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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

Acitretin



Prior Authorization Guideline

Guideline ID	GL-434337
Guideline Name	Acitretin
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State New Jersey Medicaid - Community & State New Mexico Medicaid - Community & State New York Medicaid - Community & State New York EPP 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: acitretin	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of severe psoriasis AND 2 - Prescribed by or in consultation with a dermatologist AND 3 - ONE of the following: 3.1 Failure to a 3-month trial of methotrexate at the maximally indicated dose, as confirmed by claims history or submission of medical records OR 3.2 History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication) AND 4 - ONE of the following: • Greater than or equal to 10% body surface area involvement • Palmoplantar, facial, or genital involvement • Severe scalp psoriasis	

Product Name:acitretin	
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
11/4/2025	Added NV Formulary.

Actimmune



Prior Authorization Guideline

Guideline ID	GL-127780
Guideline Name	Actimmune
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

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	

2 . Revision History

Date	Notes
7/10/2023	Updated formularies, simplified and combined criteria, updated indications, cleaned up criteria.

Actimmune



Prior Authorization Guideline

Guideline ID	GL-127780
Guideline Name	Actimmune
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

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	

2 . Revision History

Date	Notes
7/10/2023	Updated formularies, simplified and combined criteria, updated indications, cleaned up criteria.

Adalimumab



Prior Authorization Guideline

Guideline ID	GL-551218
Guideline Name	Adalimumab
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

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:Humira, Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi, Yuflyma, Yusimry, Adalimumab (all products)	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderately to severely active rheumatoid arthritis AND 2 - Patient is not receiving adalimumab in combination with another systemic targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)] for treatment of the same indication AND 3 - Prescribed by or in consultation with a rheumatologist AND 4 - ONE of the following: 4.1 Patient is currently on Adalimumab therapy as confirmed by claims history or submission of medical records OR 4.2 BOTH of the following: 4.2.1 ONE of the following: • Failure to a 3 month trial of ONE non-biologic DMARD (e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine) at maximally indicated doses confirmed by claims history or submission of medical records • History of intolerance or contraindication to one non-biologic DMARD (e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine) (please specify intolerance or contraindication)	

- Patient has been previously treated with a systemic targeted immunomodulator FDA-approved for the treatment of rheumatoid arthritis as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), Simponi (golimumab), Olumiant (baricitinib), Rinvoq (upadacitinib), Xeljanz/Xeljanz XR (tofacitinib)]

AND

4.2.2 If the request is for a non-preferred adalimumab product, ONE of the following:

- Failure of Tyenne (tocilizumab-aazg) confirmed by claims history or submitted medical records
- History of intolerance or contraindication to Tyenne (tocilizumab-aazg) [please specify intolerance or contraindication]

AND

5 - If the request is for a non-preferred adalimumab product, the prescriber has given a clinical reason or special circumstance why the patient is unable to use the preferred adalimumab products (please document reason/special circumstances)*

AND

6 - If the request is for BRAND Humira, ONE of the following:

6.1 Submission of medical records confirming patient allergy or intolerance to at least two preferred adalimumab biosimilars' inactive ingredients

OR

6.2 BOTH of the following:

- Submission of medical records confirming patient has previously been successfully treated with brand Humira
- Submission of medical records confirming patient has tried at least two preferred adalimumab biosimilars for 6-8 weeks per product and saw a decrease in effectiveness

Notes	*If approving a non-preferred adalimumab, please enter 1) The group authorization CSPREFADAL (for NY EPP and NY use: CSNYADAL)

	2) An authorization for the non-preferred adalimumab at GPI-12 level See PDL links in Background

Product Name: Humira, Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi, Yuflyma, Yusimry, Adalimumab (all products)	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (PJIA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ALL of the following: 1.1 Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis AND 1.2 Patient is not receiving adalimumab in combination with another systemic targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olanercept (baricitinib), Rinvoq (upadacitinib)] for treatment of the same indication AND 1.3 Prescribed by or in consultation with a rheumatologist AND 1.4 If the request is for a non-preferred adalimumab product, the prescriber has given a clinical reason or special circumstance why the patient is unable to use the preferred adalimumab products (please document reason/special circumstances)* AND	

1.5 If the request is for a non-preferred adalimumab product, ONE of the following:

- Failure of Tyenne (tocilizumab-aazg) confirmed by claims history or submitted medical records
- History of intolerance or contraindication to Tyenne (tocilizumab-aazg) [please specify intolerance or contraindication]

AND

1.6 If the request is for BRAND Humira, ONE of the following:

1.6.1 Submission of medical records confirming patient allergy or intolerance to at least two preferred adalimumab biosimilars' inactive ingredients

OR

1.6.2 BOTH of the following:

- Submission of medical records confirming patient has previously been successfully treated with brand Humira
- Submission of medical records confirming patient has tried at least two preferred adalimumab biosimilars for 6-8 weeks per product and saw a decrease in effectiveness

OR

2 - ALL of the following:

2.1 Patient is currently on Adalimumab therapy as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis

AND

2.3 Patient is not receiving adalimumab in combination with another systemic targeted

immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)] for treatment of the same indication

AND

2.4 Prescribed by or in consultation with a rheumatologist

AND

2.5 If the request is for a non-preferred adalimumab product, the prescriber has given a clinical reason or special circumstance why the patient is unable to use the preferred adalimumab products (please document reason/special circumstances)*

AND

2.6 If the request is for BRAND Humira, ONE of the following:

2.6.1 Submission of medical records confirming patient allergy or intolerance to at least two preferred adalimumab biosimilars' inactive ingredients

OR

2.6.2 BOTH of the following:

- Submission of medical records confirming patient has previously been successfully treated with brand Humira
- Submission of medical records confirming patient has tried at least two preferred adalimumab biosimilars for 6-8 weeks per product and saw a decrease in effectiveness

Notes	*If approving a non-preferred adalimumab, please enter 1) The group authorization CSPREFADAL (for NY EPP and NY use: CSNYADAL) 2) An authorization for the non-preferred adalimumab at GPI-12 level See PDL links in Background

Product Name: Humira, Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi, Yuflyma, Yusimry, Adalimumab (all products)	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of active psoriatic arthritis AND 2 - Patient is not receiving adalimumab in combination with another systemic targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), ustekinumab, Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)] for treatment of the same indication AND 3 - Prescribed by or in consultation with one of the following: • Rheumatologist • Dermatologist AND 4 - ONE of the following: 4.1 Patient is currently on Adalimumab therapy as confirmed by claims history or submission of medical records OR 4.2 ONE of the following:	

- Failure to a 3 month trial of methotrexate at the maximally indicated dose confirmed by claims history or submission of medical records
- History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)
- Patient has been previously treated with a systemic targeted immunomodulator FDA-approved for the treatment of psoriatic arthritis as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), Simponi (golimumab), ustekinumab, Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), Otezla (apremilast), Skyrizi (risankizumab-rzaa)]

AND

5 - If the request is for a non-preferred adalimumab product, the prescriber has given a clinical reason or special circumstance why the patient is unable to use the preferred adalimumab products (please document reason/special circumstances)*

AND

6 - If the request is for BRAND Humira, ONE of the following:

6.1 Submission of medical records confirming patient allergy or intolerance to at least two preferred adalimumab biosimilars' inactive ingredients

OR

6.2 BOTH of the following:

- Submission of medical records confirming patient has previously been successfully treated with brand Humira
- Submission of medical records confirming patient has tried at least two preferred adalimumab biosimilars for 6-8 weeks per product and saw a decrease in effectiveness

Notes

*If approving a non-preferred adalimumab, please enter
 1) The group authorization CSPREFADAL (for NY EPP and NY use: CSNYADAL)
 2) An authorization for the non-preferred adalimumab at GPI-12 level
 See PDL links in Background

Product Name:Humira, Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi, Yuflyma, Yusimry, Adalimumab (all products)	
Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderate to severe chronic plaque psoriasis AND 2 - Patient is not receiving adalimumab in combination with another systemic targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), ustekinumab, Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)] for treatment of the same indication AND 3 - Prescribed by or in consultation with a dermatologist AND 4 - ONE of the following: 4.1 Patient is currently on Adalimumab therapy as confirmed by claims history or submission of medical records OR 4.2 ONE of the following: 4.2.1 ALL of the following:	

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

AND

4.2.1.2 ONE of the following:

4.2.1.2.1 Failure to ONE of the following topical therapy classes confirmed by claims history or submission of medical records:

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Anthralin
- Coal tar

OR

4.2.1.2.2 History of intolerance or contraindication to ALL of the following topical therapy classes (please specify intolerance or contraindication):

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Anthralin
- Coal tar

AND

4.2.1.3 ONE of the following:

4.2.1.3.1 Failure to a 3 month trial of methotrexate at the maximally indicated dose confirmed by claims history or submission of medical records

OR

4.2.1.3.2 History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

OR

4.2.2 Patient has been previously treated with a systemic targeted immunomodulator FDA-approved for the treatment of plaque psoriasis as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), Otezla (apremilast), Skyrizi (risankizumab-rzaa), ustekinumab, Tremfya (guselkumab)]

AND

5 - If the request is for a non-preferred adalimumab product, the prescriber has given a clinical reason or special circumstance why the patient is unable to use the preferred adalimumab products (please document reason/special circumstances)*

AND

6 - If the request is for BRAND Humira, ONE of the following:

6.1 Submission of medical records confirming patient allergy or intolerance to at least two preferred adalimumab biosimilars' inactive ingredients

OR

6.2 BOTH of the following:

- Submission of medical records confirming patient has previously been successfully treated with brand Humira
- Submission of medical records confirming patient has tried at least two preferred adalimumab biosimilars for 6-8 weeks per product and saw a decrease in effectiveness

Notes

*If approving a non-preferred adalimumab, please enter
 1) The group authorization CSPREFADAL (for NY EPP and NY use: CSNYADAL)
 2) An authorization for the non-preferred adalimumab at GPI-12 level

See PDL links in Background

Product Name: Humira, Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi, Yuflyma, Yusimry, Adalimumab (all products)	
Diagnosis	Ankylosing Spondylitis (AS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of active ankylosing spondylitis AND 2 - Patient is not receiving adalimumab in combination with another systemic targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)] for treatment of the same indication AND 3 - Prescribed by or in consultation with a rheumatologist AND 4 - ONE of the following: 4.1 Patient is currently on Adalimumab therapy as confirmed by claims history or submission of medical records OR 4.2 ONE of the following: 4.2.1 Failure to two NSAIDs (e.g., ibuprofen, naproxen) at maximally indicated doses, each used for at least 4 weeks, as confirmed by claims history or submission of medical records	

OR

4.2.2 History of intolerance or contraindication to TWO NSAIDs (e.g., ibuprofen, naproxen) (please specify intolerance or contraindication)

OR

4.2.3 Patient has been previously treated with a systemic targeted immunomodulator FDA-approved for the treatment of ankylosing spondylitis as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib)]

AND

5 - If the request is for a non-preferred adalimumab product, the prescriber has given a clinical reason or special circumstance why the patient is unable to use the preferred adalimumab products (please document reason/special circumstances)*

AND

6 - If the request is for BRAND Humira, ONE of the following:

6.1 Submission of medical records confirming patient allergy or intolerance to at least two preferred adalimumab biosimilars' inactive ingredients

OR

6.2 BOTH of the following:

- Submission of medical records confirming patient has previously been successfully treated with brand Humira
- Submission of medical records confirming patient has tried at least two preferred adalimumab biosimilars for 6-8 weeks per product and saw a decrease in effectiveness

Notes

*If approving a non-preferred adalimumab, please enter
1) The group authorization CSPREFADAL (for NY EPP and NY use:

	CSNYADAL) 2) An authorization for the non-preferred adalimumab at GPI-12 level See PDL links in Background

Product Name: Humira, Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi, Yuflyma, Yusimry, Adalimumab (all products)	
Diagnosis	Crohn's Disease (CD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderately to severely active Crohn's disease AND 2 - Patient is not receiving adalimumab in combination with another systemic targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), ustekinumab, Skyrizi (risankizumab)] for treatment of the same indication AND 3 - Prescribed by or in consultation with a gastroenterologist AND 4 - ONE of the following: 4.1 Patient is currently on Adalimumab therapy as confirmed by claims history or submission of medical records OR	

4.2 ONE of the following:

4.2.1 Failure to ONE of the following conventional drugs or classes at maximally indicated doses, as confirmed by claims history or submitted medical records:

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

OR

4.2.2 History of intolerance or contraindication to ALL of the following conventional drugs or classes (please specify intolerance or contraindication):

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

OR

4.2.3 Patient has been previously treated with a systemic targeted immunomodulator FDA-approved for the treatment of Crohn's disease as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), ustekinumab]

AND

5 - If the request is for a non-preferred adalimumab product, the prescriber has given a clinical reason or special circumstance why the patient is unable to use the preferred adalimumab products (please document reason/special circumstances)*

AND

6 - If the request is for BRAND Humira, ONE of the following:

6.1 Submission of medical records confirming patient allergy or intolerance to at least two preferred adalimumab biosimilars' inactive ingredients

OR

6.2 BOTH of the following:

- Submission of medical records confirming patient has previously been successfully treated with brand Humira
- Submission of medical records confirming patient has tried at least two preferred adalimumab biosimilars for 6-8 weeks per product and saw a decrease in effectiveness

Notes

*If approving a non-preferred adalimumab, please enter
 1) The group authorization CSPREFADAL (for NY EPP and NY use: CSNYADAL)
 2) An authorization for the non-preferred adalimumab at GPI-12 level
 See PDL links in Background

Product Name: Humira, Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi, Yuflyma, Yusimry, Adalimumab (all products)

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

Approval Criteria

1 - Diagnosis of moderately to severely active ulcerative colitis

AND

2 - Patient is not receiving adalimumab in combination with another systemic targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), ustekinumab, Skyrizi (risankizumab)] for treatment of the same indication

AND

3 - Prescribed by or in consultation with a gastroenterologist

AND

4 - ONE of the following:

4.1 Patient is currently on Adalimumab therapy as confirmed by claims history or submission of medical records

OR

4.2 ONE of the following:

4.2.1 Patient has had prior or concurrent inadequate response to a therapeutic course of oral corticosteroids or immunosuppressants (e.g., azathioprine, 6-mercaptopurine) as confirmed by claims history or submitted medical records

OR

4.2.2 Patient has been previously treated with a systemic targeted immunomodulator FDA-approved for the treatment of ulcerative colitis as confirmed by claims history or submission medical records [e.g., Simponi (golimumab), ustekinumab, Xeljanz (tofacitinib)]

AND

5 - If the request is for a non-preferred adalimumab product, the prescriber has given a clinical reason or special circumstance why the patient is unable to use the preferred adalimumab products (please document reason/special circumstances)*

AND

6 - If the request is for BRAND Humira, ONE of the following:

6.1 Submission of medical records confirming patient allergy or intolerance to at least two preferred adalimumab biosimilars' inactive ingredients

OR

6.2 BOTH of the following:

- Submission of medical records confirming patient has previously been successfully treated with brand Humira
- Submission of medical records confirming patient has tried at least two preferred adalimumab biosimilars for 6-8 weeks per product and saw a decrease in effectiveness

Notes

*If approving a non-preferred adalimumab, please enter
 1) The group authorization CSPREFADAL (for NY EPP and NY use: CSNYADAL)
 2) An authorization for the non-preferred adalimumab at GPI-12 level

 See PDL links in Background

Product Name: Humira, Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi, Yuflyma, Yusimry, Adalimumab (all products)

Diagnosis	Hidradenitis Suppurativa (HS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe hidradenitis suppurativa (i.e., Hurley Stage II or III)

AND

2 - Patient is not receiving adalimumab in combination with another systemic targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)] for treatment of the same indication

AND

3 - Prescribed by or in consultation with a dermatologist

AND

4 - ONE of the following:

4.1 Patient is currently on Adalimumab therapy as confirmed by claims history or submission of medical records

OR

4.2 ONE of the following:

4.2.1 Failure to at least ONE oral antibiotic (e.g., doxycycline, clindamycin, rifampin) at maximally indicated doses, as confirmed by claims history or submission of medical records

OR

4.2.2 History of intolerance or contraindication to at least ONE oral antibiotic (e.g., doxycycline, clindamycin, rifampin) (please specify intolerance or contraindication)

OR

4.2.3 Patient has been previously treated with a systemic targeted immunomodulator FDA-approved for the treatment of hidradenitis suppurativa as confirmed by claims history or submitted medical records [e.g., Bimzelx (bimekizumab-bkzx), Cosentyx (secukinumab)]

AND

5 - If the request is for a non-preferred adalimumab product, the prescriber has given a clinical reason or special circumstance why the patient is unable to use the preferred adalimumab products (please document reason/special circumstances)*

AND

6 - If the request is for BRAND Humira, ONE of the following:

6.1 Submission of medical records confirming patient allergy or intolerance to at least two preferred adalimumab biosimilars' inactive ingredients

OR

6.2 BOTH of the following:

- Submission of medical records confirming patient has previously been successfully treated with brand Humira
- Submission of medical records confirming patient has tried at least two preferred adalimumab biosimilars for 6-8 weeks per product and saw a decrease in effectiveness

Notes	*If approving a non-preferred adalimumab, please enter 1) The group authorization CSPREFADAL (for NY EPP and NY use: CSNYADAL) 2) An authorization for the non-preferred adalimumab at GPI-12 level See PDL links in Background

Product Name:Humira, Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi, Yuflyma, Yusimry, Adalimumab (all products)	
Diagnosis	Uveitis (UV)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of non-infectious uveitis	

AND

2 - Uveitis is classified as ONE of the following:

- Intermediate
- Posterior
- Panuveitis

AND

3 - Patient is not receiving adalimumab in combination with another systemic targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)] for treatment of the same indication

AND

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

- Rheumatologist
- Ophthalmologist

AND

5 - ONE of the following:

5.1 Patient is currently on Adalimumab therapy as confirmed by claims history or submission of medical records

OR

5.2 BOTH of the following:

5.2.1 ONE of the following:

5.2.1.1 Failure to at least ONE corticosteroid (e.g., prednisolone, prednisone) at maximally indicated dose, as confirmed by claims history or submission of medical records

OR

5.2.1.2 History of intolerance or contraindication to at least ONE corticosteroid (e.g., prednisolone, prednisone) (please specify intolerance or contraindication)

AND

5.2.2 ONE of the following:

5.2.2.1 Failure to at least ONE systemic non-biologic immunosuppressant (e.g., methotrexate, cyclosporine, azathioprine, mycophenolate) at maximally indicated dose, as confirmed by claims history or submission of medical records

OR

5.2.2.2 History of intolerance or contraindication to at least ONE systemic non-biologic immunosuppressant (e.g., methotrexate, cyclosporine, azathioprine, mycophenolate) (please specify intolerance or contraindication)

AND

6 - If the request is for a non-preferred adalimumab product, the prescriber has given a clinical reason or special circumstance why the patient is unable to use the preferred adalimumab products (please document reason/special circumstances)*

AND

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

7.1 Submission of medical records confirming patient allergy or intolerance to at least two preferred adalimumab biosimilars' inactive ingredients

OR

7.2 BOTH of the following:

• Submission of medical records confirming patient has previously been successfully treated with brand Humira • Submission of medical records confirming patient has tried at least two preferred adalimumab biosimilars for 6-8 weeks per product and saw a decrease in effectiveness	
Notes	*If approving a non-preferred adalimumab, please enter 1) The group authorization CSPREFADAL (for NY EPP and NY use: CSNYADAL) 2) An authorization for the non-preferred adalimumab at GPI-12 level See PDL links in Background

Product Name: Humira, Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi, Yuflyma, Yusimry, Adalimumab (all products)	
Diagnosis	RA, PJA, PsA, Plaque Psoriasis, AS, CD, Ulcerative Colitis, HS, UV
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Adalimumab therapy AND 2 - Patient is not receiving adalimumab in combination with another systemic targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), ustekinumab, Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]^ for treatment of the same indication AND 3 - If the request is for a non-preferred adalimumab product, the prescriber has given a clinical	

reason or special circumstance why the patient is unable to use the preferred adalimumab products (please document reason/special circumstances)* AND 4 - If the request is for BRAND Humira, ONE of the following: 4.1 Submission of medical records confirming patient allergy or intolerance to at least two preferred adalimumab biosimilars' inactive ingredients OR 4.2 BOTH of the following: • Submission of medical records confirming patient has previously been successfully treated with brand Humira • Submission of medical records confirming patient has tried at least two preferred adalimumab biosimilars for 6-8 weeks per product and saw a decrease in effectiveness	
Notes	*If approving a non-preferred adalimumab, please enter 1) The group authorization CSPREFADAL (for NY EPP and NY use: CSNYADAL) 2) An authorization for the non-preferred adalimumab at GPI-12 level See PDL links in Background ^ Examples of drug(s) may not be applicable based on the requested indication.

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
NM: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-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 CHIP: 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

3 . Revision History

Date	Notes
3/17/2026	Updated GPIs. Changed 'and/or' to 'or' in the ulcerative colitis section for clarification, no change to intent

Adbry



Prior Authorization Guideline

Guideline ID	GL-228273
Guideline Name	Adbry
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State New Jersey Medicaid - Community & State New Mexico Medicaid - Community & State New York Medicaid - Community & State New York EPP Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island

Guideline Note:

Effective Date:	6/1/2025

1 . Criteria

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

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderate to severe chronic atopic dermatitis AND 2 - ONE of the following: 2.1 Failure to TWO of the following therapeutic classes of topical therapies, confirmed by claims history or submission of medical records: • One medium, high or very-high potency topical corticosteroid [e.g., mometasone furoate (generic Elocon), fluocinolone acetonide (generic Synalar), fluocinonide (generic Lidex)] (see Table 1 in Background) • One topical calcineurin inhibitor [e.g., pimecrolimus (generic Elidel), tacrolimus (generic Protopic)] • Eucrisa (crisaborole) OR 2.2 History of intolerance or contraindication to ALL of the following therapeutic classes of topical therapies (please specify intolerance or contraindication): • One medium, high or very-high potency topical corticosteroid [e.g., mometasone furoate (generic Elocon), fluocinolone acetonide (generic Synalar), fluocinonide (generic Lidex)] (see Table 1 in Background) • One topical calcineurin inhibitor [e.g., pimecrolimus (generic Elidel), tacrolimus (generic Protopic)] • Eucrisa (crisaborole) OR 2.3 Patient is currently on Adbry therapy as confirmed by claims history or submission of medical records AND	

3 - Patient is NOT receiving Adbry in combination with EITHER of the following:

- Biologic immunomodulator [e.g., Dupixent (dupilumab), Ebglyss (lebrikizumab-lbkz), Nemluvio (nemolizumab-ilto)]
- Janus kinase inhibitor [e.g., Cibinqo (abrocitinib), Opzelura (topical ruxolitinib), Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib)]

AND

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

- Dermatologist
- Allergist
- Immunologist

Product Name:Adbry	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Adbry therapy AND 2 - Patient is NOT receiving Adbry in combination with either of the following: • Biologic immunomodulator [e.g., Dupixent (dupilumab), Ebglyss (lebrikizumab-lbkz), Nemluvio (nemolizumab-ilto)] • Janus kinas inhibitor [e.g., Cibinqo (abrocitinib), Opzelura (topical ruxolitinib), Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib)] AND	

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

- Dermatologist
- Allergist
- Immunologist

2 . Background

Benefit/Coverage/Program Information			
Table 1. Relative potencies of topical corticosteroids			
Class	Drug	Dosage Form	Strength (%)
Very high potency	Augmented betamethasone dipropionate	Ointment, gel	0.05
	Clobetasol propionate	Cream, foam, ointment	0.05
	Diflorasone diacetate	Ointment	0.05
	Halobetasol propionate	Cream, ointment	0.05
High Potency	Amcinonide	Cream, lotion, ointment	0.1
	Augmented betamethasone dipropionate	Cream, lotion	0.05
	Betamethasone dipropionate	Cream, foam, ointment, solution	0.05
	Desoximetasone	Cream, ointment	0.25
	Desoximetasone	Gel	0.05
	Diflorasone diacetate	Cream	0.05
	Fluocinonide	Cream, gel, ointment, solution	0.05
	Halcinonide	Cream, ointment	0.1
	Mometasone furoate	Ointment	0.1

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

3 . Revision History

Date	Notes

4/2/2025	Updated formularies. Removed step through Dupixent, updated prescriber requirement to allow for consultation. Updated examples in safety check to add Ebglyss and Nemluvio.

ADHD Products



Prior Authorization Guideline

Guideline ID	GL-551249
Guideline Name	ADHD Products
Formulary	Medicaid - Community & State Rhode Island

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:generic amphetamine/dextroamphetamine salts (generic Adderall), generic amphetamine/dextroamphetamine salts ER (generic Adderall XR), generic methylphenidate ER tabs (generic Concerta), generic methylphenidate ER cp24 20mg, 30mg, and 40mg (generic Ritalin LA), generic methylphenidate ER tabs (generic Metadate ER), generic methylphenidate tabs (generic Ritalin), generic methylphenidate ER (CD) caps (generic Metadate CD), generic dexamethylphenidate, generic dexamethylphenidate ER, generic dextroamphetamine ER, generic dextroamphetamine 5 mg and 10 mg	
Diagnosis	Requests for Patients Greater Than or Equal to the Maximum Age Edit of 18 Years
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has Attention Deficit Hyperactivity Disorder/Attention Deficit Disorder (ADHD/ADD)

OR

2 - Patient has depression

OR

3 - Patient has narcolepsy

OR

4 - Patient has other hypersomnia of central origin

OR

5 - Patient has Autism Spectrum Disorder

OR

6 - Patient has mental fatigue secondary to traumatic brain injury (e.g., post-concussion syndrome)

OR

7 - Patient has fatigue associated with medical illness in palliative or end of life care

OR

8 - Patient has fatigue associated with multiple sclerosis

OR

9 - BOTH of the following:

9.1 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

9.2 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:generic lisdexamfetamine capsules, generic lisdexamfetamine chewable tablets

Diagnosis	Patient is greater than 18 years

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is greater than 18 years of age

AND

2 - ONE of the following:

2.1 BOTH of the following:

2.1.1 Diagnosis of ONE of the following:

2.1.1.1 Attention Deficit Hyperactivity Disorder/Attention Deficit Disorders (ADHD/ADD)

OR

2.1.1.2 Depression

OR

2.1.1.3 Narcolepsy

OR

2.1.1.4 Other hypersomnia of central origin

OR

2.1.1.5 Autism Spectrum Disorder

OR

2.1.1.6 Mental fatigue secondary to traumatic brain injury (e.g., post-concussion syndrome)

OR

2.1.1.7 Fatigue associated with medical illness in patients in palliative or end of life care

OR

2.1.1.8 Fatigue associated with multiple sclerosis

OR

2.1.1.9 BOTH of the following:

2.1.1.9.1 The use of this drug is supported by information from ONE of the following appropriate 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 (USP-NF)

AND

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

AND

2.1.2 ONE of the following:

2.1.2.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Amphetamine/dextroamphetamine salts extended-release (generic Adderall XR)
- Methylphenidate extended-release tablet or capsule (e.g., generic Concerta or Metadate CD)
- Dexmethylphenidate ER capsule (generic Focalin XR)

OR

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

- Amphetamine/dextroamphetamine salts extended-release (generic Adderall XR)
- Methylphenidate extended-release tablet or capsule (e.g., generic Concerta or Metadate CD)
- Dexmethylphenidate ER capsule (generic Focalin XR)

OR

2.1.2.3 History of, or potential for, a substance abuse disorder

OR

2.2 Diagnosis of Binge Eating Disorder (BED)

Product Name:generic lisdexamfetamine capsules, generic lisdexamfetamine chewable tablets

Diagnosis	Patient is 18 years or younger

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is 18 years of age or younger

AND

2 - Diagnosis of ONE of the following:

2.1 Attention Deficit Hyperactivity Disorder/Attention Deficit Disorders (ADHD/ADD)

OR

2.2 Binge Eating Disorder (BED)

OR

2.3 Depression

OR

2.4 Narcolepsy

OR

2.5 Other hypersomnia of central origin

OR

2.6 Autism Spectrum Disorder

OR

2.7 Mental fatigue secondary to traumatic brain injury (e.g., post-concussion syndrome)

OR

2.8 Fatigue associated with medical illness in patients in palliative or end of life care

OR

2.9 Fatigue associated with multiple sclerosis

OR

2.10 BOTH of the following:

2.10.1 The use of this drug is supported by information from ONE of the following appropriate 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 (USP-NF)

AND

2.10.2 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:(All) Brand Adderall, generic amphetamine/dextroamphetamine, Brand Adderall XR, generic amphetamine/dextroamphetamine ER, Brand Intuniv, generic guanfacine ER, generic methylphenidate ER tab, Brand Metadate CD, generic methylphenidate ER (CD), Brand Concerta, generic methylphenidate ER OSM, (generic Concerta), Brand Ritalin, generic methylphenidate tablet, Brand Ritalin LA, generic methylphenidate ER (LA), Brand Strattera, generic atomoxetine, Brand Vyvanse chewable tablets, Brand Vyvanse capsules, generic lisdexamfetamine chewable tablet, generic lisdexamfetamine capsules, Brand Adzenys XR-ODT, generic amphetamine ER ODT, Brand Aptensio XR, generic methylphenidate ER (XR) cap, Cotempla XR-ODT, Brand Daytrana, generic methylphenidate patch, Brand Desoxyn, generic methamphetamine, Brand Dexedrine, generic dextroamphetamine ER, Dyanavel XR, Brand Evekeo, generic amphetamine, Brand Focalin, generic dexmethylphenidate, Brand Focalin XR, generic dexmethylphenidate ER, Jornay PM, generic clonidine ER, Brand Methylin, generic methylphenidate soln, methylphenidate chew tabs, Brand Mydayis, generic amphetamine/dextroamphetamine ER (generic Mydayis), Brand Procentra, generic dextroamphetamine soln, Quillichew ER, Quillivant XR, Brand Zenzedi, generic dextroamphetamine, Brand Relexxii, Brand Methylphenidate ER OSM, generic methylphenidate ER OSM (generic Relexxii), Qelbree, Azstarys, Xelstryl, Onyda XR

Diagnosis	Members Less than the FDA Approved Minimum Age*
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Diagnosis of Attention Deficit Hyperactivity Disorder/Attention Deficit Disorder (ADHD/ADD)

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 - The child is unresponsive to, or has had an inadequate response to behavioral therapy

AND

3 - The child is experiencing moderate-severe continuing disturbance in function despite behavioral therapy

AND

4 - ONE of the following**:

4.1 If the request is for a preferred product, the patient has history of ONE of the following:

4.1.1 Failure to THREE preferred alternatives approved for use in the patient's age, as confirmed by claims history or submission of medical records (In instances where there are fewer than three preferred alternatives approved for use in the patient's age, the patient must have a history of failure to ALL of the preferred products for the patient's age as confirmed by claims history or submission of medical records)

OR

4.1.2 Contraindication or intolerance to THREE preferred alternatives approved for use in the patient's age (In instances where there are fewer than three preferred alternatives approved for use in the patient's age, the patient must have a history of contraindication or intolerance to ALL of the preferred products for the patient's age) (please specify contraindication or intolerance)

OR

4.2 If the request is for a non-preferred product, non-preferred criteria must also be met***

Notes	*See Table 1 in background section for FDA approved min ages. **PDL link: https://www.uhcprovider.com/en/health-plans-by-state/rhode-island-health-plans/ri-comm-plan-home/ri-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. ***For non-preferred criteria, please reference the Non-Preferred section below.

Product Name: Onyda XR	
Diagnosis	Non-Preferred
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 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 - The patient is currently receiving treatment with the requested non-preferred behavioral health medication in the hospital and must continue upon discharge OR 3 - BOTH of the following: 3.1 Diagnosis of Attention Deficit Hyperactivity Disorder/Attention Deficit Disorders (ADHD/ADD)	

AND

3.2 ONE of the following

- Failure to clonidine ER tablet (generic Kapvay) as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to clonidine ER tablet (generic Kapvay) (please specify contraindication or intolerance)

Product Name: Qelbree	
Diagnosis	Non-Preferred
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 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 - The patient is currently receiving treatment with the requested non-preferred behavioral health medication in the hospital and must continue upon discharge OR 3 - ALL of the following: 3.1 Diagnosis of Attention Deficit Hyperactivity Disorder/Attention Deficit Disorders (ADHD/ADD) AND	

3.2 ONE of the following:

3.2.1 Failure to ALL of the following, as confirmed by claims history or submission of medical records:

- guanfacine ER (generic Intuniv)
- atomoxetine (generic Strattera)
- clonidine ER (generic Kapvay)

OR

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

- guanfacine ER (generic Intuniv)
- atomoxetine (generic Strattera)
- clonidine ER (generic Kapvay)

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:

- Amphetamine/dextroamphetamine extended-release capsule (generic Adderall XR)
- Methylphenidate extended-release tablet (generic Concerta)
- Methylphenidate extended-release capsule (generic Metadate CD)
- Methylphenidate 20 mg (milligrams), 30 mg, 40 mg extended-release capsule (generic Ritalin LA)
- Dexmethylphenidate ER capsule (generic Focalin XR)
- Lisdexamfetamine dimesylate capsule (generic Vyvanse)

OR

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

- Amphetamine/dextroamphetamine extended-release capsule (generic Adderall XR)
- Methylphenidate extended-release tablet (generic Concerta)
- Methylphenidate extended-release capsule (generic Metadate CD)
- Methylphenidate 20 mg, 30 mg, 40 mg extended-release capsule (generic Ritalin LA)

- Dexmethylphenidate ER capsule (generic Focalin XR)
- Lisdexamfetamine dimesylate capsule (generic Vyvanse)

OR

3.3.3 Physician attestation that use of a stimulant medication is not appropriate for the patient

Product Name: Brand Adderall, Brand Adderall XR, Brand Adzenys XR-ODT, generic amphetamine ER ODT, Brand Aptensio XR, generic methylphenidate ER (XR) cap (generic Aptensio XR), Brand Concerta, Cotempla XR-ODT, Brand Daytrana, generic methylphenidate patch, Brand Desoxyn, generic methamphetamine, Brand Dexedrine, Dyanavel XR, Brand Evekeo, generic amphetamine, Brand Focalin, Brand Focalin XR, Brand Intuniv, Jornay PM, Brand Metadate CD, Brand Methylin, generic methylphenidate soln, methylphenidate chew tabs, Brand Mydayis, generic amphetamine/dextroamphetamine ER (generic Mydayis), Brand Procentra, generic dextroamphetamine soln, Quillichew ER, Quillivant XR, Brand Relexxii, Brand Methylphenidate ER OSM, generic methylphenidate ER OSM (generic Relexxii), Brand Ritalin, Brand Ritalin LA, generic methylphenidate ER (LA) 10 mg and 60 mg caps, Brand Strattera, Brand Zenzedi, generic dextroamphetamine 2.5 mg, 7.5 mg, 15 mg, 20 mg and 30 mg, Azstarys, Xelstryl

Diagnosis	Non-Preferred*
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

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

OR

3 - If the request is non-preferred*, ALL of the following:

3.1 The patient has a history of ONE of the following:

3.1.1 Failure to a majority (not more than three) of the preferred* formulary/PDL alternatives for the given diagnosis, as confirmed by claims history or submission of medical records (In instances where there are fewer than three preferred alternatives, the patient must have a history of failure to ALL of the preferred products for the patient's age as confirmed by claims history or submission of medical records)

OR

3.1.2 Contraindication or intolerance to a majority (not more than three) of the preferred* formulary/PDL alternatives for the given diagnosis (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 for the patient's age) (please specify contraindication or intolerance)

OR

3.1.3 If the request is for a combination product, ONE of the following:

- Failure to THREE combinations of preferred products taken concomitantly as confirmed by claims history or submitted medical records (In instances where there are fewer than three preferred combination alternatives, the patient must have a history of failure to ALL of the preferred combination products)
- History of contraindication or intolerance to THREE preferred combinations (please specify contraindication or intolerance) (In instances where there are fewer than three preferred combination alternatives, the patient must have a history of failure to ALL of the preferred combination products)

AND

3.2 If the request is for a multi-source brand medication, ONE of the following:

3.2.1 The multi-source brand is being requested because of an adverse reaction, allergy, or sensitivity to a generic equivalent (specify the adverse reaction, allergy or sensitivity)

OR

3.2.2 The multi-source brand is being requested due to a therapeutic failure with the generic equivalent, as documented by submission of medical records

OR

3.2.3 The multi-source brand is being requested because transition to a generic equivalent could result in destabilization of the patient

OR

3.2.4 Special clinical circumstances exist that preclude the use of a generic version of the multi-source brand medication for the patient (document special clinical circumstances)

AND

3.3 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

AND

3.4 ONE of the following:

3.4.1 The requested drug must be used for an FDA (Food and Drug Administration)-approved indication

OR

3.4.2 BOTH of the following:

3.4.2.1 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 Pharmacopoeia-National Formulary (USP-NF)

AND	
3.4.2.2 The drug is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plans' program	
Notes	*PDL link https://www.uhcprovider.com/en/health-plans-by-state/rhode-island-health-plans/ri-comm-plan-home/ri-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 Vyvanse capsules, Brand Vyvanse chewable tablet	
Diagnosis	ADHD/ADD
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 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 - The patient is currently receiving treatment with the requested non-preferred behavioral health medication in the hospital and must continue upon discharge OR 3 - ALL of the following: 3.1 Diagnosis of Attention Deficit Hyperactivity Disorder/Attention Deficit Disorders (ADHD/ADD) AND 3.2 ONE of the following:	

3.2.1 Failure to ALL of the following as confirmed by claims history or submission of medical records:

- Amphetamine/dextroamphetamine salts extended-release (generic Adderall XR)
- Methylphenidate extended-release tablet or capsule (e.g., generic Concerta or Metadate CD)
- Dexmethylphenidate ER capsule (generic Focalin XR)

OR

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

- Amphetamine/dextroamphetamine salts extended-release (generic Adderall XR)
- Methylphenidate extended-release tablet or capsule (e.g., generic Concerta or Metadate CD)
- Dexmethylphenidate ER capsule (generic Focalin XR)

OR

3.2.3 BOTH of the following:

3.2.3.1 History of, or potential for, a substance abuse disorder

AND

3.2.3.2 ONE of the following:

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

AND

3.3 ONE of the following*:

3.3.1 The multi-source brand is being requested because of an adverse reaction, allergy, or sensitivity to a generic equivalent (specify the adverse reaction, allergy or sensitivity)

OR

3.3.2 The multi-source brand is being requested due to a therapeutic failure with the generic equivalent, as documented by submission of medical records

OR

3.3.3 The multi-source brand is being requested because transition to a generic equivalent could result in destabilization of the patient

OR

3.3.4 Special clinical circumstances exist that preclude the use of a generic version of the multi-source brand medication for the patient (document special clinical circumstances)

Notes	*Generic Vyvanse became available 9/2023. Requests for members currently on brand Vyvanse should be evaluated for use of the GENERIC, unless the provider provides specific rationale for ongoing use of the brand.

Product Name: Brand Vyvanse capsules, Brand Vyvanse chewable tablet	
Diagnosis	Non-ADHD/ADD Diagnoses
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 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 - The patient is currently receiving treatment with the requested non-preferred behavioral health medication in the hospital and must continue upon discharge	

OR

3 - ONE of the following:

3.1 ALL of the following:

3.1.1 ONE of the following diagnoses:

3.1.1.1 Depression

OR

3.1.1.2 Narcolepsy

OR

3.1.1.3 Other hypersomnia of central origin

OR

3.1.1.4 Autism Spectrum Disorder

OR

3.1.1.5 Mental fatigue secondary to traumatic brain injury (e.g., post-concussion syndrome)

OR

3.1.1.6 Fatigue associated with medical illness in patients in palliative or end of life care

OR

3.1.1.7 Fatigue associated with multiple sclerosis

OR

3.1.1.8 BOTH of the following:

3.1.1.8.1 The use of this drug is supported by information from ONE of the following appropriate 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 (USP-NF)

AND

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

AND

3.1.2 ONE of the following:

3.1.2.1 Failure to ALL of the following as confirmed by claims history or submission of medical records:

- Amphetamine/dextroamphetamine salts extended-release (generic Adderall XR)
- Methylphenidate extended-release tablet or capsule (e.g., generic Concerta or Metadate CD)
- Dexmethylphenidate ER capsule (generic Focalin XR)

OR

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

- Amphetamine/dextroamphetamine salts extended-release (generic Adderall XR)
- Methylphenidate extended-release tablet or capsule (e.g., generic Concerta or Metadate CD)
- Dexmethylphenidate ER capsule (generic Focalin XR)

OR

3.1.2.3 History of or potential for a substance abuse disorder

AND

3.1.3 ONE of the following*:

3.1.3.1 The multi-source brand is being requested because of an adverse reaction, allergy, or sensitivity to a generic equivalent (specify the adverse reaction, allergy or sensitivity)

OR

3.1.3.2 The multi-source brand is being requested due to a therapeutic failure with the generic equivalent, as documented by submission of medical records

OR

3.1.3.3 The multi-source brand is being requested because transition to a generic equivalent could result in destabilization of the patient

OR

3.1.3.4 Special clinical circumstances exist that preclude the use of a generic version of the multi-source brand medication for the patient (document special clinical circumstances)

OR

3.2 BOTH of the following:

3.2.1 Diagnosis of Binge Eating Disorder (BED)

AND

3.2.2 ONE of the following*:

3.2.2.1 The multi-source brand is being requested because of an adverse reaction, allergy, or sensitivity to a generic equivalent (specify the adverse reaction, allergy or sensitivity)

OR

3.2.2.2 The multi-source brand is being requested due to a therapeutic failure with the generic equivalent, as documented by submission of medical records

OR

3.2.2.3 The multi-source brand is being requested because transition to a generic equivalent could result in destabilization of the patient

OR

3.2.2.4 Special clinical circumstances exist that preclude the use of a generic version of the multi-source brand medication for the patient (document special clinical circumstances)

Notes	*Generic Vyvanse became available 9/2023. Requests for members currently on brand Vyvanse should be evaluated for use of the GENER IC, unless the provider provides specific rationale for ongoing use of the brand.

2 . Background

Benefit/Coverage/Program Information	
Table 1: FDA Approved Minimum Age Table	
Product name	FDA Approved Minimum Age
All products NOT listed below	6 years of age
Adderall (amphetamine/dextroamphetamine salts)	3 years of age
Dexedrine (dextroamphetamine)	3 years of age

Evekeo (amphetamine) tablet	3 years of age
Mydayis (mixed amphetamine salts) ER capsule	13 years of age
ProCentra (dextroamphetamine) solution	3 years of age
Zenzedi (dextroamphetamine) tablet	3 years of age

3 . Revision History

Date	Notes
3/18/2026	Added t/f language for combination products into the NP section

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

Afrezza



Prior Authorization Guideline

Guideline ID	GL-267200
Guideline Name	Afrezza
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

Guideline Note:

Effective Date:	7/1/2025

1 . Criteria

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

Guideline Type	Prior Authorization
	Approval Criteria 1 - One of the following: 1.1 Diagnosis of type 1 diabetes mellitus and used in combination with a basal insulin or continuous insulin pump OR 1.2 Diagnosis of type 2 diabetes mellitus AND 2 - Patient is unable to self-inject medications (e.g. Humalog, Lantus, Levemir) due to ONE of the following: • Physical impairment • Visual impairment • Lipohypertrophy • Documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-5 for specific phobia diagnostic criteria) AND 3 - Forced Expiratory Volume (FEV1) within the last 60 days is greater than or equal to 70% of expected normal as determined by the physician AND 4 - Afrezza will not be approved in patients with ONE of the following: • Who smoke cigarettes • Who recently quit smoking (within the past 6 months) • With chronic lung disease (e.g. asthma, chronic obstructive pulmonary disease)

Product Name: Afrezza	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Repeat pulmonary function test confirms that patient has NOT experienced a decline of 20% or more in Forced Expiratory Volume (FEV1) AND 2 - Patient continues to be unable to self-inject short-acting insulin due to ONE of the following: • Physical impairment • Visual impairment • Lipohypertrophy • Documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-5 for specific phobia diagnostic criteria) AND 3 - Patient continues to not smoke cigarettes	

2 . Revision History

Date	Notes
5/15/2025	Updated formularies

Agamree



Prior Authorization Guideline

Guideline ID	GL-469190
Guideline Name	Agamree
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 New Mexico

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Agamree	
Diagnosis	Duchenne Muscular Dystrophy
Guideline Type	Prior Authorization

Approval Criteria

1 - Published clinical evidence shows Agamree is likely to produce equivalent therapeutic results as other available corticosteroids (e.g., prednisone); therefore, Agamree is not medically necessary for treatment of Duchenne muscular dystrophy

Notes	All requests for authorization will be denied by OptumRx and must be submitted through the appeals process to the UnitedHealthcare Community Plan Pharmacy Appeals team for consideration.

2 . Revision History

Date	Notes
12/10/2025	Added Nebraska and New Mexico Formulary

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

Alfa Interferons



Prior Authorization Guideline

Guideline ID	GL-480213
Guideline Name	Alfa Interferons
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

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Pegasys	
Diagnosis	Chronic Hepatitis B
Approval Length	12 month(s)

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chronic hepatitis B infection AND 2 - Patient does not have decompensated liver disease (defined as Child-Pugh Class B or C)	

Product Name:Pegasys	
Diagnosis	Chronic Hepatitis C
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chronic hepatitis C infection AND 2 - Patient does not have decompensated liver disease (defined as Child-Pugh Class B or C) AND 3 - Will be used as part of a combination antiviral treatment regimen	

Product Name:Pegasys	
Diagnosis	Diagnoses Other Than Hepatitis
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has ONE of the following diagnoses:

- Chronic myeloid leukemia (CML)
- Hairy cell leukemia
- Erdheim-Chester disease (ECD)
- Myeloproliferative neoplasms (MPNs) such as essential thrombocythemia (ET), polycythemia vera (PV), or myelofibrosis (MF)
- Mycosis fungoides/Sezary syndrome
- Primary cutaneous CD30+ T-cell lymphoproliferative disorders
- Systemic mastocytosis
- Adult T-cell leukemia/lymphoma

Product Name:Pegasys	
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:Pegasys	
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 Pegasys therapy

2 . Revision History

Date	Notes
12/16/2025	Combined formularies. Updated approval length for treatment of Chronic Hepatitis B and C criteria.

Alhemo



Prior Authorization Guideline

Guideline ID	GL-429196
Guideline Name	Alhemo
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

Guideline Note:

Effective Date:	11/1/2025

1 . Criteria

Product Name:Alhemo	
Diagnosis	Hemophilia A With Inhibitors
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following: 1.1 Diagnosis of hemophilia A AND 1.2 Patient has developed high-titer factor VIII inhibitors (i.e., patient has developed factor VIII inhibitors greater than or equal to 5 Bethesda units [BU]) AND 2 - Patient is 12 years of age or older AND 3 - Prescribed for the prevention of bleeding episodes (i.e., routine prophylaxis)	

Product Name:Alhemo	
Diagnosis	Hemophilia A Without Inhibitors
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following: 1.1 Diagnosis of hemophilia A	

AND

1.2 Patient has NOT developed high-titer factor VIII inhibitors (i.e., patient has NOT developed factor VIII inhibitors greater than or equal to 5 Bethesda units [BU])

AND

2 - Patient is 12 years of age or older

AND

3 - Alhemo is prescribed for the prevention of bleeding episodes (i.e., routine prophylaxis)

Product Name:Alhemo	
Diagnosis	Hemophilia B With Inhibitors
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following: 1.1 Diagnosis of hemophilia B AND 1.2 Patient has developed high-titer factor IX inhibitors (i.e., patient has developed factor IX inhibitors greater than or equal to 5 Bethesda units [BU]) AND	

2 - Patient is 12 years of age or older

AND

3 - Prescribed for the prevention of bleeding episodes (i.e., routine prophylaxis)

Product Name:Alhemo

Diagnosis	Hemophilia B Without Inhibitors

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - BOTH of the following:

1.1 Diagnosis of hemophilia B

AND

1.2 Patient has NOT developed high-titer factor IX inhibitors (i.e., patient has NOT developed factor IX inhibitors greater than or equal to 5 Bethesda units [BU])

AND

2 - Patient is 12 years of age or older

AND

3 - Alhemo is prescribed for the prevention of bleeding episodes (i.e., routine prophylaxis)

Product Name:Alhemo

Diagnosis	Hemophilia A With Inhibitors, Hemophilia A Without Inhibitors, Hemophilia B With Inhibitors, Hemophilia B Without Inhibitors
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Alhemo therapy	

2 . Revision History

Date	Notes
10/24/2025	Removed MI from markets in scope. Added new criteria for hemophili a A and B without inhibitors. Updated high titer factor criterion in initial auth sections for hemophilia A and B with inhibitors.

Alinia



Prior Authorization Guideline

Guideline ID	GL-375606
Guideline Name	Alinia
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

Guideline Note:

Effective Date:	10/1/2025

1 . Criteria

Product Name:generic nitazoxanide, Brand Alinia	
Diagnosis	Diarrhea caused by Giardia lamblia
Approval Length	1 month(s)

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of giardiasis AND 2 - ONE of the following: 2.1 Failure to metronidazole, as confirmed by claims history or submission of medical records OR 2.2 History of contraindication or intolerance to metronidazole (please specify contraindication or intolerance)	

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

2 . Revision History

Date	Notes
8/27/2025	Added NM formulary.

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 Rhode Island Clinical Pharmacy Program Guidelines

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

Alyftrek



Prior Authorization Guideline

Guideline ID	GL-551230
Guideline Name	Alyftrek
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

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

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

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of cystic fibrosis (CF) AND 2 - Submission of laboratory results documenting that the patient has at least one of the following responsive mutations in the CFTR gene*: • F508del mutation • A mutation that is responsive based on clinical data • A mutation that is responsive based on in vitro data • A mutation that is responsive based on extrapolated data AND 3 - The patient is at least 6 years of age AND 4 - Prescribed by or in consultation with a provider who specializes in the treatment of CF	
Notes	*See Table 1 in Background for list of CFTR gene mutations responsive to Alyftrek. A complete up to date list of responsive mutations can be referenced in the Alyftrek Prescribing Information.

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

1 - Documentation of positive clinical response to Alyftrek therapy (e.g., improved lung function, stable lung function)

2 . Background

Benefit/Coverage/Program Information						
*Table 1						
*List of <i>CFTR</i> gene mutations responsive to Alyftrek. A complete up to date list of responsive mutations can be referenced in the Alyftrek Prescribing Information.						
Based on clinical data**						
A455E	G551D	L1077P†	R352Q	S549N	V754M	
D1152H	G85E†	L206W	R75Q	S549R	W1098C †	
F508del†	H1054D	M1101K†	S1159F	S945L	W1282R	
G1244E	I336K	R1066H	S1251N	V562I	Y563N†	
Based on in vitro data‡						
1507_1515de/9	E116Q	G424S	I556V	P140S	R334L	T1053I
2183A→G	E193K	G463V	I601F	P205S	R334Q	T1086I
3141del9	E292K	G480C	I618T	P499A	R347H	T1246I
3195del6	E403D	G480S	I807M	P5L	R347L	T1299I
3199del6	E474K	G551A	I980K	P574H	R347P	T338I
546insCTA	E56K	G551S	K1060T	P67L	R352W	T351I
A1006E	E588V	G576A	K162E	P750L	R516G	T604I
A1067P	E60K	G576A; R668C§	K464E	P99L	R516S	V1153E
A1067T	E822K	G622D	L1011S	Q1100P	R553Q	V1240G
A107G	E92K	G628R	L102R	Q1291R	R555G	V1293G
A120T	F1016S	G91R	L1065P	Q1313K	R560S	V201M
A234D	F1052V	G970D	L1324P	Q237E	R560T	V232D
A309D	F1074L	G970S	L1335P	Q237H	R668C	V392G
A46D	F1107L	H1085R	L1480P	Q372H	R74Q	V456F
A554E	F191V	H1375P	L15P	Q452P	R74W	V520F
A559T	F200I	H139R	L165S	Q493R	R74W; D1270N§	V603F

A559V	F311del	H199R	L320V	Q552P	R74W; V201M§	W361R
A561E	F311L	H199Y	L333F	Q98R	R74W; V201M; D1270N§	Y1014C
A613T	F508C	H609R	L333H	R1048G	R75L	Y1032C
A62P	F508C; S1251N§	H620P	L346P	R1066C	R751L	Y109N
A72D	F575Y	H620Q	L441P	R1066L	R792G	Y161D
C491R	F587I	H939R	L453S	R1066M	R933G	Y161S
D110E	G1047R	H939R; H949L	L619S	R1070Q	S1045Y	Y301C
D110H	G1061R	I1027T	L967S	R1070W	S108F	Y569C
D1270N	G1069R	I105N	L997F	R1162L	S1118F	Y913C
D1445N	G1123R	I1139V	M1101R	R117C	S1159P	
D192G	G1247R	I1234Vdel6 aa	M1137V	R117C; G576A; R668C	S1235R	
D443Y	G1249R	I125T	M150K	R117G	S1255P	
D443Y; G576A; R668C§	G126D	I331N	M26SR	R117L	S13F	
D513G	G1349D	I331N	M265R	R117L	S341P	
D565G	G149R	I1366N	M952I	R117P	S364P	
D579G	G178E	I1398S	M952T	R1283M	S492F	
D614G	G178R	I148N	N1088D	R1283S	S549I	
D836Y	G194R	I148T	N1303I	R170H	S589N	
D924N	G194V	I175V	N1303K‡	R258G	S737F	
D979V	G27E	I502T	N186K	R297Q	S912L	
D993Y	G27R	I506L	N187K	R31C	S977F	
E116K	G314E	I506T	N418S	R31L	T1036N	
Based on extrapolation¶						
1341G→A	2789+2ins A	3041- 15T→G	3849+10kbC →T	3850- 3T→G	5T; TG13	711+3A →G
1898+3A→G	2789+5G →A	3272- 26A→G	3849+4A→G	4005+2T →C	621+3A →G	E831X
2752- 26A→G	296+28A →G	3600G→A	3849+40A→ G	5T; TG12		
** Clinical data is obtained from Trial 1, NCT05033080 and Trial 2, NCT05076149.						

† This mutation is also predicted to be responsive by FRT assay with Alyftrek.

‡ The *N1303K* mutation is predicted to be responsive only by HBE assay. All other mutations predicted to be responsive with in vitro data are supported by FRT assay.

§ Complex/compound mutations where a single allele of the *CFTR* gene has multiple mutations; these exist independent of the presence of mutations on the other allele.

¶ Efficacy is extrapolated to certain non-canonical splice mutations because clinical trials in all mutations in this subgroup are infeasible and these mutations are not amenable to interrogation by FRT system.

3 . Revision History

Date	Notes
3/17/2026	Removed PA CAID

Ampyra



Prior Authorization Guideline

Guideline ID	GL-133253
Guideline Name	Ampyra
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

Guideline Note:

Effective Date:	11/1/2023

1 . Criteria

Product Name: Brand Ampyra, generic dalfampridine ER	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of multiple sclerosis

2 . Revision History

Date	Notes
9/19/2023	Updated criteria to only require diagnosis to allow for DX2RX.

Andembry



Prior Authorization Guideline

Guideline ID	GL-504190
Guideline Name	Andembry
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 New Mexico

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Andembry	
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, and 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 prophylaxis of HAE attacks AND 3 - Not used in combination with other products indicated for prophylaxis against HAE attacks (e.g., Cinryze, Dawnzera, Haegarda, Orladeyo, Takhzyro) AND 4 - Prescriber attests that patient has experienced attacks of a severity and/or frequency such that they would clinically benefit from prophylactic therapy with Andembry	

AND

5 - Prescribed by ONE of the following:

- Immunologist
- Allergist

AND

6 - ONE of the following:

6.1 Failure to Haegarda confirmed by claims history or submitted medical records

OR

6.2 History of contraindication or intolerance to Haegarda (please specify intolerance or contraindication)

OR

6.3 Patient is currently on Andembry therapy confirmed by claims history or submitted medical records

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

AND

3 - Reduction in the utilization of on-demand therapies used for acute attacks (e.g., Berinert, Firazyr, Ruconest) as determined by claims information, while on Andembry therapy

AND

2 - Prescribed for the prophylaxis of HAE attacks

AND

4 - Not used in combination with other products indicated for prophylaxis against HAE attacks (e.g., Cinryze, Dawnzera, Haegarda, Orladeyo, Takhzyro)

AND

5 - Prescribed by ONE of the following:

- Immunologist
- Allergist

2 . Revision History

Date	Notes
1/15/2026	New Program.

Anthelmintics



Prior Authorization Guideline

Guideline ID	GL-434339
Guideline Name	Anthelmintics
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 New Mexico Medicaid - Community & State Nevada

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Generic albendazole

Approval Length	*Approve for 1 month, **Approve for 6 months, ***Approve for 12 months
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following*: • Enterobius vermicularis (pinworm) • Ascariasis (roundworm) • Toxocariasis (roundworm) • Trichinellosis • Trichuriasis (whipworm) • Capillariasis • Baylisascaris • Clonorchiasis (liver flukes) • Gnathostomiasis • Strongyloidiasis • Loiasis • Opisthorchiasis • Anisakiasis OR 2 - Diagnosis of ONE of the following**: • Taeniasis or Cysticercosis/Neurocysticercosis • Hydatid Disease [Echinococcosis (Tapeworm)] • Ancylostoma/Necatoriasis (Hookworm) OR 3 - Diagnosis of microsporidiosis not caused by Enterocytozoon bienersi or Vittaforma corneae***	

Product Name:Emverm	
Approval Length	*Approve for 1 month, **Approve for 6 months
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following*:

- Enterobius vermicularis (pinworm)
- Ancylostoma/Necatoriasis (Hookworm)
- Ascariasis (roundworm)
- Toxocariasis (roundworm)
- Trichinellosis
- Trichuriasis (whipworm)
- Capillariasis
- Baylisascaris

OR

2 - Diagnosis of hydatid Disease [Echinococcosis (Tapeworm)]**

2 . Revision History

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

Anthelmintics



Prior Authorization Guideline

Guideline ID	GL-434339
Guideline Name	Anthelmintics
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 New Mexico Medicaid - Community & State Nevada

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Generic albendazole

Approval Length	*Approve for 1 month, **Approve for 6 months, ***Approve for 12 months
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following*: • Enterobius vermicularis (pinworm) • Ascariasis (roundworm) • Toxocariasis (roundworm) • Trichinellosis • Trichuriasis (whipworm) • Capillariasis • Baylisascaris • Clonorchiasis (liver flukes) • Gnathostomiasis • Strongyloidiasis • Loiasis • Opisthorchiasis • Anisakiasis OR 2 - Diagnosis of ONE of the following**: • Taeniasis or Cysticercosis/Neurocysticercosis • Hydatid Disease [Echinococcosis (Tapeworm)] • Ancylostoma/Necatoriasis (Hookworm) OR 3 - Diagnosis of microsporidiosis not caused by Enterocytozoon bienersi or Vittaforma corneae***	

Product Name:Emverm	
Approval Length	*Approve for 1 month, **Approve for 6 months
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following*:

- Enterobius vermicularis (pinworm)
- Ancylostoma/Necatoriasis (Hookworm)
- Ascariasis (roundworm)
- Toxocariasis (roundworm)
- Trichinellosis
- Trichuriasis (whipworm)
- Capillariasis
- Baylisascaris

OR

2 - Diagnosis of hydatid Disease [Echinococcosis (Tapeworm)]**

2 . Revision History

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

Anticonvulsants



Prior Authorization Guideline

Guideline ID	GL-568190
Guideline Name	Anticonvulsants
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 Nebraska Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name: Brand Aptiom, generic eslicarbazepine, Brand Briviact tabs/oral soln, generic brivaracetam tabs/oral soln, Xcopri	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - For continuation of prior therapy for a seizure disorder

OR

2 - ALL of the following:

2.1 Diagnosis of partial-onset seizures

AND

2.2 History of greater than or equal to 8 week trial of at least TWO of the following (any release formulation qualifies) confirmed by claims history or submitted medical records:

- Carbamazepine (e.g., generic Tegretol)
- Divalproex (e.g., generic Depakote)
- Gabapentin (e.g., generic Neurontin)
- Lacosamide (e.g. generic Vimpat)
- Lamotrigine (e.g., generic Lamictal)
- Levetiracetam (e.g., generic Keppra)
- Oxcarbazepine (e.g., generic Trileptal)
- Phenytoin (e.g., generic Dilantin)
- Pregabalin (e.g., generic Lyrica)
- Topiramate (e.g., generic Topamax)
- Valproic acid (e.g., generic Depakene)
- Zonisamide (generic Zonegran)

Product Name:Brand Fycompa, generic perampanel	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - For continuation of prior therapy for a seizure disorder	

OR

2 - ALL of the following:

2.1 ONE of the following:

2.1.1 Diagnosis of partial-onset seizures with or without secondarily generalized seizures

OR

2.1.2 ALL of the following:

- Diagnosis of primary generalized tonic-clonic seizures
- Used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment)
- Not used as primary treatment

AND

2.2 History of greater than or equal to 8 week trial of at least TWO of the following (any release formulation qualifies) confirmed by claims history or submitted medical records:

- Carbamazepine (e.g., generic Tegretol)
- Divalproex (e.g., generic Depakote)
- Gabapentin (e.g., generic Neurontin)
- Lacosamide (e.g. generic Vimpat)
- Lamotrigine (e.g., generic Lamictal)
- Levetiracetam (e.g., generic Keppra)
- Oxcarbazepine (e.g., generic Trileptal)
- Phenytoin (e.g., generic Dilantin)
- Pregabalin (e.g., generic Lyrica)
- Topiramate (e.g., generic Topamax)
- Valproic acid (e.g., generic Depakene)
- Zonisamide (generic Zonegran)

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

Approval Criteria

1 - For continuation of prior therapy for a seizure disorder

OR

2 - ALL of the following:

2.1 ONE of the following:

2.1.1 Diagnosis of partial onset seizures

OR

2.1.2 ALL of the following:

- Diagnosis of primary generalized tonic-clonic seizures
- Used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment)
- Not used as primary treatment

AND

2.2 History of greater than or equal to 8 week trial of at least TWO of the following (any release formulation qualifies) confirmed by claims history or submitted medical records:

- Carbamazepine (e.g., generic Tegretol)
- Divalproex (e.g., generic Depakote)
- Gabapentin (e.g., generic Neurontin)
- Lacosamide (e.g. generic Vimpat)
- Lamotrigine (e.g., generic Lamictal)
- Levetiracetam (e.g., generic Keppra)
- Oxcarbazepine (e.g., generic Trileptal)
- Phenytoin (e.g., generic Dilantin)
- Pregabalin (e.g., generic Lyrica)
- Topiramate (e.g., generic Topamax)
- Valproic acid (e.g., generic Depakene)
- Zonisamide (generic Zonegran)

Product Name:Epidiolex	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - For continuation of prior therapy for a seizure disorder OR 2 - Diagnosis of seizures associated with Dravet syndrome or tuberous sclerosis complex OR 3 - BOTH of the following: 3.1 Diagnosis of seizures associated with Lennox-Gastaut syndrome AND 3.2 History of greater than or equal to 8 week trial of at least TWO generic anticonvulsants (e.g., divalproex, lamotrigine, topiramate, valproic acid)	

Product Name:generic rufinamide, Brand Banzel	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - For continuation of prior therapy for a seizure disorder OR	

2 - Diagnosis of seizures associated with Lennox-Gastaut syndrome

Product Name: Tiagabine

Approval Length 12 month(s)

Guideline Type Prior Authorization

Approval Criteria

1 - For continuation of prior therapy for a seizure disorder

OR

2 - ALL of the following:

2.1 Diagnosis of partial-onset seizures

AND

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

AND

2.3 Not used as primary treatment

AND

2.4 History of greater than or equal to 8 week trial of at least TWO of the following (any release formulation qualifies), confirmed by claims history or submitted medical records:

- Carbamazepine (e.g., generic Tegretol)
- Divalproex (e.g., generic Depakote)
- Gabapentin (e.g., generic Neurontin)
- Lacosamide (e.g. generic Vimpat)
- Lamotrigine (e.g., generic Lamictal)

- Levetiracetam (e.g., generic Keppra)
- Oxcarbazepine (e.g., generic Trileptal)
- Phenytoin (e.g., generic Dilantin)
- Pregabalin (e.g., generic Lyrica)
- Topiramate (e.g., generic Topamax)
- Valproic acid (e.g., generic Depakene)
- Zonisamide (generic Zonegran)

Product Name: Sympazan	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - For continuation of prior therapy for a seizure disorder OR 2 - ALL of the following: 2.1 Diagnosis of seizures associated with Lennox-Gastaut syndrome (LGS) AND 2.2 BOTH of the following: • Used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment) • Not used as primary treatment AND 2.3 History of greater than or equal to 8 week trial of at least TWO of the following (any release formulation qualifies), confirmed by claims history or submitted medical records: • Clobazam (e.g. generic Onfi) • Divalproex (e.g., generic Depakote)	

- Lamotrigine (e.g., generic Lamictal)
- Topiramate (e.g., generic Topamax)
- Valproic acid (e.g., generic Depakene)
- Felbamate (generic Felbatol)
- Rufinamide (generic Banzel)

AND

2.4 Prescriber provides a reason or special circumstance the patient cannot use clobazam (generic Onfi) tablets or suspension

OR

3 - ALL of the following:

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

AND

3.2 BOTH of the following:

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

AND

3.3 History of greater than or equal to 8 week trial of at least TWO of the following (any release formulation qualifies), confirmed by claims history or submitted medical records:

- Carbamazepine (e.g., generic Tegretol)
- Divalproex (e.g., generic Depakote)
- Gabapentin (e.g., generic Neurontin)
- Lacosamide (e.g. generic Vimpat)
- Lamotrigine (e.g., generic Lamictal)
- Levetiracetam (e.g., generic Keppra)
- Oxcarbazepine (e.g., generic Trileptal)
- Phenytoin (e.g., generic Dilantin)
- Pregabalin (e.g., generic Lyrica)
- Topiramate (e.g., generic Topamax)

- Valproic acid (e.g., generic Depakene)
- Zonisamide (generic Zonegran)

AND

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

OR

4 - ALL of the following:

- Diagnosis of Dravet syndrome
- Patient is currently taking Diacomit
- Prescriber provides a reason or special circumstance the patient cannot use generic clobazam tablets or suspension

Product Name: Brand Sabril powd pack, Brand Vigadrone powd pack, generic vigabatrin powd pack, generic Vigpoder powd pack

Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - For continuation of prior therapy for a seizure disorder

OR

2 - Diagnosis of infantile spasms

OR

3 - ALL of the following:

3.1 Diagnosis of complex partial seizures

AND

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

AND

3.3 Not used as primary treatment

AND

3.4 History of greater than or equal to 8 week trial of at least TWO of the following (any release formulation qualifies), confirmed by claims history or submitted medical records:

- Carbamazepine (e.g., generic Tegretol)
- Divalproex (e.g., generic Depakote)
- Gabapentin (e.g., generic Neurontin)
- Lamotrigine (e.g., generic Lamictal)
- Levetiracetam (e.g., generic Keppra)
- Oxcarbazepine (e.g., generic Trileptal)
- Phenytoin (e.g., generic Dilantin)
- Pregabalin (e.g., generic Lyrica)
- Topiramate (e.g., generic Topamax)
- Valproic acid (e.g., generic Depakene)
- Zonisamide (generic Zonegran)

Product Name: Brand Sabril tablets, Brand Vigadrone tablets, generic vigabatrin tablets	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - For continuation of prior therapy for a seizure disorder	

OR

2 - ALL of the following:

2.1 Diagnosis of complex partial seizures

AND

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

AND

2.3 Not used as primary treatment

AND

2.4 History of greater than or equal to 8 week trial of at least TWO of the following (any release formulation qualifies), confirmed by claims history or submitted medical records:

- Carbamazepine (e.g., generic Tegretol)
- Divalproex (e.g., generic Depakote)
- Gabapentin (e.g., generic Neurontin)
- Lamotrigine (e.g., generic Lamictal)
- Levetiracetam (e.g., generic Keppra)
- Oxcarbazepine (e.g., generic Trileptal)
- Phenytoin (e.g., generic Dilantin)
- Pregabalin (e.g., generic Lyrica)
- Topiramate (e.g., generic Topamax)
- Valproic acid (e.g., generic Depakene)
- Zonisamide (generic Zonegran)

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

Approval Criteria

1 - Diagnosis of infantile spasms

OR

2 - For continuation of prior therapy for a seizure disorder

Product Name:Diacomit

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - For continuation of prior therapy for a seizure disorder

OR

2 - Diagnosis of Dravet syndrome and currently taking clobazam

Product Name:Fintepla

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - For continuation of prior therapy for a seizure disorder

OR

2 - BOTH of the following:

2.1 Diagnosis of seizures associated with Dravet syndrome

AND

2.2 History of greater than or equal to 8-week trial of at least TWO of the following (any release formulation qualifies), confirmed by claims history or submitted medical records:

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

OR

3 - BOTH of the following:

3.1 Diagnosis of seizures associated with Lennox-Gastaut syndrome

AND

3.2 History of greater than or equal to 8 week trial of at least TWO of the following (any release formulation qualifies) confirmed by claims history or submitted medical records:

- Clobazam (generic Onfi)
- Divalproex (e.g., generic Depakote)
- Lamotrigine (e.g., generic Lamictal)
- Topiramate (e.g., generic Topamax)
- Valproic acid (e.g., generic Depakene)

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

Approval Criteria

1 - For continuation of prior therapy for a seizure disorder

OR

2 - ALL of the following:

2.1 Diagnosis of seizures associated with cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder confirmed with genetic testing

AND

2.2 History of greater than or equal to 8-week trial of at least TWO of the following (any release formulation qualifies), confirmed by claims history or submitted medical records:

- Carbamazepine (e.g., generic Tegretol)
- Divalproex (e.g., generic Depakote)
- Gabapentin (e.g., generic Neurontin)
- Lamotrigine (e.g., generic Lamictal)
- Levetiracetam (e.g., generic Keppra)
- Oxcarbazepine (e.g., generic Trileptal)
- Phenytoin (e.g., generic Dilantin)
- Pregabalin (e.g., generic Lyrica)
- Topiramate (e.g., generic Topamax)
- Valproic acid (e.g., generic Depakene)
- Zonisamide (generic Zonegran)

2 . Revision History

Date	Notes
4/8/2026	Updated GPIs and product lists

Antipsychotics



Prior Authorization Guideline

Guideline ID	GL-551275
Guideline Name	Antipsychotics
Formulary	Medicaid - Community & State Rhode Island

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:generic risperidone tabs/soln, Brand Risperdal tabs/soln, generic quetiapine, Brand Seroquel, generic ziprasidone, Brand Geodon, Brand Zyprexa, generic olanzapine, generic clozapine, Brand Clozaril, Cobenfy, Brand Abilify tabs/soln, generic aripiprazole tabs/soln, Abilify Maintena, Invega Sustenna, Perseris, Brand Risperdal Consta, generic risperidone ER IM injection, Aristada, Aristada Initio, generic paliperidone ER, Brand Invega, generic risperidone ODT, aripiprazole ODT, aripiprazole soln, generic olanzapine ODT, Brand Zyprexa Zydis, Fanapt, generic quetiapine ER, Brand Seroquel XR, Brand Latuda, Rexulti, Brand Saphris, Secuado, Vraylar, Versacloz, clozapine ODT, generic asenapine, Invega Hafyera, Lybalvi, Invega Trinza, Caplyta, Abilify Mycite, generic lurasidone, Uzedy, Abilify Asimtufii, Fanapt Titration Pack, Rykindo, Erzofri, Opipza	
Diagnosis	Minimum Age Edit*
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

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

AND

2 - The patient has tried and failed ALL available preferred** atypical antipsychotics that are Food and Drug Administration (FDA) approved for the patient's age

AND

3 - ONE of the following:

3.1 Patient has ONE of the following diagnoses:

- Schizophrenia or schizoaffective disorder
- Autism
- Bipolar disorder

OR

3.2 Patient displays symptoms of aggression as a symptom of developmental delay, Tourette's syndrome or chronic tics, oppositional defiant disorder, or conduct disorder

Notes	*See Table 1 in Background for UHC C&S Minimum Age Edits. **PDL link: https://www.uhcprovider.com/en/health-plans-by-state/rhode-island-health-plans/ri-comm-plan-home/ri-cp-pharmacy.html

Product Name: Brand Risperdal soln, generic risperidone soln	
Diagnosis	Maximum Age Edit*
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Requested drug must be used for a Food and Drug Administration (FDA)-approved indication

OR

1.2 BOTH of the following:

1.2.1 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
- Clinical pharmacology
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex
- United States Pharmacopoeia-National Formulary (USP-NF)

AND

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

AND

2 - ONE of the following:

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

OR

2.2 The drug is prescribed 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 - ONE of the following:

3.1 The patient is unable to swallow the oral solid preferred** alternatives

OR

3.2 ONE of the following:

3.2.1 Failure to a majority (not more than 3) of the oral solid preferred** alternatives as confirmed by claims history or submission of medical records

OR

3.2.2 History of contraindication or intolerance to a majority (not more than 3) of the oral solid preferred** alternatives (please specify contraindication or intolerance)

Notes

*See Table 2 in Background for UHC C&S Maximum Age Edits.
 **PDL link: <https://www.uhcprovider.com/en/health-plans-by-state/rhode-island-health-plans/ri-comm-plan-home/ri-cp-pharmacy.html>

Product Name: Abilify Maintena

Approval Length 12 month(s)

Guideline Type Prior Authorization

Approval Criteria

1 - Patient has ONE of the following diagnoses:

- Schizophrenia or schizoaffective disorder
- Bipolar disorder

AND

2 - ONE of the following:

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

OR

2.2 Patient has established tolerability with oral aripiprazole

OR

2.3 Patient is unable to take oral solid alternatives

Product Name:Aristada, Aristada Initio	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has ONE of the following diagnoses: • Schizophrenia • Schizoaffective disorder AND 2 - ONE of the following: 2.1 Patient is non-adherent with oral atypical antipsychotic dosage forms OR 2.2 Patient has established tolerability with oral aripiprazole	

OR

2.3 Patient is unable to take oral solid alternatives

Product Name: Invega Hafyera	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has ONE of the following diagnoses: • Schizophrenia • Schizoaffective disorder AND 2 - ONE of the following: 2.1 Patient has been established on once-a-month paliperidone palmitate extended-release injectable suspension (e.g., Invega Sustenna) for at least 4 months OR 2.2 Patient has been established on every-three-month paliperidone palmitate extended-release injectable suspension (e.g., Invega Trinza) for at least one three-month cycle	

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

Approval Criteria

1 - Patient has ONE of the following diagnoses:

- Schizophrenia
- Schizoaffective disorder

AND

2 - ONE of the following:

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

OR

2.2 Patient has established tolerability with oral paliperidone or oral risperidone

OR

2.3 Patient is unable to take oral solid alternatives

Product Name: Invega Trinza	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has ONE of the following diagnoses: • Schizophrenia • Schizoaffective disorder AND 2 - Patient has been established on Invega Sustenna for at least 4 consecutive months prior to initiating Invega Trinza	

Product Name:Perseris	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has ONE of the following diagnoses: • Schizophrenia • Schizoaffective disorder AND 2 - ONE of the following: 2.1 Patient is non-adherent with oral atypical antipsychotic dosage forms OR 2.2 Patient has established tolerability with oral risperidone OR 2.3 Patient is unable to take oral solid alternatives	

Product Name:Brand Risperdal Consta, generic risperidone ER IM injection	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has ONE of the following diagnoses:	

- Schizophrenia or schizoaffective disorder
- Bipolar disorder

AND

2 - ONE of the following:

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

OR

2.2 Patient has established tolerability with oral risperidone

OR

2.3 Patient is unable to take oral solid alternatives

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

OR

2.2 Patient has established tolerability with oral aripiprazole

OR

2.3 Patient is unable to take oral solid alternatives

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

Approval Criteria

1 - Patient has **ONE** of the following diagnoses:

- Schizophrenia
- Schizoaffective disorder
- Bipolar disorder

AND

2 - **ONE** of the following:

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

OR

2.2 Patient has established tolerability with oral risperidone

OR

2.3 Patient is unable to take oral solid alternatives

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

Approval Criteria

1 - Patient has ONE of the following diagnoses:

- Schizophrenia or schizoaffective disorder
- Bipolar disorder

AND

2 - ONE of the following:

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

OR

2.2 Patient has established tolerability with oral risperidone

OR

2.3 Patient is unable to take oral solid alternatives

Product Name: Abilify MyCite	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Patient has ONE of the following diagnoses:

- Schizophrenia or schizoaffective disorder
- Bipolar disorder
- Autism
- Major depressive disorder
- Tourette's

AND

1.2 Submission of medical records documenting the patient is currently prescribed aripiprazole and tolerates the medication

AND

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

AND

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

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

AND

1.5 Submission of medical records documenting patient has experienced life-threatening or

potentially life-threatening symptoms, or has experienced a severe worsening of symptoms leading to a hospitalization which was attributed to the lack of adherence to aripiprazole

AND

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

AND

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

AND

1.8 ONE of the following:

1.8.1 History of failure to TWO of the following as confirmed by claims history or submission of medical records:

- Abilify Maintena
- Invega Sustenna
- Risperidone ER injection (generic Risperdal Consta)
- Aristada
- Perseris

OR

1.8.2 History of contraindication, intolerance, reason, or special circumstance they cannot use ALL of the following (please specify contraindication, intolerance, reason, or special circumstance):

- Abilify Maintena
- Invega Sustenna
- Risperidone ER injection (generic Risperdal Consta)
- Aristada
- Perseris

OR

2 - 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

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

Product Name:Abilify MyCite	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation that patient is clinically stable on Abilify MyCite AND 2 - Submission of medical records documenting that the use of Abilify MyCite has increased adherence to 80% or more AND 3 - Prescriber attests that the patient requires the continued use of Abilify MyCite to remain adherent	

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

Guideline Type	Prior Authorization
	Approval Criteria 1 - BOTH of the following: 1.1 Mania or mixed episodes associated with Bipolar Disorder AND 1.2 ONE of the following: 1.2.1 Failure to THREE preferred* alternatives, one of which must be aripiprazole, as confirmed by claims history or submission of medical records OR 1.2.2 History of contraindication or intolerance to THREE preferred* alternatives, one of which must be aripiprazole (please specify contraindication or intolerance) OR 2 - ALL of the following: 2.1 Diagnosis of major depressive disorder (MDD) AND 2.2 Vraylar is being used in combination with an antidepressant medication AND 2.3 ONE of the following: • Failure to a trial of at least one selective serotonin reuptake inhibitor (SSRI) as confirmed by claims history or submission of medical records

- History of contraindication or intolerance to an SSRI (please specify contraindication or intolerance)

AND

2.4 ONE of the following:

- Failure to a trial of at least one serotonin norepinephrine reuptake inhibitor (SNRI) as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to an SNRI (please specify contraindication or intolerance)

AND

2.5 ONE of the following:

2.5.1 Failure to a trial of at least one of the following atypical antipsychotics approved by the FDA (Food and Drug Administration) for the adjunctive treatment of major depressive disorder with an antidepressant as confirmed by claims history or submission of medical records:

- Aripiprazole
- Olanzapine
- Quetiapine extended-release

OR

2.5.2 History of contraindication or intolerance to all of the following atypical antipsychotics approved by the FDA for the adjunctive treatment of major depressive disorder with an antidepressant (please specify contraindication or intolerance):

- Aripiprazole
- Olanzapine
- Quetiapine extended-release

OR

3 - BOTH of the following:

3.1 Patient has a diagnosis of schizophrenia or schizoaffective disorder

AND

3.2 ONE of the following:

3.2.1 Failure to THREE preferred atypical antipsychotics*, which must include both aripiprazole and lurasidone, as confirmed by claims history or submission of medical records

OR

3.2.2 History of contraindication or intolerance to THREE preferred atypical antipsychotics*, which must include both aripiprazole and lurasidone (please specify contraindication or intolerance)

OR

4 - BOTH of the following:

4.1 Patient has a diagnosis of depressive episodes associated with Bipolar I Disorder (bipolar depression)

AND

4.2 ONE of the following:

4.2.1 Failure to ALL of the following as confirmed by claims history or submission of medical records:

- Fluoxetine used in combination with olanzapine
- Lurasidone
- Quetiapine

OR

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

- Fluoxetine used in combination with olanzapine
- Lurasidone

- Quetiapine

OR

5 - 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

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

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

Product Name:Cobenfy	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following: 1.1 Patient has a diagnosis of schizophrenia or schizoaffective disorder AND 1.2 ONE of the following: 1.2.1 Failure to THREE preferred atypical antipsychotics*, which must include both aripiprazole and lurasidone, as confirmed by claims history or submission of medical records OR 1.2.2 History of contraindication or intolerance to THREE preferred atypical antipsychotics*,	

which must include both aripiprazole and lurasidone (please specify contraindication or intolerance)

OR

2 - 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

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

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

Product Name:Caplyta	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following: 1.1 Diagnosis of schizophrenia or schizoaffective disorder AND 1.2 ONE of the following: 1.2.1 Failure to THREE preferred atypical antipsychotics*, which must include both aripiprazole and lurasidone, as confirmed by claims history or submission of medical records OR	

1.2.2 History of contraindication or intolerance to THREE preferred atypical antipsychotics*, which must include both aripiprazole and lurasidone (please specify contraindication or intolerance)

OR

2 - BOTH of the following:

2.1 Diagnosis of depressive episodes associated with bipolar I or II disorder (bipolar depression)

AND

2.2 ONE of the following:

2.2.1 Failure to all of the following as confirmed by claims history or submission of medical records:

- Fluoxetine used in combination with olanzapine
- Lurasidone
- Quetiapine

OR

2.2.2 History of contraindication or intolerance to all of the following (please specify contraindication or intolerance):

- Fluoxetine used in combination with olanzapine
- Lurasidone
- Quetiapine

OR

3 - ALL of the following:

3.1 Diagnosis of major depressive disorder (MDD)

AND

3.2 Caplyta is being used in combination with an antidepressant medication

AND

3.3 ONE of the following:

- Failure to a trial of at least one selective serotonin reuptake inhibitor (SSRI) as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to an SSRI (please specify contraindication or intolerance)

AND

3.4 ONE of the following:

- Failure to a trial of at least one serotonin norepinephrine reuptake inhibitor (SNRI) as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to an SNRI (please specify contraindication or intolerance)

AND

3.5 ONE of the following:

3.5.1 Failure to a trial of at least one of the following atypical antipsychotics approved by the FDA (Food and Drug Administration) for the adjunctive treatment of major depressive disorder with an antidepressant as confirmed by claims history or submission of medical records:

- Aripiprazole
- Olanzapine
- Quetiapine extended-release

OR

3.5.2 History of contraindication or intolerance to all of the following atypical antipsychotics approved by the FDA for the adjunctive treatment of major depressive disorder with an antidepressant (please specify contraindication or intolerance):

- Aripiprazole
- Olanzapine

Quetiapine extended-release	
OR	
4 - 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	
5 - The patient is currently receiving treatment with the requested non-preferred behavioral health medication in the hospital and must continue upon discharge	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/rhode-island-health-plans/ri-comm-plan-home/ri-cp-pharmacy.html

Product Name:Vraylar, Cobenfy, Caplyta	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of a positive clinical response to therapy	

Product Name:Brand Risperdal tabs/soln, Brand Seroquel, Brand Geodon, Brand Zyprexa, Brand Clozaril, Brand Abilify tabs/soln, Brand Invega, aripiprazole ODT, aripiprazole soln, Brand Zyprexa Zydis, Fanapt, Brand Seroquel XR, Brand Latuda, Rexulti, Brand Saphris, Secuado, Versacloz, clozapine ODT, generic asenapine, Lybalvi, Fanapt Titration Pack, Erzofri, Opipza	
Diagnosis	Non-Preferred
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:

1.1.1 Patient must demonstrate failure to a majority (not more than 3) of the preferred* formulary/preferred drug list (PDL) alternatives, one of which must be aripiprazole, for the given diagnosis as confirmed by claims history or submission of medical records (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)

OR

1.1.2 Patient must demonstrate intolerance to a majority (not more than 3) of the preferred* formulary/PDL alternatives, one of which must be aripiprazole, for the given diagnosis (please specify intolerance) (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)

OR

1.1.3 There are no preferred* formulary alternatives for the requested drug

OR

1.1.4 If the request is for a combination product, one of the following:

- Failure to three combinations of preferred products taken concomitantly as confirmed by claims history or submitted medical records. Prior trials of formulary/PDL combination alternatives must sufficiently demonstrate that the formulary/PDL combination alternatives are either ineffective or inappropriate at the time of the request. NOTE: In instances where there are fewer than three preferred combination alternatives, the patient must have a history of failure to all of the preferred combination alternatives.
- History of contraindication or intolerance to three preferred combinations (please specify contraindication or intolerance). Prior trials of formulary/PDL combination alternatives must sufficiently demonstrate that the formulary/PDL combination alternatives are either ineffective or inappropriate at the time of the request. NOTE: In

instances where there are fewer than three preferred combination alternatives, the patient must have a history of failure to all of the preferred combination alternatives.

AND

1.2 If the request is for a multi-source brand medication, ONE of the following:

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

AND

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

AND

1.4 ONE of the following:

1.4.1 The requested drug must be used for a Food and Drug Administration (FDA)-approved indication

OR

1.4.2 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

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

OR

2 - The 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

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

Notes

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

Product Name: Brand Risperdal tabs/soln, Brand Seroquel, Brand Geodon, Brand Zyprexa, Brand Clozaril, Brand Abilify tabs/soln, Brand Invega, aripiprazole ODT, aripiprazole soln, Brand Zyprexa Zydis, Fanapt, Brand Seroquel XR, Brand Latuda, Rexulti, Brand Saphris, Secuado, Versacloz, clozapine ODT, generic asenapine, Lybalvi, Fanapt Titration Pack, Erzofri, Opipza

Diagnosis	Non-Preferred

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of a positive clinical response to therapy

Product Name: Caplyta

Diagnosis	Requests Exceeding Quantity Limit*
Approval Length	12 month(s)
Guideline Type	Quantity Limit
Approval Criteria 1 - ONE of the following: 1.1 The requested drug must be used for a Food and Drug Administration (FDA)-approved indication OR 1.2 The use of this drug is supported by information from ONE of the following appropriate compendia of current literature: • American Hospital Formulary Service Drug Information • National Comprehensive Cancer Network Drugs and Biologics Compendium • Thomson Micromedex DrugDex • Clinical pharmacology • United States Pharmacopoeia-National Formulary (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 requested dose 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

AND

5 - Physician has provided rationale for needing to exceed the quantity limit of one capsule per day, at a maximum dose of 42 mg (milligrams) (NOTE: The treatment effect of Caplyta at doses higher than 42 mg daily versus placebo was NOT statistically significant in clinical trials)

Notes

*This section is for Caplyta quantity limit requests only.

2 . Background

Benefit/Coverage/Program Information

Table 1: Minimum Age Edits

Based on FDA-approved uses, prior authorization is required for atypical antipsychotic medications for members less than the following ages:

- Abilify Discmelt, Abilify oral solution: 6 years of age
- Abilify Maintena – 18 years of age
- Abilify MyCite – 18 years of age
- Abilify oral tablets – 6 years of age
- Abilify Asimtufii – 18 years of age
- Aristada – 18 years of age
- Caplyta – 18 years of age
- Clozaril – 18 years of age
- Cobenfy – 18 years of age
- Erzofri – 18 years of age
- Fanapt- 18 years of age

- Geodon – 18 years of age
- Invega – 12 years of age
- Invega Sustenna – 18 years of age
- Invega Trinza- 18 years of age
- Invega Hafyera – 18 years of age
- Latuda- 10 years of age
- Lybalvi - 18 years of age
- Opipta – 6 years of age
- Perseris – 18 years of age
- Rexulti-13 years of age
- Risperdal – 5 years of age
- Risperdal Consta – 18 years of age
- Rykindo – 18 years of age
- Saphris- 10 years of age
- Secuado- 18 years of age
- Seroquel, Seroquel XR – 10 years of age
- Uzedo – 18 years of age
- Vraylar- 10 years of age
- Zyprexa – 13 years of age
- Zyprexa Zydis – 6 years of age

Table 2: Maximum Age Edits

Prior authorization is required for atypical antipsychotic claims for members greater than the following ages:

- Risperidone oral solution: 7 years of age

3 . Revision History

Date	Notes
3/20/2026	Updated Vraylar criteria. Added Caplyta specific criteria. Added reauthorization criteria for Vraylar, Cobenfy, Caplyta and non-preferred products. Added non-preferred criteria for combination requests. Updated age minimum for Vraylar in the background.

Anzupgo



Prior Authorization Guideline

Guideline ID	GL-563238
Guideline Name	Anzupgo
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 New Mexico

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

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

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderate to severe chronic hand eczema AND 2 - ONE of the following: 2.1 Failure to TWO of the following topical therapeutic classes as confirmed by claims history or submission of medical records: • One topical corticosteroid of at least medium- to high-potency (e.g., mometasone furoate (generic Elocon), fluocinolone Synalar (fluocinolone acetonide), fluocinonide (generic Lidex)) • One topical calcineurin inhibitor [e.g., Elidel (pimecrolimus), tacrolimus (generic Protopic)] • Eucrisa (crisaborole) OR 2.2 History of intolerance or contraindication to ALL of the following topical therapeutic classes (please specify intolerance or contraindication): • One topical corticosteroid of at least medium- to high-potency (e.g., mometasone furoate (generic Elocon), fluocinolone Synalar (fluocinolone acetonide), fluocinonide (generic Lidex)) • One topical calcineurin inhibitor [e.g., Elidel (pimecrolimus), tacrolimus (generic Protopic)] • Eucrisa (crisaborole) OR 2.3 Patient is currently on Anzupgo therapy as confirmed by claims history or submission of medical records AND	

3 - Patient is NOT receiving Anzupgo in combination with a biologic medication or JAK inhibitor [e.g., Adbry (tralokinumab-ldrm), Cibinqo (abrocitinib), Dupixent (dupilumab), Ebglyss (lebrikizumab-lbkz), Nemluvio (nemolizumab-ilto), Rinvoq (upadacitinib)]

AND

4 - Patient is NOT receiving Anzupgo in combination with a potent immunosuppressant medication (e.g., azathioprine, cyclosporine)

AND

5 - Prescribed by, or in consultation with, a dermatologist or allergist/immunologist

Product Name:Anzupgo	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy AND 2 - Patient is NOT receiving Anzupgo in combination with a biologic medication or JAK inhibitor [e.g., Adbry (tralokinumab-ldrm), Cibinqo (abrocitinib), Dupixent (dupilumab), Ebglyss (lebrikizumab-lbkz), Nemluvio (nemolizumab-ilto), Rinvoq (upadacitinib)] AND 3 - Patient is not receiving Anzupgo in combination with a potent immunosuppressant medication (e.g., azathioprine, cyclosporine)	

2 . Revision History

Date	Notes
4/6/2026	Updated policy to clarify combination use language and add prescriber check for initial authorization

Anzupgo



Prior Authorization Guideline

Guideline ID	GL-563238
Guideline Name	Anzupgo
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 New Mexico

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

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

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderate to severe chronic hand eczema AND 2 - ONE of the following: 2.1 Failure to TWO of the following topical therapeutic classes as confirmed by claims history or submission of medical records: • One topical corticosteroid of at least medium- to high-potency (e.g., mometasone furoate (generic Elocon), fluocinolone Synalar (fluocinolone acetonide), fluocinonide (generic Lidex)) • One topical calcineurin inhibitor [e.g., Elidel (pimecrolimus), tacrolimus (generic Protopic)] • Eucrisa (crisaborole) OR 2.2 History of intolerance or contraindication to ALL of the following topical therapeutic classes (please specify intolerance or contraindication): • One topical corticosteroid of at least medium- to high-potency (e.g., mometasone furoate (generic Elocon), fluocinolone Synalar (fluocinolone acetonide), fluocinonide (generic Lidex)) • One topical calcineurin inhibitor [e.g., Elidel (pimecrolimus), tacrolimus (generic Protopic)] • Eucrisa (crisaborole) OR 2.3 Patient is currently on Anzupgo therapy as confirmed by claims history or submission of medical records AND	

3 - Patient is NOT receiving Anzupgo in combination with a biologic medication or JAK inhibitor [e.g., Adbry (tralokinumab-ldrm), Cibinqo (abrocitinib), Dupixent (dupilumab), Ebglyss (lebrikizumab-lbkz), Nemluvio (nemolizumab-ilto), Rinvoq (upadacitinib)]

AND

4 - Patient is NOT receiving Anzupgo in combination with a potent immunosuppressant medication (e.g., azathioprine, cyclosporine)

AND

5 - Prescribed by, or in consultation with, a dermatologist or allergist/immunologist

Product Name:Anzupgo	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy AND 2 - Patient is NOT receiving Anzupgo in combination with a biologic medication or JAK inhibitor [e.g., Adbry (tralokinumab-ldrm), Cibinqo (abrocitinib), Dupixent (dupilumab), Ebglyss (lebrikizumab-lbkz), Nemluvio (nemolizumab-ilto), Rinvoq (upadacitinib)] AND 3 - Patient is not receiving Anzupgo in combination with a potent immunosuppressant medication (e.g., azathioprine, cyclosporine)	

2 . Revision History

Date	Notes
4/6/2026	Updated policy to clarify combination use language and add prescriber check for initial authorization

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.

Aqneursa



Prior Authorization Guideline

Guideline ID	GL-249190
Guideline Name	Aqneursa
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 Nebraska Medicaid - Community & State New Mexico Medicaid - Community & State Pennsylvania Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	7/1/2025

1 . Criteria

Product Name:Aqneursa	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Niemann-Pick disease type C (NPC) AND 2 - Diagnosis has been genetically confirmed by mutation analysis of NPC1 and NPC2 genes AND 3 - Medication is being used to treat neurological manifestations of NPC AND 4 - ONE of the following: • Aqneursa is prescribed in combination with miglustat • Failure to miglustat as confirmed by claims history or submission of medical records • History of intolerance or contraindication to miglustat (please specify intolerance or contraindication) AND 5 - Medication is not being used in combination with Miplyffa (arimoclomol) AND 6 - Medication is prescribed by or in consultation with a provider with expertise in the treatment of NPC	

Product Name:Aqneursa	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Aqneursa therapy (e.g., slowed disease progression from baseline based on assessment with NPC–specific scales) AND 2 - ONE of the following: • Aqneursa is prescribed in combination with miglustat • Failure to miglustat as confirmed by claims history or submission of medical records • History of intolerance or contraindication to miglustat (please specify intolerance or contraindication) AND 3 - Medication is not being used in combination with Miplyffa (arimoclomol) AND 4 - Medication is prescribed by or in consultation with a provider with expertise in the treatment of Niemann-Pick disease type C (NPC)	

2 . Revision History

Date	Notes
4/29/2025	Updated formularies to add PA CAID

Arcalyst



Prior Authorization Guideline

Guideline ID	GL-506210
Guideline Name	Arcalyst
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

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Arcalyst	
Diagnosis	Cryopyrin-Associated Periodic Syndromes (CAPS)
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Cryopyrin-Associated Periodic Syndromes (CAPS), including Familial Cold Auto-inflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS) AND 2 - Prescribed by or in consultation with a rheumatologist	

Product Name:Arcalyst	
Diagnosis	Deficiency of Interleukin-1 Receptor Antagonist (DIRA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Deficiency of Interleukin-1 Receptor Antagonist (DIRA) AND 2 - Disease is in remission (e.g., diary score of less than 0.5 [reflecting no fever, skin rash and bone pain], acute phase reactants [less than 0.5 mg/dL CRP (milligrams per deciliter C-Reactive protein)], absence of objective skin rash, no radiological evidence of active bone lesions) AND 3 - Prescribed by or in consultation with a rheumatologist	

Product Name:Arcalyst	
Diagnosis	Pericarditis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of recurrent pericarditis (RP)	

Product Name:Arcalyst	
Diagnosis	Cryopyrin-Associated Periodic Syndromes (CAPS), Deficiency of Interleukin-1 Receptor Antagonist (DIRA), Pericarditis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Arcalyst therapy	

2 . Revision History

Date	Notes
1/22/2026	Combined formularies. Added a prescriber check to the CAPS and DI RA sections.

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

Attruby



Prior Authorization Guideline

Guideline ID	GL-532194
Guideline Name	Attruby
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 Nebraska Medicaid - Community & State Nevada Medicaid - Community & State New Mexico Medicaid - Community & State Pennsylvania Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Attruby	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of transthyretin (ATTR)-mediated amyloidosis with cardiomyopathy (ATTR-CM)

AND

2 - ONE of the following:

2.1 Documentation that the patient has a pathogenic transthyretin (TTR) mutation (e.g., V30M)

OR

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

OR

2.3 ALL of the following:

2.3.1 Echocardiogram or cardiac magnetic resonance imaging suggestive of amyloidosis

AND

2.3.2 Radionuclide imaging (99mTc-DPD, 99mTc-PYP, or 99m Tc-HMDP) showing grade 2 or 3 cardiac uptake*

AND

2.3.3 Absence of light chain amyloidosis

AND

3 - Patient has New York Heart Association (NYHA) Functional Class I, II, or III heart failure

AND

4 - Physician attests that the patient has an N-terminal pro-B-type natriuretic peptide (NT-proBNP) level that, when combined with signs and symptoms, is considered definitive for a diagnosis of ATTR-CM

AND

5 - ONE of the following:

- History of heart failure, with at least one prior hospitalization for heart failure
- Presence of signs and symptoms of heart failure (e.g., dyspnea, edema)

AND

6 - Prescribed by or in consultation with a cardiologist

AND

7 - Patient is NOT receiving Attriby in combination with an RNA-targeted therapy for ATTR amyloidosis [i.e., Amvuttra (vutrisiran), Onpattro (patisiran), Tegsedi (inotersen), Vyndaqel/Vyndamax (tafamadis), or Wainua (eplontersen)]

Notes	*May require prior authorization and notification.

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

Approval Criteria

1 - Documentation that the patient has experienced a positive clinical response to Attruby (e.g., improved symptoms, quality of life, slowing of disease progression, decreased hospitalizations, etc.)

AND

2 - Documentation that patient continues to have New York Heart Association (NYHA) Functional Class I, II, or III heart failure

AND

3 - Prescribed by or in consultation with a cardiologist

AND

4 - Patient is NOT receiving Attruby in combination with an RNA-targeted therapy for ATTR amyloidosis [i.e., Amvuttra (vutrisiran), Onpattro (patisiran), Tegsedi (inotersen), Vyndaqel/Vyndamax (tafamadis), or Wainua (eplontersen)]

2 . Revision History

Date	Notes
2/26/2026	Rearranged order of formularies. Minor cosmetic/formatting updates and spelled out TTR abbreviation, with no changes to clinical intent.

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.

Austedo, Austedo XR



Prior Authorization Guideline

Guideline ID	GL-242253
Guideline Name	Austedo, Austedo XR
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State New Jersey Medicaid - Community & State New Mexico Medicaid - Community & State New York Medicaid - Community & State New York EPP Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island

Guideline Note:

Effective Date:	7/1/2025

1 . Criteria

Product Name:Austedo, Austedo XR	
Diagnosis	Tardive Dyskinesia
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderate to severe tardive dyskinesia AND 2 - ONE of the following: • Patient has persistent symptoms of tardive dyskinesia despite a trial of dose reduction, tapering, or discontinuation of the offending medication • Patient is not a candidate for a trial of dose reduction, tapering, or discontinuation of the offending medication AND 3 - Prescribed by or in consultation with ONE of the following: • Neurologist • Psychiatrist AND 4 - If the request is for Austedo XR, the prescriber has given a clinical reason or special circumstance why the patient is unable to use Austedo immediate release (please document reason/special circumstance)	

Product Name:Austedo, Austedo XR	
Diagnosis	Chorea associated with Huntington's Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chorea associated with Huntington's Disease

AND

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

- Neurologist
- Psychiatrist

AND

3 - If the request is for Austedo XR, the prescriber has given a clinical reason or special circumstance why the patient is unable to use Austedo immediate release (please document reason/special circumstance)

Product Name:Austedo, Austedo XR	
Diagnosis	Chorea associated with Huntington's Disease, Tardive Dyskinesia
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
4/23/2025	Added Austedo XR

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.

Azole Antifungals



Prior Authorization Guideline

Guideline ID	GL-563218
Guideline Name	Azole Antifungals
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 New Mexico

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name: Brand Sporanox capsules, generic itraconazole capsules	
Diagnosis	Systemic Fungal Infections
Approval Length	12 month(s)

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following: • Blastomycosis • Histoplasmosis • Aspergillosis OR 2 - BOTH of the following: 2.1 Diagnosis of coccidioidomycosis AND 2.2 ONE of the following: 2.2.1 Failure to fluconazole (generic Diflucan) as confirmed by claims history or submission of medical records OR 2.2.2 History of contraindication, intolerance, or resistance to fluconazole (generic Diflucan) (please specify intolerance, contraindication, or resistance)	

Product Name: Brand Sporanox capsules, generic itraconazole capsules	
Diagnosis	Onychomycosis Fingernails
Approval Length	2 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of fingernail onychomycosis confirmed by ONE of the following:

- KOH (potassium hydroxide) test
- Fungal culture
- Nail biopsy

Product Name: Brand Sporanox capsules, generic itraconazole capsules

Diagnosis	Onychomycosis Fingernails

Approval Length	2 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

Product Name: Brand Sporanox capsules, generic itraconazole capsules

Diagnosis	Onychomycosis Toenails

Approval Length	3 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of toenail onychomycosis confirmed by ONE of the following:

- KOH (potassium hydroxide) test
- Fungal culture
- Nail biopsy

Product Name: Brand Sporanox capsules, generic itraconazole capsules

Diagnosis	Onychomycosis Toenails
Approval Length	3 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy	

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

Product Name:Brand Vfend tablets, generic voriconazole tablets	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of invasive aspergillosis OR 2 - ALL of the following:	

2.1 Diagnosis of candidemia

AND

2.2 Patient is non-neutropenic

AND

2.3 ONE of the following:

2.3.1 Failure to fluconazole (generic Diflucan) as confirmed by claims history or submission of medical records

OR

2.3.2 History of contraindication, intolerance, or resistance to fluconazole (generic Diflucan) (please specify intolerance, contraindication, or resistance)

OR

3 - BOTH of the following:

3.1 ONE of the following diagnoses:

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

AND

3.2 ONE of the following:

3.2.1 Failure to fluconazole (generic Diflucan) as confirmed by claims history or submission of medical records

OR

3.2.2 History of contraindication, intolerance, or resistance to fluconazole (generic Diflucan) (please specify intolerance, contraindication, or resistance)

OR

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

OR

5 - Diagnosis of *Fusarium* spp. infection including *Fusarium solani*

OR

6 - Diagnosis of *Exserohilum* species infection

Product Name: Brand Vfend susp, generic voriconazole susp

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Diagnosis of invasive aspergillosis

OR

1.2 ALL of the following:

1.2.1 Diagnosis of Candidemia

AND

1.2.2 Patient is non-neutropenic

AND

1.2.3 ONE of the following:

1.2.3.1 Failure to fluconazole (generic Diflucan) as confirmed by claims history or submission of medical records

OR

1.2.3.2 History of contraindication, intolerance, or resistance to fluconazole (generic Diflucan) (please specify intolerance, contraindication, or resistance)

OR

1.3 BOTH of the following:

1.3.1 ONE of the following diagnoses:

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

AND

1.3.2 ONE of the following:

1.3.2.1 Failure to fluconazole (generic Diflucan) as confirmed by claims history or submission of medical records

OR

1.3.2.2 History of contraindication, intolerance, or resistance to fluconazole (generic Diflucan) (please specify intolerance, contraindication, or resistance)

OR

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

OR

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

OR

1.6 Diagnosis of *Exserohilum* species infection

AND

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

Product Name: Brand Noxafil tablets, generic posaconazole tablets	
Diagnosis	Prophylaxis of Aspergillus or Candida Infections
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Used as prophylaxis of invasive fungal infections caused by ONE of the following:	

- Aspergillus
- Candida

AND

2 - ONE of the following conditions:

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

2.1.1 Hematopoietic stem cell transplant (HSCT) with graft-versus-host disease (GVHD)

OR

2.1.2 Hematologic malignancies with prolonged neutropenia from chemotherapy [e.g., acute myeloid leukemia (AML), myelodysplastic syndromes (MDS)]

OR

2.2 Patient has a prior fungal infection requiring secondary prophylaxis

Product Name: Brand Noxafil tablets, generic posaconazole tablets	
Diagnosis	Treatment of Invasive Aspergillosis
Approval Length	3 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of invasive aspergillosis AND 2 - ONE of the following:	

2.1 Failure to voriconazole (generic Vfend) as confirmed by claims history or submission of medical records

OR

2.2 History of contraindication, intolerance, or resistance to voriconazole (generic Vfend) (please specify intolerance, contraindication, or resistance)

Product Name: Brand Noxafil suspension, generic posaconazole suspension, Noxafil delayed release suspension packets

Diagnosis	Prophylaxis of Aspergillus or Candida Infections
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

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

- Aspergillus
- Candida

AND

2 - ONE of the following conditions:

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

2.1.1 Hematopoietic stem cell transplant (HSCT) with graft-versus-host disease (GVHD)

OR

2.1.2 Hematologic malignancies with prolonged neutropenia from chemotherapy [e.g., acute myeloid leukemia (AML), myelodysplastic syndromes (MDS)]

OR

2.2 Patient has a prior fungal infection requiring secondary prophylaxis

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

Approval Criteria

1 - Diagnosis of oropharyngeal candidiasis (OPC)

AND

2 - ONE of the following:

2.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Fluconazole (generic Diflucan)
- Itraconazole (generic Sporanox)

OR

2.2 History of contraindication, intolerance, or resistance to BOTH of the following (please specify intolerance, contraindication, or resistance):

- Fluconazole (generic Diflucan)
- Itraconazole (generic Sporanox)

Product Name: Cresemba	
Approval Length	3 month(s)

Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following: 1.1 Diagnosis of invasive aspergillosis AND 1.2 ONE of the following: 1.2.1 Failure to voriconazole (generic Vfend) as confirmed by claims history or submission of medical records OR 1.2.2 History of contraindication, intolerance, or resistance to voriconazole (generic Vfend) (please specify intolerance, contraindication, or resistance) OR 2 - Diagnosis of invasive mucormycosis	

Product Name:Tolsura	
Approval Length	3 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following fungal infections: • Blastomycosis • Histoplasmosis	

- Aspergillosis

AND

2 - ONE of the following:

2.1 Failure to itraconazole capsules (generic Sporanox) as confirmed by claims history or submission of medical records

OR

2.2 History of contraindication or intolerance to itraconazole capsules (generic Sporanox) (please specify intolerance or contraindication)

Product Name: Brand Sporanox capsules, generic itraconazole capsules, Brand Sporanox oral solution, generic itraconazole oral solution, Brand Vfend tablets, generic voriconazole tablets, Brand Vfend suspension, generic voriconazole suspension, Brand Noxafil tablets, generic posaconazole tablets, Brand Noxafil oral suspension, generic posaconazole oral suspension, Noxafil delayed release suspension packets, Cresemba, Tolsura

Diagnosis	Infectious Diseases Society of America (IDSA) Recommended Regimens
Approval Length	Based on provider and IDSA recommended treatment durations, up to 12 months
Guideline Type	Prior Authorization

Approval Criteria

1 - Use is recognized for treatment of the diagnosis by the Infectious Diseases Society of America (IDSA)

2 . Revision History

Date	Notes

4/6/2026	Updated GPIs. Simplified invasive aspergillosis in the Vfend powder f or oral suspension section. Updated length of authorization for Noxafi l tablets to reference months for consistency within policy

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

Baxdela



Prior Authorization Guideline

Guideline ID	GL-521296
Guideline Name	Baxdela
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 New Mexico

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Baxdela tablet	
Diagnosis	Community-Acquired Bacterial Pneumonia
Approval Length	10 Day(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 community-acquired bacterial pneumonia (CABP)

AND

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

AND

3.3 ONE of the following:

3.3.1 Failure to THREE of the following antibiotics or antibiotic regimens as confirmed by claims history or submission of medical records:

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

OR

3.3.2 History of intolerance or contraindication to ALL of the following antibiotics or antibiotic regimens (please specify intolerance or contraindication)

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

Product Name: Baxdela tablet	
Diagnosis	Acute Bacterial Skin and Skin Structure Infections
Approval Length	14 Day(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 ONE of the following diagnoses:

3.1.1 BOTH of the following:

3.1.1.1 Acute bacterial skin and skin structure infections

AND

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

OR

3.1.2 BOTH of the following:

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

AND

3.1.2.2 Presence of MRSA infection is likely

AND

3.2 ONE of the following:

3.2.1 Failure of linezolid (generic Zyvox) confirmed by claims history or submitted medical records

OR

3.2.2 History of intolerance or contraindication to linezolid (generic Zyvox) (please specify intolerance or contraindication)

AND

3.3 ONE of the following:

3.3.1 Failure to ONE of the following antibiotics as confirmed by claims history or submitted medical records:

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

OR

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

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

OR

4 - ALL of the following:

4.1 Diagnosis of acute bacterial skin and skin structure infections

AND

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

AND

4.3 ONE of the following:

4.3.1 Failure to THREE of the following antibiotics as confirmed by claims history or submitted medical records:

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

OR

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

- A penicillin

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

Product Name: Baxdela tablet	
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 - The drug has been recognized for treatment of the indication by the Infectious Diseases Society of America (IDSA)	

2 . Revision History

Date	Notes
2/23/2026	Removed NY-CHIP and NY-EPP. Update product name list to indicate Baxdela tablet. Minor cosmetic updates.

Belbuca_Butrans



Prior Authorization Guideline

Guideline ID	GL-487245
Guideline Name	Belbuca_Butrans
Formulary	Medicaid - Community & State Rhode Island

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Belbuca, generic buprenorphine patches, Brand Butrans	
Diagnosis	Cancer related pain/Hospice/End of Life Related Pain
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - The patient is being treated for one of the following:	

- Cancer-related pain (i.e., patients undergoing active cancer treatment; or cancer survivors with chronic pain who have completed cancer treatment, are in clinical remission, or are under cancer surveillance)
- Hospice related pain
- End of life related pain

AND

2 - If the request is for Belbuca or Brand Butrans, the prescriber provides a reason or special circumstance the patient cannot use generic buprenorphine patches

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

Product Name: Belbuca, generic buprenorphine patches, Brand Butrans	
Diagnosis	Non-cancer related pain/Non-hospice/Non-end of life care pain
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Prescriber attests to BOTH of the following: 1.1 Patient has been screened for substance abuse/opioid dependence	

AND

1.2 Pain is moderate to severe and expected to persist for an extended period of time (chronic)

AND

2 - Treatment goals are defined and include estimated duration of treatment (must document treatment goals)

AND

3 - BOTH of the following:

3.1 Patient has been screened for underlying depression and/or anxiety

AND

3.2 If applicable, any underlying conditions have been or will be addressed

AND

4 - ONE of the following:

4.1 The patient has a history of failure to a trial of tramadol IR (immediate release) as confirmed by claims history or submission of medical records

OR

4.2 The patient has a contraindication or intolerance to tramadol IR (please specify contraindication or intolerance)

OR

4.3 The patient is already receiving chronic opioid therapy prior to surgery for postoperative pain, or if the postoperative pain is expected to be moderate to severe and persist for an extended period of time

OR

4.4 Patient is new to plan and currently established on Belbuca or Butrans for at least the past 30 days

AND

5 - If the request is for neuropathic pain (examples of neuropathic pain include neuralgias and neuropathies), One of the following:

5.1 BOTH of the following:

5.1.1 Unless it is contraindicated, the patient has not exhibited an adequate response to 8 weeks of treatment with gabapentin titrated to a therapeutic dose (document date of trial) (if contraindicated, document contraindication)

AND

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

OR

5.2 Patient is new to plan and currently established on therapy for at least the past 30 days

AND

6 - If the request is for Belbuca or Brand Butrans, the prescriber provides a reason or special circumstance the patient cannot use generic buprenorphine patches

Notes	If the patient is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be is

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

Product Name: Belbuca, generic buprenorphine patches, Brand Butrans	
Diagnosis	Non-cancer related pain/Non-hospice/Non-end of life care pain
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documented meaningful improvement in pain and function when assessed against treatment goals (document improvement in function or pain score improvement) AND 2 - Documented rationale for not tapering and discontinuing opioid if treatment goals are not being met AND 3 - Prescriber attests to BOTH of the following: 3.1 Patient has been screened for substance abuse/opioid dependence AND	

3.2 Pain is moderate to severe and expected to persist for an extended period of time (chronic)	
AND	
4 - If the request is for Belbuca or Brand Butrans, the prescriber provides a reason or special circumstance the patient cannot use generic buprenorphine patches	
Notes	If the patient is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. If the patient is currently taking the requested long-acting opioid for at least 30 days and has met the medical necessity authorization criteria requirements for treatment with an opioid, but has not tried generic buprenorphine patches, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. Additionally, a 6 month authorization should be entered for generic buprenorphine patches.

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

Product Name:Belbuca, generic buprenorphine patches, Brand Butrans	
Diagnosis	Cancer related pain/Hospice/End of Life Related Pain
Approval Length	12 month(s)
Guideline Type	Morphine Milligram Equivalents (MME)
Approval Criteria 1 - Patient has one of the following: • Cancer-related pain (i.e., patients undergoing active cancer treatment; or cancer survivors with chronic pain who have completed cancer treatment, are in clinical remission, or are under cancer surveillance) • Hospice pain • End of life diagnosis	
Notes	The authorization should be entered for an MME of 9999 so as to prevent future disruptions in therapy if the patient's dose is increased.

Product Name:Belbuca, generic buprenorphine patches, Brand Butrans	
Diagnosis	Non-cancer related pain/Non-hospice/Non-End of Life Related Pain
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Morphine Milligram Equivalents (MME)
Approval Criteria 1 - Prescriber attests that the patient has been screened for substance abuse/opioid dependence AND 2 - Treatment goals are defined and include estimated duration of treatment (must document treatment goals)	

AND

3 - BOTH of the following:

3.1 Patient has been screened for underlying depression and/or anxiety

AND

3.2 If applicable, any underlying conditions have been or will be addressed

AND

4 - ONE of the following:

4.1 Opioid medication doses of less than 90 MME (Morphine Milligram Equivalents) have been tried and did not adequately control pain (document drug regimen or MME and dates of therapy)

OR

4.2 Patient is new to plan and currently established on the requested MME for at least the past 30 days

Notes	Authorization will be issued for 6 months for non-cancer related pain/non-hospice/non-end of life related pain up to the current requested MME plus 90 MME. If the patient has been established on the requested MME dose for at least 30 days and does not meet the medical necessity authorization criteria requirements, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested MME dose.

Product Name: Belbuca, generic buprenorphine patches, Brand Butrans	
Diagnosis	Non-cancer related pain/Non-hospice/Non-End of Life Related Pain
Approval Length	6 month(s)
Therapy Stage	Reauthorization

Guideline Type	Morphine Milligram Equivalents (MME)
Approval Criteria 1 - Prescriber attests that the patient has been screened for substance abuse/opioid dependence AND 2 - Documented rationale for not tapering and discontinuing opioid if treatment goals are not being met AND 3 - Documented meaningful improvement in pain and function when assessed against treatment goals (document improvement in function or pain score improvement)	
Notes	Authorization will be issued for 6 months for non-cancer related pain/non-hospice/non-end of life related pain up to the current requested MME plus 90 MME If the patient has been established on the requested MME dose for at least 30 days and does not meet the medical necessity authorization criteria requirements, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested MME dose.

2 . Revision History

Date	Notes
12/23/2025	Updated Non-cancer related pain initial auth to add bypass step if patient is ntp and established on therapy for 30 days.

Benefit Determination Mifeprex



Prior Authorization Guideline

Guideline ID	GL-243187
Guideline Name	Benefit Determination Mifeprex
Formulary	Medicaid - Community & State Rhode Island

Guideline Note:

Effective Date:	5/1/2025

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 - One of the following:

2.1 Submission of all necessary state form(s) and/or certification document(s)

OR

2.2 Attestation that documents one of the following:

2.2.1 I certify that on behalf of my professional judgment, the procedure performed was necessary to save the life of the mother.

OR

2.2.2 I certify that on behalf of my professional judgment, the procedure performed was necessary to terminate a pregnancy that was the result of rape. I have counseled the recipient concerning the availability of health and social support services and the importance of reporting the rape to the appropriate law enforcement authorities.

OR

2.2.3 I certify that on behalf of my professional judgment, the procedure performed was necessary to terminate a pregnancy that was the result of incest. I have counseled the recipient concerning the availability of health and social support services and the importance of reporting the incest to the appropriate law enforcement authorities.

OR

2.2.4 I certify that on behalf of my professional judgment, mifepristone is not being utilized for one of the three scenarios above (must provide the reason for use).

2 . Revision History

Date	Notes
4/28/2025	Creating RI standalone Mifeprex GL. Criteria now contains provider attestations.

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-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., 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

UnitedHealthcare Community Plan of Rhode Island Clinical Pharmacy Program Guidelines

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

Biltricide



Prior Authorization Guideline

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

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

2 . Revision History

Date	Notes
11/4/2025	Added Nevada Formulary

Bimzelx



Prior Authorization Guideline

Guideline ID	GL-526196
Guideline Name	Bimzelx
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 New Mexico

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Bimzelx	
Diagnosis	Plaque Psoriasis (PsO)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of moderate to severe plaque psoriasis

AND

1.2 ONE of the following:

1.2.1 ALL of the following:

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

AND

1.2.1.2 ONE of the following:

1.2.1.2.1 Failure of ONE of the following topical therapy classes confirmed by claims history or submitted medical records:

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Anthralin
- Coal tar

OR

1.2.1.2.2 History of intolerance or contraindication to ALL of the following topical therapy classes (please specify intolerance or contraindication):

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Anthralin

- Coal tar

AND

1.2.1.3 ONE of the following:

- Failure of a 3 month trial of methotrexate, at the maximally indicated doses, confirmed by claims history or submitted medical records
- History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

OR

1.2.2 Patient has been previously treated with a targeted immunomodulator FDA (Food and Drug Administration)-approved for the treatment of plaque psoriasis as confirmed by claims history or submission of medical records [e.g., Enbrel (etanercept), Cimzia (certolizumab), adalimumab, Orencia (abatacept), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Otezla (apremilast), ustekinumab]

AND

1.3 Patient is not receiving Bimzelx in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast), ustekinumab]

AND

1.4 ONE of the following:

1.4.1 Failure to TWO of the following preferred products confirmed by claims history or submitted medical records:

- One of the preferred adalimumab products*
- Enbrel (etanercept)
- One of the preferred ustekinumab products*

OR

1.4.2 History of intolerance or contraindication to ALL of the following preferred products (please specify intolerance or contraindication):

- One of the preferred adalimumab products*
- Enbrel (etanercept)
- One of the preferred ustekinumab products*

AND

1.5 ONE of the following:

- Failure to Cosentyx (secukinumab) confirmed by claims history or submitted medical records
- History of intolerance or contraindication to Cosentyx (secukinumab) (please specify intolerance or contraindication)

AND

1.6 Prescribed by or in consultation with a dermatologist

OR

2 - ALL of the following:

2.1 Patient is currently on Bimzelx therapy as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of moderate to severe plaque psoriasis

AND

2.3 Patient is not receiving Bimzelx in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept),

adalimumab, Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast), ustekinumab]

AND

2.4 Prescribed by or in consultation with a dermatologist

Notes	*See PDL links in Background

Product Name:Bimzelx	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of active psoriatic arthritis AND 2 - ONE of the following: • Failure to a 3 month trial of methotrexate at the maximally indicated dose as confirmed by claims history or submission of medical records • History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication) • Patient has been previously treated with a targeted immunomodulator FDA-approved for the treatment of psoriatic arthritis as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), Cosentyx (secukinumab), adalimumab, Simponi (golimumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), Otezla (apremilast), Skyrizi (risankizumab), Rinvoq (upadacitinib), Enbrel (etanercept), ustekinumab] AND	

3 - ONE of the following:

3.1 BOTH of the following:

3.1.1 ONE of the following:

3.1.1.1 Failure to TWO of the following as confirmed by claims history or submitted medical records

- One of the preferred adalimumab products*
- Enbrel (etanercept)
- One of the preferred ustekinumab products*

OR

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

- One of the preferred adalimumab products*
- Enbrel (etanercept)
- One of the preferred ustekinumab products*

AND

3.1.2 ONE of the following:

- Failure to Cosentyx (secukinumab) as confirmed by claims history or submitted medical records
- History of intolerance or contraindication to Cosentyx (secukinumab) (please specify intolerance or contraindication)

OR

3.2 Patient is currently on Bimzelx therapy as confirmed by claims history or submission of medical records

AND

4 - Patient is not receiving Bimzelx in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept),

adalimumab, Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast), ustekinumab]

AND

5 - Prescribed by or in consultation with a rheumatologist or dermatologist

Notes	*See PDL links in Background

Product Name: Bimzelx

Diagnosis	Ankylosing Spondylitis (AS)

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of active ankylosing spondylitis

AND

2 - ONE of the following:

- Failure to two NSAIDs (e.g., ibuprofen, naproxen) at maximally indicated doses, each used for at least 4 weeks, as confirmed by claims history or submission of medical records
- History of intolerance or contraindication to two NSAIDs (e.g., ibuprofen, naproxen) (please specify intolerance or contraindication)
- Patient has been previously treated with a targeted immunomodulator FDA-approved for the treatment of ankylosing spondylitis as confirmed by claims history or submission of medical records [e.g., adalimumab, Simponi (golimumab), Rinvoq (upadacitinib), Xeljanz/Xeljanz XR (tofacitinib), Enbrel (etanercept)]

AND

3 - ONE of the following:

3.1 ONE of the following:

3.1.1 Failure of ALL of the following as confirmed by claims history or submitted medical records

- One of the preferred adalimumab products*
- Enbrel (etanercept)
- Cosentyx (secukinumab)

OR

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

- One of the preferred adalimumab products*
- Enbrel (etanercept)
- Cosentyx (secukinumab)

OR

3.2 Patient is currently on Bimzelx therapy as confirmed by claims history or submission of medical records

AND

4 - Patient is not receiving Bimzelx in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Cosentyx (secukinumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

AND

5 - Prescribed by or in consultation with a rheumatologist

Notes	*See PDL links in Background

Product Name:Bimzelx	
Diagnosis	Non-radiographic Axial Spondyloarthritis

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of active non-radiographic axial spondyloarthritis AND 2 - ONE of the following: • Failure to two NSAIDs (e.g., ibuprofen, naproxen) at maximally indicated doses, each used for at least 4 weeks, as confirmed by claims history or submission of medical records • History of intolerance or contraindication to two NSAIDs (e.g., ibuprofen, naproxen) (please specify intolerance or contraindication) • Patient has been previously treated with a targeted immunomodulator FDA-approved for the treatment of non-radiographic axial spondyloarthritis as confirmed by claims history or submission of medical records [e.g. Cimzia (certolizumab), Cosentyx (secukinumab), Rinvoq (upadacitinib)] AND 3 - ONE of the following: • Failure to Cosentyx (secukinumab) as confirmed by claims history or submitted medical records • History of intolerance or contraindication to Cosentyx (secukinumab) (please specify intolerance or contraindication) • Patient is currently on Bimzelx therapy as confirmed by claims history or submission of medical records AND 4 - Patient is not receiving Bimzelx in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Cosentyx (secukinumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]	

AND

5 - Prescribed by or in consultation with a rheumatologist

Notes	*See PDL links in Background

Product Name:Bimzelx

Diagnosis	Hidradenitis Suppurativa (HS)

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe hidradenitis suppurativa (i.e., Hurley Stage II or III)

AND

2 - ONE of the following:

- Failure to at least one oral antibiotic (e.g., doxycycline, clindamycin, rifampin) at maximally indicated doses, as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to at least one oral antibiotic (e.g., doxycycline, clindamycin, rifampin) (please specify contraindication or intolerance)
- Patient has been previously treated with a targeted immunomodulator FDA-approved for the treatment of hidradenitis suppurativa as confirmed by claims history or submitted medical records [e.g., adalimumab, Cosentyx (secukinumab)]

AND

3 - ONE of the following:

3.1 ONE of the following:

3.1.1 Failure to BOTH of the following preferred products confirmed by claims history or submission of medical records

- One of the preferred adalimumab products*
- Cosentyx (secukinumab)

OR

3.1.2 History of contraindication or intolerance to BOTH of the following preferred products (please specify contraindication or intolerance)

- One of the preferred adalimumab products*
- Cosentyx (secukinumab)

OR

3.2 Patient is currently on Bimzelx therapy as confirmed by claims history or submission of medical records

AND

4 - Patient is not receiving Bimzelx in combination with another targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Olumiant (baricitinib), Orenzia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz (tofacitinib)]

AND

5 - Prescribed by or in consultation with a dermatologist

Notes

*See PDL links in Background

Product Name: Bimzelx

Diagnosis

Plaque Psoriasis (PsO), Psoriatic Arthritis (PsA), Ankylosing Spondylitis (AS), Non-radiographic Axial Spondyloarthritis, Hidradenitis Suppurativa (HS)

Approval Length

12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Bimzelx therapy AND 2 - Patient is not receiving Bimzelx in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast), ustekinumab]*	
Notes	*Examples of drug(s) may not be applicable based on the requested indication.

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

NM: <https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-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>

RI: <https://www.uhcprovider.com/en/health-plans-by-state/rhode-island-health-plans/ri-comm-plan-home/ri-cp-pharmacy.html>

3 . Revision History

Date	Notes
2/24/2026	Removed NY-CHIP. Changed reference of brand Stelara to generic ustekinumab under reauth criteria. Removed PDL link for NY from Background. Minor cosmetic updates.

