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Actimmune

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146461 |
| **Guideline Name** | Actimmune |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Actimmune | |
|---|---|
| Diagnosis | Chronic Granulomatous Disease (CGD) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ACTIMMUNE | INTERFERON GAMMA-1B INJ 100 MCG/0.5ML (2000000 UNIT/0.5ML) | 21700060702020 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ACTIMMUNE | INTERFERON GAMMA-1B INJ 100 MCG/0.5ML (2000000 UNIT/0.5ML) | 21700060702020 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ACTIMMUNE | INTERFERON GAMMA-1B INJ 100 MCG/0.5ML (2000000 UNIT/0.5ML) | 21700060702020 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ACTIMMUNE | INTERFERON GAMMA-1B INJ 100 MCG/0.5ML (2000000 UNIT/0.5ML) | 21700060702020 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ACTIMMUNE | INTERFERON GAMMA-1B INJ 100 MCG/0.5ML (2000000 UNIT/0.5ML) | 21700060702020 | Brand |

**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 |
|---|---|

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ACTIMMUNE | INTERFERON GAMMA-1B INJ 100 MCG/0.5ML (2000000 UNIT/0.5ML) | 21700060702020 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Actimmune therapy

Adalimumab

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-155442 |
| **Guideline Name** | Adalimumab |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 10/1/2024 |

## 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| HUMIRA PEN-PS/UV STARTER | ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML | 6627001500F520 | Brand |
| HUMIRA PEN | ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML | 6627001500F520 | Brand |
| HUMIRA PEN-CD/UC/HS STARTER | ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML | 6627001500F520 | Brand |

| | | | |
|---|---|---|---|
| HUMIRA PEN | ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.4ML | 6627001500F530 | Brand |
| HUMIRA PEN-PEDIATRIC UC STARTER PACK | ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML | 6627001500F540 | Brand |
| HUMIRA PEN | ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML | 6627001500F540 | Brand |
| HUMIRA PEN-CD/UC/HS STARTER | ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML | 6627001500F540 | Brand |
| HUMIRA PEN-PS/UV STARTER | ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML & 40 MG/0.4ML | 6627001500F550 | Brand |
| HUMIRA | ADALIMUMAB PREFILLED SYRINGE KIT 10 MG/0.1ML | 6627001500F804 | Brand |
| HUMIRA | ADALIMUMAB PREFILLED SYRINGE KIT 20 MG/0.2ML | 6627001500F809 | Brand |
| HUMIRA | ADALIMUMAB PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001500F820 | Brand |
| HUMIRA | ADALIMUMAB PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001500F830 | Brand |
| HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK | ADALIMUMAB PREFILLED SYRINGE KIT 80 MG/0.8ML | 6627001500F840 | Brand |
| HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK | ADALIMUMAB PREFILLED SYRINGE KIT 80 MG/0.8ML & 40 MG/0.4ML | 6627001500F880 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 40 MG/0.8ML | 6627001510D520 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 20 MG/0.4ML | 6627001510E510 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 40 MG/0.8ML | 6627001510E520 | Brand |
| IDACIO STARTER PACKAGE FOR CROHNS DISEASE | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| IDACIO STARTER PACKAGE FOR PLAQUE PSORIASIS | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| ADALIMUMAB-FKJP | ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001535F520 | Brand |
| HULIO | ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001535F520 | Brand |
| ADALIMUMAB-FKJP | ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001535F810 | Brand |
| HULIO | ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001535F810 | Brand |
| ADALIMUMAB-FKJP | ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001535F820 | Brand |

| | | | |
|---|---|---|---|
| HULIO | ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001535F820 | Brand |
| CYLTEZO STARTER PACKAGE FOR PSORIASIS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 10 MG/0.2ML | 6627001505F805 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001505F810 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001505F820 | Brand |
| YUSIMRY | ADALIMUMAB-AQVH SOLN PEN-INJECTOR 40 MG/0.8ML | 6627001509D520 | Brand |
| HADLIMA PUSHTOUCH | ADALIMUMAB-BWWD SOLN AUTO-INJECTOR 40 MG/0.4ML | 6627001520D510 | Brand |
| HADLIMA PUSHTOUCH | ADALIMUMAB-BWWD SOLN AUTO-INJECTOR 40 MG/0.8ML | 6627001520D520 | Brand |
| HADLIMA | ADALIMUMAB-BWWD SOLN PREFILLED SYRINGE 40 MG/0.4ML | 6627001520E510 | Brand |
| HADLIMA | ADALIMUMAB-BWWD SOLN PREFILLED SYRINGE 40 MG/0.8ML | 6627001520E520 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.4ML | 6627001504D515 | Brand |
| ADALIMUMAB-ADAZ | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.4ML | 6627001504D515 | Brand |
| HYRIMOZ CROHN'S DISEASE AND ULCERATIVE COLITIS STARTER PACK | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML | 6627001504D540 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML | 6627001504D540 | Brand |
| HYRIMOZ PLAQUE PSORIASIS STARTER PACK | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML & 40 MG/0.4ML | 6627001504D560 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 10 MG/0.1ML | 6627001504E508 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 20 MG/0.2ML | 6627001504E513 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.4ML | 6627001504E515 | Brand |
| ADALIMUMAB-ADAZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.4ML | 6627001504E515 | Brand |

| | | | |
|---|---|---|---|
| HYRIMOZ PEDIATRIC CROHNS DISEASE STARTER PACK | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 80 MG/0.8ML | 6627001504E540 | Brand |
| HYRIMOZ PEDIATRIC CROHN'SDISEASE STARTER PACK | ADALIMUMAB-ADAZ SOLN PREFILLED SYR 80 MG/0.8ML & 40 MG/0.4ML | 6627001504E560 | Brand |
| ABRILADA | ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001507F520 | Brand |
| ABRILADA | ADALIMUMAB-AFZB PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001507F810 | Brand |
| ABRILADA | ADALIMUMAB-AFZB PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001507F820 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| ADALIMUMAB-ADBM CROHNS/UC/HS STARTER | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| ADALIMUMAB-ADBM PSORIASIS/UVEITIS STARTER | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 10 MG/0.2ML | 6627001505F805 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001505F810 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001505F820 | Brand |
| YUFLYMA 2-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001503F530 | Brand |
| YUFLYMA 1-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001503F530 | Brand |
| YUFLYMA 2-SYRINGE KIT | ADALIMUMAB-AATY PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001503F830 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 10 MG/0.2ML | 6627001510E505 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.8ML | 6627001504D520 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.8ML | 6627001504E520 | Brand |
| SIMLANDI 1-PEN KIT | ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001540F520 | Brand |
| SIMLANDI 2-PEN KIT | ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001540F520 | Brand |
| HYRIMOZ SENSOREADY PENS | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML | 6627001504D540 | Brand |
| IDACIO (2 PEN) | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |

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|---|---|---|---|
| ADALIMUMAB-AACF (2 PEN) | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| IDACIO (2 SYRINGE) | ADALIMUMAB-AACF PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001502F840 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 40 MG/0.4ML | 6627001510D517 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 80 MG/0.8ML | 6627001510D537 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 20 MG/0.2ML | 6627001510E508 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 40 MG/0.4ML | 6627001510E517 | Brand |
| YUFLYMA 1-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 80 MG/0.8ML | 6627001503F560 | Brand |
| YUFLYMA 2-SYRINGE KIT | ADALIMUMAB-AATY PREFILLED SYRINGE KIT 20 MG/0.2ML | 6627001503F820 | Brand |
| ADALIMUMAB-RYVK (2 PEN) | ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001540F520 | Brand |
| ADALIMUMAB-AATY 1-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001503F530 | Brand |
| ADALIMUMAB-AATY 2-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001503F530 | Brand |
| ADALIMUMAB-AATY 1-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 80 MG/0.8ML | 6627001503F560 | Brand |
| ADALIMUMAB-AATY 2-SYRINGE KIT | ADALIMUMAB-AATY PREFILLED SYRINGE KIT 20 MG/0.2ML | 6627001503F820 | Brand |
| ADALIMUMAB-AATY 2-SYRINGE KIT | ADALIMUMAB-AATY PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001503F830 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| ADALIMUMAB-ADBM STARTER PACKAGE FOR CROHNS DISEASE/UC/HS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| ADALIMUMAB-ADBM STARTER PACKAGE FOR PSORIASIS/UVEITIS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| CYLTEZO STARTER PACKAGE FOR PSORIASIS/UVEITIS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001505F815 | Brand |

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| CYLTEZO | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001505F815 | Brand |
| ADALIMUMAB-RYVK | ADALIMUMAB-RYVK PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001540F820 | Brand |
| ABRILADA 1-PEN KIT | ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001507F520 | Brand |
| ABRILADA 2-PEN KIT | ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001507F520 | Brand |
| ADALIMUMAB-AACF STARTER PACK/CD/UC/HS (6 PEN) | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| ADALIMUMAB-AACF STARTER PACK/PSORIASIS/UVEITIS (4 PEN) | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| HYRIMOZ PLAQUE PSORIASIS/UVEITIS STARTER PACK | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML & 40 MG/0.4ML | 6627001504D560 | Brand |
| ADALIMUMAB-AACF (2 SYRINGE) | ADALIMUMAB-AACF PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001502F840 | Brand |

**Approval Criteria**

**1** - Diagnosis of moderately to severely active rheumatoid arthritis

**AND**

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

**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 biologic or targeted synthetic DMARD 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)*

| | |
|---|---|
| Notes | *If approving a non-preferred adalimumab, please enter<br>1) The group authorization CSPREFADAL (for NY EPP and NY use: CSNYADAL)<br>2) An authorization for the non-preferred adalimumab at GPI-12 level<br><br>For a list of preferred adalimumab products please reference drug cov erage tools. |

| 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| HUMIRA PEN-PS/UV STARTER | ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML | 6627001500F520 | Brand |
| HUMIRA PEN | ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML | 6627001500F520 | Brand |
| HUMIRA PEN-CD/UC/HS STARTER | ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML | 6627001500F520 | Brand |
| HUMIRA PEN | ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.4ML | 6627001500F530 | Brand |
| HUMIRA PEN-PEDIATRIC UC STARTER PACK | ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML | 6627001500F540 | Brand |
| HUMIRA PEN | ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML | 6627001500F540 | Brand |
| HUMIRA PEN-CD/UC/HS STARTER | ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML | 6627001500F540 | Brand |
| HUMIRA PEN-PS/UV STARTER | ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML & 40 MG/0.4ML | 6627001500F550 | Brand |
| HUMIRA | ADALIMUMAB PREFILLED SYRINGE KIT 10 MG/0.1ML | 6627001500F804 | Brand |
| HUMIRA | ADALIMUMAB PREFILLED SYRINGE KIT 20 MG/0.2ML | 6627001500F809 | Brand |
| HUMIRA | ADALIMUMAB PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001500F820 | Brand |
| HUMIRA | ADALIMUMAB PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001500F830 | Brand |
| HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK | ADALIMUMAB PREFILLED SYRINGE KIT 80 MG/0.8ML | 6627001500F840 | Brand |
| HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK | ADALIMUMAB PREFILLED SYRINGE KIT 80 MG/0.8ML & 40 MG/0.4ML | 6627001500F880 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 40 MG/0.8ML | 6627001510D520 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 20 MG/0.4ML | 6627001510E510 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 40 MG/0.8ML | 6627001510E520 | Brand |

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|---|---|---|---|
| IDACIO STARTER PACKAGE FOR CROHNS DISEASE | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| IDACIO STARTER PACKAGE FOR PLAQUE PSORIASIS | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| ADALIMUMAB-FKJP | ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001535F520 | Brand |
| HULIO | ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001535F520 | Brand |
| ADALIMUMAB-FKJP | ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001535F810 | Brand |
| HULIO | ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001535F810 | Brand |
| ADALIMUMAB-FKJP | ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001535F820 | Brand |
| HULIO | ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001535F820 | Brand |
| CYLTEZO STARTER PACKAGE FOR PSORIASIS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 10 MG/0.2ML | 6627001505F805 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001505F810 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001505F820 | Brand |
| YUSIMRY | ADALIMUMAB-AQVH SOLN PEN-INJECTOR 40 MG/0.8ML | 6627001509D520 | Brand |
| HADLIMA PUSHTOUCH | ADALIMUMAB-BWWD SOLN AUTO-INJECTOR 40 MG/0.4ML | 6627001520D510 | Brand |
| HADLIMA PUSHTOUCH | ADALIMUMAB-BWWD SOLN AUTO-INJECTOR 40 MG/0.8ML | 6627001520D520 | Brand |
| HADLIMA | ADALIMUMAB-BWWD SOLN PREFILLED SYRINGE 40 MG/0.4ML | 6627001520E510 | Brand |
| HADLIMA | ADALIMUMAB-BWWD SOLN PREFILLED SYRINGE 40 MG/0.8ML | 6627001520E520 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.4ML | 6627001504D515 | Brand |
| ADALIMUMAB-ADAZ | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.4ML | 6627001504D515 | Brand |

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| HYRIMOZ CROHN'S DISEASE AND ULCERATIVE COLITIS STARTER PACK | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML | 6627001504D540 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML | 6627001504D540 | Brand |
| HYRIMOZ PLAQUE PSORIASIS STARTER PACK | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML & 40 MG/0.4ML | 6627001504D560 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 10 MG/0.1ML | 6627001504E508 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 20 MG/0.2ML | 6627001504E513 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.4ML | 6627001504E515 | Brand |
| ADALIMUMAB-ADAZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.4ML | 6627001504E515 | Brand |
| HYRIMOZ PEDIATRIC CROHNS DISEASE STARTER PACK | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 80 MG/0.8ML | 6627001504E540 | Brand |
| HYRIMOZ PEDIATRIC CROHN'SDISEASE STARTER PACK | ADALIMUMAB-ADAZ SOLN PREFILLED SYR 80 MG/0.8ML & 40 MG/0.4ML | 6627001504E560 | Brand |
| ABRILADA | ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001507F520 | Brand |
| ABRILADA | ADALIMUMAB-AFZB PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001507F810 | Brand |
| ABRILADA | ADALIMUMAB-AFZB PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001507F820 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| ADALIMUMAB-ADBM CROHNS/UC/HS STARTER | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| ADALIMUMAB-ADBM PSORIASIS/UVEITIS STARTER | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 10 MG/0.2ML | 6627001505F805 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001505F810 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001505F820 | Brand |
| YUFLYMA 2-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001503F530 | Brand |
| YUFLYMA 1-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001503F530 | Brand |

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| YUFLYMA 2-SYRINGE KIT | ADALIMUMAB-AATY PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001503F830 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 10 MG/0.2ML | 6627001510E505 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.8ML | 6627001504D520 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.8ML | 6627001504E520 | Brand |
| SIMLANDI 1-PEN KIT | ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001540F520 | Brand |
| SIMLANDI 2-PEN KIT | ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001540F520 | Brand |
| HYRIMOZ SENSOREADY PENS | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML | 6627001504D540 | Brand |
| IDACIO (2 PEN) | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| ADALIMUMAB-AACF (2 PEN) | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| IDACIO (2 SYRINGE) | ADALIMUMAB-AACF PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001502F840 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 40 MG/0.4ML | 6627001510D517 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 80 MG/0.8ML | 6627001510D537 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 20 MG/0.2ML | 6627001510E508 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 40 MG/0.4ML | 6627001510E517 | Brand |
| YUFLYMA 1-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 80 MG/0.8ML | 6627001503F560 | Brand |
| YUFLYMA 2-SYRINGE KIT | ADALIMUMAB-AATY PREFILLED SYRINGE KIT 20 MG/0.2ML | 6627001503F820 | Brand |
| ADALIMUMAB-RYVK (2 PEN) | ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001540F520 | Brand |
| ADALIMUMAB-AATY 1-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001503F530 | Brand |
| ADALIMUMAB-AATY 2-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001503F530 | Brand |
| ADALIMUMAB-AATY 1-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 80 MG/0.8ML | 6627001503F560 | Brand |
| ADALIMUMAB-AATY 2-SYRINGE KIT | ADALIMUMAB-AATY PREFILLED SYRINGE KIT 20 MG/0.2ML | 6627001503F820 | Brand |
| ADALIMUMAB-AATY 2-SYRINGE KIT | ADALIMUMAB-AATY PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001503F830 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |

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|---|---|---|---|
| ADALIMUMAB-ADBM STARTER PACKAGE FOR CROHNS DISEASE/UC/HS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| ADALIMUMAB-ADBM STARTER PACKAGE FOR PSORIASIS/UVEITIS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| CYLTEZO STARTER PACKAGE FOR PSORIASIS/UVEITIS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001505F815 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001505F815 | Brand |
| ADALIMUMAB-RYVK | ADALIMUMAB-RYVK PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001540F820 | Brand |
| ABRILADA 1-PEN KIT | ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001507F520 | Brand |
| ABRILADA 2-PEN KIT | ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001507F520 | Brand |
| ADALIMUMAB-AACF STARTER PACK/CD/UC/HS (6 PEN) | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| ADALIMUMAB-AACF STARTER PACK/PSORIASIS/UVEITIS (4 PEN) | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| HYRIMOZ PLAQUE PSORIASIS/UVEITIS STARTER PACK | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML & 40 MG/0.4ML | 6627001504D560 | Brand |
| ADALIMUMAB-AACF (2 SYRINGE) | ADALIMUMAB-AACF PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001502F840 | Brand |

**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 targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

**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]

**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 targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

**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)*

| | |
|---|---|
| Notes | *If approving a non-preferred adalimumab, please enter<br>1) The group authorization CSPREFADAL (for NY EPP and NY use: CSNYADAL)<br>2) An authorization for the non-preferred adalimumab at GPI-12 level<br><br>For a list of preferred adalimumab products please reference drug cov erage tools. |

| 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| HUMIRA PEN-PS/UV STARTER | ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML | 6627001500F520 | Brand |
| HUMIRA PEN | ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML | 6627001500F520 | Brand |
| HUMIRA PEN-CD/UC/HS STARTER | ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML | 6627001500F520 | Brand |
| HUMIRA PEN | ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.4ML | 6627001500F530 | Brand |
| HUMIRA PEN-PEDIATRIC UC STARTER PACK | ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML | 6627001500F540 | Brand |

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|---|---|---|---|
| HUMIRA PEN | ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML | 6627001500F540 | Brand |
| HUMIRA PEN-CD/UC/HS STARTER | ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML | 6627001500F540 | Brand |
| HUMIRA PEN-PS/UV STARTER | ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML & 40 MG/0.4ML | 6627001500F550 | Brand |
| HUMIRA | ADALIMUMAB PREFILLED SYRINGE KIT 10 MG/0.1ML | 6627001500F804 | Brand |
| HUMIRA | ADALIMUMAB PREFILLED SYRINGE KIT 20 MG/0.2ML | 6627001500F809 | Brand |
| HUMIRA | ADALIMUMAB PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001500F820 | Brand |
| HUMIRA | ADALIMUMAB PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001500F830 | Brand |
| HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK | ADALIMUMAB PREFILLED SYRINGE KIT 80 MG/0.8ML | 6627001500F840 | Brand |
| HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK | ADALIMUMAB PREFILLED SYRINGE KIT 80 MG/0.8ML & 40 MG/0.4ML | 6627001500F880 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 40 MG/0.8ML | 6627001510D520 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 20 MG/0.4ML | 6627001510E510 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 40 MG/0.8ML | 6627001510E520 | Brand |
| IDACIO STARTER PACKAGE FOR CROHNS DISEASE | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| IDACIO STARTER PACKAGE FOR PLAQUE PSORIASIS | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| ADALIMUMAB-FKJP | ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001535F520 | Brand |
| HULIO | ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001535F520 | Brand |
| ADALIMUMAB-FKJP | ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001535F810 | Brand |
| HULIO | ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001535F810 | Brand |
| ADALIMUMAB-FKJP | ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001535F820 | Brand |
| HULIO | ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001535F820 | Brand |
| CYLTEZO STARTER PACKAGE FOR PSORIASIS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |

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|---|---|---|---|
| CYLTEZO | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 10 MG/0.2ML | 6627001505F805 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001505F810 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001505F820 | Brand |
| YUSIMRY | ADALIMUMAB-AQVH SOLN PEN-INJECTOR 40 MG/0.8ML | 6627001509D520 | Brand |
| HADLIMA PUSHTOUCH | ADALIMUMAB-BWWD SOLN AUTO-INJECTOR 40 MG/0.4ML | 6627001520D510 | Brand |
| HADLIMA PUSHTOUCH | ADALIMUMAB-BWWD SOLN AUTO-INJECTOR 40 MG/0.8ML | 6627001520D520 | Brand |
| HADLIMA | ADALIMUMAB-BWWD SOLN PREFILLED SYRINGE 40 MG/0.4ML | 6627001520E510 | Brand |
| HADLIMA | ADALIMUMAB-BWWD SOLN PREFILLED SYRINGE 40 MG/0.8ML | 6627001520E520 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.4ML | 6627001504D515 | Brand |
| ADALIMUMAB-ADAZ | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.4ML | 6627001504D515 | Brand |
| HYRIMOZ CROHN'S DISEASE AND ULCERATIVE COLITIS STARTER PACK | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML | 6627001504D540 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML | 6627001504D540 | Brand |
| HYRIMOZ PLAQUE PSORIASIS STARTER PACK | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML & 40 MG/0.4ML | 6627001504D560 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 10 MG/0.1ML | 6627001504E508 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 20 MG/0.2ML | 6627001504E513 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.4ML | 6627001504E515 | Brand |
| ADALIMUMAB-ADAZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.4ML | 6627001504E515 | Brand |
| HYRIMOZ PEDIATRIC CROHNS DISEASE STARTER PACK | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 80 MG/0.8ML | 6627001504E540 | Brand |

