)
Cocaine Dependence (dextroamphetamine only)
Personality Disorder
Schizophrenia
Sleep Deprivation

3 . Revision History

Date	Notes
1/28/2026	Updated GPIs and product names. Added drug specific criteria for generic dextroamphetamine soln, Vyvanse (lisdexamfetamine) chew, Jornay, Aptensio (methylphenidate) ER (XR) cap, Adzenys (amphetamine) XR ODT, Mydayis (amphetamine/dextroamphetamine ER caps),

	Cotempla XR-ODT, Brand Procentra, Relexxii, Brand Zenedi and X elstryl. Corrected spelling of Diagnosis in Table 1.

Stivarga



Prior Authorization Guideline

Guideline ID	GL-370210
Guideline Name	Stivarga
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland 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 Virginia Medicaid - Community & State Indiana Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	9/1/2025

1 . Criteria

Product Name:Stivarga	
Diagnosis	Colorectal Cancer (CRC)

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of advanced or metastatic colorectal cancer AND 2 - History of failure, contraindication, or intolerance to treatment with ALL of the following: • Oxaliplatin-based chemotherapy • Irinotecan-based chemotherapy • Anti-VEGF based chemotherapy AND 3 - ONE of the following: 3.1 Tumor is RAS mutant-type OR 3.2 BOTH of the following: • Tumor is RAS wild-type • History of failure, contraindication, or intolerance to anti-EGFR therapy [e.g., Erbitux (cetuximab), Vectibix (panitumumab)]	

Product Name:Stivarga	
Diagnosis	Soft Tissue Sarcoma (STS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of soft tissue sarcoma (STS) AND 2 - ONE of the following: 2.1 Extremity/superficial trunk or head/neck that is non-adipocytic with advanced/metastatic disease with disseminated metastases OR 2.2 Retroperitoneal/intra-abdominal that is non-adipocytic with recurrent unresectable or stage IV disease OR 2.3 Advanced/metastatic pleomorphic rhabdomyosarcoma OR 2.4 Angiosarcoma	

Product Name:Stivarga	
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 - Disease is one of the following:

- Gross residual (R2 resection)
- Unresectable primary
- Tumor rupture
- Recurrent/metastatic

AND

3 - One of the following:

3.1 SDH-deficient GIST

OR

3.2 History of disease progression on BOTH of the following as confirmed by claims history or submission of medical records:

3.2.1 Imatinib mesylate (generic Gleevec)

AND

3.2.2 One of the following:

- sunitinib malate (generic Sutent)
- Qinlock (ripretinib)

Product Name:Stivarga	
Diagnosis	Hepatobiliary Cancers
Approval Length	12 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: • Gallbladder cancer • Extrahepatic cholangiocarcinoma • Intrahepatic cholangiocarcinoma AND 1.2 Disease is ONE of the following: • Unresectable • Gross residual (R2) • Metastatic OR 2 - BOTH of the following: 2.1 Diagnosis of hepatocellular carcinoma AND 2.2 Used as subsequent-line therapy for disease progression	

Product Name:Stivarga	
Diagnosis	Bone Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following bone cancers:

- Dedifferentiated chondrosarcoma
- Ewing Sarcoma
- High grade undifferentiated pleomorphic sarcoma (UPS)
- Mesenchymal chondrosarcoma
- Osteosarcoma
- Other primary round cell tumors of the bone (e.g., CIC::DUX4, BCOR::CCNB3)

AND

2 - Used as second-line therapy

Product Name:Stivarga	
Diagnosis	Glioblastoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of recurrent or progressive glioblastoma	

Product Name:Stivarga	
Diagnosis	Uterine Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of uterine sarcoma

AND

2 - Disease is one of the following:

- Advanced
- Recurrent/metastatic
- Inoperable

AND

3 - Used as second-line or subsequent therapy

Product Name:Stivarga	
Diagnosis	Colorectal Cancer (CRC), Soft Tissue Sarcoma (STS), Gastrointestinal Stromal Tumor (GIST), Hepatobiliary Cancer, Bone Cancer, Glioblastoma, Uterine 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 Stivarga therapy	

Product Name:Stivarga	
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:Stivarga	
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 Stivarga therapy	

2 . Revision History

Date	Notes
8/15/2025	Combined formularies. Added criteria for uterine sarcoma. Other criteria updates.

Strensiq



Prior Authorization Guideline

Guideline ID	GL-467197
Guideline Name	Strensiq
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 Indiana Medicaid - Community & State Nebraska Medicaid - Community & State New Mexico Medicaid - Community & State Pennsylvania Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Strensiq	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records documenting diagnosis of perinatal/infantile or juvenile-onset hypophosphatasia AND 2 - Submission of medical records documenting confirmation of diagnosis by ALL of the following: 2.1 Presence of clinical signs and symptoms of hypophosphatasia (e.g., skeletal abnormalities, respiratory insufficiency, failure to thrive, hypotonia, dental abnormalities, short stature, rickets, fractures, delayed walking, waddling gate) AND 2.2 Onset of disease less than 18 years of age [If member is greater than or equal to 18 years of age at time of request, documentation of disease onset before age of 18 must be provided (e.g., member began experiencing symptoms at age 8)] AND 2.3 ONE of the following: 2.3.1 ALL of the following: • Persistent serum alkaline phosphatase (ALP) levels below the gender- and age-specific reference range (i.e., present in at least two measurements) • Elevated tissue non-specific alkaline phosphatase (TNSALP) substrate level (e.g., serum pyridoxal 5'-phosphate [PLP] level, serum or urine phosphoethanolamine [PEA] level, urinary inorganic pyrophosphate [PPi level]) • Radiographic imaging demonstrating skeletal abnormalities (e.g., craniosynostosis, rickets, non-traumatic fractures)	

OR

2.3.2 Presence of a known pathological mutation in the ALPL gene as detected by ALPL molecular genetic testing*

AND

3 - Prescribed by ONE of the following:

- Endocrinologist
- A specialist experienced in the treatment of metabolic bone disorders

AND

4 - ONE of the following:

4.1 BOTH of the following:

4.1.1 Diagnosis of perinatal/infantile-onset hypophosphatasia

AND

4.1.2 Request does not exceed a maximum supply limit of 9 mg/kg/week (milligrams/kilogram/week)

OR

4.2 BOTH of the following:

4.2.1 Diagnosis of juvenile-onset hypophosphatasia

AND

4.2.2 Request does not exceed a maximum supply limit of 6 mg/kg/week

AND

5 - ONE of the following:

5.1 Patient is prescribed Strensiq 18 mg/0.45 mL (milliliter), Strensiq 28 mg/0.7 mL, or Strensiq 40 mg/mL vials

OR

5.2 BOTH of the following:

5.2.1 Patient is prescribed Strensiq 80 mg/0.8 mL vial

AND

5.2.2 Patient's weight is greater than or equal to 40 kg

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

Approval Length 12 month(s)

Therapy Stage Reauthorization

Guideline Type Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Strensiq therapy (e.g., improvement in clinical symptoms, improvement in Radiographic Global Impression of Change)

AND

2 - Prescribed by ONE of the following:

- Endocrinologist
- A specialist experienced in the treatment of metabolic bone diseases

AND

3 - ONE of the following:

3.1 BOTH of the following:

3.1.1 Diagnosis of perinatal/infantile-onset hypophosphatasia

AND

3.1.2 Request does not exceed a maximum supply limit of 9 mg/kg/week (milligrams/kilogram/week)

OR

3.2 BOTH of the following:

3.2.1 Diagnosis of juvenile-onset hypophosphatasia

AND

3.2.2 Request does not exceed a maximum supply limit of 6 mg/kg/week

AND

4 - ONE of the following:

4.1 Patient is prescribed Strensiq 18 mg/0.45 mL (milliliter), Strensiq 28 mg/0.7 mL, or Strensiq 40 mg/mL vials

OR

4.2 BOTH of the following:

4.2.1 Patient is prescribed Strensiq 80 mg/0.8 mL vials

AND

4.2.2 Patient's weight is greater than or equal to 40 kg

2 . Revision History

Date	Notes
12/9/2025	Combined formularies. Updated initial and reauth criteria.

Sucraid



Prior Authorization Guideline

Guideline ID	GL-206584
Guideline Name	Sucraid
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Indiana 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 CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	4/1/2025

1 . Criteria

Product Name: Sucraid

Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records documenting a diagnosis of congenital sucrase-isomaltase deficiency (CSID) AND 2 - Submission of medical records documenting diagnosis has been confirmed by one of the following: 2.1 Endoscopic biopsy of the small bowel indicating ALL of the following: 2.1.1 Normal small bowel morphology AND 2.1.2 Absent or markedly reduced sucrase activity AND 2.1.3 Isomaltase activity varying from 0 to full activity AND 2.1.4 Reduced maltase activity AND 2.1.5 ONE of the following: 2.1.5.1 Normal lactase activity	

OR

2.1.5.2 BOTH of the following:

- Reduced lactase
- Sucrase:lactase ratio of less than 1.0

OR

2.2 Molecular genetic testing of the sucrase-isomaltase (SI) gene indicating a pathogenic isomaltase gene variant

OR

2.3 Carbon-13 sucrose breath test (13C SBT) indicating a cumulative [13C] CO₂ exhalation over 90 minutes below 10th percentile (i.e., less than 3.9% for men and less than 5.2% for women)

AND

3 - Prescribed by or in consultation with a gastroenterologist or rare disease specialist

AND

4 - Will be used with a sucrose-free, low starch diet

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

1 - Documentation of positive clinical response to Sucraid therapy [e.g., reduced symptoms (e.g., abdominal pain, bloating, gas, vomiting), reduced number of stools per day, reduced number of symptomatic days]

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

2 . Revision History

Date	Notes
3/5/2025	Updated formularies. Added requirement for submission of medical records documenting diagnosis and confirmation of diagnosis

Sutent



Prior Authorization Guideline

Guideline ID	GL-331198
Guideline Name	Sutent
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 Virginia Medicaid - Community & State Indiana Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	8/1/2025

1 . Criteria

Product Name: Brand Sutent, generic sunitinib	
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 - ONE of the following: 2.1 Disease progression on ONE of the following as confirmed by claims history or submission of medical records: • imatinib (generic Gleevec) • Stivarga (regorafenib) • Standard dose Qinlock (ripretinib)* OR 2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication): • imatinib (generic Gleevec) • Stivarga (regorafenib) OR 2.3 SDH (succinate dehydrogenase)-deficient GIST	
Notes	*Qinlock is non-preferred

Product Name: Brand Sutent, generic sunitinib	
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 Disease is advanced 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: Brand Sutent, generic sunitinib	
Diagnosis	Neuroendocrine and Adrenal Tumors
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Progressive pancreatic neuroendocrine tumors (pNET)

Product Name: Brand Sutent, generic sunitinib

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
- Extraskelatal myxoid chondrosarcoma

Product Name: Brand Sutent, generic sunitinib

Diagnosis	Thyroid Carcinoma

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of ONE of the following:

- Follicular carcinoma
- Oncocytic carcinoma
- Papillary carcinoma

AND

1.2 ONE of the following:

- Unresectable locoregional recurrent disease
- Persistent disease
- Metastatic disease

AND

1.3 ONE of the following:

- Patient has symptomatic disease
- Patient has progressive disease

AND

1.4 Disease is refractory to radioactive iodine treatment

OR

2 - ALL of the following:

2.1 Diagnosis of medullary thyroid carcinoma

AND

2.2 ONE of the following:

- Patient has progressive disease
- Patient has symptomatic metastatic disease

AND

2.3 ONE of the following:

2.3.1 Clinical trials or preferred systemic therapy options are not available or appropriate [e.g., Caprelsa (vandetanib), Cometriq (cabozantinib)]

OR

2.3.2 There is progression on preferred systemic therapy options [e.g., Caprelsa (vandetanib), Cometriq (cabozantinib)]

Product Name:Brand Sutent, generic sunitinib

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

Approval Criteria

1 - Diagnosis of recurrent chordoma

Product Name:Brand Sutent, generic sunitinib

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:Brand Sutent, generic sunitinib	
Diagnosis	Thymic Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of thymic carcinoma	

Product Name:Brand Sutent, generic sunitinib	
Diagnosis	Myeloid/Lymphoid Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of lymphoid, myeloid, or mixed lineage neoplasms with eosinophilia AND 2 - Patient has an FMS-like tyrosine kinase 3 (FLT3) rearrangement in chronic or blast phase	

Product Name:Brand Sutent, generic sunitinib	
Diagnosis	GIST, RCC, Neuroendocrine and Adrenal Tumors, Soft Tissue Sarcoma, Thyroid Carcinoma, Chordoma, Central Nervous System Cancer, Thymic Carcinoma, Myeloid/Lymphoid Neoplasms
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:Brand Sutent, generic sunitinib	
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:Brand Sutent, generic sunitinib	
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
7/15/2025	Updated formularies to add IN

Systemic Antifungals



Prior Authorization Guideline

Guideline ID	GL-548196
Guideline Name	Systemic Antifungals
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name: Brand Sporanox soln, generic itraconazole soln, Brand Vfend susp, generic voriconazole susp	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Patient has tried and failed ALL preferred agents* (i.e., each preferred chemical entity)	

OR

1.2 Provider has provided medical justification as to why each preferred agent* is not appropriate for use (e.g., infection being treated is not susceptible to preferred agents)

AND

2 - ONE of the following:

2.1 Patient is 12 years of age or under

OR

2.2 Patient is unable to swallow capsules/tablets

Notes

*PDL: <https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html>

Product Name:generic posaconazole DR tab, Brand Noxafil susp, generic posaconazole susp

Approval Length 12 month(s)

Guideline Type Prior Authorization

Approval Criteria

1 - BOTH of the following:

- The requested agent is being used for the treatment of oropharyngeal candidiasis
- Patient has tried fluconazole

OR

2 - BOTH of the following:

2.1 Patient is severely immunocompromised

AND

2.2 The requested agent is being used as prophylaxis against ONE of the following:

- Invasive Aspergillus
- Candida Infections

Product Name:Noxafil packet	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Member is 2 years of age or older AND less than 13 years of age	

2 . Revision History

Date	Notes
3/11/2026	Removed Brand Noxafil tablet. Updated GPIs and target name list to specify brand Noxafil susp. Updated itraconazole solution and voriconazole suspension criteria to specify capsules, with no changes to clinical intent. Minor cosmetic updates.

Tabrecta



Prior Authorization Guideline

Guideline ID	GL-578265
Guideline Name	Tabrecta
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name: Tabrecta	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of non-small cell lung cancer (NSCLC) AND 2 - Disease is recurrent, advanced, or metastatic AND 3 - ONE of the following: 3.1 Mesenchymal-epithelial transition (MET) exon 14 skipping mutation positive tumor(s) OR 3.2 High level MET amplification	

Product Name:Tabrecta	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
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 Tabrecta therapy	

Product Name:Tabrecta	
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:Tabrecta	
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 Tabrecta therapy	

2 . Revision History

Date	Notes
4/16/2026	Updated formularies to add ACUIN for eff 6/1/2026.

Tafinlar



Prior Authorization Guideline

Guideline ID	GL-522195
Guideline Name	Tafinlar
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 Virginia Medicaid - Community & State Indiana Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	2/15/2026

1 . Criteria

Product Name:Tafinlar	
Diagnosis	Melanoma

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Unresectable melanoma OR 1.2 Metastatic melanoma OR 1.3 BOTH of the following: 1.3.1 Prescribed as adjuvant therapy for melanoma involving the lymph node(s) AND 1.3.2 Used in combination with Mekinist (trametinib) AND 2 - Cancer is positive for BRAF V600 mutation AND 3 - If the request is for Tafinlar tablets for oral solution, there is a reason or special circumstance why the patient is unable to use Tafinlar capsules (document reason or special circumstance)	

Product Name:Tafinlar	
Diagnosis	Central Nervous System (CNS) Cancers
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: 1.1.1 Patient has metastatic brain lesions AND 1.1.2 Tafinlar is active against primary tumor (melanoma) OR 1.2 Patient has a glioma AND 2 - Cancer is positive for BRAF V600E mutation AND 3 - Used in combination with Mekinist (trametinib) AND 4 - If the request is for Tafinlar tablets for oral solution, there is a reason or special	

circumstance why the patient is unable to use Tafinlar capsules (document reason or special circumstance)

Product Name:Tafinlar	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of non-small cell lung cancer (NSCLC)

AND

2 - Disease is ONE of the following:

- Metastatic
- Advanced
- Recurrent

AND

3 - Cancer is positive for BRAF V600E mutation

AND

4 - ONE of the following:

- Used in combination with Mekinist (trametinib)
- Used as a single agent if the combination of Mekinist and Tafinlar is not tolerated

AND

5 - If the request is for Tafenlar tablets for oral solution, there is a reason or special circumstance why the patient is unable to use Tafenlar capsules (document reason or special circumstance)

Product Name:Tafenlar	
Diagnosis	Thyroid Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of anaplastic thyroid cancer (ATC)

AND

1.2 Cancer is positive for BRAF V600E mutation

AND

1.3 Used in combination with Mekinist (trametinib)

AND

1.4 ONE of the following:

1.4.1 Disease is ONE of the following:

- Metastatic
- Locally advanced
- Unresectable

OR

1.4.2 Prescribed as adjuvant therapy following resection

AND

1.5 If the request is for Tafenlar tablets for oral solution, there is a reason or special circumstance why the patient is unable to use Tafenlar capsules (document reason or special circumstance)

OR

2 - ALL of the following:

2.1 ONE of the following diagnoses:

- Follicular carcinoma
- Oncocytic carcinoma
- Papillary carcinoma

AND

2.2 ONE of the following:

- Unresectable locoregional recurrent disease
- Persistent disease
- Metastatic disease

AND

2.3 ONE of the following:

- Patient has symptomatic disease
- Patient has progressive disease

AND

2.4 Disease is refractory to radioactive iodine treatment

AND

2.5 Cancer is positive for BRAF V600 mutation

AND

2.6 If the request is for Tafenlar tablets for oral solution, there is a reason or special circumstance why the patient is unable to use Tafenlar capsules (document reason or special circumstance)

Product Name:Tafenlar	
Diagnosis	Hepatobiliary Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following:

- Gallbladder cancer
- Extrahepatic Cholangiocarcinoma
- Intrahepatic Cholangiocarcinoma

AND

2 - Used as subsequent treatment after progression on or after systemic treatment

AND

3 - Disease is unresectable or metastatic

AND

4 - Cancer is positive for BRAF V600E mutation

AND

5 - Used in combination with Mekinist (trametinib)

AND

6 - If the request is for Tafenlar tablets for oral solution, there is a reason or special circumstance why the patient is unable to use Tafenlar capsules (document reason or special circumstance)

Product Name:Tafenlar	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following: • Langerhans Cell Histiocytosis • Erdheim-Chester Disease AND 2 - Cancer is positive for BRAF V600E mutation	

AND

3 - If the request is for Tafenlar tablets for oral solution, there is a reason or special circumstance why the patient is unable to use Tafenlar capsules (document reason or special circumstance)

Product Name:Tafenlar	
Diagnosis	Solid Tumors
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Presence of solid tumor

AND

2 - Used as subsequent treatment after progression on or after systemic treatment

AND

3 - Disease is unresectable or metastatic

AND

4 - Cancer is positive for BRAF V600E mutation

AND

5 - Used in combination with Mekinist (trametinib)

AND

6 - If the request is for Tafenlar tablets for oral solution, there is a reason or special circumstance why the patient is unable to use Tafenlar capsules (document reason or special circumstance)

Product Name:Tafenlar	
Diagnosis	Epithelial Ovarian Cancer/Fallopian Tube Cancer/Primary Peritoneal Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following:

- Epithelial Ovarian Cancer
- Fallopian Tube Cancer
- Primary Peritoneal Cancer

AND

2 - ONE of the following:

- Persistent disease
- Recurrence in BRAF V600E positive tumors
- Recurrence of low-grade serous carcinoma

AND

3 - Used in combination with Mekinist (trametinib)

AND

4 - If the request is for Tafenlar tablets for oral solution, there is a reason or special circumstance why the patient is unable to use Tafenlar capsules (document reason or special circumstance)

Product Name:Tafenlar	
Diagnosis	Pancreatic Cancer / Ampullary Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following:

- Pancreatic adenocarcinoma
- Ampullary adenocarcinoma

AND

2 - Disease is ONE of the following:

- Metastatic
- Locally advanced
- Unresectable

AND

3 - Cancer is positive for BRAF V600E mutation

AND

4 - Used in combination with Mekinist (trametinib)

AND

5 - If the request is for Tafenlar tablets for oral solution, there is a reason or special circumstance why the patient is unable to use Tafenlar capsules (document reason or special circumstance)

Product Name:Tafenlar

Diagnosis	Hairy Cell Leukemia

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of hairy cell leukemia

AND

2 - Used in combination with Mekinist (trametinib)

AND

3 - If the request is for Tafenlar tablets for oral solution, there is a reason or special circumstance why the patient is unable to use Tafenlar capsules (document reason or special circumstance)

Product Name:Tafenlar

Diagnosis	Salivary Gland Tumor

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of salivary gland tumor AND 2 - Disease is ONE of the following: • Recurrent and unresectable • Metastatic AND 3 - Cancer is positive for BRAF V600E mutation AND 4 - Used in combination with Mekinist (trametinib) AND 5 - If the request is for Tafenlar tablets for oral solution, there is a reason or special circumstance why the patient is unable to use Tafenlar capsules (document reason or special circumstance)	

Product Name:Tafenlar	
Diagnosis	Gastrointestinal Stromal Tumor (GIST)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of BRAF V600E-mutated gastrointestinal stromal tumor (GIST)

AND

2 - Disease is ONE of the following:

- Gross residual disease (R2 resection)
- Unresectable primary disease
- Tumor rupture
- Progressive
- Recurrent
- Metastatic

AND

3 - Used in combination with Mekinist (trametinib)

AND

4 - If the request is for Tafenlar tablets for oral solution, there is a reason or special circumstance why the patient is unable to use Tafenlar capsules (document reason or special circumstance)

Product Name:Tafenlar	
Diagnosis	All Indications except NCCN Recommended Regimens
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 Tafenlar therapy

Product Name:Tafenlar	
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 AND 2 - If the request is for Tafenlar tablets for oral solution, there is a reason or special circumstance why the patient is unable to use Tafenlar capsules (document reason or special circumstance)	

Product Name:Tafenlar	
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 Tafenlar therapy	

2 . Revision History

UnitedHealthcare Community Plan of Indiana Clinical Pharmacy Program Guidelines

Date	Notes
2/11/2026	Removed WA from formularies, WA moved to state mandated criteria . No other changes to guideline.

Tagrisso



Prior Authorization Guideline

Guideline ID	GL-369250
Guideline Name	Tagrisso
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 Virginia Medicaid - Community & State Indiana Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	9/1/2025

1 . Criteria

Product Name: Tagrisso	
Diagnosis	Central Nervous System (CNS) Cancer

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of brain metastases from EGFR mutation-positive non-small cell lung cancer (NSCLC) OR 2 - Diagnosis of leptomeningeal metastases from EGFR mutation-positive NSCLC	

Product Name:Tagrisso	
Diagnosis	Central Nervous System (CNS) Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Tagrisso therapy	

Product Name:Tagrisso	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of non-small cell lung cancer (NSCLC)

AND

2 - Disease is positive for at least ONE of the following EGFR mutations:

- Exon 19
- Exon 21 L858R
- S768I
- L861Q
- G719X
- T790M

AND

3 - One of the following:

3.1 All of the following:

- disease is stage IB, II, IIIA, or IIIB (T3, N2)
- Patient has undergone complete resection
- Patient has received previous adjuvant chemotherapy or ineligible to receive platinum-based chemotherapy

OR

3.2 All of the following:

- Disease is stage II-III
- Disease is locally advanced or unresectable
- No disease progression during or following concurrent or sequential chemoradiation

OR

3.3 Disease is recurrent, advanced, or metastatic

Product Name: Tagrisso

Diagnosis

Non-Small Cell Lung Cancer (NSCLC)

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 Tagrisso therapy	

Product Name:Tagrisso	
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:Tagrisso	
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 Tagrisso therapy	

2 . Revision History

UnitedHealthcare Community Plan of Indiana Clinical Pharmacy Program Guidelines

Date	Notes
8/18/2025	Updated formularies. Updated misspelled EGFR mutation type in NS CLC

Talzenna



Prior Authorization Guideline

Guideline ID	GL-257189
Guideline Name	Talzenna
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 Virginia Medicaid - Community & State Indiana Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2025

1 . Criteria

Product Name: Talzenna	
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 - Disease is ONE of the following: • Locally advanced • Metastatic AND 3 - Presence of a germline BRCA (breast cancer)-mutation AND 4 - ONE of the following: 4.1 Patient is currently on Talzenna therapy as confirmed by claims history or submitted medical records OR 4.2 History of intolerance or contraindication to Lynparza (olaparib) (please specify intolerance or contraindication) OR 4.3 Provider attests that the patient is not an appropriate candidate for Lynparza (olaparib) based on the patient's clinical status or comorbidities	

Product Name:Talzenna	
Diagnosis	Prostate Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of metastatic castration-resistant prostate cancer AND 2 - Presence of homologous recombination repair (HRR) gene mutations AND 3 - Used in combination with Xtandi (enzalutamide) AND 4 - ONE of the following: 4.1 Used in combination with a gonadotropin-releasing hormone (GnRH) analog [e.g., Lupron (leuprolide), Zoladex (goserelin), Trelstar (triptorelin), Vantas (histrelin), Firmagon (degarelix)] OR 4.2 Patient has had bilateral orchiectomy	

Product Name:Talzenna	
Diagnosis	Breast Cancer, 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 Talzena therapy	

Product Name:Talzena	
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:Talzena	
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 Talzena therapy	

2 . Revision History

UnitedHealthcare Community Plan of Indiana Clinical Pharmacy Program Guidelines

Date	Notes
5/5/2025	Updated formularies. Revised wording in breast cancer section without change to intent

Targeted Immunomodulators



Prior Authorization Guideline

Guideline ID	GL-531208
Guideline Name	Targeted Immunomodulators
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Adalimumab-ADAZ, Hadlima	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 ONE of the following diagnoses:	

- Ankylosing spondylitis
- Polyarticular juvenile idiopathic arthritis
- Psoriatic arthritis
- Ulcerative colitis

OR

1.2 Diagnosis of Crohn's disease, and ONE of the following:

1.2.1 Diagnosis of Crohn's disease classified as moderate, severe, or fistulizing

OR

1.2.2 Previous trial and failure of another targeted immunomodulator agent

OR

1.2.3 At least 90 days of drug therapy with at least ONE of the following:

- Azathioprine
- Mercaptopurine
- Mesalamine
- Methotrexate
- Systemic glucocorticoid