Bonjesta and Diclegis



Prior Authorization Guideline

Guideline ID	GL-228323
Guideline Name	Bonjesta and Diclegis
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State New Jersey Medicaid - Community & State New Mexico Medicaid - Community & State New York Medicaid - Community & State New York EPP Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island

Guideline Note:

Effective Date:	6/1/2025

1 . Criteria

Product Name:generic doxylamine/pyridoxine, Brand Diclegis, Bonjesta	
Approval Length	9 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of nausea and vomiting associated with pregnancy

AND

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

AND

3 - ONE of the following:

3.1 Failure to a five day trial of over-the-counter doxylamine taken together with pyridoxine (i.e., not a combined dosage form, but separate formulations taken concomitantly), as confirmed by claims history or submission of medical records

OR

3.2 History of contraindication or intolerance to over-the-counter doxylamine taken together with pyridoxine (i.e., not a combined dosage form, but separate formulations taken concomitantly) (please specify contraindication or intolerance)

2 . Revision History

Date	Notes
4/3/2025	Updated formularies

Bonsity, Forteo



Prior Authorization Guideline

Guideline ID	GL-458424
Guideline Name	Bonsity, Forteo
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

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name: Brand Forteo, generic teriparatide, brand Teriparatide, Bonsity	
Diagnosis	Osteoporosis
Approval Length	24 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 BOTH of the following: • Patient is female • Diagnosis of postmenopausal osteoporosis OR 1.2 BOTH of the following: • Patient is male • Diagnosis of osteoporosis AND 2 - ONE of the following: 2.1 Patient is at high risk of fracture [e.g., recent fracture (e.g., within the past 12 months), fractures while on approved osteoporosis therapy, multiple fractures, fractures while on drugs causing skeletal harm (e.g., long-term glucocorticoids), very low T-score (e.g., less than -3.0), high risk for falls or history of injurious falls, and very high fracture probability by FRAX (fracture risk assessment tool) (e.g., major osteoporosis fracture greater than 30%, hip fracture greater than 4.5%)] OR 2.2 Patient has a history of failure to at least one other available osteoporosis therapy (e.g., alendronate, denosumab, risedronate, zoledronate) as confirmed by claims history or submission of medical records OR	

2.3 Patient has contraindication or intolerance to at least one other available osteoporosis therapy (e.g., alendronate, denosumab, risedronate, zoledronate) (please specify contraindication or intolerance)

AND

3 - ONE of the following:

3.1 Treatment duration has not exceeded a total of 24 months of cumulative use of parathyroid hormone analogs (e.g., Bonsity, teriparatide injection, Forteo, Tymlos) during the patient's lifetime

OR

3.2 BOTH of the following:

3.2.1 Patient is currently or has previously been treated with parathyroid hormone analogs (e.g., Bonsity, teriparatide injection, Forteo, Tymlos)

AND

3.2.2 The prescriber attests that the patient remains at or has returned to having a high risk for fracture

AND

4 - If the request is for Bonsity, Brand Forteo, or Brand Teriparatide, BOTH of the following:

4.1 ONE of the following:

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

AND

4.2 ONE of the following:

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

Product Name: Brand Forteo, generic teriparatide, brand Teriparatide, Bonsity	
Diagnosis	Osteoporosis Associated with Sustained Systemic Glucocorticoid Therapy
Approval Length	24 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of glucocorticoid-induced osteoporosis AND 2 - History of prednisone or its equivalent at a dose greater than or equal to 5 mg (milligrams)/day as confirmed by claims history or submission of medical records AND 3 - ONE of the following: 3.1 Patient is at high risk of fracture [e.g., recent fracture (e.g., within the past 12 months), fractures while on approved osteoporosis therapy, multiple fractures, fractures while on drugs causing skeletal harm (e.g., long-term glucocorticoids), very low T-score (e.g., less than -3.0), high risk for falls or history of injurious falls, and very high fracture probability by FRAX (fracture risk assessment tool) (e.g., major osteoporosis fracture greater than 30%, hip fracture greater than 4.5%)] OR 3.2 Patient has a history of failure to at least one other available osteoporosis therapy (e.g.,	

alendronate, denosumab, risedronate, zoledronate) as confirmed by claims history or submission of medical records

OR

3.3 Patient has contraindication or intolerance to at least one other available osteoporosis therapy (e.g., alendronate, denosumab, risedronate, zoledronate) (please specify contraindication or intolerance)

AND

4 - ONE of the following:

4.1 Treatment duration has not exceeded a total of 24 months of cumulative use of parathyroid hormone analogs (e.g., Bonsity, teriparatide injection, Forteo, Tymlos)

OR

4.2 BOTH of the following:

4.2.1 Patient is currently or has previously been treated with parathyroid hormone analogs (e.g., Bonsity, teriparatide injection, Forteo, Tymlos)

AND

4.2.2 The prescriber attests that the patient remains at or has returned to having a high risk for fracture

AND

5 - If the request is for Bonsity, Brand Forteo, or Brand Teriparatide, ONE of the following:

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

Product Name: Brand Forteo, generic teriparatide, brand Teriparatide, Bonsity	
Diagnosis	Osteoporosis, Osteoporosis Associated with Sustained Systemic Glucocorticoid Therapy
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Treatment duration of parathyroid hormones (e.g., Bonsity, teriparatide injection, Forteo, Tymlos) has not exceeded a total of 24 months during the patient's lifetime OR 2 - The patient remains at or has returned to having a high risk for fracture despite a total of 24 months of use of parathyroid hormones (e.g., Bonsity, teriparatide injection, Forteo, Tymlos)	

2 . Revision History

Date	Notes
12/9/2025	Added a step through generic Forteo for Bonsity, Brand Forteo, or Brand Teriparatide requests under initial criteria for Osteoporosis and Osteoporosis Associated with Sustained Systemic Glucocorticoid Therapy.

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

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-506314
Guideline Name	Brekiya, Migranal, Trudhesa
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State New Jersey Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	2/1/2026

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), one of which must be sumatriptan nasal spray, 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), one of which must be sumatriptan nasal spray (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 - 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 3 - 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: Brekya	
Approval Length	12 month(s)
Guideline Type	Quantity Limit
Approval Criteria 1 - ONE of the following: 1.1 BOTH of the following: 1.1.1 Diagnosis of migraine headaches with or without aura AND 1.1.2 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)] OR 1.2 Diagnosis of cluster headaches AND 2 - Prescribed by, or in consultation with, ONE of the following: • Neurologist • Pain management specialist	

AND

3 - BOTH of the following:

3.1 ONE of the following:

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

OR

3.1.2 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

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 Food and Drug Administration (FDA) for the diagnosis indicated

AND

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

1/26/2026	Updated title and formularies. Added Brekiya

Brexafemme



Prior Authorization Guideline

Guideline ID	GL-539241
Guideline Name	Brexafemme
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 New Mexico

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name: Brexafemme	
Diagnosis	Vulvovaginal candidiasis
Approval Length	3 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of vulvovaginal candidiasis (VVC)

AND

2 - ONE of the following:

2.1 Confirmed azole resistance demonstrated by culture and susceptibility testing

OR

2.2 BOTH of the following:

- Other causes (including but not limited to bacterial vaginosis or trichomoniasis) have been ruled out
- Failure of oral fluconazole therapy for the current episode of VVC

AND

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

- Infectious disease physician
- Obstetrician/Gynecologist

Product Name: Brexafemme	
Diagnosis	Recurrent vulvovaginal candidiasis
Approval Length	6 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of recurrent vulvovaginal candidiasis (RVVC)	

AND

2 - ONE of the following:

2.1 Confirmed azole resistance demonstrated by culture and susceptibility testing

OR

2.2 BOTH of the following:

- Other causes (including but not limited to bacterial vaginosis or trichomoniasis) have been ruled out
- Failure of a maintenance course of oral fluconazole confirmed by claims history or submission of medical records defined as 100-mg, 150-mg, or 200-mg taken weekly for 6 months

AND

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

- Infectious disease physician
- Obstetrician/Gynecologist

2 . Revision History

Date	Notes
3/6/2026	Removed NY. Removed the 7-day trial requirement of fluconazole for treatment of vulvovaginal candidiasis

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.

Budesonide delayed-release capsule



Prior Authorization Guideline

Guideline ID	GL-534201
Guideline Name	Budesonide delayed-release capsule
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

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

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

Approval Criteria

1 - Used for the treatment of Crohn's disease

2 . Revision History

Date	Notes
2/25/2026	Updated title. Minor formatting changes

Buphenyl



Prior Authorization Guideline

Guideline ID	GL-434347
Guideline Name	Buphenyl
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 New Mexico Medicaid - Community & State Virginia Medicaid - Community & State Nevada

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name: Brand Buphenyl oral powder, generic sodium phenylbutyrate oral powder

Diagnosis	Urea Cycle Disorders (UCDs)
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of urea cycle disorders (UCDs)	

Product Name:Brand Buphenyl tablets, generic sodium phenylbutyrate tablets	
Diagnosis	Urea Cycle Disorders (UCDs)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of urea cycle disorders (UCDs) AND 2 - Prescriber provides a reason or special circumstance the patient cannot use sodium phenylbutyrate (generic Buphenyl) powder for oral solution	

Product Name:Brand Buphenyl tablets, generic sodium phenylbutyrate tablets	
Diagnosis	Urea Cycle Disorders (UCDs)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Documentation of positive clinical response to Buphenyl (sodium phenylbutyrate) tablets

2 . Revision History

Date	Notes
11/4/2025	Added Nevada Formulary

Buprenorphine for Opioid Dependence



Prior Authorization Guideline

Guideline ID	GL-534215
Guideline Name	Buprenorphine for Opioid Dependence
Formulary	Medicaid - Community & State Rhode Island

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Brand Suboxone, Zubsolv	
Approval Length	12 month(s)*
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - The patient has a DSM-V-TR (diagnostic and statistical manual, fifth edition, text revision) diagnosis of opioid use disorder	

AND	
2 - The patient must have a reason or special circumstance that they cannot use BOTH of the following (please specify reason or special circumstance): • Buprenorphine/naloxone sublingual film (generic Suboxone sublingual film) • Buprenorphine/naloxone sublingual tablet	
Notes	*Up to 32 mg per day of buprenorphine, or equivalent dosing of an alternative medication, will be authorized.

Product Name: Brand Suboxone, Zubsolv	
Approval Length	12 month(s)*
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - The patient has been prescribed a buprenorphine product for the purpose of opioid use disorder maintenance therapy AND 2 - The patient must have a reason or special circumstance that they cannot use BOTH of the following (please specify reason or special circumstance): • Buprenorphine/naloxone sublingual film (generic Suboxone sublingual film) • Buprenorphine/naloxone sublingual tablet	
Notes	*Up to 32 mg per day of buprenorphine, or equivalent dosing of an alternative medication, will be authorized.

Product Name: generic buprenorphine/naloxone SL film, Brand Suboxone, buprenorphine/naloxone SL tabs, Zubsolv, buprenorphine SL tabs	
Diagnosis	Exceeding 32 mg of buprenorphine or Equivalent

Approval Length	Authorization length will be issued for requested duration of therapy, not to exceed 12 months
Guideline Type	Drug Utilization Review
Approval Criteria 1 - Physician has provided rationale for needing to exceed the 32 mg (milligrams) buprenorphine daily limit	

Product Name:generic buprenorphine/naloxone SL film, Brand Suboxone, buprenorphine/naloxone SL tabs, Zubsolv, buprenorphine SL tabs	
Approval Length	Authorization length will be issued for requested duration of therapy, not to exceed 12 months
Guideline Type	Quantity Limit
Approval Criteria 1 - ONE of the following: 1.1 The requested dosage cannot be achieved using the plan accepted quantity limit of a different dose or formulation OR 1.2 Physician has provided rationale for requiring the specific quantity requested	

2 . Revision History

Date	Notes
2/26/2026	Updated title. Updated GPIs. Updated max daily dosage limit for buprenorphine to 32 mg per day from 24 mg per day

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 Rhode Island 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 Rhode Island 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

Cablivi



Prior Authorization Guideline

Guideline ID	GL-434348
Guideline Name	Cablivi
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

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.

Camzyos



Prior Authorization Guideline

Guideline ID	GL-564238
Guideline Name	Camzyos
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 Virginia

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Camzyos

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of obstructive hypertrophic cardiomyopathy (HCM) AND 2 - Heart failure is classified as ONE of the following: • New York Heart Association (NYHA) class II heart failure • NYHA class III heart failure AND 3 - BOTH of the following were measured prior to Camzyos therapy: 3.1 Patient had a left ventricular ejection fraction of greater than or equal to 55% AND 3.2 Patient had a Valsalva left ventricular outflow tract (LVOT) peak gradient greater than or equal to 50 mmHg (millimeter of mercury) at rest or with provocation AND 4 - ONE of the following: 4.1 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

4.2 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

5 - Camzyos is not used in combination with another cardiac myosin inhibitor [i.e., Myqorzo (aficamten)]

AND

6 - Camzyos is prescribed by, or in consultation with, a cardiologist

Product Name:Camzyos	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy (e.g., 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 - Camzyos is not used in combination with another cardiac myosin inhibitor [i.e., Myqorzo (aficamten)]

AND

4 - Camzyos is prescribed by, or in consultation with, a cardiologist

2 . Revision History

Date	Notes
4/6/2026	Removed PACAID. Updated criteria for a LVEF and LVOT to clarify these measurements are prior to Camzyos therapy without change to clinical intent. Added not used in combination criteria to initial and reauth sections.

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.

Carbaglu



Prior Authorization Guideline

Guideline ID	GL-434813
Guideline Name	Carbaglu
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 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:Brand Carbaglu, generic carglumic acid	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of hyperammonemia due to ONE of the following: • N-acetylglutamate synthase (NAGS) deficiency • Propionic acidemia (PA) • Methylmalonic acidemia (MMA)	

Product Name:Brand Carbaglu, generic carglumic acid	
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
11/4/2025	Added Nevada Formulary

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.

CGRP



Prior Authorization Guideline

Guideline ID	GL-534202
Guideline Name	CGRP
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State New Jersey Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Ajovy, Emgality 120mg	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of migraine consistent with The International Classification of Headache Disorders, 3rd edition

AND

2 - ONE of the following:

2.1 4 to 7 migraine days per month and at least ONE of the following:

- Less than 15 headache days per month
- Provider attests this is the patient's predominant headache diagnosis (i.e., primary driver of headaches is not a different, non-migrainous condition)

OR

2.2 Greater than or equal to 8 migraine days per month

AND

3 - ONE of the following:

3.1 Failure (after a trial of at least two months), to TWO of the following prophylactic therapies or classes as confirmed by claims history or submission of medical records:

- A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol)*
- Candesartan (generic Atacand)*
- Divalproex sodium [generic Depakote/Depakote ER (extended-release)]
- OnabotulinumtoxinA (generic Botox)**
- A serotonin-norepinephrine reuptake inhibitor [i.e., duloxetine (Cymbalta), venlafaxine (Effexor/Effexor XR)]
- Topiramate (generic Topamax)
- A tricyclic antidepressant [i.e., amitriptyline (Elavil), nortriptyline (Pamelor)]

OR

3.2 History of intolerance or contraindication to TWO of the following prophylactic therapies or classes (please specify intolerance or contraindication):

- A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol)*

- Candesartan (generic Atacand)*
- Divalproex sodium [generic Depakote/Depakote ER (extended-release)]
- OnabotulinumtoxinA (generic Botox)**
- A serotonin-norepinephrine reuptake inhibitor [i.e., duloxetine (Cymbalta), venlafaxine (Effexor/Effexor XR)]
- Topiramate (generic Topamax)
- A tricyclic antidepressant [i.e., amitriptyline (Elavil), nortriptyline (Pamelor)]

AND

4 - Medication will NOT be used in combination with another CGRP (calcitonin gene-related peptide) antagonist or inhibitor used for the preventive treatment of migraines [e.g., Aimovig, Nurtec ODT (orally disintegrating tablet), Qulipta, Vyepti (eptinezumab-jjmr)]

Notes	*Timolol and candesartan are non-preferred and should not be included in denial to provider. **OnabotulinumtoxinA (generic Botox) is a medical benefit and should not be included in denial to provider.

Product Name:Aimovig	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of migraine consistent with The International Classification of Headache Disorders, 3rd edition AND 2 - ONE of the following: 2.1 4 to 7 migraine days per month and at least ONE of the following: • Less than 15 headache days per month • Provider attests this is the patient's predominant headache diagnosis (i.e., primary driver of headaches is not a different, non-migrainous condition)	

OR

2.2 Greater than or equal to 8 migraine days per month

AND

3 - ONE of the following:

3.1 Failure (after a trial of at least two months), to TWO of the following prophylactic therapies or classes as confirmed by claims history or submission of medical records:

- A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol)*
- Candesartan (generic Atacand)*
- Divalproex sodium [generic Depakote/Depakote ER (extended-release)]
- OnabotulinumtoxinA (generic Botox)**
- A serotonin-norepinephrine reuptake inhibitor [i.e., duloxetine (Cymbalta), venlafaxine (Effexor/Effexor XR)]
- Topiramate (generic Topamax)
- A tricyclic antidepressant [i.e., amitriptyline (Elavil), nortriptyline (Pamelor)]

OR

3.2 History of intolerance or contraindication to TWO of the following prophylactic therapies or classes (please specify intolerance or contraindication):

- A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol)*
- Candesartan (generic Atacand)*
- Divalproex sodium [generic Depakote/Depakote ER (extended-release)]
- OnabotulinumtoxinA (generic Botox)**
- A serotonin-norepinephrine reuptake inhibitor [i.e., duloxetine (Cymbalta), venlafaxine (Effexor/Effexor XR)]
- Topiramate (generic Topamax)
- A tricyclic antidepressant [i.e., amitriptyline (Elavil), nortriptyline (Pamelor)]

AND

4 - ONE of the following:

4.1 Failure (after a trial of at least three months), to BOTH of the following as documented by claims history or submission of medical records:

- Ajovy
- Emgality [120 mg (milligram) strength]

OR

4.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Ajovy
- Emgality (120 mg strength)

AND

5 - Medication will not be used in combination with another CGRP (calcitonin gene-related peptide) antagonist or inhibitor used for the preventive treatment of migraines [e.g., Ajovy, Emgality, Nurtec ODT (orally disintegrating tablet), Qulipta, Vyepti]

Notes	*Timolol and candesartan are non-preferred and should not be included in denial to provider. **OnabotulinumtoxinA (generic Botox) is a medical benefit and should not be included in denial to provider.

Product Name:Aimovig, Ajovy, Emgality 120mg	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity AND 2 - Medication will NOT be used in combination with another CGRP (calcitonin gene-related peptide) antagonist or inhibitor used for the preventive treatment of migraines [e.g., Nurtec ODT (orally disintegrating tablet), Qulipta, Vyepti]	

Product Name:Emgality 100mg	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of episodic cluster headache AND 2 - Patient has experienced at least 2 cluster periods lasting from 7 days to 365 days, separated by pain-free periods lasting at least three months AND 3 - Medication will NOT be used in combination with another CGRP (calcitonin gene-related peptide) antagonist or inhibitor [e.g., Aimovig, Ajovy, Nurtec ODT (orally disintegrating tablet), Qulipta, Ubrelvy, Vyepti]	

Product Name:Emgality 100mg	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity AND	

2 - Medication will NOT be used in combination with another CGRP (calcitonin gene-related peptide) antagonist or inhibitor [e.g., Aimovig, Ajoovy, Nurtec ODT (orally disintegrating tablet), Qulipta, Ubrelvy, Vyepti]

2 . Revision History

Date	Notes
2/25/2026	Removed NY-CHIP. Updated combination therapy language. Minor formatting changes

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.

Cialis and Chewtadzy for BPH



Prior Authorization Guideline

Guideline ID	GL-421302
Guideline Name	Cialis and Chewtadzy for BPH
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 New Mexico

Guideline Note:

Effective Date:	11/1/2025

1 . Criteria

Product Name:Chewtadzy 5mg, Brand Cialis 5 mg, generic tadalafil 5 mg	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of benign prostatic hyperplasia (BPH)

AND

2 - ONE of the following:

2.1 Failure to BOTH of the following as confirmed by claims history or submission of medical records:

- Alpha Blockers: (e.g., tamsulosin, alfuzosin ER, doxazosin, or terazosin)
- 5-alpha reductase inhibitors (e.g., finasteride)

OR

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

- Alpha Blockers: (e.g., tamsulosin, alfuzosin ER, doxazosin, or terazosin)
- 5-alpha reductase inhibitors (e.g., finasteride)

AND

3 - Dose does not exceed 5 mg (milligrams) once daily

AND

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

- Failure to tadalafil 5 mg (generic Cialis 5 mg) confirmed by claims history or submission of medical records
- History of intolerance or contraindication to tadalafil 5 mg (generic Cialis 5 mg) (please specify intolerance or contraindication)

2 . Revision History

Date	Notes
10/15/2025	Updated formularies

Cibinqo



Prior Authorization Guideline

Guideline ID	GL-518194
Guideline Name	Cibinqo
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 New Mexico

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name:Cibinqo	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate-to-severe chronic atopic dermatitis

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 TWO of the following therapeutic classes of topical therapies as confirmed by claims history or submission of medical records:

- One medium, high, or very-high potency topical corticosteroid* [e.g., mometasone furoate (generic Elocon), fluocinolone acetonide (generic Synalar), fluocinonide (generic Lidex)]
- One topical calcineurin inhibitor [e.g., pimecrolimus (generic Elidel), tacrolimus (generic Protopic)]
- Eucrisa (crisaborole)

OR

2.1.1.2 History of intolerance or contraindication to ALL of the following therapeutic classes of topical therapies (please specify intolerance or contraindication):

- One medium, high, or very-high potency topical corticosteroid* [e.g., mometasone furoate (generic Elocon), fluocinolone acetonide (generic Synalar), fluocinonide (generic Lidex)]
- One topical calcineurin inhibitor [e.g., pimecrolimus (generic Elidel), tacrolimus (generic Protopic)]
- Eucrisa (crisaborole)

AND

2.1.2 ONE of the following:

2.1.2.1 BOTH of the following:

- Submission of medical records (e.g., chart notes, laboratory values) documenting a 3 month trial of a systemic drug product for the treatment of atopic dermatitis [e.g., Adbry (tralokinumab-ldrm), Dupixent (dupilumab), Ebglyss (lebrikizumab-lbkz), Nemluvio (nemolizumab-ilto), cyclosporine, azathioprine, methotrexate, mycophenolate mofetil, etc]
- Physician attests that the patient was not adequately controlled with the documented systemic drug product

OR

2.1.2.2 Physician attests that systemic treatment with ALL of the following FDA-approved chronic atopic dermatitis therapies is inadvisable (document drug and contraindication rationale):

- Adbry (tralokinumab-ldrm)
- Dupixent (dupilumab)
- Ebglyss (lebrikizumab-lbkz)
- Nemluvio (nemolizumab-ilto)

OR

2.1.2.3 Patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure [refer to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition Text Revision (DSM-V-TR) 300.29 for specific phobia diagnostic criteria]

OR

2.2 Patient is currently on Cibinqo therapy as confirmed by claims history or submission of medical records

AND

3 - Patient is NOT receiving Cibinqo in combination with any of the following:

- Targeted immunomodulator [e.g., Adbry (tralokinumab-ldrm), Dupixent (dupilumab), Ebglyss (lebrikizumab-lbkz), Nemluvio (nemolizumab-ilto), Olumiant (baricitinib), Opzelura (topical ruxolitinib), Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib)]
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

AND

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

- Dermatologist
- Allergist
- Immunologist

Notes

*See list of "Relative Potencies of Topical Corticosteroids" in Table 1 of the Background.

Product Name:Cibinqo

Approval Length 12 month(s)

Therapy Stage Reauthorization

Guideline Type Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Cibinqo therapy

AND

2 - Patient is NOT receiving Cibinqo in combination with any of the following:

- Targeted immunomodulator [e.g., Adbry (tralokinumab-ldrm), Dupixent (dupilumab), Ebglyss (lebrikizumab-lbkz), Nemluvio (nemolizumab-ilto), Olumiant (baricitinib), Opzelura (topical ruxolitinib), Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib)]
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

AND

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

- Dermatologist
- Allergist

- Immunologist

2 . Background

Benefit/Coverage/Program Information			
Table 1: Relative potencies of topical corticosteroids			
Class	Drug	Dosage Form	Strength (%)
Very high potency	Augmented betamethasone dipropionate	Ointment, gel	0.05
	Clobetasol propionate	Cream, foam, ointment	0.05
	Diflorasone diacetate	Ointment	0.05
	Halobetasol propionate	Cream, ointment	0.05
High Potency	Amcinonide	Cream, lotion, ointment	0.1
	Augmented betamethasone dipropionate	Cream, lotion	0.05
	Betamethasone dipropionate	Cream, foam, ointment, solution	0.05
	Desoximetasone	Cream, ointment	0.25
	Desoximetasone	Gel	0.05
	Diflorasone diacetate	Cream	0.05
	Fluocinonide	Cream, gel, ointment, solution	0.05
	Halcinonide	Cream, ointment	0.1
	Mometasone furoate	Ointment	0.1
	Triamcinolone acetonide	Cream, ointment	0.5
	Betamethasone valerate	Cream, foam, lotion, ointment	0.1

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

3 . Revision History

Date	Notes
2/9/2026	Removed NY

Cimzia



Prior Authorization Guideline

Guideline ID	GL-534194
Guideline Name	Cimzia
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 New Mexico

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Cimzia	
Diagnosis	Crohn's Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of moderately to severely active Crohn's disease

AND

1.2 ONE of the following:

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

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

OR

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

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

OR

1.2.3 Patient has been previously treated with a systemic targeted immunomodulator FDA (Food and Drug Administration)-approved for the treatment of Crohn's disease as confirmed by claims history or submission of medical records [e.g., adalimumab, Entyvio (vedolizumab), Omvoh (mirikizumab-mrkz), Rinvoq (upadacitinib), Skyrizi (risankizumab), Tremfya (guselkumab), ustekinumab]

AND

1.3 ONE of the following:

1.3.1 Failure to ONE of the following as confirmed by claims history or submitted medical records:

- One of the preferred adalimumab products*
- One of the preferred ustekinumab products*

OR

1.3.2 History of contraindication or intolerance to BOTH of the following (please specify contraindication or intolerance):

- One of the preferred adalimumab products*
- One of the preferred ustekinumab products*

AND

1.4 Patient is NOT receiving Cimzia in combination with another systemic targeted immunomodulator [e.g., adalimumab, Entyvio (vedolizumab), Omvoh (mirikizumab-mrkz), Rinvoq (upadacitinib), Skyrizi (risankizumab), Tremfya (guselkumab), ustekinumab] for treatment of the same indication

AND

1.5 Prescribed by or in consultation with a gastroenterologist

OR

2 - ALL of the following:

2.1 Patient is currently on Cimzia therapy as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of moderately to severely active Crohn's disease

AND

2.3 Patient is NOT receiving Cimzia in combination with another systemic targeted immunomodulator [e.g., adalimumab, Entyvio (vedolizumab), Omvoh (mirikizumab-mrkz), Rinvoq (upadacitinib), Skyrizi (risankizumab), Tremfya (guselkumab), ustekinumab] for treatment of the same indication

AND

2.4 Prescribed by or in consultation with a gastroenterologist

Notes	*See PDL links in Background

Product Name:Cimzia	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ALL of the following: 1.1 Diagnosis of moderately to severely active rheumatoid arthritis (RA) AND 1.2 ONE of the following: 1.2.1 Failure to a 3 month trial of ONE non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine], at the maximally indicated doses, confirmed by claims history or submitted medical records OR	

1.2.2 History of intolerance or contraindication to ONE non-biologic DMARD [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] (please specify intolerance or contraindication)

OR

1.2.3 Patient has been previously treated with a systemic targeted immunomodulator FDA-approved for the treatment of rheumatoid arthritis as confirmed by claims history or submission of medical records [e.g., adalimumab, Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib)]

AND

1.3 ONE of the following:

1.3.1 Failure to ALL of the following as confirmed by claims history or submitted medical records:

- Enbrel (etanercept)
- One of the preferred adalimumab products*
- Tyenne (tocilizumab-aazg)

OR

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

- Enbrel (etanercept)
- One of the preferred adalimumab products*
- Tyenne (tocilizumab-aazg)

AND

1.4 Patient is NOT receiving Cimzia in combination with another systemic targeted immunomodulator [e.g., adalimumab, Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib)] for treatment of the same indication

AND

1.5 Prescribed by or in consultation with a rheumatologist

OR

2 - ALL of the following:

2.1 Patient is currently on Cimzia therapy as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of moderately to severely active rheumatoid arthritis (RA)

AND

2.3 Patient is NOT receiving Cimzia in combination with another systemic targeted immunomodulator [e.g., adalimumab, Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib)] for treatment of the same indication

AND

2.4 Prescribed by or in consultation with a rheumatologist

Notes	*See PDL links in Background

Product Name:Cimzia	
Diagnosis	Psoriatic Arthritis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of active psoriatic arthritis

AND

1.2 ONE of the following:

1.2.1 Failure to a 3 month trial of methotrexate, at the maximally indicated dose, confirmed by claims history or submitted medical records

OR

1.2.2 History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

OR

1.2.3 Patient has been previously treated with a systemic targeted immunomodulator FDA-approved for the treatment of psoriatic arthritis as confirmed by claims history or submission of medical records [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cosentyx (secukinumab), Enbrel (etanercept), Orencia (abatacept), Otezla (apremilast), Rinvoq (upadacitinib), Simponi (golimumab), Skyrizi (risankizumab), Taltz (ixekizumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), ustekinumab]

AND

1.3 ONE of the following:

1.3.1 Failure to TWO of the following as confirmed by claims history or submitted medical records:

- Enbrel (etanercept)
- One of the preferred adalimumab products*
- One of the preferred ustekinumab products*

OR

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

- Enbrel (etanercept)
- One of the preferred adalimumab products*
- One of the preferred ustekinumab products*

AND

1.4 Patient is NOT receiving Cimzia in combination with another systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cosentyx (secukinumab), Enbrel (etanercept), Orencia (abatacept), Otezla (apremilast), Rinvoq (upadacitinib), Simponi (golimumab), Skyrizi (risankizumab), Taltz (ixekizumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), ustekinumab] for treatment of the same indication

AND

1.5 Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Dermatologist

OR

2 - ALL of the following:

2.1 Patient is currently on Cimzia therapy as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of active psoriatic arthritis

AND

2.3 Patient is NOT receiving Cimzia in combination with another systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cosentyx (secukinumab), Enbrel (etanercept), Orencia (abatacept), Otezla (apremilast), Rinvoq (upadacitinib), Simponi (golimumab), Skyrizi (risankizumab), Taltz (ixekizumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), ustekinumab] for treatment of the same indication

AND

2.4 Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Dermatologist

Notes

*See PDL links in Background

Product Name:Cimzia

Diagnosis Ankylosing Spondylitis

Approval Length 12 month(s)

Therapy Stage Initial Authorization

Guideline Type Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of active ankylosing spondylitis

AND

1.2 ONE of the following:

1.2.1 Failure of TWO NSAIDs (non-steroidal anti-inflammatory drugs) (e.g., ibuprofen, naproxen) at maximally indicated doses, each used for at least 4 weeks, confirmed by claims history or submitted medical records

OR

1.2.2 History of intolerance or contraindication to TWO NSAIDs (please specify intolerance or contraindication)

OR

1.2.3 Patient has been previously treated with a systemic targeted immunomodulator FDA-approved for the treatment of ankylosing spondylitis as confirmed by claims history or submission of medical records [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cosentyx (secukinumab), Enbrel (etanercept), Simponi (golimumab), Rinvoq (upadacitinib), Taltz (ixekizumab), Xeljanz (tofacitinib)]

AND

1.3 ONE of the following:

1.3.1 Failure to BOTH of the following as confirmed by claims history or submitted medical records:

- Enbrel (etanercept)
- One of the preferred adalimumab products*

OR

1.3.2 History of contraindication or intolerance to BOTH of the following (please specify contraindication or intolerance):

- Enbrel (etanercept)
- One of the preferred adalimumab products*

AND

1.4 Patient is NOT receiving Cimzia in combination with another systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cosentyx (secukinumab), Enbrel (etanercept), Simponi (golimumab), Rinvoq (upadacitinib), Taltz (ixekizumab), Xeljanz (tofacitinib)] for treatment of the same indication

AND

1.5 Prescribed by or in consultation with a rheumatologist

OR

2 - ALL of the following:

2.1 Patient is currently on Cimzia therapy as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of active ankylosing spondylitis

AND

2.3 Patient is NOT receiving Cimzia in combination with another systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cosentyx (secukinumab), Enbrel (etanercept), Simponi (golimumab), Rinvoq (upadacitinib), Taltz (ixekizumab), Xeljanz (tofacitinib)] for treatment of the same indication

AND

2.4 Prescribed by or in consultation with a rheumatologist

Notes	*See PDL links in Background

Product Name:Cimzia	
Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of moderate to severe plaque psoriasis

AND

1.2 ONE of the following:

1.2.1 ALL of the following:

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

AND

1.2.1.2 ONE of the following:

1.2.1.2.1 Failure to ONE of the following topical therapies, confirmed by claims history or submitted medical records:

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Anthralin
- Coal tar

OR

1.2.1.2.2 History of intolerance or contraindication to ALL of the following topical therapies (please specify intolerance or contraindication):

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Anthralin

- Coal tar

AND

1.2.1.3 ONE of the following:

1.2.1.3.1 Failure to a 3 month trial of methotrexate at the maximally indicated dose, confirmed by claims history or submitted medical records

OR

1.2.1.3.2 History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

OR

1.2.2 Patient has been previously treated with a systemic targeted immunomodulator FDA-approved for the treatment of plaque psoriasis as confirmed by claims history or submission of medical records [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cosentyx (secukinumab), Enbrel (etanercept), Ilumya (tildrakizumab), Otezla (apremilast), Skyrizi (risankizumab), Siliq (brodalumab), Sotyktu (deucravacitinib), Taltz (ixekizumab), Tremfya (guselkumab), ustekinumab]

AND

1.3 ONE of the following:

1.3.1 Failure to TWO of the following preferred products, confirmed by claims history or submitted medical records:

- One of the preferred adalimumab products*
- Enbrel (etanercept)
- One of the preferred ustekinumab products*

OR

1.3.2 History of intolerance or contraindication to ALL of the following preferred products (please specify intolerance or contraindication)

- One of the preferred adalimumab products*
- Enbrel (etanercept)
- One of the preferred ustekinumab products*

AND

1.4 Patient is NOT receiving Cimzia in combination with another systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cosentyx (secukinumab), Enbrel (etanercept), Ilumya (tildrakizumab), Otezla (apremilast), Skyrizi (risankizumab), Siliq (brodalumab), Sotyktu (deucravacitinib), Taltz (ixekizumab), Tremfya (guselkumab), ustekinumab] for treatment of the same indication

AND

1.5 Prescribed by or in consultation with a dermatologist

OR

2 - ALL of the following:

2.1 Patient is currently on Cimzia therapy as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of moderate to severe plaque psoriasis

AND

2.3 Patient is NOT receiving Cimzia in combination with another systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cosentyx (secukinumab), Enbrel (etanercept), Ilumya (tildrakizumab), Otezla (apremilast), Skyrizi (risankizumab), Siliq (brodalumab), Sotyktu (deucravacitinib), Taltz (ixekizumab), Tremfya (guselkumab), ustekinumab] for treatment of the same indication

AND

2.4 Prescribed by or in consultation with a dermatologist

Notes	*See PDL links in Background

Product Name: Cimzia	
Diagnosis	Non-Radiographic Axial Spondyloarthritis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of non-radiographic axial spondyloarthritis

AND

1.2 ONE of the following:

1.2.1 Failure of TWO NSAIDs (non-steroidal anti-inflammatory drugs) (e.g., ibuprofen, naproxen) at maximally indicated doses, each used for at least 4 weeks, confirmed by claims history or submitted medical records

OR

1.2.2 History of intolerance or contraindication to TWO NSAIDs (please specify intolerance or contraindication)

OR

1.2.3 Patient has been previously treated with a systemic targeted immunomodulator FDA-approved for the treatment of non-radiographic axial spondyloarthritis as confirmed by claims history or submission of medical records [e.g., Bimzelx (bimekizumab-bkzx), Cosentyx (secukinumab), Simponi (golimumab), Rinvoq (upadacitinib), Taltz (ixekizumab)]

AND

1.3 ONE of the following:

- Failure to Cosentyx (secukinumab) as confirmed by claims history or submitted medical records
- History of contraindication or intolerance to Cosentyx (please specify contraindication or intolerance)

AND

1.4 Patient is NOT receiving Cimzia in combination with another systemic targeted immunomodulator [e.g., Bimzelx (bimekizumab-bkzx), Cosentyx (secukinumab), Simponi (golimumab), Rinvoq (upadacitinib), Taltz (ixekizumab)] for treatment of the same indication

AND

1.5 Prescribed by or in consultation with a rheumatologist

OR

2 - ALL of the following:

2.1 Patient is currently on Cimzia therapy as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of non-radiographic axial spondyloarthritis

AND

2.3 Patient is NOT receiving Cimzia in combination with another systemic targeted immunomodulator [e.g., Bimzelx (bimekizumab-bkzx), Cosentyx (secukinumab), Simponi (golimumab), Rinvoq (upadacitinib), Taltz (ixekizumab)] for treatment of the same indication

AND

2.4 Prescribed by or in consultation with a rheumatologist

Product Name:Cimzia	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (pJIA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of active polyarticular juvenile idiopathic arthritis (pJIA)

AND

1.2 ONE of the following:

1.2.1 Failure to ALL of the following as confirmed by claims history or submitted medical records:

- Enbrel (etanercept)
- One of the preferred adalimumab products*
- Tyenne (tocilizumab-aazg)

OR

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

- Enbrel (etanercept)
- One of the preferred adalimumab products*
- Tyenne (tocilizumab-aazg)

AND

1.3 Patient is NOT receiving Cimzia in combination with another systemic targeted immunomodulator [e.g., adalimumab, Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib)] for treatment of the same indication

AND

1.4 Prescribed by or in consultation with a rheumatologist

OR

2 - ALL of the following:

2.1 Patient is currently on Cimzia therapy as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of active polyarticular juvenile idiopathic arthritis (pJIA)

AND

2.3 Patient is NOT receiving Cimzia in combination with another systemic targeted immunomodulator [e.g., adalimumab, Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib)] for treatment of the same indication

AND

2.4 Prescribed by or in consultation with a rheumatologist

Notes	*See PDL links in Background

Product Name:Cimzia

Diagnosis	Crohn's Disease, Rheumatoid Arthritis (RA), Psoriatic Arthritis, Ankylosing Spondylitis, Plaque Psoriasis, Non-Radiographic Axial Spondyloarthritis, Polyarticular Juvenile Idiopathic Arthritis (pJIA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Cimzia therapy AND 2 - Patient is NOT receiving Cimzia in combination with another systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cosentyx (secukinumab), Enbrel (etanercept), Orencia (abatacept), Otezla (apremilast), Rinvoq (upadacitinib), Simponi (golimumab), Skyrizi (risankizumab), Taltz (ixekizumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), ustekinumab, Entyvio (vedolizumab), Omvoh (mirikizumab-mrkz), Olumiant (baricitinib), Siliq (brodalumab), Sotyktu (deucravacitinib)]* for treatment of the same indication	
Notes	* Examples of drug(s) may not be applicable based on the requested indication.

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>

NM: <https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-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>

3 . Revision History

Date	Notes
2/25/2026	Removed NY.

Cinryze



Prior Authorization Guideline

Guideline ID	GL-563242
Guideline Name	Cinryze
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

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Cinryze	
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, and 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 prophylaxis of HAE attacks AND 3 - Not used in combination with other products indicated for prophylaxis against HAE attacks (e.g., Andembry, Dawnzera, Haegarda, Orladeyo, Takhzyro) AND 4 - Prescriber attests that the patient has experienced attacks of a severity and/or frequency such that they would clinically benefit from prophylactic therapy with Cinryze	

AND

5 - One of the following:

5.1 Failure to Haegarda confirmed by claims history or submitted medical records

OR

5.2 History of intolerance or contraindication to Haegarda (please specify intolerance or contraindication)

OR

5.3 Patient is currently on Cinryze therapy confirmed by claims history or submitted medical records

AND

6 - Prescribed by ONE of the following:

- Immunologist
- Allergist

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

AND

2 - Reduction in the utilization of on-demand therapies used for acute attacks (e.g., Berinert, Ekterly, Firazyr, icatibant, Ruconest) as determined by claims information, while on Cinryze therapy

AND

3 - Prescribed for the prophylaxis of HAE attacks

AND

4 - Not used in combination with other products indicated for prophylaxis against HAE attacks (e.g., Andembry, Dawnzera, Haegarda, Orladeyo, Takhzyro)

AND

5 - Prescribed by ONE of the following:

- Immunologist
- Allergist

2 . Revision History

Date	Notes
4/6/2026	Updated list of examples of prophylactic and acute HAE therapies

Ciprofloxacin/dexamethasone otic suspension



Prior Authorization Guideline

Guideline ID	GL-563243
Guideline Name	Ciprofloxacin/dexamethasone otic suspension
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

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Ciprofloxacin/dexamethasone	
Approval Length	1 Month
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a perforated tympanic membrane or tympanostomy tubes

OR

2 - ONE of the following:

- Failure with ONE preferred alternative* as confirmed by claims history or submission of medical records
- History of intolerance or contraindication to ONE preferred alternative* (please specify intolerance or contraindication)

Notes

*See PDL links in Background

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>

NM: <https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html>

NY: <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>

3 . Revision History

Date	Notes
4/6/2026	Updated title. Removed brand Ciprodex.

Colony Stimulating Factors



Prior Authorization Guideline

Guideline ID	GL-551251
Guideline Name	Colony Stimulating Factors
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

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:Leukine, Zarxio	
Diagnosis	Bone Marrow/Stem Cell Transplant
Approval Length	3 months or duration of therapy

Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Patient has non-myeloid malignancies and is undergoing myeloablative chemotherapy followed by autologous or allogeneic bone marrow transplant (BMT) OR 1.2 Used for mobilization of hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis OR 1.3 Patient has had a peripheral stem cell transplant (PSCT) and has received myeloablative chemotherapy AND 2 - Prescribed by or in consultation with a hematologist or oncologist	

Product Name: Neupogen, Nivestym, Nypozi, Releuko	
Diagnosis	Bone Marrow/Stem Cell Transplant
Approval Length	3 months or duration of therapy
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Patient has non-myeloid malignancies and is undergoing myeloablative chemotherapy followed by autologous or allogeneic bone marrow transplant (BMT)	

OR

1.2 Used for mobilization of hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis

OR

1.3 Patient has had a peripheral stem cell transplant (PSCT) and has received myeloablative chemotherapy

AND

2 - Prescribed by or in consultation with a hematologist or oncologist

AND

3 - ONE of the following:

3.1 The request is for Neupogen vial, Nivestym vial, or Releuko vial AND the requested dose is less than 0.3 milliliters

OR

3.2 Both of the following:

3.2.1 Physician attestation that in their clinical opinion the clinical response would be expected to be superior with Neupogen, Nivestym, Nypozi, or Releuko than experienced with Zarxio

AND

3.2.2 One of the following:

- Failure to Zarxio as confirmed by claims history or submission of medical records

- History of contraindication, intolerance or adverse event to Zarxio (please specify contraindication, intolerance, or adverse event)

Product Name:Leukine, Zarxio	
Diagnosis	AML Induction or Consolidation Therapy
Approval Length	3 months or duration of therapy
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of acute myeloid leukemia (AML)

AND

2 - ONE of the following:

2.1 Patient achieved complete remission after induction therapy

OR

2.2 Patient is receiving consolidation chemotherapy

OR

2.3 Patient is receiving fludarabine, cytarabine with or without idarubicin for relapsed or refractory disease

OR

2.4 Patient is receiving cladribine, cytarabine with or without mitoxantrone or idarubicin for relapsed or refractory disease

AND

3 - Prescribed by or in consultation with a hematologist or oncologist

Product Name: Neupogen, Nivestym, Nypozi, Releuko

Diagnosis	AML Induction or Consolidation Therapy

Approval Length	3 months or duration of therapy

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of acute myeloid leukemia (AML)

AND

2 - One of the following:

2.1 Patient achieved complete remission after induction therapy

OR

2.2 Patient is receiving consolidation chemotherapy

OR

2.3 Patient is receiving fludarabine, cytarabine with or without idarubicin for relapsed or refractory disease

OR

2.4 Patient is receiving cladribine, cytarabine with or without mitoxantrone or idarubicin for relapsed or refractory disease

AND

3 - Prescribed by or in consultation with a hematologist or oncologist

AND

4 - ONE of the following:

4.1 The request is for Neupogen vial, Nivestym vial, or Releuko vial AND the requested dose is less than 0.3 milliliters

OR

4.2 Both of the following:

4.2.1 Physician attestation that in their clinical opinion the clinical response would be expected to be superior with Neupogen, Nivestym, Nypozi, or Releuko than experienced with Zarxio

AND

4.2.2 One of the following:

- Failure to Zarxio as confirmed by claims history or submission of medical records
- History of contraindication, intolerance or adverse effect to Zarxio (please specify contraindication, intolerance, or adverse effect)

Product Name:Leukine, Neulasta, Neulasta Onpro, Zarxio, Udenyca, Udenyca Onbody	
Diagnosis	Primary Prophylaxis of Chemotherapy-Induced Febrile Neutropenia (FN)
Approval Length	3 months or duration of therapy.
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 One of the following:

- Patient is receiving dose dense MVAC (methotrexate, vinblastine, doxorubicin, cisplatin) for bladder cancer
- Patient is receiving dose dense AC (doxorubicin, cyclophosphamide) followed by dose-dense paclitaxel for breast cancer
- Patient is receiving chemotherapy regimen(s) associated with greater than 20% incidence of febrile neutropenia (FN)

OR

1.2 Both of the following:

1.2.1 Patient is receiving chemotherapy regimen(s) associated with 10-20% incidence of FN

AND

1.2.2 Patient has one or more risk factors for chemotherapy-induced febrile neutropenia such as:

- Persistent neutropenia due to prior chemotherapy, radiation therapy, or bone marrow involvement by tumor (< 500 neutrophils/mcL or $< 1,000$ neutrophils/mcL and a predicted decline to ≤ 500 neutrophils/mcL over the next 48 hours)
- Liver dysfunction (bilirubin > 2.0)
- Renal dysfunction (creatinine clearance < 50)
- Age greater than 65 years receiving full chemotherapy dose intensity

AND

2 - Prescribed by or in consultation with a hematologist or oncologist

Product Name: Granix, Neupogen, Nivestym, Nypozi, Releuko	
Diagnosis	Primary Prophylaxis of Chemotherapy-Induced Febrile Neutropenia (FN)
Approval Length	3 months or duration of therapy.
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 One of the following:

- Patient is receiving dose dense MVAC (methotrexate, vinblastine, doxorubicin, cisplatin) for bladder cancer
- Patient is receiving dose dense AC (doxorubicin, cyclophosphamide) followed by dose-dense paclitaxel for breast cancer
- Patient is receiving chemotherapy regimen(s) associated with greater than 20% incidence of febrile neutropenia (FN)

OR

1.2 Both of the following:

1.2.1 Patient is receiving chemotherapy regimen(s) associated with 10-20% incidence of FN

AND

1.2.2 Patient has one or more risk factors for chemotherapy-induced febrile neutropenia such as:

- Persistent neutropenia due to prior chemotherapy, radiation therapy, or bone marrow involvement by tumor (< 500 neutrophils/mcL or $< 1,000$ neutrophils/mcL and a predicted decline to ≤ 500 neutrophils/mcL over the next 48 hours)
- Liver dysfunction (bilirubin > 2.0)
- Renal dysfunction (creatinine clearance < 50)
- Age greater than 65 years receiving full chemotherapy dose intensity

AND

2 - Prescribed by or in consultation with a hematologist or oncologist

AND

3 - ONE of the following:

3.1 The request is for Granix vial, Neupogen vial, Nivestym vial, or Releuko vial AND the requested dose is less than 0.3 milliliters

OR

3.2 Both of the following:

3.2.1 Physician attestation that in their clinical opinion the clinical response would be expected to be superior with Granix, Neupogen, Nivestym, Nypozi, or Releuko than experienced with Zarxio

AND

3.2.2 One of the following:

- Failure to Zarxio as confirmed by claims history or submission of medical records
- History of contraindication, intolerance, or adverse effect to Zarxio (please specify contraindication, intolerance, or adverse effect)

Product Name:Fulphila, Fylnetra, Nyvepria, Rolvedon, Ryzneuta, Stimufend, Ziextenzo	
Diagnosis	Primary Prophylaxis of Chemotherapy-Induced Febrile Neutropenia (FN)
Approval Length	3 months or duration of therapy
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 One of the following: • Patient is receiving dose dense MVAC (methotrexate, vinblastine, doxorubicin, cisplatin) for bladder cancer • Patient is receiving dose dense AC (doxorubicin, cyclophosphamide) followed by dose-dense paclitaxel for breast cancer	

- Patient is receiving chemotherapy regimen(s) associated with greater than 20% incidence of febrile neutropenia (FN)

OR

1.2 Both of the following:

1.2.1 Patient is receiving chemotherapy regimen(s) associated with 10-20% incidence of FN

AND

1.2.2 Patient has one or more risk factors for chemotherapy-induced febrile neutropenia:

- Persistent neutropenia due to prior chemotherapy, radiation therapy or bone marrow involvement by tumor (< 500 neutrophils/mcL or < 1,000 neutrophils/mcL and a predicted decline to ≤ 500 neutrophils/mcL over the next 48 hours)
- Liver dysfunction (bilirubin > 2.0)
- Renal dysfunction (creatinine clearance < 50)
- Age greater than 65 years receiving full chemotherapy dose intensity

AND

2 - Prescribed by or in consultation with a hematologist or oncologist

AND

3 - BOTH of the following:

3.1 Physician attestation that in their clinical opinion the clinical response would be expected to be superior with the requested medication than experienced with Neulasta or Udenyca/Udenyca Onbody

AND

3.2 One of the following:

- Failure to Neulasta or Udenyca/Udenyca Onbody as confirmed by claims history or submission of medical records

- History of intolerance, contraindication, or adverse effect to Neulasta or Udenyca/Udenyca Onbody (please specify intolerance, contraindication or adverse effect)

Product Name:Leukine, Neulasta, Neulasta Onpro, Zarxio, Udenyca, Udenyca Onbody	
Diagnosis	Secondary Prophylaxis of Febrile Neutropenia (FN)
Approval Length	3 months or duration of therapy
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 Patient is receiving myelosuppressive anticancer drug(s) given with a curative intent (curative chemotherapy, chemotherapy in curative adjuvant/neoadjuvant setting)

OR

1.1.1.2 Patient is receiving myelosuppressive anticancer drug(s) with a non-curative intent and use of secondary prophylaxis is in accordance with the United States Food and Drug Administration approved labeling

OR

1.1.1.3 Patient is receiving myelosuppressive anticancer drug(s) for definitive therapy (bridge to stem cell transplant, organ transplant, definitive surgery for oligometastatic disease)

AND

1.1.2 ONE of the following:

1.1.2.1 Patient has a documented history of a neutropenic event (febrile neutropenia or low

neutrophil count leading to delay of subsequent cycle) during a previous cycle of the same chemotherapy regimen at full dose for which primary prophylaxis was not received

OR

1.1.2.2 Patient has a documented history of neutropenic event from a previous course of chemotherapy

OR

1.2 ONE of the following:

1.2.1 BOTH of the following:

1.2.1.1 Patient is receiving myelosuppressive anticancer drug(s) given with non-curative intent

AND

1.2.1.2 Patient has a documented history of neutropenic event (febrile neutropenia or low neutrophil count leading to delay of subsequent cycle) during a previous cycle of the same chemotherapy regimen after a trial of dose reduction

OR

1.2.2 Patient is receiving myelosuppressive anticancer drug(s) where primary prophylaxis is indicated

AND

2 - Prescribed by or in consultation with a hematologist or oncologist

Product Name: Granix, Neupogen, Nivestym, Nypozi, Releuko	
Diagnosis	Secondary Prophylaxis of Febrile Neutropenia (FN)
Approval Length	3 months or duration of therapy
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 Patient is receiving myelosuppressive anticancer drug(s) given with a curative intent (curative chemotherapy, chemotherapy in curative adjuvant/neoadjuvant setting)

OR

1.1.1.2 Patient is receiving myelosuppressive anticancer drug(s) with a non-curative intent and use of secondary prophylaxis is in accordance with the United States Food and Drug Administration approved labeling

OR

1.1.1.3 Patient is receiving myelosuppressive anticancer drug(s) for definitive therapy (bridge to stem cell transplant, organ transplant, definitive surgery for oligometastatic disease)

AND

1.1.2 ONE of the following:

1.1.2.1 Patient has a documented history of a neutropenic event (febrile neutropenia or low neutrophil count leading to delay of subsequent cycle) during a previous cycle of the same chemotherapy regimen at full dose for which primary prophylaxis was not received

OR

1.1.2.2 Patient has a documented history of neutropenic event from a previous course of chemotherapy

OR

1.2 ONE of the following:

1.2.1 BOTH of the following:

1.2.1.1 Patient is receiving myelosuppressive anticancer drug(s) given with non-curative intent

AND

1.2.1.2 Patient has a documented history of neutropenic event (febrile neutropenia or low neutrophil count leading to delay of subsequent cycle) during a previous cycle of the same chemotherapy regimen after a trial of dose reduction

OR

1.2.2 Patient is receiving myelosuppressive anticancer drug(s) where primary prophylaxis is indicated

AND

2 - Prescribed by or in consultation with a hematologist or oncologist

AND

3 - ONE of the following:

3.1 The request is for Granix vial, Neupogen vial, Nivestym vial, or Releuko vial AND the requested dose is less than 0.3 milliliters

OR

3.2 Both of the following:

3.2.1 Physician attestation that in their clinical opinion the clinical response would be expected to be superior with Granix, Neupogen, Nivestym, Nypozi, or Releuko than experienced with Zarxio

AND

3.2.2 One of the following:

- Failure to Zarxio as confirmed by claims history or submission of medical records
- History of intolerance, contraindication or adverse effect to Zarxio (please specify intolerance, contraindication or adverse effect)

Product Name:Fulphila, Fylnetra, Nyvepria, Rolvedon, Ryzneuta, Stimufend, Ziextenzo	
Diagnosis	Secondary Prophylaxis of Febrile Neutropenia (FN)
Approval Length	3 months or duration of therapy
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 Patient is receiving myelosuppressive anticancer drug(s) given with a curative intent (curative chemotherapy, chemotherapy in curative adjuvant/neoadjuvant setting) OR 1.1.1.2 Patient is receiving myelosuppressive anticancer drug(s) with a non-curative intent and use of secondary prophylaxis is in accordance with the United States Food and Drug Administration approved labeling OR 1.1.1.3 Patient is receiving myelosuppressive anticancer drug(s) for definitive therapy (bridge to stem cell transplant, organ transplant, definitive surgery for oligometastatic disease)	

AND

1.1.2 One of the following:

1.1.2.1 Patient has a documented history of a neutropenic event (febrile neutropenia or low neutrophil count leading to delay of subsequent cycle) during a previous cycle of the same chemotherapy regimen at full dose for which primary prophylaxis was not received

OR

1.1.2.2 Patient has a documented history of neutropenic event from a previous course of chemotherapy

OR

1.2 One of the following:

1.2.1 Both of the following:

1.2.1.1 Patient is receiving myelosuppressive anticancer drug(s) given with non-curative intent

AND

1.2.1.2 Patient has a documented history of neutropenic event (febrile neutropenia or low neutrophil count leading to delay of subsequent cycle) during a previous cycle of the same chemotherapy regimen after a trial of dose reduction

OR

1.2.2 Patient is receiving myelosuppressive anticancer drug(s) where primary prophylaxis is indicated

AND

2 - Prescribed by or in consultation with a hematologist or oncologist

AND

3 - BOTH of the following:

3.1 Physician attestation that in their clinical opinion the clinical response would be expected to be superior with the requested medication than experienced with Neulasta or Udenyca/Udenyca Onbody

AND

3.2 One of the following:

- Failure to Neulasta or Udenyca/Udenyca Onbody as confirmed by claims history or submission of medical records
- History of intolerance, contraindication or adverse effect to Neulasta or Udenyca/Udenyca Onbody (please specify intolerance, contraindication or adverse effect)

Product Name:Leukine, Neulasta, Neulasta Onpro, Zarxio, Udenyca, Udenyca Onbody	
Diagnosis	Treatment of Febrile Neutropenia (FN)
Approval Length	1 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of febrile neutropenia (FN) AND 2 - Patient has not received long-acting prophylactic pegfilgrastim in the last 14 days AND	

3 - Patient has one or more risk factors for an infection-associated complication such as:

- Sepsis syndrome
- Greater than 65 years of age
- Absolute Neutrophil Count (ANC) less than 100/mcL
- Neutropenia expected to be greater than 10 days in duration
- Pneumonia
- Clinically documented infections including invasive fungal infection
- Hospitalization at the time of fever
- Prior episode(s) of FN

AND

4 - Prescribed by or in consultation with a hematologist or oncologist

Product Name: Neupogen, Nivestym, Nypozi, Releuko

Diagnosis	Treatment of Febrile Neutropenia (FN)

Approval Length	1 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of febrile neutropenia (FN)

AND

2 - Patient has not received long-acting prophylactic pegfilgrastim in the last 14 days

AND

3 - Patient has one or more risk factors for an infection-associated complication such as:

- Sepsis syndrome
- Greater than 65 years of age
- Absolute Neutrophil Count (ANC) less than 100/mcL
- Neutropenia expected to be greater than 10 days in duration

- Pneumonia
- Clinically documented infections including invasive fungal infection
- Hospitalization at the time of fever
- Prior episode(s) of FN

AND

4 - Prescribed by or in consultation with a hematologist or oncologist

AND

5 - One of the following:

5.1 The request is for Neupogen vial, Nivestym vial, or Releuko vial AND the requested dose is less than 0.3 milliliters

OR

5.2 Both of the following:

5.2.1 Physician attestation that in their clinical opinion the clinical response would be expected to be superior with Neupogen, Nivestym, Nypozi or Releuko than experienced with Zarxio

AND

5.2.2 One of the following:

- Failure to Zarxio as confirmed by claims history or submission of medical records
- History of intolerance, contraindication or adverse effect to Zarxio (please specify intolerance, contraindication or adverse effect)

Product Name:Fulphila, Fylnetra, Nyvepria, Rolvedon, Ryzneuta, Stimufend, Ziextenzo	
Diagnosis	Treatment of Febrile Neutropenia (FN)
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of febrile neutropenia (FN)

AND

2 - Patient has not received long-acting prophylactic pegfilgrastim in the last 14 days

AND

3 - Patient has one or more risk factors for an infection-associated complication such as:

- Sepsis syndrome
- Greater than 65 years of age
- Absolute Neutrophil Count (ANC) less than 100/mcL
- Neutropenia expected to be greater than 10 days in duration
- Pneumonia
- Clinically documented infections including invasive fungal infection
- Hospitalization at the time of fever
- Prior episode(s) of FN

AND

4 - Prescribed by or in consultation with a hematologist or oncologist

AND

5 - Both of the following:

5.1 Physician attestation that in their clinical opinion the clinical response would be expected to be superior with the requested medication than experienced with Neulasta or Udenyca/Udenyca Onbody

AND

5.2 One of the following:

- Failure to Neulasta or Udenyca/Udenyca Onbody as confirmed by claims history or submission of medical records
- History of intolerance, contraindication or adverse effect to Neulasta or Udenyca/Udenyca Onbody (please specify intolerance, contraindication or adverse effect)

Product Name:Zarxio	
Diagnosis	Severe Chronic Neutropenia (SCN)
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of severe chronic neutropenia (SCN) [i.e., congenital, cyclic, and idiopathic neutropenias with chronic absolute neutrophil count (ANC) less than or equal to 500 neutrophils/microliter] AND 2 - Prescribed by or in consultation with a hematologist or oncologist	

Product Name:Neupogen, Nivestym, Nypozi, Releuko	
Diagnosis	Severe Chronic Neutropenia (SCN)
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of severe chronic neutropenia (SCN) [i.e., congenital, cyclic, and idiopathic neutropenias with chronic absolute neutrophil count (ANC) less than or equal to 500 neutrophils/microliter]	

AND

2 - Prescribed by or in consultation with a hematologist or oncologist

AND

3 - ONE of the following:

3.1 The request is for Neupogen vial, Nivestym vial, or Releuko vial AND the requested dose is less than 0.3 milliliters

OR

3.2 Both of the following:

3.2.1 Physician attestation that in their clinical opinion the clinical response would be expected to be superior with Neupogen, Nivestym, Nypozi, or Releuko than experienced with Zarxio

AND

3.2.2 One of the following:

- Failure to Zarxio as confirmed by claims history or submission of medical records
- History of intolerance, contraindication or adverse effect to Zarxio (please specify intolerance, contraindication or adverse effect)

Product Name:Leukine, Neulasta, Zarxio, Udenyca, Udenyca Onbody	
Diagnosis	Hematopoietic Syndrome of Acute Radiation Syndrome
Approval Length	3 months or duration of therapy
Guideline Type	Prior Authorization
Approval Criteria	

1 - Patient has been acutely exposed to myelosuppressive doses of radiation

AND

2 - Prescribed by or in consultation with a hematologist or oncologist

Product Name: Neupogen, Nivestym, Nypozi, Releuko

Diagnosis	Hematopoietic Syndrome of Acute Radiation Syndrome

Approval Length	3 months or duration of therapy

Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has been acutely exposed to myelosuppressive doses of radiation

AND

2 - Prescribed by or in consultation with a hematologist or oncologist

AND

3 - ONE of the following:

3.1 The request is for Neupogen vial, Nivestym vial, or Releuko vial AND the requested dose is less than 0.3 milliliters

OR

3.2 Both of the following:

3.2.1 Physician attestation that in their clinical opinion the clinical response would be expected to be superior with Neupogen, Nivestym, Nypozi, or Releuko than experienced with Zarxio

AND

3.2.2 One of the following:

- Failure to Zarxio as confirmed by claims history or submission of medical records
- History of intolerance, contraindication or adverse effect to Zarxio (please specify intolerance, contraindication or adverse effect)

Product Name:Fulphila, Fylnetra, Nyvepria, Rolvedon, Ryzneuta, Stimufend, Ziextenzo	
Diagnosis	Hematopoietic Syndrome of Acute Radiation Syndrome
Approval Length	3 months or duration of therapy
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has been acutely exposed to myelosuppressive doses of radiation AND 2 - Prescribed by or in consultation with a hematologist or oncologist AND 3 - BOTH of the following: 3.1 Physician attestation that in their clinical opinion the clinical response would be expected to be superior with the requested medication than experienced with Neulasta or Udenyca/ Udenyca Onbody AND 3.2 One of the following:	

- Failure to Neulasta or Udenyca/Udenyca Onbody as confirmed by claims history or submission of medical records
- History of intolerance, contraindication or adverse effect to Neulasta or Udenyca/Udenyca Onbody (please specify intolerance, contraindication or adverse effect)

2 . Revision History

Date	Notes
3/18/2026	Added Ryzneuta

Combination Basal Insulin/GLP-1 Receptor Agonist



Prior Authorization Guideline

Guideline ID	GL-242251
Guideline Name	Combination Basal Insulin/GLP-1 Receptor Agonist
Formulary	Medicaid - Community & State Rhode Island

Guideline Note:

Effective Date:	7/1/2025

1 . Criteria

Product Name:Soliqua	
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., chart notes) confirming diagnosis of type 2 diabetes mellitus as evidenced by ONE of the following laboratory values:	

- A1C greater than or equal to 6.5%
- Fasting plasma glucose (FPG) greater than or equal to 126 mg/dL
- 2-hour plasma glucose (PG) greater than or equal to 200 mg/dL during oral glucose tolerance test
- Random plasma glucose greater than or equal to 200 mg/dL in patient with classic symptoms of hyperglycemia or hyperglycemic crisis

OR

1.2 For patients requiring ongoing treatment for type 2 diabetes mellitus (i.e., diagnosed greater than 2 years ago), submission of medical records (e.g., chart notes) confirming diagnosis of type 2 diabetes mellitus

AND

2 - Suboptimal response (i.e., suboptimal glycemic control) to ONE of the following, for a minimum of 90 days, as confirmed by claims history or submission of medical records:

- GLP-1 (glucagon-like peptide-1) receptor agonist [e.g., Victoza (liraglutide injection), Ozempic (semaglutide), Rybelsus (semaglutide)]
- Basal insulin (e.g., insulin glargine, insulin degludec, insulin detemir)

Product Name:Xultophy	
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., chart notes) confirming diagnosis of type 2 diabetes mellitus as evidenced by ONE of the following laboratory values: • A1C greater than or equal to 6.5% • Fasting plasma glucose (FPG) greater than or equal to 126 mg/dL	

- 2-hour plasma glucose (PG) greater than or equal to 200 mg/dL during oral glucose tolerance test
- Random plasma glucose greater than or equal to 200 mg/dL in patient with classic symptoms of hyperglycemia or hyperglycemic crisis

OR

1.2 For patients requiring ongoing treatment for type 2 diabetes mellitus (i.e., diagnosed greater than 2 years ago), submission of medical records (e.g., chart notes) confirming diagnosis of type 2 diabetes mellitus

AND

2 - Suboptimal response (i.e., suboptimal glycemic control) to ONE of the following, for a minimum of 90 days, as confirmed by claims history or submission of medical records:

- GLP-1 (glucagon-like peptide-1) receptor agonist [e.g., Victoza (liraglutide injection), Ozempic (semaglutide), Rybelsus (semaglutide)]
- Basal insulin (e.g., insulin glargine, insulin degludec, insulin detemir)

AND

3 - One of the following:

- Failure to Soliqua, after a minimum of 90 days of therapy, as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to Soliqua (please specify contraindication or intolerance)

Product Name:Xultophy, Soliqua	
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
4/22/2025	Created RI-specific guideline. Updated diagnosis and step therapy language. Added reauth criteria for Soliqua

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.

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) Valdecixib

(62) Zomepirac sodium

3 . Revision History

Date	Notes
2/25/2026	Removed LA from formularies.

Constipation Agents



Prior Authorization Guideline

Guideline ID	GL-563249
Guideline Name	Constipation Agents
Formulary	Medicaid - Community & State Rhode Island

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:generic lubiprostone	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Diagnosis of opioid-induced constipation in an adult with chronic, non-cancer pain	

OR

1.2 Diagnosis of opioid-induced constipation in patients with chronic pain related to prior cancer or its treatment who do not require frequent (e.g., weekly) opioid dosage escalation

OR

1.3 Diagnosis of chronic idiopathic constipation

OR

1.4 BOTH of the following:

- Diagnosis of irritable bowel syndrome with constipation
- Patient was female at birth

AND

2 - ONE of the following:

2.1 Failure to BOTH of the following as confirmed by claims history or submission of medical records:

- Lactulose
- Polyethylene glycol (Miralax)

OR

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

- Lactulose
- Polyethylene glycol (Miralax)

Product Name:Brand Amitiza

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - For diagnosis of opioid-induced constipation (OIC), ALL of the following: 1.1 ONE of the following: • Diagnosis of OIC in an adult with chronic, non-cancer pain • Diagnosis of OIC in patients with chronic pain related to prior cancer or its treatment who do not require frequent (e.g., weekly) opioid dosage escalation AND 1.2 ONE of the following: 1.2.1 Failure to ALL of the following as confirmed by claims history or submission of medical records: • Lactulose • Polyethylene glycol (Miralax) • Movantik • Lubiprostone (generic Amitiza) OR 1.2.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication): • Lactulose • Polyethylene glycol (Miralax) • Movantik • Lubiprostone (generic Amitiza) OR 2 - For diagnosis of chronic idiopathic constipation, ONE of the following:	

2.1 Failure to ALL of the following as confirmed by claims history or submission of medical records:

- Lactulose
- Polyethylene glycol (Miralax)
- Prucalopride (generic Motegrity)
- Lubiprostone (generic Amitiza)

OR

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

- Lactulose
- Polyethylene glycol (Miralax)
- Prucalopride (generic Motegrity)
- Lubiprostone (generic Amitiza)

OR

3 - For diagnosis of irritable bowel syndrome with constipation (IBS-C), BOTH of the following:

3.1 Patient was female at birth

AND

3.2 ONE of the following:

3.2.1 Failure to ALL of the following as confirmed by claims history or submission of medical records:

- Lactulose
- Polyethylene glycol (Miralax)
- Lubiprostone (generic Amitiza)

OR

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

- Lactulose
- Polyethylene glycol (Miralax)
- Lubiprostone (generic Amitiza)

Product Name: Linzess	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - For diagnosis of chronic idiopathic constipation, ONE of the following:

1.1 Failure to ALL of the following as confirmed by claims history or submission of medical records:

- Lactulose
- Polyethylene glycol (Miralax)
- Lubiprostone (generic Amitiza)
- Prucalopride (generic Motegrity)

OR

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

- Lactulose
- Polyethylene glycol (Miralax)
- Lubiprostone (generic Amitiza)
- Prucalopride (generic Motegrity)

OR

2 - For diagnosis of irritable bowel syndrome with constipation (IBS-C), BOTH of the following:

2.1 ONE of the following:

2.1.1 Failure to BOTH of the following as confirmed by claims history or submission of medical records:

- Lactulose
- Polyethylene glycol (Miralax)

OR

2.1.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Lactulose
- Polyethylene glycol (Miralax)

AND

2.2 ONE of the following:

- Failure to lubiprostone (generic Amitiza) as confirmed by claims history or submission of medical records
- History of intolerance or contraindication to lubiprostone (generic Amitiza) (please specify intolerance or contraindication)
- Patient is less than 18 years of age

OR

3 - For diagnosis of functional constipation, ONE of the following:

3.1 Failure to BOTH of the following as confirmed by claims history or submission of medical records:

- Lactulose
- Polyethylene glycol (Miralax)

OR

3.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication)

- Lactulose

- Polyethylene glycol (Miralax)

Product Name: Trulance	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - For diagnosis of chronic idiopathic constipation, ONE of the following:

1.1 Failure to ALL of the following as confirmed by claims history or submission of medical records:

- Lactulose
- Polyethylene glycol (Miralax)
- Lubiprostone (generic Amitiza)
- Prucalopride (generic Motegrity)

OR

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

- Lactulose
- Polyethylene glycol (Miralax)
- Lubiprostone (generic Amitiza)
- Prucalopride (generic Motegrity)

OR

2 - For diagnosis of irritable bowel syndrome with constipation (IBS-C), ONE of the following:

2.1 Failure to ALL of the following as confirmed by claims history or submission of medical records:

- Lactulose
- Polyethylene glycol (Miralax)

- Lubiprostone (generic Amitiza)

OR

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

- Lactulose
- Polyethylene glycol (Miralax)
- Lubiprostone (generic Amitiza)

Product Name: Brand Motegrity, generic prucalopride	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic idiopathic constipation

AND

2 - ONE of the following:

2.1 Failure to ALL of the following as confirmed by claims history or submission of medical records:

- Lactulose
- Polyethylene glycol (Miralax)
- Lubiprostone (generic Amitiza)

OR

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

- Lactulose
- Polyethylene glycol (Miralax)
- Lubiprostone (generic Amitiza)

Product Name: Movantik	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: • Diagnosis of opioid-induced constipation in a patient being treated for chronic, non-cancer pain • Diagnosis of opioid-induced constipation in a patient with chronic pain related to prior cancer or its treatment who does not require frequent (e.g., weekly) opioid dosage escalation AND 2 - ONE of the following: 2.1 Failure to ALL of the following as confirmed by claims history or submission of medical records: • Lactulose • Polyethylene glycol (Miralax) • Lubiprostone (generic Amitiza) OR 2.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication): • Lactulose • Polyethylene glycol (Miralax)	

- Lubiprostone (generic Amitiza)

Product Name: Symproic, Relistor tabs	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: • Diagnosis of opioid-induced constipation in a patient being treated for chronic, non-cancer pain • Diagnosis of opioid-induced constipation in a patient with chronic pain related to prior cancer or its treatment who does not require frequent (e.g., weekly) opioid dosage escalation AND 2 - ONE of the following: 2.1 Failure to ALL of the following as confirmed by claims history or submission of medical records: • Lactulose • Polyethylene glycol (Miralax) • Lubiprostone (generic Amitiza) • Movantik OR 2.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication): • Lactulose • Polyethylene glycol (Miralax) • Lubiprostone (generic Amitiza)	

- Movantik

Product Name:Relistor inj	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of opioid induced constipation (OIC) in patients with advanced illness receiving palliative care OR 2 - BOTH of the following: 2.1 ONE of the following: • Diagnosis of OIC in a patient being treated for chronic, non-cancer pain • Diagnosis of OIC in a patient with chronic pain related to prior cancer diagnosis or its treatment who does not require frequent (e.g., weekly) opioid dosage escalation AND 2.2 ONE of the following: 2.2.1 The patient is not able to swallow oral medications OR 2.2.2 Failure to ALL of the following as confirmed by claims history or submitted medical records: • Lactulose • Polyethylene glycol (Miralax) • Lubiprostone (generic Amitiza)	

- Movantik

OR

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

- Lactulose
- Polyethylene glycol (Miralax)
- Lubiprostone (generic Amitiza)
- Movantik

Product Name: Ibsrela	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of irritable bowel syndrome with constipation

AND

2 - ONE of the following:

2.1 Failure to ALL of the following as confirmed by claims history or submission of medical records:

- Lactulose
- Polyethylene glycol (Miralax)
- Lubiprostone (generic Amitiza)

OR

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

- Lactulose
- Polyethylene glycol (Miralax)
- Lubiprostone (generic Amitiza)

Product Name: Brand Amitiza, generic lubiprostone, Ibsrela, Linzess, Brand Motegrity, generic prucalopride, Movantik, Symproic, Trulance, Relistor tabs/inj

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
4/6/2026	Removed Zelnorm. Minor language updates

Continuous Glucose Monitors



Prior Authorization Guideline

Guideline ID	GL-555350
Guideline Name	Continuous Glucose Monitors
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 Michigan Medicaid - Community & State Washington Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	5/1/2026

Note:

For Medicaid - Community & State Colorado - this guideline only applies to CAG ACUCOC. This guideline does NOT apply to CAG ACUCO.

1 . Criteria

Product Name: Continuous Glucose Monitors, sensors, and transmitters (all brands)	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of diabetes AND 2 - One of the following: 2.1 Patient is on an intensive insulin regimen (3 or more insulin injections per day or uses continuous subcutaneous insulin infusion pump) OR 2.2 One of the following: 2.2.1 Patient has a history of a level 3 hypoglycemic event [glucose less than 54mg/dL (3.0mmol/L)] characterized by altered mental and/or physical state requiring third-party assistance for treatment of hypoglycemia OR 2.2.2 Patient has a history of more than one level 2 hypoglycemia event [glucose less than 54mg/dL (3.0mmol/L)] that persist despite multiple attempts to adjust medication(s) or modify diabetes treatment plan AND 3 - Patient regularly monitors blood glucose 4 or more times per day AND	

4 - If the request is for a non-preferred continuous glucose monitor (all components), **ONE** of the following:

4.1 BOTH of the following:

- Patient has a physical or mental limitation that makes utilization of a Dexcom product (i.e., Dexcom G6 or Dexcom G7) unsafe, inaccurate, or otherwise not feasible (e.g., manual dexterity) (document limitation)
- Patient has a physical or mental limitation that makes utilization of the preferred Freestyle Libre product unsafe, inaccurate, or otherwise not feasible (e.g., manual dexterity) (document limitation)

OR

4.2 Provider submits documentation why the patient requires use of a non-preferred continuous glucose monitor system for treatment of diabetes, rather than one of the preferred products

Product Name:Continuous Glucose Monitors, sensors, and transmitters (all brands)	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response	

2 . Revision History

Date	Notes
3/25/2026	Removed Maryland. Updated GPIs. Updated verbiage without change to intent describing a preferred Dexcom product

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 Rhode Island 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

Corlanor



Prior Authorization Guideline

Guideline ID	GL-432257
Guideline Name	Corlanor
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

Guideline Note:

Effective Date:	12/1/2025

1 . Criteria

Product Name: Brand Corlanor, generic ivabradine	
Diagnosis	Symptomatic Chronic Heart Failure
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ALL of the following: 1.1 Worsening heart failure in a diagnosis of stable, symptomatic, chronic [e.g., New York Heart Association (NYHA) class II, III, or IV] heart failure AND 1.2 Patient has a left ventricular ejection fraction (EF) less than or equal to 35% AND 1.3 The patient is in sinus rhythm AND 1.4 Patient has a resting heart rate greater than or equal to 70 beats per minute AND 1.5 ONE of the following: 1.5.1 Patient is on a stabilized dose and receiving concomitant therapy with maximum tolerated beta blocker (e.g., carvedilol, metoprolol succinate, bisoprolol) as confirmed by claims history or submission of medical records OR 1.5.2 Patient has a contraindication or intolerance to beta-blocker therapy (please specify contraindication or intolerance)	

AND

1.6 ONE of the following:

1.6.1 Patient is on a stabilized dose and receiving concomitant therapy with dapagliflozin (Farxiga authorized generic) (includes combination products containing dapagliflozin) as confirmed by claims history or submission of medical records

OR

1.6.2 Patient has a contraindication or intolerance to SGLT2 (sodium-glucose co-transporter 2) inhibitor therapy (please specify contraindication or intolerance)

AND

1.7 ONE of the following:

1.7.1 Patient is on a stabilized dose and receiving concomitant therapy with ONE of the following, as confirmed by claims history or submission of medical records:

1.7.1.1 Angiotensin-converting enzyme (ACE) inhibitor (e.g., captopril, enalapril)

OR

1.7.1.2 Angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan)

OR

1.7.1.3 Angiotensin receptor-neprilysin inhibitor (ARNI) (e.g., Entresto)

OR

1.7.2 Patient has a contraindication or intolerance to ACE inhibitors, ARBs, and ARNIs (please specify contraindication or intolerance)

AND

1.8 ONE of the following:

1.8.1 Patient is on a stabilized dose and receiving concomitant therapy with a maximally tolerated aldosterone antagonist (e.g., eplerenone, spironolactone) as confirmed by claims history or submission of medical records

OR

1.8.2 Patient has a contraindication or intolerance to aldosterone antagonist therapy (please specify contraindication or intolerance)

AND

1.9 Prescribed by or in consultation with a cardiologist

OR

2 - ALL of the following:

2.1 Diagnosis of stable symptomatic heart failure due to dilated cardiomyopathy (DCM)

AND

2.2 Patient is in sinus rhythm

AND

2.3 Patient has an elevated heart rate

AND

2.4 Prescribed by or in consultation with a cardiologist

OR

3 - Patient is currently established on Corlanor therapy

Product Name: Brand Corlanor, generic ivabradine	
Diagnosis	Inappropriate Sinus Tachycardia (IST)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ALL of the following 1.1 Diagnosis of inappropriate sinus tachycardia (IST) AND 1.2 Patient is in sinus rhythm AND 1.3 ONE of the following: • Patient has tried and failed or had an inadequate response to a beta blocker (e.g., carvedilol, metoprolol succinate, bisoprolol) as confirmed by claims history or submission of medical records • Patient has a contraindication or intolerance to beta-blocker therapy (please specify contraindication or intolerance) AND 1.4 Prescribed by or in consultation with a cardiologist	

OR

2 - Patient is currently established on Corlanor therapy

Product Name:Brand Corlanor, generic ivabradine	
Diagnosis	Symptomatic Chronic Heart Failure, Inappropriate Sinus Tachycardia (IST)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Corlanor therapy	

2 . Revision History

Date	Notes
10/29/2025	Combined formularies. Updated Farxiga for SGLT2 requirement to reference the preferred authorized generic product. Minor cosmetic updates.

Cosentyx



Prior Authorization Guideline

Guideline ID	GL-534218
Guideline Name	Cosentyx
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 New Mexico

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Cosentyx	
Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe plaque psoriasis

AND

2 - Patient is NOT receiving Cosentyx in combination with another systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Enbrel (etanercept), Ilumya (tildrakizumab), Otezla (apremilast), Skyrizi (risankizumab), Siliq (brodalumab), Sotyktu (deucravacitinib), Taltz (ixekizumab), Tremfya (guselkumab), ustekinumab] for treatment of the same indication

AND

3 - Prescribed by or in consultation with a dermatologist

AND

4 - ONE of the following:

4.1 Patient is currently on Cosentyx therapy as confirmed by claims history or submission of medical records

OR

4.2 BOTH of the following:

4.2.1 ONE of the following:

4.2.1.1 Patient has been previously treated with a systemic targeted immunomodulator FDA-approved for the treatment of plaque psoriasis as confirmed by claims history or submission of medical records [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Enbrel (etanercept), Ilumya (tildrakizumab), Otezla (apremilast), Skyrizi (risankizumab), Siliq (brodalumab), Sotyktu (deucravacitinib), Taltz (ixekizumab), Tremfya (guselkumab), ustekinumab]

OR

4.2.1.2 ALL of the following:

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

AND

4.2.1.2.2 ONE of the following:

- Failure of ONE of the following confirmed by claims history or submitted medical records: Corticosteroids (e.g., betamethasone, clobetasol, desonide), Vitamin D analogs (e.g., calcitriol, calcipotriene), Tazarotene, Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus), Anthralin, Coal tar
- History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication): Corticosteroids (e.g., betamethasone, clobetasol, desonide), Vitamin D analogs (e.g., calcitriol, calcipotriene), Tazarotene, Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus), Anthralin, Coal tar

AND

4.2.1.2.3 ONE of the following:

- Failure of a 3 month trial of methotrexate, at the maximally indicated doses, confirmed by claims history or submitted medical records
- History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

AND

4.2.2 ONE of the following:

4.2.2.1 Failure to TWO of the following preferred products as confirmed by claims history or submitted medical records:

- One of the preferred adalimumab products*
- Enbrel (etanercept)
- One of the preferred ustekinumab products*

OR

4.2.2.2 History of intolerance or contraindication to ALL of the following preferred products (please specify intolerance or contraindication):

- One of the preferred adalimumab products*
- Enbrel (etanercept)
- One of the preferred ustekinumab products*

Notes

*See PDL links in Background

Product Name: Cosentyx

Diagnosis Ankylosing Spondylitis

Approval Length 12 month(s)

Therapy Stage Initial Authorization

Guideline Type Prior Authorization

Approval Criteria

1 - Diagnosis of active ankylosing spondylitis

AND

2 - Patient is not receiving Cosentyx in combination with another systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Simponi (golimumab), Rinvoq (upadacitinib), Taltz (ixekizumab), Xeljanz (tofacitinib)] for treatment of the same indication

AND

3 - Prescribed by or in consultation with a rheumatologist

AND

4 - ONE of the following:

4.1 Patient is currently on Cosentyx therapy as confirmed by claims history or submission of medical records

OR

4.2 BOTH of the following:

4.2.1 ONE of the following:

4.2.1.1 Failure to TWO NSAIDs (e.g., ibuprofen, naproxen) at maximally indicated doses, each used for at least 4 weeks confirmed by claims history or submitted medical records

OR

4.2.1.2 History of intolerance or contraindication to TWO NSAIDs (please specify intolerance or contraindication)

OR

4.2.1.3 Patient has been previously treated with a systemic targeted immunomodulator FDA-approved for the treatment of ankylosing spondylitis as confirmed by claims history or submission of medical records [e.g., adalimumab, Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib), Rinvoq (upadacitinib), Enbrel (etanercept)]

AND

4.2.2 ONE of the following:

- Failure of BOTH of the following confirmed by claims history or submitted medical records: One of the preferred adalimumab products*, Enbrel (etanercept)
- History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication): One of the preferred adalimumab products*, Enbrel (etanercept)

Notes

*See PDL links in Background

Product Name: Cosentyx	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of active psoriatic arthritis AND 2 - Patient is NOT receiving Cosentyx in combination with another systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Enbrel (etanercept), Orencia (abatacept), Otezla (apremilast), Rinvoq (upadacitinib), Simponi (golimumab), Skyrizi (risankizumab), Taltz (ixekizumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), ustekinumab] for treatment of the same indication AND 3 - Prescribed by or in consultation with a rheumatologist OR dermatologist AND 4 - ONE of the following: 4.1 Patient is currently on Cosentyx therapy as confirmed by claims history or submission of medical records OR 4.2 BOTH of the following: 4.2.1 ONE of the following:	

- Failure of a 3 month trial of methotrexate at the maximally indicated dose confirmed by claims history or submitted medical records
- History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)
- Patient has been previously treated with a systemic targeted immunomodulator FDA-approved for the treatment of psoriatic arthritis as confirmed by claims history or submission of medical records [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Enbrel (etanercept), Orencia (abatacept), Otezla (apremilast), Rinvoq (upadacitinib), Simponi (golimumab), Skyrizi (risankizumab), Taltz (ixekizumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), ustekinumab]

AND

4.2.2 ONE of the following:

4.2.2.1 Failure to TWO of the following confirmed by claims history or submitted medical records:

- One of the preferred adalimumab products*
- Enbrel (etanercept)
- One of the preferred ustekinumab products*

OR

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

- One of the preferred adalimumab products*
- Enbrel (etanercept)
- One of the preferred ustekinumab products*

Notes	*See PDL links in Background

Product Name:Cosentyx	
Diagnosis	Non-radiographic axial spondyloarthritis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of active non-radiographic axial spondyloarthritis

AND

2 - Patient is NOT receiving Cosentyx in combination with another systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Simponi (golimumab), Rinvoq (upadacitinib), Taltz (ixekizumab), Xeljanz (tofacitinib)] for treatment of the same indication

AND

3 - Prescribed by or in consultation with a rheumatologist

AND

4 - ONE of the following:

4.1 Patient is currently on Cosentyx therapy as confirmed by claims history or submission of medical records

OR

4.2 ONE of the following:

4.2.1 Failure to TWO NSAIDs (e.g., ibuprofen, naproxen) at maximally indicated doses, each used for at least 4 weeks confirmed by claims history or submitted medical records

OR

4.2.2 History of intolerance or contraindication to TWO NSAIDs (e.g., ibuprofen, naproxen) (please specify intolerance or contraindication)

OR

4.2.3 Patient has been previously treated with a systemic targeted immunomodulator FDA-approved for the treatment of non-radiographic axial spondyloarthritis as confirmed by claims history or submission of medical records [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Simponi (golimumab), Rinvoq (upadacitinib), Taltz (ixekizumab), Xeljanz (tofacitinib)]

Product Name: Cosentyx

Diagnosis	Enthesitis-Related Arthritis

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of active enthesitis-related arthritis

AND

2 - ONE of the following:

2.1 Failure to TWO NSAIDs (e.g., ibuprofen, naproxen) at maximally indicated doses, each used for at least 4 weeks confirmed by claims history or submitted medical records

OR

2.2 History of intolerance or contraindication to TWO NSAIDs (e.g., ibuprofen, naproxen) (please specify intolerance or contraindication)

OR

2.3 Patient is currently on Cosentyx therapy as confirmed by claims history or submission of medical records

AND

3 - Patient is not receiving Cosentyx in combination with another systemic targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz (tofacitinib)] for treatment of the same indication

AND

4 - Prescribed by or in consultation with a rheumatologist

Product Name: Cosentyx	
Diagnosis	Hidradenitis Suppurativa (HS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderate to severe hidradenitis suppurativa (i.e., Hurley Stage II or III) AND 2 - ONE of the following: • Failure to at least ONE oral antibiotic (e.g., doxycycline, clindamycin, rifampin) at maximally indicated doses, as confirmed by claims history or submission of medical records • History of contraindication or intolerance to at least ONE oral antibiotic (e.g., doxycycline, clindamycin, rifampin) (please specify contraindication or intolerance) • Patient has been previously treated with a systemic targeted immunomodulator FDA-approved for the treatment of hidradenitis suppurativa as confirmed by claims history or submitted medical records [e.g., adalimumab, Bimzelx (bimekizumab-bkzx)]. AND	

3 - ONE of the following:

- Failure to at least one of the preferred adalimumab products* as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to one of the preferred adalimumab products* (please specify contraindication or intolerance)
- Patient is currently on Cosentyx therapy as confirmed by claims history or submission of medical records

AND

4 - Patient is not receiving Cosentyx in combination with another systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx)] for treatment of the same indication

AND

5 - Prescribed by or in consultation with a dermatologist

Notes

*See PDL links in Background

Product Name:Cosentyx	
Diagnosis	Plaque Psoriasis, Ankylosing Spondylitis, Psoriatic Arthritis (PsA), Non-radiographic Axial Spondyloarthritis, Enthesitis-Related Arthritis, Hidradenitis Suppurativa (HS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Cosentyx therapy AND 2 - Patient is NOT receiving Cosentyx in combination with another systemic targeted	

immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Enbrel (etanercept), Ilumya (tildrakizumab), Otezla (apremilast), Skyrizi (risankizumab), Siliq (brodalumab), Sotyktu (deucravacitinib), Taltz (ixekizumab), Tremfya (guselkumab), ustekinumab]* for treatment of the same indication	
Notes	* Examples of drug(s) may not be applicable based on the requested indication.

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 NM: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html NY: 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

3 . Revision History

Date	Notes
2/26/2026	Removed NY formulary.

Cotellic



Prior Authorization Guideline

Guideline ID	GL-501285
Guideline Name	Cotellic
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

Guideline Note:

Effective Date:	2/1/2026

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 BRAF V600E positive 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
1/21/2026	Combined formularies. Updated coverage criteria for CNS cancers and histiocytic neoplasms based on NCCN recommendations. Minor cosmetic updates.

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

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

Daliresp



Prior Authorization Guideline

Guideline ID	GL-165155
Guideline Name	Daliresp
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State New Jersey Medicaid - Community & State New Mexico Medicaid - Community & State New York 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: Brand Daliresp, generic roflumilast	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic obstructive pulmonary disease (COPD)

2 . Revision History

Date	Notes
2/13/2025	Updated formularies. Removed all criteria except diagnosis check

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

Daraprim



Prior Authorization Guideline

Guideline ID	GL-315214
Guideline Name	Daraprim
Formulary	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 Pennsylvania

Guideline Note:

Effective Date:	8/1/2025

1 . Criteria

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

Approval Criteria

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

1.1 Treatment of severe acquired toxoplasmosis, including toxoplasmic encephalitis

OR

1.2 Treatment of congenital toxoplasmosis

OR

1.3 Secondary prophylaxis of toxoplasmic encephalitis

OR

1.4 ALL of the following:

1.4.1 Primary pneumocystis pneumonia (PCP) prophylaxis in human immunodeficiency virus (HIV)-infected patients or as secondary prophylaxis in HIV-infected patients who have been treated for an acute episode of pneumocystis pneumonia

AND

1.4.2 Patient has experienced intolerance to prior prophylaxis with trimethoprim-sulfamethoxazole (TMP-SMX)

AND

1.4.3 One of the following:

- Patient has been re-challenged with trimethoprim-sulfamethoxazole (TMP-SMX) using a desensitization protocol and is still unable to tolerate
- Evidence of moderately severe or life threatening-reaction to trimethoprim-sulfamethoxazole (TMP-SMX) in the past [e.g., toxic epidermal necrolysis (TEN), Stevens-Johnson syndrome]

OR

1.5 ALL of the following:

1.5.1 Primary prophylaxis of toxoplasmic encephalitis

AND

1.5.2 Toxoplasma immunoglobulin G (IgG) positive

AND

1.5.3 CD4 count less than or equal to 100 cells per mm³ if initiating prophylaxis or CD4 count 100-200 cells per mm³ if reinstituting prophylaxis*

AND

1.5.4 Will be used in combination with dapsone or atovaquone

AND

1.5.5 Patient has experienced intolerance to prior prophylaxis with trimethoprim-sulfamethoxazole (TMP-SMX)

AND

1.5.6 ONE of the following:

- Patient has been re-challenged with trimethoprim-sulfamethoxazole (TMP-SMX) using a desensitization protocol and is still unable to tolerate
- Evidence of moderately severe or life threatening-reaction to trimethoprim-sulfamethoxazole (TMP-SMX) in the past [e.g., toxic epidermal necrolysis (TEN), Stevens-Johnson syndrome]

Notes	*Consider discontinuation of primary prophylaxis if CD4 count > 200 cells/mm ³ for > 3 months after institution of combination antiretroviral therapy.

Product Name: Brand Daraprim*, generic pyrimethamine*	
Guideline Type	Reject 88 - Therapeutic Duplication
Approval Criteria 1 - There is a reason or special circumstances why the patient must be on Daraprim (pyrimethamine) commercial tablets and a compound containing pyrimethamine at the same time	
Notes	*Approval Length: 2 months (if deemed medically necessary for long-term use by the prescriber, authorization will be issued for 12 months)

2 . Revision History

Date	Notes
7/4/2025	Updated formularies. Minor language updates and formatting changes

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

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

Dawnzera



Prior Authorization Guideline

Guideline ID	GL-525264
Guideline Name	Dawnzera
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

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Dawnzera	
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, and 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 prophylaxis of HAE attacks AND 3 - NOT used in combination with other products indicated for prophylaxis against HAE attacks (e.g., Andembry, Cinryze, Haegarda, Orladeyo, Takhzyro) AND 4 - Prescriber attests that patient has experienced attacks of a severity and/or frequency such that they would clinically benefit from prophylactic therapy with Dawnzera	

AND

5 - Prescribed by ONE of the following:

- Immunologist
- Allergist

AND

6 - ONE of the following:

6.1 Failure to Haegarda confirmed by claims history or submitted medical records

OR

6.2 History of contraindication or intolerance to Haegarda (please specify intolerance or contraindication)

OR

6.3 Patient is currently on Dawnzera therapy confirmed by claims history or submitted medical records

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

AND

2 - Reduction in the utilization of on-demand therapies used for acute attacks (e.g., Berinert, Ektelyr, icatibant, Firazyr, Ruconest, Sajazir) as determined by claims information, while on Dawnzera therapy

AND

3 - Prescribed for the prophylaxis of HAE attacks

AND

4 - NOT used in combination with other products indicated for prophylaxis against HAE attacks (e.g., Andembry, Cinryze, Haegarda, Orladeyo, Takhzyro)

AND

5 - Prescribed by ONE of the following:

- Immunologist
- Allergist

2 . Revision History

Date	Notes
2/23/2026	New program.

Daybue



Prior Authorization Guideline

Guideline ID	GL-150910
Guideline Name	Daybue
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

Guideline Note:

Effective Date:	8/3/2024

1 . Criteria

Product Name:Daybue	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Rett Syndrome (RTT) confirmed by ONE of the following:

1.1 ALL of the following clinical signs and symptoms:

- A pattern of development, regression, then recovery or stabilization
- Partial or complete loss of purposeful hand skills such as grasping with fingers, reaching for things, or touching things on purpose
- Partial or complete loss of spoken language
- Repetitive hand movements, such as wringing the hands, washing, squeezing, clapping, or rubbing
- Gait abnormalities, including walking on toes or with an unsteady, wide-based, stiff-legged gait

OR

1.2 Confirmed genetic mutation in the MECP2 gene

AND

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

- Geneticist
- Pediatrician who specializes in childhood neurological or developmental disorders
- Neurologist

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

2 . Revision History

Date	Notes
8/2/2024	Updated initial approval duration from 6 months to 12 months.

Daybue



Prior Authorization Guideline

Guideline ID	GL-150910
Guideline Name	Daybue
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

Guideline Note:

Effective Date:	8/3/2024

1 . Criteria

Product Name:Daybue	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Rett Syndrome (RTT) confirmed by ONE of the following:

1.1 ALL of the following clinical signs and symptoms:

- A pattern of development, regression, then recovery or stabilization
- Partial or complete loss of purposeful hand skills such as grasping with fingers, reaching for things, or touching things on purpose
- Partial or complete loss of spoken language
- Repetitive hand movements, such as wringing the hands, washing, squeezing, clapping, or rubbing
- Gait abnormalities, including walking on toes or with an unsteady, wide-based, stiff-legged gait

OR

1.2 Confirmed genetic mutation in the MECP2 gene

AND

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

- Geneticist
- Pediatrician who specializes in childhood neurological or developmental disorders
- Neurologist

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

2 . Revision History

Date	Notes
8/2/2024	Updated initial approval duration from 6 months to 12 months.

Deflazacort



Prior Authorization Guideline

Guideline ID	GL-519198
Guideline Name	Deflazacort
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 New Mexico

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name: Brand Emflaza, generic deflazacort, Jaythari, Kymbee, Pyquvi	
Diagnosis	Duchenne Muscular Dystrophy
Guideline Type	Prior Authorization

Approval Criteria

1 - Published clinical evidence shows Emflaza, Jaythari, Kymbee and Pyquvi are likely to produce equivalent therapeutic results as other available corticosteroids (e.g. prednisone); therefore, Emflaza, Jaythari, Kymbee and Pyquvi are not medically necessary for treatment of Duchenne muscular dystrophy

Notes	All requests for authorization will be denied by OptumRx and must be submitted through the appeals process to the UnitedHealthcare Community Plan Pharmacy Appeals team for consideration.

2 . Revision History

Date	Notes
2/9/2026	Combined formularies. Updated GL name to Deflazacort. Added Jaythari, Kymbee and Pyquvi as targets and updated GPI and product name list. Updated criteria. Replacing GL-519196

DEKAs Plus



Prior Authorization Guideline

Guideline ID	GL-435253
Guideline Name	DEKAs Plus
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 New Mexico

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:DEKAs Plus Ocean, DEKAs Plus	
Diagnosis	Cystic Fibrosis

Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of cystic fibrosis	

2 . Revision History

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

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-389199
Guideline Name	Dificid
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

Guideline Note:

Effective Date:	10/1/2025

1 . Criteria

Product Name: Brand Dificid, generic fidaxomicin	
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of *Clostridioides difficile*-associated diarrhea (CDAD) [previously known as *Clostridium difficile*-associated diarrhea]

AND

2 - ONE of the following:

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

- Firvanq (vancomycin) oral solution
- vancomycin 125 mg or 250 mg capsules
- vancomycin 25 mg/ml or 50 mg/ml oral solution

OR

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

- Firvanq (vancomycin) oral solution
- vancomycin 125 mg or 250 mg capsules
- vancomycin 25 mg/ml or 50 mg/ml oral solution

OR

2.3 For continuation of prior Difcid therapy

2 . Revision History

Date	Notes
9/8/2025	Updated formularies. Added generic. Added "confirmed by claims history or submitted medical records"

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

Doptelet



Prior Authorization Guideline

Guideline ID	GL-439201
Guideline Name	Doptelet
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 Nevada

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Doptelet

Diagnosis	Thrombocytopenia in patients with chronic liver disease who are scheduled to undergo a procedure
Approval Length	1 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of thrombocytopenia AND 2 - Patient has chronic liver disease AND 3 - Patient is scheduled to undergo a procedure AND 4 - ONE of the following: • Failure to Mulpleta (lusutrombopag) as confirmed by claims history or submission of medical records • History of contraindication or intolerance to Mulpleta (lusutrombopag) (please specify contraindication or intolerance)	

Product Name:Doptelet	
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 as confirmed by claims history or submission of medical records:

- Corticosteroids
- Immunoglobulins

OR

2.1.1.2 History of contraindication or intolerance to BOTH of the following (please specify contraindication or intolerance):

- Corticosteroids
- Immunoglobulins

AND

2.1.2 ONE of the following:

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

OR

2.2 Patient is currently on Doptelet therapy

Product Name:Doptelet	
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 Doptelet therapy	

2 . Revision History

Date	Notes
11/5/2025	Added Nevada Formulary

DPP-4 Inhibitors



Prior Authorization Guideline

Guideline ID	GL-563283
Guideline Name	DPP-4 Inhibitors
Formulary	Medicaid - Community & State Rhode Island

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Alogliptin, Alogliptin/metformin, Alogliptin/pioglitazone, generic saxagliptin	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - The patient has a diagnosis of type 2 diabetes mellitus	

AND

2 - One of the following:

2.1 Suboptimal response (i.e. suboptimal glycemic control) to metformin at a minimum dose of 1500 mg daily for 90 days confirmed by claims history or submission of medical records

OR

2.2 History of intolerance or contraindication to metformin (please specify intolerance or contraindication)

Product Name:Alogliptin, Alogliptin/metformin, Alogliptin/pioglitazone, generic saxagliptin

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g., improved A1C)

Product Name:Brynovin, Januvia, Janumet, Janumet XR, generic saxagliptin/metformin ER, Tradjenta, Jentadueto, Jentadueto XR, Zituvimet, Zituvimet XR, Zituvio, Sitagliptin, Sitagliptin/metformin, Sitagliptin/metformin ER, Brand Onglyza

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a diagnosis of type 2 diabetes mellitus

AND

2 - ONE of the following:

2.1 Suboptimal response (i.e. suboptimal glycemic control) to metformin at a minimum dose of 1500 mg daily for 90 days confirmed by claims history or submission of medical records

OR

2.2 History of intolerance or contraindication to metformin (please specify intolerance or contraindication)

AND

3 - ONE of the following:

3.1 Failure to a 90 day trial with ONE of the following as confirmed by claims history or submission of medical records:

- Alogliptin
- Alogliptin/metformin
- Alogliptin/pioglitazone
- Saxagliptin (generic Onglyza)

OR

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

- Alogliptin
- Alogliptin/metformin
- Alogliptin/pioglitazone
- Saxagliptin (generic Onglyza)

Product Name: Brynovin, Januvia, Janumet, Janumet XR, generic saxagliptin/metformin ER, Tradjenta, Jentadueto, Jentadueto XR, Zituvimet, Zituvimet XR, Zituvio, Sitagliptin, Sitagliptin/metformin, Sitagliptin/metformin ER, Brand Onglyza

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy (e.g., improved A1C) AND 2 - The prescriber has given a clinical reason or special circumstance why the patient is unable to use ONE of the following (please document reason/special circumstance): • Alogliptin • Alogliptin/metformin • Alogliptin/pioglitazone	

2 . Revision History

Date	Notes
4/7/2026	Updated title. Updated GPIs. Removed Kazano, Nesina, Oseni, Kom biglyze XR. Added SITAGLIPTIN/METFORMIN ER. Removed reference to AG for alogliptin products. Separated brand and generic Ongly za due to formulary status differences

Dry Eye Disease



Prior Authorization Guideline

Guideline ID	GL-450190
Guideline Name	Dry Eye Disease
Formulary	Medicaid - Community & State Rhode Island

Guideline Note:

Effective Date:	12/1/2025

1 . Criteria

Product Name: Cequa, Miebo, Brand Restasis, Restasis Multidose, Tryptyr, Tyrvaya, Vevye, Xiidra	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following: Moderate to severe keratoconjunctivitis sicca	

- Moderate to severe dry eye disease

AND

2 - NOT prescribed to manage dry eyes peri-operative elective eye surgery [e.g., LASIK (laser-assisted in situ keratomileusis)]

AND

3 - Failure to at least two OTC (over-the-counter) artificial tear products (e.g., Systane Ultra, Akwa Tears, Refresh Optive, Soothe XP) as confirmed by claims history or submission of medical records

AND

4 - ONE of the following:

4.1 Failure to cyclosporine emulsion 0.05% (generic Restasis) as confirmed by claims history or submission of medical records

OR

4.2 History of contraindication or intolerance to cyclosporine emulsion 0.05% (generic Restasis) (please specify contraindication or intolerance)

AND

5 - Medication will NOT be used in combination with another prescription product for dry eye disease or keratoconjunctivitis sicca (e.g., Miebo, Restasis single dose-vials, Tyrvaya, Xiidra)

AND

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

- Ophthalmologist
- Optometrist

- Rheumatologist

Product Name:generic cyclosporine 0.05% emulsion	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following:

- Moderate to severe keratoconjunctivitis sicca
- Moderate to severe dry eye disease

AND

2 - NOT prescribed to manage dry eyes peri-operative elective eye surgery [e.g., LASIK (laser-assisted in situ keratomileusis)]

AND

3 - Failure to at least two OTC (over-the-counter) artificial tear products (e.g., Systane Ultra, Akwa Tears, Refresh Optive, Soothe XP) as confirmed by claims history or submission of medical records

AND

4 - Medication will NOT be used in combination with another prescription product for dry eye disease or keratoconjunctivitis sicca (e.g., Miebo, Restasis single dose-vials, Tyrvaya, Xiidra)

AND

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

- Ophthalmologist
- Optometrist
- Rheumatologist

Product Name: Cequa, Miebo, Brand Restasis, generic cyclosporine 0.05% emulsion, Restasis Multidose, Tyrvaya, Vevye, Xiidra, Tryptyr

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has demonstrated clinically significant improvement with therapy

AND

2 - Medication will NOT be used in combination with another prescription product for dry eye disease or keratoconjunctivitis sicca (e.g., Miebo, Restasis single dose-vials, Tyrvaya, Xiidra)

2 . Revision History

Date	Notes
11/10/2025	Added Tryptyr

Duexis and Vimovo



Prior Authorization Guideline

Guideline ID	GL-521213
Guideline Name	Duexis and Vimovo
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 New Mexico

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name:Brand Duexis, generic ibuprofen/famotidine	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following risk factors for NSAID (non-steroidal anti-inflammatory drug)-induced adverse GI (gastrointestinal) events:

- Patient is greater than or equal to 65 years of age
- Prior history of peptic, gastric, or duodenal ulcer
- History of NSAID-related ulcer
- History of clinically significant GI bleeding
- Untreated or active H. Pylori (*Helicobacter pylori*) gastritis
- Concurrent use of oral corticosteroids (e.g., prednisone, prednisolone, dexamethasone)
- Concurrent use of anticoagulants (e.g., warfarin, heparin)
- Concurrent use of antiplatelets (e.g., aspirin including low-dose, clopidogrel)

AND

2 - ONE of the following:

2.1 Failure to THREE combinations of preferred* NSAIDs, one of which must be celecoxib (generic Celebrex), taken concomitantly with preferred* H2-receptor antagonists, as confirmed by claims history or submitted medical records

OR

2.2 History of contraindication or intolerance to ALL preferred* NSAIDs and ALL preferred* H2-receptor antagonists (please specify contraindication or intolerance)

AND

3 - Physician has provided rationale for needing to use fixed-dose combination therapy with Duexis instead of taking individual products in combination

Notes	*PDL links in Background.

Product Name: Brand Vimovo, generic naproxen/esomeprazole	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following risk factors for NSAID (non-steroidal anti-inflammatory drug)-induced adverse GI (gastrointestinal) events:

- Patient is greater than or equal to 65 years of age
- Prior history of peptic, gastric, or duodenal ulcer
- History of NSAID-related ulcer
- History of clinically significant GI bleeding
- Untreated or active H. Pylori (Helicobacter pylori) gastritis
- Concurrent use of oral corticosteroids (e.g., prednisone, prednisolone, dexamethasone)
- Concurrent use of anticoagulants (e.g., warfarin, heparin)
- Concurrent use of antiplatelets (e.g., aspirin including low-dose, clopidogrel)

AND

2 - ONE of the following:

2.1 Failure to THREE combinations of preferred* NSAIDs, one of which must be celecoxib (generic Celebrex), taken concomitantly with preferred* proton pump inhibitors, as confirmed by claims history or submitted medical records

OR

2.2 History of contraindication or intolerance to ALL preferred* NSAIDs and ALL preferred* proton pump inhibitors (please specify contraindication or intolerance)

AND

3 - Physician has provided rationale for needing to use fixed-dose combination therapy with Vimovo instead of taking individual products in combination

Notes

*PDL links in Background.

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 PA CHIP: 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 NM: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

3 . Revision History

Date	Notes
2/12/2026	Removed NY

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 Rhode Island Clinical Pharmacy Program Guidelines

Date	Notes
10/20/2025	Combined formularies. No changes to clinical criteria.

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 Rhode Island Clinical Pharmacy Program Guidelines

Date	Notes
10/20/2025	Combined formularies. No changes to clinical criteria.

Dupixent



Prior Authorization Guideline

Guideline ID	GL-398306
Guideline Name	Dupixent
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

Guideline Note:

Effective Date:	11/1/2025

1 . Criteria

Product Name:Dupixent	
Diagnosis	Atopic Dermatitis
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderate-to-severe chronic atopic dermatitis AND 2 - ONE of the following: 2.1 Failure to TWO of the following therapeutic classes of topical therapies as confirmed by claims history or submission of medical records: • One medium, high, or very-high potency topical corticosteroid [e.g., mometasone furoate (generic Elocon), fluocinolone acetonide (generic Synalar), fluocinonide (generic Lidex)] (see Table 1 in Background) • One topical calcineurin inhibitor [e.g., pimecrolimus (generic Elidel), tacrolimus (generic Protopic)] • Eucrisa (crisaborole) OR 2.2 History of contraindication or intolerance to ALL of the following therapeutic classes of topical therapies (please specify contraindication or intolerance): • One medium, high, or very-high potency topical corticosteroid [e.g., mometasone furoate (generic Elocon), fluocinolone acetonide (generic Synalar), fluocinonide (generic Lidex)] (see Table 1 in Background) • One topical calcineurin inhibitor [e.g., pimecrolimus (generic Elidel), tacrolimus (generic Protopic)] • Eucrisa (crisaborole) OR 2.3 Patient is currently on Dupixent therapy as confirmed by claims history or submission of medical records	

AND

3 - Patient is NOT receiving Dupixent in combination with either of the following for treatment of the same indication:

- Biologic immunomodulator [e.g., Adbry (tralokinumab-ldrm), Nemluvio (nemolizumab-ilto)]
- Janus kinase inhibitor [e.g., Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib), Opzelura (topical ruxolitinib), Cibinqo (abrocitinib)]

AND

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

- Dermatologist
- Allergist
- Immunologist

Product Name:Dupixent

Diagnosis	Atopic Dermatitis

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Dupixent therapy

AND

2 - Patient is NOT receiving Dupixent in combination with either of the following for treatment of the same indication:

- Biologic immunomodulator [e.g., Adbry (tralokinumab-ldrm), Nemluvio (nemolizumab-ilto)]
- Janus kinase inhibitor [e.g., Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib), Opzelura (topical ruxolitinib), Cibinqo (abrocitinib)]

AND

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

- Dermatologist
- Allergist
- Immunologist

Product Name:Dupixent	
Diagnosis	Asthma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderate-to-severe asthma AND 2 - ONE of the following: 2.1 ALL of the following: 2.1.1 Classification of asthma as uncontrolled or inadequately controlled as defined by at least ONE of the following: • Poor symptom control [e.g., Asthma Control Questionnaire (ACQ) score consistently greater than 1.5 or Asthma Control Test (ACT) score consistently less than 20] • Two or more bursts of systemic corticosteroids for at least 3 days each in the previous 12 months	

- Asthma-related emergency treatment (e.g., emergency room visit, hospital admission, or unscheduled physician's office visit for nebulizer or other urgent treatment)
- Airflow limitation [e.g., after appropriate bronchodilator withhold forced expiratory volume in 1 second (FEV1) less than 80% predicted (in the face of reduced FEV1/forced vital capacity [FVC] defined as less than the lower limit of normal)]
- Patient is currently dependent on oral corticosteroids for the treatment of asthma

AND

2.1.2 Dupixent will be used in combination with ONE of the following:

2.1.2.1 ONE maximally-dosed (appropriately adjusted for age) combination inhaled corticosteroid (ICS)/long-acting beta2 agonist (LABA) [e.g., Advair/AirDuo Respiclick (fluticasone propionate/salmeterol), Symbicort (budesonide/formoterol), Breo Ellipta (fluticasone furoate/vilanterol)] (see Table 2 in Background)

OR

2.1.2.2 Combination therapy including BOTH of the following:

- ONE maximally-dosed (appropriately adjusted for age) ICS product [e.g., ciclesonide (Alvesco), mometasone furoate (Asmanex), beclomethasone dipropionate (QVAR)] (see Table 2 in Background)
- ONE additional asthma controller medication [e.g., LABA - olodaterol (Striverdi) or indacaterol (Arcapta); leukotriene receptor antagonist - montelukast (Singulair); theophylline]

AND

2.1.3 ONE of the following:

- Submission of medical records (e.g., chart notes, laboratory values, etc.) documenting that asthma is an eosinophilic phenotype as defined by a baseline (pre-dupilumab treatment) peripheral blood eosinophil level greater than or equal to 150 cells/microliter
- Patient is currently dependent on oral corticosteroids for the treatment of asthma

OR

2.2 BOTH of the following:

2.2.1 Patient is currently on Dupixent therapy as confirmed by claims history or submission of medical records

AND

2.2.2 Dupixent will be used in combination with ONE of the following:

2.2.2.1 ONE maximally-dosed (appropriately adjusted for age) combination inhaled corticosteroid (ICS)/long-acting beta2 agonist (LABA) [e.g., Advair/AirDuo Respiclick (fluticasone propionate/salmeterol), Symbicort (budesonide/formoterol), Breo Ellipta (fluticasone furoate/vilanterol)]

OR

2.2.2.2 Combination therapy including BOTH of the following:

- ONE maximally-dosed (appropriately adjusted for age) ICS product [e.g., ciclesonide (Alvesco), mometasone furoate (Asmanex), beclomethasone dipropionate (QVAR)]
- ONE additional asthma controller medication [e.g., LABA - olodaterol (Striverdi) or indacaterol (Arcapta); leukotriene receptor antagonist – montelukast (Singulair); theophylline]

AND

3 - Patient is NOT receiving Dupixent in combination with any of the following for treatment of the same indication:

- Anti-interleukin-5 therapy [e.g., Nucala (mepolizumab), Cinqair (reslizumab), Fasenra (benralizumab)]
- Anti-IgE (immunoglobulin E) therapy [e.g., Xolair (omalizumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

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

- Allergist
- Immunologist
- Pulmonologist

Product Name:Dupixent	
Diagnosis	Asthma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Dupixent therapy as demonstrated by at least ONE of the following: • Reduction in the frequency of exacerbations • Decreased utilization of rescue medications • Increase in percent predicted forced expiratory volume in 1 second (FEV1) from pretreatment baseline • Reduction in severity or frequency of asthma-related symptoms (e.g., wheezing, shortness of breath, coughing, etc.) • Reduction in oral corticosteroid requirements AND 2 - Dupixent will be used in combination with ONE of the following: 2.1 ONE maximally-dosed (appropriately adjusted for age) combination inhaled corticosteroid (ICS)/long-acting beta2 agonist (LABA) [e.g., Advair/AirDuo Respiclick (fluticasone propionate/salmeterol), Symbicort (budesonide/formoterol), Breo Ellipta (fluticasone furoate/vilanterol)] OR 2.2 Combination therapy including BOTH of the following: • ONE maximally-dosed (appropriately adjusted for age) ICS product [e.g., ciclesonide (Alvesco), mometasone furoate (Asmanex), beclomethasone dipropionate (QVAR)] • ONE additional asthma controller medication [e.g., LABA - olodaterol (Striverdi) or indacaterol (Arcapta); leukotriene receptor antagonist – montelukast (Singulair); theophylline]	

AND

3 - Patient is NOT receiving Dupixent in combination with any of the following for treatment of the same indication:

- Anti-interleukin-5 therapy [e.g., Nucala (mepolizumab), Cinqair (reslizumab), Fasenra (benralizumab)]
- Anti-IgE (immunoglobulin E) therapy [e.g., Xolair (omalizumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

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

- Allergist
- Immunologist
- Pulmonologist

Product Name: Dupixent	
Diagnosis	Chronic Rhinosinusitis with Nasal Polyposis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP) defined by ALL of the following: 1.1.1 TWO or more of the following symptoms for longer than 12 weeks duration: • Nasal mucopurulent discharge • Nasal obstruction, blockage, or congestion • Facial pain, pressure, and/or fullness • Reduction or loss of sense of smell	

AND

1.1.2 ONE of the following findings using nasal endoscopy and/or sinus computed tomography (CT):

- Purulent mucus or edema in the middle meatus or ethmoid regions
- Polyps in the nasal cavity or the middle meatus
- Radiographic imaging demonstrating mucosal thickening or partial or complete opacification of paranasal sinuses

AND

1.1.3 ONE of the following:

- Presence of bilateral nasal polyposis
- Patient has previously required surgical removal of bilateral nasal polyps

AND

1.1.4 ONE of the following:

1.1.4.1 Patient has required prior sinus surgery

OR

1.1.4.2 Patient has required systemic corticosteroids (e.g., prednisone, methylprednisolone) for CRSwNP in the previous 2 years

OR

1.1.4.3 Patient has been unable to obtain symptom relief after trial of TWO of the following classes of agents:

- Nasal saline irrigations
- Intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone)
- Antileukotriene agents (e.g., montelukast, zafirlukast, zileuton)

OR

1.2 BOTH of the following:

- Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP)
- Patient is currently on Dupixent therapy as confirmed by claims history or submission of medical records

AND

2 - Patient will receive Dupixent as add-on maintenance therapy in combination with intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone)

AND

3 - Patient is NOT receiving Dupixent in combination with any of the following for treatment of the same indication:

- Anti-interleukin-5 therapy [e.g., Cinqair (reslizumab), Fasenra (benralizumab), Nucala (mepolizumab)]
- Anti-IgE therapy [e.g., Xolair (omalizumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

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

- Allergist
- Immunologist
- Otolaryngologist
- Pulmonologist

Product Name: Dupixent	
Diagnosis	Chronic Rhinosinusitis with Nasal Polyposis
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Dupixent therapy AND 2 - Patient will continue to receive Dupixent as add-on maintenance therapy in combination with intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone), as confirmed by claims history or submission of medical records AND 3 - Patient is NOT receiving Dupixent in combination with any of the following for treatment of the same indication: • Anti-interleukin-5 therapy [e.g., Cinqair (reslizumab), Fasenra (benralizumab), Nucala (mepolizumab)] • Anti-IgE therapy [e.g., Xolair (omalizumab)] • Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)] AND 4 - Prescribed by or in consultation with ONE of the following: • Allergist • Immunologist • Otolaryngologist • Pulmonologist	

Product Name: Dupixent	
Diagnosis	Eosinophilic Esophagitis
Approval Length	12 month(s)*
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of eosinophilic esophagitis

AND

2 - Patient is experiencing symptoms related to esophageal dysfunction (e.g., dysphagia, food impaction, chest pain that is often centrally located and may not respond to antacids, gastroesophageal reflux disease-like symptoms/refractory heartburn, upper abdominal pain)

AND

3 - Submission of medical records (e.g., chart notes, laboratory values, etc.) documenting eosinophil-predominant inflammation on esophageal biopsy, consisting of a peak value of 15 or more intraepithelial eosinophils per high power field (HPF) [or 60 eosinophils per mm² (square millimeters)]

AND

4 - Secondary causes of esophageal eosinophilia have been ruled out

AND

5 - Mucosal eosinophilia is isolated to the esophagus and symptoms have persisted after an 8-week trial of at least ONE of the following, as confirmed by claims history or submission of medical records:

- Proton pump inhibitors (e.g., pantoprazole, omeprazole)
- Topical (esophageal) corticosteroids (e.g., budesonide, fluticasone)

AND

6 - Patient is NOT receiving Dupixent in combination with any of the following for treatment of the same indication:

- Anti-interleukin-5 therapy [e.g., Cinqair (reslizumab), Fasenra (benralizumab), Nucala (mepolizumab)]
- Anti-IgE therapy [e.g., Xolair (omalizumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

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

- Allergist
- Gastroenterologist

Notes

*If clinical criteria is met, enter a GPI-10 authorization with a MDD of 0.3 mL.

Product Name:Dupixent

Diagnosis Eosinophilic Esophagitis

Approval Length 12 month(s)*

Therapy Stage Reauthorization

Guideline Type Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Dupixent therapy as evidenced by improvement of at least ONE of the following from baseline:

- Symptoms (e.g., dysphagia, chest pain, heartburn)
- Histologic measures (e.g., esophageal intraepithelial eosinophil count)
- Endoscopic measures (e.g., edema, furrows, exudates, rings, strictures)

AND

2 - Patient is NOT receiving Dupixent in combination with any of the following for treatment of the same indication:

- Anti-interleukin-5 therapy [e.g., Cinqair (reslizumab), Fasenra (benralizumab), Nucala (mepolizumab)]

- Anti-IgE therapy [e.g., Xolair (omalizumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

3 - Prescribed by or in consultation with a gastroenterologist or allergist

Notes	*If clinical criteria is met, enter a GPI-10 authorization with a MDD of 0.3 mL.

Product Name: Dupixent

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

Approval Criteria

1 - Diagnosis of prurigo nodularis

AND

2 - Patient has greater than or equal to 20 nodular lesions

AND

3 - ONE of the following:

3.1 Failure to at least one previous prurigo nodularis treatment(s) (e.g., topical corticosteroids, topical calcineurin inhibitors, topical capsaicin) as confirmed by claims history or submission of medical records

OR

3.2 History of contraindication or intolerance to all other prurigo nodularis treatment(s) (e.g.,

topical corticosteroids, topical calcineurin inhibitors, topical capsaicin) (please specify contraindication or intolerance)

AND

4 - Patient is NOT receiving Dupixent in combination with either of the following for treatment of the same indication:

- Biologic immunomodulator [e.g., Adbry (tralokinumab-ldrm), Nemluvio (nemolizumab-ilto)]
- Janus kinase inhibitor [e.g., Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib), Opzelura (topical ruxolitinib), Cibinqo (abrocitinib)]

AND

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

- Dermatologist
- Allergist
- Immunologist

Product Name:Dupixent	
Diagnosis	Prurigo Nodularis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Dupixent therapy AND 2 - Patient is NOT receiving Dupixent in combination with either of the following for treatment of the same indication:	

- Biologic immunomodulator [e.g., Adbry (tralokinumab-ldrm), Nemluvio (nemolizumab-ilto)]
- Janus kinase inhibitor [e.g., Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib), Opzelura (topical ruxolitinib), Cibinqo (abrocitinib)]

AND

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

- Dermatologist
- Allergist
- Immunologist

Product Name:Dupixent	
Diagnosis	Chronic Obstructive Pulmonary Disorder (COPD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chronic obstructive pulmonary disorder (COPD) AND 2 - Submission of documentation (e.g., medical records, chart notes) of ALL of the following: • Post-bronchodilator forced expiratory volume (FEV1) / forced vital capacity (FVC) ratio less than 0.7 • Post-bronchodilator FEV1 % predicted greater than or equal to 30% and less than or equal to 70% • Patient has an eosinophilic phenotype defined by a baseline (pre-dupilumab treatment) peripheral blood eosinophil level greater than or equal to 300 cells/μL	

AND

3 - Uncontrolled or inadequately controlled COPD demonstrated by BOTH of the following:

3.1 ONE of the following:

- Two or more COPD exacerbations in the previous year requiring treatment with systemic corticosteroids and/or antibiotics
- One or more COPD exacerbation(s) that resulted in hospitalization or observation for over 24 hours in an emergency department or urgent care facility in the past year

AND

3.2 COPD exacerbation(s) occurred while receiving maintenance therapy with ONE of the following:

- Triple therapy with a long-acting muscarinic antagonist (LAMA), long-acting beta agonist (LABA), and inhaled corticosteroid (ICS) (e.g., Breztri Aerosphere, Trelegy Ellipta)
- Dual therapy with a LAMA and LABA (e.g., Anoro Ellipta, Bevespi Aerosphere, Stiolto Respimat) and a failure, contraindication, or intolerance to an inhaled corticosteroid (ICS)

AND

4 - Symptoms of chronic productive cough for at least 3 months in the past year

AND

5 - Dupixent will be used as add-on maintenance therapy with ONE of the following:

- Triple therapy with a long-acting muscarinic antagonist (LAMA), long-acting beta agonist (LABA), and inhaled corticosteroid (ICS) (e.g., Breztri Aerosphere, Trelegy Ellipta)
- Dual therapy with a LAMA and LABA (e.g., Anoro Ellipta, Bevespi Aerosphere, Stiolto Respimat) and a failure, contraindication, or intolerance to an inhaled corticosteroid (ICS)

AND

6 - Patient is NOT receiving Dupixent in combination with any of the following for treatment of the same indication:

- Anti-interleukin-5 therapy [e.g., Nucala (mepolizumab), Cinqair (reslizumab), Fasenra (benralizumab)]
- Anti-IgE therapy [e.g., Xolair (omalizumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

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

- Allergist
- Immunologist
- Pulmonologist

Product Name: Dupixent	
Diagnosis	Chronic Obstructive Pulmonary Disorder (COPD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of a positive clinical response to Dupixent therapy as demonstrated by at least ONE of the following:

- Reduction in the frequency of COPD exacerbations
- Increase in percent predicted FEV1 from pretreatment baseline
- Reduction in severity or frequency of COPD-related symptoms (e.g., dyspnea, wheezing, cough, sputum volume, decrease in sputum purulence)
- Reduction in oral corticosteroid requirements

AND

2 - Dupixent will be used as add-on maintenance therapy with ONE of the following:

- Triple therapy with a long-acting muscarinic antagonist (LAMA), long-acting beta agonist (LABA), and inhaled corticosteroid (ICS) (e.g., Breztri Aerosphere, Trelegy Ellipta)
- Dual therapy with a LAMA and LABA (e.g., Anoro Ellipta, Bevespi Aerosphere, Stiolto Respimat) and a failure, contraindication, or intolerance to an inhaled corticosteroid (ICS)

AND

3 - Patient is NOT receiving Dupixent in combination with any of the following for treatment of the same indication:

- Anti-interleukin-5 therapy [e.g., Nucala (mepolizumab), Cinqair (reslizumab), Fasenra (benralizumab)]
- Anti-IgE therapy [e.g., Xolair (omalizumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

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

- Allergist
- Immunologist
- Pulmonologist

Product Name: Dupixent	
Diagnosis	Chronic Spontaneous Urticaria
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chronic spontaneous urticaria	

AND

2 - ONE of the following:

2.1 Patient remains symptomatic despite at least a 2-week trial and failure of two H1-antihistamines [e.g., Allegra (fexofenadine), Benadryl (diphenhydramine), Claritin (loratadine)]* (confirmed by claims history or submitted medical records)

OR

2.2 Patient remains symptomatic despite at least a 2-week trial and failure of BOTH of the following taken in combination (confirmed by claims history or submitted medical records):

2.2.1 Second generation H1-antihistamine [e.g., Allegra (fexofenadine), Claritin (loratadine), Zyrtec (cetirizine)]

AND

2.2.2 ONE of the following:

- Different second generation H1-antihistamine [e.g., Allegra (fexofenadine), Claritin (loratadine), Zyrtec (cetirizine)]
- First generation H1-antihistamine [e.g., Benadryl (diphenhydramine), Chlor-Trimeton (chlorpheniramine), Vistaril (hydroxyzine)]*
- H2-antihistamine [e.g., Pepcid (famotidine), Tagamet HB (cimetidine), Zantac (ranitidine)]
- Leukotriene modifier [e.g., Singulair (montelukast)]

OR

2.3 History of contraindication or intolerance to ONE of the following (please specify contraindication or intolerance)

2.3.1 Two H1-antihistamines [e.g., Allegra (fexofenadine), Benadryl (diphenhydramine), Claritin (loratadine)]*

OR

2.3.2 BOTH of the following taken in combination:

2.3.2.1 Second generation H1-antihistamine [e.g., Allegra (fexofenadine), Claritin (loratadine), Zyrtec (cetirizine)]

AND

2.3.2.2 ONE of the following:

- Different second generation H1-antihistamine [e.g., Allegra (fexofenadine), Claritin (loratadine), Zyrtec (cetirizine)]
- First generation H1-antihistamine [e.g., Benadryl (diphenhydramine), Chlor-Trimeton (chlorpheniramine), Vistaril (hydroxyzine)]*
- H2-antihistamine [e.g., Pepcid (famotidine), Tagamet HB (cimetidine), Zantac (ranitidine)]
- Leukotriene modifier [e.g., Singulair (montelukast)]

AND

3 - Patient is NOT receiving Dupixent in combination with Xolair (omalizumab) for treatment of the same indication

AND

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

- Allergist
- Dermatologist
- Immunologist

Notes	*Patients 65 years of age and older in whom first generation H1-antihistamines are considered high risk medications to be avoided (e.g., Beers criteria, HEDIS) should be directed to try alternatives that are not considered high risk.