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|---|---|---|---|
| HYRIMOZ PEDIATRIC CROHN'SDISEASE STARTER PACK | ADALIMUMAB-ADAZ SOLN PREFILLED SYR 80 MG/0.8ML & 40 MG/0.4ML | 6627001504E560 | Brand |
| ABRILADA | ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001507F520 | Brand |
| ABRILADA | ADALIMUMAB-AFZB PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001507F810 | Brand |
| ABRILADA | ADALIMUMAB-AFZB PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001507F820 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| ADALIMUMAB-ADBM CROHNS/UC/HS STARTER | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| ADALIMUMAB-ADBM PSORIASIS/UVEITIS STARTER | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 10 MG/0.2ML | 6627001505F805 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001505F810 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001505F820 | Brand |
| YUFLYMA 2-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001503F530 | Brand |
| YUFLYMA 1-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001503F530 | Brand |
| YUFLYMA 2-SYRINGE KIT | ADALIMUMAB-AATY PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001503F830 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 10 MG/0.2ML | 6627001510E505 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.8ML | 6627001504D520 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.8ML | 6627001504E520 | Brand |
| SIMLANDI 1-PEN KIT | ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001540F520 | Brand |
| SIMLANDI 2-PEN KIT | ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001540F520 | Brand |
| HYRIMOZ SENSOREADY PENS | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML | 6627001504D540 | Brand |
| IDACIO (2 PEN) | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| ADALIMUMAB-AACF (2 PEN) | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |

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|---|---|---|---|
| IDACIO (2 SYRINGE) | ADALIMUMAB-AACF PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001502F840 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 40 MG/0.4ML | 6627001510D517 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 80 MG/0.8ML | 6627001510D537 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 20 MG/0.2ML | 6627001510E508 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 40 MG/0.4ML | 6627001510E517 | Brand |
| YUFLYMA 1-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 80 MG/0.8ML | 6627001503F560 | Brand |
| YUFLYMA 2-SYRINGE KIT | ADALIMUMAB-AATY PREFILLED SYRINGE KIT 20 MG/0.2ML | 6627001503F820 | Brand |
| ADALIMUMAB-RYVK (2 PEN) | ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001540F520 | Brand |
| ADALIMUMAB-AATY 1-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001503F530 | Brand |
| ADALIMUMAB-AATY 2-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001503F530 | Brand |
| ADALIMUMAB-AATY 1-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 80 MG/0.8ML | 6627001503F560 | Brand |
| ADALIMUMAB-AATY 2-SYRINGE KIT | ADALIMUMAB-AATY PREFILLED SYRINGE KIT 20 MG/0.2ML | 6627001503F820 | Brand |
| ADALIMUMAB-AATY 2-SYRINGE KIT | ADALIMUMAB-AATY PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001503F830 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| ADALIMUMAB-ADBM STARTER PACKAGE FOR CROHNS DISEASE/UC/HS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| ADALIMUMAB-ADBM STARTER PACKAGE FOR PSORIASIS/UVEITIS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| CYLTEZO STARTER PACKAGE FOR PSORIASIS/UVEITIS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001505F815 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001505F815 | Brand |

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|---|---|---|---|
| ADALIMUMAB-RYVK | ADALIMUMAB-RYVK PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001540F820 | Brand |
| ABRILADA 1-PEN KIT | ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001507F520 | Brand |
| ABRILADA 2-PEN KIT | ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001507F520 | Brand |
| ADALIMUMAB-AACF STARTER PACK/CD/UC/HS (6 PEN) | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| ADALIMUMAB-AACF STARTER PACK/PSORIASIS/UVEITIS (4 PEN) | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| HYRIMOZ PLAQUE PSORIASIS/UVEITIS STARTER PACK | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML & 40 MG/0.4ML | 6627001504D560 | Brand |
| ADALIMUMAB-AACF (2 SYRINGE) | ADALIMUMAB-AACF PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001502F840 | Brand |

**Approval Criteria**

**1** - Diagnosis of active psoriatic arthritis

**AND**

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

**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:

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

**OR**

**4.2.2** History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

**OR**

**4.2.3** Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of psoriatic arthritis as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), Simponi (golimumab), Stelara (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)*

| | |
|---|---|
| Notes | *If approving a non-preferred adalimumab, please enter<br>1) The group authorization CSPREFADAL (for NY EPP and NY use: CSNYADAL)<br>2) An authorization for the non-preferred adalimumab at GPI-12 level<br><br>For a list of preferred adalimumab products please reference drug cov erage tools. |

| 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| HUMIRA PEN-PS/UV STARTER | ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML | 6627001500F520 | Brand |
| HUMIRA PEN | ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML | 6627001500F520 | Brand |
| HUMIRA PEN-CD/UC/HS STARTER | ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML | 6627001500F520 | Brand |
| HUMIRA PEN | ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.4ML | 6627001500F530 | Brand |
| HUMIRA PEN-PEDIATRIC UC STARTER PACK | ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML | 6627001500F540 | Brand |
| HUMIRA PEN | ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML | 6627001500F540 | Brand |
| HUMIRA PEN-CD/UC/HS STARTER | ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML | 6627001500F540 | Brand |
| HUMIRA PEN-PS/UV STARTER | ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML & 40 MG/0.4ML | 6627001500F550 | Brand |
| HUMIRA | ADALIMUMAB PREFILLED SYRINGE KIT 10 MG/0.1ML | 6627001500F804 | Brand |
| HUMIRA | ADALIMUMAB PREFILLED SYRINGE KIT 20 MG/0.2ML | 6627001500F809 | Brand |
| HUMIRA | ADALIMUMAB PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001500F820 | Brand |
| HUMIRA | ADALIMUMAB PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001500F830 | Brand |
| HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK | ADALIMUMAB PREFILLED SYRINGE KIT 80 MG/0.8ML | 6627001500F840 | Brand |
| HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK | ADALIMUMAB PREFILLED SYRINGE KIT 80 MG/0.8ML & 40 MG/0.4ML | 6627001500F880 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 40 MG/0.8ML | 6627001510D520 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 20 MG/0.4ML | 6627001510E510 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 40 MG/0.8ML | 6627001510E520 | Brand |

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| IDACIO STARTER PACKAGE FOR CROHNS DISEASE | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| IDACIO STARTER PACKAGE FOR PLAQUE PSORIASIS | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| ADALIMUMAB-FKJP | ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001535F520 | Brand |
| HULIO | ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001535F520 | Brand |
| ADALIMUMAB-FKJP | ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001535F810 | Brand |
| HULIO | ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001535F810 | Brand |
| ADALIMUMAB-FKJP | ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001535F820 | Brand |
| HULIO | ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001535F820 | Brand |
| CYLTEZO STARTER PACKAGE FOR PSORIASIS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 10 MG/0.2ML | 6627001505F805 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001505F810 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001505F820 | Brand |
| YUSIMRY | ADALIMUMAB-AQVH SOLN PEN-INJECTOR 40 MG/0.8ML | 6627001509D520 | Brand |
| HADLIMA PUSHTOUCH | ADALIMUMAB-BWWD SOLN AUTO-INJECTOR 40 MG/0.4ML | 6627001520D510 | Brand |
| HADLIMA PUSHTOUCH | ADALIMUMAB-BWWD SOLN AUTO-INJECTOR 40 MG/0.8ML | 6627001520D520 | Brand |
| HADLIMA | ADALIMUMAB-BWWD SOLN PREFILLED SYRINGE 40 MG/0.4ML | 6627001520E510 | Brand |
| HADLIMA | ADALIMUMAB-BWWD SOLN PREFILLED SYRINGE 40 MG/0.8ML | 6627001520E520 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.4ML | 6627001504D515 | Brand |
| ADALIMUMAB-ADAZ | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.4ML | 6627001504D515 | Brand |

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|---|---|---|---|
| HYRIMOZ CROHN'S DISEASE AND ULCERATIVE COLITIS STARTER PACK | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML | 6627001504D540 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML | 6627001504D540 | Brand |
| HYRIMOZ PLAQUE PSORIASIS STARTER PACK | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML & 40 MG/0.4ML | 6627001504D560 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 10 MG/0.1ML | 6627001504E508 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 20 MG/0.2ML | 6627001504E513 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.4ML | 6627001504E515 | Brand |
| ADALIMUMAB-ADAZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.4ML | 6627001504E515 | Brand |
| HYRIMOZ PEDIATRIC CROHNS DISEASE STARTER PACK | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 80 MG/0.8ML | 6627001504E540 | Brand |
| HYRIMOZ PEDIATRIC CROHN'SDISEASE STARTER PACK | ADALIMUMAB-ADAZ SOLN PREFILLED SYR 80 MG/0.8ML & 40 MG/0.4ML | 6627001504E560 | Brand |
| ABRILADA | ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001507F520 | Brand |
| ABRILADA | ADALIMUMAB-AFZB PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001507F810 | Brand |
| ABRILADA | ADALIMUMAB-AFZB PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001507F820 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| ADALIMUMAB-ADBM CROHNS/UC/HS STARTER | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| ADALIMUMAB-ADBM PSORIASIS/UVEITIS STARTER | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 10 MG/0.2ML | 6627001505F805 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001505F810 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001505F820 | Brand |
| YUFLYMA 2-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001503F530 | Brand |
| YUFLYMA 1-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001503F530 | Brand |

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|---|---|---|---|
| YUFLYMA 2-SYRINGE KIT | ADALIMUMAB-AATY PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001503F830 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 10 MG/0.2ML | 6627001510E505 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.8ML | 6627001504D520 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.8ML | 6627001504E520 | Brand |
| SIMLANDI 1-PEN KIT | ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001540F520 | Brand |
| SIMLANDI 2-PEN KIT | ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001540F520 | Brand |
| HYRIMOZ SENSOREADY PENS | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML | 6627001504D540 | Brand |
| IDACIO (2 PEN) | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| ADALIMUMAB-AACF (2 PEN) | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| IDACIO (2 SYRINGE) | ADALIMUMAB-AACF PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001502F840 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 40 MG/0.4ML | 6627001510D517 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 80 MG/0.8ML | 6627001510D537 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 20 MG/0.2ML | 6627001510E508 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 40 MG/0.4ML | 6627001510E517 | Brand |
| YUFLYMA 1-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 80 MG/0.8ML | 6627001503F560 | Brand |
| YUFLYMA 2-SYRINGE KIT | ADALIMUMAB-AATY PREFILLED SYRINGE KIT 20 MG/0.2ML | 6627001503F820 | Brand |
| ADALIMUMAB-RYVK (2 PEN) | ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001540F520 | Brand |
| ADALIMUMAB-AATY 1-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001503F530 | Brand |
| ADALIMUMAB-AATY 2-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001503F530 | Brand |
| ADALIMUMAB-AATY 1-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 80 MG/0.8ML | 6627001503F560 | Brand |
| ADALIMUMAB-AATY 2-SYRINGE KIT | ADALIMUMAB-AATY PREFILLED SYRINGE KIT 20 MG/0.2ML | 6627001503F820 | Brand |
| ADALIMUMAB-AATY 2-SYRINGE KIT | ADALIMUMAB-AATY PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001503F830 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |

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|---|---|---|---|
| ADALIMUMAB-ADBM STARTER PACKAGE FOR CROHNS DISEASE/UC/HS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| ADALIMUMAB-ADBM STARTER PACKAGE FOR PSORIASIS/UVEITIS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| CYLTEZO STARTER PACKAGE FOR PSORIASIS/UVEITIS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001505F815 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001505F815 | Brand |
| ADALIMUMAB-RYVK | ADALIMUMAB-RYVK PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001540F820 | Brand |
| ABRILADA 1-PEN KIT | ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001507F520 | Brand |
| ABRILADA 2-PEN KIT | ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001507F520 | Brand |
| ADALIMUMAB-AACF STARTER PACK/CD/UC/HS (6 PEN) | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| ADALIMUMAB-AACF STARTER PACK/PSORIASIS/UVEITIS (4 PEN) | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| HYRIMOZ PLAQUE PSORIASIS/UVEITIS STARTER PACK | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML & 40 MG/0.4ML | 6627001504D560 | Brand |
| ADALIMUMAB-AACF (2 SYRINGE) | ADALIMUMAB-AACF PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001502F840 | Brand |

**Approval Criteria**

**1** - Diagnosis of moderate to severe chronic plaque psoriasis

**AND**

**2** - Patient is not receiving adalimumab in combination with another targeted

immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), 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 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 biologic or targeted synthetic DMARD 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), Stelara (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)*

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

| | |
|---|---|
| | CSNYADAL)<br>2) An authorization for the non-preferred adalimumab at GPI-12 level<br><br>For a list of preferred adalimumab products please reference drug cov erage tools. |

| 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| HUMIRA PEN-PS/UV STARTER | ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML | 6627001500F520 | Brand |
| HUMIRA PEN | ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML | 6627001500F520 | Brand |
| HUMIRA PEN-CD/UC/HS STARTER | ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML | 6627001500F520 | Brand |
| HUMIRA PEN | ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.4ML | 6627001500F530 | Brand |
| HUMIRA PEN-PEDIATRIC UC STARTER PACK | ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML | 6627001500F540 | Brand |
| HUMIRA PEN | ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML | 6627001500F540 | Brand |
| HUMIRA PEN-CD/UC/HS STARTER | ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML | 6627001500F540 | Brand |
| HUMIRA PEN-PS/UV STARTER | ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML & 40 MG/0.4ML | 6627001500F550 | Brand |
| HUMIRA | ADALIMUMAB PREFILLED SYRINGE KIT 10 MG/0.1ML | 6627001500F804 | Brand |
| HUMIRA | ADALIMUMAB PREFILLED SYRINGE KIT 20 MG/0.2ML | 6627001500F809 | Brand |
| HUMIRA | ADALIMUMAB PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001500F820 | Brand |
| HUMIRA | ADALIMUMAB PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001500F830 | Brand |
| HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK | ADALIMUMAB PREFILLED SYRINGE KIT 80 MG/0.8ML | 6627001500F840 | Brand |
| HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK | ADALIMUMAB PREFILLED SYRINGE KIT 80 MG/0.8ML & 40 MG/0.4ML | 6627001500F880 | Brand |

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|---|---|---|---|
| AMJEVITA | ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 40 MG/0.8ML | 6627001510D520 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 20 MG/0.4ML | 6627001510E510 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 40 MG/0.8ML | 6627001510E520 | Brand |
| IDACIO STARTER PACKAGE FOR CROHNS DISEASE | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| IDACIO STARTER PACKAGE FOR PLAQUE PSORIASIS | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| ADALIMUMAB-FKJP | ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001535F520 | Brand |
| HULIO | ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001535F520 | Brand |
| ADALIMUMAB-FKJP | ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001535F810 | Brand |
| HULIO | ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001535F810 | Brand |
| ADALIMUMAB-FKJP | ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001535F820 | Brand |
| HULIO | ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001535F820 | Brand |
| CYLTEZO STARTER PACKAGE FOR PSORIASIS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 10 MG/0.2ML | 6627001505F805 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001505F810 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001505F820 | Brand |
| YUSIMRY | ADALIMUMAB-AQVH SOLN PEN-INJECTOR 40 MG/0.8ML | 6627001509D520 | Brand |
| HADLIMA PUSHTOUCH | ADALIMUMAB-BWWD SOLN AUTO-INJECTOR 40 MG/0.4ML | 6627001520D510 | Brand |
| HADLIMA PUSHTOUCH | ADALIMUMAB-BWWD SOLN AUTO-INJECTOR 40 MG/0.8ML | 6627001520D520 | Brand |
| HADLIMA | ADALIMUMAB-BWWD SOLN PREFILLED SYRINGE 40 MG/0.4ML | 6627001520E510 | Brand |

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| HADLIMA | ADALIMUMAB-BWWD SOLN PREFILLED SYRINGE 40 MG/0.8ML | 6627001520E520 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.4ML | 6627001504D515 | Brand |
| ADALIMUMAB-ADAZ | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.4ML | 6627001504D515 | Brand |
| HYRIMOZ CROHN'S DISEASE AND ULCERATIVE COLITIS STARTER PACK | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML | 6627001504D540 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML | 6627001504D540 | Brand |
| HYRIMOZ PLAQUE PSORIASIS STARTER PACK | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML & 40 MG/0.4ML | 6627001504D560 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 10 MG/0.1ML | 6627001504E508 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 20 MG/0.2ML | 6627001504E513 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.4ML | 6627001504E515 | Brand |
| ADALIMUMAB-ADAZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.4ML | 6627001504E515 | Brand |
| HYRIMOZ PEDIATRIC CROHNS DISEASE STARTER PACK | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 80 MG/0.8ML | 6627001504E540 | Brand |
| HYRIMOZ PEDIATRIC CROHN'SDISEASE STARTER PACK | ADALIMUMAB-ADAZ SOLN PREFILLED SYR 80 MG/0.8ML & 40 MG/0.4ML | 6627001504E560 | Brand |
| ABRILADA | ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001507F520 | Brand |
| ABRILADA | ADALIMUMAB-AFZB PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001507F810 | Brand |
| ABRILADA | ADALIMUMAB-AFZB PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001507F820 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| ADALIMUMAB-ADBM CROHNS/UC/HS STARTER | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| ADALIMUMAB-ADBM PSORIASIS/UVEITIS STARTER | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 10 MG/0.2ML | 6627001505F805 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001505F810 | Brand |

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| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001505F820 | Brand |
| YUFLYMA 2-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001503F530 | Brand |
| YUFLYMA 1-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001503F530 | Brand |
| YUFLYMA 2-SYRINGE KIT | ADALIMUMAB-AATY PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001503F830 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 10 MG/0.2ML | 6627001510E505 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.8ML | 6627001504D520 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.8ML | 6627001504E520 | Brand |
| SIMLANDI 1-PEN KIT | ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001540F520 | Brand |
| SIMLANDI 2-PEN KIT | ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001540F520 | Brand |
| HYRIMOZ SENSOREADY PENS | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML | 6627001504D540 | Brand |
| IDACIO (2 PEN) | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| ADALIMUMAB-AACF (2 PEN) | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| IDACIO (2 SYRINGE) | ADALIMUMAB-AACF PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001502F840 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 40 MG/0.4ML | 6627001510D517 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 80 MG/0.8ML | 6627001510D537 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 20 MG/0.2ML | 6627001510E508 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 40 MG/0.4ML | 6627001510E517 | Brand |
| YUFLYMA 1-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 80 MG/0.8ML | 6627001503F560 | Brand |
| YUFLYMA 2-SYRINGE KIT | ADALIMUMAB-AATY PREFILLED SYRINGE KIT 20 MG/0.2ML | 6627001503F820 | Brand |
| ADALIMUMAB-RYVK (2 PEN) | ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001540F520 | Brand |
| ADALIMUMAB-AATY 1-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001503F530 | Brand |
| ADALIMUMAB-AATY 2-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001503F530 | Brand |
| ADALIMUMAB-AATY 1-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 80 MG/0.8ML | 6627001503F560 | Brand |

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|---|---|---|---|
| ADALIMUMAB-AATY 2-SYRINGE KIT | ADALIMUMAB-AATY PREFILLED SYRINGE KIT 20 MG/0.2ML | 6627001503F820 | Brand |
| ADALIMUMAB-AATY 2-SYRINGE KIT | ADALIMUMAB-AATY PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001503F830 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| ADALIMUMAB-ADBM STARTER PACKAGE FOR CROHNS DISEASE/UC/HS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| ADALIMUMAB-ADBM STARTER PACKAGE FOR PSORIASIS/UVEITIS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| CYLTEZO STARTER PACKAGE FOR PSORIASIS/UVEITIS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001505F815 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001505F815 | Brand |
| ADALIMUMAB-RYVK | ADALIMUMAB-RYVK PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001540F820 | Brand |
| ABRILADA 1-PEN KIT | ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001507F520 | Brand |
| ABRILADA 2-PEN KIT | ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001507F520 | Brand |
| ADALIMUMAB-AACF STARTER PACK/CD/UC/HS (6 PEN) | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| ADALIMUMAB-AACF STARTER PACK/PSORIASIS/UVEITIS (4 PEN) | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| HYRIMOZ PLAQUE PSORIASIS/UVEITIS STARTER PACK | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML & 40 MG/0.4ML | 6627001504D560 | Brand |
| ADALIMUMAB-AACF (2 SYRINGE) | ADALIMUMAB-AACF PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001502F840 | Brand |

**Approval Criteria**

**1** - Diagnosis of active ankylosing spondylitis

**AND**

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

**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 biologic or targeted synthetic DMARD 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)]

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|---|---|
| **AND**<br><br>**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)* | |
| Notes | *If approving a non-preferred adalimumab, please enter<br>1) The group authorization CSPREFADAL (for NY EPP and NY use: CSNYADAL)<br>2) An authorization for the non-preferred adalimumab at GPI-12 level<br><br>For a list of preferred adalimumab products please reference drug cov erage tools. |

| 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| HUMIRA PEN-PS/UV STARTER | ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML | 6627001500F520 | Brand |
| HUMIRA PEN | ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML | 6627001500F520 | Brand |
| HUMIRA PEN-CD/UC/HS STARTER | ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML | 6627001500F520 | Brand |
| HUMIRA PEN | ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.4ML | 6627001500F530 | Brand |
| HUMIRA PEN-PEDIATRIC UC STARTER PACK | ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML | 6627001500F540 | Brand |
| HUMIRA PEN | ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML | 6627001500F540 | Brand |
| HUMIRA PEN-CD/UC/HS STARTER | ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML | 6627001500F540 | Brand |
| HUMIRA PEN-PS/UV STARTER | ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML & 40 MG/0.4ML | 6627001500F550 | Brand |
| HUMIRA | ADALIMUMAB PREFILLED SYRINGE KIT 10 MG/0.1ML | 6627001500F804 | Brand |
| HUMIRA | ADALIMUMAB PREFILLED SYRINGE KIT 20 MG/0.2ML | 6627001500F809 | Brand |

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|---|---|---|---|
| HUMIRA | ADALIMUMAB PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001500F820 | Brand |
| HUMIRA | ADALIMUMAB PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001500F830 | Brand |
| HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK | ADALIMUMAB PREFILLED SYRINGE KIT 80 MG/0.8ML | 6627001500F840 | Brand |
| HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK | ADALIMUMAB PREFILLED SYRINGE KIT 80 MG/0.8ML & 40 MG/0.4ML | 6627001500F880 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 40 MG/0.8ML | 6627001510D520 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 20 MG/0.4ML | 6627001510E510 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 40 MG/0.8ML | 6627001510E520 | Brand |
| IDACIO STARTER PACKAGE FOR CROHNS DISEASE | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| IDACIO STARTER PACKAGE FOR PLAQUE PSORIASIS | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| ADALIMUMAB-FKJP | ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001535F520 | Brand |
| HULIO | ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001535F520 | Brand |
| ADALIMUMAB-FKJP | ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001535F810 | Brand |
| HULIO | ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001535F810 | Brand |
| ADALIMUMAB-FKJP | ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001535F820 | Brand |
| HULIO | ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001535F820 | Brand |
| CYLTEZO STARTER PACKAGE FOR PSORIASIS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 10 MG/0.2ML | 6627001505F805 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001505F810 | Brand |