OR

1.3 BOTH of the following:

1.3.1 Diagnosis of hidradenitis suppurativa

AND

1.3.2 At least 90 days of drug therapy with ONE of the following:

- Oral or topical antibiotic therapy
- Oral retinoid therapy
- Dapsone

- Acitretin

OR

1.4 BOTH of the following:

1.4.1 Diagnosis of non-infectious uveitis

AND

1.4.2 At least 90 days of drug therapy with ONE of the following:

- Oral or injectable steroid therapy
- Methotrexate
- Mycophenolate
- Azathioprine
- Cyclosporine
- Tacrolimus
- Cyclophosphamide

OR

1.5 Diagnosis of psoriasis, and ONE of the following:

1.5.1 Diagnosis of psoriasis classified as severe

OR

1.5.2 Diagnosis of psoriasis of the fingernail

OR

1.5.3 At least 90 days of topical drug therapy with ONE of the following:

- Calcipotriene
- Corticosteroids
- Tazarotene

OR

1.5.4 At least 90 days of systemic drug therapy with ONE of the following:

- Cyclosporine
- Methotrexate
- Acitretin

OR

1.5.5 Previous trial and failure of another targeted immunomodulator agent

OR

1.6 Diagnosis of rheumatoid arthritis, and ONE of the following:

1.6.1 Previous trial and failure of another targeted immunomodulator agent

OR

1.6.2 At least 90 days of drug therapy with ONE of the following:

- Azathioprine
- Hydroxychloroquine
- Leflunomide
- Methotrexate
- Sulfasalazine

AND

2 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Product Name: Adbry	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderate to severe atopic dermatitis AND 2 - Patient is 12 years of age or older AND 3 - ONE of the following: 3.1 At least 45 days of topical drug therapy with ONE of the following: • Corticosteroids • Pimecrolimus • Tacrolimus OR 3.2 Prescriber has provided valid medical justification for the use of Adbry over topical drug therapies (document rationale) AND 4 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days	

Product Name:Enbrel	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 ONE of the following diagnoses:

- Polyarticular juvenile idiopathic arthritis
- Psoriatic arthritis (adult or juvenile)
- Ankylosing spondylitis

OR

1.2 Diagnosis of psoriasis, and ONE of the following:

1.2.1 Diagnosis of psoriasis classified as severe

OR

1.2.2 At least 90 days of topical drug therapy with ONE of the following:

- Calcipotriene
- Corticosteroids
- Tazarotene

OR

1.2.3 At least 90 days of systemic drug therapy with ONE of the following:

- Cyclosporine
- Methotrexate
- Acitretin

OR

1.2.4 Previous trial and failure of another targeted immunomodulator agent

OR

1.3 Diagnosis of rheumatoid arthritis, and ONE of the following:

1.3.1 At least 90 days of drug therapy with ONE of the following:

- Azathioprine
- Hydroxychloroquine
- Leflunomide
- Methotrexate
- Sulfasalazine

OR

1.3.2 Previous trial and failure of another targeted immunomodulator agent

AND

2 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Product Name:Infliximab	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 ONE of the following diagnoses: • Ankylosing spondylitis • Psoriatic arthritis • Ulcerative colitis	

OR

1.2 Diagnosis of Crohn's disease and ONE of the following:

1.2.1 Diagnosis of Crohn's disease classified as moderate, severe, or fistulizing

OR

1.2.2 At least 90 days of drug therapy with at least ONE of the following:

- Azathioprine
- Mercaptopurine
- Mesalamine
- Methotrexate
- Systemic glucocorticoid

OR

1.2.3 Previous trial and failure of another targeted immunomodulator agent

OR

1.3 Diagnosis of psoriasis and ONE of the following:

1.3.1 Diagnosis of psoriasis classified as severe

OR

1.3.2 At least 90 days of topical drug therapy with ONE of the following:

- Calcipotriene
- Corticosteroids
- Tazarotene

OR

1.3.3 At least 90 days of systemic drug therapy with ONE of the following:

- Cyclosporine
- Methotrexate
- Acitretin

OR

1.3.4 Previous trial and failure of another targeted immunomodulator agent

OR

1.4 Diagnosis of rheumatoid arthritis and ONE of the following:

1.4.1 At least 90 days of drug therapy with one of the following:

- Azathioprine
- Hydroxychloroquine
- Leflunomide
- Methotrexate
- Sulfasalazine

OR

1.4.2 Previous trial and failure of another targeted immunomodulator agent

AND

2 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Product Name:Kineret	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 ONE of the following diagnoses:

- Neonatal onset multisystem inflammatory disease (NOMID)
- Deficiency of interleukin-1 receptor antagonist (DIRA)

OR

1.2 Diagnosis of rheumatoid arthritis, and ONE of the following:

1.2.1 At least 90 days of drug therapy with ONE of the following:

- Azathioprine
- Hydroxychloroquine
- Leflunomide
- Methotrexate
- Sulfasalazine

OR

1.2.2 Previous trial and failure of another targeted immunomodulator agent

AND

2 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Product Name: Olumiant	
Approval Length	Rheumatoid arthritis - 12 months; Severe Alopecia Areata - 6 months
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - ONE of the following:

1.1 Diagnosis of rheumatoid arthritis, and BOTH of the following:

1.1.1 Previous trial and failure of at least ONE tumor necrosis factor (TNF) blocker

AND

1.1.2 Previous trial and failure of at least ONE other targeted immunomodulator agent

OR

1.2 Submission of chart notes showing a diagnosis of severe alopecia areata defined as greater than or equal to 50% of hair loss, and BOTH of the following:

1.2.1 Patient is 18 years of age or older

AND

1.2.2 Prescribed by, or in consultation with, a dermatologist

AND

2 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

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

1 - History of the requested agent for at least 90 of the past 120 days, as confirmed by claims history or chart documentation

AND

2 - If the request is for reauthorization for treatment of severe alopecia areata, documentation of patient clinical status and response to therapy (Document status/response)

AND

3 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Product Name: Orencia	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 ONE of the following diagnoses: • Polyarticular juvenile idiopathic arthritis • Psoriatic arthritis OR 1.2 Diagnosis of rheumatoid arthritis, and ONE of the following: 1.2.1 At least 90 days of drug therapy with ONE of the following: • Azathioprine • Hydroxychloroquine • Leflunomide	

- Methotrexate
- Sulfasalazine

OR

1.2.2 Previous trial and failure of another targeted immunomodulator agent

OR

1.3 Diagnosis of acute graft-versus host disease prophylaxis, and BOTH of the following:

1.3.1 Patient will be using Otezla concurrently with both methotrexate AND a calcineurin inhibitor

AND

1.3.2 Patient will be concurrently undergoing hematopoietic stem cell transplantation from a matched or 1 allele-mismatched unrelated donor

AND

2 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Product Name:Otezla, Otezla Starter/Initiation Packs	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Diagnosis of psoriatic arthritis	

OR

1.2 Diagnosis of oral ulcers associated with Behcet's disease and BOTH of the following:

- Patient is 18 years of age and older
- At least 90 days of drug therapy with colchicine

OR

1.3 Diagnosis of psoriasis, and ONE of the following:

1.3.1 Diagnosis of psoriasis classified as severe

OR

1.3.2 At least 90 days of topical drug therapy with ONE of the following:

- Calcipotriene
- Corticosteroids
- Tazarotene

OR

1.3.3 At least 90 days of systemic drug therapy with ONE of the following:

- Cyclosporine
- Methotrexate
- Acitretin

OR

1.3.4 Previous trial and failure of another targeted immunomodulator agent

Product Name: Simponi, Simponi Aria

Approval Length	1 year(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 ONE of the following diagnoses: • Ankylosing spondylitis • Polyarticular juvenile idiopathic arthritis • Psoriatic arthritis • Ulcerative colitis OR 1.2 Diagnosis of rheumatoid arthritis, and ONE of the following: 1.2.1 At least 90 days of drug therapy with ONE of the following: • Azathioprine • Hydroxychloroquine • Leflunomide • Methotrexate • Sulfasalazine OR 1.2.2 Previous trial and failure of another targeted immunomodulator agent AND 2 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days	

Product Name: Taltz	
Approval Length	1 year(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 ONE of the following diagnoses: • Ankylosing spondylitis • Non-radiographic axial spondyloarthritis • Psoriatic arthritis OR 1.2 Diagnosis of psoriasis, and ONE of the following: 1.2.1 Diagnosis of psoriasis classified as severe OR 1.2.2 At least 90 days of topical drug therapy with ONE of the following: • Calcipotriene • Corticosteroids • Tazarotene OR 1.2.3 At least 90 days of systemic drug therapy with ONE of the following: • Cyclosporine • Methotrexate • Acitretin OR 1.2.4 Previous trial and failure of another targeted immunomodulator agent	

AND

2 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Product Name:Tyenne	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 ONE of the following diagnoses:

- Cytokine release syndrome
- Polyarticular juvenile idiopathic arthritis
- Systemic juvenile idiopathic arthritis

OR

1.2 Diagnosis of giant cell arteritis, and BOTH of the following:

1.2.1 At least 90 days of drug therapy with ONE of the following:

- Systemic glucocorticoid
- Azathioprine
- Methotrexate

AND

1.2.2 Patient will be using a systemic glucocorticoid concurrently with the requested medication

OR

1.3 Diagnosis of rheumatoid arthritis, and ONE of the following:

1.3.1 At least 90 days of drug therapy with ONE of the following:

- Azathioprine
- Hydroxychloroquine
- Leflunomide
- Methotrexate
- Sulfasalazine

OR

1.3.2 Previous trial and failure of another targeted immunomodulator agent

AND

2 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Product Name:Xeljanz tabs/oral soln	
Approval Length	1 year(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 ONE of the following diagnoses: • Ankylosing spondylitis	

- Psoriatic arthritis

AND

1.1.2 Previous trial and failure of at least ONE tumor necrosis factor (TNF) blocker

AND

1.1.3 Dose does not exceed 5 mg (milligrams) twice daily

OR

1.2 ALL of the following:

1.2.1 Diagnosis of polyarticular juvenile idiopathic arthritis

AND

1.2.2 Previous trial and failure of a TNF blocker with juvenile idiopathic arthritis indication [e.g., adalimumab agents, Enbrel (etanercept), or Simponi (golimumab)]

AND

1.2.3 Dose does not exceed 5 mg twice daily

OR

1.3 Diagnosis of rheumatoid arthritis, and BOTH of the following:

1.3.1 ONE of the following:

1.3.1.1 Previous trial and failure of at least ONE TNF blocker

OR

1.3.1.2 At least 90 days of drug therapy with ONE of the following:

- Azathioprine
- Hydroxychloroquine
- Leflunomide
- Methotrexate
- Sulfasalazine

AND

1.3.2 Dose does not exceed 5 mg twice daily

OR

1.4 ALL of the following:

1.4.1 Diagnosis of ulcerative colitis

AND

1.4.2 Previous trial and failure of a TNF blocker with an ulcerative colitis indication [e.g., adalimumab agents, Simponi (golimumab), or infliximab agents]

AND

1.4.3 ONE of the following:

1.4.3.1 Dose does not exceed 10 mg twice daily for the induction period up to 16 weeks

OR

1.4.3.2 Dose does not exceed 5 mg twice daily for the maintenance period

AND

2 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

AND

3 - If the request is for Xeljanz oral solution, ONE of the following:

3.1 Both of the following:

- Patient is 2 years of age or older AND less than 18 years of age
- Patient weighs 10 kg or more AND less than 40kg

OR

3.2 Provider has submitted documentation supporting inability to swallow tablet formulation

Product Name:Xeljanz XR	
Approval Length	1 year(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 ONE of the following diagnoses: • Ankylosing spondylitis • Psoriatic arthritis • Rheumatoid arthritis AND	

1.1.2 Previous trial and failure of a tumor necrosis factor (TNF) blocker or Xeljanz IR (immediate release)

AND

1.1.3 Dose does not exceed 11 mg once daily

OR

1.2 ALL of the following:

1.2.1 Diagnosis of ulcerative colitis

AND

1.2.2 Previous trial and failure of a TNF blocker with ulcerative colitis indication [e.g. adalimumab agents, Simponi (golimumab), or infliximab agents] or Xeljanz IR

AND

1.2.3 ONE of the following:

1.2.3.1 Dose does not exceed 22 mg once daily for the induction period up to 16 weeks

OR

1.2.3.2 Dose does not exceed 11 mg once daily for the maintenance period

AND

2 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Product Name: Xeljanz, Xeljanz XR

Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested medication for at least 90 of the past 120 days, as confirmed by claims history or chart documentation AND 2 - Dose requested does not exceed any of the established quantity limits for the indication: 2.1 For Xeljanz, ONE of the following: 2.1.1 For ankylosing spondylitis, psoriatic arthritis, polyarticular juvenile idiopathic arthritis, or rheumatoid arthritis, dose does not exceed 5 mg twice daily OR 2.1.2 For ulcerative colitis, dose does not exceed 10 mg twice daily for the induction period up to 16 weeks, and dose does not exceed 5 mg twice daily for the maintenance period OR 2.2 For Xeljanz XR, ONE of the following: 2.2.1 For ankylosing spondylitis, psoriatic arthritis, or rheumatoid arthritis, dose does not exceed 11 mg once daily OR 2.2.2 For ulcerative colitis, dose does not exceed 22 mg once daily for the induction period up to 16 weeks, and dose does not exceed 11 mg once daily for the maintenance period	

AND

3 - If the request is for Xeljanz oral solution, ONE of the following:

3.1 Both of the following

- Patient is 2 years of age or older AND less than 18 years of age
- Patient weighs 10 kg or more AND less than 40kg

OR

3.2 Provider has submitted documentation supporting inability to swallow tablet formulation

AND

4 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Product Name:Avsola	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following diagnoses: • Ankylosing spondylitis • Moderate to severe Crohn's disease • Psoriasis • Psoriatic arthritis • Rheumatoid arthritis • Ulcerative colitis	

AND

2 - BOTH of the following:

- Previous trial of preferred infliximab*
- Prescriber has provided valid medical rationale for the use of Avsola (infliximab-axxq) over the preferred infliximab product(s)* (document rationale)

AND

3 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:Avsola	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested medication for at least 90 of the past 120 days, as confirmed by claims history or chart documentation AND 2 - BOTH of the following: • Previous trial of preferred infliximab* • Prescriber has provided valid medical rationale for the use of Avsola (infliximab-axxq) over the preferred infliximab product(s)* (document rationale) AND	

3 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:Cimzia	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following diagnoses: • Ankylosing spondylitis • Moderate to severe Crohn's disease • Non-radiographic axial spondyloarthritis • Psoriasis • Psoriatic arthritis • Polyarticular juvenile idiopathic arthritis • Rheumatoid arthritis AND 2 - Previous trial and failure of another targeted immunomodulator agent AND 3 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days	

Product Name:Entyvio	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following diagnoses:

- Moderate to severe Crohn's disease
- Ulcerative colitis

AND

2 - Previous trial and failure of another targeted immunomodulator agent

AND

3 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Product Name:Kevzara

Approval Length	1 year(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 polyarticular juvenile idiopathic arthritis

AND

1.1.2 Previous trial and failure of another targeted immunomodulator agent

AND

1.1.3 Patient weighs at least 63 kilograms

OR

1.2 BOTH of the following:

1.2.1 Diagnosis of polymyalgia rheumatica

AND

1.2.2 At least 90 days of drug therapy with oral corticosteroids or methotrexate

OR

1.3 BOTH of the following:

1.3.1 Diagnosis of rheumatoid arthritis

AND

1.3.2 Previous trial and failure of another targeted immunomodulator agent

AND

2 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Product Name:Litfulo	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of chart notes showing a diagnosis of severe alopecia areata defined as greater than or equal to 50% of hair loss

AND

2 - Patient is 12 years of age or older

AND

3 - Submission of medical records documenting previous trial and failure of Olumiant

AND

4 - Prescribed by, or in consultation with, a dermatologist

AND

5 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Product Name:Litfulo	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested agent for at least 90 of the past 120 days, as confirmed by claims history or chart documentation	

AND

2 - Documentation of patient clinical status and response to therapy (document status/response)

AND

3 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Product Name:Otezla XR	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Diagnosis of psoriatic arthritis and BOTH of the following: • Patient weighs at least 50 kg (kilograms) • Previous trial and failure of Otezla IR OR 1.2 Diagnosis of oral ulcers associated with Behcet's disease and BOTH of the following: • Patient is 18 years of age and older • Previous trial and failure of Otezla IR OR 1.3 Diagnosis of psoriasis and BOTH of the following:	

- Patient weighs at least 50 kg (kilograms)
- Previous trial and failure of Otezla IR

AND

2 - Dose does not exceed 75 mg (milligrams) once daily

Product Name:Otezla XR	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested agent for at least 90 of the past 120 days, as confirmed by claims history or chart documentation AND 2 - Dose requested does not exceed 75 mg (milligrams) once daily	

Product Name:Pyzchiva, Selarsdi	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following diagnoses: • Moderate to severe Crohn's disease • Psoriasis	

- Psoriatic arthritis
- Ulcerative colitis

AND

2 - Previous trial and failure of another targeted immunomodulator agent

AND

3 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Product Name: Rinvoq ER tablets	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Diagnosis of atopic dermatitis, and ALL of the following: 1.1.1 Patient is at least 12 years of age AND weighs at least 40 kg (kilograms) AND 1.1.2 ONE of the following: 1.1.2.1 Patient has tried and failed ONE systemic agent with an atopic dermatitis indication OR 1.1.2.2 If patient was unable to utilize a systemic agent, patient has trialed at least 45 days of topical drug therapy with ONE of the following (documentation required):	

- Pimecrolimus
- Tacrolimus
- Corticosteroids

OR

1.1.2.3 Prescriber has provided valid medical justification for the use of the requested medication over topical corticosteroids and/or topical immunomodulator agents (document rationale)

AND

1.1.3 For patients 65 years of age or older, requested dose does not exceed 15 mg (milligrams) daily

OR

1.2 ALL of the following:

1.2.1 Diagnosis of ONE of the following:

- Ankylosing spondylitis
- Non-radiographic axial spondyloarthritis
- Polyarticular juvenile idiopathic arthritis
- Psoriatic arthritis
- Rheumatoid arthritis

AND

1.2.2 Previous trial and failure of at least ONE tumor necrosis factor (TNF) blocker

OR

1.3 Diagnosis of giant cell arteritis and BOTH of the following:

- At least 90 days of drug therapy with one of the following: systemic glucocorticoid, azathioprine, or methotrexate

- Patient will be using a systemic glucocorticoid concurrently with the requested medication

OR

1.4 Diagnosis of moderate to severe Crohn's disease and ONE of the following:

1.4.1 Previous trial and failure of at least ONE TNF blocker with Crohn's disease indication (adalimumab agents, Cimzia (certolizumab), infliximab agents)

OR

1.4.2 BOTH of the following:

- Prescriber has provided valid medical justification as to why it is inadvisable for patient to receive TNF-inhibitor therapy (document justification)
- Previous trial and failure of at least ONE approved systemic agent

OR

1.5 Diagnosis of ulcerative colitis and ONE of the following:

1.5.1 Previous trial and failure of at least ONE TNF blocker with ulcerative colitis indication (e.g. adalimumab agents, infliximab agents, Simponi (golimumab))

OR

1.5.2 BOTH of the following:

- Prescriber has provided valid medical justification as to why it is inadvisable for patient to receive TNF-inhibitor therapy (document justification)
- Previous trial and failure of at least ONE approved systemic agent

AND

2 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Product Name: Rinvoq LQ	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following: • Psoriatic arthritis • Polyarticular juvenile idiopathic arthritis AND 2 - Previous trial and failure of at least ONE TNF blocker AND 3 - Patient is at least 2 years of age AND weighs at least 10 kilograms AND 4 - ONE of the following: 4.1 Patient is less than 18 years of age AND weighs less than 30 kilograms OR 4.2 Provider has submitted documentation supporting inability to swallow tablet formulation AND 5 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days	

Product Name: Rinvoq LQ	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested medication for at least 90 of the past 120 days, as confirmed by claims history or chart documentation AND 2 - One of the following: 2.1 Patient is less than 18 years of age AND weighs less than 30 kilograms OR 2.2 Provider has submitted documentation supporting inability to swallow tablet formulation AND 3 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days	

Product Name: Cosentyx	
Approval Length	1 year(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 ONE of the following diagnoses:

- Ankylosing spondylitis
- Non-radiographic axial spondyloarthritis
- Psoriasis
- Psoriatic arthritis
- Rheumatoid arthritis

AND

1.1.2 Previous trial and failure of another targeted immunomodulator agent

OR

1.2 BOTH of the following:

1.2.1 Diagnosis of hidradenitis suppurativa

AND

1.2.2 Previous trial and failure of a preferred adalimumab agent*

OR

1.3 Diagnosis of enthesitis-related arthritis (ERA)

AND

2 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:Ebglyss	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of atopic dermatitis AND 2 - Patient is at least 12 years of age AND weighs at least 40 kilograms AND 3 - ONE of the following: • Submission of medical records documenting previous trial and failure of Adbry OR Dupixent • Submission of medical records documenting patient is unable to utilize Adbry AND Dupixent, and patient has trialed at least 45 days of topical drug therapy with one of the following: corticosteroids, pimecrolimus, or tacrolimus • Prescriber has provided valid medical justification for the use of Ebglyss over Adbry AND Dupixent (document rationale) AND 4 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days	

Product Name:Nemluvio	
Approval Length	1 year(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 atopic dermatitis

AND

1.1.2 Patient is 12 years of age or older

AND

1.1.3 ONE of the following:

- Submission of medical records documenting previous trial and failure of Adbry OR Dupixent
- Submission of medical records documenting patient is unable to utilize Adbry AND Dupixent, and patient has trialed at least 45 days of topical drug therapy with one of the following: corticosteroids, pimecrolimus, or tacrolimus
- Prescriber has provided valid medical justification for the use of Nemludio over Adbry AND Dupixent (document rationale)

OR

1.2 ALL of the following:

1.2.1 Diagnosis of prurigo nodularis

AND

1.2.2 Patient is 18 years of age or older

AND

1.2.3 ONE of the following:

- Submission of medical records documenting previous trial and failure of Dupixent
- Submission of medical records documenting patient is unable to utilize Dupixent and patient has trialed at least 30 days of topical drug therapy with one of the following: corticosteroids, pimecrolimus, or tacrolimus
- Prescriber has provided valid medical justification for the use of Nemludio over Dupixent (document rationale)

AND

2 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Product Name: Abridada, Adalimumab-AACF, Idacio, Adalimumab-FKJP, Hulio, Hyrimoz, Adalimumab-ADB, Cyltezo, Adalimumab-RYVK, Simlandi, Amjevita, Humira, Adalimumab-AATY, Yuflyma, Yusimry

Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following diagnoses:

- Ankylosing spondylitis
- Moderate to severe Crohn's disease
- Hidradenitis suppurativa
- Non-infectious uveitis
- Polyarticular juvenile idiopathic arthritis
- Psoriasis
- Psoriatic arthritis
- Rheumatoid arthritis
- Ulcerative colitis

AND

2 - Previous trial and failure of at least ONE other targeted immunomodulator agent that is not adalimumab

AND

3 - Both of the following:

- Previous trial of ALL preferred adalimumab product(s)*
- Prescriber has provided valid medical rationale for the use of the requested non-preferred adalimumab product over ALL of the preferred adalimumab product(s)* (document rationale)

AND

4 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name: Abrilada, Adalimumab-AACF, Idacio, Adalimumab-FKJP, Hulio, Hyrimoz, Adalimumab-ADB, Cyltezo, Adalimumab-RYVK, Simlandi, Amjevita, Humira, Adalimumab-AATY, Yuflyma, Yusimry

Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - History of the requested medication for at least 90 of the past 120 days, as confirmed by claims history or chart documentation

AND

2 - Both of the following:

- Previous trial of ALL preferred adalimumab product(s)*

- Prescriber has provided valid medical rationale for the use of the requested non-preferred adalimumab product over ALL of the preferred adalimumab product(s)* (document rationale)

AND

3 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Notes

*PDL link: <https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html>

Product Name: Actemra

Approval Length

1 year(s)

Therapy Stage

Initial Authorization

Guideline Type

Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Diagnosis of Systemic sclerosis-associated interstitial lung disease (SSc-ILD)

OR

1.2 ALL of the following:

1.2.1 Diagnosis of ONE of the following:

- Cytokine release syndrome
- Giant cell arteritis
- Polyarticular juvenile idiopathic arthritis
- Rheumatoid arthritis
- Systemic juvenile idiopathic arthritis

AND

1.2.2 Previous trial and failure of at least ONE other targeted immunomodulator agent that is not tocilizumab

AND

1.2.3 BOTH of the following:

- Previous trial of preferred tocilizumab product(s)*
- Prescriber has provided valid medical rationale for the use of the requested non-preferred tocilizumab product over the preferred tocilizumab product(s)* (document rationale)

AND

2 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:Actemra	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested medication for at least 90 of the past 120 days, as confirmed by claims history or chart documentation AND 2 - ONE of the following: 2.1 Diagnosis of systemic sclerosis-associated interstitial lung disease (SSc-ILD)	

OR

2.2 BOTH of the following:

2.2.1 Diagnosis of ONE of the following:

- Cytokine release syndrome
- Giant cell arteritis
- Polyarticular juvenile idiopathic arthritis
- Rheumatoid arthritis
- Systemic juvenile idiopathic arthritis

AND

2.2.2 BOTH of the following:

- Previous trial of preferred tocilizumab product(s)*
- Prescriber has provided valid medical rationale for the use of the requested non-preferred tocilizumab product over the preferred tocilizumab product(s)* (document rationale)

AND

3 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Product Name:Arcalyst	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following:	

1.1 Diagnosis of Cryopyrin-Associated Periodic Syndrome (CAPS) [including familial cold autoinflammatory syndrome (FCAS) and Muckle-Wells syndrome (MWS)]

OR

1.2 BOTH of the following:

1.2.1 Diagnosis of recurrent pericarditis (RP)

AND

1.2.2 At least 90 days of drug therapy with ONE of the following:

- Colchicine
- Systemic glucocorticoids

OR

1.3 BOTH of the following:

1.3.1 Diagnosis of deficiency of interleukin-1 receptor antagonist (DIRA)

AND

1.3.2 Previous trial and failure of Kineret (anakinra)

AND

2 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Product Name:Avtozma	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following diagnoses:

- Cytokine release syndrome
- Giant cell arteritis
- Polyarticular juvenile idiopathic arthritis
- Rheumatoid arthritis
- Systemic juvenile idiopathic arthritis

AND

2 - Previous trial and failure of at least ONE other targeted immunomodulator agent that is not tocilizumab