Product Name: Dupixent	
Diagnosis	Chronic Spontaneous Urticaria
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Dupixent therapy (e.g., reduction in exacerbations, itch severity, hives) AND 2 - Patient is NOT receiving Dupixent in combination with Xolair (omalizumab) for treatment of the same indication AND 3 - Prescribed by or in consultation with ONE of the following: • Allergist • Dermatologist • Immunologist	

Product Name: Dupixent	
Diagnosis	Bullous Pemphigoid
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of bullous pemphigoid AND	

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

- Dermatologist
- Allergist
- Immunologist

Product Name:Dupixent

Diagnosis	Bullous Pemphigoid

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Dupixent therapy

AND

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

- Dermatologist
- Allergist
- Immunologist

2 . Background

Benefit/Coverage/Program Information

Table 1: Relative potencies of topical corticosteroids

Class	Drug	Dosage Form	Strength (%)

Very high potency	Augmented betamethasone dipropionate	Ointment, gel	0.05
	Clobetasol propionate	Cream, foam, ointment	0.05
	Diflorasone diacetate	Ointment	0.05
	Halobetasol propionate	Cream, ointment	0.05
High Potency	Amcinonide	Cream, lotion, ointment	0.1
	Augmented betamethasone dipropionate	Cream, lotion	0.05
	Betamethasone dipropionate	Cream, foam, ointment, solution	0.05
	Desoximetasone	Cream, ointment	0.25
	Desoximetasone	Gel	0.05
	Diflorasone diacetate	Cream	0.05
	tridifloronide	Cream, gel, ointment, solution	0.05
	Halcinonide	Cream, ointment	0.1
	Mometasone furoate	Ointment	0.1
	Triamcinolone acetonide	Cream, ointment	0.5
Medium potency	Betamethasone valerate	Cream, foam, lotion, ointment	0.1
	Clocortolone pivalate	Cream	0.1
	Desoximetasone	Cream	0.05
	Fluocinolone acetonide	Cream, ointment	0.025
	Flurandrenolide	Cream, ointment, lotion	0.05
	Fluticasone propionate	Cream	0.05
	Fluticasone propionate	Ointment	0.005
	Mometasone furoate	Cream, lotion	0.1
	Triamcinolone acetonide	Cream, ointment, lotion	0.1
	Hydrocortisone butyrate	Cream, ointment, solution	0.1

Lower-medium potency	Hydrocortisone probutate	Cream	0.1
	Hydrocortisone valerate	Cream, ointment	0.2
	Prednicarbate	Cream	0.1
Low potency	Alclometasone dipropionate	Cream, ointment	0.05
	Desonide	Cream, gel, foam, ointment	0.05
	Fluocinolone acetonide	Cream, solution	0.01
Lowest potency	Dexamethasone	Cream	0.1
	Hydrocortisone	Cream, lotion, ointment, solution	0.25, 0.5, 1
	Hydrocortisone acetate	Cream, ointment	0.5-1

Table 2: Low, medium, and high daily doses of inhaled corticosteroids. Adults and adolescents (12 years of age and older)

Drug	Daily dose (mcg)		
	Low	Medium	High
Beclomethasone dipropionate (CFC)	200-500	>500-1000	>1000
Beclomethasone dipropionate (HFA)	100-200	>200-400	>400
Budesonide DPI	200-400	>400-800	>800
Ciclesonide (HFA)	80-160	>160-320	>320
Fluticasone furoate (DPI)	100	N/A	200
Fluticasone propionate (DPI)	100-250	>250-500	>500
Fluticasone propionate (HFA)	100-250	>250-500	>500
Mometasone furoate	110-220	>220-440	>440
Triamcinolone acetonide	400-1000	>1000-2000	>2000

3 . Revision History

UnitedHealthcare Community Plan of Rhode Island Clinical Pharmacy Program Guidelines

Date	Notes
10/15/2025	Added criteria for the new indication for bullous pemphigoid. Minor cosmetic updates.

Duvyzat



Prior Authorization Guideline

Guideline ID	GL-501208
Guideline Name	Duvyzat
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 New Mexico

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

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

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Duchenne muscular dystrophy (DMD) AND 2 - Diagnosis confirmed by the presence of a mutation in the DMD gene AND 3 - Patient is 6 years of age or older AND 4 - Submission of medical records (e.g., chart notes) confirming that the patient is ambulatory without needing an assistive device (e.g., without side-by-side assist, cane, walker, wheelchair, etc.) AND 5 - Patient has been or will be established on a stable corticosteroid regimen AND 6 - Prescribed by, or in consultation with, a pediatric neuromuscular specialist with expertise in the treatment of DMD AND 7 - ONE of the following:	

7.1 Patient has not received gene therapy [e.g., Elevidys (delandistrogene moxparvovec-rokl)] for the treatment of DMD

OR

7.2 BOTH of the following:

- Patient has previously received gene therapy [e.g., Elevidys (delandistrogene moxparvovec-rokl)] for the treatment of DMD
- Submission of medical records (e.g., chart notes, laboratory values) documenting a clinically meaningful functional decline resulting from loss of muscle strength/motor ability (e.g., loss of a motor milestone) since receiving gene replacement therapy [e.g., Elevidys (delandistrogene moxparvovec-rokl)]

AND

8 - Patient will not receive Duvyzat in combination with exon-skipping therapies for DMD [e.g., Amondys (casimersen), Exondys 51 (eteplirsen), Viltepso (viltolarsen), Vyondys 53 (golodirsen)]

Product Name:Duvyzat	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Physician attestation that patient would benefit from continued administration AND 2 - Submission of medical records (e.g., chart notes) confirming that the patient is ambulatory without needing an assistive device (e.g., without side-by-side assist, cane, walker, wheelchair, etc.)	

AND

3 - Patient continues to receive concomitant corticosteroid regimen

AND

4 - Prescribed by, or in consultation with, a pediatric neuromuscular specialist with expertise in the treatment of DMD

AND

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

2 . Revision History

Date	Notes
1/14/2026	Updated initial auth to include previous treatment with gene therapy f or DMD. Removed criteria addressing previous treatment with gene t herapy for DMD in reauth section.

Duvyzat



Prior Authorization Guideline

Guideline ID	GL-501208
Guideline Name	Duvyzat
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 New Mexico

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

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

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Duchenne muscular dystrophy (DMD) AND 2 - Diagnosis confirmed by the presence of a mutation in the DMD gene AND 3 - Patient is 6 years of age or older AND 4 - Submission of medical records (e.g., chart notes) confirming that the patient is ambulatory without needing an assistive device (e.g., without side-by-side assist, cane, walker, wheelchair, etc.) AND 5 - Patient has been or will be established on a stable corticosteroid regimen AND 6 - Prescribed by, or in consultation with, a pediatric neuromuscular specialist with expertise in the treatment of DMD AND 7 - ONE of the following:	

7.1 Patient has not received gene therapy [e.g., Elevidys (delandistrogene moxparvovec-rokl)] for the treatment of DMD

OR

7.2 BOTH of the following:

- Patient has previously received gene therapy [e.g., Elevidys (delandistrogene moxparvovec-rokl)] for the treatment of DMD
- Submission of medical records (e.g., chart notes, laboratory values) documenting a clinically meaningful functional decline resulting from loss of muscle strength/motor ability (e.g., loss of a motor milestone) since receiving gene replacement therapy [e.g., Elevidys (delandistrogene moxparvovec-rokl)]

AND

8 - Patient will not receive Duvyzat in combination with exon-skipping therapies for DMD [e.g., Amondys (casimersen), Exondys 51 (eteplirsen), Viltepso (viltolarsen), Vyondys 53 (golodirsen)]

Product Name:Duvyzat	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Physician attestation that patient would benefit from continued administration AND 2 - Submission of medical records (e.g., chart notes) confirming that the patient is ambulatory without needing an assistive device (e.g., without side-by-side assist, cane, walker, wheelchair, etc.)	

AND

3 - Patient continues to receive concomitant corticosteroid regimen

AND

4 - Prescribed by, or in consultation with, a pediatric neuromuscular specialist with expertise in the treatment of DMD

AND

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

2 . Revision History

Date	Notes
1/14/2026	Updated initial auth to include previous treatment with gene therapy f or DMD. Removed criteria addressing previous treatment with gene t herapy for DMD in reauth section.

Ebglyss



Prior Authorization Guideline

Guideline ID	GL-563286
Guideline Name	Ebglyss
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 New Mexico

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Ebglyss	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate-to-severe chronic atopic dermatitis

AND

2 - ONE of the following:

2.1 Inadequate response to TWO of the following therapeutic classes of topical therapies as confirmed by claims history or submission of medical records:

- One medium, high or very-high potency topical corticosteroid [e.g., mometasone furoate (generic Elocon), fluocinolone acetonide (generic Synalar), fluocinonide (generic Lidex)]*
- One topical calcineurin inhibitor [e.g., pimecrolimus (generic Elidel), tacrolimus (generic Protopic)]
- Eucrisa (crisaborole)

OR

2.2 History of contraindication or intolerance to ALL of the following therapeutic classes of topical therapies (please specify contraindication or intolerance):

- One medium, high or very-high potency topical corticosteroid [e.g., mometasone furoate (generic Elocon), fluocinolone acetonide (generic Synalar), fluocinonide (generic Lidex)]*
- One topical calcineurin inhibitor [e.g., pimecrolimus (generic Elidel), tacrolimus (generic Protopic)]
- Eucrisa (crisaborole)

OR

2.3 Patient has been previously treated with a targeted immunomodulator FDA-approved for the treatment of atopic dermatitis as documented by claims history or submission of medical records [e.g., Adbry (tralokinumab-ldrm), Cibinqo (abrocitinib), Dupixent (dupilumab), Ebglyss (lebrikizumab-lbkz), Opzelura (ruxolitinib), Rinvoq (upadacitinib)]

AND

3 - ONE of the following:

3.1 Failure to BOTH of the following as confirmed by claims history or submission of medical records:

- Adbry (tralokinumab-ldrm)
- Dupixent (dupilumab)

OR

3.2 History of contraindication or intolerance to BOTH of the following (please specify contraindication or intolerance):

- Adbry (tralokinumab-ldrm)
- Dupixent (dupilumab)

OR

3.3 Patient is currently on Ebglyss therapy as confirmed by claims history or submission of medical records

AND

4 - Patient is NOT receiving Ebglyss in combination with either of the following for treatment of the same indication:

- Biologic immunomodulator [e.g., Adbry (tralokinumab-ldrm), Dupixent (dupilumab), Nemluvio (nemolizumab-ilto)]
- Janus kinase inhibitor [e.g., Cibinqo (abrocitinib), Opzelura (topical ruxolitinib), Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib)]

AND

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

- Dermatologist
- Allergist
- Immunologist

Notes	*See Table 1 for relative potencies of topical corticosteroids.

Product Name:Ebglyss	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Ebglyss therapy AND 2 - Patient is NOT receiving Ebglyss in combination with either of the following for treatment of the same indication: • Biologic immunomodulator [e.g., Adbry (tralokinumab-ldrm), Dupixent (dupilumab), Nemluvio (nemolizumab-ilto)] • Janus kinase inhibitor [e.g., Cibinqo (abrocitinib), Opzelura (topical ruxolitinib), Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib)] AND 3 - Prescribed by or in consultation with ONE of the following: • Dermatologist • Allergist • Immunologist	

2 . Background

Benefit/Coverage/Program Information

Table 1: Relative potencies of topical corticosteroids

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

Lowest potency	Hydrocortisone	Cream, lotion, ointment, solution	0.25, 0.5, 1
	Hydrocortisone acetate	Cream, ointment	0.5-1

3 . Revision History

Date	Notes
4/7/2026	Updated combination use language to clarify Ebglyss will not be used in combination with another targeted immunomodulator used for the treatment of the same indication

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

Eliquis



Prior Authorization Guideline

Guideline ID	GL-62718
Guideline Name	Eliquis
Formulary	Medicaid - Community & State Rhode Island

Guideline Note:

Effective Date:	4/1/2020

1 . Criteria

Product Name:Eliquis, Eliquis Starter Pack	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of one of the following: 1.1 Atrial fibrillation	

	OR	
1.2 Deep vein thrombosis		
	OR	
1.3 Pulmonary embolism		
	OR	
1.4 Knee replacement		
	OR	
1.5 Hip replacement		
	OR	
1.6 Presence of artificial hip/knee joint		

2 . Revision History

Date	Notes
2/27/2020	C&S 2020 IMPLENTATIONS

Empaveli



Prior Authorization Guideline

Guideline ID	GL-443192
Guideline Name	Empaveli
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 Nebraska Medicaid - Community & State New Mexico Medicaid - Community & State Pennsylvania

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Empaveli	
Diagnosis	Paroxysmal Nocturnal Hemoglobinuria (PNH)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - 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: 1.1 Flow cytometry analysis confirming presence of PNH clones AND 1.2 Laboratory results, signs, and/or symptoms attributed to PNH (e.g., abdominal pain, anemia, dyspnea, extreme fatigue, smooth muscle dystonia, unexplained/unusual thrombosis, hemolysis/hemoglobinuria, kidney disease, pulmonary hypertension, etc.) AND 2 - ONE of the following: 2.1 Patient will not be prescribed Empaveli in combination with another complement inhibitor used for the treatment of PNH (e.g., Bkempv, Epysqli, Fabhalta, PiaSky, Soliris, Ultomiris) OR 2.2 Patient is currently receiving another complement inhibitor (e.g., Bkempv, Epysqli, Fabhalta, PiaSky, Soliris, Ultomiris) which will be discontinued and Empaveli will be initiated in accordance with the United States Food and Drug Administration approved labeling AND 3 - Prescribed by, or in consultation with, ONE of the following:	

- Hematologist
- Oncologist

Product Name:Empaveli	
Diagnosis	Paroxysmal Nocturnal Hemoglobinuria (PNH)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Empaveli therapy [e.g., increased or stabilization of hemoglobin levels, reduction in transfusions, improvement in hemolysis, decrease in LDH (lactate dehydrogenase), increased reticulocyte count, etc.] AND 2 - Patient is not receiving Empaveli in combination with another complement inhibitor used for the treatment of paroxysmal nocturnal hemoglobinuria (PNH) (e.g., Bkempv, Epysqli, Fabhalta, PiaSky, Soliris, Ultomiris) AND 3 - Prescribed by, or in consultation with, ONE of the following: • Hematologist • Oncologist	

Product Name:Empaveli	
Diagnosis	C3 Glomerulopathy (C3G) or Primary Immune-Complex Membranoproliferative Glomerulonephritis (IC-MPGN)
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following: 1.1 All of the following: 1.1.1 Diagnosis of immune complex/monoclonal immunoglobulin-mediated Membranoproliferative glomerulonephritis (IC-MPGN) AND 1.1.2 Confirmation of diagnosis is based on immunofluorescence microscopy on kidney biopsy AND 1.1.3 All of the following secondary causes of IC-MPGN have been ruled out: • Infections (e.g., Hepatitis B and hepatitis C virus, chronic bacterial infections, parasitic infections) • Autoimmune diseases [e.g., systemic lupus erythematosus (SLE), Sjogren's syndrome, rheumatoid arthritis, systemic sclerosis] • Monoclonal gammopathy AND 1.1.4 Patient has NOT had a kidney transplant OR 1.2 All of the following: 1.2.1 Diagnosis of complement 3 glomerulopathy (C3G)	

AND

1.2.2 Confirmation of diagnosis is based on immunofluorescence microscopy on kidney biopsy

AND

1.2.3 One of the following:

1.2.3.1 Serum complement 3 (C3) protein less than 77 milligrams per deciliter (alternatively, less than 0.85 x lower limit of the central laboratory normal range)

OR

1.2.3.2 Other complement abnormalities are present [e.g., soluble membrane attack complex (sC5b-9), serum factor H, serum factor B, factor I, membrane cofactor protein (MCP, CD46), C3/C4/C5 nephritic factor (NeF)] which are suggestive of a C3 glomerulopathy

AND

1.2.4 Presence of monoclonal gammopathy of undetermined significance (MGUS) has been excluded by measurement of serum free light chains or other investigative means based on standards of care

AND

2 - Glomerulonephritis has persisted ≥ 3 months in duration

AND

3 - Disease is considered to be moderate to severe based on proteinuria greater than or equal to 1.5 grams per day and/or abnormal kidney function

AND

4 - Used to reduce proteinuria

AND

5 - One of the following:

- Failure to a glucocorticoid (e.g., methylprednisolone, prednisone) as confirmed by claims history or submission of medical records
- History of intolerance or contraindication to a glucocorticoid (e.g., methylprednisolone, prednisone) (please specify contraindication or intolerance)

AND

6 - One of the following:

6.1 Patient is on a stabilized dose and receiving concomitant therapy with one of the following as confirmed by claims history or submission of medical records:

- Maximally tolerated angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril)
- Maximally tolerated angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan)

OR

6.2 Patient has an allergy, contraindication, or intolerance to ACE inhibitors and ARBs (please specify allergy, contraindication or intolerance)

AND

7 - Patient is not receiving Empaveli in combination with another complement inhibitor used for the treatment of C3G or IC-MPGN (e.g., Bkempv, Epysqli, Fabhalsa, PiaSky, Soliris, Ultomiris)

AND

8 - Prescribed by or in consultation with a nephrologist

Product Name:Empaveli	
Diagnosis	C3 Glomerulopathy (C3G) or Primary Immune-Complex Membranoproliferative Glomerulonephritis (IC-MPGN)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Empaveli therapy demonstrated by a reduction in proteinuria AND 2 - Patient is not receiving Empaveli in combination with another complement inhibitor used for the treatment of C3G or IC-MPGN (e.g., Bkerv, Epysqli, Fabhalta, PiaSky, Soliris, Ultomiris) AND 3 - Prescribed by, or in consultation with, a nephrologist	

2 . Revision History

Date	Notes
11/6/2025	Added Epysqli to examples of other complement inhibitors. Added criteria for new FDA-approved indications C3G and IC-MPGN. Added N V formulary.

Enbrel



Prior Authorization Guideline

Guideline ID	GL-470207
Guideline Name	Enbrel
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 Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Enbrel	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria 1 - All of the following: 1.1 Diagnosis of moderately to severely active rheumatoid arthritis (RA) AND 1.2 ONE of the following: 1.2.1 Failure to a 3 month trial of ONE non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] at maximally indicated doses, confirmed by claims history or submission of medical records OR 1.2.2 History of intolerance or contraindication to one non-biologic DMARD [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] (please specify intolerance or contraindication) OR 1.2.3 Patient has been previously treated with a systemic targeted immunomodulator FDA-approved for the treatment of rheumatoid arthritis as confirmed by claims history or submission of medical records [e.g., adalimumab, Cimzia (certolizumab), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib)] AND 1.3 Patient is NOT receiving Enbrel in combination with another systemic targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib)] for treatment of the same indication	

AND

1.4 Prescribed by or in consultation with a rheumatologist

OR

2 - All of the following:

2.1 Patient is currently on Enbrel therapy as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of moderately to severely active rheumatoid arthritis

AND

2.3 Patient is NOT receiving Enbrel in combination with another systemic targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib)] for treatment of the same indication

AND

2.4 Prescribed by or in consultation with a rheumatologist

Product Name:Enbrel	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (PJIA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis

AND

2 - Patient is NOT receiving Enbrel in combination with another systemic targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib)] for treatment of the same indication

AND

3 - Prescribed by or in consultation with a rheumatologist

Product Name:Enbrel	
Diagnosis	Psoriatic Arthritis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - All of the following: 1.1 Diagnosis of active psoriatic arthritis AND 1.2 ONE of the following: 1.2.1 Failure to a 3 month trial of methotrexate at the maximally indicated dose confirmed by claims history or submission of medical records	

OR

1.2.2 History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

OR

1.2.3 Patient has been previously treated with a systemic targeted immunomodulator FDA-approved for the treatment of psoriatic arthritis as confirmed by claims history or submission of medical records [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Orencia (abatacept), Otezla (apremilast), Rinvoq (upadacitinib), Simponi (golimumab), Skyrizi (risankizumab), Taltz (ixekizumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), ustekinumab]

AND

1.3 Patient is NOT receiving Enbrel in combination with another systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Orencia (abatacept), Otezla (apremilast), Rinvoq (upadacitinib), Simponi (golimumab), Skyrizi (risankizumab), Taltz (ixekizumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), ustekinumab] for treatment of the same indication

AND

1.4 Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Dermatologist

OR

2 - All of the following:

2.1 Patient is currently on Enbrel therapy as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of active psoriatic arthritis

AND

2.3 Patient is NOT receiving Enbrel in combination with another systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Orencia (abatacept), Otezla (apremilast), Rinvoq (upadacitinib), Simponi (golimumab), Skyrizi (risankizumab), Taltz (ixekizumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), ustekinumab] for treatment of the same indication

AND

2.4 Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Dermatologist

Product Name:Enbrel	
Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - All of the following: 1.1 Diagnosis of moderate to severe chronic plaque psoriasis AND	

1.2 ONE of the following:

1.2.1 ALL of the following:

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

AND

1.2.1.2 ONE of the following:

1.2.1.2.1 Failure to one of the following topical therapy classes confirmed by claims history or submission of medical records:

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Anthralin
- Coal tar

OR

1.2.1.2.2 History of intolerance or contraindication to all of the following topical therapy classes (please specify intolerance or contraindication)

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Anthralin
- Coal tar

AND

1.2.1.3 ONE of the following:

1.2.1.3.1 Failure to a 3 month trial of methotrexate at the maximally indicated dose confirmed by claims history or submission of medical records

OR

1.2.1.3.2 History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

OR

1.2.2 Patient has been previously treated with a systemic targeted immunomodulator FDA-approved for the treatment of plaque psoriasis as confirmed by claims history or submission of medical records [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Ilumya (tildrakizumab), Otezla (apremilast), Skyrizi (risankizumab), Siliq (brodalumab), Sotyktu (deucravacitinib), Taltz (ixekizumab), Tremfya (guselkumab), ustekinumab]

AND

1.3 Patient is NOT receiving Enbrel in combination with another systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Ilumya (tildrakizumab), Otezla (apremilast), Skyrizi (risankizumab), Siliq (brodalumab), Sotyktu (deucravacitinib), Taltz (ixekizumab), Tremfya (guselkumab), ustekinumab] for treatment of the same indication

AND

1.4 Prescribed by or in consultation with a dermatologist

OR

2 - All of the following:

2.1 Patient is currently on Enbrel therapy as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of moderate to severe chronic plaque psoriasis

AND

2.3 Patient is NOT receiving Enbrel in combination with another systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Ilumya (tildrakizumab), Otezla (apremilast), Skyrizi (risankizumab), Siliq (brodalumab), Sotyktu (deucravacitinib), Taltz (ixekizumab), Tremfya (guselkumab), ustekinumab] for treatment of the same indication

AND

2.4 Prescribed by or in consultation with a dermatologist

Product Name:Enbrel	
Diagnosis	Ankylosing Spondylitis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - All of the following: 1.1 Diagnosis of active ankylosing spondylitis AND 1.2 ONE of the following: 1.2.1 Failure to two non-steroidal anti-inflammatory drugs (NSAIDs: e.g., ibuprofen, naproxen) at maximally indicated doses, each used for at least 4 weeks confirmed by claims history or submission of medical records OR	

1.2.2 History of intolerance or contraindication to two NSAIDs (e.g., ibuprofen, naproxen) (please specify intolerance or contraindication)

OR

1.2.3 Patient has been previously treated with a systemic targeted immunomodulator FDA-approved for the treatment of ankylosing spondylitis as confirmed by claims history or submission of medical records [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Simponi (golimumab), Rinvoq (upadacitinib), Taltz (ixekizumab), Xeljanz (tofacitinib)]

AND

1.3 Patient is NOT receiving Enbrel in combination with another systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Simponi (golimumab), Rinvoq (upadacitinib), Taltz (ixekizumab), Xeljanz (tofacitinib)] for treatment of the same indication

AND

1.4 Prescribed by or in consultation with a rheumatologist

OR

2 - All of the following:

2.1 Patient is currently on Enbrel therapy as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of active ankylosing spondylitis

AND

2.3 Patient is NOT receiving Enbrel in combination with another systemic targeted

immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Simponi (golimumab), Rinvoq (upadacitinib), Taltz (ixekizumab), Xeljanz (tofacitinib)] for treatment of the same indication

AND

2.4 Prescribed by or in consultation with a rheumatologist

Product Name:Enbrel	
Diagnosis	Rheumatoid Arthritis (RA), Polyarticular Juvenile Idiopathic Arthritis (PJIA), Plaque Psoriasis, Ankylosing Spondylitis, Psoriatic Arthritis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Enbrel therapy AND 2 - Patient is NOT receiving Enbrel in combination with another systemic targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib)]* for treatment of the same indication	
Notes	* Examples of drug(s) may not be applicable based on the requested indication.

2 . Revision History

Date	Notes
12/10/2025	Updated drug example language.

Enbumyst, Furoscix, Lasix ONYU



Prior Authorization Guideline

Guideline ID	GL-551255
Guideline Name	Enbumyst, Furoscix, Lasix ONYU
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 Pennsylvania Medicaid - Community & State New Mexico Medicaid - Community & State Nevada

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name: Enbumyst, Furoscix, Lasix ONYU	
Approval Length	1 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has edema associated with ONE of the following: • Congestive heart failure • Renal disease, including nephrotic syndrome • Hepatic disease AND 2 - Submission of medical records confirming that the patient is established on background loop diuretic therapy (e.g., bumetanide, furosemide, torsemide) for the treatment of edema AND 3 - BOTH of the following: • Patient does NOT require ongoing emergency care or hospitalization • Patient is currently a candidate for parenteral or nasal diuresis outside of the hospital AND 4 - Prescribed by or in consultation with ONE of the following: • Cardiologist • Hepatologist • Nephrologist	

2 . Revision History

Date	Notes

3/19/2026	Updated title. Added Enbumyst and Lasix ONYU. Criteria updates throughout

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 Rhode Island 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 Rhode Island 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-461329
Guideline Name	Enspryng
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State New Jersey Medicaid - Community & State New York Medicaid - Community & State New York EPP Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Arizona Medicaid - Community & State New Mexico Medicaid - Community & State Pennsylvania

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Enspryng	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of neuromyelitis optica spectrum disorder (NMOSD) AND 2 - Patient has a positive serologic test for anti-aquaporin-4 (AQP4) antibodies AND 3 - History of failure, contraindication, or intolerance to rituximab therapy AND 4 - ONE of the following: • History of one or more relapses that required rescue therapy during the previous 12 months • History of two or more relapses that required rescue therapy during the previous 24 months AND 5 - Prescribed by, or in consultation with, a neurologist AND 6 - Patient is NOT receiving Enspryng in combination with any of the following for the treatment of the same indication: • Disease modifying therapies for the treatment of multiple sclerosis [e.g., Gilenya (fingolimod), Tecfidera (dimethyl fumarate), Ocrevus (ocrelizumab), etc.]	

- Complement inhibitors [e.g., eculizumab, Ultomiris (ravulizumab), etc.]
- Anti-IL6 (anti-interleukin-6) therapy [e.g., Actemra (tocilizumab)]
- B-cell depletion therapy [e.g., rituximab, Uplizna (inebilizumab)]

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

Approval Criteria

1 - Documentation of positive clinical response to Enspryng therapy

AND

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

AND

3 - Patient is NOT receiving Enspryng in combination with any of the following for the treatment of the same indication:

- Disease modifying therapies for the treatment of multiple sclerosis [e.g., Gilenya (fingolimod), Tecfidera (dimethyl fumarate), Ocrevus (ocrelizumab), etc.]
- Complement inhibitors [e.g., eculizumab, Ultomiris (ravulizumab), etc.]
- Anti-IL6 (anti-interleukin-6) therapy [e.g., Actemra (tocilizumab)]
- B-cell depletion therapy [e.g., rituximab, Uplizna (inebilizumab)]

2 . Revision History

Date	Notes

12/5/2025	Combined formularies. Updated statement for concomitant use and updated examples of complement inhibitors in both initial and reauth sections. Minor cosmetic updates.

Entresto



Prior Authorization Guideline

Guideline ID	GL-501250
Guideline Name	Entresto
Formulary	Medicaid - Community & State Colorado 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

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name: Brand Entresto, generic sacubitril/valsartan, Entresto Sprinkles	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Request is for continuation of therapy initiated during an inpatient stay

OR

2 - ALL of the following:

2.1 Diagnosis of pediatric heart failure with systemic left ventricular systolic dysfunction which is symptomatic

AND

2.2 Prescribed by or in consultation with a cardiologist

AND

2.3 If the request is for Entresto Sprinkles, the prescriber has given a clinical reason or special circumstance why the patient is unable to use regular Entresto tablets

OR

3 - ALL of the following:

3.1 Diagnosis of heart failure (with or without hypertension)

AND

3.2 ONE of the following:

3.2.1 Ejection fraction is less than or equal to 40 percent

OR

3.2.2 BOTH of the following:

3.2.2.1 Ejection fraction is greater than 40 percent

AND

3.2.2.2 Patient has structural heart disease [i.e., left atrial enlargement (LAE) or left ventricular hypertrophy (LVH)]

AND

3.3 Heart failure is classified as ONE of the following:

- New York Heart Association Class II
- New York Heart Association Class III
- New York Heart Association Class IV

AND

3.4 Patient does not have a history of angioedema

AND

3.5 Patient will discontinue any use of concomitant ACE (angiotensin converting enzyme) Inhibitor or ARB (angiotensin II receptor blocker) before initiating treatment with Entresto*

AND

3.6 Patient is not concomitantly on aliskiren therapy

AND

3.7 Entresto is prescribed by, or in consultation with, a cardiologist

Notes	*ACE inhibitors must be discontinued at least 36 hours prior to initiation of Entresto.

Product Name: Brand Entresto, generic sacubitril/valsartan, Entresto Sprinkles	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - The Entresto dose has been titrated to a dose of 97 mg (milligrams)/103 mg twice daily or the maximum labeled dose for pediatric patients, or to a maximum dose as tolerated by the patient AND 2 - Documentation of positive clinical response to therapy	

2 . Revision History

Date	Notes
1/17/2026	Combined formularies. Added generic sacubitril/valsartan tablet as a target to the guideline.

Entyvio SC



Prior Authorization Guideline

Guideline ID	GL-511322
Guideline Name	Entyvio SC
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

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name:Entyvio SC	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records documenting clinical rationale for need of subcutaneous Entyvio in place of Entyvio administered intravenously (covered under the medical benefit) AND 2 - Diagnosis of moderately to severely active ulcerative colitis (UC) AND 3 - ONE of the following: 3.1 Patient has been established on therapy with Entyvio under an active UnitedHealthcare medical benefit prior authorization for the treatment of moderately to severely active ulcerative colitis OR 3.2 Patient is currently on Entyvio for subcutaneous use therapy as confirmed by claims history or submission of medical records AND 4 - Patient is NOT receiving Entyvio for subcutaneous use in combination with another systemic targeted immunomodulator [e.g., adalimumab, Omvoh (mirikizumab-mrkz), Rinvoq (upadacitinib), Simponi (golimumab), Skyrizi (risankizumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), ustekinumab, Zeposia (ozanimod)] for treatment of the same indication AND 5 - Prescribed by or in consultation with a gastroenterologist	

Product Name:Entyvio SC	
Diagnosis	Crohn's disease (CD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records documenting clinical rationale for need of subcutaneous Entyvio in place of Entyvio administered intravenously (covered under the medical benefit) AND 2 - Diagnosis of moderately to severely active Crohn's disease (CD) AND 3 - ONE of the following: 3.1 Patient has been established on therapy with Entyvio under an active UnitedHealthcare medical benefit prior authorization for the treatment of moderately to severely active Crohn's disease OR 3.2 Patient is currently on Entyvio for subcutaneous use therapy as confirmed by claims history or submission of medical records AND 4 - Patient is NOT receiving Entyvio in combination with a systemic targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Omvoh (mirikizumab-mrkz), Rinvoq (upadacitinib), Skyrizi (risankizumab), Tremfya (guselkumab), ustekinumab] for treatment of the same indication	

AND

5 - Prescribed by or in consultation with a gastroenterologist

Product Name:Entyvio SC	
Diagnosis	Ulcerative Colitis (UC), Crohn's disease (CD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Entyvio for subcutaneous use therapy AND 2 - Patient is NOT receiving Entyvio in combination with a systemic targeted immunomodulator [e.g., adalimumab, Omvoh (mirikizumab-mrkz), Rinvoq (upadacitinib), Simponi (golimumab), Skyrizi (risankizumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), ustekinumab, Zeposia (ozanimod)] for treatment of the same indication	

2 . Revision History

Date	Notes
2/5/2026	Updated combination examples and language with no change to clinical intent. Minor cosmetic updates.

Eohilia



Prior Authorization Guideline

Guideline ID	GL-317188
Guideline Name	Eohilia
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

Guideline Note:

Effective Date:	8/1/2025

1 . Criteria

Product Name:Eohilia	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of eosinophilic esophagitis (EoE) AND 2 - Patient is experiencing symptoms related to esophageal dysfunction (e.g., dysphagia, food impaction, chest pain that is often centrally located and may not respond to antacids, gastroesophageal reflux disease-like symptoms/refractory heartburn, upper abdominal pain) AND 3 - Submission of medical records (e.g., chart notes, laboratory values, etc.) documenting eosinophil-predominant inflammation on esophageal biopsy, consisting of a peak value of ≥ 15 intraepithelial eosinophils per high power field (HPF) AND 4 - Secondary causes of esophageal eosinophilia have been ruled out AND 5 - ONE of the following: 5.1 History of suboptimal response to an 8 week trial of BOTH of the following as confirmed by claims history or submission of medical records: • Proton pump inhibitor (e.g., pantoprazole, omeprazole) • Inhalational corticosteroid administered orally [e.g., budesonide inhalation suspension (generic Pulmicort Respules), Fluticasone HFA (Flovent HFA authorized generic)] OR	

5.2 History of contraindication or intolerance to BOTH of the following (please specify intolerance or contraindication):

- Proton pump inhibitor (e.g., pantoprazole, omeprazole)
- Inhalational corticosteroid administered orally [e.g., budesonide inhalation suspension (generic Pulmicort Respules), Fluticasone HFA (Flovent HFA authorized generic)]

AND

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

- Allergist/Immunologist
- Gastroenterologist

Product Name:Eohilia	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Eohilia therapy as evidenced by a reduction in intraepithelial eosinophils per high power field (HPF)	

2 . Revision History

Date	Notes
7/2/2025	Combined formularies. Added reauth criteria section. For initial auth, updated approval duration and updated failure language to suboptimal response. Minor cosmetic updates.

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.

Erythropoietic Agents



Prior Authorization Guideline

Guideline ID	GL-238236
Guideline Name	Erythropoietic Agents
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State New Jersey Medicaid - Community & State New Mexico Medicaid - Community & State New York Medicaid - Community & State New York EPP Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island

Guideline Note:

Effective Date:	6/1/2025

1 . Criteria

Product Name:Aranesp, Epogen, Procrit, Retacrit	
Diagnosis	Anemia Due to Chronic Kidney Disease (CKD)
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chronic kidney disease (CKD) AND 2 - Hematocrit is less than 30 percent at initiation of therapy AND 3 - Patient does not have evidence of other causes of anemia (e.g., iron deficiency, hemolysis, vitamin B12 deficiency) AND 4 - ONE of the following: 4.1 Patient is on dialysis OR 4.2 ALL of the following: 4.2.1 Patient is NOT on dialysis AND 4.2.2 The rate of hematocrit decline indicates the likelihood of requiring a red blood cell (RBC) transfusion	

AND

4.2.3 Therapeutic goal is reducing the risk of alloimmunization and/or other RBC transfusion-related risks

Product Name:Aranesp, Epogen, Procrit, Retacrit	
Diagnosis	Anemia Due to Chronic Kidney Disease (CKD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to erythropoietin stimulating agent (ESA) therapy AND 2 - ONE of the following: 2.1 BOTH of the following: 2.1.1 Patient is on dialysis AND 2.1.2 Hematocrit remains less than 33 percent OR 2.2 ALL of the following: 2.2.1 Patient is NOT on dialysis	

AND

2.2.2 Hematocrit remains less than 30 percent

AND

2.2.3 Therapeutic goal is reducing the risk of alloimmunization and/or other RBC transfusion

Product Name:Epogen, Procrit, Retacrit	
Diagnosis	Anemia Associated with Zidovudine Treatment in HIV-Infected Patients
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is receiving zidovudine administered at less than or equal to 4200 milligrams per week AND 2 - Endogenous serum erythropoietin level is less than or equal to 500 milliunits per milliliter AND 3 - Hematocrit is less than 30 percent at initiation of therapy AND	

4 - Patient does not have evidence of other causes of anemia (e.g., iron deficiency, hemolysis, vitamin B12 deficiency)

Product Name:Epogen, Procrit, Retacrit	
Diagnosis	Anemia Associated with Zidovudine Treatment in HIV-Infected Patients
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to erythropoietin stimulating agent (ESA) therapy AND 2 - Patient is receiving zidovudine administered at less than or equal to 4200 milligrams per week AND 3 - Endogenous serum erythropoietin level less than or equal to 500 milliunits per milliliter AND 4 - Hematocrit remains less than or equal to 36 percent for continuation of therapy	

Product Name:Aranesp, Epogen, Procrit, Retacrit	
Diagnosis	Anemia Due to Cancer Chemotherapy
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Hematocrit less than or equal to 30 percent at initiation of therapy AND 2 - Patient does not have evidence of other causes of anemia (e.g., iron deficiency, hemolysis, vitamin B12 deficiency) and there is documentation of normal iron stores AND 3 - One of the following: 3.1 Patient has moderate to severe chronic kidney disease (CKD) OR 3.2 Undergoing palliative treatment OR 3.3 Receiving myelosuppressive chemotherapy not given with curative intent OR 3.4 Both of the following: • Receiving myelosuppressive chemotherapy with curative intent • Patient is refusing blood transfusion(s)	

Product Name: Aranesp, Epogen, Procrit, Retacrit

Diagnosis	Anemia Due to Cancer Chemotherapy
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to erythropoietin stimulating agent (ESA) therapy AND 2 - Chemotherapy is given as palliative treatment AND 3 - Hematocrit remains less than 30 percent for continuation of therapy	

Product Name:Epogen, Procrit, Retacrit	
Diagnosis	Preoperative Use for Reduction of Allogeneic Blood Transfusions in Surgery Patients
Approval Length	3 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Perioperative hematocrit is greater than 30 percent and less than or equal to 39 percent AND 2 - Patient is expected to require at least 2 units of blood during the surgical procedure	

AND

3 - Patient is at high risk for blood loss during surgery

AND

4 - Patient is unable or unwilling to donate autologous blood

AND

5 - Surgery procedure is elective, non-cardiac, and non-vascular

Product Name: Aranesp, Epogen, Procrit, Retacrit	
Diagnosis	Anemia Associated with Myelodysplastic Syndrome
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of myelodysplastic syndrome (MDS) AND 2 - Serum erythropoietin level less than or equal to 500 milliunits per milliliter AND 3 - Hematocrit is less than or equal to 30 percent at the initiation of therapy	

AND

4 - Patient does not have evidence of other causes of anemia (e.g., iron deficiency, hemolysis, vitamin B12 deficiency)

AND

5 - Treatment of lower risk [defined as IPSS-R (Very Low, Low, Intermediate)] disease with symptomatic anemia

AND

6 - One of the following:

6.1 Patient is with del(5q) chromosomal abnormality

OR

6.2 Both of the following:

- Patient is without del(5q) chromosomal abnormality
- Ring sideroblasts less than 15% (or ring sideroblasts less than 5% with an SF3B1 mutation)

OR

6.3 All of the following:

- Patient is without del(5q) chromosomal abnormality
- Ring sideroblasts greater than or equal to 15% (or ring sideroblasts greater than or equal to 5% with an SF3B1 mutation)
- Following no response to Reblozyl (luspatercept-aamt)

Product Name: Aranesp, Epogen, Procrit, or Retacrit	
Diagnosis	Anemia Associated with Myelodysplastic syndrome

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Hematocrit remains less than or equal to 36 percent for continuation of therapy AND 2 - Documentation of positive clinical response to erythropoietin stimulating agent (ESA) therapy AND 3 - Serum erythropoietin level less than or equal to 500 milliunits per milliliter	

Product Name: Aranesp, Epogen, Procrit, Retacrit	
Diagnosis	Anemia associated with Myeloproliferative Neoplasms – Myelofibrosis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Serum erythropoietin level less than or equal to 500 mUnits/mL AND 2 - Hematocrit is less than or equal to 30 percent at the initiation of therapy	

AND

3 - Patient does not have evidence of other causes of anemia (e.g., iron deficiency, hemolysis, vitamin B12 deficiency)

Product Name:Aranesp, Epogen, Procrit, Retacrit	
Diagnosis	Anemia associated with Myeloproliferative Neoplasms – Myelofibrosis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to erythropoietin stimulating agent (ESA) therapy AND 2 - Serum erythropoietin level less than or equal to 500 mUnits/mL AND 3 - Hematocrit remains less than or equal to 36 percent for continuation of therapy	

Product Name:Epogen, Procrit, Retacrit	
Diagnosis	Anemia in Patients with Hepatitis C with Ribavirin and Interferon Therapy
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of hepatitis C virus (HCV) infection

AND

2 - Patient is receiving ribavirin and interferon therapy

AND

3 - Hematocrit is less than or equal to 30 percent at initiation of therapy

AND

4 - Patient does not have evidence of other causes of anemia (e.g., iron deficiency, hemolysis, vitamin B12 deficiency)

Product Name:Epogen, Procrit, Retacrit	
Diagnosis	Anemia in Patients with Hepatitis C with Ribavirin and Interferon Therapy
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Hematocrit remains less than or equal to 36 percent for continuation of care AND	

2 - Documentation of positive clinical response to erythropoietin stimulating agent (ESA) therapy

AND

3 - Patient is receiving ribavirin and interferon therapy

Product Name: Aranesp, Epogen, Procrit, Retacrit

Diagnosis	Erythropoietin Stimulating Agents -Off-Label Uses

Guideline Type	Prior Authorization

Approval Criteria

1 - Off-label requests will be evaluated on a case-by-case basis by a clinical pharmacist

AND

2 - Requests for coverage in patients with hemoglobin (Hgb) greater than 10 grams per deciliter or hematocrit (Hct) greater than 30 percent will not be approved

2 . Revision History

Date	Notes
4/16/2025	Updated formularies

Eucrisa



Prior Authorization Guideline

Guideline ID	GL-510410
Guideline Name	Eucrisa
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

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name:Eucrisa	
Approval Length	12 month(s)
Guideline Type	Step Therapy

Approval Criteria

1 - BOTH of the following:

1.1 ONE of the following:

1.1.1 Failure to ONE topical corticosteroid [e.g., mometasone furoate, fluocinolone acetonide (generic Synalar), fluocinonide] as confirmed by claims history or submission of medical records

OR

1.1.2 History of contraindication or intolerance ONE topical corticosteroid [e.g., mometasone furoate, fluocinolone acetonide (generic Synalar), fluocinonide] (please specify contraindication or intolerance)

AND

1.2 ONE of the following:

1.2.1 Patient is less than 2 years of age

OR

1.2.2 Patient is greater than or equal to 2 years of age and ONE of the following:

- Failure to ONE topical calcineurin inhibitor [e.g., pimecrolimus (generic Elidel), tacrolimus (generic Protopic)] as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to ONE topical calcineurin inhibitor [e.g., pimecrolimus (generic Elidel), tacrolimus (generic Protopic)] (Please specify contraindication or intolerance)

OR

2 - Patient is currently on Eucrisa therapy as confirmed by claims history or submission of medical records

2 . Revision History

Date	Notes
2/5/2026	Combined formularies. No changes to clinical criteria.

Evrysdi



Prior Authorization Guideline

Guideline ID	GL-246201
Guideline Name	Evrysdi
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State Nebraska Medicaid - Community & State New Jersey Medicaid - Community & State New Mexico Medicaid - Community & State New York Medicaid - Community & State New York EPP Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	7/1/2025

1 . Criteria

Product Name:Evrysdi	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of spinal muscular atrophy (SMA) AND 2 - Submission of medical records (e.g., chart notes, laboratory values) confirming the mutation or deletion of genes in chromosome 5q resulting in ONE of the following: • Homozygous gene deletion or mutation of SMN1 gene (e.g., homozygous deletion of exon 7 at locus 5q13) • Compound heterozygous mutation of SMN1 gene [e.g., deletion of SMN1 exon 7 (allele 1) and mutation of SMN1 (allele 2)] AND 3 - Patient is not dependent on invasive ventilation AND 4 - Patient is not dependent on the use of non-invasive ventilation beyond use for naps and nighttime sleep AND 5 - Patient is not receiving concomitant chronic survival motor neuron (SMN)-modifying therapy [e.g., Spinraza (nusinersen)] AND 6 - One of the following:	

6.1 Patient has not previously received gene replacement therapy for the treatment of SMA [e.g., Zolgensma (onasemnogene abeparvovec-xioi)]

OR

6.2 Both of the following:

- Patient has previously received gene replacement therapy [e.g., Zolgensma (onasemnogene abeparvovec-xioi)] for the treatment of SMA
- Submission of medical records (e.g., chart notes, laboratory values) documenting a clinically meaningful functional decline (e.g., loss of motor milestone) since receiving gene replacement therapy [e.g., Zolgensma (onasemnogene abeparvovec-xioi)]

AND

7 - Submission of medical records (e.g., chart notes, laboratory values) documenting the baseline assessment of at least ONE of the following exams (based on patient age and motor ability) to establish baseline motor ability (baseline motor function analysis could include assessments evaluated prior to receipt of previous chronic SMN-modifying therapy if transitioning therapy)*:

- Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND)
- Hammersmith Infant Neurological Exam Part 2 (HINE-2)
- Hammersmith Functional Motor Scale Expanded (HF MSE)
- Revised Upper Limb Module (RULM) Test
- Motor Function Measure 32 (MFM-32) Scale

AND

8 - Prescribed by or in consultation with a neurologist with expertise in the treatment of SMA

Notes	*Baseline assessments for patients less than 2 months of age requesting Evrysdi are not necessary in order not to delay access to initial therapy in recently diagnosed infants. Initial assessments shortly post-therapy can serve as baseline with respect to efficacy reauthorization assessment.

Product Name:Evrysdi	
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes, laboratory values) with the most recent results documenting a positive clinical response to Evrysdi compared to pretreatment baseline status [inclusive of baseline assessments prior to receipt of previous chronic survival motor neuron (SMN)-modifying therapy] as demonstrated by at least ONE of the following exams: 1.1 Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND) with ONE of the following: - Improvement or maintenance of previous improvement of at least a 4-point increase in score from pretreatment baseline - Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so OR 1.2 Hammersmith Infant Neurological Exam Part 2 (HINE-2) with ONE of the following: - Improvement or maintenance of previous improvement of at least a 2-point (or maximal score) increase in ability to kick - Improvement or maintenance of previous improvement of at least a 1-point increase in any other HINE-2 milestone (e.g., head control, rolling, sitting, crawling, etc.), excluding voluntary grasp - The patient exhibited improvement, or maintenance of previous improvement, in more HINE motor milestones than worsening, from pretreatment baseline (net positive improvement) - Patient has achieved and maintained any new motor milestones when they would otherwise be unexpected to do so OR 1.3 Hammersmith Functional Motor Scale Expanded (HFMSE) with ONE of the following: - Improvement or maintenance of previous improvement of at least a 3-point increase in score from pretreatment baseline - Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so	

OR

1.4 Revised Upper Limb Module (RULM) with ONE of the following:

- Improvement or maintenance of previous improvement of at least a 2-point increase in score from pretreatment baseline
- Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so

OR

1.5 Motor Function Measure 32 (MFM-32) with ONE of the following:

- Improvement or maintenance of previous improvement of at least a 3-point increase in score from pretreatment baseline
- Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so

AND

2 - Patient is not dependent on invasive ventilation

AND

3 - Patient is not dependent on the use of non-invasive ventilation beyond use for naps and nighttime sleep

AND

4 - Patient is not receiving concomitant chronic SMN-modifying therapy [e.g., Spinraza (nusinersen)]

AND

5 - Prescribed by or in consultation with a neurologist with expertise in the treatment of spinal muscular atrophy (SMA)

2 . Revision History

Date	Notes
4/28/2025	Updated GPIs and formularies. Revised criteria for patients that have documented decline from pretreatment baseline status following administration of gene replacement therapy. Removed trach dependence

Fabhalta



Prior Authorization Guideline

Guideline ID	GL-439205
Guideline Name	Fabhalta
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 Nevada

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Fabhalta

Diagnosis	Paroxysmal nocturnal hemoglobinuria (PNH)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - 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: 1.1 Flow cytometry analysis confirming presence of PNH clones AND 1.2 Laboratory results, signs, and/or symptoms attributed to PNH (e.g., abdominal pain, anemia, dyspnea, extreme fatigue, smooth muscle dystonia, unexplained/unusual thrombosis, hemolysis/hemoglobinuria, kidney disease, pulmonary hypertension, etc.) AND 2 - ONE of the following: 2.1 Patient will not be prescribed Fabhalta in combination with another complement inhibitor used for the treatment of PNH (e.g., Empaveli, PiaSky, eculizumab, Ultomiris) OR 2.2 Patient is currently receiving another complement inhibitor (e.g., Empaveli, PiaSky, eculizumab, Ultomiris) which will be discontinued and Fabhalta will be initiated in accordance with the United States Food and Drug Administration approved labeling AND 3 - Prescribed by, or in consultation with, ONE of the following: Hematologist	

- Oncologist

Product Name:Fabhalta	
Diagnosis	Paroxysmal nocturnal hemoglobinuria (PNH)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Fabhalta therapy (e.g., increased or stabilization of hemoglobin levels, reduction in transfusions, improvement in hemolysis, decrease in LDH, increased reticulocyte count, etc.) AND 2 - Patient is not receiving Fabhalta in combination with another complement inhibitor used for the treatment of PNH (e.g., Empaveli, PiaSky, eculizumab, Ultomiris) AND 3 - Prescribed by, or in consultation with, ONE of the following: • Hematologist • Oncologist	

Product Name:Fabhalta	
Diagnosis	Primary immunoglobulin A nephropathy (IgAN)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of primary immunoglobulin A nephropathy (IgAN) confirmed by renal biopsy

AND

2 - Patient is at risk of rapid disease progression [e.g., generally a urine protein-to-creatinine ratio (UPCR) greater than or equal to 1.5 g/g, or by other criteria such as clinical risk scoring using the International IgAN Prediction Tool]

AND

3 - Used to reduce proteinuria

AND

4 - Estimated glomerular filtration rate (eGFR) greater than or equal to 30 mL/min/1.73 m²

AND

5 - ONE of the following:

5.1 Patient is on a stabilized dose and receiving concomitant therapy with ONE of the following as confirmed by claims history or submission of medical records:

- Maximally tolerated angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril)
- Maximally tolerated angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan)

OR

5.2 Patient has an allergy, contraindication, or intolerance to ACE inhibitors and ARBs (please specify allergy, contraindication, or intolerance)

AND

6 - ONE of the following:

6.1 Patient is on a stabilized dose and receiving concomitant therapy with a maximally tolerated sodium-glucose cotransporter-2 (SGLT2) inhibitor [e.g., Jardiance (empagliflozin)] as confirmed by claims history or submission of medical records

OR

6.2 Patient has an allergy, contraindication, or intolerance to SGLT2 inhibitors (please specify allergy, contraindication, or intolerance)

AND

7 - ONE of the following:

7.1 Failure to a 30-day trial of a glucocorticoid (e.g., methylprednisolone, prednisone) as confirmed by claims history or submission of medical records

OR

7.2 History of intolerance or contraindication to a glucocorticoid (please specify intolerance or contraindication)

AND

8 - Prescribed by or in consultation with a nephrologist

Product Name: Fabhalta	
Diagnosis	Complement 3 glomerulopathy (C3G)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of complement 3 glomerulopathy (C3G) confirmed by all of the following:

1.1 Documentation of a kidney biopsy demonstrating characteristic findings of C3G

AND

1.2 Glomerulonephritis has persisted at least 3 months in duration

AND

1.3 ONE of the following:

- Serum complement 3 (C3) protein less than 77 mg/dL (alternatively, less than 0.85 x lower limit of the central laboratory normal range)
- Other complement abnormalities are present [e.g., soluble membrane attack complex (sC5b-9), serum factor H, serum factor B, factor I, membrane cofactor protein (MCP, CD46), C3/C4/C5 nephritic factor (NeF)] which are suggestive of a C3 glomerulopathy

AND

1.4 Presence of monoclonal gammopathy of undetermined significance (MGUS) has been excluded by measurement of serum free light chains or other investigative means based on standards of care

AND

2 - Disease is considered to be moderate to severe based on proteinuria greater than or equal to 1.5 g/day and/or abnormal kidney function

AND

3 - Used to reduce proteinuria

AND

4 - ONE of the following:

- Failure to a glucocorticoid (e.g., methylprednisolone, prednisone) as confirmed by claims history or submission of medical records
- History of intolerance or contraindication to a glucocorticoid (please specify intolerance or contraindication)

AND

5 - ONE of the following:

5.1 Patient is on a stabilized dose and receiving concomitant therapy with ONE of the following as confirmed by claims history or submission of medical records:

- Maximally tolerated angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril)
- Maximally tolerated angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan)

OR

5.2 Patient has an allergy, contraindication, or intolerance to ACE inhibitors and ARBs (please specify allergy, contraindication, or intolerance)

AND

6 - Patient has NOT undergone a solid-organ or cell transplant, including kidney transplant

AND

7 - Prescribed by or in consultation with a nephrologist

Product Name: Fabhalta

Diagnosis	Primary immunoglobulin A nephropathy (IgAN), Complement 3 glomerulopathy (C3G)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Fabhalta therapy demonstrated by a reduction in proteinuria	

2 . Revision History

Date	Notes
11/5/2025	Added Nevada Formulary

Fasenra



Prior Authorization Guideline

Guideline ID	GL-376242
Guideline Name	Fasenra
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 New Mexico

Guideline Note:

Effective Date:	10/1/2025

1 . Criteria

Product Name:Fasenra Pen	
Diagnosis	Severe Asthma
Approval Length	12 month(s)

Therapy Stage	Initial Authorization - Transitioning from UHC medical benefits
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has been established on therapy with Fasenra under an active UnitedHealthcare medical benefit prior authorization for the treatment of severe asthma AND 2 - Documentation of positive clinical response to Fasenra therapy as demonstrated by ONE of the following: • Reduction in the frequency of exacerbations • Decreased utilization of rescue medications • Increase in percent predicted forced expiratory volume in 1 second (FEV1) from pretreatment baseline • Reduction in severity or frequency of asthma-related symptoms (e.g., wheezing, shortness of breath, coughing, etc.) • Reduction in oral corticosteroid requirements AND 3 - Fasenra is being used in combination with an inhaled corticosteroid (ICS)-containing maintenance medication [e.g., Advair/AirDuo (fluticasone/salmeterol), Breo Ellipta (fluticasone furoate/vilanterol), Symbicort (budesonide/ formoterol), Trelegy Ellipta (fluticasone furoate/umeclidinium/vilanterol)] AND 4 - Patient is NOT receiving Fasenra in combination with any of the following for treatment of the same indication: • Anti-interleukin 5 therapy [e.g., Cinqair (reslizumab), Nucala (mepolizumab)] • Anti-IgE (immunoglobulin E) therapy [e.g., Xolair (omalizumab)] • Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)] • Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]	

AND

5 - Prescribed by ONE of the following:

- Allergist
- Immunologist
- Pulmonologist

Product Name:Fasenra Pen

Diagnosis	Severe Asthma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization – Not transitioning from UHC medical benefits
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of severe asthma

AND

2 - Classification of asthma as uncontrolled or inadequately controlled as defined by ONE of the following:

- Poor symptom control [e.g., Asthma Control Questionnaire (ACQ) score consistently greater than 1.5 or Asthma Control Test (ACT) score consistently less than 20]
- Two or more bursts of systemic corticosteroids for at least 3 days each in the previous 12 months
- Asthma-related emergency treatment (e.g., emergency room visit, hospital admission, or unscheduled physician's office visit for nebulizer or other urgent treatment)
- Airflow limitation [e.g., after appropriate bronchodilator withhold forced expiratory volume in 1 second (FEV1) less than 80% predicted (in the face of reduced FEV1/forced vital capacity [FVC] defined as less than the lower limit of normal)]
- Patient is currently dependent on oral corticosteroids for the treatment of asthma

AND

3 - Submission of medical records (e.g., chart notes, laboratory values, etc.) confirming asthma is an eosinophilic phenotype as defined by a baseline (pre-treatment) peripheral blood eosinophil level greater than or equal to 150 cells per microliter

AND

4 - Fasenra will be used in combination with ONE of the following:

4.1 ONE maximally-dosed (appropriately adjusted for age) combination inhaled corticosteroid (ICS)/long-acting beta2 agonist (LABA) [e.g., fluticasone/salmeterol (authorized generic of AirDuo), fluticasone propionate/salmeterol diskus (generic for Advair Diskus), Wixela Inhub (generic for Advair Diskus), Advair/AirDuo Respiclick (fluticasone propionate/salmeterol), Symbicort (budesonide/formoterol), Breo Ellipta (fluticasone furoate/vilanterol), Dulera (mometasone/formoterol)]

OR

4.2 Combination therapy including BOTH of the following:

- ONE maximally-dosed (appropriately adjusted for age) ICS product [e.g., ciclesonide (Alvesco), mometasone furoate (Asmanex), beclomethasone dipropionate (QVAR), Arnuity Ellipta (fluticasone furoate)]
- ONE additional asthma controller medication [e.g., LABA - Striverdi (olodaterol) or Arcapta (indacaterol); leukotriene receptor antagonist - montelukast (Singulair); theophylline]

AND

5 - Patient is NOT receiving Fasenra in combination with any of the following for treatment of the same indication:

- Anti-interleukin 5 therapy [e.g., Cinqair (reslizumab), Nucala (mepolizumab)]
- Anti-IgE (immunoglobulin E) therapy [e.g., Xolair (omalizumab)]
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

6 - Prescribed by ONE of the following:

- Allergist
- Immunologist
- Pulmonologist

Product Name:Fasenra Pen	
Diagnosis	Severe Asthma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response as demonstrated by at least ONE of the following: • Reduction in the frequency of exacerbations • Decreased utilization of rescue medications • Increase in percent predicted FEV1 (forced expiratory volume in 1 second) from pretreatment baseline • Reduction in severity or frequency of asthma-related symptoms (e.g., wheezing, shortness of breath, coughing, etc.) • Reduction in oral corticosteroid requirements AND 2 - Used in combination with an inhaled corticosteroid (ICS)-containing maintenance medication [e.g., Advair/AirDuo (fluticasone/salmeterol), Breo Ellipta (fluticasone furoate/vilanterol), Symbicort (budesonide/ formoterol), Trelegy Ellipta (fluticasone furoate/umeclidinium/vilanterol)] AND 3 - Patient is NOT receiving Fasenra in combination with any of the following for treatment of the same indication: • Anti-interleukin 5 therapy [e.g., Cinqair (reslizumab), Nucala (mepolizumab)] • Anti-IgE (immunoglobulin E) therapy [e.g., Xolair (omalizumab)]	

- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

Product Name:Fasenra Pen	
Diagnosis	Eosinophilic granulomatosis with polyangiitis (EGPA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization - Transitioning from UHC medical benefits
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has been established on therapy with Fasenra under an active UnitedHealthcare medical benefit prior authorization for the treatment of Eosinophilic granulomatosis with polyangiitis (EGPA) AND 2 - Documentation of positive clinical response to Fasenra therapy as demonstrated by ONE of the following: • Reduction in the frequency and/or severity of relapses • Reduction or discontinuation of doses of corticosteroids and/or immunosuppressant • Disease remission • Reduction in severity or frequency of EGPA-related symptoms AND 3 - Patient is NOT receiving Fasenra in combination with any of the following for treatment of the same indication: • Anti-interleukin 5 therapy [e.g., Cinqair (reslizumab), Nucala (mepolizumab)] • Anti-IgE (immunoglobulin E) therapy [e.g., Xolair (omalizumab)] • Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)] • Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)] AND	

4 - Prescribed by ONE of the following:

- Pulmonologist
- Rheumatologist
- Allergist
- Immunologist

Product Name:Fasenra Pen	
Diagnosis	Eosinophilic granulomatosis with polyangiitis (EGPA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization – Not transitioning from UHC medical benefits
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of relapsing or refractory Eosinophilic granulomatosis with polyangiitis (EGPA) AND 2 - Past medical history or presence of asthma AND 3 - TWO of the following: • Histopathological evidence of eosinophilic vasculitis • Histopathological evidence of perivascular eosinophilic infiltration • Histopathological evidence of eosinophil-rich granulomatous inflammation • Neuropathy, mono or poly (motor deficit or nerve conduction abnormality) • Pulmonary infiltrates, non-fixed • Sino-nasal abnormality • Cardiomyopathy (established by echocardiography or MRI) • Glomerulonephritis (hematuria, red cell casts, proteinuria) • Alveolar hemorrhage • Palpable purpura • Anti-neutrophil cytoplasmic antibody (ANCA) positive	

AND

4 - History of relapsing or refractory disease defined as one of the following:

- Relapsing disease as defined as a past history (within the past 2 years) of at least one EGPA relapse (requiring additional or dose escalation of corticosteroids or immunosuppressant, or hospitalization)
- Refractory disease as defined as failure to attain remission within the prior 6 months following induction treatment with standard therapy regimens

AND

5 - Patient is currently taking standard therapy [i.e., systemic glucocorticoids (e.g., prednisone, methylprednisolone) with or without immunosuppressive therapy (e.g., cyclophosphamide, rituximab)]

AND

6 - Patient is NOT receiving Fasenra in combination with any of the following for treatment of the same indication:

- Anti-interleukin 5 therapy [e.g., Cinqair (reslizumab), Nucala (mepolizumab)]
- Anti-IgE (immunoglobulin E) therapy [e.g., Xolair (omalizumab)]
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

7 - Prescribed by ONE of the following:

- Pulmonologist
- Rheumatologist
- Allergist
- Immunologist

Product Name:Fasenra Pen

Diagnosis

Eosinophilic granulomatosis with polyangiitis (EGPA)

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response as demonstrated by at least ONE of the following: • Reduction in the frequency and/or severity of relapses • Reduction or discontinuation of doses of corticosteroids and/or immunosuppressant • Disease remission • Reduction in severity or frequency of EGPA-related symptoms AND 2 - Patient is NOT receiving Fasenra in combination with any of the following for treatment of the same indication: • Anti-interleukin 5 therapy [e.g., Cinqair (reslizumab), Nucala (mepolizumab)] • Anti-IgE (immunoglobulin E) therapy [e.g., Xolair (omalizumab)] • Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)] • Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]	

2 . Revision History

Date	Notes
8/28/2025	Updated formularies. Added new indication and criteria for EGPA. Updated statement for concomitant use.

Fentanyl IR



Prior Authorization Guideline

Guideline ID	GL-450262
Guideline Name	Fentanyl IR
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

Guideline Note:

Effective Date:	12/1/2025

1 . Criteria

Product Name:Fentanyl citrate lozenges	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records demonstrating use is for the management of breakthrough pain associated with a cancer diagnosis (cancer diagnosis must be documented)

AND

2 - Patient must have at least a one week history of ONE of the following medications to demonstrate tolerance to opioids (Document drug and date of trial):

- Oral morphine sulfate at a dose of greater than or equal to 60 mg/day
- Fentanyl transdermal patch at a dose of greater than or equal to 25 mcg/hr
- Oral oxycodone at a dose of greater than or equal to 30 mg/day
- Oral hydromorphone at a dose of greater than or equal to 8 mg/day
- Oral oxymorphone at a dose of greater than or equal to 25 mg/day
- Oral hydrocodone at a dose of greater than or equal to 60 mg/day
- An alternative opioid at an equianalgesic dose (e.g., oral methadone greater than or equal to 20 mg/day)

AND

3 - The patient is currently taking a long-acting opioid around the clock for cancer pain (Document drug)

AND

4 - ONE of the following:

4.1 The patient is not concurrently receiving an alternative fentanyl transmucosal product

OR

4.2 BOTH of the following:

4.2.1 The patient is currently receiving an alternative transmucosal fentanyl product

AND

4.2.2 The prescriber is requesting the termination of all current authorizations for alternative transmucosal fentanyl products in order to begin treatment with the requested medication (Only one transmucosal fentanyl product will be approved at a time. If previous authorizations cannot be terminated, the PA request will be denied)

Product Name: Brand Fentora, fentanyl citrate buccal tablet (authorized generic of Fentora)	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records demonstrating use is for the management of breakthrough pain associated with a cancer diagnosis (cancer diagnosis must be documented) AND 2 - Patient must have at least a one week history of ONE of the following medications to demonstrate tolerance to opioids (Document drug and date of trial): • Oral morphine sulfate at a dose of greater than or equal to 60 mg/day • Fentanyl transdermal patch at a dose of greater than or equal to 25 mcg/hr • Oral oxycodone at a dose of greater than or equal to 30 mg/day • Oral hydromorphone at a dose of greater than or equal to 8 mg/day • Oral oxymorphone at a dose of greater than or equal to 25 mg/day • Oral hydrocodone at a dose of greater than or equal to 60 mg/day • An alternative opioid at an equianalgesic dose (e.g., oral methadone greater than or equal to 20 mg/day) AND 3 - The patient is currently taking a long-acting opioid around the clock for cancer pain (Document drug)	

AND

4 - ONE of the following:

4.1 The patient is not concurrently receiving an alternative fentanyl transmucosal product

OR

4.2 BOTH of the following:

4.2.1 The patient is currently receiving an alternative fentanyl transmucosal product

AND

4.2.2 The prescriber is requesting the termination of all current authorizations for alternative transmucosal fentanyl products in order to begin treatment with the requested medication (Only one transmucosal fentanyl product will be approved at a time. If previous authorizations cannot be terminated, the PA request will be denied)

AND

5 - One of the following:

- Failure to fentanyl citrate lozenges confirmed by claims history or submission of medical records
- History of intolerance or contraindication to fentanyl citrate lozenges (document intolerance or contraindication)

2 . Revision History

Date	Notes
11/17/2025	Removed brand Actiq.

Filspari



Prior Authorization Guideline

Guideline ID	GL-563288
Guideline Name	Filspari
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 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:Filspari	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of primary immunoglobulin A nephropathy (IgAN) confirmed by renal biopsy AND 2 - Patient is at risk of disease progression AND 3 - Used to slow kidney function decline AND 4 - Used to reduce proteinuria AND 5 - Estimated glomerular filtration rate (eGFR) greater than or equal to 30 mL/min/1.73 m² AND 6 - BOTH of the following: 6.1 Patient is on a maximized stable dose with ONE of the following prior to initiating therapy confirmed by claims history or submitted medical records: Maximally tolerated angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril)	

- Maximally tolerated angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan)

AND

6.2 Use of renin-angiotensin-aldosterone system (RAAS) inhibitors (e.g., ACE inhibitors, ARBs), endothelin receptor antagonists [(ERAs) e.g., Letairis, Opsumit, Tracleer)], and Tekturna will be discontinued prior to initiating treatment

AND

7 - ONE of the following:

- Failure to a 30-day trial of a glucocorticoid (e.g., budesonide, methylprednisolone, prednisone) confirmed by claims history or submitted medical records
- History of contraindication or intolerance to a 30-day trial of a glucocorticoid (e.g., budesonide, methylprednisolone, prednisone) (please specify intolerance or contraindication)

AND

8 - Prescribed by or in consultation with a nephrologist

Product Name:Filspari	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response demonstrated by a reduction in proteinuria	

2 . Revision History

UnitedHealthcare Community Plan of Rhode Island Clinical Pharmacy Program Guidelines

Date	Notes
4/7/2026	Added budesonide as a corticosteroid example. Removed step through SGLT2

Filsuvez



Prior Authorization Guideline

Guideline ID	GL-531199
Guideline Name	Filsuvez
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

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Filsuvez	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is at least 6 months of age or older AND 2 - One of the following diagnoses: • Dystrophic epidermolysis bullosa (DEB) • Junctional epidermolysis bullosa (JEB) AND 3 - Submission of medical records (e.g., chart notes, laboratory values) confirming a genetic mutation associated with DEB or JEB (i.e., COL7A1, LAMA3, LAMB3, LAMC2, COL17A1, ITGA6, ITGB4, ITGA3) AND 4 - Patient has at least one partial thickness wound that meets ALL of the following criteria: • 10-50 cm² in size • Present for at least 3 weeks • Adequate granulation tissue • Excellent vascularization • No evidence of active wound infection • No evidence or history of basal or squamous cell carcinomas (SCC) AND 5 - Prescribed by, or in consultation with, a dermatologist with expertise in the treatment of epidermolysis bullosa (EB)	

AND

6 - Patient is NOT receiving Filsuvez in combination with Vyjuvek on the same wound(s)

Product Name:Filsuvez

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Filsuvez therapy (e.g., complete wound closure, reduction in wound size, decrease in procedural pain, less frequent dressing changes, decreased total body wound burden)

AND

2 - Wound(s) being treated meets ALL of the following criteria:

- Adequate granulation tissue
- Excellent vascularization
- No evidence of active wound infection
- No evidence or history of basal or squamous cell carcinomas (SCC)

AND

3 - Filsuvez is prescribed by, or in consultation with, a dermatologist with expertise in the treatment of epidermolysis bullosa (EB)

AND

4 - Patient is not receiving Filsuvez in combination with Vyjuvek on the same wound(s)

2 . Revision History

Date	Notes
2/25/2026	Removed IN formulary - see state Epidermolysis Bullosa Agents GL-531198 for 4/1/26. No other changes to guideline.

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.

Fortamet, Glumetza



Prior Authorization Guideline

Guideline ID	GL-267202
Guideline Name	Fortamet, Glumetza
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

Guideline Note:

Effective Date:	7/1/2025

1 . Criteria

Product Name:generic metformin extended-release (generic Fortamet)	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - History of greater than or equal to 12-week trial of metformin extended-release (generic Glucophage XR) as confirmed by claims history or submission of medical records

AND

2 - One of the following:

2.1 Submission of medical records (e.g. chart notes, laboratory values) documenting an inadequate response to metformin extended-release (generic Glucophage XR) as evidenced by the hemoglobin A1c level being above the patient's goal

OR

2.2 Submission of medical records (e.g. chart notes, laboratory values) documenting an intolerance to metformin extended-release (generic Glucophage XR) which is unable to be resolved with attempts to minimize the adverse effects where appropriate (e.g. dose reduction)

Product Name:Brand Glumetza, generic metformin extended-release (generic Glumetza)

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - History of greater than or equal to 12 week trial of metformin extended-release (generic Glucophage XR) as confirmed by claims history or submission of medical records

AND

2 - One of the following:

2.1 Submission of medical records (e.g. chart notes, laboratory values) documenting an

inadequate response to metformin extended-release (generic Glucophage XR) as evidenced by the hemoglobin A1c level being above the patient's goal

OR

2.2 Submission of medical records (e.g. chart notes, laboratory values) documenting an intolerance to metformin extended-release (generic Glucophage XR) which is unable to be resolved with attempts to minimize the adverse effects where appropriate (e.g. dose reduction)

AND

3 - History of greater than or equal to 12 week trial of metformin extended-release (generic Fortamet) as confirmed by claims history or submission of medical records

AND

4 - One of the following:

4.1 Submission of medical records (e.g. chart notes, laboratory values) documenting an inadequate response to metformin extended-release (generic Fortamet) as evidenced by the hemoglobin A1c level being above the patient's goal

OR

4.2 Submission of medical records (e.g. chart notes, laboratory values) documenting an intolerance to metformin extended-release (generic Fortamet) which is unable to be resolved with attempts to minimize the adverse effects where appropriate (e.g. dose reduction)

AND

5 - Submission of article(s) published in the peer-reviewed medical literature showing that the requested drug is likely to be more efficacious to this patient than metformin extended-release (generic Glucophage XR AND generic Fortamet)

2 . Revision History

UnitedHealthcare Community Plan of Rhode Island Clinical Pharmacy Program Guidelines

Date	Notes
5/15/2025	Updated formularies

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 TFAZZIN 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.

Fotivda



Prior Authorization Guideline

Guideline ID	GL-317191
Guideline Name	Fotivda
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State New Jersey Medicaid - Community & State New York Medicaid - Community & State New York EPP Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Arizona Medicaid - Community & State New Mexico Medicaid - Community & State Virginia Medicaid - Community & State Washington

Guideline Note:

Effective Date:	8/1/2025

1 . Criteria

Product Name:Fotivda

Diagnosis	Renal Cell Carcinoma (RCC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of advanced renal cell carcinoma (RCC) AND 2 - ONE of the following: • Disease has relapsed • Disease is refractory AND 3 - Patient has received two or more prior systemic therapies	

Product Name:Fotivda	
Diagnosis	Renal Cell Carcinoma (RCC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient does not show evidence of progressive disease while on Fotivda therapy	

Product Name:Fotivda	
Diagnosis	NCCN Recommended Regimens

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

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

2 . Revision History

Date	Notes
7/2/2025	Combined formularies. Added RCC abbreviation in dx header section s. No changes to clinical criteria.

Fotivda



Prior Authorization Guideline

Guideline ID	GL-317191
Guideline Name	Fotivda
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State New Jersey Medicaid - Community & State New York Medicaid - Community & State New York EPP Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Arizona Medicaid - Community & State New Mexico Medicaid - Community & State Virginia Medicaid - Community & State Washington

Guideline Note:

Effective Date:	8/1/2025

1 . Criteria

Product Name:Fotivda

Diagnosis	Renal Cell Carcinoma (RCC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of advanced renal cell carcinoma (RCC) AND 2 - ONE of the following: • Disease has relapsed • Disease is refractory AND 3 - Patient has received two or more prior systemic therapies	

Product Name:Fotivda	
Diagnosis	Renal Cell Carcinoma (RCC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient does not show evidence of progressive disease while on Fotivda therapy	

Product Name:Fotivda	
Diagnosis	NCCN Recommended Regimens

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

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

2 . Revision History

Date	Notes
7/2/2025	Combined formularies. Added RCC abbreviation in dx header section s. No changes to clinical criteria.

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-435261
Guideline Name	Galafold
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 Nebraska Medicaid - Community & State New Mexico Medicaid - Community & State Pennsylvania

Guideline Note:

Effective Date:	1/1/2026

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
11/4/2025	Combined formularies - added NV, VA, NE, NM, PA CAID. No clinical changes.

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 and Dual GIP, GLP-1 Receptor Agonists



Prior Authorization Guideline

Guideline ID	GL-404242
Guideline Name	GLP-1 and Dual GIP, GLP-1 Receptor Agonists
Formulary	Medicaid - Community & State Rhode Island

Guideline Note:

Effective Date:	11/1/2025

1 . Criteria

Product Name: Brand Victoza 1.2mg per day (2 Pen Pack), generic liraglutide 1.2mg per day (2 Pen Pack), Mounjaro, Ozempic, Rybelsus	
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., chart notes) confirming diagnosis of type 2 diabetes mellitus as evidenced by ONE of the following laboratory values:

- A1C greater than or equal to 6.5%
- Fasting plasma glucose (FPG) greater than or equal to 126 milligrams per deciliter (mg/dL)
- 2-hour plasma glucose (PG) greater than or equal to 200 mg/dL during oral glucose tolerance test
- Random plasma glucose greater than or equal to 200 mg/dL in patient with classic symptoms of hyperglycemia or hyperglycemic crisis

OR

1.2 For patients requiring ongoing treatment for type 2 diabetes mellitus (i.e., diagnosed greater than 2 years ago), submission of medical records (e.g., chart notes) confirming diagnosis of type 2 diabetes mellitus

AND

2 - ONE of the following:

2.1 Suboptimal response (i.e., suboptimal glycemic control) to one product, or a combination thereof, from ONE of the following drugs/classes for 90 days in the past 365 days, as confirmed by claims history or submission of medical records

- Metformin
- Metformin combinations
- DPP-4 inhibitors
- DPP-4 inhibitor combinations
- SGLT2 inhibitors
- SGLT2 inhibitor combinations
- Sulfonylureas

OR

2.2 History of contraindication or intolerance to ONE product from any of the following drugs/classes: (please specify contraindication or intolerance)

- Metformin
- Metformin combinations
- DPP-4 inhibitors
- DPP-4 inhibitor combinations

- SGLT2 inhibitors
- SGLT2 inhibitor combinations
- Sulfonylureas

Product Name: Brand Victoza 1.2mg per day (2 Pen Pack), generic liraglutide 1.2mg per day (2 Pen Pack), Mounjaro, Ozempic, Rybelsus

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

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g., improved A1C)

Product Name: Brand Victoza 1.8mg per day (3 Pen Pack), generic liraglutide 1.8mg per day (3 Pen Pack)

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., chart notes) confirming diagnosis of type 2 diabetes mellitus as evidenced by ONE of the following laboratory values:

- A1C greater than or equal to 6.5%
- Fasting plasma glucose (FPG) greater than or equal to 126 milligrams per deciliter (mg/dL)
- 2-hour plasma glucose (PG) greater than or equal to 200 mg/dL during oral glucose tolerance test
- Random plasma glucose greater than or equal to 200 mg/dL in patient with classic symptoms of hyperglycemia or hyperglycemic crisis

OR

1.2 For patients requiring ongoing treatment for type 2 diabetes mellitus (i.e., diagnosed greater than 2 years ago), submission of medical records (e.g., chart notes) confirming diagnosis of type 2 diabetes mellitus

AND

2 - ONE of the following:

- Suboptimal response to metformin (i.e., suboptimal glycemic control) at a minimum dose of 1500mg daily for 90 days, as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to metformin (please specify contraindication or intolerance)

AND

3 - History of failure to achieve acceptable glycemic control with Victoza (brand or generic) 1.2mg per day for 90 days (2 Pen Pack), as confirmed by claims history or submission of medical records

Product Name:Brand Victoza 1.8mg per day (3 Pen Pack), generic liraglutide 1.8mg per day (3 Pen Pack)

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g., improved A1C)

Product Name:Bydureon BCise, Byetta, Exenatide, Trulicity

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., chart notes) confirming diagnosis of type 2 diabetes mellitus as evidenced by ONE of the following laboratory values: • A1C greater than or equal to 6.5% • Fasting plasma glucose (FPG) greater than or equal to 126 milligrams per deciliter (mg/dL) • 2-hour plasma glucose (PG) greater than or equal to 200 mg/dL during oral glucose tolerance test • Random plasma glucose greater than or equal to 200 mg/dL in patient with classic symptoms of hyperglycemia or hyperglycemic crisis OR 1.2 For patients requiring ongoing treatment for type 2 diabetes mellitus (i.e., diagnosed greater than 2 years ago), submission of medical records (e.g., chart notes) confirming diagnosis of type 2 diabetes mellitus AND 2 - ONE of the following: • Suboptimal response to metformin (i.e., suboptimal glycemic control) at a minimum dose of 1500mg daily for 90 days, as confirmed by claims history or submission of medical records • History of contraindication or intolerance to metformin (please specify contraindication or intolerance) AND 3 - ONE of the following: 3.1 Suboptimal response (i.e., suboptimal glycemic control) to BOTH of the following, each for a minimum of 90 days, as confirmed by claims history or submission of medical records:	

- A commercially available semaglutide product indicated for type 2 diabetes mellitus (e.g., Ozempic, Rybelsus)
- Mounjaro

OR

3.2 History of contraindication or intolerance to BOTH of the following (please specify contraindication or intolerance)

- A commercially available semaglutide product indicated for type 2 diabetes mellitus (e.g., Ozempic, Rybelsus)
- Mounjaro

Product Name:Bydureon BCise, Byetta, Exenatide, Trulicity	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy (e.g., improved A1C)	

2 . Revision History

Date	Notes
10/1/2025	Updated criteria to include brand or generic Victoza. Updated GPls.

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-518205
Guideline Name	Gonadotropin-Releasing Hormone Agonists
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 Nebraska Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	3/1/2026

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
Guideline Type	Prior Authorization

Approval Criteria

1 - For a diagnosis of advanced or metastatic prostate cancer, the requested medication is not delegated to OptumRx for review and should be processed as a medical benefit

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., Cytoxan (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., Cytoxan (cyclophosphamide), procarbazine, vinblastine, cisplatin]

Product Name:leuprolide acetate inj kit 5 mg/mL

Diagnosis	Salivary Gland Tumors
Guideline Type	Prior Authorization

Approval Criteria

1 - For a diagnosis of salivary gland tumors, the requested medication is not delegated to OptumRx for review and should be processed as a medical benefit

Product Name:leuprolide acetate inj kit 5 mg/mL

Diagnosis	Uterine Sarcoma
Guideline Type	Prior Authorization

Approval Criteria

1 - For a diagnosis of uterine sarcoma, the requested medication is not delegated to OptumRx for review and should be processed as a medical benefit

Product Name:Lupron Depot, Lupron Depot-Ped, leuprolide acetate inj kit 5 mg/mL

Diagnosis	NCCN Recommended Regimens

Guideline Type	Prior Authorization

Approval Criteria

1 - For uses supported by the National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium, the requested medication is not delegated to OptumRx for review and should be processed as a medical benefit

2 . Revision History

Date	Notes
2/10/2026	Added CO, NE, NM formularies (manually end dated all previous guidelines). 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.

Growth Hormone, Growth Stimulating Agents



Prior Authorization Guideline

Guideline ID	GL-565261
Guideline Name	Growth Hormone, Growth Stimulating 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 Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ NuSpin, Omnitrope, Saizen, Zomacton, Zorbtive, Serostim	
Diagnosis	Congenital Growth Hormone Deficiency (GHD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Infant is less than 12 months of age AND 2 - Submission of medical records documenting evidence of growth failure confirmed by all of the following: • Growth charts for length/height and weight for age and gender with evidence of growth velocity deceleration over time • Documentation of length/height and weight for age and gender including percentile and/or standard deviation scores • Calculated growth velocity AND 3 - Submission of medical records documenting one of the following: 3.1 Both of the following: • Hypothalamic-pituitary defect (e.g., ectopic posterior pituitary, empty sella, hypoplastic pituitary, major congenital malformation, optic nerve hypoplasia, tumor or irradiation) • Deficiency of at least one additional pituitary hormone OR 3.2 All of the following: • Neonatal hypoglycemia and/or micropenis • Serum GH (growth hormone) concentration less than or equal to 5 micrograms per liter in the first 28 days of life • Deficiency of at least one additional pituitary hormone • Classical imaging triad (i.e., ectopic posterior pituitary and pituitary hypoplasia with abnormal stalk)	

AND

4 - Submission of medical records documenting one of the following is below the age and gender adjusted normal range as provided by the physician's lab:

- Insulin-like Growth Factor 1 (IGF-1/Somatomedin-C)
- Insulin Growth Factor Binding Protein-3 (IGFBP-3)

AND

5 - Prescribed by an endocrinologist

AND

6 - Request does not exceed a maximum supply limit of 0.3 mg/kg/week (milligrams per kilogram per week)

AND

7 - If the request is for a non-preferred medication, there must be a reason or special circumstance that the patient must be treated with a non-preferred medication* (document reason or special circumstance)

Notes	*See Table 1 in Background section

Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ NuSpin, Omnitrope, Saizen, Zomacton, Zorbtive, Serostim	
Diagnosis	Congenital Growth Hormone Deficiency (GHD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Submission of medical records documenting a height increase of at least 2 centimeters per year over the previous year confirmed by all of the following:

- Previous length/height and date obtained
- Current length/height and date obtained
- Calculated growth velocity
- Growth chart for length/height for age and gender

AND

2 - Submission of medical records documenting both of the following:

- Expected adult height not attained
- Documentation of expected adult height goal (e.g. genetic potential)

AND

3 - Prescribed by an endocrinologist

AND

4 - Request does not exceed a maximum supply limit of 0.3mg/kg/week (milligrams per kilogram per week)

Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ NuSpin, Omnitrope, Saizen, Zomacton, Zorbtive, Serostim, Ngenla, Skytrofa, Sogroya	
Diagnosis	Pediatric Growth Hormone Deficiency (GHD)*
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records documenting a diagnosis of pediatric GH (growth hormone) deficiency	

AND

2 - Submission of medical records documenting evidence of growth failure confirmed by all of the following:

- Growth charts for length/height and weight for age and gender with evidence of growth velocity deceleration over time
- Documentation of length/height and weight for age and gender including percentile and/or standard deviation scores
- Calculated growth velocity

AND

3 - Submission of medical records documenting open epiphyses in the last 12 months

AND

4 - Submission of medical records documenting Tanner stage less than or equal to 4

AND

5 - Submission of medical records documenting both of the following:

5.1 Patient has undergone two of the following provocative GH stimulation tests:

- Arginine
- Clonidine
- Glucagon
- Insulin
- Levodopa

AND

5.2 Peak GH responses to each agent is less than 10 mcg/L (micrograms per liter)

AND

6 - If patient has a history of malignancy, one of the following:

- Patient is in remission
- Patient has been stable for at least 12 months

AND

7 - Prescribed by an endocrinologist

AND

8 - One of the following:

8.1 If the request is for Ngenla, request does not exceed a maximum supply limit of 0.66 mg/kg/week (milligrams per kilogram per week)

OR

8.2 If the request is for any other product, one of the following:

8.2.1 Request does not exceed a maximum supply limit of 0.3 mg/kg/week

OR

8.2.2 All of the following:

8.2.2.1 One of the following:

- Poor catch-up growth while on standard dosing
- IGF-1 (Insulin-like Growth Factor 1) less than 2 standard deviations from the mean while on standard dosing

AND

8.2.2.2 Tanner Stage 2 or greater

AND

8.2.2.3 Request does not exceed a maximum supply limit of 0.7 mg/kg/week

AND

9 - One of the following:

9.1 If the request is for a non-preferred somatropin medication, there must be a reason or special circumstance that the patient must be treated with a non-preferred medication** (document reason or special circumstance)

OR

9.2 If the request is for Sogroya, one of the following:

9.2.1 Failure to one of the following, confirmed by claims history or submission of medical records:

- Somatropin (Norditropin)
- Somatropin (Omnitrope)

OR

9.2.2 History of intolerance or contraindication to both of the following (please specify intolerance or contraindication):

- Somatropin (Norditropin)
- Somatropin (Omnitrope)

OR

9.3 If the request is for Ngenla or Skytrofa, one of the following:

9.3.1 Failure to both of the following, confirmed by claims history or submission of medical records:

- Somatropin (Norditropin or Omnitrope)

- Sogroya (somapacitan) OR 9.3.2 History of intolerance or contraindication to both of the following (please specify intolerance or contraindication): - Somatropin (Norditropin or Omnitrope) - Sogroya (somapacitan)	
Notes	*If patient is a Transition Phase Adolescent or Adult who had childhood onset GH deficiency, utilize criteria for Transition Phase Adolescent or Adult GH Deficiency. **See Table 1 in Background section

Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ NuSpin, Omnitrope, Saizen, Zomacton, Zorbtive, Serostim, Ngenla, Skytrofa, Sogroya	
Diagnosis	Pediatric Growth Hormone Deficiency (GHD)*
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records documenting a height increase of at least 2 centimeters per year over the previous year confirmed by all of the following: - Previous length/height and date obtained - Current length/height and date obtained - Calculated growth velocity - Growth chart for length/height for age and gender AND 2 - Submission of medical records documenting both of the following: - Expected adult height not attained	

- Documentation of expected adult height goal (e.g. genetic potential)

AND

3 - Prescribed by an endocrinologist

AND

4 - ONE of the following:

4.1 If the request is for Ngenla, request does not exceed a maximum supply limit of 0.66 mg/kg/week (milligrams per kilogram per week)

OR

4.2 If the request is for any other product, one of the following:

4.2.1 Request does not exceed a maximum supply limit of 0.3 mg/kg/week

OR

4.2.2 All of the following:

4.2.2.1 One of the following:

- Poor catch-up growth while on standard dosing
- IGF-1 (Insulin-like Growth Factor 1) less than 2 standard deviations from the mean while on standard dosing

AND

4.2.2.2 Tanner Stage 2 or greater

AND

4.2.2.3 Request does not exceed a maximum supply limit of 0.7 mg/kg/week

Notes	*If patient is a Transition Phase Adolescent or Adult who had childhood onset GH deficiency, utilize criteria for Transition Phase Adolescent or Adult GH Deficiency.

Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ NuSpin, Omnitrope, Saizen, Zomacton, Zorbtive, Serostim	
Diagnosis	Transition Phase Adolescent Patients*
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records documenting one of the following: 1.1 Genetic mutation OR 1.2 Deficiency of three of the following anterior pituitary hormones: • ACTH (adrenocorticotrophic hormone) • TSH (thyroid stimulating hormone) • Prolactin • FSH/LH (follicle-stimulating hormone/luteinizing hormone) OR 1.3 Irreversible structural hypothalamic-pituitary disease OR 1.4 Panhypopituitarism AND	

2 - Submission of medical records documenting one of the following:

2.1 IGF-1 (Insulin-like Growth Factor 1) level is below the age and gender adjusted normal range as provided by the physician's lab

OR

2.2 Both of the following:

2.2.1 Patient has undergone one of the following GH (growth hormone) stimulation tests after discontinuation of therapy for at least 1 month:

- Insulin tolerance test (ITT)
- GH-releasing hormone-arginine test (GHRH and ARG)
- Glucagon stimulation test (GST)
- Macimorelin

AND

2.2.2 One of the following peak GH values:

- ITT less than or equal to 5.1 micrograms per liter
- GHRH and ARG less than or equal to 11 micrograms per liter
- Glucagon less than or equal to 3 micrograms per liter
- Macimorelin less than or equal to 2.8 ng/mL (nanograms per milliliter)

AND

3 - Prescribed by an endocrinologist

AND

4 - One of the following:

4.1 Request does not exceed a maximum supply limit of 0.3mg/kg/week (milligrams per kilogram per week)

OR

4.2 All of the following:

4.2.1 One of the following:

- Poor catch-up growth while on standard dosing
- IGF-1 less than 2 standard deviations from the mean while on standard dosing

AND

4.2.2 Tanner Stage 2 or greater

AND

4.2.3 Request does not exceed a maximum supply limit of 0.7 mg/kg/week

AND

5 - If the request is for a non-preferred medication, there must be a reason or special circumstance that the patient must be treated with a non-preferred medication** (document reason or special circumstance)

Notes	*Use this criteria for patients diagnosed with GHD in childhood during the transition period from puberty to adulthood (the period from mid to late teens until 6 to 7 years after achievement of adult height) **See Table 1 in Background section

Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ NuSpin, Omnitrope, Saizen, Zomacton, Zorbtive, Serostim	
Diagnosis	Transition Phase Adolescent Patients*
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records documenting a positive response to therapy (e.g., increase	

in total lean body mass, exercise capacity or IGF-1 [Insulin-like Growth Factor 1] and IGFBP-3 [Insulin-like growth factor binding protein 3] levels)

AND

2 - Prescribed by an endocrinologist

AND

3 - One of the following:

3.1 Request does not exceed a maximum supply limit of 0.3 mg/kg/week (milligrams per kilogram per week)

OR

3.2 All of the following:

3.2.1 One of the following:

- Poor catch-up growth while on standard dosing
- IGF-1 less than 2 standard deviations from the mean while on standard dosing

AND

3.2.2 Tanner Stage 2 or greater

AND

3.2.3 Request does not exceed a maximum supply limit of 0.7 mg/kg/week

Notes

*Use this criteria for patients diagnosed with GHD in childhood during the transition period from puberty to adulthood (the period from mid to late teens until 6 to 7 years after achievement of adult height)

Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ NuSpin, Omnitrope, Saizen, Zomacton, Zorbtive, Serostim, Skytrofa, Sogroya

Diagnosis	Adult Growth Hormone Deficiency
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records documenting a diagnosis of adult growth hormone deficiency (GHD) as a result of one of the following: • Known hypothalamic or pituitary disease • Panhypopituitarism • History of GHD in childhood AND 2 - Submission of medical records documenting one of the following: 2.1 IGF-1 (Insulin-like Growth Factor 1) level is below the age and gender adjusted normal range as provided by the physician's lab OR 2.2 All of the following: 2.2.1 Patient does not have a low IGF-1 AND 2.2.2 Patient has undergone one of the following GH (growth hormone) stimulation tests: • GH-releasing hormone-arginine test (GHRH and ARG) • Glucagon stimulation test (GST) • Macimorelin AND	

2.2.3 One of the following peak GH values:

- GHRH and ARG less than or equal to 11 micrograms per liter
- Glucagon less than or equal to 3 ng/mL (nanograms per milliliter)
- Macimorelin less than or equal to 2.8 ng/mL

AND

3 - ONE of the following:

3.1 Diagnosis of panhypopituitarism

OR

3.2 Other diagnosis and not used in combination with the following:

- Aromatase inhibitors [e.g., Arimidex (anastrozole), Femara (letrozole)]
- Androgens [e.g., Delatestyl (testosterone enanthate), Depo-Testosterone (testosterone cypionate)]

AND

4 - Prescribed by an endocrinologist

AND

5 - One of the following:

5.1 If the request is for a non-preferred somatropin medication, there must be a reason or special circumstance that the patient must be treated with a non-preferred medication* (document reason or special circumstance)

OR

5.2 If the request is for Sogroya, one of the following:

5.2.1 Failure to one of the following, confirmed by claims history or submission of medical records:

- Somatropin (Norditropin)
- Somatropin (Omnitrope)

OR

5.2.2 History of intolerance or contraindication to both of the following (please specify intolerance or contraindication):

- Somatropin (Norditropin)
- Somatropin (Omnitrope)

OR

5.3 If the request is for Skytrofa, one of the following:

5.3.1 Failure to both of the following, confirmed by claims history or submission of medical records:

- Somatropin (Norditropin or Omnitrope)
- Sogroya (somapacitan)

OR

5.3.2 History of intolerance or contraindication to both of the following (please specify intolerance or contraindication):

- Somatropin (Norditropin or Omnitrope)
- Sogroya (somapacitan)

Notes	*See Table 1 in Background section

Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ NuSpin, Omnitrope, Saizen, Zomacton, Zorbtive, Serostim, Skytrofa, Sogroya	
Diagnosis	Adult Growth Hormone Deficiency
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records documenting an IGF-1 (Insulin-like Growth Factor 1) level within the past 12 months

AND

2 - ONE of the following:

2.1 Diagnosis of panhypopituitarism

OR

2.2 Other diagnosis and not used in combination with the following:

- Aromatase inhibitors [e.g., Arimidex (anastrozole), Femara (letrozole)]
- Androgens [e.g., Delatestryl (testosterone enanthate), Depo-Testosterone (testosterone cypionate)]

AND

3 - Prescribed by an endocrinologist

Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ NuSpin, Omnitrope, Saizen, Zomacton, Zorbtive, Serostim

Diagnosis	Prader-Willi Syndrome
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records documenting both of the following:

1.1 Diagnosis of Prader-Willi Syndrome

AND

1.2 Diagnosis confirmed by genetic testing

AND

2 - One of the following:

2.1 Both of the following:

2.1.1 Patient is less than 18 years of age

AND

2.1.2 Submission of medical records documenting evidence of growth failure confirmed by all of the following:

- Growth charts for length/height and weight for age and gender with evidence of growth velocity deceleration over time
- Documentation of length/height and weight for age and gender including percentile and/or standard deviation scores
- Calculated growth velocity

OR

2.2 Patient is greater than or equal to 18 years of age

AND

3 - Patient does NOT have any one of the following:

- Active malignancy
- Severe obesity (weight greater than 225 percent of ideal body weight)
- Severe respiratory impairment

AND

4 - Prescribed by ONE of the following:

- Endocrinologist
- Geneticist
- Specialist with knowledge in the treatment of Prader-Willi syndrome

AND

5 - If the request is for a non-preferred medication, there must be a reason or special circumstance that the patient must be treated with a non-preferred medication* (document reason or special circumstance)

Notes

*See Table 1 in Background section

Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ NuSpin, Omnitrope, Saizen, Zomacton, Zorbtive, Serostim

Diagnosis

Prader-Willi Syndrome

Approval Length

12 month(s)

Therapy Stage

Reauthorization

Guideline Type

Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 All of the following:

1.1.1 Patient is less than 18 years of age

AND

1.1.2 Submission of medical records documenting a height increase of at least 2 centimeters per year over the previous year of treatment as confirmed by all of the following:

- Previous length/height and date obtained

- Current length/height and date obtained
- Calculated growth velocity
- Growth charts for length/height for age and gender

AND

1.1.3 Submission of medical records documenting both of the following:

- Expected adult height not attained
- Documentation of expected adult height goal

OR

1.2 Both of the following:

1.2.1 Patient is greater than or equal to 18 years of age

AND

1.2.2 Submission of medical records documenting a positive response to therapy (e.g., reduction in fat mass, increase in lean body mass, improved strength and exercise tolerance)

AND

2 - Prescribed by ONE of the following:

- Endocrinologist
- Geneticist
- Specialist with knowledge in the treatment of Prader-Willi syndrome

Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ NuSpin, Omnitrope, Saizen, Zomacton, Zorbtive, Serostim	
Diagnosis	Growth Failure in Children Small for Gestational Age (SGA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records documenting diagnosis of growth failure associated with SGA (small for gestational age)

AND

2 - Submission of medical records documenting diagnosis has been confirmed by all of the following:

2.1 Growth charts for length/height and weight for gestational age and gender at birth

AND

2.2 Documentation that birth length/height and/or weight greater than or equal to 2 SD (standard deviations) below mean for gestational age

AND

2.3 Infant growth charts for length/height and weight for age and gender between birth and 24 to 36 months of age do not show evidence of catch-up growth in length/height and/or weight (i.e., length/height or weight remained greater than or equal 2 SD below mean for age and gender from birth to age 2 to 3)

AND

2.4 Documentation that current length/height and/or weight remains greater than or equal to 2 SD below mean for age and gender

AND

2.5 Calculated growth velocity

AND

3 - Prescribed by an endocrinologist

AND

4 - If the request is for a non-preferred medication, there must be a reason or special circumstance that the patient must be treated with a non-preferred medication* (document reason or special circumstance)

Notes

*See Table 1 in Background section

Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ NuSpin, Omnitrope, Saizen, Zomacton, Zorbtive, Serostim

Diagnosis	Growth Failure in Children Small for Gestational Age (SGA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records documenting a height increase of at least 2 centimeters per year over the previous year confirmed by all of the following:

- Previous length/height and date obtained
- Current length/height and date obtained
- Calculated growth velocity
- Growth chart for length/height for age and gender

AND

2 - Submission of medical records documenting both of the following:

- Expected adult height not attained
- Expected adult height goal

AND

3 - Prescribed by an endocrinologist

Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ NuSpin, Omnitrope, Saizen, Zomacton, Zorbtive, Serostim

Diagnosis	Turner Syndrome or Noonan Syndrome

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records documenting one of the following:

1.1 BOTH of the following:

1.1.1 Diagnosis of Turner Syndrome

AND

1.1.2 Diagnosis confirmed by genetic testing

OR

1.2 BOTH of the following:

1.2.1 Diagnosis of Noonan Syndrome

AND

1.2.2 Diagnosis confirmed by the presence of clinical features consistent with Noonan Syndrome (e.g., distinct facial features such as high forehead, hypertelorism, down slanting palpebral fissures with high arched eyebrows, epicanthic folds, full upper lip with a depressed nasal bridge, low set ears, blue irises, ptosis and neck webbing, pulmonary valve stenosis, hypertrophic cardiomyopathy, pectus carinatum/excavatum, mild developmental delay, cryptorchidism, lymphatic dysplasia)

AND

2 - Submission of medical records documenting all of the following:

- Growth charts for length/height and weight for age and gender with evidence of growth velocity deceleration over time
- Documentation of length/height and weight for age and gender including percentile and/or standard deviation score
- Calculated growth velocity

AND

3 - Submission of medical records documenting open epiphyses in the last 12 months

AND

4 - Submission of medical records documenting Tanner staging less than or equal to 4

AND

5 - Prescribed by an endocrinologist

AND

6 - If the request is for a non-preferred medication, there must be a reason or special circumstance that the patient must be treated with a non-preferred medication* (document reason or special circumstance)

Notes	*See Table 1 in Background section

Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ NuSpin, Omnitrope, Saizen, Zomacton, Zorbtive, Serostim	
Diagnosis	Turner Syndrome or Noonan Syndrome
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records documenting a height increase of at least 2 centimeters per year over the previous year confirmed by all of the following: • Previous length/height and date obtained • Current length/height and date obtained • Calculated growth velocity • Growth chart for height for age and gender AND 2 - Submission of medical records documenting both of the following: • Expected adult height not attained • Expected adult height goal AND 3 - Prescribed by an endocrinologist	

Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ NuSpin, Omnitrope, Saizen, Zomacton, Zorbtive, Serostim	
Diagnosis	Short-Stature Homeobox (SHOX) Gene Deficiency
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records documenting both of the following: 1.1 Diagnosis of short-stature homeobox (SHOX) gene deficiency	

AND

1.2 Diagnosis confirmed by genetic testing

AND

2 - Submission of medical records documenting all of the following:

- Growth charts for length/height and weight for age and gender with evidence of growth velocity deceleration over time
- Documentation of length/height and weight for age and gender including percentile and/or standard deviation scores
- Calculated growth velocity

AND

3 - Submission of medical records documenting open epiphyses in the last 12 months

AND

4 - Submission of medical records documenting Tanner stage less than or equal to 4

AND

5 - Prescribed by an endocrinologist

AND

6 - If the request is for a non-preferred medication, there must be a reason or special circumstance that the patient must be treated with a non-preferred medication* (document reason or special circumstance)

Notes	*See Table 1 in Background section

Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ NuSpin, Omnitrope, Saizen, Zomacton, Zorbtive, Serostim	
Diagnosis	Short-Stature Homeobox (SHOX) Gene Deficiency
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records documenting a height increase of at least 2 centimeters per year over the previous year confirmed by all of the following: • Previous length/height and date obtained • Current length/height and date obtained • Calculated growth velocity • Growth chart for height for age and gender AND 2 - Submission of medical records documenting both of the following: • Expected adult height not attained • Expected adult height goal AND 3 - Prescribed by an endocrinologist	

Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ NuSpin, Omnitrope, Saizen, Zomacton, Zorbtive, Serostim	
Diagnosis	Growth Failure associated with Chronic Renal Insufficiency
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records documenting all of the following:

1.1 Diagnosis of chronic renal insufficiency

AND

1.2 Documentation of all of the following:

- Growth charts for length/height and weight for age and gender with evidence of growth velocity deceleration over time
- Documentation of length/height and weight for age and gender including percentile and/or standard deviation scores
- Calculated growth velocity

AND

1.3 Documentation of open epiphyses in the last 12 months

AND

1.4 Tanner stage less than or equal to 4

AND

2 - Patient has not yet had a renal transplant

AND

3 - Prescribed by ONE of the following:

- Endocrinologist
- Nephrologist

AND	
4 - If the request is for a non-preferred medication, there must be a reason or special circumstance that the patient must be treated with a non-preferred medication* (document reason or special circumstance)	
Notes	*See Table 1 in Background section

Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ NuSpin, Omnitrope, Saizen, Zomacton, Zorbtive, Serostim	
Diagnosis	Growth Failure associated with Chronic Renal Insufficiency
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records documenting a height increase of at least 2 centimeters per year over the previous year confirmed by all of the following: • Previous length/height and date obtained • Current length/height and date obtained • Calculated growth velocity • Growth chart for height for age and gender AND 2 - Submission of medical records documenting of both of the following: • Expected adult height not attained • Expected adult height goal AND 3 - Patient has not yet had a renal transplant	

AND

4 - Prescribed by ONE of the following:

- Endocrinologist
- Nephrologist

Product Name: Serostim

Diagnosis	Human Immunodeficiency Virus (HIV)-associated wasting syndrome or cachexia
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records documenting all of the following:

1.1 Diagnosis of HIV (human immunodeficiency virus)-associated wasting syndrome or cachexia

AND

1.2 Involuntary weight loss of greater than 10 percent

AND

1.3 One of the following:

1.3.1 Chronic diarrhea (2 loose stools daily for more than 30 days)

OR

1.3.2 Both of the following:

- Chronic weakness
- Fever

AND

1.4 Symptoms lasting greater than or equal to 30 days (intermittent or constant)

AND

1.5 Absence of a concurrent condition other than HIV infection that may cause these findings (e.g., depression, mycobacterium avium complex, chronic infectious diarrhea, or malignancy except for Kaposi's sarcoma limited to skin or mucous membranes)

AND

1.6 A nutritional evaluation has been completed since onset of wasting first occurred

AND

1.7 Patient's anti-retroviral therapy has been optimized to decrease the viral load

Product Name: Serostim	
Diagnosis	Human Immunodeficiency Virus (HIV)-associated wasting syndrome or cachexia
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records documenting both of the following:	

1.1 Documentation of a positive response to therapy (i.e., greater than or equal to 2 percent increase in body weight and/or body cell mass)

AND

1.2 One of the following targets or goals has not been achieved:

- Weight
- Body cell mass (BCM)
- Body mass index (BMI)

Product Name:Zorbtive	
Diagnosis	Short Bowel Syndrome
Approval Length	*4 weeks
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records documenting all of the following: 1.1 Diagnosis of Short Bowel Syndrome AND 1.2 Patient is currently receiving specialized nutritional support (e.g., intravenous parenteral nutrition, fluid, and micronutrient supplements) AND 1.3 Patient has not previously received 4 weeks of treatment with Zorbtive*	
Notes	*Treatment with Zorbtive will not be authorized beyond 4 weeks. Administration for more than 4 weeks has not been adequately studied.

Product Name:Increlex	
Diagnosis	Severe Primary IGF-1 Deficiency / Growth Hormone Gene Deletion
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records documenting all of the following: 1.1 Diagnosis of severe primary IGF-1 deficiency (PIGFD) AND 1.2 Documentation of height below -3.0 SD (standard deviation) mean for age and gender AND 1.3 Documentation of IGF-1 below -3.0 SD mean for age and gender AND 1.4 Documentation of both of the following: • Growth charts for length/height and weight for age and gender with evidence of growth velocity deceleration over time • Calculated growth velocity AND 1.5 One of the following: 1.5.1 Patient is unresponsive to a trial of growth hormone therapy	

OR

1.5.2 Documentation of one of the following:

- Very low or undetectable level of GHBP (growth hormone-binding protein)
- Very low or undetectable level of GHR (growth hormone receptor) mutations known to cause Laron syndrome/GH insensitivity syndrome
- GH1 gene deletion (GHD type 1A)
- GH-neutralizing antibodies
- STT5b gene mutation
- IGF-1 gene deletion or mutation

AND

2 - Other causes of low IGF-I levels have been ruled out (e.g., growth hormone deficiency, undernutrition, hepatic disease)

AND

3 - Patient will not be treated with concurrent growth hormone therapy

AND

4 - Prescribed by an endocrinologist

Product Name:Increlex	
Diagnosis	Severe Primary IGF-1 Deficiency / Growth Hormone Gene Deletion
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Submission of medical records documenting a height increase of at least 2 centimeters per year over the previous year of treatment as confirmed by all of the following:

- Previous length/height and date obtained
- Current length/height and date obtained
- Calculated growth velocity
- Growth chart for height for age and gender

AND

2 - Submission of medical records documenting both of the following:

- Expected adult height not obtained
- Expected adult height goal

AND

3 - Patient is not treated with concurrent growth hormone therapy

AND

4 - Prescribed by an endocrinologist

Product Name:Growth Hormones (All)	
Diagnosis	Idiopathic Short Stature (ISS)
Guideline Type	Prior Authorization
Approval Criteria 1 - The request for growth hormone (GH) injections to treat idiopathic short stature (ISS) is not authorized. There is no consensus in current peer-reviewed medical literature regarding the indications, efficacy, safety, or long-term consequences of GH therapy in children with ISS who are otherwise healthy.	

2 . Background

Benefit/Coverage/Program Information	
Table 1: Human Growth Hormone: Preferred Agents: • Somatropin (Norditropin) • Somatropin (Omnitrope) • Sogroya (somapacitan) Nonpreferred Agents: • Somatropin (Genotropin, Humatrope, Nutropin AQ NuSpin, Saizen, Zorbtive, Serostim, and Zomacton) • Skytrofa (lonapegsomatropin-tcgd) • Ngenla (somatrogen) Growth Stimulating Products: • Mecasermin (Increlex)	

3 . Revision History

Date	Notes
4/3/2026	Added a criteria box for ISS to address note in policy indicating ISS i s not covered.

Haegarda



Prior Authorization Guideline

Guideline ID	GL-563289
Guideline Name	Haegarda
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

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Haegarda	
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, and 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 prophylaxis of HAE attacks AND 3 - Not used in combination with other products indicated for prophylaxis against HAE attacks (e.g., Andembry, Cinryze, Dawnzera, Orladeyo, Takhzyro) AND 4 - Prescriber attests that patient has experienced attacks of a severity and/or frequency such that they would clinically benefit from prophylactic therapy with Haegarda	

AND

5 - Prescribed by ONE of the following:

- Immunologist
- Allergist

Product Name:Haegarda

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Haegarda therapy

AND

2 - Reduction in the utilization of on-demand therapies used for acute attacks (e.g., Berinert, Ektelyr, Firazyr, icatibant, Ruconest) as determined by claims information, while on Haegarda therapy

AND

3 - Prescribed for the prophylaxis of HAE attacks

AND

4 - Not used in combination with other products indicated for prophylaxis against HAE attacks (e.g., Andembry, Cinryze, Dawnzera, Orladeyo, Takhzyro)

AND

5 - Prescribed by ONE of the following:

- Immunologist
- Allergist

2 . Revision History

Date	Notes
4/7/2026	Updated list of examples of prophylactic and acute HAE treatments

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

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.

Hemangeol



Prior Authorization Guideline

Guideline ID	GL-164950
Guideline Name	Hemangeol
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State New Jersey Medicaid - Community & State New Mexico Medicaid - Community & State New York 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:Hemangeol	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of proliferating infantile hemangioma

AND

2 - Prescriber provides a reason or special circumstance the patient cannot use generic propranolol oral solution

2 . Revision History

Date	Notes
2/10/2025	Updated formularies

Hemlibra



Prior Authorization Guideline

Guideline ID	GL-406205
Guideline Name	Hemlibra
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

Guideline Note:

Effective Date:	11/1/2025

1 . Criteria

Product Name:Hemlibra	
Diagnosis	Hemophilia A with Inhibitors
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of hemophilia A AND 2 - Patient has developed high-titer factor VIII inhibitors (i.e., patient has developed factor VIII inhibitors greater than or equal to 5 Bethesda units [BU]) AND 3 - Prescribed for the prevention of bleeding episodes (i.e., routine prophylaxis)	

Product Name:Hemlibra	
Diagnosis	Hemophilia A with Inhibitors
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Hemlibra therapy	

Product Name:Hemlibra	
Diagnosis	Hemophilia A without Inhibitors
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of hemophilia A

AND

2 - Patient has not developed high-titer factor VIII inhibitors (i.e., patient has NOT developed factor VIII inhibitors greater than or equal to 5 Bethesda units [BU])

AND

3 - Prescribed for the prevention of bleeding episodes (i.e., routine prophylaxis)

Product Name:Hemlibra	
Diagnosis	Hemophilia A without Inhibitors
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Hemlibra therapy	

2 . Revision History

Date	Notes
9/29/2025	Removed criteria of failure to meet clinical goals after a trial of prophylactic factor VIII replacement products. Clarified high titer inhibitor criteria.

Hepatitis C Criteria



Prior Authorization Guideline

Guideline ID	GL-223192
Guideline Name	Hepatitis C Criteria
Formulary	Medicaid - Community & State Rhode Island

Guideline Note:

Effective Date:	5/1/2025

1 . Criteria

Product Name: Brand Epclusa, generic sofosbuvir/velpatasvir, Brand Harvoni, generic ledipasvir/sofosbuvir, Sovaldi, Zepatier	
Guideline Type	Prior Authorization
Approval Criteria 1 - ALL of the following: 1.1 Prescribers must be enrolled as a billing provider, or an ordering prescribing or referring (OPR) provider with Rhode Island Medicaid*	

AND

1.2 Documentation of ALL of the following:

1.2.1 Chronic hepatitis C stage 0 through 4

AND

1.2.2 Hepatitis C genotyping

AND

1.2.3 History of prior hepatitis C treatment, if relevant

AND

1.2.4 Treatment plan which includes:

1.2.4.1 Medication name, dose, and duration

AND

1.2.4.2 Agreement to submit post-treatment viral load data, if requested

AND

1.3 The request includes clinical documentation of need for an alternative, non-preferred** agent

OR

2 - The request is for continuity of treatment when transitioning between publicly funded delivery systems (e.g., between Fee for Service Medicaid and Managed Care Medicaid,

between Managed Care Medicaid and Fee for Service Medicaid, or between the Department of Corrections and the Medicaid program)***

OR

3 - The patient is completing a cycle of therapy which was initiated prior to current policy implementation date

Notes	*Provider attestation is not accepted as verification of RI PAR status **Requests for non-preferred medications will be reviewed on a case by case basis. Approval will be for the full course of treatment. ***Any medication approval by the prior delivery system will be honored for the portion of the treatment that remains after the transition.

Product Name:Vosevi	
Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following: 1.1 Prescribers must be enrolled as a billing provider or an ordering prescribing or referring (OPR) provider with Rhode Island Medicaid* AND 1.2 ONE of the following: 1.2.1 Used as a salvage medication after prior treatment failure** OR 1.2.2 Documentation of ALL of the following: 1.2.2.1 Chronic hepatitis C stage 0 through 4 AND	

1.2.2.2 History of prior hepatitis C treatment, if relevant

AND

1.2.2.3 Treatment plan which includes ALL of the following:

- Medication name, dose, and duration
- Agreement to submit post-treatment viral load data, if requested

OR

2 - The request is for continuity of treatment when transitioning between publicly funded delivery systems (e.g., between Fee for Service Medicaid and Managed Care Medicaid, between Managed Care Medicaid and Fee for Service Medicaid, or between the Department of Corrections and the Medicaid program)***

Notes	*Provider attestation is not accepted as verification of RI PAR status **Prior authorization is not required for Vosevi when used as a salvage e medication after prior treatment failure. See package insert for FDA approved indication and prescribing information. Approval will be for t he full course of treatment. ***Any medication approval by the prior delivery system will be honore d for the portion of the treatment that remains after the transition.

Product Name:Mavyret	
Guideline Type	Prior Authorization
Approval Criteria 1 - Prescribers must be enrolled as a billing provider or an ordering prescribing or referring (OPR) provider with Rhode Island Medicaid* OR 2 - The request is for continuity of treatment when transitioning between publicly funded delivery systems (e.g., between Fee for Service Medicaid and Managed Care Medicaid, between Managed Care Medicaid and Fee for Service Medicaid, or between the Department of Corrections and the Medicaid program)**	

Notes	Approval will be for the full course of treatment. *Provider attestation is not accepted as verification of RI PAR status **Any medication approval by the prior delivery system will be honored for the portion of the treatment that remains after the transition.

2 . Revision History

Date	Notes
3/24/2025	Removed Viekira Pak

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.

Hetlioz



Prior Authorization Guideline

Guideline ID	GL-551243
Guideline Name	Hetlioz
Formulary	Medicaid - Community & State Hawaii Medicaid - Community & State New Jersey Medicaid - Community & State New Mexico Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:Brand Hetlioz, generic tasimelteon, Hetlioz LQ	
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 non-24-hour sleep wake disorder (also known as free-running disorder, free-running or non-entrained type circadian rhythm sleep disorder, or hypernycthemeral syndrome)
- Patient is totally blind (has no light perception)

OR

1.2 Diagnosis of nighttime sleep disturbances in Smith-Magenis-Syndrome (SMS)

AND

2 - ONE of the following:

2.1 History of contraindication or intolerance to melatonin therapy (please specify contraindication or intolerance)

OR

2.2 BOTH of the following:

- Failure of at least 6 months of continuous therapy (i.e., uninterrupted daily treatment) with melatonin, as confirmed by claims history or submission of medical records
- Continuous trial of melatonin was done under the guidance of a specialist in sleep disorders

AND

3 - Prescribed by or in consultation with a specialist in sleep disorders

Product Name: Brand Hetlioz, generic tasimelteon, Hetlioz LQ	
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
3/18/2026	Removed NY formularies (see GL-551244 for NY specific guideline). No other updates to guideline.

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.

Hypmavzi



Prior Authorization Guideline

Guideline ID	GL-402257
Guideline Name	Hypmavzi
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

Guideline Note:

Effective Date:	11/1/2025

1 . Criteria

Product Name:Hypmavzi	
Diagnosis	Hemophilia A Without Inhibitors
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of hemophilia A AND 2 - Patient has not developed high-titer factor VIII inhibitors (i.e., patient has NOT developed factor VIII inhibitors greater than or equal to 5 Bethesda units [BU]) AND 3 - Patient is 12 years of age or older AND 4 - Hymovavzi is prescribed for the prevention of bleeding episodes (i.e., routine prophylaxis)	

Product Name:Hymovavzi	
Diagnosis	Hemophilia A Without Inhibitors
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Hymovavzi therapy	

Product Name:Hymovavzi

Diagnosis	Hemophilia B Without Inhibitors
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of hemophilia B AND 2 - Patient has not developed high-titer factor IX inhibitors (i.e., patient has NOT developed factor IX inhibitors greater than or equal to 5 Bethesda units [BU]) AND 3 - Patient is 12 years of age or older AND 4 - Hymovavzi is prescribed for the prevention of bleeding episodes (i.e., routine prophylaxis)	

Product Name:Hymovavzi	
Diagnosis	Hemophilia B Without Inhibitors
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Hymovavzi therapy	

2 . Revision History

Date	Notes
9/30/2025	Criteria updated. Clarified high titer inhibitor criteria. Removed note from reauth section.

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.

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

ICS.LABA Combination Products



Prior Authorization Guideline

Guideline ID	GL-523215
Guideline Name	ICS.LABA Combination Products
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 New Mexico

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name:Generic Breyna, generic budesonide/formoterol	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 BOTH of the following:

1.1.1 Diagnosis of chronic obstructive pulmonary disease (COPD)

AND

1.1.2 ONE of the following:

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

- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

OR

1.1.2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

OR

1.2 BOTH of the following:

1.2.1 Diagnosis of asthma

AND

1.2.2 ONE of the following:

1.2.2.1 Patient is less than 12 years of age

OR

1.2.2.2 ONE of the following:

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

- fluticasone/salmeterol (authorized generic of AirDuo Respiclick)
- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

OR

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

- fluticasone/salmeterol (authorized generic of AirDuo Respiclick)
- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

Product Name: Fluticasone/vilanterol (authorized generic of Breo 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 BOTH of the following: 1.2.1 ONE of the following: 1.2.1.1 Patient is less than 12 years of age	

OR

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

- fluticasone/salmeterol (authorized generic of AirDuo Resplick)
- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

OR

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

- fluticasone/salmeterol (authorized generic of AirDuo Resplick)
- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

AND

1.2.2 ONE of the following:

1.2.2.1 Patient is 5 years of age

OR

1.2.2.2 Failure of Breyna or budesonide/formoterol (generic of Symbicort) confirmed by claims history or submitted medical records

OR

1.2.2.3 History of intolerance or contraindication to Breyna or budesonide/formoterol (generic of Symbicort) (please specify intolerance or contraindication)

OR

2 - ALL of the following:

2.1 Diagnosis of chronic obstructive pulmonary disease (COPD)

AND

2.2 ONE of the following:

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

- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

OR

2.2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

AND

2.3 ONE of the following:

2.3.1 Failure of Breyna or budesonide/formoterol (generic of Symbicort) confirmed by claims history or submitted medical records

OR

2.3.2 History of intolerance or contraindication to Breyna or budesonide/formoterol (generic of Symbicort) (please specify intolerance or contraindication)

Product Name: Advair HFA, Fluticasone-salmeterol (authorized generic of Advair HFA), Dulera, AirDuo Digihaler, AirDuo Respiclick *

Approval Length	12 month(s)

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of asthma AND 2 - ONE of the following: 2.1 Failure of ONE of the following confirmed by claims history or submitted medical records: • fluticasone/salmeterol (authorized generic of AirDuo Resplick) • fluticasone propionate/salmeterol diskus (generic Advair Diskus) • Wixela Inhub (generic Advair Diskus) OR 2.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication): • fluticasone/salmeterol (authorized generic of AirDuo Resplick) • fluticasone propionate/salmeterol diskus (generic Advair Diskus) • Wixela Inhub (generic Advair Diskus) AND 3 - ONE of the following: 3.1 Failure of BOTH of the following confirmed by claims history or submitted medical records: • Breyna or budesonide/formoterol (generic of Symbicort) • fluticasone/vilanterol (authorized generic of Breo Ellipta) OR	

3.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Breyna or budesonide/formoterol (generic of Symbicort)
- fluticasone/vilanterol (authorized generic of Breo Ellipta)

Notes

*Policy applies to Brand Necessary requests

Product Name: Brand Symbicort, Brand Advair Diskus*

Approval Length

12 month(s)

Guideline Type

Prior Authorization

Approval Criteria

1 - All of the following:

1.1 Diagnosis of asthma

AND

1.2 ONE of the following:

1.2.1 BOTH of the following:

1.2.1.1 Patient is less than 12 years of age

AND

1.2.1.2 ONE of the following:

1.2.1.2.1 Failure of Breyna or budesonide/formoterol (generic of Symbicort) confirmed by claims history or submitted medical records

OR

1.2.1.2.2 History of intolerance or contraindication to Breyna or budesonide/formoterol (generic of Symbicort) (please specify intolerance or contraindication)

OR

1.2.2 BOTH of the following:

1.2.2.1 ONE of the following:

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

- fluticasone/salmeterol (authorized generic of AirDuo Respiclick)
- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

OR

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

- fluticasone/salmeterol (authorized generic of AirDuo Respiclick)
- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

AND

1.2.2.2 ONE of the following:

1.2.2.2.1 Failure of BOTH of the following confirmed by claims history or submitted medical records:

- Breyna or budesonide/formoterol (generic of Symbicort)
- fluticasone/vilanterol (authorized generic of Breo Ellipta)

OR

1.2.2.2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Breyna or budesonide/formoterol (generic of Symbicort)
- fluticasone/vilanterol (authorized generic of Breo Ellipta)

OR

2 - ALL of the following:

2.1 Diagnosis of chronic obstructive pulmonary disease (COPD)

AND

2.2 ONE of the following:

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

- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

OR

2.2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

AND

2.3 ONE of the following:

2.3.1 Failure of BOTH of the following confirmed by claims history or submitted medical records:

- Breyna or budesonide/formoterol (generic of Symbicort)
- fluticasone/vilanterol (authorized generic of Breo Ellipta)

OR

2.3.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):	
- Breyna or budesonide/formoterol (generic of Symbicort) - fluticasone/vilanterol (authorized generic of Breo Ellipta)	
Notes	*Policy applies to Brand Necessary requests

Product Name: Breo 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 BOTH of the following: 1.2.1 ONE of the following: 1.2.1.1 Failure of ONE of the following confirmed by claims history or submitted medical records: - fluticasone/salmeterol (authorized generic of AirDuo Respiclick) - fluticasone propionate/salmeterol diskus (generic Advair Diskus) - Wixela Inhub (generic Advair Diskus) OR 1.2.1.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication): - fluticasone/salmeterol (authorized generic of AirDuo Respiclick) - fluticasone propionate/salmeterol diskus (generic Advair Diskus)	

- Wixela Inhub (generic Advair Diskus)

AND

1.2.2 ONE of the following:

1.2.2.1 Failure of BOTH of the following confirmed by claims history or submitted medical records:

- Breyna or budesonide/formoterol (generic of Symbicort)
- fluticasone/vilanterol (authorized generic of Breo Ellipta)

OR

1.2.2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Breyna or budesonide/formoterol (generic of Symbicort)
- fluticasone/vilanterol (authorized generic of Breo Ellipta)

OR

2 - ALL of the following:

2.1 Diagnosis of chronic obstructive pulmonary disease (COPD)

AND

2.2 ONE of the following:

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

- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

OR

2.2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

AND

2.3 ONE of the following:

2.3.1 Failure of BOTH of the following confirmed by claims history or submitted medical records:

- Breyna or budesonide/formoterol (generic of Symbicort)
- fluticasone/vilanterol (authorized generic of Breo Ellipta)

OR

2.3.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Breyna or budesonide/formoterol (generic of Symbicort)
- fluticasone/vilanterol (authorized generic of Breo Ellipta)

Notes	*Policy applies to Brand Necessary requests

2 . Revision History

Date	Notes
2/16/2026	Removed NY

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.

Ilaris



Prior Authorization Guideline

Guideline ID	GL-501245
Guideline Name	Ilaris
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 New Mexico

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name: Ilaris	
Diagnosis	Cryopyrin-Associated Periodic Syndromes (CAPS)
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Cryopyrin-Associated Periodic Syndromes (CAPS), including familial cold autoinflammatory syndrome (FCAS) and Muckle-Wells Syndrome (MWS) AND 2 - Prescribed by or in consultation with a rheumatologist	

Product Name: Ilaris	
Diagnosis	Cryopyrin-Associated Periodic Syndromes (CAPS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Ilaris therapy	

Product Name: Ilaris	
Diagnosis	Tumor Necrosis Factor (TNF) Receptor-Associated Periodic Syndrome (TRAPS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of tumor necrosis factor (TNF) receptor-associated periodic syndrome (TRAPS)

AND

2 - Prescribed by or in consultation with a rheumatologist or immunologist

Product Name:Ilaris

Diagnosis	Tumor Necrosis Factor (TNF) Receptor-Associated Periodic Syndrome (TRAPS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Ilaris therapy, defined as a decrease in frequency or severity of attacks

Product Name:Ilaris

Diagnosis	Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following:

- Hyperimmunoglobulin D Syndrome (HIDS)
- Mevalonate Kinase Deficiency (MKD)

AND

2 - Prescribed by or in consultation with a rheumatologist or immunologist

Product Name: Ilaris

Diagnosis	Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD)

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Ilaris therapy, defined as a decrease in frequency or severity of attacks

Product Name: Ilaris

Diagnosis	Familial Mediterranean Fever (FMF)

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Familial Mediterranean Fever (FMF)

AND

2 - ONE of the following:

2.1 Failure to colchicine as confirmed by claims history or submission of medical records

OR

2.2 History of contraindication or intolerance to colchicine (please specify contraindication or intolerance)

AND

3 - Prescribed by or in consultation with a rheumatologist or immunologist

Product Name:Ilaris	
Diagnosis	Familial Mediterranean Fever (FMF)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Ilaris therapy, defined by a decrease in index disease flare or normalization of CRP (C-reactive protein)	

Product Name:Ilaris	
Diagnosis	Systemic Juvenile Idiopathic Arthritis (SJIA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of systemic juvenile idiopathic arthritis (SJIA)	

AND

2 - ONE of the following:

2.1 Failure of Tyenne (tocilizumab-aazg) confirmed by claims history or submitted medical records

OR

2.2 History of intolerance or contraindication to Tyenne (tocilizumab-aazg) (please specify intolerance or contraindication)

OR

2.3 Patient is currently on Ilaris as confirmed by claims history or submission of medical records

AND

3 - Patient is NOT receiving Ilaris in combination with a targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz (tofacitinib)]

AND

4 - Prescribed by or in consultation with a rheumatologist

Product Name:Ilaris	
Diagnosis	Systemic Juvenile Idiopathic Arthritis (SJIA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Ilaris therapy

AND

2 - Patient is NOT receiving Ilaris in combination with a targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz (tofacitinib)]

Product Name:Ilaris

Diagnosis	Still's Disease [Adult-Onset Still's Disease (AOSD)]
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Adult Onset Still's Disease (AOSD)

AND

2 - Patient is NOT receiving Ilaris in combination with a targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz (tofacitinib)]

AND

3 - Prescribed by or in consultation with a rheumatologist

Product Name:Ilaris

Diagnosis	Still's Disease [Adult-Onset Still's Disease (AOSD)]
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Ilaris therapy AND 2 - Patient is NOT receiving Ilaris in combination with a targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz (tofacitinib)]	

Product Name:Ilaris	
Diagnosis	Gout Flare
Approval Length	12 Week(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of a gout flare AND 2 - ONE of the following: 2.1 History of failure to BOTH of the following confirmed by claims history or submission of medical records: • Colchicine • Non-steroidal anti-inflammatory drugs (NSAIDs)	

OR

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

- Colchicine
- Non-steroidal anti-inflammatory drugs (NSAIDs)

AND

3 - Provider attests that the patient is not an appropriate candidate for systemic corticosteroids

AND

4 - Prescribed by ONE of the following:

- Rheumatologist
- Nephrologist

AND

5 - The patient has not received Ilaris in the past 12 weeks

2 . Revision History

Date	Notes
1/16/2026	Updated prescriber requirement throughout the guideline. Updated criteria for CAPS, TRAPS, HIDS/MKD, FMF, SJIA and AOSD. Added a step through Tyenne for SJIA indication. Minor cosmetic updates.