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|---|---|---|---|
| CYLTEZO | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001505F820 | Brand |
| YUSIMRY | ADALIMUMAB-AQVH SOLN PEN-INJECTOR 40 MG/0.8ML | 6627001509D520 | Brand |
| HADLIMA PUSHTOUCH | ADALIMUMAB-BWWD SOLN AUTO-INJECTOR 40 MG/0.4ML | 6627001520D510 | Brand |
| HADLIMA PUSHTOUCH | ADALIMUMAB-BWWD SOLN AUTO-INJECTOR 40 MG/0.8ML | 6627001520D520 | Brand |
| HADLIMA | ADALIMUMAB-BWWD SOLN PREFILLED SYRINGE 40 MG/0.4ML | 6627001520E510 | Brand |
| HADLIMA | ADALIMUMAB-BWWD SOLN PREFILLED SYRINGE 40 MG/0.8ML | 6627001520E520 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.4ML | 6627001504D515 | Brand |
| ADALIMUMAB-ADAZ | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.4ML | 6627001504D515 | Brand |
| HYRIMOZ CROHN'S DISEASE AND ULCERATIVE COLITIS STARTER PACK | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML | 6627001504D540 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML | 6627001504D540 | Brand |
| HYRIMOZ PLAQUE PSORIASIS STARTER PACK | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML & 40 MG/0.4ML | 6627001504D560 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 10 MG/0.1ML | 6627001504E508 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 20 MG/0.2ML | 6627001504E513 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.4ML | 6627001504E515 | Brand |
| ADALIMUMAB-ADAZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.4ML | 6627001504E515 | Brand |
| HYRIMOZ PEDIATRIC CROHNS DISEASE STARTER PACK | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 80 MG/0.8ML | 6627001504E540 | Brand |
| HYRIMOZ PEDIATRIC CROHN'SDISEASE STARTER PACK | ADALIMUMAB-ADAZ SOLN PREFILLED SYR 80 MG/0.8ML & 40 MG/0.4ML | 6627001504E560 | Brand |
| ABRILADA | ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001507F520 | Brand |
| ABRILADA | ADALIMUMAB-AFZB PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001507F810 | Brand |
| ABRILADA | ADALIMUMAB-AFZB PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001507F820 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |

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|---|---|---|---|
| ADALIMUMAB-ADBM CROHNS/UC/HS STARTER | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| ADALIMUMAB-ADBM PSORIASIS/UVEITIS STARTER | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 10 MG/0.2ML | 6627001505F805 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001505F810 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001505F820 | Brand |
| YUFLYMA 2-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001503F530 | Brand |
| YUFLYMA 1-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001503F530 | Brand |
| YUFLYMA 2-SYRINGE KIT | ADALIMUMAB-AATY PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001503F830 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 10 MG/0.2ML | 6627001510E505 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.8ML | 6627001504D520 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.8ML | 6627001504E520 | Brand |
| SIMLANDI 1-PEN KIT | ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001540F520 | Brand |
| SIMLANDI 2-PEN KIT | ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001540F520 | Brand |
| HYRIMOZ SENSOREADY PENS | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML | 6627001504D540 | Brand |
| IDACIO (2 PEN) | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| ADALIMUMAB-AACF (2 PEN) | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| IDACIO (2 SYRINGE) | ADALIMUMAB-AACF PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001502F840 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 40 MG/0.4ML | 6627001510D517 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 80 MG/0.8ML | 6627001510D537 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 20 MG/0.2ML | 6627001510E508 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 40 MG/0.4ML | 6627001510E517 | Brand |
| YUFLYMA 1-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 80 MG/0.8ML | 6627001503F560 | Brand |

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|---|---|---|---|
| YUFLYMA 2-SYRINGE KIT | ADALIMUMAB-AATY PREFILLED SYRINGE KIT 20 MG/0.2ML | 6627001503F820 | Brand |
| ADALIMUMAB-RYVK (2 PEN) | ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001540F520 | Brand |
| ADALIMUMAB-AATY 1-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001503F530 | Brand |
| ADALIMUMAB-AATY 2-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001503F530 | Brand |
| ADALIMUMAB-AATY 1-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 80 MG/0.8ML | 6627001503F560 | Brand |
| ADALIMUMAB-AATY 2-SYRINGE KIT | ADALIMUMAB-AATY PREFILLED SYRINGE KIT 20 MG/0.2ML | 6627001503F820 | Brand |
| ADALIMUMAB-AATY 2-SYRINGE KIT | ADALIMUMAB-AATY PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001503F830 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| ADALIMUMAB-ADBM STARTER PACKAGE FOR CROHNS DISEASE/UC/HS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| ADALIMUMAB-ADBM STARTER PACKAGE FOR PSORIASIS/UVEITIS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| CYLTEZO STARTER PACKAGE FOR PSORIASIS/UVEITIS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001505F815 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001505F815 | Brand |
| ADALIMUMAB-RYVK | ADALIMUMAB-RYVK PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001540F820 | Brand |
| ABRILADA 1-PEN KIT | ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001507F520 | Brand |
| ABRILADA 2-PEN KIT | ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001507F520 | Brand |
| ADALIMUMAB-AACF STARTER PACK/CD/UC/HS (6 PEN) | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| ADALIMUMAB-AACF STARTER PACK/PSORIASIS/UVEITIS (4 PEN) | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |

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|---|---|---|---|
| HYRIMOZ PLAQUE PSORIASIS/UVEITIS STARTER PACK | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML & 40 MG/0.4ML | 6627001504D560 | Brand |
| ADALIMUMAB-AACF (2 SYRINGE) | ADALIMUMAB-AACF PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001502F840 | Brand |

**Approval Criteria**

**1** - Diagnosis of moderately to severely active Crohn's disease

**AND**

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

**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 biologic or targeted synthetic DMARD FDA-approved for the treatment of Crohn's disease as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), Stelara (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)*

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|---|---|
| Notes | *If approving a non-preferred adalimumab, please enter<br>1) The group authorization CSPREFADAL (for NY EPP and NY use: CSNYADAL)<br>2) An authorization for the non-preferred adalimumab at GPI-12 level<br><br>For a list of preferred adalimumab products please reference drug cov erage tools. |

| 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

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|---|---|---|---|
| HUMIRA PEN-PS/UV STARTER | ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML | 6627001500F520 | Brand |
| HUMIRA PEN | ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML | 6627001500F520 | Brand |
| HUMIRA PEN-CD/UC/HS STARTER | ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML | 6627001500F520 | Brand |
| HUMIRA PEN | ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.4ML | 6627001500F530 | Brand |
| HUMIRA PEN-PEDIATRIC UC STARTER PACK | ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML | 6627001500F540 | Brand |
| HUMIRA PEN | ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML | 6627001500F540 | Brand |
| HUMIRA PEN-CD/UC/HS STARTER | ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML | 6627001500F540 | Brand |
| HUMIRA PEN-PS/UV STARTER | ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML & 40 MG/0.4ML | 6627001500F550 | Brand |
| HUMIRA | ADALIMUMAB PREFILLED SYRINGE KIT 10 MG/0.1ML | 6627001500F804 | Brand |
| HUMIRA | ADALIMUMAB PREFILLED SYRINGE KIT 20 MG/0.2ML | 6627001500F809 | Brand |
| HUMIRA | ADALIMUMAB PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001500F820 | Brand |
| HUMIRA | ADALIMUMAB PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001500F830 | Brand |
| HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK | ADALIMUMAB PREFILLED SYRINGE KIT 80 MG/0.8ML | 6627001500F840 | Brand |
| HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK | ADALIMUMAB PREFILLED SYRINGE KIT 80 MG/0.8ML & 40 MG/0.4ML | 6627001500F880 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 40 MG/0.8ML | 6627001510D520 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 20 MG/0.4ML | 6627001510E510 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 40 MG/0.8ML | 6627001510E520 | Brand |
| IDACIO STARTER PACKAGE FOR CROHNS DISEASE | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| IDACIO STARTER PACKAGE FOR PLAQUE PSORIASIS | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| ADALIMUMAB-FKJP | ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001535F520 | Brand |
| HULIO | ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001535F520 | Brand |

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|---|---|---|---|
| ADALIMUMAB-FKJP | ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001535F810 | Brand |
| HULIO | ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001535F810 | Brand |
| ADALIMUMAB-FKJP | ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001535F820 | Brand |
| HULIO | ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001535F820 | Brand |
| CYLTEZO STARTER PACKAGE FOR PSORIASIS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 10 MG/0.2ML | 6627001505F805 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001505F810 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001505F820 | Brand |
| YUSIMRY | ADALIMUMAB-AQVH SOLN PEN-INJECTOR 40 MG/0.8ML | 6627001509D520 | Brand |
| HADLIMA PUSHTOUCH | ADALIMUMAB-BWWD SOLN AUTO-INJECTOR 40 MG/0.4ML | 6627001520D510 | Brand |
| HADLIMA PUSHTOUCH | ADALIMUMAB-BWWD SOLN AUTO-INJECTOR 40 MG/0.8ML | 6627001520D520 | Brand |
| HADLIMA | ADALIMUMAB-BWWD SOLN PREFILLED SYRINGE 40 MG/0.4ML | 6627001520E510 | Brand |
| HADLIMA | ADALIMUMAB-BWWD SOLN PREFILLED SYRINGE 40 MG/0.8ML | 6627001520E520 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.4ML | 6627001504D515 | Brand |
| ADALIMUMAB-ADAZ | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.4ML | 6627001504D515 | Brand |
| HYRIMOZ CROHN'S DISEASE AND ULCERATIVE COLITIS STARTER PACK | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML | 6627001504D540 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML | 6627001504D540 | Brand |
| HYRIMOZ PLAQUE PSORIASIS STARTER PACK | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML & 40 MG/0.4ML | 6627001504D560 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 10 MG/0.1ML | 6627001504E508 | Brand |

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| HYRIMOZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 20 MG/0.2ML | 6627001504E513 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.4ML | 6627001504E515 | Brand |
| ADALIMUMAB-ADAZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.4ML | 6627001504E515 | Brand |
| HYRIMOZ PEDIATRIC CROHNS DISEASE STARTER PACK | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 80 MG/0.8ML | 6627001504E540 | Brand |
| HYRIMOZ PEDIATRIC CROHN'SDISEASE STARTER PACK | ADALIMUMAB-ADAZ SOLN PREFILLED SYR 80 MG/0.8ML & 40 MG/0.4ML | 6627001504E560 | Brand |
| ABRILADA | ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001507F520 | Brand |
| ABRILADA | ADALIMUMAB-AFZB PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001507F810 | Brand |
| ABRILADA | ADALIMUMAB-AFZB PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001507F820 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| ADALIMUMAB-ADBM CROHNS/UC/HS STARTER | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| ADALIMUMAB-ADBM PSORIASIS/UVEITIS STARTER | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 10 MG/0.2ML | 6627001505F805 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001505F810 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001505F820 | Brand |
| YUFLYMA 2-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001503F530 | Brand |
| YUFLYMA 1-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001503F530 | Brand |
| YUFLYMA 2-SYRINGE KIT | ADALIMUMAB-AATY PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001503F830 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 10 MG/0.2ML | 6627001510E505 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.8ML | 6627001504D520 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.8ML | 6627001504E520 | Brand |
| SIMLANDI 1-PEN KIT | ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001540F520 | Brand |

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| SIMLANDI 2-PEN KIT | ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001540F520 | Brand |
| HYRIMOZ SENSOREADY PENS | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML | 6627001504D540 | Brand |
| IDACIO (2 PEN) | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| ADALIMUMAB-AACF (2 PEN) | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| IDACIO (2 SYRINGE) | ADALIMUMAB-AACF PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001502F840 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 40 MG/0.4ML | 6627001510D517 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 80 MG/0.8ML | 6627001510D537 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 20 MG/0.2ML | 6627001510E508 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 40 MG/0.4ML | 6627001510E517 | Brand |
| YUFLYMA 1-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 80 MG/0.8ML | 6627001503F560 | Brand |
| YUFLYMA 2-SYRINGE KIT | ADALIMUMAB-AATY PREFILLED SYRINGE KIT 20 MG/0.2ML | 6627001503F820 | Brand |
| ADALIMUMAB-RYVK (2 PEN) | ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001540F520 | Brand |
| ADALIMUMAB-AATY 1-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001503F530 | Brand |
| ADALIMUMAB-AATY 2-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001503F530 | Brand |
| ADALIMUMAB-AATY 1-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 80 MG/0.8ML | 6627001503F560 | Brand |
| ADALIMUMAB-AATY 2-SYRINGE KIT | ADALIMUMAB-AATY PREFILLED SYRINGE KIT 20 MG/0.2ML | 6627001503F820 | Brand |
| ADALIMUMAB-AATY 2-SYRINGE KIT | ADALIMUMAB-AATY PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001503F830 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| ADALIMUMAB-ADBM STARTER PACKAGE FOR CROHNS DISEASE/UC/HS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| ADALIMUMAB-ADBM STARTER PACKAGE FOR PSORIASIS/UVEITIS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |

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| CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| CYLTEZO STARTER PACKAGE FOR PSORIASIS/UVEITIS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001505F815 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001505F815 | Brand |
| ADALIMUMAB-RYVK | ADALIMUMAB-RYVK PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001540F820 | Brand |
| ABRILADA 1-PEN KIT | ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001507F520 | Brand |
| ABRILADA 2-PEN KIT | ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001507F520 | Brand |
| ADALIMUMAB-AACF STARTER PACK/CD/UC/HS (6 PEN) | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| ADALIMUMAB-AACF STARTER PACK/PSORIASIS/UVEITIS (4 PEN) | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| HYRIMOZ PLAQUE PSORIASIS/UVEITIS STARTER PACK | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML & 40 MG/0.4ML | 6627001504D560 | Brand |
| ADALIMUMAB-AACF (2 SYRINGE) | ADALIMUMAB-AACF PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001502F840 | Brand |

**Approval Criteria**

**1** - Diagnosis of moderately to severely active ulcerative colitis

**AND**

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

**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 and/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 biologic or targeted synthetic DMARD FDA-approved for the treatment of ulcerative colitis as confirmed by claims history or submission medical records [e.g., Simponi (golimumab), Stelara (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)*

| Notes | *If approving a non-preferred adalimumab, please enter<br>1) The group authorization CSPREFADAL (for NY EPP and NY use: CSNYADAL)<br>2) An authorization for the non-preferred adalimumab at GPI-12 level<br><br>For a list of preferred adalimumab products please reference drug cov erage tools. |
|---|---|

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

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| HUMIRA PEN-PS/UV STARTER | ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML | 6627001500F520 | Brand |
| HUMIRA PEN | ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML | 6627001500F520 | Brand |
| HUMIRA PEN-CD/UC/HS STARTER | ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML | 6627001500F520 | Brand |
| HUMIRA PEN | ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.4ML | 6627001500F530 | Brand |
| HUMIRA PEN-PEDIATRIC UC STARTER PACK | ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML | 6627001500F540 | Brand |
| HUMIRA PEN | ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML | 6627001500F540 | Brand |
| HUMIRA PEN-CD/UC/HS STARTER | ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML | 6627001500F540 | Brand |
| HUMIRA PEN-PS/UV STARTER | ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML & 40 MG/0.4ML | 6627001500F550 | Brand |
| HUMIRA | ADALIMUMAB PREFILLED SYRINGE KIT 10 MG/0.1ML | 6627001500F804 | Brand |
| HUMIRA | ADALIMUMAB PREFILLED SYRINGE KIT 20 MG/0.2ML | 6627001500F809 | Brand |
| HUMIRA | ADALIMUMAB PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001500F820 | Brand |
| HUMIRA | ADALIMUMAB PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001500F830 | Brand |
| HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK | ADALIMUMAB PREFILLED SYRINGE KIT 80 MG/0.8ML | 6627001500F840 | Brand |
| HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK | ADALIMUMAB PREFILLED SYRINGE KIT 80 MG/0.8ML & 40 MG/0.4ML | 6627001500F880 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 40 MG/0.8ML | 6627001510D520 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 20 MG/0.4ML | 6627001510E510 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 40 MG/0.8ML | 6627001510E520 | Brand |
| IDACIO STARTER PACKAGE FOR CROHNS DISEASE | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |

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| IDACIO STARTER PACKAGE FOR PLAQUE PSORIASIS | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| ADALIMUMAB-FKJP | ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001535F520 | Brand |
| HULIO | ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001535F520 | Brand |
| ADALIMUMAB-FKJP | ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001535F810 | Brand |
| HULIO | ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001535F810 | Brand |
| ADALIMUMAB-FKJP | ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001535F820 | Brand |
| HULIO | ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001535F820 | Brand |
| CYLTEZO STARTER PACKAGE FOR PSORIASIS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 10 MG/0.2ML | 6627001505F805 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001505F810 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001505F820 | Brand |
| YUSIMRY | ADALIMUMAB-AQVH SOLN PEN-INJECTOR 40 MG/0.8ML | 6627001509D520 | Brand |
| HADLIMA PUSHTOUCH | ADALIMUMAB-BWWD SOLN AUTO-INJECTOR 40 MG/0.4ML | 6627001520D510 | Brand |
| HADLIMA PUSHTOUCH | ADALIMUMAB-BWWD SOLN AUTO-INJECTOR 40 MG/0.8ML | 6627001520D520 | Brand |
| HADLIMA | ADALIMUMAB-BWWD SOLN PREFILLED SYRINGE 40 MG/0.4ML | 6627001520E510 | Brand |
| HADLIMA | ADALIMUMAB-BWWD SOLN PREFILLED SYRINGE 40 MG/0.8ML | 6627001520E520 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.4ML | 6627001504D515 | Brand |
| ADALIMUMAB-ADAZ | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.4ML | 6627001504D515 | Brand |
| HYRIMOZ CROHN'S DISEASE AND ULCERATIVE COLITIS STARTER PACK | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML | 6627001504D540 | Brand |

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| HYRIMOZ | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML | 6627001504D540 | Brand |
| HYRIMOZ PLAQUE PSORIASIS STARTER PACK | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML & 40 MG/0.4ML | 6627001504D560 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 10 MG/0.1ML | 6627001504E508 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 20 MG/0.2ML | 6627001504E513 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.4ML | 6627001504E515 | Brand |
| ADALIMUMAB-ADAZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.4ML | 6627001504E515 | Brand |
| HYRIMOZ PEDIATRIC CROHNS DISEASE STARTER PACK | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 80 MG/0.8ML | 6627001504E540 | Brand |
| HYRIMOZ PEDIATRIC CROHN'SDISEASE STARTER PACK | ADALIMUMAB-ADAZ SOLN PREFILLED SYR 80 MG/0.8ML & 40 MG/0.4ML | 6627001504E560 | Brand |
| ABRILADA | ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001507F520 | Brand |
| ABRILADA | ADALIMUMAB-AFZB PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001507F810 | Brand |
| ABRILADA | ADALIMUMAB-AFZB PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001507F820 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| ADALIMUMAB-ADBM CROHNS/UC/HS STARTER | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| ADALIMUMAB-ADBM PSORIASIS/UVEITIS STARTER | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 10 MG/0.2ML | 6627001505F805 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001505F810 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001505F820 | Brand |
| YUFLYMA 2-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001503F530 | Brand |
| YUFLYMA 1-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001503F530 | Brand |
| YUFLYMA 2-SYRINGE KIT | ADALIMUMAB-AATY PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001503F830 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 10 MG/0.2ML | 6627001510E505 | Brand |

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| HYRIMOZ | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.8ML | 6627001504D520 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.8ML | 6627001504E520 | Brand |
| SIMLANDI 1-PEN KIT | ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001540F520 | Brand |
| SIMLANDI 2-PEN KIT | ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001540F520 | Brand |
| HYRIMOZ SENSOREADY PENS | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML | 6627001504D540 | Brand |
| IDACIO (2 PEN) | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| ADALIMUMAB-AACF (2 PEN) | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| IDACIO (2 SYRINGE) | ADALIMUMAB-AACF PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001502F840 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 40 MG/0.4ML | 6627001510D517 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 80 MG/0.8ML | 6627001510D537 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 20 MG/0.2ML | 6627001510E508 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 40 MG/0.4ML | 6627001510E517 | Brand |
| YUFLYMA 1-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 80 MG/0.8ML | 6627001503F560 | Brand |
| YUFLYMA 2-SYRINGE KIT | ADALIMUMAB-AATY PREFILLED SYRINGE KIT 20 MG/0.2ML | 6627001503F820 | Brand |
| ADALIMUMAB-RYVK (2 PEN) | ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001540F520 | Brand |
| ADALIMUMAB-AATY 1-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001503F530 | Brand |
| ADALIMUMAB-AATY 2-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001503F530 | Brand |
| ADALIMUMAB-AATY 1-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 80 MG/0.8ML | 6627001503F560 | Brand |
| ADALIMUMAB-AATY 2-SYRINGE KIT | ADALIMUMAB-AATY PREFILLED SYRINGE KIT 20 MG/0.2ML | 6627001503F820 | Brand |
| ADALIMUMAB-AATY 2-SYRINGE KIT | ADALIMUMAB-AATY PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001503F830 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| ADALIMUMAB-ADBM STARTER PACKAGE FOR CROHNS DISEASE/UC/HS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |

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| ADALIMUMAB-ADBM STARTER PACKAGE FOR PSORIASIS/UVEITIS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| CYLTEZO STARTER PACKAGE FOR PSORIASIS/UVEITIS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001505F815 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001505F815 | Brand |
| ADALIMUMAB-RYVK | ADALIMUMAB-RYVK PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001540F820 | Brand |
| ABRILADA 1-PEN KIT | ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001507F520 | Brand |
| ABRILADA 2-PEN KIT | ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001507F520 | Brand |
| ADALIMUMAB-AACF STARTER PACK/CD/UC/HS (6 PEN) | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| ADALIMUMAB-AACF STARTER PACK/PSORIASIS/UVEITIS (4 PEN) | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| HYRIMOZ PLAQUE PSORIASIS/UVEITIS STARTER PACK | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML & 40 MG/0.4ML | 6627001504D560 | Brand |
| ADALIMUMAB-AACF (2 SYRINGE) | ADALIMUMAB-AACF PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001502F840 | Brand |