AND

3 - BOTH of the following:

- Previous trial of preferred tocilizumab product(s)*
- Prescriber has provided valid medical rationale for the use of the requested non-preferred tocilizumab product over the preferred tocilizumab product(s)* (document rationale)

AND

4 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name: Tofidence	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following diagnoses:

- Giant cell arteritis
- Polyarticular juvenile idiopathic arthritis
- Rheumatoid arthritis
- Systemic juvenile idiopathic arthritis

AND

2 - Previous trial and failure of at least ONE other targeted immunomodulator agent that is not tocilizumab

AND

3 - BOTH of the following:

- Previous trial of preferred tocilizumab product(s)*
- Prescriber has provided valid medical rationale for the use of the requested non-preferred tocilizumab product over the preferred tocilizumab product(s)* (document rationale)

AND

4 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name: Avtozma, Tofidence	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - History of the requested medication for at least 90 of the past 120 days, as confirmed by claims history or chart documentation

AND

2 - BOTH of the following:

- Previous trial of preferred tocilizumab product(s)*
- Prescriber has provided valid medical rationale for the use of the requested non-preferred tocilizumab product over the preferred tocilizumab product(s)* (document rationale)

AND

3 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name: Bimzelx

Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following diagnoses:

- Ankylosing spondylitis
- Hidradenitis suppurativa
- Non-radiographic axial spondyloarthritis
- Psoriasis

- Psoriatic arthritis

AND

2 - Previous trial and failure of at least TWO other targeted immunomodulator agents

AND

3 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Product Name:Cibinqo	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderate to severe atopic dermatitis AND 2 - Patient is at least 12 years of age AND 3 - ONE of the following: 3.1 BOTH of the following: • At least 60 days of therapy with Dupixent (dupilumab) • At least 120 days of therapy with Adbry (tralokinumab-ldrm)	

OR

3.2 At least 60 days of therapy with Rinvoq (upadacitinib)

OR

3.3 Prescriber has provided valid medical justification for the use of the requested medication over Dupixent (dupilumab), Adbry (tralokinumab-ldrm), and Rinvoq (upadacitinib) (document rationale)

AND

4 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Product Name: Ilaris	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 ONE of the following diagnoses: • Cryopyrin-Associated Periodic Syndrome (CAPS) [including familial cold autoinflammatory syndrome (FCAS) and Muckle-Wells syndrome (MWS)] • Systemic juvenile idiopathic arthritis • Tumor necrosis factor receptor associated periodic syndrome (TRAPS) • Hyperimmunoglobulin D (Hyper-IgD) syndrome (HIDS)/mevalonate kinase deficiency (MKD) OR	

1.2 BOTH of the following:

1.2.1 Diagnosis of adult-onset Still's disease

AND

1.2.2 At least 90 days of drug therapy with ONE of the following:

- Corticosteroids
- Methotrexate
- NSAIDs (non-steroidal anti-inflammatory drugs)

OR

1.3 BOTH of the following:

1.3.1 Diagnosis of familial Mediterranean fever (FMF)

AND

1.3.2 At least 90 days of drug therapy with colchicine

OR

1.4 BOTH of the following:

1.4.1 Diagnosis of gout flares

AND

1.4.2 ONE of the following:

1.4.2.1 Both of the following:

- Previous trial and failure of colchicine, corticosteroids, AND NSAIDs (non-steroidal anti-inflammatory drugs) in the past 30 days
- Prescriber has submitted chart documentation illustrating inadequate response

OR

1.4.2.2 Prescriber has submitted chart documentation supporting contraindication to colchicine, NSAIDs, AND prolonged corticosteroid use

AND

2 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Product Name:Ilumya	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of psoriasis AND 2 - Previous trial and failure of at least TWO other targeted immunomodulator agents AND 3 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days	

Product Name:Imuldosa, Otulfi, Starjemza, Stelara, Steqeyma, Ustekinumab, Ustekinumab-AAUZ, Ustekinumab-AEKN, Ustekinumab-TTWE, Yesintek	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following diagnoses: • Moderate to severe Crohn's disease • Psoriasis • Psoriatic arthritis • Ulcerative colitis AND 2 - ALL of the following: • Previous trial and failure of at least ONE other targeted immunomodulator agent that is not ustekinumab • Previous trial of ALL preferred ustekinumab product(s)* • Prescriber has provided valid medical rationale for the use of the requested non-preferred ustekinumab product over ALL of the preferred ustekinumab product(s)* (document rationale) AND 3 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:Imuldosa, Otulfi, Starjemza, Stelara, Steqeyma, Ustekinumab, Ustekinumab-AAUZ, Ustekinumab-AEKN, Ustekinumab-TTWE, Yesintek	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - History of the requested medication for at least 90 of the past 120 days, as confirmed by claims history or chart documentation

AND

2 - BOTH of the following:

- Previous trial of ALL preferred ustekinumab product(s)*
- Prescriber has provided valid medical rationale for the use of the requested non-preferred ustekinumab product over ALL of the preferred ustekinumab product(s)* (document rationale)

AND

3 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name: Inflectra, Remicade, Renflexis	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following diagnoses: • Ankylosing spondylitis • Moderate to severe Crohn's disease • Psoriasis • Psoriatic arthritis • Rheumatoid arthritis • Ulcerative colitis AND	

2 - Previous trial and failure of at least ONE other targeted immunomodulator agent that is not infliximab

AND

3 - BOTH of the following:

- Previous trial of preferred infliximab*
- Prescriber has provided valid medical rationale for the use of the requested non-preferred infliximab product over the preferred infliximab product(s)* (document rationale)

AND

4 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name: Inflectra, Remicade, Renflexis	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested medication for at least 90 of the past 120 days, as confirmed by claims history or chart documentation AND 2 - BOTH of the following: • Previous trial of preferred infliximab*	

- Prescriber has provided valid medical rationale for the use of the requested non-preferred infliximab product over the preferred infliximab product(s)* (document rationale)

AND

3 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Notes

*PDL link: <https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html>

Product Name:Leqselvi

Approval Length 6 month(s)

Therapy Stage Initial Authorization

Guideline Type Prior Authorization

Approval Criteria

1 - Submission of medical records documenting diagnosis of severe alopecia areata defined as at least 50% of hair loss

AND

2 - Patient is 18 years of age or older

AND

3 - Prescribed by, or in consultation with, a dermatologist

AND

4 - ONE of the following:

- Submission of medical records documenting previous trial and failure of Olumiant and Litfulo

- Prescriber has provided valid medical justification for the use of Leqselvi over Olumiant AND Litfulo (document rationale)

AND

5 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Product Name:Leqselvi	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested agent for at least 90 of the past 120 days, as confirmed by claims history or chart documentation AND 2 - Submission of documentation regarding clinical status of patient and response to therapy AND 3 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days	

Product Name:OmvoH	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following diagnoses:

- Moderate to severe Crohn's disease
- Ulcerative colitis

AND

2 - Previous trial and failure of at least TWO other targeted immunomodulator agents

AND

3 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Product Name:Rhapsido	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chronic spontaneous urticaria AND 2 - Documentation of at least 6 weeks of symptoms AND 3 - Patient is 18 years of age or older	

AND

4 - One of the following:

4.1 Previous trial and failure of Dupixent (dupilumab) or Xolair (omalizumab)

OR

4.2 BOTH of the following:

4.2.1 Prescriber has provided valid medical justification for the use of Rhapsido (remibrutinib) over Dupixent (dupilumab) AND Xolair (omalizumab) (document justification)

AND

4.2.2 Submission of medical records supporting previous trial and failure of BOTH of the following:

4.2.2.1 At least 14 days with a single second generation antihistamine as monotherapy (e.g., cetirizine, desloratadine, fexofenadine, levocetirizine, loratadine)

AND

4.2.2.2 At least 14 days of TWO of the following (trial history is considered as 14 days or greater of each individual option):

- Two different second generation H1 receptor antagonists as concomitant therapy
- Second generation H1 receptor antagonist as monotherapy with dose advancement (e.g., four time max FDA dose/day)
- Second generation H1 receptor antagonist used concomitantly with H2-antagonist
- Second generation H1 receptor antagonist used concomitantly with leukotriene-receptor antagonist (LTRA)
- Second generation H1 receptor antagonist used concomitantly with bedtime first generation antihistamine

AND

5 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Product Name:Skyrizi

Approval Length 1 year(s)

Therapy Stage Initial Authorization

Guideline Type Prior Authorization

Approval Criteria

1 - ONE of the following diagnoses:

- Moderate to severe Crohn's disease
- Psoriasis
- Psoriatic arthritis
- Ulcerative colitis

AND

2 - Previous trial and failure of at least TWO other targeted immunomodulator agents

AND

3 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Product Name:Sotyktu

Approval Length 1 year(s)

Therapy Stage Initial Authorization

Guideline Type Prior Authorization

Approval Criteria

1 - Patient is 18 years of age and older

AND

2 - Diagnosis of psoriasis

AND

3 - Previous trial and failure of at least TWO other targeted immunomodulator agents

AND

4 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Product Name:Spevigo	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of generalized pustular psoriasis (GPP) AND 2 - Patient is at least 12 years of age AND weighs at least 40 kilograms AND 3 - Prescribed by, or in consultation with, a dermatologist or rheumatologist	

AND

4 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Product Name:Tremfya	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following diagnoses:

- Moderate to severe Crohn's disease
- Psoriasis
- Psoriatic arthritis
- Ulcerative Colitis

AND

2 - Previous trial and failure of at least TWO other targeted immunomodulator agents

AND

3 - If the request is for Tremfya induction pack, the quantity does not exceed 1 induction pack per 90 days

AND

4 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Product Name:Velsipity	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ulcerative colitis AND 2 - Previous trial and failure of BOTH of the following: • Zeposia (ozanimod) • At least ONE other targeted immunomodulator agent AND 3 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days	

Product Name:Zymfentra	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderate to severe Crohn's disease or ulcerative colitis AND	

2 - Previous trial and failure of at least ONE other targeted immunomodulator agent that is not infliximab

AND

3 - Both of the following:

- Previous trial of preferred infliximab product(s)*
- Prescriber has provided valid medical rationale for the use of the requested non-preferred infliximab product over the preferred infliximab product(s)* (document rationale)

AND

4 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name: Zymfentra	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested medication for at least 90 of the past 120 days, as confirmed by claims history or chart documentation AND 2 - Both of the following: • Previous trial of preferred infliximab product(s)*	

Prescriber has provided valid medical rationale for the use of the requested non-preferred infliximab product over the preferred infliximab product(s)* (document rationale)	
AND	
3 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name: Adalimumab-ADAZ, Adbry, Arcalyst, Bimzelx, Cibinqo, Cimzia, Cosentyx, Ebglyss, Enbrel, Entyvio, Hadlima, Ilaris, Ilumya, Infliximab, Kevzara, Kineret, Nemluvio, Omvoh, Orenzia, Otezla, Otezla Starter/Initiation Packs, Pyzchiva, Rhapsido, Rinvoq ER tablets, Simponi, Simponi Aria, Skyrizi, Sotyktu, Spevigo, Selarsdi, Taltz, Tremfya, Tyenne, Velsipity	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested medication for at least 90 of the past 120 days, as confirmed by claims history or chart documentation AND 2 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days	

2 . Revision History

Date	Notes
3/3/2026	Updated GPs. Updated Actemra criteria. Added Infliximab. Updated Otezla criteria and added Otezla XR criteria. Updated Avtozma criteri

	a and added Tofidence. Added Avsola. Updated Rinvoq ER tablet criteria. Added Ustekinumab-AAUZ and rearranged product names. Added Inflectra, Remicade and Renflexis. Added Rhapsido. Added quantity criteria for Tremfya induction pack. Added PDL links and updated medical rationale to adalimumab and Zymfentra sections, added PDL link to Cosentyx and ustekinumab sections.

Targretin



Prior Authorization Guideline

Guideline ID	GL-596192
Guideline Name	Targretin
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 Indiana Medicaid - Community & State Nebraska Medicaid - Community & State New Mexico Medicaid - Community & State Pennsylvania Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name: Brand Targretin, generic bexarotene	
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 - ONE of the following: 2.1 Failure 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)] as confirmed by claims history or submission of medical records OR 2.2 History of 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)] (please specify contraindication or intolerance)	

Product Name: Brand Targretin, generic bexarotene	
Diagnosis	Cutaneous T-Cell Lymphoma
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 the requested therapy

Product Name:Brand Targretin, generic bexarotene	
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:Brand Targretin, generic bexarotene	
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 the requested therapy	

2 . Revision History

Date	Notes
4/27/2026	Updated formularies to add ACUIN for eff 6/1/2026. Updated guideline name. Replaced "Targretin" verbiage with "the requested therapy" verbiage in reauth sections, where applicable (no changes to clinical intent).

Tavalisse



Prior Authorization Guideline

Guideline ID	GL-438193
Guideline Name	Tavalisse
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 Nevada Medicaid - Community & State Indiana Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Tavalisse	
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 - ONE of the following: 2.1 BOTH of the following: 2.1.1 ONE of the following: 2.1.1.1 Failure to at least ONE of the following classes confirmed by claims history or submitted medical records: • Corticosteroids • Immunoglobulins OR 2.1.1.2 History of contraindication or intolerance to BOTH of the following classes (please specify intolerance or contraindication): • Corticosteroids • Immunoglobulins AND 2.1.2 ONE of the following: 2.1.2.1 Failure to eltrombopag (generic Promacta) confirmed by claims history or submitted medical records	

OR

2.1.2.2 History of contraindication or intolerance to eltrombopag (generic Promacta) (please specify intolerance or contraindication)

OR

2.2 Patient is currently on Tavalisse therapy

Product Name:Tavalisse	
Diagnosis	Chronic immune thrombocytopenia (ITP)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Tavalisse therapy	

2 . Revision History

Date	Notes
11/5/2025	Added NV formulary. No clinical 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 Indiana Clinical Pharmacy Program Guidelines

Date	Notes
4/17/2026	Updated formularies to add ACUIN and ACUPA for eff 6/1/2026.

Tazverik



Prior Authorization Guideline

Guideline ID	GL-242232
Guideline Name	Tazverik
Formulary	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:	6/1/2025

1 . Criteria

Product Name:Tazverik

Diagnosis	Epithelioid Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of epithelioid sarcoma AND 2 - Disease is ONE of the following: • Metastatic • Locally advanced AND 3 - Disease is not eligible for complete resection	

Product Name:Tazverik	
Diagnosis	Follicular Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of relapsed or refractory follicular lymphoma AND	

2 - ONE of the following:

2.1 Subsequent therapy in EZH2 (gene) mutation positive disease after 2 prior therapies

OR

2.2 Second-line therapy irrespective of EZH2 mutation status for older or infirm patients with indications for treatment (i.e., other therapy options are not expected to be tolerable)

OR

2.3 Third-line and/or subsequent therapy (if not previously given) irrespective of EZH2 mutation status in patients with indications for treatment

Product Name:Tazverik	
Diagnosis	Epithelioid Sarcoma, Follicular Lymphoma
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 Tazverik therapy	

Product Name:Tazverik	
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:Tazverik

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 Tazverik therapy

2 . Revision History

Date	Notes
4/18/2025	Combined formularies. Updated GPI entry in product details section. No changes to clinical criteria.

Tepmetko



Prior Authorization Guideline

Guideline ID	GL-578268
Guideline Name	Tepmetko
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia Medicaid - Community & State Washington

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Tepmetko

Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of non-small cell lung cancer (NSCLC) AND 2 - Disease is recurrent, advanced, or metastatic AND 3 - ONE of the following: 3.1 Mesenchymal-epithelial transition (MET) exon 14 skipping mutation positive tumor(s) OR 3.2 High level MET amplification	

Product Name: Tepmetko	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
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 Tepmetko therapy	

Product Name:Tepmetko	
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:Tepmetko	
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 Tepmetko therapy	

2 . Revision History

Date	Notes
4/16/2026	Updated formularies to add ACUIN for eff 6/1/2026. Minor update to add "(NSCLC)" acronym in dx headers and minor formatting update i n initial auth section for NSCLC, with no changes to clinical intent.

Test Strips



Prior Authorization Guideline

Guideline ID	GL-356188
Guideline Name	Test Strips
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	9/1/2025

1 . Criteria

Product Name:Non-preferred Test Strips	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - If the request is non-preferred*, ONE of the following: 1.1 BOTH of the following: 1.1.1 ONE of the following:	

1.1.1.1 Failure of ALL of the following as confirmed by claims history or submitted medical records:

- Accu-Chek Guide Retail Test Strips
- True Metrix Test Strips
- ReliOn Rx TMX Test Strips

OR

1.1.1.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- Accu-Chek Guide Retail Test Strips
- True Metrix Test Strips
- ReliOn Rx TMX Test Strips

AND

1.1.2 Documentation provided from the prescriber of the medical necessity rationale for the non-preferred test strips

OR

1.2 Patient is on an insulin pump

Notes	*PDL: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:All Test Strips	
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:

- The patient is experiencing or is prone to hypoglycemia or hyperglycemia and requires additional testing to achieve glycemic control
- The patient's physician is adjusting medications and the patient requires additional blood glucose testing during this time
- The patient's physician is adjusting MNT (medical nutrition therapy) and the patient requires additional blood glucose testing during this time
- The patient requires additional testing due to fluctuations in blood glucose due to physical activity or exercise
- Other circumstances where prescribing physician confirms that the patient requires a greater quantity because of more frequent blood glucose testing (clinical review required by UnitedHealthcare reviewing pharmacist and/or medical director)

Notes	NOTE: The quantity limit for insulin-dependent and pregnant patients is 6 test strips/day. The quantity limit for non-insulin dependent and non-pregnant patients is 2 test strips/day.

2 . Revision History

Date	Notes
7/31/2025	Updated GPIs and non-preferred language. Minor formatting changes

Testosterones



Prior Authorization Guideline

Guideline ID	GL-289256
Guideline Name	Testosterones
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	7/1/2025

1 . Criteria

Product Name: Brand Depo-Testosterone, generic testosterone cypionate, Testosterone cypionate	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization*
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Diagnosis of delayed puberty	

OR

1.2 Submission of documentation of total testosterone level less than or equal to 350 ng/dL (nanograms/deciliter) within the past 3 months

AND

2 - Provider attests that the patient does NOT have any of the following contraindications to therapy:

- Breast cancer in a patient assigned male at birth
- Pregnancy
- Prostate cancer

Notes

*If patient has had history with injectable/topical product within the past 120 days, confirmed by claims history, and switching formulations to preferred injectable formulation, use reauthorization criteria.

Product Name: Brand Depo-Testosterone, generic testosterone cypionate, Testosterone cypionate

Approval Length 12 month(s)

Therapy Stage Reauthorization

Guideline Type Prior Authorization

Approval Criteria

1 - History of injectable or topical testosterone agent(s) within the past 120 days, confirmed by claims history or chart documentation

AND

2 - Submission of documentation of total testosterone level less than or equal to 1000 ng/dL within the past 6 months

AND

3 - Prescriber attests that the patient remains a candidate for treatment, indicating that they have NOT developed any of the contraindication(s) listed in initial authorization criteria (breast cancer in a patient assigned male at birth, pregnancy, prostate cancer)

Product Name: testosterone enanthate	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization*
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 ONE of the following:

- Diagnosis of delayed puberty
- Submission of documentation of total testosterone level less than or equal to 350 ng/dL (nanograms/deciliter) within the past 3 months

AND

1.2 ONE of the following:

- Previous trial and failure of ALL preferred** injectable testosterone agents, as confirmed by claims history, chart documentation, or provider attestation including dates of trial
- Medical justification for use of the requested medication over ALL preferred** injectable testosterone agents

AND

1.3 Provider attests that the patient does NOT have any of the following contraindications to therapy:

- Breast cancer in a patient assigned male at birth
- Pregnancy
- Prostate cancer

OR

2 - BOTH of the following:

2.1 Palliative treatment of metastatic breast cancer

AND

2.2 Provider attests that the patient does NOT have any of the following contraindications to therapy:

- Breast cancer in a patient assigned male at birth
- Pregnancy
- Prostate cancer

Notes	*If patient has had history with injectable/topical product within the past 120 days, confirmed by claims history, and are switching formulations to nonpreferred injectable formulation, use reauthorization criteria. **PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name: testosterone enanthate	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 History of the requested medication within the past 120 days, confirmed by claims history or chart documentation	

OR

1.2 Patient has had history with injectable/topical product within the past 120 days, confirmed by claims history, and are switching formulations to the requested agent

AND

2 - Submission of documentation of total testosterone level less than or equal to 1000 ng/dL within the past 6 months

AND

3 - ONE of the following: (not required for palliative treatment of breast cancer)

- Previous trial and failure of at least one preferred* injectable testosterone agent, as confirmed by claims history, chart documentation, or provider attestation including dates of trial
- Medical justification for use of the requested medication over ALL preferred* injectable testosterone agents

AND

4 - Prescriber attests that the patient remains a candidate for treatment, indicating that they have NOT developed any of the contraindication(s) listed in initial authorization criteria (breast cancer in a patient assigned male at birth, pregnancy, prostate cancer)

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:Aveed, Azmiro, Testopel, Xyosted	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization*
Guideline Type	Prior Authorization
Approval Criteria	

1 - ONE of the following:

- Diagnosis of delayed puberty
- Submission of documentation of total testosterone level less than or equal to 350 ng/dL (nanograms/deciliter) within the past 3 months

AND

2 - ONE of the following:

- Previous trial and failure of ALL preferred** injectable testosterone agents, as confirmed by claims history, chart documentation, or provider attestation including dates of trial
- Medical justification for use of the requested medication over ALL preferred** injectable testosterone agents

AND

3 - Provider attests that the patient does NOT have any of the following contraindications to therapy:

- Breast cancer in a patient assigned male at birth
- Hypogonadal conditions not associated with structural or genetic etiologies (Xyosted ONLY)
- Pregnancy
- Prostate cancer

Notes	*If patient has had history with injectable/topical product within the past 120 days, confirmed by claims history, and are switching formulations to nonpreferred injectable formulation, use reauthorization criteria. **PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name: Aved, Azmiro, Testopel, Xyosted	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 History of the requested medication within the past 120 days, confirmed by claims history or chart documentation

OR

1.2 Patient has had history with injectable/topical product within the past 120 days, confirmed by claims history, and are switching formulations to the requested agent

AND

2 - Submission of documentation of total testosterone level less than or equal to 1000 ng/dL within the past 6 months

AND

3 - ONE of the following:

- Previous trial and failure of at least one preferred* injectable testosterone agent, as confirmed by claims history, chart documentation, or provider attestation including dates of trial
- Medical justification for use of the requested medication over ALL preferred* injectable testosterone agents

AND

4 - Prescriber attests that the patient remains a candidate for treatment, indicating that they have NOT developed any of the contraindication(s) listed in initial authorization criteria (breast cancer in a patient assigned male at birth, hypogonadal conditions not associated with structural or genetic etiologies [Xyosted ONLY], pregnancy, prostate cancer)

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:Generic testosterone gel, Brand Androgel, Brand Testim, Brand Vogelxo, testosterone topical soln, Brand Fortesta, Natesto	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization*
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is 16 years of age or older AND 2 - Submission of documentation of total testosterone level is less than or equal to 350 ng/dL (nanograms/deciliter) within the past 3 months AND 3 - If the request is non-preferred, ONE of the following: • Previous trial and failure of ALL preferred** topical testosterone agents, as confirmed by claims history, chart documentation, or provider attestation including dates of trial • Medical justification for use of the requested medication over ALL preferred** topical testosterone agents AND 4 - Provider attests that the patient does NOT have any of the following contraindications to therapy: • Breast cancer in a patient assigned male at birth • Pregnancy • Prostate cancer	
Notes	*If patient has had history with injectable/topical product within the past 120 days, confirmed by claims history, and are switching formulations to a topical formulation, use reauthorization criteria.