Ilaris



Prior Authorization Guideline

Guideline ID	GL-501245
Guideline Name	Ilaris
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 New Mexico

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name: Ilaris	
Diagnosis	Cryopyrin-Associated Periodic Syndromes (CAPS)
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Cryopyrin-Associated Periodic Syndromes (CAPS), including familial cold autoinflammatory syndrome (FCAS) and Muckle-Wells Syndrome (MWS) AND 2 - Prescribed by or in consultation with a rheumatologist	

Product Name: Ilaris	
Diagnosis	Cryopyrin-Associated Periodic Syndromes (CAPS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Ilaris therapy	

Product Name: Ilaris	
Diagnosis	Tumor Necrosis Factor (TNF) Receptor-Associated Periodic Syndrome (TRAPS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of tumor necrosis factor (TNF) receptor-associated periodic syndrome (TRAPS)

AND

2 - Prescribed by or in consultation with a rheumatologist or immunologist

Product Name:Ilaris

Diagnosis	Tumor Necrosis Factor (TNF) Receptor-Associated Periodic Syndrome (TRAPS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Ilaris therapy, defined as a decrease in frequency or severity of attacks

Product Name:Ilaris

Diagnosis	Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following:

- Hyperimmunoglobulin D Syndrome (HIDS)
- Mevalonate Kinase Deficiency (MKD)

AND

2 - Prescribed by or in consultation with a rheumatologist or immunologist

Product Name: Ilaris

Diagnosis	Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD)

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Ilaris therapy, defined as a decrease in frequency or severity of attacks

Product Name: Ilaris

Diagnosis	Familial Mediterranean Fever (FMF)

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Familial Mediterranean Fever (FMF)

AND

2 - ONE of the following:

2.1 Failure to colchicine as confirmed by claims history or submission of medical records

OR

2.2 History of contraindication or intolerance to colchicine (please specify contraindication or intolerance)

AND

3 - Prescribed by or in consultation with a rheumatologist or immunologist

Product Name: Ilaris	
Diagnosis	Familial Mediterranean Fever (FMF)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Ilaris therapy, defined by a decrease in index disease flare or normalization of CRP (C-reactive protein)	

Product Name: Ilaris	
Diagnosis	Systemic Juvenile Idiopathic Arthritis (SJIA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of systemic juvenile idiopathic arthritis (SJIA)	

AND

2 - ONE of the following:

2.1 Failure of Tyenne (tocilizumab-aazg) confirmed by claims history or submitted medical records

OR

2.2 History of intolerance or contraindication to Tyenne (tocilizumab-aazg) (please specify intolerance or contraindication)

OR

2.3 Patient is currently on Ilaris as confirmed by claims history or submission of medical records

AND

3 - Patient is NOT receiving Ilaris in combination with a targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz (tofacitinib)]

AND

4 - Prescribed by or in consultation with a rheumatologist

Product Name:Ilaris	
Diagnosis	Systemic Juvenile Idiopathic Arthritis (SJIA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Ilaris therapy

AND

2 - Patient is NOT receiving Ilaris in combination with a targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz (tofacitinib)]

Product Name:Ilaris

Diagnosis	Still's Disease [Adult-Onset Still's Disease (AOSD)]
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Adult Onset Still's Disease (AOSD)

AND

2 - Patient is NOT receiving Ilaris in combination with a targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz (tofacitinib)]

AND

3 - Prescribed by or in consultation with a rheumatologist

Product Name:Ilaris

Diagnosis	Still's Disease [Adult-Onset Still's Disease (AOSD)]
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Ilaris therapy AND 2 - Patient is NOT receiving Ilaris in combination with a targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz (tofacitinib)]	

Product Name:Ilaris	
Diagnosis	Gout Flare
Approval Length	12 Week(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of a gout flare AND 2 - ONE of the following: 2.1 History of failure to BOTH of the following confirmed by claims history or submission of medical records: • Colchicine • Non-steroidal anti-inflammatory drugs (NSAIDs)	

OR

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

- Colchicine
- Non-steroidal anti-inflammatory drugs (NSAIDs)

AND

3 - Provider attests that the patient is not an appropriate candidate for systemic corticosteroids

AND

4 - Prescribed by ONE of the following:

- Rheumatologist
- Nephrologist

AND

5 - The patient has not received Ilaris in the past 12 weeks

2 . Revision History

Date	Notes
1/16/2026	Updated prescriber requirement throughout the guideline. Updated criteria for CAPS, TRAPS, HIDS/MKD, FMF, SJIA and AOSD. Added a step through Tyenne for SJIA indication. Minor cosmetic updates.

Ilumya



Prior Authorization Guideline

Guideline ID	GL-534212
Guideline Name	Ilumya
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 New Mexico

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name: Ilumya	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic moderate to severe plaque psoriasis

AND

2 - Patient is NOT receiving Ilumya in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, ustekinumab, Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

AND

3 - Prescribed by, or in consultation with, a dermatologist

AND

4 - One of the following:

4.1 Patient is currently on Ilumya therapy as confirmed by claims history or submission of medical records

OR

4.2 BOTH of the following:

4.2.1 ONE of the following:

4.2.1.1 Patient has been previously treated with a targeted immunomodulator FDA-approved for the treatment of plaque psoriasis as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), adalimumab, Otezla (apremilast), Skyrizi (risankizumab-rzaa), ustekinumab, Tremfya (guselkumab), Enbrel (etanercept)]

OR

4.2.1.2 ALL of the following:

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

AND

4.2.1.2.2 ONE of the following:

- Failure to ONE of the following topical therapy classes confirmed by claims history or submission of medical records: Corticosteroids (e.g., betamethasone, clobetasol, desonide), Vitamin D analogs (e.g., calcitriol, calcipotriene), Tazarotene, Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus), Anthralin, Coal tar
- History of intolerance or contraindication to ALL of the following topical therapy classes (please specify intolerance or contraindication): Corticosteroids (e.g., betamethasone, clobetasol, desonide), Vitamin D analogs (e.g., calcitriol, calcipotriene), Tazarotene, Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus), Anthralin, Coal tar

AND

4.2.1.2.3 ONE of the following:

- Failure to a 3 month trial of methotrexate at the maximally indicated dose confirmed by claims history or submission of medical records
- History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

AND

4.2.2 ONE of the following:

4.2.2.1 Failure to TWO of the following preferred products as confirmed by claims history or submitted medical records

- One of the preferred adalimumab products*
- Enbrel (etanercept)
- One of the preferred ustekinumab products*

OR

4.2.2.2 History of intolerance or contraindication to ALL of the following preferred products (please specify intolerance or contraindication)

- One of the preferred adalimumab products*
- Enbrel (etanercept)
- One of the preferred ustekinumab products*

Notes	*See PDL links in Background

Product Name: Ilumya

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Ilumya therapy

AND

2 - Patient is NOT receiving Ilumya in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, ustekinumab, Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

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>

NM: <https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-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>

3 . Revision History

Date	Notes
2/26/2026	Removed NY-CHIP

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.

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.

Ingrezza



Prior Authorization Guideline

Guideline ID	GL-164976
Guideline Name	Ingrezza
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii 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:Ingrezza	
Diagnosis	Tardive Dyskinesia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderate to severe tardive dyskinesia AND 2 - ONE of the following: 2.1 Patient has persistent symptoms of tardive dyskinesia despite a trial of dose reduction, tapering, or discontinuation of the offending medication OR 2.2 Patient is not a candidate for a trial of dose reduction, tapering, or discontinuation of the offending medication AND 3 - Prescribed by or in consultation with ONE of the following: • Neurologist • Psychiatrist	

Product Name: Ingrezza	
Diagnosis	Chorea associated with Huntington's Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of chorea associated with Huntington's disease

AND

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

- Neurologist
- Psychiatrist

Product Name:Ingrezza	
Diagnosis	Tardive Dyskinesia, Chorea associated with Huntington's Disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Ingrezza therapy	

2 . Revision History

Date	Notes
2/11/2025	Updated formularies. Updated GPIs

Ingrezza



Prior Authorization Guideline

Guideline ID	GL-164976
Guideline Name	Ingrezza
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii 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:Ingrezza	
Diagnosis	Tardive Dyskinesia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderate to severe tardive dyskinesia AND 2 - ONE of the following: 2.1 Patient has persistent symptoms of tardive dyskinesia despite a trial of dose reduction, tapering, or discontinuation of the offending medication OR 2.2 Patient is not a candidate for a trial of dose reduction, tapering, or discontinuation of the offending medication AND 3 - Prescribed by or in consultation with ONE of the following: • Neurologist • Psychiatrist	

Product Name: Ingrezza	
Diagnosis	Chorea associated with Huntington's Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of chorea associated with Huntington's disease

AND

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

- Neurologist
- Psychiatrist

Product Name:Ingrezza

Diagnosis	Tardive Dyskinesia, Chorea associated with Huntington's Disease

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Ingrezza therapy

2 . Revision History

Date	Notes
2/11/2025	Updated formularies. Updated GPIs

Inhaled Corticosteroids



Prior Authorization Guideline

Guideline ID	GL-542226
Guideline Name	Inhaled Corticosteroids
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State New Jersey Medicaid - Community & State Rhode Island Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Alvesco, ArmonAir Digihaler, Arnuity Ellipta, Fluticasone Furoate Ellipta, Flovent Diskus, Fluticasone Propionate Diskus, Brand Flovent HFA, Pulmicort Flexhaler, Qvar RediHaler	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of asthma

AND

2 - ONE of the following:

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

- Fluticasone propionate HFA
- Asmanex HFA or Asmanex Twisthaler

OR

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

- Fluticasone propionate HFA
- Asmanex HFA or Asmanex Twisthaler

2 . Revision History

Date	Notes
3/5/2026	Updated GPI and product name list.

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

Insulins



Prior Authorization Guideline

Guideline ID	GL-548194
Guideline Name	Insulins
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 New Mexico

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Admelog vial, Apidra vial, Humalog 100U/ml vial, Insulin Aspart vial, Lyumjev vial	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Failure to insulin lispro vial confirmed by claims history or submission of medical records

OR

1.2 History of contraindication or intolerance to insulin lispro vial (please specify intolerance or contraindication)

Product Name:Novolog vial, Fiasp vial, Merilog vial, Kirsty vial

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Failure to BOTH of the following confirmed by claims history or submission of medical records:

- insulin lispro vial
- Insulin Aspart vial

OR

1.2 History of contraindication or intolerance to BOTH of the following (please specify intolerance or contraindication):

- insulin lispro vial
- Insulin Aspart vial

Product Name:Novolog Mix 70/30 vial, Novolog Mix 70/30 Relion vial

Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Failure to Insulin Aspart mix vial confirmed by claims history or submission of medical records OR 1.2 History of contraindication or intolerance to Insulin Aspart mix vial (please specify intolerance or contraindication)	

Product Name:Humalog Mix 75/25 vial	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Failure to Insulin lispro protamine/insulin lispro Kwikpen 75/25 100U/ML confirmed by claims history or submission of medical records OR 1.2 History of contraindication or intolerance to Insulin lispro protamine/insulin lispro Kwikpen 75/25 100U/ML (please specify intolerance or contraindication)	

Product Name:Humulin R U-500 vial, Humulin R U-500 Kwikpen	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient requires more than 200 units of U-100 insulin per day

Product Name: Insulin Lispro Kwikpen, Insulin Lispro Junior Kwikpen

Approval Length 12 month(s)

Guideline Type Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 A visual impairment that prevents the patient from using a vial and syringe to accurately draw up the dose of insulin

OR

1.2 A physical disability or handicap that prevents the patient from using a vial and syringe to draw up the dose and administer the insulin

OR

1.3 History of failure to insulin lispro vial as demonstrated by poorly controlled diabetes based on hemoglobin A1c

OR

1.4 The patient is unable to use the vial dosage form of the drug due to documented poor compliance with vials and syringes resulting in poorly controlled diabetes based on hemoglobin A1c

Product Name: Apidra Solostar pen, Humalog cartridge, Humalog Kwikpen, Humalog Junior Kwikpen, Insulin Aspart Penfill, Insulin Aspart Flexpen, Admelog Solostar pen, Lyumjev Kwikpen, Merilog Solostar, Kirsty Pen	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 One of the following: 1.1.1 Failure to insulin lispro vial confirmed by claims history or submission of medical records OR 1.1.2 History of contraindication or intolerance to insulin lispro vial (please specify intolerance or contraindication) OR 1.2 ONE of the following: 1.2.1 A visual impairment that prevents the patient from using a vial and syringe to accurately draw up the dose of insulin OR 1.2.2 A physical disability or handicap that prevents the patient from using a vial and syringe to draw up the dose and administer the insulin OR 1.2.3 The patient is unable to use the vial dosage form of the drug due to documented poor compliance with vials and syringes resulting in poorly controlled diabetes based on hemoglobin A1c	

AND

2 - ONE of the following:

2.1 Failure to insulin lispro Kwikpen confirmed by claims history or submission of medical records

OR

2.2 History of contraindication or intolerance to insulin lispro Kwikpen (please specify intolerance or contraindication)

Product Name:Humalog Tempo Pen, Lyumjev Tempo Pen

Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - BOTH of the following:

1.1 ONE of the following:

1.1.1 Failure to insulin lispro Kwikpen confirmed by claims history or submission of medical records

OR

1.1.2 History of contraindication or intolerance to insulin lispro Kwikpen (please specify intolerance or contraindication)

AND

1.2 Prescriber provides a reason or special circumstance the patient has to use the Tempo product

Product Name:Novolog Penfill, Novolog Flexpen, Fiasp Penfill, Fiasp Pumpcart, Fiasp FlexTouch	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following: 1.1 One of the following: 1.1.1 Failure to insulin lispro vial confirmed by claims history or submission of medical records OR 1.1.2 History of contraindication or intolerance to insulin lispro vial (please specify intolerance or contraindication) OR 1.2 ONE of the following: - A visual impairment that prevents the patient from using a vial and syringe to accurately draw up the dose of insulin - A physical disability or handicap that prevents the patient from using a vial and syringe to draw up the dose and administer the insulin - The patient is unable to use the vial dosage form of the drug due to documented poor compliance with vials and syringes resulting in poorly controlled diabetes based on hemoglobin A1c AND 2 - One of the following: 2.1 Failure to BOTH of the following confirmed by claims history or submission of medical records: - Insulin lispro Kwikpen	

- Insulin aspart pen or cartridge

OR

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

- Insulin lispro Kwikpen
- Insulin aspart pen or cartridge

Product Name:Novolin R Flexpen, Novolin R Flexpen Relion

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Failure to ONE of the following confirmed by claims history or submission of medical records:

- Humulin R U-100 vial
- Novolin R U-100 vial

OR

1.2 History of contraindication or intolerance to BOTH of the following (please specify intolerance or contraindication):

- Humulin R U-100 vial
- Novolin R U-100 vial

OR

2 - ONE of the following:

2.1 A visual impairment that prevents the patient from using a vial and syringe to accurately draw up the dose of insulin

OR

2.2 A physical disability or handicap that prevents the patient from using a vial and syringe to draw up the dose and administer the insulin

OR

2.3 The patient is unable to use the vial dosage form of the drug due to documented poor compliance with vials and syringes resulting in poorly controlled diabetes based on hemoglobin A1c

Product Name:Humulin N Kwikpen, Novolin N Flexpen, Novolin N Flexpen Relion	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Failure to ONE of the following confirmed by claims history or submission of medical records: • Humulin N U-100 vial • Novolin N U-100 vial OR 1.2 History of contraindication or intolerance to BOTH of the following (please specify intolerance or contraindication): • Humulin N U-100 vial • Novolin N U-100 vial	

OR

2 - ONE of the following:

2.1 A visual impairment that prevents the patient from using a vial and syringe to accurately draw up the dose of insulin

OR

2.2 A physical disability or handicap that prevents the patient from using a vial and syringe to draw up the dose and administer the insulin

OR

2.3 The patient is unable to use the vial dosage form of the drug due to documented poor compliance with vials and syringes resulting in poorly controlled diabetes based on hemoglobin A1c

Product Name:Humalog Mix Kwikpen 50/50, Insulin Aspart Flexpen 70/30, Humulin Kwikpen 70/30, Novolin Flexpen 70/30, Novolin Flexpen Relion 70/30

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Failure to the corresponding preferred insulin mix vial confirmed by claims history or submission of medical records

OR

1.2 History of contraindication or intolerance to the corresponding preferred insulin mix vial (please specify intolerance or contraindication)

OR

2 - ONE of the following:

2.1 A visual impairment that prevents the patient from using a vial and syringe to accurately draw up the dose of insulin

OR

2.2 A physical disability or handicap that prevents the patient from using a vial and syringe to draw up the dose and administer the insulin

OR

2.3 The patient is unable to use the vial dosage form of the drug due to documented poor compliance with vials and syringes resulting in poorly controlled diabetes based on hemoglobin A1c

Product Name:Novolog Mix 70/30 Flexpen, Novolog Mix 70/30 Flexpen Relion

Approval Length 12 month(s)

Guideline Type Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 ONE of the following:

- Failure to the corresponding preferred insulin mix vial confirmed by claims history or submission of medical records
- History of contraindication or intolerance to the corresponding preferred insulin mix vial (please specify intolerance or contraindication)

OR

1.2 ONE of the following:

- A visual impairment that prevents the patient from using a vial and syringe to accurately draw up the dose of insulin
- A physical disability or handicap that prevents the patient from using a vial and syringe to draw up the dose and administer the insulin
- The patient is unable to use the vial dosage form of the drug due to documented poor compliance with vials and syringes resulting in poorly controlled diabetes based on hemoglobin A1c

AND

2 - ONE of the following:

- Failure to Insulin Aspart Flexpen 70/30 100U/ML confirmed by claims history or submission of medical records
- History of contraindication or intolerance to Insulin Aspart Flexpen 70/30 100U/ML (please specify intolerance or contraindication)

Product Name:Humalog Mix Kwikpen 75/25	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following: 1.1 ONE of the following: • Failure to the corresponding preferred insulin mix vial confirmed by claims history or submission of medical records • History of contraindication or intolerance to the corresponding preferred insulin mix vial (please specify intolerance or contraindication) OR 1.2 ONE of the following:	

- A visual impairment that prevents the patient from using a vial and syringe to accurately draw up the dose of insulin
- A physical disability or handicap that prevents the patient from using a vial and syringe to draw up the dose and administer the insulin
- The patient is unable to use the vial dosage form of the drug due to documented poor compliance with vials and syringes resulting in poorly controlled diabetes based on hemoglobin A1c

AND

2 - One of the following:

- Failure to insulin lispro protamine/insulin lispro Kwikpen 75/25 100U/ML confirmed by claims history or submission of medical records
- History of contraindication or intolerance to Insulin lispro protamine/insulin lispro Kwikpen 75/25 100U/ML (please specify intolerance or contraindication)

Product Name: Basaglar Kwikpen, Insulin Glargine Solostar 100U/ml, Insulin glargine-yfgn Pen, Semglee yfgn Pen Injector

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - BOTH of the following:

1.1 ONE of the following:

1.1.1 Failure to BOTH of the following confirmed by claims history or submission of medical records:

- Rezvoglar Kwikpen
- Lantus (pens or vials)

OR

1.1.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Rezvoglar Kwikpen
- Lantus (pens or vials)

AND

1.2 The provider has given clinical justification why the patient is unable to use the preferred insulin glargine products

Product Name: Basaglar Tempo Pen

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - BOTH of the following:

1.1 ONE of the following:

1.1.1 Failure to BOTH of the following confirmed by claims history or submission of medical records:

- Rezvoglar Kwikpen
- Lantus (pens or vials)

OR

1.1.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Rezvoglar Kwikpen
- Lantus (pens or vials)

AND

1.2 Prescriber provides a reason or special circumstance the patient has to use the Tempo product

Product Name:Toujeo Solostar, Insulin Glargine Solostar 300U/ml, Toujeo Max Solostar, Insulin Glargine Max Solostar 300U/ml	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following: 1.1 ONE of the following: 1.1.1 Failure to BOTH of the following confirmed by claims history or submission of medical records: • Rezvoglar Kwikpen • Lantus (pens or vials) OR 1.1.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication): • Rezvoglar Kwikpen • Lantus (pens or vials) OR 1.1.3 The provider has given clinical justification why the patient needs a concentrated glargine formulation AND 1.2 If the request is for Toujeo Solostar or Toujeo Solostar Max, ONE of the following: 1.2.1 Failure to ONE of the following confirmed by claims history or submission of medical records: • Insulin glargine Solostar 300U/ml	

- Insulin glargine Max Solostar 300U/ml

OR

1.2.2 History of intolerance or contraindication to ONE of the following (please specify intolerance or contraindication):

- Insulin glargine Solostar 300U/ml
- Insulin glargine Max Solostar 300U/ml

Product Name:Levemir Flexpen, Insulin Degludec Flextouch 100U/mL

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - Failure to ONE of the following confirmed by claims history or submission of medical records:

- Rezvoglar Kwikpen
- Lantus (pens or vials)

OR

2 - History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Rezvoglar Kwikpen
- Lantus (pens or vials)

Product Name:Tresiba Flextouch 100U/mL

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Failure to ONE of the following confirmed by claims history or submission of medical records:

- Rezvoglar Kwikpen
- Lantus (pens or vials)

OR

1.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Rezvoglar Kwikpen
- Lantus (pens or vials)

AND

2 - The provider has given clinical justification why the patient is unable to use the insulin degludec flextouch product

Product Name: Insulin Degludec Flextouch 200U/mL	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Failure to ONE of the following confirmed by claims history or submission of medical records: • Rezvoglar Kwikpen • Lantus (pens or vials)	

OR

2 - History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Rezvoglar Kwikpen
- Lantus (pens or vials)

OR

3 - The provider has given clinical justification why the patient needs a concentrated formulation

Product Name:Tresiba Flextouch 200U/mL	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Failure to ONE of the following confirmed by claims history or submission of medical records:

- Rezvoglar Kwikpen
- Lantus (pens or vials)

OR

1.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Rezvoglar Kwikpen
- Lantus (pens or vials)

OR

1.3 The provider has given clinical justification why the patient needs a concentrated formulation

AND

2 - The provider has given clinical justification why the patient is unable to use the insulin degludec flextouch product

Product Name: Insulin Glargine vial, Insulin glargine-yfgn vial, Semglee yfgn vial

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - BOTH of the following:

1.1 ONE of the following:

1.1.1 Failure to BOTH of the following confirmed by claims history or submission of medical records:

- Rezvoglar Kwikpen
- Lantus (pens or vials)

OR

1.1.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Rezvoglar Kwikpen
- Lantus (pens or vials)

AND

1.2 The provider has given clinical justification why the patient is unable to use the preferred insulin glargine products

Product Name:Levemir vial, Insulin Degludec vial	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Failure to ONE of the following confirmed by claims history or submission of medical records: • Rezvoglar Kwikpen • Lantus (pens or vials) OR 1.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication): • Rezvoglar Kwikpen • Lantus (pens or vials)	

Product Name:Tresiba vial	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following: 1.1 Failure to ONE of the following confirmed by claims history or submission of medical records: • Rezvoglar Kwikpen • Lantus (pens or vials)	

OR

1.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Rezvoglar Kwikpen
- Lantus (pens or vials)

AND

2 - The provider has given clinical justification why the patient is unable to use the insulin degludec product

Product Name:Admelog Solostar, Apidra, Insulin Aspart vial, Insulin Lispro vial, Humalog vial, Novolog vial, Novolog Relion vial, Fiasp vial, Lyumjev vial, Novolog Mix 70/30 vial, Novolog Mix 70/30 Relion vial, Humulin R U-500 vial, Apidra Solostar, Insulin Aspart Flexpen, Insulin Aspart Penfill, Insulin Lispro Junior Kwikpen, Insulin Lispro Kwikpen, Humalog Junior Kwikpen, Humalog Kwikpen, Humalog Tempo Pen, Novolog Flexpen, Novolog Flexpen Relion, Novolog Penfill, Fiasp Flextouch, Fiasp Penfill, Fiasp Pumpcart, Lyumjev Kwikpen, Lyumjev Tempo Pen, Novolin R Flexpen Relion, Novolin R Flexpen, Humulin R U-500 Kwikpen, Humulin N Kwikpen, Novolin N Flexpen Relion, Novolin N Flexpen, Humalog Mix 75/25 Kwikpen, Insulin Lispro Mix Kwikpen 75/25, Humalog Mix 50/50 Kwikpen, Insulin Aspart Protamine/Insulin Aspart 70/30 Flexpen, Humulin 70/30 Kwikpen, Novolin 70/30 Flexpen, Novolin 70/30 Flexpen Relion, Novolog Mix 70/30 Flexpen, Novolog Mix 70/30 Flexpen Relion, Lantus Solostar, Basaglar Tempo Pen, Toujeo Solostar, Insulin Glargine Solostar 300U/ml, Toujeo Max Solostar, Insulin Glargine Max Solostar 300U/ml, Semglee yfgn Pen Injector, Semglee yfgn vial, Levemir Flexpen, Tresiba Flextouch, Insulin Degludec Flextouch, Semglee vial, Lantus vial, Levemir vial, Tresiba vial, Insulin Degludec vial, Basaglar Kwikpen, Insulin Glargine vial, Insulin Glargine-YFGN pen and vial, Insulin Glargine Solostar 100U/ml, Humulin R vial, Novolin R vial, Novolin R Relion vial, Humulin N vial, Novolin N Relion vial, Novolin N vial, Insulin Aspart Protamine/Insulin Aspart 70/30 vial, Humalog Mix 75/25 vial, Humalog Mix 50/50 vial, Humulin 70/30 vial, Novolin 70/30 Relion vial, Novolin 70/30 vial, Admelog vial, Humalog Cartridge, Rezvoglar Kwikpen, Merilog vial, Merilog Solostar, Kirsty pen, Kirsty vial

Approval Length	12 month(s)
Guideline Type	Quantity Limit

Approval Criteria

1 - Quantity requests exceeding the limited amount will be approved based on physician

confirmation that the patient requires a greater quantity due to poorly controlled diabetes based on blood glucose and/or hemoglobin A1c

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>

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>

NM: <https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-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>

3 . Revision History

Date	Notes
3/10/2026	Updated U-500 criteria language. Removed NY

Insulins



Prior Authorization Guideline

Guideline ID	GL-548194
Guideline Name	Insulins
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 New Mexico

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Admelog vial, Apidra vial, Humalog 100U/ml vial, Insulin Aspart vial, Lyumjev vial	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Failure to insulin lispro vial confirmed by claims history or submission of medical records

OR

1.2 History of contraindication or intolerance to insulin lispro vial (please specify intolerance or contraindication)

Product Name:Novolog vial, Fiasp vial, Merilog vial, Kirsty vial

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Failure to BOTH of the following confirmed by claims history or submission of medical records:

- insulin lispro vial
- Insulin Aspart vial

OR

1.2 History of contraindication or intolerance to BOTH of the following (please specify intolerance or contraindication):

- insulin lispro vial
- Insulin Aspart vial

Product Name:Novolog Mix 70/30 vial, Novolog Mix 70/30 Relion vial

Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Failure to Insulin Aspart mix vial confirmed by claims history or submission of medical records OR 1.2 History of contraindication or intolerance to Insulin Aspart mix vial (please specify intolerance or contraindication)	

Product Name:Humalog Mix 75/25 vial	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Failure to Insulin lispro protamine/insulin lispro Kwikpen 75/25 100U/ML confirmed by claims history or submission of medical records OR 1.2 History of contraindication or intolerance to Insulin lispro protamine/insulin lispro Kwikpen 75/25 100U/ML (please specify intolerance or contraindication)	

Product Name:Humulin R U-500 vial, Humulin R U-500 Kwikpen	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient requires more than 200 units of U-100 insulin per day

Product Name: Insulin Lispro Kwikpen, Insulin Lispro Junior Kwikpen

Approval Length 12 month(s)

Guideline Type Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 A visual impairment that prevents the patient from using a vial and syringe to accurately draw up the dose of insulin

OR

1.2 A physical disability or handicap that prevents the patient from using a vial and syringe to draw up the dose and administer the insulin

OR

1.3 History of failure to insulin lispro vial as demonstrated by poorly controlled diabetes based on hemoglobin A1c

OR

1.4 The patient is unable to use the vial dosage form of the drug due to documented poor compliance with vials and syringes resulting in poorly controlled diabetes based on hemoglobin A1c

Product Name: Apidra Solostar pen, Humalog cartridge, Humalog Kwikpen, Humalog Junior Kwikpen, Insulin Aspart Penfill, Insulin Aspart Flexpen, Admelog Solostar pen, Lyumjev Kwikpen, Merilog Solostar, Kirsty Pen	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 One of the following: 1.1.1 Failure to insulin lispro vial confirmed by claims history or submission of medical records OR 1.1.2 History of contraindication or intolerance to insulin lispro vial (please specify intolerance or contraindication) OR 1.2 ONE of the following: 1.2.1 A visual impairment that prevents the patient from using a vial and syringe to accurately draw up the dose of insulin OR 1.2.2 A physical disability or handicap that prevents the patient from using a vial and syringe to draw up the dose and administer the insulin OR 1.2.3 The patient is unable to use the vial dosage form of the drug due to documented poor compliance with vials and syringes resulting in poorly controlled diabetes based on hemoglobin A1c	

AND

2 - ONE of the following:

2.1 Failure to insulin lispro Kwikpen confirmed by claims history or submission of medical records

OR

2.2 History of contraindication or intolerance to insulin lispro Kwikpen (please specify intolerance or contraindication)

Product Name:Humalog Tempo Pen, Lyumjev Tempo Pen	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following: 1.1 ONE of the following: 1.1.1 Failure to insulin lispro Kwikpen confirmed by claims history or submission of medical records OR 1.1.2 History of contraindication or intolerance to insulin lispro Kwikpen (please specify intolerance or contraindication) AND 1.2 Prescriber provides a reason or special circumstance the patient has to use the Tempo product	

Product Name:Novolog Penfill, Novolog Flexpen, Fiasp Penfill, Fiasp Pumpcart, Fiasp FlexTouch	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following: 1.1 One of the following: 1.1.1 Failure to insulin lispro vial confirmed by claims history or submission of medical records OR 1.1.2 History of contraindication or intolerance to insulin lispro vial (please specify intolerance or contraindication) OR 1.2 ONE of the following: - A visual impairment that prevents the patient from using a vial and syringe to accurately draw up the dose of insulin - A physical disability or handicap that prevents the patient from using a vial and syringe to draw up the dose and administer the insulin - The patient is unable to use the vial dosage form of the drug due to documented poor compliance with vials and syringes resulting in poorly controlled diabetes based on hemoglobin A1c AND 2 - One of the following: 2.1 Failure to BOTH of the following confirmed by claims history or submission of medical records: - Insulin lispro Kwikpen	

- Insulin aspart pen or cartridge

OR

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

- Insulin lispro Kwikpen
- Insulin aspart pen or cartridge

Product Name:Novolin R Flexpen, Novolin R Flexpen Relion

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Failure to ONE of the following confirmed by claims history or submission of medical records:

- Humulin R U-100 vial
- Novolin R U-100 vial

OR

1.2 History of contraindication or intolerance to BOTH of the following (please specify intolerance or contraindication):

- Humulin R U-100 vial
- Novolin R U-100 vial

OR

2 - ONE of the following:

2.1 A visual impairment that prevents the patient from using a vial and syringe to accurately draw up the dose of insulin

OR

2.2 A physical disability or handicap that prevents the patient from using a vial and syringe to draw up the dose and administer the insulin

OR

2.3 The patient is unable to use the vial dosage form of the drug due to documented poor compliance with vials and syringes resulting in poorly controlled diabetes based on hemoglobin A1c

Product Name:Humulin N Kwikpen, Novolin N Flexpen, Novolin N Flexpen Relion	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Failure to ONE of the following confirmed by claims history or submission of medical records: • Humulin N U-100 vial • Novolin N U-100 vial OR 1.2 History of contraindication or intolerance to BOTH of the following (please specify intolerance or contraindication): • Humulin N U-100 vial • Novolin N U-100 vial	

OR

2 - ONE of the following:

2.1 A visual impairment that prevents the patient from using a vial and syringe to accurately draw up the dose of insulin

OR

2.2 A physical disability or handicap that prevents the patient from using a vial and syringe to draw up the dose and administer the insulin

OR

2.3 The patient is unable to use the vial dosage form of the drug due to documented poor compliance with vials and syringes resulting in poorly controlled diabetes based on hemoglobin A1c

Product Name:Humalog Mix Kwikpen 50/50, Insulin Aspart Flexpen 70/30, Humulin Kwikpen 70/30, Novolin Flexpen 70/30, Novolin Flexpen Relion 70/30

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Failure to the corresponding preferred insulin mix vial confirmed by claims history or submission of medical records

OR

1.2 History of contraindication or intolerance to the corresponding preferred insulin mix vial (please specify intolerance or contraindication)

OR

2 - ONE of the following:

2.1 A visual impairment that prevents the patient from using a vial and syringe to accurately draw up the dose of insulin

OR

2.2 A physical disability or handicap that prevents the patient from using a vial and syringe to draw up the dose and administer the insulin

OR

2.3 The patient is unable to use the vial dosage form of the drug due to documented poor compliance with vials and syringes resulting in poorly controlled diabetes based on hemoglobin A1c

Product Name:Novolog Mix 70/30 Flexpen, Novolog Mix 70/30 Flexpen Relion	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 ONE of the following: • Failure to the corresponding preferred insulin mix vial confirmed by claims history or submission of medical records • History of contraindication or intolerance to the corresponding preferred insulin mix vial (please specify intolerance or contraindication) OR	

1.2 ONE of the following:

- A visual impairment that prevents the patient from using a vial and syringe to accurately draw up the dose of insulin
- A physical disability or handicap that prevents the patient from using a vial and syringe to draw up the dose and administer the insulin
- The patient is unable to use the vial dosage form of the drug due to documented poor compliance with vials and syringes resulting in poorly controlled diabetes based on hemoglobin A1c

AND

2 - ONE of the following:

- Failure to Insulin Aspart Flexpen 70/30 100U/ML confirmed by claims history or submission of medical records
- History of contraindication or intolerance to Insulin Aspart Flexpen 70/30 100U/ML (please specify intolerance or contraindication)

Product Name:Humalog Mix Kwikpen 75/25	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following: 1.1 ONE of the following: • Failure to the corresponding preferred insulin mix vial confirmed by claims history or submission of medical records • History of contraindication or intolerance to the corresponding preferred insulin mix vial (please specify intolerance or contraindication) OR 1.2 ONE of the following:	

- A visual impairment that prevents the patient from using a vial and syringe to accurately draw up the dose of insulin
- A physical disability or handicap that prevents the patient from using a vial and syringe to draw up the dose and administer the insulin
- The patient is unable to use the vial dosage form of the drug due to documented poor compliance with vials and syringes resulting in poorly controlled diabetes based on hemoglobin A1c

AND

2 - One of the following:

- Failure to insulin lispro protamine/insulin lispro Kwikpen 75/25 100U/ML confirmed by claims history or submission of medical records
- History of contraindication or intolerance to Insulin lispro protamine/insulin lispro Kwikpen 75/25 100U/ML (please specify intolerance or contraindication)

Product Name: Basaglar Kwikpen, Insulin Glargine Solostar 100U/ml, Insulin glargine-yfgn Pen, Semglee yfgn Pen Injector

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - BOTH of the following:

1.1 ONE of the following:

1.1.1 Failure to BOTH of the following confirmed by claims history or submission of medical records:

- Rezvoglar Kwikpen
- Lantus (pens or vials)

OR

1.1.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Rezvoglar Kwikpen
- Lantus (pens or vials)

AND

1.2 The provider has given clinical justification why the patient is unable to use the preferred insulin glargine products

Product Name:Basaglar Tempo Pen

Approval Length 12 month(s)

Guideline Type Prior Authorization

Approval Criteria

1 - BOTH of the following:

1.1 ONE of the following:

1.1.1 Failure to BOTH of the following confirmed by claims history or submission of medical records:

- Rezvoglar Kwikpen
- Lantus (pens or vials)

OR

1.1.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Rezvoglar Kwikpen
- Lantus (pens or vials)

AND

1.2 Prescriber provides a reason or special circumstance the patient has to use the Tempo product

Product Name:Toujeo Solostar, Insulin Glargine Solostar 300U/ml, Toujeo Max Solostar, Insulin Glargine Max Solostar 300U/ml	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following: 1.1 ONE of the following: 1.1.1 Failure to BOTH of the following confirmed by claims history or submission of medical records: • Rezvoglar Kwikpen • Lantus (pens or vials) OR 1.1.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication): • Rezvoglar Kwikpen • Lantus (pens or vials) OR 1.1.3 The provider has given clinical justification why the patient needs a concentrated glargine formulation AND 1.2 If the request is for Toujeo Solostar or Toujeo Solostar Max, ONE of the following: 1.2.1 Failure to ONE of the following confirmed by claims history or submission of medical records: • Insulin glargine Solostar 300U/ml	

- Insulin glargine Max Solostar 300U/ml

OR

1.2.2 History of intolerance or contraindication to ONE of the following (please specify intolerance or contraindication):

- Insulin glargine Solostar 300U/ml
- Insulin glargine Max Solostar 300U/ml

Product Name:Levemir Flexpen, Insulin Degludec Flextouch 100U/mL	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Failure to ONE of the following confirmed by claims history or submission of medical records: • Rezvoglar Kwikpen • Lantus (pens or vials) OR 2 - History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication): • Rezvoglar Kwikpen • Lantus (pens or vials)	

Product Name:Tresiba Flextouch 100U/mL	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Failure to ONE of the following confirmed by claims history or submission of medical records:

- Rezvoglar Kwikpen
- Lantus (pens or vials)

OR

1.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Rezvoglar Kwikpen
- Lantus (pens or vials)

AND

2 - The provider has given clinical justification why the patient is unable to use the insulin degludec flextouch product

Product Name: Insulin Degludec Flextouch 200U/mL	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Failure to ONE of the following confirmed by claims history or submission of medical records: • Rezvoglar Kwikpen • Lantus (pens or vials)	

OR

2 - History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Rezvoglar Kwikpen
- Lantus (pens or vials)

OR

3 - The provider has given clinical justification why the patient needs a concentrated formulation

Product Name:Tresiba Flextouch 200U/mL	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following: 1.1 Failure to ONE of the following confirmed by claims history or submission of medical records: • Rezvoglar Kwikpen • Lantus (pens or vials) OR 1.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication): • Rezvoglar Kwikpen • Lantus (pens or vials) OR	

1.3 The provider has given clinical justification why the patient needs a concentrated formulation

AND

2 - The provider has given clinical justification why the patient is unable to use the insulin degludec flextouch product

Product Name:Insulin Glargine vial, Insulin glargine-yfgn vial, Semglee yfgn vial

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - BOTH of the following:

1.1 ONE of the following:

1.1.1 Failure to BOTH of the following confirmed by claims history or submission of medical records:

- Rezvoglar Kwikpen
- Lantus (pens or vials)

OR

1.1.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Rezvoglar Kwikpen
- Lantus (pens or vials)

AND

1.2 The provider has given clinical justification why the patient is unable to use the preferred insulin glargine products

Product Name:Levemir vial, Insulin Degludec vial	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Failure to ONE of the following confirmed by claims history or submission of medical records: • Rezvoglar Kwikpen • Lantus (pens or vials) OR 1.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication): • Rezvoglar Kwikpen • Lantus (pens or vials)	

Product Name:Tresiba vial	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following: 1.1 Failure to ONE of the following confirmed by claims history or submission of medical records: • Rezvoglar Kwikpen • Lantus (pens or vials)	

OR

1.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Rezvoglar Kwikpen
- Lantus (pens or vials)

AND

2 - The provider has given clinical justification why the patient is unable to use the insulin degludec product

Product Name:Admelog Solostar, Apidra, Insulin Aspart vial, Insulin Lispro vial, Humalog vial, Novolog vial, Novolog Relion vial, Fiasp vial, Lyumjev vial, Novolog Mix 70/30 vial, Novolog Mix 70/30 Relion vial, Humulin R U-500 vial, Apidra Solostar, Insulin Aspart Flexpen, Insulin Aspart Penfill, Insulin Lispro Junior Kwikpen, Insulin Lispro Kwikpen, Humalog Junior Kwikpen, Humalog Kwikpen, Humalog Tempo Pen, Novolog Flexpen, Novolog Flexpen Relion, Novolog Penfill, Fiasp Flextouch, Fiasp Penfill, Fiasp Pumpcart, Lyumjev Kwikpen, Lyumjev Tempo Pen, Novolin R Flexpen Relion, Novolin R Flexpen, Humulin R U-500 Kwikpen, Humulin N Kwikpen, Novolin N Flexpen Relion, Novolin N Flexpen, Humalog Mix 75/25 Kwikpen, Insulin Lispro Mix Kwikpen 75/25, Humalog Mix 50/50 Kwikpen, Insulin Aspart Protamine/Insulin Aspart 70/30 Flexpen, Humulin 70/30 Kwikpen, Novolin 70/30 Flexpen, Novolin 70/30 Flexpen Relion, Novolog Mix 70/30 Flexpen, Novolog Mix 70/30 Flexpen Relion, Lantus Solostar, Basaglar Tempo Pen, Toujeo Solostar, Insulin Glargine Solostar 300U/ml, Toujeo Max Solostar, Insulin Glargine Max Solostar 300U/ml, Semglee yfgn Pen Injector, Semglee yfgn vial, Levemir Flexpen, Tresiba Flextouch, Insulin Degludec Flextouch, Semglee vial, Lantus vial, Levemir vial, Tresiba vial, Insulin Degludec vial, Basaglar Kwikpen, Insulin Glargine vial, Insulin Glargine-YFGN pen and vial, Insulin Glargine Solostar 100U/ml, Humulin R vial, Novolin R vial, Novolin R Relion vial, Humulin N vial, Novolin N Relion vial, Novolin N vial, Insulin Aspart Protamine/Insulin Aspart 70/30 vial, Humalog Mix 75/25 vial, Humalog Mix 50/50 vial, Humulin 70/30 vial, Novolin 70/30 Relion vial, Novolin 70/30 vial, Admelog vial, Humalog Cartridge, Rezvoglar Kwikpen, Merilog vial, Merilog Solostar, Kirsty pen, Kirsty vial

Approval Length	12 month(s)
Guideline Type	Quantity Limit

Approval Criteria

1 - Quantity requests exceeding the limited amount will be approved based on physician

confirmation that the patient requires a greater quantity due to poorly controlled diabetes based on blood glucose and/or hemoglobin A1c

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>

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>

NM: <https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-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>

3 . Revision History

Date	Notes
3/10/2026	Updated U-500 criteria language. Removed NY

Interstitial Lung Disease Agents



Prior Authorization Guideline

Guideline ID	GL-555285
Guideline Name	Interstitial Lung Disease 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 New Mexico Medicaid - Community & State Nevada

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name: Brand Esbriet, generic pirfenidone, Ofev, Jascayd	
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 ALL 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 - ONE of the following: • If the request is for Esbriet (pirfenidone), it is not being used in combination with Ofev • If the request is for Ofev, it is not being used in combination with Esbriet (pirfenidone) • The request is for Jascayd AND 3 - The prescriber is a pulmonologist	

Product Name: Brand Esbriet, generic pirfenidone, Ofev, Jascayd	
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 AND 2 - ONE of the following: • If the request is for Esbriet (pirfenidone), it is not being used in combination with Ofev • If the request is for Ofev, it is not being used in combination with Esbriet (pirfenidone) • The request is for Jascayd	

Product Name: Ofev, Jascayd	
Diagnosis	Progressive Pulmonary Fibrosis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of progressive pulmonary fibrosis AND 2 - At least TWO of the following criteria occurring within the past 12 months with no alternative explanation:	

2.1 Worsening respiratory symptoms

OR

2.2 Physiological evidence of disease progression demonstrated by ONE of the following:

- Absolute decline in forced vital capacity (FVC) at least 5% predicted
- Absolute decline in diffusing capacity of the lungs for carbon monoxide (DLco) (corrected for Hb) at least 10% predicted

OR

2.3 Radiological evidence of disease progression by at least ONE of the following via high-resolution computed tomography (HRCT):

- Increased extent or severity of traction bronchiectasis/bronchiolectasis
- Increased extent or increased coarseness of reticular abnormality
- Increased lobar volume loss
- New ground-glass opacity with traction bronchiectasis
- New fine reticulation
- New or increased honeycombing

AND

3 - The prescriber is a pulmonologist

Product Name:Ofev, Jascayd	
Diagnosis	Progressive Pulmonary Fibrosis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy	

AND

2 - Prescribed by a pulmonologist

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 ALL of the following:

1.1 ONE of the following:

1.1.1 Skin thickening of the fingers of both hands extending proximal to the metacarpophalangeal joints

OR

1.1.2 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 - Ofev is not being used in combination with Esbriet (pirfenidone)

AND

3 - The prescriber is a pulmonologist

Product Name:Ofev	
Diagnosis	Systemic Sclerosis-Associated Interstitial Lung Disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Ofev therapy AND 2 - Ofev is not being used in combination with Esbriet (pirfenidone)	

2 . Revision History

Date	Notes
3/23/2026	Updated title. Added Jascayd. Updated Ofev coverage criteria by removing chronic fibrosing interstitial lung disease with progressive phe

	notype and including Ofev into the section for progressive pulmonary fibrosis

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

Isotretinoin



Prior Authorization Guideline

Guideline ID	GL-512239
Guideline Name	Isotretinoin
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 Nevada

Guideline Note:

Effective Date:	2/3/2026

1 . Criteria

Product Name:Accutane, generic isotretinoin, Claravis, Amnesteem, Zenatane, Brand Absorica, Absorica LD	
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)	

Product Name:Accutane, generic isotretinoin, Claravis, Amnesteem, Zenatane, Brand Absorica, Absorica LD	
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	

Product Name:Accutane, generic isotretinoin, Claravis, Amnesteem, Zenatane, Brand Absorica, Absorica LD	
Diagnosis	Acne
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following:	

- Diagnosis of severe recalcitrant nodular acne unresponsive to conventional therapy
- Diagnosis of treatment resistant acne

AND

2 - ONE of the following:

2.1 Failure to an adequate trial on TWO of the following conventional therapy regimens confirmed by claims history or submission of medical records:

- Topical retinoid or retinoid-like agent [e.g., Retin-A/Retin-A Micro (tretinoin)]
- Oral antibiotic [e.g., Ery-Tab (erythromycin), Biaxin (clarithromycin), Minocin (minocycline)]
- Topical antibiotic with or without benzoyl peroxide [e.g., Cleocin-T (clindamycin), erythromycin, BenzaClin (benzoyl peroxide/clindamycin), Benzamycin (benzoyl peroxide/erythromycin)]

OR

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

- Topical retinoid or retinoid-like agent [e.g., Retin-A/Retin-A Micro (tretinoin)]
- Oral antibiotic [e.g., Ery-Tab (erythromycin), Biaxin (clarithromycin), Minocin (minocycline)]
- Topical antibiotic with or without benzoyl peroxide [e.g., Cleocin-T (clindamycin), erythromycin, BenzaClin (benzoyl peroxide/clindamycin), Benzamycin (benzoyl peroxide/erythromycin)]

AND

3 - If the request is non-preferred*, the prescriber has given a clinical reason or special circumstance why the patient is unable to use the preferred product (please document reason or special circumstance)

Notes	*PDL links are listed in Background.

Product Name: Accutane, generic isotretinoin, Claravis, Amnesteem, Zenatane, Brand Absorica, Absorica LD	
Diagnosis	Acne

Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - After greater than or equal to 2 months OFF therapy, persistent or recurring severe recalcitrant nodular acne is still present OR 2 - Total cumulative dose for total duration of therapy is less than 150 mg/kg (document patient's dose and weight)*	
Notes	*Will be approved up to a total of 150 mg/kg

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 CHIP: https://www.uhcprovider.com/en/health-plans-by-state/pennsylvania-health-plans/pa-chip-pharmacy.html

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>

VA: <https://www.uhcprovider.com/en/health-plans-by-state/virginia-health-plans/va-comm-plan-home/va-cp-pharmacy.html>

NE: <https://www.uhcprovider.com/en/health-plans-by-state/nebraska-health-plans/ne-comm-plan-home/ne-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>

NV: <https://myhpnmedicaid.com/member/pharmacy-benefits>

3 . Revision History

Date	Notes
2/3/2026	Updated PDL Link

Isturisa



Prior Authorization Guideline

Guideline ID	GL-531193
Guideline Name	Isturisa
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 New Mexico Medicaid - Community & State Pennsylvania Medicaid - Community & State Virginia Medicaid - Community & State Nevada

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 Cushing's syndrome AND 2 - ONE of the following: • Patient is not a candidate for pituitary surgery • Pituitary surgery has not been curative	

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

2 . Revision History

Date	Notes
2/25/2026	Removed IN formulary - see state Cushing's Syndrome Agents GL-5 31190 for 4/1/26. No other changes to guideline.

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

lwlfin



Prior Authorization Guideline

Guideline ID	GL-220213
Guideline Name	lwlfin
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:lwlfin

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: Iwifin	
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 Iwifin 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



Prior Authorization Guideline

Guideline ID	GL-228224
Guideline Name	Jesduvroq
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State New Jersey Medicaid - Community & State New Mexico Medicaid - Community & State New York Medicaid - Community & State New York EPP Medicaid - Community & State Pennsylvania Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Washington

Guideline Note:

Effective Date:	5/1/2025

1 . Criteria

Product Name: Jesduvroq	
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 four months AND 3 - BOTH of the following: • Ferritin greater than 100 mcg/L (micrograms per liter) • Transferrin saturation (TSAT) greater than 20% AND 4 - Hemoglobin level is less than 11 g/dL (grams per deciliter) 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) (please specify contraindication or intolerance)	

AND

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

- Hematologist
- Nephrologist

Product Name:Jesduvroq

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Jesduvroq 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 (micrograms per liter)
- Transferrin saturation (TSAT) greater than 20%

AND

3 - Hemoglobin level does not exceed 12 g/dL (grams per deciliter)

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
3/27/2025	Updated formularies

Joenna



Prior Authorization Guideline

Guideline ID	GL-150140
Guideline Name	Joenna
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

Guideline Note:

Effective Date:	8/1/2024

1 . Criteria

Product Name:Joenna	
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

UnitedHealthcare Community Plan of Rhode Island Clinical Pharmacy Program Guidelines

7/23/2024	Updated initial authorization duration to 12 months.

Joenna



Prior Authorization Guideline

Guideline ID	GL-150140
Guideline Name	Joenna
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

Guideline Note:

Effective Date:	8/1/2024

1 . Criteria

Product Name:Joenna	
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

7/23/2024	Updated initial authorization duration to 12 months.

Journavx



Prior Authorization Guideline

Guideline ID	GL-492189
Guideline Name	Journavx
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 Washington Medicaid - Community & State Nebraska Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	1/7/2026

1 . Criteria

Product Name: Journavx

Approval Length	14 Day(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderate to severe acute pain AND 2 - Prescriber has given a clinical reason or special circumstance why the patient is unable to use an NSAID (nonsteroidal anti-inflammatory drug) (e.g., ibuprofen, naproxen) to treat the patient's pain (please document reason/special circumstance) AND 3 - Physician attests that Journavx will not be used for more than 14 days of therapy for the current pain episode	

2 . Revision History

Date	Notes
1/7/2026	Updated formularies to remove PA

Juxtapid



Prior Authorization Guideline

Guideline ID	GL-564237
Guideline Name	Juxtapid
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

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

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

Guideline Type	Prior Authorization
	Approval Criteria 1 - Diagnosis of homozygous familial hypercholesterolemia (HoFH) as confirmed by ONE of the following: 1.1 Submission of medical records (e.g., chart notes, laboratory values) confirming genetic confirmation of bi-allelic pathogenic/likely pathogenic variants on different chromosomes at the low-density lipoprotein receptor (LDLR), apolipoprotein B (APOB), proprotein convertase subtilisin kexin type 9 (PCSK9), or low-density lipoprotein receptor adaptor protein 1 (LDLRAP1) genes or greater than or equal to 2 such variants at different loci OR 1.2 BOTH of the following: 1.2.1 Untreated low-density lipoprotein cholesterol (LDL-C) greater than 400 mg/dL AND 1.2.2 ONE of the following: • Xanthoma before 10 years of age • Evidence of familial hypercholesterolemia in at least one parent AND 2 - Patient is on a low-fat diet AND 3 - Patient is receiving other lipid-lowering therapy (e.g., statin, ezetimibe, LDL apheresis) AND

4 - Prescribed by ONE of the following:

- Cardiologist
- Endocrinologist
- Lipid specialist

AND

5 - ONE of the following:

5.1 Failure to Repatha (evolocumab) as confirmed by claims history or submission of medical records

OR

5.2 History of intolerance or contraindication to Repatha (evolocumab) (please specify intolerance or contraindication)

AND

6 - Not used in combination with a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor [e.g., Praluent (alirocumab), Repatha (evolocumab)]

AND

7 - Not used in combination with Evkeeza (evinacumab-dgnb)

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

1 - Patient is on a low-fat diet

AND

2 - Patient continues to receive other lipid-lowering therapy (e.g., statin, low density lipoprotein [LDL] apheresis)

AND

3 - Documentation of a positive clinical response to therapy from pre-treatment baseline

AND

4 - Prescribed by ONE of the following:

- Cardiologist
- Endocrinologist
- Lipid specialist

AND

5 - Not used in combination with a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor [e.g., Praluent (alirocumab), Repatha (evolocumab)]

AND

6 - Not used in combination with Evkeeza (evinacumab-dgnb)

2 . Revision History

Date	Notes
4/6/2026	Removed MI

Kalydeco



Prior Authorization Guideline

Guideline ID	GL-353227
Guideline Name	Kalydeco
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

Guideline Note:

Effective Date:	9/1/2025

1 . Criteria

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

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of cystic fibrosis (CF) AND 2 - Submission of laboratory results confirming that patient has at least ONE of the mutations in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to Kalydeco, listed in Table 1 (see Background) AND 3 - Prescribed by, or in consultation with a provider who specializes in the treatment of CF	

Product Name:Kalydeco	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Kalydeco therapy (e.g., improved lung function, stable lung function)	

2 . Background

Benefit/Coverage/Program Information
Table 1. CFTR Gene Mutations (A complete up to date list of responsive mutations can be referenced in the Kalydeco Prescribing Information)

711+3A→G *	F311del	I148T	R75Q	S589N
2789+5G→A *	F311L	I175V	R117C *	S737F
3272-26A→G *	F508C	I807M	R117G	S945L *
3849+10kbC→T *	F508C;S1251N †	I1027T	R117H *	S977F *
A120T	F1052V	I1139V	R117L	S1159F
A234D	F1074L	K1060T	R117P	S1159P
A349V	G178E	L206W *	R170H	S1251N *
A455E *	G178R *	L320V	R347H *	S1255P *
A1067T	G194R	L967S	R347L	T338I
D110E	G314E	L997F	R352Q *	T1053I
D110H	G551D *	L1480P	R553Q	V232D
D192G	G551S *	M152V	R668C	V562I
D579G *	G576A	M952I	R792G	V754M
D924N	G970D	M952T	R933G	V1293G
D1152H *	G1069R	P67L *	R1070Q	W1282R
D1270N	G1244E *	Q237E	R1070W *	Y1014C
E56K	G1249R	Q237H	R1162L	Y1032C

E193K	G1349D *	Q359R	R1283M	
E822K	H939R	Q1291R	S549N *	
E831X *	H1375P	R74W	S549R *	

* Clinical data exist for these mutations.

† Complex/compound mutations where a single allele of the CFTR gene has multiple mutations; these exist independent of the presence of mutations on the other allele.

3 . Revision History

Date	Notes
8/6/2025	Added Virginia formulary. Updated background title information.

Kerendia



Prior Authorization Guideline

Guideline ID	GL-439215
Guideline Name	Kerendia
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 Pennsylvania Medicaid - Community & State Virginia Medicaid - Community & State Nevada

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Kerendia

Diagnosis	Chronic kidney disease (CKD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chronic kidney disease (CKD) associated with type 2 diabetes (T2D) AND 2 - BOTH of the following: 2.1 UACR (urinary albumin-to-creatinine ratio) greater than or equal to 30 mg/g AND 2.2 eGFR (estimated glomerular filtration rate) greater than or equal to 25 mL/min/1.73 m² AND 3 - Kerendia is being used to reduce the risk of at least ONE of the following: • Sustained eGFR decline • End-stage kidney disease • Cardiovascular death • Non-fatal myocardial infarction • Hospitalization for heart failure AND 4 - Serum potassium level is less than or equal to 5 mEq/L (milliequivalents/liter) prior to initiating treatment	

AND

5 - ONE of the following:

5.1 Patient is on a stabilized dose and receiving concomitant therapy with ONE of the following as confirmed by claims history or submission of medical records:

- Maximally tolerated angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril)
- Maximally tolerated angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan)

OR

5.2 Patient has an allergy, contraindication, or intolerance to ACE inhibitors and ARBs (please specify allergy, contraindication, or intolerance)

AND

6 - Prescriber attests the patient's diabetes is being managed with a diabetes medication with proven CKD benefit [e.g., SGLT2 inhibitor (e.g., Jardiance), GLP1 receptor agonist (e.g., Ozempic)]

Product Name:Kerendia	
Diagnosis	Heart Failure with Preserved Ejection Fraction (HFpEF)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of heart failure with preserved ejection fraction (HFpEF) AND	

2 - Ejection fraction is greater than or equal to 50%

AND

3 - An eGFR of greater than or equal to 25 mL/min/1.73 m²

AND

4 - Serum potassium level is less than or equal to 5 mEq/L prior to initiating treatment

AND

5 - ONE of the following:

5.1 Patient is on a stabilized dose and receiving concomitant therapy with ONE of the following as confirmed by claims history or submission of medical records:

- Maximally tolerated angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril)
- Maximally tolerated angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan)
- Maximally tolerated angiotensin receptor-neprilysin inhibitor (ARNI) (e.g., sacubitril/valsartan)

OR

5.2 Patient has an allergy, contraindication, or intolerance to ACE inhibitors, ARBs, and ARNIs (please specify allergy, contraindication, or intolerance)

AND

6 - ONE of the following:

- Patient is on a stabilized dose and receiving concomitant therapy with a SGLT-2 inhibitor (e.g., Jardiance) as confirmed by claims history or submission of medical records

- Patient has an allergy, contraindication, or intolerance to a SGLT-2 inhibitor (e.g., Jardiance) (please specify allergy, contraindication, or intolerance)

AND

7 - ONE of the following:

- History of trial and failure to a mineralocorticoid receptor antagonist [MRA (e.g., spironolactone, eplerenone)] as confirmed by claims history or submission of medical records
- Patient has an intolerance or contraindication to a mineralocorticoid receptor antagonist [MRA (e.g., spironolactone, eplerenone)] (please specify intolerance or contraindication)

Product Name:Kerendia	
Diagnosis	Heart Failure with mildly reduced ejection fraction (HFmrEF)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of heart failure with mildly reduced ejection fraction (HFmrEF) AND 2 - Ejection fraction 40% to less than 50% AND 3 - An eGFR of greater than or equal to 25 mL/min/1.73 m2 AND	

4 - Serum potassium level is less than or equal to 5 mEQ/L prior to initiating treatment

AND

5 - ONE of the following:

5.1 Patient is on a stabilized dose and receiving concomitant therapy with ONE of the following as confirmed by claims history or submission of medical records:

- Maximally tolerated angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril)
- Maximally tolerated angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan)
- Maximally tolerated angiotensin receptor-neprilysin inhibitor (ARNI) (e.g., sacubitril/valsartan)

OR

5.2 Patient has an allergy, contraindication, or intolerance to ACE inhibitors, ARBs, and ARNIs (please specify allergy, contraindication, or intolerance)

AND

6 - ONE of the following:

- Patient is on a stabilized dose and receiving concomitant therapy with a SGLT-2 inhibitor (e.g., Jardiance) as confirmed by claims history or submission of medical records
- Patient has an allergy, contraindication, or intolerance to a SGLT-2 inhibitor (e.g., Jardiance) (please specify allergy, contraindication, or intolerance)

AND

7 - ONE of the following:

- Patient is on a stabilized dose and receiving concomitant therapy with a beta-blocker (e.g., carvedilol, metoprolol succinate, bisoprolol) as confirmed by claims history or submission of medical records

- Patient has an allergy, contraindication, or intolerance to a beta-blocker (e.g., carvedilol, metoprolol succinate, bisoprolol) (please specify allergy, intolerance, or contraindication)

AND

8 - ONE of the following:

- History of trial and failure to a mineralocorticoid receptor antagonist [MRA (e.g., spironolactone, eplerenone)] as confirmed by claims history or submission of medical records
- Patient has an intolerance or contraindication to a mineralocorticoid receptor antagonist [MRA (e.g., spironolactone, eplerenone)] (please specify intolerance or contraindication)

Product Name:Kerendia	
Diagnosis	CKD, HFpEF, HFmrEF
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

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

Kevzara



Prior Authorization Guideline

Guideline ID	GL-534210
Guideline Name	Kevzara
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 New Mexico

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Kevzara	
Diagnosis	Rheumatoid Arthritis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active rheumatoid arthritis (RA)

AND

2 - One of the following:

2.1 Patient is currently on Kevzara therapy as confirmed by claims history or submission of medical records

OR

2.2 All of the following:

2.2.1 One of the following:

2.2.1.1 Failure to a 3-month trial of one non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] at maximally indicated doses as confirmed by claims history or submitted medical records

OR

2.2.1.2 History of intolerance or contraindication to one non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] (please specify intolerance or contraindication)

OR

2.2.1.3 Patient has been previously treated with a targeted immunomodulator FDA-approved for the treatment of rheumatoid arthritis as confirmed by claims history or submission of medical records [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib)]

AND

2.2.2 One of the following:

2.2.2.1 Failure of one preferred adalimumab product* confirmed by claims history or submitted medical records

OR

2.2.2.2 History of intolerance or contraindication to all preferred adalimumab products* (please specify intolerance or contraindication)

AND

2.2.3 One of the following:

2.2.3.1 Failure of Tyenne (tocilizumab-aazg) confirmed by claims history or submitted medical records

OR

2.2.3.2 History of intolerance or contraindication to Tyenne (tocilizumab-aazg) (please specify intolerance or contraindication)

AND

3 - Patient is not receiving Kevzara in combination with another targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib)]

AND

4 - Prescribed by or in consultation with a rheumatologist

Notes	*See Table 1 for PDL Links

Product Name:Kevzara	
Diagnosis	Rheumatoid Arthritis

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Kevzara therapy AND 2 - Patient is not receiving Kevzara in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]	

Product Name:Kevzara	
Diagnosis	Polymyalgia Rheumatica (PMR)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of polymyalgia rheumatica (PMR) AND 2 - Patient has had an inadequate response to corticosteroids or cannot tolerate corticosteroid taper AND 3 - Patient is not receiving Kevzara in combination with another targeted immunomodulator	

[e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib)]

Product Name:Kevzara	
Diagnosis	Polymyalgia Rheumatica (PMR)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Kevzara therapy AND 2 - Patient is not receiving Kevzara in combination with another targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib)]	

Product Name:Kevzara	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (pJIA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of active polyarticular juvenile idiopathic arthritis AND 2 - Patient is NOT receiving Kevzara in combination with another targeted immunomodulator	

[e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib)]

AND

3 - One of the following:

- Failure of one preferred adalimumab product* confirmed by claims history or submitted medical records
- History of intolerance or contraindication to all preferred adalimumab products* (please specify intolerance or contraindication)

AND

4 - One of the following:

- Failure of Tyenne (tocilizumab-aazg) confirmed by claims history or submitted medical records
- History of intolerance or contraindication to Tyenne (tocilizumab-aazg) (please specify intolerance or contraindication)

AND

5 - Prescribed by or in consultation with a rheumatologist

Notes	*See Table 1 for PDL Links

Product Name:Kevzara	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (pJIA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Kevzara therapy	

AND

2 - Patient is not receiving Kevzara in combination with another targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib)]

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>

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>

PA CHIP: <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>

NM: <https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html>

3 . Revision History

UnitedHealthcare Community Plan of Rhode Island Clinical Pharmacy Program Guidelines

Date	Notes
2/25/2026	Removed NY-CHIP

Kineret



Prior Authorization Guideline

Guideline ID	GL-532228
Guideline Name	Kineret
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 New Mexico

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Kineret	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active rheumatoid arthritis (RA)

AND

2 - Patient is NOT receiving Kineret in combination with another systemic targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)] for treatment of the same indication

AND

3 - Prescribed by or in consultation with a rheumatologist

AND

4 - ONE of the following:

4.1 Patient is currently on Kineret therapy as confirmed by claims history or submission of medical records

OR

4.2 BOTH of the following:

4.2.1 ONE of the following:

4.2.1.1 Patient has been previously treated with systemic targeted immunomodulator FDA-approved for the treatment of rheumatoid arthritis as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Olumiant (baricitinib), Rinvoq (upadacitinib), Xeljanz (tofacitinib)]

OR

4.2.1.2 Failure to a 3 month trial of ONE non-biologic disease modifying anti-rheumatic drug

(DMARD) [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] at maximally indicated doses confirmed by claims history or submitted medical records

OR

4.2.1.3 History of intolerance or contraindication to ONE non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] (please specify intolerance or contraindication)

AND

4.2.2 ONE of the following:

4.2.2.1 Failure of THREE of the following confirmed by claims history or submission of medical records:

- One of the preferred adalimumab products*
- Enbrel (etanercept)
- Olumiant (baricitinib)
- Tyenne (tocilizumab-aazg)

OR

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

- One of the preferred adalimumab products*
- Enbrel (etanercept)
- Olumiant (baricitinib)
- Tyenne (tocilizumab-aazg)

Notes	*See PDL links in Background

Product Name:Kineret	
Diagnosis	Neonatal-Onset Multisystem Inflammatory Disease (NOMID)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of neonatal-onset multisystem inflammatory disease (NOMID)

AND

2 - Patient is NOT receiving Kineret in combination with another systemic targeted immunomodulator. [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orenzia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)] for treatment of the same indication

AND

3 - Prescribed by or in consultation with a rheumatologist

Product Name:Kineret	
Diagnosis	Systemic Juvenile Idiopathic Arthritis (SJIA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of active systemic juvenile idiopathic arthritis (SJIA) (formerly Still's Disease) AND 2 - Patient is NOT receiving Kineret in combination with another systemic targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orenzia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)] for treatment of the same indication	

AND

3 - Prescribed by or in consultation with a rheumatologist

AND

4 - ONE of the following:

4.1 Patient is currently on Kineret therapy as confirmed by claims history or submission of medical records

OR

4.2 ONE of the following:

4.2.1 Failure of Tyenne (tocilizumab-aazg) confirmed by claims history or submitted medical records

OR

4.2.2 History of intolerance or contraindication to Tyenne (tocilizumab-aazg) (please specify intolerance or contraindication)

Product Name:Kineret	
Diagnosis	Adult Onset Still's Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of adult onset Still's Disease	

AND

2 - Patient is NOT receiving Kineret in combination with another systemic targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)] for treatment of the same indication

AND

3 - Prescribed by or in consultation with a rheumatologist

Product Name:Kineret	
Diagnosis	Deficiency of Interleukin-1 Receptor Antagonist (DIRA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of deficiency of Interleukin-1 Receptor Antagonist (DIRA) AND 2 - Patient is NOT receiving Kineret in combination with another systemic targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)] for treatment of the same indication AND 3 - Prescribed by or in consultation with a rheumatologist	

Product Name:Kineret	
Diagnosis	Rheumatoid Arthritis (RA), Neonatal-Onset Multisystem Inflammatory Disease (NOMID), Systemic Juvenile Idiopathic Arthritis (SJIA), Adult Onset Still's Disease, Deficiency of Interleukin-1 Receptor Antagonist (DIRA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Kineret therapy AND 2 - Patient is NOT receiving Kineret in combination with another systemic targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)] for treatment of the same indication	

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 PA CHIP: https://www.uhcprovider.com/en/health-plans-by-state/pennsylvania-health-plans/pa-chip-pharmacy.html

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>

NM: <https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html>

3 . Revision History

Date	Notes
3/3/2026	Removed NY. Added PDL links

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.

Korlym



Prior Authorization Guideline

Guideline ID	GL-531194
Guideline Name	Korlym
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State Nebraska Medicaid - Community & State New Jersey Medicaid - Community & State New Mexico Medicaid - Community & State New York Medicaid - Community & State New York EPP Medicaid - Community & State Pennsylvania Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Virginia Medicaid - Community & State Washington Medicaid - Community & State Nevada

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Brand Korlym, generic mifepristone	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of endogenous Cushing's syndrome (i.e., hypercortisolism is not a result of chronic administration of high dose glucocorticoids) AND 2 - ONE of the following: • Diagnosis of type 2 diabetes mellitus • Diagnosis of glucose intolerance AND 3 - ONE of the following: • Patient has failed surgery • Patient is not a candidate for surgery	

Product Name:Brand Korlym, generic mifepristone	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of a positive clinical response while on the requested therapy	

2 . Revision History

Date	Notes
2/25/2026	Removed IN formulary - see state Cushing's Syndrome Agents GL-5 31190 for 4/1/26. No other changes to guideline.

Korlym



Prior Authorization Guideline

Guideline ID	GL-531194
Guideline Name	Korlym
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State Nebraska Medicaid - Community & State New Jersey Medicaid - Community & State New Mexico Medicaid - Community & State New York Medicaid - Community & State New York EPP Medicaid - Community & State Pennsylvania Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Virginia Medicaid - Community & State Washington Medicaid - Community & State Nevada

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Brand Korlym, generic mifepristone	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of endogenous Cushing's syndrome (i.e., hypercortisolism is not a result of chronic administration of high dose glucocorticoids) AND 2 - ONE of the following: • Diagnosis of type 2 diabetes mellitus • Diagnosis of glucose intolerance AND 3 - ONE of the following: • Patient has failed surgery • Patient is not a candidate for surgery	

Product Name:Brand Korlym, generic mifepristone	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of a positive clinical response while on the requested therapy	

2 . Revision History

Date	Notes
2/25/2026	Removed IN formulary - see state Cushing's Syndrome Agents GL-5 31190 for 4/1/26. No other changes to guideline.

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

UnitedHealthcare Community Plan of Rhode Island Clinical Pharmacy Program Guidelines

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.

Kuvan, Zelvysia



Prior Authorization Guideline

Guideline ID	GL-522277
Guideline Name	Kuvan, Zelvysia
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

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name: Brand Kuvan, generic sapropterin, Zelvysia	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of phenylketonuria (PKU)	

2 . Revision History

Date	Notes
2/23/2026	Updated formularies to add ACUPA for eff 4/1/2026.

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

Leqembi IQLIK



Prior Authorization Guideline

Guideline ID	GL-521193
Guideline Name	Leqembi IQLIK
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 Medicaid - Community & State Rhode Island Medicaid - Community & State Michigan Medicaid - Community & State Nebraska Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name:Leqembi IQLIK

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has a diagnosis of Alzheimer's disease AND 2 - Presence of amyloid beta pathology has been confirmed AND 3 - Patient has been established on intravenous Leqembi therapy under an active UnitedHealthcare medical benefit prior authorization AND 4 - BOTH of the following: 4.1 Submission of medical records (e.g., chart notes) confirming follow-up brain magnetic resonance imaging (MRI) has been completed after the initiation of intravenous Leqembi therapy AND 4.2 ONE of the following: 4.2.1 Amyloid-related imaging abnormalities (ARIA) have not been observed on MRI OR 4.2.2 ALL of the following:	

4.2.2.1 ARIA has been observed on MRI

AND

4.2.2.2 Prescriber attests that continuation of therapy with Leqembi IQLIK is appropriate based on the severity of the patient's clinical symptoms

AND

4.2.2.3 ONE of the following:

- Follow-up MRI demonstrates radiographic resolution and/or stabilization
- Prescriber attests that continuation of therapy with Leqembi IQLIK is appropriate based on the radiographic severity of ARIA

AND

5 - Not used in combination with other A β monoclonal antibodies (mAbs) for Alzheimer's Disease (e.g., Kisunla)

AND

6 - Prescribed by a neurologist, geriatric psychiatrist, or geriatrician who specializes in treating dementia

Product Name:Leqembi IQLIK	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Not used in combination with other Aβ monoclonal antibodies (mAbs) for Alzheimer's Disease (e.g., Kisunla)	

AND

2 - Prescribed by a neurologist, geriatric psychiatrist, or geriatrician who specializes in treating dementia

2 . Revision History

Date	Notes
2/11/2026	Removed criteria for staging of dementia due to Alzheimer's disease under initial and reauth criteria.

Leqselvi



Prior Authorization Guideline

Guideline ID	GL-439220
Guideline Name	Leqselvi
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Maryland Medicaid - Community & State New Jersey Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State New Mexico Medicaid - Community & State Nevada

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Leqselvi	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of severe alopecia areata

AND

2 - Other causes of hair loss have been ruled out (e.g., androgenetic alopecia, cicatricial alopecia, secondary syphilis, tinea capitis, triangular alopecia, and trichotillomania)

AND

3 - Patient requesting therapy for current episode of alopecia areata

AND

4 - ONE of the following:

- Failure to Olumiant confirmed by claims history or submission of medical records
- History of intolerance or contraindication to Olumiant (please specify intolerance or contraindication)

AND

5 - Patient is not receiving Leqselvi in combination with any of the following:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Rinvoq (upadacitinib), Litfulo (ritlecitinib), Olumiant (baricitinib)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)

AND

6 - Prescribed by or in consultation with a dermatologist

Product Name:Leqselvi	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Leqselvi therapy AND 2 - Patient is not receiving Leqselvi in combination with any of the following: - Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Rinvoq (upadacitinib), Litfulo (ritlecinib), Olumiant (baricitinib)] - Potent immunosuppressant (e.g., azathioprine or cyclosporine)	

2 . Revision History

Date	Notes
11/5/2025	Added Nevada Formulary

Levalbuterol inhalation solution



Prior Authorization Guideline

Guideline ID	GL-555296
Guideline Name	Levalbuterol inhalation solution
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

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:levalbuterol inhalation soln	
Approval Length	12 month(s)
Guideline Type	Step Therapy

Approval Criteria

1 - Failure to treatment with albuterol inhalation solution, as confirmed by claims history or submission of medical records

OR

2 - History of contraindication or intolerance to albuterol inhalation solution (please specify contraindication or intolerance)

2 . Revision History

Date	Notes
3/23/2026	Renamed policy to levalbuterol inhalation solution Removed brand X openex

Lidoderm



Prior Authorization Guideline

Guideline ID	GL-518196
Guideline Name	Lidoderm
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State New Jersey Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Nebraska Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name:generic lidocaine 5% patch, Brand Lidoderm	
Diagnosis	Post-Herpetic Neuralgia
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of post-herpetic neuralgia

Product Name:generic lidocaine 5% patch, Brand Lidoderm

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

Approval Criteria

1 - Diagnosis of neuropathic pain

AND

2 - ONE of the following:

2.1 Failure to ALL of the following as confirmed by claims history or submission of medical records:

- Tricyclic anti-depressant (e.g., amitriptyline)
- SNRI (serotonin and norepinephrine reuptake inhibitor) anti-depressant (e.g., duloxetine, venlafaxine)
- Anticonvulsant (e.g., gabapentin, pregabalin)

OR

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

- Tricyclic anti-depressant (e.g., amitriptyline)
- SNRI anti-depressant (e.g., duloxetine, venlafaxine)
- Anticonvulsant (e.g., gabapentin, pregabalin)

Product Name:generic lidocaine 5% patch, Brand Lidoderm	
Diagnosis	Neuropathic Pain
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
2/9/2026	Added NM and NE formulary. Removed NY

Litfulo



Prior Authorization Guideline

Guideline ID	GL-510414
Guideline Name	Litfulo
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Maryland Medicaid - Community & State New Jersey Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Nevada Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name:Litfulo	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of severe alopecia areata

AND

2 - Other causes of hair loss have been ruled out (e.g., androgenetic alopecia, cicatricial alopecia, secondary syphilis, tinea capitis, triangular alopecia, and trichotillomania)

AND

3 - Patient requesting therapy for current episode of alopecia areata

AND

4 - ONE of the following:

4.1 Patient is less than 18 years of age

OR

4.2 Failure to Olumiant confirmed by claims history or submission of medical records

OR

4.3 History of intolerance or contraindication to Olumiant (please specify intolerance or contraindication)

AND

5 - Patient is not receiving Litfulo in combination with either of the following:

- Biologic immunomodulator or Janus kinase (JAK) inhibitor [e.g., Adbry (tralokinumab-ldrm), Cibinqo (abrocitinib), Dupixent (dupilumab), Ebglyss (lebrikizumab-lbkz), Leqselvi (deuruxolitinib), Nemluvio (nemolizumab-ilto), Olumiant (baricitinib), Rinvoq (upadacitinib)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)

AND

6 - Prescribed by or in consultation with a dermatologist

Product Name:Litfulo	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Litfulo therapy AND 2 - Patient is not receiving Litfulo in combination with either of the following: • Biologic immunomodulator or Janus kinase (JAK) inhibitor [e.g., Adbry (tralokinumab-ldrm), Cibinqo (abrocitinib), Dupixent (dupilumab), Ebglyss (lebrikizumab-lbkz), Leqselvi (deuruxolitinib), Nemluvio (nemolizumab-ilto), Olumiant (baricitinib), Rinvoq (upadacitinib)] • Potent immunosuppressant (e.g., azathioprine or cyclosporine)	

2 . Revision History

Date	Notes

2/6/2026	Updated combination examples and language with no change to clinical intent.

Litfulo



Prior Authorization Guideline

Guideline ID	GL-510414
Guideline Name	Litfulo
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Maryland Medicaid - Community & State New Jersey Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Nevada Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name:Litfulo	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of severe alopecia areata

AND

2 - Other causes of hair loss have been ruled out (e.g., androgenetic alopecia, cicatricial alopecia, secondary syphilis, tinea capitis, triangular alopecia, and trichotillomania)

AND

3 - Patient requesting therapy for current episode of alopecia areata

AND

4 - ONE of the following:

4.1 Patient is less than 18 years of age

OR

4.2 Failure to Olumiant confirmed by claims history or submission of medical records

OR

4.3 History of intolerance or contraindication to Olumiant (please specify intolerance or contraindication)

AND

5 - Patient is not receiving Litfulo in combination with either of the following:

- Biologic immunomodulator or Janus kinase (JAK) inhibitor [e.g., Adbry (tralokinumab-ldrm), Cibinqo (abrocitinib), Dupixent (dupilumab), Ebglyss (lebrikizumab-lbkz), Leqselvi (deuruxolitinib), Nemluvio (nemolizumab-ilto), Olumiant (baricitinib), Rinvoq (upadacitinib)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)

AND

6 - Prescribed by or in consultation with a dermatologist

Product Name:Litfulo	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Litfulo therapy AND 2 - Patient is not receiving Litfulo in combination with either of the following: • Biologic immunomodulator or Janus kinase (JAK) inhibitor [e.g., Adbry (tralokinumab-ldrm), Cibinqo (abrocitinib), Dupixent (dupilumab), Ebglyss (lebrikizumab-lbkz), Leqselvi (deuruxolitinib), Nemluvio (nemolizumab-ilto), Olumiant (baricitinib), Rinvoq (upadacitinib)] • Potent immunosuppressant (e.g., azathioprine or cyclosporine)	

2 . Revision History

Date	Notes

2/6/2026	Updated combination examples and language with no change to clinical intent.

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 Rhode Island 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:Livtencity	
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 Livtencity in combination with ganciclovir or valganciclovir	

2 . Revision History

Date	Notes
3/26/2025	Combined formularies.

Lokelma, Veltassa



Prior Authorization Guideline

Guideline ID	GL-448297
Guideline Name	Lokelma, Veltassa
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 New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	12/1/2025

1 . Criteria

Product Name:Lokelma, Veltassa	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of non-life threatening hyperkalemia AND 2 - Where clinically appropriate, loop or thiazide diuretic therapy for potassium removal has failed AND 3 - Patient follows a low potassium diet (less than or equal to 3 grams per day)	

Product Name:Lokelma, Veltassa	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has a positive clinical response to Lokelma or Veltassa therapy AND 2 - Patient continues to require treatment for hyperkalemia AND 3 - Patient follows a low potassium diet (less than or equal to 3 grams per day)	

2 . Revision History

Date	Notes
11/12/2025	Combined formularies. Updated GPI list. No changes to clinical criteria.

Long-Acting Opioid Products



Prior Authorization Guideline

Guideline ID	GL-264221
Guideline Name	Long-Acting Opioid Products
Formulary	Medicaid - Community & State Rhode Island

Guideline Note:

Effective Date:	7/1/2025

1 . Criteria

Product Name:generic morphine sulfate ER/CR tabs, fentanyl 12, 25, 50, 75, 100 mcg/hr patches	
Diagnosis	Cancer/Hospice/End of Life Related Pain*
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is being treated for cancer-related pain (i.e., patients undergoing active cancer treatment; or cancer survivors with chronic pain who have completed cancer treatment, are in clinical remission, or are under cancer surveillance)	

OR

2 - Patient is in hospice or is receiving end of life care

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

Product Name:hydrocodone bitartrate ER caps, methadone 5 mg or 10 mg tablets	
Diagnosis	Cancer/Hospice/End of Life Related Pain*
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Patient is being treated for cancer-related pain (i.e., patients undergoing active cancer treatment; or cancer survivors with chronic pain who have completed cancer treatment, are in clinical remission, or are under cancer surveillance) OR 1.2 Patient is in hospice or is receiving end of life care AND 2 - ONE of the following: 2.1 The patient has failed a trial of at least ONE of the following, as confirmed by claims history or submission of medical records: morphine sulfate controlled release tablets (generic MS Contin)	

- preferred fentanyl transdermal

OR

2.2 The patient has a history of contraindication or intolerance to BOTH of the following (please specify contraindication or intolerance):

- morphine sulfate controlled release tablets (generic MS Contin)
- preferred fentanyl transdermal

OR

2.3 BOTH of the following:

2.3.1 Patient is established on pain therapy with the requested medication for cancer-related pain (i.e., patients undergoing active cancer treatment; or cancer survivors with chronic pain who have completed cancer treatment, are in clinical remission, or are under cancer surveillance), hospice related pain, or end of life care related pain

AND

2.3.2 The medication is not a new regimen for treatment of cancer-related pain (i.e., patients undergoing active cancer treatment; or cancer survivors with chronic pain who have completed cancer treatment, are in clinical remission, or are under cancer surveillance), hospice, or end of life care pain (document date regimen was started)

Notes	*If the patient is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. If the request is for hydrocodone extended-release capsules (generic Zohydro ER), methadone 5 mg tablets or methadone 10 mg tablets and the patient is currently taking the requested long-acting opioid for at least 30 days and has met the medical necessity authorization criteria requirements for treatment with an opioid, but has not tried the preferred alternatives, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. Additionally, a 12 month authorization should be entered for morphine sulfate controlled release tablets (generic MS Contin) and preferred fentanyl transdermal.

Product Name:morphine sulfate ER caps, hydromorphone ER, generic hydrocodone bitartrate ER tabs, Brand Hysingla ER, Brand MS Contin, Nucynta ER, Oxycodone ER, Oxycontin, oxymorphone ER, Xtampza ER, fentanyl 37.5, 62.5, 87.5 mcg/hr patches, methadone soln, generic methadone conc, Brand Methadose conc, Brand Zohydro ER	
Diagnosis	Cancer/Hospice/End of Life Related Pain*
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Patient is being treated for cancer-related pain (i.e., patients undergoing active cancer treatment; or cancer survivors with chronic pain who have completed cancer treatment, are in clinical remission, or are under cancer surveillance)

OR

1.2 Patient is in hospice or is receiving end of life care

AND

2 - ONE of the following:

2.1 The patient has failed a trial of ALL of the following, as confirmed by claims history or submission of medical records:

- morphine sulfate controlled release tablets (generic MS Contin)
- preferred fentanyl transdermal
- hydrocodone extended-release capsules (generic Zohydro ER)

OR

2.2 The patient has a history of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- morphine sulfate controlled release tablets (generic MS Contin)
- preferred fentanyl transdermal

- hydrocodone extended-release capsules (generic Zohydro ER)

OR

2.3 BOTH of the following:

2.3.1 Patient is established on pain therapy with the requested medication for cancer-related pain (i.e., patients undergoing active cancer treatment; or cancer survivors with chronic pain who have completed cancer treatment, are in clinical remission, or are under cancer surveillance), hospice related pain, or end of life care related pain

AND

2.3.2 The medication is not a new regimen for treatment of cancer-related pain (i.e., patients undergoing active cancer treatment; or cancer survivors with chronic pain who have completed cancer treatment, are in clinical remission, or are under cancer surveillance), hospice, or end of life care pain (document date regimen was started)

Notes

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

If the request is for a non-preferred product and the patient is currently taking the requested long-acting opioid for at least 30 days and has met the medical necessity authorization criteria requirements for treatment with an opioid, but has not tried the preferred alternatives, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. Additionally, a 12 month authorization should be entered for preferred products, depending on what the patient has already tried:

- If the patient has tried morphine sulfate controlled release tablets (generic MS Contin) or preferred fentanyl transdermal, an authorization should be entered for hydrocodone extended-release capsules (generic Zohydro ER), methadone 5 mg tablets and methadone 10 mg tablets.
- If the patient has not tried any of the preferred products [morphine sulfate controlled release tablets (generic MS Contin), preferred fentanyl transdermal, hydrocodone extended-release capsules (generic Zohydro ER), methadone 5 mg tablets or methadone 10 mg tablets], an authorization should be entered for morphine sulfate controlled release tablets (generic MS Contin) and preferred fentanyl transdermal.

Product Name:generic morphine sulfate ER/CR tabs, fentanyl 12, 25, 50, 75, 100 mcg/hr patches	
Diagnosis	Non-cancer/Non-hospice/Non-end of life care related pain*
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Prescriber attests to BOTH of the following:

1.1 Patient has been screened for substance abuse/opioid dependence

AND

1.2 Pain is moderate to severe and expected to persist for an extended period of time (chronic)

AND

2 - Treatment goals are defined and include estimated duration of treatment (must document treatment goals)

AND

3 - BOTH of the following:

3.1 Patient has been screened for underlying depression and/or anxiety

AND

3.2 If applicable, any underlying conditions have been or will be addressed

AND

4 - ONE of the following:

4.1 Prior to the start of therapy with the long-acting opioid, the patient has failed an adequate (minimum of 2 week) trial of a short-acting opioid within the last 30 days [document drug(s) and date of trial]

OR

4.2 The patient is already receiving chronic opioid therapy prior to surgery for postoperative pain

OR

4.3 Postoperative pain is expected to be moderate to severe and persist for an extended period of time

OR

4.4 Patient is new to plan and currently established on long-acting opioid therapy for at least the past 30 days

AND

5 - If the request is for neuropathic pain (examples of neuropathic pain include neuralgias and neuropathies), ONE of the following:

5.1 BOTH of the following:

5.1.1 Unless it is contraindicated, the patient has not exhibited an adequate response to 8 weeks of treatment with gabapentin titrated to a therapeutic dose (document date of trial) (if contraindicated, document contraindication)

AND

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

OR

5.2 Patient is new to plan and currently established on long-acting opioid therapy for at least the past 30 days

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

Product Name:hydrocodone bitartrate ER caps, methadone 5 mg or 10 mg tablets	
Diagnosis	Non-cancer/Non-hospice/Non-end of life care related pain*
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Prescriber attests to BOTH of the following: 1.1 Patient has been screened for substance abuse/opioid dependence AND 1.2 Pain is moderate to severe and expected to persist for an extended period of time (chronic) AND 2 - Treatment goals are defined and include estimated duration of treatment (must document treatment goals)	

AND

3 - BOTH of the following:

3.1 Patient has been screened for underlying depression and/or anxiety

AND

3.2 If applicable, any underlying conditions have been or will be addressed

AND

4 - ONE of the following:

4.1 Prior to the start of therapy with the long-acting opioid, the patient has failed an adequate (minimum of 2 week) trial of a short-acting opioid within the last 30 days [document drug(s) and date of trial]

OR

4.2 The patient is already receiving chronic opioid therapy prior to surgery for postoperative pain

OR

4.3 Postoperative pain is expected to be moderate to severe and persist for an extended period of time

OR

4.4 Patient is new to plan and currently established on long-acting opioid therapy for at least the past 30 days

AND

5 - If the request is for neuropathic pain (examples of neuropathic pain include neuralgias and neuropathies), **ONE** of the following:

5.1 BOTH of the following:

5.1.1 Unless it is contraindicated, the patient has not exhibited an adequate response to 8 weeks of treatment with gabapentin titrated to a therapeutic dose (document date of trial) (if contraindicated, document contraindication)

AND

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

OR

5.2 Patient is new to plan and currently established on long-acting opioid therapy for at least the past 30 days

AND

6 - **ONE** of the following:

6.1 Patient has failed a trial of at least **ONE** of the following, as confirmed by claims history or submission of medical records:

- morphine sulfate controlled release tablets (generic MS Contin)
- preferred fentanyl transdermal

OR

6.2 Patient has a history of contraindication or intolerance to **BOTH** of the following (please specify contraindication or intolerance):

- morphine sulfate controlled release tablets (generic MS Contin)
- preferred fentanyl transdermal

Notes	*If the patient is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. If the request is for hydrocodone extended-release capsules (generic Zohydro ER), methadone 5 mg tablets or methadone 10 mg tablets and the patient is currently taking the requested long-acting opioid for at least 30 days and has met the medical necessity authorization criteria requirements for treatment with an opioid, but has not tried the preferred alternatives, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. Additionally, a 6 month authorization should be entered for morphine sulfate controlled release tablets (generic MS Contin) and preferred fentanyl transdermal.

Product Name:morphine sulfate ER caps, hydromorphone ER, generic hydrocodone bitartrate ER tabs, Brand Hysingla ER, Brand MS Contin, Nucynta ER, Oxycodone ER, Oxycontin, oxymorphone ER, Xtampza ER, fentanyl 37.5, 62.5, 87.5 mcg/hr patches, methadone soln, generic methadone conc, Brand Methadose conc, Brand Zohydro ER	
Diagnosis	Non-cancer/Non-hospice/Non-end of life care related pain*
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Prescriber attests to BOTH of the following: 1.1 Patient has been screened for substance abuse/opioid dependence AND 1.2 Pain is moderate to severe and expected to persist for an extended period of time (chronic) AND	

2 - Treatment goals are defined and include estimated duration of treatment (must document treatment goals)

AND

3 - BOTH of the following:

3.1 Patient has been screened for underlying depression and/or anxiety

AND

3.2 If applicable, any underlying conditions have been or will be addressed

AND

4 - ONE of the following:

4.1 Prior to the start of therapy with the long-acting opioid, the patient has failed an adequate (minimum of 2 week) trial of a short-acting opioid within the last 30 days [document drug(s) and date of trial]

OR

4.2 The patient is already receiving chronic opioid therapy prior to surgery for postoperative pain

OR

4.3 Postoperative pain is expected to be moderate to severe and persist for an extended period of time

OR

4.4 Patient is new to plan and currently established on long-acting opioid therapy for at least the past 30 days

AND

5 - If the request is for neuropathic pain (examples of neuropathic pain include neuralgias and neuropathies), ONE of the following:

5.1 BOTH of the following:

5.1.1 Unless it is contraindicated, the patient has not exhibited an adequate response to 8 weeks of treatment with gabapentin titrated to a therapeutic dose (document date of trial) (if contraindicated, document contraindication)

AND

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

OR

5.2 Patient is new to plan and currently established on long-acting opioid therapy for at least the past 30 days

AND

6 - ONE of the following:

6.1 Patient has failed a trial of ALL of the following, as confirmed by claims history or submission of medical records:

- morphine sulfate controlled release tablets (generic MS Contin)
- preferred fentanyl transdermal
- hydrocodone extended-release capsules (generic Zohydro ER)

OR

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

• morphine sulfate controlled release tablets (generic MS Contin) • preferred fentanyl transdermal • hydrocodone extended-release capsules (generic Zohydro ER)	
Notes	*If the patient is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. If the request is for a non-preferred product and the patient is currently taking the requested long-acting opioid for at least 30 days and has met the medical necessity authorization criteria requirements for treatment with an opioid, but has not tried the preferred alternatives, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. Additionally, a 6 month authorization should be entered for preferred products, depending on what the patient has already tried: • If the patient has tried morphine sulfate controlled release tablets (generic MS Contin) or preferred fentanyl transdermal, an authorization should be entered for hydrocodone extended-release capsules (generic Zohydro ER), methadone 5 mg tablets and methadone 10 mg tablets. • If the patient has not tried any of the preferred products [morphine sulfate controlled release tablets (generic MS Contin), preferred fentanyl transdermal, hydrocodone extended-release capsules (generic Zohydro ER), methadone 5 mg tablets or methadone 10 mg tablets], an authorization should be entered for morphine sulfate controlled release tablets (generic MS Contin) and preferred fentanyl transdermal.

Product Name:generic morphine sulfate ER/CR tabs, fentanyl 12, 25, 50, 75, 100 mcg/hr patches	
Diagnosis	Non-cancer/Non-hospice/Non-end of life care related pain*
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documented meaningful improvement in pain and function when assessed against treatment goals (document improvement in function or pain score improvement)	

AND

2 - Document rationale for not tapering or discontinuing opioid if treatment goals are not being met

AND

3 - Prescriber attests to BOTH of the following:

3.1 Patient has been screened for substance abuse/opioid dependence

AND

3.2 Pain is moderate to severe and expected to persist for an extended period of time (chronic)

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

Product Name:hydrocodone bitartrate ER caps, methadone 5mg or 10 mg tablets	
Diagnosis	Non-cancer/Non-hospice/Non-end of life care related pain*
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documented meaningful improvement in pain and function when assessed against treatment goals (document improvement in function or pain score improvement)	

AND

2 - Document rationale for not tapering or discontinuing opioid if treatment goals are not being met

AND

3 - Prescriber attests to BOTH of the following:

3.1 Patient has been screened for substance abuse/opioid dependence

AND

3.2 Pain is moderate to severe and expected to persist for an extended period of time (chronic)

AND

4 - ONE of the following:

4.1 Patient has failed a trial of at least ONE of the following, as confirmed by claims history or submission of medical records:

- morphine sulfate controlled release tablets (generic MS Contin)
- preferred fentanyl transdermal

OR

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

- morphine sulfate controlled release tablets (generic MS Contin)
- preferred fentanyl transdermal

Notes

*If the patient is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be i

	issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. If the request is for hydrocodone extended-release capsules (generic Zohydro ER), methadone 5 mg tablets or methadone 10 mg tablets and the patient is currently taking the requested long-acting opioid for at least 30 days and has met the medical necessity authorization criteria requirements for treatment with an opioid, but has not tried the preferred alternatives, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. Additionally, a 6 month authorization should be entered for morphine sulfate controlled release tablets (generic MS Contin) and preferred fentanyl transdermal.

Product Name:morphine sulfate ER caps, hydromorphone ER, generic hydrocodone bitartrate ER tabs, Brand Hysingla ER, Brand MS Contin, Nucynta ER, Oxycodone ER, Oxycontin, oxymorphone ER, Xtampza ER, fentanyl 37.5, 62.5, 87.5 mcg/hr patches, methadone soln, generic methadone conc, Brand Methadose conc, Brand Zohydro ER	
Diagnosis	Non-cancer/Non-hospice/Non-end of life care related pain*
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documented meaningful improvement in pain and function when assessed against treatment goals (document improvement in function or pain score improvement) AND 2 - Document rationale for not tapering or discontinuing opioid if treatment goals are not being met AND 3 - Prescriber attests to BOTH of the following: 3.1 Patient has been screened for substance abuse/opioid dependence	

AND

3.2 Pain is moderate to severe and expected to persist for an extended period of time (chronic)

AND

4 - ONE of the following:

4.1 Patient has failed a trial of ALL of the following, as confirmed by claims history or submission of medical records:

- morphine sulfate controlled release tablets (generic MS Contin)
- preferred fentanyl transdermal
- hydrocodone extended-release capsules (generic Zohydro ER)

OR

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

- morphine sulfate controlled release tablets (generic MS Contin)
- preferred fentanyl transdermal
- hydrocodone extended-release capsules (generic Zohydro ER)

Notes	*If the patient is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. If the request is for a non-preferred product and the patient is currently taking the requested long-acting opioid for at least 30 days and has met the medical necessity authorization criteria requirements for treatment with an opioid, but has not tried the preferred alternatives, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. Additionally, a 6 month authorization should be entered for preferred products, depending on what the patient has already tried: • If the patient has tried morphine sulfate controlled release tablets (generic MS Contin) or preferred fentanyl transdermal, an authorization s

	ould be entered for hydrocodone extended-release capsules (generic Zohydro ER), methadone 5 mg tablets and methadone 10 mg tablets. • If the patient has not tried any of the preferred products [morphine sulfate controlled release tablets (generic MS Contin), preferred fentanyl transdermal, hydrocodone extended-release capsules (generic Zohydro ER), methadone 5 mg tablets or methadone 10 mg tablets], an authorization should be entered for morphine sulfate controlled release tablets (generic MS Contin) and preferred fentanyl transdermal.

Product Name: tramadol ER, Conzip	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 The patient has failed a trial of tramadol IR (immediate release) as confirmed by claims history or submission of medical records OR 1.2 The patient has a history of contraindication or intolerance to tramadol IR (please specify contraindication or intolerance) OR 2 - BOTH of the following: 2.1 ONE of the following: 2.1.1 Patient is being treated for cancer-related pain (i.e., patients undergoing active cancer treatment; or cancer survivors with chronic pain who have completed cancer treatment, are in clinical remission, or are under cancer surveillance) OR	

2.1.2 Patient is in hospice or is receiving end of life care

AND

2.2 BOTH of the following:

2.2.1 Patient is established on pain therapy with the requested medication for cancer-related pain (i.e., patients undergoing active cancer treatment; or cancer survivors with chronic pain who have completed cancer treatment, are in clinical remission, or are under cancer surveillance), hospice related pain, or end of life care related pain

AND

2.2.2 The medication is not a new regimen for treatment of cancer-related pain (i.e., patients undergoing active cancer treatment; or cancer survivors with chronic pain who have completed cancer treatment, are in clinical remission, or are under cancer surveillance), hospice, or end of life care pain (document date regimen was started)

Product Name: generic morphine sulfate ER/CR tabs, fentanyl patches, hydrocodone bitartrate ER caps, oxymorphone ER, morphine sulfate ER caps, hydromorphone ER, generic hydrocodone bitartrate ER tabs, Brand Hysingla ER, Brand MS Contin, Nucynta ER, Oxycodone ER, Oxycontin, Xtampza ER, methadone 5mg or 10 mg tabs/soln, generic methadone conc, Brand Methadose conc, tramadol ER, Conzip, Brand Zohydro ER

Guideline Type	Quantity Limit
Approval Criteria 1 - The requested dose cannot be achieved by moving to a higher strength of the product AND 2 - The requested dose is within the Food and Drug Administration (FDA) maximum dose per day, where an FDA maximum dose per day exists (see Table 1 in Background)	
Notes	Authorization will be issued for: • 12 months for cancer/hospice/end of life related pain. • 12 months for all Tramadol ER requests. • 6 months for non-cancer/non-hospice/non-end of life related pain.

Product Name:generic morphine sulfate ER/CR tabs, fentanyl patches, hydrocodone bitartrate ER caps, oxymorphone ER, morphine sulfate ER caps, hydromorphone ER, generic hydrocodone bitartrate ER tabs, Brand Hysingla ER, Brand MS Contin, Nucynta ER, Oxycodone ER, Oxycontin, Xtampza ER, methadone 5mg or 10 mg tabs/soln, generic methadone conc, Brand Methadose conc, tramadol ER, Conzip, Brand Zohydro ER	
Diagnosis	Cancer/Hospice/End of Life Related Pain
Approval Length	12 Months*
Guideline Type	Morphine Milligram Equivalent (MME)
Approval Criteria 1 - Doses exceeding the cumulative morphine milligram equivalent (MME) of 90 milligrams (mg) will be approved up to the requested amount for ALL opioid products if the patient has cancer-related pain (i.e., patients undergoing active cancer treatment; or cancer survivors with chronic pain who have completed cancer treatment, are in clinical remission, or are under cancer surveillance), hospice pain, or an end of life diagnosis	
Notes	*Authorization will be issued for 12 months for cancer/hospice/end of life related pain. The authorization should be entered for an MME of 99 99 so as to prevent future disruptions in therapy if the patient's dose is increased.

Product Name:generic morphine sulfate ER/CR tabs, fentanyl patches, hydrocodone bitartrate ER caps, oxymorphone ER, morphine sulfate ER caps, hydromorphone ER, generic hydrocodone bitartrate ER tabs, Brand Hysingla ER, Brand MS Contin, Nucynta ER, Oxycodone ER, Oxycontin, Xtampza ER, methadone 5 mg or 10 mg tabs/soln, generic methadone conc, Brand Methadose conc, tramadol ER, Conzip, Brand Zohydro ER	
Diagnosis	Non-cancer/non-hospice/non-end of life related pain
Approval Length	6 Months*
Therapy Stage	Initial Authorization
Guideline Type	Morphine Milligram Equivalent (MME)
Approval Criteria 1 - If the dose exceeds the maximum cumulative morphine milligram equivalent (MME) of 90 mg, ALL of the following:	

1.1 Prescriber attests that the patient has been screened for substance abuse/opioid dependence

AND

1.2 Treatment goals are defined and include estimated duration of treatment (must document treatment goals)

AND

1.3 BOTH of the following:

1.3.1 Patient has been screened for underlying depression and/or anxiety

AND

1.3.2 If applicable, any underlying conditions have been or will be addressed

AND

1.4 ONE of the following:

1.4.1 Opioid medication doses of less than 90 MME have been tried and did not adequately control pain (document drug regimen or MME and dates of therapy)

OR

1.4.2 Patient is new to plan and currently established on the requested MME for at least the past 30 days

Notes	*Authorization will be issued for 6 months for non-cancer/non-hospice/non-end of life related pain up to the current requested MME plus 90 MME. If the patient has been established on the requested MME dose for at least 30 days and does not meet the medical necessity authorization criteria requirements, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested MME dose.

Product Name:generic morphine sulfate ER/CR tabs, fentanyl patches, hydrocodone bitartrate ER caps, oxymorphone ER, morphine sulfate ER caps, hydromorphone ER, generic hydrocodone bitartrate ER tabs, Brand Hysingla ER, Brand MS Contin, Nucynta ER, Oxycodone ER, Oxycontin, Xtampza ER, methadone 5 mg or 10 mg tabs/soln, generic methadone conc, Brand Methadose conc, tramadol ER, Conzip, Brand Zohydro ER	
Diagnosis	Non-cancer/non-hospice/non-end of life related pain
Approval Length	6 Months*
Therapy Stage	Reauthorization
Guideline Type	Morphine Milligram Equivalent (MME)
Approval Criteria 1 - If the dose exceeds the maximum cumulative morphine milligram equivalent (MME) of 90 milligrams, ALL of the following: 1.1 Prescriber attests that the patient has been screened for substance abuse/opioid dependence AND 1.2 Document rationale for not tapering or discontinuing opioid if treatment goals are not being met AND 1.3 Documented meaningful improvement in pain and function when assessed against treatment goals (document improvement in function or pain score improvement)	
Notes	*Authorization will be issued for 6 months for non-cancer/non-hospice/non-end of life related pain up to the current requested MME plus 90 MME. If the patient has been established on the requested MME dose for at least 30 days and does not meet the medical necessity authorization criteria requirements, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested MME dose.

2 . Revision History

Date	Notes
5/15/2025	Updated Oxycontin GPs. Updated product names. Moved methadone tablets to preferred and oxycodone ER to non-preferred. Updated notes in reference to updated PDL status of products.

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-267205
Guideline Name	Lucemyra
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

Guideline Note:

Effective Date:	7/1/2025

1 . Criteria

Product Name:Brand Lucemyra, generic lofexidine	
Approval Length	14 Day(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - For symptoms of abrupt opioid withdrawal

AND

2 - Opioids have been discontinued

AND

3 - ONE of the following:

3.1 ONE of the following:

- Failure to clonidine confirmed by claims history or submission of medical records
- History of contraindication or intolerance to clonidine (please specify intolerance or contraindication)

OR

3.2 Lucemyra was initiated in the inpatient setting*

Notes	*Authorization will be issued for 14 days of therapy. If Lucemyra was initiated in the inpatient setting, the total course of therapy should not exceed 14 days.

2 . Revision History

Date	Notes
5/16/2025	Updated GPIs to add generic

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

UnitedHealthcare Community Plan of Rhode Island Clinical Pharmacy Program Guidelines

10/21/2025	Updated formularies to include IN for eff 11/1/25. Minor cosmetic updates.

Lupkynis



Prior Authorization Guideline

Guideline ID	GL-439223
Guideline Name	Lupkynis
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 Michigan Medicaid - Community & State Virginia Medicaid - Community & State New Mexico Medicaid - Community & State Nebraska Medicaid - Community & State Nevada

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Lupkynis	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of active lupus nephritis AND 2 - Provider attests to ONE of the following: • Diagnosis is biopsy proven • Biopsy is contraindicated in the patient AND 3 - Provider attests to ONE of the following: 3.1 Clinical progression (e.g., worsening of proteinuria or serum creatinine) after 3 months of induction therapy with immunosuppressive agents (e.g., mycophenolate, cyclophosphamide, methylprednisolone), as confirmed by claims history or submission of medical records OR 3.2 Failure to respond after 6 months of induction therapy with immunosuppressive agents (e.g., mycophenolate, cyclophosphamide, methylprednisolone), as confirmed by claims history or submission of medical records AND 4 - Prescribed in combination with a background immunosuppressive therapy regimen (e.g., mycophenolate mofetil and corticosteroids)	

AND

5 - Patient is NOT receiving Lupkynis in combination with either of the following:

- Cyclophosphamide
- Benlysta (belimumab)

AND

6 - Prescribed by ONE of the following:

- Nephrologist
- Rheumatologist

Product Name:Lupkynis	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Lupkynis therapy AND 2 - Prescribed in combination with a background immunosuppressive therapy regimen (e.g., mycophenolate mofetil and corticosteroids) AND 3 - Patient is NOT receiving Lupkynis in combination with either of the following: • Cyclophosphamide	

- Benlysta (belimumab)

AND

4 - Prescribed by ONE of the following:

- Nephrologist
- Rheumatologist

2 . Revision History

Date	Notes
11/5/2025	Added Nevada Formulary

Lynkuet, Veozah



Prior Authorization Guideline

Guideline ID	GL-578255
Guideline Name	Lynkuet, Veozah
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 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:	6/1/2026

1 . Criteria

Product Name:Lynkuet, Veozah	
Approval Length	12 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 - ONE of the following:

2.1 Failure (after a 30-day trial) to ONE of the following as confirmed by claims history or submission of medical records:

- Hormonal therapy (e.g., estradiol, Premarin, Prempro)
- Non-hormonal therapy [e.g., clonidine, gabapentin, selective serotonin inhibitors (e.g., paroxetine), serotonin and norepinephrine reuptake inhibitors (e.g., venlafaxine)]

OR

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

- Hormonal therapy (e.g., estradiol, Premarin, Prempro)
- Non-hormonal therapy [e.g., clonidine, gabapentin, selective serotonin inhibitors (e.g., paroxetine), serotonin and norepinephrine reuptake inhibitors (e.g., venlafaxine)]

AND

3 - Patient has received baseline hepatic laboratory tests to rule out the presence of underlying liver disease

Product Name:Lynkuet, Veozah	
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy (e.g., decrease in frequency and severity of vasomotor symptoms from baseline) AND 2 - Patient has received periodic evaluation of hepatic laboratory tests to rule out liver injury associated with the requested medication use	

2 . Revision History

Date	Notes
4/16/2026	Added PA CAID to formularies. No other updates to guideline.

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

UnitedHealthcare Community Plan of Rhode Island Clinical Pharmacy Program Guidelines

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.

Marinol, Syndros



Prior Authorization Guideline

Guideline ID	GL-555310
Guideline Name	Marinol, Syndros
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 New Mexico

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:Syndros	
Diagnosis	Chemotherapy-induced nausea and vomiting
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is receiving cancer chemotherapy

AND

2 - ONE of the following:

2.1 Failure to formulary generic dronabinol as confirmed by claims history or submission of medical records

OR

2.2 History of contraindication or intolerance to formulary generic dronabinol (please specify contraindication or intolerance)

OR

2.3 ONE of the following:

- Patient is unable to swallow a solid dosage form
- Patient utilizes a feeding tube for medication administration

AND

3 - ONE of the following:

3.1 Failure to a 5HT-3 (5-hydroxytryptamine type 3) receptor antagonist [e.g., Anzemet (dolasetron), Kytril (granisetron), or Zofran (ondansetron)] as confirmed by claims history or submission of medical records

OR

3.2 History of contraindication or intolerance to a 5HT-3 receptor antagonist [e.g., Anzemet (dolasetron), Kytril (granisetron), or Zofran (ondansetron)] (please specify contraindication or intolerance)

AND

4 - ONE of the following:

4.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Lorazepam (generic Ativan)
- Prochlorperazine (generic Compazine)
- Dexamethasone (generic Decadron)
- Haloperidol (generic Haldol)
- Promethazine (generic Phenergan)
- Metoclopramide (generic Reglan)
- Olanzapine (generic Zyprexa)

OR

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

- Lorazepam (generic Ativan)
- Prochlorperazine (generic Compazine)
- Dexamethasone (generic Decadron)
- Haloperidol (generic Haldol)
- Promethazine (generic Phenergan)
- Metoclopramide (generic Reglan)
- Olanzapine (generic Zyprexa)

Product Name: Brand Marinol, generic dronabinol	
Diagnosis	Chemotherapy-induced nausea and vomiting
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is receiving cancer chemotherapy	

AND

2 - ONE of the following:

2.1 Failure to a 5HT-3 (5-hydroxytryptamine type 3) receptor antagonist [e.g., Anzemet (dolasetron), Kytril (granisetron), or Zofran (ondansetron)] as confirmed by claims history or submission of medical records

OR

2.2 History of contraindication or intolerance to a 5HT-3 receptor antagonist [e.g., Anzemet (dolasetron), Kytril (granisetron), or Zofran (ondansetron)] (please specify contraindication or intolerance)

AND

3 - ONE of the following:

3.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Lorazepam (generic Ativan)
- Prochlorperazine (generic Compazine)
- Dexamethasone (generic Decadron)
- Haloperidol (generic Haldol)
- Promethazine (generic Phenergan)
- Metoclopramide (generic Reglan)
- Olanzapine (generic Zyprexa)

OR

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

- Lorazepam (generic Ativan)
- Prochlorperazine (generic Compazine)
- Dexamethasone (generic Decadron)
- Haloperidol (generic Haldol)
- Promethazine (generic Phenergan)
- Metoclopramide (generic Reglan)

- Olanzapine (generic Zyprexa)

Product Name: Syndros	
Diagnosis	Anorexia in a patient with AIDS
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of anorexia with weight loss in a patient with AIDS (acquired immunodeficiency syndrome) AND 2 - Patient is on antiretroviral therapy AND 3 - ONE of the following: 3.1 Patient is 65 years of age or greater OR 3.2 BOTH of the following: 3.2.1 Patient is less than 65 years of age AND 3.2.2 ONE of the following: 3.2.2.1 Failure to megestrol (generic Megace) as confirmed by claims history or submission of medical records	

OR

3.2.2.2 History of intolerance or contraindication to megestrol (generic Megace) (please specify intolerance or contraindication)

AND

4 - ONE of the following:

4.1 Failure to formulary generic dronabinol as confirmed by claims history or submission of medical records

OR

4.2 History of contraindication or intolerance to formulary generic dronabinol (please specify contraindication or intolerance)

OR

4.3 ONE of the following:

- Patient is unable to swallow a solid dosage form
- Patient utilizes a feeding tube for medication administration

Product Name: Brand Marinol, generic dronabinol	
Diagnosis	Anorexia in a patient with AIDS
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of anorexia with weight loss in a patient with AIDS (acquired immunodeficiency syndrome)	

AND

2 - Patient is on antiretroviral therapy

AND

3 - ONE of the following:

3.1 Patient is 65 years of age or greater

OR

3.2 BOTH of the following:

3.2.1 Patient is less than 65 years of age

AND

3.2.2 ONE of the following:

3.2.2.1 Failure to megestrol (generic Megace) as confirmed by claims history or submission of medical records

OR

3.2.2.2 History of intolerance or contraindication to megestrol (generic Megace) (please specify intolerance or contraindication)

2 . Revision History

Date	Notes
3/23/2026	Removed NY

Mavenclad



Prior Authorization Guideline

Guideline ID	GL-249188
Guideline Name	Mavenclad
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State New Jersey Medicaid - Community & State New Mexico Medicaid - Community & State New York Medicaid - Community & State New York EPP Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island

Guideline Note:

Effective Date:	7/1/2025

1 . Criteria

Product Name:Mavenclad	
Approval Length	2 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of relapsing form of multiple sclerosis (MS) (e.g., relapsing-remitting MS, secondary progressive MS with relapses) AND 2 - Prescribed by, or in consultation with, a specialist in the treatment of MS (e.g., neurologist) AND 3 - ONE of the following: 3.1 Trial and failure (after trial of at least 4 weeks) to TWO of the following disease-modifying therapies for MS (one of which must be a preferred dimethyl fumarate product) as confirmed by claims history or submission of medical records: • Interferon beta-1a (Avonex*, Rebif*, Plegridy) • Interferon beta-1b (Betaseron*, Extavia*) • Glatiramer acetate products (e.g., Copaxone, Glatopa) • A preferred dimethyl fumarate product (e.g., Tecfidera) • Teriflunomide (generic Aubagio) • Fingolimod (generic Gilenya) • Mayzent (siponimod) • Tyruko (natalizumab-sztn)** • Tysabri (natalizumab)** • Ocrevus (ocrelizumab)** • Lemtrada (alemtuzumab)** • Zeposia (ozanimod)* • Kesimpta (ofatumumab)* • Bafiertam (monomethyl fumarate)* • Briumvi (ublituximab)** OR 3.2 History of contraindication or intolerance to TWO of the following disease-modifying therapies for MS (please specify contraindication or intolerance)	

- Interferon beta-1a (Avonex*, Rebif*, Plegridy)
- Interferon beta-1b (Betaseron*, Extavia*)
- Glatiramer acetate products (e.g., Copaxone, Glatopa)
- A preferred dimethyl fumarate product (e.g., Tecfidera)
- Teriflunomide (generic Aubagio)
- Fingolimod (generic Gilenya)
- Mayzent (siponimod)
- Tyruko (natalizumab-sztn)**
- Tysabri (natalizumab)**
- Ocrevus (ocrelizumab)**
- Lemtrada (alemtuzumab)**
- Zeposia (ozanimod)*
- Kesimpta (ofatumumab)*
- Bafiertam (monomethyl fumarate)*
- Briumvi (ublituximab)**

OR

3.3 Patient is currently on Mavenclad

AND

4 - Patient is NOT receiving Mavenclad in combination with another disease modifying therapy [e.g., interferon beta preparations, glatiramer acetate products, Tecfidera (dimethyl fumarate), Tysabri (natalizumab), Gilenya (fingolimod), Mayzent (siponimod), Ocrevus (ocrelizumab), Lemtrada (alemtuzumab), or Aubagio (teriflunomide)]

AND

5 - Patient has not already received the FDA-recommended limit of 2 lifetime treatment courses (4 treatment cycles) of Mavenclad

Notes	*Avonex, Rebif, Betaseron, Bafiertam, Kesimpta, Zeposia, and Extavia are non-preferred **Briumvi, Tyruko, Tysabri, Ocrevus, and Lemtrada are medical benefits

Product Name:Mavenclad	
Approval Length	2 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Mavenclad treatment AND 2 - Patient is NOT receiving Mavenclad in combination with another disease modifying therapy [e.g., interferon beta preparations, glatiramer acetate products, Tecfidera (dimethyl fumarate), Tysabri (natalizumab), Gilenya (fingolimod), Mayzent (siponimod), Ocrevus (ocrelizumab), Lemtrada (alemtuzumab), or Aubagio (teriflunomide)] AND 3 - Patient has not already received the FDA-recommended limit of 2 lifetime treatment courses (4 treatment cycles) of Mavenclad	
Notes	Duration of coverage will be limited to 1 reauthorization to allow 2 cumulative treatment courses (4 treatment cycles) of Mavenclad therapy.

2 . Revision History

Date	Notes
4/29/2025	Added lifetime limit to initial criteria and revised statement in reauth. Added Tyruko to list of alternatives and updated operational notes

Mekinist



Prior Authorization Guideline

Guideline ID	GL-150996
Guideline Name	Mekinist
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

Guideline Note:

Effective Date:	8/7/2024

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 Tafenlar (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 Tafinlar (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 Tafenlar (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, 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 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
8/6/2024	Added criteria for hairy cell leukemia, salivary gland tumor, and GIST.

Mekinist



Prior Authorization Guideline

Guideline ID	GL-150996
Guideline Name	Mekinist
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

Guideline Note:

Effective Date:	8/7/2024

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 Tafenlar (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 Tafinlar (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 Tafenlar (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, 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 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
8/6/2024	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

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 Tafinlar (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 Tafinlar (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

Mepron



Prior Authorization Guideline

Guideline ID	GL-439225
Guideline Name	Mepron
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

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name: Brand Mepron, generic atovaquone	
Diagnosis	Pneumocystis Jirovecii Pneumonia (PCP) Prophylaxis
Approval Length	12 month(s)

Guideline Type	Prior Authorization
Approval Criteria 1 - The patient has a diagnosis [e.g., HIV (human immunodeficiency virus)] warranting PCP (pneumocystis jirovecii pneumonia) infection prophylaxis AND 2 - The patient has a documented intolerance or contraindication to trimethoprim-sulfamethoxazole (TMP-SMX) and dapsone (please specify intolerance or contraindication)	

Product Name: Brand Mepron, generic atovaquone	
Diagnosis	Pneumocystis Jirovecii Pneumonia (PCP) Treatment
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - The patient has a diagnosis of mild to moderate pneumonia caused by pneumocystis jirovecii AND 2 - ONE of the following: 2.1 Failure of trimethoprim-sulfamethoxazole (TMP-SMX) confirmed by claims history or submitted medical records OR 2.2 History of intolerance or contraindication to TMP-SMX (please specify intolerance or contraindication)	

2 . Revision History

Date	Notes
11/5/2025	Added Nevada Formulary

Miplyffa



Prior Authorization Guideline

Guideline ID	GL-459189
Guideline Name	Miplyffa
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 New Mexico Medicaid - Community & State Pennsylvania Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	12/1/2025

1 . Criteria

Product Name:Miplyffa

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Niemann-Pick disease type C (NPC) AND 2 - Diagnosis has been genetically confirmed by mutation analysis of NPC1 and NPC2 genes AND 3 - Miplyffa is being used to treat neurological manifestations of NPC AND 4 - Miplyffa is prescribed in combination with miglustat AND 5 - Patient is NOT receiving Miplyffa in combination with Aqneursa (levacetylleucine) AND 6 - Miplyffa is prescribed by or in consultation with a provider with expertise in the treatment of NPC	

Product Name:Miplyffa	
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Miplyffa therapy (e.g., slowed disease progression from baseline based on assessment with NPC–specific scales) AND 2 - Miplyffa continues to be prescribed in combination with miglustat AND 3 - Patient is NOT receiving Miplyffa in combination with Aqneursa (levacetylleucine) AND 4 - Miplyffa is prescribed by or in consultation with a provider with expertise in the treatment of NPC	

2 . Revision History

Date	Notes
11/19/2025	Removed ACUMI from markets in scope. Rearranged formulary order. No changes to clinical criteria.

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.

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

MS Agents



Prior Authorization Guideline

Guideline ID	GL-331199
Guideline Name	MS 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 New Mexico

Guideline Note:

Effective Date:	8/1/2025

1 . Criteria

Product Name:generic glatiramer, Glatopa, Mayzent, Plegridy	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of multiple sclerosis (MS)

Product Name:Avonex, Bafiertam, Betaseron, Extavia, Kesimpta, Ponvory, Rebif, Vumerity

Approval Length 12 month(s)

Therapy Stage Initial Authorization

Guideline Type Prior Authorization

Approval Criteria

1 - Diagnosis of multiple sclerosis (MS)

AND

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

- Failure of at least TWO of the preferred alternatives (one of which must be a preferred dimethyl fumarate product) confirmed by claims history or submitted medical records
- History of intolerance or contraindication to ALL of the preferred alternatives (please specify intolerance or contraindication)
- Patient is currently on the requested drug therapy as confirmed by claims history or submission of medical records

Notes *See table 1 in background for PDL links

Product Name:Tascenso ODT

Approval Length 12 month(s)

Therapy Stage Initial Authorization

Guideline Type Prior Authorization

Approval Criteria

1 - Diagnosis of multiple sclerosis (MS)

AND

2 - Patient is 10 years of age or older

AND

3 - ONE of the following:

- Failure of fingolimod 0.5mg (generic Gilenya 0.5 mg) confirmed by claims history or submitted medical records
- History of intolerance or contraindication to fingolimod 0.5mg (generic Gilenya 0.5 mg) (please specify intolerance or contraindication)
- Patient is currently on Tascenso ODT therapy as confirmed by claims history or submission of medical records

Product Name: Brand Aubagio, Brand Copaxone, Brand Gilenya 0.5mg, Brand Tecfidera	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of multiple sclerosis (MS) AND 2 - If the request is non-preferred*, ONE of the following: • Failure of at least two of the preferred alternatives (one of which must be a preferred dimethyl fumarate product) confirmed by claims history or submitted medical records • History of intolerance or contraindication to all of the preferred alternatives (please specify intolerance or contraindication)	

- Patient is currently on the requested drug therapy as confirmed by claims history or submission of medical records

AND

3 - 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)

Notes

*See table 1 in background for PDL links

Product Name:Avonex, Bafiertam, Betaseron, Extavia, Kesimpta, Ponvory, Rebif, Vumerity, Tascenso ODT, Brand Aubagio, Brand Copaxone, Brand Gilenya 0.5 mg, Brand Tecfidera

Approval Length 12 month(s)

Therapy Stage Reauthorization

Guideline Type Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

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>
- **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 CHIP:** <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>
- **NM:** <https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html>

3 . Revision History

Date	Notes
7/15/2025	Updated formularies. Updated nonpreferred language. Minor formatting changes

Mulpleta



Prior Authorization Guideline

Guideline ID	GL-485191
Guideline Name	Mulpleta
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 New Mexico

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name: Mulpleta	
Diagnosis	Thrombocytopenia

Approval Length	1 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of thrombocytopenia AND 2 - Patient has chronic liver disease AND 3 - Patient is scheduled to undergo a procedure	

2 . Revision History

Date	Notes
12/18/2025	Removed IN from formularies - see state specific GL-475187 for IN 1 .1.26. No other changes to guideline.

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 Rhode Island Clinical Pharmacy Program Guidelines

Date	Notes
11/5/2025	Combined formularies - added NV, VA, IN, NE, NM. No clinical changes.

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

Mycapssa



Prior Authorization Guideline

Guideline ID	GL-577270
Guideline Name	Mycapssa
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

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name: Mycapssa	
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: • 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 • Elevated serum IGF-1 (insulin-like growth factor-1) levels (above the age and gender adjusted normal range as provided by the provider's lab) at time of diagnosis AND 1.2 Patient has responded to and tolerated treatment with ONE of the following: • Octreotide (e.g., Sandostatin, Sandostatin LAR*) • Lanreotide (e.g., Lanreotide Injection*, Somatuline Depot*) AND 1.3 The provider has submitted clinical justification on why the patient is unable to be maintained on current octreotide or lanreotide therapy** AND 1.4 Prescribed by or in consultation with an endocrinologist OR 2 - BOTH of the following: 2.1 Patient is currently on Mycapssa therapy for acromegaly	

AND

2.2 Prescribed by or in consultation with an endocrinologist

Notes	*Sandostatin LAR, Lanreotide Injection, and Somatuline Depot are medical benefits and should not be included in denial to provider. **UHC generally does not consider frequency of dosing and/or lack of compliance to dosing regimens, an indication of medical necessity.

Product Name: Mycapssa	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Mycapssa therapy [e.g., age-normalized serum IGF-1 (insulin-like growth factor-1) level]	

2 . Revision History

Date	Notes
4/14/2026	Added PA CAID to formularies. Removed unnecessary Acromegaly diagnosis headings. Clarified asterisks and notes. Updated step 2 of initial auth to both of the following.

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.

Nasonex, Xhance



Prior Authorization Guideline

Guideline ID	GL-155771
Guideline Name	Nasonex, Xhance
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

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name: Brand Nasonex, generic mometasone (Rx version only), Allergy nasal spray	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Failure to ONE of the following as confirmed by claims history or submission of medical record

- Prescription fluticasone nasal spray (generic Flonase)
- Flonase allergy relief (fluticasone propionate) OTC brand or generic

OR

2 - History of contraindication or intolerance to BOTH of the following (please specify contraindication or intolerance)

- Prescription fluticasone nasal spray (generic Flonase)
- Flonase allergy relief (fluticasone propionate) OTC brand or generic

Product Name: Xhance

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Diagnosis of chronic rhinosinusitis with nasal polyps

OR

1.2 Diagnosis of chronic rhinosinusitis without nasal polyps

AND

2 - One of the following:

2.1 Failure to BOTH of the following as confirmed by claims history or submission of medical records

- Fluticasone nasal spray (generic Flonase, Flonase Allergy)
- Mometasone nasal spray (generic Nasonex or Nasonex 24H Allergy)

OR

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

- Fluticasone nasal spray (generic Flonase, Flonase Allergy)
- Mometasone nasal spray (generic Nasonex or Nasonex 24H Allergy)

2 . Revision History

Date	Notes
9/24/2024	New.

Nasonex, Xhance



Prior Authorization Guideline

Guideline ID	GL-155771
Guideline Name	Nasonex, Xhance
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

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name: Brand Nasonex, generic mometasone (Rx version only), Allergy nasal spray	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Failure to ONE of the following as confirmed by claims history or submission of medical record

- Prescription fluticasone nasal spray (generic Flonase)
- Flonase allergy relief (fluticasone propionate) OTC brand or generic

OR

2 - History of contraindication or intolerance to BOTH of the following (please specify contraindication or intolerance)

- Prescription fluticasone nasal spray (generic Flonase)
- Flonase allergy relief (fluticasone propionate) OTC brand or generic

Product Name: Xhance

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Diagnosis of chronic rhinosinusitis with nasal polyps

OR

1.2 Diagnosis of chronic rhinosinusitis without nasal polyps

AND

2 - One of the following:

2.1 Failure to BOTH of the following as confirmed by claims history or submission of medical records

- Fluticasone nasal spray (generic Flonase, Flonase Allergy)
- Mometasone nasal spray (generic Nasonex or Nasonex 24H Allergy)

OR

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

- Fluticasone nasal spray (generic Flonase, Flonase Allergy)
- Mometasone nasal spray (generic Nasonex or Nasonex 24H Allergy)

2 . Revision History

Date	Notes
9/24/2024	New.

Nayzilam and Valtoco



Prior Authorization Guideline

Guideline ID	GL-242259
Guideline Name	Nayzilam and Valtoco
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii 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

Guideline Note:

Effective Date:	7/1/2025

1 . Criteria

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

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of epilepsy AND 2 - Nayzilam is being prescribed for the acute treatment of intermittent, stereotypic episodes of frequent seizure activity that are distinct from a patient's usual seizure pattern AND 3 - Prescriber has given a clinical reason or special circumstance why the patient is unable to use diazepam rectal gel (please document reason/special circumstance)	

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

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

1 - Diagnosis of epilepsy

AND

2 - Valtoco is being prescribed for the acute treatment of intermittent, stereotypic episodes of frequent seizure activity that are distinct from a patient's usual seizure pattern

AND

3 - Prescriber has given a clinical reason or special circumstance why the patient is unable to use diazepam rectal gel (please document reason/special circumstance)

AND

4 - ONE of the following:

4.1 Patient is less than 12 years of age

OR

4.2 ONE of the following:

4.2.1 Failure of Nayzilam confirmed by claims history or submitted medical records

OR

4.2.2 History of contraindication or intolerance to Nayzilam (please specify contraindication or intolerance)

Product Name:Valtoco	
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
4/23/2025	Combined formularies. Updated language for criterion pertaining to diazepam gel, where applicable.