**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 targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

**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)

**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)*

| | |
|---|---|
| Notes | *If approving a non-preferred adalimumab, please enter<br>1) The group authorization CSPREFADAL (for NY EPP and NY use: CSNYADAL)<br>2) An authorization for the non-preferred adalimumab at GPI-12 level<br><br>For a list of preferred adalimumab products please reference drug cov erage tools. |

| 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| HUMIRA PEN-PS/UV STARTER | ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML | 6627001500F520 | Brand |
| HUMIRA PEN | ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML | 6627001500F520 | Brand |
| HUMIRA PEN-CD/UC/HS STARTER | ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML | 6627001500F520 | Brand |
| HUMIRA PEN | ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.4ML | 6627001500F530 | Brand |
| HUMIRA PEN-PEDIATRIC UC STARTER PACK | ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML | 6627001500F540 | Brand |
| HUMIRA PEN | ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML | 6627001500F540 | Brand |
| HUMIRA PEN-CD/UC/HS STARTER | ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML | 6627001500F540 | Brand |
| HUMIRA PEN-PS/UV STARTER | ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML & 40 MG/0.4ML | 6627001500F550 | Brand |
| HUMIRA | ADALIMUMAB PREFILLED SYRINGE KIT 10 MG/0.1ML | 6627001500F804 | Brand |
| HUMIRA | ADALIMUMAB PREFILLED SYRINGE KIT 20 MG/0.2ML | 6627001500F809 | Brand |
| HUMIRA | ADALIMUMAB PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001500F820 | Brand |
| HUMIRA | ADALIMUMAB PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001500F830 | Brand |
| HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK | ADALIMUMAB PREFILLED SYRINGE KIT 80 MG/0.8ML | 6627001500F840 | Brand |
| HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK | ADALIMUMAB PREFILLED SYRINGE KIT 80 MG/0.8ML & 40 MG/0.4ML | 6627001500F880 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 40 MG/0.8ML | 6627001510D520 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 20 MG/0.4ML | 6627001510E510 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 40 MG/0.8ML | 6627001510E520 | Brand |

| | | | |
|---|---|---|---|
| IDACIO STARTER PACKAGE FOR CROHNS DISEASE | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| IDACIO STARTER PACKAGE FOR PLAQUE PSORIASIS | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| ADALIMUMAB-FKJP | ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001535F520 | Brand |
| HULIO | ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001535F520 | Brand |
| ADALIMUMAB-FKJP | ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001535F810 | Brand |
| HULIO | ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001535F810 | Brand |
| ADALIMUMAB-FKJP | ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001535F820 | Brand |
| HULIO | ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001535F820 | Brand |
| CYLTEZO STARTER PACKAGE FOR PSORIASIS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 10 MG/0.2ML | 6627001505F805 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001505F810 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001505F820 | Brand |
| YUSIMRY | ADALIMUMAB-AQVH SOLN PEN-INJECTOR 40 MG/0.8ML | 6627001509D520 | Brand |
| HADLIMA PUSHTOUCH | ADALIMUMAB-BWWD SOLN AUTO-INJECTOR 40 MG/0.4ML | 6627001520D510 | Brand |
| HADLIMA PUSHTOUCH | ADALIMUMAB-BWWD SOLN AUTO-INJECTOR 40 MG/0.8ML | 6627001520D520 | Brand |
| HADLIMA | ADALIMUMAB-BWWD SOLN PREFILLED SYRINGE 40 MG/0.4ML | 6627001520E510 | Brand |
| HADLIMA | ADALIMUMAB-BWWD SOLN PREFILLED SYRINGE 40 MG/0.8ML | 6627001520E520 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.4ML | 6627001504D515 | Brand |
| ADALIMUMAB-ADAZ | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.4ML | 6627001504D515 | Brand |

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|---|---|---|---|
| HYRIMOZ CROHN'S DISEASE AND ULCERATIVE COLITIS STARTER PACK | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML | 6627001504D540 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML | 6627001504D540 | Brand |
| HYRIMOZ PLAQUE PSORIASIS STARTER PACK | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML & 40 MG/0.4ML | 6627001504D560 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 10 MG/0.1ML | 6627001504E508 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 20 MG/0.2ML | 6627001504E513 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.4ML | 6627001504E515 | Brand |
| ADALIMUMAB-ADAZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.4ML | 6627001504E515 | Brand |
| HYRIMOZ PEDIATRIC CROHNS DISEASE STARTER PACK | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 80 MG/0.8ML | 6627001504E540 | Brand |
| HYRIMOZ PEDIATRIC CROHN'SDISEASE STARTER PACK | ADALIMUMAB-ADAZ SOLN PREFILLED SYR 80 MG/0.8ML & 40 MG/0.4ML | 6627001504E560 | Brand |
| ABRILADA | ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001507F520 | Brand |
| ABRILADA | ADALIMUMAB-AFZB PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001507F810 | Brand |
| ABRILADA | ADALIMUMAB-AFZB PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001507F820 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| ADALIMUMAB-ADBM CROHNS/UC/HS STARTER | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| ADALIMUMAB-ADBM PSORIASIS/UVEITIS STARTER | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 10 MG/0.2ML | 6627001505F805 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001505F810 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001505F820 | Brand |
| YUFLYMA 2-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001503F530 | Brand |
| YUFLYMA 1-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001503F530 | Brand |

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|---|---|---|---|
| YUFLYMA 2-SYRINGE KIT | ADALIMUMAB-AATY PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001503F830 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 10 MG/0.2ML | 6627001510E505 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.8ML | 6627001504D520 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.8ML | 6627001504E520 | Brand |
| SIMLANDI 1-PEN KIT | ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001540F520 | Brand |
| SIMLANDI 2-PEN KIT | ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001540F520 | Brand |
| HYRIMOZ SENSOREADY PENS | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML | 6627001504D540 | Brand |
| IDACIO (2 PEN) | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| ADALIMUMAB-AACF (2 PEN) | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| IDACIO (2 SYRINGE) | ADALIMUMAB-AACF PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001502F840 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 40 MG/0.4ML | 6627001510D517 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 80 MG/0.8ML | 6627001510D537 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 20 MG/0.2ML | 6627001510E508 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 40 MG/0.4ML | 6627001510E517 | Brand |
| YUFLYMA 1-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 80 MG/0.8ML | 6627001503F560 | Brand |
| YUFLYMA 2-SYRINGE KIT | ADALIMUMAB-AATY PREFILLED SYRINGE KIT 20 MG/0.2ML | 6627001503F820 | Brand |
| ADALIMUMAB-RYVK (2 PEN) | ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001540F520 | Brand |
| ADALIMUMAB-AATY 1-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001503F530 | Brand |
| ADALIMUMAB-AATY 2-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001503F530 | Brand |
| ADALIMUMAB-AATY 1-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 80 MG/0.8ML | 6627001503F560 | Brand |
| ADALIMUMAB-AATY 2-SYRINGE KIT | ADALIMUMAB-AATY PREFILLED SYRINGE KIT 20 MG/0.2ML | 6627001503F820 | Brand |
| ADALIMUMAB-AATY 2-SYRINGE KIT | ADALIMUMAB-AATY PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001503F830 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |

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|---|---|---|---|
| ADALIMUMAB-ADBM STARTER PACKAGE FOR CROHNS DISEASE/UC/HS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| ADALIMUMAB-ADBM STARTER PACKAGE FOR PSORIASIS/UVEITIS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| CYLTEZO STARTER PACKAGE FOR PSORIASIS/UVEITIS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001505F815 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001505F815 | Brand |
| ADALIMUMAB-RYVK | ADALIMUMAB-RYVK PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001540F820 | Brand |
| ABRILADA 1-PEN KIT | ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001507F520 | Brand |
| ABRILADA 2-PEN KIT | ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001507F520 | Brand |
| ADALIMUMAB-AACF STARTER PACK/CD/UC/HS (6 PEN) | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| ADALIMUMAB-AACF STARTER PACK/PSORIASIS/UVEITIS (4 PEN) | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| HYRIMOZ PLAQUE PSORIASIS/UVEITIS STARTER PACK | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML & 40 MG/0.4ML | 6627001504D560 | Brand |
| ADALIMUMAB-AACF (2 SYRINGE) | ADALIMUMAB-AACF PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001502F840 | Brand |

**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 targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

**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)*

| | |
|---|---|
| Notes | *If approving a non-preferred adalimumab, please enter<br>1) The group authorization CSPREFADAL (for NY EPP and NY use: CSNYADAL)<br>2) An authorization for the non-preferred adalimumab at GPI-12 level<br><br>For a list of preferred adalimumab products please reference drug cov erage tools. |

| Product Name: Humira, Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi, Yuflyma, Yusimry, Adalimumab (all products) | |
|---|---|
| Diagnosis | RA, PJIA, PsA, Plaque Psoriasis, AS, CD, Ulcerative Colitis, HS, UV |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| HUMIRA PEN-PS/UV STARTER | ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML | 6627001500F520 | Brand |

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|---|---|---|---|
| HUMIRA PEN | ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML | 6627001500F520 | Brand |
| HUMIRA PEN-CD/UC/HS STARTER | ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML | 6627001500F520 | Brand |
| HUMIRA PEN | ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.4ML | 6627001500F530 | Brand |
| HUMIRA PEN-PEDIATRIC UC STARTER PACK | ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML | 6627001500F540 | Brand |
| HUMIRA PEN | ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML | 6627001500F540 | Brand |
| HUMIRA PEN-CD/UC/HS STARTER | ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML | 6627001500F540 | Brand |
| HUMIRA PEN-PS/UV STARTER | ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML & 40 MG/0.4ML | 6627001500F550 | Brand |
| HUMIRA | ADALIMUMAB PREFILLED SYRINGE KIT 10 MG/0.1ML | 6627001500F804 | Brand |
| HUMIRA | ADALIMUMAB PREFILLED SYRINGE KIT 20 MG/0.2ML | 6627001500F809 | Brand |
| HUMIRA | ADALIMUMAB PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001500F820 | Brand |
| HUMIRA | ADALIMUMAB PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001500F830 | Brand |
| HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK | ADALIMUMAB PREFILLED SYRINGE KIT 80 MG/0.8ML | 6627001500F840 | Brand |
| HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK | ADALIMUMAB PREFILLED SYRINGE KIT 80 MG/0.8ML & 40 MG/0.4ML | 6627001500F880 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 40 MG/0.8ML | 6627001510D520 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 20 MG/0.4ML | 6627001510E510 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 40 MG/0.8ML | 6627001510E520 | Brand |
| IDACIO STARTER PACKAGE FOR CROHNS DISEASE | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| IDACIO STARTER PACKAGE FOR PLAQUE PSORIASIS | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| ADALIMUMAB-FKJP | ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001535F520 | Brand |
| HULIO | ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001535F520 | Brand |
| ADALIMUMAB-FKJP | ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001535F810 | Brand |

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|---|---|---|---|
| HULIO | ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001535F810 | Brand |
| ADALIMUMAB-FKJP | ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001535F820 | Brand |
| HULIO | ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001535F820 | Brand |
| CYLTEZO STARTER PACKAGE FOR PSORIASIS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 10 MG/0.2ML | 6627001505F805 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001505F810 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001505F820 | Brand |
| YUSIMRY | ADALIMUMAB-AQVH SOLN PEN-INJECTOR 40 MG/0.8ML | 6627001509D520 | Brand |
| HADLIMA PUSHTOUCH | ADALIMUMAB-BWWD SOLN AUTO-INJECTOR 40 MG/0.4ML | 6627001520D510 | Brand |
| HADLIMA PUSHTOUCH | ADALIMUMAB-BWWD SOLN AUTO-INJECTOR 40 MG/0.8ML | 6627001520D520 | Brand |
| HADLIMA | ADALIMUMAB-BWWD SOLN PREFILLED SYRINGE 40 MG/0.4ML | 6627001520E510 | Brand |
| HADLIMA | ADALIMUMAB-BWWD SOLN PREFILLED SYRINGE 40 MG/0.8ML | 6627001520E520 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.4ML | 6627001504D515 | Brand |
| ADALIMUMAB-ADAZ | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.4ML | 6627001504D515 | Brand |
| HYRIMOZ CROHN'S DISEASE AND ULCERATIVE COLITIS STARTER PACK | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML | 6627001504D540 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML | 6627001504D540 | Brand |
| HYRIMOZ PLAQUE PSORIASIS STARTER PACK | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML & 40 MG/0.4ML | 6627001504D560 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 10 MG/0.1ML | 6627001504E508 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 20 MG/0.2ML | 6627001504E513 | Brand |

| | | | |
|---|---|---|---|
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.4ML | 6627001504E515 | Brand |
| ADALIMUMAB-ADAZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.4ML | 6627001504E515 | Brand |
| HYRIMOZ PEDIATRIC CROHNS DISEASE STARTER PACK | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 80 MG/0.8ML | 6627001504E540 | Brand |
| HYRIMOZ PEDIATRIC CROHN'SDISEASE STARTER PACK | ADALIMUMAB-ADAZ SOLN PREFILLED SYR 80 MG/0.8ML & 40 MG/0.4ML | 6627001504E560 | Brand |
| ABRILADA | ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001507F520 | Brand |
| ABRILADA | ADALIMUMAB-AFZB PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001507F810 | Brand |
| ABRILADA | ADALIMUMAB-AFZB PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001507F820 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| ADALIMUMAB-ADBM CROHNS/UC/HS STARTER | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| ADALIMUMAB-ADBM PSORIASIS/UVEITIS STARTER | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 10 MG/0.2ML | 6627001505F805 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001505F810 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001505F820 | Brand |
| YUFLYMA 2-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001503F530 | Brand |
| YUFLYMA 1-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001503F530 | Brand |
| YUFLYMA 2-SYRINGE KIT | ADALIMUMAB-AATY PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001503F830 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 10 MG/0.2ML | 6627001510E505 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.8ML | 6627001504D520 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.8ML | 6627001504E520 | Brand |
| SIMLANDI 1-PEN KIT | ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001540F520 | Brand |
| SIMLANDI 2-PEN KIT | ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001540F520 | Brand |

| | | | |
|---|---|---|---|
| HYRIMOZ SENSOREADY PENS | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML | 6627001504D540 | Brand |
| IDACIO (2 PEN) | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| ADALIMUMAB-AACF (2 PEN) | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| IDACIO (2 SYRINGE) | ADALIMUMAB-AACF PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001502F840 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 40 MG/0.4ML | 6627001510D517 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 80 MG/0.8ML | 6627001510D537 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 20 MG/0.2ML | 6627001510E508 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 40 MG/0.4ML | 6627001510E517 | Brand |
| YUFLYMA 1-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 80 MG/0.8ML | 6627001503F560 | Brand |
| YUFLYMA 2-SYRINGE KIT | ADALIMUMAB-AATY PREFILLED SYRINGE KIT 20 MG/0.2ML | 6627001503F820 | Brand |
| ADALIMUMAB-RYVK (2 PEN) | ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001540F520 | Brand |
| ADALIMUMAB-AATY 1-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001503F530 | Brand |
| ADALIMUMAB-AATY 2-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001503F530 | Brand |
| ADALIMUMAB-AATY 1-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 80 MG/0.8ML | 6627001503F560 | Brand |
| ADALIMUMAB-AATY 2-SYRINGE KIT | ADALIMUMAB-AATY PREFILLED SYRINGE KIT 20 MG/0.2ML | 6627001503F820 | Brand |
| ADALIMUMAB-AATY 2-SYRINGE KIT | ADALIMUMAB-AATY PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001503F830 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| ADALIMUMAB-ADBM STARTER PACKAGE FOR CROHNS DISEASE/UC/HS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| ADALIMUMAB-ADBM STARTER PACKAGE FOR PSORIASIS/UVEITIS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |

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|---|---|---|---|
| CYLTEZO STARTER PACKAGE FOR PSORIASIS/UVEITIS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001505F815 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001505F815 | Brand |
| ADALIMUMAB-RYVK | ADALIMUMAB-RYVK PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001540F820 | Brand |
| ABRILADA 1-PEN KIT | ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001507F520 | Brand |
| ABRILADA 2-PEN KIT | ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001507F520 | Brand |
| ADALIMUMAB-AACF STARTER PACK/CD/UC/HS (6 PEN) | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| ADALIMUMAB-AACF STARTER PACK/PSORIASIS/UVEITIS (4 PEN) | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| HYRIMOZ PLAQUE PSORIASIS/UVEITIS STARTER PACK | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML & 40 MG/0.4ML | 6627001504D560 | Brand |
| ADALIMUMAB-AACF (2 SYRINGE) | ADALIMUMAB-AACF PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001502F840 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Adalimumab therapy

**AND**

**2** - Patient is not receiving adalimumab in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Stelara (ustekinumab), 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 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)* | |
|---|---|
| Notes | *If approving a non-preferred adalimumab, please enter<br>1) The group authorization CSPREFADAL (for NY EPP and NY use: CSNYADAL)<br>2) An authorization for the non-preferred adalimumab at GPI-12 level<br><br>For a list of preferred adalimumab products please reference drug coverage tools.<br>^ Examples of drug(s) may not be applicable based on the requested indication. |

## 2 . Background

| Benefit/Coverage/Program Information |
|---|
| **PDL link**<br><br>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 |
|---|---|
| 9/23/2024 | Updated RA and PJIA to require step through of Tyenne for nonpreferred agents. Added additional targeted immunomodulator examples to reauth. Added PDL link |

Adbry

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-161236 |
| **Guideline Name** | Adbry |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 12/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ADBRY | TRALOKINUMAB-LDRM SUBCUTANEOUS SOLN PREFILLED SYR 150 MG/ML | 9027308045E520 | Brand |
| ADBRY | TRALOKINUMAB-LDRM SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML | 9027308045D530 | Brand |

**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** - ONE of the following:

**3.1** Failure to Dupixent confirmed by claims history or submission of medical records

**OR**

**3.2** History of intolerance or contraindication to Dupixent (please specify intolerance or contraindication)

**OR**

**3.3** Patient is currently on Adbry therapy as confirmed by claims history or submission of medical records

**AND**

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

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

**AND**

**5** - Prescribed by ONE of the following:

- Dermatologist
- Allergist
- Immunologist

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ADBRY | TRALOKINUMAB-LDRM SUBCUTANEOUS SOLN PREFILLED SYR 150 MG/ML | 9027308045E520 | Brand |
| ADBRY | TRALOKINUMAB-LDRM SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML | 9027308045D530 | Brand |

**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)]
- Janus kinas inhibitor [e.g., Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib), Opzelura (topical ruxolitinib), Cibinqo (abrocitinib)]

**AND**

**3** - Prescribed by 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 |
| 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 |

ADHD Products

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-148172 |
| **Guideline Name** | ADHD Products |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ADDERALL | AMPHETAMINE-DEXTROAMPHETAMINE TAB 5 MG | 61109902100305 | Brand |
| AMPHETAMINE/DEXTROAMPHETAMINE | AMPHETAMINE-DEXTROAMPHETAMINE TAB 5 MG | 61109902100305 | Generic |
| ADDERALL | AMPHETAMINE-DEXTROAMPHETAMINE TAB 7.5 MG | 61109902100307 | Brand |
| AMPHETAMINE/DEXTROAMPHETAMINE | AMPHETAMINE-DEXTROAMPHETAMINE TAB 7.5 MG | 61109902100307 | Generic |
| ADDERALL | AMPHETAMINE-DEXTROAMPHETAMINE TAB 10 MG | 61109902100310 | Brand |
| AMPHETAMINE/DEXTROAMPHETAMINE | AMPHETAMINE-DEXTROAMPHETAMINE TAB 10 MG | 61109902100310 | Generic |
| ADDERALL | AMPHETAMINE-DEXTROAMPHETAMINE TAB 12.5 MG | 61109902100312 | Brand |
| AMPHETAMINE/DEXTROAMPHETAMINE | AMPHETAMINE-DEXTROAMPHETAMINE TAB 12.5 MG | 61109902100312 | Generic |
| ADDERALL | AMPHETAMINE-DEXTROAMPHETAMINE TAB 15 MG | 61109902100315 | Brand |
| AMPHETAMINE/DEXTROAMPHETAMINE | AMPHETAMINE-DEXTROAMPHETAMINE TAB 15 MG | 61109902100315 | Generic |
| ADDERALL | AMPHETAMINE-DEXTROAMPHETAMINE TAB 20 MG | 61109902100320 | Brand |
| AMPHETAMINE/DEXTROAMPHETAMINE | AMPHETAMINE-DEXTROAMPHETAMINE TAB 20 MG | 61109902100320 | Generic |
| ADDERALL | AMPHETAMINE-DEXTROAMPHETAMINE TAB 30 MG | 61109902100330 | Brand |
| AMPHETAMINE/DEXTROAMPHETAMINE | AMPHETAMINE-DEXTROAMPHETAMINE TAB 30 MG | 61109902100330 | Generic |

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|---|---|---|---|
| ADDERALL XR | AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 5 MG | 61109902107005 | Brand |
| AMPHETAMINE/DEXTROAMPHETAMINE | AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 5 MG | 61109902107005 | Generic |
| ADDERALL XR | AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 10 MG | 61109902107010 | Brand |
| AMPHETAMINE/DEXTROAMPHETAMINE ER | AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 10 MG | 61109902107010 | Generic |
| AMPHETAMINE/DEXTROAMPHETAMINE | AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 10 MG | 61109902107010 | Generic |
| ADDERALL XR | AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 15 MG | 61109902107015 | Brand |
| AMPHETAMINE/DEXTROAMPHETAMINE | AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 15 MG | 61109902107015 | Generic |
| ADDERALL XR | AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 20 MG | 61109902107020 | Brand |
| AMPHETAMINE/DEXTROAMPHETAMINE ER | AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 20 MG | 61109902107020 | Generic |
| AMPHETAMINE/DEXTROAMPHETAMINE | AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 20 MG | 61109902107020 | Generic |
| ADDERALL XR | AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 25 MG | 61109902107025 | Brand |
| AMPHETAMINE/DEXTROAMPHETAMINE | AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 25 MG | 61109902107025 | Generic |
| ADDERALL XR | AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 30 MG | 61109902107030 | Brand |
| AMPHETAMINE/DEXTROAMPHETAMINE ER | AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 30 MG | 61109902107030 | Generic |
| AMPHETAMINE/DEXTROAMPHETAMINE | AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 30 MG | 61109902107030 | Generic |
| ADZENYS XR-ODT | AMPHETAMINE TAB EXTENDED RELEASE DISINTEGRATING 3.1 MG | 6110001000H410 | Brand |