	**PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name: Generic testosterone gel, Brand Androgel, Brand Testim, Brand Vogelxo, testosterone topical soln, Brand Fortesta, Natesto	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 If the request is preferred*, patient has a history of topical or injectable testosterone agent(s) within the past 120 days, confirmed by claims history or chart documentation OR 1.2 If the request is non-preferred*, BOTH of the following: 1.2.1 ONE of the following: 1.2.1.1 Patient has a history of the requested medication within the past 120 days, confirmed by claims history or chart documentation OR 1.2.1.2 Patient has had history with injectable/topical product within the past 120 days, confirmed by claims history, and are switching formulations to the requested nonpreferred topical formulation AND 1.2.2 ONE of the following:	

- Previous trial and failure of at least one preferred* topical testosterone agent, as confirmed by claims history, chart documentation, or provider attestation including dates of trial
- Medical justification for use of the requested medication over ALL preferred* topical testosterone agents

AND

2 - Submission of documentation of total testosterone is less than or equal to 1000 ng/dL within the past 6 months

AND

3 - Prescriber attests that the patient remains a candidate for treatment, indicating that they have NOT developed any of the contraindications listed in initial authorization criteria (breast cancer in a patient assigned male at birth, pregnancy, prostate cancer)

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name: Generic testosterone gel, Brand Androgel, Brand Testim, Brand Vogelxo, testosterone topical soln, Brand Fortesta, Natesto

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Quantity Limit

Approval Criteria

1 - Patient is 16 years of age or older

AND

2 - Patient has utilized at least 14 days of topical testosterone therapy

AND

3 - Submission of documentation of total testosterone level is less than or equal to 400 ng/dL (nanograms/deciliter) while on topical testosterone therapy

Product Name: Generic testosterone gel, Brand Androgel, Brand Testim, Brand Vogelxo, testosterone topical soln, Brand Fortesta, Natesto

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Quantity Limit

Approval Criteria

1 - Patient has historical approval to exceed the established quantity limits

Product Name: danazol

Approval Length	6 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Must have ONE of the following indications for treatment:

- Angioedema prophylaxis for hereditary angioedema
- Autoimmune hemolytic anemia
- Discoid lupus erythematosus
- Endometriosis
- Fibrocystic breast disease
- Myelosclerosis with myeloid metaplasia

AND

2 - Provider attests that the patient does NOT have any of the following contraindications to therapy

- Active or history of thrombosis or thromboembolic disease

- Androgen-dependent tumor
- Cardiac disease
- Porphyria
- Pregnancy or breast-feeding
- Severe hepatic disease
- Severe renal disease
- Undiagnosed genital bleeding

Product Name: danazol	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested medication for at least 90 days within the past 120 days, confirmed by claims history or chart documentation AND 2 - Documentation from prescriber indicating continued benefit from the medication without significant adverse events AND 3 - Prescriber attests that the patient remains a candidate for treatment, indicating that they have NOT developed any of the contraindication(s) listed in initial authorization criteria (active or history of thrombosis or thromboembolic disease, androgen-dependent tumor, cardiac disease, porphyria, pregnancy or breast-feeding, severe hepatic disease, severe renal disease, undiagnosed genital bleeding)	

Product Name: Jatenzo	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

- Patient is 18 years of age or older
- Diagnosis of hypogonadism
- Submission of documentation of total testosterone level less than or equal to 350 ng/dL (nanograms/deciliter) within the past 3 months

AND

2 - Provider attests that the patient does NOT have any of the following contraindications to therapy:

- Breast cancer in a patient assigned male at birth
- Hypogonadal conditions not associated with structural or genetic etiologies
- Pregnancy
- Prostate cancer

AND

3 - ONE of the following:

- Previous trial and failure of at least one preferred* injectable agent, as confirmed by claims history, chart documentation, or provider attestation including dates of trial
- Medical justification for use of the requested medication over ALL preferred* injectable testosterone agents

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

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

Approval Criteria

1 - Must meet BOTH of the following:

1.1 History of the requested medication within the past 120 days, confirmed by claims history or chart documentation

AND

1.2 Submission of documentation of total testosterone less than or equal to 1000 ng/dL within the past 6 months

AND

2 - ONE of the following:

- Previous trial and failure of at least one preferred* injectable agent, as confirmed by claims history, chart documentation, or provider attestation including dates of trial
- Medical justification for use of the requested medication over ALL preferred* injectable testosterone agents

AND

3 - Prescriber attests that the patient remains a candidate for treatment, indicating that they have NOT developed any of the contraindication(s) listed in initial authorization criteria (breast cancer in a patient assigned male at birth, hypogonadal conditions not associated with structural or genetic etiologies, pregnancy, prostate cancer)

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:Methitest, methyltestosterone caps	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Must have ONE of the following indications for treatment:

- Cryptorchidism
- Delayed puberty
- Hypogonadism (primary or hypogonadotropic) with submission of documentation of a total testosterone level less than or equal to 350 ng/dL within the past 3 months
- Palliative treatment of metastatic breast cancer

AND

2 - Provider attests that the patient does NOT have any of the following contraindications to therapy:

- Breast cancer in a patient assigned male at birth
- Pregnancy
- Prostate cancer

AND

3 - ONE of the following:

- Previous trial and failure of a preferred* injectable agent, as confirmed by claims history, chart documentation, or provider attestation including dates of trial
- Medical justification for use over ALL preferred* injectable agents

AND

4 - ONE of the following:

4.1 If the request is for breast cancer indication, the requested dose does NOT exceed 50 capsules or tablets per day

OR

4.2 For all other indications, the requested dose does NOT exceed 5 capsules or tablets per day

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name:Methitest, methyltestosterone caps	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of delayed puberty, palliative treatment of metastatic breast cancer, or cryptorchidism AND all of the following: 1.1 History of the requested medication for at least 90 days within the past 120 days, confirmed by claims history or chart documentation AND 1.2 Documentation from prescriber indicating continued benefit from the medication without significant adverse events AND 1.3 ONE of the following: • Previous trial and failure of a preferred* injectable agent, as confirmed by claims history, chart documentation, or provider attestation including dates of trial • Medical justification for use over ALL preferred* injectable agents AND 1.4 Prescriber attests that the patient remains a candidate for treatment, indicating that they have NOT developed any of the contraindication(s) listed in initial authorization criteria (breast cancer in a patient assigned male at birth, pregnancy, prostate cancer)	

AND

1.5 ONE of the following:

1.5.1 If the request is for breast cancer indication, the requested dose does NOT exceed 50 capsules or tablets per day

OR

1.5.2 For all other indications, the requested dose does NOT exceed 5 capsules or tablets per day

OR

2 - Diagnosis of hypogonadism AND all of the following:

2.1 History of the requested medication within the past 120 days, confirmed by claims history or chart documentation

AND

2.2 Submission of documentation of total testosterone level less than or equal to 1000 ng/dL within the past 6 months

AND

2.3 ONE of the following:

- Previous trial and failure of a preferred* injectable agent, as confirmed by claims history, chart documentation, or provider attestation including dates of trial
- Medical justification for use over ALL preferred* injectable agents

AND

2.4 Prescriber attests that the patient remains a candidate for treatment, indicating that they

have NOT developed any of the contraindication(s) listed in initial authorization criteria (breast cancer in a patient assigned male at birth, pregnancy, prostate cancer)

AND

2.5 The requested dose does NOT exceed 5 capsules or tablets per day

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name: Tlando	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

- Patient is 18 years of age or older
- Diagnosis of hypogonadism
- Submission of documentation of total testosterone level less than or equal to 350 ng/dL (nanograms/deciliter) within the past 3 months

AND

2 - Provider attests that the patient does NOT have any of the following contraindications to therapy:

- Breast cancer
- Hypogonadal conditions not associated with structural or genetic etiologies
- Pregnancy
- Prostate cancer

AND

3 - ONE of the following:

• Previous trial and failure of a preferred* injectable agent, as confirmed by claims history, chart documentation, or provider attestation including dates of trial • Medical justification for use over ALL preferred* injectable agents	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name: Tlando	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested medication within the past 120 days, confirmed by claims history or chart documentation AND 2 - Submission of documentation of total testosterone less than or equal to 1000 ng/dL within the past 6 months AND 3 - ONE of the following: • Previous trial and failure of a preferred* injectable agent, as confirmed by claims history, chart documentation, or provider attestation including dates of trial • Medical justification for use over ALL preferred* injectable agents AND 4 - Prescriber attests that the patient remains a candidate for treatment, indicating that they have NOT developed any of the contraindication(s) listed in initial authorization criteria (breast cancer, hypogonadal conditions not associated with structural or genetic etiologies, pregnancy, prostate cancer)	

Product Name: Undecatrex	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

- Patient is 18 years of age or older
- Diagnosis of hypogonadism
- Submission of documentation of total testosterone level less than or equal to 350 ng/dL (nanograms/deciliter) within the past 3 months

AND

2 - Provider attests that the patient does NOT have any of the following contraindications to therapy:

- Breast cancer in a patient assigned male at birth
- Hypogonadal conditions not associated with structural or genetic etiologies
- Pregnancy
- Prostate cancer

AND

3 - ONE of the following:

- Previous trial and failure of Jatenzo AND Tlando, as confirmed by claims history, chart documentation, or provider attestation including dates of trial
- Medical justification for use of the requested medication over Jatenzo AND Tlando

Product Name: Undecatrex	
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested medication within the past 120 days, confirmed by claims history or chart documentation AND 2 - Submission of documentation of total testosterone less than or equal to 1000 ng/dL within the past 6 months AND 3 - ONE of the following: • Previous trial and failure of Jatenzo AND Tlando, as confirmed by claims history, chart documentation, or provider attestation including dates of trial • Medical justification for use of the requested medication over Jatenzo AND Tlando AND 4 - Prescriber attests that the patient remains a candidate for treatment, indicating that they have NOT developed any of the contraindication(s) listed in initial authorization criteria (breast cancer in a patient assigned male at birth, hypogonadal conditions not associated with structural or genetic etiologies, pregnancy, prostate cancer)	

2 . Revision History

Date	Notes
6/4/2025	Removed obsolete Androderm and Androgel GPIs. Added Azmiro. Updated 1 year(s) authorization length to 12 month(s).

Thalomid



Prior Authorization Guideline

Guideline ID	GL-373190
Guideline Name	Thalomid
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 Virginia Medicaid - Community & State Indiana Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	9/1/2025

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	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: • Used for acute treatment • Used as maintenance therapy for prevention and suppression of cutaneous manifestations of ENL recurrence	

Product Name:Thalomid	
Diagnosis	Castleman Disease (CD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Castleman Disease (CD)

AND

2 - ONE of the following:

2.1 NOT used as first line therapy

OR

2.2 ALL of the following:

- Therapy is for active idiopathic multicentric CD with no evidence of organ failure
- Used in combination with cyclophosphamide and prednisone
- Patient is human immunodeficiency virus (HIV)-negative
- Patient is human herpesvirus-8 (HHV8)-negative

Product Name:Thalomid	
Diagnosis	Kaposi Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Diagnosis of HIV (human immunodeficiency virus)-negative Kaposi Sarcoma OR	

1.2 BOTH of the following:

- Diagnosis of AIDS-related Kaposi Sarcoma
- Patient is currently being treated with antiretroviral therapy (ART) as confirmed by claims history or submission of medical records

AND

2 - NOT used as first line therapy

AND

3 - Patient has immune reconstitution inflammatory syndrome (IRIS)

Product Name:Thalomid	
Diagnosis	Langerhans Cell Histiocytosis, Rosai-Dorfman Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Langerhans cell histiocytosis OR 2 - Diagnosis of Rosai-Dorfman Disease	

Product Name:Thalomid	
Diagnosis	Pediatric medulloblastoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of pediatric medulloblastoma AND 2 - Disease is recurrent or progressive	

Product Name:Thalomid	
Diagnosis	Multiple Myeloma, Castleman Disease (CD), Kaposi Sarcoma, Langerhans Cell Histiocytosis, Rosai-Dorfman Disease, Pediatric medulloblastoma
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 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	

Product Name:Thalomid	
Diagnosis	Erythema Nodosum Leprosum (ENL), 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
8/19/2025	Updated formularies to add IN

Therapeutic Duplication (Subtype A)



Prior Authorization Guideline

Guideline ID	GL-599194
Guideline Name	Therapeutic Duplication (Subtype A)
Formulary	Medicaid - Community & State Indiana Medicaid - Community & State Nevada

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, Lonhala 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/cafeine, 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, meclofenamate 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, Jantoven, warfarin tabs, Pradaxa, generic dabigatran, Eliquis, Savaysa, Xarelto, 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 (USP-NF)

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 (document special circumstances)

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, Exdensusur, 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.

Tibsovo



Prior Authorization Guideline

Guideline ID	GL-599214
Guideline Name	Tibsovo
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Tibsovo	
Diagnosis	Acute Myeloid Leukemia (AML)

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of acute myeloid leukemia (AML) AND 2 - AML is IDH1 (isocitrate dehydrogenase-1) mutation-positive AND 3 - ONE of the following: 3.1 Disease is relapsed or refractory OR 3.2 BOTH of the following: 3.2.1 New diagnosis of AML AND 3.2.2 ONE of the following: • Patient is 75 years of age or older • Patient has comorbidities that preclude the use of intensive induction chemotherapy • Patient is not a candidate for or declines intensive induction therapy • Patient is receiving post-induction therapy following response to previous lower intensity therapy	

Product Name: Tibsovo

Diagnosis	Bone Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chondrosarcoma AND 2 - Susceptible IDH1 (isocitrate dehydrogenase-1) mutation-positive AND 3 - Disease is ONE of the following: • Conventional (grades 1-3) • Dedifferentiated	

Product Name: Tibsovo	
Diagnosis	Biliary Tract Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of cholangiocarcinoma AND	

2 - Susceptible IDH1 (isocitrate dehydrogenase-1) mutation-positive

AND

3 - Disease is ONE of the following:

- Locally advanced
- Unresectable
- Metastatic

AND

4 - Disease has progressed on or after systemic treatment

Product Name:Tibsovo	
Diagnosis	Oligodendroglioma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of oligodendroglioma AND 2 - Disease is recurrent or progressive AND 3 - Presence of BOTH of the following: • IDH1 (isocitrate dehydrogenase-1) mutation	

- 1p19q codeletion

AND

4 - Disease is WHO (World Health Organization) grade 2 or 3

Product Name:Tibsovo	
Diagnosis	Astrocytoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of astrocytoma AND 2 - Disease is recurrent or progressive AND 3 - Presence of IDH1 (isocitrate dehydrogenase-1) mutation AND 4 - Disease is WHO (World Health Organization) grade 2, 3, or 4	

Product Name:Tibsovo	
Diagnosis	Myelodysplastic Syndrome (MDS)
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of myelodysplastic syndrome (MDS) AND 2 - Disease is relapsed or refractory AND 3 - Presence of IDH1 (isocitrate dehydrogenase-1) mutation	

Product Name:Tibsovo	
Diagnosis	Acute Myeloid Leukemia (AML), Bone Cancer, Biliary Tract Cancer, Oligodendroglioma, Astrocytoma, 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 Tibsovo therapy	

Product Name:Tibsovo	
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:Tibsovo	
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 Tibsovo therapy	

2 . Revision History

Date	Notes
4/29/2026	Added IN.

Tobramycin Inhalation



Prior Authorization Guideline

Guideline ID	GL-479208
Guideline Name	Tobramycin Inhalation
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 Indiana Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Generic tobramycin 300 mg/5mL nebu soln (generic TOBI)	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of cystic fibrosis (CF)

OR

2 - BOTH of the following:

2.1 Diagnosis of noncystic fibrosis bronchiectasis

AND

2.2 ONE of the following:

2.2.1 Three or more exacerbations per year

OR

2.2.2 Two or more exacerbations requiring hospitalization per year

Product Name: Kitabis Pak, Brand Tobi nebu soln, Tobi Podhaler, Brand Bethkis, generic tobramycin 300 mg/4mL nebu soln (generic Bethkis), Brand Tobramycin solution for inhalation

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

Approval Criteria

1 - ONE of the following:

1.1 Diagnosis of cystic fibrosis (CF)

OR

1.2 BOTH of the following:

1.2.1 Diagnosis of noncystic fibrosis bronchiectasis

AND

1.2.2 ONE of the following:

1.2.2.1 Three or more exacerbations per year

OR

1.2.2.2 Two or more exacerbations requiring hospitalization per year

AND

2 - Lung infection with positive culture demonstrating *Pseudomonas aeruginosa* infection

AND

3 - ONE of the following:

3.1 Failure to generic tobramycin 300 mg/5mL solution for inhalation (generic TOBI) as confirmed by claims history or submission of medical records

OR

3.2 History of contraindication or intolerance to generic tobramycin 300 mg/5mL solution for inhalation (generic TOBI) (please specify contraindication or intolerance)

Product Name: Kitabis Pak, Brand Tobi nebu soln, Tobi Podhaler, Brand Bethkis, generic tobramycin 300 mg/4mL nebu soln (generic Bethkis), Brand Tobramycin solution for inhalation

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
12/15/2025	Updated formularies to include IN for eff 1/1/26.

Tolvaptan



Prior Authorization Guideline

Guideline ID	GL-439214
Guideline Name	Tolvaptan
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 Virginia Medicaid - Community & State Pennsylvania 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 Jynarque, generic tolvaptan tab, generic tolvaptan pack	
Diagnosis	Autosomal dominant polycystic kidney disease (ADPKD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of autosomal dominant polycystic kidney disease (ADPKD)	
Notes	This criteria comes from the Jynarque policy.

Product Name:Brand Jynarque, generic tolvaptan tab, generic tolvaptan pack	
Diagnosis	Autosomal dominant polycystic kidney disease (ADPKD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy	
Notes	This criteria comes from the Jynarque policy.

Product Name:Brand Samsca, generic tolvaptan tab	
Diagnosis	Hypervolemic or Euvolemic Hyponatremia
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	
Notes	This criteria comes from the Samsca policy.

2 . Revision History

Date	Notes
11/5/2025	Added Nevada Formulary

Topical Anti-Inflammatory Agents, NSAIDs



Prior Authorization Guideline

Guideline ID	GL-161715
Guideline Name	Topical Anti-Inflammatory Agents, NSAIDs
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2025

1 . Criteria

Product Name: Diclofenac epolamine patch, generic diclofenac topical solution	
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 Physician documentation indicating oral medications are unsuitable for use	

AND

1.1.2 Trial and failure of BOTH of the following:

- Diclofenac 1% gel
- Pennsaid topical solution

OR

1.2 Medical justification for use over the preferred* agents

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

2 . Revision History

Date	Notes
12/5/2024	Removed Flector patch and Licart as targets from the guideline. Updated product name list and GPI table accordingly. Updated criteria and notes sections. Minor cosmetic updates.

Topical Immunomodulator Agents



Prior Authorization Guideline

Guideline ID	GL-545238
Guideline Name	Topical Immunomodulator Agents
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:generic pimecrolimus cream, tacrolimus 0.03% ointment	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is 2 years of age or older	

AND

2 - ONE of the following:

2.1 Greater than or equal to 30 days of drug therapy with topical corticosteroids, supported by chart documentation, claims history, or prescriber attestation including dates of trial

OR

2.2 Prescriber has provided valid medical justification for the use of the requested agent over topical corticosteroids (please document justification)

Product Name:generic pimecrolimus cream, tacrolimus 0.03% ointment	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested agent within the past 180 days	

Product Name:tacrolimus 0.1% ointment	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is 16 years of age or older	

AND

2 - ONE of the following:

2.1 Greater than or equal to 30 days of drug therapy with topical corticosteroids, supported by chart documentation, claims history, or prescriber attestation including dates of trial

OR

2.2 Prescriber has provided valid medical justification for the use of the requested agent over topical corticosteroids (please document justification)

Product Name: tacrolimus 0.1% ointment	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested agent within the past 180 days	

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

AND

2 - Patient is 3 months of age or older

AND

3 - ONE of the following:

3.1 Greater than or equal to 30 days of drug therapy with ONE of the following, supported by chart documentation, claims history, or prescriber attestation including dates of trial:

- Topical corticosteroids
- Topical calcineurin inhibitors (pimecrolimus OR tacrolimus)*

OR

3.2 Prescriber has provided valid medical justification for the use of the requested agent over topical corticosteroids, pimecrolimus, AND tacrolimus (please document justification)

AND

4 - Requested quantity does NOT exceed 300 grams per year

Notes	*Those under 2 years of age are exempt from tacrolimus and pimecrolimus step therapy requirement (topical corticosteroids are still required).

Product Name:Eucrisa	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested agent within the past 365 days	

AND

2 - Patient demonstrates positive clinical response to therapy (e.g., improvement/stabilization in symptoms of the respective disease from baseline) (submission of medical records is required)

AND

3 - Requested quantity does NOT exceed 300 grams per year

Product Name:Opzelura

Approval Length	1 year(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 mild to moderate atopic dermatitis

AND

1.1.2 Patient is 2 years of age or older

AND

1.1.3 ONE of the following:

1.1.3.1 Greater than or equal to 30 days of drug therapy with ONE of the following, supported by chart documentation, claims history, or prescriber attestation including dates of trial:

- Topical corticosteroids
- Topical calcineurin inhibitors (pimecrolimus OR tacrolimus)

OR

1.1.3.2 Prescriber has provided valid medical justification for the use of the requested agent over topical corticosteroids, pimecrolimus, AND tacrolimus (please document justification)

OR

1.2 ALL of the following:

1.2.1 Diagnosis of non-segmental vitiligo

AND

1.2.2 Patient is 12 years of age or older

AND

1.2.3 ONE of the following:

1.2.3.1 Greater than or equal to 90 days of drug therapy with ONE of the following, supported by chart documentation, claims history, or prescriber attestation including dates of trial:

- Topical corticosteroids
- Topical tacrolimus

OR

1.2.3.2 Prescriber has provided valid medical justification for the use of the requested agent over topical corticosteroids AND tacrolimus (please document justification)

AND

2 - Patient will NOT be using concurrently with therapeutic biologics, other Janus kinase inhibitors, or potent immunosuppressants such as azathioprine or cyclosporine

AND

3 - Requested quantity does NOT exceed 360 grams per year

Product Name:Opzelura

Approval Length	1 year(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - History of the requested agent within the past 180 days

AND

2 - Patient demonstrates positive clinical response to therapy (e.g., improvement/stabilization in symptoms of the respective disease from baseline) (submission of medical records is required)

AND

3 - Requested quantity does NOT exceed 360 grams per year

Product Name:Zoryve 0.05% cream

Approval Length	6 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of mild to moderate atopic dermatitis

AND

2 - Patient is 2 years of age or older AND less than 6 years of age

AND

3 - ONE of the following:

3.1 Greater than or equal to 60 days of drug therapy with topical Eucrisa (crisaborole), supported by chart documentation, claims history, or prescriber attestation including dates of trial

OR

3.2 Prescriber has provided valid medical justification for the use of the requested agent over topical Eucrisa (crisaborole) (please document justification)

AND

4 - Requested quantity does NOT exceed 360 grams per year

Product Name:Zoryve 0.05% cream	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - History of the requested agent within the past 180 days

AND

2 - Patient demonstrates positive clinical response to therapy (e.g., improvement/stabilization in symptoms of the respective disease from baseline) (submission of medical records is required)

AND

3 - Requested quantity does NOT exceed 360 grams per year

Product Name: Zoryve 0.15% cream

Approval Length	6 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of mild to moderate atopic dermatitis

AND

2 - Patient is 6 years of age or older

AND

3 - ONE of the following:

3.1 Greater than or equal to 60 days of drug therapy with topical Eucrisa (crisaborole), supported by chart documentation, claims history, or prescriber attestation including dates of trial

OR

3.2 Prescriber has provided valid medical justification for the use of the requested agent over topical Eucrisa (crisaborole) (please document justification)

AND

4 - Requested quantity does NOT exceed 360 grams per year

Product Name: Zoryve 0.15% cream

Approval Length	1 year(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - History of the requested agent within the past 180 days

AND

2 - Patient demonstrates positive clinical response to therapy (e.g., improvement/stabilization in symptoms of the respective disease from baseline) (submission of medical records is required)

AND

3 - Requested quantity does NOT exceed 360 grams per year

Product Name: Zoryve 0.3% cream

Approval Length	6 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of plaque psoriasis, including intertriginous areas AND 2 - Patient is 6 years of age or older AND 3 - ONE of the following: 3.1 Greater than or equal to 90 days of drug therapy with each of the following, supported by chart documentation, claims history, or prescriber attestation including dates of trial: • Topical corticosteroids • Topical calcineurin inhibitors (pimecrolimus OR tacrolimus) OR 3.2 Prescriber has provided valid medical justification for the use of the requested agent over topical corticosteroids, pimecrolimus, AND tacrolimus (please document justification) AND 4 - Requested quantity does NOT exceed 360 grams per year	

Product Name: Zoryve 0.3% cream	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - History of the requested agent within the past 180 days

AND

2 - Patient demonstrates positive clinical response to therapy (e.g., improvement/stabilization in symptoms of the respective disease from baseline) (submission of medical records is required)

AND

3 - Requested quantity does NOT exceed 360 grams per year

Product Name: Zoryve foam

Approval Length	6 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 seborrheic dermatitis

AND

1.1.2 Patient is 9 years of age or older

AND

1.1.3 ONE of the following:

1.1.3.1 Greater than or equal to 30 days of drug therapy with a product from each of the following categories, supported by chart documentation, claims history, or prescriber attestation including dates of trial:

- Topical antifungal (ciclopirox OR ketoconazole)
- Topical corticosteroid
- Topical calcineurin inhibitors (pimecrolimus OR tacrolimus)

OR

1.1.3.2 Prescriber has provided valid medical justification for the use of the requested agent over topical antifungals, topical corticosteroids, pimecrolimus, AND tacrolimus (please document justification)

OR

1.2 ALL of the following:

1.2.1 Diagnosis of plaque psoriasis of the scalp and body

AND

1.2.2 Patient is 12 years of age or older

AND

1.2.3 ONE of the following:

1.2.3.1 Greater than or equal to 90 days of drug therapy with each of the following, supported by chart documentation, claims history, or prescriber attestation including dates of trial:

- Topical corticosteroids
- Topical calcineurin inhibitors (pimecrolimus OR tacrolimus)

OR

1.2.3.2 Prescriber has provided valid medical justification for the use of the requested agent over topical corticosteroids, pimecrolimus, AND tacrolimus (please document justification)

AND

2 - Requested quantity does NOT exceed 360 grams per year

Product Name:Zoryve foam

Approval Length	1 year(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - History of the requested agent within the past 180 days

AND

2 - Patient demonstrates positive clinical response to therapy (e.g., improvement/stabilization in symptoms of the respective disease from baseline) (submission of medical records is required)

AND

3 - Requested quantity does NOT exceed 360 grams per year

Product Name:Vtama

Approval Length	6 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 atopic dermatitis

AND

1.1.2 Patient is 2 years of age or older

AND

1.1.3 ONE of the following:

1.1.3.1 Greater than or equal to 30 days of drug therapy with ONE of the following, supported by chart documentation, claims history, or prescriber attestation including dates of trial:

- Topical corticosteroids
- Topical calcineurin inhibitors (pimecrolimus OR tacrolimus)

OR

1.1.3.2 Prescriber has provided valid medical justification for the use of the requested agent over topical corticosteroids, pimecrolimus, AND tacrolimus (please document justification)

OR

1.2 ALL of the following:

1.2.1 Diagnosis of plaque psoriasis

AND

1.2.2 Patient is 18 years of age or older

AND

1.2.3 ONE of the following:

1.2.3.1 Greater than or equal to 90 days of drug therapy with ONE of the following, supported by chart documentation, claims history, or prescriber attestation including dates of trial:

- Topical corticosteroids
- Topical calcineurin inhibitors (pimecrolimus OR tacrolimus)

OR

1.2.3.2 Prescriber has provided valid medical justification for the use of the requested agent over topical corticosteroids, pimecrolimus, AND tacrolimus (please document justification)

AND

2 - Requested quantity does NOT exceed 360 grams per year

Product Name:Vtama	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested agent within the past 180 days AND 2 - Patient demonstrates positive clinical response to therapy (e.g., improvement/stabilization)	

in symptoms of the respective disease from baseline) (submission of medical records is required)

AND

3 - Requested quantity does NOT exceed 360 grams per year

Product Name: Anzupgo

Approval Length	6 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe chronic hand eczema (CHE) that has persisted for more than 3 months or returned twice or more within the last 12 months (submission of medical records supporting chronicity is required)

AND

2 - Patient is 18 years of age or older

AND

3 - ONE of the following:

3.1 Greater than or equal to 30 days of drug therapy with topical corticosteroids, supported by chart documentation, claims history, or prescriber attestation including dates of trial

OR

3.2 Prescriber has provided valid medical justification for the use of the requested agent over topical corticosteroids (please document justification)

AND

4 - Patient will NOT be using concurrently with therapeutic biologics, other Janus kinase inhibitors, or potent immunosuppressants such as azathioprine or cyclosporine

AND

5 - Requested quantity does NOT exceed 60 grams per month

Product Name:Anzupgo	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested agent within the past 90 days AND 2 - Patient will NOT be using concurrently with therapeutic biologics, other Janus kinase inhibitors, or potent immunosuppressants, such as azathioprine or cyclosporine AND 3 - Patient demonstrates positive clinical response to therapy (e.g., hand eczema clarity, reduction in itch/pain, etc.) (submission of medical records is required) AND 4 - Requested quantity does NOT exceed 60 grams per month	

2 . Revision History

Date	Notes
3/11/2026	Removed Elidel. Added language to populate free text box for justification of use over other products.