Nemluvio



Prior Authorization Guideline

Guideline ID	GL-521216
Guideline Name	Nemluvio
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 New Mexico

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

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

Approval Criteria

1 - Diagnosis of moderate-to-severe chronic atopic dermatitis

AND

2 - One of the following:

2.1 Inadequate response to TWO of the following therapeutic classes of topical therapies as confirmed by claims history or submission of medical records:

- One medium, high or very-high potency topical corticosteroid [e.g., mometasone furoate (generic Elocon), fluocinolone acetonide (generic Synalar), fluocinonide (generic Lidex)]*
- One topical calcineurin inhibitor [e.g., pimecrolimus (generic Elidel), tacrolimus (generic Protopic)]
- Eucrisa (crisaborole)

OR

2.2 History of contraindication or intolerance to ALL of the following therapeutic classes of topical therapies (please specify contraindication or intolerance):

- One medium, high very-high potency topical corticosteroid [e.g., mometasone furoate (generic Elocon), fluocinolone acetonide (generic Synalar), fluocinonide (generic Lidex)]*
- One topical calcineurin inhibitor [e.g., pimecrolimus (generic Elidel), tacrolimus (generic Protopic)]
- Eucrisa (crisaborole)

OR

2.3 Patient has been previously treated with a targeted immunomodulator FDA-approved for the treatment of atopic dermatitis as documented by claims history or submission of medical records [e.g., Adbry (tralokinumab-ldrm), Cibinqo (abrocitinib), Dupixent (dupilumab), Ebglyss (lebrikizumab-lbkz), Opzelura (ruxolitinib), Rinvoq (upadacitinib)]

AND

3 - One of the following:

3.1 Failure to BOTH of the following as confirmed by claims history or submission of medical records:

- Adbry (tralokinumab-ldrm)
- Dupixent (dupilumab)

OR

3.2 History of contraindication or intolerance to BOTH of the following (please specify contraindication or intolerance):

- Adbry (tralokinumab-ldrm)
- Dupixent (dupilumab)

OR

3.3 Patient is currently on Nemluvio therapy as confirmed by claims history or submission of medical records

AND

4 - Nemluvio will be used in combination with a topical corticosteroid and/or topical calcineurin inhibitor

AND

5 - Patient is not receiving Nemluvio in combination with either of the following for treatment of the same indication:

- Biologic immunomodulator [e.g., Adbry (tralokinumab-ldrm), Dupixent (dupilumab), Ebglyss (lebrikizumab-lbkz)]
- Janus kinase inhibitor [e.g., Cibinqo (abrocitinib), Opzelura (topical ruxolitinib), Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib)]

AND

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

- Dermatologist
- Allergist
- Immunologist

Notes

*See Table 1 for relative potencies of topical corticosteroids.

Product Name:Nemluvio

Diagnosis Atopic Dermatitis

Therapy Stage Reauthorization

Guideline Type Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Nemluvio therapy

AND

2 - Patient is not receiving Nemluvio in combination with either of the following for the treatment of the same indication:

- Biologic immunomodulator [e.g., Adbry (tralokinumab-ldrm), Dupixent (dupilumab), Ebglyss (lebrikizumab-lbkz)]
- Janus kinase inhibitor [e.g., Cibinqo (abrocitinib), Opzelura (topical ruxolitinib), Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib)]

AND

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

- Dermatologist
- Allergist
- Immunologist

AND

4 - One of the following:

4.1 Patient has achieved clear or almost clear skin and the request is for Nemluvio 30 milligrams given every 8 weeks (authorize approval length for 12 months)

OR

4.2 Patient has not yet achieved clear or almost clear skin and the request is for Nemluvio 30 milligrams given every 4 weeks (authorize approval length for 6 months)

Product Name:Nemluvio	
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 has greater than or equal to 20 nodular lesions AND 3 - One of the following: 3.1 Failure to at least ONE previous prurigo nodularis treatment(s) (e.g., topical corticosteroids, topical calcineurin inhibitors, topical capsaicin) as confirmed by claims history or submission of medical records	

OR

3.2 History of contraindication or intolerance to ALL other prurigo nodularis treatment(s) (e.g., topical corticosteroids, topical calcineurin inhibitors, topical capsaicin) (please specify contraindication or intolerance)

AND

4 - One of the following:

4.1 Failure to Dupixent (dupilumab) as confirmed by claims history or submission of medical records

OR

4.2 History of contraindication or intolerance to Dupixent (dupilumab) (please specify contraindication or intolerance)

OR

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

AND

5 - Patient is not receiving Nemluvio in combination with either of the following for the treatment of the same indication:

- Biologic immunomodulator [e.g., Adbry (tralokinumab-ldrm), Dupixent (dupilumab), Ebglyss (lebrikizumab-lbkz)]
- Janus kinase inhibitor [e.g., Cibinqo (abrocitinib), Opzelura (topical ruxolitinib), Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib)]

AND

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

- Dermatologist
- Allergist
- Immunologist

Product Name:Nemluvio	
Diagnosis	Prurigo Nodularis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Nemluvio therapy

AND

2 - Patient is not receiving Nemluvio in combination with either of the following for the treatment of the same indication:

- Biologic immunomodulator [e.g., Adbry (tralokinumab-ldrm), Dupixent (dupilumab), Ebglyss (lebrikizumab-lbkz)]
- Janus kinase inhibitor [e.g., Cibinqo (abrocitinib), Opzelura (topical ruxolitinib), Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib)]

AND

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

- Dermatologist
- Allergist
- Immunologist

2 . Background

Benefit/Coverage/Program Information			
Table 1: Relative potencies of topical corticosteroids			
Class	Drug	Dosage Form	Strength (%)
Very high potency	Augmented betamethasone dipropionate	Ointment, gel	0.05
	Clobetasol propionate	Cream, foam, ointment	0.05
	Diflorasone diacetate	Ointment	0.05
	Halobetasol propionate	Cream, ointment	0.05
High Potency	Amcinonide	Cream, lotion, ointment	0.1
	Augmented betamethasone dipropionate	Cream, lotion	0.05
	Betamethasone dipropionate	Cream, foam, ointment, solution	0.05
	Desoximetasone	Cream, ointment	0.25
	Desoximetasone	Gel	0.05
	Diflorasone diacetate	Cream	0.05
	tridifloronide	Cream, gel, ointment, solution	0.05
	Halcinonide	Cream, ointment	0.1
	Mometasone furoate	Ointment	0.1
Medium potency	Triamcinolone acetonide	Cream, ointment	0.5
	Betamethasone valerate	Cream, foam, lotion, ointment	0.1
	Clocortolone pivalate	Cream	0.1
	Desoximetasone	Cream	0.05
	Fluocinolone acetonide	Cream, ointment	0.025
	Flurandrenolide	Cream, ointment, lotion	0.05
	Fluticasone propionate	Cream	0.05
	Fluticasone propionate	Ointment	0.005
	Mometasone furoate	Cream, lotion	0.1
Lower-medium potency	Triamcinolone acetonide	Cream, ointment, lotion	0.1
	Hydrocortisone butyrate	Cream, ointment, solution	0.1
	Hydrocortisone probutate	Cream	0.1
	Hydrocortisone valerate	Cream, ointment	0.2
Low potency	Prednicarbate	Cream	0.1
	Alclometasone dipropionate	Cream, ointment	0.05
Low potency	Desonide	Cream, gel, foam, ointment	0.05

Lowest potency	Fluocinolone acetonide	Cream, solution	0.01
	Dexamethasone	Cream	0.1
	Hydrocortisone	Cream, lotion, ointment, solution	0.25, 0.5, 1
	Hydrocortisone acetate	Cream, ointment	0.5-1

3 . Revision History

Date	Notes
2/12/2026	Removed NY

Nemluvio



Prior Authorization Guideline

Guideline ID	GL-521216
Guideline Name	Nemluvio
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 New Mexico

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

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

Approval Criteria

1 - Diagnosis of moderate-to-severe chronic atopic dermatitis

AND

2 - One of the following:

2.1 Inadequate response to TWO of the following therapeutic classes of topical therapies as confirmed by claims history or submission of medical records:

- One medium, high or very-high potency topical corticosteroid [e.g., mometasone furoate (generic Elocon), fluocinolone acetonide (generic Synalar), fluocinonide (generic Lidex)]*
- One topical calcineurin inhibitor [e.g., pimecrolimus (generic Elidel), tacrolimus (generic Protopic)]
- Eucrisa (crisaborole)

OR

2.2 History of contraindication or intolerance to ALL of the following therapeutic classes of topical therapies (please specify contraindication or intolerance):

- One medium, high very-high potency topical corticosteroid [e.g., mometasone furoate (generic Elocon), fluocinolone acetonide (generic Synalar), fluocinonide (generic Lidex)]*
- One topical calcineurin inhibitor [e.g., pimecrolimus (generic Elidel), tacrolimus (generic Protopic)]
- Eucrisa (crisaborole)

OR

2.3 Patient has been previously treated with a targeted immunomodulator FDA-approved for the treatment of atopic dermatitis as documented by claims history or submission of medical records [e.g., Adbry (tralokinumab-ldrm), Cibinqo (abrocitinib), Dupixent (dupilumab), Ebglyss (lebrikizumab-lbkz), Opzelura (ruxolitinib), Rinvoq (upadacitinib)]

AND

3 - One of the following:

3.1 Failure to BOTH of the following as confirmed by claims history or submission of medical records:

- Adbry (tralokinumab-ldrm)
- Dupixent (dupilumab)

OR

3.2 History of contraindication or intolerance to BOTH of the following (please specify contraindication or intolerance):

- Adbry (tralokinumab-ldrm)
- Dupixent (dupilumab)

OR

3.3 Patient is currently on Nemluvio therapy as confirmed by claims history or submission of medical records

AND

4 - Nemluvio will be used in combination with a topical corticosteroid and/or topical calcineurin inhibitor

AND

5 - Patient is not receiving Nemluvio in combination with either of the following for treatment of the same indication:

- Biologic immunomodulator [e.g., Adbry (tralokinumab-ldrm), Dupixent (dupilumab), Ebglyss (lebrikizumab-lbkz)]
- Janus kinase inhibitor [e.g., Cibinqo (abrocitinib), Opzelura (topical ruxolitinib), Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib)]

AND

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

- Dermatologist
- Allergist
- Immunologist

Notes

*See Table 1 for relative potencies of topical corticosteroids.

Product Name:Nemluvio

Diagnosis Atopic Dermatitis

Therapy Stage Reauthorization

Guideline Type Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Nemluvio therapy

AND

2 - Patient is not receiving Nemluvio in combination with either of the following for the treatment of the same indication:

- Biologic immunomodulator [e.g., Adbry (tralokinumab-ldrm), Dupixent (dupilumab), Ebglyss (lebrikizumab-lbkz)]
- Janus kinase inhibitor [e.g., Cibinqo (abrocitinib), Opzelura (topical ruxolitinib), Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib)]

AND

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

- Dermatologist
- Allergist
- Immunologist

AND

4 - One of the following:

4.1 Patient has achieved clear or almost clear skin and the request is for Nemluvio 30 milligrams given every 8 weeks (authorize approval length for 12 months)

OR

4.2 Patient has not yet achieved clear or almost clear skin and the request is for Nemluvio 30 milligrams given every 4 weeks (authorize approval length for 6 months)

Product Name:Nemluvio	
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 has greater than or equal to 20 nodular lesions AND 3 - One of the following: 3.1 Failure to at least ONE previous prurigo nodularis treatment(s) (e.g., topical corticosteroids, topical calcineurin inhibitors, topical capsaicin) as confirmed by claims history or submission of medical records	

OR

3.2 History of contraindication or intolerance to ALL other prurigo nodularis treatment(s) (e.g., topical corticosteroids, topical calcineurin inhibitors, topical capsaicin) (please specify contraindication or intolerance)

AND

4 - One of the following:

4.1 Failure to Dupixent (dupilumab) as confirmed by claims history or submission of medical records

OR

4.2 History of contraindication or intolerance to Dupixent (dupilumab) (please specify contraindication or intolerance)

OR

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

AND

5 - Patient is not receiving Nemluvio in combination with either of the following for the treatment of the same indication:

- Biologic immunomodulator [e.g., Adbry (tralokinumab-ldrm), Dupixent (dupilumab), Ebglyss (lebrikizumab-lbkz)]
- Janus kinase inhibitor [e.g., Cibinqo (abrocitinib), Opzelura (topical ruxolitinib), Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib)]

AND

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

- Dermatologist
- Allergist
- Immunologist

Product Name:Nemluvio	
Diagnosis	Prurigo Nodularis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Nemluvio therapy AND 2 - Patient is not receiving Nemluvio in combination with either of the following for the treatment of the same indication: • Biologic immunomodulator [e.g., Adbry (tralokinumab-ldrm), Dupixent (dupilumab), Ebglyss (lebrikizumab-lbkz)] • Janus kinase inhibitor [e.g., Cibinqo (abrocitinib), Opzelura (topical ruxolitinib), Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib)] AND 3 - Prescribed by or in consultation with one of the following: • Dermatologist • Allergist • Immunologist	

2 . Background

Benefit/Coverage/Program Information			
Table 1: Relative potencies of topical corticosteroids			
Class	Drug	Dosage Form	Strength (%)
Very high potency	Augmented betamethasone dipropionate	Ointment, gel	0.05
	Clobetasol propionate	Cream, foam, ointment	0.05
	Diflorasone diacetate	Ointment	0.05
	Halobetasol propionate	Cream, ointment	0.05
High Potency	Amcinonide	Cream, lotion, ointment	0.1
	Augmented betamethasone dipropionate	Cream, lotion	0.05
	Betamethasone dipropionate	Cream, foam, ointment, solution	0.05
	Desoximetasone	Cream, ointment	0.25
	Desoximetasone	Gel	0.05
	Diflorasone diacetate	Cream	0.05
	tridifloronide	Cream, gel, ointment, solution	0.05
	Halcinonide	Cream, ointment	0.1
	Mometasone furoate	Ointment	0.1
Medium potency	Triamcinolone acetonide	Cream, ointment	0.5
	Betamethasone valerate	Cream, foam, lotion, ointment	0.1
	Clocortolone pivalate	Cream	0.1
	Desoximetasone	Cream	0.05
	Fluocinolone acetonide	Cream, ointment	0.025
	Flurandrenolide	Cream, ointment, lotion	0.05
	Fluticasone propionate	Cream	0.05
	Fluticasone propionate	Ointment	0.005
	Mometasone furoate	Cream, lotion	0.1
Lower-medium potency	Triamcinolone acetonide	Cream, ointment, lotion	0.1
	Hydrocortisone butyrate	Cream, ointment, solution	0.1
	Hydrocortisone probutate	Cream	0.1
	Hydrocortisone valerate	Cream, ointment	0.2
Low potency	Prednicarbate	Cream	0.1
	Alclometasone dipropionate	Cream, ointment	0.05
	Desonide	Cream, gel, foam, ointment	0.05

Lowest potency	Fluocinolone acetonide	Cream, solution	0.01
	Dexamethasone	Cream	0.1
	Hydrocortisone	Cream, lotion, ointment, solution	0.25, 0.5, 1
	Hydrocortisone acetate	Cream, ointment	0.5-1

3 . Revision History

Date	Notes
2/12/2026	Removed NY

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.

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.

Nexletol, Nexlizet



Prior Authorization Guideline

Guideline ID	GL-555322
Guideline Name	Nexletol, Nexlizet
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

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:Nexletol, Nexlizet	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
	Approval Criteria 1 - ONE of the following diagnoses: 1.1 Primary hyperlipidemia, including heterozygous familial hypercholesterolemia (HeFH) OR 1.2 Established cardiovascular disease (CVD) as documented by one of the following: • coronary artery disease • symptomatic peripheral arterial disease • cerebrovascular atherosclerotic disease OR 1.3 High risk for cardiovascular disease (CVD) as documented by one of the following: • Diabetes and over 60 years old • Reynolds risk score greater than 30% • Coronary artery calcium score greater than 400 Agatston units • ASCVD risk score greater than or equal to 20% with the American College of Cardiology/American Heart Association (ACC/AHA) risk estimator AND 2 - Submission of medical records (e.g., chart notes, laboratory values) confirming ONE of the following [prescription claims history may be used in conjunction as confirmation of medication use, dose, and duration]: 2.1 Patient has been receiving at least 12 consecutive weeks of high intensity statin therapy [i.e., atorvastatin 40-80 mg (milligrams), rosuvastatin 20-40 mg] and will continue to receive a high intensity statin at maximally tolerated dose OR

2.2 BOTH of the following:

2.2.1 Patient is unable to tolerate high-intensity statin as evidenced by ONE of the following intolerable and persistent (i.e., more than 2 weeks) symptoms:

- Myalgia [muscle symptoms without CK (creatinine kinase) elevations]
- Myositis [muscle symptoms with CK elevations less than 10 times upper limit of normal (ULN)]

AND

2.2.2 Patient has been receiving at least 12 consecutive weeks of low-intensity or moderate-intensity statin therapy [i.e., atorvastatin 10-20 mg, rosuvastatin 5-10 mg, simvastatin greater than or equal to 10 mg, pravastatin greater than or equal to 10 mg, lovastatin 20-40 mg, fluvastatin extended-release 80 mg, fluvastatin 20-40 mg up to 40mg twice daily or Livalo (pitavastatin) greater than or equal to 1 mg] and will continue to receive a low-intensity or moderate-intensity statin at maximally tolerated dose

OR

2.3 Patient is unable to tolerate low or moderate-, and high-intensity statins as evidenced by ONE of the following:

2.3.1 ONE of the following intolerable and persistent (i.e., more than 2 weeks) symptoms for low or moderate-, and high-intensity statins:

- Myalgia (muscle symptoms without CK elevations)
- Myositis (muscle symptoms with CK elevations less than 10 times ULN)

OR

2.3.2 Patient has a labeled contraindication to all statins as documented in medical records

OR

2.3.3 Patient has experienced rhabdomyolysis or muscle symptoms with statin treatment with CK elevations greater than 10 times ULN

AND

3 - ONE of the following:

3.1 Submission of medical records (e.g., laboratory values) confirming ONE of the following LDL-C (low-density lipoprotein cholesterol) values while on maximally tolerated lipid lowering therapy for a minimum of at least 12 weeks within the last 120 days:

- LDL-C greater than or equal to 100 mg/dL (milligrams/deciliter) with ASCVD
- LDL-C greater than or equal to 130 mg/dL without ASCVD

OR

3.2 BOTH of the following:

3.2.1 Submission of medical records (e.g., laboratory values) confirming ONE of the following LDL-C values while on maximally tolerated lipid lowering therapy for a minimum of at least 12 weeks within the last 120 days:

- LDL-C between 55 mg/dL and 99 mg/dL with ASCVD
- LDL-C between 100 mg/dL and 129 mg/dL without ASCVD

AND

3.2.2 Submission of medical records (e.g., chart notes, laboratory values) confirming ONE of the following [prescription claims history may be used in conjunction as confirmation of medication use, dose, and duration]:

3.2.2.1 Patient has been receiving at least 12 consecutive weeks of ezetimibe (Zetia) therapy as adjunct to maximally tolerated statin therapy

OR

3.2.2.2 Patient has a history of contraindication, or intolerance to ezetimibe

Product Name:Nexletol, Nexlizet	
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of a positive clinical response to therapy AND 2 - Patient continues to receive statin at maximally tolerated dose (unless patient has documented inability to take statins)	

2 . Revision History

Date	Notes
3/24/2026	In initial auth, added 12 week statin trial under 3.1

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-559225
Guideline Name	Non-Preferred Drugs
Formulary	Medicaid - Community & State Rhode Island

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:Non-Preferred Medications	
Approval Length	12 month(s)
Guideline Type	Administrative
Approval Criteria 1 - If the requested medication is a behavioral health medication, ONE of the following: The patient has been receiving treatment with the requested non-preferred behavioral health medication and is new to the plan (enrollment effective date within the past 90 days)	

- 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 History of failure or inadequate response to at least THREE generic or preferred alternatives as confirmed by claims history or submission of medical records* NOTE: In instances where there are fewer than three generic or preferred alternatives, the patient must have a history of failure to all of the generic or preferred products.

OR

2.1.2 History of contraindication, side effect, or intolerance to THREE generic or preferred alternatives (please specify contraindication or intolerance)* NOTE: In instances where there are fewer than three generic or preferred alternatives, the patient must have a history of contraindication or intolerance to all of the generic or preferred products.

OR

2.1.3 There are no generic or preferred formulary alternatives for the requested drug

OR

2.1.4 If the request is for a combination product, one of the following:

- Failure or inadequate response to THREE combinations of generic or preferred products taken concomitantly as confirmed by claims history or submitted medical records.* NOTE: In instances where there are fewer than three generic or preferred combination alternatives, the patient must have a history of failure to all of the generic or preferred combination alternatives
- History of contraindication, side effect, or intolerance to THREE generic or preferred combinations (please specify contraindication or intolerance).* NOTE: In instances where there are fewer than three generic or preferred combination alternatives, the patient must have a history of failure to all of the generic or preferred combination alternatives.

AND

2.2 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)
- There are no generic or preferred formulary alternatives for the requested drug

AND

2.3 If the request is for a generic when there is a brand available and the brand is the preferred formulation, 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)
- There are no generic or preferred formulary alternatives for the requested drug

AND

2.4 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

AND

2.5 One of the following:

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

OR

2.5.2 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

2.6 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	* Prior trials of generic or formulary/PDL alternatives must sufficiently demonstrate that the generic or formulary/PDL alternatives are either ineffective or inappropriate at the time of the request. PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/rhode-island-health-plans/ri-comm-plan-home/ri-cp-pharmacy.html

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

UnitedHealthcare Community Plan of Rhode Island Clinical Pharmacy Program Guidelines

Date	Notes
3/27/2026	Updated GL-559224 to fix typo. same go live of 5/1/26

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.

Nucala



Prior Authorization Guideline

Guideline ID	GL-523216
Guideline Name	Nucala
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

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name:Nucala auto-injector and pre-filled syringe	
Diagnosis	Eosinophilic Granulomatosis with Polyangiitis (EGPA)
Approval Length	12 month(s)

Therapy Stage	Initial Authorization - Transitioning from UHC medical benefits
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has been established on therapy with Nucala under an active UnitedHealthcare medical benefit prior authorization for the treatment of EGPA AND 2 - Documentation of positive clinical response to Nucala therapy as demonstrated by at least ONE of the following: • Reduction in the frequency and/or severity of relapses • Reduction or discontinuation of doses of corticosteroids and/or immunosuppressant • Disease remission • Reduction in severity or frequency of EGPA-related symptoms AND 3 - Patient is not receiving Nucala in combination with ONE of the following for treatment of the same indication: • Anti-interleukin 5 therapy [e.g., Cinqair (reslizumab), Fasenra (benralizumab)] • Anti-IgE therapy [e.g., Xolair (omalizumab)] • Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)] • Thymic stromal lymphopoietin (TSLP) inhibitor therapy [e.g., Tezspire (tezepelumab)] AND 4 - Prescribed by ONE of the following: • Allergist • Immunologist • Pulmonologist • Rheumatologist	

Product Name:Nucala auto-injector and pre-filled syringe	
Diagnosis	Eosinophilic Granulomatosis with Polyangiitis (EGPA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization – Not transitioning from UHC medical benefits
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of relapsing or refractory eosinophilic granulomatosis with polyangiitis (EGPA) as defined by ALL of the following: 1.1 Diagnosis of EGPA AND 1.2 Past medical history or presence of asthma AND 1.3 Presence of at least TWO of the following characteristics typical of EGPA: 1.3.1 Histopathological evidence of ALL of the following: • Eosinophilic vasculitis • Perivascular eosinophilic infiltration • Eosinophil-rich granulomatous inflammation OR 1.3.2 Neuropathy, mono or poly (motor deficit or nerve conduction abnormality) OR 1.3.3 Pulmonary infiltrates, non-fixed	

OR

1.3.4 Sino-nasal abnormality

OR

1.3.5 Cardiomyopathy [established by echocardiography or magnetic resonance imaging (MRI)]

OR

1.3.6 Glomerulonephritis (hematuria, red cell casts, proteinuria)

OR

1.3.7 Alveolar hemorrhage

OR

1.3.8 Palpable purpura

OR

1.3.9 Anti-neutrophil cytoplasmic antibody (ANCA) positive

AND

1.4 History of relapsing or refractory disease defined as ONE of the following:

1.4.1 Relapsing disease as defined as a past history (within the past 2 years) of at least one EGPA relapse (requiring additional or dose escalation of corticosteroids or immunosuppressant, or hospitalization)

OR

1.4.2 Refractory disease as defined as failure to attain remission within the prior 6 months following induction treatment with standard therapy regimens

AND

2 - Patient is currently taking standard therapy [i.e., systemic glucocorticoids (e.g., prednisone, methylprednisolone) with or without immunosuppressive therapy (e.g., cyclophosphamide, rituximab)] as supported by claims history or submitted medical records

AND

3 - Patient is not receiving Nucala in combination with ONE of the following for treatment of the same indication:

- Anti-interleukin 5 therapy [e.g., Cinqair (reslizumab), Fasenra (benralizumab)]
- Anti-IgE (immunoglobulin E) therapy [e.g., Xolair (omalizumab)]
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor therapy [e.g., Tezspire (tezepelumab)]

AND

4 - Prescribed by ONE of the following:

- Allergist
- Immunologist
- Pulmonologist
- Rheumatologist

Product Name:Nucala auto-injector and pre-filled syringe	
Diagnosis	Eosinophilic Granulomatosis with Polyangiitis (EGPA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Nucala therapy as demonstrated by at least ONE of the following:

1.1 Reduction in the frequency and/or severity of relapses

OR

1.2 Reduction or discontinuation of doses of corticosteroids and/or immunosuppressant

OR

1.3 Disease remission

OR

1.4 Reduction in severity or frequency of eosinophilic granulomatosis with polyangiitis (EGPA)-related symptoms

AND

2 - Patient is not receiving Nucala in combination with ONE of the following for treatment of the same indication:

- Anti-interleukin 5 therapy [e.g., Cinqair (reslizumab), Fasenra (benralizumab)]
- Anti-IgE (immunoglobulin E) therapy [e.g., Xolair (omalizumab)]
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor therapy [e.g., Tezspire (tezepelumab)]

Product Name:Nucala auto-injector and pre-filled syringe	
Diagnosis	Severe Asthma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization - Transitioning from UHC medical benefits

Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has been established on therapy with Nucala under an active UnitedHealthcare medical benefit prior authorization for the treatment of severe asthma AND 2 - Documentation of positive clinical response to Nucala therapy as demonstrated by at least ONE of the following: • Reduction in the frequency of exacerbations • Decreased utilization of rescue medications • Increase in percent predicted FEV1 from pretreatment baseline • Reduction in severity or frequency of asthma-related symptoms (e.g., wheezing, shortness of breath, coughing, etc.) • Reduction in oral corticosteroid requirements AND 3 - Nucala is being used in combination with an inhaled corticosteroid (ICS) containing maintenance medication [e.g., Advair/AirDuo (fluticasone/salmeterol), Breo Ellipta (fluticasone furoate/vilanterol), Symbicort (budesonide/ formoterol), Trelegy Ellipta (fluticasone furoate/umeclidinium/vilanterol)] AND 4 - Patient is not receiving Nucala in combination with ONE of the following for treatment of the same indication: • Anti-interleukin 5 therapy [e.g., Cinqair (reslizumab), Fasenra (benralizumab)] • Anti-IgE therapy [e.g., Xolair (omalizumab)] • Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)] • Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)] AND	

5 - Prescribed by ONE of the following:

- Allergist
- Immunologist
- Pulmonologist

Product Name:Nucala auto-injector and pre-filled syringe	
Diagnosis	Severe Asthma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization – Not transitioning from UHC medical benefits
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of severe asthma AND 2 - Classification of asthma as uncontrolled or inadequately controlled as defined by at least ONE of the following: 2.1 Poor symptom control [e.g., Asthma Control Questionnaire (ACQ) score consistently greater than 1.5 or Asthma Control Test (ACT) score consistently less than 20] OR 2.2 Two or more bursts of systemic corticosteroids for at least 3 days each in the previous 12 months OR 2.3 Asthma-related emergency treatment (e.g., emergency room visit, hospital admission, or unscheduled physician's office visit for nebulizer or other urgent treatment)	

OR

2.4 Airflow limitation [e.g., after appropriate bronchodilator withhold forced expiratory volume in 1 second (FEV1) less than 80% predicted (in the face of reduced FEV1/forced vital capacity [FVC] defined as less than the lower limit of normal)]

OR

2.5 Patient is currently dependent on oral corticosteroids for the treatment of asthma

AND

3 - Submission of medical records (e.g., chart notes, laboratory values, etc.) confirming asthma is an eosinophilic phenotype as defined by a baseline (pre-treatment) peripheral blood eosinophil level greater than or equal to 150 cells per microliter

AND

4 - Nucala will be used in combination with ONE of the following:

4.1 ONE maximally-dosed (appropriately adjusted for age) combination inhaled corticosteroid (ICS)/long-acting beta2 agonist (LABA) [e.g., Advair/AirDuo Respiclick (fluticasone propionate/salmeterol), Symbicort (budesonide/formoterol), Breo Ellipta (fluticasone furoate/vilanterol)]

OR

4.2 Combination therapy including BOTH of the following:

4.2.1 ONE maximally-dosed (appropriately adjusted for age) ICS product [e.g., ciclesonide (Alvesco), mometasone furoate (Asmanex), beclomethasone dipropionate (QVAR)]

AND

4.2.2 ONE additional asthma controller medication [e.g., LABA - olodaterol (Striverdi) or indacaterol (Arcapta); leukotriene receptor antagonist - montelukast (Singulair); theophylline]

AND

5 - Patient is not receiving Nucala in combination with ONE of the following for treatment of the same indication:

- Anti-interleukin 5 therapy [e.g., Cinqair (reslizumab), Fasenra (benralizumab)]
- Anti-IgE (immunoglobulin E) therapy [e.g., Xolair (omalizumab)]
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

6 - Prescribed by ONE of the following:

- Allergist
- Immunologist
- Pulmonologist

AND

7 - ONE of the following:

- Failure to a 4 month trial of Fasenra (benralizumab) as confirmed by claims history or submitted medical records
- History of contraindication or intolerance to Fasenra (benralizumab) (please specify intolerance or contraindication)

Product Name:Nucala auto-injector and pre-filled syringe	
Diagnosis	Severe Asthma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Documentation of positive clinical response to Nucala therapy as demonstrated by at least ONE of the following:

1.1 Reduction in the frequency of exacerbations

OR

1.2 Decreased utilization of rescue medications

OR

1.3 Increase in percent predicted forced expiratory volume in 1 second (FEV1) from pretreatment baseline

OR

1.4 Reduction in severity or frequency of asthma-related symptoms (e.g., wheezing, shortness of breath, coughing, etc.)

OR

1.5 Reduction in oral corticosteroid requirements

AND

2 - Nucala is being used in combination with an inhaled corticosteroid (ICS)-containing maintenance medication [e.g., Advair/AirDuo (fluticasone/salmeterol), Breo Ellipta (fluticasone furoate/vilanterol), Symbicort (budesonide/ formoterol), Trelegy Ellipta (fluticasone furoate/umeclidinium/vilanterol)]

AND

3 - Patient is not receiving Nucala in combination with ONE of the following for treatment of the same indication:

- Anti-interleukin 5 therapy [e.g., Cinqair (reslizumab), Fasenra (benralizumab)]

- Anti-IgE (immunoglobulin E) therapy [e.g., Xolair (omalizumab)]
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

Product Name:Nucala auto-injector and pre-filled syringe	
Diagnosis	Hypereosinophilic Syndrome (HES)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization - Transitioning from UHC medical benefits
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has been established on therapy with Nucala under an active UnitedHealthcare medical benefit prior authorization for the treatment of hypereosinophilic syndrome (HES) AND 2 - Documentation of positive clinical response to Nucala therapy as demonstrated by at least ONE of the following: • Reduction in frequency of HES flares • Maintenance or reduction in background HES therapy requirements AND 3 - Patient is not receiving Nucala in combination with ONE of the following for treatment of the same indication: • Anti-interleukin 5 therapy [e.g., Cinqair (reslizumab), Fasenra (benralizumab)] • Anti-IgE therapy [e.g., Xolair (omalizumab)] • Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)] • Thymic stromal lymphopoietin (TSLP) inhibitor therapy [e.g., Tezspire (tezepelumab)] AND 4 - Prescribed by ONE of the following:	

- Allergist
- Cardiologist
- Hematologist
- Immunologist
- Pulmonologist

Product Name:Nucala auto-injector and pre-filled syringe	
Diagnosis	Hypereosinophilic Syndrome (HES)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization – Not transitioning from UHC medical benefits
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Hypereosinophilic Syndrome (HES) greater than or equal to 6 months ago AND 2 - BOTH of the following: 2.1 There is no identifiable non-hematologic secondary cause of the patient’s HES [e.g., drug hypersensitivity, parasitic helminth infection, HIV (human immunodeficiency virus) infection, non-hematologic malignancy] AND 2.2 HES is not FIP1L1-PDGFR alpha (gene) kinase-positive AND 3 - Submission of medical records (e.g., chart notes, laboratory values, etc.) documenting BOTH of the following: 3.1 Baseline [pre-Nucala (mepolizumab) treatment] blood eosinophil level greater than or equal to 1000 cells per microliter within the past 4 weeks	

AND

3.2 Patient is currently receiving a stable dose of background HES therapy (e.g., oral corticosteroid, immunosuppressor, or cytotoxic therapy)

AND

4 - Patient is not receiving Nucala in combination with ONE of the following for treatment of the same indication:

- Anti-interleukin 5 therapy [e.g., Cinqair (reslizumab), Fasenra (benralizumab)]
- Anti-IgE (immunoglobulin E) therapy [e.g., Xolair (omalizumab)]
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor therapy [e.g., Tezspire (tezepelumab)]

AND

5 - Prescribed by ONE of the following:

- Allergist
- Cardiologist
- Hematologist
- Immunologist
- Pulmonologist

Product Name:Nucala auto-injector and pre-filled syringe	
Diagnosis	Hypereosinophilic Syndrome (HES)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Nucala therapy as demonstrated by at least ONE of the following:	

1.1 Reduction in the frequency of Hypereosinophilic Syndrome (HES) flares

OR

1.2 Maintenance or reduction in background HES therapy requirements

AND

2 - Patient is not receiving Nucala in combination with ONE of the following for treatment of the same indication:

- Anti-interleukin 5 therapy [e.g., Cinqair (reslizumab), Fasenra (benralizumab)]
- Anti-IgE (immunoglobulin E) therapy [e.g., Xolair (omalizumab)]
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor therapy [e.g., Tezspire (tezepelumab)]

Product Name:Nucala auto-injector and pre-filled syringe	
Diagnosis	Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization - Transitioning from UHC medical benefits
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has been established on therapy with Nucala under an active UnitedHealthcare medical benefit prior authorization for the treatment of chronic rhinosinusitis with nasal polyps (CRSwNP) AND 2 - Documentation of positive clinical response to Nucala therapy	

AND

3 - Patient will continue to receive Nucala as add-on maintenance therapy in combination with intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone)

AND

4 - Patient is not receiving Nucala in combination with ONE of the following for treatment of the same indication:

- Anti-interleukin 5 therapy [e.g., Cinqair (reslizumab), Fasenra (benralizumab)]
- Anti-IgE therapy [e.g., Xolair (omalizumab)]
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor therapy [e.g., Tezspire (tezepelumab)]

AND

5 - Prescribed by ONE of the following:

- Allergist
- Immunologist
- Otolaryngologist
- Pulmonologist

Product Name:Nucala auto-injector and pre-filled syringe

Diagnosis	Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization – Not transitioning from UHC medical benefits
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP) defined by ALL of the following:

1.1 TWO or more of the following symptoms for longer than 12 weeks duration:

- Nasal mucopurulent discharge
- Nasal obstruction, blockage, or congestion
- Facial pain, pressure, and/or fullness
- Reduction or loss of sense of smell

AND

1.2 ONE of the following findings using nasal endoscopy and/or sinus computed tomography (CT):

- Purulent mucus or edema in the middle meatus or ethmoid regions
- Polyps in the nasal cavity or the middle meatus
- Radiographic imaging demonstrating mucosal thickening or partial or complete opacification of paranasal sinuses

AND

1.3 ONE of the following:

- Presence of bilateral nasal polyposis
- Patient has previously required surgical removal of bilateral nasal polyps

AND

1.4 ONE of the following:

1.4.1 Patient has required prior sinus surgery

OR

1.4.2 Patient has required systemic corticosteroids (e.g., prednisone, methylprednisolone) for CRSwNP in the previous 2 years

OR

1.4.3 Patient has been unable to obtain symptom relief after trial of TWO of the following classes of agents:

- Nasal saline irrigations
- Intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone)
- Antileukotriene agents (e.g., montelukast, zafirlukast, zileuton)

AND

2 - Patient will receive Nucala as add-on maintenance therapy in combination with intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone)

AND

3 - Patient is not receiving Nucala in combination with ONE of the following for treatment of the same indication:

- Anti-interleukin 5 therapy [e.g., Cinqair (reslizumab), Fasenra (benralizumab)]
- Anti-IgE (immunoglobulin E) therapy [e.g., Xolair (omalizumab)]
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor therapy [e.g., Tezspire (tezepelumab)]

AND

4 - Prescribed by ONE of the following:

- Allergist
- Immunologist
- Otolaryngologist
- Pulmonologist

Product Name:Nucala auto-injector and pre-filled syringe	
Diagnosis	Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Nucala therapy

AND

2 - Patient will continue to receive Nucala as add-on maintenance therapy in combination with intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone)

AND

3 - Patient is not receiving Nucala in combination with ONE of the following for treatment of the same indication:

- Anti-interleukin 5 therapy [e.g., Cinqair (reslizumab), Fasenra (benralizumab)]
- Anti-IgE (immunoglobulin E) therapy [e.g., Xolair (omalizumab)]
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor therapy [e.g., Tezspire (tezepelumab)]

Product Name:Nucala auto-injector and pre-filled syringe	
Diagnosis	Chronic Obstructive Pulmonary Disease (COPD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization - Transitioning from UHC medical benefits
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has been established on therapy with Nucala under an active UnitedHealthcare medical benefit prior authorization for the treatment of chronic obstructive pulmonary disease (COPD) AND	

2 - Documentation of positive clinical response to Nucala therapy

AND

3 - Patient will continue to receive Nucala as add-on maintenance therapy

AND

4 - Patient is not receiving Nucala in combination with ONE of the following for treatment of the same indication:

- Anti-interleukin 5 therapy [e.g., Cinqair (reslizumab), Fasenra (benralizumab)]
- Anti-IgE therapy [e.g., Xolair (omalizumab)]
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

Product Name:Nucala auto-injector and pre-filled syringe

Diagnosis	Chronic Obstructive Pulmonary Disease (COPD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization – Not transitioning from UHC medical benefits
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic obstructive pulmonary disease (COPD)

AND

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

- Post-bronchodilator forced expiratory volume (FEV1) / forced vital capacity (FVC) ratio less than 0.7
- Post-bronchodilator FEV1 % predicted greater than or equal to 20% and less than or equal to 80%

- Patient has an eosinophilic phenotype defined by a baseline (pre-mepolizumab treatment) peripheral blood eosinophil level greater than or equal to 300 cells per microliter

AND

3 - Uncontrolled or inadequately controlled COPD demonstrated by BOTH of the following:

3.1 ONE of the following:

- Two or more COPD exacerbations in the previous year requiring treatment with systemic corticosteroids and/or antibiotics
- One or more COPD exacerbation(s) that resulted in hospitalization or observation for over 24 hours in an emergency department or urgent care facility in the past year

AND

3.2 COPD exacerbation(s) occurred while receiving maintenance therapy with ONE of the following:

- Triple therapy with a long-acting muscarinic antagonist (LAMA), long-acting beta agonist (LABA), and inhaled corticosteroid (ICS) (e.g., Breztri Aerosphere, Trelegy Ellipta)
- Dual therapy with a LAMA and LABA (e.g., Anoro Ellipta, Bevespi Aerosphere, Stiolto Respimat) and a failure, contraindication, or intolerance to an ICS

AND

4 - Nucala will be used as add-on maintenance therapy in combination with one of the following:

- Triple therapy with a long-acting muscarinic antagonist (LAMA), long-acting beta agonist (LABA), and inhaled corticosteroid (ICS) (e.g., Breztri Aerosphere, Trelegy Ellipta)
- Dual therapy with a LAMA and LABA (e.g., Anoro Ellipta, Bevespi Aerosphere, Stiolto Respimat) and a failure, contraindication, or intolerance to an ICS

AND

5 - Patient is not receiving Nucala in combination with ONE of the following for treatment of the same indication:

- Anti-interleukin 5 therapy [e.g., Cinqair (reslizumab), Fasenra (benralizumab)]
- Anti-IgE (immunoglobulin E) therapy [e.g., Xolair (omalizumab)]
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

6 - Prescribed by ONE of the following:

- Allergist
- Immunologist
- Pulmonologist

Product Name:Nucala auto-injector and pre-filled syringe	
Diagnosis	Chronic Obstructive Pulmonary Disease (COPD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Nucala therapy as demonstrated by at least ONE of the following: • Reduction in the frequency of chronic obstructive pulmonary disease (COPD) exacerbations • Increase in percent predicted FEV1 from pretreatment baseline • Reduction in severity or frequency of COPD-related symptoms (e.g., dyspnea, wheezing, cough, sputum volume, decrease in sputum purulence) • Reduction in oral corticosteroid requirements AND 2 - Nucala is being used as add-on maintenance therapy in combination with ONE of the following:	

- Triple therapy with a long-acting muscarinic antagonist (LAMA), long-acting beta agonist (LABA), and inhaled corticosteroid (ICS) (e.g., Breztri Aerosphere, Trelegy Ellipta)
- Dual therapy with a LAMA and LABA (e.g., Anoro Ellipta, Bevespi Aerosphere, Stiolto Respimat) and a failure, contraindication, or intolerance to an ICS

AND

3 - Patient is not receiving Nucala in combination with ONE of the following for treatment of the same indication:

- Anti-interleukin 5 therapy [e.g., Cinqair (reslizumab), Fasenra (benralizumab)]
- Anti-IgE (immunoglobulin E) therapy [e.g., Xolair (omalizumab)]
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

4 - Prescribed by ONE of the following:

- Allergist
- Immunologist
- Pulmonologist

2 . Revision History

Date	Notes
2/13/2026	Updated initial auth criteria for COPD. Updated combination language under CRSwNP and COPD, with no changes to clinical intent.

Nuedexta



Prior Authorization Guideline

Guideline ID	GL-436482
Guideline Name	Nuedexta
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 New Mexico Medicaid - Community & State Pennsylvania Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	12/1/2025

1 . Criteria

Product Name:Nuedexta

Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of pseudobulbar affect (PBA)	

2 . Revision History

Date	Notes
10/31/2025	Combined formularies. No changes to clinical criteria.

Nuplazid



Prior Authorization Guideline

Guideline ID	GL-596196
Guideline Name	Nuplazid
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 Nebraska

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Nuplazid	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Parkinson's disease

AND

2 - Patient is currently experiencing hallucinations and delusions associated with Parkinson's disease psychosis (i.e., hallucination and delusion symptoms started after Parkinson's disease diagnosis)

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

2 . Revision History

Date	Notes
4/27/2026	Removed ACUNM from markets in scope. Rearranged order of formularies. No changes to clinical criteria.

Nurtec, Qulipta, Ubrelvy, Zavzpret



Prior Authorization Guideline

Guideline ID	GL-564222
Guideline Name	Nurtec, Qulipta, Ubrelvy, Zavzpret
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State New Jersey Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Nurtec ODT	
Diagnosis	Acute Treatment of Migraine
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Used for acute treatment of migraine

AND

2 - One of the following:

2.1 Failure (after at least 3 migraine episodes and a minimum of a 30-day trial) to TWO of the following as confirmed by claims history or submission of medical records:

- eletriptan (generic Relpax)
- frovatriptan (generic Frova)
- naratriptan (generic Amerge)
- rizatriptan (generic Maxalt/Maxalt MLT)
- sumatriptan (generic Imitrex)
- zolmitriptan (generic Zomig/Zomig-ZMT)

OR

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

- eletriptan (generic Relpax)
- frovatriptan (generic Frova)
- naratriptan (generic Amerge)
- rizatriptan (generic Maxalt/Maxalt MLT)
- sumatriptan (generic Imitrex)
- zolmitriptan (generic Zomig/Zomig-ZMT)

AND

3 - One of the following:

3.1 Patient is currently treated with ONE of the following prophylactic therapies or classes as confirmed by claims history or submission of medical records:

- A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol)*
- Candesartan* (generic Atacand)

- Monoclonal antibodies or small-molecules targeting calcitonin gene-related peptide (CGRP) or its receptor for preventive treatment of migraine [i.e., Aimovig, Ajovy*, Emgality, Qulipta*, Vyepti**] ***
- Divalproex sodium (generic Depakote/Depakote ER)
- OnabotulinumtoxinA** (generic Botox)
- A serotonin-norepinephrine reuptake inhibitor [i.e., duloxetine (Cymbalta), venlafaxine (Effexor/Effexor XR)]
- Topiramate (generic Topamax)
- A tricyclic antidepressant [i.e., amitriptyline (Elavil), nortriptyline (Pamelor)]

OR

3.2 Patient has less than 4 migraine days per month

OR

3.3 Patient has greater than or equal to 4 migraine days per month and has contraindication or intolerance to TWO of the following prophylactic therapies or classes (please specify contraindication or intolerance):

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

AND

4 - Medication will not be used in combination with another small-molecule targeting the CGRP receptor ("gepants") (e.g., Qulipta, Ubrelvy, Zavzpret)

Notes	* Timolol, candesartan, Ajovy and Qulipta are non-preferred and should not be included in denial to provider **Vyepti, OnabotulinumtoxinA are medical benefits and should not be included in denial to provider. ***CGRP antagonists for preventive treatment of migraines require a prior authorization.

Product Name:Nurtec ODT	
Diagnosis	Preventive Treatment of Episodic Migraine
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of episodic migraines with greater than or equal to 4 migraine days per month AND 2 - Used for preventive treatment of migraines AND 3 - One of the following: 3.1 Failure (after a trial of at least two months), to TWO of the following prophylactic therapies as confirmed by claims history or submission of medical records: • A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol*) • Candesartan* (generic Atacand) • Divalproex sodium (generic Depakote/Depakote ER) • Topiramate (generic Topamax) • A serotonin-norepinephrine reuptake inhibitor [i.e., duloxetine (Cymbalta), venlafaxine (Effexor/Effexor XR)] • A tricyclic antidepressant [i.e., amitriptyline (Elavil), nortriptyline (Pamelor)] OR 3.2 History of contraindication or intolerance to TWO of the following prophylactic therapies (please specify contraindication or intolerance): • A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol*) • Candesartan* (generic Atacand) • Divalproex sodium (generic Depakote/Depakote ER) • Topiramate (generic Topamax)	

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

AND

4 - BOTH of the following:

- Medication will not be used in combination with a monoclonal antibody targeting CGRP (calcitonin gene-related peptide) or its receptor used for the preventive treatment of migraines (e.g., Aimovig, Ajovy, Emgality, Vyepti)
- Medication will not be used in combination with another small-molecule targeting the CGRP receptor ("gepants") (e.g., Qulipta, Ubrelvy, Zavzpret)

Notes

* Timolol and candesartan are non-preferred and should not be included in denial to provider

Product Name:Nurtec ODT

Diagnosis	Acute Treatment of Migraine, Preventive Treatment of Episodic Migraine

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - ONE of the following:

2.1 If being used for acute treatment of migraine, the requested medication will not be used in combination with another small-molecule targeting the CGRP (calcitonin gene-related peptide) receptor ("gepants") (e.g., Qulipta, Ubrelvy, Zavzpret)

OR

2.2 If being used for preventive treatment of episodic migraine, BOTH of the following:

- The requested medication will not be used in combination with a monoclonal antibody targeting CGRP or its receptor (e.g., Aimovig, Ajovy, Emgality, Vyepti)
- The requested medication will not be used in combination with another small-molecule targeting the CGRP receptor ("gepants") (Qulipta, Ubrelvy, Zavzpret)

Product Name:Zavzpret	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Used for acute treatment of migraine AND 2 - One of the following: 2.1 Failure (after at least 3 migraine episodes and a minimum of a 30-day trial) to BOTH of the following as confirmed by claims history or submission of medical records: 2.1.1 TWO preferred 5-HT₁ receptor agonist (triptan) alternatives (e.g., sumatriptan, rizatriptan, or naratriptan), one of which must be sumatriptan nasal spray AND 2.1.2 ONE of the following: • Nurtec ODT • Ubrelvy	

OR

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

- TWO preferred 5-HT₁ receptor agonist (triptan) alternatives (e.g., sumatriptan, rizatriptan, or naratriptan), one of which must be sumatriptan nasal spray
- Nurtec ODT
- Ubrelvy

AND

3 - One of the following:

3.1 Patient is currently treated with ONE of the following prophylactic therapies or classes as confirmed by claims history or submission of medical records:

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

OR

3.2 Patient has less than 4 migraine days per month

OR

3.3 Patient has greater than or equal to 4 migraine days per month and has contraindication or intolerance to TWO of the following prophylactic therapies or classes (please specify contraindication or intolerance):

- A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol)*
- Candesartan* (generic Atacand)

- Monoclonal antibodies or small-molecules targeting calcitonin gene-related peptide (CGRP) or its receptor for preventive treatment of migraine [i.e., Aimovig, Ajovy*, Emgality, Nurtec ODT, Qulipta*, Vyepti**] ***
- Divalproex sodium (generic Depakote/Depakote ER)
- OnabotulinumtoxinA** (generic Botox)
- A serotonin-norepinephrine reuptake inhibitor [i.e., duloxetine (Cymbalta), venlafaxine (Effexor/Effexor XR)]
- Topiramate (generic Topamax)
- A tricyclic antidepressant [i.e., amitriptyline (Elavil), nortriptyline (Pamelor)]

AND

4 - Medication will not be used in combination with another small-molecule targeting the CGRP (calcitonin gene-related peptide) receptor ("gepants") (e.g., Nurtec ODT, Qulipta, Ubrelvy)

Notes	* Timolol, candesartan, Ajovy and Qulipta are non-preferred and should not be included in denial to provider **Vyepti, OnabotulinumtoxinA are medical benefits and should not be included in denial to provider. ***CGRP antagonists for preventive treatment of migraines require a prior authorization.

Product Name:Ubrelvy	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Used for acute treatment of migraine AND 2 - One of the following: 2.1 Failure (after at least 3 migraine episodes and a minimum of a 30-day trial) to TWO of the following as confirmed by claims history or submission of medical records: • eletriptan (generic Relpax)	

- frovatriptan (generic Frova)
- naratriptan (generic Amerge)
- rizatriptan (generic Maxalt/Maxalt MLT)
- sumatriptan (generic Imitrex)
- zolmitriptan (generic Zomig/Zomig-ZMT)

OR

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

- eletriptan (generic Relpax)
- frovatriptan (generic Frova)
- naratriptan (generic Amerge)
- rizatriptan (generic Maxalt/Maxalt MLT)
- sumatriptan (generic Imitrex)
- zolmitriptan (generic Zomig/Zomig-ZMT)

AND

3 - One of the following:

3.1 Patient is currently treated with ONE of the following prophylactic therapies or classes as confirmed by claims or submission of medical records:

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

OR

3.2 Patient has less than 4 migraine days per month

OR

3.3 Patient has greater than or equal to 4 migraine days per month and has contraindication or intolerance to TWO of the following prophylactic therapies or classes (please specify contraindication or intolerance):

- A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol)*
- Candesartan* (generic Atacand)
- Monoclonal antibodies or small-molecules targeting CGRP or its receptor for preventive treatment of migraine [i.e., Aimovig, Ajovy*, Emgality, Nurtec ODT, Qulipta*, Vyepti**] ***
- Divalproex sodium (generic Depakote/Depakote ER)
- OnabotulinumtoxinA** (generic Botox)
- A serotonin-norepinephrine reuptake inhibitor [i.e., duloxetine (Cymbalta), venlafaxine (Effexor/Effexor XR)]
- Topiramate (generic Topamax)
- A tricyclic antidepressant [i.e., amitriptyline (Elavil), nortriptyline (Pamelor)]

AND

4 - Medication will not be used in combination with another small-molecule targeting the CGRP receptor ("gepants") (e.g., Nurtec ODT, Qulipta, Zavzpret)

Notes	* Timolol, Ajovy, Qulipta and candesartan are non-preferred and should not be included in denial to provider **Vyepti, OnabotulinumtoxinA are medical benefit and should not be included in denial to provider. ***CGRP antagonists for preventive treatment of migraines require a prior authorization.

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

AND

2 - Medication will not be used in combination with another acute small-molecule targeting the CGRP (calcitonin gene-related peptide) receptor ("gepants") (e.g., Nurtec ODT, Qulipta)

Product Name:Qulipta	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of migraine consistent with The International Classification of Headache Disorders, 3rd edition AND 2 - ONE of the following: 2.1 Patient has 4 to 7 migraine days per month and at least ONE of the following: 2.1.1 Less than 15 headache days per month OR 2.1.2 Provider attests this is the patient's predominant headache diagnosis (i.e., primary driver of headaches is not different, non-migrainous condition) OR 2.2 Greater than or equal to 8 migraine days per month	

AND

3 - One of the following:

3.1 Failure (after a trial of at least two months) to TWO of the following prophylactic therapies as confirmed by claims history or submission of medical records:

- A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol*)
- Candesartan* (Atacand)
- Divalproex sodium (Depakote/Depakote ER)
- OnabotulinumtoxinA** (generic 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)]

OR

3.2 History of contraindication or intolerance to TWO of the following prophylactic therapies (please specify contraindication or intolerance):

- A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol*)
- Candesartan* (Atacand)
- Divalproex sodium (Depakote/Depakote ER)
- OnabotulinumtoxinA** (generic 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 - One of the following:

4.1 Failure (after a trial of at least three months) to Nurtec ODT as confirmed by claims history or submission of medical records

OR

4.2 History of contraindication or intolerance to Nurtec ODT (please specify contraindication or intolerance)

AND

5 - BOTH of the following:

- The requested medication will not be used in combination with a monoclonal antibody targeting CGRP (calcitonin gene related peptide) or its receptor (e.g. Aimovig, Ajovy, Emgality, Vyepti)
- The requested medication will not be used in combination with another small-molecule targeting the CGRP receptor ("gepants") (e.g., Nurtec ODT, Ubrelvy, Zavzpret)

Notes

* Timolol, candesartan are non-preferred and should not be included in denial to provider
 **OnabotulinumtoxinA is a medical benefit and should not be included in denial to provider.

Product Name: Qulipta

Approval Length 12 month(s)

Therapy Stage Reauthorization

Guideline Type Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - BOTH of the following:

- The requested medication will not be used in combination with a monoclonal antibody targeting CGRP (calcitonin gene related peptide) or its receptor (e.g. Aimovig, Ajovy, Emgality, Vyepti)
- The requested medication will not be used in combination with another small-molecule targeting the CGRP receptor ("gepants") (e.g., Nurtec ODT, Ubrelvy, Zavzpret)

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 NJ: https://www.uhcprovider.com/en/health-plans-by-state/new-jersey-health-plans/nj-comm-plan-home/nj-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 PA: https://www.uhcprovider.com/en/health-plans-by-state/pennsylvania-health-plans/pa-comm-plan-home/pa-cp-pharmacy.html?rfid=UHCCEP RI: https://www.uhcprovider.com/en/health-plans-by-state/rhode-island-health-plans/ri-comm-plan-home/ri-cp-pharmacy.html

3 . Revision History

Date	Notes
4/13/2026	Updated language on concomitant CGRP use. Updated member to patient in step 2.1.2 of Qulipta initial auth.

Nuzyra



Prior Authorization Guideline

Guideline ID	GL-558338
Guideline Name	Nuzyra
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 Michigan Medicaid - Community & State Nevada Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:Nuzyra tablets	
Guideline Type	Prior Authorization

Approval Criteria

1 - For continuation of therapy upon hospital discharge

OR

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

OR

3 - ALL of the following:

3.1 Diagnosis of community-acquired bacterial pneumonia (CABP)

AND

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

AND

3.3 ONE of the following:

3.3.1 Failure to THREE of the following antibiotics or antibiotic regimens, as confirmed by claims history or submission of medical records:

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

OR

3.3.2 History of intolerance or contraindication to ALL of the following antibiotics or antibiotic regimens (please specify intolerance or contraindication):

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

OR

4 - ALL of the following:

4.1 ONE of the following diagnoses:

4.1.1 BOTH of the following:

- Acute bacterial skin and skin structure infections
- Infection caused by methicillin-resistant *Staphylococcus aureus* (MRSA) documented by culture and sensitivity report

OR

4.1.2 BOTH of the following:

- Empirical treatment of a patient with acute bacterial skin and skin structure infections
- Presence of MRSA infection is likely

AND

4.2 ONE of the following:

4.2.1 Failure to linezolid (generic Zyvox) as confirmed by claims history or submission medical records

OR

4.2.2 History of intolerance or contraindication to linezolid (generic Zyvox) (please specify intolerance or contraindication)

AND

4.3 ONE of the following:

4.3.1 Failure to ONE of the following antibiotics as confirmed by claims history or submission medical records:

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

OR

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

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

OR

5 - ALL of the following:

5.1 Diagnosis of acute bacterial skin and skin structure infections

AND

5.2 Infection caused by an organism that is confirmed to be or likely to be susceptible to treatment with Nuzyra

AND

5.3 ONE of the following:

5.3.1 Failure to THREE of the following antibiotics confirmed by claims history or submission medical records:

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

OR

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

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

OR

6 - The drug has been recognized for treatment of the indication by the Infectious Diseases Society of America (IDSA)

Notes	Authorization duration for CABP and acute bacterial skin and skin structure infections will be issued for up to 14 days. For all IDSA recognized indications, authorization duration is based on provider and IDSA recommended treatment durations, up to 6 months.

2 . Revision History

Date	Notes
3/31/2026	Removed IN.

OAB Agents



Prior Authorization Guideline

Guideline ID	GL-521225
Guideline Name	OAB Agents
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 New Mexico

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name:generic tolterodine IR	
Approval Length	12 month(s)
Guideline Type	Step Therapy

Approval Criteria

1 - Failure to treatment with oxybutynin immediate release as confirmed by claims history or submission of medical records

OR

2 - History of contraindication or intolerance to oxybutynin immediate release (please specify contraindication or intolerance)

Product Name:generic tolterodine ER

Approval Length	12 month(s)

Guideline Type	Step Therapy

Approval Criteria

1 - Failure to treatment with oxybutynin extended-release as confirmed by claims history or submission of medical records

OR

2 - History of contraindication or intolerance to oxybutynin extended-release (please specify contraindication or intolerance)

Product Name:Brand Detrol LA, Gelnique, Gemtesa, trospium ER, Brand Vesicare

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - Failure to a trial of THREE of the following confirmed by claims history or submission of medical records:

- darifenacin extended-release tablet
- oxybutynin extended-release tablet (generic Ditropan XL)

- tolterodine extended-release capsule (generic Detrol LA)
- trospium tablet
- solifenacin tablet (generic Vesicare)

OR

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

- darifenacin extended-release tablet
- oxybutynin extended-release tablet (generic Ditropan XL)
- tolterodine extended-release capsule (generic Detrol LA)
- trospium tablet
- solifenacin tablet (generic Vesicare)

Product Name: Oxytrol (Rx)	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Failure to a trial of THREE of the following, confirmed by claims history or submission of medical records: • darifenacin extended-release tablet • Oxytrol for Women (oxybutynin OTC) patch • tolterodine immediate release (generic Detrol) or tolterodine extended-release capsule (generic Detrol LA) • trospium tablet • solifenacin tablet (generic Vesicare) OR 2 - History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance): • darifenacin extended-release tablet • Oxytrol for Women (oxybutynin OTC) patch	

- tolterodine immediate release (generic Detrol) or tolterodine extended-release capsule (generic Detrol LA)
- trospium tablet
- solifenacin tablet (generic Vesicare)

Product Name:flavoxate, Brand Detrol	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Failure to a trial of ALL of the following, confirmed by claims history or submission of medical records: • oxybutynin solution or tablet • tolterodine tablet (generic Detrol) • trospium tablet OR 2 - History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance): • oxybutynin solution or tablet • tolterodine tablet (generic Detrol) • trospium tablet	

Product Name:Vesicare LS	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of neurogenic detrusor overactivity (NDO) (neurogenic bladder)	

AND

2 - ONE of the following:

2.1 Failure to a trial of ONE of the following, as confirmed by claims history or submission of medical records:

- oxybutynin solution
- oxybutynin tablet
- oxybutynin extended release tablet (generic Ditropan XL)

OR

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

- oxybutynin solution
- oxybutynin tablet
- oxybutynin extended release tablet (generic Ditropan XL)

Product Name: Brand Myrbetriq tabs, generic mirabegron tabs, Brand Toviaz, generic fesoterodine ER

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - BOTH of the following:

1.1 Diagnosis of overactive bladder (OAB)

AND

1.2 ONE of the following:

1.2.1 Failure to a trial of THREE of the following confirmed by claims history or submission of medical records:

- darifenacin extended-release tablet
- oxybutynin extended-release tablet (generic Ditropan XL)
- tolterodine immediate release (generic Detrol) or tolterodine extended-release capsule (generic Detrol LA)
- trospium tablet
- solifenacin tablet (generic Vesicare)

OR

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

- darifenacin extended-release tablet
- oxybutynin extended-release tablet (generic Ditropan XL)
- tolterodine immediate release (generic Detrol) or tolterodine extended-release capsule (generic Detrol LA)
- trospium tablet
- solifenacin tablet (generic Vesicare)

OR

2 - BOTH of the following:

2.1 Diagnosis of neurogenic detrusor overactivity (NDO) (neurogenic bladder)

AND

2.2 ONE of the following:

2.2.1 Failure to a trial of ONE of the following, as confirmed by claims history or submission of medical records:

- oxybutynin solution
- oxybutynin tablet
- oxybutynin extended release tablet (generic Ditropan XL)

OR

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

- oxybutynin solution
- oxybutynin tablet
- oxybutynin extended release tablet (generic Ditropan XL)

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

Approval Criteria

1 - Diagnosis of neurogenic detrusor overactivity (NDO) (neurogenic bladder)

AND

2 - ONE of the following:

2.1 Failure to a trial of ONE of the following, as confirmed by claims history or submission of medical records:

- oxybutynin solution
- oxybutynin tablet
- oxybutynin extended release tablet (generic Ditropan XL)

OR

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

- oxybutynin solution
- oxybutynin tablet
- oxybutynin extended release tablet (generic Ditropan XL)

AND

3 - ONE of the following:

3.1 Patient is 3 years of age to (including) 17 years of age

OR

3.2 BOTH of the following:

3.2.1 Physician has provided rationale for needing to use this medication in an unapproved age range

AND

3.2.2 The use of this medication for a patient outside the FDA (Food and Drug Administration) approved age range is supported by information from ONE of the following appropriate 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 (USP-NF)

2 . Revision History

Date	Notes
2/16/2026	Removed NY. Removed oxybutynin oral solution as target

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.

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.

Ohtuvayre



Prior Authorization Guideline

Guideline ID	GL-558197
Guideline Name	Ohtuvayre
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 New Mexico Medicaid - Community & State Washington

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:Ohtuvayre	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic obstructive pulmonary disease (COPD)

AND

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

2.1 Post-bronchodilator forced expiratory volume (FEV1) / forced vital capacity (FVC) ratio less than 0.7

AND

2.2 Post-bronchodilator FEV1 % predicted greater than or equal to 30% and less than 80%

AND

3 - BOTH of the following:

3.1 ONE of the following:

3.1.1 FEV1 is less than 80% of predicted but greater than or equal to 50% of predicted

OR

3.1.2 ALL of the following:

3.1.2.1 FEV1 less than 50% of predicted

AND

3.1.2.2 History of chronic bronchitis

AND

3.1.2.3 ONE of the following:

- Failure to a selective phosphodiesterase 4 (PDE4) inhibitor [i.e., roflumilast (Daliresp)] as confirmed by claims history or submission of medical record
- History of contraindication or intolerance to a selective phosphodiesterase 4 (PDE4) inhibitor [i.e., roflumilast (Daliresp)] (please specify contraindication or intolerance)

AND

3.2 ONE of the following:

3.2.1 Patient is on a stabilized dose and receiving concomitant therapy with ONE of the following as confirmed by claims history or submission of medical records:

- A long-acting beta-agonist [LABA (e.g., Serevent Diskus)]
- A long-acting antimuscarinic agent [LAMA (e.g., Spiriva Respimat/HandiHaler)]
- A LABA/LAMA (e.g., Anoro Ellipta, Bevespi Aerosphere, Stiolto Respimat)
- An ICS/LABA/LAMA (i.e., Breztri Aerosphere, Trelegy Ellipta)

OR

3.2.2 Patient has a failure to ALL of the following as confirmed by claims history or submission of medical records:

- A long-acting beta-agonist [LABA (e.g., Serevent Diskus)]
- A long-acting antimuscarinic agent [LAMA (e.g., Spiriva Respimat/HandiHaler)]
- A LABA/LAMA (e.g., Anoro Ellipta, Bevespi Aerosphere, Stiolto Respimat)
- An ICS/LABA/LAMA (i.e., Breztri Aerosphere, Trelegy Ellipta)

OR

3.2.3 Patient has a contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- A long-acting beta-agonist [LABA (e.g., Serevent Diskus)]
- A long-acting antimuscarinic agent [LAMA (e.g., Spiriva Respimat/HandiHaler)]
- A LABA/LAMA (e.g., Anoro Ellipta, Bevespi Aerosphere, Stiolto Respimat)
- An ICS/LABA/LAMA (i.e., Breztri Aerosphere, Trelegy Ellipta)

OR

3.2.4 BOTH of the following:

3.2.4.1 Patient is unable to use a metered-dose, dry powder or slow mist inhaler (e.g. Spiriva Respimat) to control their COPD due to ONE of the following:

- Cognitive or physical impairment limiting coordination of handheld devices (e.g., cognitive decline, arthritis in the hands) (Document impairment)
- Patient is unable to generate adequate inspiratory force (e.g., peak inspiratory flow rate (PIFR) resistance is less than 60 liters per minute))

AND

3.2.4.2 Patient requires the use of BOTH of the following as confirmed by claims history or submission of medical records:

- A nebulized LABA [i.e., arformoterol (generic Brovana), formoterol (generic Perforomist)]
- A nebulized long-acting antimuscarinic agent [LAMA (i.e., Yupelri)]

AND

4 - Patient experiences dyspnea during everyday activities (e.g., short of breath when walking up a slight hill)

AND

5 - Prescribed by or in consultation with a Pulmonologist

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

1 - Documentation of positive clinical response to Ohtuvayre therapy demonstrated by BOTH of the following:

1.1 Improved COPD (chronic obstructive pulmonary disease) symptoms (e.g., dyspnea)

AND

1.2 Improved FEV1 (forced expiratory volume)

2 . Revision History

Date	Notes
3/25/2026	Removed NY. Corrected ICS spelling

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.

Olumiant



Prior Authorization Guideline

Guideline ID	GL-435227
Guideline Name	Olumiant
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Maryland Medicaid - Community & State New Jersey Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	12/1/2025

1 . Criteria

Product Name:Olumiant	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active rheumatoid arthritis (RA)

AND

2 - Patient is not receiving Olumiant in combination with any of the following:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Rinvoq (upadacitinib)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)

AND

3 - Prescribed by or in consultation with a rheumatologist

AND

4 - ONE of the following:

4.1 Patient is currently on Olumiant therapy as confirmed by claims history or submission of medical records

OR

4.2 BOTH of the following:

4.2.1 ONE of the following:

- Failure to a 3 month trial of ONE non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] at maximally indicated doses as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to ONE non-biologic DMARD [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] (please specify contraindication or intolerance)

- Patient has been previously treated with a targeted immunomodulator FDA-approved for the treatment of rheumatoid arthritis as confirmed by claims history or submission of medical records [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Rinvoq (upadacitinib)]

AND

4.2.2 ONE of the following:

- Failure to at least ONE TNF (tumor necrosis factor) antagonist therapy as confirmed by claims history or submission of medical records
- History of intolerance or contraindication to at least ONE TNF antagonist therapy (please specify intolerance or contraindication)
- Patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-V-TR 300.29 for specific phobia diagnostic criteria)

Product Name: Olumiant	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Olumiant therapy AND 2 - Patient is not receiving Olumiant in combination with any of the following: • Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Rinvoq (upadacitinib)] • Potent immunosuppressant (e.g., azathioprine or cyclosporine)	

Product Name: Olumiant	
Diagnosis	Alopecia Areata
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of severe alopecia areata

AND

2 - Other causes of hair loss have been ruled out (e.g., androgenetic alopecia, cicatricial alopecia, secondary syphilis, tinea capitis, triangular alopecia, and trichotillomania)

AND

3 - Patient requesting therapy for current episode of alopecia areata

AND

4 - Patient is not receiving Olumiant in combination with any of the following:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Rinvoq (upadacitinib), Litfulo (ritlecitinib)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)

AND

5 - Prescribed by or in consultation with a dermatologist

Product Name: Olumiant	
Diagnosis	Alopecia Areata

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Olumiant therapy AND 2 - Patient is not receiving Olumiant in combination with any of the following: - Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Rinvoq (upadacitinib), Litfulo (ritlecitinib)] - Potent immunosuppressant (e.g., azathioprine or cyclosporine)	

2 . Revision History

Date	Notes
10/30/2025	Removed criteria requiring a minimum of 50% scalp hair loss with current episode lasting six months under initial auth for alopecia areata.

Omega



Prior Authorization Guideline

Guideline ID	GL-568187
Guideline Name	Omega
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

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name: Brand Lovaza, generic omega-3-acid ethyl esters, Brand Vascepa, generic icosapent ethyl	
Diagnosis	Severe Hypertriglyceridemia
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of severe hypertriglyceridemia [pre-treatment triglyceride level of greater than or equal to 500 milligrams/deciliter (mg/dL)] AND 2 - Patient is on an appropriate lipid-lowering diet and exercise regimen AND 3 - ONE of the following: 3.1 Failure to at least 90 days of a fibric acid derivative, as confirmed by claims history or submission of medical records OR 3.2 History of contraindication or intolerance to a fibric acid derivative (please specify contraindication or intolerance) AND 4 - If the request is for a non-preferred* product, ONE of the following: 4.1 Failure to omega-3-acid ethyl esters (generic Lovaza), as confirmed by claims history or submission of medical records OR 4.2 History of contraindication or intolerance to omega-3-acid ethyl esters (generic Lovaza) (please specify contraindication or intolerance)	

Notes	*Omega 3-acid esters (generic Lovaza) is preferred. Other omega-3 acid derivatives are non-preferred.

Product Name: Brand Lovaza, generic omega-3-acid ethyl esters, Brand Vascepa, generic icosapent ethyl	
Diagnosis	Severe Hypertriglyceridemia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy AND 2 - Patient is on an appropriate lipid-lowering diet and exercise regimen	

Product Name: Brand Vascepa, generic icosapent ethyl	
Diagnosis	Cardiovascular Risk Reduction
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of hypertriglyceridemia [pre-treatment triglyceride level greater than or equal to 150 milligrams/deciliter (mg/dL)] AND	

2 - Patient currently has or is considered high or very high risk for cardiovascular disease (CVD) as evidenced by ONE of the following:

2.1 BOTH of the following:

2.1.1 At least 45 years of age

AND

2.1.2 Established CVD confirmed by ONE of the following:

- Acute coronary syndrome
- History of myocardial infarction
- Stable or unstable angina
- Coronary or other arterial revascularization
- Stroke
- Transient ischemic attack
- Peripheral arterial disease

OR

2.2 ALL of the following:

2.2.1 Diagnosis of Type 2 diabetes

AND

2.2.2 TWO of the following risk factors for developing cardiovascular disease:

- Family history of premature CVD (Men < 55 years or women < 65 years)
- Primary hypercholesterolemia (e.g., LDL cholesterol, 160 to 189 mg/dL; non-HDL cholesterol 190 to 219 mg/dL)
- Metabolic syndrome [e.g., increased waist circumference, elevated triglycerides (>150 mg/dL, nonfasting), elevated blood pressure, elevated glucose, and low HDL cholesterol (<40 mg/dL in males; <50 mg/dL in females)]
- Chronic kidney disease (eGFR 15 to 59 mL/min/1.73 m² with or without albuminuria; not treated with dialysis or kidney transplantation)
- Chronic inflammatory conditions (e.g., psoriasis, rheumatoid arthritis, lupus, HIV/AIDS)
- History of premature menopause (before age 40 years) and/or history of pregnancy-associated conditions that increase later CVD risk (e.g., preeclampsia)

- Biomarkers associated with increased CVD risk [e.g., elevated high-sensitivity C-reactive protein (2 mg/L or greater), elevated Lp(a), elevated apoB (130 mg/dL or greater)]
- Abnormal ankle-brachial index [ABI (< 0.9)]
- Cigarette smoker or stopped smoking within the past 3 months
- Hypertension (pretreatment blood pressure at least 140 mmHg systolic or at least 90 mmHg diastolic)

AND

3 - Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following (prescription claims history may be used in conjunction as documentation of medication use, dose, and duration):

3.1 Patient has been receiving at least 12 consecutive weeks of high-intensity statin therapy (i.e., atorvastatin 40-80 mg, rosuvastatin 20-40 mg) and will continue to receive a high-intensity statin at maximally tolerated dose

OR

3.2 BOTH of the following:

3.2.1 Patient is unable to tolerate high-intensity statin as evidenced by ONE of the following intolerable and persistent (i.e., more than 2 weeks) symptoms:

- Myalgia [muscle symptoms without creatine kinase (CK) elevations]
- Myositis [muscle symptoms with CK elevations less than 10 times upper limit of normal (ULN)]

AND

3.2.2 Patient has been receiving at least 12 consecutive weeks of low-intensity or moderate-intensity statin therapy [i.e., atorvastatin 10-20 mg, rosuvastatin 5-10 mg, simvastatin greater than or equal to 10 mg, pravastatin greater than or equal to 10 mg, lovastatin 20-40 mg, fluvastatin XL 80 mg, fluvastatin 20-40 mg up to 40 mg twice daily, or Livalo (pitavastatin) greater than or equal to 1 mg] and will continue to receive a low-intensity or moderate-intensity statin at maximally tolerated dose

AND

4 - Submission of medical record (e.g., chart notes, laboratory values) documenting ONE of

the following (prescription claims history may be used in conjunction as documentation of medication use, dose, and duration):

4.1 Patient has been receiving at least 12 consecutive weeks of ezetimibe (generic Zetia) therapy as adjunct to maximally tolerated statin therapy

OR

4.2 History of contraindication or intolerance to ezetimibe (please specify contraindication or intolerance)

OR

4.3 Patient has an LDL-C (low density lipoprotein cholesterol) less than 100 mg/dL while on maximally tolerated statin therapy

AND

5 - Used as an adjunct to a low-fat diet and exercise

AND

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

- Cardiologist
- Endocrinologist
- Lipid specialist

Product Name: Brand Vascepa, generic icosapent ethyl	
Diagnosis	Cardiovascular Risk Reduction
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Patient is on an appropriate low-fat diet and exercise regimen

AND

3 - Patient is receiving maximally tolerated statin therapy

2 . Revision History

Date	Notes
4/8/2026	Updated risk factors to mirror cardiovascular disease risk assessment in adults

Omnipod 5, Twiist



Prior Authorization Guideline

Guideline ID	GL-588187
Guideline Name	Omnipod 5, Twiist
Formulary	Medicaid - Community & State Arizona Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Michigan Medicaid - Community & State New Jersey Medicaid - Community & State New Mexico Medicaid - Community & State New York Medicaid - Community & State New York EPP Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name: Omnipod 5, Twiist	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: • For Omnipod 5 product: Diagnosis of diabetes • For Twist product: Diagnosis of Type 1 diabetes AND 2 - ALL of the following: 2.1 Patient has done ONE of the following for at least 8 weeks: • Regularly tests blood glucose at least 4 times/day • Utilizes a continuous glucose monitor (CGM) AND 2.2 Patient has completed a diabetes management program AND 2.3 Patient injects insulin at least 3 times/day AND 3 - BOTH of the following: 3.1 Patient or caregiver is motivated to assume responsibility for self-care and insulin management AND	

3.2 Patient or caregiver demonstrates knowledge of importance of nutrition including carbohydrate counting and meal planning

AND

4 - Prescriber attests that there is a reason or special circumstance the patient cannot use external insulin pumps obtained on the medical benefit

Notes	If patient meets criteria, approve using NDC List OMNIPOD5

Product Name:Omnipod 5, Twiist	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response	
Notes	If patient meets criteria, approve using NDC List OMNIPOD5

Product Name:Omnipod 5 pods	
Approval Length	12 month(s)
Guideline Type	Quantity Limit
Approval Criteria 1 - Physician confirmation that the patient requires a greater quantity	
Notes	Authorization for quantity limit overrides should be entered at the NDC level for the requested Omnipod 5 pods, for the requested quantity.

2 . Revision History

UnitedHealthcare Community Plan of Rhode Island Clinical Pharmacy Program Guidelines

Date	Notes
4/20/2026	Updated GPIs

OmvoH



Prior Authorization Guideline

Guideline ID	GL-571199
Guideline Name	OmvoH
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

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:OmvoH SC	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderately to severely active ulcerative colitis AND 2 - ONE of the following: • Patient has been approved for loading dose of Omvoh under an active UnitedHealthcare medical benefit prior authorization for the treatment of moderately to severely active ulcerative colitis • Patient is currently on Omvoh therapy for subcutaneous use as confirmed by claims history or submission of medical records AND 3 - Patient is NOT receiving Omvoh in combination with another systemic targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Entyvio (vedolizumab), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Skyrizi (risankizumab), ustekinumab, Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), Zeposia (ozanimod)] for treatment of the same indication AND 4 - Prescribed by or in consultation with a gastroenterologist	

Product Name:Omvoh SC	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Omvoh therapy

AND

2 - Patient is NOT receiving Omvoh in combination with another systemic targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Entyvio (vedolizumab), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Skyrizi (risankizumab), ustekinumab, Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), Zeposia (ozanimod)] for treatment of the same indication

Product Name:Omvoh SC	
Diagnosis	Crohn's Disease (CD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderately to severely active Crohn's disease AND 2 - ONE of the following: • Patient has been approved for loading dose of Omvoh under an active UnitedHealthcare medical benefit prior authorization for the treatment of moderately to severely active Crohn's disease • Patient is currently on Omvoh therapy for subcutaneous use for moderately to severely active Crohn's disease as confirmed by claims history or submission of medical records	

AND

3 - Patient is NOT receiving Omvoh in combination with another systemic targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Skyrizi (risankizumab-rzaa), ustekinumab, Xeljanz (tofacitinib)] for treatment of the same indication

AND

4 - Prescribed by or in consultation with a gastroenterologist

Product Name:Omvoh SC	
Diagnosis	Crohn's Disease (CD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Omvoh therapy AND 2 - Patient is NOT receiving Omvoh in combination with another systemic targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Skyrizi (risankizumab-rzaa), ustekinumab, Xeljanz (tofacitinib)] for treatment of the same indication	

2 . Revision History

Date	Notes

UnitedHealthcare Community Plan of Rhode Island Clinical Pharmacy Program Guidelines

4/10/2026	Updated GPIs. Updated establishment of therapy on the medical benefit and combination examples and language with no change to clinical intent.

Onureg



Prior Authorization Guideline

Guideline ID	GL-521222
Guideline Name	Onureg
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State New Jersey Medicaid - Community & State New York Medicaid - Community & State New York EPP Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Arizona Medicaid - Community & State Nebraska Medicaid - Community & State New Mexico Medicaid - Community & State Virginia Medicaid - Community & State Washington

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name:Onureg	
Diagnosis	Acute Myeloid Leukemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of acute myeloid leukemia AND 2 - Achieved first complete remission (CR) or complete remission with incomplete blood count recovery (CRi) following intensive induction chemotherapy AND 3 - Patient is not able to complete intensive curative therapy (e.g., transplant-ineligible)	

Product Name:Onureg	
Diagnosis	Peripheral T-cell Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following T-cell lymphomas: • Angioimmunoblastic T-cell lymphoma (AITL) • Nodal peripheral T-cell lymphoma with TFH phenotype (PTCL, TFH) • Follicular T-cell lymphoma (FTCL)	

AND

2 - ONE of the following:

- Used as initial palliative intent therapy
- Used as second-line and subsequent therapy

Product Name: Onureg

Diagnosis	Acute Lymphoblastic Leukemia

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of T-cell acute lymphoblastic leukemia/lymphoma (T-ALL/T-LBL)

AND

2 - Used with Venclexta (venetoclax) – containing regimens as part of relapsed/refractory therapy

Product Name: Onureg

Diagnosis	Acute Myeloid Leukemia, Peripheral T-cell Lymphoma, Acute Lymphoblastic Leukemia

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

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

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

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

2 . Revision History

Date	Notes
2/12/2026	Added criteria for acute lymphoblastic leukemia. Minor cosmetic update to diagnosis header for NCCN sections, with no changes to clinical intent.

Opfolda



Prior Authorization Guideline

Guideline ID	GL-555328
Guideline Name	Opfolda
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 Pennsylvania Medicaid - Community & State Nevada

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:Opfolda	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of late-onset Pompe disease as confirmed by ONE of the following: 1.1 Absence or deficiency (less than 40% of the lab specific normal mean) of acid alpha-glucosidase (GAA) activity in lymphocytes, fibroblasts or muscle OR 1.2 Molecular genetic testing for deletion or mutations in the GAA gene AND 2 - Presence of clinical signs and symptoms of the disease (e.g., cardiac hypertrophy, respiratory distress, skeletal muscle weakness, etc.) AND 3 - Provider attests that the patient is not improving on their current enzyme replacement therapy (ERT) (e.g., Lumizyme, Nexviazyme) for the treatment of late-onset Pompe disease and this therapy will be stopped AND 4 - Patient weighs at least 40kg AND 5 - Patient is NOT receiving Opfolda in combination with another disease-modifying enzyme	

therapy used for the treatment of Pompe disease [e.g., Lumizyme (alglucosidase alfa), Nexviazyme (avalglucosidase alfa-ngpt)]

AND

6 - Opfolda will be prescribed in combination with Pombiliti (cipaglucosidase alfa-atga)

Product Name:Opfolda	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Opfolda plus Pombiliti AND 2 - Patient is NOT receiving Opfolda in combination with another disease-modifying enzyme therapy used for the treatment of Pompe disease [e.g., Lumizyme (alglucosidase alfa), Nexviazyme (avalglucosidase alfa-ngpt)] AND 3 - Opfolda continues to be prescribed in combination with Pombiliti	

2 . Revision History

Date	Notes
3/24/2026	Added combination use safety language

Ophthalmic Antihistamine



Prior Authorization Guideline

Guideline ID	GL-479209
Guideline Name	Ophthalmic Antihistamine
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State New Jersey Medicaid - Community & State New York Medicaid - Community & State New York EPP Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Arizona Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:azelastine ophth soln	
Approval Length	12 month(s)
Guideline Type	Step Therapy

Approval Criteria

1 - Failure to Pataday OTC (over-the-counter), as confirmed by claims history or submission of medical records

OR

2 - History of contraindication or intolerance to Pataday OTC (please specify contraindication or intolerance)

Product Name: olopatadine ophth soln (Rx formulation)

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Failure to Pataday OTC (over-the-counter), as confirmed by claims history or submission of medical records

OR

1.2 History of contraindication or intolerance to Pataday OTC (please specify contraindication or intolerance)

AND

2 - ONE of the following:

2.1 Failure to ONE of the following, as confirmed by claims history or submission of medical records:

- Azelastine ophthalmic solution
- Ketotifen

- Cromolyn

OR

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

- Azelastine ophthalmic solution
- Ketotifen
- Cromolyn

2 . Revision History

Date	Notes
12/15/2025	Combined formularies. Cleaned up GPI list. No changes to clinical criteria.

Opzelura



Prior Authorization Guideline

Guideline ID	GL-523209
Guideline Name	Opzelura
Formulary	Medicaid - Community & State Hawaii Medicaid - Community & State New York Medicaid - Community & State New York EPP Medicaid - Community & State Rhode Island

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name:Opzelura	
Diagnosis	Atopic Dermatitis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of mild to moderate atopic dermatitis*

AND

2 - ONE of the following:

2.1 Patient is currently on Opzelura therapy as confirmed by claims history or submission of medical records

OR

2.2 For mild atopic dermatitis:

2.2.1 Failure to TWO of the following topical therapeutic classes as confirmed by claims history or submission of medical records:

- A topical corticosteroid [e.g., DesOwen (desonide), hydrocortisone] (any potency)
- One topical calcineurin inhibitor [e.g., Elidel (pimecrolimus), Protopic (tacrolimus)]
- Eucrisa (crisaborole)

OR

2.2.2 History of intolerance or contraindication to ALL of the following topical therapeutic classes (please specify intolerance or contraindication):

- A topical corticosteroid [e.g., DesOwen (desonide), hydrocortisone] (any potency)
- One topical calcineurin inhibitor [e.g., Elidel (pimecrolimus), Protopic (tacrolimus)]
- Eucrisa (crisaborole)

OR

2.3 For moderate atopic dermatitis:

2.3.1 Failure to TWO of the following topical therapeutic classes as confirmed by claims history or submission of medical records:

- A topical corticosteroid of at least a medium- to high-potency topical corticosteroid [e.g., Elocon (mometasone furoate), Synalar (fluocinolone acetonide), Lidex (fluocinonide)]
- One topical calcineurin inhibitor [e.g., Elidel (pimecrolimus), Protopic (tacrolimus)]

- Eucrisa (crisaborole)

OR

2.3.2 History of intolerance or contraindication to ALL of the following topical therapeutic classes (please specify intolerance or contraindication):

- A topical corticosteroid of at least a medium- to high-potency topical corticosteroid [e.g., Elocon (mometasone furoate), Synalar (fluocinolone acetonide), Lidex (fluocinonide)]
- One topical calcineurin inhibitor [e.g., Elidel (pimecrolimus), Protopic (tacrolimus)]
- Eucrisa (crisaborole)

AND

3 - Patient is NOT receiving Opzelura in combination with a biologic medication or JAK inhibitor [e.g., Adbry (tralokinumab-ldrm), Cibinqo (abrocitinib), Dupixent (dupilumab), Ebglyss (lebrikizumab-lbkz), Nemluvio (nemolizumab-ilto), Rinvoq (upadacitinib)]

AND

4 - Patient is NOT receiving Opzelura in combination with a potent immunosuppressant medication (e.g., azathioprine, cyclosporine)

Notes	*Opzelura when used solely for the treatment of nonsegmental vitiligo is considered cosmetic, is excluded, and is to be denied as a benefit exclusion.

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

AND	
2 - Patient is NOT receiving Opzelura in combination with a biologic medication or JAK inhibitor [e.g., Adbry (tralokinumab-ldrm), Cibinqo (abrocitinib), Dupixent (dupilumab), Ebglyss (lebrikizumab-lbkz), Nemluvio (nemolizumab-ilto), Rinvoq (upadacitinib)]	
AND	
3 - Patient is NOT receiving Opzelura in combination with a potent immunosuppressant medication (e.g., azathioprine, cyclosporine)	
Notes	Opzelura when used solely for the treatment of nonsegmental vitiligo is considered cosmetic, is excluded, and is to be denied as a benefit exclusion.

2 . Revision History

Date	Notes
2/13/2026	Updated combination examples and language. Changed GL name.

Orencia



Prior Authorization Guideline

Guideline ID	GL-532230
Guideline Name	Orencia
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 New Mexico

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Orencia	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of moderately to severely active rheumatoid arthritis

AND

1.2 One of the following:

1.2.1 Failure to a 3 month trial of one non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] at maximally indicated doses as confirmed by claims history or submitted medical records

OR

1.2.2 History of intolerance or contraindication to one non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] (please specify intolerance or contraindication)

OR

1.2.3 Patient has been previously treated with a targeted immunomodulator FDA-approved for the treatment of rheumatoid arthritis as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Olumiant (baricitinib), Rinvoq (upadacitinib), Xeljanz/Xeljanz XR (tofacitinib)]

AND

1.3 Patient is NOT receiving Orencia in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

AND

1.4 ONE of the following:

1.4.1 BOTH of the following:

1.4.1.1 Failure of one of the preferred adalimumab products*, confirmed by claims history or submitted medical records

AND

1.4.1.2 Failure of TWO of the following confirmed by claims history or submitted medical records:

- Enbrel (etanercept)
- Olumiant (baricitinib)
- Tyenne (tocilizumab-aazg)

OR

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

- One of the preferred adalimumab products*
- Enbrel (etanercept)
- Olumiant (baricitinib)
- Tyenne (tocilizumab-aazg)

AND

1.5 Prescribed by, or in consultation with, a rheumatologist

OR

2 - ALL of the following:

2.1 Patient is currently on Orencia therapy as confirmed by claims history or submitted medical records

AND

2.2 Diagnosis of moderately to severely active rheumatoid arthritis

AND

2.3 Patient is NOT receiving Orenzia in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

AND

2.4 Prescribed by, or in consultation with, a rheumatologist

Notes	*See PDL links in Background

Product Name:Orenzia	
Diagnosis	Psoriatic Arthritis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ALL of the following: 1.1 Diagnosis of active psoriatic arthritis AND 1.2 ONE of the following: 1.2.1 Failure to a 3 month trial of methotrexate at the maximally indicated dose confirmed by claims history or submission of medical records OR	

1.2.2 History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

OR

1.2.3 Patient has been previously treated with a targeted immunomodulator FDA-approved for the treatment of psoriatic arthritis as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), ustekinumab, Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), Otezla (apremilast), Skyrizi (risankizumab-rzaa)]

AND

1.3 Patient is NOT receiving Orencia in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), adalimumab, ustekinumab, Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

AND

1.4 BOTH of the following:

1.4.1 ONE of the following:

1.4.1.1 Failure to TWO of the following as confirmed by claims history or submission of medical records:

- One of the preferred adalimumab products*
- Enbrel (etanercept)
- One of the preferred ustekinumab products*

OR

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

- One of the preferred adalimumab products*
- Enbrel (etanercept)

- One of the preferred ustekinumab products*

AND

1.4.2 ONE of the following:

1.4.2.1 Failure to Cosentyx (secukinumab) as confirmed by claims history or submission of medical records

OR

1.4.2.2 History of intolerance or contraindication to Cosentyx (secukinumab) (please specify intolerance or contraindication)

AND

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

- Rheumatologist
- Dermatologist

OR

2 - ALL of the following:

2.1 Patient is currently on Orencia therapy as confirmed by claims history or submitted medical records

AND

2.2 Diagnosis of active psoriatic arthritis

AND

2.3 Patient is NOT receiving Orencia in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), adalimumab, ustekinumab, Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz

(ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

AND

2.4 Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Dermatologist

Notes

*See PDL links in Background

Product Name: Orenzia

Diagnosis Polyarticular Juvenile Idiopathic Arthritis (PJIA)

Approval Length 12 month(s)

Therapy Stage Initial Authorization

Guideline Type Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe polyarticular juvenile idiopathic arthritis

AND

2 - Patient is NOT receiving Orenzia in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

AND

3 - ONE of the following:

3.1 Failure to ALL of the following as confirmed by claims history or submission of medical records:

- One of the preferred adalimumab products*

- Enbrel (etanercept)
- Tyenne (tocilizumab-aazg)

OR

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

- One of the preferred adalimumab products*
- Enbrel (etanercept)
- Tyenne (tocilizumab-aazg)

OR

3.3 Patient is currently on Orenzia therapy as confirmed by claims history or submitted medical records

AND

4 - Prescribed by, or in consultation with, a rheumatologist

Notes	*See PDL links in Background

Product Name:Orenzia	
Diagnosis	Rheumatoid Arthritis (RA), Psoriatic Arthritis, Polyarticular Juvenile Idiopathic Arthritis (PJIA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Orenzia therapy AND	

2 - Patient is NOT receiving Orencia in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), adalimumab, ustekinumab, Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]*

Notes

*Examples of drug(s) may not be applicable based on the requested indication.

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>

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>

NM: <https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html>

3 . Revision History

UnitedHealthcare Community Plan of Rhode Island Clinical Pharmacy Program Guidelines

Date	Notes
3/3/2026	Removed NY

Orgovyx



Prior Authorization Guideline

Guideline ID	GL-219253
Guideline Name	Orgovyx
Formulary	Medicaid - Community & State Arizona Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State New Jersey Medicaid - Community & State New Mexico Medicaid - Community & State New York EPP Medicaid - Community & State New York Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Virginia Medicaid - Community & State Washington

Guideline Note:

Effective Date:	5/1/2025

1 . Criteria

Product Name:Orgovyx

Diagnosis	Prostate Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of advanced prostate cancer	

Product Name:Orgovyx	
Diagnosis	Prostate Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient does not show evidence of progressive disease while on Orgovyx therapy	

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

Product Name:Orgovyx	

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

2 . Revision History

Date	Notes
3/14/2025	Combined formularies. Updated initial auth criteria section for prostate cancer and minor update in reauth section for prostate cancer.

Oriahnn_MyFembree



Prior Authorization Guideline

Guideline ID	GL-555329
Guideline Name	Oriahnn_MyFembree
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 Virginia Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:Oriahnn, MyFembree	
Diagnosis	Uterine Fibroids
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of uterine fibroids (leiomyomas) AND 2 - Used for the management of heavy menstrual bleeding AND 3 - ONE of the following: 3.1 Failure after a three-month trial to ONE of the following as confirmed by claims history or submission of medical records: • Estrogen/progestin contraceptive (e.g., Loestrin FE) • Progestin-releasing intrauterine devices (IUDs) (e.g., Mirena)* • Progestin-only contraceptive [e.g., norethindrone (generic Aygestin)] OR 3.2 Contraindication or intolerance to ALL of the following (please specify contraindication or intolerance): • Estrogen/progestin contraceptive (e.g., Loestrin FE) • Progestin-releasing intrauterine devices (IUDs) (e.g., Mirena)* • Progestin-only contraceptive [e.g., norethindrone (generic Aygestin)] AND 4 - ONE of the following: • Failure after a three-month trial of tranexamic acid (e.g., Lysteda) as confirmed by claims history or submission of medical records	

- History of contraindication or intolerance to tranexamic acid (e.g., Lysteda) (please specify contraindication or intolerance) AND 5 - Prescribed by or in consultation with ONE of the following: - Obstetrics/Gynecologist (OB/GYN) - Reproductive endocrinologist	
Notes	*This is a medical benefit, should not be included in denial to provider

Product Name: Oriahnn, MyFembree	
Diagnosis	Uterine Fibroids
Approval Length	12 months*
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy AND 2 - Impact to bone mineral density has been considered AND 3 - Treatment duration has not exceeded a total of 24 months*	
Notes	*Authorization will be issued for 12 months up to a maximum treatment duration of 24 months. Oriahnn and MyFembree are indicated for a maximum treatment duration of 24 months.

Product Name: MyFembree

Diagnosis	Pain Associated with Endometriosis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderate to severe pain associated with endometriosis AND 2 - ONE of the following: • Failure (e.g., inadequate pain relief) to a three-month trial of TWO analgesics (e.g., ibuprofen, meloxicam, naproxen) as confirmed by claims history or submission of medical records • History of contraindication or intolerance to TWO analgesics (e.g., ibuprofen, meloxicam, naproxen) (please specify contraindication or intolerance) AND 3 - ONE of the following: 3.1 Failure to a three-month trial of ONE of the following, as confirmed by claims history or submission of medical records: • Hormonal contraceptives • Progestins [e.g., norethindrone (generic Aygestin)] OR 3.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication): • Hormonal contraceptives • Progestins [e.g., norethindrone (generic Aygestin)]	

AND

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

- Obstetrics/Gynecologist (OB/GYN)
- Reproductive endocrinologist

Product Name: MyFembree

Diagnosis	Pain Associated with Endometriosis
Approval Length	12 months*
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Impact to bone mineral density has been considered

AND

3 - Treatment duration has not exceeded a total of 24 months*

Notes	*Authorization will be issued for 12 months up to a maximum treatment duration of 24 months. MyFembree are indicated for a maximum treatment duration of 24 months.

2 . Revision History

Date	Notes

3/24/2026	Removed NY. Updated medical benefit note

Orilissa



Prior Authorization Guideline

Guideline ID	GL-555331
Guideline Name	Orilissa
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 New Mexico

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:Orilissa 150 mg	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe pain associated with endometriosis

AND

2 - ONE of the following:

2.1 Failure (e.g., inadequate pain relief) to a three month trial of TWO analgesics (e.g., ibuprofen, meloxicam, naproxen) as confirmed by claims history or submission of medical records

OR

2.2 History of contraindication or intolerance to TWO analgesics (e.g., ibuprofen, meloxicam, naproxen) (please specify contraindication or intolerance)

AND

3 - ONE of the following:

3.1 Failure to a three month trial to ONE of the following as confirmed by claims history or submission of medical records:

- Hormonal contraceptives
- Progestins [e.g., norethindrone (generic Aygestin)]

OR

3.2 History of contraindication or intolerance to BOTH of the following (please specify contraindication or intolerance)

- Hormonal contraceptives
- Progestins [e.g., norethindrone (generic Aygestin)]

AND

4 - Treatment duration of Orilissa 150 mg once daily has not exceeded a total of 24 months, as confirmed by claims history or submission of medical records

AND

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

- Obstetrics/Gynecologist (OB/GYN)
- Reproductive endocrinologist

Product Name:Orilissa 150 mg	
Approval Length	12 months up to a maximum treatment duration of 24 months
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy AND 2 - Impact to bone mineral density has been considered AND 3 - Treatment duration has not exceeded a total of 24 months, as confirmed by claims history or submission of medical records	

Product Name:Orilissa 200 mg	
Approval Length	Up to a maximum of 6 months
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe pain associated with endometriosis

AND

2 - ONE of the following:

2.1 Failure (e.g., inadequate pain relief) to a three month trial of TWO analgesics (e.g., ibuprofen, meloxicam, naproxen), as confirmed by claims history or submission of medical records

OR

2.2 History of intolerance or contraindication to TWO analgesics (e.g., ibuprofen, meloxicam, naproxen) (please specify intolerance or contraindication)

AND

3 - ONE of the following:

3.1 Failure after a three month trial to ONE of the following as confirmed by claims history or submission of medical records:

- Hormonal contraceptives
- Progestins [e.g., norethindrone (generic Aygestin)]

OR

3.2 History of contraindication or intolerance to BOTH of the following (please specify contraindication or intolerance):

- Hormonal contraceptives
- Progestins [e.g., norethindrone (generic Aygestin)]

AND

4 - Treatment duration of Orilissa 200 mg twice daily has not exceeded a total of 6 months, as confirmed by claims history or submission of medical records

AND

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

- Obstetrics/Gynecologist (OB/GYN)
- Reproductive endocrinologist

2 . Revision History

Date	Notes
3/24/2026	Removed NY

Orkambi



Prior Authorization Guideline

Guideline ID	GL-151768
Guideline Name	Orkambi
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

Guideline Note:

Effective Date:	9/1/2024

1 . Criteria

Product Name:Orkambi	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of cystic fibrosis (CF)

AND

2 - Submission of laboratory results confirming that patient is homozygous for the F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene

AND

3 - The patient is greater than or equal to 1 years of age

AND

4 - Prescribed by, or in consultation with, a provider who specializes in the treatment of CF

Product Name:Orkambi	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Orkambi therapy (e.g., improved lung function, stable lung function)	

2 . Revision History

Date	Notes

8/14/2024	Removed prescriber requirement from reauthorization criteria

Orkambi



Prior Authorization Guideline

Guideline ID	GL-151768
Guideline Name	Orkambi
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

Guideline Note:

Effective Date:	9/1/2024

1 . Criteria

Product Name:Orkambi	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of cystic fibrosis (CF)

AND

2 - Submission of laboratory results confirming that patient is homozygous for the F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene

AND

3 - The patient is greater than or equal to 1 years of age

AND

4 - Prescribed by, or in consultation with, a provider who specializes in the treatment of CF

Product Name:Orkambi	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Orkambi therapy (e.g., improved lung function, stable lung function)	

2 . Revision History

Date	Notes

8/14/2024	Removed prescriber requirement from reauthorization criteria

Orladeyo



Prior Authorization Guideline

Guideline ID	GL-534256
Guideline Name	Orladeyo
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

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Orladeyo	
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, and 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 - ALL of the following: 2.1 Prescribed for the prophylaxis of HAE attacks AND 2.2 Not used in combination with other approved products indicated for prophylaxis against HAE attacks (i.e., Cinryze, Haegarda, Takhzyro) AND	

2.3 Prescriber attests that patient has experienced attacks of a severity and/or frequency such that they would clinically benefit from prophylactic therapy with Orladeyo

AND

3 - Prescribed by ONE of the following:

- Immunologist
- Allergist

AND

4 - ONE of the following:

4.1 Patient is greater than or equal to 2 years of age and less than 6 years of age

OR

4.2 Failure to Haegarda as confirmed by history or submission of medical records

OR

4.3 History of contraindication, or intolerance to Haegarda (please specify a contraindication or intolerance)

OR

4.4 Patient is unable to self-inject Haegarda due to ONE of the following:

- Physical impairment
- Visual impairment
- Lipohypertrophy
- Documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure [refer to DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition) for specific phobia diagnostic criteria]

OR

4.5 Patient is currently on Orladeyo therapy, as confirmed by claims history or submission of medical records

Product Name:Orladeyo	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Orladeyo therapy AND 2 - Reduction in the utilization of on-demand therapies used for acute attacks (e.g., Berinert, Firazyr, Ruconest), as confirmed by claims history or submission of medical records, while on Orladeyo therapy AND 3 - BOTH of the following: 3.1 Prescribed for the prophylaxis of hereditary angioedema (HAE) attacks AND 3.2 Not used in combination with other products indicated for prophylaxis against HAE attacks (i.e., Cinryze, Haegarda, Takhzyro) AND	

4 - Prescribed by ONE of the following:

- Immunologist
- Allergist

2 . Revision History

Date	Notes
2/27/2026	Updated GPIs to include Orladeyo pellets. Expanded on HAE abbreviation under reauth, with no changes to clinical intent. Updated initial auth criteria by separating tried/failed therapies based on age limitations for Haegarda.

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-442195
Guideline Name	Osphena
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii 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 Nevada

Guideline Note:

Effective Date:	1/1/2026

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

2 . Revision History

Date	Notes
11/6/2025	Added Nevada Formulary

Otezla, Otezla XR



Prior Authorization Guideline

Guideline ID	GL-506329
Guideline Name	Otezla, Otezla XR
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

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Otezla, Otezla XR	
Diagnosis	Psoriatic Arthritis
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - All of the following: 1.1 Diagnosis of active psoriatic arthritis AND 1.2 One of the following: 1.2.1 Failure to a 3 month trial of methotrexate at the maximally indicated dose, as confirmed by claims history or submission of medical records OR 1.2.2 History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication) OR 1.2.3 Patient has been previously treated with a systemic targeted immunomodulator FDA-approved for the treatment of psoriatic arthritis as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), Simponi (golimumab), ustekinumab, Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), Skyrizi (risankizumab-rzaa)] AND 1.3 Patient is not receiving the requested medication in combination with another systemic targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, ustekinumab, Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)] for treatment of the same indication	

AND

1.4 If the request is for Otezla XR, the prescriber provides a reason or special circumstance the patient cannot use Otezla (please document reason/special circumstances)

AND

1.5 Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Dermatologist

OR

2 - All of the following:

2.1 Patient is currently on Otezla or Otezla XR therapy as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of active psoriatic arthritis

AND

2.3 Patient is not receiving the requested medication in combination with another systemic targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, ustekinumab, Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)] for treatment of the same indication

AND

2.4 If the request is for Otezla XR, the prescriber provides a reason or special circumstance the patient cannot use Otezla (please document reason/special circumstances)

AND

2.5 Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Dermatologist

Product Name: Otezla, Otezla XR	
Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - All of the following: 1.1 Diagnosis of plaque psoriasis in those who are candidates for phototherapy or systemic therapy AND 1.2 One of the following: 1.2.1 All of the following: 1.2.1.1 Greater than or equal to 3 percent body surface area involvement, palmoplantar, facial, or genital involvement, or severe scalp psoriasis AND 1.2.1.2 One of the following: 1.2.1.2.1 Failure to ONE of the following topical therapy classes confirmed by claims history or submission of medical records:	

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Anthralin
- Coal tar

OR

1.2.1.2.2 History of intolerance or contraindication to ALL of the following topical therapy classes (please specify intolerance or contraindication)

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Anthralin
- Coal tar

AND

1.2.1.3 One of the following:

1.2.1.3.1 Failure to a 3 month trial of methotrexate at the maximally indicated dose confirmed by claims history or submission of medical records

OR

1.2.1.3.2 History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

OR

1.2.2 Patient has been previously treated with a systemic targeted immunomodulator FDA-approved for the treatment of plaque psoriasis as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), Skyrizi (risankizumab-rzaa), ustekinumab, Tremfya (guselkumab)]

AND

1.3 Patient is not receiving the requested medication in combination with another systemic targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, ustekinumab, Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)] for treatment of the same indication

AND

1.4 If the request is for Otezla XR, the prescriber provides a reason or special circumstance the patient cannot use Otezla (please document reason/special circumstances)

AND

1.5 Prescribed by or in consultation with a dermatologist

OR

2 - All of the following:

2.1 Patient is currently on Otezla or Otezla XR therapy as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of plaque psoriasis in those who are candidates for phototherapy or systemic therapy

AND

2.3 Patient is not receiving the requested medication in combination with another systemic targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, ustekinumab, Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)] for treatment of the same indication

AND

2.4 If the request is for Otezla XR, the prescriber provides a reason or special circumstance the patient cannot use Otezla (please document reason/special circumstances)

AND

2.5 Prescribed by or in consultation with a dermatologist

Product Name:Otezla, Otezla XR	
Diagnosis	Behcet's Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - All of the following: 1.1 Diagnosis of Behcet's Disease AND 1.2 Patient has active oral ulcers attributed to Behcet's Disease AND 1.3 One of the following: 1.3.1 Failure to one non-biologic (e.g., corticosteroids, colchicine) used for treating Behcet's Disease, as confirmed by claims history or submission of medical records	

OR

1.3.2 History of contraindication or intolerance to one non-biologic (e.g., corticosteroids, colchicine) used for treating Behcet's Disease (please specify contraindication or intolerance)

OR

1.3.3 Patient has been previously treated with a systemic targeted immunomodulator used for the treatment of Behcet's Disease as confirmed by claims history or submission of medical records [e.g., Remicade (infliximab), adalimumab, Enbrel (etanercept)]

AND

1.4 Patient is not receiving the requested medication in combination with another systemic targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, ustekinumab, Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)] for treatment of the same indication

AND

1.5 If the request is for Otezla XR, the prescriber provides a reason or special circumstance the patient cannot use Otezla (please document reason/special circumstances)

AND

1.6 Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Dermatologist

OR

2 - All of the following:

2.1 Patient is currently on Otezla or Otezla XR therapy as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of Behcet's Disease

AND

2.3 Patient has active oral ulcers attributed to Behcet's Disease

AND

2.4 Patient is not receiving the requested medication in combination with another systemic targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, ustekinumab, Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)] for treatment of the same indication

AND

2.5 If the request is for Otezla XR, the prescriber provides a reason or special circumstance the patient cannot use Otezla (please document reason/special circumstances)

AND

2.6 Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Dermatologist

Product Name:Otezla, Otezla XR	
Diagnosis	Psoriatic Arthritis, Behcet's Disease, Plaque Psoriasis
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response AND 2 - Patient is not receiving Otezla in combination with another systemic targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, ustekinumab, Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)] for treatment of the same indication	

2 . Revision History

Date	Notes
1/26/2026	Updated title. Added Otezla XR

Oxervate



Prior Authorization Guideline

Guideline ID	GL-230188
Guideline Name	Oxervate
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 New Mexico

Guideline Note:

Effective Date:	5/1/2025

1 . Criteria

Product Name: Oxervate	
Diagnosis	Neurotrophic keratitis

Approval Length	8 Week(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Stage 2 or 3 neurotrophic keratitis AND 2 - Failure to at least ONE OTC (over the counter) ocular artificial tear product (e.g., Systane Ultra, Akwa Tears, Refresh Optive, Soothe XP) as confirmed by claims history or submission of medical records AND 3 - Prescribed by or in consultation with ONE of the following: • Ophthalmologist • Optometrist	

2 . Revision History

Date	Notes
3/26/2025	Combined formularies.

PAH



Prior Authorization Guideline

Guideline ID	GL-396199
Guideline Name	PAH
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 New Mexico

Guideline Note:

Effective Date:	10/1/2025

1 . Criteria

Product Name:Adempas, Brand Letairis, generic ambrisentan, Opsumit, generic sildenafil 20 mg, Brand Revatio tabs/susp, generic sildenafil susp, Tracleer, generic bosentan, Brand Adcirca, Alyq, generic tadalafil (PAH, generic of Adcirca)	
Diagnosis	Pulmonary Arterial Hypertension (PAH)

Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of pulmonary arterial hypertension (PAH)	

Product Name:Liqrev, Tadliq	
Diagnosis	Pulmonary Arterial Hypertension (PAH)
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: - Pulmonary arterial hypertension is symptomatic - Diagnosis of pulmonary arterial hypertension that is confirmed by right heart catheterization OR 1.2 Patient is currently on any therapy for the diagnosis of pulmonary arterial hypertension AND 2 - ONE of the following: 2.1 Failure to BOTH of the following as confirmed by claims history or submission of medical records: 2.1.1 ONE of the following:	

- Adempas
- Sildenafil citrate oral suspension (generic Revatio)

AND

2.1.2 An ERA (endothelin receptor antagonist) [e.g., ambrisentan (generic Letairis), Opsumit, or bosentan (generic Tracleer)]

OR

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

2.2.1 ONE of the following:

- Adempas
- Sildenafil citrate oral suspension (generic Revatio)

AND

2.2.2 An ERA [e.g., ambrisentan (generic Letairis), Opsumit, or bosentan (generic Tracleer)]

Product Name: Orenitram, Tyvaso DPI, Upravi, Yutrepia	
Diagnosis	Pulmonary Arterial Hypertension (PAH)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Both of the following: 1.1 As continuation of therapy	

AND

1.2 Patient is not taking the requested medication in combination with a prostanoid/prostacyclin analogue (e.g., epoprostenol, iloprost, treprostinil)

OR

2 - ALL of the following:

2.1 ONE of the following:

2.1.1 BOTH of the following:

- Pulmonary arterial hypertension is symptomatic
- Diagnosis of pulmonary arterial hypertension that is confirmed by right heart catheterization

OR

2.1.2 Patient is currently on any therapy for the diagnosis of pulmonary arterial hypertension

AND

2.2 ONE of the following:

2.2.1 Failure to BOTH of the following as confirmed by claims history or submission of medical records:

2.2.1.1 ONE of the following:

- Adempas
- A PDE-5 inhibitor [e.g., sildenafil citrate (generic Revatio), tadalafil (generic Adcirca)]

AND

2.2.1.2 An ERA (endothelin receptor antagonist) [e.g., ambrisentan (generic Letairis), Opsumit, or bosentan (generic Tracleer)]

OR

2.2.2 History of contraindication or intolerance to BOTH of the following (please specify contraindication or intolerance):

2.2.2.1 ONE of the following:

- Adempas
- A PDE-5 inhibitor [e.g., sildenafil citrate (generic Revatio), tadalafil (generic Adcirca)]

AND

2.2.2.2 An ERA [e.g., ambrisentan (generic Letairis), Opsumit, or bosentan (generic Tracleer)]

AND

2.3 Patient is not taking the requested medication in combination with a prostanoid/prostacyclin analogue (e.g., epoprostenol, iloprost, treprostinil)

Product Name:Opsynvi	
Diagnosis	Pulmonary Arterial Hypertension (PAH)
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: • Pulmonary arterial hypertension is symptomatic • Diagnosis of pulmonary arterial hypertension that is confirmed by right heart catheterization	

OR

1.2 Patient is currently on any therapy for the diagnosis of pulmonary arterial hypertension

AND

2 - Failure to BOTH of the following taken together as confirmed by claims history or submission of medical records:

- A PDE-5 inhibitor [e.g., sildenafil citrate (generic Revatio), tadalafil (generic Adcirca)]
- A preferred ERA [e.g., ambrisentan (generic Letairis), Opsumit, or bosentan (generic Tracleer)]

Product Name:Tadliq, Liqrev, Opsynvi	
Diagnosis	Pulmonary Arterial Hypertension (PAH)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation the patient is receiving clinical benefit to therapy	

Product Name:Orenitram, Tyvaso DPI, Upravi, Yutrepia	
Diagnosis	Pulmonary Arterial Hypertension (PAH)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Documentation the patient is receiving clinical benefit to therapy

AND

2 - Patient is not taking the requested medication in combination with a prostanoid/prostacyclin analogue (e.g., epoprostenol, iloprost, treprostinil)

Product Name:Adempas

Diagnosis	Chronic Thromboembolic Pulmonary Hypertension (CTEPH)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of inoperable or persistent/recurrent chronic thromboembolic pulmonary hypertension (CTEPH)

Product Name:Tyvaso DPI, Yutrepia

Diagnosis	Pulmonary Hypertension Associated with Interstitial Lung Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of pulmonary hypertension associated with interstitial lung disease [WHO (World Health Organization) group 3] confirmed by right heart catheterization

AND

2 - Interstitial lung disease is diagnosed based on evidence of diffuse parenchymal lung disease on computed tomography of the chest

AND

3 - Pulmonary hypertension is symptomatic

Product Name: Tyvaso DPI, Yutrepia	
Diagnosis	Pulmonary Hypertension Associated with Interstitial Lung 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 (e.g., improved exercise ability)	

2 . Revision History

Date	Notes
9/12/2025	Added Yutrepia to the GL. Updated GPI

Palforzia



Prior Authorization Guideline

Guideline ID	GL-442196
Guideline Name	Palforzia
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State New Jersey Medicaid - Community & State New Mexico Medicaid - Community & State New York Medicaid - Community & State New York EPP 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:Palforzia	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis and clinical history of peanut allergy as documented by BOTH of the following: • A serum peanut-specific IgE (immunoglobulin E) level of greater than or equal to 0.35 kUA/L (kilounits of allergen/liter) • A mean wheal diameter that is at least 3 mm (millimeters) larger than the negative control on skin-prick testing for peanut AND 2 - ONE of the following: 2.1 BOTH of the following: • Patient is 1 to 17 years of age • Patient is in the initial dose escalation phase of therapy OR 2.2 BOTH of the following: • Patient is 1 year of age and older • Patient is in the up-dosing or maintenance phase of therapy AND 3 - Used in conjunction with a peanut-avoidant diet AND 4 - Patient does not have any of the following: • History of eosinophilic esophagitis (EoE) or eosinophilic gastrointestinal disease • History of severe or life-threatening episode(s) of anaphylaxis or anaphylactic shock within the past 2 months	

- Severe or poorly controlled asthma

AND

5 - Prescribed by or in consultation with an allergist/immunologist

AND

6 - Prescriber is certified/enrolled in the Palforzia REMS (Risk Evaluation and Mitigation Strategy) Program

Product Name:Palforzia

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Palforzia therapy

AND

2 - Used in conjunction with a peanut-avoidant diet

AND

3 - Prescribed by or in consultation with an allergist/immunologist

AND

4 - Prescriber is certified/enrolled in the Palforzia REMS (Risk Evaluation and Mitigation Strategy) Program

2 . Revision History

Date	Notes
11/6/2025	Added Nevada Formulary

Palsonify



Prior Authorization Guideline

Guideline ID	GL-572197
Guideline Name	Palsonify
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 Virginia Medicaid - Community & State Washington Medicaid - Community & State New Mexico Medicaid - Community & State Pennsylvania

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name: Palsonify	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has a diagnosis of acromegaly

AND

2 - Patient is greater than or equal to 18 years old

AND

3 - Diagnosis confirmed by ONE of the following:

- Serum growth hormone (GH) level > 1 ng/mL after a 2-hour oral glucose tolerance test (OGTT) at time of diagnosis
- Elevated serum insulin-like growth factor 1 (IGF-1) levels (above the age and gender adjusted normal range as provided by the provider's lab) at time of diagnosis

AND

4 - ONE of the following:

- Patient had an inadequate response to surgery
- Patient is not a candidate for surgery

AND

5 - Prescribed by or in consultation with an endocrinologist

Product Name: Palsonify

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Palsonify therapy (e.g., age-normalized serum IGF-1 level)	

2 . Revision History

Date	Notes
4/9/2026	Added PA-CAID. Updated criteria to include: confirmation of diagnosis, prescriber check, added examples of positive clinical response in reauthorization language

Palynziq



Prior Authorization Guideline

Guideline ID	GL-534250
Guideline Name	Palynziq
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

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name: Palynziq	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of phenylketonuria (PKU)

AND

2 - Patient is actively on a phenylalanine-restricted diet

AND

3 - ONE of the following:

3.1 Failure to sapropterin as confirmed by claims history or submission of medical records

OR

3.2 History of contraindication or intolerance to sapropterin therapy (please specify contraindication or intolerance)

OR

3.3 Patient is not an appropriate candidate for sapropterin due to two null mutations in trans

AND

4 - Physician attestation that the patient will not be receiving Palynziq in combination with sapropterin dihydrochloride or Sepiience (sepiapterin)

AND

5 - Submission of medical records (e.g., chart notes, laboratory values) documenting that the patient has a blood phenylalanine concentration greater than 600 micromoles/liter

Product Name: Palynziq	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is actively on a phenylalanine-restricted diet AND 2 - ONE of the following: 2.1 Submission of medical records (e.g., chart notes, laboratory values) documenting that the patient has a blood phenylalanine concentration less than 600 micromoles/liter OR 2.2 Submission of medical records (e.g., chart notes, laboratory values) documenting that the patient has achieved a 20% reduction in blood phenylalanine concentration from pre-treatment baseline OR 2.3 Patient is in initial titration/maintenance phase of dosing regimen and dose is being titrated based on blood phenylalanine concentration response up to maximum labeled dosage of 60 milligrams once daily	

AND

3 - Submission of medical records (e.g., chart notes, laboratory values) documenting that the patient is not receiving Palynziq in combination with sapropterin dihydrochloride or Sephience (sepiapterin) [Prescription claim history that does not show any concomitant sapropterin dihydrochloride or Sephience (sepiapterin) claim within 60 days of reauthorization request may be used as documentation]

2 . Revision History

Date	Notes
2/27/2026	Added PA-CAID.

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.

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.

Phexxi



Prior Authorization Guideline

Guideline ID	GL-555342
Guideline Name	Phexxi
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State New Jersey Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Arizona Medicaid - Community & State Nebraska Medicaid - Community & State Pennsylvania Medicaid - Community & State Virginia Medicaid - Community & State Nevada

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:Phexxi, Phexx	
Approval Length	12 month(s)

Guideline Type	Prior Authorization
Approval Criteria 1 - Used for the prevention of pregnancy AND 2 - ONE of the following: 2.1 Failure to ALL of the following methods of contraception as confirmed by claims history or submission of medical records: • Injection (e.g., Depo-Provera) • Oral Contraceptive [e.g., norethindrone (generic Micronor), Yaz] • Transdermal Patch (e.g., Twirla, Xulane) • Vaginal Contraceptive Ring (e.g., Annovera, NuvaRing) • Diaphragm • Cervical Cap (e.g., FemCap) • Female Condom OR 2.2 History of intolerance or contraindication to ALL of the following methods of contraception (please document intolerance or contraindication): • Injection (e.g., Depo-Provera) • Oral Contraceptive [e.g., norethindrone (generic Micronor), Yaz] • Transdermal Patch (e.g., Twirla, Xulane) • Vaginal Contraceptive Ring (e.g., Annovera, NuvaRing) • Diaphragm • Cervical Cap (e.g., FemCap) • Female Condom AND 3 - ONE of the following: 3.1 Failure to nonoxynol-9 based spermicide as confirmed by claims history or submission of medical records	

OR

3.2 History of intolerance or contraindication to nonoxynol-9 based spermicide (please document intolerance or contraindication)

AND

4 - Provider attests they have counseled the patient regarding higher rate of pregnancy prevention with the use of other methods of contraception (e.g., injection, oral contraception, transdermal patch, vaginal ring) compared to Phexxi/Phexx

2 . Revision History

Date	Notes
3/24/2026	Removed NY. Add Phexx

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.

PPI (Proton Pump Inhibitors)



Prior Authorization Guideline

Guideline ID	GL-522241
Guideline Name	PPI (Proton Pump Inhibitors)
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 New Mexico

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name:generic lansoprazole ODT, generic esomeprazole magnesium susp packets	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient is less than 2 years of age

OR

2 - ONE of the following:

2.1 Failure to BOTH of the following, as confirmed by claims history or submission of medical records

- Lansoprazole DR capsule as sprinkle administration (generic Prevacid)
- Esomeprazole magnesium OTC capsule (generic Nexium capsule 24 HR OTC) or esomeprazole magnesium capsule (generic Nexium) as sprinkle administration

OR

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

- Lansoprazole DR capsule as sprinkle administration (generic Prevacid)
- Esomeprazole magnesium OTC capsule (generic Nexium capsule 24 HR OTC) or esomeprazole magnesium capsule (generic Nexium) as sprinkle administration

Product Name:Prilosec OTC, omeprazole tabs, Brand Protonix tabs, Brand Prevacid, Prevacid 24HR, Brand Aciphex, generic rabeprazole, Brand Dexilant, generic dexlansoprazole, Brand Nexium caps, Nexium 24HR

Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Failure to at least a 30 day trial of THREE of the following as confirmed by claims history or submission of medical records:

- Omeprazole OTC capsule (generic Prilosec OTC capsule) or omeprazole capsule (generic Prilosec)
- Pantoprazole tablet (generic Protonix)
- Lansoprazole delayed release (DR) capsule (generic Prevacid)

- Esomeprazole magnesium OTC capsule (generic Nexium capsule 24 HR OTC) or esomeprazole magnesium capsule (generic Nexium)

OR

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

- Omeprazole OTC capsule (generic Prilosec OTC capsule) or omeprazole capsule (generic Prilosec)
- Pantoprazole tablet (generic Protonix)
- Lansoprazole DR capsule (generic Prevacid)
- Esomeprazole magnesium OTC capsule (generic Nexium capsule 24 HR OTC) or esomeprazole magnesium capsule (generic Nexium)

Product Name:Prilosec susp packets, Brand Protonix susp packets, generic pantoprazole susp packets, Brand Prevacid Solutab, Brand Nexium susp packets, Rabeprazole Sprinkle

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - Failure to at least a 30 day trial to THREE of the following products as confirmed by claims history or submission of medical records:

- Lansoprazole DR capsule as sprinkle administration (generic Prevacid)
- Esomeprazole magnesium OTC capsule (generic Nexium capsule 24 HR OTC) or esomeprazole magnesium capsule (generic Nexium) as sprinkle administration
- Lansoprazole oral disintegrating tablet (generic Prevacid Solutab) (Prior authorization required)
- Esomeprazole magnesium granule suspension (generic Nexium granule suspension) (Prior authorization required)

OR

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

- Lansoprazole DR capsule as sprinkle administration (generic Prevacid)

- Esomeprazole magnesium OTC capsule (generic Nexium capsule 24 HR OTC) or esomeprazole magnesium capsule (generic Nexium) as sprinkle administration
- Lansoprazole oral disintegrating tablet (generic Prevacid Solutab)
- Esomeprazole magnesium granule suspension (generic Nexium granule suspension)

Product Name:omeprazole caps, Prilosec susp packets, Prilosec OTC, omeprazole tabs, generic pantoprazole tabs/susp packets, Brand Protonix tabs/susp packets, generic lansoprazole, Brand Prevacid, Prevacid 24HR, generic lansoprazole ODT, Brand Prevacid Solutab, generic rabeprazole, Brand Aciphex, Rabeprazole Sprinkle, generic dexlansoprazole, Brand Dexilant, generic esomeprazole magnesium caps/susp packets, Brand Nexium caps/susp packets, Nexium 24HR, esomeprazole magnesium tabs (OTC)

Therapy Stage	Initial Authorization
Guideline Type	Quantity Limit
Approval Criteria 1 - The patient did not exhibit an adequate response to treatment within the quantity limit* OR 2 - The patient has documented erosive disease* OR 3 - The patient has documented symptoms of complicated disease (e.g., dysphagia, bleeding, weight loss, choking, chest pain)* OR 4 - The patient has a pathological hypersecretory condition such as Zollinger-Ellison syndrome, Barrett's Esophagus, multiple endocrine adenomas, or systemic mastocytosis**	
Notes	Authorization will be issued based on circumstance. *Authorization will be issued for 8 weeks. **Authorization of therapy will be issued for 12 months.

Product Name:omeprazole caps, Prilosec susp packets, Prilosec OTC, omeprazole tabs, generic pantoprazole tabs/susp packets, Brand Protonix tabs/susp packets, generic lansoprazole, Brand Prevacid, Prevacid 24HR, generic lansoprazole ODT, Brand Prevacid Solutab, generic rabeprazole, Brand Aciphex, Rabeprazole Sprinkle, generic dexlansoprazole, Brand Dexilant, generic esomeprazole magnesium caps/susp packets, Brand Nexium caps/susp packets, Nexium 24HR, esomeprazole magnesium tabs (OTC)	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Quantity Limit
Approval Criteria 1 - The patient is continuing therapy for a pathological hypersecretory condition such as Zollinger-Ellison syndrome, Barrett's Esophagus, multiple adenomas, or systemic mastocytosis	

2 . Revision History

Date	Notes
2/16/2026	Removed NY and NY EPP formularies - see separate guideline for these formularies. No other changes to guideline.