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|---|---|---|---|
| ADZENYS XR-ODT | AMPHETAMINE TAB EXTENDED RELEASE DISINTEGRATING 6.3 MG | 6110001000H420 | Brand |
| ADZENYS XR-ODT | AMPHETAMINE TAB EXTENDED RELEASE DISINTEGRATING 9.4 MG | 6110001000H430 | Brand |
| ADZENYS XR-ODT | AMPHETAMINE TAB EXTENDED RELEASE DISINTEGRATING 12.5 MG | 6110001000H440 | Brand |
| ADZENYS XR-ODT | AMPHETAMINE TAB EXTENDED RELEASE DISINTEGRATING 15.7 MG | 6110001000H450 | Brand |
| ADZENYS XR-ODT | AMPHETAMINE TAB EXTENDED RELEASE DISINTEGRATING 18.8 MG | 6110001000H460 | Brand |
| APTENSIO XR | METHYLPHENIDATE HCL CAP ER 24HR 10 MG (XR) | 61400020107055 | Brand |
| METHYLPHENIDATE HYDROCHLORIDE ER | METHYLPHENIDATE HCL CAP ER 24HR 10 MG (XR) | 61400020107055 | Generic |
| APTENSIO XR | METHYLPHENIDATE HCL CAP ER 24HR 15 MG (XR) | 61400020107060 | Brand |
| METHYLPHENIDATE HYDROCHLORIDE ER | METHYLPHENIDATE HCL CAP ER 24HR 15 MG (XR) | 61400020107060 | Generic |
| APTENSIO XR | METHYLPHENIDATE HCL CAP ER 24HR 20 MG (XR) | 61400020107065 | Brand |
| METHYLPHENIDATE HYDROCHLORIDE ER | METHYLPHENIDATE HCL CAP ER 24HR 20 MG (XR) | 61400020107065 | Generic |
| APTENSIO XR | METHYLPHENIDATE HCL CAP ER 24HR 30 MG (XR) | 61400020107070 | Brand |
| METHYLPHENIDATE HYDROCHLORIDE ER | METHYLPHENIDATE HCL CAP ER 24HR 30 MG (XR) | 61400020107070 | Generic |
| APTENSIO XR | METHYLPHENIDATE HCL CAP ER 24HR 40 MG (XR) | 61400020107075 | Brand |
| METHYLPHENIDATE HYDROCHLORIDE ER | METHYLPHENIDATE HCL CAP ER 24HR 40 MG (XR) | 61400020107075 | Generic |
| APTENSIO XR | METHYLPHENIDATE HCL CAP ER 24HR 50 MG (XR) | 61400020107080 | Brand |
| METHYLPHENIDATE HYDROCHLORIDE ER | METHYLPHENIDATE HCL CAP ER 24HR 50 MG (XR) | 61400020107080 | Generic |
| APTENSIO XR | METHYLPHENIDATE HCL CAP ER 24HR 60 MG (XR) | 61400020107085 | Brand |
| METHYLPHENIDATE HYDROCHLORIDE ER | METHYLPHENIDATE HCL CAP ER 24HR 60 MG (XR) | 61400020107085 | Generic |

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| AZSTARYS | SERDEXMETHYLPHENIDATE-DEXMETHYLPHENIDATE CAP 26.1-5.2 MG | 61409802800120 | Brand |
| AZSTARYS | SERDEXMETHYLPHENIDATE-DEXMETHYLPHENIDATE CAP 39.2-7.8 MG | 61409802800130 | Brand |
| AZSTARYS | SERDEXMETHYLPHENIDATE-DEXMETHYLPHENIDATE CAP 52.3-10.4 MG | 61409802800140 | Brand |
| CONCERTA | METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 18 MG | 61400020100460 | Brand |
| METHYLPHENIDATE HYDROCHLORIDE ER | METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 18 MG | 61400020100460 | Generic |
| CONCERTA | METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 27 MG | 61400020100465 | Brand |
| METHYLPHENIDATE HYDROCHLORIDE ER | METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 27 MG | 61400020100465 | Generic |
| CONCERTA | METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 36 MG | 61400020100470 | Brand |
| METHYLPHENIDATE HYDROCHLORIDE ER | METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 36 MG | 61400020100470 | Generic |
| CONCERTA | METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 54 MG | 61400020100480 | Brand |
| METHYLPHENIDATE HYDROCHLORIDE ER | METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 54 MG | 61400020100480 | Generic |
| COTEMPLA XR-ODT | METHYLPHENIDATE TAB EXTENDED RELEASE DISINTEGRATING 8.6 MG | 6140002000H410 | Brand |
| COTEMPLA XR-ODT | METHYLPHENIDATE TAB EXTENDED RELEASE DISINTEGRATING 17.3 MG | 6140002000H420 | Brand |
| COTEMPLA XR-ODT | METHYLPHENIDATE TAB EXTENDED RELEASE DISINTEGRATING 25.9 MG | 6140002000H430 | Brand |
| DAYTRANA | METHYLPHENIDATE TD PATCH 10 MG/9HR | 61400020005910 | Brand |
| METHYLPHENIDATE | METHYLPHENIDATE TD PATCH 10 MG/9HR | 61400020005910 | Generic |
| DAYTRANA | METHYLPHENIDATE TD PATCH 15 MG/9HR | 61400020005915 | Brand |

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| METHYLPHENIDATE | METHYLPHENIDATE TD PATCH 15 MG/9HR | 61400020005915 | Generic |
| DAYTRANA | METHYLPHENIDATE TD PATCH 20 MG/9HR | 61400020005920 | Brand |
| METHYLPHENIDATE | METHYLPHENIDATE TD PATCH 20 MG/9HR | 61400020005920 | Generic |
| DAYTRANA | METHYLPHENIDATE TD PATCH 30 MG/9HR | 61400020005930 | Brand |
| METHYLPHENIDATE | METHYLPHENIDATE TD PATCH 30 MG/9HR | 61400020005930 | Generic |
| DESOXYN | METHAMPHETAMINE HCL TAB 5 MG | 61100030100305 | Brand |
| METHAMPHETAMINE HCL | METHAMPHETAMINE HCL TAB 5 MG | 61100030100305 | Generic |
| DEXEDRINE | DEXTROAMPHETAMINE SULFATE CAP ER 24HR 10 MG | 61100020107010 | Brand |
| DEXTROAMPHETAMINE SULFATE ER | DEXTROAMPHETAMINE SULFATE CAP ER 24HR 10 MG | 61100020107010 | Generic |
| DYANAVEL XR | AMPHETAMINE EXTENDED RELEASE SUSP 2.5 MG/ML | 6110001000G120 | Brand |
| DYANAVEL XR | AMPHETAMINE CHEW TAB EXTENDED RELEASE 5 MG | 61100010000410 | Brand |
| DYANAVEL XR | AMPHETAMINE CHEW TAB EXTENDED RELEASE 10 MG | 61100010000420 | Brand |
| DYANAVEL XR | AMPHETAMINE CHEW TAB EXTENDED RELEASE 15 MG | 61100010000430 | Brand |
| DYANAVEL XR | AMPHETAMINE CHEW TAB EXTENDED RELEASE 20 MG | 61100010000440 | Brand |
| AMPHETAMINE SULFATE | AMPHETAMINE SULFATE TAB 5 MG | 61100010100310 | Generic |
| EVEKEO | AMPHETAMINE SULFATE TAB 5 MG | 61100010100310 | Brand |
| AMPHETAMINE SULFATE | AMPHETAMINE SULFATE TAB 10 MG | 61100010100320 | Generic |
| EVEKEO | AMPHETAMINE SULFATE TAB 10 MG | 61100010100320 | Brand |
| GUANFACINE ER | GUANFACINE HCL TAB ER 24HR 1 MG (BASE EQUIV) | 61353030107520 | Generic |

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| INTUNIV | GUANFACINE HCL TAB ER 24HR 1 MG (BASE EQUIV) | 61353030107520 | Brand |
| GUANFACINE HYDROCHLORIDE | GUANFACINE HCL TAB ER 24HR 1 MG (BASE EQUIV) | 61353030107520 | Generic |
| GUANFACINE HYDROCHLORIDE ER | GUANFACINE HCL TAB ER 24HR 1 MG (BASE EQUIV) | 61353030107520 | Generic |
| GUANFACINE ER | GUANFACINE HCL TAB ER 24HR 2 MG (BASE EQUIV) | 61353030107530 | Generic |
| INTUNIV | GUANFACINE HCL TAB ER 24HR 2 MG (BASE EQUIV) | 61353030107530 | Brand |
| GUANFACINE HYDROCHLORIDE | GUANFACINE HCL TAB ER 24HR 2 MG (BASE EQUIV) | 61353030107530 | Generic |
| GUANFACINE HYDROCHLORIDE ER | GUANFACINE HCL TAB ER 24HR 2 MG (BASE EQUIV) | 61353030107530 | Generic |
| GUANFACINE ER | GUANFACINE HCL TAB ER 24HR 3 MG (BASE EQUIV) | 61353030107540 | Generic |
| INTUNIV | GUANFACINE HCL TAB ER 24HR 3 MG (BASE EQUIV) | 61353030107540 | Brand |
| GUANFACINE HYDROCHLORIDE | GUANFACINE HCL TAB ER 24HR 3 MG (BASE EQUIV) | 61353030107540 | Generic |
| GUANFACINE HYDROCHLORIDE ER | GUANFACINE HCL TAB ER 24HR 3 MG (BASE EQUIV) | 61353030107540 | Generic |
| GUANFACINE ER | GUANFACINE HCL TAB ER 24HR 4 MG (BASE EQUIV) | 61353030107550 | Generic |
| INTUNIV | GUANFACINE HCL TAB ER 24HR 4 MG (BASE EQUIV) | 61353030107550 | Brand |
| GUANFACINE HYDROCHLORIDE | GUANFACINE HCL TAB ER 24HR 4 MG (BASE EQUIV) | 61353030107550 | Generic |
| GUANFACINE HYDROCHLORIDE ER | GUANFACINE HCL TAB ER 24HR 4 MG (BASE EQUIV) | 61353030107550 | Generic |
| JORNAY PM | METHYLPHENIDATE HCL CAP DELAYED ER 24HR 20 MG (PM) | 61400020107067 | Brand |
| JORNAY PM | METHYLPHENIDATE HCL CAP DELAYED ER 24HR 40 MG (PM) | 61400020107077 | Brand |
| JORNAY PM | METHYLPHENIDATE HCL CAP DELAYED ER 24HR 60 MG (PM) | 61400020107087 | Brand |
| JORNAY PM | METHYLPHENIDATE HCL CAP DELAYED ER 24HR 80 MG (PM) | 61400020107090 | Brand |

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| JORNAY PM | METHYLPHENIDATE HCL CAP DELAYED ER 24HR 100 MG (PM) | 61400020107094 | Brand |
| CLONIDINE HCL ER | CLONIDINE HCL TAB ER 12HR 0.1 MG | 61353020107420 | Generic |
| CLONIDINE HYDROCHLORIDE | CLONIDINE HCL TAB ER 12HR 0.1 MG | 61353020107420 | Generic |
| CLONIDINE HYDROCHLORIDE ER | CLONIDINE HCL TAB ER 12HR 0.1 MG | 61353020107420 | Generic |
| METHYLPHENIDATE HYDROCHLORIDE | METHYLPHENIDATE HCL SOLN 5 MG/5ML | 61400020102020 | Generic |
| METHYLIN | METHYLPHENIDATE HCL SOLN 5 MG/5ML | 61400020102020 | Brand |
| METHYLPHENIDATE HYDROCHLORIDE | METHYLPHENIDATE HCL SOLN 10 MG/5ML | 61400020102030 | Generic |
| METHYLIN | METHYLPHENIDATE HCL SOLN 10 MG/5ML | 61400020102030 | Brand |
| METHYLPHENIDATE HYDROCHLORIDE | METHYLPHENIDATE HCL CHEW TAB 2.5 MG | 61400020100510 | Generic |
| METHYLPHENIDATE HYDROCHLORIDE | METHYLPHENIDATE HCL CHEW TAB 5 MG | 61400020100520 | Generic |
| METHYLPHENIDATE HYDROCHLORIDE | METHYLPHENIDATE HCL CHEW TAB 10 MG | 61400020100530 | Generic |
| METHYLPHENIDATE HYDROCHLORIDE CD | METHYLPHENIDATE HCL CAP ER 10 MG (CD) | 61400020100210 | Generic |
| METHYLPHENIDATE HYDROCHLORIDE ER | METHYLPHENIDATE HCL CAP ER 10 MG (CD) | 61400020100210 | Generic |
| METADATE CD | METHYLPHENIDATE HCL CAP ER 10 MG (CD) | 61400020100210 | Brand |
| METHYLPHENIDATE HYDROCHLORIDE CD | METHYLPHENIDATE HCL CAP ER 20 MG (CD) | 61400020100220 | Generic |
| METHYLPHENIDATE HYDROCHLORIDE ER | METHYLPHENIDATE HCL CAP ER 20 MG (CD) | 61400020100220 | Generic |
| METADATE CD | METHYLPHENIDATE HCL CAP ER 20 MG (CD) | 61400020100220 | Brand |
| METHYLPHENIDATE HYDROCHLORIDE CD | METHYLPHENIDATE HCL CAP ER 30 MG (CD) | 61400020100230 | Generic |
| METHYLPHENIDATE HYDROCHLORIDE ER | METHYLPHENIDATE HCL CAP ER 30 MG (CD) | 61400020100230 | Generic |
| METADATE CD | METHYLPHENIDATE HCL CAP ER 30 MG (CD) | 61400020100230 | Brand |
| METHYLPHENIDATE HYDROCHLORIDE ER | METHYLPHENIDATE HCL CAP ER 40 MG (CD) | 61400020100240 | Generic |

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| METADATE CD | METHYLPHENIDATE HCL CAP ER 40 MG (CD) | 61400020100240 | Brand |
| METHYLPHENIDATE HYDROCHLORIDE CD | METHYLPHENIDATE HCL CAP ER 50 MG (CD) | 61400020100250 | Generic |
| METHYLPHENIDATE HYDROCHLORIDE ER | METHYLPHENIDATE HCL CAP ER 50 MG (CD) | 61400020100250 | Generic |
| METADATE CD | METHYLPHENIDATE HCL CAP ER 50 MG (CD) | 61400020100250 | Brand |
| METHYLPHENIDATE HYDROCHLORIDE CD | METHYLPHENIDATE HCL CAP ER 60 MG (CD) | 61400020100260 | Generic |
| METHYLPHENIDATE HYDROCHLORIDE ER | METHYLPHENIDATE HCL CAP ER 60 MG (CD) | 61400020100260 | Generic |
| METADATE CD | METHYLPHENIDATE HCL CAP ER 60 MG (CD) | 61400020100260 | Brand |
| MYDAYIS | AMPHETAMINE-DEXTROAMPHETAMINE 3-BEAD CAP ER 24HR 12.5 MG | 61109902107060 | Brand |
| AMPHETAMINE/DEXTROAMPHETAMINE ER | AMPHETAMINE-DEXTROAMPHETAMINE 3-BEAD CAP ER 24HR 12.5 MG | 61109902107060 | Generic |
| MYDAYIS | AMPHETAMINE-DEXTROAMPHETAMINE 3-BEAD CAP ER 24HR 25 MG | 61109902107065 | Brand |
| AMPHETAMINE/DEXTROAMPHETAMINE ER | AMPHETAMINE-DEXTROAMPHETAMINE 3-BEAD CAP ER 24HR 25 MG | 61109902107065 | Generic |
| MYDAYIS | AMPHETAMINE-DEXTROAMPHETAMINE 3-BEAD CAP ER 24HR 37.5 MG | 61109902107070 | Brand |
| AMPHETAMINE/DEXTROAMPHETAMINE ER | AMPHETAMINE-DEXTROAMPHETAMINE 3-BEAD CAP ER 24HR 37.5 MG | 61109902107070 | Generic |
| MYDAYIS | AMPHETAMINE-DEXTROAMPHETAMINE 3-BEAD CAP ER 24HR 50 MG | 61109902107075 | Brand |
| AMPHETAMINE/DEXTROAMPHETAMINE ER | AMPHETAMINE-DEXTROAMPHETAMINE 3-BEAD CAP ER 24HR 50 MG | 61109902107075 | Generic |
| DEXTROAMPHETAMINE SULFATE | DEXTROAMPHETAMINE SULFATE ORAL SOLUTION 5 MG/5ML | 61100020102020 | Generic |
| PROCENTRA | DEXTROAMPHETAMINE SULFATE ORAL SOLUTION 5 MG/5ML | 61100020102020 | Brand |

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| QELBREE | VILOXAZINE HCL CAP ER 24HR 100 MG | 61354080207020 | Brand |
| QELBREE | VILOXAZINE HCL CAP ER 24HR 150 MG | 61354080207030 | Brand |
| QELBREE | VILOXAZINE HCL CAP ER 24HR 200 MG | 61354080207040 | Brand |
| QUILLICHEW ER | METHYLPHENIDATE HCL CHEW TAB EXTENDED RELEASE 20 MG | 6140002010H220 | Brand |
| QUILLICHEW ER | METHYLPHENIDATE HCL CHEW TAB EXTENDED RELEASE 30 MG | 6140002010H230 | Brand |
| QUILLICHEW ER | METHYLPHENIDATE HCL CHEW TAB EXTENDED RELEASE 40 MG | 6140002010H240 | Brand |
| QUILLIVANT XR | METHYLPHENIDATE HCL FOR ER SUSP 25 MG/5ML (5 MG/ML) | 6140002010G220 | Brand |
| RELEXXII | METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 18 MG | 61400020100460 | Brand |
| RELEXXII | METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 27 MG | 61400020100465 | Brand |
| RELEXXII | METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 36 MG | 61400020100470 | Brand |
| RELEXXII | METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 45 MG | 61400020100475 | Generic |
| RELEXXII | METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 54 MG | 61400020100480 | Brand |
| RELEXXII | METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 63 MG | 61400020100485 | Generic |
| RELEXXII | METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 72 MG | 61400020100490 | Brand |
| METHYLPHENIDATE HYDROCHLORIDE | METHYLPHENIDATE HCL TAB 5 MG | 61400020100305 | Generic |
| RITALIN | METHYLPHENIDATE HCL TAB 5 MG | 61400020100305 | Brand |
| METHYLPHENIDATE HYDROCHLORIDE | METHYLPHENIDATE HCL TAB 10 MG | 61400020100310 | Generic |
| RITALIN | METHYLPHENIDATE HCL TAB 10 MG | 61400020100310 | Brand |

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| METHYLPHENIDATE HYDROCHLORIDE | METHYLPHENIDATE HCL TAB 20 MG | 61400020100315 | Generic |
| RITALIN | METHYLPHENIDATE HCL TAB 20 MG | 61400020100315 | Brand |
| RITALIN LA | METHYLPHENIDATE HCL CAP ER 24HR 10 MG (LA) | 61400020107010 | Brand |
| METHYLPHENIDATE HYDROCHLORIDE ER | METHYLPHENIDATE HCL CAP ER 24HR 10 MG (LA) | 61400020107010 | Generic |
| RITALIN LA | METHYLPHENIDATE HCL CAP ER 24HR 20 MG (LA) | 61400020107020 | Brand |
| METHYLPHENIDATE HYDROCHLORIDE ER | METHYLPHENIDATE HCL CAP ER 24HR 20 MG (LA) | 61400020107020 | Generic |
| RITALIN LA | METHYLPHENIDATE HCL CAP ER 24HR 30 MG (LA) | 61400020107030 | Brand |
| METHYLPHENIDATE HYDROCHLORIDE ER | METHYLPHENIDATE HCL CAP ER 24HR 30 MG (LA) | 61400020107030 | Generic |
| RITALIN LA | METHYLPHENIDATE HCL CAP ER 24HR 40 MG (LA) | 61400020107040 | Brand |
| METHYLPHENIDATE HYDROCHLORIDE ER | METHYLPHENIDATE HCL CAP ER 24HR 40 MG (LA) | 61400020107040 | Generic |
| ATOMOXETINE HYDROCHLORIDE | ATOMOXETINE HCL CAP 10 MG (BASE EQUIV) | 61354015100110 | Generic |
| ATOMOXETINE | ATOMOXETINE HCL CAP 10 MG (BASE EQUIV) | 61354015100110 | Generic |
| STRATTERA | ATOMOXETINE HCL CAP 10 MG (BASE EQUIV) | 61354015100110 | Brand |
| ATOMOXETINE HYDROCHLORIDE | ATOMOXETINE HCL CAP 18 MG (BASE EQUIV) | 61354015100118 | Generic |
| ATOMOXETINE | ATOMOXETINE HCL CAP 18 MG (BASE EQUIV) | 61354015100118 | Generic |
| STRATTERA | ATOMOXETINE HCL CAP 18 MG (BASE EQUIV) | 61354015100118 | Brand |
| ATOMOXETINE HYDROCHLORIDE | ATOMOXETINE HCL CAP 25 MG (BASE EQUIV) | 61354015100125 | Generic |
| ATOMOXETINE | ATOMOXETINE HCL CAP 25 MG (BASE EQUIV) | 61354015100125 | Generic |
| STRATTERA | ATOMOXETINE HCL CAP 25 MG (BASE EQUIV) | 61354015100125 | Brand |
| ATOMOXETINE HYDROCHLORIDE | ATOMOXETINE HCL CAP 40 MG (BASE EQUIV) | 61354015100140 | Generic |
| ATOMOXETINE | ATOMOXETINE HCL CAP 40 MG (BASE EQUIV) | 61354015100140 | Generic |