Topical Post-Herpetic Neuralgia Agents



Prior Authorization Guideline

Guideline ID	GL-161834
Guideline Name	Topical Post-Herpetic Neuralgia Agents
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2025

1 . Criteria

Product Name: Qutenza	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has tried lidocaine patches AND	

2 - Patient has tried over-the-counter capsaicin cream

Product Name:Ztlido	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has previous trial of at least 30 days of therapy with preferred lidocaine 5% patches*	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

2 . Revision History

Date	Notes
12/10/2024	Added Ztlido

Transthyretin Impacting Agents



Prior Authorization Guideline

Guideline ID	GL-531209
Guideline Name	Transthyretin Impacting Agents
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Amvuttra	
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 ONE of the following:

- Cardiomyopathy associated with transthyretin-mediated amyloidosis (ATTR)
- Polyneuropathy associated with hereditary ATTR

AND

3 - Submission of medical records (e.g., charts, labs, progress notes, etc.) of ONE of the following confirming ATTR diagnosis:

- Imaging
- Histological testing
- Genetic testing

AND

4 - ONE of the following:

- For cardiomyopathy associated with ATTR diagnosis: Amvuttra (vutrisiran) must be prescribed by, or in consultation with, a cardiologist
- For polyneuropathy associated with hereditary ATTR: Amvuttra (vutrisiran) must be prescribed by, or in consultation with, a neurologist

AND

5 - Prescriber attests that the patient will NOT be using Amvuttra (vutrisiran) with any other transthyretin silencer(s) or stabilizer(s)

AND

6 - Requested dose does NOT exceed 25 mg (milligrams) every 3 months

Product Name:Amvuttra	
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested medication within the past 120 days AND 2 - Prescriber attests that the patient will NOT be using Amvuttra (vutrisiran) with any other transthyretin silencer(s) or stabilizer(s) AND 3 - Requested dose does NOT exceed 25 mg (milligrams) every 3 months	

Product Name: Onpattro, Wainua	
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 polyneuropathy associated with hereditary ATTR (transthyretin amyloidosis) AND	

3 - Submission of medical records (e.g., charts, labs, progress notes, etc.) of ONE of the following confirming hereditary ATTR diagnosis:

- Imaging
- Histological testing
- Genetic testing

AND

4 - Prescribed by, or in consultation with, a neurologist

AND

5 - Prescriber attests that the patient will NOT be using the requested medication with any other transthyretin silencer(s) or stabilizer(s)

AND

6 - ONE of the following:

- For Onpattro (patisiran), the requested dose does NOT exceed 30 milligrams (15 milliliters) every 3 weeks
- For Wainua (eplontersen), the requested dose does NOT exceed 45 milligrams (0.8 milliliters) monthly

Product Name:Onpattro, Wainua	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested medication within the past 90 days	

AND

2 - Prescriber attests that the patient will NOT be using the requested medication with any other transthyretin silencer(s) or stabilizer(s)

AND

3 - ONE of the following:

- For Onpattro (patisiran), the requested dose does NOT exceed 30 milligrams (15 milliliters) every 3 weeks
- For Wainua (eplontersen), the requested dose does NOT exceed 45 milligrams (0.8 milliliters) monthly

Product Name:Attruby, Vyndamax	
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 cardiomyopathy associated with transthyretin-mediated amyloidosis (ATTR) AND 3 - Submission of medical records (e.g., charts, labs, progress notes, etc.) of ONE of the following confirming ATTR diagnosis: • Imaging	

- Histological testing
- Genetic testing

AND

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

AND

5 - Prescriber attests that the patient will NOT be using the requested medication with any other transthyretin silencer(s) or stabilizer(s)

AND

6 - ONE of the following:

- For Attruby, the requested dose does NOT exceed 1,424 milligrams (4 capsules) daily
- For Vyndamax, the requested dose does NOT exceed 61 milligrams (1 capsule) daily

Product Name:Attruby, Vyndamax	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested medication within the past 90 days AND 2 - Prescriber attests that the patient will NOT be using the requested medication with any other transthyretin silencer(s) or stabilizer(s)	

AND

3 - ONE of the following:

- For Attruby, the requested dose does NOT exceed 1,424 milligrams (4 capsules) daily
- For Vyndamax, the requested dose does NOT exceed 61 milligrams (1 capsule) daily

2 . Revision History

Date	Notes
2/26/2026	Added Amvuttra and Onpattro. Removed Vyndaqel. Combined Attruby and Vyndamax criteria and clarified diagnoses.

Truqap



Prior Authorization Guideline

Guideline ID	GL-202194
Guideline Name	Truqap
Formulary	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 EPP Medicaid - Community & State New York Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	4/1/2025

1 . Criteria

Product Name: Truqap	
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 - Disease is ONE of the following: • Locally advanced • Recurrent unresectable (local or regional) • Metastatic AND 3 - Disease is hormone receptor (HR)-positive AND 4 - Disease is human epidermal growth factor receptor 2 (HER2)-negative AND 5 - Presence of one or more PIK3CA/AKT1/PTEN-alterations AND 6 - ONE of the following: 6.1 Has progressed on at least one endocrine-based regimen in the metastatic setting (e.g., anastrozole, letrozole, exemestane, tamoxifen)	

OR

6.2 Recurrence on or within 12 months of completing adjuvant therapy

AND

7 - Used in combination with fulvestrant

Product Name:Truqap	
Diagnosis	Breast 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 Truqap therapy AND 2 - Used in combination with fulvestrant	

Product Name:Truqap	
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:Truqap

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 Truqap therapy

2 . Revision History

Date	Notes
2/25/2025	Combined formularies. Added new GPIs for Truqap therapy packs. F or BC initial auth section, added "recurrent unresectable (local or regional)" as an option for disease type.

Tukysa



Prior Authorization Guideline

Guideline ID	GL-594199
Guideline Name	Tukysa
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 Virginia Medicaid - Community & State New Mexico Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Tukysa	
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 - Disease is ONE of the following: - Advanced unresectable - Metastatic AND 3 - Disease is human epidermal growth factor receptor 2 (HER2)-positive AND 4 - Patient has been previously treated with an anti-HER2-based regimen in the metastatic setting (e.g., trastuzumab [Kanjinti, Ogivri, Trazimera], pertuzumab [Perjeta], ado-trastuzumab emtansine [Kadcyla]) AND 5 - Used in combination with trastuzumab (e.g., Kanjinti, Ogivri, Trazimera) and capecitabine (Xeloda)	

Product Name:Tukysa	
Diagnosis	CNS Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of brain metastases AND 2 - Disease is HER2 (human epidermal growth factor receptor 2) positive AND 3 - Patient has been previously treated with an anti-HER2-based regimen (e.g., trastuzumab [Kanjinti, Ogivri, Trazimera], pertuzumab [Perjeta], ado-trastuzumab emtansine [Kadcyla]) AND 4 - Used in combination with trastuzumab (e.g., Kanjinti, Ogivri, Trazimera) and capecitabine (Xeloda)	

Product Name:Tukysa	
Diagnosis	Colorectal Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of unresectable, advanced, or metastatic colorectal cancer [HER2-amplified and RAS (gene) and BRAF (gene) wild-type] AND	

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

AND

3 - ONE of the following:

3.1 Patient has previously been treated with ONE of the following regimens:

- Fluoropyrimidine-based chemotherapy
- Oxaliplatin-based chemotherapy
- Irinotecan-based chemotherapy

OR

3.2 Patient is not appropriate for intensive therapy

AND

4 - Used in combination with trastuzumab (e.g., Kanjinti, Ogivri, Trazimera)

Product Name:Tukysa	
Diagnosis	Biliary Tract Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following: • Gallbladder Cancer • Intrahepatic cholangiocarcinoma • Extrahepatic cholangiocarcinoma	

AND

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

AND

3 - Disease is ONE of the following:

- Unresectable
- Resected gross residual (R2)
- Metastatic

AND

4 - Patient has received at least one prior systemic therapy

AND

5 - Used in combination with trastuzumab (e.g., Kanjinti, Ogivri, Trazimera)

Product Name:Tukysa	
Diagnosis	Breast Cancer, CNS Cancers, Colorectal Cancer, Biliary Tract 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 Tukysa therapy	

Product Name:Tukysa	
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:Tukysa	
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 Tukysa therapy	

2 . Revision History

Date	Notes
4/23/2026	Changed wording for CNS cancers.

Turalio



Prior Authorization Guideline

Guideline ID	GL-479191
Guideline Name	Turalio
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Turalio

Diagnosis	Tenosynovial Giant Cell Tumor (TGCT)/Pigmented Villonodular Synovitis (PVNS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of tenosynovial giant cell tumor (TGCT)/pigmented villonodular synovitis (PVNS)	

Product Name:Turalio	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following: • Langerhans Cell Histiocytosis • Erdheim-Chester Disease • Rosai-Dorfman Disease AND 2 - Colony stimulating factor 1 receptor (CSF1R) mutation positive	

Product Name:Turalio	
Diagnosis	Tenosynovial Giant Cell Tumor (TGCT)/Pigmented Villonodular Synovitis (PVNS), Histiocytic Neoplasms
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 Turalio therapy	

Product Name:Turalio	
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:Turalio	
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 Turalio therapy	

2 . Revision History

Date	Notes

12/12/2025	Combined formularies. Minor verbiage update in initial auth section f or TGCT/PVNS, with no changes to clinical intent.

Twist



Prior Authorization Guideline

Guideline ID	GL-422560
Guideline Name	Twist
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	11/1/2025

1 . Criteria

Product Name:Twist	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - 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:

- Patient or caregiver is motivated to assume responsibility for self-care and insulin management
- 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

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

Approval Criteria

1 - Documentation of positive clinical response

2 . Revision History

Date	Notes
10/22/2025	New program

Tykerb



Prior Authorization Guideline

Guideline ID	GL-482195
Guideline Name	Tykerb
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name: Brand Tykerb, generic lapatinib	
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 - Disease is human epidermal growth factor receptor 2-positive (HER2+) AND 3 - ONE of the following: 3.1 ALL of the following: • Disease is recurrent unresectable (local or regional) or stage IV breast cancer • Disease is hormone receptor positive • Used in combination with an aromatase inhibitor [e.g., Aromasin (exemestane), Femara (letrozole), Arimidex (anastrozole)] OR 3.2 BOTH of the following: 3.2.1 ONE of the following: • Disease is recurrent unresectable (local or regional) or stage IV breast cancer • Breast cancer is unresponsive to preoperative systemic therapy AND 3.2.2 Used as fourth line therapy and beyond in combination with ONE of the following: • Herceptin (trastuzumab)	

- Xeloda (capecitabine)

Product Name: Brand Tykerb, generic lapatinib	
Diagnosis	Central Nervous System (CNS) Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following: 1.1 Diagnosis of brain metastases in human epidermal growth factor receptor 2 (HER2)-positive breast cancer AND 1.2 Used in combination with Xeloda (capecitabine) OR 2 - ALL of the following: 2.1 Diagnosis of progressive or recurrent intracranial or spinal ependymoma (excluding subependymoma) AND 2.2 Patient has received previous radiation therapy AND 2.3 ONE of the following:	

- Patient has received gross total or subtotal resection with negative cerebrospinal fluid (CSF) cytology
- Patient has received subtotal resection and evidence of metastasis (brain, spine, or CSF)
- Patient has unresectable disease

AND

2.4 Used in combination with Temodar (temozolomide)

Product Name:Brand Tykerb, generic lapatinib	
Diagnosis	Chordoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of recurrent conventional or chondroid chordoma AND 2 - Disease is epidermal growth factor receptor (EGFR)-positive	

Product Name:Brand Tykerb, generic lapatinib	
Diagnosis	Colon Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of colon cancer

AND

2 - Disease is ALL of the following:

2.1 Human epidermal growth factor receptor 2 (HER2)-amplified

AND

2.2 RAS wild-type

AND

2.3 BRAF wild-type

AND

3 - ONE of the following:

3.1 BOTH of the following:

3.1.1 ONE of the following:

3.1.1.1 Disease is proficient mismatch repair/microsatellite-stable (pMMR/MSS)

OR

3.1.1.2 BOTH of the following:

3.1.1.2.1 Disease is positive for ONE of the following:

- Deficient mismatch repair/microsatellite instability-high (dMMR/MSI-H)
- Polymerase epsilon/delta (POLE/POLD1) mutation with ultra-hypermutated phenotype [tumor mutation burden (TMB) greater than 50 mut/Mb (mutations/megabase)]

AND

3.1.1.2.2 Ineligible for, progressed on, or has a contraindication to checkpoint inhibitor immunotherapy [e.g., Opdivo (nivolumab), Keytruda (pembrolizumab), Jemperli (dostarlimab-gxly)]

AND

3.1.2 ONE of the following:

3.1.2.1 BOTH of the following:

- Used as initial therapy for unresectable metachronous metastases
- Previous therapy with FOLFOX (fluorouracil, leucovorin, and oxaliplatin) or CapeOX (capecitabine and oxaliplatin) within the past 12 months

OR

3.1.2.2 Intensive chemotherapy is not recommended

OR

3.1.2.3 Used as second-line and subsequent therapy for progression of advanced or metastatic disease

OR

3.2 BOTH of the following:

3.2.1 Used in combination with hepatic artery infusion

AND

3.2.2 ONE of the following:

- Used for resectable synchronous liver metastases and undergoing synchronous or staged colectomy with liver resection

- Used for resectable metachronous metastases and undergoing resection

AND

4 - Used in combination with trastuzumab

AND

5 - Patient has not previously been treated with a HER2 inhibitor [e.g., trastuzumab, Perjeta (pertuzumab), Nerlynx (neratinib)]

Product Name: Brand Tykerb, generic lapatinib

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

Approval Criteria

1 - Diagnosis of rectal cancer

AND

2 - Disease is ALL of the following:

2.1 Human epidermal growth factor receptor 2 (HER2)-amplified

AND

2.2 RAS wild-type

AND

2.3 BRAF wild-type

AND

3 - ONE of the following:

3.1 BOTH of the following:

3.1.1 ONE of the following:

3.1.1.1 Disease is proficient mismatch repair/microsatellite-stable (pMMR/MSS)

OR

3.1.1.2 BOTH of the following:

3.1.1.2.1 Disease is positive for ONE of the following:

- Deficient mismatch repair/microsatellite instability-high (dMMR/MSI-H)
- Polymerase epsilon/delta (POLE/POLD1) mutation with ultra-hypermutated phenotype [tumor mutation burden (TMB) greater than 50 mut/Mb (mutations/megabase)]

AND

3.1.1.2.2 Ineligible for, progressed on, or has a contraindication to checkpoint inhibitor immunotherapy [e.g., Opdivo (nivolumab), Keytruda (pembrolizumab), Jemperli (dostarlimab-gxly)]

AND

3.1.2 ONE of the following:

3.1.2.1 BOTH of the following:

- Used as initial therapy for unresectable metachronous metastases
- Previous therapy with FOLFOX (fluorouracil, leucovorin, and oxaliplatin) or CapeOX (capecitabine and oxaliplatin) within the past 12 months

OR

3.1.2.2 Intensive chemotherapy is not recommended

OR

3.1.2.3 Used as second-line and subsequent therapy for progression of advanced or metastatic disease

OR

3.2 BOTH of the following:

3.2.1 Used in combination with hepatic artery infusion

AND

3.2.2 ONE of the following:

- Used for resectable metachronous metastases and undergoing resection
- Used for unresectable metachronous metastases that converted to resectable after initial therapy and undergoing resection

AND

4 - Used in combination with trastuzumab

AND

5 - Patient has not previously been treated with a HER2 inhibitor [e.g., trastuzumab, Perjeta (pertuzumab), Nerlynx (neratinib)]

Product Name:Brand Tykerb, generic lapatinib	
Diagnosis	Breast Cancer, Central Nervous System (CNS) Cancers, Chordoma, Colon Cancer, Rectal 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 Tykerb therapy	

Product Name:Brand Tykerb, generic lapatinib	
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:Brand Tykerb, generic lapatinib	
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 Tykerb therapy	

2 . Revision History

UnitedHealthcare Community Plan of Indiana Clinical Pharmacy Program Guidelines

Date	Notes
12/13/2025	Combined formularies. Updated criteria for breast cancer, central nervous system cancer, colon cancer, and rectal cancer.

Urea Cycle Disorder Agents



Prior Authorization Guideline

Guideline ID	GL-480223
Guideline Name	Urea Cycle Disorder Agents
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name: Brand Carbaglu, generic carglumic acid	
Diagnosis	Acute hyperammonemia due to N-acetylglutamate synthase (NAGS) deficiency
Approval Length	6 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of acute hyperammonemia due to N-acetylglutamate synthase (NAGS) deficiency (submission of chart documentation required)	

AND

2 - Dose requested does not exceed 250 mg/kg/day (milligrams per kilogram per day)

AND

3 - Submission of medical records (e.g., chart notes, assessments) confirming patient will be using Carbaglu (carglumic acid) as adjunctive therapy with standard ammonia lowering therapies

AND

4 - Prescribed by, or in consultation with, a metabolic geneticist or practitioner specialized in treating metabolic disorders

Product Name:Brand Carbaglu, generic carglumic acid	
Diagnosis	Acute hyperammonemia due to propionic acidemia (PA) or methylmalonic acidemia (MMA) hyperammonemia
Approval Length	6 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of acute hyperammonemia due to propionic acidemia (PA) or methylmalonic acidemia (MMA) hyperammonemia (submission of chart documentation required) AND 2 - ONE of the following: 2.1 Patient weighs less than or equal to 15 kg (kilograms) and the requested dose does not exceed 150 mg/kg/day (milligrams per kilograms per day)	

OR

2.2 Patients weighs greater than 15 kg and the requested dose does not exceed 3.3 grams/m²/day (grams per square meter per day)

AND

3 - Submission of medical records (e.g., chart notes, assessments) confirming patient will be using Carbaglu (carglumic acid) as adjunctive therapy with standard ammonia lowering therapies

AND

4 - Prescribed by, or in consultation with, a metabolic geneticist or practitioner specialized in treating metabolic disorders

Product Name:Brand Carbaglu, generic carglumic acid	
Diagnosis	Chronic hyperammonemia due to N-acetylglutamate synthase (NAGS) deficiency
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chronic hyperammonemia due to N-acetylglutamate synthase (NAGS) deficiency (submission of chart documentation required) AND 2 - Dose requested does not exceed 100 mg/kg/day (milligrams per kilogram per day)	

AND

3 - Prescribed by, or in consultation with, a metabolic geneticist or practitioner specialized in treating 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 - History of the requested agent within the past 90 days, confirmed by claims history or chart documentation AND 2 - Submission of medical records confirming evidence of continued clinical benefit (e.g., lower plasma ammonia levels, fewer hyperammonemic crises, etc.) AND 3 - Dose requested does not exceed 100 mg/kg/day (milligrams per kilogram per day)	

Product Name:Brand Buphenyl, generic sodium phenylbutyrate	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic urea cycle disorder requiring management in patients with at least ONE of the following enzymatic deficiency(ies) (submission of chart documentation required):

- Argininosuccinic acid synthetase (AS)
- Carbamylphosphate synthetase (CPS)
- Ornithine transcarbamylase (OTC)

AND

2 - Submission of medical records (e.g., chart notes, assessments) confirming patient will be using Buphenyl (sodium phenylbutyrate) as adjunctive therapy with standard ammonia lowering therapies

AND

3 - Prescribed by, or in consultation with, a metabolic geneticist or practitioner specialized in treating metabolic disorders

AND

4 - Requested dose does not exceed 20 grams per day

AND

5 - ONE of the following:

5.1 The request is for powder for oral solution and does not exceed 2 bottles per 25 days

OR

5.2 The request is for tablets, and BOTH of the following:

- The patient is an adult or pediatric patient weighing greater than or equal to 20 kg (kilograms)

- The requested quantity does not exceed 40 tablets per day (4 bottles per 25 days)

Product Name: Brand Buphenyl, generic sodium phenylbutyrate	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - History of the requested agent within the past 90 days, confirmed by claims history or chart documentation

AND

2 - Submission of medical records (e.g., chart notes, assessments) confirming patient has been using Buphenyl (sodium phenylbutyrate) as adjunctive therapy and will continue to use standard of care therapies while on Buphenyl therapy

AND

3 - Submission of medical records confirming evidence of continued clinical benefit (e.g., lower plasma ammonia levels, fewer hyperammonemic crises, etc.)

AND

4 - Requested dose does not exceed 20 grams per day

AND

5 - ONE of the following:

5.1 The request is for powder for oral solution and does not exceed 2 bottles per 25 days

OR

5.2 The request is for tablets, and BOTH of the following:

- The patient is an adult or pediatric patient weighing greater than or equal to 20 kg (kilograms)
- The requested quantity does not exceed 40 tablets per day (4 bottles per 25 days)

Product Name: Olpruva	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chronic urea cycle disorder requiring management in patients with at least ONE of the following enzymatic deficiency(ies) (submission of chart documentation required): • Argininosuccinic acid synthetase (AS) • Carbamylphosphate synthetase (CPS) • Ornithine transcarbamylase (OTC) AND 2 - BOTH of the following: • Patient is 1 year of age or older • Patients weighs 7 kg (kilograms) or greater AND 3 - Submission of medical records (e.g., chart notes, assessments) confirming patient will be using Olpruva (sodium phenylbutyrate) as adjunctive therapy with standard ammonia lowering therapies	

AND

4 - Prescribed by, or in consultation with, a metabolic geneticist or practitioner specialized in treating metabolic disorders

AND

5 - ONE of the following:

5.1 Patient has tried and failed at least 30 days of Buphenyl (sodium phenylbutyrate) AND 30 days Pheburane (sodium phenylbutyrate) therapy, confirmed by claims history or chart documentation

OR

5.2 Prescriber has submitted valid medical justification for the use of Olpruva (sodium phenylbutyrate) over Buphenyl (sodium phenylbutyrate) AND Pheburane (sodium phenylbutyrate)

AND

6 - Requested dose does not exceed 20 g/day (grams per day)

AND

7 - Requested quantity does not exceed 1 kit/90 packets per 30 days

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

Approval Criteria

1 - History of the requested agent within the past 90 days, confirmed by claims history or chart documentation

AND

2 - ONE of the following:

2.1 Patient has previous trial and failure of at least 30 days of Buphenyl (sodium phenylbutyrate) OR 30 days of Pheburane (sodium phenylbutyrate) therapy, confirmed by claims history or chart documentation

OR

2.2 Prescriber has submitted valid medical justification for the use of Olpruva (sodium phenylbutyrate) over Buphenyl (sodium phenylbutyrate) AND Pheburane (sodium phenylbutyrate)

AND

3 - Submission of medical records (e.g., chart notes, assessments) confirming patient has been using Olpruva (sodium phenylbutyrate) as adjunctive therapy and will continue to use standard of care therapies while on Olpruva therapy

AND

4 - Submission of medical records confirming evidence of continued clinical benefit (e.g., lower plasma ammonia levels, fewer hyperammonemic crises, etc.)

AND

5 - Requested dose does not exceed 20 g/day (grams per day)

AND

6 - Requested quantity does not exceed 1 kit/90 packets per 30 days

Product Name:Pheburane	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Management of chronic urea cycle disorder in patients at least ONE of the following enzymatic deficiency(ies) (submission of chart documentation required): • Argininosuccinic acid synthetase (AS) • Carbamylphosphate synthetase (CPS) • Ornithine transcarbamylase (OTC) AND 2 - Submission of medical records (e.g., chart notes, assessments) confirming patient will be using Pheburane (sodium phenylbutyrate) as adjunctive therapy with standard ammonia lowering therapies AND 3 - Prescribed by, or in consultation with, a metabolic geneticist or practitioner specialized in treating metabolic disorders AND 4 - Requested dose does not exceed 20 g/day (grams per day) AND 5 - Requested quantity does not exceed 7 bottles per 28 days	

Product Name:Pheburane	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested agent within the past 90 days, confirmed by claims history or chart documentation AND 2 - Submission of medical records (e.g., chart notes, assessments) confirming patient has been using Pheburane (sodium phenylbutyrate) as adjunctive therapy and will continue to use standard of care therapies while on Pheburane therapy AND 3 - Submission of medical records confirming evidence of continued clinical benefit (e.g., lower plasma ammonia levels, fewer hyperammonemic crises, etc.) AND 4 - Requested dose does not exceed 20 g/day (grams per day) AND 5 - Requested quantity does not exceed 7 bottles per 28 days	

Product Name:Brand Ravicti, generic glycerol phenylbutyrate	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic urea cycle disorder requiring management in patients who cannot be managed by dietary protein restriction and/or amino acid supplementation alone with at least ONE of the following enzymatic deficiency(ies) (submission of chart documentation required):

- Argininosuccinic acid synthetase (AS)
- Carbamylphosphate synthetase (CPS)
- Ornithine transcarbamylase (OTC)

AND

2 - Patient is 2 months of age or older

AND

3 - Prescriber attests patient is NOT being treated for N-acetylglutamate synthase (NAGS) deficiency

AND

4 - Submission of medical records (e.g., chart notes, assessments) confirming patient will be using Ravicti (glycerol phenylbutyrate) as adjunctive therapy with standard ammonia lowering therapies

AND

5 - Prescribed by, or in consultation with, a metabolic geneticist or practitioner specialized in treating metabolic disorders

AND

6 - ONE of the following:

6.1 Patient has tried and failed at least 30 days of sodium phenylbutyrate therapy (can cumulate Buphenyl, Pheburane, Olpruva), confirmed by claims history or chart documentation

OR

6.2 Prescriber has submitted valid medical justification for the use of Ravicti (glycerol phenylbutyrate) over all sodium phenylbutyrate products

AND

7 - Dose requested does not exceed 19 grams (17.5 milliliters) per day

AND

8 - Requested quantity does not exceed 21 bottles per 30 days

Product Name:Brand Ravicti, generic glycerol phenylbutyrate	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of the requested agent within the past 90 days, confirmed by claims history or chart documentation AND 2 - ONE of the following: 2.1 Patient has previous trial and failure of at least 30 days of sodium phenylbutyrate therapy (can cumulate Buphenyl, Pheburane, Olpruva), confirmed by claims history or chart documentation OR	

2.2 Prescriber has submitted valid medical justification for the use of Ravicti (glycerol phenylbutyrate) over all sodium phenylbutyrate products

AND

3 - Submission of medical records (e.g., chart notes, assessments) confirming patient has been using Ravicti (glycerol phenylbutyrate) as adjunctive therapy and will continue to use standard of care therapies while on Ravicti therapy

AND

4 - Submission of medical records confirming evidence of continued clinical benefit (e.g., lower plasma ammonia levels, fewer hyperammonemic crises, etc.)