PPI (Proton Pump Inhibitors)



Prior Authorization Guideline

Guideline ID	GL-522241
Guideline Name	PPI (Proton Pump Inhibitors)
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 New Mexico

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name:generic lansoprazole ODT, generic esomeprazole magnesium susp packets	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient is less than 2 years of age

OR

2 - ONE of the following:

2.1 Failure to BOTH of the following, as confirmed by claims history or submission of medical records

- Lansoprazole DR capsule as sprinkle administration (generic Prevacid)
- Esomeprazole magnesium OTC capsule (generic Nexium capsule 24 HR OTC) or esomeprazole magnesium capsule (generic Nexium) as sprinkle administration

OR

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

- Lansoprazole DR capsule as sprinkle administration (generic Prevacid)
- Esomeprazole magnesium OTC capsule (generic Nexium capsule 24 HR OTC) or esomeprazole magnesium capsule (generic Nexium) as sprinkle administration

Product Name:Prilosec OTC, omeprazole tabs, Brand Protonix tabs, Brand Prevacid, Prevacid 24HR, Brand Aciphex, generic rabeprazole, Brand Dexilant, generic dexlansoprazole, Brand Nexium caps, Nexium 24HR

Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Failure to at least a 30 day trial of THREE of the following as confirmed by claims history or submission of medical records:

- Omeprazole OTC capsule (generic Prilosec OTC capsule) or omeprazole capsule (generic Prilosec)
- Pantoprazole tablet (generic Protonix)
- Lansoprazole delayed release (DR) capsule (generic Prevacid)

- Esomeprazole magnesium OTC capsule (generic Nexium capsule 24 HR OTC) or esomeprazole magnesium capsule (generic Nexium)

OR

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

- Omeprazole OTC capsule (generic Prilosec OTC capsule) or omeprazole capsule (generic Prilosec)
- Pantoprazole tablet (generic Protonix)
- Lansoprazole DR capsule (generic Prevacid)
- Esomeprazole magnesium OTC capsule (generic Nexium capsule 24 HR OTC) or esomeprazole magnesium capsule (generic Nexium)

Product Name: Prilosec susp packets, Brand Protonix susp packets, generic pantoprazole susp packets, Brand Prevacid Solutab, Brand Nexium susp packets, Rabeprazole Sprinkle

Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - Failure to at least a 30 day trial to THREE of the following products as confirmed by claims history or submission of medical records:

- Lansoprazole DR capsule as sprinkle administration (generic Prevacid)
- Esomeprazole magnesium OTC capsule (generic Nexium capsule 24 HR OTC) or esomeprazole magnesium capsule (generic Nexium) as sprinkle administration
- Lansoprazole oral disintegrating tablet (generic Prevacid Solutab) (Prior authorization required)
- Esomeprazole magnesium granule suspension (generic Nexium granule suspension) (Prior authorization required)

OR

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

- Lansoprazole DR capsule as sprinkle administration (generic Prevacid)

- Esomeprazole magnesium OTC capsule (generic Nexium capsule 24 HR OTC) or esomeprazole magnesium capsule (generic Nexium) as sprinkle administration
- Lansoprazole oral disintegrating tablet (generic Prevacid Solutab)
- Esomeprazole magnesium granule suspension (generic Nexium granule suspension)

Product Name:omeprazole caps, Prilosec susp packets, Prilosec OTC, omeprazole tabs, generic pantoprazole tabs/susp packets, Brand Protonix tabs/susp packets, generic lansoprazole, Brand Prevacid, Prevacid 24HR, generic lansoprazole ODT, Brand Prevacid Solutab, generic rabeprazole, Brand Aciphex, Rabeprazole Sprinkle, generic dexlansoprazole, Brand Dexilant, generic esomeprazole magnesium caps/susp packets, Brand Nexium caps/susp packets, Nexium 24HR, esomeprazole magnesium tabs (OTC)

Therapy Stage	Initial Authorization
Guideline Type	Quantity Limit
Approval Criteria 1 - The patient did not exhibit an adequate response to treatment within the quantity limit* OR 2 - The patient has documented erosive disease* OR 3 - The patient has documented symptoms of complicated disease (e.g., dysphagia, bleeding, weight loss, choking, chest pain)* OR 4 - The patient has a pathological hypersecretory condition such as Zollinger-Ellison syndrome, Barrett's Esophagus, multiple endocrine adenomas, or systemic mastocytosis**	
Notes	Authorization will be issued based on circumstance. *Authorization will be issued for 8 weeks. **Authorization of therapy will be issued for 12 months.

Product Name:omeprazole caps, Prilosec susp packets, Prilosec OTC, omeprazole tabs, generic pantoprazole tabs/susp packets, Brand Protonix tabs/susp packets, generic lansoprazole, Brand Prevacid, Prevacid 24HR, generic lansoprazole ODT, Brand Prevacid Solutab, generic rabeprazole, Brand Aciphex, Rabeprazole Sprinkle, generic dexlansoprazole, Brand Dexilant, generic esomeprazole magnesium caps/susp packets, Brand Nexium caps/susp packets, Nexium 24HR, esomeprazole magnesium tabs (OTC)	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Quantity Limit
Approval Criteria 1 - The patient is continuing therapy for a pathological hypersecretory condition such as Zollinger-Ellison syndrome, Barrett's Esophagus, multiple adenomas, or systemic mastocytosis	

2 . Revision History

Date	Notes
2/16/2026	Removed NY and NY EPP formularies - see separate guideline for these formularies. No other changes to guideline.

Praluent



Prior Authorization Guideline

Guideline ID	GL-558194
Guideline Name	Praluent
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

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:Praluent	
Diagnosis	Primary Hyperlipidemia (including HeFH), ASCVD and ASCVD prevention
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: • Diagnosis of heterozygous familial hypercholesterolemia (HeFH) • Diagnosis of atherosclerotic cardiovascular disease (ASCVD) (e.g., acute coronary syndromes, history of myocardial infarction, stable or unstable angina, coronary or other arterial revascularization, stroke, transient ischemic attack, or peripheral arterial disease presumed to be of atherosclerotic origin) • Diagnosis of primary hyperlipidemia • Patient is at increased risk for a major adverse cardiovascular (CV) event (CV death, myocardial infarction, stroke, unstable angina requiring hospitalization, or coronary revascularization) but without established cardiovascular disease AND 2 - Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following (prescription claims history may be used in conjunction as documentation of medication use, dose, and duration): 2.1 Patient has been receiving at least 12 consecutive weeks of high-intensity statin therapy [i.e., atorvastatin 40-80 milligrams (mg), rosuvastatin 20-40 mg] and will continue to receive high intensity statin at maximally tolerated dose OR 2.2 BOTH of the following: 2.2.1 Patient is unable to tolerate high-intensity statin as evidenced by ONE of the following intolerable and persistent (i.e., more than 2 weeks) symptoms: • Myalgia [muscle symptoms without creatine kinase (CK) elevations] • Myositis [muscle symptoms with CK elevations less than 10 times upper limit of normal (ULN)] AND	

2.2.2 Patient has been receiving at least 12 consecutive weeks of low-intensity or moderate-intensity statin therapy [i.e., atorvastatin 10-20 mg, rosuvastatin 5-10 mg, simvastatin greater than or equal to 10 mg, pravastatin greater than or equal to 10 mg, lovastatin 20-40 mg, fluvastatin XL 80 mg, fluvastatin 20-40 mg up to 40 mg twice daily, or Livalo (pitavastatin) greater than or equal to 1 mg] and will continue to receive a low-intensity or moderate-intensity statin at maximally tolerated dose

OR

2.3 Patient is unable to tolerate low- or moderate-, and high-intensity statins as evidenced by ONE of the following:

2.3.1 ONE of the following intolerable and persistent (i.e., more than 2 weeks) symptoms for low or moderate-, and high-intensity statins:

- Myalgia (muscle symptoms without CK elevations)
- Myositis (muscle symptoms with CK elevations less than 10 times ULN)

OR

2.3.2 Patient has a contraindication to all statins as documented in medical records

OR

2.3.3 Patient has experienced rhabdomyolysis or muscle symptoms with statin treatment with CK elevations greater than 10 times ULN

AND

3 - Submission of medical records (e.g., laboratory values) documenting LDL-C greater than or equal to 55 mg/dL

AND

4 - Prescribed by ONE of the following:

- Cardiologist
- Endocrinologist

- Lipid specialist

AND

5 - Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor [e.g., Lerochol (Ierodalcibep-liga), Repatha (evolocumab)]

AND

6 - Not used in combination with Leqvio (inclisiran)

AND

7 - If the request is for a non-preferred* product, ONE of the following:

7.1 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

7.2 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	*PDL links in Background

Product Name:Praluent	
Diagnosis	Primary Hyperlipidemia (including HeFH), ASCVD and ASCVD prevention
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Prescribed by ONE of the following:

- Cardiologist
- Endocrinologist
- Lipid specialist

AND

2 - Submission of medical records (e.g., chart notes, laboratory values) documenting low density lipoprotein cholesterol (LDL-C) reduction while on Praluent therapy

AND

3 - Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor [e.g., Lerochol (Ierodalcibep-liga), Repatha (evolocumab)]

AND

4 - Not used in combination with Leqvio (inclisiran)

Product Name:Praluent	
Diagnosis	Homozygous Familial Hypercholesterolemia (HoFH)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of homozygous familial hypercholesterolemia (HoFH) as confirmed by submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following:	

1.1 Submission of medical records (e.g., chart notes, laboratory values) confirming genetic confirmation of bi-allelic pathogenic/likely pathogenic variants on different chromosomes at the low-density lipoprotein receptor (LDLR), apolipoprotein B (APOB), proprotein convertase subtilisin kexin type 9 (PCSK9), or low-density lipoprotein receptor adaptor protein 1 (LDLRAP1) genes or greater than or equal to 2 such variants at different loci

OR

1.2 BOTH of the following:

1.2.1 Untreated low density lipoprotein cholesterol (LDL-C) greater than 400mg/dL

AND

1.2.2 ONE of the following:

- Xanthoma before 10 years of age
- Evidence of familial hypercholesterolemia in at least one parent

AND

2 - Prescribed by ONE of the following:

- Cardiologist
- Endocrinologist
- Lipid specialist

AND

3 - Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor [e.g., Repatha (evolocumab)]

AND

4 - Not used in combination with Juxtapid (lomitapide)

AND

5 - If the request is for a non-preferred* product, ONE of the following:

5.1 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

5.2 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	*PDL links in Background

Product Name:Praluent

Diagnosis	Homozygous Familial Hypercholesterolemia (HoFH)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Prescribed by ONE of the following:

- Cardiologist
- Endocrinologist
- Lipid specialist

AND

2 - Submission of medical records (e.g., chart notes, laboratory values) documenting low density lipoprotein cholesterol (LDL-C) reduction while on Praluent therapy

AND

3 - Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor [e.g., Repatha (evolocumab)]

AND

4 - Not used in combination with Juxtapid (lomitapide)

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>

NM: <https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html>

NY: <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>

3 . Revision History

Date	Notes
3/25/2026	Added ASCVD prevention. Removed verification patient is receiving other lipid lowering therapy from HoFH

Preferred Non-Solid Dosage Forms



Prior Authorization Guideline

Guideline ID	GL-560218
Guideline Name	Preferred Non-Solid Dosage Forms
Formulary	Medicaid - Community & State Rhode Island

Guideline Note:

Effective Date:	5/1/2026

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 Food and Drug Administration (FDA)-approved indication	

OR

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

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex
- Clinical pharmacology
- United States Pharmacopeia-National Formulary (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 The patient has history of failure or inadequate response to at least THREE generic or preferred solid oral dosage forms as confirmed by claims history or submission of medical records. NOTE: In instances where there are fewer than three generic or preferred alternatives, the patient must have a history of failure to all of the generic or preferred products

OR

3.1.2.2 The patient has a history of contraindication, side effect, or intolerance to THREE generic or preferred solid oral dosage forms (please specify contraindication or intolerance).

NOTE: In instances where there are fewer than three generic or preferred alternatives, the patient must have a history of contraindication or intolerance to all of the generic or preferred products

OR

3.1.2.3 There are no generic or 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 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

Notes	*PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/rhode-island-health-plans/ri-comm-plan-home/ri-cp-pharmacy.html . Prior trials of generic or formulary/PDL alternatives must sufficiently demonstrate that the generic or formulary/PDL alternatives are either ineffective or inappropriate at the time of the request.

2 . Revision History

Date	Notes
3/30/2026	Updated trial and failure language to match policy.

Presbyopia



Prior Authorization Guideline

Guideline ID	GL-467208
Guideline Name	Presbyopia
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 Pennsylvania Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name: Qlosi, Vizz, Brand Vuity, generic pilocarpine 1.25% ophthalmic solution	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of presbyopia AND 2 - ONE of the following: • For Qlosi: Patient is between the ages of 45 to 64 • For Vizz: Patient is between ages of 45 to 75 • For Vuity: Patient is between the ages of 40 to 55 AND 3 - Patient is unable to use corrective lens (e.g., glasses, contacts) (document medical rationale why patient is unable to use corrective lenses) AND 4 - Prescribed by ONE of the following: • Optometrist • Ophthalmologist	

Product Name:Qlosi, Vizz, Brand Vuity, generic pilocarpine 1.25% ophthalmic solution	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Documentation of positive clinical response to therapy

AND

2 - ONE of the following:

- For Qlosi: Age less than 64
- For Vizz: Age less than 75
- For Vuity: Age less than 55

AND

3 - Prescribed by ONE of the following:

- Optometrist
- Ophthalmologist

2 . Revision History

Date	Notes
12/10/2025	Updated GL name to Presbyopia. Added Vizz as a target and updated GPIs and product name list. Updated initial and reauth criteria.

Pretomanid



Prior Authorization Guideline

Guideline ID	GL-442201
Guideline Name	Pretomanid
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 New Mexico Medicaid - Community & State Nevada

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Pretomanid	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following: 1.1 Diagnosis of pulmonary extensively drug resistant (XDR) tuberculosis (TB) OR 1.2 Treatment-intolerant or nonresponsive multidrug-resistant (MDR) tuberculosis (TB) AND 2 - Pretomanid will be used in combination with bedaquiline and linezolid	

2 . Revision History

Date	Notes
11/6/2025	Added Nevada Formulary

Prevymis



Prior Authorization Guideline

Guideline ID	GL-435235
Guideline Name	Prevymis
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 Nebraska Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	1/1/2026

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 to both of the following: • Prevydis will be initiated between Day 0 and Day 28 post-transplantation (before or after engraftment) • Prevydis 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 to both of the following:

- Prevymis will be initiated between Day 0 and Day 7 post-transplantation (before or after engraftment)
- Prevymis is being prescribed as prophylaxis and not treatment of CMV infection

2 . Revision History

Date	Notes
11/3/2025	Updated formatting of attestations. Combined VA, NE, NM formularies. Added NV 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-577265
Guideline Name	Progesterone - Non-Oral
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 Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Crinone, Brad 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	Removed NV from formularies, see GL-577266 for NV specific guideline. Added generic progesterone vaginal insert.

Progesterone - Oral



Prior Authorization Guideline

Guideline ID	GL-442204
Guideline Name	Progesterone - Oral
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State New Jersey Medicaid - Community & State New York Medicaid - Community & State New York EPP Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Arizona Medicaid - Community & State New Mexico Medicaid - Community & State Nebraska Medicaid - Community & State Nevada

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name: Brand Prometrium, generic progesterone caps	
Approval Length	12 month(s)

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following: • Amenorrhea • Endometrial hyperplasia or prevention of endometrial hyperplasia • Abnormal uterine or vaginal bleeding • History of preterm birth • Prevention of preterm delivery for current pregnancy	

2 . Revision History

Date	Notes
11/6/2025	Added Nevada Formulary

Promacta, Alvaiz



Prior Authorization Guideline

Guideline ID	GL-485189
Guideline Name	Promacta, Alvaiz
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 Michigan Medicaid - Community & State Virginia Medicaid - Community & State Nevada

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Promacta, generic eltrombopag, Alvaiz

Diagnosis	Chronic Immune Thrombocytopenia (ITP)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chronic idiopathic thrombocytopenic purpura (ITP) AND 2 - ONE of the following: 2.1 Failure to at least ONE of the following as confirmed by claims history or submission of medical records: • Corticosteroids • Immunoglobulins • Splenectomy OR 2.2 History of contraindication or intolerance to ALL of the following (please specify intolerance or contraindication): • Corticosteroids • Immunoglobulins • Splenectomy AND 3 - If the request is for Alvaiz, ONE of the following: 3.1 Failure to eltrombopag (generic Promacta) as confirmed by claims history or submission of medical records OR	

3.2 History of contraindication or intolerance to eltrombopag (generic Promacta) (please specify intolerance or contraindication)

AND

4 - If the request is for Promacta powder for oral suspension, 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

Product Name:Brand Promacta, generic eltrombopag, Alvaiz	
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 Promacta (eltrombopag) or Alvaiz therapy	

Product Name:Brand Promacta, generic eltrombopag, Alvaiz	
Diagnosis	Chronic Hepatitis C-Associated Thrombocytopenia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic hepatitis C-associated thrombocytopenia

AND

2 - ONE of the following:

- Planning to initiate and maintain interferon-based treatment
- Currently receiving interferon-based treatment

AND

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

3.1 Failure to eltrombopag (generic Promacta) as confirmed by claims history or submission of medical records

OR

3.2 History of contraindication or intolerance to eltrombopag (generic Promacta) (please specify intolerance or contraindication)

AND

4 - If the request is for Promacta powder for oral suspension, 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

Product Name: Brand Promacta, generic eltrombopag, Alvaiz	
Diagnosis	Chronic Hepatitis C-Associated Thrombocytopenia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Promacta (eltrombopag) or Alvaiz therapy AND 2 - Patient is currently on antiviral interferon therapy for treatment of chronic hepatitis C	

Product Name: Brand Promacta, generic eltrombopag, Alvaiz	
Diagnosis	Aplastic Anemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of severe aplastic anemia AND 2 - ONE of the following:	

2.1 Used in combination with standard immunosuppressive therapy [e.g., Atgam (antithymocyte globulin equine), Thymoglobulin (antithymocyte globulin rabbit), cyclosporine]

OR

2.2 History of failure, contraindication, or intolerance to at least one course of immunosuppressive therapy [e.g., Atgam (antithymocyte globulin equine), Thymoglobulin (antithymocyte globulin rabbit), cyclosporine]

AND

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

3.1 Failure to eltrombopag (generic Promacta) as confirmed by claims history or submission of medical records

OR

3.2 History of contraindication or intolerance to eltrombopag (generic Promacta) (please specify intolerance or contraindication)

AND

4 - If the request is for Promacta powder for oral suspension, 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

Product Name:Brand Promacta, generic eltrombopag, Alvaiz	
Diagnosis	Aplastic Anemia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Promacta (eltrombopag) or Alvaiz therapy	

Product Name:Brand Promacta, generic eltrombopag, Alvaiz	
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 Promacta, generic eltrombopag, Alvaiz	
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
12/18/2025	Removed IN from formularies - see state specific GL-475187 for IN 1 .1.26. No other changes to guideline.

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

Pyrukynd



Prior Authorization Guideline

Guideline ID	GL-150402
Guideline Name	Pyrukynd
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

Guideline Note:

Effective Date:	8/1/2024

1 . Criteria

Product Name:Pyrukynd Taper Pack, Pyrukynd	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of pyruvate kinase (PK) deficiency based on ALL of the following:

1.1 Presence of at least 2 variant alleles in the pyruvate kinase liver and red blood cell (PKLR) gene, of which at least 1 is a missense variant

AND

1.2 Patient is not homozygous for the c.1436G > A (p.R479H) variant

AND

1.3 Patient does not have 2 non-missense variants (without the presence of another missense variant) in the PKLR gene

AND

2 - Used for the treatment of hemolytic anemia

AND

3 - ONE of the following:

3.1 BOTH of the following:

3.1.1 Baseline hemoglobin less than or equal to 10 grams/deciliter (g/dL)

AND

3.1.2 Patient has had no more than 4 transfusions in the previous 52 weeks and no transfusions in the preceding 3-month period

OR

3.2 Patient has had a minimum of 6 transfusion episodes in the preceding 52 weeks

AND

4 - Prescribed by a nephrologist or hematologist

Product Name:Pyrukynd Taper Pack, Pyrukynd	
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following*: 1.1 Documentation of positive clinical response to Pyrukynd therapy AND 1.2 Prescribed by, or in consultation with, a nephrologist or hematologist OR 2 - Documentation does not provide evidence of positive clinical response to Pyrukynd therapy, allow for dose titration with discontinuation of therapy**	
Notes	*If criteria is met under step 1, authorization length is 12 months. **If criteria is met under step 2, authorization length is 4 weeks.

2 . Revision History

Date	Notes
7/24/2024	Updated initial approval duration from 6 months to 12 months. Simplified reauthorization criteria.

Pyrukynd



Prior Authorization Guideline

Guideline ID	GL-150402
Guideline Name	Pyrukynd
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

Guideline Note:

Effective Date:	8/1/2024

1 . Criteria

Product Name:Pyrukynd Taper Pack, Pyrukynd	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of pyruvate kinase (PK) deficiency based on ALL of the following:

1.1 Presence of at least 2 variant alleles in the pyruvate kinase liver and red blood cell (PKLR) gene, of which at least 1 is a missense variant

AND

1.2 Patient is not homozygous for the c.1436G > A (p.R479H) variant

AND

1.3 Patient does not have 2 non-missense variants (without the presence of another missense variant) in the PKLR gene

AND

2 - Used for the treatment of hemolytic anemia

AND

3 - ONE of the following:

3.1 BOTH of the following:

3.1.1 Baseline hemoglobin less than or equal to 10 grams/deciliter (g/dL)

AND

3.1.2 Patient has had no more than 4 transfusions in the previous 52 weeks and no transfusions in the preceding 3-month period

OR

3.2 Patient has had a minimum of 6 transfusion episodes in the preceding 52 weeks

AND

4 - Prescribed by a nephrologist or hematologist

Product Name:Pyrukynd Taper Pack, Pyrukynd	
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following*: 1.1 Documentation of positive clinical response to Pyrukynd therapy AND 1.2 Prescribed by, or in consultation with, a nephrologist or hematologist OR 2 - Documentation does not provide evidence of positive clinical response to Pyrukynd therapy, allow for dose titration with discontinuation of therapy**	
Notes	*If criteria is met under step 1, authorization length is 12 months. **If criteria is met under step 2, authorization length is 4 weeks.

2 . Revision History

Date	Notes
7/24/2024	Updated initial approval duration from 6 months to 12 months. Simplified reauthorization criteria.

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.

Qfitlia



Prior Authorization Guideline

Guideline ID	GL-402269
Guideline Name	Qfitlia
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

Guideline Note:

Effective Date:	11/1/2025

1 . Criteria

Product Name:Qfitlia	
Diagnosis	Hemophilia A with Inhibitors
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of hemophilia A AND 2 - Patient has developed high-titer factor VIII inhibitors (i.e., patient has developed factor VIII inhibitors greater than or equal to 5 Bethesda units [BU]) AND 3 - Patient is 12 years of age or older AND 4 - Qfitlia is prescribed for the prevention of bleeding episodes (i.e., routine prophylaxis)	

Product Name:Qfitlia	
Diagnosis	Hemophilia A without Inhibitors
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of hemophilia A AND	

2 - Patient has not developed high-titer factor VIII inhibitors (i.e., patient has NOT developed factor VIII inhibitors greater than or equal to 5 Bethesda units [BU])

AND

3 - Patient is 12 years of age or older

AND

4 - Qfitlia is prescribed for the prevention of bleeding episodes (i.e., routine prophylaxis)

Product Name:Qfitlia	
Diagnosis	Hemophilia B with Inhibitors
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of hemophilia B

AND

2 - Patient has developed high-titer factor IX inhibitors (i.e., patient has developed factor IX inhibitors greater than or equal to 5 Bethesda units [BU])

AND

3 - Patient is 12 years of age or older

AND

4 - Qfitlia is prescribed for the prevention of bleeding episodes (i.e., routine prophylaxis)

Product Name:Qfitlia	
Diagnosis	Hemophilia B without Inhibitors
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of hemophilia B AND 2 - Patient has not developed high-titer factor IX inhibitors (i.e., patient has NOT developed factor IX inhibitors greater than or equal to 5 Bethesda units [BU]) AND 3 - Patient is 12 years of age or older AND 4 - Qfitlia is prescribed for the prevention of bleeding episodes (i.e., routine prophylaxis)	

Product Name:Qfitlia	
Diagnosis	Hemophilia A with Inhibitors, Hemophilia A without Inhibitors, Hemophilia B with Inhibitors, Hemophilia B without Inhibitors
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Qfitlia therapy

2 . Revision History

Date	Notes
10/1/2025	Updated criteria. Clarified high titer inhibitor criteria.

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-442207
Guideline Name	Quantity Limits
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

Guideline Note:

Effective Date:	1/1/2026

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
11/6/2025	Added Nevada Formulary

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

Ravicti



Prior Authorization Guideline

Guideline ID	GL-442210
Guideline Name	Ravicti
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State Nebraska Medicaid - Community & State New Jersey Medicaid - Community & State New Mexico Medicaid - Community & State New York Medicaid - Community & State New York EPP Medicaid - Community & State Pennsylvania 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:Ravicti

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of urea cycle disorders (UCDs) AND 2 - Patient does not have N-acetylglutamate synthase (NAGS) deficiency AND 3 - Inadequate response to ONE of the following: • Dietary protein restriction • Amino acid supplementation AND 4 - Will be used concomitantly with dietary protein restriction and, in some cases, dietary supplements (e.g., essential amino acids, arginine, citrulline, protein-free calorie supplements) AND 5 - ONE of the following: 5.1 BOTH of the following: 5.1.1 Failure to sodium phenylbutyrate (Buphenyl) as confirmed by claims history or submission of medical records* AND	

5.1.2 Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following while on sodium phenylbutyrate

- Fasting ammonia level greater than 0.5 ULN
- Any ammonia level (fasting/non-fasting) above the ULN

OR

5.2 History of intolerance or contraindication to sodium phenylbutyrate (Buphenyl) (please specify contraindication or intolerance)*

OR

5.3 Patient is currently on Ravicti therapy

Notes	*UHC generally does not consider frequency of dosing and/or lack of compliance to dosing regimens an indication of medical necessity

Product Name: Ravicti

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Ravicti therapy

AND

2 - Patient is actively on dietary protein restriction and, in some cases, dietary supplements (e.g., essential amino acids, arginine, citrulline, protein-free calorie supplements)

2 . Revision History

UnitedHealthcare Community Plan of Rhode Island Clinical Pharmacy Program Guidelines

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 Rhode Island 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.

Repatha



Prior Authorization Guideline

Guideline ID	GL-558215
Guideline Name	Repatha
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

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name: Repatha	
Diagnosis	Primary Hyperlipidemia (including HeFH), ASCVD, ASCVD prevention
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: • Diagnosis of heterozygous familial hypercholesterolemia (HeFH) • Diagnosis of atherosclerotic cardiovascular disease (ASCVD) (e.g., acute coronary syndromes, history of myocardial infarction, stable or unstable angina, coronary or other arterial revascularization, stroke, transient ischemic attack, or peripheral arterial disease presumed to be of atherosclerotic origin) • Diagnosis of primary hyperlipidemia • Patient is at increased risk for a major adverse cardiovascular (CV) event (CV death, myocardial infarction, stroke, unstable angina requiring hospitalization, or coronary revascularization) but without established cardiovascular disease AND 2 - Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following (prescription claims history may be used in conjunction as documentation of medication use, dose, and duration): 2.1 Patient has been receiving at least 12 consecutive weeks of high-intensity statin therapy (i.e., atorvastatin 40-80 mg, rosuvastatin 20-40 mg) and will continue to receive high-intensity statin at maximally tolerated dose OR 2.2 BOTH of the following: 2.2.1 Patient is unable to tolerate high-intensity statin as evidenced by ONE of the following intolerable and persistent (i.e., more than 2 weeks) symptoms: • Myalgia [muscle symptoms without creatine kinase (CK) elevations] • Myositis [muscle symptoms with CK elevations less than 10 times upper limit of normal (ULN)] AND	

2.2.2 Patient has been receiving at least 12 consecutive weeks of low-intensity or moderate-intensity statin therapy [i.e., atorvastatin 10-20 mg, rosuvastatin 5-10 mg, simvastatin greater than or equal to 10 mg, pravastatin greater than or equal to 10 mg, lovastatin 20-40 mg, fluvastatin XL 80 mg, fluvastatin 20-40 mg up to 40 mg twice daily or Livalo (pitavastatin) greater than or equal to 1 mg] and will continue to receive a low-intensity or moderate-intensity statin at maximally tolerated dose

OR

2.3 Patient is unable to tolerate low- or moderate-, and high-intensity statins as evidenced by ONE of the following:

2.3.1 ONE of the following intolerable and persistent (i.e., more than 2 weeks) symptoms for low- or moderate-, and high-intensity statins:

- Myalgia (muscle symptoms without CK elevations)
- Myositis [muscle symptoms with CK elevations less than 10 times upper limit of normal (ULN)]

OR

2.3.2 Patient has a contraindication to all statins as confirmed by medical records

OR

2.3.3 Patient has experienced rhabdomyolysis or muscle symptoms with statin treatment with CK elevations greater than 10 times ULN

AND

3 - Submission of medical records (e.g., laboratory values) documenting a LDL-C greater than or equal 55 mg/dL

AND

4 - Prescribed by ONE of the following:

- Cardiologist

- Endocrinologist
- Lipid specialist

AND

5 - Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor [e.g., Lerobol (lerodalcibep-liga), Praluent (alirocumab)]

AND

6 - Not used in combination with Leqvio (inclisiran)

Product Name: Repatha	
Diagnosis	Primary Hyperlipidemia (including heterozygous familial hypercholesterolemia), ASCVD, ASCVD prevention
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Prescribed by ONE of the following: • Cardiologist • Endocrinologist • Lipid specialist AND 2 - Submission of medical records (e.g. chart notes, laboratory values) documenting LDL-C (low-density lipoprotein cholesterol) reduction while on Repatha therapy AND	

3 - Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor [e.g., Lerochol (lerodalcibep-liga), Praluent (alirocumab)]

AND

4 - Not used in combination with Leqvio (inclisiran)

Product Name: Repatha	
Diagnosis	Homozygous Familial Hypercholesterolemia (HoFH)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of homozygous familial hypercholesterolemia (HoFH) as confirmed by submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following: 1.1 Genetic confirmation of bi-allelic pathogenic/likely pathogenic variants on different chromosomes at the low-density lipoprotein receptor (LDLR), apolipoprotein B (APOB), proprotein convertase subtilisin kexin type 9 (PCSK9), or low-density lipoprotein receptor adaptor protein 1 (LDLRAP1) genes or 2 or more such variants at different loci OR 1.2 BOTH of the following: 1.2.1 Untreated LDL-C (low-density lipoprotein cholesterol) greater than 400 mg/dL AND 1.2.2 ONE of the following: • Xanthoma before 10 years of age	

- Evidence of familial hypercholesterolemia in at least one parent

AND

2 - Prescribed by ONE of the following:

- Cardiologist
- Endocrinologist
- Lipid specialist

AND

3 - Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor [e.g., Praluent (alirocumab)]

AND

4 - Not used in combination with Juxtapid (lomitapide)

Product Name: Repatha	
Diagnosis	Homozygous Familial Hypercholesterolemia (HoFH)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes, laboratory values) documenting LDL-C (low-density lipoprotein cholesterol) reduction while on Repatha therapy AND 2 - Prescribed by ONE of the following:	

- Cardiologist
- Endocrinologist
- Lipid Specialist

AND

3 - Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor [e.g., Praluent (alirocumab)]

AND

4 - Not used in combination with Juxtapid (lomitapide)

2 . Revision History

Date	Notes
3/25/2026	Added Lerochol to list of PCSK9 inhibitor examples

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

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.

Reyvow



Prior Authorization Guideline

Guideline ID	GL-507195
Guideline Name	Reyvow
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State New Jersey Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Reyvow	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Used for acute treatment of migraine

AND

2 - Patient is 18 years of age or older

AND

3 - ONE of the following:

3.1 Failure (after at least 3 migraine episodes and a minimum of a 30-day trial), to BOTH of the following as confirmed by claims history or submission of medical records:

3.1.1 TWO of the following:

- eletriptan (generic Relpax)
- naratriptan (generic Amerge)
- rizatriptan (generic Maxalt/Maxalt MLT)
- sumatriptan (generic Imitrex)
- zolmitriptan (generic Zomig)

AND

3.1.2 ONE of the following:

- Nurtec ODT
- Ubrelvy

OR

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

- eletriptan (generic Relpax)
- naratriptan (generic Amerge)
- rizatriptan (generic Maxalt/Maxalt MLT)
- sumatriptan (generic Imitrex)
- zolmitriptan (generic Zomig)
- Nurtec ODT

- Ubrelvy

AND

4 - Prescriber attests to BOTH of the following:

4.1 Patient has been informed the use of Reyvow may result in significant CNS (central nervous system) impairment, and may impact the patient's ability to drive or operate machinery for 8 hours after each dose

AND

4.2 If used concurrently with a benzodiazepine or other drugs that could potentially cause CNS depression, the prescriber has acknowledged that they have completed an assessment of increased risk for sedation and other cognitive and/or neuropsychiatric adverse events

AND

5 - ONE of the following:

5.1 Patient is currently treated with ONE of the following prophylactic therapies:

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

OR

5.2 Patient has less than 4 migraine days per month

OR

5.3 Patient has greater than or equal to 4 migraine days per month and has contraindication or intolerance to TWO of the following prophylactic therapies:

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

Notes

*Timolol, candesartan, Aimovig, and Qulipta are non-preferred

**Vyepti and OnabotulinumtoxinA (generic Botox) are medical benefits

***CGRP antagonists for preventive treatment of migraines require a prior authorization.

Product Name:Reyvow

Approval Length 12 month(s)

Therapy Stage Reauthorization

Guideline Type Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

2 . Revision History

Date Notes

1/22/2026 Remove NY

Rezdiffra



Prior Authorization Guideline

Guideline ID	GL-589190
Guideline Name	Rezdiffra
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 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:Rezdiffra	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of metabolic dysfunction-associated steatohepatitis (MASH) [formerly known as nonalcoholic steatohepatitis (NASH)] AND 2 - Submission of medical records documenting that disease is fibrosis stage F2 or F3 as confirmed by ONE of the following: 2.1 Liver stiffness measurement (LSM) by vibration-controlled transient elastography (VCTE) (e.g., FibroScan) OR 2.2 LSM by magnetic resonance elastography (MRE) OR 2.3 Liver biopsy within the past 12 months AND 3 - Patient has received comprehensive counseling regarding lifestyle modification (e.g., dietary or caloric restriction, exercise, behavioral support, community-based program) AND 4 - Provider attests Rezdiffra will not be initiated at the same time as Wegovy (semaglutide)	

AND

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

- Gastroenterologist
- Hepatologist

Product Name:Rezdiffra

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Rezdiffra therapy (e.g., improvement in or stabilization of fibrosis)

AND

2 - Patient has NOT progressed to cirrhosis

AND

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

- Gastroenterologist
- Hepatologist

2 . Revision History

Date	Notes

UnitedHealthcare Community Plan of Rhode Island Clinical Pharmacy Program Guidelines

4/20/2026	Updated formularies to add ACUPA for eff 6/1/2026.

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.

Rhapsido



Prior Authorization Guideline

Guideline ID	GL-594193
Guideline Name	Rhapsido
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 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:Rhapsido	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chronic spontaneous urticaria AND 2 - ONE of the following: 2.1 Patient remains symptomatic despite at least a 2-week trial of, or history of contraindication or intolerance to, TWO H1-antihistamines [e.g., Allegra (fexofenadine), Benadryl (diphenhydramine), Claritin (loratadine)]* (confirmed by claims history or submitted medical records) OR 2.2 Patient remains symptomatic despite at least a 2-week trial and failure of BOTH of the following taken in combination (confirmed by claims history or submitted medical records): 2.2.1 A second generation H1-antihistamine [e.g., Allegra (fexofenadine), Claritin (loratadine), Zyrtec (cetirizine)] AND 2.2.2 ONE of the following: • A different second generation H1-antihistamine [e.g., Allegra (fexofenadine), Claritin (loratadine), Zyrtec (cetirizine)] • A first generation H1-antihistamine [e.g., Benadryl (diphenhydramine), Chlor-Trimeton (chlorpheniramine), Vistaril (hydroxyzine)]* • An H2-antihistamine [e.g., Pepcid (famotidine), Tagamet HB (cimetidine), Zantac (ranitidine)] • A leukotriene modifier [e.g., Singulair (montelukast)]	

OR

2.3 History of contraindication or intolerance to ONE of the following (please specify contraindication or intolerance):

2.3.1 TWO H1-antihistamines [e.g., Allegra (fexofenadine), Benadryl (diphenhydramine), Claritin (loratadine)]*

OR

2.3.2 BOTH of the following taken in combination:

2.3.2.1 A second generation H1-antihistamine [e.g., Allegra (fexofenadine), Claritin (loratadine), Zyrtec (cetirizine)]

AND

2.3.2.2 ONE of the following:

- A different second generation H1-antihistamine [e.g., Allegra (fexofenadine), Claritin (loratadine), Zyrtec (cetirizine)]
- A first generation H1-antihistamine [e.g., Benadryl (diphenhydramine), Chlor-Trimeton (chlorpheniramine), Vistaril (hydroxyzine)]*
- An H2-antihistamine [e.g., Pepcid (famotidine), Tagamet HB (cimetidine), Zantac (ranitidine)]
- A leukotriene modifier [e.g., Singulair (montelukast)]

AND

3 - Patient is not receiving Rhapsodo in combination with Dupixent (dupilumab) or Xolair (omalizumab) for treatment of the same indication

AND

4 - Prescribed by ONE of the following:

- Allergist
- Dermatologist

Immunologist	
Notes	* Patients 65 years of age and older in whom first generation H1-antihistamines are considered high risk medications to be avoided [e.g., Beers criteria, HEDIS (Healthcare Effectiveness Data and Information Set)] should be directed to try alternatives that are not considered high risk

Product Name:Rhapsido	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Rhapsido therapy (e.g., reduction in exacerbations, itch severity, hives) AND 2 - Patient is not receiving Rhapsido in combination with Dupixent (dupilumab) or Xolair (omalizumab) for treatment of the same indication AND 3 - Prescribed by ONE of the following: - Allergist - Dermatologist - Immunologist	

2 . Revision History

Date	Notes

4/22/2026	Added PACAID. Expanded on HEDIS abbreviation, with no changes to clinical intent. Minor cosmetic updates.

Rinvoq



Prior Authorization Guideline

Guideline ID	GL-518200
Guideline Name	Rinvoq
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 New Mexico

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name:Rinvoq	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active rheumatoid arthritis (RA)

AND

2 - ONE of the following:

2.1 ALL of the following:

2.1.1 ONE of the following:

- Failure to a 3 month trial of ONE non-biologic disease modifying anti-rheumatic drug (DMARD) (e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine) at maximally indicated doses as confirmed by claims history or submission of medical records
- History of intolerance or contraindication to ONE non-biologic DMARD (e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine) (please specify intolerance or contraindication)
- Patient has been previously treated with a systemic targeted immunomodulator FDA-approved for the treatment of rheumatoid arthritis as confirmed by claims history or submission of medical records [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Orencia (abatacept), Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib)]

AND

2.1.2 ONE of the following:

2.1.2.1 Failure to ALL of the following as confirmed by claims history or submission of medical records:

- Enbrel (etanercept)
- One of the preferred adalimumab products*
- Tyenne (tocilizumab-aazg)

OR

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

- Enbrel (etanercept)
- One of the preferred adalimumab products*
- Tyenne (tocilizumab-aazg)

OR

2.1.2.3 Patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-V-TR 300.29 for specific phobia diagnostic criteria)

AND

2.1.3 ONE of the following:

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

OR

2.2 Patient is currently on Rinvoq therapy as confirmed by claims history or submission of medical records

AND

3 - Patient is NOT receiving Rinvoq in combination with either of the following:

- Systemic targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Orencia (abatacept), Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib)] for treatment of the same indication
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)

AND

4 - Prescribed by or in consultation with a rheumatologist

Notes	*See Table 2 in Background for PDL links.

Product Name: Rinvoq, Rinvoq LQ	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of active psoriatic arthritis AND 2 - ONE of the following: 2.1 BOTH of the following: 2.1.1 ONE of the following: • Failure to a 3 month trial of methotrexate at maximally indicated dose as confirmed by claims history or submission of medical records • History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication) • Patient has been previously treated with a systemic targeted immunomodulator FDA-approved for the treatment of psoriatic arthritis as confirmed by claims history or submission of medical records [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Orencia (abatacept), Otezla (apremilast), Simponi (golimumab), Skyrizi (risankizumab), Taltz (ixekizumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), ustekinumab] AND 2.1.2 ONE of the following: 2.1.2.1 BOTH of the following: 2.1.2.1.1 ONE of the following: 2.1.2.1.1.1 Failure to TWO of the following as confirmed by claims history or submission of medical records:	

- One of the preferred adalimumab products*
- Enbrel (etanercept)
- One of the preferred ustekinumab products*

OR

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

- One of the preferred adalimumab products*
- Enbrel (etanercept)
- One of the preferred ustekinumab products*

AND

2.1.2.1.2 ONE of the following:

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

OR

2.1.2.2 Patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-V-TR 300.29 for specific phobia diagnostic criteria)

OR

2.2 Patient is currently on Rinvoq or Rinvoq LQ therapy as confirmed by claims history or submission of medical records

AND

3 - Patient is NOT receiving Rinvoq or Rinvoq LQ in combination with either of the following:

- Systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Orencia (abatacept), Otezla (apremilast), Simponi (golimumab), Skyrizi (risankizumab), Taltz (ixekizumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), ustekinumab] for treatment of the same indication
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)

AND

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

- Rheumatologist
- Dermatologist

Notes

*See Table 2 in Background for PDL links.

Product Name: Rinvoq

Diagnosis Atopic Dermatitis

Approval Length 12 month(s)

Therapy Stage Initial Authorization

Guideline Type Prior Authorization

Approval Criteria

1 - Diagnosis of moderate-to-severe chronic atopic dermatitis

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 TWO of the following therapeutic classes of topical therapies, as confirmed by claims history or submission of medical records:

- One medium to very-high potency topical corticosteroid [e.g., mometasone furoate (generic Elocon), fluocinolone acetonide (generic Synalar), fluocinonide (generic Lidex)] (see Table 1 in Background)
- One topical calcineurin inhibitor [e.g., pimecrolimus (generic Elidel), tacrolimus (generic Protopic)]
- Eucrisa (crisaborole)

OR

2.1.1.2 History of intolerance or contraindication to ALL of the following therapeutic classes of topical therapies (please specify intolerance or contraindication):

- One medium to very-high potency topical corticosteroid [e.g., mometasone furoate (generic Elocon), fluocinolone acetonide (generic Synalar), fluocinonide (generic Lidex)] (see Table 1 in Background)
- One topical calcineurin inhibitor [e.g., pimecrolimus (generic Elidel), tacrolimus (generic Protopic)]
- Eucrisa (crisaborole)

AND

2.1.2 ONE of the following:

2.1.2.1 BOTH of the following:

- Submission of medical records (e.g., chart notes, laboratory values) documenting a 3 month trial of a systemic drug product for the treatment of atopic dermatitis [e.g., Adbry (tralokinumab-ldrm), Dupixent (dupilumab), Ebglyss (lebrikizumab-lbkz), Nemluvio (nemolizumab-ilto), cyclosporine, azathioprine, methotrexate, mycophenolate mofetil, etc.]
- Physician attests that the patient was not adequately controlled with the documented systemic drug product

OR

2.1.2.2 Physician attests that systemic treatment with ALL of the following FDA-approved atopic dermatitis therapies is inadvisable (document drug and contraindication rationale):

- Adbry (tralokinumab-ldrm)

- Dupixent (dupilumab)
- Ebglyss (lebrikizumab-lbkz)
- Nemluvio (nemolizumab-ilto)

OR

2.1.2.3 Patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure [refer to Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition Text Revision (DSM-V-TR) 300.29 for specific phobia diagnostic criteria]

OR

2.2 Patient is currently on Rinvoq therapy as confirmed by claims history or submission of medical records

AND

3 - Patient is NOT receiving Rinvoq in combination with either of the following:

- Systemic targeted immunomodulator [e.g., Adbry (tralokinumab-ldrm), Dupixent (dupilumab), Cibinqo (abrocitinib), Ebglyss (lebrikizumab-lbkz), Nemluvio (nemolizumab-ilto), Xeljanz/XR (tofacitinib), Olumiant (baricitinib), Opzelura (topical ruxolitinib)] for treatment of the same indication
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

AND

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

- Dermatologist
- Allergist
- Immunologist

Product Name:Rinvoq	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderately to severely active ulcerative colitis (UC) AND 2 - ONE of the following: 2.1 BOTH of the following: 2.1.1 ONE of the following: • Patient has had prior or concurrent inadequate response to a therapeutic course of oral corticosteroids and/or immunosuppressants (e.g., azathioprine, 6-mercaptopurine) • Patient has been previously treated with a systemic targeted immunomodulator FDA-approved for the treatment of ulcerative colitis as confirmed by claims history or submission of medical records [e.g., adalimumab, Entyvio (vedolizumab), Omvoh (mirikizumab-mrkz), Simponi (golimumab), Skyrizi (risankizumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), ustekinumab, Zeposia (ozanimod)] AND 2.1.2 ONE of the following: 2.1.2.1 Failure to BOTH of the following as confirmed by claims history or submission of medical records: • One of the preferred adalimumab products* • One of the preferred ustekinumab products* OR 2.1.2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication) • One of the preferred adalimumab products*	

- One of the preferred ustekinumab products*

OR

2.1.2.3 Patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-V-TR 300.29 for specific phobia diagnostic criteria)

OR

2.2 Patient is currently on Rinvoq therapy as confirmed by claims history or submission of medical records

AND

3 - Patient is NOT receiving Rinvoq in combination with either of the following:

- Systemic targeted immunomodulator [e.g., adalimumab, Entyvio (vedolizumab), Omvoh (mirikizumab-mrkz), Simponi (golimumab), Skyrizi (risankizumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), ustekinumab, Zeposia (ozanimod)] for treatment of the same indication
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

AND

4 - Prescribed by or in consultation with a gastroenterologist

Notes

*See Table 2 in Background for PDL links.

Product Name:Rinvoq	
Diagnosis	Ankylosing Spondylitis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of active ankylosing spondylitis

AND

1.2 ONE of the following:

- Failure to TWO NSAIDs (non-steroidal anti-inflammatory drugs) (e.g., ibuprofen, naproxen) at maximally indicated doses, each used for at least 4 weeks, as confirmed by claims history or submission of medical records
- History of intolerance or contraindication to two NSAIDs (e.g., ibuprofen, naproxen) (please specify intolerance or contraindication)
- Patient has been previously treated with a systemic targeted immunomodulator FDA-approved for the treatment of ankylosing spondylitis as confirmed by claims history or submission of medical records [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Simponi (golimumab), Taltz (ixekizumab), Xeljanz (tofacitinib)]

AND

1.3 ONE of the following:

1.3.1 BOTH of the following:

1.3.1.1 ONE of the following:

1.3.1.1.1 Failure to BOTH of the following as confirmed by claims history or submission of medical records:

- One of the preferred adalimumab products*
- Enbrel (etanercept)

OR

1.3.1.1.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- One of the preferred adalimumab products*

- Enbrel (etanercept)

AND

1.3.1.2 ONE of the following:

- Failure to Cosentyx (secukinumab), as confirmed by claims history or submission of medical records
- History of intolerance or contraindication to Cosentyx (secukinumab) (please specify intolerance or contraindication)

OR

1.3.2 Patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-V-TR 300.29 for specific phobia diagnostic criteria)

AND

1.4 Patient is NOT receiving Rinvoq in combination with either of the following:

- Systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Simponi (golimumab), Taltz (ixekizumab), Xeljanz (tofacitinib)] for treatment of the same indication
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

AND

1.5 Prescribed by or in consultation with a rheumatologist

OR

2 - ALL of the following:

2.1 Patient is currently on Rinvoq therapy, as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of active ankylosing spondylitis

AND

2.3 Patient is NOT receiving Rinvoq in combination with either of the following:

- Systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Simponi (golimumab), Taltz (ixekizumab), Xeljanz (tofacitinib)] for treatment of the same indication
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

AND

2.4 Prescribed by or in consultation with a rheumatologist

Notes	*See Table 2 in Background for PDL links.

Product Name:Rinvoq	
Diagnosis	Non-Radiographic Axial Spondyloarthritis (nr-axSpA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of non-radiographic axial spondyloarthritis AND 2 - ONE of the following:	

2.1 ALL of the following:

2.1.1 ONE of the following:

- Failure to TWO NSAIDs (non-steroidal anti-inflammatory drugs) (e.g., ibuprofen, naproxen) at maximally indicated doses, each used for at least 4 weeks, as confirmed by claims history or submission of medical records
- History of intolerance or contraindication to TWO NSAIDs (e.g., ibuprofen, naproxen) (please specify intolerance or contraindication)
- Patient has been previously treated with a systemic targeted immunomodulator FDA-approved for the treatment of non-radiographic axial spondyloarthritis as confirmed by claims history or submission of medical records [e.g., Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Taltz (ixekizumab)]

AND

2.1.2 ONE of the following:

2.1.2.1 ONE of the following:

- Failure to Cosentyx (secukinumab), as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to Cosentyx (secukinumab) (please specify contraindication or intolerance)

OR

2.1.2.2 Patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-V-TR 300.29 for specific phobia diagnostic criteria)

OR

2.2 Patient is currently on Rinvoq therapy as confirmed by claims history or submission of medical records

AND

3 - Patient is NOT receiving Rinvoq in combination with either of the following:

- Systemic targeted immunomodulator [e.g., Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Taltz (ixekizumab)] for treatment of the same indication
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

AND

4 - Prescribed by or in consultation with a rheumatologist

Product Name:Rinvoq	
Diagnosis	Crohn's Disease (CD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderately to severely active Crohn's Disease 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 ONE of the following conventional therapy drugs or classes at maximally indicated dose confirmed by claims history or submitted medical records: • Corticosteroids (e.g., prednisone, methylprednisolone, budesonide) • 6-mercaptopurine (Purinethol) • Azathioprine (Imuran) • Methotrexate (Rheumatrex, Trexall) OR	

2.1.1.2 History of intolerance or contraindication to ALL of the following conventional therapy drugs or classes (please specify intolerance or contraindication)

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

OR

2.1.1.3 Patient has been previously treated with a systemic targeted immunomodulator FDA-approved for the treatment of Crohn's disease as confirmed by claims history or submission of medical records [e.g., adalimumab, Cimzia (certolizumab), Entyvio (vedolizumab), Omvoh (mirikizumab-mrkz), Rinvoq (upadacitinib), Skyrizi (risankizumab), Tremfya (guselkumab), ustekinumab]

AND

2.1.2 ONE of the following:

2.1.2.1 Failure to BOTH of the following as confirmed by claims history or submission of medical records:

- One of the preferred adalimumab products*
- One of the preferred ustekinumab products*

OR

2.1.2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- One of the preferred adalimumab products*
- One of the preferred ustekinumab products*

OR

2.2 Patient is currently on Rinvoq therapy for moderately to severely active Crohn's disease as confirmed by claims history or submitted medical records

AND

3 - Patient is NOT receiving Rinvoq in combination with either of the following:

- Systemic targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Entyvio (vedolizumab), Omvoh (mirikizumab-mrkz), Rinvoq (upadacitinib), Skyrizi (risankizumab), Tremfya (guselkumab), ustekinumab] for treatment of the same indication
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

AND

4 - Prescribed by or in consultation with a gastroenterologist

Notes	*See Table 2 in Background for PDL links.

Product Name: Rinvoq, Rinvoq LQ	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (pJIA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of active polyarticular juvenile idiopathic arthritis AND 2 - One of the following: 2.1 One of the following: 2.1.1 Failure to ALL of the following as confirmed by claims history or submission of medical records • One of the preferred adalimumab products*	

- Enbrel (etanercept)
- Tyenne (tocilizumab-aazg)

OR

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

- One of the preferred adalimumab products*
- Enbrel (etanercept)
- Tyenne (tocilizumab-aazg)

OR

2.2 Patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-V-TR 300.29 for specific phobia diagnostic criteria)

OR

2.3 Patient is currently on Rinvoq or Rinvoq LQ therapy as confirmed by claims history or submission of medical records

AND

3 - Patient is not receiving Rinvoq or Rinvoq LQ in combination with either of the following:

- Systemic targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib)] for treatment of the same indication
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

AND

4 - Prescribed by or in consultation with a rheumatologist

Notes

*See Table 2 in Background for PDL links.

Product Name:Rinvoq	
Diagnosis	Rheumatoid Arthritis (RA), Ulcerative Colitis (UC), Ankylosing Spondylitis, Non-Radiographic Axial Spondyloarthritis (nr-axSpA), Crohn's Disease (CD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Rinvoq therapy AND 2 - Patient is NOT receiving Rinvoq in combination with either of the following: - Systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Orencia (abatacept), Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib)] for treatment of the same indication* - Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)*	
Notes	* Examples of drug(s) may not be applicable based on the requested indication.

Product Name:Rinvoq, Rinvoq LQ	
Diagnosis	Psoriatic Arthritis (PsA), Polyarticular Juvenile Idiopathic Arthritis (pJIA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Rinvoq or Rinvoq LQ therapy	

AND

2 - Patient is NOT receiving Rinvoq or Rinvoq LQ in combination with either of the following:

- Systemic targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib)] for treatment of the same indication*
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)*

Notes

* Examples of drug(s) may not be applicable based on the requested indication.

Product Name: Rinvoq

Diagnosis Atopic Dermatitis

Approval Length 12 month(s)

Therapy Stage Reauthorization

Guideline Type Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Rinvoq therapy

AND

2 - Patient is NOT receiving Rinvoq in combination with either of the following:

- Systemic targeted immunomodulator [e.g., Adbry (tralokinumab-ldrm), Dupixent (dupilumab), Cibinqo (abrocitinib), Ebglyss (lebrikizumab-lbkz), Nemluvio (nemolizumab-ilto), Xeljanz/XR (tofacitinib), Olumiant (baricitinib), Opzelura (topical ruxolitinib)] for treatment of the same indication
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

AND

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

- Dermatologist
- Allergist
- Immunologist

Product Name: Rinvoq	
Diagnosis	Giant Cell Arteritis (GCA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of giant cell arteritis

AND

2 - One of the following:

2.1 Failure to one glucocorticoid (e.g., prednisone) confirmed by claims history or submitted medical records

OR

2.2 History of intolerance or contraindication to all glucocorticoids (e.g., prednisone) (please specify intolerance or contraindication)

OR

2.3 Patient has been previously treated with a systemic targeted immunomodulator FDA-approved for the treatment of giant cell arteritis as confirmed by claims history or submission of medical records [e.g., tocilizumab]

AND

3 - One of the following:

3.1 One of the following:

- Failure to Tyenne (tocilizumab-aazg) as confirmed by claims history or submission of medical records
- History of intolerance or contraindication to Tyenne (tocilizumab-aazg) (please specify intolerance or contraindication)

OR

3.2 Patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-V-TR 300.29 for specific phobia diagnostic criteria)

OR

3.3 Patient is currently on Rinvoq or Rinvoq LQ therapy as confirmed by claims history or submission of medical records

AND

4 - Patient is not receiving Rinvoq in combination with either of the following:

- Systemic targeted immunomodulator [e.g., tocilizumab] for treatment of the same indication
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

AND

5 - Prescribed by or in consultation with a rheumatologist

Product Name:Rinvoq	
Diagnosis	Giant Cell Arteritis (GCA)

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Rinvoq therapy AND 2 - Patient is NOT receiving Rinvoq in combination with either of the following: - Systemic targeted immunomodulator [e.g., tocilizumab] for treatment of the same indication - Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)	

2 . Background

Benefit/Coverage/Program Information			
Table 1: Relative potencies of topical corticosteroids			
<u>Class</u>	<u>Drug</u>	<u>Dosage Form</u>	<u>Strength (%)</u>
<u>Very high potency</u>	<u>Augmented betamethasone dipropionate</u>	<u>Ointment, gel</u>	<u>0.05</u>
	<u>Clobetasol propionate</u>	<u>Cream, foam, ointment</u>	<u>0.05</u>
	<u>Diflorasone diacetate</u>	<u>Ointment</u>	<u>0.05</u>
	<u>Halobetasol propionate</u>	<u>Cream, ointment</u>	<u>0.05</u>
<u>High Potency</u>	<u>Amcinonide</u>	<u>Cream, lotion, ointment</u>	<u>0.1</u>
	<u>Augmented betamethasone dipropionate</u>	<u>Cream, lotion</u>	<u>0.05</u>

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

<u>Lowest potency</u>	<u>Hydrocortisone</u>	<u>Cream, lotion, ointment, solution</u>	<u>0.25, 0.5, 1</u>
	<u>Hydrocortisone acetate</u>	<u>Cream, ointment</u>	<u>0.5-1</u>

Table 2: PDL links

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
Maryland	https://www.uhcprovider.com/en/health-plans-by-state/maryland-health-plans/md-comm-plan-home/md-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 York	https://www.uhcprovider.com/en/health-plans-by-state/new-york-health-plans/ny-comm-plan-home/ny-cp-pharmacy.html
Rhode Island	https://www.uhcprovider.com/en/health-plans-by-state/rhode-island-health-plans/ri-comm-plan-home/ri-cp-pharmacy.html
Pennsylvania CHIP	https://www.uhcprovider.com/en/health-plans-by-state/pennsylvania-health-plans/pa-comm-plan-home/pa-cp-pharmacy.html?rfid=UHCCP
New Mexico	https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

3 . Revision History

Date	Notes
2/12/2026	Removed NY. Updated criteria for CD/UC to step through both preferred adalimumab and ustekinumab.

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 Oxlummo (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

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 Rhode Island 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.

Sandostatin



Prior Authorization Guideline

Guideline ID	GL-511287
Guideline Name	Sandostatin
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State Nebraska Medicaid - Community & State New Jersey Medicaid - Community & State New Mexico Medicaid - Community & State New York Medicaid - Community & State New York EPP Medicaid - Community & State Pennsylvania Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Virginia Medicaid - Community & State Nevada

Guideline Note:

Effective Date:	2/15/2026

1 . Criteria

Product Name:Brand Sandostatin, generic octreotide	
Diagnosis	Acromegaly
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of acromegaly AND 2 - ONE of the following: 2.1 Inadequate response to ONE of the following: • Surgical resection • Pituitary irradiation • Dopamine agonist (e.g., bromocriptine, cabergoline) therapy OR 2.2 NOT a candidate for any of the following: • Surgical resection • Pituitary irradiation • Dopamine agonist (e.g., bromocriptine, cabergoline) therapy	

Product Name:Brand Sandostatin, generic octreotide	
Diagnosis	Meningioma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of meningioma

AND

2 - Disease is surgically inaccessible

AND

3 - ONE of the following:

- Disease is recurrent
- Disease is progressive

AND

4 - Radiation is not possible

Product Name: Brand Sandostatin, generic octreotide	
Diagnosis	Neuroendocrine and Adrenal Tumors
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has a neuroendocrine tumor [i.e., carcinoid tumors, Islet cell tumors, gastrinomas, glucagonomas, insulinomas, lung tumors, somatostatinomas, tumors of the pancreas, GI (gastrointestinal) tract, lung and thymus, adrenal glands, and vasoactive intestinal polypeptidomas (VIPomas)]	

OR

2 - BOTH of the following:

2.1 ONE of the following:

- Diagnosis of Pheochromocytoma or Paraganglioma
- Well-differentiated grade 3 neuroendocrine tumor

AND

2.2 Disease is ONE of the following:

- Locally unresectable
- Metastatic

Product Name:Brand Sandostatin, generic octreotide	
Diagnosis	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 the requested therapy OR 2 - Documentation of positive clinical response (e.g., suppression of severe diarrhea, flushing, etc.) to the requested therapy	

Product Name:Brand Sandostatin, generic octreotide

Diagnosis	Thymoma or Thymic Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of thymoma or thymic carcinoma AND 2 - ONE of the following: 2.1 Used as a second-line therapy for ONE of the following: • Unresectable locally advanced disease • Solitary metastasis or ipsilateral pleural metastasis • Extrathoracic metastatic disease OR 2.2 BOTH of the following: 2.2.1 Used as first line therapy for ONE of the following: • Potentially resectable locally advanced disease • Potentially resectable solitary metastasis or ipsilateral pleural metastasis • Consideration following surgery for solitary metastasis or ipsilateral pleural metastasis • Medically inoperable/unresectable solitary metastasis or ipsilateral pleural metastasis • Extrathoracic metastatic disease • Postoperative treatment for thymoma after R2 resection • Preoperative systemic therapy for surgically resectable disease if R0 resection uncertain AND 2.2.2 Patient is unable to tolerate first-line combination regimens	

Product Name: Brand Sandostatin, generic octreotide	
Diagnosis	Meningioma, Thymoma or 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 the requested therapy	

Product Name: Brand Sandostatin, generic octreotide	
Diagnosis	Malignant Bowel Obstruction
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of malignant bowel obstruction AND 2 - Gut function cannot be maintained	

Product Name: Brand Sandostatin, generic octreotide	
Diagnosis	Chemotherapy- and/or Radiation-Induced Diarrhea
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of diarrhea due to concurrent cancer chemotherapy and/or radiation

AND

2 - ONE of the following:

2.1 Presence of Grade 3 or 4 severe diarrhea

OR

2.2 Patient is in palliative or end of life care

Product Name: Brand Sandostatin, generic octreotide

Diagnosis	Bleeding Gastroesophageal Varices
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of bleeding gastroesophageal varices associated with liver disease

Product Name: Brand Sandostatin, generic octreotide

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 Sandostatin, generic octreotide	
Diagnosis	Acromegaly, Malignant Bowel Obstruction, Chemotherapy- and/or Radiation-Induced Diarrhea, Bleeding Gastroesophageal Varices, 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
2/3/2026	Removed WA

Savaysa



Prior Authorization Guideline

Guideline ID	GL-205208
Guideline Name	Savaysa
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

Guideline Note:

Effective Date:	4/1/2025

1 . Criteria

Product Name:Savaysa	
Diagnosis	Therapy upon hospital discharge
Approval Length	35 Day(s)

Guideline Type	Prior Authorization
Approval Criteria 1 - Medication is being used as continuation of therapy upon hospital discharge	

Product Name:Savaysa	
Diagnosis	Stroke & Systemic Embolism Prevention in Adult Patients with Non-Valvular Atrial Fibrillation
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of atrial fibrillation (AF) AND 2 - Patient does not have an artificial heart valve AND 3 - One of the following: 3.1 Failure to Eliquis as confirmed by claims history or submission of medical records OR 3.2 History of contraindication or intolerance to Eliquis (please specify contraindication or intolerance) OR	

3.3 Continuation of prior Savaysa therapy

Product Name:Savaysa	
Diagnosis	Deep Vein Thrombosis or Pulmonary Embolism Treatment in Adult Patients
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of one of the following:

- Deep vein thrombosis (DVT)
- Pulmonary embolism (PE)

AND

2 - Patient does not have an artificial heart valve

AND

3 - One of the following:

3.1 Failure to Eliquis as confirmed by claims history or submission of medical records

OR

3.2 History of contraindication or intolerance to Eliquis (please specify contraindication or intolerance)

OR

3.3 Continuation of prior Savaysa therapy

2 . Revision History

Date	Notes
2/28/2025	New

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 Rhode Island Clinical Pharmacy Program Guidelines

Date	Notes
4/29/2026	Added IN.

Sensipar



Prior Authorization Guideline

Guideline ID	GL-442214
Guideline Name	Sensipar
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State New Jersey Medicaid - Community & State New York Medicaid - Community & State New York EPP Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Arizona Medicaid - Community & State Michigan Medicaid - Community & State Virginia Medicaid - Community & State Pennsylvania Medicaid - Community & State Nebraska Medicaid - Community & State Indiana Medicaid - Community & State New Mexico Medicaid - Community & State Nevada

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Sensipar, generic cinacalcet	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Prescribed by or in consultation with an oncologist, endocrinologist, or nephrologist AND 2 - ONE of the following: 2.1 BOTH of the following: • Diagnosis of secondary hyperparathyroidism with chronic kidney disease • Patient is on dialysis OR 2.2 Diagnosis of hypercalcemia with parathyroid carcinoma OR 2.3 ALL of the following: • Diagnosis of primary hyperparathyroidism (HPT) • Severe hypercalcemia [serum calcium level greater than 12.5 mg/dL (milligrams/deciliter)] due to primary HPT • Patient is unable to undergo parathyroidectomy	

Product Name:Brand Sensipar, generic cinacalcet

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has experienced a reduction in serum calcium from baseline	

2 . Revision History

Date	Notes
11/6/2025	Added Nevada Formulary

Sephience



Prior Authorization Guideline

Guideline ID	GL-535230
Guideline Name	Sephience
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

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Sephience	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of phenylketonuria (PKU) AND 2 - Patient is actively on a phenylalanine (Phe)-restricted diet AND 3 - ONE of the following: 3.1 Failure to sapropterin as confirmed by claims history or submission of medical records OR 3.2 History of contraindication or intolerance to sapropterin therapy (please specify contraindication or intolerance) OR 3.3 Patient is not an appropriate candidate for sapropterin due to two null mutations in trans AND 4 - Physician attestation that the patient will not be receiving Sephience in combination with sapropterin dihydrochloride or Palynziq (pegvaliase-pqpz)	

Product Name:Sephience	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is actively on a phenylalanine (Phe)-restricted diet AND 2 - Blood Phe levels continue to remain lower than baseline level AND 3 - Submission of medical records (e.g., chart notes, laboratory values) documenting that the patient is not receiving Sephience in combination with sapropterin dihydrochloride or Palynziq (pegvaliase-pqpz)*	
Notes	*Prescription claim history that does not show any concomitant sapropterin dihydrochloride or Palynziq (pegvaliase-pqpz) claim within 60 days of reauthorization request may be used as documentation

2 . Revision History

Date	Notes
2/26/2026	Added PA-CAID. Expanded on (Phe) to keep it consistent, with no changes to clinical intent. Minor cosmetic updates.

SGLT2 Inhibitors



Prior Authorization Guideline

Guideline ID	GL-450222
Guideline Name	SGLT2 Inhibitors
Formulary	Medicaid - Community & State Rhode Island

Guideline Note:

Effective Date:	12/1/2025

1 . Criteria

Product Name:Steglatro, Segluromet	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - The patient has a diagnosis of type 2 diabetes mellitus	

AND

2 - ONE of the following:

- Suboptimal response to metformin at a minimum dose of 1500 mg daily for 90 days confirmed by claims history or submission of medical records
- History of intolerance or contraindication to metformin (please specify intolerance or contraindication)

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

Product Name:Jardiance	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - For diagnosis of type 2 diabetes mellitus, BOTH of the following: 1.1 ONE of the following: • Suboptimal response to metformin at a minimum dose of 1500mg daily for 90 days confirmed by claims history or submission of medical records	

- History of intolerance or contraindication to metformin (please specify intolerance or contraindication)

AND

1.2 ONE of the following:

1.2.1 Failure to ONE of the following therapies for 90 days confirmed by claims history or submission of medical records:

- Steglatro (ertugliflozin) OR Segluromet (ertugliflozin/metformin)
- Dapagliflozin (Farxiga authorized generic)

OR

1.2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Steglatro (ertugliflozin) OR Segluromet (ertugliflozin/metformin)
- Dapagliflozin (Farxiga authorized generic)

OR

2 - For diagnosis of heart failure (NYHA class II-IV), ONE of the following:

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

OR

3 - For diagnosis of chronic kidney disease (CKD), BOTH of the following:

3.1 ONE of the following:

- Patient is currently taking an ACE inhibitor or ARB, confirmed by claims history or submission of medical records
- History of intolerance or contraindication to ACE inhibitor or ARB (please specify intolerance or contraindication)

AND

3.2 ONE of the following:

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

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

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - ONE of the following:

2.1 For diagnosis of type 2 diabetes mellitus, ONE of the following:

2.1.1 The prescriber has given a clinical reason or special circumstance why the patient is unable to use dapagliflozin (Farxiga authorized generic) (please document reason/special circumstance)

OR

2.1.2 The prescriber has given a clinical reason or special circumstance why the patient is unable to use Steglatro (ertugliflozin) or Segluromet (ertugliflozin/metformin) (please document reason/special circumstance)

OR

2.2 For diagnosis of heart failure (NYHA class II-IV) or CKD: Prescriber has given a clinical reason or special circumstance why the patient is unable to use dapagliflozin (Farxiga authorized generic) (please document reason/special circumstance)

Product Name: Invokana	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of type 2 diabetes mellitus

AND

2 - ONE of the following:

- Suboptimal response to metformin at a minimum dose of 1500 mg daily for 90 days confirmed by claims history or submission of medical records
- History of intolerance or contraindication to metformin (please specify intolerance or contraindication)

AND

3 - ONE of the following:

3.1 ONE of the following:

3.1.1 Failure to ONE of the following therapies for 90 days confirmed by claims history or submission of medical records:

- Steglatro (ertugliflozin) OR Segluromet (ertugliflozin/metformin)
- Dapagliflozin (Farxiga authorized generic)

OR

3.1.2 History of contraindication or intolerance to BOTH of the following (please specify contraindication or intolerance):

- Steglatro (ertugliflozin) OR Segluromet (ertugliflozin/metformin)
- Dapagliflozin (Farxiga authorized generic)

OR

3.2 Documented history of diabetic nephropathy with albuminuria

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

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - One of the following:

2.1 One of the following:

- The prescriber has given a clinical reason or special circumstance why the patient is unable to use dapagliflozin (Farxiga authorized generic) (please document reason/special circumstance)
- The prescriber has given a clinical reason or special circumstance why the patient is unable to use Steglatro (ertugliflozin) or Segluromet (ertugliflozin/metformin) (please document reason/special circumstance)

OR

2.2 Documented history of diabetic nephropathy with albuminuria

Product Name:Dapagliflozin (Farxiga authorized generic)	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - For diagnosis of type 2 diabetes mellitus, ONE of the following: - Suboptimal response to metformin at a minimum dose of 1500mg daily for 90 days, as confirmed by claims history or submission of medical records - History of contraindication or intolerance to metformin (please specify contraindication or intolerance) OR 2 - Diagnosis of heart failure (NYHA class II-IV) OR 3 - For diagnosis of chronic kidney disease, ONE of the following: - Patient currently taking an ACE inhibitor or ARB, confirmed by claims history or submission of medical records - Patient has documentation of intolerance or contraindication to ACE inhibitor or ARB (please specify intolerance or contraindication)	

Product Name:Dapagliflozin (Farxiga authorized generic)	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

Product Name:Farxiga

Approval Length 12 month(s)

Therapy Stage Initial Authorization

Guideline Type Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 For diagnosis of type 2 diabetes mellitus, ONE of the following:

- Suboptimal response to metformin at a minimum dose of 1500 mg daily for 90 days confirmed by claims history or submission of medical records
- History of intolerance or contraindication to metformin (please specify intolerance or contraindication)

OR

1.2 Diagnosis of heart failure (NYHA class II-IV)

OR

1.3 For diagnosis of chronic kidney disease, ONE of the following:

- Patient is currently taking an ACE inhibitor or ARB confirmed by claims history or submission of medical records
- Patient has documentation of intolerance or contraindication to ACE inhibitor or ARB (please specify intolerance or contraindication)

AND

2 - The prescriber has given a clinical reason or special circumstance why the patient is unable to use dapagliflozin (Farxiga authorized generic) (please document reason/special circumstance)

Product Name:Farxiga	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy AND 2 - The prescriber has given a clinical reason or special circumstance why the patient is unable to use dapagliflozin (Farxiga authorized generic) (please document reason/special circumstance)	

Product Name:Brenzavvy, Bexagliflozin, Synjardy, Synjardy XR, Invokamet, Invokamet XR, Xigduo XR, Dapagliflozin/Metformin ER	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of type 2 diabetes mellitus AND 2 - ONE of the following:	

- Suboptimal response to metformin at a minimum dose of 1500 mg daily for 90 days confirmed by claims history or submission of medical records
- History of intolerance or contraindication to metformin (please specify intolerance or contraindication)

AND

3 - ONE of the following:

3.1 Failure to ONE of the following therapies for 90 days confirmed by claims history or submission of medical records:

- Steglatro (ertugliflozin) OR Segluromet (ertugliflozin/metformin)
- Dapagliflozin (Farxiga authorized generic)

OR

3.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Steglatro (ertugliflozin) OR Segluromet (ertugliflozin/metformin)
- Dapagliflozin (Farxiga authorized generic)

Product Name: Brenzavvy, Bexagliflozin, Synjardy, Synjardy XR, Invokamet, Invokamet XR, Xigduo XR, Dapagliflozin/Metformin ER

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

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - One of the following:

2.1 The prescriber has given a clinical reason or special circumstance why the patient is unable to use dapagliflozin (Farxiga authorized generic) (please document reason/special circumstance)

OR

2.2 The prescriber has given a clinical reason or special circumstance why the patient is unable to use Steglatro (ertugliflozin) or Segluromet (ertugliflozin/metformin) (please document reason/special circumstance)

Product Name: Inpefa	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 The patient has a diagnosis of heart failure OR 1.2 ALL of the following: 1.2.1 Diagnosis of type 2 diabetes mellitus AND 1.2.2 Diagnosis of chronic kidney disease AND	

1.2.3 At least ONE additional cardiovascular risk factor such as:

- History of heart failure
- Obesity
- Dyslipidemia
- Hypertension
- Elevated cardiac and inflammatory biomarkers

AND

2 - ONE of the following:

- Failure to dapagliflozin (Farxiga authorized generic) confirmed by claims history or submission of medical records
- History of contraindication or intolerance to dapagliflozin (Farxiga authorized generic) (please specify contraindication or intolerance)

Product Name: Inpefa	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy AND 2 - The prescriber has given a clinical reason or special circumstance why the patient is unable to use dapagliflozin (Farxiga authorized generic) (please document reason/special circumstance)	

2 . Revision History

UnitedHealthcare Community Plan of Rhode Island Clinical Pharmacy Program Guidelines

Date	Notes
11/14/2025	Updated multiple Reauth criteria with clarified step through therapy language.

Short-Acting Opioid Products



Prior Authorization Guideline

Guideline ID	GL-480220
Guideline Name	Short-Acting Opioid Products
Formulary	Medicaid - Community & State Rhode Island

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:butorphanol nasal soln, codeine, acetaminophen/codeine, generic butalbital/acetaminophen/caffeine/codeine, Brand Fioricet/codeine, Brand Ascomp/codeine, generic butalbital/aspirin/caffeine/codeine, morphine tabs/oral soln/supp, generic hydrocodone/acetaminophen, Brand Xodol, hydrocodone/acetaminophen soln, hydrocodone/ibuprofen, generic hydromorphone tabs/liqd, Brand Dilaudid, hydromorphone supp, generic oxycodone, Brand Roxicodone, Oxaydo, Nalocet, Brand Percocet, generic oxycodone/acetaminophen, Endocet, Prolate, Roxybond, Oxycodone abuse deterrent tabs, oxymorphone, pentazocine/naloxone, generic tramadol, Qdolo, tramadol oral soln, generic tramadol/acetaminophen, Synapryn Fusepaq, Nucynta, meperidine tab/oral soln, levorphanol, generic acetaminophen/caffeine/dihydrocodeine, Brand Trezix, belladonna/opium, opium, Seglentis	
Approval Length	12 month(s)
Guideline Type	Quantity Limit

Approval Criteria

1 - The requested dose cannot be achieved by a higher strength formulary product

AND

2 - The requested dose is within Food and Drug Administration (FDA) maximum dose per day, where an FDA maximum dose per day exists

Notes	This section does NOT apply to cough and cold products.

Product Name: butorphanol nasal soln, codeine, acetaminophen/codeine, generic butalbital/acetaminophen/caffeine/codeine, Brand Fioricet/codeine, Brand Ascomp/codeine, generic butalbital/aspirin/caffeine/codeine, morphine tabs/oral soln/supp, generic hydrocodone/acetaminophen, Brand Xodol, hydrocodone/acetaminophen soln, hydrocodone/ibuprofen, generic hydromorphone tabs/liqd, Brand Dilaudid, hydromorphone supp, generic oxycodone, Brand Roxicodone, Oxaydo, Nalocet, Brand Percocet, generic oxycodone/acetaminophen, Endocet, Prolate, Roxybond, Oxycodone abuse deterrent tabs, oxymorphone, pentazocine/naloxone, generic tramadol, Qdolo, tramadol oral soln, generic tramadol/acetaminophen, Synapryn Fusepaq, Nucynta, meperidine tab/oral soln, levorphanol, generic acetaminophen/caffeine/dihydrocodeine, Brand Trezix, belladonna/opium, opium, Seglantis

Diagnosis	Non-Preferred Reviews
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - If the request is for tramadol 100 milligram (mg) tablets, the physician has provided rationale for needing to use the 100 mg tramadol tablet instead of two 50 mg tramadol tablets

OR

2 - If the request is for tramadol 25 mg tablets, the physician has provided rationale why the patient is unable to use half of a 50 mg tramadol tablet

OR

3 - If the request is for Qdolo (tramadol soln), ONE of the following:

3.1 The patient has a history of failure to a trial of tramadol 50 mg tablets as confirmed by claims history or submission of medical records

OR

3.2 History of intolerance or contraindication to tramadol 50 mg tablets (please specify intolerance or contraindication)

OR

3.3 Patient is unable to swallow a solid dosage form

OR

3.4 Patient utilizes a feeding tube for medication administration

OR

4 - If the request is for another non-preferred* medication, then ONE of the following:

4.1 Failure of at least THREE unique active ingredients from the preferred* short-acting opioids list as confirmed by claims history or submission of medical records

OR

4.2 History of intolerance or contraindication to THREE unique active ingredients from the preferred* short-acting opioids list (please specify intolerance or contraindication)

Notes	This section does NOT apply to cough and cold products. *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/rhode-island-health-plans/ri-comm-plan-home/ri-cp-pharmacy.html

Product Name:acetaminophen/codeine tabs, morphine supp, generic hydrocodone/acetaminophen tabs, Brand Xodol, hydrocodone/ibuprofen, generic oxycodone caps/tabs, Brand Roxicodone, Oxaydo, Nalocet, Brand Percocet, generic oxycodone/acetaminophen tabs, Endocet, Prolate tabs, generic tramadol tabs, generic tramadol/acetaminophen, meperidine tabs	
Diagnosis	Opioid Naïve (not having filled an opioid in the past 30 days)
Guideline Type	Quantity Limit/Morphine Milligram Equivalents (MME)*
Approval Criteria 1 - Requests for quantities exceeding 30 MME (morphine milligram equivalents, see Table 1 in Background) and/or 20 units will be approved for patients who meet at least ONE of the following: • End of life care, including hospice care • Palliative care • Cancer-related pain (i.e., patients undergoing active cancer treatment; or cancer survivors with chronic pain who have completed cancer treatment, are in clinical remission, or are under cancer surveillance) • Post-surgery • Sickle cell diagnosis • Attestation from the provider that the patient is not opioid-naïve	
Notes	This section does NOT apply to cough and cold products. *Authorization will be issued for a one-time override to allow for the requested MME and/or quantity limit

Product Name:butorphanol nasal soln, codeine, acetaminophen/codeine, generic butalbital/acetaminophen/cafeine/codeine, Brand Fioricet/codeine, Brand Ascomp/codeine, generic butalbital/aspirin/cafeine/codeine, morphine tabs/oral soln/supp, generic hydrocodone/acetaminophen, Brand Xodol, hydrocodone/acetaminophen soln, hydrocodone/ibuprofen, generic hydromorphone tabs/liqd, Brand Dilaudid, hydromorphone supp, generic oxycodone, Brand Roxicodone, Oxaydo, Nalocet, Brand Percocet, generic oxycodone/acetaminophen, Endocet, Prolate, Roxybond, Oxycodone abuse deterrent tabs, oxymorphone, pentazocine/naloxone, generic tramadol, Qdolo, tramadol oral soln, generic tramadol/acetaminophen, Synapryn Fusepaq, Nucynta, meperidine tab/oral soln, levorphanol, generic acetaminophen/cafeine/dihydrocodeine, Brand Trezix, belladonna/opium, opium, Seglentsis	
Diagnosis	Cancer-related pain/Hospice/End-of-Life Related Pain Exceeding the 90 MME Cumulative Threshold
Approval Length	12 month(s)
Guideline Type	Morphine Milligram Equivalents (MME) Reviews*

Approval Criteria

1 - Doses exceeding the cumulative morphine milligram equivalents (MME) of 90 milligrams will be approved if the patient has ONE of the following:

- Cancer-related pain (i.e., patients undergoing active cancer treatment; or cancer survivors with chronic pain who have completed cancer treatment, are in clinical remission, or are under cancer surveillance)
- Hospice pain
- An end-of-life diagnosis

Notes

This section does NOT apply to cough and cold products.
*Authorization will be issued for 12 months for cancer-related pain/hospice/end-of-life related pain. The authorization should be entered for a n MME of 9999 so as to prevent future disruptions in therapy if the patient's dose is increased.

Product Name:butorphanol nasal soln, codeine, acetaminophen/codeine, generic butalbital/acetaminophen/caffeine/codeine, Brand Fioricet/codeine, Brand Ascomp/codeine, generic butalbital/aspirin/caffeine/codeine, morphine tabs/oral soln/supp, generic hydrocodone/acetaminophen, Brand Xodol, hydrocodone/acetaminophen soln, hydrocodone/ibuprofen, generic hydromorphone tabs/liqd, Brand Dilaudid, hydromorphone supp, generic oxycodone, Brand Roxicodone, Oxaydo, Nalocet, Brand Percocet, generic oxycodone/acetaminophen, Endocet, Prolate, Roxybond, Oxycodone abuse deterrent tabs, oxymorphone, pentazocine/naloxone, generic tramadol, Qdolo, tramadol oral soln, generic tramadol/acetaminophen, Synapryn Fusepaq, Nucynta, meperidine tab/oral soln, levorphanol, generic acetaminophen/caffeine/dihydrocodeine, Brand Trezix, belladonna/opium, opium, Seglentsis

Diagnosis	Non-Cancer-related pain/Non-Hospice/Non-end-of-life Related Pain Exceeding the 90 MME Cumulative Threshold
Therapy Stage	Initial Authorization
Guideline Type	Morphine Milligram Equivalents (MME) Reviews*

Approval Criteria

1 - Prescriber attests that the patient has been screened for substance abuse/opioid dependence

AND

2 - Treatment goals are defined and include estimated duration of treatment (must document treatment goals)

AND

3 - Patient has been screened for underlying depression and/or anxiety. If applicable, any underlying conditions have been or will be addressed

AND

4 - BOTH of the following:

4.1 Patient has tried and failed non-opioid pain medication (document drug name and date of trial)

AND

4.2 Opioid medication doses of less than 90 morphine milligram equivalents (MME) have been tried and did not adequately control pain (document drug regimen or MME and dates of therapy)

Notes	This section does NOT apply to cough and cold products. *Authorization will be issued for 6 months for non-cancer-related pain/non-hospice/non-end-of-life related pain up to the current requested MME plus 90 MME. If the patient has been established on the requested MME dose for at least 30 days and does not meet the medical necessity authorization criteria requirements, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested MME dose.

Product Name: butorphanol nasal soln, codeine, acetaminophen/codeine, generic butalbital/acetaminophen/caffeine/codeine, Brand Fioricet/codeine, Brand Ascomp/codeine, generic butalbital/aspirin/caffeine/codeine, morphine tabs/oral soln/supp, generic hydrocodone/acetaminophen, Brand Xodol, hydrocodone/acetaminophen soln, hydrocodone/ibuprofen, generic hydromorphone tabs/liqd, Brand Dilaudid, hydromorphone

supp, generic oxycodone, Brand Roxicodone, Oxaydo, Nalocet, Brand Percocet, generic oxycodone/acetaminophen, Endocet, Prolate, Roxybond, Oxycodone abuse deterrent tabs, oxymorphone, pentazocine/naloxone, generic tramadol, Qdolo, tramadol oral soln, generic tramadol/acetaminophen, Synapryn Fusepaq, Nucynta, meperidine tab/oral soln, levorphanol, generic acetaminophen/caffeine/dihydrocodeine, Brand Trezix, belladonna/opium, opium, Seglantis	
Diagnosis	Non-Cancer-related pain/Non-Hospice/Non-end-of-life Related Pain Exceeding the 90 MME Cumulative Threshold
Therapy Stage	Reauthorization
Guideline Type	Morphine Milligram Equivalents (MME) Reviews*
Approval Criteria 1 - Prescriber attests that the patient has been screened for substance abuse/opioid dependence AND 2 - Documented rationale for not tapering or discontinuing opioid if treatment goals are not met AND 3 - Documented meaningful improvement in pain and function when assessed against treatment goals (Document improvement in function or pain score improvement)	
Notes	This section does NOT apply to cough and cold products. *Authorization will be issued for 6 months for non-cancer-related pain/non-hospice/non-end-of-life related pain up to the current requested MME plus 90 MME. If the patient has been established on the requested MME dose for at least 30 days and does not meet the medical necessity authorization criteria requirements, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested MME dose.

Product Name: Brand Hycodan, generic hydrocodone/homatropine, Hydromet, hydrocodone/chlorpheniramine, Tuxarin ER, Ninjacof-XG, Coditussin AC, Mar-Cof CG Expectorant, codeine/guaifenesin, G Tussin AC, GuaiaTussin AC, guaifenesin AC, guaifenesin/codeine, Maxi-Tuss AC, Virtussin A/C, Poly-Tussin AC, Rydex, Mar-Cof BP,

Maxi-Tuss CD, Capcof, Pro-Red AC, promethazine VC/codeine, promethazine/phenylephrine/codeine, promethazine/codeine, Coditussin DAC	
Diagnosis	Cough and Cold Products Exceeding the 90 MME Cumulative Threshold
Guideline Type	Morphine Milligram Equivalents (MME) Reviews*
Approval Criteria 1 - The prescriber attests they are aware of patient's current opioid therapy and morphine milligram equivalent (MME) dose and feels the treatment with the requested product is medically necessary	
Notes	*Approval duration: Authorization will be issued for up to 30 days for cough and cold related treatment. The authorization should be entered for the MME requested.

Product Name: Brand Hycodan, generic hydrocodone/homatropine, Hydromet, hydrocodone/chlorpheniramine, Tuxarin ER, Ninjacof-XG, Coditussin AC, Mar-Cof CG Expectorant, codeine/guaifenesin, G Tussin AC, GuaiaTussin AC, guaifenesin AC, guaifenesin/codeine, Maxi-Tuss AC, Virtussin A/C, Poly-Tussin AC, Rydex, Mar-Cof BP, Maxi-Tuss CD, Capcof, Pro-Red AC, promethazine VC/codeine, promethazine/phenylephrine/codeine, promethazine/codeine, Coditussin DAC	
Diagnosis	Under the Age of 18 Years for Cough and Cold Products
Approval Length	30 Day(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Prescriber attests they are aware of the Food and Drug Administration (FDA) labeled contraindications regarding use of opioid containing cough and cold products in patients less than 18 years of age and feels the treatment with the requested product is medically necessary (Document rationale for use) AND 2 - Patient does not have a comorbid condition that may impact respiratory depression (e.g., asthma or other chronic lung disease, sleep apnea, body mass index greater than 30)	

AND

3 - Patient has tried and failed at least one non-opioid containing cough and cold remedy

Product Name: Brand Hycodan, generic hydrocodone/homatropine, Hydromet, hydrocodone/chlorpheniramine, Tuxarin ER, Ninjacof-XG, Coditussin AC, Mar-Cof CG Expectorant, codeine/guaifenesin, G Tussin AC, GuaiaTussin AC, guaifenesin AC, guaifenesin/codeine, Maxi-Tuss AC, Virtussin A/C, Poly-Tussin AC, Rydex, Mar-Cof BP, Maxi-Tuss CD, Capcof, Pro-Red AC, promethazine VC/codeine, promethazine/phenylephrine/codeine, promethazine/codeine, Coditussin DAC

Diagnosis	Cough and Cold Products Exceeding 120mL per fill and/or 360mL per 30 days*

Guideline Type	Quantity Limit**

Approval Criteria

1 - Doses exceeding the quantity limit will be approved up to the requested amount if the prescriber attests that a larger quantity is medically necessary

AND

2 - The requested dose is within the Food and Drug Administration (FDA) maximum dose per day, where an FDA maximum dose per day exists

Notes	*Quantity Limit Rules in place: • 120mL/fill • 360mL/30 days ** Authorization will be issued for up to 30 days. The authorization should be entered for the quantity requested.

Product Name: Brand Hycodan, generic hydrocodone/homatropine, Hydromet, hydrocodone/chlorpheniramine, Tuxarin ER, Ninjacof-XG, Coditussin AC, Mar-Cof CG Expectorant, codeine/guaifenesin, G Tussin AC, GuaiaTussin AC, guaifenesin AC, guaifenesin/codeine, Maxi-Tuss AC, Virtussin A/C, Poly-Tussin AC, Rydex, Mar-Cof BP, Maxi-Tuss CD, Capcof, Pro-Red AC, promethazine VC/codeine, promethazine/phenylephrine/codeine, promethazine/codeine, Coditussin DAC

Diagnosis	Non-Preferred Cough and Cold Product Reviews

Approval Length	30 Day(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - If the request is for a non-preferred* medication, then ONE of the following: 1.1 Failure of at least THREE unique active ingredients from the preferred* cough and cold products list as confirmed by claims history or submission of medical records OR 1.2 History of intolerance or contraindication to at least THREE unique active ingredients from the preferred* cough and cold products list (please specify intolerance or contraindication)	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/rhode-island-health-plans/ri-comm-plan-home/ri-cp-pharmacy.html

2 . Background

Clinical Practice Guidelines		
Table 1.		
Drug Name	Dosage Strength	Max # of units/day
Acetaminophen-cod #2 Tablet	300MG-15MG	13.33333333
Acetaminophen-cod #3 Tablet	300MG-30MG	6.666666667
Acetaminophen-cod #4 Tablet	300MG-60MG	3.333333333
Endocet 2.5-325 Mg Tablet	2.5-325 MG	8
Endocet 5-325 Tablet	5 MG-325MG	4
Endocet 7.5-325 Mg Tablet	7.5-325 MG	2.666666667
Hydrocodone-acetaminophen 2.5-325	2.5-325 MG	12
Hydrocodone-acetaminophen 7.5-300	7.5-300 MG	4
Hydrocodone-acetaminophen 7.5-325	7.5-325 MG	4

Hydrocodone-acetaminophen 7.5-750	7.5-750 MG	4
Hydrocodone-acetaminophen 5-300	5 MG-300MG	6
Hydrocodone-acetaminophen 5-325	5 MG-325MG	6
Hydrocodone-acetaminophen 5-500	5 MG-500MG	6
Hydrocodone-acetaminophen 10-300	10MG-300MG	3
Hydrocodone-acetaminophen 10-325	10MG-325MG	3
Hydrocodone-ibuprofen 2.5-200	2.5-200MG	12
Hydrocodone-ibuprofen 5-200 Mg	5MG-200MG	6
Hydrocodone-ibuprofen 7.5-200	7.5-200 MG	4
Hydrocodone-ibuprofen 10-200	10MG-200MG	3
Meperidine 50 Mg Tablet	50 MG	6
Meperidine 100 Mg Tablet	100 MG	3
Morphine 10 Mg Suppository	10 MG	3
Oxaydo 7.5 Mg Tablet	7.5 MG	2.666666667
Oxycodone 5 Mg Capsule	5 MG	4
Oxycodone 5 Mg Tablet	5 MG	4
Oxycodone-aspirin 4.83-325 Mg	4.8355-325	4.136076931
Primlev 5-300 Mg Tablet	5 MG-300MG	4
Tramadol 50 Mg Tablet	50 MG	6
Tramadol-acetaminophen 37.5-325	37.5-325MG	8

3 . Revision History

Date	Notes
12/17/2025	Update GPI list to remove obsolete products.

Signifor



Prior Authorization Guideline

Guideline ID	GL-531196
Guideline Name	Signifor
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 Nebraska Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Signifor

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of endogenous Cushing's disease (i.e., hypercortisolism is not a result of chronic administration of high dose glucocorticoids) AND 2 - One of the following: - Pituitary surgery has not been curative for the patient - Patient is not a candidate for pituitary surgery	

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

2 . Revision History

Date	Notes
2/25/2026	Removed IN formulary - see state Cushing's Syndrome Agents GL-5 31190 for 4/1/26. No other changes to guideline.

Siklos



Prior Authorization Guideline

Guideline ID	GL-504203
Guideline Name	Siklos
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

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Siklos	
Diagnosis	Sickle Cell Anemia
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has moderate to severe painful crises AND 2 - Prescriber provides a reason or special circumstance the patient cannot use Droxia capsules (please document reason/special circumstances)	

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

2 . Revision History

Date	Notes
1/15/2026	New Program.

Siliq



Prior Authorization Guideline

Guideline ID	GL-531243
Guideline Name	Siliq
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 New Mexico

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Siliq	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic moderate to severe plaque psoriasis

AND

2 - Patient is not receiving Siliq in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, ustekinumab, Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

AND

3 - Prescribed by or in consultation with a dermatologist

AND

4 - One of the following:

4.1 Patient is currently on Siliq therapy as confirmed by claims history or submitted medical records

OR

4.2 All of the following:

4.2.1 One of the following:

4.2.1.1 All of the following:

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

AND

4.2.1.1.2 One of the following:

- Failure of ONE of the following topical therapy classes as confirmed by claims history or submitted medical records: Corticosteroids (e.g., betamethasone, clobetasol, desonide), Vitamin D analogs (e.g., calcitriol, calcipotriene), Tazarotene, Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus), Anthralin, Coal tar
- History of intolerance or contraindication to ALL of the following topical therapy classes (please specify intolerance or contraindication): Corticosteroids (e.g., betamethasone, clobetasol, desonide), Vitamin D analogs (e.g., calcitriol, calcipotriene), Tazarotene, Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus), Anthralin, Coal tar

AND

4.2.1.1.3 One of the following:

- Failure of a 3 month trial of methotrexate, at maximally indicated dose, confirmed by claims history or submitted medical records
- History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

OR

4.2.1.2 Patient has been previously treated with a targeted immunomodulator FDA-approved for the treatment of plaque psoriasis as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), adalimumab, Otezla (apremilast), Skyrizi (risankizumab-rzaa), ustekinumab, Tremfya (guselkumab)]

AND

4.2.2 One of the following:

4.2.2.1 Failure to TWO of the following preferred products, confirmed by claims history or submitted medical records:

- One of the preferred adalimumab products*
- Enbrel (etanercept)
- One of the preferred ustekinumab products*

OR

4.2.2.2 History of intolerance or contraindication to ALL of the following preferred products (please specify intolerance or contraindication):

- One of the preferred adalimumab products*
- Enbrel (etanercept)
- One of the preferred ustekinumab products*

AND

4.2.3 One of the following:

4.2.3.1 Failure to Cosentyx (secukinumab) as confirmed by claims history or submitted medical records

OR

4.2.3.2 History of contraindication or intolerance to Cosentyx (secukinumab) (please specify contraindication or intolerance)

Notes	*See PDL links in Background

Product Name:Siliq

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Siliq therapy

AND

2 - Patient is not receiving Siliq in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, ustekinumab, Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

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 NM: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-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 RI: https://www.uhcprovider.com/en/health-plans-by-state/rhode-island-health-plans/ri-comm-plan-home/ri-cp-pharmacy.html

3 . Revision History

Date	Notes
3/3/2026	Removed NY

Simponi



Prior Authorization Guideline

Guideline ID	GL-537193
Guideline Name	Simponi
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 New Mexico

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name: Simponi	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active rheumatoid arthritis (RA)

AND

2 - Patient is NOT receiving Simponi in combination with another systemic targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Orenzia (abatacept), Rinvoq (upadacitinib), Xeljanz/Xeljanz XR (tofacitinib)] for the treatment of the same indication

AND

3 - Prescribed by or in consultation with a rheumatologist

AND

4 - ONE of the following:

4.1 Patient is currently on Simponi therapy as confirmed by claims history or submission of medical records

OR

4.2 BOTH of the following:

4.2.1 ONE of the following:

4.2.1.1 Failure to a 3 month trial of ONE non-biologic DMARD (e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine) at maximally indicated doses, confirmed by claims history or submitted medical records

OR

4.2.1.2 History of intolerance or contraindication to ONE non-biologic DMARD (e.g.,

methotrexate, leflunomide, sulfasalazine, hydroxychloroquine) (please specify intolerance or contraindication)

OR

4.2.1.3 Patient has been previously treated with a systemic targeted immunomodulator FDA-approved for the treatment of rheumatoid arthritis as confirmed by claims history or submission of medical records [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Xeljanz/Xeljanz XR (tofacitinib)]

AND

4.2.2 ONE of the following:

- Failure to THREE of the following as confirmed by claims history or submitted medical records: One of the preferred adalimumab products*, Enbrel (etanercept), Olumiant (baricitinib), Tyenne (tocilizumab-aazg)
- History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication): One of the preferred adalimumab products*, Enbrel (etanercept), Olumiant (baricitinib), Tyenne (tocilizumab-aazg)

Notes	*See PDL links in Background

Product Name: Simponi

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

Approval Criteria

1 - Diagnosis of active psoriatic arthritis

AND

2 - Patient is NOT receiving Simponi in combination with another systemic targeted immunomodulator [e.g., e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Otezla (apremilast), Rinvoq (upadacitinib), Skyrizi (risankizumab), Taltz (ixekizumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), ustekinumab] for the treatment of the same indication

AND

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

- Rheumatologist
- Dermatologist

AND

4 - ONE of the following:

4.1 Patient is currently on Simponi therapy as confirmed by claims history or submission of medical records

OR

4.2 BOTH of the following:

4.2.1 ONE of the following:

4.2.1.1 Failure to a 3 month trial of methotrexate at maximally indicated dose, confirmed by claims history or submitted medical records

OR

4.2.1.2 History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

OR

4.2.1.3 Patient has been previously treated with a systemic targeted immunomodulator

FDA-approved for the treatment of psoriatic arthritis as confirmed by claims history or submission of medical records [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Orencia (abatacept), Otezla (apremilast), Rinvoq (upadacitinib), Skyrizi (risankizumab), Taltz (ixekizumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), ustekinumab]

AND

4.2.2 BOTH of the following:

4.2.2.1 ONE of the following:

- Failure to TWO of the following as confirmed by claims history or submitted medical records: One of the preferred adalimumab products*, Enbrel (etanercept), One of the preferred ustekinumab products*
- History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication): One of the preferred adalimumab products*, Enbrel (etanercept), One of the preferred ustekinumab products*

AND

4.2.2.2 ONE of the following:

- Failure to Cosentyx (secukinumab) as confirmed by claims history or submitted medical records
- History of intolerance or contraindication to Cosentyx (secukinumab) (please specify intolerance or contraindication)

Notes	*See PDL links in Background

Product Name: Simponi

Diagnosis	Ankylosing Spondylitis

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of active ankylosing spondylitis

AND

2 - Patient is NOT receiving Simponi in combination with another systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Rinvoq (upadacitinib), Taltz (ixekizumab), Xeljanz (tofacitinib)] for treatment of the same indication

AND

3 - Prescribed by or in consultation with a rheumatologist

AND

4 - ONE of the following:

4.1 Patient is currently on Simponi therapy as confirmed by claims history or submission of medical records

OR

4.2 BOTH of the following:

4.2.1 ONE of the following:

4.2.1.1 Failure to TWO NSAIDs (non-steroidal anti-inflammatory drugs) (e.g., ibuprofen, naproxen) at maximally indicated doses, each used for at least 4 weeks confirmed by claims history or submitted medical records

OR

4.2.1.2 History of intolerance or contraindication to TWO NSAIDs (please specify intolerance or contraindication)

OR

4.2.1.3 Patient has been previously treated with a systemic targeted immunomodulator FDA-approved for the treatment of ankylosing spondylitis as confirmed by claims history or submission of medical records [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Rinvoq (upadacitinib), Taltz (ixekizumab), Xeljanz (tofacitinib)]

AND

4.2.2 BOTH of the following:

4.2.2.1 ONE of the following:

- Failure to BOTH of the following as confirmed by claims history or submitted medical records: One of the preferred adalimumab products*, Enbrel (etanercept)
- History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication): One of the preferred adalimumab products*, Enbrel (etanercept)

AND

4.2.2.2 ONE of the following:

- Failure to Cosentyx (secukinumab) as confirmed by claims history or submitted medical records
- History of intolerance or contraindication to Cosentyx (secukinumab) (please specify intolerance or contraindication)

Notes

*See PDL links in Background

Product Name: Simponi

Diagnosis | Ulcerative Colitis

Approval Length | 12 month(s)

Therapy Stage | Initial Authorization

Guideline Type | Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severely active ulcerative colitis

AND

2 - Patient is NOT receiving Simponi in combination with another systemic targeted immunomodulator [e.g., adalimumab, Entyvio (vedolizumab), Omvoh (mirikizumab-mrkz), Rinvoq (upadacitinib), Skyrizi (risankizumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), ustekinumab, Zeposia (ozanimod)] for the same indication

AND

3 - Prescribed by or in consultation with a gastroenterologist

AND

4 - ONE of the following:

4.1 Patient is currently on Simponi therapy as confirmed by claims history or submission of medical records

OR

4.2 BOTH of the following:

4.2.1 ONE of the following:

4.2.1.1 Patient has had prior or concurrent inadequate response to a therapeutic course of oral corticosteroids and/or immunosuppressants (e.g., azathioprine, 6-mercaptopurine) as confirmed by claims history or submitted medical records

OR

4.2.1.2 Patient has been previously treated with a systemic targeted immunomodulator FDA-approved for the treatment of ulcerative colitis as confirmed by claims history or submission of medical records [e.g., adalimumab, Entyvio (vedolizumab), Omvoh (mirikizumab-mrkz), Rinvoq (upadacitinib), Skyrizi (risankizumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), ustekinumab, Zeposia (ozanimod)]

AND

4.2.2 ONE of the following:

- Failure to one of the following as confirmed by claims history or submitted medical records: One of the preferred adalimumab products*, One of the preferred ustekinumab products*
- History of intolerance or contraindication to both of the following (please specify intolerance or contraindication): One of the preferred adalimumab products*, One of the preferred ustekinumab products*

Notes	*See PDL links in Background

Product Name: Simponi	
Diagnosis	Rheumatoid Arthritis (RA), Psoriatic Arthritis, Ankylosing Spondylitis, Ulcerative Colitis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Simponi therapy AND 2 - Patient is not receiving Simponi in combination with another systemic targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Xeljanz/Xeljanz XR (tofacitinib)] for the treatment of the same indication*	
Notes	* Examples of drug(s) may not be applicable based on the requested indication.

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 NM: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-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

3 . Revision History

Date	Notes
3/3/2026	Removed NY

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 Staphylococcus aureus (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.

Skyclarys



Prior Authorization Guideline

Guideline ID	GL-127205
Guideline Name	Skyclarys
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

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

Date	Notes
6/28/2023	New guideline

Skyclarys



Prior Authorization Guideline

Guideline ID	GL-127205
Guideline Name	Skyclarys
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

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

Date	Notes
6/28/2023	New guideline

Skyrizi



Prior Authorization Guideline

Guideline ID	GL-537199
Guideline Name	Skyrizi
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 New Mexico

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Skyrizi	
Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe plaque psoriasis

AND

2 - Patient is NOT receiving Skyrizi in combination with another targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Ilumya (tildrakizumab), Otezla (apremilast), Siliq (brodalumab), Sotyktu (deucravacitinib), Taltz (ixekizumab), Tremfya (guselkumab), ustekinumab]

AND

3 - Prescribed by or in consultation with a dermatologist

AND

4 - One of the following:

4.1 Patient is currently on Skyrizi therapy as confirmed by claims history or submission of medical records

OR

4.2 ALL of the following:

4.2.1 One of the following:

4.2.1.1 Patient has been previously treated with a targeted immunomodulator FDA-approved for the treatment of plaque psoriasis as confirmed by claims history or submission of medical records [e.g., adalimumab, Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Otezla (apremilast), Sotyktu (deucravacitinib), Tremfya (guselkumab), ustekinumab]

OR

4.2.1.2 All of the following:

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

AND

4.2.1.2.2 One of the following:

- Failure to ONE of the following topical therapy classes confirmed by claims history or submission of medical records: Corticosteroids (e.g., betamethasone, clobetasol, desonide), Vitamin D analogs (e.g., calcitriol, calcipotriene), Tazarotene, Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus), Anthralin, Coal tar
- History of intolerance or contraindication to ALL of the following topical therapies classes (please specify intolerance or contraindication): Corticosteroids (e.g., betamethasone, clobetasol, desonide), Vitamin D analogs (e.g., calcitriol, calcipotriene), Tazarotene, Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus), Anthralin, Coal tar

AND

4.2.1.2.3 One of the following:

- Failure to a 3 month trial of methotrexate at maximally indicated dose confirmed by claims history or submission of medical records
- History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

AND

4.2.2 One of the following:

4.2.2.1 Failure to TWO of the following preferred* products, confirmed by claims history or submitted medical records:

- One of the preferred adalimumab products
- Enbrel (etanercept)
- One of the preferred ustekinumab products

OR

4.2.2.2 History of intolerance or contraindication to ALL of the following preferred* products (please specify intolerance or contraindication):

- One of the preferred adalimumab products
- Enbrel (etanercept)
- One of the preferred ustekinumab products

AND

4.2.3 One of the following:

- Failure to Cosentyx (secukinumab) confirmed by claims history or submission of medical records
- History of intolerance or contraindication to Cosentyx (secukinumab) (please specify intolerance or contraindication)

Notes	*See PDL links in Background

Product Name:Skyrizi	
Diagnosis	Psoriatic Arthritis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of active psoriatic arthritis AND 2 - Patient is NOT receiving Skyrizi in combination with another targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Ilumya (tildrakizumab), Otezla (apremilast), Siliq (brodalumab), Sotyktu (deucravacitinib), Taltz (ixekizumab), Tremfya (guselkumab), ustekinumab]	

AND

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

- Rheumatologist
- Dermatologist

AND

4 - One of the following:

4.1 Patient is currently on Skyrizi therapy as confirmed by claims history or submission of medical records

OR

4.2 BOTH of the following:

4.2.1 One of the following:

- Failure to a 3 month trial of methotrexate at the maximally indicated dose confirmed by claims history or submission of medical records
- History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)
- Patient has been previously treated with a targeted immunomodulator FDA-approved for the treatment of psoriatic arthritis as confirmed by claims history or submission of medical records [e.g., adalimumab, Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Otezla (apremilast), Rinvoq (upadacitinib), Simponi (golimumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), ustekinumab]

AND

4.2.2 Both of the following:

4.2.2.1 One of the following:

- Failure to TWO of the following as confirmed by claims history or submission of medical records: One of the preferred adalimumab products*, Enbrel (etanercept), One of the preferred ustekinumab products*

- History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication): One of the preferred adalimumab products*, Enbrel (etanercept), One of the preferred ustekinumab products*

AND

4.2.2.2 One of the following:

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

Notes

*See PDL links in Background

Product Name:Skyrizi

Diagnosis Crohn's Disease

Approval Length 12 month(s)

Therapy Stage Initial Authorization

Guideline Type Prior Authorization

Approval Criteria

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

AND

2 - One of the following:

2.1 Patient has been approved for loading dose of Skyrizi under an active UnitedHealthcare medical benefit prior authorization for the treatment of moderately to severely active Crohn's disease

OR

2.2 Patient is currently on Skyrizi therapy for moderately to severely active Crohn's disease as confirmed by claims history or submission of medical records

AND

3 - Patient is NOT receiving Skyrizi in combination with another targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Ilumya (tildrakizumab), Otezla (apremilast), Siliq (brodalumab), Sotyktu (deucravacitinib), Taltz (ixekizumab), Tremfya (guselkumab), ustekinumab]

AND

4 - Prescribed by or in consultation with a gastroenterologist

Product Name:Skyrizi	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderately to severely active ulcerative colitis AND 2 - One of the following: 2.1 Patient has been approved for loading dose of Skyrizi under an active UnitedHealthcare medical benefit prior authorization for the treatment of moderately to severely active ulcerative colitis OR	

2.2 Patient is currently on Skyrizi therapy for moderately to severely active ulcerative colitis as confirmed by claims history or submission of medical records

AND

3 - Patient is NOT receiving Skyrizi in combination with another targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Ilumya (tildrakizumab), Otezla (apremilast), Siliq (brodalumab), Sotyktu (deucravacitinib), Taltz (ixekizumab), Tremfya (guselkumab), ustekinumab]

AND

4 - Prescribed by or in consultation with a gastroenterologist

Product Name:Skyrizi	
Diagnosis	Plaque Psoriasis, Psoriatic Arthritis (PsA), Crohn's Disease (CD), Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Skyrizi therapy AND 2 - Patient is NOT receiving Skyrizi in combination with another targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Ilumya (tildrakizumab), Otezla (apremilast), Siliq (brodalumab), Sotyktu (deucravacitinib), Taltz (ixekizumab), Tremfya (guselkumab), ustekinumab]*	
Notes	* Examples of drug(s) may not be applicable based on the requested indication.

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 NM: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-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

3 . Revision History

Date	Notes
3/3/2026	Removed NY

Skyrizi



Prior Authorization Guideline

Guideline ID	GL-537199
Guideline Name	Skyrizi
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 New Mexico

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Skyrizi	
Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe plaque psoriasis

AND

2 - Patient is NOT receiving Skyrizi in combination with another targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Ilumya (tildrakizumab), Otezla (apremilast), Siliq (brodalumab), Sotyktu (deucravacitinib), Taltz (ixekizumab), Tremfya (guselkumab), ustekinumab]

AND

3 - Prescribed by or in consultation with a dermatologist

AND

4 - One of the following:

4.1 Patient is currently on Skyrizi therapy as confirmed by claims history or submission of medical records

OR

4.2 ALL of the following:

4.2.1 One of the following:

4.2.1.1 Patient has been previously treated with a targeted immunomodulator FDA-approved for the treatment of plaque psoriasis as confirmed by claims history or submission of medical records [e.g., adalimumab, Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Otezla (apremilast), Sotyktu (deucravacitinib), Tremfya (guselkumab), ustekinumab]

OR

4.2.1.2 All of the following:

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

AND

4.2.1.2.2 One of the following:

- Failure to ONE of the following topical therapy classes confirmed by claims history or submission of medical records: Corticosteroids (e.g., betamethasone, clobetasol, desonide), Vitamin D analogs (e.g., calcitriol, calcipotriene), Tazarotene, Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus), Anthralin, Coal tar
- History of intolerance or contraindication to ALL of the following topical therapies classes (please specify intolerance or contraindication): Corticosteroids (e.g., betamethasone, clobetasol, desonide), Vitamin D analogs (e.g., calcitriol, calcipotriene), Tazarotene, Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus), Anthralin, Coal tar

AND

4.2.1.2.3 One of the following:

- Failure to a 3 month trial of methotrexate at maximally indicated dose confirmed by claims history or submission of medical records
- History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

AND

4.2.2 One of the following:

4.2.2.1 Failure to TWO of the following preferred* products, confirmed by claims history or submitted medical records:

- One of the preferred adalimumab products
- Enbrel (etanercept)
- One of the preferred ustekinumab products

OR

4.2.2.2 History of intolerance or contraindication to ALL of the following preferred* products (please specify intolerance or contraindication):

- One of the preferred adalimumab products
- Enbrel (etanercept)
- One of the preferred ustekinumab products

AND

4.2.3 One of the following:

- Failure to Cosentyx (secukinumab) confirmed by claims history or submission of medical records
- History of intolerance or contraindication to Cosentyx (secukinumab) (please specify intolerance or contraindication)

Notes	*See PDL links in Background

Product Name:Skyrizi	
Diagnosis	Psoriatic Arthritis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of active psoriatic arthritis AND 2 - Patient is NOT receiving Skyrizi in combination with another targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Ilumya (tildrakizumab), Otezla (apremilast), Siliq (brodalumab), Sotyktu (deucravacitinib), Taltz (ixekizumab), Tremfya (guselkumab), ustekinumab]	

AND

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

- Rheumatologist
- Dermatologist

AND

4 - One of the following:

4.1 Patient is currently on Skyrizi therapy as confirmed by claims history or submission of medical records

OR

4.2 BOTH of the following:

4.2.1 One of the following:

- Failure to a 3 month trial of methotrexate at the maximally indicated dose confirmed by claims history or submission of medical records
- History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)
- Patient has been previously treated with a targeted immunomodulator FDA-approved for the treatment of psoriatic arthritis as confirmed by claims history or submission of medical records [e.g., adalimumab, Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Otezla (apremilast), Rinvoq (upadacitinib), Simponi (golimumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), ustekinumab]

AND

4.2.2 Both of the following:

4.2.2.1 One of the following:

- Failure to TWO of the following as confirmed by claims history or submission of medical records: One of the preferred adalimumab products*, Enbrel (etanercept), One of the preferred ustekinumab products*

- History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication): One of the preferred adalimumab products*, Enbrel (etanercept), One of the preferred ustekinumab products*

AND

4.2.2.2 One of the following:

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

Notes	*See PDL links in Background

Product Name:Skyrizi

Diagnosis	Crohn's Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

AND

2 - One of the following:

2.1 Patient has been approved for loading dose of Skyrizi under an active UnitedHealthcare medical benefit prior authorization for the treatment of moderately to severely active Crohn's disease

OR

2.2 Patient is currently on Skyrizi therapy for moderately to severely active Crohn's disease as confirmed by claims history or submission of medical records

AND

3 - Patient is NOT receiving Skyrizi in combination with another targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Ilumya (tildrakizumab), Otezla (apremilast), Siliq (brodalumab), Sotyktu (deucravacitinib), Taltz (ixekizumab), Tremfya (guselkumab), ustekinumab]

AND

4 - Prescribed by or in consultation with a gastroenterologist

Product Name:Skyrizi	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderately to severely active ulcerative colitis AND 2 - One of the following: 2.1 Patient has been approved for loading dose of Skyrizi under an active UnitedHealthcare medical benefit prior authorization for the treatment of moderately to severely active ulcerative colitis OR	

2.2 Patient is currently on Skyrizi therapy for moderately to severely active ulcerative colitis as confirmed by claims history or submission of medical records

AND

3 - Patient is NOT receiving Skyrizi in combination with another targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Ilumya (tildrakizumab), Otezla (apremilast), Siliq (brodalumab), Sotyktu (deucravacitinib), Taltz (ixekizumab), Tremfya (guselkumab), ustekinumab]

AND

4 - Prescribed by or in consultation with a gastroenterologist

Product Name:Skyrizi	
Diagnosis	Plaque Psoriasis, Psoriatic Arthritis (PsA), Crohn's Disease (CD), Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Skyrizi therapy AND 2 - Patient is NOT receiving Skyrizi in combination with another targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Ilumya (tildrakizumab), Otezla (apremilast), Siliq (brodalumab), Sotyktu (deucravacitinib), Taltz (ixekizumab), Tremfya (guselkumab), ustekinumab]*	
Notes	* Examples of drug(s) may not be applicable based on the requested indication.

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 NM: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-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

3 . Revision History

Date	Notes
3/3/2026	Removed NY

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.

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.

Sotyktu



Prior Authorization Guideline

Guideline ID	GL-542197
Guideline Name	Sotyktu
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 New Mexico

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Sotyktu	
Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe plaque psoriasis

AND

2 - ONE of the following:

2.1 ALL of the following:

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

AND

2.1.2 ONE of the following:

2.1.2.1 Failure to ONE of the following topical therapy classes confirmed by claims history or submission of medical records:

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Anthralin
- Coal tar

OR

2.1.2.2 History of intolerance or contraindication to ALL of the following topical therapy classes (please specify intolerance or contraindication):

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Anthralin
- Coal tar

AND

2.1.3 ONE of the following:

2.1.3.1 Failure to a 3 month trial of methotrexate at the maximally indicated dose confirmed by claims history or submission of medical records

OR

2.1.3.2 History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

OR

2.2 Patient has been previously treated with a systemic targeted immunomodulator FDA-approved for the treatment of plaque psoriasis as confirmed by claims history or submission of medical records [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Ilumya (tildrakizumab), Otezla (apremilast), Skyrizi (risankizumab), Siliq (brodalumab), Taltz (ixekizumab), Tremfya (guselkumab), ustekinumab]

AND

3 - ONE of the following:

3.1 Patient is currently on Sotyktu therapy as confirmed by claims history or submission of medical records

OR

3.2 BOTH of the following:

3.2.1 ONE of the following:

3.2.1.1 Failure to ALL of the following preferred products confirmed by claims history or submission of medical records:

- One of the preferred adalimumab products*
- Enbrel (etanercept)

- One of the preferred ustekinumab products*

OR

3.2.1.2 History of intolerance or contraindication to ALL of the following preferred products (please specify intolerance or contraindication):

- One of the preferred adalimumab products*
- Enbrel (etanercept)
- One of the preferred ustekinumab products*

AND

3.2.2 ONE of the following:

3.2.2.1 Failure to Cosentyx (secukinumab) confirmed by claims history or submission of medical records

OR

3.2.2.2 History of intolerance or contraindication to Cosentyx (secukinumab) (please specify intolerance or contraindication)

AND

4 - Patient is NOT receiving Sotyktu in combination with another systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Ilumya (tildrakizumab), Otezla (apremilast), Skyrizi (risankizumab), Siliq (brodalumab), Taltz (ixekizumab), Tremfya (guselkumab), ustekinumab] for the treatment of the same indication

AND

5 - Prescribed by or in consultation with a dermatologist

Notes

*See PDL links in Background

Product Name:Sotyktu

Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Sotyktu therapy AND 2 - Patient is NOT receiving Sotyktu in combination with another systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Ilumya (tildrakizumab), Otezla (apremilast), Skyrizi (risankizumab), Siliq (brodalumab), Taltz (ixekizumab), Tremfya (guselkumab), ustekinumab] for the treatment of the same indication	

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>

NM: <https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-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>

3 . Revision History

Date	Notes
3/4/2026	Removed NY-CHIP. Removed PDL link for NY from Background.

Spevigo



Prior Authorization Guideline

Guideline ID	GL-507572
Guideline Name	Spevigo
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

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

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

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of generalized pustular psoriasis (GPP) based on BOTH of the following: 1.1 Presence of primary, sterile, macroscopically visible pustules on erythematous base AND 1.2 Pustulation is NOT restricted to the acral region or within psoriatic plaques AND 2 - BOTH of the following: • Used to prevent GPP flares • Patient is NOT currently experiencing a GPP flare AND 3 - ONE of the following: 3.1 Patient has been established on therapy with Spevigo for GPP under an active UnitedHealthcare medical benefit prior authorization OR 3.2 Patient is currently on Spevigo therapy for GPP as documented by claims history or submission of medical records OR 3.3 ALL of the following: 3.3.1 Patient has not previously been treated with Spevigo	

AND

3.3.2 During the previous 12 months prior to initiating subcutaneous Spevigo the patient has had one or more moderate to severe GPP flares based on ONE of the following:

- Generalized Pustular Psoriasis Physician Global Assessment (GPPPGA) total score greater than or equal to 3 (moderate)
- GPPPGA pustulation subscore greater than or equal to 2 (mild)
- Erythema and pustules cover greater than or equal to 5% of body-surface area
- New appearance or worsening of pustules

AND

3.3.3 Prescriber attests that the patient has experienced flares of a severity and/or frequency such that they would clinically benefit from prophylactic therapy with subcutaneous Spevigo

AND

4 - Patient is NOT receiving Spevigo in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), ustekinumab, Skyrizi (risankizumab)] for treatment of the same indication

AND

5 - Prescribed by a dermatologist

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

1 - Documentation of positive clinical response to therapy [e.g., preventing flares, reducing frequency of flares, prolonging time between flares, controlling signs and symptoms of GPP (e.g. pustules, erythema, pain, itching) between flares]

AND

2 - Reduction in the utilization of therapy (e.g., intravenous Spevigo) used for GPP flares

AND

3 - Patient is NOT receiving Spevigo in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), ustekinumab, Skyrizi (risankizumab)] for treatment of the same indication

AND

4 - Prescribed by a dermatologist

2 . Revision History

Date	Notes
1/27/2026	Removed WA

Spravato



Prior Authorization Guideline

Guideline ID	GL-578191
Guideline Name	Spravato
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 Virginia

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Spravato	
Diagnosis	Major Depressive Disorder (Treatment-Resistant)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of major depressive disorder (treatment-resistant), according to the current Diagnostic and Statistical Manual of Mental Disorders (DSM) (i.e., DSM-5-TR) criteria, by a mental health professional

AND

2 - Submission of medical records (e.g., chart notes, laboratory values) documenting baseline scoring (prior to starting Spravato) on at least ONE of the following clinical assessments has been completed:

- Beck Depression Inventory (BDI)
- Hamilton Rating Scale for Depression (HAM-D)
- Montgomery-Asberg Depression Rating Scale (MADRS)
- 9-item Patient Health Questionnaire (PHQ-9)
- Quick Inventory of Depressive Symptomatology (QIDS)

AND

3 - History of failure of a trial of at least TWO different antidepressant medications or treatment regimens for a duration of at least 8 weeks each, confirmed by claims history or submitted medical records. An antidepressant or treatment regimen would include any of the following classes or combinations:

- Selective serotonin reuptake inhibitors (e.g., citalopram, fluoxetine, paroxetine, sertraline)
- Serotonin norepinephrine reuptake inhibitors (e.g., duloxetine, venlafaxine, etc.)
- Bupropion
- Tricyclic antidepressants (e.g., amitriptyline, clomipramine, nortriptyline, etc.)
- Mirtazapine
- Monoamine oxidase inhibitors (e.g., selegiline, tranylcypromine, etc.)
- Serotonin modulators (e.g., nefazodone, trazodone, etc.)
- Augmentation with antipsychotics, lithium, or thyroid hormone

AND

4 - Provider and/or the provider's healthcare setting is certified in the Spravato REMS (Risk Evaluation and Mitigation Strategy) program

AND

5 - Prescribed by or in consultation with a psychiatrist

Product Name: Spravato

Diagnosis	Major Depressive Disorder (Treatment-Resistant)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of remission or a positive clinical response to Spravato therapy

AND

2 - Submission of medical records (e.g., chart notes, laboratory values) documenting baseline and recent (within the last month) scoring on at least ONE of the following assessments demonstrating remission or clinical response (e.g., score reduction from baseline):

- Beck Depression Inventory (BDI)
- Hamilton Rating Scale for Depression (HAM-D)
- Montgomery-Asberg Depression Rating Scale (MADRS)
- 9-item Patient Health Questionnaire (PHQ-9)
- Quick Inventory of Depressive Symptomatology (QIDS)

AND

3 - Provider and/or the provider's healthcare setting is certified in the Spravato REMS (Risk Evaluation and Mitigation Strategy) program

AND

4 - Prescribed by or in consultation with a psychiatrist

Product Name:Spravato*	
Diagnosis	Depressive symptoms in an adult with major depressive disorder (MDD) with acute suicidal ideation or behavior
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of major depressive disorder according to the current Diagnostic and Statistical Manual of Mental Disorders (DSM) (i.e., DSM-5-TR) criteria, by a mental health professional AND 2 - Patient is experiencing an acute suicidal ideation or behavior AND 3 - Spravato will be used in combination with a newly initiated or optimized oral antidepressant AND 4 - Provider and/or the provider's healthcare setting is certified in the Spravato REMS (Risk Evaluation and Mitigation Strategy) program	
Notes	*Spravato is hard-coded with a quantity of 0.29 per day for the 56mg strength and 0.43 per day for the 84mg strength. If criteria are met, enter one GPI-12 authorization with an MDD override of 1 and a PQE of 24 per 28 days.

Product Name:Spravato*	
Diagnosis	Depressive symptoms in an adult with major depressive disorder (MDD) with acute suicidal ideation or behavior
Approval Length	12 month(s)

Guideline Type	Quantity Limit
Approval Criteria 1 - The requested drug is prescribed within the manufacturer's published dosing guidelines or falls within dosing guidelines found in the compendia of current literature	
Notes	*Spravato is hard-coded with a quantity of 0.29 per day for the 56mg strength and 0.43 per day for the 84mg strength. If criteria are met, enter one GPI-12 authorization with an MDD override of 1 and a PQE of 24 per 28 days.

2 . Revision History

Date	Notes
4/13/2026	Removed NM

Spravato



Prior Authorization Guideline

Guideline ID	GL-578191
Guideline Name	Spravato
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 Virginia

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Spravato	
Diagnosis	Major Depressive Disorder (Treatment-Resistant)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of major depressive disorder (treatment-resistant), according to the current Diagnostic and Statistical Manual of Mental Disorders (DSM) (i.e., DSM-5-TR) criteria, by a mental health professional

AND

2 - Submission of medical records (e.g., chart notes, laboratory values) documenting baseline scoring (prior to starting Spravato) on at least ONE of the following clinical assessments has been completed:

- Beck Depression Inventory (BDI)
- Hamilton Rating Scale for Depression (HAM-D)
- Montgomery-Asberg Depression Rating Scale (MADRS)
- 9-item Patient Health Questionnaire (PHQ-9)
- Quick Inventory of Depressive Symptomatology (QIDS)

AND

3 - History of failure of a trial of at least TWO different antidepressant medications or treatment regimens for a duration of at least 8 weeks each, confirmed by claims history or submitted medical records. An antidepressant or treatment regimen would include any of the following classes or combinations:

- Selective serotonin reuptake inhibitors (e.g., citalopram, fluoxetine, paroxetine, sertraline)
- Serotonin norepinephrine reuptake inhibitors (e.g., duloxetine, venlafaxine, etc.)
- Bupropion
- Tricyclic antidepressants (e.g., amitriptyline, clomipramine, nortriptyline, etc.)
- Mirtazapine
- Monoamine oxidase inhibitors (e.g., selegiline, tranylcypromine, etc.)
- Serotonin modulators (e.g., nefazodone, trazodone, etc.)
- Augmentation with antipsychotics, lithium, or thyroid hormone

AND

4 - Provider and/or the provider's healthcare setting is certified in the Spravato REMS (Risk Evaluation and Mitigation Strategy) program

AND

5 - Prescribed by or in consultation with a psychiatrist

Product Name: Spravato

Diagnosis	Major Depressive Disorder (Treatment-Resistant)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of remission or a positive clinical response to Spravato therapy

AND

2 - Submission of medical records (e.g., chart notes, laboratory values) documenting baseline and recent (within the last month) scoring on at least ONE of the following assessments demonstrating remission or clinical response (e.g., score reduction from baseline):

- Beck Depression Inventory (BDI)
- Hamilton Rating Scale for Depression (HAM-D)
- Montgomery-Asberg Depression Rating Scale (MADRS)
- 9-item Patient Health Questionnaire (PHQ-9)
- Quick Inventory of Depressive Symptomatology (QIDS)

AND

3 - Provider and/or the provider's healthcare setting is certified in the Spravato REMS (Risk Evaluation and Mitigation Strategy) program

AND

4 - Prescribed by or in consultation with a psychiatrist

Product Name:Spravato*	
Diagnosis	Depressive symptoms in an adult with major depressive disorder (MDD) with acute suicidal ideation or behavior
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of major depressive disorder according to the current Diagnostic and Statistical Manual of Mental Disorders (DSM) (i.e., DSM-5-TR) criteria, by a mental health professional AND 2 - Patient is experiencing an acute suicidal ideation or behavior AND 3 - Spravato will be used in combination with a newly initiated or optimized oral antidepressant AND 4 - Provider and/or the provider's healthcare setting is certified in the Spravato REMS (Risk Evaluation and Mitigation Strategy) program	
Notes	*Spravato is hard-coded with a quantity of 0.29 per day for the 56mg strength and 0.43 per day for the 84mg strength. If criteria are met, enter one GPI-12 authorization with an MDD override of 1 and a PQE of 24 per 28 days.

Product Name:Spravato*	
Diagnosis	Depressive symptoms in an adult with major depressive disorder (MDD) with acute suicidal ideation or behavior
Approval Length	12 month(s)

Guideline Type	Quantity Limit
Approval Criteria 1 - The requested drug is prescribed within the manufacturer's published dosing guidelines or falls within dosing guidelines found in the compendia of current literature	
Notes	*Spravato is hard-coded with a quantity of 0.29 per day for the 56mg strength and 0.43 per day for the 84mg strength. If criteria are met, enter one GPI-12 authorization with an MDD override of 1 and a PQE of 24 per 28 days.

2 . Revision History

Date	Notes
4/13/2026	Removed NM

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

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

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.