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| STRATTERA | ATOMOXETINE HCL CAP 40 MG (BASE EQUIV) | 61354015100140 | Brand |
| ATOMOXETINE HYDROCHLORIDE | ATOMOXETINE HCL CAP 60 MG (BASE EQUIV) | 61354015100160 | Generic |
| ATOMOXETINE | ATOMOXETINE HCL CAP 60 MG (BASE EQUIV) | 61354015100160 | Generic |
| STRATTERA | ATOMOXETINE HCL CAP 60 MG (BASE EQUIV) | 61354015100160 | Brand |
| ATOMOXETINE HYDROCHLORIDE | ATOMOXETINE HCL CAP 80 MG (BASE EQUIV) | 61354015100170 | Generic |
| ATOMOXETINE | ATOMOXETINE HCL CAP 80 MG (BASE EQUIV) | 61354015100170 | Generic |
| STRATTERA | ATOMOXETINE HCL CAP 80 MG (BASE EQUIV) | 61354015100170 | Brand |
| ATOMOXETINE HYDROCHLORIDE | ATOMOXETINE HCL CAP 100 MG (BASE EQUIV) | 61354015100180 | Generic |
| ATOMOXETINE | ATOMOXETINE HCL CAP 100 MG (BASE EQUIV) | 61354015100180 | Generic |
| STRATTERA | ATOMOXETINE HCL CAP 100 MG (BASE EQUIV) | 61354015100180 | Brand |
| LISDEXAMFETAMINE DIMESYLATE | LISDEXAMFETAMINE DIMESYLATE CAP 10 MG | 61100025100110 | Generic |
| VYVANSE | LISDEXAMFETAMINE DIMESYLATE CAP 10 MG | 61100025100110 | Brand |
| LISDEXAMFETAMINE DIMESYLATE | LISDEXAMFETAMINE DIMESYLATE CAP 20 MG | 61100025100120 | Generic |
| VYVANSE | LISDEXAMFETAMINE DIMESYLATE CAP 20 MG | 61100025100120 | Brand |
| LISDEXAMFETAMINE DIMESYLATE | LISDEXAMFETAMINE DIMESYLATE CAP 30 MG | 61100025100130 | Generic |
| VYVANSE | LISDEXAMFETAMINE DIMESYLATE CAP 30 MG | 61100025100130 | Brand |
| LISDEXAMFETAMINE DIMESYLATE | LISDEXAMFETAMINE DIMESYLATE CAP 40 MG | 61100025100140 | Generic |
| VYVANSE | LISDEXAMFETAMINE DIMESYLATE CAP 40 MG | 61100025100140 | Brand |
| LISDEXAMFETAMINE DIMESYLATE | LISDEXAMFETAMINE DIMESYLATE CAP 50 MG | 61100025100150 | Generic |
| VYVANSE | LISDEXAMFETAMINE DIMESYLATE CAP 50 MG | 61100025100150 | Brand |
| LISDEXAMFETAMINE DIMESYLATE | LISDEXAMFETAMINE DIMESYLATE CAP 60 MG | 61100025100160 | Generic |

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| VYVANSE | LISDEXAMFETAMINE DIMESYLATE CAP 60 MG | 61100025100160 | Brand |
| LISDEXAMFETAMINE DIMESYLATE | LISDEXAMFETAMINE DIMESYLATE CAP 70 MG | 61100025100170 | Generic |
| VYVANSE | LISDEXAMFETAMINE DIMESYLATE CAP 70 MG | 61100025100170 | Brand |
| LISDEXAMFETAMINE DIMESYLATE | LISDEXAMFETAMINE DIMESYLATE CHEW TAB 10 MG | 61100025100510 | Generic |
| VYVANSE | LISDEXAMFETAMINE DIMESYLATE CHEW TAB 10 MG | 61100025100510 | Brand |
| LISDEXAMFETAMINE DIMESYLATE | LISDEXAMFETAMINE DIMESYLATE CHEW TAB 20 MG | 61100025100520 | Generic |
| VYVANSE | LISDEXAMFETAMINE DIMESYLATE CHEW TAB 20 MG | 61100025100520 | Brand |
| LISDEXAMFETAMINE DIMESYLATE | LISDEXAMFETAMINE DIMESYLATE CHEW TAB 30 MG | 61100025100530 | Generic |
| VYVANSE | LISDEXAMFETAMINE DIMESYLATE CHEW TAB 30 MG | 61100025100530 | Brand |
| LISDEXAMFETAMINE DIMESYLATE | LISDEXAMFETAMINE DIMESYLATE CHEW TAB 40 MG | 61100025100540 | Generic |
| VYVANSE | LISDEXAMFETAMINE DIMESYLATE CHEW TAB 40 MG | 61100025100540 | Brand |
| LISDEXAMFETAMINE DIMESYLATE | LISDEXAMFETAMINE DIMESYLATE CHEW TAB 50 MG | 61100025100550 | Generic |
| VYVANSE | LISDEXAMFETAMINE DIMESYLATE CHEW TAB 50 MG | 61100025100550 | Brand |
| LISDEXAMFETAMINE DIMESYLATE | LISDEXAMFETAMINE DIMESYLATE CHEW TAB 60 MG | 61100025100560 | Generic |
| VYVANSE | LISDEXAMFETAMINE DIMESYLATE CHEW TAB 60 MG | 61100025100560 | Brand |
| XELSTRYM | DEXTROAMPHETAMINE TD PATCH 4.5 MG/9HR | 61100020005910 | Brand |
| XELSTRYM | DEXTROAMPHETAMINE TD PATCH 9 MG/9HR | 61100020005920 | Brand |
| XELSTRYM | DEXTROAMPHETAMINE TD PATCH 13.5 MG/9HR | 61100020005930 | Brand |

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| XELSTRYM | DEXTROAMPHETAMINE TD PATCH 18 MG/9HR | 61100020005940 | Brand |
| DEXTROAMPHETAMINE SULFATE | DEXTROAMPHETAMINE SULFATE TAB 2.5 MG | 61100020100303 | Generic |
| ZENZEDI | DEXTROAMPHETAMINE SULFATE TAB 2.5 MG | 61100020100303 | Brand |
| DEXTROAMPHETAMINE SULFATE | DEXTROAMPHETAMINE SULFATE TAB 5 MG | 61100020100305 | Generic |
| ZENZEDI | DEXTROAMPHETAMINE SULFATE TAB 5 MG | 61100020100305 | Brand |
| DEXTROAMPHETAMINE SULFATE | DEXTROAMPHETAMINE SULFATE TAB 7.5 MG | 61100020100308 | Generic |
| ZENZEDI | DEXTROAMPHETAMINE SULFATE TAB 7.5 MG | 61100020100308 | Brand |
| DEXTROAMPHETAMINE SULFATE | DEXTROAMPHETAMINE SULFATE TAB 10 MG | 61100020100310 | Generic |
| ZENZEDI | DEXTROAMPHETAMINE SULFATE TAB 10 MG | 61100020100310 | Brand |
| DEXTROAMPHETAMINE SULFATE | DEXTROAMPHETAMINE SULFATE TAB 15 MG | 61100020100315 | Generic |
| ZENZEDI | DEXTROAMPHETAMINE SULFATE TAB 15 MG | 61100020100315 | Brand |
| DEXTROAMPHETAMINE SULFATE | DEXTROAMPHETAMINE SULFATE TAB 20 MG | 61100020100330 | Generic |
| ZENZEDI | DEXTROAMPHETAMINE SULFATE TAB 20 MG | 61100020100330 | Brand |
| DEXTROAMPHETAMINE SULFATE | DEXTROAMPHETAMINE SULFATE TAB 30 MG | 61100020100350 | Generic |
| ZENZEDI | DEXTROAMPHETAMINE SULFATE TAB 30 MG | 61100020100350 | Brand |
| METHYLPHENIDATE HYDROCHLORIDE ER | METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 45 MG | 61400020100475 | Generic |
| METHYLPHENIDATE HYDROCHLORIDE ER | METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 63 MG | 61400020100485 | Generic |
| METHYLPHENIDATE HYDROCHLORIDE ER | METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 72 MG | 61400020100490 | Generic |
| FOCALIN | DEXMETHYLPHENIDATE HCL TAB 2.5 MG | 61400016100320 | Brand |
| DEXMETHYLPHENIDATE HYDROCHLORIDE | DEXMETHYLPHENIDATE HCL TAB 2.5 MG | 61400016100320 | Generic |

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| FOCALIN | DEXMETHYLPHENIDATE HCL TAB 5 MG | 61400016100330 | Brand |
| DEXMETHYLPHENIDATE HYDROCHLORIDE | DEXMETHYLPHENIDATE HCL TAB 5 MG | 61400016100330 | Generic |
| DEXMETHYLPHENIDATE HCL | DEXMETHYLPHENIDATE HCL TAB 5 MG | 61400016100330 | Generic |
| FOCALIN | DEXMETHYLPHENIDATE HCL TAB 10 MG | 61400016100340 | Brand |
| DEXMETHYLPHENIDATE HYDROCHLORIDE | DEXMETHYLPHENIDATE HCL TAB 10 MG | 61400016100340 | Generic |
| DEXMETHYLPHENIDATE HCL | DEXMETHYLPHENIDATE HCL TAB 10 MG | 61400016100340 | Generic |
| DEXMETHYLPHENIDATE HYDROCHLORIDE ER | DEXMETHYLPHENIDATE HCL CAP ER 24 HR 5 MG | 61400016107020 | Generic |
| FOCALIN XR | DEXMETHYLPHENIDATE HCL CAP ER 24 HR 5 MG | 61400016107020 | Brand |
| DEXMETHYLPHENIDATE HCL ER | DEXMETHYLPHENIDATE HCL CAP ER 24 HR 5 MG | 61400016107020 | Generic |
| DEXMETHYLPHENIDATE HYDROCHLORIDE ER | DEXMETHYLPHENIDATE HCL CAP ER 24 HR 10 MG | 61400016107030 | Generic |
| FOCALIN XR | DEXMETHYLPHENIDATE HCL CAP ER 24 HR 10 MG | 61400016107030 | Brand |
| DEXMETHYLPHENIDATE HCL ER | DEXMETHYLPHENIDATE HCL CAP ER 24 HR 10 MG | 61400016107030 | Generic |
| DEXMETHYLPHENIDATE HYDROCHLORIDE ER | DEXMETHYLPHENIDATE HCL CAP ER 24 HR 15 MG | 61400016107035 | Generic |
| FOCALIN XR | DEXMETHYLPHENIDATE HCL CAP ER 24 HR 15 MG | 61400016107035 | Brand |
| DEXMETHYLPHENIDATE HCL ER | DEXMETHYLPHENIDATE HCL CAP ER 24 HR 15 MG | 61400016107035 | Generic |
| DEXMETHYLPHENIDATE HYDROCHLORIDE ER | DEXMETHYLPHENIDATE HCL CAP ER 24 HR 20 MG | 61400016107040 | Generic |
| FOCALIN XR | DEXMETHYLPHENIDATE HCL CAP ER 24 HR 20 MG | 61400016107040 | Brand |
| DEXMETHYLPHENIDATE HCL ER | DEXMETHYLPHENIDATE HCL CAP ER 24 HR 20 MG | 61400016107040 | Generic |
| DEXMETHYLPHENIDATE HYDROCHLORIDE ER | DEXMETHYLPHENIDATE HCL CAP ER 24 HR 25 MG | 61400016107045 | Generic |
| DEXMETHYLPHENIDATE HYDROCHLORIDE | DEXMETHYLPHENIDATE HCL CAP ER 24 HR 25 MG | 61400016107045 | Generic |
| FOCALIN XR | DEXMETHYLPHENIDATE HCL CAP ER 24 HR 25 MG | 61400016107045 | Brand |

| | | | |
|---|---|---|---|
| DEXMETHYLPHENIDATE HCL ER | DEXMETHYLPHENIDATE HCL CAP ER 24 HR 25 MG | 61400016107045 | Generic |
| DEXMETHYLPHENIDATE HYDROCHLORIDE ER | DEXMETHYLPHENIDATE HCL CAP ER 24 HR 30 MG | 61400016107050 | Generic |
| FOCALIN XR | DEXMETHYLPHENIDATE HCL CAP ER 24 HR 30 MG | 61400016107050 | Brand |
| DEXMETHYLPHENIDATE HCL ER | DEXMETHYLPHENIDATE HCL CAP ER 24 HR 30 MG | 61400016107050 | Generic |
| DEXMETHYLPHENIDATE HYDROCHLORIDE ER | DEXMETHYLPHENIDATE HCL CAP ER 24 HR 35 MG | 61400016107055 | Generic |
| FOCALIN XR | DEXMETHYLPHENIDATE HCL CAP ER 24 HR 35 MG | 61400016107055 | Brand |
| DEXMETHYLPHENIDATE HCL ER | DEXMETHYLPHENIDATE HCL CAP ER 24 HR 35 MG | 61400016107055 | Generic |
| DEXMETHYLPHENIDATE HYDROCHLORIDE ER | DEXMETHYLPHENIDATE HCL CAP ER 24 HR 40 MG | 61400016107060 | Generic |
| FOCALIN XR | DEXMETHYLPHENIDATE HCL CAP ER 24 HR 40 MG | 61400016107060 | Brand |
| DEXMETHYLPHENIDATE HCL ER | DEXMETHYLPHENIDATE HCL CAP ER 24 HR 40 MG | 61400016107060 | Generic |
| DEXTROAMPHETAMINE SULFATE ER | DEXTROAMPHETAMINE SULFATE CAP ER 24HR 15 MG | 61100020107015 | Generic |
| DEXTROAMPHETAMINE SULFATE ER | DEXTROAMPHETAMINE SULFATE CAP ER 24HR 5 MG | 61100020107005 | Generic |
| EVEKEO ODT | AMPHETAMINE SULFATE ORALLY DISINTEGRATING TAB 5 MG | 61100010107210 | Brand |
| EVEKEO ODT | AMPHETAMINE SULFATE ORALLY DISINTEGRATING TAB 10 MG | 61100010107220 | Brand |
| EVEKEO ODT | AMPHETAMINE SULFATE ORALLY DISINTEGRATING TAB 15 MG | 61100010107230 | Brand |
| EVEKEO ODT | AMPHETAMINE SULFATE ORALLY DISINTEGRATING TAB 20 MG | 61100010107240 | Brand |
| ADHANSIA XR | METHYLPHENIDATE HCL CAP ER 24HR 25 MG | 61400020107068 | Brand |
| ADHANSIA XR | METHYLPHENIDATE HCL CAP ER 24HR 35 MG | 61400020107073 | Brand |
| ADHANSIA XR | METHYLPHENIDATE HCL CAP ER 24HR 45 MG | 61400020107078 | Brand |

| | | | |
|---|---|---|---|
| ADHANSIA XR | METHYLPHENIDATE HCL CAP ER 24HR 55 MG | 61400020107083 | Brand |
| ADHANSIA XR | METHYLPHENIDATE HCL CAP ER 24HR 70 MG | 61400020107088 | Brand |
| ADHANSIA XR | METHYLPHENIDATE HCL CAP ER 24HR 85 MG | 61400020107091 | Brand |
| DEXEDRINE | DEXTROAMPHETAMINE SULFATE CAP ER 24HR 15 MG | 61100020107015 | Brand |
| KAPVAY | CLONIDINE HCL TAB ER 12HR 0.1 MG | 61353020107420 | Brand |
| METHYLPHENIDATE HYDROCHLORIDE ER | METHYLPHENIDATE HCL TAB ER 24HR 18 MG | 61400020107518 | Generic |
| METHYLPHENIDATE HYDROCHLORIDE ER | METHYLPHENIDATE HCL TAB ER 24HR 27 MG | 61400020107527 | Generic |
| METHYLPHENIDATE HYDROCHLORIDE ER | METHYLPHENIDATE HCL TAB ER 24HR 36 MG | 61400020107536 | Generic |
| METHYLPHENIDATE HYDROCHLORIDE ER | METHYLPHENIDATE HCL TAB ER 24HR 54 MG | 61400020107554 | Generic |
| METHYLPHENIDATE HYDROCHLORIDE ER | METHYLPHENIDATE HCL TAB ER 10 MG | 61400020100403 | Generic |
| METHYLPHENIDATE HYDROCHLORIDE ER | METHYLPHENIDATE HCL TAB ER 20 MG | 61400020100405 | Generic |
| METHYLPHENIDATE HYDROCHLORIDE ER (LA) | METHYLPHENIDATE HCL CAP ER 24HR 60 MG (LA) | 61400020107048 | Generic |

**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<br>• United States Pharmacopoeia-National Formulary (USP-NF)<br><br>**AND**<br><br>**2** - The child is unresponsive to, or has had an inadequate response to behavioral therapy<br><br>**AND**<br><br>**3** - The child is experiencing moderate-severe continuing disturbance in function despite behavioral therapy | |
| Notes | *See Table 1 in background section for FDA approved min ages. |

## 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 ODT/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 |
| --- | --- |
| 6/12/2024 | New program. |

Aemcolo

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146288 |
| **Guideline Name** | Aemcolo |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AEMCOLO | RIFAMYCIN SODIUM TAB DELAYED RELEASE 194 MG (BASE EQUIV) | 16000048200620 | Brand |

**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)

Afinitor

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-155816 |
| **Guideline Name** | Afinitor |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 11/1/2024 |

## 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AFINITOR | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Brand |
| AFINITOR | EVEROLIMUS TAB 5 MG | 21532530000320 | Brand |
| AFINITOR | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Brand |

| | | | |
|---|---|---|---|
| AFINITOR | EVEROLIMUS TAB 10 MG | 21532530000330 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Brand |
| EVEROLIMUS | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |
| TORPENZ | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| TORPENZ | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| TORPENZ | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| TORPENZ | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |

**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** Disease is progressive

**AND**

**1.3** ONE of the following:

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

**AND**

**1.4** 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)

**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 disease and/or metastatic disease
- Used as preoperative therapy of locoregional insulinoma with or without diazoxide

**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)

| Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO | |
|---|---|
| Diagnosis | Neuroendocrine Tumors |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AFINITOR | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Brand |
| AFINITOR | EVEROLIMUS TAB 5 MG | 21532530000320 | Brand |
| AFINITOR | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Brand |
| AFINITOR | EVEROLIMUS TAB 10 MG | 21532530000330 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Brand |
| EVEROLIMUS | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |
| TORPENZ | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| TORPENZ | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| TORPENZ | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| TORPENZ | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |

**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 | Renal cell cancer, Kidney Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AFINITOR | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Brand |
| AFINITOR | EVEROLIMUS TAB 5 MG | 21532530000320 | Brand |
| AFINITOR | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Brand |
| AFINITOR | EVEROLIMUS TAB 10 MG | 21532530000330 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Brand |
| EVEROLIMUS | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |
| TORPENZ | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| TORPENZ | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| TORPENZ | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| TORPENZ | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |

**Approval Criteria**

**1** - Diagnosis of advanced renal cell cancer/kidney cancer

**AND**

**2** - Disease is ONE of the following:

- Relapsed
- Stage IV disease

**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 | Renal cell cancer, Kidney Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AFINITOR | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Brand |
| AFINITOR | EVEROLIMUS TAB 5 MG | 21532530000320 | Brand |
| AFINITOR | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Brand |
| AFINITOR | EVEROLIMUS TAB 10 MG | 21532530000330 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Brand |
| EVEROLIMUS | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |

| | | | |
|---|---|---|---|
| EVEROLIMUS | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |
| TORPENZ | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| TORPENZ | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| TORPENZ | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| TORPENZ | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |

**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 | Tuberous Sclerosis Complex-Associated Renal Cell Carcinoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AFINITOR | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Brand |
| AFINITOR | EVEROLIMUS TAB 5 MG | 21532530000320 | Brand |
| AFINITOR | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Brand |
| AFINITOR | EVEROLIMUS TAB 10 MG | 21532530000330 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Brand |
| EVEROLIMUS | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |

| | | | |
|---|---|---|---|
| EVEROLIMUS | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |
| TORPENZ | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| TORPENZ | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| TORPENZ | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| TORPENZ | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |

**Approval Criteria**

**1** - 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 | Tuberous Sclerosis Complex-Associated Renal Cell Carcinoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AFINITOR | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Brand |

| | | | |
|---|---|---|---|
| AFINITOR | EVEROLIMUS TAB 5 MG | 21532530000320 | Brand |
| AFINITOR | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Brand |
| AFINITOR | EVEROLIMUS TAB 10 MG | 21532530000330 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Brand |
| EVEROLIMUS | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |
| TORPENZ | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| TORPENZ | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| TORPENZ | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| TORPENZ | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |

**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 | Subependymal Giant Cell Astrocytoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AFINITOR | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Brand |

| | | | |
|---|---|---|---|
| AFINITOR | EVEROLIMUS TAB 5 MG | 21532530000320 | Brand |
| AFINITOR | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Brand |
| AFINITOR | EVEROLIMUS TAB 10 MG | 21532530000330 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Brand |
| EVEROLIMUS | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |
| TORPENZ | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| TORPENZ | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| TORPENZ | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| TORPENZ | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |

**Approval Criteria**

**1** - Diagnosis of subependymal giant cell astrocytoma (SEGA)

**AND**

**2** - Used as adjuvant treatment

**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 | Subependymal Giant Cell Astrocytoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AFINITOR | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Brand |
| AFINITOR | EVEROLIMUS TAB 5 MG | 21532530000320 | Brand |
| AFINITOR | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Brand |
| AFINITOR | EVEROLIMUS TAB 10 MG | 21532530000330 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Brand |
| EVEROLIMUS | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |
| TORPENZ | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| TORPENZ | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| TORPENZ | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| TORPENZ | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AFINITOR | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Brand |
| AFINITOR | EVEROLIMUS TAB 5 MG | 21532530000320 | Brand |
| AFINITOR | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Brand |
| AFINITOR | EVEROLIMUS TAB 10 MG | 21532530000330 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Brand |
| EVEROLIMUS | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |
| TORPENZ | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| TORPENZ | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| TORPENZ | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| TORPENZ | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |

**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 | Waldenströms Macroglobulinemia or Lymphoplasmacytic Lymphoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AFINITOR | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Brand |
| AFINITOR | EVEROLIMUS TAB 5 MG | 21532530000320 | Brand |
| AFINITOR | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Brand |
| AFINITOR | EVEROLIMUS TAB 10 MG | 21532530000330 | Brand |

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|---|---|---|---|
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Brand |
| EVEROLIMUS | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |
| TORPENZ | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| TORPENZ | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| TORPENZ | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| TORPENZ | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AFINITOR | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Brand |
| AFINITOR | EVEROLIMUS TAB 5 MG | 21532530000320 | Brand |
| AFINITOR | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Brand |
| AFINITOR | EVEROLIMUS TAB 10 MG | 21532530000330 | Brand |

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|---|---|---|---|
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Brand |
| EVEROLIMUS | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |
| TORPENZ | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| TORPENZ | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| TORPENZ | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| TORPENZ | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |

**Approval Criteria**

**1** - Diagnosis of breast cancer

**AND**

**2** - One of the following:

**2.1** Disease is recurrent

**OR**

**2.2** Disease is metastatic

**AND**

**3** - Disease is hormone receptor positive (HR+) [i.e., estrogen-receptor-positive (ER+) or progesterone-receptor-positive (PR+)]

**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:

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

**OR**

**6.2** Fulvestrant

**OR**

**6.3** 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 | Breast Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AFINITOR | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Brand |
| AFINITOR | EVEROLIMUS TAB 5 MG | 21532530000320 | Brand |
| AFINITOR | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Brand |
| AFINITOR | EVEROLIMUS TAB 10 MG | 21532530000330 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Brand |
| EVEROLIMUS | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |

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|---|---|---|---|
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |
| TORPENZ | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| TORPENZ | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| TORPENZ | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| TORPENZ | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AFINITOR | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Brand |
| AFINITOR | EVEROLIMUS TAB 5 MG | 21532530000320 | Brand |
| AFINITOR | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Brand |
| AFINITOR | EVEROLIMUS TAB 10 MG | 21532530000330 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Brand |
| EVEROLIMUS | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |

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|---|---|---|---|
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |
| TORPENZ | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| TORPENZ | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| TORPENZ | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| TORPENZ | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |

**Approval Criteria**

**1** - Diagnosis of classic Hodgkin lymphoma

**AND**

**2** - Disease is refractory to at least 3 prior lines of 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 | Hodgkin Lymphoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AFINITOR | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Brand |
| AFINITOR | EVEROLIMUS TAB 5 MG | 21532530000320 | Brand |
| AFINITOR | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Brand |
| AFINITOR | EVEROLIMUS TAB 10 MG | 21532530000330 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Brand |
| EVEROLIMUS | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |
| TORPENZ | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| TORPENZ | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| TORPENZ | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| TORPENZ | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |

**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 | PEComa (perivascular epitheliod cell tumor), recurrent angiomyolipoma, or lymphangioleiomyomatosis |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AFINITOR | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Brand |
| AFINITOR | EVEROLIMUS TAB 5 MG | 21532530000320 | Brand |
| AFINITOR | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Brand |
| AFINITOR | EVEROLIMUS TAB 10 MG | 21532530000330 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Brand |
| EVEROLIMUS | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |
| TORPENZ | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| TORPENZ | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| TORPENZ | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| TORPENZ | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |

**Approval Criteria**

**1** - Diagnosis of one of the following soft tissue sarcoma subtypes:

**1.1** Locally advanced unresectable or metastatic malignant perivascular epithelioid cell tumor (PEComa)

**OR**

**1.2** Recurrent angiomyolipoma

**OR**

**1.3** 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 | PEComa (perivascular epitheliod cell tumor), recurrent angiomyolipoma, or lymphangioleiomyomatosis |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AFINITOR | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Brand |
| AFINITOR | EVEROLIMUS TAB 5 MG | 21532530000320 | Brand |
| AFINITOR | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Brand |
| AFINITOR | EVEROLIMUS TAB 10 MG | 21532530000330 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Brand |
| EVEROLIMUS | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |

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|---|---|---|---|
| EVEROLIMUS | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |
| TORPENZ | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| TORPENZ | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| TORPENZ | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| TORPENZ | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |

**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 | Thymic Carcinoma or Thymoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AFINITOR | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Brand |
| AFINITOR | EVEROLIMUS TAB 5 MG | 21532530000320 | Brand |
| AFINITOR | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Brand |
| AFINITOR | EVEROLIMUS TAB 10 MG | 21532530000330 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Brand |
| EVEROLIMUS | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |

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|---|---|---|---|
| EVEROLIMUS | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |
| TORPENZ | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| TORPENZ | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| TORPENZ | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| TORPENZ | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |

**Approval Criteria**

**1** - One of the following:

- Diagnosis of thymic carcinoma
- Diagnosis of thymoma

**AND**

**2** - ONE of the following:

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

**OR**

**2.2** 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 | Thymic Carcinoma or Thymoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AFINITOR | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Brand |
| AFINITOR | EVEROLIMUS TAB 5 MG | 21532530000320 | Brand |
| AFINITOR | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Brand |
| AFINITOR | EVEROLIMUS TAB 10 MG | 21532530000330 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Brand |
| EVEROLIMUS | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |
| TORPENZ | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| TORPENZ | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| TORPENZ | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| TORPENZ | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |

**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 | Follicular carcinoma, Oncocytic carcinoma, or papillary carcinoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AFINITOR | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Brand |
| AFINITOR | EVEROLIMUS TAB 5 MG | 21532530000320 | Brand |
| AFINITOR | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Brand |
| AFINITOR | EVEROLIMUS TAB 10 MG | 21532530000330 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Brand |
| EVEROLIMUS | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |
| TORPENZ | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| TORPENZ | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| TORPENZ | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| TORPENZ | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |

**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** - Disease is refractory to radioactive iodine treatment

**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 | Follicular carcinoma, Oncocytic carcinoma, or papillary carcinoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AFINITOR | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Brand |
| AFINITOR | EVEROLIMUS TAB 5 MG | 21532530000320 | Brand |
| AFINITOR | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Brand |
| AFINITOR | EVEROLIMUS TAB 10 MG | 21532530000330 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Brand |
| EVEROLIMUS | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |
| TORPENZ | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| TORPENZ | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| TORPENZ | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| TORPENZ | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AFINITOR | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Brand |
| AFINITOR | EVEROLIMUS TAB 5 MG | 21532530000320 | Brand |
| AFINITOR | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Brand |
| AFINITOR | EVEROLIMUS TAB 10 MG | 21532530000330 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Brand |
| EVEROLIMUS | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |
| TORPENZ | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| TORPENZ | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| TORPENZ | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| TORPENZ | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |

**Approval Criteria**

**1** - Diagnosis of meningioma

**AND**

**2** - Disease is recurrent or progressive

**AND**

**3** - Surgery and/or radiation is not possible

**AND**

**4** - One of the following:

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

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AFINITOR | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Brand |
| AFINITOR | EVEROLIMUS TAB 5 MG | 21532530000320 | Brand |
| AFINITOR | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Brand |
| AFINITOR | EVEROLIMUS TAB 10 MG | 21532530000330 | Brand |

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|---|---|---|---|
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Brand |
| EVEROLIMUS | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |
| TORPENZ | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| TORPENZ | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| TORPENZ | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| TORPENZ | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AFINITOR | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Brand |
| AFINITOR | EVEROLIMUS TAB 5 MG | 21532530000320 | Brand |
| AFINITOR | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Brand |
| AFINITOR | EVEROLIMUS TAB 10 MG | 21532530000330 | Brand |

| | | | |
|---|---|---|---|
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Brand |
| EVEROLIMUS | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |
| TORPENZ | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| TORPENZ | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| TORPENZ | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| TORPENZ | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |

**Approval Criteria**

**1** - Diagnosis of endometrial carcinoma

**AND**

**2** - Used in combination with letrozole

**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 | Endometrial Carcinoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AFINITOR | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Brand |
| AFINITOR | EVEROLIMUS TAB 5 MG | 21532530000320 | Brand |
| AFINITOR | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Brand |
| AFINITOR | EVEROLIMUS TAB 10 MG | 21532530000330 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Brand |
| EVEROLIMUS | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |
| TORPENZ | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| TORPENZ | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| TORPENZ | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| TORPENZ | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AFINITOR | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Brand |
| AFINITOR | EVEROLIMUS TAB 5 MG | 21532530000320 | Brand |
| AFINITOR | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Brand |
| AFINITOR | EVEROLIMUS TAB 10 MG | 21532530000330 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Brand |
| EVEROLIMUS | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |
| TORPENZ | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| TORPENZ | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| TORPENZ | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| TORPENZ | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AFINITOR | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Brand |
| AFINITOR | EVEROLIMUS TAB 5 MG | 21532530000320 | Brand |
| AFINITOR | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Brand |
| AFINITOR | EVEROLIMUS TAB 10 MG | 21532530000330 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Brand |
| EVEROLIMUS | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |

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|---|---|---|---|
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |
| TORPENZ | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| TORPENZ | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| TORPENZ | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| TORPENZ | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |

**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 | Osteosarcoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AFINITOR | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Brand |
| AFINITOR | EVEROLIMUS TAB 5 MG | 21532530000320 | Brand |
| AFINITOR | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Brand |
| AFINITOR | EVEROLIMUS TAB 10 MG | 21532530000330 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Brand |
| EVEROLIMUS | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |

| | | | |
|---|---|---|---|
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |
| TORPENZ | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| TORPENZ | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| TORPENZ | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| TORPENZ | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AFINITOR | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Brand |
| AFINITOR | EVEROLIMUS TAB 5 MG | 21532530000320 | Brand |
| AFINITOR | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Brand |
| AFINITOR | EVEROLIMUS TAB 10 MG | 21532530000330 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Brand |
| EVEROLIMUS | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |
| TORPENZ | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| TORPENZ | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| TORPENZ | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| TORPENZ | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AFINITOR | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Brand |
| AFINITOR | EVEROLIMUS TAB 5 MG | 21532530000320 | Brand |
| AFINITOR | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Brand |
| AFINITOR | EVEROLIMUS TAB 10 MG | 21532530000330 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Brand |
| EVEROLIMUS | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |
| TORPENZ | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| TORPENZ | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| TORPENZ | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| TORPENZ | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |

**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 | Histiocytic Neoplasms |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AFINITOR | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Brand |
| AFINITOR | EVEROLIMUS TAB 5 MG | 21532530000320 | Brand |
| AFINITOR | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Brand |
| AFINITOR | EVEROLIMUS TAB 10 MG | 21532530000330 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Brand |

| | | | |
|---|---|---|---|
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Brand |
| EVEROLIMUS | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |
| TORPENZ | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| TORPENZ | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| TORPENZ | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| TORPENZ | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |

**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 | Gastrointestinal Stromal Tumor (GIST) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AFINITOR | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Brand |
| AFINITOR | EVEROLIMUS TAB 5 MG | 21532530000320 | Brand |
| AFINITOR | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Brand |
| AFINITOR | EVEROLIMUS TAB 10 MG | 21532530000330 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Brand |

| | | | |
|---|---|---|---|
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Brand |
| EVEROLIMUS | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |
| TORPENZ | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| TORPENZ | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| TORPENZ | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| TORPENZ | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |

**Approval Criteria**

**1** - Diagnosis of Gastrointestinal Stromal Tumor (GIST)

**AND**

**2** - Disease is one of the following:

- Unresectable
- Progressive
- 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 | Gastrointestinal Stromal Tumor (GIST) |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AFINITOR | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Brand |
| AFINITOR | EVEROLIMUS TAB 5 MG | 21532530000320 | Brand |
| AFINITOR | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Brand |
| AFINITOR | EVEROLIMUS TAB 10 MG | 21532530000330 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Brand |

| | | | |
|---|---|---|---|
| EVEROLIMUS | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |
| TORPENZ | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| TORPENZ | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| TORPENZ | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| TORPENZ | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AFINITOR | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Brand |
| AFINITOR | EVEROLIMUS TAB 5 MG | 21532530000320 | Brand |
| AFINITOR | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Brand |
| AFINITOR | EVEROLIMUS TAB 10 MG | 21532530000330 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Brand |

| | | | |
|---|---|---|---|
| EVEROLIMUS | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |
| TORPENZ | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| TORPENZ | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| TORPENZ | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| TORPENZ | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AFINITOR | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Brand |
| AFINITOR | EVEROLIMUS TAB 5 MG | 21532530000320 | Brand |
| AFINITOR | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Brand |
| AFINITOR | EVEROLIMUS TAB 10 MG | 21532530000330 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Brand |
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Brand |

| | | | |
|---|---|---|---|
| AFINITOR DISPERZ | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Brand |
| EVEROLIMUS | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 2 MG | 21532530007310 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 3 MG | 21532530007320 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB FOR ORAL SUSP 5 MG | 21532530007340 | Generic |
| EVEROLIMUS | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |
| TORPENZ | EVEROLIMUS TAB 2.5 MG | 21532530000310 | Generic |
| TORPENZ | EVEROLIMUS TAB 5 MG | 21532530000320 | Generic |
| TORPENZ | EVEROLIMUS TAB 7.5 MG | 21532530000325 | Generic |
| TORPENZ | EVEROLIMUS TAB 10 MG | 21532530000330 | Generic |

**Approval Criteria**

**1** - Documentation of positive clinical response to therapy

## 2 . Revision History

| Date | Notes |
|---|---|
| 9/24/2024 | Added step thru everolimus for Torpenz |

Afrezza

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146289 |
| **Guideline Name** | Afrezza |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AFREZZA | INSULIN REGULAR (HUMAN) INHALATION POWDER 4 UNIT/CARTRIDGE | 27104010002940 | Brand |
| AFREZZA | INSULIN REGULAR (HUMAN) INHALATION POWDER 8 UNIT/CARTRIDGE | 27104010002950 | Brand |
| AFREZZA | INSULIN REGULAR (HUMAN) INHALATION POWDER 12 UNIT/CARTRIDGE | 27104010002955 | Brand |

| | | | |
|---|---|---|---|
| AFREZZA | INSULIN REGULAR (HUMAN) INHAL POWD 90 X 4 UNIT & 90 X 8 UNIT | 27104010002978 | Brand |
| AFREZZA | INSULIN REGULAR (HUMAN) INH POWD 90 X 8 UNIT & 90 X 12 UNIT | 27104010002988 | Brand |
| AFREZZA | INSULIN REGULAR (HUMAN) INH POWD 60X4 & 60X8 & 60X12 UT/CART | 27104010002990 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AFREZZA | INSULIN REGULAR (HUMAN) INHALATION POWDER 4 UNIT/CARTRIDGE | 27104010002940 | Brand |
| AFREZZA | INSULIN REGULAR (HUMAN) INHALATION POWDER 8 UNIT/CARTRIDGE | 27104010002950 | Brand |
| AFREZZA | INSULIN REGULAR (HUMAN) INHALATION POWDER 12 UNIT/CARTRIDGE | 27104010002955 | Brand |
| AFREZZA | INSULIN REGULAR (HUMAN) INHAL POWD 90 X 4 UNIT & 90 X 8 UNIT | 27104010002978 | Brand |
| AFREZZA | INSULIN REGULAR (HUMAN) INH POWD 90 X 8 UNIT & 90 X 12 UNIT | 27104010002988 | Brand |
| AFREZZA | INSULIN REGULAR (HUMAN) INH POWD 60X4 & 60X8 & 60X12 UT/CART | 27104010002990 | Brand |

**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

Agamree

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-155765 |
| **Guideline Name** | Agamree |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 10/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AGAMREE | VAMOROLONE ORAL SUSP 40 MG/ML | 22100075001820 | Brand |

**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. |

Akeega

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146465 |
| **Guideline Name** | Akeega |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Akeega | |
|---|---|
| Diagnosis | Prostate Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AKEEGA | NIRAPARIB TOSYLATE-ABIRATERONE ACETATE TAB 50-500 MG | 21409902120320 | Brand |
| AKEEGA | NIRAPARIB TOSYLATE-ABIRATERONE ACETATE TAB 100-500 MG | 21409902120330 | Brand |

**Approval Criteria**

**1** - Diagnosis of metastatic castration-resistant prostate cancer (mCRPC)

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AKEEGA | NIRAPARIB TOSYLATE-ABIRATERONE ACETATE TAB 50-500 MG | 21409902120320 | Brand |
| AKEEGA | NIRAPARIB TOSYLATE-ABIRATERONE ACETATE TAB 100-500 MG | 21409902120330 | Brand |

**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 |
|---|---|

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AKEEGA | NIRAPARIB TOSYLATE-ABIRATERONE ACETATE TAB 50-500 MG | 21409902120320 | Brand |
| AKEEGA | NIRAPARIB TOSYLATE-ABIRATERONE ACETATE TAB 100-500 MG | 21409902120330 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AKEEGA | NIRAPARIB TOSYLATE-ABIRATERONE ACETATE TAB 50-500 MG | 21409902120320 | Brand |
| AKEEGA | NIRAPARIB TOSYLATE-ABIRATERONE ACETATE TAB 100-500 MG | 21409902120330 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Akeega therapy

Alecensa

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-151762 |
| **Guideline Name** | Alecensa |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 9/1/2024 |

## 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ALECENSA | ALECTINIB HCL CAP 150 MG (BASE EQUIVALENT) | 21530507100120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ALECENSA | ALECTINIB HCL CAP 150 MG (BASE EQUIVALENT) | 21530507100120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ALECENSA | ALECTINIB HCL CAP 150 MG (BASE EQUIVALENT) | 21530507100120 | Brand |

**Approval Criteria**

**1** - Diagnosis of anaplastic large cell lymphoma (ALCL)

**AND**

**2** - Used as second-line or initial palliative intent therapy 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ALECENSA | ALECTINIB HCL CAP 150 MG (BASE EQUIVALENT) | 21530507100120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ALECENSA | ALECTINIB HCL CAP 150 MG (BASE EQUIVALENT) | 21530507100120 | Brand |

**Approval Criteria**

**1** - Diagnosis of metastatic brain cancer from NSCLC

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ALECENSA | ALECTINIB HCL CAP 150 MG (BASE EQUIVALENT) | 21530507100120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ALECENSA | ALECTINIB HCL CAP 150 MG (BASE EQUIVALENT) | 21530507100120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ALECENSA | ALECTINIB HCL CAP 150 MG (BASE EQUIVALENT) | 21530507100120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ALECENSA | ALECTINIB HCL CAP 150 MG (BASE EQUIVALENT) | 21530507100120 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Alecensa therapy

## 2 . Revision History

| Date | Notes |
|---|---|
| 8/14/2024 | Added criteria for adjuvant treatment following tumor resection of AL K-positive NSCLC per FDA label. Updated references. |

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-159206 |
| **Guideline Name** | Alfa Interferons |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 1 . Criteria

| Product Name: Pegasys | |
|---|---|
| Diagnosis | Chronic Hepatitis B |
| Approval Length | 48 Week(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| PEGASYS | PEGINTERFERON ALFA-2A SOLN PREFILLED SYR 180 MCG/0.5ML | 1235306005E540 | Brand |
| PEGASYS | PEGINTERFERON ALFA-2A INJ 180 MCG/ML | 12353060052020 | Brand |

**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 | 48 Week(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| PEGASYS | PEGINTERFERON ALFA-2A SOLN PREFILLED SYR 180 MCG/0.5ML | 1235306005E540 | Brand |
| PEGASYS | PEGINTERFERON ALFA-2A INJ 180 MCG/ML | 12353060052020 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| PEGASYS | PEGINTERFERON ALFA-2A SOLN PREFILLED SYR 180 MCG/0.5ML | 1235306005E540 | Brand |
| PEGASYS | PEGINTERFERON ALFA-2A INJ 180 MCG/ML | 12353060052020 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| PEGASYS | PEGINTERFERON ALFA-2A SOLN PREFILLED SYR 180 MCG/0.5ML | 1235306005E540 | Brand |
| PEGASYS | PEGINTERFERON ALFA-2A INJ 180 MCG/ML | 12353060052020 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| PEGASYS | PEGINTERFERON ALFA-2A SOLN PREFILLED SYR 180 MCG/0.5ML | 1235306005E540 | Brand |
| PEGASYS | PEGINTERFERON ALFA-2A INJ 180 MCG/ML | 12353060052020 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Pegasys therapy

## 2 . Revision History

| Date | Notes |
|---|---|
| 11/4/2024 | Removed Intron A |

Alinia

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146290 |
| **Guideline Name** | Alinia |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: generic nitazoxanide, Brand Alinia | |
|---|---|
| Diagnosis | Diarrhea caused by Giardia lamblia |
| Approval Length | 1 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NITAZOXANIDE | NITAZOXANIDE TAB 500 MG | 16400060000330 | Generic |
| ALINIA | NITAZOXANIDE TAB 500 MG | 16400060000330 | Brand |
| ALINIA | NITAZOXANIDE FOR SUSP 100 MG/5ML | 16400060001920 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NITAZOXANIDE | NITAZOXANIDE TAB 500 MG | 16400060000330 | Generic |
| ALINIA | NITAZOXANIDE TAB 500 MG | 16400060000330 | Brand |
| ALINIA | NITAZOXANIDE FOR SUSP 100 MG/5ML | 16400060001920 | Brand |

**Approval Criteria**

**1** - Diagnosis of cryptosporidiosis

Alunbrig

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-158241 |
| **Guideline Name** | Alunbrig |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 12/1/2024 |

## 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ALUNBRIG | BRIGATINIB TAB INITIATION THERAPY PACK 90 MG & 180 MG | 2153051000B720 | Brand |
| ALUNBRIG | BRIGATINIB TAB 30 MG | 21530510000330 | Brand |
| ALUNBRIG | BRIGATINIB TAB 90 MG | 21530510000350 | Brand |

| | | | |
|---|---|---|---|
| ALUNBRIG | BRIGATINIB TAB 180 MG | 21530510000365 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ALUNBRIG | BRIGATINIB TAB INITIATION THERAPY PACK 90 MG & 180 MG | 2153051000B720 | Brand |
| ALUNBRIG | BRIGATINIB TAB 30 MG | 21530510000330 | Brand |
| ALUNBRIG | BRIGATINIB TAB 90 MG | 21530510000350 | Brand |
| ALUNBRIG | BRIGATINIB TAB 180 MG | 21530510000365 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ALUNBRIG | BRIGATINIB TAB INITIATION THERAPY PACK 90 MG & 180 MG | 2153051000B720 | Brand |
| ALUNBRIG | BRIGATINIB TAB 30 MG | 21530510000330 | Brand |
| ALUNBRIG | BRIGATINIB TAB 90 MG | 21530510000350 | Brand |
| ALUNBRIG | BRIGATINIB TAB 180 MG | 21530510000365 | Brand |