AND

5 - Dose requested does not exceed 19 grams (17.5 milliliters) per day

AND

6 - Requested quantity does not exceed 21 bottles per 30 days

2 . Revision History

Date	Notes
12/17/2025	Added generic glycerol phenylbutyrate. Updated dosing and quantity limits for Buphenyl (sodium phenylbutyrate), Olpruva, Pheburane and Ravicti (glycerol phenylbutyrate) . Updated age and weight for Olpruva. Added submission of medical records for evidence of clinical benefit for all reauthorizations.

Urinary Tract Antispasmodic, Anti-Incontinence Agents



Prior Authorization Guideline

Guideline ID	GL-288204
Guideline Name	Urinary Tract Antispasmodic, Anti-Incontinence Agents
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	7/1/2025

1 . Criteria

Product Name: Myrbetriq granules	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is 3 years of age or older AND less than 12 years of age OR	

2 - Patient is unable to swallow tablets

Product Name:Vesicare LS

Approval Length 12 month(s)

Guideline Type Prior Authorization

Approval Criteria

1 - Patient is 2 years of age or older AND less than 12 years of age

OR

2 - Patient is unable to swallow tablets

Product Name:Gemtesa

Approval Length 12 month(s)

Guideline Type Prior Authorization

Approval Criteria

1 - Patient has tried and failed Myrbetriq

OR

2 - Prescriber has provided medical justification for the use of Gemtesa over Myrbetriq

2 . Revision History

Date	Notes

5/29/2025	Updated age criterion for Myrbetriq granules. Updated criteria for Gemtesa. Minor spelling/cosmetic updates.

Uterine Disorders



Prior Authorization Guideline

Guideline ID	GL-161798
Guideline Name	Uterine Disorders
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2025

1 . Criteria

Product Name: Myfembree	
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 - ONE of the following:

2.1 BOTH of the following:

2.1.1 Diagnosis of menorrhagia associated with uterine leiomyomas (fibroids) in a premenopausal female

AND

2.1.2 Previous trial and failure of hormonal contraceptives/therapy [oral tablets, vaginal ring, patch, intrauterine contraception (IUD)]

OR

2.2 BOTH of the following:

2.2.1 Diagnosis of moderate to severe pain associated with endometriosis in a premenopausal female

AND

2.2.2 One of the following:

2.2.2.1 Previous trial and failure of BOTH of the following:

- Hormonal contraceptives/therapy [oral tablets, vaginal ring, patch, intrauterine contraception (IUD)]
- NSAID (non-steroidal anti-inflammatory drug) therapy

OR

2.2.2.2 Prescriber has submitted valid medical rationale against the use of both hormonal contraceptives/therapy AND NSAID therapy

AND

3 - Must have a negative pregnancy test in the past 30 days

AND

4 - Must have laboratory tests confirming no hepatic disease in the past 30 days

AND

5 - Requested dose does not exceed 1 tablet (40/1/0.5mg) per day

AND

6 - Patient does NOT have current diagnosis of, risk factors for, or previous history of thromboembolic disorders or vascular events

AND

7 - Patient does NOT have a current diagnosis or history of breast cancer or other hormone-sensitive malignancies

AND

8 - Patient does NOT have increased risk factors for hormone-sensitive malignancies

AND

9 - Patient does NOT have a diagnosis of osteoporosis

AND

10 - Patient does NOT have undiagnosed abnormal uterine bleeding

Product Name: Myfembree

Approval Length 12 month(s)

Therapy Stage Reauthorization

Guideline Type Prior Authorization

Approval Criteria

1 - Patient has a history of the requested medication for at least 90 days within the past 120 days, confirmed by claims history or chart documentation

AND

2 - Patient will not be exceeding 24 total months of therapy per lifetime with relugolix/estradiol/norethindrone acetate (Myfembree)

AND

3 - Prescriber states that the patient remains a candidate for treatment, indicating that they have NOT developed any of the contraindication(s) listed below:

- Current diagnosis of, risk factors for, or previous history of thromboembolic disorders or vascular events
- Current diagnosis or history of breast cancer or other hormone-sensitive malignancies
- Increased risk factors for hormone-sensitive malignancies
- Diagnosis of osteoporosis
- Undiagnosed abnormal uterine bleeding

Product Name: Oriahnn

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 - Diagnosis of menorrhagia associated with uterine leiomyomas (fibroids) in a premenopausal female

AND

3 - Previous trial and failure of hormonal contraceptives/therapy [oral tablets, vaginal ring, patch, intrauterine contraception (IUD)]

AND

4 - Must have a negative pregnancy test in the past 30 days

AND

5 - Must have laboratory tests confirming no hepatic disease in the past 30 days

AND

6 - Requested dose does not exceed 2 capsules [1 x 300/1/0.5 mg (milligrams); 1 x 300 mg] per day

AND

7 - Patient will NOT have concurrent use of organic anion transporting polypeptide (OATP)1B1 inhibitors that are known or expected to significantly increase elagolix plasma concentrations (e.g., cyclosporine, gemfibrozil)

AND

8 - Patient does NOT have current diagnosis of, risk factors for, or previous history of thromboembolic disorders or vascular events

AND

9 - Patient does NOT have a current diagnosis or history of breast cancer or other hormone-sensitive malignancies

AND

10 - Patient does NOT have increased risk factors for hormone-sensitive malignancies

AND

11 - Patient does NOT have a diagnosis of osteoporosis

AND

12 - Patient does NOT have undiagnosed abnormal uterine bleeding

Product Name: Oriahnn	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has a history of the requested medication for at least 90 days within the past 120 days, confirmed by claims history or chart documentation	

AND

2 - Patient will not be exceeding 24 total months of therapy per lifetime with elagolix/estradiol/norethindrone acetate (Oriahnn)

AND

3 - Prescriber states that the patient remains a candidate for treatment, indicating that they have NOT developed any of the contraindication(s) listed below:

- Concurrent use of organic anion transporting polypeptide (OATP)1B1 inhibitors that are known or expected to significantly increase elagolix plasma concentrations (e.g., cyclosporine, gemfibrozil)
- Current diagnosis of, risk factors for, or previous history of thromboembolic disorders or vascular events
- Current diagnosis or history of breast cancer or other hormone-sensitive malignancies
- Increased risk factors for hormone-sensitive malignancies
- Diagnosis of osteoporosis
- Undiagnosed abnormal uterine bleeding

Product Name:Orilissa 150 mg	
Diagnosis	Endometriosis
Approval Length	Endometriosis alone: 12 month ; Endometriosis-related dyspareunia: 6 month approval maximum *
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is 18 years of age or older AND 2 - ONE of the following:	

2.1 BOTH of the following:

2.1.1 Diagnosis of moderate to severe pain associated with endometriosis

AND

2.1.2 Requested dose does not exceed 150 mg (milligrams) daily

OR

2.2 BOTH of the following:

2.2.1 Diagnosis of moderate to severe pain associated with endometriosis with co-existing endometriosis-related dyspareunia

AND

2.2.2 Requested dose does not exceed 400 mg daily for a maximum of 6 months

AND

3 - ONE of the following:

3.1 Previous trial and failure of BOTH of the following:

- Hormonal contraceptives/therapy [oral tablets, vaginal ring, patch, intrauterine contraception (IUD)]
- NSAID (non-steroidal anti-inflammatory drug) therapy

OR

3.2 Prescriber has submitted valid medical justification for the use of Orilissa (elagolix) over both hormonal contraceptives/therapy AND NSAID therapy

AND

4 - Patient has a negative pregnancy test in the past 30 days

AND

5 - ONE of the following:

5.1 Laboratory tests confirming no hepatic disease worse than Child-Pugh A in the past 30 days

OR

5.2 Patient has Child-Pugh B hepatic disease, and adjusted dosing will be limited to 150 mg daily for a maximum of 6 months**

AND

6 - Patient will NOT have concurrent use of organic anion transporting polypeptide (OATP)1B1 inhibitors that are known or expected to significantly increase elagolix plasma concentrations (e.g., cyclosporine, gemfibrozil)

AND

7 - Patient does NOT have a diagnosis of osteoporosis

Notes	* Patients with Child-Pugh class B hepatic impairment will be limited to the 150mg daily dose for a maximum of 6 months irrespective of indication.

Product Name:Orilissa 150 mg	
Diagnosis	Endometriosis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has a history of the requested medication for at least 90 days within the past 120 days, confirmed by claims history or chart documentation

AND

2 - Patient will not be exceeding 24 total months of therapy per lifetime with elagolix (Orilissa)

AND

3 - Prescriber states that the patient remains a candidate for treatment, indicating that they do NOT have concurrent use of organic anion transporting polypeptide (OATP)1B1 inhibitors that are known or expected to significantly increase elagolix plasma concentrations (e.g., cyclosporine, gemfibrozil)

AND

4 - Patient does NOT have a diagnosis of osteoporosis

Product Name:Orilissa 200 mg

Diagnosis	Endometriosis with Co-existing Endometriosis-Related Dyspareunia

Approval Length	6 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is 18 years of age or older

AND

2 - BOTH of the following:

2.1 Diagnosis of moderate to severe pain associated with endometriosis with co-existing endometriosis-related dyspareunia

AND

2.2 Requested dose does not exceed 400 mg (milligrams) daily for a maximum of 6 months

AND

3 - ONE of the following:

3.1 Previous trial and failure of BOTH of the following:

- Hormonal contraceptives/therapy [oral tablets, vaginal ring, patch, intrauterine contraception (IUD)]
- NSAID (non-steroidal anti-inflammatory drug) therapy

OR

3.2 Prescriber has submitted valid medical justification for the use of Orilissa (elagolix) over both hormonal contraceptives/therapy AND NSAID therapy

AND

4 - Patient has a negative pregnancy test in the past 30 days

AND

5 - Laboratory tests confirming no hepatic disease worse than Child-Pugh A in the past 30 days

AND

6 - Patient will NOT have concurrent use of organic anion transporting polypeptide (OATP)1B1 inhibitors that are known or expected to significantly increase elagolix plasma concentrations (e.g., cyclosporine, gemfibrozil)

AND

7 - Patient does NOT have a diagnosis of osteoporosis

2 . Revision History

Date	Notes
12/10/2024	Updated Myfembree criteria

Vafseo



Prior Authorization Guideline

Guideline ID	GL-461210
Guideline Name	Vafseo
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Pennsylvania Medicaid - Community & State Virginia Medicaid - Community & State Washington

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name: Vafseo	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of anemia due to chronic kidney disease (CKD)

AND

2 - Patient has been receiving dialysis for at least three months

AND

3 - BOTH of the following:

- Ferritin greater than 100 mcg/L
- Transferrin saturation (TSAT) greater than 20%

AND

4 - Hemoglobin level less than 11 g/dL

AND

5 - ONE of the following:

5.1 Failure to an erythropoietin stimulating agent (ESA) [e.g., Aranesp (darbepoetin), Epogen (epoetin alfa), Procrit (epoetin alfa), Retacrit (epoetin alfa-epbx)] as confirmed by claims history or submission of medical records

OR

5.2 History of contraindication or intolerance to an erythropoietin stimulating agent (ESA) [e.g., Aranesp (darbepoetin), Epogen (epoetin alfa), Procrit (epoetin alfa), Retacrit (epoetin alfa-epbx)] (please specify contraindication or intolerance)

AND

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

- Hematologist
- Nephrologist

Product Name: Vafseo

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Vafseo therapy (e.g., clinically meaningful increase in hemoglobin level)

AND

2 - Adequate iron stores confirmed by BOTH of the following:

- Ferritin greater than 100 mcg/L
- Transferrin saturation (TSAT) greater than 20%

AND

3 - Hemoglobin level does not exceed 11 g/dL

AND

4 - Patient is not on concurrent treatment with an erythropoietin stimulating agent (ESA) [e.g., Aranesp (darbepoetin), Epogen (epoetin alfa), Procrit (epoetin alfa), Retacrit (epoetin alfa-epbx)]

AND

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

- Hematologist
- Nephrologist

2 . Revision History

Date	Notes
11/20/2025	Updated formularies to include IN for eff 1/1/26.

Vaginal Antimicrobials



Prior Authorization Guideline

Guideline ID	GL-154729
Guideline Name	Vaginal Antimicrobials
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name:Xaciato gel	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Previous trial and failure of a preferred topical antibacterial agent*	
Notes	*PDL: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name: Tinidazole tablets	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has tried and failed metronidazole OR 2 - Prescriber has provided medical justification as to why metronidazole is not appropriate for use (e.g., infection being treated is not susceptible to preferred agent)	

2 . Revision History

Date	Notes
9/11/2024	New

Valchlor



Prior Authorization Guideline

Guideline ID	GL-509218
Guideline Name	Valchlor
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 Indiana Medicaid - Community & State Nebraska Medicaid - Community & State Nevada Medicaid - Community & State New Mexico Medicaid - Community & State Pennsylvania Medicaid - Community & State Virginia Medicaid - Community & State Washington

Guideline Note:

Effective Date:	2/1/2026

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	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Langerhans Cell Histiocytosis (LCH) AND 2 - Skin disease is unifocal and isolated	

Product Name:Valchlor

Diagnosis	Primary Cutaneous Lymphomas, Histiocytic Neoplasms
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 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	

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
1/27/2026	Combined formularies. Reorganized WA policy to match CORE since no changes to clinical intent.

Vanflyta



Prior Authorization Guideline

Guideline ID	GL-479213
Guideline Name	Vanflyta
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name: Vanflyta	
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 (AML) AND 2 - Disease is FLT3 internal tandem duplication (ITD) positive	

Product Name:Vanflyta	
Diagnosis	Myeloid/Lymphoid Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of lymphoid, myeloid, or mixed lineage neoplasms with eosinophilia in the chronic or blast phase AND 2 - Patient has an FLT3 rearrangement	

Product Name:Vanflyta	
Diagnosis	Acute Myeloid Leukemia, Myeloid/Lymphoid Neoplasms
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 Vanflyta therapy	

Product Name:Vanflyta	
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:Vanflyta	
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 Vanflyta therapy	

2 . Revision History

Date	Notes

12/15/2025	Updated formularies to include IN for eff 1/1/26.

Vecamyl



Prior Authorization Guideline

Guideline ID	GL-465190
Guideline Name	Vecamyl
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 Indiana Medicaid - Community & State Nebraska Medicaid - Community & State New Mexico Medicaid - Community & State Pennsylvania Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	1/1/2026

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
12/9/2025	Combined formularies. No changes to clinical criteria.

Venclexta



Prior Authorization Guideline

Guideline ID	GL-260192
Guideline Name	Venclexta
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland 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 Virginia Medicaid - Community & State Indiana Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2025

1 . Criteria

Product Name:Venclexta

Diagnosis	Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma (CLL/SLL)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL)	

Product Name:Venclexta	
Diagnosis	Mantle Cell Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of mantle cell lymphoma (MCL) AND 2 - Not used as first line therapy	

Product Name:Venclexta	
Diagnosis	Acute Myeloid Leukemia (AML)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of newly-diagnosed acute myeloid leukemia (AML)

AND

1.2 ONE of the following:

- Used as treatment induction in candidates for intensive induction therapy
- Used as treatment induction in candidates for lower-intensity induction therapy
- Used as follow-up after induction therapy following response to previous lower intensity therapy with the same regimen
- Used as consolidation therapy as continuation of lower-intensity regimen used for induction

AND

1.3 Used in combination with decitabine, azacitidine, or low-dose cytarabine

OR

2 - ALL of the following:

- Diagnosis of relapsed/refractory acute myeloid leukemia (AML)
- Used as a component of repeating the initial successful induction regimen
- Greater than or equal to 12 months since induction regimen if not administered continuously
- Therapy was not stopped due to development of clinical resistance

OR

3 - ALL of the following:

- Diagnosis of blastic plasmacytoid dendritic cell neoplasm (BPDCN) - acute myeloid leukemia (AML)
- Considered systemic disease and therapy is given as palliative intent
- Patient has low performance and/or nutritional status (i.e., serum albumin less than 3.2 g/dL [grams/deciliter]; not a candidate for intensive remission therapy or Elzonris)

- Venclexta therapy to be given in combination with azacitidine, decitabine, or low-dose cytarabine

Product Name:Venclexta	
Diagnosis	Multiple Myeloma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of relapsed or progressive multiple myeloma which has been previously treated AND 2 - Patient has t(11;14) translocation AND 3 - Venclexta therapy to be given in combination with ONE of the following: • dexamethasone • dexamethasone and daratumumab • dexamethasone and either bortezomib, carfilzomib, or ixazomib	

Product Name:Venclexta	
Diagnosis	Acute Lymphoblastic Leukemia (ALL)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of relapsed/refractory T-cell acute lymphoblastic leukemia (T-ALL)

AND

2 - Venclexta therapy to be given in combination with ONE of the following:

- Decitabine
- Hyper-CVAD
- Nelarabine
- Mini hyper-CVD

Product Name:Venclexta

Diagnosis	Chronic Myelomonocytic Leukemia (CMML)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic myelomonocytic leukemia (CMML)

AND

2 - Classified as CMML-2 (less than 20% bone marrow blasts or blast equivalents)

AND

3 - Venclexta therapy to be given in combination with azacitidine or decitabine

Product Name:Venclexta	
Diagnosis	Hairy Cell Leukemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of hairy cell leukemia AND 2 - Disease is progressive after relapsed/refractory therapy AND 3 - Disease is resistant to BRAF inhibitor therapy (i.e., Zelboraf, Tafenlar)	

Product Name:Venclexta	
Diagnosis	Accelerated/Blast Phase Myeloproliferative Neoplasm
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of accelerated/blast phase myeloproliferative neoplasm AND 2 - Used for management of disease progression of myeloproliferative neoplasm	

AND

3 - Venclexta therapy to be given in combination with azacitidine or decitabine

Product Name:Venclexta

Diagnosis	Systemic Light Chain Amyloidosis

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of relapsed/refractory systemic light chain amyloidosis

AND

2 - Patient has t(11;14) translocation

Product Name:Venclexta

Diagnosis	Waldenstrom Macroglobulinemia/Lymphoplasmacytic Lymphoma

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma which has been previously treated

Product Name:Venclexta

Diagnosis	Myelodysplastic Syndromes
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Disease is higher risk (IPSS-R Intermediate, High, or Very High) AND 2 - Used as initial treatment AND 3 - Used in combination with azacitidine or decitabine	

Product Name:Venclexta	
Diagnosis	All Indications except NCCN Recommended Regimens
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 Venclexta therapy	

Product Name:Venclexta	
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:Venclexta	
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 Venclexta therapy	

2 . Revision History

Date	Notes
5/12/2025	Updated formularies. Minor formatting changes. Added criteria for Myelodysplastic Syndromes. Updated multiple myeloma criteria to include additional drugs to be given in combination

Verzenio



Prior Authorization Guideline

Guideline ID	GL-373191
Guideline Name	Verzenio
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 Virginia Medicaid - Community & State Indiana Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	9/1/2025

1 . Criteria

Product Name:Verzenio	
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 - Disease is hormone-receptor (HR)-positive AND 3 - Disease is human epidermal growth factor receptor 2 (HER2)-negative AND 4 - ONE of the following: 4.1 BOTH of the following: 4.1.1 Disease is advanced, recurrent, or metastatic AND 4.1.2 ONE of the following: 4.1.2.1 Used in combination with an aromatase inhibitor (e.g., anastrozole, letrozole, exemestane) or Faslodex (fulvestrant) OR 4.1.2.2 ALL of the following:	

- Used as monotherapy
- Patient has disease progression following endocrine therapy
- Patient has already received at least one prior chemotherapy regimen

OR

4.2 ALL of the following:

4.2.1 Disease is early breast cancer at high risk of recurrence defined by ONE of the following (confirmed preoperatively and/or at surgery):

4.2.1.1 Greater than or equal to 4 positive lymph nodes

OR

4.2.1.2 BOTH of the following:

- 1-3 positive lymph nodes
- Grade 3 disease or tumor size at least 5 cm

AND

4.2.2 Used in combination with an aromatase inhibitor (e.g., anastrozole, letrozole, exemestane) or tamoxifen

AND

4.2.3 Use has not exceeded two years in duration

Product Name:Verzenio	
Diagnosis	Breast Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - BOTH of the following:

- Diagnosis of advanced, recurrent or metastatic breast cancer
- Patient does not show evidence of progressive disease while on Verzenio therapy

OR

2 - ALL of the following:

- Diagnosis of early breast cancer at high risk of recurrence
- Patient does not show evidence of progressive disease while on Verzenio therapy
- Use has not exceeded two years in duration

Product Name:Verzenio

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

Approval Criteria

1 - Diagnosis of recurrent or metastatic endometrial cancer

AND

2 - Tumor is estrogen receptor (ER)-positive

AND

3 - Used in combination with letrozole

Product Name:Verzenio	
Diagnosis	Endometrial 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 Verzenio therapy	

Product Name:Verzenio	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Verzenio will be approved for uses supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	

Product Name:Verzenio	
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 Verzenio therapy	

2 . Revision History

Date	Notes
8/19/2025	Updated formularies to add IN

Vijoice



Prior Authorization Guideline

Guideline ID	GL-356189
Guideline Name	Vijoice
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 Indiana Medicaid - Community & State Nebraska Medicaid - Community & State New Mexico Medicaid - Community & State Pennsylvania Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	9/1/2025

1 . Criteria

Product Name: Vioice tablets, Vioice granules	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of PIK3CA-Related Overgrowth Spectrum (PROS) AND 2 - ONE of the following: 2.1 Confirmed presence of a mutation in the PIK3CA gene OR 2.2 ONE of the following: 2.2.1 TWO or more of the following spectrum features: • Overgrowth: adipose, muscle, nerve, skeletal • Vascular malformations: capillary, venous, arteriovenous, lymphatic • Epidermal nevus OR 2.2.2 ONE or more of the following isolated features: • Large isolated lymphatic malformation • Isolated macrodactyly or overgrown splayed feet/ hands with overgrown limbs • Truncal adipose overgrowth • Hemimegalencephaly (bilateral) / dysplastic megalencephaly / focal cortical dysplasia • Epidermal nevus • Seborrheic keratoses • Benign lichenoid keratoses	

AND

3 - Patient is 2 years of age or older

AND

4 - Patient has severe manifestations of PROS requiring systemic therapy

AND

5 - Prescribed by, or in consultation with, a clinical geneticist or a practitioner who has specialized expertise in the management of PROS manifestations

Product Name:Vioice tablets, Vioice granules	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Vioice therapy AND 2 - Prescribed by, or in consultation with, a clinical geneticist or a practitioner who has specialized expertise in the management of PIK3CA-Related Overgrowth Spectrum (PROS) manifestations	

2 . Revision History

Date	Notes

7/31/2025	Combined formularies. No changes to clinical criteria.

Vitrakvi



Prior Authorization Guideline

Guideline ID	GL-535271
Guideline Name	Vitrakvi
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Vitrakvi	
Diagnosis	Ampullary Adenocarcinoma

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ampullary adenocarcinoma AND 2 - Disease is positive for neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1, etc.) AND 3 - ONE of the following: • Used for metastatic disease • Used for disease progression	

Product Name:Vitrakvi	
Diagnosis	Appendiceal Neoplasms and Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following appendiceal neoplasms and cancers: • Appendiceal adenocarcinoma • Goblet cell adenocarcinoma • Undifferentiated carcinoma not otherwise specified	

AND

2 - Disease is positive for neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1, etc.)

AND

3 - Used as second-line or subsequent therapy

Product Name:Vitrakvi

Diagnosis	Biliary Tract Cancer

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of biliary tract cancer (e.g., gallbladder, cholangiocarcinoma)

AND

2 - Disease is positive for neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1, etc.)

AND

3 - Disease is ONE of the following:

- Gross Residual (R2)
- Metastatic
- Resectable locoregionally advanced
- Unresectable

Product Name:Vitrakvi	
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 - Disease is positive for neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1, etc.) AND 3 - Disease is without a known acquired resistance mutation [e.g., TRKA G595R substitution, TRKA G667C substitution, or other recurrent kinase domain (solvent front and xDFG) mutations] AND 4 - Disease is ONE of the following: • Metastatic • Recurrent unresectable • Unresponsive to preoperative systemic therapy	

Product Name:Vitrakvi	
Diagnosis	Central Nervous System Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following: • Circumscribed glioma • Glioblastoma • High-grade glioma • Brain metastases AND 2 - Disease is positive for neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1, etc.) AND 3 - Disease is ONE of the following: • Metastatic • Recurrent or progressive	

Product Name:Vitrakvi	
Diagnosis	Cervical Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of cervical cancer	

AND

2 - Disease is positive for neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1, etc.)

AND

3 - Used as second-line or subsequent therapy

Product Name:Vitrakvi	
Diagnosis	Colorectal Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of colon or rectal cancer AND 2 - Disease is positive for neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1, etc.) AND 3 - Used as second-line or subsequent therapy	

Product Name:Vitrakvi	
Diagnosis	Esophageal, Esophagogastric Junction, and Gastric Cancers
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of esophageal, esophagogastric junction, or gastric cancer AND 2 - Disease is positive for neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1, etc.) AND 3 - Disease is ONE of the following: • Metastatic • Recurrent • Unresectable locally advanced	

Product Name:Vitrakvi	
Diagnosis	Gastrointestinal Stromal Tumors
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of gastrointestinal stromal tumor AND	

2 - Disease is positive for neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1, etc.)

AND

3 - Used in ONE of the following settings:

- Neoadjuvant therapy to decrease surgical morbidity
- Gross residual disease (R2 resection)
- Unresectable primary disease
- Preoperative/intraoperative tumor rupture
- Recurrent/metastatic disease

Product Name:Vitrakvi

Diagnosis	Head and Neck Cancers

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of salivary gland tumor

AND

2 - Disease is positive for neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1, etc.)

AND

3 - Used as second-line or subsequent therapy

Product Name:Vitrakvi

Diagnosis	Hepatocellular Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of hepatocellular carcinoma AND 2 - Disease is positive for neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1, etc.) AND 3 - Disease is recurrent or metastatic	

Product Name:Vitrakvi	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of histiocytic neoplasm AND 2 - Disease is positive for neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1, etc.)	

AND

3 - Disease is ONE of the following:

- Metastatic
- Relapsed/refractory
- Symptomatic unresectable or multifocal

Product Name:Vitrakvi

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

Approval Criteria

1 - Diagnosis of cutaneous melanoma

AND

2 - Disease is positive for ONE of the following gene fusions:

- ROS1-gene fusion
- NTRK-gene fusion

AND

3 - Disease is metastatic or unresectable

Product Name:Vitrakvi

Diagnosis	Neuroendocrine and Adrenal Tumors
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of neuroendocrine tumor AND 2 - Disease is positive for neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1, etc.) AND 3 - Disease is ONE of the following: • Locoregional unresectable • Metastatic	

Product Name:Vitrakvi	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of metastatic non-small cell lung cancer (NSCLC) AND	

2 - Disease is positive for neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1, etc.)