Stribild



Prior Authorization Guideline

Guideline ID	GL-204213
Guideline Name	Stribild
Formulary	Medicaid - Community & State Rhode Island

Guideline Note:

Effective Date:	4/1/2025

1 . Criteria

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. *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/rhode-island-health-plans/ri-comm-plan-home/ri-cp-pharmacy.html

2 . Revision History

Date	Notes
3/5/2025	Removed CO, NY, and NY EPP from markets in scope. For CO, Genvoya/Stribild are moving to the HIV guideline. For NY/NY EPP, Genvoya/Stribild are moving to open access. For RI, Genvoya is moving to open access, therefore removed Genvoya as a target from this guideline. Updated criteria and notes section for Stribild. Updated guideline name.

Stromectol



Prior Authorization Guideline

Guideline ID	GL-438197
Guideline Name	Stromectol
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 Washington Medicaid - Community & State New Mexico Medicaid - Community & State Pennsylvania

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name: Brand Stromectol, generic ivermectin tabs	
Approval Length	1 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following: • Onchocerciasis due to nematode parasite • Pediculosis • Strongyloidiasis • Ascariasis • Scabies (including crusted scabies) • Cutaneous larva migrans (hook worm disease) • Enterobiasis • Filariasis • Trichuriasis • Gnathostomiasis	

2 . Revision History

Date	Notes
11/5/2025	Added NV formulary. No clinical changes.

Sublingual Immunotherapy (SLIT)



Prior Authorization Guideline

Guideline ID	GL-438198
Guideline Name	Sublingual Immunotherapy (SLIT)
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 New Mexico Medicaid - Community & State Pennsylvania

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Grastek	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderate to severe grass pollen-induced allergic rhinitis defined by symptoms severe enough to interfere with quality of life (e.g., sleep disturbances; impairment of daily, sport, or leisure activities; impairment of school or work performance) AND 2 - Diagnosis confirmed by ONE of the following: 2.1 Positive skin test to Timothy grass or cross-reactive grass pollens (e.g., Sweet Vernal, Orchard/Cocksfoot, Perennial Rye, Kentucky blue/June grass, Meadow Fescue, or Redtop) OR 2.2 In vitro testing for pollen-specific IgE (immunoglobulin E) antibodies for Timothy grass or cross-reactive grass pollens (e.g., Sweet Vernal, Orchard/Cocksfoot, Perennial Rye, Kentucky blue/June grass, Meadow Fescue, or Redtop) AND 3 - Treatment is started or will be started at least 12 weeks before the beginning of the grass pollen season AND 4 - ONE of the following: 4.1 Failure to TWO of the following as confirmed by claims history or submission of medical records: • oral antihistamine [e.g., cetirizine (Zyrtec)] • intranasal antihistamine [e.g., azelastine (Astelin)] • intranasal corticosteroid [e.g., fluticasone (Flonase)]	

- leukotriene inhibitor [e.g., montelukast (Singulair)]

OR

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

- oral antihistamine [e.g., cetirizine (Zyrtec)]
- intranasal antihistamine [e.g., azelastine (Astelin)]
- intranasal corticosteroid [e.g., fluticasone (Flonase)]
- leukotriene inhibitor [e.g., montelukast (Singulair)]

AND

5 - Not received in combination with similar cross-reactive grass pollen immunotherapy (e.g., Oralair)

AND

6 - Patient does not have unstable and/or uncontrolled asthma

AND

7 - Prescribed by or in consultation with a specialist in allergy and immunology

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

Product Name:Oralair	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderate to severe grass pollen-induced allergic rhinitis defined by symptoms severe enough to interfere with quality of life (e.g., sleep disturbances; impairment of daily, sport, or leisure activities; impairment of school or work performance) AND 2 - Diagnosis confirmed by ONE of the following: 2.1 Positive skin test to any of the five grass species contained in Oralair [(i.e., Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue grass mixed pollens) or cross-reactive grass pollens (e.g., Cocksfoot, Meadow Fescue, or Redtop)] OR 2.2 In vitro testing for pollen-specific IgE (immunoglobulin E) antibodies for any of the five grass species contained in Oralair [(i.e., Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue grass mixed pollens) or cross-reactive grass pollens (e.g., Cocksfoot, Meadow Fescue, or Redtop)] AND 3 - Treatment is started or will be started at least 4 months before the beginning of the grass pollen season AND 4 - ONE of the following: 4.1 Failure to TWO of the following as confirmed by claims history or submission of medical records:	

- oral antihistamine [e.g., cetirizine (Zyrtec)]
- intranasal antihistamine [e.g., azelastine (Astelin)]
- intranasal corticosteroid [e.g., fluticasone (Flonase)]
- leukotriene inhibitor [e.g., montelukast (Singulair)]

OR

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

- oral antihistamine [e.g., cetirizine (Zyrtec)]
- intranasal antihistamine [e.g., azelastine (Astelin)]
- intranasal corticosteroid [e.g., fluticasone (Flonase)]
- leukotriene inhibitor [e.g., montelukast (Singulair)]

AND

5 - Not received in combination with similar cross-reactive grass pollen immunotherapy (e.g., Grastek)

AND

6 - Patient does not have unstable and/or uncontrolled asthma

AND

7 - Prescribed by or in consultation with a specialist in allergy and immunology

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

1 - Documentation of positive clinical response to Oralair therapy

Product Name:Ragwitek

Approval Length 12 month(s)

Therapy Stage Initial Authorization

Guideline Type Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe short ragweed pollen-induced allergic rhinitis defined by symptoms severe enough to interfere with quality of life (e.g., sleep disturbances; impairment of daily, sport, or leisure activities; impairment of school or work performance)

AND

2 - Diagnosis confirmed by ONE of the following:

- Positive skin test to short ragweed pollen
- In vitro testing for pollen-specific IgE (immunoglobulin E) antibodies for short ragweed pollen

AND

3 - Treatment is started or will be started at least 12 weeks before the beginning of the short ragweed pollen season

AND

4 - ONE of the following:

4.1 Failure to TWO of the following as confirmed by claims history or submission of medical records:

- oral antihistamine [e.g., cetirizine (Zyrtec)]
- intranasal antihistamine [e.g., azelastine (Astelin)]
- intranasal corticosteroid [e.g., fluticasone (Flonase)]

- leukotriene inhibitor [e.g., montelukast (Singulair)]

OR

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

- oral antihistamine [e.g., cetirizine (Zyrtec)]
- intranasal antihistamine [e.g., azelastine (Astelin)]
- intranasal corticosteroid [e.g., fluticasone (Flonase)]
- leukotriene inhibitor [e.g., montelukast (Singulair)]

AND

5 - Patient does not have unstable and/or uncontrolled asthma

AND

6 - Prescribed by or in consultation with a specialist in allergy and immunology

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

Product Name:Odactra	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of house dust mite (HDM)-induced allergic rhinitis

AND

2 - Diagnosis confirmed by ONE of the following:

- Positive skin test to licensed house dust mite allergen extracts
- In vitro testing for IgE (immunoglobulin E) antibodies to *Dermatophagoides farinae* or *Dermatophagoides pteronyssinus* house dust mites

AND

3 - ONE of the following:

3.1 Failure to TWO of the following as confirmed by claims history or submission of medical records:

- oral antihistamine [e.g., cetirizine (Zyrtec)]
- intranasal antihistamine [e.g., azelastine (Astelin)]
- intranasal corticosteroid [e.g., fluticasone (Flonase)]
- leukotriene inhibitor [e.g., montelukast (Singular)]

OR

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

- oral antihistamine [e.g., cetirizine (Zyrtec)]
- intranasal antihistamine [e.g., azelastine (Astelin)]
- intranasal corticosteroid [e.g., fluticasone (Flonase)]
- leukotriene inhibitor [e.g., montelukast (Singular)]

AND

4 - Patient does not have unstable and/or uncontrolled asthma

AND

5 - Prescribed by or in consultation with a specialist in allergy and immunology

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

2 . Revision History

Date	Notes
11/5/2025	Added NV formulary. No clinical changes.

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

Sunosi



Prior Authorization Guideline

Guideline ID	GL-451199
Guideline Name	Sunosi
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 New Mexico

Guideline Note:

Effective Date:	12/1/2025

1 . Criteria

Product Name:Sunosi	
Diagnosis	Narcolepsy
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
	Approval Criteria 1 - Submission of medical records (e.g., chart notes, lab values) documenting a diagnosis of narcolepsy with BOTH of the following: 1.1 The patient has daily periods of irrepressible need to sleep or daytime lapses into sleep occurring for at least three months. AND 1.2 A mean sleep latency of less than or equal to 8 minutes and two or more sleep onset rapid eye movement (REM) periods (SOREMPs) are found on a multiple sleep latency test (MSLT) performed according to standard techniques following a normal overnight polysomnogram. A SOREMP (within 15 minutes of sleep onset) on the preceding nocturnal polysomnogram may replace one of the SOREMPs on the MSLT. AND 2 - Physician attestation that other causes of sleepiness have been ruled out or treated (including but not limited to obstructive sleep apnea, insufficient sleep syndrome, shift work, the effects of substances or medications or their withdrawal, sleep phase disorder, or other sleep disorders) AND 3 - ONE of the following: 3.1 Failure to BOTH of the following as confirmed by claims history or submission of medical records: 3.1.1 ONE of the following: • Amphetamine based stimulant (e.g., amphetamine, dextroamphetamine) • Methylphenidate based stimulant AND

3.1.2 ONE of the following:

- Modafinil (generic Provigil)
- Armodafinil (generic Nuvigil)

OR

3.2 History of contraindication or intolerance to ALL of the following drugs or classes (please specify contraindication or intolerance):

- Amphetamine based stimulant (e.g., amphetamine, dextroamphetamine)
- Methylphenidate based stimulant
- Modafinil (generic Provigil)
- Armodafinil (generic Nuvigil)

AND

4 - Prescribed by ONE of the following:

- Neurologist
- Psychiatrist
- Sleep Medicine Specialist
- Pulmonologist

Product Name:Sunosi	
Diagnosis	Narcolepsy
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Reduction in symptoms of excessive daytime sleepiness associated with Sunosi therapy	

Product Name:Sunosi

Diagnosis	Obstructive Sleep Apnea
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab values) documenting a diagnosis of obstructive sleep apnea with ONE of the following:

1.1 Fifteen or more obstructive respiratory events per hour of sleep confirmed by a sleep study

OR

1.2 BOTH of the following:

1.2.1 Five or more obstructive respiratory events per hour of sleep confirmed by a sleep study

AND

1.2.2 ONE or more of the following signs/symptoms are present:

- Daytime sleepiness
- Nonrestorative sleep
- Fatigue
- Insomnia
- Waking up with breath holding, gasping, or choking
- Habitual snoring noted by bed partner or other observer
- Observed apnea

AND

2 - BOTH of the following:

2.1 Standard treatments for the underlying airway obstruction [e.g., continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP)] have been used for one month or longer

AND

2.2 Patient is fully compliant with ongoing treatment(s) for the underlying airway obstruction

AND

3 - ONE of the following:

3.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Modafinil (generic Provigil)
- Armodafinil (generic Nuvigil)

OR

3.2 History of contraindication or intolerance to BOTH of the following (please specify contraindication or intolerance):

- Modafinil (generic Provigil)
- Armodafinil (generic Nuvigil)

AND

4 - Prescribed by ONE of the following:

- Neurologist
- Psychiatrist
- Sleep Medicine Specialist
- Pulmonologist

Product Name:Sunosi	
Diagnosis	Obstructive Sleep Apnea
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria 1 - Reduction in symptoms of excessive daytime sleepiness associated with Sunosi therapy AND 2 - Patient continues to be fully compliant with ongoing treatment(s) for the underlying airway obstruction (e.g., CPAP, BiPAP)	

2 . Revision History

Date	Notes
11/10/2025	Combined formularies. No changes to clinical criteria.

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

Symdeko



Prior Authorization Guideline

Guideline ID	GL-371244
Guideline Name	Symdeko
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

Guideline Note:

Effective Date:	9/1/2025

1 . Criteria

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

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of cystic fibrosis (CF) AND 2 - Submission of laboratory result documenting ONE of the following: 2.1 The patient is homozygous for the F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene OR 2.2 The patient has at least ONE mutation in the CFTR gene that is responsive to Symdeko (See Table in Background Section) AND 3 - Prescribed by, or in consultation with, a provider who specializes in the treatment of CF	

Product Name: Symdeko	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Symdeko therapy (e.g., improved lung function, stable lung function)	

2 . Background

Benefit/Coverage/Program Information					
Table 1: List of CFTR gene mutations responsive to Symdeko (A complete up to date list of responsive mu-tations can be referenced in the Symdeko Prescribing Information)					
546insCTA	E92K	G576A	L346P	R117G	S589N
711+3A→G*	E116K	G576A;R668C †	L967S	R117H	S737F
2789+5G→A*	E193K	G622D	L997F	R117L	S912L
3272-26A→G*	E403D	G970D	L1324P	R117P	S945L *
3849+10kbC→T *	E588V	G1069R	L1335P	R170H	S977F*
A120T	E822K	G1244E	L1480P	R258G	S1159F
A234D	E831X	G1249R	M152V	R334L	S1159P
A349V	F191V	G1349D	M265R	R334Q	S1251N
A455E *	F311del	H939R	M952I	R347H *	S1255P
A554E	F311L	H1054D	M952T	R347L	T338I
A1006E	F508C	H1375P	P5L	R347P	T1036N
A1067T	F508C; S1251N †	I148T	P67L *	R352Q *	T1053I
D110E	F508del ‡	I175V	P205S	R352W	V201M
D110H *	F575Y	I336K	Q98R	R553Q	V232D

D192G	F1016S	I601F	Q237E	R668C	V562I
D443Y	F1052V	I618T	Q237H	R751L	V754M
D443Y; G576A; R668C †	F1074L	I807M	Q359R	R792G	V1153E
D579G *	F1099L	I980K	Q1291R	R933G	V1240G
D614G	G126D	I1027T	R31L	R1066H	V1293G
D836Y	G178E	I1139V	R74Q	R1070Q	W1282R
D924N	G178R	I1269N	R74W	R1070W *	Y109N
D979V	G194R	I1366N	R74W; D1270N †	R1162L	Y161S
D1152H *	G194V	K1060T	R74W; V201M †	R1283M	Y1014C
D1270N	G314E	L15P	R74W; V201M; D1270N †	R1283S	Y1032C
E56K	G551D	L206W *	R75Q	S549N	
E60K	G551S	L320V	R117C *	S549R	

* Clinical data for these mutations in Clinical Studies.

† Complex/compound mutations where a single allele of the CFTR gene has multiple mutations; these exist independent of the presence of mutations on the other allele.

3 . Revision History

UnitedHealthcare Community Plan of Rhode Island Clinical Pharmacy Program Guidelines

Date	Notes
8/18/2025	Removed PA CAID

Synagis



Prior Authorization Guideline

Guideline ID	GL-450216
Guideline Name	Synagis
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 New Mexico

Guideline Note:

Effective Date:	12/1/2025

1 . Criteria

Product Name:Synagis*	
Diagnosis	Prematurity

Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following: 1.1 Patient is an infant born before 29 weeks, 0 days gestation AND 1.2 Patient is less than 12 months of age at the start of RSV “season” AND 2 - Administered during RSV season** AND 3 - Monthly dose of Synagis does not exceed 15 milligram per kilogram per dose AND 4 - Dosage of Synagis does not exceed 5 monthly doses per single RSV “season”*** AND 5 - Patient has not previously received treatment with Beyfortus (nirsevimab-alip) or Enflonsia (clesrovimab-cfor) during or entering the current RSV “season” AND 6 - Synagis is not being requested for any of the following situations alone:	

- Infants and children with hemodynamically insignificant heart disease (e.g., secundum atrial septal defect, small ventricular septal defect, pulmonic stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, and patent ductus arteriosus)
- Infants with congenital heart disease and cardiac lesions adequately corrected by surgery, unless they continue to require medication for congestive heart failure
- Infants with cardiomyopathy sufficiently mild that they do not require pharmacotherapy
- Routine use of prophylaxis in children with Down syndrome [unless qualifying heart disease, CLD, airway clearance issues (the inability to clear secretions from the upper airway because of ineffective cough), or prematurity (less than 29 weeks, 0 days gestation) is present]
- Routine use of prophylaxis in children with cystic fibrosis (unless indications noted in proven indications above are present)
- Prophylaxis for primary asthma prevention or to reduce subsequent episodes of wheezing in infants and children
- Synagis prophylaxis for prevention of nosocomial disease

AND

7 - The request is NOT for one of the following:

- Administration of monthly Synagis prophylaxis after an infant or child has experienced a breakthrough RSV hospitalization during the current season if child had met criteria for palivizumab
- Treatment of symptomatic RSV disease

Notes	*Approval for up to 5 doses per single RSV "season." **Information regarding RSV season may be found at: • Centers for Disease and Prevention (CDC) surveillance reports: https://www.cdc.gov/nrevss/php/dashboard/index.html ***Infants in a neonatal intensive care unit who qualify for prophylaxis may receive the first dose 48 to 72 hours before discharge to home or promptly after discharge. If the first dose is administered in the hospital, this dose will be considered the first dose of the maximum 5 dose series for the season. Any subsequent doses received in the hospital setting, are also considered as part of the maximum 5 dose series. For infants born during the RSV "season," fewer than 5 monthly doses may be needed.

Product Name: Synagis*	
Diagnosis	Chronic Lung Disease (CLD)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 ALL of the following for patients age 0 to less than 12 months:

1.1.1 The patient is a preterm infant defined as gestational age less than 32 weeks, 0 days

AND

1.1.2 Patient has developed chronic lung disease (CLD) of prematurity

AND

1.1.3 There was a requirement for greater than 21% oxygen for at least the first 28 days after birth

OR

1.2 ALL of the following for patients age greater than or equal to 12 months to less than 24 months:

1.2.1 The patient was born at less than 32 weeks, 0 days gestation

AND

1.2.2 The patient required at least 28 days of oxygen after birth

AND

1.2.3 The patient continues to require supplemental oxygen, diuretics, or chronic systemic corticosteroid therapy within 6 months of the start of the second RSV "season"

AND

2 - Administered during RSV season**

AND

3 - Monthly dose of Synagis does not exceed 15 milligram per kilogram per dose

AND

4 - Dosage of Synagis does not exceed 5 monthly doses per single RSV "season"***

AND

5 - Patient has not previously received treatment with Beyfortus (nirsevimab-alip) or Enflonsia (clesrovimab-cfor) during or entering the current RSV "season"

AND

6 - Synagis is not being requested for any of the following situations alone:

- Infants and children with hemodynamically insignificant heart disease (e.g., secundum atrial septal defect, small ventricular septal defect, pulmonic stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, and patent ductus arteriosus)
- Infants with congenital heart disease and cardiac lesions adequately corrected by surgery, unless they continue to require medication for congestive heart failure
- Infants with cardiomyopathy sufficiently mild that they do not require pharmacotherapy
- Routine use of prophylaxis in children with Down syndrome [unless qualifying heart disease, CLD, airway clearance issues (the inability to clear secretions from the upper airway because of ineffective cough), or prematurity (less than 29 weeks, 0 days gestation) is present]
- Routine use of prophylaxis in children with cystic fibrosis (unless indications noted in proven indications above are present)
- Prophylaxis for primary asthma prevention or to reduce subsequent episodes of wheezing in infants and children
- Synagis prophylaxis for prevention of nosocomial disease

AND

7 - The request is NOT for one of the following:

- Administration of monthly Synagis prophylaxis after an infant or child has experienced a breakthrough RSV hospitalization during the current season if child had met criteria for palivizumab - Treatment of symptomatic RSV disease	
Notes	*Approval for up to 5 doses per single RSV "season." **Information regarding RSV season may be found at: Centers for Disease and Prevention (CDC) surveillance reports: https://www.cdc.gov/nrevss/php/dashboard/index.html ***Infants in a neonatal intensive care unit who qualify for prophylaxis may receive the first dose 48 to 72 hours before discharge to home or promptly after discharge. If the first dose is administered in the hospital, this dose will be considered the first dose of the maximum 5 dose series for the season. Any subsequent doses received in the hospital setting, are also considered as part of the maximum 5 dose series. For infants born during the RSV "season," fewer than 5 monthly doses may be needed.

Product Name: Synagis*	
Diagnosis	Congenital Heart Disease (CHD)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 ONE of the following for patients age 0 to less than 12 months: 1.1.1 Patient has hemodynamically significant congenital heart disease (CHD) including ONE of the following: - Acyanotic heart disease and receiving medication to control congestive heart failure and will require cardiac surgical procedures - Moderate to severe pulmonary hypertension - Documentation that decisions regarding prophylaxis for infants with cyanotic heart defects were made in consultation with a pediatric cardiologist OR 1.1.2 The patient is undergoing cardiac transplantation during the RSV "season"	

OR

1.2 BOTH of the following:

1.2.1 The patient is greater than or equal to 12 months to less than 24 months of age

AND

1.2.2 ONE of the following:

- After cardiac bypass
- At the conclusion of extracorporeal membrane oxygenation
- The patient is undergoing cardiac transplantation during the RSV “season”

AND

2 - Administered during RSV season**

AND

3 - Monthly dose of Synagis does not exceed 15 milligram per kilogram per dose

AND

4 - Dosage of Synagis does not exceed 5 monthly doses per single RSV “season”***

AND

5 - Patient has not previously received treatment with Beyfortus (nirsevimab-alip) or Enflonsia (clesrovimab-cfor) during or entering the current RSV “season”

AND

6 - Synagis is not being requested for any of the following situations alone:

- Infants and children with hemodynamically insignificant heart disease (e.g., secundum atrial septal defect, small ventricular septal defect, pulmonic stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, and patent ductus arteriosus)
- Infants with congenital heart disease and cardiac lesions adequately corrected by surgery, unless they continue to require medication for congestive heart failure
- Infants with cardiomyopathy sufficiently mild that they do not require pharmacotherapy
- Routine use of prophylaxis in children with Down syndrome [unless qualifying heart disease, CLD, airway clearance issues (the inability to clear secretions from the upper airway because of ineffective cough), or prematurity (less than 29 weeks, 0 days gestation) is present]
- Routine use of prophylaxis in children with cystic fibrosis (unless indications noted in proven indications above are present)
- Prophylaxis for primary asthma prevention or to reduce subsequent episodes of wheezing in infants and children
- Synagis prophylaxis for prevention of nosocomial disease

AND

7 - The request is NOT for one of the following:

- Administration of monthly Synagis prophylaxis after an infant or child has experienced a breakthrough RSV hospitalization during the current season if child had met criteria for palivizumab
- Treatment of symptomatic RSV disease

Notes	*Approval for up to 5 doses per single RSV "season." **Information regarding RSV season may be found at: • Centers for Disease and Prevention (CDC) surveillance reports: https://www.cdc.gov/nrevss/php/dashboard/index.html ***Infants in a neonatal intensive care unit who qualify for prophylaxis may receive the first dose 48 to 72 hours before discharge to home or promptly after discharge. If the first dose is administered in the hospital, this dose will be considered the first dose of the maximum 5 dose series for the season. Any subsequent doses received in the hospital setting, are also considered as part of the maximum 5 dose series. For infants born during the RSV "season," fewer than 5 monthly doses may be needed.

Product Name: Synagis*	
Diagnosis	Congenital abnormalities of the airway or neuromuscular disease
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Patient is age 0 to less than 12 months

AND

1.2 Patient has ONE of the following:

- Neuromuscular disease
- A congenital anomaly that impairs the ability to clear secretions from the lower airway because of ineffective cough

AND

2 - Administered during RSV season**

AND

3 - Monthly dose of Synagis does not exceed 15 milligram per kilogram per dose

AND

4 - Dosage of Synagis does not exceed 5 monthly doses per single RSV "season"***

AND

5 - Patient has not previously received treatment with Beyfortus (nirsevimab-alip) or Enflonsia (clesrovimab-cfor) during or entering the current RSV "season"

AND

6 - Synagis is not being requested for any of the following situations alone:

- Infants and children with hemodynamically insignificant heart disease (e.g., secundum atrial septal defect, small ventricular septal defect, pulmonic stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, and patent ductus arteriosus)
- Infants with congenital heart disease and cardiac lesions adequately corrected by surgery, unless they continue to require medication for congestive heart failure
- Infants with cardiomyopathy sufficiently mild that they do not require pharmacotherapy
- Routine use of prophylaxis in children with Down syndrome [unless qualifying heart disease, CLD, airway clearance issues (the inability to clear secretions from the upper airway because of ineffective cough), or prematurity (less than 29 weeks, 0 days gestation) is present]
- Routine use of prophylaxis in children with cystic fibrosis (unless indications noted in proven indications above are present)
- Prophylaxis for primary asthma prevention or to reduce subsequent episodes of wheezing in infants and children
- Synagis prophylaxis for prevention of nosocomial disease

AND

7 - The request is NOT for one of the following:

- Administration of monthly Synagis prophylaxis after an infant or child has experienced a breakthrough RSV hospitalization during the current season if child had met criteria for palivizumab
- Treatment of symptomatic RSV disease

Notes	*Approval for up to 5 doses per single RSV "season." **Information regarding RSV season may be found at: • Centers for Disease and Prevention (CDC) surveillance reports: https://www.cdc.gov/nrevss/php/dashboard/index.html ***Infants in a neonatal intensive care unit who qualify for prophylaxis may receive the first dose 48 to 72 hours before discharge to home or promptly after discharge. If the first dose is administered in the hospital, this dose will be considered the first dose of the maximum 5 dose series for the season. Any subsequent doses received in the hospital setting, are also considered as part of the maximum 5 dose series. For infants born during the RSV "season," fewer than 5 monthly doses may be needed.

Product Name: Synagis*	
Diagnosis	Immunocompromised children less than 24 months of age
Guideline Type	Prior Authorization

Approval Criteria

1 - BOTH of the following:

1.1 Patient is less than 24 months of age

AND

1.2 The patient is immunocompromised (e.g. receiving cancer chemotherapy, undergoing hematopoietic stem cell transplantation, or solid organ transplantation)

AND

2 - Administered during RSV season**

AND

3 - Monthly dose of Synagis does not exceed 15 milligram per kilogram per dose

AND

4 - Dosage of Synagis does not exceed 5 monthly doses per single RSV "season"***

AND

5 - Patient has not previously received treatment with Beyfortus (nirsevimab-alip) or Enflonsia (clesrovimab-cfor) during or entering the current RSV "season"

AND

6 - Synagis is not being requested for any of the following situations alone:

- Infants and children with hemodynamically insignificant heart disease (e.g., secundum atrial septal defect, small ventricular septal defect, pulmonic stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, and patent ductus arteriosus)
- Infants with congenital heart disease and cardiac lesions adequately corrected by surgery, unless they continue to require medication for congestive heart failure
- Infants with cardiomyopathy sufficiently mild that they do not require pharmacotherapy
- Routine use of prophylaxis in children with Down syndrome [unless qualifying heart disease, CLD, airway clearance issues (the inability to clear secretions from the upper airway because of ineffective cough), or prematurity (less than 29 weeks, 0 days gestation) is present]
- Routine use of prophylaxis in children with cystic fibrosis (unless indications noted in proven indications above are present)
- Prophylaxis for primary asthma prevention or to reduce subsequent episodes of wheezing in infants and children
- Synagis prophylaxis for prevention of nosocomial disease

AND

7 - The request is NOT for one of the following:

- Administration of monthly Synagis prophylaxis after an infant or child has experienced a breakthrough RSV hospitalization during the current season if child had met criteria for palivizumab
- Treatment of symptomatic RSV disease

Notes	*Approval for up to 5 doses per single RSV "season." **Information regarding RSV season may be found at: • Centers for Disease and Prevention (CDC) surveillance reports: https://www.cdc.gov/nrevss/php/dashboard/index.html ***Infants in a neonatal intensive care unit who qualify for prophylaxis may receive the first dose 48 to 72 hours before discharge to home or promptly after discharge. If the first dose is administered in the hospital, this dose will be considered the first dose of the maximum 5 dose series for the season. Any subsequent doses received in the hospital setting, are also considered as part of the maximum 5 dose series. For infants born during the RSV "season," fewer than 5 monthly doses may be needed.

Product Name: Synagis*	
Diagnosis	Cystic fibrosis (CF)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 BOTH of the following for patients age 0 to less than 12 months:

1.1.1 Patient has cystic fibrosis

AND

1.1.2 Patient has clinical evidence of at least ONE of the following:

- Chronic lung disease (CLD)
- Nutritional compromise
- Failure to thrive defined as weight for length less than the 10th percentile on a pediatric growth chart

OR

1.2 BOTH of the following:

1.2.1 Patient is greater than or equal to 12 months to less than 24 months of age

AND

1.2.2 Patient has manifestations of severe lung disease including ONE of the following:

- Previous hospitalization for pulmonary exacerbation in the first year of life
- Abnormalities on chest radiography or chest computed tomography that persists when stable
- Weight for length less than the 10th percentile on a pediatric growth chart

AND

2 - Administered during RSV season**

AND

3 - Monthly dose of Synagis does not exceed 15 milligram per kilogram per dose

AND

4 - Dosage of Synagis does not exceed 5 monthly doses per single RSV “season”***

AND

5 - Patient has not previously received treatment with Beyfortus (nirsevimab-alip) or Enflonsia (clesrovimab-cfor) during or entering the current RSV “season”

AND

6 - Synagis is not being requested for any of the following situations alone:

- Infants and children with hemodynamically insignificant heart disease (e.g., secundum atrial septal defect, small ventricular septal defect, pulmonic stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, and patent ductus arteriosus)
- Infants with congenital heart disease and cardiac lesions adequately corrected by surgery, unless they continue to require medication for congestive heart failure
- Infants with cardiomyopathy sufficiently mild that they do not require pharmacotherapy
- Routine use of prophylaxis in children with Down syndrome [unless qualifying heart disease, CLD, airway clearance issues (the inability to clear secretions from the upper airway because of ineffective cough), or prematurity (less than 29 weeks, 0 days gestation) is present]
- Routine use of prophylaxis in children with cystic fibrosis (unless indications noted in proven indications above are present)
- Prophylaxis for primary asthma prevention or to reduce subsequent episodes of wheezing in infants and children
- Synagis prophylaxis for prevention of nosocomial disease

AND

7 - The request is NOT for one of the following:

- Administration of monthly Synagis prophylaxis after an infant or child has experienced a breakthrough RSV hospitalization during the current season if child had met criteria for palivizumab - Treatment of symptomatic RSV disease	
Notes	*Approval for up to 5 doses per single RSV "season." **Information regarding RSV season may be found at: Centers for Disease and Prevention (CDC) surveillance reports: https://www.cdc.gov/nrevss/php/dashboard/index.html ***Infants in a neonatal intensive care unit who qualify for prophylaxis may receive the first dose 48 to 72 hours before discharge to home or promptly after discharge. If the first dose is administered in the hospital, this dose will be considered the first dose of the maximum 5 dose series for the season. Any subsequent doses received in the hospital setting, are also considered as part of the maximum 5 dose series. For infants born during the RSV "season," fewer than 5 monthly doses may be needed.

2 . Background

Benefit/Coverage/Program Information
Additional Information Because the timing of the onset, peak, and decline of RSV activity might vary geographically, providers can adjust administration schedules based on local epidemiology. RSV seasonality in tropical climates (including southern Florida, Guam, Hawaii, Puerto Rico, U.S.-affiliated Pacific Islands, and U.S. Virgin Islands) might differ from that of most of the continental United States or be unpredictable. In Alaska, RSV seasonality is less predictable, and the duration of RSV activity is often longer than the national average duration. For analysis of National Respiratory and Enteric Virus Surveillance System (NREVSS) reports in the CDC Morbidity and Mortality Weekly Report, season onset is defined as the first of 2 consecutive weeks during which the mean percentage of specimens testing positive for RSV antigen is $\geq 10\%$ or the mean percentage of specimens testing positive for RSV by PCR is $\geq 3\%$, whichever occurs first. RSV "season" offset is defined as the last week during which the mean percentage of positive specimens by antigen is $\geq 10\%$, or the mean percentage of positive specimens by PCR is $\geq 3\%$, whichever occurs last. Use of specimens

to determine the start of the RSV “season” requires that the number of specimens tested be statistically significant.

3 . Revision History

Date	Notes
11/12/2025	Combined formularies. Updated background info. Added criteria to ensure no prior use of Enflonsia in same RSV season.

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 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	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 Rhode Island 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

Date	Notes
8/18/2025	Updated formularies. Updated misspelled EGFR mutation type in NS CLC

Takhzyro



Prior Authorization Guideline

Guideline ID	GL-578192
Guideline Name	Takhzyro
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 New Mexico

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Takhzyro	
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 variant(s) in the gene(s) for factor XII, angiopoietin-1, plasminogen-1, kininogen-1, myoferlin, and 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 prophylaxis of HAE attacks

AND

3 - Not used in combination with other products indicated for prophylaxis against HAE attacks (e.g., Andembry, Cinryze, Dawnzera, Haegarda, Orladeyo)

AND

4 - Prescriber attests that patient has experienced attacks of a severity and/or frequency such that they would clinically benefit from prophylactic therapy with Takhzyro

AND

5 - Prescribed by ONE of the following:

Immunologist

Allergist

AND

6 - ONE of the following:

Patient is greater than or equal to 2 years of age and less than 6 years of age

Failure to Haegarda confirmed by claims history or submitted medical records

History of contraindication or intolerance to Haegarda (please specify intolerance or contraindication)

Patient is currently on Takhzyro therapy confirmed by claims history or submitted medical records

AND

7 - ONE of the following:

For adult and pediatric patients 12 years and older, Takhzyro 300 mg (milligrams) is given every 2 weeks*

For pediatric patients 6 to less than 12 years of age, Takhzyro 150 mg is given every 2 weeks*

For pediatric patients less than 6 years of age, Takhzyro 150 mg is given every 4 weeks**

Notes

*Adult and pediatric patients 6 years of age and older approval length: 8 months.

**Pediatric patients less than 6 years of age approval length: 12 months.

Product Name:Takhzyro	
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response while on Takhzyro therapy AND 2 - Reduction in the utilization of on-demand therapies used for acute attacks (e.g., Berinert, Ekterly, Firazyr, icatibant, Kalbitor, Ruconest) as determined by claims information, while on Takhzyro therapy AND 3 - Prescribed by ONE of the following: Immunologist Allergist AND 4 - Prescribed for prophylaxis of HAE attacks AND 5 - Not used in combination with other products indicated for prophylaxis against HAE attacks (e.g., Andembry, Cinryze, Dawnzera, Haegarda, Orladeyo) AND 6 - ONE of the following:	

6.1 Patient is less than 6 years of age and Takhzyro 150 mg (milligrams) is given every 4 weeks*

OR

6.2 Patient is at least 6 years of age, and BOTH of the following:

6.2.1 Documentation of the number of acute HAE attacks in the previous 6 months, while on Takhzyro therapy

AND

6.2.2 ONE of the following:

6.2.2.1 If the patient experienced no (zero) acute HAE attacks in the previous 6 months, ONE of the following*:

For adult and pediatric patients 12 years of age and older, Takhzyro 300 mg is given every 4 weeks**

For pediatric patients 6 to less than 12 years of age, Takhzyro 150 mg is given every 4 weeks**

OR

6.2.2.2 If the patient experienced one or more HAE attacks in the previous 6 months, ONE of the following***:

For adult and pediatric patients 12 years of age and older, Takhzyro 300 mg is given every 2 weeks

For pediatric patients 6 to less than 12 years of age, Takhzyro 150 mg is given every 2 weeks

Notes

*Patient experienced no acute HAE attacks in the previous 6 months, or is less than 6 years of age approval length: 12 months.

**Patients experiencing unexpected breakthrough HAE attacks once switched to every 4 week dosing will require additional review to allow for 2 weeks dosing.

***Patient experienced 1 or more HAE attacks in the previous 6 months approval length: 6 months.

2 . Revision History

Date	Notes
4/13/2026	Updated GPIs. Updated list of examples of prophylactic and acute HAE treatments. Updated criteria by removing requirement to document frequency of HAE attacks. Added bypass to Haegarda step for patients 2 years of age and older and less than 6 per label

Taltz



Prior Authorization Guideline

Guideline ID	GL-539210
Guideline Name	Taltz
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 New Mexico

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Taltz	
Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of chronic moderate to severe plaque psoriasis

AND

1.2 ONE of the following:

1.2.1 ALL of the following:

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

AND

1.2.1.2 One of the following:

1.2.1.2.1 Failure to ONE of the following topical therapy classes as confirmed by claims history or submission of medical records:

Corticosteroids (e.g., betamethasone, clobetasol, desonide)

Vitamin D analogs (e.g., calcitriol, calcipotriene)

Tazarotene

Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)

Anthralin

Coal tar

OR

1.2.1.2.2 History of intolerance or contraindication to ALL of the following topical therapy classes (please specify intolerance or contraindication)

Corticosteroids (e.g., betamethasone, clobetasol, desonide)

Vitamin D analogs (e.g., calcitriol, calcipotriene)

Tazarotene

Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)

Anthralin

Coal tar

AND

1.2.1.3 ONE of the following:

Failure to a 3 month trial of methotrexate at the maximally indicated dose as confirmed by claims history or submission of medical records

History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

OR

1.2.2 Patient has been previously treated with a systemic targeted immunomodulator FDA-approved for the treatment of plaque psoriasis as confirmed by claims history or submitted medical records [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Ilumya (tildrakizumab), Otezla (apremilast), Skyrizi (risankizumab-rzaa), Siliq (brodalumab), Sotyktu (deucravacitinib), Tremfya (guselkumab), ustekinumab]

AND

1.3 One of the following:

1.3.1 Failure to TWO of the following preferred products, as confirmed by claims history or submission of medical records:

One of the preferred adalimumab products^

Enbrel (etanercept)

One of the preferred ustekinumab products^

OR

1.3.2 History of intolerance or contraindication to ALL of the following preferred products (please specify intolerance or contraindication):

One of the preferred adalimumab products^

Enbrel (etanercept)

One of the preferred ustekinumab products^

AND

1.4 ONE of the following:

Failure to Cosentyx (secukinumab) as confirmed by claims history or submission of medical records

History of contraindication or intolerance to Cosentyx (secukinumab) (please specify contraindication or intolerance)

AND

1.5 Patient is NOT receiving Taltz in combination with another systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Ilumya (tildrakizumab), Otezla (apremilast), Skyrizi (risankizumab-rzaa), Siliq (brodalumab), Sotyktu (deucravacitinib), Tremfya (guselkumab), ustekinumab] for treatment of the same indication

AND

1.6 Prescribed by or in consultation with a dermatologist

OR

2 - ALL of the following:

2.1 Patient is currently on Taltz therapy as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of chronic moderate to severe plaque psoriasis

AND

2.3 Patient is NOT receiving Taltz in combination with another systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Ilumya (tildrakizumab), Otezla (apremilast), Skyrizi (risankizumab-rzaa), Siliq (brodalumab), Sotyktu (deucravacitinib), Tremfya (guselkumab), ustekinumab] for treatment of the same indication

AND

2.4 Prescribed by or in consultation with a dermatologist

Notes	^See Table 1 for PDL Links

Product Name:Taltz	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ALL of the following: 1.1 Diagnosis of active psoriatic arthritis	

AND

1.2 ONE of the following:

1.2.1 Failure to a 3 month trial of methotrexate at the maximally indicated dose as confirmed by claims history or submission of medical records

OR

1.2.2 History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

OR

1.2.3 Patient has been previously treated with a systemic targeted immunomodulator FDA-approved for the treatment of psoriatic arthritis as confirmed by claims history or submitted medical records [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Orencia (abatacept), Otezla (apremilast), Rinvoq (upadacitinib), Simponi (golimumab), Skyrizi (risankizumab), Tremfya (guselkumab), ustekinumab, Xeljanz/Xeljanz XR (tofacitinib)]

AND

1.3 One of the following:

1.3.1 Failure to TWO of the following preferred products as confirmed by claims history or submission of medical records

One of the preferred adalimumab products^

Enbrel (etanercept)

One of the preferred ustekinumab products^

OR

1.3.2 History of intolerance or contraindication to ALL of the following preferred products (please specify intolerance or contraindication)

One of the preferred adalimumab products^

Enbrel (etanercept)

One of the preferred ustekinumab products^

AND

1.4 ONE of the following:

Failure to Cosentyx (secukinumab) as confirmed by claims history or submission of medical records

History of contraindication or intolerance to Cosentyx (secukinumab) (please specify contraindication or intolerance)

AND

1.5 Patient is NOT receiving Taltz in combination with another systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Orenzia (abatacept), Otezla (apremilast), Rinvoq (upadacitinib), Simponi (golimumab), Skyrizi (risankizumab), Tremfya (guselkumab), ustekinumab, Xeljanz/Xeljanz XR (tofacitinib)] for treatment of the same indication

AND

1.6 Prescribed by or in consultation with one of the following:

Rheumatologist

Dermatologist

OR

2 - ALL of the following:

2.1 Patient is currently on Taltz therapy as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of active psoriatic arthritis

AND

2.3 Patient is NOT receiving Taltz in combination with another systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Ocrencia (abatacept), Otezla (apremilast), Rinvoq (upadacitinib), Simponi (golimumab), Skyrizi (risankizumab), Tremfya (guselkumab), ustekinumab, Xeljanz/Xeljanz XR (tofacitinib)] for treatment of the same indication

AND

2.4 Prescribed by or in consultation with one of the following:

Rheumatologist

Dermatologist

Notes	^See Table 1 for PDL Links

Product Name:Taltz	
Diagnosis	Ankylosing Spondylitis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ALL of the following: 1.1 Diagnosis of active ankylosing spondylitis	

AND

1.2 ONE of the following:

1.2.1 Failure to TWO NSAIDs (non-steroidal anti-inflammatory drugs) (e.g., ibuprofen, naproxen) at maximally indicated doses, each used for at least 4 weeks, as confirmed by claims history or submission of medical records

OR

1.2.2 History of intolerance or contraindication to two NSAIDs (e.g., ibuprofen, naproxen) (please specify intolerance or contraindication)

OR

1.2.3 Patient has been previously treated with a systemic targeted immunomodulator FDA-approved for the treatment of ankylosing spondylitis as confirmed by claims history or submitted medical records [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib)]

AND

1.3 One of the following:

1.3.1 Failure to BOTH of the following as confirmed by claims history or submission of medical records:

One of the preferred adalimumab products^

Enbrel (etanercept)

OR

1.3.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication)

One of the preferred adalimumab products^

Enbrel (etanercept)

AND

1.4 ONE of the following:

Failure to Cosentyx (secukinumab) as confirmed by claims history or submission of medical records

History of contraindication or intolerance to Cosentyx (secukinumab) (please specify contraindication or intolerance)

AND

1.5 Patient is NOT receiving Taltz in combination with another systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib)] for treatment of the same indication

AND

1.6 Prescribed by or in consultation with a rheumatologist

OR

2 - ALL of the following:

2.1 Patient is currently on Taltz therapy as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of active ankylosing spondylitis

AND

2.3 Patient is NOT receiving Taltz in combination with another systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib)] for treatment of the same indication

AND

2.4 Prescribed by or in consultation with a rheumatologist

Notes	^See Table 1 for PDL Links

Product Name:Taltz	
Diagnosis	Non-Radiographic Axial Spondyloarthritis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ALL of the following: 1.1 Diagnosis of active non-radiographic axial spondyloarthritis AND 1.2 ONE of the following: 1.2.1 Failure to two NSAIDs (non-steroidal anti-inflammatory drugs) (e.g., ibuprofen, naproxen) at maximally indicated doses, each used for at least 4 weeks, as confirmed by claims history or submission of medical records OR	

1.2.2 History of intolerance or contraindication to two NSAIDs (e.g., ibuprofen, naproxen) (please specify intolerance or contraindication)

OR

1.2.3 Patient has been previously treated with a systemic targeted immunomodulator FDA-approved for the treatment of non-radiographic axial spondyloarthritis as confirmed by claims history or submitted medical records [e.g., Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Rinvoq (upadacitinib)]

AND

1.3 ONE of the following:

Failure to Cosentyx (secukinumab) as confirmed by claims history or submission of medical records

History of contraindication or intolerance to Cosentyx (secukinumab) (please specify contraindication or intolerance)

AND

1.4 Patient is NOT receiving Taltz in combination with another systemic targeted immunomodulator [e.g., Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Rinvoq (upadacitinib)] for treatment of the same indication

AND

1.5 Prescribed by or in consultation with a rheumatologist

OR

2 - ALL of the following:

2.1 Patient is currently on Taltz therapy as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of active non-radiographic axial spondyloarthritis

AND

2.3 Patient is NOT receiving Taltz in combination with another systemic targeted immunomodulator [e.g., Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Rinvoq (upadacitinib)] for treatment of the same indication

AND

2.4 Prescribed by or in consultation with a rheumatologist

Product Name:Taltz	
Diagnosis	Plaque Psoriasis, Psoriatic Arthritis (PsA), Ankylosing Spondylitis, Non-Radiographic Axial Spondyloarthritis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Taltz therapy AND 2 - Patient is NOT receiving Taltz in combination with another systemic targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, ustekinumab, Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast), Bimzelx (bimekizumab-bkzx), Sotyktu (deucravacitinib)]* for treatment of the same indication	

Notes	*Examples of drug(s) may not be applicable based on the requested indication.

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 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 PA CHIP: 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 NM: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

3 . Revision History

Date	Notes
3/4/2026	Removed NY. Updated examples with no change to clinical intent

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 Talzena 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 Talzenna therapy	

Product Name:Talzenna	
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:Talzenna	
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 Talzenna therapy	

2 . Revision History

Date	Notes
5/5/2025	Updated formularies. Revised wording in breast cancer section without change to intent

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).

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).

Tarpeyo



Prior Authorization Guideline

Guideline ID	GL-578190
Guideline Name	Tarpeyo
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 Virginia

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name: Tarpeyo

Approval Length	9 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of primary immunoglobulin A nephropathy (IgAN) confirmed by renal biopsy AND 2 - Patient is at risk for disease progression AND 3 - Used to reduce the loss of kidney function AND 4 - Estimated glomerular filtration rate (eGFR) greater than or equal to 35 mL/min/1.73 m² (milliliters/minute/1.73 square meters) AND 5 - ONE of the following: 5.1 Patient is on a stabilized dose and receiving concomitant therapy with ONE of the following, as confirmed by claims history or submitted medical records: Maximally tolerated angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril) Maximally tolerated angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan) OR	

5.2 Patient has an allergy, contraindication, or intolerance to ACE inhibitors and ARBs
(please specify allergy, contraindication, or intolerance)

AND

6 - Prescribed by or in consultation with a nephrologist

2 . Revision History

Date	Notes
4/13/2026	Removed corticosteroid step

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

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 and Glucose Meters



Prior Authorization Guideline

Guideline ID	GL-558241
Guideline Name	Test Strips and Glucose Meters
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 Washington Medicaid - Community & State Nebraska Medicaid - Community & State New Mexico Medicaid - Community & State Texas

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:Non-preferred Test Strips and Glucose Meters	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - If the request is non-preferred*, ONE of the following: 1.1 Failure of both of the following confirmed by claims history or submitted medical records: Accu-Chek Contour OR 1.2 History of intolerance or contraindication to both of the following (please specify intolerance or contraindication): Accu-Chek Contour OR 1.3 Patient is on an insulin pump	
Notes	*See PDL links in Background

Product Name:All Test Strips	
Approval Length	12 month(s)
Guideline Type	Quantity Limit
Approval Criteria 1 - If the patient is insulin dependent or pregnant, 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

2 - If the patient is not insulin dependent nor pregnant, **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/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	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 . 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](https://www.uhcprovider.com/en/health-plans-by-state/new-york-health-plans/ny-comm-plan-home/ny-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 CHIP: <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>

MI: <https://www.uhcprovider.com/en/health-plans-by-state/michigan-health-plans/mi-comm-plan-home/mi-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>

NM: <https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html>

TX: <https://www.uhcprovider.com/en/health-plans-by-state/texas-health-plans/tx-comm-plan-home/tx-cp-pharmacy.html>

3 . Revision History

Date	Notes
3/26/2026	Updated title. Updated GPIs. Added glucometers

Testosterone



Prior Authorization Guideline

Guideline ID	GL-506372
Guideline Name	Testosterone
Formulary	Medicaid - Community & State Rhode Island

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:generic testosterone gel, generic testosterone gel pump, Brand Androgel Pump, testosterone soln, Brand Fortesta, generic testosterone TD gel, Natesto, Brand Testim, Brand Vogelxo, Brand Vogelxo Pump, Xyosted, Jatenzo, Kyzatrex, Tlando, Brand Depo-Testosterone, generic testosterone cypionate, testosterone enanthate, Undecatrex	
Diagnosis	Hypogonadism
Approval Length	12 month(s)
Therapy Stage	Initial Authorization*
Guideline Type	Prior Authorization
Approval Criteria	

1 - ONE of the following:

1.1 TWO pre-treatment serum total testosterone levels less than 300 ng/dL (nanograms/deciliter) [less than 10.4 nmol/L (nanomoles/liter)] or less than the reference range for the lab, taken at separate times (This may require treatment to be temporarily held. Document lab value and date for both levels)

OR

1.2 BOTH of the following:

1.2.1 Patient has a condition that may cause altered sex-hormone binding globulin (SHBG) [e.g., thyroid disorder, HIV (human immunodeficiency virus) disease, liver disorder, diabetes, obesity]

AND

1.2.2 ONE pre-treatment calculated free or bioavailable testosterone level less than 50 pg/mL (picograms/milliliter) (< 5 ng/dL or < 0.17 nmol/L) or less than the reference range for the lab (This may require treatment to be temporarily held. Document lab value and date)

OR

1.3 Patient has a history of ONE of the following:

Bilateral orchiectomy

Panhypopituitarism

A genetic disorder known to cause hypogonadism (e.g., congenital anorchia, Klinefelter's syndrome)

AND

2 - Patient is NOT taking any of the following growth hormones, unless diagnosed with panhypopituitarism:

Genotropin

Humatrope

Norditropin FlexPro

Nutropin AQ

Omnitrope

Saizen

AND

3 - Patient is NOT taking any aromatase inhibitor [e.g., Arimidex (anastrozole), Femara (letrozole), Aromasin (exemestane)]

AND

4 - Patient was male at birth

AND

5 - Diagnosis of hypogonadism

AND

6 - ONE of the following:

Significant reduction in weight (less than 90% ideal body weight) [e.g., AIDS (acquired immunodeficiency syndrome) wasting syndrome]

Osteopenia

Osteoporosis

Decreased bone density

Decreased libido

Organic cause of testosterone deficiency (e.g., injury, tumor, infection, or genetic defects)

AND

7 - ONE of the following:

7.1 If the request is for a non-preferred** topical testosterone (gel, solution) or testosterone transdermal systems (patches), **ONE** of the following:

7.1.1 Failure to **ONE** of the following, confirmed by claims history or submitted medical records:

generic testosterone 1% topical gel

testosterone 1.62% pump (generic Androgel 1.62% pump)

OR

7.1.2 History of intolerance or contraindication to **BOTH** of the following (please specify intolerance or contraindication):

generic testosterone 1% topical gel

testosterone 1.62% pump (generic Androgel 1.62% pump)

OR

7.2 If the request is for Jatenzo, Kyzatrex, Tlando, Undecatrex, or Xyosted, **ONE** of the following:

7.2.1 Failure to **ALL** of the following:

testosterone cypionate vials

testosterone enanthate vials

testosterone gel - tube, pack, or pump bottle, or testosterone 1.62% pump (generic Androgel 1.62% pump)

OR

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

testosterone cypionate vials testosterone enanthate vials testosterone gel - tube, pack, or pump bottle or testosterone 1.62% pump (generic Androgel 1.62% pump)	
Notes	*Patients that have previously received injectable testosterone open access should be reviewed using reauthorization criteria **PDL link: https://www.uhcprovider.com/en/health-plans-by-state/rhode-island-health-plans/ri-comm-plan-home/ri-cp-pharmacy.html

Product Name:generic testosterone gel, generic testosterone gel pump, Brand Androgel Pump, testosterone soln, Brand Fortesta, generic testosterone TD gel, Natesto, Brand Testim, Brand Vogelxo, Brand Vogelxo Pump, Xyosted, Jatenzo, Kyzatrex, Tlando, Brand Depo-Testosterone, generic testosterone cypionate, testosterone enanthate, Undecatrex	
Diagnosis	Gender Dysphoria
Approval Length	12 month(s)
Therapy Stage	Initial Authorization*
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient must be diagnosed with gender dysphoria, as defined by the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) AND 2 - ONE of the following: 2.1 If the request is for a non-preferred** topical testosterone (gel, solution) or testosterone transdermal systems (patches), ONE of the following: 2.1.1 Failure to ONE of the following, confirmed by claims history or submitted medical records: generic testosterone 1% topical gel	

testosterone 1.62% pump (generic AndroGel 1.62% pump)

OR

2.1.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

generic testosterone 1% topical gel

testosterone 1.62% pump (generic AndroGel 1.62% pump)

OR

2.2 If the request is for Jatenzo, Kyzatrex, Tlando, Undecatrex, or Xyosted, ONE of the following:

2.2.1 Failure to ALL of the following:

testosterone cypionate vials

testosterone enanthate vials

testosterone gel - tube, pack, or pump bottle or testosterone 1.62% pump (generic AndroGel 1.62% pump)

OR

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

testosterone cypionate vials

testosterone enanthate vials

testosterone gel - tube, pack, or pump bottle or testosterone 1.62% pump (generic AndroGel 1.62% pump)

Notes

*Patients that have previously received injectable testosterone open access should be reviewed using reauthorization criteria

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

Product Name:generic testosterone gel, generic testosterone gel pump, Brand Androgel Pump, testosterone soln, Brand Fortesta, generic testosterone TD gel, Natesto, Brand Testim, Brand Vogelxo, Brand Vogelxo Pump, Xyosted, Jatenzo, Kyzatrex, Tlando, Brand Depo-Testosterone, generic testosterone cypionate, testosterone enanthate, Undecatrex	
Diagnosis	Hypogonadism, Gender Dysphoria
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Patient has a diagnosis of Gender Dysphoria, as defined by the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) OR 1.2 ALL of the following: 1.2.1 Patient has a history of ONE of the following: Bilateral orchiectomy Panhypopituitarism A genetic disorder known to cause hypogonadism (e.g., congenital anorchia, Klinefelter's syndrome) AND 1.2.2 Patient is NOT taking any of the following growth hormones, unless diagnosed with panhypopituitarism: Genotropin Humatrope Norditropin FlexPro	

Nutropin AQ

Omnitrope

Saizen

AND

1.2.3 Patient is NOT taking any aromatase inhibitors [e.g., Arimidex (anastrozole), Femara (letrozole), Aromasin (exemestane)]

OR

1.3 ALL of the following:

1.3.1 Patient has a diagnosis of Hypogonadism

AND

1.3.2 ONE of the following:

1.3.2.1 Follow-up total serum testosterone level drawn within the past 12 months is within or below the normal male limits of the reporting lab (document value and date)

OR

1.3.2.2 Follow-up total serum testosterone level drawn within the past 12 months is outside of upper male limits of normal for the reporting lab and the dose is adjusted (document value and date)

OR

1.3.2.3 BOTH of the following:

1.3.2.3.1 Patient has a condition that may cause altered sex-hormone binding globulin (SHBG) [e.g., thyroid disorder, HIV (human immunodeficiency virus) disease, liver disorder, diabetes, obesity]

AND

1.3.2.3.2 ONE of the following:

Follow-up calculated free or bioavailable testosterone level drawn within the past 12 months is within or below the normal male limits of the reporting lab (document lab value and date)

Follow-up calculated free or bioavailable testosterone level drawn within the past 12 months is outside of upper male limits of normal for the reporting lab and the dose is adjusted (document value and date)

AND

1.3.3 Patient is NOT taking any of the following growth hormones, unless diagnosed with panhypopituitarism:

Genotropin

Humatrope

Norditropin FlexPro

Nutropin AQ

Omnitrope

Saizen

AND

1.3.4 Patient is NOT taking any aromatase inhibitors [e.g., Arimidex (anastrozole), Femara (letrozole), Aromasin (exemestane)]

2 . Revision History

Date	Notes

1/27/2026	Updated title. Updated GPIs. Removed Androderm. Added step through topical products for Xyosted

Tezspire



Prior Authorization Guideline

Guideline ID	GL-521230
Guideline Name	Tezspire
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

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name: Tezspire auto-injector pen	
Diagnosis	Severe Asthma
Approval Length	12 month(s)

Therapy Stage	Initial Authorization - Transitioning from UHC medical benefits
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has been established on therapy with Tezspire under an active UnitedHealthcare medical benefit prior authorization for the treatment of severe asthma AND 2 - Documentation of positive clinical response to Tezspire therapy as demonstrated by at least ONE of the following: 2.1 Reduction in the frequency of exacerbations OR 2.2 Decreased utilization of rescue medications OR 2.3 Increase in percent predicted FEV1 (forced expiratory volume in 1 second) from pretreatment baseline OR 2.4 Reduction in severity or frequency of asthma-related symptoms (e.g., wheezing, shortness of breath, coughing, etc.) AND 3 - Tezspire is being used in combination with an inhaled corticosteroid (ICS)-containing maintenance medication [e.g., Advair/AirDuo Respiclick (fluticasone propionate/salmeterol), Symbicort (budesonide/formoterol), Breo Ellipta (fluticasone furoate/vilanterol)]	

AND

4 - Patient is NOT receiving Tezspire in combination with any of the following for treatment of the same indication:

Anti-interleukin-5 therapy [e.g., Cinqair (reslizumab), Fasenra (benralizumab), Nucala (mepolizumab)]

Anti-IgE-therapy [e.g., Xolair (omalizumab)]

Anti-interleukin-4 therapy [e.g., Dupixent (dupilumab)]

AND

5 - Prescribed by ONE of the following:

Allergist

Immunologist

Pulmonologist

Product Name: Tezspire auto-injector pen	
Diagnosis	Severe Asthma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization - Not transitioning from UHC medical benefits
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of severe asthma AND	

2 - Classification of asthma as uncontrolled or inadequately controlled as defined by at least ONE of the following:

2.1 Poor symptom control (e.g., Asthma Control Questionnaire [ACQ] score consistently greater than 1.5 or Asthma Control test [ACT] score consistently less than 20)

OR

2.2 Two or more bursts of systemic corticosteroids for at least 3 days each in the previous 12 months

OR

2.3 Asthma-related emergency treatment (e.g., emergency room visit, hospital admission, or unscheduled physician's office visit for nebulizer or other urgent treatment)

OR

2.4 Airflow limitation (e.g., after appropriate bronchodilator withhold forced expiratory volume in 1 second [FEV1] less than 80% predicted [in the face of reduced FEV1/forced vital capacity [FVC] defined as less than the lower limit of normal])

OR

2.5 Patient is currently dependent on oral corticosteroids for the treatment of asthma

AND

3 - Tezspire will be used in combination with ONE of the following:

3.1 ONE maximally-dosed (appropriately adjusted for age) combination inhaled corticosteroid (ICS)/long-acting beta2 agonist (LABA) product [e.g., Advair/AirDuo Respiclick (fluticasone propionate/salmeterol), Symbicort (budesonide/formoterol), Breo Ellipta (fluticasone furoate/vilanterol)]

OR

3.2 Combination therapy including BOTH of the following:

3.2.1 ONE maximally-dosed (appropriately adjusted for age) ICS product [e.g., ciclesonide (Alvesco), mometasone furoate (Asmanex), beclomethasone dipropionate (QVAR)]

AND

3.2.2 ONE additional asthma controller medication [e.g., LABA - olodaterol (Striverdi) or indacaterol (Arcapta); leukotriene receptor antagonist – montelukast (Singulair); theophylline]

AND

4 - ONE of the following:

4.1 BOTH of the following:

4.1.1 Tezspire will be used to treat eosinophilic asthma

AND

4.1.2 BOTH of the following:

4.1.2.1 ONE of the following

Failure to a 4-month trial of an anti-interleukin 5 therapy [e.g., Nucala (mepolizumab), Fasenra (benralizumab)] as confirmed by claims history or submission of medical records

History of contraindication or intolerance to an anti-interleukin 5 therapy [e.g., Nucala (mepolizumab), Fasenra (benralizumab)] (please specify contraindication or intolerance)

AND

4.1.2.2 ONE of the following:

Failure to a 4-month trial of Dupixent (dupilumab) as confirmed by claims history or submission of medical records

History of contraindication or intolerance to Dupixent (dupilumab) (please specify contraindication or intolerance)

OR

4.2 BOTH of the following:

4.2.1 Tezspire will be used to treat persistent allergic asthma

AND

4.2.2 ONE of the following:

Failure to a 4-month trial of Xolair (omalizumab) as confirmed by claims history or submission of medical records

History of intolerance or contraindication to Xolair (omalizumab) (please specify contraindication or intolerance)

OR

4.3 BOTH of the following:

4.3.1 Tezspire will be used to treat oral corticosteroid dependent asthma

AND

4.3.2 ONE of the following:

Failure to a 4-month trial of Dupixent (dupilumab) as confirmed by claims history or submission of medical records

History of intolerance or contraindication to Dupixent (dupilumab) (please specify contraindication or intolerance)

OR

4.4 Patient's asthma is not of the eosinophilic, allergic, or oral corticosteroid dependent phenotype

AND

5 - Patient is NOT receiving Tezspire in combination with any of the following for treatment of the same indication:

Anti-interleukin 5 therapy [e.g., Cinqair (reslizumab), Fasenra (benralizumab), Nucala (mepolizumab)]

Anti-IgE therapy [e.g., Xolair (omalizumab)]

Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]

AND

6 - Prescribed by ONE of the following:

Allergist

Immunologist

Pulmonologist

Product Name: Tezspire auto-injector pen	
Diagnosis	Severe Asthma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Tezspire therapy as demonstrated by at least ONE of the following: Reduction in the frequency of exacerbations	

Decreased utilization of rescue medications

Increase in percent predicted FEV1 (forced expiratory volume in 1 second) from pretreatment baseline

Reduction in severity or frequency of asthma-related symptoms (e.g., wheezing, shortness of breath, coughing, etc.)

AND

2 - Tezspire is being used in combination with an ICS-containing maintenance medication [e.g., Advair/AirDuo Resplick (fluticasone propionate/salmeterol), Symbicort (budesonide/formoterol), Breo Ellipta (fluticasone furoate/vilanterol)]

AND

3 - Patient is NOT receiving Tezspire in combination with any of the following for treatment of the same indication:

Anti-interleukin-5 therapy [e.g., Cinqair (reslizumab), Fasenra (benralizumab), Nucala (mepolizumab)]

Anti-IgE therapy [e.g., Xolair (omalizumab)]

Anti-interleukin-4 therapy [e.g., Dupixent (dupilumab)]

Product Name: Tezspire auto-injector pen	
Diagnosis	Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization - Transitioning from UHC medical benefits
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has been established on therapy with Tezspire under an active UnitedHealthcare medical benefit prior authorization for the treatment of chronic rhinosinusitis with nasal polyps	

AND

2 - Documentation of positive clinical response to Tezspire therapy

AND

3 - Patient continues to receive Tezspire as add-on maintenance therapy in combination with intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone)

AND

4 - Patient is NOT receiving Tezspire in combination with any of the following for treatment of the same indication:

Anti-interleukin-5 therapy [e.g., Cinqair (reslizumab), Fasenra (benralizumab), Nucala (mepolizumab)]

Anti-IgE-therapy [e.g., Xolair (omalizumab)]

Anti-interleukin-4 therapy [e.g., Dupixent (dupilumab)]

AND

5 - Prescribed by ONE of the following:

Allergist

Immunologist

Otolaryngologist

Pulmonologist

Product Name: Tezspire auto-injector pen	
Diagnosis	Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)
Approval Length	12 month(s)

Therapy Stage	Initial Authorization - Not transitioning from UHC medical benefits
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP) defined by ALL of the following: 1.1 TWO or more of the following symptoms for longer than 12 weeks duration: Nasal mucopurulent discharge Nasal obstruction, blockage, or congestion Facial pain, pressure, and/or fullness Reduction or loss of sense of smell AND 1.2 ONE of the following findings using nasal endoscopy and/or sinus computed tomography (CT): Purulent mucus or edema in the middle meatus or ethmoid regions Polyps in the nasal cavity or the middle meatus Radiographic imaging demonstrating mucosal thickening or partial or complete opacification of paranasal sinuses AND 1.3 ONE of the following: Presence of bilateral nasal polyposis Patient has previously required surgical removal of bilateral nasal polyps AND	

1.4 ONE of the following:

1.4.1 Patient has required prior sinus surgery

OR

1.4.2 Patient has required systemic corticosteroids (e.g., prednisone, methylprednisolone) for CRSwNP in the previous 2 years

OR

1.4.3 Patient has been unable to obtain symptom relief after trial of TWO of the following classes of agents:

Nasal saline irrigations

Intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone)

Antileukotriene agents (e.g., montelukast, zafirlukast, zileuton)

AND

2 - Patient will receive Tezspire as add-on maintenance therapy in combination with intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone)

AND

3 - Patient is NOT receiving Tezspire in combination with any of the following for treatment of the same indication:

Anti-interleukin 5 therapy [e.g., Cinqair (reslizumab), Fasenra (benralizumab), Nucala (mepolizumab)]

Anti-IgE therapy [e.g., Xolair (omalizumab)]

Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]

AND

4 - Prescribed by ONE of the following:

Allergist

Immunologist

Otolaryngologist

Pulmonologist

AND

5 - ONE of the following:

5.1 Failure to a 4-month trial of TWO of the following as confirmed by claims history or submission of medical records:

Dupixent (dupilumab)

Nucala (mepolizumab)

Xolair (omalizumab)

OR

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

Dupixent (dupilumab)

Nucala (mepolizumab)

Xolair (omalizumab)

Product Name: Tezspire auto-injector pen

Diagnosis	Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Tezspire therapy AND 2 - Patient will continue to receive Tezspire as add-on maintenance therapy in combination with intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone) AND 3 - Patient is NOT receiving Tezspire in combination with any of the following for treatment of the same indication: Anti-interleukin-5 therapy [e.g., Cinqair (reslizumab), Fasenra (benralizumab), Nucala (mepolizumab)] Anti-IgE therapy [e.g., Xolair (omalizumab)] Anti-interleukin-4 therapy [e.g., Dupixent (dupilumab)]	

2 . Revision History

Date	Notes
2/13/2026	Updated initial authorization duration for severe asthma to 12 months . Added criteria for chronic rhinosinusitis with nasal polyps.

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-599193
Guideline Name	Therapeutic Duplication (Subtype A)
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 Nebraska Medicaid - Community & State Kansas Medicaid - Community & State New Mexico Medicaid - Community & State North Carolina Medicaid - Community & State Virginia Medicaid - Community & State Texas

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 ReditHaler, 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, meclufenamate 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, Brand Lunesta, generic eszopiclone, zaleplon, Zolpidem, Brand Ambien, generic zolpidem, Brand Ambien CR, generic zolpidem CR. Edluar, Zolpimist, Brand Rozerem, generic ramelteon, Brand Silenor, generic doxepin (sleep) 3mg and 6 mg tabs, Belsomra, Dayvigo, Quviviq, Brand Precedex, generic dexmedetomidine, Dexmedetomidine, Igalmi, Brand Hetlioz, generic tasimelteon, Hetlioz LQ, Brand Restoril, generic temazepam, Brand Halcion, generic triazolam, Brand Doral, generic quazepam, flurazepam, estazolam, 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.

Tocilizumab



Prior Authorization Guideline

Guideline ID	GL-599189
Guideline Name	Tocilizumab
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

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Actemra subcutaneous, Tyenne subcutaneous, Avtozma subcutaneous	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ALL of the following: 1.1 Diagnosis of moderately to severely active rheumatoid arthritis (RA) AND 1.2 ONE of the following: 1.2.1 Failure to a 3 month trial of ONE non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] at maximally indicated doses confirmed by claims history or submitted medical records OR 1.2.2 History of intolerance or contraindication to ONE non-biologic DMARD [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] (please specify intolerance or contraindication) OR 1.2.3 Patient has been previously treated with a systemic targeted immunomodulator FDA-approved for the treatment of rheumatoid arthritis as confirmed by claims history or submission of medical records [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib)] AND 1.3 ONE of the following: 1.3.1 Failure of ONE of the preferred adalimumab products confirmed by claims history or submitted medical records	

OR

1.3.2 History of intolerance or contraindication to ALL preferred adalimumab products (please specify intolerance or contraindication)

AND

1.4 If the request is for a non-preferred tocilizumab product, the prescriber has given a clinical reason or special circumstance why the patient is unable to use the preferred tocilizumab products (please document reason/special circumstances)

AND

1.5 Patient is NOT receiving tocilizumab in combination with another systemic targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Orenzia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib)] for treatment of the same indication

AND

1.6 Prescribed by or in consultation with a rheumatologist

AND

1.7 If the request is for BRAND Actemra, one of the following:

1.7.1 Submission of medical records confirming patient allergy or intolerance to at least one preferred tocilizumab biosimilar's inactive ingredients

OR

1.7.2 Both of the following:

Submission of medical records confirming patient has previously been successfully treated with brand Actemra

Submission of medical records confirming patient has tried at least one preferred tocilizumab biosimilar for 6-8 weeks per product and saw a decrease in effectiveness

OR

2 - ALL of the following:

2.1 Patient is currently on tocilizumab therapy as confirmed by claims history or submitted medical records

AND

2.2 Diagnosis of moderately to severely active RA

AND

2.3 Patient is NOT receiving tocilizumab in combination with another systemic targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib)] for treatment of the same indication

AND

2.4 If the request is for a non-preferred tocilizumab product, the prescriber has given a clinical reason or special circumstance why the patient is unable to use the preferred tocilizumab products (please document reason/special circumstances)

AND

2.5 Prescribed by or in consultation with a rheumatologist

AND

2.6 If the request is for BRAND Actemra, one of the following:

2.6.1 Submission of medical records confirming patient allergy or intolerance to at least one preferred tocilizumab biosimilar's inactive ingredients

OR

2.6.2 Both of the following:

Submission of medical records confirming patient has previously been successfully treated with brand Actemra

Submission of medical records confirming patient has tried at least one preferred tocilizumab biosimilar for 6-8 weeks per product and saw a decrease in effectiveness

Product Name: Actemra subcutaneous, Tyenne subcutaneous, Avtozma subcutaneous	
Diagnosis	Giant Cell Arteritis (GCA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of giant cell arteritis AND 2 - ONE of the following: 2.1 Failure to ONE glucocorticoid (e.g., prednisone) confirmed by claims history or submitted medical records OR 2.2 History of intolerance or contraindication to ALL glucocorticoids (e.g., prednisone) (please specify intolerance or contraindication)	

OR

2.3 Patient is currently on tocilizumab therapy as confirmed by claims history or submitted medical records

AND

3 - If the request is for a non-preferred tocilizumab product, the prescriber has given a clinical reason or special circumstance why the patient is unable to use the preferred tocilizumab products (please document reason/special circumstances)

AND

4 - Patient is NOT receiving tocilizumab in combination with another systemic targeted immunomodulator for treatment of the same indication

AND

5 - Prescribed by or in consultation with a rheumatologist

AND

6 - If the request is for BRAND Actemra, one of the following:

6.1 Submission of medical records confirming patient allergy or intolerance to at least one preferred tocilizumab biosimilar's inactive ingredients

OR

6.2 Both of the following:

Submission of medical records confirming patient has previously been successfully treated with brand Actemra

Submission of medical records confirming patient has tried at least one preferred tocilizumab biosimilar for 6-8 weeks per product and saw a decrease in effectiveness

Product Name: Actemra subcutaneous, Tyenne subcutaneous, Avtozma subcutaneous	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (PJIA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis (PJIA)

AND

2 - ONE of the following:

2.1 Failure to ONE of the preferred adalimumab products confirmed by claims history or submitted medical records

OR

2.2 History of intolerance or contraindication to ALL of the preferred adalimumab products (please specify intolerance or contraindication)

OR

2.3 Patient is currently on tocilizumab therapy as confirmed by claims history or submitted medical records

AND

3 - If the request is for a non-preferred tocilizumab product, the prescriber has given a clinical

reason or special circumstance why the patient is unable to use the preferred tocilizumab products (please document reason/special circumstances)

AND

4 - Patient is NOT receiving tocilizumab in combination with another systemic targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib)] for treatment of the same indication

AND

5 - Prescribed by or in consultation with a rheumatologist

AND

6 - If the request is for BRAND Actemra, one of the following:

6.1 Submission of medical records confirming patient allergy or intolerance to at least one preferred tocilizumab biosimilar's inactive ingredients

OR

6.2 Both of the following:

Submission of medical records confirming patient has previously been successfully treated with brand Actemra

Submission of medical records confirming patient has tried at least one preferred tocilizumab biosimilar for 6-8 weeks per product and saw a decrease in effectiveness

Product Name:Actemra subcutaneous, Tyenne subcutaneous, Avtozma subcutaneous	
Diagnosis	Systemic Juvenile Idiopathic Arthritis (SJIA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of active systemic juvenile idiopathic arthritis (SJIA)

AND

2 - Patient is NOT receiving tocilizumab in combination with another systemic targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib)] for treatment of the same indication

AND

3 - If the request is for a non-preferred tocilizumab product, the prescriber has given a clinical reason or special circumstance why the patient is unable to use the preferred tocilizumab products (please document reason/special circumstances)

AND

4 - Prescribed by or in consultation with a rheumatologist

AND

5 - If the request is for BRAND Actemra, one of the following:

5.1 Submission of medical records confirming patient allergy or intolerance to at least one preferred tocilizumab biosimilar's inactive ingredients

OR

5.2 Both of the following:

Submission of medical records confirming patient has previously been successfully treated with brand Actemra

Submission of medical records confirming patient has tried at least one preferred tocilizumab biosimilar for 6-8 weeks per product and saw a decrease in effectiveness

Product Name:Actemra subcutaneous, Tyenne subcutaneous, Avtozma subcutaneous	
Diagnosis	Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of systemic sclerosis-associated interstitial lung disease (SSc-ILD) as documented by ALL of the following: 1.1 ONE of the following: 1.1.1 Skin thickening of the fingers of both hands extending proximal to the metacarpophalangeal joints OR 1.1.2 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 polymerase III)	

AND

1.2 Presence of interstitial lung disease as determined by finding evidence of pulmonary fibrosis on HRCT (high-resolution computed tomography), involving at least 10% of the lungs

AND

2 - Patient is NOT receiving tocilizumab in combination with another systemic targeted immunomodulator for treatment of the same indication

AND

3 - If the request is for a non-preferred tocilizumab product, the prescriber has given a clinical reason or special circumstance why the patient is unable to use the preferred tocilizumab products (please document reason/special circumstances)

AND

4 - Prescribed by or in consultation with a pulmonologist

AND

5 - If the request is for BRAND Actemra, one of the following:

5.1 Submission of medical records confirming patient allergy or intolerance to at least one preferred tocilizumab biosimilar's inactive ingredients

OR

5.2 Both of the following:

Submission of medical records confirming patient has previously been successfully treated with brand Actemra

Submission of medical records confirming patient has tried at least one preferred tocilizumab biosimilar for 6-8 weeks per product and saw a decrease in effectiveness

Product Name:Actemra subcutaneous, Tyenne subcutaneous, Avtozma subcutaneous	
Diagnosis	RA, GCA, PJIA, SJIA, SSc-ILD
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to tocilizumab therapy AND 2 - Patient is NOT receiving tocilizumab in combination with another systemic targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib)] for treatment of the same indication* AND 3 - If the request is for a non-preferred tocilizumab product, the prescriber has given a clinical reason or special circumstance why the patient is unable to use the preferred tocilizumab products (please document reason/special circumstances) AND 4 - If the request is for BRAND Actemra, one of the following: 4.1 Submission of medical records confirming patient allergy or intolerance to at least one preferred tocilizumab biosimilar's inactive ingredients OR 4.2 Both of the following:	

Submission of medical records confirming patient has previously been successfully treated with brand Actemra Submission of medical records confirming patient has tried at least one preferred tocilizumab biosimilar for 6-8 weeks per product and saw a decrease in effectiveness	
Notes	* Examples of drug(s) may not be applicable based on the requested indication.

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: 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>

NM: <https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html>

3 . Revision History

Date	Notes
4/27/2026	Updated combination examples and language with no change to clinical intent.

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

Tonmya



Prior Authorization Guideline

Guideline ID	GL-572187
Guideline Name	Tonmya
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State New Jersey Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Nevada Medicaid - Community & State Virginia Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name: Tonmya	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of fibromyalgia

AND

2 - Fibromyalgia diagnosed based on ALL of the following American College of Rheumatology criteria:

2.1 Generalized pain, defined as pain in at least 4 of 5 regions, is present

AND

2.2 Symptoms have been present at a similar level for at least 3 months

AND

2.3 Diagnosis of fibromyalgia is valid irrespective of other diagnoses

AND

2.4 Diagnosis of fibromyalgia does not exclude the presence of other clinically important illnesses

AND

2.5 ONE of the following:

Widespread pain index (WPI) greater than or equal to 7 and symptom severity scale (SSS) score greater than or equal to 5

WPI of 4–6 and SSS score greater than or equal to 9

AND

3 - Patient has implemented ALL of the following nonpharmacologic measures for the treatment of fibromyalgia:

Patient education (e.g., sleep hygiene)

Physical activity and exercise

Cognitive therapy (e.g., meditation and relaxation, cognitive-behavioral therapy, mindfulness-based stress reduction)

AND

4 - History of failure or intolerance to cyclobenzaprine (generic Flexeril) (please specify intolerance or contraindication) which is unable to be resolved with attempts to minimize the adverse effects where appropriate (e.g., dose reduction)

AND

5 - One of the following:

5.1 Failure to TWO of the following as confirmed by claims history of submission of medical records:

amitriptyline (generic Elavil)

duloxetine (generic Cymbalta)

gabapentin (generic Neurontin)

pregabalin (generic Lyrica)

OR

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

amitriptyline (generic Elavil)

duloxetine (generic Cymbalta)
gabapentin (generic Neurontin)
pregabalin (generic Lyrica)

Product Name: Tonmya	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of a reduction in pain intensity with Tonmya use	

2 . Revision History

Date	Notes
4/9/2026	Removed MI

Topical NSAIDs



Prior Authorization Guideline

Guideline ID	GL-522247
Guideline Name	Topical NSAIDs
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 New Mexico

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name:Brand Diclofenac Epolamine patch, Flector patch	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of acute pain due to minor strains, sprains, or contusions

AND

2 - The patient did not receive adequate pain relief when treated with at least TWO preferred* non-steroidal anti-inflammatory drugs (NSAIDs), one of which must be celecoxib (generic for Celebrex), as confirmed by claims history or submitted medical records. An inadequate response to treatment is defined as pain and/or inflammatory symptoms not resolved after 14 days of therapy

AND

3 - ONE of the following:

3.1 Failure to ONE of the following, as confirmed by claims history or submission of medical records:

diclofenac topical gel 1% [Rx (prescription) formulation]

diclofenac topical gel 1% [OTC (over-the-counter) formulation]

OR

3.2 History of intolerance or contraindication to BOTH of the following (please provide intolerance or contraindication):

diclofenac topical gel 1% (Rx formulation)

diclofenac topical gel 1% (OTC formulation)

Notes

*PDL links are listed in Background.

Product Name: Brand Pennsaid, generic diclofenac sodium soln 2%, diclofenac sodium soln 1.5%

Approval Length

12 month(s)

Guideline Type

Prior Authorization

Approval Criteria

1 - Diagnosis of pain due to osteoarthritis of the knee(s)

AND

2 - The patient did not receive adequate pain relief when treated with at least TWO preferred* non-steroidal anti-inflammatory drugs (NSAIDs), one of which must be celecoxib (generic for Celebrex), as confirmed by claims history or submitted medical records. An inadequate response to treatment is defined as pain and/or inflammatory symptoms not resolved after 14 days of therapy

AND

3 - ONE of the following:

3.1 If the request is for Pennsaid (diclofenac sodium soln 2%), ONE of the following:

3.1.1 Failure to BOTH of the following, as confirmed by claims history or submission of medical records:

diclofenac topical gel 1% [Rx (prescription) or OTC (over-the-counter) formulation]
(generic for Voltaren)

diclofenac 1.5% topical solution

OR

3.1.2 History of intolerance or contraindication to BOTH of the following (please provide intolerance or contraindication):

diclofenac topical gel 1% (Rx or OTC formulation) (generic for Voltaren)

diclofenac 1.5% topical solution

OR

3.2 If the request is for diclofenac topical solution 1.5%, ONE of the following:

3.2.1 Failure to ONE of the following, as confirmed by claims history or submission of medical records:

diclofenac topical gel 1% (Rx formulation) (generic for Voltaren)

diclofenac topical gel 1% (OTC formulation) (generic for Voltaren)

OR

3.2.2 History of intolerance or contraindication to BOTH of the following (please provide intolerance or contraindication):

diclofenac topical gel 1% (Rx formulation) (generic for Voltaren)

diclofenac topical gel 1% (OTC formulation) (generic for Voltaren)

Notes

*PDL links are listed in Background.

Product Name: Brand Voltaren (Rx and OTC formulations)

Approval Length

12 month(s)

Guideline Type

Prior Authorization

Approval Criteria

1 - Diagnosis of pain due to osteoarthritis of joints amenable to topical treatment, including but not limited to the hands, knees, ankles, elbows, feet, and wrists

AND

2 - ONE of the following:

2.1 If the request is for Brand Voltaren Rx (prescription) formulation, BOTH of the following:

2.1.1 The patient did not receive adequate pain relief when treated with at least TWO preferred* non-steroidal anti-inflammatory drugs (NSAIDs), one of which must be celecoxib (generic for Celebrex), as confirmed by claims history or submitted medical records. An inadequate response to treatment is defined as pain and/or inflammatory symptoms not resolved after 14 days of therapy

AND

2.1.2 ONE of the following:

2.1.2.1 Failure to BOTH of the following, as confirmed by claims history or submission of medical records:

diclofenac topical gel 1% [Rx or OTC (over-the-counter) formulation] (generic Voltaren)

Brand Voltaren topical gel 1% (OTC formulation)

OR

2.1.2.2 History of intolerance or contraindication to BOTH of the following (please provide intolerance or contraindication):

diclofenac topical gel 1% (Rx or OTC formulation) (generic Voltaren)

Brand Voltaren topical gel 1% (OTC formulation)

OR

2.2 If the request is for Brand Voltaren OTC formulation, ONE of the following:

2.2.1 Failure to ONE of the following, as confirmed by claims history or submission of medical records:

diclofenac topical gel 1% (Rx formulation) (generic Voltaren)

diclofenac topical gel 1% (OTC formulation) (generic Voltaren)

OR

2.2.2 History of intolerance or contraindication to BOTH of the following (please provide intolerance or contraindication):

diclofenac topical gel 1% (Rx formulation) (generic Voltaren)

diclofenac topical gel 1% (OTC formulation) (generic Voltaren)	
Notes	*PDL links are listed in Background.

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 PA CHIP: 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 NM: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

3 . Revision History

UnitedHealthcare Community Plan of Rhode Island Clinical Pharmacy Program Guidelines

Date	Notes
2/17/2026	Removed NY and NY EPP formularies - see separate guideline for these formularies. Removed NY/NY EPP PDL link from background. No other changes to guideline.

Topical Retinoid Products



Prior Authorization Guideline

Guideline ID	GL-506355
Guideline Name	Topical Retinoid Products
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 New Mexico

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:generic tretinoin microsphere, Brand Retin-A Micro, Brand Differin cream, generic adapalene cream, Differin gel (Rx only)/lotion, adapalene gel/soln/pads, Fabior, tazarotene foam, Brand Tazorac, generic tazarotene, generic adapalene/benzoyl peroxide, Brand Epiduo, Brand Epiduo Forte, Brand Atralin, generic tretinoin gel, Brand Retin-A, Altreno, Aklief, Arazlo	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a non-cosmetic medical condition (e.g., acne vulgaris, psoriasis, precancerous skin lesions) (See Table 1 in Background for additional list of non-cosmetic medical conditions)

AND

2 - Medication is not being requested solely for cosmetic purposes (e.g., photo-aging, wrinkling, hyperpigmentation, sun damage, melasma) (See Table 1 in Background for additional list of non-cosmetic medical conditions)

AND

3 - ONE of the following:

3.1 BOTH of the following:

3.1.1 Patient has a diagnosis of acne vulgaris

AND

3.1.2 ONE of the following:

3.1.2.1 Failure to a trial of BOTH of the following as confirmed by claims history or submission of medical records:

Differin OTC (over the counter)

Tretinoin cream (generic Retin-A cream)

OR

3.1.2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

Differin OTC

Tretinoin cream (generic Retin-A cream)	
OR	
3.2 BOTH of the following:	
3.2.1 Patient does NOT have a diagnosis of acne vulgaris	
AND	
3.2.2 ONE of the following:	
3.2.2.1 Failure to a trial of at least THREE preferred* products as confirmed by claims history or submission of medical records	
OR	
3.2.2.2 History of intolerance or contraindication to ALL preferred* products (please specify intolerance or contraindication)	
Notes	*Step therapy is not limited to topical retinoids. 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. *See Table 2 in Background for PDL links.

Product Name:generic tretinoin cream	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is less than 18 years old OR	

2 - ALL of the following:

2.1 Patient is 18 years of age or older

AND

2.2 Patient has a non-cosmetic medical condition (e.g., acne vulgaris, psoriasis, precancerous skin lesions) (See Table 1 in Background for additional list of non-cosmetic medical conditions)

AND

2.3 Medication is not being requested solely for cosmetic purposes (e.g., photo-aging, wrinkling, hyperpigmentation, sun damage, melasma) (See Table 1 in Background for additional list of non-cosmetic medical conditions)

2 . Background

Benefit/Coverage/Program Information

Table 1: Examples of non-cosmetic medical conditions include, but are not limited to, the following:

Acanthosis nigricans	Keratoderma
Acne	Keratoderma palmaris et plantaris
Acne keloidalis nuchae	Keratosis rubra figurata
Acne rosacea	Kyrle's disease
Acne vulgaris	Lamellar ichthyosis
Actinic cheilitis	Leukoplakia
Actinic dermatitis	Lichen planus
Actinic keratosis	Mal de Meleda
	Malignancy

Basal cell carcinoma	Mendes da Costa syndrome
Bowen's disease	Molluscum contagiosum
Cystic acne	Non-bullous congenital ichthyosis
Darier's disease	Papillon-Lefevre syndrome
Darier-White Disease	Porokeratosis
Dermal mucinosis	Pseudofollicular barbae
Discoid lupus erythematosus	Pseudoacanthosis nigricans
Epidermoid cysts	Psoriasis
Epidermolytic hyperkeratosis	Psoriasis erythrodermic, palmoplantar
Erythrokeratoderma variabilis	Psoriasis pustular
Favre Racouchot disease	Psoriatic arthritis
Flat warts	Rosacea
Folliculitis	Sebaceous cysts
Fox Fordyce disease	Senile keratosis
Grover's disease	Solar keratosis
Hidradenitis suppurativa	Squamous cell carcinoma
Hyperkeratosis	Systematized epidermal nevus
Hyperkeratosis follicularis	Transient acantholytic dermatosis
Hyperkeratotic eczema	Tylotic eczema
Ichthyoses	X-linked ichthyosis
Ichthyosis vulgaris	Verruca planae
Keloid scar	Von Zumbusch pustular
Keratoacanthoma	Warts

Keratosis follicularis

Wound healing (mild)

Table 2: 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>

PA CHIP: <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>

NM: <https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html>

3 . Revision History

Date	Notes
1/27/2026	Removed NY. Added NM. Removed brand Avita

Topical Retinoid Products



Prior Authorization Guideline

Guideline ID	GL-506355
Guideline Name	Topical Retinoid Products
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 New Mexico

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:generic tretinoin microsphere, Brand Retin-A Micro, Brand Differin cream, generic adapalene cream, Differin gel (Rx only)/lotion, adapalene gel/soln/pads, Fabior, tazarotene foam, Brand Tazorac, generic tazarotene, generic adapalene/benzoyl peroxide, Brand Epiduo, Brand Epiduo Forte, Brand Atralin, generic tretinoin gel, Brand Retin-A, Altreno, Aklief, Arazlo	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a non-cosmetic medical condition (e.g., acne vulgaris, psoriasis, precancerous skin lesions) (See Table 1 in Background for additional list of non-cosmetic medical conditions)

AND

2 - Medication is not being requested solely for cosmetic purposes (e.g., photo-aging, wrinkling, hyperpigmentation, sun damage, melasma) (See Table 1 in Background for additional list of non-cosmetic medical conditions)

AND

3 - ONE of the following:

3.1 BOTH of the following:

3.1.1 Patient has a diagnosis of acne vulgaris

AND

3.1.2 ONE of the following:

3.1.2.1 Failure to a trial of BOTH of the following as confirmed by claims history or submission of medical records:

Differin OTC (over the counter)

Tretinoin cream (generic Retin-A cream)

OR

3.1.2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

Differin OTC

Tretinoin cream (generic Retin-A cream)	
OR	
3.2 BOTH of the following:	
3.2.1 Patient does NOT have a diagnosis of acne vulgaris	
AND	
3.2.2 ONE of the following:	
3.2.2.1 Failure to a trial of at least THREE preferred* products as confirmed by claims history or submission of medical records	
OR	
3.2.2.2 History of intolerance or contraindication to ALL preferred* products (please specify intolerance or contraindication)	
Notes	*Step therapy is not limited to topical retinoids. 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. *See Table 2 in Background for PDL links.

Product Name:generic tretinoin cream	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is less than 18 years old OR	

2 - ALL of the following:

2.1 Patient is 18 years of age or older

AND

2.2 Patient has a non-cosmetic medical condition (e.g., acne vulgaris, psoriasis, precancerous skin lesions) (See Table 1 in Background for additional list of non-cosmetic medical conditions)

AND

2.3 Medication is not being requested solely for cosmetic purposes (e.g., photo-aging, wrinkling, hyperpigmentation, sun damage, melasma) (See Table 1 in Background for additional list of non-cosmetic medical conditions)

2 . Background

Benefit/Coverage/Program Information

Table 1: Examples of non-cosmetic medical conditions include, but are not limited to, the following:

Acanthosis nigricans	Keratoderma
Acne	Keratoderma palmaris et plantaris
Acne keloidalis nuchae	Keratosis rubra figurata
Acne rosacea	Kyrle's disease
Acne vulgaris	Lamellar ichthyosis
Actinic cheilitis	Leukoplakia
Actinic dermatitis	Lichen planus
Actinic keratosis	Mal de Meleda
	Malignancy

Basal cell carcinoma	Mendes da Costa syndrome
Bowen's disease	Molluscum contagiosum
Cystic acne	Non-bullous congenital ichthyosis
Darier's disease	Papillon-Lefevre syndrome
Darier-White Disease	Porokeratosis
Dermal mucinosis	Pseudofollicular barbae
Discoid lupus erythematosus	Pseudoacanthosis nigricans
Epidermoid cysts	Psoriasis
Epidermolytic hyperkeratosis	Psoriasis erythrodermic, palmoplantar
Erythrokeratoderma variabilis	Psoriasis pustular
Favre Racouchot disease	Psoriatic arthritis
Flat warts	Rosacea
Folliculitis	Sebaceous cysts
Fox Fordyce disease	Senile keratosis
Grover's disease	Solar keratosis
Hidradenitis suppurativa	Squamous cell carcinoma
Hyperkeratosis	Systematized epidermal nevus
Hyperkeratosis follicularis	Transient acantholytic dermatosis
Hyperkeratotic eczema	Tylotic eczema
Ichthyoses	X-linked ichthyosis
Ichthyosis vulgaris	Verruca planae
Keloid scar	Von Zumbusch pustular
Keratoacanthoma	Warts

Keratosis follicularis

Wound healing (mild)

Table 2: 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>

PA CHIP: <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>

NM: <https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html>

3 . Revision History

Date	Notes
1/27/2026	Removed NY. Added NM. Removed brand Avita

Trelegy Ellipta, Breztri



Prior Authorization Guideline

Guideline ID	GL-398257
Guideline Name	Trelegy Ellipta, Breztri
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 Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	10/1/2025

1 . Criteria

Product Name: Trelegy Ellipta, Breztri Aerosphere	
Diagnosis	Chronic Obstructive Pulmonary Disease (COPD)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic obstructive pulmonary disease (COPD), including chronic bronchitis and/or emphysema

AND

2 - ONE of the following:

2.1 Failure to a 30 day trial of ONE of the following combinations as confirmed by claims history or submission of medical records:

2.1.1 ONE of the following long-acting muscarinic antagonist (LAMA) plus long-acting beta2-agonist (LABA)

Anoro Ellipta (umeclidinium/vilanterol)

Stiolto Respimat (tiotropium/olodaterol)

OR

2.1.2 ONE of the following inhaled corticosteroid (ICS) plus long-acting beta2-agonist (LABA)

Fluticasone propionate/salmeterol diskus (generic Advair Diskus) or Wixela Inhub (generic Advair Diskus)

Breyna or budesonide/formoterol (generic of Symbicort)

Fluticasone/vilanterol (authorized generic of Breo Ellipta)

OR

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

Anoro Ellipta (umeclidinium/vilanterol)

Stiolto Respimat (tiotropium/olodaterol)

fluticasone propionate/salmeterol diskus (generic Advair Diskus) or Wixela Inhub (generic Advair Diskus)

Breyna or budesonide/formoterol (generic of Symbicort)

Fluticasone/vilanterol (authorized generic of Breo Ellipta)

OR

2.3 Eosinophil count greater than or equal to 300 cells/microliter as confirmed by submission of medical records

Product Name: Trelegy Ellipta	
Diagnosis	Asthma
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of asthma

AND

2 - ONE of the following:

2.1 Failure to treatment with at least a 30-day trial of ONE of the following, confirmed by claims history or submission of medical records:

Fluticasone/salmeterol (authorized generic of AirDuo Respiclick)

Fluticasone propionate/salmeterol diskus (generic Advair Diskus)

Wixela Inhub (generic Advair Diskus)

OR

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

Fluticasone/salmeterol (authorized generic of AirDuo Respiclick)

Fluticasone propionate/salmeterol diskus (generic Advair Diskus)

Wixela Inhub (generic Advair Diskus)

2 . Revision History

Date	Notes
9/18/2025	Updated COPD ICS.LABA step thru agents.

Tremfya



Prior Authorization Guideline

Guideline ID	GL-537204
Guideline Name	Tremfya
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 New Mexico

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Tremfya	
Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic moderate to severe plaque psoriasis

AND

2 - Patient is NOT receiving Tremfya in combination with another systemic targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, ustekinumab, Skyrizi (risankizumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)] for treatment of the same indication

AND

3 - Prescribed by or in consultation with a dermatologist

AND

4 - One of the following:

4.1 Patient is currently on Tremfya therapy as confirmed by claims history or submission of medical records

OR

4.2 All of the following:

4.2.1 One of the following:

4.2.1.1 Patient has been previously treated with a systemic targeted immunomodulator FDA-approved for the treatment of plaque psoriasis as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), adalimumab, Otezla (apremilast), Skyrizi (risankizumab-rzaa), ustekinumab]

OR

4.2.1.2 All of the following:

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

AND

4.2.1.2.2 One of the following:

Failure to ONE of the following topical therapy classes confirmed by claims history or submission of medical records: Corticosteroids (e.g., betamethasone, clobetasol, desonide), Vitamin D analogs (e.g., calcitriol, calcipotriene), Tazarotene, Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus), Anthralin, Coal tar

History of intolerance or contraindication to ALL of the following topical therapy classes (please specify intolerance or contraindication): Corticosteroids (e.g., betamethasone, clobetasol, desonide), Vitamin D analogs (e.g., calcitriol, calcipotriene), Tazarotene, Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus), Anthralin, Coal tar

AND

4.2.1.2.3 One of the following:

Failure to a 3 month trial of methotrexate at maximally indicated dose confirmed by claims history or submitted medical records

History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

AND

4.2.2 One of the following:

4.2.2.1 Failure to TWO of the following preferred products as confirmed by claims history or submitted medical records:

One of the preferred adalimumab products*

Enbrel (etanercept)

One of the preferred ustekinumab products*

OR

4.2.2.2 History of intolerance or contraindication to ALL of the following preferred products (please specify intolerance or contraindication):

One of the preferred adalimumab products*

Enbrel (etanercept)

One of the preferred ustekinumab products*

AND

4.2.3 One of the following:

Failure to Cosentyx (secukinumab) as confirmed by claims history or submission of medical records

History of intolerance or contraindication to Cosentyx (secukinumab) (please specify intolerance or contraindication)

Notes	*See PDL links in Background

Product Name:Tremfya

Diagnosis	Psoriatic Arthritis (PsA)

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of active psoriatic arthritis

AND

2 - Patient is NOT receiving Tremfya in combination with another systemic targeted

immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, ustekinumab, Skyrizi (risankizumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)] for treatment of the same indication

AND

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

Rheumatologist

Dermatologist

AND

4 - One of the following:

4.1 Patient is currently on Tremfya therapy as confirmed by claims history or submission of medical records

OR

4.2 ALL of the following:

4.2.1 One of the following:

Failure to a 3 month trial of methotrexate at the maximally indicated dose, confirmed by claims history or submitted medical records

History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

Patient has been previously treated with a systemic targeted immunomodulator FDA-approved for the treatment of psoriatic arthritis as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), ustekinumab, Xeljanz/XR (tofacitinib), Otezla (apremilast), Rinvoq (upadacitinib)]

AND

4.2.2 One of the following:

4.2.2.1 Failure to TWO of the following preferred products as confirmed by claims history or submitted medical records:

One of the preferred adalimumab products*

Enbrel (etanercept)

One of the preferred ustekinumab products*

OR

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

One of the preferred adalimumab products*

Enbrel (etanercept)

One of the preferred ustekinumab products*

AND

4.2.3 One of the following:

Failure to Cosentyx (secukinumab) as confirmed by claims history or submitted medical records

History of intolerance or contraindication to Cosentyx (secukinumab) (please specify intolerance or contraindication)

Notes	*See PDL links in Background

Product Name:Tremfya	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active ulcerative colitis

AND

2 - Patient is NOT receiving Tremfya in combination with another systemic targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), ustekinumab, adalimumab, Skyrizi (risankizumab)] for treatment of the same indication

AND

3 - Prescribed by or in consultation with a gastroenterologist

AND

4 - One of the following:

4.1 Patient has been approved for loading dose of Tremfya under an active UnitedHealthcare medical benefit prior authorization for the treatment of moderately to severely active ulcerative colitis

OR

4.2 Patient is currently on Tremfya therapy for moderately to severely active ulcerative colitis as confirmed by claims history or submission of medical records

OR

4.3 Both of the following

4.3.1 One of the following:

4.3.1.1 Patient has had prior or concurrent inadequate response to a therapeutic course of

oral corticosteroids and/or immunosuppressants (e.g., azathioprine, 6-mercaptopurine), as confirmed by claims history or submitted medical records

OR

4.3.1.2 Patient has been previously treated with a systemic targeted immunomodulator FDA-approved for the treatment of ulcerative colitis as confirmed by claims history or submission of medical records [e.g., adalimumab, Rinvok (upadacitinib), Simponi (golimumab), Skyrizi (risankizumab), ustekinumab, Xeljanz (tofacitinib)]

AND

4.3.2 One of the following:

4.3.2.1 Failure to both of the following as confirmed by claims history or submitted medical records:

One of the preferred adalimumab products*

One of the preferred ustekinumab products*

OR

4.3.2.2 History of intolerance or contraindication to both of the following (please specify intolerance or contraindication):

One of the preferred adalimumab products*

One of the preferred ustekinumab products*

Notes	*See PDL links in Background

Product Name:Tremfya	
Diagnosis	Crohn's Disease (CD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

AND

2 - Patient is NOT receiving Tremfya in combination with another systemic targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Entyvio (vedolizumab), Omvoh (miri-kizumab-mrkz), Rinvoq (upadacitinib), Skyrizi (risankizumab), ustekinumab] for treatment of the same indication

AND

3 - Prescribed by or in consultation with a gastroenterologist

AND

4 - ONE of the following:

4.1 Patient has been approved for loading dose of Tremfya under an active UnitedHealthcare medical benefit prior authorization for the treatment of moderately to severely active Crohn's disease

OR

4.2 Patient is currently on Tremfya therapy for moderately to severely active Crohn's disease as confirmed by claims history or submission of medical records

OR

4.3 ONE of the following:

4.3.1 Failure to ONE of the following conventional drugs or classes at maximally indicated doses, as confirmed by claims history or submitted medical records:

Corticosteroids (e.g., prednisone, methylprednisolone, budesonide)

Azathioprine (generic Imuran)

6-mercaptopurine (generic Purinethol)

Methotrexate

OR

4.3.2 History of intolerance or contraindication to ALL of the following conventional drugs or classes (please specify intolerance or contraindication):

Corticosteroids (e.g., prednisone, methylprednisolone, budesonide)

Azathioprine (generic Imuran)

6-mercaptopurine (generic Purinethol)

Methotrexate

OR

4.3.3 Patient has been previously treated with a systemic targeted immunomodulator FDA-approved for the treatment of Crohn's disease as confirmed by claims history or submission of medical records [e.g., adalimumab, Cimzia (certolizumab), Entyvio (vedolizumab), Omvoh (mirikizumab-mrkz), Rinvoq (upadacitinib), Skyrizi (risankizumab), ustekinumab]

Product Name:Tremfya	
Diagnosis	Plaque Psoriasis, Psoriatic Arthritis (PsA), Ulcerative Colitis (UC), Crohn's Disease (CD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Documentation of positive clinical response to Tremfya therapy

AND

2 - Patient is NOT receiving Tremfya in combination with another systemic targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Entyvio (vedolizumab), Omvoh (mirikizumab-mrkz), Simponi (golimumab), Orencia (abatacept), adalimumab, ustekinumab, Skyrizi (risankizumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]* for treatment of the same indication

Notes

*Examples of drug(s) may not be applicable based on the requested indication.

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>

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>

NM: <https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html>

3 . Revision History

Date	Notes
3/3/2026	Removed NY

Trikafta



Prior Authorization Guideline

Guideline ID	GL-556224
Guideline Name	Trikafta
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

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

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

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of cystic fibrosis (CF) AND 2 - Submission of laboratory results documenting that the patient has at least ONE of the following responsive mutations in the cystic fibrosis transmembrane conductance regulator (CFTR) gene (see Table 1 in Background): F508del mutation A mutation that is responsive based on clinical data A mutation that is responsive based on in vitro data A mutation that is responsive based on extrapolated data AND 3 - Patient is 2 years of age or older AND 4 - Prescribed by, or in consultation with a provider who specializes in the treatment of CF	

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

1 - Documentation of positive clinical response to Trikafta therapy (e.g., improved lung function, stable lung function)

2 . Background

Benefit/Coverage/Program Information

Table 1: List of CFTR Gene Mutations Responsive to Trikafta

List of CFTR (cystic fibrosis transmembrane conductance regulator) Gene Mutations Responsive to Trikafta

Based on clinical data**

2789+5G→A	D1152H†	L206W†	R1066H†	S945L†
3272-26A→G	F508del†	L997F†	R117C†	T338I†
3849+10kbC→T	G85E†	M1101K†	R347H†	V232D†
A455E†	L1077P†	P5L†	R347P†	

Based on *in vitro* data‡

N1303K	F200I	I1139V	P574H	S1045Y
1507_1515del9	F311del	I125T	P67L	S108F
2183A→G	F311L	I1269N	P750L	S1118F
3141del9	F508C	I1366N	Q1291R	S1159F
546insCTA	F508C; S1251N	I148N	Q1313K	S1159P
A1006E	F575Y	I148T	Q237E	S1235R
A1067P	F587I	I175V	Q237H	S1251N
A1067T	G1047R	I331N	Q359R	S1255P
A107G	G1061R	I336K	Q372H	S13F
A120T	G1069R	I502T	Q493R	S341P
A234D	G1123R	I506L	Q552P	S364P
A309D	G1244E	I556V	Q98R	S492F
A349V	G1247R	I601F	R1048G	S549I
A46D	G1249R	I618T	R1070Q	S549N
A554E	G126D	I807M	R1070W	S549R
A62P	G1349D	I980K	R1162L	S589N
C491R	G178E	K1060T	R117C; G576A; R668C	S737F
D110E	G178R	K162E	R117G	S912L
D110H	G194R	K464E	R117H	S977F

D1270N	G194V	L1011S	R117L	T1036N
D1445N	G27E	L1324P	R117P	T1053I
D192G	G27R	L1335P	R1283M	T1086I
D443Y	G314E	L137P	R1283S	T1246I
D443Y; G576A; R668C	G424S	L1480P	R170H	T1299I
D565G	G463V	L15P	R258G	T351I
D579G	G480C	L165S	R297Q	V1153E
D614G	G480S	L320V	R31C	V1240G
D836Y	G551A	L333F	R31L	V1293G
D924N	G551D	L333H	R334L	V201M
D979V	G551S	L346P	R334Q	V392G
D993Y	G576A	L441P	R347L	V456A
E116K	G576A; R668C	L453S	R352Q	V456F
E116Q	G622D	L619S	R352W	V562I
E193K	G628R	L967S	R516S	V603F
E292K	G970D	M1137V	R553Q	V754M
E474K	H1054D	M152V	R668C	W1282R
E56K	H1085P	M265R	R709Q	W361R
E588V	H1085R	M952I	R74Q	Y1014C
E60K	H1375P	M952T	R74W	Y1032C
E92K	H199Y	N1303I	R74W; V201M	Y161D
F1016S	H620P	N186K	R74W; V201M; D1270N	Y161S
F1052V	H620Q	N187K	R751L	Y301C
F1074L	H939R	N418S	R75L	Y563N
F1099L	H939R; H949L	P140S	R75Q	
F1107L	I1027T	P205S	R792G	
F191V	I105N	P499A	R933G	
Based on extrapolation from Trial 5 ^s				
4005+2T→C	2789+2insA	3849+40A→G	5T; TG13	
1341G→A	296+28A→G	3849+4A→G	621+3A→G	
1898+3A→G	3041-15T→G	3850-3T→G	711+3A→G	
2752-26A→G	3600G→A	5T; TG12	E831X	
** Clinical data obtained from Trials 1 (NCT03525444), 2 (NCT03525548), and 5 (NCT05274269).				
† This mutation is also predicted to be responsive by FRT assay.				

‡ The N1303K mutation is predicted to be responsive by HBE assay. All other mutations predicted to be responsive with in vitro data are supported by FRT assay.

§ Efficacy is extrapolated from Trial 5 to non-canonical splice mutations because clinical trials in all mutations of this subgroup are infeasible and these mutations are not amenable to interrogation by FRT system.

3 . Revision History

Date	Notes
3/26/2026	Removed diagnosis from indication tab. Expanded on CFTR abbreviation. Minor cosmetic updates.

Triptans



Prior Authorization Guideline

Guideline ID	GL-506352
Guideline Name	Triptans
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State New Jersey Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:almotriptan, generic eletriptan, Brand Relpax, generic frovatriptan, Brand Frova, Onzetra XSail, generic rizatriptan, Brand Maxalt, generic rizatriptan ODT, Brand Maxalt-MLT, Imitrex Statdose System, sumatriptan auto-inj, Brand Imitrex nasal spr/tabs, generic sumatriptan nasal spr/tabs/inj, Brand Imitrex Statdose Refill, generic sumatriptan refill, generic sumatriptan/naproxen, Brand Treximet, Zembrace Symtouch, generic zolmitriptan tabs/nasal spr, Brand Zomig tabs/nasal spr, Brand Zolmitriptan nasal spr, zolmitriptan ODT, Tosymra, Symbravo, generic naratriptan	
Approval Length	12 month(s)

Guideline Type	Prior Authorization
	Approval Criteria 1 - If the requested medication is non-preferred*, BOTH of the following: 1.1 Diagnosis of migraine headaches with or without aura AND 1.2 ONE of the following: 1.2.1 Patient has failure to THREE of the following as confirmed by claims history or submission of medical records: Eletriptan (generic Relpax) Frovatriptan (generic Frova) Naratriptan Rizatriptan One of the following sumatriptan formulations: tablets, nasal spray, 4 mg injection, or 6 mg injection Zolmitriptan (generic Zomig/Zomig-ZMT) OR 1.2.2 Patient has a history of contraindication or intolerance to ALL of the following (please specify intolerance or contraindication): Eletriptan (generic Relpax) Frovatriptan (generic Frova) Naratriptan Rizatriptan

One of the following sumatriptan formulations: tablets, nasal spray, 4 mg injection, or 6 mg injection	
Zolmitriptan (generic Zomig/Zomig-ZMT)	
Notes	*PDL links in Background.

Product Name: Imitrex Statdose System, sumatriptan auto-inj, sumatriptan inj, Brand Imitrex Statdose Refill, generic sumatriptan refill	
Diagnosis	Migraine Headaches
Approval Length	12 month(s)
Guideline Type	Quantity Limit
Approval Criteria 1 - Diagnosis of migraine headaches with or without aura AND 2 - Currently receiving prophylactic therapy with at least ONE of the following as confirmed by claims history or submission of medical records: 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, Ajovy*, Emgality, Qulipta*, Vyepti**] Divalproex sodium (generic Depakote/Depakote ER) OnabotulinumtoxinA (generic Botox)** A serotonin-norepinephrine reuptake inhibitor [i.e., duloxetine (Cymbalta), venlafaxine (Effexor/Effexor XR)] Topiramate (generic Topamax) A tricyclic antidepressant [i.e., amitriptyline (Elavil), nortriptyline (Pamelor)]	

AND

3 - ONE of the following:

3.1 Higher dose or quantity is supported in the dosage and administration section of the manufacturer's prescribing information

OR

3.2 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

3.3 Provider 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

4 - Provider acknowledges that the potential benefit outweighs the risk associated with the higher dose or quantity

Notes	See Table 1 in Background. *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 prior authorization

Product Name: Imitrex Statdose System, sumatriptan auto-inj, sumatriptan inj, Brand Imitrex Statdose Refill, generic sumatriptan refill

Diagnosis	Cluster Headaches
Approval Length	12 month(s)
Guideline Type	Quantity Limit
Approval Criteria 1 - Diagnosis of cluster headaches AND 2 - Patient has experienced at least 2 cluster periods lasting from 7 days to 365 days, separated by pain-free periods lasting at least three months AND 3 - ONE of the following: 3.1 Higher dose or quantity is supported in the dosage and administration section of the manufacturer's prescribing information OR 3.2 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 3.3 Provider 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

4 - Provider acknowledges that the potential benefit outweighs the risk associated with the higher dose or quantity

Notes	See Table 1 in Background.

Product Name: almotriptan, generic eletriptan, Brand Relpax, generic frovatriptan, Brand Frova, Onzetra XSail, generic rizatriptan, Brand Maxalt, generic rizatriptan ODT, Brand Maxalt-MLT, Brand Imitrex nasal spr/tabs, generic sumatriptan nasal spr/tabs, generic sumatriptan/naproxen, Brand Treximet, Zembrace Symtouch, generic zolmitriptan tabs/nasal spr, Brand Zomig tabs/nasal spr, Brand Zolmitriptan nasal spr, zolmitriptan ODT, Tosymra, generic naratriptan, Symbravo

Approval Length	12 month(s)

Guideline Type	Quantity Limit

Approval Criteria

1 - Diagnosis of migraine headaches with or without aura

AND

2 - Currently receiving prophylactic therapy with at least ONE of the following as confirmed by claims history or submission of medical records:

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, Ajovy*, Emgality, Qulipta*, Vyepti**]

Divalproex sodium (generic Depakote/Depakote ER)

OnabotulinumtoxinA (generic Botox)**

A serotonin-norepinephrine reuptake inhibitor [i.e., duloxetine (Cymbalta), venlafaxine (Effexor/Effexor XR)]

Topiramate (generic Topamax)

A tricyclic antidepressant [i.e., amitriptyline (Elavil), nortriptyline (Pamelor)]

AND

3 - ONE of the following:

3.1 Higher dose or quantity is supported in the dosage and administration section of the manufacturer's prescribing information

OR

3.2 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

3.3 Provider 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

4 - Provider acknowledges that the potential benefit outweighs the risk associated with the higher dose or quantity

Notes	See Table 1 in Background. *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 prior authorization

2 . Background

Benefit/Coverage/Program Information

Table 1. Quantity Limits

Drug Name	Strength	Quantity Limit
Brand Amerge	1mg, 2.5mg	9 tabs/month
Generic naratriptan		
Brand Frova	2.5mg	9 tabs/month
Generic frovatriptan		
Brand Imitrex tablets	25mg, 50mg, 100mg	9 tabs/month
Generic sumatriptan tablets		
Brand Maxalt	5mg, 10mg	9 tabs/month
Generic rizatriptan		
Brand Maxalt MLT	5mg, 10mg	9 tabs/month
Generic rizatriptan ODT		
Generic almotriptan	6.25mg, 12.5mg	6 tabs/month
Relpax	20mg, 40mg	6 tabs/month
Generic eletriptan		
Brand Zomig	2.5mg, 5mg	6 tabs/month
Generic zolmitriptan		
Brand Zomig ZMT	2.5mg, 5mg	6 tabs/month

Generic zolmitriptan ODT		
Brand Imitrex nasal spray Generic sumatriptan nasal spray	5mg, 20mg	6 spray devices/month
Zomig nasal spray	2.5mg, 5mg	6 spray devices/month
Treximet Generic sumatriptan/naproxen	85mg/500 mg, 10mg/60mg	9 tabs/month
Onzetra Xsail	11mg	1 box (8 units)/month
Zembrace SymTouch	3mg/0.5mL	2 boxes (8 units)/month
Brand Imitrex Generic Sumatriptan Autoinjector/Cartridge Refills	4mg/0.5mL 6mg/0.5mL	8 autoinjectors or cartridge refills/month (4 boxes/month)
Brand Imitrex Generic Sumatriptan Vials	6mg/0.5mL	10 vials/month (2 boxes/month)
Generic Sumatriptan Pre-filled Syringe	6mg/0.5mL	8 prefilled syringes (4 boxes/month)
Tosymra nasal spray	10mg	6 units per month
Symbravo (meloxicam/rizatriptan)	20mg/10mg	9 tabs/month

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>

NJ: <https://www.uhcprovider.com/en/health-plans-by-state/new-jersey-health-plans/nj-comm-plan-home/nj-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>

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>

3 . Revision History

Date	Notes
1/27/2026	Removed NY

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.

Tryngolza



Prior Authorization Guideline

Guideline ID	GL-558261
Guideline Name	Tryngolza
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 New Mexico

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:Tryngolza	
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 AND 3 - Prescribed by one of the following: Cardiologist Endocrinologist Gastroenterologist	

Lipid specialist (lipidologist)

AND

4 - Not used in combination with Redemplo (plozasiran)

Product Name:Tryngolza	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Tryngolza 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 Redemplo (plozasiran)	

2 . Revision History

UnitedHealthcare Community Plan of Rhode Island Clinical Pharmacy Program Guidelines

Date	Notes
3/26/2026	Simplified genetic confirmation criteria. Added combination use criteria

Tryvio



Prior Authorization Guideline

Guideline ID	GL-594189
Guideline Name	Tryvio
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 Nebraska 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: Tryvio	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of resistant hypertension AND 2 - ONE of the following: Systolic blood pressure greater than or equal to 130 mm Hg (millimeters of mercury) on two consecutive measurements despite maximally tolerated antihypertensive treatment Diastolic blood pressure greater than or equal to 80 mm Hg on two consecutive measurements despite maximally tolerated antihypertensive treatment AND 3 - Patient has not achieved target blood pressure (e.g., systolic blood pressure [SBP] less than 130 mmHg) after treatment with at least THREE of the following antihypertensive medications from different classes for a minimum 4 weeks each: Renin-angiotensin system blocker [angiotensin-converting enzyme (ACE) inhibitor (e.g., enalapril, lisinopril) or angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan)] Calcium channel blocker (e.g., amlodipine, diltiazem, verapamil) Diuretic (e.g., hydrochlorothiazide, chlorthalidone) Mineralocorticoid receptor antagonist (MRA) (e.g., spironolactone, eplerenone)] AND 4 - Provider attests other causes of hypertension have been excluded (e.g., secondary causes [e.g., primary hyperaldosteronism], white coat effect, medication nonadherence)	

AND

5 - Used as an adjunct to lifestyle modification (e.g., dietary or caloric restriction, exercise, behavioral support, community-based program)

AND

6 - Tryvio will be used in combination with at least 3 antihypertensive medications from different classes at maximally tolerated doses

AND

7 - Prescribed by or in consultation with a specialist experienced in the treatment of resistant hypertension (e.g., cardiologist, nephrologist)

Product Name:Tryvio	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation the patient is receiving clinical benefit to Tryvio therapy AND 2 - Tryvio will be used in combination with at least 3 antihypertensive medications from different classes at maximally tolerated doses	

2 . Revision History

UnitedHealthcare Community Plan of Rhode Island Clinical Pharmacy Program Guidelines

Date	Notes
4/22/2026	Removed NV from formularies. Updated the language for previous antihypertensive therapies to an attestation and reduced the minimum required from all of the following to three of the following.

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

UnitedHealthcare Community Plan of Rhode Island Clinical Pharmacy Program Guidelines

Date	Notes
12/12/2025	Combined formularies. Minor verbiage update in initial auth section f or TGCT/PVNS, with no changes to clinical intent.

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-hypermuted 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

Date	Notes
12/13/2025	Combined formularies. Updated criteria for breast cancer, central nervous system cancer, colon cancer, and rectal cancer.

Tymlos



Prior Authorization Guideline

Guideline ID	GL-468188
Guideline Name	Tymlos
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

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Tymlos	
Approval Length	24 Months*
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 BOTH of the following:

Patient is female

Diagnosis of postmenopausal osteoporosis

OR

1.2 BOTH of the following:

Patient is male

Diagnosis of osteoporosis

AND

2 - ONE of the following:

2.1 Patient is at high risk of fracture [e.g., recent fracture (e.g., within the past 12 months), fractures while on approved osteoporosis therapy, multiple fractures, fractures while on drugs causing skeletal harm (e.g., long-term glucocorticoids), very low T-score (e.g., less than -3.0), high risk for falls or history of injurious falls, and very high fracture probability by FRAX (fracture risk assessment tool) (e.g., major osteoporosis fracture greater than 30%, hip fracture greater than 4.5%)]

OR

2.2 Patient has a history of failure, intolerance, or contraindication to other available osteoporosis therapy (e.g., alendronate, denosumab, risedronate, zoledronate)

AND

3 - Treatment duration has not exceeded a total of 24 months* of cumulative use of

parathyroid hormone analogs (e.g., Teriparatide Injection, Forteo, Tymlos) during the patient's lifetime	
Notes	*Duration of coverage will be limited to 24 months of cumulative parathyroid hormone analog therapy (e.g., Teriparatide Injection, Forteo, Tymlos) in the patient's lifetime.

2 . Revision History

Date	Notes
12/10/2025	Combined formularies. No changes to clinical criteria.

Upneeq



Prior Authorization Guideline

Guideline ID	GL-208217
Guideline Name	Upneeq
Formulary	Medicaid - Community & State Arizona Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State Nebraska Medicaid - Community & State New Jersey Medicaid - Community & State New Mexico Medicaid - Community & State New York Medicaid - Community & State New York EPP Medicaid - Community & State Pennsylvania Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	3/1/2025

1 . Criteria

Product Name:Upneeq	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of acquired blepharoptosis AND 2 - Patient has a functional impairment related to the position of the eyelid AND 3 - ONE of the following: Marginal reflex distance-1 (MRD-1) is less than or equal to 2 millimeters (mm) in primary gaze Marginal reflex distance-1 (MRD-1) is less than or equal to 2 mm in down gaze Superior visual field loss of at least 12 degrees or 24 percent AND 4 - Other treatable causes of blepharoptosis have been ruled out (e.g., recent botulinum toxin injections, myasthenia gravis)	

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

Approval Criteria

1 - Documentation of a positive clinical response to therapy

2 . Revision History

Date	Notes
3/5/2025	Added PA-CAID for 4/1 go-live. No change to criteria.

Ustekinumab



Prior Authorization Guideline

Guideline ID	GL-522218
Guideline Name	Ustekinumab
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 New Mexico

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name: All subcutaneous formulations of the following: Stelara, Imuldosa, Otulfi, Pyzchiva, Selarsdi, Steqeyma, Ustekinumab, Wezlana, Yesintek, Starjemza	
Diagnosis	Plaque Psoriasis
Approval Length	12 month(s) NOTE: If approving a non-preferred ustekinumab, please enter: 1) The group authorization CSPREFUSTE and 2) An authorization for the non-preferred ustekinumab at GPI-12 level

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ALL of the following: 1.1 Diagnosis of chronic moderate to severe plaque psoriasis AND 1.2 ONE of the following: 1.2.1 ALL of the following: 1.2.1.1 Greater than or equal to 3% body surface area involvement, palmoplantar, facial, or genital involvement, or severe scalp psoriasis AND 1.2.1.2 ONE of the following: 1.2.1.2.1 Failure to ONE of the following topical therapy classes, confirmed by claims history or submitted medical records: Corticosteroids (e.g., betamethasone, clobetasol, desonide) Vitamin D analogs (e.g., calcitriol, calcipotriene) Tazarotene Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus) Anthralin Coal tar OR	

1.2.1.2.2 History of intolerance or contraindication to ALL of the following topical therapy classes (please specify intolerance or contraindication):

Corticosteroids (e.g., betamethasone, clobetasol, desonide)

Vitamin D analogs (e.g., calcitriol, calcipotriene)

Tazarotene

Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)

Anthralin

Coal tar

AND

1.2.1.3 ONE of the following:

Failure to a 3 month trial of methotrexate at maximally indicated dose, confirmed by claims history or submitted medical records

History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

OR

1.2.2 Patient has been previously treated with a targeted immunomodulator FDA-approved for the treatment of plaque psoriasis as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), adalimumab, Otezla (apremilast), Skyrizi (risankizumab-rzaa), Tremfya (guselkumab)]

AND

1.3 ONE of the following:

Failure to one of the preferred adalimumab products confirmed by claims history or submitted medical records

History of intolerance or contraindication to one of the preferred adalimumab products
(please specify intolerance or contraindication)

AND

1.4 Patient is NOT receiving ustekinumab in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

AND

1.5 ONE of the following:

1.5.1 Requested medication is ustekinumab 45 mg (milligrams)/0.5 mL (milliliters)

OR

1.5.2 BOTH of the following:

Requested medication is ustekinumab 90 mg/1 mL

Patient's weight is greater than 100 kilograms (220 pounds)

AND

1.6 Prescribed by or in consultation with a dermatologist

AND

1.7 If the request is for a non-preferred ustekinumab product, the prescriber has given a clinical reason or special circumstance why the patient is unable to use the preferred ustekinumab products (please document reason/special circumstances)*

AND

1.8 If the request is for Brand Stelara, ONE of the following:

1.8.1 Submission of medical records confirming patient allergy or intolerance to at least two preferred ustekinumab biosimilars' inactive ingredients*

OR

1.8.2 BOTH of the following:

Submission of medical records confirming patient has previously been successfully treated with brand Stelara

Submission of medical records confirming patient has tried at least two preferred ustekinumab biosimilars for 6-8 weeks per product and saw a decrease in effectiveness*

OR

2 - ALL of the following:

2.1 Patient is currently on ustekinumab therapy as confirmed by claims history or submitted medical records

AND

2.2 Diagnosis of chronic moderate to severe plaque psoriasis

AND

2.3 Patient is NOT receiving ustekinumab in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

AND

2.4 Prescribed by or in consultation with a dermatologist

AND

2.5 If the request is for a non-preferred ustekinumab product, the prescriber has given a clinical reason or special circumstance why the patient is unable to use the preferred ustekinumab products (please document reason/special circumstances)*

AND

2.6 If the request is for Brand Stelara, ONE of the following:

2.6.1 Submission of medical records confirming patient allergy or intolerance to at least two preferred ustekinumab biosimilars' inactive ingredients*

OR

2.6.2 BOTH of the following:

Submission of medical records confirming patient has previously been successfully treated with brand Stelara

Submission of medical records confirming patient has tried at least two preferred ustekinumab biosimilars for 6-8 weeks per product and saw a decrease in effectiveness*

Notes

*See PDL links in Background

Product Name: All subcutaneous formulations of the following: Stelara, Imuldosa, Otulfi, Pyzchiva, Selarsdi, Steqeyma, Ustekinumab, Wezlana, Yesintek, Starjemza

Diagnosis	Psoriatic Arthritis
Approval Length	12 month(s) NOTE: If approving a non-preferred ustekinumab, please enter: 1) The group authorization CSPREFUSTE and 2) An authorization for the non-preferred ustekinumab at GPI-12 level
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 ONE of the following:

1.1.1 BOTH of the following:

Requested medication is ustekinumab 45 mg (milligrams)/0.5 mL (milliliters)

Diagnosis of active psoriatic arthritis

OR

1.1.2 ALL of the following:

Requested medication is ustekinumab 90 mg/1 mL

Patient's weight is greater than 100 kilograms (220 pounds)

Diagnosis of active psoriatic arthritis

Diagnosis of co-existent moderate to severe plaque psoriasis

AND

1.2 Patient is NOT receiving ustekinumab in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

AND

1.3 ONE of the following:

Failure to a 3 month trial of methotrexate at maximally indicated dose, confirmed by claims history or submitted medical records

History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

Patient has been previously treated with a targeted immunomodulator FDA-approved for the treatment of psoriatic arthritis as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Tremfya (guselkumab) Xeljanz (tofacitinib), Otezla (apremilast), Rinvoq (upadacitinib)]

AND

1.4 ONE of the following:

Failure to one of the preferred adalimumab products confirmed by claims history or submitted medical records

History of intolerance or contraindication to one of the preferred adalimumab products (please specify intolerance or contraindication)

AND

1.5 Prescribed by or in consultation with ONE of the following:

Rheumatologist

Dermatologist

AND

1.6 If the request is for a non-preferred ustekinumab product, the prescriber has given a clinical reason or special circumstance why the patient is unable to use the preferred ustekinumab products (please document reason/special circumstances)*

AND

1.7 If the request is for Brand Stelara, ONE of the following:

1.7.1 Submission of medical records confirming patient allergy or intolerance to at least two preferred ustekinumab biosimilars' inactive ingredients*

OR

1.7.2 BOTH of the following:

Submission of medical records confirming patient has previously been successfully treated with brand Stelara

Submission of medical records confirming patient has tried at least two preferred ustekinumab biosimilars for 6-8 weeks per product and saw a decrease in effectiveness*

OR

2 - ALL of the following:

2.1 Patient is currently on ustekinumab therapy as confirmed by claims history or submitted medical records

AND

2.2 Diagnosis of active psoriatic arthritis

AND

2.3 Patient is NOT receiving ustekinumab in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

AND

2.4 Prescribed by or in consultation with ONE of the following:

Rheumatologist

Dermatologist

AND

2.5 If the request is for a non-preferred ustekinumab product, the prescriber has given a

clinical reason or special circumstance why the patient is unable to use the preferred ustekinumab products (please document reason/special circumstances)* AND 2.6 If the request is for Brand Stelara, ONE of the following: 2.6.1 Submission of medical records confirming patient allergy or intolerance to at least two preferred ustekinumab biosimilars' inactive ingredients* OR 2.6.2 BOTH of the following: Submission of medical records confirming patient has previously been successfully treated with brand Stelara Submission of medical records confirming patient has tried at least two preferred ustekinumab biosimilars for 6-8 weeks per product and saw a decrease in effectiveness*	
Notes	*See PDL links in Background

Product Name: All subcutaneous formulations of the following: Stelara, Imuldosa, Otulfi, Pyzchiva, Selarsdi, Steqeyma, Ustekinumab, Wezlana, Yesintek, Starjemza	
Diagnosis	Plaque Psoriasis, Psoriatic Arthritis
Approval Length	12 month(s) NOTE: If approving a non-preferred ustekinumab, please enter: 1) The group authorization CSPREFUSTE and 2) An authorization for the non-preferred ustekinumab at GPI-12 level
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to ustekinumab therapy	

AND

2 - Patient is NOT receiving ustekinumab in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]*

AND

3 - If the request is for a non-preferred ustekinumab product, the prescriber has given a clinical reason or special circumstance why the patient is unable to use the preferred ustekinumab products (please document reason/special circumstances)**

AND

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

4.1 Submission of medical records confirming patient allergy or intolerance to at least two preferred ustekinumab biosimilars' inactive ingredients**

OR

4.2 BOTH of the following:

Submission of medical records confirming patient has previously been successfully treated with brand Stelara

Submission of medical records confirming patient has tried at least two preferred ustekinumab biosimilars for 6-8 weeks per product and saw a decrease in effectiveness**

Notes

*Examples of drug(s) may not be applicable based on the requested indication.