AND

3 - Disease is ONE of the following:

- Advanced
- Metastatic
- Recurrent

Product Name:Vitrakvi

Diagnosis	Occult Primary [Cancer of Unknown Primary (CUP)]
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following occult primary cancers:

- Adenocarcinoma
- Carcinoma not otherwise specified
- Squamous cell carcinoma

AND

2 - Disease is positive for neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1, etc.)

AND

3 - Disease is without a known acquired resistance mutation [e.g., TRKA G595R substitution, TRKA G667C substitution, or other recurrent kinase domain (solvent front and xDFG) mutations]

AND

4 - Used in ONE of the following settings:

- Asymptomatic patients with performance status (PS) 0 and aggressive disease
- Symptomatic patients with PS 1-2

Product Name:Vitrakvi	
Diagnosis	Ovarian/Fallopian Tube/Primary Peritoneal Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following: • Fallopian tube cancer • Ovarian cancer • Primary peritoneal cancer AND 2 - Disease is positive for neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1, etc.) AND 3 - ONE of the following histologies: • Endometrioid • Carcinosarcoma (Malignant Mixed Müllerian Tumors) • Clear cell carcinoma of the ovary • Mucinous carcinoma	

- Serous carcinoma

AND

4 - Disease is persistent or recurrent

Product Name:Vitrakvi	
Diagnosis	Pancreatic Adenocarcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of pancreatic adenocarcinoma AND 2 - Disease is positive for neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1, etc.) AND 3 - Disease is ONE of the following: • Locally advanced • Metastatic	

Product Name:Vitrakvi	
Diagnosis	Small Bowel Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of small bowel adenocarcinoma AND 2 - Disease is positive for neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1, etc.) AND 3 - Used as second-line or subsequent therapy	

Product Name:Vitrakvi	
Diagnosis	Soft Tissue Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of soft tissue sarcoma AND 2 - Disease is positive for neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1, etc.) AND	

3 - Disease is ONE of the following:

- Advanced
- Metastatic

Product Name:Vitrakvi

Diagnosis	Thyroid Carcinoma

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following thyroid cancers:

- Papillary carcinoma
- Follicular carcinoma
- Oncocytic carcinoma
- Anaplastic carcinoma

AND

2 - Disease is positive for neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1, etc.)

AND

3 - Disease is ONE of the following:

- Metastatic
- Persistent
- Unresectable locoregional recurrent

Product Name:Vitrakvi

Diagnosis	Uterine Neoplasm
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following uterine neoplasms: • Endometrial carcinoma • Uterine Sarcoma AND 2 - Disease is positive for neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1, etc.) AND 3 - Disease is ONE of the following: • Advanced • Inoperable • Recurrent • Metastatic	

Product Name:Vitrakvi	
Diagnosis	Vaginal/Vulvar Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of vaginal or vulvar cancer

AND

2 - Disease is positive for neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1, etc.)

AND

3 - Used as second-line or subsequent therapy

Product Name:Vitrakvi

Diagnosis	Ampullary Adenocarcinoma, Appendiceal Neoplasms and Cancers, Biliary Tract Cancer, Breast Cancer, Central Nervous System Cancers, Cervical Cancer, Colorectal Cancers, Esophageal, Esophagogastric Junction, and Gastric Cancers, Gastrointestinal Stromal Tumors, Head and Neck Cancers, Hepatocellular Carcinoma, Histiocytic Neoplasms, Melanoma, Neuroendocrine and Adrenal Tumors, Non-Small Cell Lung Cancer (NSCLC), Occult Primary [Cancer of Unknown Primary (CUP)], Ovarian/Fallopian Tube/Primary Peritoneal Cancers, Pancreatic Adenocarcinoma, Small Bowel Cancer, Soft Tissue Sarcoma, Thyroid Carcinoma, Uterine Neoplasm, Vaginal/Vulvar 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 Vitrakvi therapy

Product Name:Vitrakvi

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:Vitrakvi	
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 Vitrakvi therapy	

2 . Revision History

Date	Notes
3/3/2026	Expanded section on solid tumors to specify each type with their own criteria.

Vizimpro



Prior Authorization Guideline

Guideline ID	GL-507205
Guideline Name	Vizimpro
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name: Vizimpro	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of non-small cell lung cancer (NSCLC) AND 2 - Disease is recurrent, advanced, or metastatic AND 3 - Disease is positive for ONE of the following EGFR (epidermal growth factor receptor) mutations: • Exon 19 deletion • Exon 21 L858R substitution • S768I • L861Q • G719X	

Product Name:Vizimpro	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
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 Vizimpro therapy	

Product Name:Vizimpro	
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:Vizimpro	
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 Vizimpro therapy	

2 . Revision History

Date	Notes
1/23/2026	Combined formularies. No changes to clinical criteria.

Vizimpro



Prior Authorization Guideline

Guideline ID	GL-507205
Guideline Name	Vizimpro
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name: Vizimpro	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of non-small cell lung cancer (NSCLC) AND 2 - Disease is recurrent, advanced, or metastatic AND 3 - Disease is positive for ONE of the following EGFR (epidermal growth factor receptor) mutations: • Exon 19 deletion • Exon 21 L858R substitution • S768I • L861Q • G719X	

Product Name:Vizimpro	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
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 Vizimpro therapy	

Product Name:Vizimpro	
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:Vizimpro	
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 Vizimpro therapy	

2 . Revision History

Date	Notes
1/23/2026	Combined formularies. No changes to clinical criteria.

Voranigo



Prior Authorization Guideline

Guideline ID	GL-597212
Guideline Name	Voranigo
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia Medicaid - Community & State Washington

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Voranigo

Diagnosis	Astrocytoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of astrocytoma AND 2 - Presence of an isocitrate dehydrogenase-1 (IDH1) or isocitrate dehydrogenase-2 (IDH2) mutation AND 3 - Disease is World Health Organization (WHO) Grade 2, 3, or 4 AND 4 - History of prior surgery, including biopsy, sub-total resection, or gross total resection	

Product Name: Voranigo	
Diagnosis	Oligodendroglioma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of oligodendroglioma	

AND

2 - Presence of an isocitrate dehydrogenase-1 (IDH1) or isocitrate dehydrogenase-2 (IDH2) mutation with 1p19q codeletion

AND

3 - Disease is World Health Organization (WHO) Grade 2 or 3

AND

4 - History of prior surgery, including biopsy, sub-total resection, or gross total resection

Product Name:Vorango	
Diagnosis	Astrocytoma, Oligodendroglioma
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 Vorango therapy	

Product Name:Vorango	
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:Voranigo

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 Voranigo therapy

2 . Revision History

Date	Notes
4/27/2026	Added IN.

Votrient



Prior Authorization Guideline

Guideline ID	GL-597195
Guideline Name	Votrient
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name: Brand Votrient, generic pazopanib	
Diagnosis	Renal Cell Carcinoma (RCC)/Kidney Cancer

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following 1.1 Diagnosis of renal cell carcinoma (RCC) AND 1.2 ONE of the following: • Disease has relapsed • Stage IV disease • Disease is advanced OR 2 - Diagnosis of von Hippel-Lindau (VHL)-associated renal cell carcinoma	

Product Name:Brand Votrient, generic pazopanib	
Diagnosis	Soft Tissue Sarcoma (STS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has ONE of the following diagnoses: • Alveolar soft part sarcoma • Angiosarcoma • Dedifferentiated Chordoma	

- Dedifferentiated liposarcoma with or without concurrent well-differentiated liposarcoma
- Dermatofibrosarcoma Protuberans (DFSP) with Fibrosarcomatous Transformation
- Desmoid tumors (aggressive fibromatosis)
- Epithelioid hemangioendothelioma
- Extraskelatal myxoid chondrosarcoma
- Soft tissue sarcoma of the extremity/superficial trunk or head/neck with disease that is stage IV or recurrent and has disseminated metastases
- Retroperitoneal/intra-abdominal disease that is unresectable, stage IV, or postoperative treatment for residual disease
- Pleomorphic rhabdomyosarcoma
- Solitary fibrous tumor/hemangiopericytoma

Product Name:Brand Votrient, generic pazopanib	
Diagnosis	Thyroid Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ALL of the following: 1.1 Diagnosis of ONE of the following: • Follicular carcinoma • Papillary carcinoma AND 1.2 ONE of the following: • Unresectable locoregional recurrent disease • Persistent disease • Metastatic disease AND 1.3 ONE of the following:	

- Patient has symptomatic disease
- Patient has progressive disease

AND

1.4 ONE of the following:

- Disease is refractory to radioactive iodine treatment
- Distant metastatic disease not amenable to radioactive iodine treatment

OR

2 - ALL of the following:

2.1 Diagnosis of oncocytic carcinoma

AND

2.2 ONE of the following:

- Unresectable locoregional recurrent disease
- Persistent disease
- Metastatic disease

AND

2.3 ONE of the following:

- Patient has symptomatic disease
- Patient has progressive disease

OR

3 - ALL of the following:

3.1 Diagnosis of medullary carcinoma

AND

3.2 ONE of the following:

- Disease is progressive
- Disease is symptomatic with distant metastases

AND

3.3 ONE of the following:

3.3.1 Failure to ONE of the following, as confirmed by claims history or submission of medical records:

- vandetanib
- Cometriq (cabozantinib)

OR

3.3.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- vandetanib
- Cometriq (cabozantinib)

Product Name:Brand Votrient, generic pazopanib	
Diagnosis	Uterine Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of uterine sarcoma	

AND

2 - ONE of the following:

- Disease is advanced
- Disease is recurrent/metastatic
- Disease is inoperable

Product Name:Brand Votrient, generic pazopanib

Diagnosis	Ovarian Cancer

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following:

- Epithelial ovarian cancer
- Fallopian tube cancer
- Primary peritoneal cancer

AND

2 - ONE of the following:

- Disease is persistent
- Disease is recurrent

Product Name:Brand Votrient, generic pazopanib

Diagnosis	Chondrosarcoma

Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chondrosarcoma AND 2 - Disease is metastatic and widespread	

Product Name:Brand Votrient, generic pazopanib	
Diagnosis	Gastrointestinal Stromal Tumors (GIST)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Gastrointestinal Stromal Tumors (GIST) AND 2 - Disease is residual, unresectable, progressive, or metastatic AND 3 - ONE of the following: 3.1 Used as first-line therapy in SDH-deficient GIST	

OR

3.2 Used after progression on ALL of the following:

- imatinib (generic Gleeevac)
- sunitinib (generic Sutent)
- Stivarga (regorafenib)
- standard dose Qinlock (ripretinib)

Product Name:Brand Votrient, generic pazopanib	
Diagnosis	Merkel Cell Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Merkel Cell Carcinoma AND 2 - ONE of the following: 2.1 Anti-PD-L1 or anti-PD-1 therapy is contraindicated OR 2.2 Disease has progressed on anti-PD-L1 or anti-PD-1 therapy	

Product Name:Brand Votrient, generic pazopanib	
Diagnosis	Renal Cell Carcinoma (RCC)/Kidney Cancer, Soft Tissue Sarcoma (STS), Thyroid Carcinoma, Uterine Sarcoma, Ovarian Cancer,

	Chondrosarcoma, Gastrointestinal Stromal Tumors (GIST), Merkel Cell 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 the requested therapy	

Product Name:Brand Votrient, generic pazopanib	
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:Brand Votrient, generic pazopanib	
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 the requested therapy	

2 . Revision History

Date	Notes
4/27/2026	Added IN. Updated reference from "Votrient" to "the requested therapy" in reauth sections (where applicable), with no changes to clinical intent. Updated language for NCCN Recommended Regimens for initial auth, with no changes to clinical intent. Minor cosmetic updates.

Vowst



Prior Authorization Guideline

Guideline ID	GL-434326
Guideline Name	Vowst
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Indiana Medicaid - Community & State Maryland Medicaid - Community & State Nevada 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 Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Vowst	
Approval Length	1 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of recurrent Clostridioides difficile infection (rCDI) 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 Clostridioides difficile toxin AND 2 - Patient is 18 years of age or older AND 3 - Patient has had one or more recurrences of CDI following an initial episode of CDI AND 4 - Patient has completed at least 10 days of ONE of the following antibiotic therapies for rCDI 2 to 4 days prior to initiating Vowst as confirmed by claims history or submission of medical records: • Oral vancomycin • Difidol (fidaxomicin) AND	

5 - 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

6 - Patient will drink magnesium citrate on the day before and at least 8 hours prior to taking the first dose of Vowst

AND

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

- Gastroenterologist
- Infectious disease specialist

2 . Revision History

Date	Notes
11/3/2025	Added NV Formulary

Voydeya



Prior Authorization Guideline

Guideline ID	GL-373192
Guideline Name	Voydeya
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 Virginia Medicaid - Community & State Pennsylvania Medicaid - Community & State Nebraska Medicaid - Community & State Indiana Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	9/1/2025

1 . Criteria

Product Name:Voydeya	
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.) documenting the diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) as confirmed by both of the following: - Flow cytometry analysis confirming presence of PNH clones - 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 2 - All of the following: - Patient is currently receiving complement protein C5 inhibitor eculizumab or Ultomiris (ravulizumab) - Patient is experiencing extravascular hemolysis (EVH) while on complement protein C5 inhibitor eculizumab or Ultomiris (ravulizumab) - Patient will continue to receive complement protein C5 inhibitor eculizumab or Ultomiris (ravulizumab) AND 3 - Patient is not receiving Voydeya in combination with a complement protein C3 inhibitor [e.g., Empaveli (Pegcetacoplan)] or a complement factor B inhibitor [e.g., Fabhalta (iptacopan)] used for the treatment of PNH AND 4 - Prescribed by, or in consultation with one of the following: - Hematologist	

- Oncologist

Product Name:Voydeya	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Voydeya therapy [e.g., decrease in extravascular hemolysis (EVH), increased or stabilization of hemoglobin levels, reduction in transfusions, improvement in hemolysis, etc.]] AND 2 - Patient continues to receive Voydeya in combination with complement protein C5 inhibitor eculizumab or Ultomiris (ravulizumab) for PNH AND 3 - Patient is not receiving Voydeya in combination with a complement protein C3 inhibitor [e.g., Empaveli (Pegcetacoplan)] or a complement factor B inhibitor [e.g., Fabhalta (iptacopan)] used for the treatment of PNH AND 4 - Prescribed by, or in consultation with one of the following: • Hematologist • Oncologist	

2 . Revision History

UnitedHealthcare Community Plan of Indiana Clinical Pharmacy Program Guidelines

Date	Notes
8/19/2025	Updated formularies to add IN

Vyalev



Prior Authorization Guideline

Guideline ID	GL-596191
Guideline Name	Vyalev
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 Indiana Medicaid - Community & State Michigan Medicaid - Community & State Nevada Medicaid - Community & State New Mexico Medicaid - Community & State Virginia Medicaid - Community & State Washington

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

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 has inadequately controlled motor fluctuations despite being treated with optimized oral therapies (e.g., levodopa) AND 3 - Prescribed by or in consultation with a neurologist	

Product Name:Vyalev	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Vyalev therapy demonstrated by an increase in “on” time without troublesome dyskinesia	

2 . Revision History

Date	Notes

4/27/2026	Rearranged order of formularies. Updated GPI entry for Vyalev due to minor change in generic name. Minor punctuation update in initial authorization criteria section, with no changes to clinical intent.

Vykat XR



Prior Authorization Guideline

Guideline ID	GL-458423
Guideline Name	Vykat XR
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Vykat XR	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of hyperphagia associated with Prader-Willi syndrome (PWS)	

AND

2 - Submission of genetic testing confirming PWS

AND

3 - Submission of medical records confirming patient's baseline associated behaviors of hyperphagia including food-seeking, hoarding, foraging, stealing, or attempts to eat inedible objects

AND

4 - Submission of medical records confirming patient's baseline weight obtained within the past 30 days

AND

5 - Patient is 4 years of age or older

AND

6 - Prescribed by, or in consultation with, an endocrinologist

AND

7 - Prescriber attests the patient is in a food-secure environment (e.g., locked food storage)

AND

8 - The requested dose does not exceed 525 mg/day (milligrams per day)

AND

9 - The request does not exceed one of the following quantity limits:

- 25 mg: 4 tablets per day
- 75 mg: 3 tablets per day
- 150 mg: 3 tablets per day

Product Name:Vykat XR	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - History of requested agent for 90 of the past 120 days, as confirmed by claims history or chart documentation AND 2 - Submission of medical records supporting improvement or stabilization in hyperphagic symptoms (e.g., decreased food-seeking, hoarding, food related aggression, etc.) as compared to baseline AND 3 - Submission of medical records supporting decrease or stabilization in weight compared to baseline AND 4 - The requested dose does not exceed 525 mg/day (milligrams per day)	

AND

5 - The request does not exceed one of the following quantity limits:

- 25 mg: 4 tablets per day
- 75 mg: 3 tablets per day
- 150 mg: 3 tablets per day

2 . Revision History

Date	Notes
12/8/2025	New guideline

Vyvgart Hytrulo



Prior Authorization Guideline

Guideline ID	GL-479212
Guideline Name	Vyvgart Hytrulo
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 Indiana Medicaid - Community & State Michigan Medicaid - Community & State Nebraska Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Vyvgart Hytrulo prefilled syringe	
Diagnosis	Generalized Myasthenia Gravis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of generalized Myasthenia Gravis (gMG) AND 2 - Positive serologic test for anti-acetylcholine receptor (AChR) antibodies AND 3 - Patient has a Myasthenia Gravis Foundation of America (MGFA) Clinical Classification of class II, III, or IV at initiation of therapy AND 4 - Patient has a Myasthenia Gravis Activities of Daily Living scale (MG-ADL) total score greater than or equal to 5 at initiation of therapy AND 5 - ONE of the following: 5.1 History of failure of a minimum of two immunosuppressive agents over the course of at least 12 months (e.g., azathioprine, corticosteroids, cyclosporine, methotrexate, mycophenolate, etc.) as confirmed by claims history or submission of medical records OR	

5.2 BOTH of the following:

- History of failure of at least one immunosuppressive therapy as confirmed by claims history or submission of medical records
- Patient has required four or more courses of plasmapheresis/plasma exchanges and/or immune globulin over the course of at least 12 months without symptom control

AND

6 - Patient is not receiving Vyvgart Hytrulo in combination with ANY of the following for treatment of the same indication:

- A complement inhibitor [e.g., eculizumab, Ultomiris (ravulizumab), Zilbrysq (zilucoplan)]
- Another neonatal Fc receptor (FcRn) blocker [e.g., Imaavy (nipocalimab), Rystiggo (rozanolixizumab)]
- Immune globulin (e.g., Gammagard, Privigen, Hizentra)

AND

7 - Prescribed by or in consultation with a neurologist

Product Name:Vyvgart Hytrulo prefilled syringe	
Diagnosis	Generalized Myasthenia Gravis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes, laboratory tests) demonstrating ALL of the following: • Improvement and/or maintenance of at least a 2-point improvement (reduction in score) in the MG-ADL score from pre-treatment baseline • Reduction in signs and symptoms of myasthenia gravis • Maintenance, reduction, or discontinuation of dose(s) of baseline immunosuppressive therapy (IST) prior to starting Vyvgart Hytrulo. Note: Add on, dose escalation of IST, or	

additional rescue therapy from baseline to treat myasthenia gravis or exacerbation of symptoms while on Vyvgart Hytrulo therapy will be considered as treatment failure

AND

2 - Patient is not receiving Vyvgart Hytrulo in combination with ANY of the following for treatment of the same indication:

- A complement inhibitor [e.g., eculizumab, Ultomiris (ravulizumab), Zilbrysq (zilucoplan)]
- Another neonatal Fc receptor (FcRn) blocker [e.g., Imaavy (nipocalimab), Rystiggo (rozanolixizumab)]
- Immune globulin (e.g., Gammagard, Privigen, Hizentra)

AND

3 - Prescribed by or in consultation with a neurologist

Product Name:Vyvgart Hytrulo prefilled syringe	
Diagnosis	Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chronic inflammatory demyelinating polyneuropathy (CIDP) AND 2 - ALL of the following: 2.1 Progressive symptoms present for at least 2 months AND	

2.2 Symptomatic polyradiculoneuropathy as indicated by progressive or relapsing motor or sensory impairment of more than one limb

AND

2.3 Electrodiagnostic findings (consistent with EFNS/PNS guidelines for definite CIDP) indicating the presence of at least ONE of the following:

- 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 CMAP duration increase in at least 1 nerve

AND

3 - ONE of the following:

3.1 Failure (after a trial of at least two months) to a corticosteroid (e.g., prednisone, methylprednisolone) as confirmed by claims history or submission of medical records

OR

3.2 History of contraindication or intolerance to a corticosteroid (please specify contraindication or intolerance)

AND

4 - ONE of the following:

4.1 Trial and failure (after a trial of at least three months) to an immune globulin (e.g., Gammagard, Privigen, Hizentra) with the maximally allowable and/or tolerated dose as confirmed by claims history or submission of medical records

OR

4.2 BOTH of the following:

- Intolerance to all immune globulins (e.g., Gammagard, Privigen, Hizentra) (please specify intolerance)
- Dose has been adjusted or escalated to the maximally allowable and/or tolerated dose

OR

4.3 Contraindication to ALL immune globulins (e.g., Gammagard, Privigen, Hizentra) (please specify contraindication)

AND

5 - Patient is not receiving Vyvgart Hytrulo in combination with an immune globulin (e.g., Gammagard, Privigen, Hizentra) for treatment of the same indication

AND

6 - Prescribed by or in consultation with a neurologist

Product Name:Vyvgart Hytrulo prefilled syringe	
Diagnosis	Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of a positive clinical response to Vyvgart Hytrulo as measured by an objective scale [e.g., Rankin, Modified Rankin, Medical Research Council (MRC) scale] AND	

2 - Patient is not receiving Vyvgart Hytrulo in combination with an immune globulin (e.g., Gammagard, Privigen, Hizentra) used for treatment of the same indication

AND

3 - Prescribed by or in consultation with a neurologist

2 . Revision History

Date	Notes
12/15/2025	Updated formularies to include IN for eff 1/1/26.

Xalkori



Prior Authorization Guideline

Guideline ID	GL-562207
Guideline Name	Xalkori
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Xalkori	
Diagnosis	Soft Tissue Sarcoma

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of soft tissue sarcoma AND 2 - Tumor is an inflammatory myofibroblastic tumor (IMT) with anaplastic lymphoma kinase (ALK) translocation	

Product Name:Xalkori	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of non-small cell lung cancer (NSCLC) AND 2 - Disease is ONE of the following: • Metastatic • Recurrent • Advanced AND	

3 - ONE of the following:

- Tumor is anaplastic lymphoma kinase (ALK)-positive
- Tumor is ROS1-positive
- Tumor is positive for mesenchymal-epithelial transition (MET) amplification
- Tumor is positive for MET exon 14 skipping mutation

Product Name:Xalkori	
Diagnosis	Central Nervous System (CNS) Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of metastatic brain cancer from non-small cell lung cancer (NSCLC) AND 2 - ONE of the following: • Tumor is anaplastic lymphoma kinase (ALK)-positive • Tumor is ROS1-positive	

Product Name:Xalkori	
Diagnosis	Anaplastic Large Cell Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of anaplastic large cell lymphoma

AND

2 - Tumor is anaplastic lymphoma kinase (ALK)-positive

AND

3 - Disease is relapsed or refractory

Product Name:Xalkori

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

Approval Criteria

1 - Diagnosis of ONE of the following:

- Langerhans Cell Histiocytosis
- Erdheim-Chester Disease
- Rosai-Dorfman Disease

AND

2 - Disease is positive for anaplastic lymphoma kinase (ALK) rearrangement

Product Name:Xalkori

Diagnosis	Melanoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of metastatic or unresectable cutaneous melanoma AND 2 - Disease is ROS1 gene fusion-positive AND 3 - Used as second-line or subsequent therapy for disease progression, intolerance, and/or projected risk of progression with BRAF-targeted therapy	

Product Name:Xalkori	
Diagnosis	Uterine Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of uterine sarcoma AND 2 - Tumor is an inflammatory myofibroblastic tumor (IMT) with anaplastic lymphoma kinase (ALK) translocation AND	

3 - Disease is ONE of the following:

- Metastatic
- Recurrent
- Advanced
- Inoperable

Product Name:Xalkori	
Diagnosis	Soft Tissue Sarcoma, Non-Small Cell Lung Cancer (NSCLC), Central Nervous System (CNS) Cancers, Anaplastic Large Cell Lymphoma, Histiocytic Neoplasms, Melanoma, Uterine Neoplasms
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 Xalkori therapy	

Product Name:Xalkori	
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:Xalkori	
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 Xalkori therapy	

2 . Revision History

Date	Notes
4/2/2026	Added IN.

Xdemvy



Prior Authorization Guideline

Guideline ID	GL-505195
Guideline Name	Xdemvy
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 Indiana Medicaid - Community & State Michigan Medicaid - Community & State Nebraska Medicaid - Community & State Nevada Medicaid - Community & State New Mexico Medicaid - Community & State Pennsylvania Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Xdemvy	
Approval Length	6 Week(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Demodex blepharitis AND 2 - Patient demonstrates ONE of the following signs of Demodex infestation: • Cylindrical cuff at the root of the eyelashes • Lid margin erythema • Eyelash anomalies (e.g., eyelash misdirection, eyelash loss) AND 3 - Patient demonstrates TWO of the following symptoms of Demodex infestation: • Itching/Burning • Foreign body sensation • Crusting/matted lashes • Blurry vision • Discomfort/irritation • Tearing/lacrimation • Dryness • Purulence/discharge AND 4 - Patient is practicing good eye-lid hygiene (e.g., non-prescription tree-tea oil) AND	

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

- Ophthalmologist
- Optometrist

2 . Revision History

Date	Notes
1/22/2026	Combined formularies. No changes to clinical criteria.

Xermelo



Prior Authorization Guideline

Guideline ID	GL-356196
Guideline Name	Xermelo
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 Indiana Medicaid - Community & State Nebraska Medicaid - Community & State New Mexico Medicaid - Community & State Pennsylvania Medicaid - Community & State Virginia Medicaid - Community & State Washington

Guideline Note:

Effective Date:	9/1/2025

1 . Criteria

Product Name:Xermelo	
Diagnosis	Carcinoid Syndrome Diarrhea
Approval Length	12 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, Lanreotide), as confirmed by claims history or submission of medical records AND 3 - Used in combination with somatostatin analog therapy (e.g., octreotide, Sandostatin LAR, Somatuline Depot, Lanreotide)	

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
8/1/2025	Combined formularies. No changes to clinical criteria.

Xifaxan



Prior Authorization Guideline

Guideline ID	GL-424188
Guideline Name	Xifaxan
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii 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 New Mexico

Guideline Note:

Effective Date:	11/1/2025

1 . Criteria

Product Name:Xifaxan 200mg	
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of travelers' diarrhea

AND

2 - ONE of the following:

2.1 Failure of ONE of the following confirmed by claims history or submitted medical records:

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

OR

2.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

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

Product Name:Xifaxan 550mg	
Diagnosis	Hepatic Encephalopathy (HE)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Used for prophylaxis of hepatic encephalopathy (HE) recurrence	

AND

2 - ONE of the following:

2.1 BOTH of the following:

- Used as add-on therapy to lactulose, confirmed by claims history or submitted medical records
- Patient is unable to achieve an optimal clinical response with lactulose monotherapy, confirmed by claims history or submitted medical records

OR

2.2 History of contraindication or intolerance to lactulose (please specify intolerance or contraindication)

Product Name:Xifaxan 550mg	
Diagnosis	Hepatic Encephalopathy (HE)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Xifaxan therapy	

Product Name:Xifaxan 550mg	
Diagnosis	Irritable Bowel Syndrome with Diarrhea (IBS-D)
Approval Length	1 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of irritable bowel syndrome with diarrhea (IBS-D)

AND

2 - ONE of the following:

2.1 Failure of ONE tricyclic antidepressant (e.g. amitriptyline) confirmed by claims history or submitted medical records

OR

2.2 History of intolerance or contraindication to tricyclic antidepressants (e.g. amitriptyline) (please specify intolerance or contraindication)

Product Name:Xifaxan 550mg	
Diagnosis	Irritable Bowel Syndrome with Diarrhea (IBS-D)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient continues to need Xifaxan and has experienced positive results with prior use	

2 . Revision History

Date	Notes
10/16/2025	Removed NJ

Xolremdi



Prior Authorization Guideline

Guideline ID	GL-424218
Guideline Name	Xolremdi
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 Indiana Medicaid - Community & State Nebraska Medicaid - Community & State New Mexico Medicaid - Community & State Pennsylvania Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	11/1/2025

1 . Criteria

Product Name:Xolremdi	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of WHIM (warts, hypogammaglobulinemia, infections and myelokathexis) syndrome AND 2 - Patient has a genotype-confirmed mutation of chemokine (C-X-C motif) receptor 4 (CXCR4) consistent with WHIM phenotype AND 3 - Patient has an absolute neutrophil count (ANC) less than or equal to 500 cells per microliter AND 4 - Prescribed by or in consultation with ONE of the following: • Allergist • Geneticist • Hematologist • Immunologist	

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

Approval Criteria

1 - Documentation of positive clinical response [e.g., improvement in absolute neutrophil counts (ANC), improvement in absolute lymphocyte counts (ALC), reduction in infections] to Xolremdi therapy

AND

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

- Allergist
- Geneticist
- Hematologist
- Immunologist

2 . Revision History

Date	Notes
10/20/2025	Combined formularies. No changes to clinical criteria.

Xospata



Prior Authorization Guideline

Guideline ID	GL-590200
Guideline Name	Xospata
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 Indiana Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Xospata	
Diagnosis	Acute Myeloid Leukemia (AML)
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of acute myeloid leukemia (AML) AND 2 - AML is FMS-like tyrosine kinase 3 (FLT3) mutation-positive AND 3 - ONE of the following: • Used as low-intensity treatment induction when not a candidate for intensive induction therapy • Follow-up after induction therapy with response to previous lower intensity therapy with the same regimen • Post-allogeneic hematopoietic cell transplantation and in remission • Disease is relapsed or refractory • Consolidation therapy as continuation of low-intensity regimen used for induction in patients with poor-risk AML	

Product Name:Xospata	
Diagnosis	Myeloid/Lymphoid Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of lymphoid, myeloid, or mixed lineage neoplasms with eosinophilia	

AND

2 - ONE of the following:

- Patient has an FMS-like tyrosine kinase 3 (FLT3) rearrangement in chronic phase
- Patient has an FMS-like tyrosine kinase 3 (FLT3) rearrangement in blast phase

Product Name:Xospata	
Diagnosis	Acute Myeloid Leukemia (AML), Myeloid/Lymphoid Neoplasms
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 Xospata therapy	

Product Name:Xospata	
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:Xospata	
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 Xospata therapy	

2 . Revision History

Date	Notes
4/24/2026	Rearranged order of formularies. Minor update to add "(AML)" acronym in dx header, where applicable. Minor language update to initial auth criterion for NCCN Recommended Regimens, with no changes to clinical intent.

Xospata



Prior Authorization Guideline

Guideline ID	GL-590200
Guideline Name	Xospata
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 Indiana Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Xospata	
Diagnosis	Acute Myeloid Leukemia (AML)
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of acute myeloid leukemia (AML) AND 2 - AML is FMS-like tyrosine kinase 3 (FLT3) mutation-positive AND 3 - ONE of the following: • Used as low-intensity treatment induction when not a candidate for intensive induction therapy • Follow-up after induction therapy with response to previous lower intensity therapy with the same regimen • Post-allogeneic hematopoietic cell transplantation and in remission • Disease is relapsed or refractory • Consolidation therapy as continuation of low-intensity regimen used for induction in patients with poor-risk AML	

Product Name:Xospata	
Diagnosis	Myeloid/Lymphoid Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of lymphoid, myeloid, or mixed lineage neoplasms with eosinophilia	

AND

2 - ONE of the following:

- Patient has an FMS-like tyrosine kinase 3 (FLT3) rearrangement in chronic phase
- Patient has an FMS-like tyrosine kinase 3 (FLT3) rearrangement in blast phase

Product Name:Xospata	
Diagnosis	Acute Myeloid Leukemia (AML), Myeloid/Lymphoid Neoplasms
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 Xospata therapy	

Product Name:Xospata	
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:Xospata	
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 Xospata therapy	

2 . Revision History

Date	Notes
4/24/2026	Rearranged order of formularies. Minor update to add "(AML)" acronym in dx header, where applicable. Minor language update to initial auth criterion for NCCN Recommended Regimens, with no changes to clinical intent.

Xpovio



Prior Authorization Guideline

Guideline ID	GL-535206
Guideline Name	Xpovio
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Xpovio	
Diagnosis	Multiple Myeloma

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ALL of the following: 1.1 Diagnosis of relapsed or refractory multiple myeloma (RRMM) AND 1.2 Patient has received at least four prior therapies AND 1.3 Disease is refractory to ALL of the following: • Two proteasome inhibitors • Two immunomodulatory agents • An anti-CD38 monoclonal antibody AND 1.4 Used in combination with dexamethasone OR 2 - ALL of the following: 2.1 Diagnosis of multiple myeloma AND 2.2 Patient has received at least one prior therapy	

AND

2.3 Used in combination with ONE of the following:

- Velcade (bortezomib) and dexamethasone
- Darzalex (daratumumab) and dexamethasone
- Kyprolis (carfilzomib) and dexamethasone

OR

3 - ALL of the following:

3.1 Diagnosis of multiple myeloma

AND

3.2 Patient has received at least 2 prior therapies, including an immunomodulatory agent (e.g., lenalidomide, thalidomide) and a proteasome inhibitor (e.g., bortezomib, carfilzomib)

AND

3.3 Patient has demonstrated progression on or within 60 days of completion of the last therapy

AND

3.4 Used in combination with Pomalyst (pomalidomide) and dexamethasone

Product Name:Xpovio	
Diagnosis	Diffuse Large B-cell Lymphoma (DLBCL)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Diagnosis of relapsed or refractory diffuse large B-cell lymphoma (DLBCL) (including histologic transformation of indolent lymphomas to DLBCL)

OR

1.2 Diagnosis of relapsed or refractory HIV (human immunodeficiency virus)-related diffuse large B-cell lymphoma, primary effusion lymphoma, or HHV8-positive diffuse large B-cell lymphoma

OR

1.3 Diagnosis of relapsed or refractory monomorphic B-Cell type post-transplant lymphoproliferative disorder

AND

2 - Patient has received at least 2 lines of systemic therapies

Product Name:Xpovio	
Diagnosis	Multiple Myeloma, Diffuse Large B-cell Lymphoma (DLBCL)
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 Xpovio therapy	

Product Name:Xpovio	
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:Xpovio	
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 Xpovio therapy	

2 . Revision History

Date	Notes
2/26/2026	Updated GPIs. No changes to clinical criteria.

Xtandi



Prior Authorization Guideline

Guideline ID	GL-457325
Guideline Name	Xtandi
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Xtandi	
Diagnosis	Prostate Cancer

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of prostate cancer AND 2 - ONE of the following: 2.1 BOTH of the following: 2.1.1 Disease is castration-resistant AND 2.1.2 ONE of the following: • Used in combination with a gonadotropin-releasing hormone (GnRH) analog [e.g., Lupron (leuprolide), Zoladex (goserelin), Trelstar (triptorelin), Vantas (histrelin), Firmagon (degarelix)] • Patient has had bilateral orchiectomy OR 2.2 BOTH of the following: 2.2.1 Disease is metastatic castration-sensitive AND 2.2.2 ONE of the following:	

- Used in combination with a gonadotropin-releasing hormone (GnRH) analog [e.g., Lupron (leuprolide), Zoladex (goserelin), Trelstar (triptorelin), Vantas (histrelin), Firmagon (degarelix)]
- Patient has had bilateral orchiectomy

OR

2.3 Disease is non-metastatic castration-sensitive with biochemical recurrence at high risk for metastasis

AND

3 - ONE of the following:

3.1 Failure to abiraterone (generic Zytiga) as confirmed by claims history or submission of medical records

OR

3.2 History of contraindication or intolerance to abiraterone (generic Zytiga) (please specify contraindication or intolerance)

OR

3.3 Continuation of ongoing Xtandi therapy

AND

4 - If the request is for Xtandi capsules, provider gives a reason or special circumstance why the patient is unable to use Xtandi tablets

Product Name:Xtandi	
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 Xtandi therapy	

Product Name:Xtandi	
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:Xtandi	
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 Xtandi therapy	

2 . Revision History

Date	Notes

12/5/2025	Combined formularies. Removed step through Erleada and Nubeqa throughout the policy. Added a verification why patients are unable to use tablets if requesting capsules. Minor cosmetic updates.

Xuriden



Prior Authorization Guideline

Guideline ID	GL-356205
Guideline Name	Xuriden
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 Indiana Medicaid - Community & State Nebraska Medicaid - Community & State New Mexico Medicaid - Community & State Pennsylvania Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	9/1/2025

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
8/4/2025	Combined formularies. No changes to clinical criteria.

Yorvipath



Prior Authorization Guideline

Guideline ID	GL-398213
Guideline Name	Yorvipath
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	10/1/2025

1 . Criteria

Product Name:Yorvipath	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of hypoparathyroidism for 6 months or greater	

AND

2 - Submission of labs supporting historic hypocalcemia along with inappropriately low serum PTH levels

AND

3 - Patient is 18 years of age or older

AND

4 - Patient has had inadequate response to BOTH of the following therapies:

- At least 90 days of elemental calcium at greater than or equal to 800 mg/day
- At least 90 days vitamin D analog agent (e.g., calcitriol greater than or equal to 0.5 mcg/day)

AND

5 - Prescribed by, or in consultation with, an endocrinologist

AND

6 - Prescriber attests Yorvipath will not be used for acute postsurgical hypoparathyroidism treatment

AND

7 - Prescriber attests to ALL of the following lab values:

- Vitamin D level within normal limits (i.e., 20 – 80 ng/mL) within 2 weeks prior to initiation
- Albumin-corrected serum calcium greater than or equal to 7.8 mg/dL within 2 weeks prior to initiation

- Baseline magnesium concentration greater than or equal to 1.3 mg/dL

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

Approval Criteria

1 - History of Yorvipath for at least 84 days within the past 112 days, confirmed by claims history or chart documentation

AND

2 - Patient is experiencing positive clinical response from Yorvipath

AND

3 - One of the following:

3.1 Submission of labs collected within the past 3 months showing maintenance or normalization of albumin-corrected serum calcium levels compared to baseline

OR

3.2 Documentation that there has been a reduction in dose of or independence from conventional therapy (i.e., vitamin D analog and/or elemental calcium therapy)

2 . Revision History

Date	Notes
9/16/2025	New

Zejula



Prior Authorization Guideline

Guideline ID	GL-467219
Guideline Name	Zejula
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia Medicaid - Community & State Washington

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Zejula

Diagnosis	Ovarian Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following: • Epithelial ovarian cancer • Fallopian tube cancer • Primary peritoneal cancer AND 2 - Disease is stage II-IV AND 3 - ONE of the following: 3.1 BOTH of the following: • Maintenance therapy for those who are in complete or partial response after first-line platinum-based chemotherapy • Recurrence therapy for platinum-sensitive disease in combination with bevacizumab OR 3.2 BOTH of the following: • Maintenance therapy for those who are in complete or partial response to platinum-based chemotherapy for recurrent disease • Disease with a deleterious or suspected deleterious germline BRCA mutation OR	

3.3 BOTH of the following:

- Recurrent therapy for platinum-sensitive disease
- Used in combination with bevacizumab

Product Name:Zejula	
Diagnosis	Prostate Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of castration-resistant distant metastatic (M1) prostate cancer

AND

2 - Patient is positive for pathogenic BRCA1 or BRCA2 mutation

AND

3 - Patient has not had treatment since disease progression to metastatic castration-resistant prostate cancer (mCRPC)

AND

4 - ONE of the following:

- Patient has not received prior docetaxel and prior novel hormone therapy
- Patient had progression on prior docetaxel therapy and has not received prior novel hormone therapy
- Patient had progression on prior novel hormone therapy and has not received prior docetaxel therapy

AND

5 - Used in combination with abiraterone or Yonsa (fine-particle abiraterone)

Product Name:Zejula

Diagnosis	Uterine Sarcoma

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of BRCA-2 (breast cancer) altered uterine leiomyosarcoma (LMS)

AND

2 - Disease is advanced, recurrent/metastatic, or inoperable

AND

3 - Used as second-line or subsequent therapy

Product Name:Zejula

Diagnosis	Ovarian Cancer, Prostate Cancer, Uterine 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 Zejula therapy

Product Name:Zejula

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:Zejula

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 Zejula therapy

2 . Revision History

Date	Notes
12/9/2025	Updated formularies to include IN for eff 1/1/26.

Zelboraf



Prior Authorization Guideline

Guideline ID	GL-522196
Guideline Name	Zelboraf
Formulary	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

Guideline Note:

Effective Date:	2/15/2026

1 . Criteria

Product Name:Zelboraf	
Diagnosis	Melanoma

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following diagnoses: • Unresectable melanoma • Metastatic melanoma AND 2 - Patient is positive for BRAF V600 mutation	

Product Name:Zelboraf	
Diagnosis	Central Nervous System (CNS) Cancers
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: 1.1.1 Patient has metastatic brain lesions AND 1.1.2 Zelboraf is active against primary tumor (melanoma)	

OR

1.2 BOTH of the following:

1.2.1 Diagnosis of glioma

AND

1.2.2 ONE of the following:

- Incomplete resection, biopsy, or surgically inaccessible location
- Disease is recurrent or progressive

AND

2 - Cancer is positive for BRAF V600E mutation

AND

3 - Used in combination with Cotellic (cobimetinib)

Product Name:Zelboraf	
Diagnosis	Hairy Cell Leukemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of hairy cell leukemia	

Product Name:Zelboraf

Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of non-small cell lung cancer (NSCLC) AND 2 - Disease is ONE of the following: • Metastatic • Advanced • Recurrent AND 3 - Cancer is positive for BRAF V600E mutation	

Product Name:Zelboraf	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following: • Erdheim-Chester Disease • Langerhans Cell Histiocytosis	

AND

2 - Cancer is positive for BRAF V600 mutation

Product Name:Zelboraf

Diagnosis	Thyroid Cancer

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following:

- Follicular carcinoma
- Oncocytic carcinoma
- Papillary carcinoma

AND

2 - ONE of the following:

- Unresectable locoregional recurrent disease
- Metastatic disease
- Persistent disease

AND

3 - ONE of the following:

- Patient has symptomatic disease
- Patient has progressive disease

AND

4 - Disease is refractory to radioactive iodine

AND

5 - Cancer is positive for BRAF V600 mutation

Product Name:Zelboraf

Diagnosis	Melanoma, CNS Cancers, Hairy Cell Leukemia, NSCLC, Histiocytic Neoplasms, Thyroid 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 Zelboraf therapy

Product Name:Zelboraf

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:Zelboraf

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 Zelboraf therapy	

2 . Revision History

Date	Notes
2/11/2026	Removed WA from formularies, WA moved to state mandated criteria . No other changes to guideline.

Zilbrysq



Prior Authorization Guideline

Guideline ID	GL-571198
Guideline Name	Zilbrysq
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 Indiana Medicaid - Community & State Nebraska Medicaid - Community & State Nevada Medicaid - Community & State New Mexico Medicaid - Community & State Pennsylvania Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Zilbrysq	
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.) confirming ALL of the following:

1.1 Diagnosis of generalized myasthenia gravis (gMG)

AND

1.2 Positive serologic test for anti-AChR antibodies

AND

1.3 Patient has a Myasthenia Gravis Foundation of America (MGFA) Clinical Classification of class II, III, or IV at initiation of therapy

AND

1.4 Patient has a Myasthenia Gravis Activities of Daily Living scale (MG-ADL) total score greater than or equal to 6 at initiation of therapy

AND

2 - ONE of the following:

2.1 History of failure of at least two immunosuppressive agents over the course of at least 12 months (e.g., azathioprine, corticosteroids, cyclosporine, methotrexate, mycophenolate, etc.) as confirmed by claims history or submission of medical records

OR

2.2 Patient has a history of failure of at least one immunosuppressive therapy (as confirmed by claims history or submission of medical records) and has required four or more courses of plasmapheresis/ plasma exchanges and/or intravenous immune globulin over the course of at least 12 months without symptom control

OR

2.3 Contraindication or intolerance to at least two immunosuppressive agents (please specify contraindication or intolerance)

AND

3 - Patient is NOT receiving Zilbrysq in combination with another complement inhibitor [e.g., eculizumab, Ultomiris (ravulizumab-cwvz)] or a neonatal Fc receptor blocker [e.g., Imaavy (nipocalimab-aahu), Rystiggo (rozanolixizumab-noli), Vyvgart (efgartigimod alfa-fcab) or Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc)]

AND

4 - 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 - Submission of medical records (e.g., chart notes, laboratory tests) to demonstrate a positive clinical response from baseline as demonstrated by at least ALL of the following: 1.1 Improvement and/or maintenance of at least a 2-point improvement (reduction in score) in the Myasthenia Gravis Activities of Daily Living scale (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 Zilbrysq*

AND

2 - Patient is NOT receiving Zilbrysq in combination with another complement inhibitor [e.g., eculizumab, Ultomiris (ravulizumab-cwvz)] or a neonatal Fc receptor blocker [e.g., Imaavy (nipocalimab-aahu), Rystiggo (rozanolixizumab-noli) or Vyvgart (efgartigimod alfa-fcab), Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc)]

AND

3 - Prescribed by, or in consultation with, a neurologist

Notes	*Add on, dose escalation of IST, or additional rescue therapy from baseline to treat myasthenia gravis or exacerbation of symptoms while on Zilbrysq therapy will be considered as treatment failure

2 . Revision History

Date	Notes
4/10/2026	Added IN and PACAID.

Zolanza



Prior Authorization Guideline

Guideline ID	GL-467220
Guideline Name	Zolanza
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia Medicaid - Community & State Washington

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Zolanza

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) [e.g., mycosis fungoides (MF) or Sezary syndrome) AND 2 - ONE of the following: 2.1 Used as primary treatment in ONE of the following settings: • Stage IB – IIA • Stage IIB with limited tumor lesions • Stage IIB with generalized tumor lesions, in combination with skin-directed therapy (e.g., phototherapy, topical corticosteroids, topical imiquimod) • Stage III, in combination with skin-directed therapy (e.g., phototherapy, topical corticosteroids, topical imiquimod) • Stage IVA1 or IVA2 Sezary syndrome, in combination with skin-directed therapy (e.g., phototherapy, topical corticosteroids, topical imiquimod) OR 2.2 Used as subsequent treatment in progressive, persistent, or recurrent disease	

Product Name:Zolinza	
Diagnosis	Classic Hodgkin Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Classic Hodgkin Lymphoma

AND

2 - Disease is refractory to at least 3 prior lines of subsequent therapy (e.g., rituximab, doxorubicin, cyclophosphamide, ifosfamide, carboplatin, etoposide, etc.)

AND

3 - Used in combination with Keytruda (pembrolizumab)

Product Name:Zolinza	
Diagnosis	Cutaneous T-Cell Lymphoma, Classic Hodgkin Lymphoma
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 Zolinza therapy	

Product Name:Zolinza	
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:Zolinza

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 Zolinza therapy

2 . Revision History

Date	Notes
12/10/2025	Combined formularies. Updated coverage criteria for cutaneous t-cell lymphoma per NCCN recommendation. Added new criteria for Classic Hodgkin Lymphoma.

Zolanza



Prior Authorization Guideline

Guideline ID	GL-467220
Guideline Name	Zolanza
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia Medicaid - Community & State Washington

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Zolanza

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) [e.g., mycosis fungoides (MF) or Sezary syndrome) AND 2 - ONE of the following: 2.1 Used as primary treatment in ONE of the following settings: • Stage IB – IIA • Stage IIB with limited tumor lesions • Stage IIB with generalized tumor lesions, in combination with skin-directed therapy (e.g., phototherapy, topical corticosteroids, topical imiquimod) • Stage III, in combination with skin-directed therapy (e.g., phototherapy, topical corticosteroids, topical imiquimod) • Stage IVA1 or IVA2 Sezary syndrome, in combination with skin-directed therapy (e.g., phototherapy, topical corticosteroids, topical imiquimod) OR 2.2 Used as subsequent treatment in progressive, persistent, or recurrent disease	

Product Name:Zolinza	
Diagnosis	Classic Hodgkin Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Classic Hodgkin Lymphoma

AND

2 - Disease is refractory to at least 3 prior lines of subsequent therapy (e.g., rituximab, doxorubicin, cyclophosphamide, ifosfamide, carboplatin, etoposide, etc.)

AND

3 - Used in combination with Keytruda (pembrolizumab)

Product Name:Zolinza

Diagnosis	Cutaneous T-Cell Lymphoma, Classic Hodgkin Lymphoma
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 Zolinza therapy

Product Name:Zolinza

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:Zolinza

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 Zolinza therapy

2 . Revision History

Date	Notes
12/10/2025	Combined formularies. Updated coverage criteria for cutaneous t-cell lymphoma per NCCN recommendation. Added new criteria for Classic Hodgkin Lymphoma.

Zurzuvae



Prior Authorization Guideline

Guideline ID	GL-143437
Guideline Name	Zurzuvae
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2024

1 . Criteria

Product Name:Zurzuvae	
Approval Length	14 Day(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of postpartum depression (PPD) AND	

2 - Patient is 18 years of age or older

AND

3 - Patient is within 12 months (365 days) of being postpartum (Documentation of date of delivery required)

AND

4 - Patient is not exceeding one treatment course (14 days of therapy) per 365 days

AND

5 - Requested dose does not exceed one of the following:

5.1 If the request is for 20 mg OR 25 mg capsules: 28 capsules for 14-day period (2 capsules per day)

OR

5.2 If the request is for 30 mg capsules, BOTH of the following:

5.2.1 Dose does not exceed 14 capsules for 14-day period (1 capsule per day)

AND

5.2.2 Submission of medical records (e.g., chart notes, laboratory tests/values, assessments) confirming one of the following:

- Severe hepatic impairment (Child-Pugh C)
- Moderate to severe renal impairment (eGFR less than 60 mL/min/1.73m²)

2 . Revision History

UnitedHealthcare Community Plan of Indiana Clinical Pharmacy Program Guidelines

Date	Notes
2/22/2024	New

Zydelig



Prior Authorization Guideline

Guideline ID	GL-127469
Guideline Name	Zydelig
Formulary	Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	8/1/2023

1 . Criteria

Product Name:Zydelig	
Diagnosis	Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chronic lymphocytic leukemia (CLL)/ small lymphocytic lymphoma (SLL)	

AND

2 - ONE of the following:

- Disease has relapsed
- Disease is refractory

Product Name:Zydelig	
Diagnosis	Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL)
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 Zydelig therapy	

Product Name:Zydelig	
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:Zydelig

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 Zydelig therapy	

2 . Revision History

Date	Notes
7/3/2023	Clarified criteria for CLL/SLL per NCCN guidelines. Updated Markets in Scope

Zykadia



Prior Authorization Guideline

Guideline ID	GL-581200
Guideline Name	Zykadia
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 Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Zykadia	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of non-small cell lung cancer (NSCLC) AND 2 - ONE of the following: • Disease is metastatic • Disease is recurrent • Disease is advanced AND 3 - Tumor is ALK (anaplastic lymphoma kinase)-positive	

Product Name:Zykadia	
Diagnosis	Soft Tissue Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of inflammatory myofibroblastic tumor (IMT) with anaplastic lymphoma kinase (ALK) translocation	

Product Name:Zykadia	
Diagnosis	Central Nervous System (CNS) Cancers

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of metastatic brain cancer from non-small cell lung cancer (NSCLC) AND 2 - Tumor is anaplastic lymphoma kinase (ALK)-positive	

Product Name:Zykadia	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Erdheim-Chester Disease AND 2 - Disease is positive for anaplastic lymphoma kinase (ALK) rearrangement	

Product Name:Zykadia	
Diagnosis	Anaplastic Large Cell Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of anaplastic large cell lymphoma

AND

2 - Tumor is anaplastic lymphoma kinase (ALK)-positive

AND

3 - Disease is relapsed or refractory

AND

4 - Used as palliative intent therapy or second-line and subsequent therapy

Product Name:Zykadia

Diagnosis	Uterine Neoplasms

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of inflammatory myofibroblastic tumor (IMT) with anaplastic lymphoma kinase (ALK) translocation

AND

2 - ONE of the following:

- Disease is metastatic
- Disease is recurrent
- Disease is advanced

Product Name:Zykadia	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC), Soft Tissue Sarcoma, Central Nervous System (CNS) Cancers, Histiocytic Neoplasms, Anaplastic Large Cell Lymphoma, Uterine Neoplasms
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 Zykadia therapy	

Product Name:Zykadia	
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:Zykadia	
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 Zykadia therapy	

2 . Revision History

Date	Notes
4/15/2026	Added IN.