**See PDL links in Background

Product Name: 90 mg/mL subcutaneous formulation of the following: Stelara, Imuldosa, Otulfi, Pyzchiva, Selarsdi, Steqeyma, Ustekinumab, Wezlana, Yesintek, Starjemza

Diagnosis	Crohn's Disease (CD)
Approval Length	12 month(s) NOTE: If approving a non-preferred ustekinumab, please enter: 1) The group authorization CSPREFUSTE and 2) An authorization for the non-preferred ustekinumab at GPI-12 level
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderately to severely active Crohn's disease 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 ONE of the following conventional therapy drugs or classes at maximally indicated dose, confirmed by claims history or submitted medical records: Corticosteroids (e.g., prednisone, methylprednisolone, budesonide) 6-mercaptopurine (Purinethol) Azathioprine (Imuran) Methotrexate (Rheumatrex, Trexall) OR 2.1.1.2 History of intolerance or contraindication to ALL of the following conventional therapy drugs or classes (please specify intolerance or contraindication): Corticosteroids (e.g., prednisone, methylprednisolone, budesonide) 6-mercaptopurine (Purinethol)	

Azathioprine (Imuran)

Methotrexate (Rheumatrex, Trexall)

OR

2.1.1.3 Patient has been previously treated with a targeted immunomodulator FDA-approved for the treatment of Crohn's disease as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), adalimumab]

AND

2.1.2 ONE of the following:

Failure to one of the preferred adalimumab products, as confirmed by claims history or submitted medical records

History of intolerance or contraindication to one of the preferred adalimumab products (please specify intolerance or contraindication)

OR

2.2 Patient is currently on ustekinumab therapy for moderately to severely active Crohn's disease as confirmed by claims history or submitted medical records

OR

2.3 Patient has been established on therapy with ustekinumab under an active UnitedHealthcare medical benefit prior authorization for treatment of moderately to severely active Crohn's disease

AND

3 - Patient is NOT receiving ustekinumab in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Skyrizi (risankizumab)]

AND

4 - Prescribed by or in consultation with a gastroenterologist

AND

5 - If the request is for a non-preferred ustekinumab product, the prescriber has given a clinical reason or special circumstance why the patient is unable to use the preferred ustekinumab products (please document reason/special circumstances)*

AND

6 - If the request is for Brand Stelara, ONE of the following:

6.1 Submission of medical records confirming patient allergy or intolerance to at least two preferred ustekinumab biosimilars' inactive ingredients*

OR

6.2 BOTH of the following:

Submission of medical records confirming patient has previously been successfully treated with brand Stelara

Submission of medical records confirming patient has tried at least two preferred ustekinumab biosimilars for 6-8 weeks per product and saw a decrease in effectiveness*

Notes

*See PDL links in Background

Product Name: 90 mg/mL subcutaneous formulation of the following: Stelara, Imuldosa, Otulfi, Pyzchiva, Selarsdi, Steqeyma, Ustekinumab, Wezlana, Yesintek, Starjemza

Diagnosis	Ulcerative Colitis
Approval Length	12 month(s) NOTE: If approving a non-preferred ustekinumab, please enter: 1) The group authorization CSPREFUSTE and 2) An authorization for the non-preferred ustekinumab at GPI-12 level

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderately to severely active ulcerative colitis AND 2 - ONE of the following: 2.1 BOTH of the following: 2.1.1 ONE of the following: Patient has had prior or concurrent inadequate response to a therapeutic course of oral corticosteroids and/or immunosuppressants (e.g., azathioprine, 6-mercaptopurine), as confirmed by claims history or submitted medical records Patient has been previously treated with a targeted immunomodulator FDA-approved for the treatment of ulcerative colitis as confirmed by claims history or submission of medical records [e.g., adalimumab, Simponi (golimumab), Xeljanz (tofacitinib)] AND 2.1.2 ONE of the following: Failure to one of the preferred adalimumab products, confirmed by claims history or submitted medical records History of intolerance or contraindication to one of the preferred adalimumab products (please specify intolerance or contraindication) OR 2.2 Patient is currently on ustekinumab therapy for moderately to severely active ulcerative colitis as confirmed by claims history or submitted medical records	

OR

2.3 Patient has been established on therapy with ustekinumab under an active UnitedHealthcare medical benefit prior authorization for treatment of moderately to severely active ulcerative colitis

AND

3 - Patient is NOT receiving ustekinumab in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orenzia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Skyrizi (risankizumab)]

AND

4 - Prescribed by or in consultation with a gastroenterologist

AND

5 - If the request is for a non-preferred ustekinumab product, the prescriber has given a clinical reason or special circumstance why the patient is unable to use the preferred ustekinumab products (please document reason/special circumstances)*

AND

6 - If the request is for Brand Stelara, ONE of the following:

6.1 Submission of medical records confirming patient allergy or intolerance to at least two preferred ustekinumab biosimilars' inactive ingredients*

OR

6.2 BOTH of the following:

Submission of medical records confirming patient has previously been successfully treated with brand Stelara Submission of medical records confirming patient has tried at least two preferred ustekinumab biosimilars for 6-8 weeks per product and saw a decrease in effectiveness*	
Notes	*See PDL links in Background

Product Name:90 mg/mL subcutaneous formulation of the following: Stelara, Imuldosa, Otulfi, Pyzchiva, Selarsdi, Steqeyma, Ustekinumab, Wezlana, Yesintek, Starjemza	
Diagnosis	Crohn's Disease (CD), Ulcerative Colitis
Approval Length	12 month(s) NOTE: If approving a non-preferred ustekinumab, please enter: 1) The group authorization CSPREFUSTE and 2) An authorization for the non-preferred ustekinumab at GPI-12 level
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to ustekinumab therapy AND 2 - Patient is NOT receiving ustekinumab in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Skyrizi (risankizumab)] AND 3 - If the request is for a non-preferred ustekinumab product, the prescriber has given a clinical reason or special circumstance why the patient is unable to use the preferred ustekinumab products (please document reason/special circumstances)*	

AND

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

4.1 Submission of medical records confirming patient allergy or intolerance to at least two preferred ustekinumab biosimilars' inactive ingredients*

OR

4.2 BOTH of the following:

Submission of medical records confirming patient has previously been successfully treated with brand Stelara

Submission of medical records confirming patient has tried at least two preferred ustekinumab biosimilars for 6-8 weeks per product and saw a decrease in effectiveness*

Notes

*See PDL links in Background

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>

NM: <https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-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>

3 . Revision History

Date	Notes
2/12/2026	Removed New York formulary (add to NY EPP guideline). Added ustekinumab-aauz, ustekinumab-ttwe and Starjemza GPIs. Updated GPI's in CD and UC section to only include 90 mg/mL strengths. Removed NY PDL link from background.

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.

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.

Vanrafia



Prior Authorization Guideline

Guideline ID	GL-588219
Guideline Name	Vanrafia
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 New Mexico Medicaid - Community & State Pennsylvania Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Vanrafia

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of primary immunoglobulin A nephropathy (IgAN) confirmed by renal biopsy AND 2 - Patient is at risk of disease progression AND 3 - Medication is used to slow kidney function decline AND 4 - Medication is used to reduce proteinuria AND 5 - Estimated glomerular filtration rate (eGFR) is greater than or equal to 30 mL/min/1.73 m² AND 6 - BOTH of the following: 6.1 Patient is on a maximized stable dose with ONE of the following prior to initiating therapy confirmed by claims history or submitted medical records: Maximally tolerated angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril)	

Maximally tolerated angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan)

AND

6.2 Use of endothelin receptor antagonists [(ERAs) e.g., Letairis, Opsumit, Tracleer]] will be discontinued prior to initiating treatment

AND

7 - ONE of the following:

7.1 Failure to a 30-day trial of a glucocorticoid (e.g., budesonide, methylprednisolone, prednisone) confirmed by claims history or submitted medical records

OR

7.2 History of contraindication or intolerance to a 30-day trial of a glucocorticoid (e.g., budesonide, methylprednisolone, prednisone) (please specify intolerance or contraindication)

AND

8 - Prescribed by or in consultation with a nephrologist

Product Name: Vanrafia

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response demonstrated by a reduction in proteinuria

2 . Revision History

UnitedHealthcare Community Plan of Rhode Island Clinical Pharmacy Program Guidelines

Date	Notes
4/22/2026	Removed NV. Added budesonide as a corticosteroid example under initial auth. Minor cosmetic updates.

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.

Velsipity



Prior Authorization Guideline

Guideline ID	GL-559230
Guideline Name	Velsipity
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 Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:Velsipity	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active ulcerative colitis (UC)

AND

2 - ONE of the following:

2.1 Patient has had prior or concurrent inadequate response to a therapeutic course of oral corticosteroids or immunosuppressants (e.g., azathioprine, 6-mercaptopurine)

OR

2.2 Patient has been previously treated with a targeted immunomodulator FDA (Food and Drug Administration)-approved for the treatment of ulcerative colitis as confirmed by claims history or submission of medical records [e.g., adalimumab, Simponi (golimumab), ustekinumab, Xeljanz (tofacitinib), Rinvoq (upadacitinib)]

AND

3 - ONE of the following:

3.1 Patient is currently on Velsipity therapy as confirmed by claims history or submission of medical records

OR

3.2 Failure to ONE of the following as confirmed by claims history or submission of medical records:

One of the preferred adalimumab products

One of the preferred ustekinumab products

OR

3.3 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

One of the preferred adalimumab products

One of the preferred ustekinumab products

AND

4 - Patient is NOT receiving Velsipity in combination with a targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), ustekinumab, Skyrizi (risankizumab), Omvoh (mirikizumab-mrkz), Entyvio (vedolizumab)]

AND

5 - Prescribed by or in consultation with a gastroenterologist

Product Name:Velsipity	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Velsipity therapy AND 2 - Patient is NOT receiving Velsipity in combination with a targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), ustekinumab, Skyrizi (risankizumab), Omvoh (mirikizumab-mrkz), Entyvio (vedolizumab)]	

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 NM: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html NY: https://www.uhcprovider.com/en/health-plans-by-state/new-york-health-plans/ny-comm-plan-home/ny-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 RI: https://www.uhcprovider.com/en/health-plans-by-state/rhode-island-health-plans/ri-comm-plan-home/ri-cp-pharmacy.html

3 . Revision History

Date	Notes
3/27/2026	Removed note to reference drug coverage tools for preferred products.

Vemlidy



Prior Authorization Guideline

Guideline ID	GL-434328
Guideline Name	Vemlidy
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State Nevada Medicaid - Community & State New Jersey Medicaid - Community & State New York Medicaid - Community & State New York EPP Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

Guideline Type	Prior Authorization
	Approval Criteria 1 - Diagnosis of chronic hepatitis B infection AND 2 - ONE of the following: Failure to entecavir (generic Baraclude) as confirmed by claims history or submission of medical records History of contraindication or intolerance to entecavir (generic Baraclude) (please specify contraindication or intolerance) Patient is not a suitable candidate for entecavir (generic Baraclude) AND 3 - ONE of the following: 3.1 Failure to tenofovir disoproxil fumarate (generic Viread) as confirmed by claims history or submission of medical records OR 3.2 History of contraindication or intolerance to tenofovir disoproxil fumarate (generic Viread) (please specify contraindication or intolerance) OR 3.3 Submission of medical records documenting an estimated glomerular filtration rate below 90 mL/min (milliliters/minute) OR

3.4 Submission of medical records documenting a diagnosis of osteopenia as defined by a BMD (bone mineral density) 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 one of the following with evidence of progressive bone loss on serial DEXA (dual-energy X-ray absorptiometry) scan [Provider must submit patient specific BMD T-scores]:

Lumbar spine (at least two vertebral bodies)

Hip (femoral neck, total hip)

Radius (one-third radius site)

OR

3.5 Submission of medical records documenting a diagnosis of osteoporosis as defined by a BMD T-score less than or equal to -2.5 based on BMD measurements from one of the following [Provider must submit patient specific BMD T-score]:

Lumbar spine (at least two vertebral bodies)

Hip (femoral neck, total hip)

Radius (one-third radius site)

OR

3.6 Submission of medical records documenting a prior low-trauma or non-traumatic fracture

OR

3.7 Patient is less than 20 years of age

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

Approval Criteria

1 - Documentation of positive clinical response to Vemlidy therapy

AND

2 - Patient is not a suitable candidate for entecavir (generic Baraclude) or tenofovir disoproxil fumarate (generic Viread)

2 . Revision History

Date	Notes
11/3/2025	Added NV Formulary

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

Verkazia



Prior Authorization Guideline

Guideline ID	GL-127288
Guideline Name	Verkazia
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

Guideline Note:

Effective Date:	8/1/2023

1 . Criteria

Product Name:Verkazia, Cyclosporine in Klarity	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe vernal keratoconjunctivitis

AND

2 - ONE of the following:

2.1 Failure to TWO of the following categories as confirmed by claims history or submission of medical records:

Ophthalmic antihistamines (e.g., azelastine, olopatadine)

Ophthalmic mast cell stabilizers (e.g., cromolyn sodium)

Ophthalmic corticosteroids (e.g., dexamethasone, prednisolone, fluorometholone)

OR

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

Ophthalmic antihistamines (e.g., azelastine, olopatadine)

Ophthalmic mast cell stabilizers (e.g., cromolyn sodium)

Ophthalmic corticosteroids (e.g., dexamethasone, prednisolone, fluorometholone)

Product Name: Verkazia, Cyclosporine in Klarity	
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
6/29/2023	Updated formularies, cleaned up criteria.

Verquvo



Prior Authorization Guideline

Guideline ID	GL-274203
Guideline Name	Verquvo
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State New Jersey Medicaid - Community & State New York Medicaid - Community & State New York EPP Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Arizona Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	7/1/2025

1 . Criteria

Product Name: Verquvo	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of heart failure AND 2 - Ejection fraction is less than 45 percent AND 3 - Heart failure is classified as ONE of the following: New York Heart Association Class II New York Heart Association Class III New York Heart Association Class IV AND 4 - ONE of the following: 4.1 Hospitalization for heart failure within the past six months OR 4.2 Outpatient IV (intravenous) diuretics for heart failure within the past three months AND 5 - ONE of the following:	

5.1 Patient is on a stabilized dose and receiving concomitant therapy with a maximally tolerated beta-blocker (e.g., bisoprolol, carvedilol, metoprolol) confirmed by claims history or submission of medical records

OR

5.2 Patient has a contraindication or intolerance to beta-blocker therapy (please specify intolerance or contraindication)

AND

6 - ONE of the following:

6.1 Patient is on a stabilized dose and receiving concomitant therapy with ONE of the following, confirmed by claims history or submission of medical records:

Angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril)

Angiotensin II receptor blocker (ARB) (e.g., losartan)

Angiotensin receptor-neprilysin inhibitor (ARNI) (e.g., Entresto)

OR

6.2 Patient has an allergy, contraindication, or intolerance to ACE inhibitors, ARBs, and ARNIs (please specify intolerance or contraindication)

AND

7 - ONE of the following:

7.1 Patient is on a stabilized dose and receiving concomitant therapy with a maximally tolerated aldosterone antagonist (e.g., spironolactone) confirmed by claims history or submission of medical records

OR

7.2 Patient has a contraindication or intolerance to aldosterone antagonist therapy (please specify intolerance or contraindication)

AND

8 - ONE of the following:

8.1 Patient is on a stabilized dose and receiving concomitant therapy with a sodium-glucose cotransporter 2 (SGLT2) inhibitor indicated for heart failure (e.g., Farxiga) confirmed by claims history or submission of medical records

OR

8.2 Patient has a contraindication or intolerance to SGLT2 inhibitor therapy (please specify intolerance or contraindication)

AND

9 - Verquvo is prescribed by or in consultation with a cardiologist

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

2 . Revision History

Date	Notes

UnitedHealthcare Community Plan of Rhode Island Clinical Pharmacy Program Guidelines

5/20/2025	Combined formularies. No changes to clinical criteria. Minor cosmetic updates.

Verquvo



Prior Authorization Guideline

Guideline ID	GL-274203
Guideline Name	Verquvo
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State New Jersey Medicaid - Community & State New York Medicaid - Community & State New York EPP Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Arizona Medicaid - Community & State New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	7/1/2025

1 . Criteria

Product Name: Verquvo	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of heart failure AND 2 - Ejection fraction is less than 45 percent AND 3 - Heart failure is classified as ONE of the following: New York Heart Association Class II New York Heart Association Class III New York Heart Association Class IV AND 4 - ONE of the following: 4.1 Hospitalization for heart failure within the past six months OR 4.2 Outpatient IV (intravenous) diuretics for heart failure within the past three months AND 5 - ONE of the following:	

5.1 Patient is on a stabilized dose and receiving concomitant therapy with a maximally tolerated beta-blocker (e.g., bisoprolol, carvedilol, metoprolol) confirmed by claims history or submission of medical records

OR

5.2 Patient has a contraindication or intolerance to beta-blocker therapy (please specify intolerance or contraindication)

AND

6 - ONE of the following:

6.1 Patient is on a stabilized dose and receiving concomitant therapy with ONE of the following, confirmed by claims history or submission of medical records:

Angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril)

Angiotensin II receptor blocker (ARB) (e.g., losartan)

Angiotensin receptor-neprilysin inhibitor (ARNI) (e.g., Entresto)

OR

6.2 Patient has an allergy, contraindication, or intolerance to ACE inhibitors, ARBs, and ARNIs (please specify intolerance or contraindication)

AND

7 - ONE of the following:

7.1 Patient is on a stabilized dose and receiving concomitant therapy with a maximally tolerated aldosterone antagonist (e.g., spironolactone) confirmed by claims history or submission of medical records

OR

7.2 Patient has a contraindication or intolerance to aldosterone antagonist therapy (please specify intolerance or contraindication)

AND

8 - ONE of the following:

8.1 Patient is on a stabilized dose and receiving concomitant therapy with a sodium-glucose cotransporter 2 (SGLT2) inhibitor indicated for heart failure (e.g., Farxiga) confirmed by claims history or submission of medical records

OR

8.2 Patient has a contraindication or intolerance to SGLT2 inhibitor therapy (please specify intolerance or contraindication)

AND

9 - Verquvo is prescribed by or in consultation with a cardiologist

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

2 . Revision History

Date	Notes

UnitedHealthcare Community Plan of Rhode Island Clinical Pharmacy Program Guidelines

5/20/2025	Combined formularies. No changes to clinical criteria. Minor cosmetic updates.

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.

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	

Globet 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.

Vivjoa



Prior Authorization Guideline

Guideline ID	GL-558299
Guideline Name	Vivjoa
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 New Mexico

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name: Vivjoa	
Approval Length	4 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of recurrent vulvovaginal candidiasis

AND

2 - Patient is not of reproductive potential (i.e., persons who are biological females who are postmenopausal or have another reason for permanent infertility [(e.g., tubal ligation, hysterectomy, salpingo-oophorectomy)])

AND

3 - BOTH of the following:

3.1 Other causes (including but not limited to bacterial vaginosis or trichomoniasis) have been ruled out

AND

3.2 Failure of a maintenance course of oral fluconazole defined as 100-mg, 150-mg, or 200-mg taken weekly for 6 months confirmed by claims history or submission of medical records

AND

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

Infectious disease physician

Obstetrician/Gynecologist

2 . Revision History

Date	Notes
3/30/2026	Removed NY-CHIP and NY-EPP. Minor cosmetic updates.

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.

Vonjo



Prior Authorization Guideline

Guideline ID	GL-398295
Guideline Name	Vonjo
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 New Mexico

Guideline Note:

Effective Date:	10/1/2025

1 . Criteria

Product Name: Vonjo	
Diagnosis	Myeloproliferative Neoplasms (MPN)

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Both of the following: 1.1 One of the following diagnosis: Primary myelofibrosis Post-polycythemia vera myelofibrosis Post-essential thrombocythemia myelofibrosis AND 1.2 One of the following: 1.2.1 Both of the following: Patient has symptomatic lower-risk myelofibrosis Patient has a platelet count less than 50 x 10⁹/L OR 1.2.2 Both of the following: Patient has higher-risk myelofibrosis Patient has a platelet count less than 50 x 10⁹/L OR 1.2.3 All of the following:	

Patient has higher-risk myelofibrosis

Patient has symptomatic splenomegaly and/or constitutional symptoms

Patient has a platelet count of at least $50 \times 10^9/L$

OR

2 - Used for treatment of myelofibrosis-associated anemia

OR

3 - Both of the following:

3.1 Diagnosis of accelerated/blast phase myeloproliferative neoplasm

AND

3.2 One of the following:

3.2.1 Continued treatment near the start of conditioning therapy in transplant candidates for the improvement of splenomegaly and other disease-related symptoms

OR

3.2.2 Palliation in combination with hypomethylating agents (azacitidine or decitabine) as bridging therapy prior to transplant

OR

3.2.3 Palliation in combination with hypomethylating agents (azacitidine or decitabine) if not a candidate for transplant

Product Name: Vonjo

Diagnosis

Myeloproliferative Neoplasms (MPN)

Approval Length	12 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 Vonjo	

Product Name: Vonjo	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Vonjo will be approved for uses supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	

Product Name: Vonjo	
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 Vonjo therapy	

2 . Revision History

UnitedHealthcare Community Plan of Rhode Island Clinical Pharmacy Program Guidelines

Date	Notes
9/19/2025	Combined formularies. Changed dx from MF to MPN. Criteria updates for dx of MPN.

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 Dificid (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

Voxzogo



Prior Authorization Guideline

Guideline ID	GL-210193
Guideline Name	Voxzogo
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State Nebraska Medicaid - Community & State New Jersey Medicaid - Community & State New Mexico Medicaid - Community & State New York Medicaid - Community & State New York EPP Medicaid - Community & State Pennsylvania Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	3/1/2025

1 . Criteria

Product Name:Voxzogo

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient is less than 18 years of age AND 2 - Diagnosis of achondroplasia as confirmed by ONE of the following: 2.1 Submission of medical records documenting BOTH of the following: 2.1.1 Patient has clinical manifestations characteristic of achondroplasia (e.g., macrocephaly, frontal bossing, midface retrusion, disproportionate short stature with rhizomelic shortening of the arms and the legs, brachydactyly, trident configuration of the hands, thoracolumbar kyphosis, and accentuated lumbar lordosis) AND 2.1.2 Patient has radiographic findings characteristic of achondroplasia (e.g., large calvaria and narrowing of the foramen magnum region, undertubulated, shortened long bones with metaphyseal abnormalities, narrowing of the interpedicular distance of the caudal spine, square ilia and horizontal acetabula, small sacrosciatic notches, proximal scooping of the femoral metaphyses, and short and narrow chest) OR 2.2 Submission of medical records documenting molecular genetic testing confirmed c.1138G > A or c.1138G > C variant (i.e., p.Gly380Arg mutation) in the fibroblast growth factor receptor-3 (FGFR3) gene AND 3 - Patient has open epiphyses	

AND

4 - BOTH of the following:

4.1 Patient has not had limb-lengthening surgery in the previous 18 months

AND

4.2 Patient does not plan to have limb-lengthening surgery while on Voxzogo

AND

5 - Prescribed by ONE of the following:

Clinical geneticist

Endocrinologist

A practitioner who has specialized expertise in the management of achondroplasia

Product Name:Voxzogo	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria	
1 - Documentation of positive clinical response to Voxzogo therapy [e.g., improvement in annualized growth velocity (AGV) compared to baseline]	
AND	
2 - Patient has open epiphyses	

AND

3 - Patient does not plan to have limb-lengthening surgery while on Voxzogo

AND

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

Clinical geneticist

Endocrinologist

A practitioner who has specialized expertise in the management of achondroplasia

2 . Revision History

Date	Notes
3/6/2025	Added PA-CAID for 4/1 go-live. No change to criteria.

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

Date	Notes
8/19/2025	Updated formularies to add IN

Voyxact



Prior Authorization Guideline

Guideline ID	GL-529189
Guideline Name	Voyxact
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 Nebraska Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name: Voyxact	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of primary immunoglobulin A nephropathy (IgAN) confirmed by renal biopsy AND 2 - Patient is at risk of rapid disease progression AND 3 - Medication will be used to reduce proteinuria AND 4 - Estimated glomerular filtration rate (eGFR) is greater than or equal to 30 mL/min/1.73 m² AND 5 - One of the following: 5.1 Patient is on a stabilized dose and receiving concomitant therapy with one of the following prior to initiating therapy confirmed by claims history or submitted medical records: Maximally tolerated angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril) Maximally tolerated angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan) OR	

5.2 Patient has a contraindication or intolerance to ACE inhibitors and ARBs

AND

6 - One of the following:

6.1 Patient is on a stabilized dose and receiving concomitant therapy with a maximally tolerated sodium-glucose cotransporter-2 (SGLT2) inhibitor [e.g., Jardiance (empagliflozin)] prior to initiating therapy confirmed by claims history or submitted medical records

OR

6.2 Patient has a contraindication or intolerance to SGLT2 inhibitors

AND

7 - One of the following:

7.1 Failure to a 30-day trial of a glucocorticoid (e.g., methylprednisolone, prednisone) confirmed by claims history or submitted medical records

OR

7.2 History of contraindication or intolerance to a 30-day trial of a glucocorticoid (e.g., methylprednisolone, prednisone) (please specify intolerance or contraindication)

AND

8 - Prescribed by or in consultation with a nephrologist

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

Approval Criteria

1 - Documentation of positive clinical response demonstrated by a reduction in proteinuria

2 . Revision History

Date	Notes
2/24/2026	New

Vtama



Prior Authorization Guideline

Guideline ID	GL-432344
Guideline Name	Vtama
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

Guideline Note:

Effective Date:	12/1/2025

1 . Criteria

Product Name:Vtama	
Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of plaque psoriasis AND 2 - ONE of the following: 2.1 Failure to a minimum duration of a 4-week trial to TWO of the following topical therapies as confirmed by claims history or submission of medical records: Corticosteroids (e.g., betamethasone, clobetasol, desonide) Vitamin D analogs (e.g., calcitriol, calcipotriene) Tazarotene Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus) Anthralin Coal tar OR 2.2 History of intolerance or contraindication to ALL of the following topical therapies (please specify intolerance or contraindication): Corticosteroids (e.g., betamethasone, clobetasol, desonide) Vitamin D analogs (e.g., calcitriol, calcipotriene) Tazarotene Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus) Anthralin	

Coal tar

OR

2.3 Patient is currently on Vtama therapy as confirmed by claims history or submission of medical records

AND

3 - Patient is NOT receiving Vtama in combination with a targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, ustekinumab, Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

Product Name:Vtama	
Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy AND 2 - Patient is NOT receiving Vtama in combination with a targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, ustekinumab, Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]	

Product Name:Vtama	
Diagnosis	Atopic Dermatitis

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of atopic dermatitis AND 2 - ONE of the following: 2.1 Failure to TWO of the following therapeutic classes of topical therapies, confirmed by claims history or submission of medical records: One medium, high, or very-high potency topical corticosteroid [e.g., mometasone furoate (generic Elocon), fluocinolone acetonide (generic Synalar), fluocinonide (generic Lidex)] One topical calcineurin inhibitor [e.g., pimecrolimus (generic Elidel), tacrolimus (generic Protopic)] Eucrisa (crisaborole) OR 2.2 History of intolerance or contraindication to ALL of the following therapeutic classes of topical therapies (please specify intolerance or contraindication): One medium, high, or very-high potency topical corticosteroid [e.g., mometasone furoate (generic Elocon), fluocinolone acetonide (generic Synalar), fluocinonide (generic Lidex)] One topical calcineurin inhibitor [e.g., pimecrolimus (generic Elidel), tacrolimus (generic Protopic)] Eucrisa (crisaborole) OR	

2.3 Patient is currently on Vtama therapy as confirmed by claims history or submission of medical records

AND

3 - Patient is NOT receiving Vtama in combination with a targeted immunomodulator [e.g., Adbry (tralokinumab-ldrm), Cibinqo (abrocitinib), Dupixent (dupilumab), Rinvoq (upadacitinib)]

Product Name:Vtama	
Diagnosis	Atopic Dermatitis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy AND 2 - Patient is NOT receiving Vtama in combination with a targeted immunomodulator [e.g., Adbry (tralokinumab-ldrm), Cibinqo (abrocitinib), Dupixent (dupilumab), Rinvoq (upadacitinib)]	

2 . Revision History

Date	Notes
11/4/2025	Updated atopic dermatitis topical step therapy options to list a medium, high, or very high potency TCS. Removed VA eff 12/1/25.

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-434324
Guideline Name	Vykat XR
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Maryland Medicaid - Community & State Nevada 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 New Mexico Medicaid - Community & State Pennsylvania

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Vykat XR

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of hyperphagia associated with Prader-Willi Syndrome AND 2 - Prader-Willi Syndrome is confirmed by genetic testing AND 3 - Patient is at least 4 years of age or older AND 4 - Prescribed by or in consultation with an endocrinologist, geneticist, or a specialist with knowledge in the treatment of Prader-Willi syndrome	

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

2 . Revision History

UnitedHealthcare Community Plan of Rhode Island Clinical Pharmacy Program Guidelines

Date	Notes
11/3/2025	Added NV Formulary

Vyndaqel and Vyndamax



Prior Authorization Guideline

Guideline ID	GL-534198
Guideline Name	Vyndaqel and Vyndamax
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 New Mexico Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Vyndaqel, Vyndamax

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of transthyretin (ATTR)-mediated amyloidosis with cardiomyopathy (ATTR-CM) AND 2 - ONE of the following: 2.1 Documentation that the patient has a pathogenic transthyretin (TTR) mutation (e.g., V30M) OR 2.2 Cardiac or noncardiac tissue biopsy demonstrating histologic confirmation of ATTR amyloid deposits OR 2.3 ALL of the following: 2.3.1 Echocardiogram or cardiac magnetic resonance imaging suggestive of amyloidosis AND 2.3.2 Radionuclide imaging (99mTc-DPD, 99mTc-PYP, or 99m Tc-HMDP) showing grade 2 or 3 cardiac uptake* AND 2.3.3 Absence of light chain amyloidosis	

AND

3 - Patient has New York Heart Association (NYHA) Functional Class I, II, or III heart failure

AND

4 - Physician attests that the patient has an N-terminal pro-B-type natriuretic peptide (NT-proBNP) level that, when combined with signs and symptoms, is considered definitive for a diagnosis of ATTR-CM

AND

5 - ONE of the following:

History of heart failure, with at least one prior hospitalization for heart failure

Presence of clinical signs and symptoms of heart failure (e.g., dyspnea, edema)

AND

6 - ONE of the following:

Failure to Attruby as confirmed by claims history or submission of medical records

History of intolerance or contraindication to Attruby (please specify intolerance or contraindication)

AND

7 - Prescribed by or in consultation with a cardiologist

AND

8 - Patient is NOT receiving Vyndaqel/Vyndamax in combination with an RNA-targeted

therapy for ATTR amyloidosis [i.e., Amvuttra (vutrisiran), Attruby (acoramadis), Onpattro (patisiran), Tegsedi (inotersen), or Wainua (eplontersen)]	
Notes	*May require prior authorization and notification.

Product Name:Vyndaqel, Vyndamax	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation that the patient has experienced a positive clinical response to Vyndaqel or Vyndamax (e.g., improved symptoms, quality of life, slowing of disease progression, decreased hospitalizations, etc.) AND 2 - Documentation that patient continues to have New York Heart Association (NYHA) Functional Class I, II, or III heart failure AND 3 - Prescribed by or in consultation with a cardiologist AND 4 - Patient is NOT receiving Vyndaqel/Vyndamax in combination with an RNA-targeted therapy for ATTR amyloidosis [i.e., Amvuttra (vutrisiran), Attruby (acoramadis), Onpattro (patisiran), Tegsedi (inotersen), or Wainua (eplontersen)]	

2 . Revision History

Date	Notes

UnitedHealthcare Community Plan of Rhode Island Clinical Pharmacy Program Guidelines

2/25/2026	Rearranged order of formularies. Minor cosmetic/formatting updates, with no changes to clinical criteria.

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.

Wainua



Prior Authorization Guideline

Guideline ID	GL-328241
Guideline Name	Wainua
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State Nebraska Medicaid - Community & State New Jersey Medicaid - Community & State New Mexico Medicaid - Community & State New York Medicaid - Community & State New York EPP Medicaid - Community & State Pennsylvania Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	8/1/2025

1 . Criteria

Product Name:Wainua

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - BOTH of the following: 1.1 Diagnosis of hereditary transthyretin-mediated (hATTR) amyloidosis with polyneuropathy AND 1.2 Documentation that the patient has a pathogenic transthyretin (TTR) mutation (e.g., V30M) AND 2 - Prescribed by or in consultation with a neurologist AND 3 - Documentation of ONE of the following: Patient has a baseline polyneuropathy disability (PND) score less than or equal to IIIb Patient has a baseline familial amyloidotic polyneuropathy (FAP) Stage 1 or 2 Patient has a baseline neuropathy impairment (NIS) score greater than or equal to 10 and less than or equal to 130 AND 4 - Patient has NOT had a liver transplant AND	

5 - Presence of clinical signs and symptoms of the disease (e.g., peripheral sensorimotor polyneuropathy, autonomic neuropathy, motor disability, etc.)

AND

6 - Patient is NOT receiving Wainua in combination with ONE of the following:

Oligonucleotide agents [e.g., Onpattro (patisiran), Amvuttra (vutrisiran), Tegsedi (inotersen)]

Transthyretin stabilizer [e.g., Vyndaqel/Vyndamax (tafamadis), Attruby (acoramidis)]

Product Name:Wainua	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation that the patient has experienced a positive clinical response to Wainua therapy (e.g., improved neurologic impairment, motor function, quality of life, slowing of disease progression, etc.) AND 2 - Patient is NOT receiving Wainua in combination with ONE of the following: Oligonucleotide agents [e.g., Onpattro (patisiran), Amvuttra (vutrisiran), Tegsedi (inotersen)] Transthyretin stabilizer [e.g., Vyndaqel/Vyndamax (tafamadis), Attruby (acoramidis)]	

2 . Revision History

UnitedHealthcare Community Plan of Rhode Island Clinical Pharmacy Program Guidelines

Date	Notes
7/15/2025	Removed IN from formularies. No change to clinical criteria. See GL-328240 for state specific IN Wainua criteria.

Wakix



Prior Authorization Guideline

Guideline ID	GL-521228
Guideline Name	Wakix
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State New Jersey Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name:Wakix	
Diagnosis	Narcolepsy without Cataplexy (i.e., Narcolepsy Type 2)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab values) documenting a diagnosis of narcolepsy with BOTH of the following:

1.1 The patient has daily periods of irrepressible need to sleep or daytime lapses into sleep occurring for at least three months

AND

1.2 A mean sleep latency of less than or equal to 8 minutes and two or more sleep onset rapid eye movement (REM) periods (SOREMPs) are found on a MSLT (Multiple Sleep Latency Test) performed according to standard techniques following a normal overnight polysomnogram. A SOREMP (within 15 minutes of sleep onset) on the preceding nocturnal polysomnogram may replace one of the SOREMPs on the MSLT

AND

2 - Physician attestation that other causes of sleepiness have been ruled out or treated (including but not limited to obstructive sleep apnea, insufficient sleep syndrome, shift work, the effects of substances or medications or their withdrawal, sleep phase disorder, or other sleep disorders)

AND

3 - ONE of the following:

3.1 Failure to ALL of the following, as confirmed by claims history or submission of medical records:

An amphetamine-based stimulant (e.g., amphetamine, dextroamphetamine) OR a methylphenidate-based stimulant

Armodafinil (generic Nuvigil) OR modafinil (generic Provigil)

Sunosi (solriamfetol)

OR

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

An amphetamine-based stimulant (e.g., amphetamine, dextroamphetamine) OR a methylphenidate-based stimulant

Armodafinil (generic Nuvigil) OR modafinil (generic Provigil)

Sunosi (solriamfetol)

OR

3.3 Patient has a history of or potential for a substance abuse disorder

AND

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

Neurologist

Psychiatrist

Pulmonologist

Sleep Medicine Specialist

Product Name:Wakix	
Diagnosis	Narcolepsy without Cataplexy (i.e., Narcolepsy Type 2)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Reduction in symptoms of excessive daytime sleepiness associated with Wakix therapy	

Product Name:Wakix	
Diagnosis	Narcolepsy with Cataplexy (i.e., Narcolepsy Type 1)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab values) documenting a diagnosis of narcolepsy with cataplexy (i.e., Narcolepsy Type 1) with BOTH of the following:

1.1 The patient has daily periods of irrepressible need to sleep or daytime lapses into sleep occurring for at least three months

AND

1.2 A mean sleep latency of less than or equal to 8 minutes and two or more sleep onset rapid eye movement (REM) periods (SOREMPs) are found on a MSLT (Multiple Sleep Latency Test) performed according to standard techniques following a normal overnight polysomnogram. A SOREMP (within 15 minutes of sleep onset) on the preceding nocturnal polysomnogram may replace one of the SOREMPs on the MSLT

AND

2 - Physician attestation to BOTH of the following:

2.1 Patient has experienced cataplexy defined as more than one episode of sudden loss of muscle tone with retained consciousness

AND

2.2 Other causes of sleepiness have been ruled out or treated (including but not limited to obstructive sleep apnea, insufficient sleep syndrome, shift work, the effects of substances or medications or their withdrawal, sleep phase disorder, or other sleep disorders)

AND

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

Neurologist

Psychiatrist

Pulmonologist

Sleep Medicine Specialist

Product Name:Wakix	
Diagnosis	Narcolepsy with Cataplexy (i.e., Narcolepsy Type 1)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Reduction in frequency of cataplexy attacks associated with therapy OR 2 - Reduction in symptoms of excessive daytime sleepiness associated with therapy	

2 . Revision History

Date	Notes
2/12/2026	Removed NY

Wayrilz



Prior Authorization Guideline

Guideline ID	GL-594209
Guideline Name	Wayrilz
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 New Mexico Medicaid - Community & State Pennsylvania Medicaid - Community & State Virginia

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Wayrilz

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of persistent or chronic immune thrombocytopenia (ITP) AND 2 - ONE of the following: 2.1 Patient has had a prior splenectomy OR 2.2 ONE of the following: 2.2.1 Failure to at least ONE of the following as confirmed by claims history or submission of medical records: Corticosteroids (e.g., prednisone, methylprednisolone) Immunoglobulins OR 2.2.2 History of contraindication or intolerance to BOTH of the following (please specify contraindication or intolerance): Corticosteroids (e.g., prednisone, methylprednisolone) Immunoglobulins AND 3 - ONE of the following:	

3.1 Failure to eltrombopag olamine (generic Promacta) as confirmed by claims history or submission of medical records

OR

3.2 History of contraindication or intolerance to eltrombopag olamine (generic Promacta) (please specify contraindication or intolerance)

OR

3.3 Patient is currently on Wayrilz therapy

AND

4 - Platelet count remains less than 30,000/mcL (per microliter) despite previous treatment

AND

5 - Prescribed by or in consultation with a hematologist/oncologist

Product Name:Wayrilz	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Wayrilz therapy (e.g. an increase in platelet count to a level sufficient to avoid clinically important bleeding)	

2 . Revision History

UnitedHealthcare Community Plan of Rhode Island Clinical Pharmacy Program Guidelines

Date	Notes
4/24/2026	Added PACAID and NV. Expanded on mcL abbreviation, with no changes to clinical intent. Minor cosmetic updates.

Wegovy



Prior Authorization Guideline

Guideline ID	GL-521260
Guideline Name	Wegovy
Formulary	Medicaid - Community & State Rhode Island

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name:Wegovy inj, Wegovy tabs	
Diagnosis	Reduction in the risk of major adverse cardiovascular events
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Treatment is being requested to reduce the risk of major adverse cardiovascular events	

AND

2 - Patient is 45 years of age or older

AND

3 - Submission of medical records documenting ALL of the following:

3.1 BMI (body mass index) greater than or equal to 27 kg/m² (kilograms per square meter)

AND

3.2 Established cardiovascular disease as evidenced by ONE of the following:

3.2.1 Prior myocardial infarction (MI)

OR

3.2.2 Prior ischemic or hemorrhagic stroke

OR

3.2.3 Symptomatic peripheral arterial disease (PAD) evidenced by ONE of the following:

Intermittent claudication with ankle-brachial index (ABI) less than 0.85 (at rest)

Peripheral arterial revascularization procedure

Amputation due to atherosclerotic disease

AND

4 - Used in combination with a reduced calorie diet and increased physical activity

AND

5 - ONE of the following:

5.1 For patients with history of MI, ONE of the following:

5.1.1 Patient is on therapy from each of the following classes (as confirmed by claims history or submission of medical records):

Cholesterol lowering medication (e.g., statin, PCSK9i)

Beta blocker (i.e., carvedilol, metoprolol, or bisoprolol)

Angiotensin-converting enzyme inhibitor (ACE-I)/angiotensin II receptor blocker (ARB)/angiotensin II receptor blocker neprilysin inhibitor (ARNI)

Antiplatelet (e.g., aspirin, clopidogrel)

OR

5.1.2 Patient has a history of intolerance or contraindication to ALL of the following therapeutic classes (please specify intolerance or contraindication):

Cholesterol lowering medication (e.g., statin, PCSK9i)

Beta blocker (i.e., carvedilol, metoprolol, or bisoprolol)

Angiotensin-converting enzyme inhibitor (ACE-I)/angiotensin II receptor blocker (ARB)/angiotensin II receptor blocker neprilysin inhibitor (ARNI)

Antiplatelet (e.g., aspirin, clopidogrel)

OR

5.2 For patients with history of ischemic or hemorrhagic stroke, or symptomatic PAD, ONE of the following:

5.2.1 Patient is on therapy from each of the following classes (as confirmed by claims history or submission of medical records):

Cholesterol lowering medication (e.g., statin, PCSK9i)

Angiotensin-converting enzyme inhibitor (ACE-I)/angiotensin II receptor blocker (ARB)/angiotensin II receptor blocker neprilysin inhibitor (ARNI)

Antiplatelet (e.g., aspirin, clopidogrel)

OR

5.2.2 Patient has a history of intolerance or contraindication to ALL of the following therapeutic classes (please specify intolerance or contraindication):

Cholesterol lowering medication (e.g., statin, PCSK9i)

Angiotensin-converting enzyme inhibitor (ACE-I)/angiotensin II receptor blocker (ARB)/angiotensin II receptor blocker neprilysin inhibitor (ARNI)

Antiplatelet (e.g., aspirin, clopidogrel)

AND

6 - Patient does NOT have diagnosis of diabetes or HgA1c greater than or equal to 6.5%

AND

7 - Patient does NOT have New York Heart Association class IV heart failure

Product Name:Wegovy inj, Wegovy tabs	
Diagnosis	Reduction in the risk of major adverse cardiovascular events
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Used in combination with a reduced calorie diet and increased physical activity

AND

2 - Patient does NOT have diagnosis of diabetes or HgA1c greater than or equal to 6.5%

AND

3 - Patient does NOT have New York Heart Association class IV heart failure

Product Name:Wegovy inj, Wegovy tabs

Diagnosis	Appetite Suppression or Weight Loss

Approval Length	5 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Treatment is being requested for appetite suppression or weight loss

AND

2 - Patient meets the age requirement:

Wegovy inj: greater than or equal to 12 years of age

Wegovy tabs: greater than or equal to 18 years of age

AND

3 - Submission of medical records confirming that Wegovy will be used as an adjunct to lifestyle modification (e.g., dietary or caloric restriction, exercise, behavioral support,

community-based program) and participation has been for at least 6 months (of lifestyle modification) prior to using Wegovy

AND

4 - ONE of the following:

4.1 BMI (body mass index) greater than or equal to 30 kg/m² (kilograms per square meter) or for pediatric patients a BMI greater than 95th percentile, as documented by submission of medical records

OR

4.2 BOTH of the following:

4.2.1 BMI greater than or equal to 27 kg/m², as documented by submission of medical records

AND

4.2.2 Patient has a weight-related comorbidity (e.g., dyslipidemia, hypertension, type 2 diabetes, sleep apnea) (please specify comorbidity, as documented by submission of medical records)

AND

5 - Wegovy is prescribed by, or in consultation with, a weight loss clinic or a dietician/nutritionist

Product Name:Wegovy inj, Wegovy tabs	
Diagnosis	Appetite Suppression or Weight Loss
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records confirming that the patient is tolerating the medication

AND

2 - Submission of medical records confirming that the patient is continuing lifestyle modification

AND

3 - The patient has completed at least 20 weeks of therapy and is currently being treated with the FDA (Food and Drug Administration)-recommended maintenance dose

AND

4 - Submission of medical records confirming the patient has lost at least 5 percent of baseline body weight while taking Wegovy

AND

5 - If this is the patient's subsequent re-authorization, ONE of the following:

Patient has continued to display weight loss

Patient has achieved a normal BMI (18.5-24.9)

If the patient has demonstrated no further weight loss, and the BMI is 25 or greater, submission of medical records showing active participation in a comprehensive weight loss program is required

Product Name:Wegovy inj	
Diagnosis	Noncirrhotic metabolic dysfunction-associated steatohepatitis (MASH)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of metabolic dysfunction-associated steatohepatitis (MASH) [formerly known as nonalcoholic steatohepatitis (NASH)]

AND

2 - Submission of medical records documenting the disease is fibrosis stage F2 or F3 as confirmed by ONE of the following:

Liver stiffness measurement (LSM) by vibration-controlled transient elastography (VCTE) (e.g., FibroScan)

LSM by magnetic resonance elastography (MRE)

Liver biopsy within the past 12 months

AND

3 - Patient has received comprehensive counseling regarding lifestyle modification (e.g., dietary or caloric restriction, exercise, behavioral support, community-based program)

AND

4 - Provider attests Wegovy injection will not be initiated at the same time as Rezdiffra (resmetirom)

AND

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

Gastroenterologist

Hepatologist

Product Name:Wegovy inj	
Diagnosis	Noncirrhotic metabolic dysfunction-associated steatohepatitis (MASH)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Wegovy injection (e.g., improvement in or stabilization of fibrosis)

AND

2 - Patient has not progressed to cirrhosis

AND

3 - Patient has received comprehensive counseling regarding lifestyle modification (e.g., dietary or caloric restriction, exercise, behavioral support, community-based program)

AND

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

Gastroenterologist

Hepatologist

2 . Revision History

Date	Notes

2/18/2026	Updated title. Added Wegovy tabs. Removed BMI from MACE reauth . Added medical records requirement for MASH and removed endocri nologist. Added lifestyle modification to MASH reauth

Weight Loss



Prior Authorization Guideline

Guideline ID	GL-548187
Guideline Name	Weight Loss
Formulary	Medicaid - Community & State Rhode Island

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name: Brand Adipex-P, generic phentermine, Lomaira	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Treatment is being requested for appetite suppression or weight loss	

AND

2 - Patient is greater than 16 years of age

AND

3 - Submission of medical records confirming that the requested weight loss medication will be used as an adjunct to lifestyle modification (e.g., dietary or caloric restriction, exercise, behavioral support, community-based program) and participation has been for at least 6 months (of lifestyle modification) prior to using the requested medication

AND

4 - ONE of the following:

4.1 Body Mass Index (BMI) greater than or equal to 30 kg/m² (kilograms/square meter) or for pediatric patients a BMI greater than 95th percentile, as documented by submission of medical records

OR

4.2 BOTH of the following:

4.2.1 BMI greater than or equal to 27 kg/m², as documented by submission of medical records

AND

4.2.2 Patient has a weight-related comorbidity (e.g., dyslipidemia, hypertension, type 2 diabetes, sleep apnea) (please specify comorbidity, as documented by submission of medical records)

AND

5 - If the request is for Brand Adipex-P or Lomaira, ONE of the following:

5.1 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)

OR

5.2 The brand is being requested due to an incomplete response with a generic/authorized generic equivalent as documented by submission of medical records

AND

6 - The requested medication is prescribed by, or in consultation with a weight loss clinic or a dietician/nutritionist

Product Name: benzphetamine, diethylpropion, diethylpropion ER, phendimetrazine, phendimetrazine ER

Approval Length	3 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Treatment is being requested for appetite suppression or weight loss

AND

2 - Patient is greater than 16 years of age

AND

3 - Submission of medical records confirming that the requested weight loss medication will be used as an adjunct to lifestyle modification (e.g., dietary or caloric restriction, exercise, behavioral support, community-based program) and participation has been for at least 6 months (of lifestyle modification) prior to using the requested medication

AND

4 - ONE of the following:

4.1 BMI greater than or equal to 30 kg/m² or for pediatric patients a BMI greater than 95th percentile, as documented by submission of medical records

OR

4.2 BOTH of the following:

4.2.1 BMI greater than or equal to 27 kg/m², as documented by submission of medical records

AND

4.2.2 Patient has a weight-related comorbidity (e.g., dyslipidemia, hypertension, type 2 diabetes, sleep apnea) (please specify comorbidity, as documented by submission of medical records)

AND

5 - The requested medication is prescribed by, or in consultation with a weight loss clinic or a dietician/nutritionist

Product Name: Brand Adipex-P, generic phentermine, Lomaira, benzphetamine, diethylpropion, diethylpropion ER, phendimetrazine, phendimetrazine ER

Approval Length	6 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records confirming that member is tolerating the medication

AND

2 - Submission of medical records confirming that member is continuing lifestyle modification

AND

3 - Weight loss of greater than or equal to 5% of baseline body weight, as documented by submission of medical records

Product Name:Orlistat, Xenical	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Treatment is being requested for appetite suppression or weight loss AND 2 - Patient is greater than or equal to 12 years of age AND 3 - Submission of medical records confirming that the requested weight loss medication will be used as an adjunct to lifestyle modification (e.g., dietary or caloric restriction, exercise, behavioral support, community-based program) and participation has been for at least 6 months (of lifestyle modification) prior to using the requested medication AND 4 - ONE of the following:	

4.1 BMI greater than or equal to 30 kg/m² or for pediatric patients a BMI greater than 95th percentile, as documented by submission of medical records

OR

4.2 BOTH of the following:

4.2.1 BMI greater than or equal to 27 kg/m², as documented by submission of medical records

AND

4.2.2 Patient has a weight-related comorbidity (e.g., dyslipidemia, hypertension, type 2 diabetes, sleep apnea) (please specify comorbidity, as documented by submission of medical records)

AND

5 - If the request is for Xenical, BOTH of the following:

5.1 ONE of the following:

5.1.1 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)

OR

5.1.2 The brand is being requested due to an incomplete response with a generic/authorized generic equivalent as documented by submission of medical records

AND

5.2 ONE of the following:

5.2.1 Patient is less 18 years of age

OR

5.2.2 Patient is greater than or equal to 18 years of age, and ONE of the following:

Failure to OTC Alli as confirmed by claims history or submission of medical records

History of contraindication or intolerance to OTC Alli (specify contraindication or intolerance)

AND

6 - If the request is for Orlistat, ONE of the following:

6.1 Patient is less than 18 years of age

OR

6.2 Patient is greater than or equal to 18 years of age, and ONE of the following:

Failure to OTC Alli as confirmed by claims history or submission of medical records

History of contraindication or intolerance to OTC Alli (specify contraindication or intolerance)

AND

7 - The requested medication is prescribed by, or in consultation with a weight loss clinic or a dietician/nutritionist

Product Name:OTC Alli	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Treatment is being requested for appetite suppression or weight loss

AND

2 - Patient is greater than or equal to 18 years of age

AND

3 - Submission of medical records confirming that the requested weight loss medication will be used as an adjunct to lifestyle modification (e.g., dietary or caloric restriction, exercise, behavioral support, community-based program) and participation has been for at least 6 months (of lifestyle modification) prior to using the requested medication

AND

4 - ONE of the following:

4.1 BMI greater than or equal to 30 kg/m² or for pediatric patients a BMI greater than 95th percentile, as documented by submission of medical records

OR

4.2 BOTH of the following:

4.2.1 BMI greater than or equal to 27 kg/m², as documented by submission of medical records

AND

4.2.2 Patient has a weight-related comorbidity (e.g., dyslipidemia, hypertension, type 2 diabetes, sleep apnea) (please specify comorbidity, as documented by submission of medical records)

AND

5 - The requested medication is prescribed by, or in consultation with a weight loss clinic or a dietician/nutritionist

Product Name:Orlistat, Xenical, OTC Alli	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records confirming that member is tolerating the medication AND 2 - Submission of medical records confirming that member is continuing lifestyle modification AND 3 - Weight loss of greater than or equal to 5% of baseline body weight, as documented by submission of medical records	

Product Name:Contrave	
Approval Length	4 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Treatment is being requested for appetite suppression or weight loss	

AND

2 - Patient is greater than 16 years of age

AND

3 - Submission of medical records confirming that the requested weight loss medication will be used as an adjunct to lifestyle modification (e.g., dietary or caloric restriction, exercise, behavioral support, community-based program) and participation has been for at least 6 months (of lifestyle modification) prior to using the requested medication

AND

4 - ONE of the following:

4.1 BMI greater than or equal to 30 kg/m² or for pediatric patients a BMI greater than 95th percentile, as documented by submission of medical records

OR

4.2 BOTH of the following:

4.2.1 BMI greater than or equal to 27 kg/m², as documented by submission of medical records

AND

4.2.2 Patient has a weight-related comorbidity (e.g., dyslipidemia, hypertension, type 2 diabetes, sleep apnea) (please specify comorbidity, as documented by submission of medical records)

AND

5 - The requested medication is prescribed by, or in consultation with a weight loss clinic or a dietician/nutritionist

Product Name:Contrave	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records confirming that member is tolerating the medication AND 2 - Submission of medical records confirming that member is continuing lifestyle modification AND 3 - ALL of the following: 3.1 The patient has completed at least 16 weeks of therapy of Contrave and are currently being treated with the FDA-(Food and Drug Administration) recommended maintenance dose AND 3.2 Submission of medical records confirming the patient lost at least 5 percent of baseline body weight while taking Contrave AND 3.3 If this is the patient's subsequent re-authorization, ONE of the following: Patient has continued to display weight loss Patient has achieved a normal BMI (18.5-24.9)	

If the patient has demonstrated no further weight loss, and the BMI is 25 or greater, submission of medical records showing active participation in a comprehensive weight loss program is required

Product Name: Brand Qsymia, generic phentermine/topiramate ER, Brand Saxenda, generic liraglutide

Approval Length	4 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Treatment is being requested for appetite suppression or weight loss

AND

2 - Patient is greater than or equal to 12 years of age

AND

3 - Submission of medical records confirming that the requested weight loss medication will be used as an adjunct to lifestyle modification (e.g., dietary or caloric restriction, exercise, behavioral support, community-based program) and participation has been for at least 6 months (of lifestyle modification) prior to using the requested medication

AND

4 - ONE of the following:

4.1 BMI greater than or equal to 30 kg/m² or for pediatric patients a BMI greater than 95th percentile, as documented by submission of medical records

OR

4.2 BOTH of the following:

4.2.1 BMI greater than or equal to 27 kg/m², as documented by submission of medical records

AND

4.2.2 Patient has a weight-related comorbidity (e.g., dyslipidemia, hypertension, type 2 diabetes, sleep apnea) (please specify comorbidity, as documented by submission of medical records)

AND

5 - The requested medication is prescribed by, or in consultation with a weight loss clinic or a dietician/nutritionist

Product Name: Brand Qsymia, generic phentermine/topiramate ER	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records confirming that member is tolerating the medication AND 2 - Submission of medical records confirming that member is continuing lifestyle modification AND 3 - There has been weight loss of greater than or equal to 3% of baseline body weight, as documented by submission of medical records	

Product Name: Brand Saxenda, generic liraglutide	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records confirming that member is tolerating the medication AND 2 - Submission of medical records confirming that member is continuing lifestyle modification AND 3 - ONE of the following: 3.1 For patients 12 to 17 years of age, ALL of the following: 3.1.1 The patient has completed at least 12 weeks of therapy on maintenance dose of therapy with Saxenda AND 3.1.2 Submission of medical records confirming the patient had at least a 1 percent reduction in body mass index (BMI) from baseline AND 3.1.3 If this is the patient's subsequent re-authorization, ONE of the following: Patient has continued to display weight loss Patient has achieved a normal BMI standardized for age and sex	

If the patient has demonstrated no further weight loss, and the BMI is classified as obese when standardized for age and sex, submission of medical records showing active participation in a comprehensive weight loss program is required

OR

3.2 For patients 18 years of age and older, ALL of the following:

3.2.1 The patient has completed at least 16 weeks of therapy of Saxenda and are currently being treated with the FDA-(Food and Drug Administration) recommended maintenance dose

AND

3.2.2 Submission of medical records confirming the patient lost at least 5 percent of baseline body weight while taking Saxenda

AND

3.2.3 If this is the patient's subsequent re-authorization, ONE of the following:

Patient has continued to display weight loss

Patient has achieved a normal BMI (18.5-24.9)

If the patient has demonstrated no further weight loss, and the BMI is 25 or greater, submission of medical records showing active participation in a comprehensive weight loss program is required

Product Name:Imcivree	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following:	

1.1 Diagnosis of obesity is due to pro-opiomelanocortin (POMC), proprotein convertase subtilisin/kexin type 1 (PCSK1), or leptin receptor (LEPR) gene deficiency confirmed with genetic testing interpreted as pathogenic, likely pathogenic, or of uncertain significance

OR

1.2 Diagnosis of Bardet-Biedl syndrome

AND

2 - ONE of the following:

2.1 Adult patient with BMI greater than or equal to 30 kg/m², as documented by submission of medical records

OR

2.2 Pediatric patient with weight greater than 95th percentile for age on growth chart assessment, as documented by submission of medical records

AND

3 - Patient is currently enrolled in or has history of a weight loss management program

Product Name:Imcivree	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - If on therapy for less than 12 months, documentation of a positive clinical response to Imcivree therapy defined as weight loss greater than or equal to 5% of baseline weight, as documented by submission of medical records	

OR

2 - If on therapy for greater than or equal to 12 months, documentation of a positive clinical response to Imcivree therapy defined as greater than or equal to 10% weight loss from baseline, as documented by submission of medical records

2 . Revision History

Date	Notes
3/9/2026	Removed "RI" in the GL title. Removed endocrinologist as a prescriber requirement option. Updated GPIs

Welireg



Prior Authorization Guideline

Guideline ID	GL-401254
Guideline Name	Welireg
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

Guideline Note:

Effective Date:	10/1/2025

1 . Criteria

Product Name: Welireg	
Diagnosis	Von Hippel-Lindau (VHL) Disease

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of von Hippel-Lindau (VHL) disease AND 2 - Patient requires therapy for ONE of the following: Renal cell carcinoma (RCC) Central nervous system (CNS) hemangioblastoma Pancreatic neuroendocrine tumor (pNET) AND 3 - Patient does not require immediate surgery	

Product Name: Welireg	
Diagnosis	Advanced Renal Cell Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of advanced renal cell carcinoma (RCC) AND	

2 - Disease has progressed after treatment with BOTH of the following:

2.1 Programmed death receptor 1 (PD-1) or programmed death ligand 1 (PD-L1) checkpoint inhibitor [e.g., Keytruda (pembrolizumab), Opdivo (nivolumab)]

AND

2.2 Vascular endothelial growth factor tyrosine kinase inhibitor (VEGF-TKI) [e.g., Cabometyx (cabozantinib), Inlyta (axitinib), Lenvima (lenvatinib)]

Product Name: Welireg	
Diagnosis	Pheochromocytoma/Paraganglioma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of pheochromocytoma or paraganglioma (PPGL) AND 2 - Disease is ONE of the following: Advanced Unresectable Metastatic	

Product Name: Welireg	
Diagnosis	All above indications
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 Welireg	

Product Name:Welireg	
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:Welireg	
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 Welireg therapy	

2 . Revision History

UnitedHealthcare Community Plan of Rhode Island Clinical Pharmacy Program Guidelines

Date	Notes
9/17/2025	Added section for pheochromocytoma/Paraganglioma. Added NM, V A, and WA formularies.

Winrevair



Prior Authorization Guideline

Guideline ID	GL-152465
Guideline Name	Winrevair
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

Guideline Note:

Effective Date:	9/1/2024

1 . Criteria

Product Name:Winrevair	
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 pulmonary arterial hypertension (PAH)

AND

1.1.2 PAH has been confirmed by right heart catheterization

AND

1.1.3 Prescriber attestation that other types of pulmonary hypertension (PH) are excluded as a diagnosis

AND

1.1.4 Pulmonary arterial hypertension is symptomatic

OR

1.2 Both of the following:

1.2.1 Diagnosis of pulmonary arterial hypertension

AND

1.2.2 Patient is currently on Winrevair therapy as documented by claims history or submission of medical records

AND

2 - One of the following:

2.1 Both of the following:

2.1.1 Patient has a cardiopulmonary comorbidity (e.g., obesity, hypertension, diabetes mellitus, coronary heart disease)

AND

2.1.2 Patient is currently taking at least ONE of the following oral therapies:

Endothelin receptor antagonist (ERA) [e.g., ambrisentan, bosentan, Opsumit (macitentan)]

Phosphodiesterase-5 inhibitor (PDE5i) (e.g., sildenafil, tadalafil)

OR

2.2 Both of the following:

2.2.1 Patient does not have a cardiopulmonary comorbidity (e.g., obesity, hypertension, diabetes mellitus, coronary heart disease)

AND

2.2.2 Patient is currently taking oral combination therapy with BOTH of the following:

2.2.2.1 Endothelin receptor antagonist (ERA) [e.g., ambrisentan, bosentan, Opsumit (macitentan)]

AND

2.2.2.2 One of the following:

Phosphodiesterase-5 inhibitor (PDE5i) (e.g., sildenafil, tadalafil)

Soluble guanylate cyclase stimulator (sGC) [e.g., Adempas (riociguat)]

AND

3 - Prescribed by, or in consultation with, a cardiologist, pulmonologist, or rheumatologist

Product Name: Winrevair	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of a positive clinical response to Winrevair therapy [e.g., improvement in symptoms of right heart failure, exercise tolerance, six-minute walk distance (6MWD), resting and ambulatory oximetry] AND 2 - Prescribed by, or in consultation with, a cardiologist, pulmonologist, or rheumatologist	

2 . Revision History

Date	Notes
8/21/2024	New.

Winrevair



Prior Authorization Guideline

Guideline ID	GL-152465
Guideline Name	Winrevair
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

Guideline Note:

Effective Date:	9/1/2024

1 . Criteria

Product Name:Winrevair	
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 pulmonary arterial hypertension (PAH)

AND

1.1.2 PAH has been confirmed by right heart catheterization

AND

1.1.3 Prescriber attestation that other types of pulmonary hypertension (PH) are excluded as a diagnosis

AND

1.1.4 Pulmonary arterial hypertension is symptomatic

OR

1.2 Both of the following:

1.2.1 Diagnosis of pulmonary arterial hypertension

AND

1.2.2 Patient is currently on Winrevair therapy as documented by claims history or submission of medical records

AND

2 - One of the following:

2.1 Both of the following:

2.1.1 Patient has a cardiopulmonary comorbidity (e.g., obesity, hypertension, diabetes mellitus, coronary heart disease)

AND

2.1.2 Patient is currently taking at least ONE of the following oral therapies:

Endothelin receptor antagonist (ERA) [e.g., ambrisentan, bosentan, Opsumit (macitentan)]

Phosphodiesterase-5 inhibitor (PDE5i) (e.g., sildenafil, tadalafil)

OR

2.2 Both of the following:

2.2.1 Patient does not have a cardiopulmonary comorbidity (e.g., obesity, hypertension, diabetes mellitus, coronary heart disease)

AND

2.2.2 Patient is currently taking oral combination therapy with BOTH of the following:

2.2.2.1 Endothelin receptor antagonist (ERA) [e.g., ambrisentan, bosentan, Opsumit (macitentan)]

AND

2.2.2.2 One of the following:

Phosphodiesterase-5 inhibitor (PDE5i) (e.g., sildenafil, tadalafil)

Soluble guanylate cyclase stimulator (sGC) [e.g., Adempas (riociguat)]

AND

3 - Prescribed by, or in consultation with, a cardiologist, pulmonologist, or rheumatologist

Product Name: Winrevair	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of a positive clinical response to Winrevair therapy [e.g., improvement in symptoms of right heart failure, exercise tolerance, six-minute walk distance (6MWD), resting and ambulatory oximetry] AND 2 - Prescribed by, or in consultation with, a cardiologist, pulmonologist, or rheumatologist	

2 . Revision History

Date	Notes
8/21/2024	New.

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.

Xarelto



Prior Authorization Guideline

Guideline ID	GL-525210
Guideline Name	Xarelto
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

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name: Brand Xarelto tabs/suspension, generic rivaroxaban tabs/suspension	
Diagnosis	Continuation of Therapy Upon Hospital Discharge
Approval Length	35 Day(s)

Guideline Type	Prior Authorization
Approval Criteria 1 - Xarelto will be approved as continuation of therapy upon hospital discharge	

Product Name:Brand Xarelto tabs/suspension, generic rivaroxaban tabs/suspension	
Diagnosis	Stroke and Systemic Embolism Prevention in Adult Patients with Non-Valvular Atrial Fibrillation (AF)
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of atrial fibrillation (AF) AND 2 - Patient does not have an artificial heart valve AND 3 - ONE of the following: Failure to Eliquis as confirmed by claims history or submission of medical records History of contraindication or intolerance to Eliquis (please specify contraindication or intolerance) Continuation of prior Xarelto therapy	

Product Name:Brand Xarelto tabs/suspension, generic rivaroxaban tabs/suspension

Diagnosis	Prophylaxis of Venous Thromboembolism (VTE) after Orthopedic Surgery (Hip Replacement or Knee Replacement) in Adult Patients
Approval Length	35 Day(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - ONE of the following: 1.1 Patient has or is scheduled to have total knee replacement surgery OR 1.2 Patient has or is scheduled to have total hip replacement surgery AND 2 - Patient does not have an artificial heart valve AND 3 - ONE of the following: 3.1 Xarelto is being prescribed as continuation of therapy following hospitalization after orthopedic surgery OR 3.2 Provider provides reason or special circumstance why the patient is unable to use Eliquis	

Product Name: Brand Xarelto tabs/suspension, generic rivaroxaban tabs/suspension	
Diagnosis	Treatment of Deep Vein Thrombosis (DVT) or Pulmonary Embolism (PE) in Adult Patients
Approval Length	12 month(s)

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following: Deep vein thrombosis (DVT) Pulmonary embolism (PE) AND 2 - Patient does not have an artificial heart valve AND 3 - ONE of the following: Failure to Eliquis as confirmed by claims history or submission of medical records History on intolerance or contraindication to Eliquis (please specify intolerance or contraindication) Continuation of prior Xarelto therapy	

Product Name: Brand Xarelto tabs/suspension, generic rivaroxaban tabs/suspension	
Diagnosis	Reduction in the Risk of Recurrence of Deep Vein Thrombosis (DVT) and Pulmonary Embolism (PE) in Adult Patients
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Previous diagnosis of ONE of the following:	

Deep vein thrombosis (DVT)

Pulmonary embolism (PE)

AND

2 - Patient does not have an artificial heart valve

AND

3 - Patient must have been treated with an anticoagulant [e.g., warfarin, Eliquis (apixaban)] for at least 6 months prior to request as confirmed by claims history or submission of medical records

AND

4 - ONE of the following:

4.1 Failure to Eliquis as confirmed by claims history or submission of medical records

OR

4.2 History of intolerance or contraindication to Eliquis (please specify intolerance or contraindication)

OR

4.3 Continuation of prior Xarelto therapy

Product Name: Brand Xarelto tabs/suspension, generic rivaroxaban tabs/suspension	
Diagnosis	Reduction in the Risk of Major Cardiovascular Events [Cardiovascular (CV) Death, Myocardial Infarction (MI) and Stroke] in Adult Patients with Chronic Coronary Artery Disease (CAD) or Peripheral Artery Disease (PAD)
Approval Length	12 month(s)

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of ONE of the following: Chronic coronary artery disease (CAD) Peripheral artery disease (PAD) AND 2 - Patient does not have an artificial heart valve AND 3 - Patient is on concurrent aspirin therapy	

Product Name: Brand Xarelto tabs/suspension, generic rivaroxaban tabs/suspension	
Diagnosis	Prophylaxis of Venous Thromboembolism (VTE) in Acutely Ill Medical Adult Patients at Risk for Thromboembolic Complications Not at High Risk of Bleeding
Approval Length	2 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient was admitted to the hospital for an acute medical illness AND 2 - Patient does not have an artificial heart valve	

AND

3 - Patient is at risk of thromboembolic complications due to moderate or severe restricted mobility

AND

4 - Patient is not at high risk of bleeding

Product Name: Brand Xarelto tabs/suspension, generic rivaroxaban tabs/suspension	
Diagnosis	Thromboprophylaxis in Pediatric Patients with Congenital Heart Disease After the Fontan Procedure
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of congenital heart disease AND 2 - Patient does not have an artificial heart valve AND 3 - Patient is at risk of thromboembolic complications due to Fontan procedure AND 4 - Patient is 2 years to 17 years of age	

Product Name: Brand Xarelto tabs/suspension, generic rivaroxaban tabs/suspension	
Diagnosis	Treatment of VTE and Reduction in the Risk of Recurrent VTE in Pediatric Patients
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - The requested medication is being used for the treatment of venous thromboembolism (VTE) or the reduction in the risk of recurrent VTE AND 2 - Patient does not have an artificial heart valve AND 3 - Patient has received at least 5 days of initial parenteral anticoagulant treatment AND 4 - Patient is 0 years to 17 years of age	

2 . Revision History

Date	Notes
2/16/2026	Updated GPIs and product name

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.

Xeljanz, Xeljanz XR, Xeljanz Oral Solution



Prior Authorization Guideline

Guideline ID	GL-525238
Guideline Name	Xeljanz, Xeljanz XR, Xeljanz Oral Solution
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 New Mexico

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name:Xeljanz tabs, Xeljanz XR	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of moderately to severely active rheumatoid arthritis (RA)

AND

1.2 ONE of the following:

1.2.1 Failure to a 3 month trial of one non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] at maximally indicated doses as confirmed by claims history or submission of medical records

OR

1.2.2 History of intolerance or contraindication to one non-biologic DMARD [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] (please specify intolerance or contraindication)

OR

1.2.3 Patient has been previously treated with a systemic targeted immunomodulator FDA-approved for the treatment of rheumatoid arthritis as confirmed by claims history or submission of medical records [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab)]

AND

1.3 BOTH of the following:

1.3.1 ONE of the following:

1.3.1.1 Failure to ALL of the following as confirmed by claims history or submission of medical records:

One of the preferred adalimumab products*

Enbrel (etanercept)

Tyenne (tocilizumab-aazg)

OR

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

One of the preferred adalimumab products*

Enbrel (etanercept)

Tyenne (tocilizumab-aazg)

OR

1.3.1.3 Patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-V-TR 300.29 for specific phobia diagnostic criteria)

AND

1.3.2 ONE of the following:

1.3.2.1 Failure to Olumiant (baricitinib) as confirmed by claims history or submission of medical records

OR

1.3.2.2 History of intolerance or contraindication to Olumiant (baricitinib) (please specify intolerance or contraindication)

AND

1.4 Patient is NOT receiving Xeljanz/Xeljanz XR in combination with either of the following:

Systemic targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab)] for treatment of the same indication

Potent immunosuppressant (e.g., azathioprine or cyclosporine)

AND

1.5 Prescribed by or in consultation with a rheumatologist

OR

2 - ALL of the following:

2.1 Diagnosis of moderately to severely active RA

AND

2.2 Patient is NOT receiving Xeljanz/Xeljanz XR in combination with either of the following:

Systemic targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab)] for treatment of the same indication

Potent immunosuppressant (e.g., azathioprine or cyclosporine)

AND

2.3 Patient is currently on Xeljanz/Xeljanz XR therapy as confirmed by claims history or submission of medical records

AND

2.4 Prescribed by or in consultation with a rheumatologist

Notes	*See Table 1 in Background for PDL Links

Product Name: Xeljanz tabs, Xeljanz XR	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of moderately to severely active ulcerative colitis (UC)

AND

1.2 ONE of the following:

1.2.1 Patient has had prior or concurrent inadequate response to a therapeutic course of oral corticosteroids and/or immunosuppressants (e.g., azathioprine, 6-mercaptopurine) as confirmed by claims history or submitted medical records

OR

1.2.2 Patient has been previously treated with a systemic targeted immunomodulator FDA-approved for the treatment of ulcerative colitis as confirmed by claims history or submission medical records [e.g., adalimumab, Entyvio (vedolizumab), Omvoh (mirikizumab-mrkz), Rinvoq (upadacitinib), Simponi (golimumab), Skyrizi (risankizumab), Tremfya (guselkumab), ustekinumab, Zeposia (ozanimod)]

AND

1.3 ONE of the following:

1.3.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

One of the preferred adalimumab products*

One of the preferred ustekinumab products*

OR

1.3.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

One of the preferred adalimumab products*

One of the preferred ustekinumab products*

OR

1.3.3 Patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-V-TR 300.29 for specific phobia diagnostic criteria)

AND

1.4 Patient is NOT receiving Xeljanz/Xeljanz XR in combination with either of the following:

Systemic targeted immunomodulator [e.g., adalimumab, Entyvio (vedolizumab), Omvoh (mirikizumab-mrkz), Rinvoq (upadacitinib), Simponi (golimumab), Skyrizi (risankizumab), Tremfya (guselkumab), ustekinumab, Zeposia (ozanimod)] for treatment of the same indication

Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

AND

1.5 Prescribed by or in consultation with a gastroenterologist

OR

2 - ALL of the following:

2.1 Patient is currently on Xeljanz/Xeljanz XR therapy as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of moderately to severely active UC

AND

2.3 Patient is NOT receiving Xeljanz/Xeljanz XR in combination with either of the following:

Systemic targeted immunomodulator [e.g., adalimumab, Entyvio (vedolizumab), Omvoh (mirikizumab-mrkz), Rinvoq (upadacitinib), Simponi (golimumab), Skyrizi (risankizumab), Tremfya (guselkumab), ustekinumab, Zeposia (ozanimod)] for treatment of the same indication

Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

AND

2.4 Prescribed by or in consultation with a gastroenterologist

Notes	*See Table 1 in Background for PDL Links

Product Name:Xeljanz tabs, Xeljanz XR	
Diagnosis	Ankylosing Spondylitis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ALL of the following: 1.1 Diagnosis of active ankylosing spondylitis AND	

1.2 ONE of the following:

1.2.1 Failure to two NSAIDs (e.g., ibuprofen, naproxen) at maximally indicated doses, each used for at least 4 weeks, as confirmed by claims history or submission of medical records

OR

1.2.2 History of intolerance or contraindication to two NSAIDs (e.g., ibuprofen, naproxen) (please specify intolerance or contraindication)

OR

1.2.3 Patient has been previously treated with a systemic targeted immunomodulator FDA-approved for the treatment of ankylosing spondylitis as confirmed by claims history or submission of medical records [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Rinvoq (upadacitinib), Simponi (golimumab), Taltz (ixekizumab)]

AND

1.3 ONE of the following:

1.3.1 BOTH of the following:

1.3.1.1 ONE of the following:

1.3.1.1.1 Failure to BOTH of the following as confirmed by claims history or submission of medical records:

One of the preferred adalimumab products*

Enbrel (etanercept)

OR

1.3.1.1.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

One of the preferred adalimumab products*

Enbrel (etanercept)

AND

1.3.1.2 ONE of the following:

1.3.1.2.1 Failure to Cosentyx (secukinumab) as confirmed by claims history or submission of medical records

OR

1.3.1.2.2 History of intolerance or contraindication to Cosentyx (secukinumab) (please specify intolerance or contraindication)

OR

1.3.2 Patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-V-TR 300.29 for specific phobia diagnostic criteria)

AND

1.4 Patient is NOT receiving Xeljanz/Xeljanz XR in combination with either of the following:

Systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Taltz (ixekizumab)] for treatment of the same indication

Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

AND

1.5 Prescribed by or in consultation with a rheumatologist

OR

2 - ALL of the following:

2.1 Patient is currently on Xeljanz/Xeljanz XR therapy as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of active ankylosing spondylitis

AND

2.3 Patient is NOT receiving Xeljanz/Xeljanz XR in combination with either of the following:

Systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Rinvoq (upadacitinib), Simponi (golimumab), Taltz (ixekizumab)] for treatment of the same indication

Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

AND

2.4 Prescribed by or in consultation with a rheumatologist

Notes	*See Table 1 in Background for PDL Links

Product Name:Xeljanz tabs, Xeljanz XR	
Diagnosis	Rheumatoid Arthritis (RA), Ulcerative Colitis (UC), Ankylosing Spondylitis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Xeljanz/Xeljanz XR therapy	

AND

2 - Patient is NOT receiving Xeljanz/Xeljanz XR in combination with either of the following:

Systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Skyrizi (risankizumab), Taltz (ixekizumab), Tremfya (guselkumab), ustekinumab, Olumiant (baricitinib), Zeposia (ozanimod), Entyvio (vedolizumab), Omvoh (mirikizumab-mrkz)]* for the treatment of the same indication

Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)*

Notes

* Examples of drug(s) may not be applicable based on the requested indication.

Product Name:Xeljanz tabs/oral soln, Xeljanz XR

Diagnosis Psoriatic Arthritis (PsA)

Approval Length 12 month(s)

Therapy Stage Initial Authorization

Guideline Type Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of active psoriatic arthritis

AND

1.2 ONE of the following:

1.2.1 Failure to a 3 month trial of methotrexate at the maximally indicated dose as confirmed by claims history or submission of medical records

OR

1.2.2 History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

OR

1.2.3 Patient has been previously treated with a systemic targeted immunomodulator FDA-approved for the treatment of psoriatic arthritis as confirmed by claims history or submission of medical records [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Orencia (abatacept), Otezla (apremilast), Rinvoq (upadacitinib), Simponi (golimumab), Skyrizi (risankizumab), Taltz (ixekizumab), Tremfya (guselkumab), ustekinumab]

AND

1.3 ONE of the following:

1.3.1 BOTH of the following:

1.3.1.1 ONE of the following:

1.3.1.1.1 Failure to TWO of the following as confirmed by claims history or submission of medical records:

One of the preferred adalimumab products*

Enbrel (etanercept)

One of the preferred ustekinumab products*

OR

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

One of the preferred adalimumab products*

Enbrel (etanercept)

One of the preferred ustekinumab products*

AND

1.3.1.2 ONE of the following:

1.3.1.2.1 Failure to Cosentyx (secukinumab) as confirmed by claims history or submission of medical records

OR

1.3.1.2.2 History of intolerance or contraindication to Cosentyx (secukinumab) (please specify intolerance or contraindication)

OR

1.3.2 Patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-V-TR 300.29 for specific phobia diagnostic criteria)

AND

1.4 Patient is NOT receiving Xeljanz, Xeljanz XR, or Xeljanz oral solution in combination with either of the following:

Systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Orencia (abatacept), Otezla (apremilast), Rinvoq (upadacitinib), Simponi (golimumab), Skyrizi (risankizumab), Taltz (ixekizumab), Tremfya (guselkumab), ustekinumab] for the treatment of the same indication

Potent immunosuppressant (e.g., azathioprine or cyclosporine)

AND

1.5 Prescribed by or in consultation with ONE of the following:

Rheumatologist

Dermatologist OR 2 - ALL of the following: 2.1 Patient is currently on Xeljanz, Xeljanz XR, or Xeljanz oral solution therapy as confirmed by claims history or submission of medical records AND 2.2 Diagnosis of active psoriatic arthritis AND 2.3 Patient is NOT receiving Xeljanz, Xeljanz XR, or Xeljanz oral solution in combination with either of the following: Systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Orencia (abatacept), Otezla (apremilast), Rinvoq (upadacitinib), Simponi (golimumab), Skyrizi (risankizumab), Taltz (ixekizumab), Tremfya (guselkumab), ustekinumab] for the treatment of the same indication Potent immunosuppressant (e.g., azathioprine or cyclosporine) AND 2.4 Prescribed by or in consultation with ONE of the following: Rheumatologist Dermatologist	
Notes	*See Table 1 in Background for PDL Links

Product Name: Xeljanz tabs/oral soln, Xeljanz XR	
Diagnosis	Psoriatic Arthritis (PsA)

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Xeljanz, /Xeljanz XR, Xeljanz oral solution therapy AND 2 - Patient is NOT receiving Xeljanz, Xeljanz XR, Xeljanz oral solution in combination with either of the following: Systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Orencia (abatacept), Otezla (apremilast), Rinvoq (upadacitinib), Simponi (golimumab), Skyrizi (risankizumab), Taltz (ixekizumab), Tremfya (guselkumab), ustekinumab] for the treatment of the same indication Potent immunosuppressant (e.g., azathioprine or cyclosporine)	

Product Name:Xeljanz tabs/oral soln	
Diagnosis	Polyarticular Course Juvenile Idiopathic Arthritis (pcJIA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ALL of the following: 1.1 Diagnosis of active polyarticular course juvenile idiopathic arthritis	

AND

1.2 ONE of the following:

1.2.1 Failure to ALL of the following as confirmed by claims history or submission of medical records:

One of the preferred adalimumab products*

Enbrel (etanercept)

Tyenne (tocilizumab-aazg)

OR

1.2.2 History of intolerance or contraindication to ALL of the following (please specific intolerance or contraindication):

One of the preferred adalimumab products*

Enbrel (etanercept)

Tyenne (tocilizumab-aazg)

OR

1.2.3 Patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-V-TR 300.29 for specific phobia diagnostic criteria)

AND

1.3 Patient is NOT receiving Xeljanz/Xeljanz oral solution in combination with either of the following:

Systemic targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Orencia (abatacept), Rinvoq (upadacitinib)] for treatment of the same indication

Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

AND

1.4 Prescribed by or in consultation with a rheumatologist

OR

2 - ALL of the following:

2.1 Patient is currently on Xeljanz/Xeljanz Oral Solution as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of active polyarticular course juvenile idiopathic arthritis

AND

2.3 Patient is NOT receiving Xeljanz/Xeljanz Oral Solution in combination with either of the following:

Systemic targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Orencia (abatacept), Rinvoq (upadacitinib)] for treatment of the same indication

Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

AND

2.4 Prescribed by or in consultation with a rheumatologist

Notes	*See Table 1 in Background for PDL Links

Product Name:Xeljanz tabs/oral soln	
Diagnosis	Polyarticular Course Juvenile Idiopathic Arthritis (pcJIA)
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Xeljanz or Xeljanz oral solution therapy AND 2 - Patient is NOT receiving Xeljanz or Xeljanz oral solution in combination with either of the following: Systemic targeted immunomodulator [e e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Orencia (abatacept), Rinvoq (upadacitinib)] for treatment of the same indication Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)	

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 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 NM: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-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>

PA CHIP: <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>

3 . Revision History

Date	Notes
2/18/2026	Removed NY-CHIP. Added Xeljanz soln as a target to PsA. Updated criteria for PsA and reauth criteria for RA/UC/AS. Removed PDL link f or NY from Background.

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

UnitedHealthcare Community Plan of Rhode Island Clinical Pharmacy Program Guidelines

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

UnitedHealthcare Community Plan of Rhode Island Clinical Pharmacy Program Guidelines

Date	Notes
10/16/2025	Removed NJ

Xolair



Prior Authorization Guideline

Guideline ID	GL-273195
Guideline Name	Xolair
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

Guideline Note:

Effective Date:	7/1/2025

1 . Criteria

Product Name:Xolair	
Diagnosis	Asthma
Approval Length	12 month(s)

Therapy Stage	Initial Authorization - Transitioning from UHC medical benefits
Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has been established on therapy with Xolair for moderate to severe persistent asthma under an active UnitedHealthcare medical benefit prior authorization AND 2 - Documentation of positive clinical response to Xolair therapy as demonstrated by at least ONE of the following 2.1 Reduction in the frequency of exacerbations OR 2.2 Decreased utilization of rescue medications OR 2.3 Increase in percent predicted forced expiratory volume (FEV1) from pretreatment baseline OR 2.4 Reduction in severity or frequency of asthma-related symptoms (e.g., wheezing, shortness of breath, coughing, etc.) AND 3 - Xolair is being used in combination with an inhaled corticosteroid (ICS)-containing maintenance medication [e.g., Advair/AirDuo (fluticasone/salmeterol), Breo Ellipta (fluticasone furoate/vilanterol), Symbicort (budesonide/ formoterol), Trelegy Ellipta (fluticasone furoate/umeclidinium/vilanterol)]	

AND

4 - Patient is not receiving Xolair in combination with any of the following:

Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]

Anti-interleukin 5 therapy [e.g., Nucala (mepolizumab), Cinqair (reslizumab), Fasenra (benralizumab)]

Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

Product Name:Xolair	
Diagnosis	Asthma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization - Not transitioning from UHC medical benefits
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderate or severe asthma AND 2 - Classification of asthma as uncontrolled or inadequately controlled as defined by at least ONE of the following: 2.1 Poor symptom control [e.g., Asthma Control Questionnaire (ACQ) score consistently greater than 1.5 or Asthma Control Test (ACT) score consistently less than 20] OR 2.2 Two or more bursts of systemic corticosteroids for at least 3 days each in the previous 12 months	

OR

2.3 Asthma-related emergency treatment (e.g., emergency room visit, hospital admission, or unscheduled physician's office visit for nebulizer or other urgent treatment)

OR

2.4 Airflow limitation [e.g., after appropriate bronchodilator withhold forced expiratory volume in 1 second (FEV1) less than 80% predicted (in the face of reduced FEV1-forced vital capacity [FVC] defined as less than the lower limit of normal)]

OR

2.5 Patient is currently dependent on oral corticosteroids for the treatment of asthma

AND

3 - Submission of medical records (e.g., chart notes, laboratory values, etc.) documenting a baseline (pre-omalizumab treatment) serum total IgE (immunoglobulin E) level greater than or equal to 30 IU/mL (international units/milliliter) and less than or equal to 1300 IU/mL

AND

4 - Positive skin test or in vitro reactivity to a perennial aeroallergen

AND

5 - Used in combination with ONE of the following:

5.1 ONE maximally-dosed (appropriately adjusted for age) combination inhaled corticosteroid (ICS)-long-acting beta2-agonist (LABA) product [e.g., fluticasone propionate-salmeterol (AirDuo, Advair), budesonide-formoterol (Symbicort)]

OR

5.2 Combination therapy including BOTH of the following:

5.2.1 One maximally-dosed (appropriately adjusted for age) ICS (inhaled corticosteroid) product [e.g., ciclesonide (Alvesco), mometasone furoate (Asmanex), beclomethasone dipropionate (QVAR)]

AND

5.2.2 One additional asthma controller medication [e.g., LABA - olodaterol (Striverdi) or indacaterol (Arcapta); leukotriene receptor antagonist - montelukast (Singulair); theophylline]

AND

6 - Patient is not receiving Xolair in combination with any of the following:

Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]

Anti-interleukin 5 therapy [e.g., Nucala (mepolizumab), Cinqair (reslizumab), Fasenra (benralizumab)]

Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

7 - Prescribed by ONE of the following:

Allergist

Immunologist

Pulmonologist

Product Name:Xolair	
Diagnosis	Asthma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response as demonstrated by at least ONE of the following:

Reduction in frequency of exacerbations

Decreased utilization of rescue medications

Increase in percent predicted FEV1 (forced expiratory volume in 1 second) from pretreatment baseline

Reduction in severity or frequency of asthma-related symptoms (e.g., wheezing, shortness of breath, coughing)

AND

2 - Used in combination with an ICS (inhaled corticosteroid)-containing maintenance medication [e.g., Advair/AirDuo (fluticasone/salmeterol), Breo Ellipta (fluticasone furoate/vilanterol), Symbicort (budesonide/ formoterol), Trelegy Ellipta (fluticasone furoate/umeclidinium/vilanterol)]

AND

3 - Patient is not receiving Xolair in combination with any of the following:

Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]

Anti-interleukin 5 therapy [e.g., Nucala (mepolizumab), Cinqair (reslizumab), Fasenra (benralizumab)]

Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

Product Name:Xolair	
Diagnosis	Chronic Urticaria
Approval Length	12 month(s)
Therapy Stage	Initial Authorization - Transitioning from UHC medical benefits

Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has been established on therapy with Xolair for chronic urticaria under an active UnitedHealthcare medical benefit prior authorization AND 2 - Documentation of positive clinical response to Xolair therapy (e.g., reduction in exacerbations, itch severity, hives) AND 3 - Patient is not receiving Xolair in combination with any of the following: Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)] Anti-interleukin 5 therapy [e.g., Nucala (mepolizumab), Cinqair (reslizumab), Fasenra (benralizumab)] Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]	

Product Name:Xolair	
Diagnosis	Chronic Urticaria
Approval Length	12 month(s)
Therapy Stage	Initial Authorization - Not transitioning from UHC medical benefits
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chronic urticaria	

AND

2 - ONE of the following:

2.1 Patient remains symptomatic despite at least a 2-week trial and failure of two H1-antihistamines [e.g., Allegra (fexofenadine), Benadryl (diphenhydramine), Claritin (loratadine)]* (confirmed by claims history or submitted medical records)

OR

2.2 Patient remains symptomatic despite at least a 2-week trial and failure of BOTH of the following taken in combination (confirmed by claims history or submitted medical records):

2.2.1 Second generation H1-antihistamine [e.g., Allegra (fexofenadine), Claritin (loratadine), Zyrtec (cetirizine)]

AND

2.2.2 ONE of the following:

Different second generation H1-antihistamine [e.g., Allegra (fexofenadine), Claritin (loratadine), Zyrtec (cetirizine)]

First generation H1-antihistamine [e.g., Benadryl (diphenhydramine), Chlor-Trimeton (chlorpheniramine), Vistaril (hydroxyzine)]*

H2-antihistamine [e.g., Pepcid (famotidine), Tagamet HB (cimetidine), Zantac (ranitidine)]

Leukotriene modifier [e.g., Singulair (montelukast)]

OR

2.3 History of contraindication or intolerance to ONE of the following (please specify contraindication or intolerance):

2.3.1 Two H1-antihistamines [e.g., Allegra (fexofenadine), Benadryl (diphenhydramine), Claritin (loratadine)]*

OR

2.3.2 BOTH of the following taken in combination:

2.3.2.1 Second generation H1-antihistamine [e.g., Allegra (fexofenadine), Claritin (loratadine), Zyrtec (cetirizine)]

AND

2.3.2.2 ONE of the following:

Different second generation H1-antihistamine [e.g., Allegra (fexofenadine), Claritin (loratadine), Zyrtec (cetirizine)]

First generation H1-antihistamine [e.g., Benadryl (diphenhydramine), Chlor-Trimeton (chlorpheniramine), Vistaril (hydroxyzine)]*

H2-antihistamine [e.g., Pepcid (famotidine), Tagamet HB (cimetidine), Zantac (ranitidine)]

Leukotriene modifier [e.g., Singulair (montelukast)]

AND

3 - Patient is not receiving Xolair in combination with any of the following:

Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]

Anti-interleukin 5 therapy [e.g., Nucala (mepolizumab), Cinqair (reslizumab), Fasenra (benralizumab)]

Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

4 - Prescribed by one of the following:

Allergist

Dermatologist	
Immunologist	
Notes	*Patients 65 years of age and older in whom first generation H1-antihistamines are considered high risk medications to be avoided (e.g., Benadryl, Beners criteria, HEDIS) should be directed to try alternatives that are not considered high risk.

Product Name:Xolair	
Diagnosis	Chronic Urticaria
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response (e.g., reduction in exacerbations, itch severity, hives) AND 2 - Patient is not receiving Xolair in combination with any of the following: Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)] Anti-interleukin 5 therapy [e.g., Nucala (mepolizumab), Cinqair (reslizumab), Fasenra (benralizumab)] Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]	

Product Name:Xolair	
Diagnosis	Nasal Polyps
Approval Length	12 month(s)
Therapy Stage	Initial Authorization - Transitioning from UHC medical benefits

Guideline Type	Prior Authorization
Approval Criteria 1 - Patient has been established on therapy with Xolair for nasal polyps under an active UnitedHealthcare medical benefit prior authorization AND 2 - Documentation of positive clinical response to Xolair therapy AND 3 - Patient will continue to receive Xolair as add-on maintenance therapy in combination with intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone) AND 4 - Patient is not receiving Xolair in combination with any of the following: Anti-interleukin 5 therapy [e.g., Cinqair (reslizumab), Fasenra (benralizumab), Nucala (mepolizumab)] Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)] Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]	

Product Name:Xolair	
Diagnosis	Nasal Polyps
Approval Length	12 month(s)
Therapy Stage	Initial Authorization - Not transitioning from UHC medical benefits
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of nasal polyps

AND

2 - TWO or more of the following symptoms for longer than 12 weeks duration:

Nasal mucopurulent discharge

Nasal obstruction, blockage, or congestion

Facial pain, pressure, and/or fullness

Reduction or loss of sense of smell

AND

3 - ONE of the following findings using nasal endoscopy and/or sinus computed tomography (CT):

Purulent mucus or edema in the middle meatus or ethmoid regions

Polyps in the nasal cavity or the middle meatus

Radiographic imaging demonstrating mucosal thickening or partial or complete opacification of paranasal sinuses

AND

4 - ONE of the following:

4.1 Patient has required prior sinus surgery

OR

4.2 Patient has required systemic corticosteroids (e.g., prednisone, methylprednisolone) for nasal polyps in the previous 2 years

OR

4.3 Patient has been unable to obtain symptom relief after trial of BOTH of the following confirmed by claims history or submitted medical records:

Intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone)

One other therapy used in management of nasal polyps [i.e., nasal saline irrigations, antileukotriene agents (e.g., montelukast, zafirlukast, zileuton)]

AND

5 - Patient will receive Xolair as add-on maintenance therapy in combination with intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone)

AND

6 - Patient is not receiving Xolair in combination with any of the following:

Anti-interleukin 5 therapy [e.g., Cinqair (reslizumab), Fasenra (benralizumab), Nucala (mepolizumab)]

Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]

Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

7 - Prescribed by one of the following:

Allergist

Immunologist

Otolaryngologist

Pulmonologist

Product Name:Xolair	
Diagnosis	Nasal Polyps
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Xolair therapy AND 2 - Patient will continue to receive Xolair as add-on maintenance therapy in combination with intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone) AND 3 - Patient is not receiving Xolair in combination with any of the following: Anti-interleukin 5 therapy [e.g., Cinqair (reslizumab), Fasenra (benralizumab), Nucala (mepolizumab)] Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)] Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]	

Product Name:Xolair	
Diagnosis	IgE-Mediated Food Allergy
Approval Length	12 month(s)
Therapy Stage	Initial Authorization - Transitioning from UHC medical benefits
Guideline Type	Prior Authorization
Approval Criteria	

1 - Patient has been established on therapy with Xolair for IgE-Mediated food allergy under an active UnitedHealthcare medical benefit prior authorization

AND

2 - Documentation of positive clinical response to Xolair therapy (e.g., reduction in type I allergic reactions)

AND

3 - Xolair will be used in conjunction with food allergen avoidance

AND

4 - Patient access to epinephrine

AND

5 - Patient is not receiving Xolair in combination with any of the following:

Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]

Anti-interleukin 5 therapy [e.g., Nucala (mepolizumab), Cinqair (reslizumab), Fasenra (benralizumab)]

Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

6 - Prescribed by an allergist or immunologist

Product Name:Xolair	
Diagnosis	IgE-Mediated Food Allergy
Approval Length	12 month(s)
Therapy Stage	Initial Authorization - Not transitioning from UHC medical benefits

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of IgE-mediated food allergy to one or more foods AND 2 - Patient is at least 1 year of age AND 3 - IgE-mediated food allergy to specific food(s) has been confirmed by both of the following: 3.1 History of type I allergic reactions (e.g., nausea, vomiting, cramping, diarrhea, flushing, pruritus, urticaria, swelling of the lips, face or throat, wheezing, lightheadedness, syncope) AND 3.2 One of the following: Food specific skin prick testing (SPT) IgE antibody in vitro testing Oral food challenge (OFC) AND 4 - Xolair will be used in conjunction with food allergen avoidance AND 5 - Patient has access to epinephrine	

AND

6 - Patient is not receiving Xolair in combination with any of the following:

Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]

Anti-interleukin 5 therapy [e.g., Nucala (mepolizumab), Cinqair (reslizumab), Fasenra (benralizumab)]

Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

7 - Prescribed by allergist or immunologist

Product Name:Xolair	
Diagnosis	IgE-Mediated Food Allergy
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Xolair therapy (e.g., reduction in type I allergic reactions) AND 2 - Xolair will be used in conjunction with food allergen avoidance AND 3 - Patient has access to epinephrine	

AND

4 - Patient is not receiving Xolair in combination with any of the following:

Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]

Anti-interleukin 5 therapy [e.g., Nucala (mepolizumab), Cinqair (reslizumab), Fasenra (benralizumab)]

Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

5 - Prescribed by an allergist or immunologist

2 . Revision History

Date	Notes
5/21/2025	Updated formularies

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.

Xphozah



Prior Authorization Guideline

Guideline ID	GL-533232
Guideline Name	Xphozah
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

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Xphozah	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of chronic kidney disease (CKD) AND 2 - Patient is receiving dialysis AND 3 - Serum phosphorus is greater than or equal to 5.5 mg/dL (milligrams per deciliter) AND 4 - Patient has had an inadequate response to at least a 4-week maximally tolerated dose of BOTH of the following phosphate binders as confirmed by claims history or submission of medical records: 4.1 calcium acetate (generic PhosLo) AND 4.2 sevelamer carbonate (generic Renvela) AND 5 - Xphozah will be used as add-on therapy AND	

6 - Prescribed by or in consultation with a nephrologist

Product Name:Xphozah	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Xphozah therapy [e.g., reduction of serum phosphorus towards the normal range (3.5 to 5.5 milligrams per deciliter)] AND 2 - Prescribed by or in consultation with a nephrologist	

2 . Revision History

Date	Notes
3/3/2026	Updated serum phosphorus requirement under initial auth.

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

UnitedHealthcare Community Plan of Rhode Island Clinical Pharmacy Program Guidelines

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.

Xyrem, Xywav, Lumryz



Prior Authorization Guideline

Guideline ID	GL-524214
Guideline Name	Xyrem, Xywav, Lumryz
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State New Jersey Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Virginia Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name:Xyrem, Sodium Oxybate, Xywav, Lumryz	
Diagnosis	Narcolepsy with Cataplexy (i.e., Narcolepsy Type 1)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, laboratory values) documenting a diagnosis of narcolepsy with cataplexy (i.e., Narcolepsy Type 1) with BOTH of the following:

1.1 The patient has daily periods of irrepressible need to sleep or daytime lapses into sleep occurring for at least three months

AND

1.2 A mean sleep latency of less than or equal to 8 minutes and two or more sleep onset rapid eye movement (REM) periods (SOREMPs) on a Multiple Sleep Latency Test (MSLT) performed according to standard techniques following a normal overnight polysomnogram. A SOREMP (within 15 minutes of sleep onset) on the preceding nocturnal polysomnogram may replace one of the SOREMPs on the MSLT

AND

2 - Physician attestation to BOTH of the following:

2.1 Patient has experienced cataplexy defined as more than one episode of sudden loss of muscle tone with retained consciousness

AND

2.2 Other causes of sleepiness have been ruled out or treated (including but not limited to obstructive sleep apnea, insufficient sleep syndrome, shift work, the effects of substances or medications, or other sleep disorders)

AND

3 - Prescribed by ONE of the following:

Neurologist

Psychiatrist

Sleep Medicine Specialist

Pulmonologist

AND

4 - ONE of the following:

4.1 Failure to Wakix (pitolisant) as confirmed by claims history or submission of medical records

OR

4.2 History of contraindication or intolerance to Wakix (pitolisant) (please specify intolerance or contraindication)

Product Name:Xyrem, Sodium Oxybate, Xywav, Lumryz	
Diagnosis	Narcolepsy with Cataplexy (i.e., Narcolepsy Type 1)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation demonstrating a reduction in frequency of cataplexy attacks associated with therapy OR 2 - Documentation demonstrating reduction in symptoms of excessive daytime sleepiness associated with therapy	

Product Name:Xyrem, Sodium Oxybate, Xywav, Lumryz	
Diagnosis	Narcolepsy without Cataplexy (i.e., Narcolepsy Type 2)

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes, lab values) documenting a diagnosis of narcolepsy without cataplexy (i.e., Narcolepsy Type 2) with BOTH of the following: 1.1 The patient has daily periods of irrepressible need to sleep or daytime lapses into sleep occurring for at least three months AND 1.2 A mean sleep latency of less than or equal to 8 minutes and two or more sleep onset rapid eye movement (REM) periods (SOREMPs) are found on a Multiple Sleep Latency Test (MSLT) performed according to standard techniques following a normal overnight polysomnogram. A SOREMP (within 15 minutes of sleep onset) on the preceding nocturnal polysomnogram may replace one of the SOREMPs on the MSLT AND 2 - Physician attestation to BOTH of the following: 2.1 Cataplexy is absent AND 2.2 Other causes of sleepiness have been ruled out or treated (including but not limited to obstructive sleep apnea, insufficient sleep syndrome, shift work, the effects of substances or medications or their withdrawal, sleep phase disorder, or other sleep disorders) AND 3 - ONE of the following:	

3.1 Failure of BOTH of the following confirmed by claims history or submission of medical records:

3.1.1 ONE of the following:

Amphetamine based stimulant (e.g., amphetamine, dextroamphetamine)

Methylphenidate based stimulant

AND

3.1.2 ONE of the following:

Modafinil (Provigil)

Armodafinil (Nuvigil)

OR

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

Amphetamine based stimulant (e.g., amphetamine, dextroamphetamine)

Methylphenidate based stimulant

Modafinil (Provigil)

Armodafinil (Nuvigil)

AND

4 - ONE of the following:

4.1 Failure to Sunosi (solriamfetol) as confirmed by claims history or submission of medical records

OR

4.2 History of contraindication or intolerance to Sunosi (solriamfetol) (please specify intolerance or contraindication)

AND

5 - Prescribed by ONE of the following:

Neurologist

Psychiatrist

Sleep Medicine Specialist

Pulmonologist

Product Name:Xyrem, Sodium Oxybate, Xywav, Lumryz

Diagnosis	Narcolepsy without Cataplexy (i.e., Narcolepsy Type 2)

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation demonstrating reduction in symptoms of excessive daytime sleepiness associated with therapy

Product Name:Xywav

Diagnosis	Idiopathic Hypersomnia

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab values) documenting a diagnosis of idiopathic hypersomnia with both of the following:

1.1 The patient has daily periods of irrepressible need to sleep or daytime lapses into sleep occurring for at least three months

AND

1.2 A mean sleep latency of < 8 minutes and fewer than two REM (rapid eye movement) periods (SOREMPs) are found on a MSLT (multiple sleep latency test) performed according to standard techniques following a normal overnight polysomnogram, or no SOREMPs if the REM sleep latency on the preceding polysomnogram was < 15 minutes

AND

2 - Physician attestation that other causes of sleepiness have been ruled out or treated (including but not limited to obstructive sleep apnea, insufficient sleep syndrome, shift work, the effects of substances or medications or their withdrawal, sleep phase disorder, or other sleep disorders)

AND

3 - ONE of the following:

3.1 Failure of BOTH of the following confirmed by claims history or submission of medical records:

3.1.1 ONE of the following:

Amphetamine based stimulant (e.g., amphetamine, dextroamphetamine)

Methylphenidate based stimulant

AND

3.1.2 ONE of the following:

Modafinil (Provigil)

Armodafinil (Nuvigil)

OR

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

Amphetamine based stimulant (e.g., amphetamine, dextroamphetamine)

Methylphenidate based stimulant

Modafinil (Provigil)

Armodafinil (Nuvigil)

AND

4 - Prescribed by ONE of the following:

Neurologist

Psychiatrist

Sleep medicine specialist

Pulmonologist

Product Name:Xywav	
Diagnosis	Idiopathic Hypersomnia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation demonstrating reduction in symptoms of excessive daytime sleepiness associated with therapy	

2 . Revision History

Date	Notes
2/12/2026	Removed NY

Yorvipath



Prior Authorization Guideline

Guideline ID	GL-581202
Guideline Name	Yorvipath
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 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:Yorvipath	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of hypoparathyroidism

AND

2 - Confirmation of initial diagnosis by BOTH of the following:

2.1 Pretreatment low albumin-corrected serum calcium [i.e., less than or equal to 8.5 mg/dL (milligrams per deciliter)] confirmed on at least two occasions separated by at least 2 weeks

AND

2.2 Pretreatment undetectable or inappropriately low intact PTH (Parathyroid Hormone) concentration [i.e., less than 20 pg/mL (picograms per milliliter)], by second- or third-generation immunoassay, on at least two occasions

AND

3 - Yorvipath is not being used to treat acute post-surgical hypoparathyroidism

AND

4 - Patient is currently on adequate supplemental calcium and active vitamin D (e.g., calcitriol) therapy as evidenced by BOTH of the following:

4.1 Albumin-corrected serum calcium 7.8–10.6 mg/dL

AND

4.2 Serum 25(OH) vitamin D 20–80 ng/mL (nanograms per milliliter)

AND

5 - Prescribed by ONE of the following:

Endocrinologist

Nephrologist

Product Name:Yorvipath

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response [e.g., albumin-corrected serum calcium level in normal range (approximately 8.3-10.6 mg/dL (milligrams per deciliter)), independence from conventional therapy (e.g., requiring no active vitamin D, less than or equal to 600 mg/day (milligrams per day) of calcium)]

AND

2 - Prescribed by ONE of the following:

Endocrinologist

Nephrologist

2 . Revision History

Date	Notes

4/15/2026	Updated formulary for CO for eff 6/1/26. Inactivated GL-581201

Yupelri



Prior Authorization Guideline

Guideline ID	GL-595188
Guideline Name	Yupelri
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

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

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

Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of moderate to severe chronic obstructive pulmonary disease (COPD) AND 2 - ONE of the following: 2.1 One of the following: Failure of Incruse Ellipta confirmed by claims history or submitted medical records History of intolerance or contraindication to Incruse Ellipta (please specify intolerance or contraindication) OR 2.2 BOTH of the following: 2.2.1 Patient is unable to use a metered-dose, dry powder or slow mist inhaler (e.g. Incruse Ellipta) to control his/her COPD due to ONE of the following: Cognitive or physical impairment limiting coordination of handheld devices (e.g., cognitive decline, arthritis in the hands) (Document impairment) Patient is unable to generate adequate inspiratory force (e.g., peak inspiratory flow rate (PIFR) resistance is less than 60 liters per minute) AND 2.2.2 One of the following: Failure of ipratropium nebulized solution (generic Atrovent) confirmed by claims history or submitted medical records History of intolerance or contraindication to ipratropium nebulized solution (generic Atrovent) (please specify intolerance or contraindication)	

Product Name:Yupelri	
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
4/24/2026	Updated guideline name. Added NM. Removed Lonhala. Updated Yupelri GPI.

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

UnitedHealthcare Community Plan of Rhode Island Clinical Pharmacy Program Guidelines

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.

Zepbound



Prior Authorization Guideline

Guideline ID	GL-548188
Guideline Name	Zepbound
Formulary	Medicaid - Community & State Rhode Island

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Zepbound	
Diagnosis	Obstructive Sleep Apnea
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Treatment is being requested for obstructive sleep apnea (OSA)	

AND

2 - Patient is greater than or equal to 18 years of age

AND

3 - Submission of medical records confirming all of the following:

3.1 Moderate-to-severe obstructive sleep apnea evidenced by both of the following:

3.1.1 Sleep study

AND

3.1.2 One of the following:

Apnea Hypopnea Index (AHI) greater than or equal to 15

Respiratory Disturbance Index (RDI) greater than or equal to 15

Respiratory Event Index (REI) greater than or equal to 15

AND

3.2 BMI (body mass index) greater than or equal to 30 kg/m² (kilograms per square meter) in the past 6 months

AND

3.3 At least one previous unsuccessful dietary effort to lose weight

AND

3.4 One of the following:

3.4.1 Both of the following:

Patient is currently on positive airway pressure (PAP) therapy for at least 3 consecutive months

Patient is adherent to PAP therapy, defined as greater than or equal to 4 hours of use per night for greater than or equal to 70 percent of nights

OR

3.4.2 Patient is not a candidate for, or is intolerant to, PAP therapy (e.g., upper airway anatomic abnormalities, etc.)

AND

4 - Used in combination with a reduced calorie diet and increased physical activity

AND

5 - Provider attests to both of the following:

Patient counseled on appropriate positional therapy

Patient counseled on avoidance of alcohol and/or sedatives before bedtime

AND

6 - Patient does NOT have a diagnosis of diabetes or HgA1c (hemoglobin A1c) greater than or equal to 6.5%

AND

7 - Prescriber attests the patient does NOT have either one of the following:

Planned surgery for sleep apnea or obesity

A diagnosis of predominant central or mixed sleep apnea (i.e. percent of mixed or central apneas/hypopneas greater than or equal to 50% of all respiratory events)

AND

8 - Prescribed by, or in consultation with, a sleep specialist

Product Name:Zepbound	
Diagnosis	Obstructive Sleep Apnea
Approval Length	For patients who have been on Zepbound therapy for fewer than 52 weeks of consecutive therapy, authorization of 6 months; OR for patients who have been on Zepbound therapy for greater than or equal to 52 weeks of consecutive therapy, authorization of 12 months
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - One of the following: 1.1 If patient has been on Zepbound for less than 52 weeks of consecutive therapy, submission of medical records confirming a decrease from baseline after initiation of Zepbound in one of the following: Apnea Hypopnea Index (AHI) Respiratory Disturbance Index (RDI) Respiratory Event Index (REI) OR 1.2 If patient has been on Zepbound for greater than or equal to 52 weeks of consecutive therapy, submission of medical records confirming a 50% decrease from baseline after initiation of Zepbound in one of the following: Apnea Hypopnea Index (AHI)	

Respiratory Disturbance Index (RDI)

Respiratory Event Index (REI)

AND

2 - Patient has had a weight loss of greater than or equal to 10% of baseline body weight

AND

3 - Used in combination with a reduced calorie diet and increased physical activity

AND

4 - Patient does NOT have a diagnosis of diabetes or HgA1c (hemoglobin A1c) greater than or equal to 6.5%

AND

5 - Patient continues to require treatment for obstructive sleep apnea

Product Name: Zepbound

Diagnosis	Appetite Suppression or Weight Loss

Approval Length	6 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Treatment is being requested for appetite suppression or weight loss

AND

2 - Patient is greater than or equal to 18 years of age

AND

3 - Submission of medical records confirming that Zepbound will be used as an adjunct to lifestyle modification (e.g., dietary or caloric restriction, exercise, behavioral support, community-based program) and participation has been for at least 6 months (of lifestyle modification) prior to using Zepbound

AND

4 - ONE of the following:

4.1 BMI (body mass index) greater than or equal to 30 kg/m², or for pediatric patients a BMI greater than 95th percentile, as documented by submission of medical records

OR

4.2 BOTH of the following:

4.2.1 BMI greater than or equal to 27 kg/m² (kilograms per square meter), as documented by submission of medical records

AND

4.2.2 Patient has a weight-related comorbidity (e.g., dyslipidemia, hypertension, type 2 diabetes, sleep apnea) (please specify comorbidity, as documented by submission of medical records)

AND

5 - Zepbound is prescribed by, or in consultation with a weight loss clinic or a dietician/nutritionist

Product Name:Zepbound	
Diagnosis	Appetite Suppression or Weight Loss

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records confirming that member is tolerating the medication AND 2 - Submission of medical records confirming that member is continuing lifestyle modification AND 3 - The patient has completed at least 24 weeks of therapy of the requested medication and is currently being treated with the FDA-(Food and Drug Administration) recommended maintenance dose AND 4 - Submission of medical records confirming the patient lost at least 5 percent of baseline body weight while taking the requested medication AND 5 - If this is the patient's subsequent re-authorization, ONE of the following: Patient has continued to display weight loss Patient has achieved a normal BMI (18.5-24.9) If the patient has demonstrated no further weight loss, and the BMI is 25 or greater, submission of medical records showing active participation in a comprehensive weight loss program is required	

2 . Revision History

Date	Notes
3/9/2026	Removed "RI" in the GL title. Removed endocrinologist as a prescriber requirement option.

Zeposia



Prior Authorization Guideline

Guideline ID	GL-556228
Guideline Name	Zeposia
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

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:Zeposia	
Diagnosis	Multiple Sclerosis
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of multiple sclerosis (MS) AND 2 - ONE of the following: 2.1 BOTH of the following: 2.1.1 Failure to a trial of a preferred* dimethyl fumarate product, as confirmed by claims history or submission of medical records AND 2.1.2 Failure to a trial of at least ONE additional preferred* alternative, as confirmed by claims history or submission of medical records OR 2.2 History of intolerance or contraindication to ALL preferred* alternatives (please specify intolerance or contraindication) OR 2.3 Patient is currently on Zeposia therapy as confirmed by claims history or submission of medical records	
Notes	*PDL links are in Table 1 of Background.

Product Name:Zeposia	
Diagnosis	Multiple Sclerosis
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Zeposia therapy	

Product Name:Zeposia	
Diagnosis	Ulcerative Colitis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - ALL of the following: 1.1 Diagnosis of moderately to severely active ulcerative colitis (UC) AND 1.2 ONE of the following: 1.2.1 Patient has had prior or concurrent inadequate response to a therapeutic course of oral corticosteroids or immunosuppressants (e.g., azathioprine, 6-mercaptopurine) as confirmed by claims history or submission of medical records OR 1.2.2 Patient has been previously treated with a targeted immunomodulator FDA (Food and Drug Administration)-approved for the treatment of ulcerative colitis as confirmed by claims history or submission of medical records [e.g., adalimumab, Simponi (golimumab), ustekinumab, Xeljanz (tofacitinib), Rinvoq (upadacitinib)]	

AND

1.3 Patient is NOT receiving Zeposia in combination with a targeted immunomodulator [e.g., adalimumab, Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), ustekinumab, Skyrizi (risankizumab), Omvoh (mirikizumab-mrkz), Entyvio (vedolizumab)]

AND

1.4 ONE of the following:

1.4.1 Failure to ONE of the preferred adalimumab products* as confirmed by claims history or submission of medical records

OR

1.4.2 History of intolerance or contraindication to ONE of the preferred adalimumab products* (please specify intolerance or contraindication)

AND

1.5 Prescribed by or in consultation with a gastroenterologist

OR

2 - ALL of the following:

2.1 Patient is currently on Zeposia therapy as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of moderately to severely active ulcerative colitis

AND

2.3 Patient is NOT receiving Zeposia in combination with a targeted immunomodulator [e.g., adalimumab, Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), ustekinumab, Skyrizi (risankizumab), Omvoh (mirikizumab-mrkz), Entyvio (vedolizumab)]

AND

2.4 Prescribed by or in consultation with a gastroenterologist

Notes	*PDL links are in Table 1 of Background.

Product Name:Zeposia	
Diagnosis	Ulcerative Colitis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Zeposia therapy AND 2 - Patient is NOT receiving Zeposia in combination with a targeted immunomodulator [e.g., adalimumab, Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), ustekinumab, Skyrizi (risankizumab), Omvoh (mirikizumab-mrkz), Entyvio (vedolizumab)]	

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>

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>

NM: <https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html>

NY: <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>

3 . Revision History

Date	Notes
3/27/2026	Removed Obsolete GPI (Zeposia Starter Kit). Changed “and/or” to “or” for ccs / immunosuppressants in UC criteria. Minor cosmetic updates.

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.

Zokinvy



Prior Authorization Guideline

Guideline ID	GL-434311
Guideline Name	Zokinvy
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State Nevada Medicaid - Community & State New Jersey Medicaid - Community & State New York EPP Medicaid - Community & State New York Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Arizona Medicaid - Community & State Virginia Medicaid - Community & State Pennsylvania Medicaid - Community & State Nebraska Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Zokinvy	
Diagnosis	Hutchinson-Gilford Progeria Syndrome
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Hutchinson-Gilford Progeria Syndrome	

Product Name:Zokinvy	
Diagnosis	Progeroid Laminopathies
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of processing deficient Progeroid laminopathy AND 2 - Documentation of ONE of the following: Heterozygous LMNA (gene) mutation with progerin-like protein accumulation Homozygous or compound heterozygous ZMPSTE24 (gene) mutations	

2 . Revision History

Date	Notes
11/3/2025	Added NV formulary

Zokinvy



Prior Authorization Guideline

Guideline ID	GL-434311
Guideline Name	Zokinvy
Formulary	Medicaid - Community & State Colorado Medicaid - Community & State Hawaii Medicaid - Community & State Maryland Medicaid - Community & State Nevada Medicaid - Community & State New Jersey Medicaid - Community & State New York EPP Medicaid - Community & State New York Medicaid - Community & State Pennsylvania CHIP Medicaid - Community & State Rhode Island Medicaid - Community & State Arizona Medicaid - Community & State Virginia Medicaid - Community & State Pennsylvania Medicaid - Community & State Nebraska Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Zokinvy	
Diagnosis	Hutchinson-Gilford Progeria Syndrome
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of Hutchinson-Gilford Progeria Syndrome	

Product Name:Zokinvy	
Diagnosis	Progeroid Laminopathies
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of processing deficient Progeroid laminopathy AND 2 - Documentation of ONE of the following: Heterozygous LMNA (gene) mutation with progerin-like protein accumulation Homozygous or compound heterozygous ZMPSTE24 (gene) mutations	

2 . Revision History

Date	Notes
11/3/2025	Added NV formulary

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.

Zoryve



Prior Authorization Guideline

Guideline ID	GL-509212
Guideline Name	Zoryve
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

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Zoryve 0.3% cream, Zoryve foam	
Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of plaque psoriasis AND 2 - ONE of the following: 2.1 Submission of medical records or claims history confirming failure to a minimum duration of a 4-week trial to TWO of the following topical therapies: Corticosteroids (e.g., betamethasone, clobetasol, desonide) Vitamin D analogs (e.g., calcitriol, calcipotriene) Tazarotene Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus) Anthralin Coal tar OR 2.2 History of intolerance or contraindication to ALL of the following topical therapies (please specify intolerance or contraindication): Corticosteroids (e.g., betamethasone, clobetasol, desonide) Vitamin D analogs (e.g., calcitriol, calcipotriene) Tazarotene Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus) Anthralin	

Coal tar

AND

3 - Patient is not receiving the requested medication in combination with a targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, ustekinumab, Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)] for treatment of the same indication

Product Name:Zoryve 0.3% cream, Zoryve foam

Diagnosis	Plaque Psoriasis

Approval Length	12 month(s)

Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Patient is not receiving the requested medication in combination with a targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, ustekinumab, Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)] for treatment of the same indication

Product Name:Zoryve foam

Diagnosis	Seborrheic dermatitis

Approval Length	12 month(s)

Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of seborrheic dermatitis

AND

2 - ONE of the following:

2.1 Submission of medical records or claims history confirming failure to a minimum duration of a 4-week trial to TWO of the following topical therapies:

Topical corticosteroids (e.g., betamethasone, hydrocortisone)

Topical, shampoo, or systemic antifungals (e.g., ketoconazole, ciclopirox, itraconazole)

Topical calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)

OR

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

Topical corticosteroids (e.g., betamethasone, hydrocortisone)

Topical, shampoo, or systemic antifungals (e.g., ketoconazole, ciclopirox, itraconazole)

Topical calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)

AND

3 - Patient is not receiving Zoryve foam in combination with either of the following for treatment of the same indication:

Biologic immunomodulator [e.g., Dupixent (dupilumab), Adbry (tralokinumab-ldrm)]

Janus kinase inhibitor [e.g., Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib), Opzelura (topical ruxolitinib), Cibinqo (abrocitinib)]

Product Name:Zoryve foam	
Diagnosis	Seborrheic Dermatitis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy AND 2 - Patient is not receiving Zoryve foam in combination with either of the following for treatment of the same indication: Biologic immunomodulator [e.g., Dupixent (dupilumab), Adbry (tralokinumab-ldrm)] Janus kinase inhibitor [e.g., Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib), Opzelura (topical ruxolitinib), Cibinqo (abrocitinib)]	

Product Name:Zoryve 0.15% cream, Zoryve 0.05% cream	
Diagnosis	Atopic Dermatitis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Diagnosis of mild to moderate atopic dermatitis AND 2 - ONE of the following:	

2.1 For mild atopic dermatitis:

2.1.1 Submission of medical records or claims history confirming failure to TWO of the following topical therapeutic classes:

A topical corticosteroid [e.g., DesOwen (desonide), hydrocortisone] (any potency)

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

Eucrisa (crisaborole)

OR

2.1.2 History of intolerance or contraindication to ALL of the following topical therapies (please specify intolerance or contraindication):

A topical corticosteroid [e.g., DesOwen (desonide), hydrocortisone] (any potency)

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

Eucrisa (crisaborole)

OR

2.2 For moderate atopic dermatitis:

2.2.1 Submission of medical records or claims history confirming failure to TWO of the following topical therapeutic classes:

A topical corticosteroid of at least a medium- to high-potency [e.g., Elocon (mometasone furoate), Synalar (fluocinolone acetonide), Lidex (fluocinonide)]

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

Eucrisa (crisaborole)

OR

2.2.2 History of intolerance or contraindication to ALL of the following topical therapies (please specify intolerance or contraindication):

A topical corticosteroid of at least a medium- to high-potency [e.g., Elocon (mometasone furoate), Synalar (fluocinolone acetonide), Lidex (fluocinonide)]

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

Eucrisa (crisaborole)

AND

3 - Patient is not receiving the requested medication in combination with a targeted immunomodulator [e.g., Adbry (tralokinumab-ldrm), Cibinqo (abrocitinib), Dupixent (dupilumab), Rinvoq (upadacitinib)] for treatment of the same indication

Product Name: Zoryve 0.15% cream, Zoryve 0.05% cream	
Diagnosis	Atopic Dermatitis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy AND 2 - Patient is not receiving the requested medication in combination with a targeted immunomodulator [e.g., Adbry (tralokinumab-ldrm), Cibinqo (abrocitinib), Dupixent (dupilumab), Rinvoq (upadacitinib)] for treatment of the same indication	

2 . Revision History

Date	Notes
1/26/2026	Added Zoryve 0.05% cream as a target to atopic dermatitis criteria. Updated product name lists and GPI accordingly. Added for treatment

	of the same indication to not used in combination with a targeted immunomodulator to all criteria.

Zurzuva



Prior Authorization Guideline

Guideline ID	GL-164996
Guideline Name	Zurzuva
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 Nebraska Medicaid - Community & State Washington

Guideline Note:

Effective Date:	3/1/2025

1 . Criteria

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

Approval Criteria

1 - Diagnosis of postpartum depression (PPD)

AND

2 - Onset of current depressive episode was during the third trimester or within 4 weeks postpartum

2 . Revision History

Date	Notes
2/11/2025	Updated formularies. No changes to clinical criteria.

Zydelig



Prior Authorization Guideline

Guideline ID	GL-159292
Guideline Name	Zydelig
Formulary	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 Colorado

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
11/5/2024	Updated CO cag to SP

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.

Zymfentra



Prior Authorization Guideline

Guideline ID	GL-468194
Guideline Name	Zymfentra
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

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Zymfentra	
Diagnosis	Ulcerative Colitis
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records documenting clinical rationale for need of subcutaneous infliximab (Zymfentra) in place of infliximab administered intravenously (covered under the medical benefit) AND 2 - Diagnosis of moderately to severely active ulcerative colitis (UC) AND 3 - ONE of the following: 3.1 Patient has been established on therapy with an infliximab product under an active UnitedHealthcare prior authorization for the treatment of moderately to severely active ulcerative colitis OR 3.2 Patient is currently on Zymfentra therapy for moderately to severely active ulcerative colitis as confirmed by claims history or submission of medical records AND 4 - Patient is NOT receiving Zymfentra in combination with a systemic targeted immunomodulator [e.g., adalimumab, Entyvio (vedolizumab), Omvoh (mirikizumab-mrkz), Rinvoq (upadacitinib), Simponi (golimumab), Skyrizi (risankizumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), ustekinumab, Zeposia (ozanimod)] for treatment of the same indication AND	

5 - Prescribed by or in consultation with a gastroenterologist

Product Name:Zymfentra	
Diagnosis	Ulcerative Colitis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to Zymfentra therapy AND 2 - Patient is NOT receiving Zymfentra in combination with a systemic targeted immunomodulator [e.g., adalimumab, Entyvio (vedolizumab), Omvoh (mirikizumab-mrkz), Rinvoq (upadacitinib), Simponi (golimumab), Skyrizi (risankizumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), ustekinumab, Zeposia (ozanimod)] for treatment of the same indication	

Product Name:Zymfentra	
Diagnosis	Crohn's disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records documenting clinical rationale for need of subcutaneous infliximab (Zymfentra) in place of infliximab administered intravenously (covered under the medical benefit)	

AND

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

AND

3 - ONE of the following:

3.1 Patient has been established on therapy with an infliximab product under an active UnitedHealthcare prior authorization for the treatment of moderately to severely active Crohn's disease

OR

3.2 Patient is currently on Zymfentra therapy for moderately to severely active Crohn's disease as confirmed by claims history or submission of medical records

AND

4 - Patient is NOT receiving Zymfentra in combination with a systemic targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Entyvio (vedolizumab), Omvoh (mirikizumab-mrkz), Rinvoq (upadacitinib), Skyrizi (risankizumab), Tremfya (guselkumab), ustekinumab] for treatment of the same indication

AND

5 - Prescribed by or in consultation with a gastroenterologist

Product Name:Zymfentra	
Diagnosis	Crohn's disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Zymfentra therapy

AND

2 - Patient is NOT receiving Zymfentra in combination with a systemic targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Entyvio (vedolizumab), Omvoh (mirikizumab-mrkz), Rinvoq (upadacitinib), Skyrizi (risankizumab), Tremfya (guselkumab), ustekinumab] for treatment of the same indication

2 . Revision History

Date	Notes
12/10/2025	Updated combination examples and language with no change to clinical intent. Minor cosmetic updates.

Zyvox



Prior Authorization Guideline

Guideline ID	GL-242235
Guideline Name	Zyvox
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 Pennsylvania

Guideline Note:

Effective Date:	6/1/2025

1 . Criteria

Product Name: Brand Zyvox, generic linezolid	
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 - ONE of the following diagnoses:

Nosocomial pneumonia

Community-acquired pneumonia

Skin and skin structure infections (complicated and uncomplicated)

OR

4 - Invasive infection caused by or likely to be caused by vancomycin-resistant *Enterococcus faecium* (VRE)

OR

5 - The drug has been recognized for treatment of the indication by the Infectious Diseases Society of America (IDSA)

Notes	Approval Duration: For vancomycin-resistant <i>Enterococcus faecium</i> , a uthorization will be issued for 28 days. For osteomyelitis, authorization will be issued for the requested duration, not to exceed 6 weeks. All o ther approvals are for 14 days.

2 . Revision History

UnitedHealthcare Community Plan of Rhode Island Clinical Pharmacy Program Guidelines

Date	Notes
4/18/2025	Combined formularies.