**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: Alunbrig | |
|---|---|
| Diagnosis | Central Nervous System (CNS) Cancers |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ALUNBRIG | BRIGATINIB TAB INITIATION THERAPY PACK 90 MG & 180 MG | 2153051000B720 | Brand |
| ALUNBRIG | BRIGATINIB TAB 30 MG | 21530510000330 | Brand |
| ALUNBRIG | BRIGATINIB TAB 90 MG | 21530510000350 | Brand |
| ALUNBRIG | BRIGATINIB TAB 180 MG | 21530510000365 | Brand |

**Approval Criteria**

**1** - Diagnosis of metastatic brain cancer from 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ALUNBRIG | BRIGATINIB TAB INITIATION THERAPY PACK 90 MG & 180 MG | 2153051000B720 | Brand |
| ALUNBRIG | BRIGATINIB TAB 30 MG | 21530510000330 | Brand |
| ALUNBRIG | BRIGATINIB TAB 90 MG | 21530510000350 | Brand |
| ALUNBRIG | BRIGATINIB TAB 180 MG | 21530510000365 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ALUNBRIG | BRIGATINIB TAB INITIATION THERAPY PACK 90 MG & 180 MG | 2153051000B720 | Brand |
| ALUNBRIG | BRIGATINIB TAB 30 MG | 21530510000330 | Brand |
| ALUNBRIG | BRIGATINIB TAB 90 MG | 21530510000350 | Brand |
| ALUNBRIG | BRIGATINIB TAB 180 MG | 21530510000365 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ALUNBRIG | BRIGATINIB TAB INITIATION THERAPY PACK 90 MG & 180 MG | 2153051000B720 | Brand |
| ALUNBRIG | BRIGATINIB TAB 30 MG | 21530510000330 | Brand |
| ALUNBRIG | BRIGATINIB TAB 90 MG | 21530510000350 | Brand |
| ALUNBRIG | BRIGATINIB TAB 180 MG | 21530510000365 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ALUNBRIG | BRIGATINIB TAB INITIATION THERAPY PACK 90 MG & 180 MG | 2153051000B720 | Brand |
| ALUNBRIG | BRIGATINIB TAB 30 MG | 21530510000330 | Brand |
| ALUNBRIG | BRIGATINIB TAB 90 MG | 21530510000350 | Brand |

| ALUNBRIG | BRIGATINIB TAB 180 MG | 21530510000365 | Brand |
|---|---|---|---|

**Approval Criteria**

**1** - Documentation of positive clinical response to Alunbrig therapy

## 2 . Revision History

| Date | Notes |
|---|---|
| 10/30/2024 | Added Anaplastic Large Cell Lymphoma |

Ampyra

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146469 |
| **Guideline Name** | Ampyra |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AMPYRA | DALFAMPRIDINE TAB ER 12HR 10 MG | 62406030007420 | Brand |
| DALFAMPRIDINE ER | DALFAMPRIDINE TAB ER 12HR 10 MG | 62406030007420 | Generic |

**Approval Criteria**

**1** - Diagnosis of multiple sclerosis

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-155832 |
| **Guideline Name** | Anthelmintics |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 11/1/2024 |

## 1 . Criteria

| Product Name: Generic albendazole, Emverm | |
|---|---|
| Diagnosis | Enterobius vermicularis (pinworm) |
| Approval Length | 1 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ALBENDAZOLE | ALBENDAZOLE TAB 200 MG | 15000002000320 | Generic |
| EMVERM | MEBENDAZOLE CHEW TAB 100 MG | 15000010000505 | Brand |

**Approval Criteria**

**1** - Diagnosis of Enterobius vermicularis (pinworm)

**AND**

**2** - ONE of the following:

**2.1** Failure of over-the-counter pyrantel pamoate confirmed by claims history or submitted medical records

**OR**

**2.2** History of intolerance or contraindication to over-the-counter pyrantel pamoate (please specify intolerance or contraindication)

| Product Name: Generic albendazole | |
|---|---|
| Diagnosis | Taenia solium and Taenia saginata (Taeniasis or Cysticercosis/Neurocysticercosis) |
| Approval Length | 6 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ALBENDAZOLE | ALBENDAZOLE TAB 200 MG | 15000002000320 | Generic |

**Approval Criteria**

**1** - Diagnosis of Taeniasis or Cysticercosis/Neurocysticercosis

| Product Name: Generic albendazole, Emverm | |
|---|---|
| Diagnosis | Echinococcosis (Tapeworm) |
| Approval Length | 6 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| ALBENDAZOLE | ALBENDAZOLE TAB 200 MG | 15000002000320 | Generic |
| EMVERM | MEBENDAZOLE CHEW TAB 100 MG | 15000010000505 | Brand |

**Approval Criteria**

**1** - Diagnosis of Hydatid Disease [Echinococcosis (Tapeworm)]

| Product Name: Emverm | |
|---|---|
| Diagnosis | Ancylostoma/Necatoriasis (Hookworm) |
| Approval Length | 1 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| EMVERM | MEBENDAZOLE CHEW TAB 100 MG | 15000010000505 | Brand |

**Approval Criteria**

**1** - Diagnosis of Ancylostoma/Necatoriasis (Hookworm)

| Product Name: Generic albendazole | |
|---|---|
| Diagnosis | Ancylostoma/Necatoriasis (Hookworm) |
| Approval Length | 6 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ALBENDAZOLE | ALBENDAZOLE TAB 200 MG | 15000002000320 | Generic |

**Approval Criteria**

**1** - Diagnosis of Ancylostoma/Necatoriasis (Hookworm)

| Product Name: Generic albendazole, Emverm | |
|---|---|
| Diagnosis | Ascariasis (Roundworm) |
| Approval Length | 1 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ALBENDAZOLE | ALBENDAZOLE TAB 200 MG | 15000002000320 | Generic |
| EMVERM | MEBENDAZOLE CHEW TAB 100 MG | 15000010000505 | Brand |

**Approval Criteria**

**1** - Diagnosis of Ascariasis (Roundworm)

| Product Name: Generic albendazole, Emverm | |
|---|---|
| Diagnosis | Toxocariasis (Roundworm) |
| Approval Length | 1 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ALBENDAZOLE | ALBENDAZOLE TAB 200 MG | 15000002000320 | Generic |
| EMVERM | MEBENDAZOLE CHEW TAB 100 MG | 15000010000505 | Brand |

**Approval Criteria**

**1** - Diagnosis of Toxocariasis (Roundworm)

| Product Name: Generic albendazole, Emverm | |
|---|---|
| Diagnosis | Trichinellosis |
| Approval Length | 1 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| ALBENDAZOLE | ALBENDAZOLE TAB 200 MG | 15000002000320 | Generic |
| EMVERM | MEBENDAZOLE CHEW TAB 100 MG | 15000010000505 | Brand |

**Approval Criteria**

**1** - Diagnosis of Trichinellosis

| Product Name: Generic albendazole, Emverm | |
|---|---|
| Diagnosis | Trichuriasis (Whipworm) |
| Approval Length | 1 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ALBENDAZOLE | ALBENDAZOLE TAB 200 MG | 15000002000320 | Generic |
| EMVERM | MEBENDAZOLE CHEW TAB 100 MG | 15000010000505 | Brand |

**Approval Criteria**

**1** - Diagnosis of Trichuriasis (Whipworm)

| Product Name: Generic albendazole, Emverm | |
|---|---|
| Diagnosis | Capillariasis |
| Approval Length | 1 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ALBENDAZOLE | ALBENDAZOLE TAB 200 MG | 15000002000320 | Generic |
| EMVERM | MEBENDAZOLE CHEW TAB 100 MG | 15000010000505 | Brand |

**Approval Criteria**

**1** - Diagnosis of Capillariasis

| Product Name: Generic albendazole, Emverm | |
|---|---|
| Diagnosis | Baylisascaris |
| Approval Length | 1 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ALBENDAZOLE | ALBENDAZOLE TAB 200 MG | 15000002000320 | Generic |
| EMVERM | MEBENDAZOLE CHEW TAB 100 MG | 15000010000505 | Brand |

**Approval Criteria**

**1** - Diagnosis of Baylisascaris

| Product Name: Generic albendazole | |
|---|---|
| Diagnosis | Clonorchiasis (Liver flukes) |
| Approval Length | 1 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ALBENDAZOLE | ALBENDAZOLE TAB 200 MG | 15000002000320 | Generic |

**Approval Criteria**

**1** - Diagnosis of Clonorchiasis (Liver flukes)

| Product Name: Generic albendazole | |
|---|---|
| Diagnosis | Gnathostomiasis |
| Approval Length | 1 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ALBENDAZOLE | ALBENDAZOLE TAB 200 MG | 15000002000320 | Generic |

**Approval Criteria**

**1** - Diagnosis of Gnathostomiasis

| Product Name: Generic albendazole | |
|---|---|
| Diagnosis | Strongyloidiasis |
| Approval Length | 1 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ALBENDAZOLE | ALBENDAZOLE TAB 200 MG | 15000002000320 | Generic |

**Approval Criteria**

**1** - Diagnosis of Strongyloidiasis

| Product Name: Generic albendazole | |
|---|---|
| Diagnosis | Loiasis |
| Approval Length | 1 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ALBENDAZOLE | ALBENDAZOLE TAB 200 MG | 15000002000320 | Generic |

**Approval Criteria**

**1** - Diagnosis of Loiasis

| Product Name: Generic albendazole | |
|---|---|
| Diagnosis | Opisthorchiasis |
| Approval Length | 1 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ALBENDAZOLE | ALBENDAZOLE TAB 200 MG | 15000002000320 | Generic |

**Approval Criteria**

**1** - Diagnosis of Opisthorchiasis

| Product Name: Generic albendazole | |
|---|---|
| Diagnosis | Anisakiasis |
| Approval Length | 1 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ALBENDAZOLE | ALBENDAZOLE TAB 200 MG | 15000002000320 | Generic |

**Approval Criteria**

**1** - Diagnosis of Anisakiasis

| Product Name: Generic albendazole | |
|---|---|
| Diagnosis | Microsporidiosis |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ALBENDAZOLE | ALBENDAZOLE TAB 200 MG | 15000002000320 | Generic |

**Approval Criteria**

**1** - Diagnosis of Microsporidiosis not caused by Enterocytozoon bieneusi or Vittaforma corneae

## 2 . Revision History

| Date | Notes |
|---|---|
| 9/24/2024 | Clarified spelling of Opisthorchiasis |

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-161699 |
| **Guideline Name** | Anticonvulsants |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 1 . Criteria

| Product Name: Aptiom, Briviact tabs/oral soln, Xcopri | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| APTIOM | ESLICARBAZEPINE ACETATE TAB 200 MG | 72600024100320 | Brand |
| APTIOM | ESLICARBAZEPINE ACETATE TAB 400 MG | 72600024100330 | Brand |
| APTIOM | ESLICARBAZEPINE ACETATE TAB 600 MG | 72600024100340 | Brand |
| APTIOM | ESLICARBAZEPINE ACETATE TAB 800 MG | 72600024100360 | Brand |
| BRIVIACT | BRIVARACETAM TAB 10 MG | 72600015000310 | Brand |
| BRIVIACT | BRIVARACETAM TAB 25 MG | 72600015000320 | Brand |

| | | | |
|---|---|---|---|
| BRIVIACT | BRIVARACETAM TAB 50 MG | 72600015000330 | Brand |
| BRIVIACT | BRIVARACETAM TAB 75 MG | 72600015000340 | Brand |
| BRIVIACT | BRIVARACETAM TAB 100 MG | 72600015000350 | Brand |
| BRIVIACT | BRIVARACETAM ORAL SOLN 10 MG/ML | 72600015002020 | Brand |
| XCOPRI | CENOBAMATE TAB TITRATION PACK 14 X 12.5 MG & 14 X 25 MG | 7212001000B720 | Brand |
| XCOPRI | CENOBAMATE TAB TITRATION PACK 14 X 50 MG & 14 X 100 MG | 7212001000B725 | Brand |
| XCOPRI | CENOBAMATE TAB TITRATION PACK 14 X 150 MG & 14 X 200 MG | 7212001000B730 | Brand |
| XCOPRI | CENOBAMATE TAB PACK 100 MG & 150 MG TABS (250 MG DAILY DOSE) | 7212001000B738 | Brand |
| XCOPRI | CENOBAMATE TAB PACK 150 MG & 200 MG TABS (350 MG DAILY DOSE) | 7212001000B740 | Brand |
| XCOPRI | CENOBAMATE TAB 50 MG | 72120010000320 | Brand |
| XCOPRI | CENOBAMATE TAB 100 MG | 72120010000325 | Brand |
| XCOPRI | CENOBAMATE TAB 150 MG | 72120010000330 | Brand |
| XCOPRI | CENOBAMATE TAB 200 MG | 72120010000335 | Brand |
| XCOPRI | CENOBAMATE TAB 25 MG | 72120010000310 | Brand |

**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)
- 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: Fycompa | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| FYCOMPA | PERAMPANEL TAB 2 MG | 72550060000310 | Brand |
| FYCOMPA | PERAMPANEL TAB 4 MG | 72550060000320 | Brand |
| FYCOMPA | PERAMPANEL TAB 6 MG | 72550060000330 | Brand |
| FYCOMPA | PERAMPANEL TAB 8 MG | 72550060000340 | Brand |
| FYCOMPA | PERAMPANEL TAB 10 MG | 72550060000350 | Brand |
| FYCOMPA | PERAMPANEL TAB 12 MG | 72550060000360 | Brand |
| FYCOMPA | PERAMPANEL SUSP 0.5 MG/ML | 72550060001820 | Brand |

**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)
- 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: generic lacosamide tabs/oral soln, Brand Vimpat tabs/oral soln | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LACOSAMIDE | LACOSAMIDE TAB 50 MG | 72600036000320 | Generic |
| VIMPAT | LACOSAMIDE TAB 50 MG | 72600036000320 | Brand |
| LACOSAMIDE | LACOSAMIDE TAB 100 MG | 72600036000330 | Generic |
| VIMPAT | LACOSAMIDE TAB 100 MG | 72600036000330 | Brand |
| LACOSAMIDE | LACOSAMIDE TAB 150 MG | 72600036000340 | Generic |

| | | | |
|---|---|---|---|
| VIMPAT | LACOSAMIDE TAB 150 MG | 72600036000340 | Brand |
| LACOSAMIDE | LACOSAMIDE TAB 200 MG | 72600036000350 | Generic |
| VIMPAT | LACOSAMIDE TAB 200 MG | 72600036000350 | Brand |
| LACOSAMIDE | LACOSAMIDE ORAL SOLUTION 10 MG/ML | 72600036002060 | Generic |
| VIMPAT | LACOSAMIDE ORAL SOLUTION 10 MG/ML | 72600036002060 | Brand |

**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)
- 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| EPIDIOLEX | CANNABIDIOL SOLN 100 MG/ML | 72600017002020 | Brand |

**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: Brand Onfi, generic clobazam | |
|---|---|
| Approval Length | 12 month(s) |

| Guideline Type | Prior Authorization |
|---|---|

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ONFI | CLOBAZAM TAB 10 MG | 72100007000310 | Brand |
| CLOBAZAM | CLOBAZAM TAB 10 MG | 72100007000310 | Generic |
| ONFI | CLOBAZAM TAB 20 MG | 72100007000320 | Brand |
| CLOBAZAM | CLOBAZAM TAB 20 MG | 72100007000320 | Generic |
| ONFI | CLOBAZAM SUSPENSION 2.5 MG/ML | 72100007001830 | Brand |
| CLOBAZAM | CLOBAZAM SUSPENSION 2.5 MG/ML | 72100007001830 | Generic |

**Approval Criteria**

**1** - For continuation of prior therapy for a seizure disorder

**OR**

**2** - BOTH of the following:

**2.1** ONE of the following:

- Diagnosis of seizures associated with Lennox-Gastaut syndrome
- Diagnosis of refractory partial onset seizures (four or more uncontrolled seizures per month after an adequate trial of at least two antiepileptic drugs)
- Diagnosis of Dravet syndrome

**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

| Product Name: generic rufinamide, Brand Banzel | |
|---|---|
| Approval Length | 12 month(s) |

| Guideline Type | Prior Authorization |
|---|---|

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RUFINAMIDE | RUFINAMIDE TAB 200 MG | 72600065000320 | Generic |
| BANZEL | RUFINAMIDE TAB 200 MG | 72600065000320 | Brand |
| RUFINAMIDE | RUFINAMIDE TAB 400 MG | 72600065000330 | Generic |
| BANZEL | RUFINAMIDE TAB 400 MG | 72600065000330 | Brand |
| RUFINAMIDE | RUFINAMIDE SUSP 40 MG/ML | 72600065001820 | Generic |
| BANZEL | RUFINAMIDE SUSP 40 MG/ML | 72600065001820 | Brand |

**Approval Criteria**

**1** - For continuation of prior therapy for a seizure disorder

**OR**

**2** - Diagnosis of seizures associated with Lennox-Gastaut syndrome

| Product Name: generic tiagabine, Brand Gabitril | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TIAGABINE HYDROCHLORIDE | TIAGABINE HCL TAB 2 MG | 72170070100302 | Generic |
| GABITRIL | TIAGABINE HCL TAB 2 MG | 72170070100302 | Brand |
| TIAGABINE HYDROCHLORIDE | TIAGABINE HCL TAB 4 MG | 72170070100305 | Generic |
| GABITRIL | TIAGABINE HCL TAB 4 MG | 72170070100305 | Brand |
| TIAGABINE HYDROCHLORIDE | TIAGABINE HCL TAB 12 MG | 72170070100315 | Generic |
| GABITRIL | TIAGABINE HCL TAB 12 MG | 72170070100315 | Brand |
| TIAGABINE HYDROCHLORIDE | TIAGABINE HCL TAB 16 MG | 72170070100320 | Generic |
| GABITRIL | TIAGABINE HCL TAB 16 MG | 72170070100320 | Brand |

**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)
- 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SYMPAZAN | CLOBAZAM ORAL FILM 5 MG | 72100007008205 | Brand |
| SYMPAZAN | CLOBAZAM ORAL FILM 10 MG | 72100007008210 | Brand |
| SYMPAZAN | CLOBAZAM ORAL FILM 20 MG | 72100007008220 | Brand |

**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:

- 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)
- 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, Vigadrone powd pack, generic vigabatrin powd pack | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SABRIL | VIGABATRIN POWD PACK 500 MG | 72170085003020 | Brand |
| VIGADRONE | VIGABATRIN POWD PACK 500 MG | 72170085003020 | Generic |
| VIGABATRIN | VIGABATRIN POWD PACK 500 MG | 72170085003020 | Generic |

**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, Vigadrone tablets, generic vigabatrin tablets | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SABRIL | VIGABATRIN TAB 500 MG | 72170085000320 | Brand |

| | | | |
|---|---|---|---|
| VIGABATRIN | VIGABATRIN TAB 500 MG | 72170085000320 | Generic |
| VIGADRONE | VIGABATRIN TAB 500 MG | 72170085000320 | Generic |

**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: Diacomit | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DIACOMIT | STIRIPENTOL CAP 250 MG | 72600070000120 | Brand |
| DIACOMIT | STIRIPENTOL CAP 500 MG | 72600070000130 | Brand |
| DIACOMIT | STIRIPENTOL PACKET 250 MG | 72600070003020 | Brand |
| DIACOMIT | STIRIPENTOL PACKET 500 MG | 72600070003030 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| FINTEPLA | FENFLURAMINE HCL ORAL SOLN 2.2 MG/ML | 72600028102020 | Brand |

**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 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** - ALL of the following:

**3.1** Diagnosis of seizures associated with Lennox-Gastaut syndrome

**AND**

**3.2** ONE of the following:

**3.2.1** Failure of a 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)
- Lamotrigine (e.g., generic Lamictal)
- Topiramate (e.g., generic Topamax)
- Valproic acid (e.g., generic Depakene)

**OR**

**3.2.2** History of intolerance or contraindication to ALL of the following (any release formulation qualifies) (please specify intolerance or contraindication):

- 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZTALMY | GANAXOLONE SUSP 50 MG/ML | 72600033001820 | Brand |

**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 |
|---|---|
| 12/5/2024 | Updated GPIs |

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146293 |
| **Guideline Name** | Antipsoriatic Agents |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: generic calcipotriene cream, generic calcipotriene ointment, generic calcitriol ointment | |
|---|---|
| Diagnosis | Psoriasis |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CALCIPOTRIENE | CALCIPOTRIENE CREAM 0.005% | 90250025003710 | Generic |
| CALCIPOTRIENE | CALCIPOTRIENE OINT 0.005% | 90250025004210 | Generic |
| CALCITRIOL | CALCITRIOL OINT 3 MCG/GM | 90250028004220 | Generic |

**Approval Criteria**

**1** - Diagnosis of psoriasis

**AND**

**2** - ONE of the following:

**2.1** Failure to TWO medium to high potency corticosteroid topical treatments (see Background) as confirmed by claims history or submission of medical records

**OR**

**2.2** History of intolerance or contraindication to TWO medium to high potency corticosteroid topical treatments (see Background) (please specify intolerance or contraindication)

## 2 . Background

**Benefit/Coverage/Program Information**

**Table 1. Relative Potency of Selected Topical Corticosteroid Products**

| Drug | Dosage Form | Strength |
|---|---|---|
| **Super-High Potency (group 1)** | | |
| Augmented betamethasone dipropionate (Diprolene) | Gel, Ointment, lotion | 0.05% |
| Clobetasol propionate (Clobex, Olux, Temovate, Temovate E) | Cream, Ointment, Gel, Solution, Lotion, Shampoo, Spray Aerosol, Foam Aerosol | 0.05% |
| Fluocinonide (Vanos) | Cream | 0.1% |
| Flurandrenolide (Cordran) | Tape (roll) | 4 mcg/cm$^2$ |
| Halobetasol propionate (Ultravate, Lexette) | Lotion, Cream, Ointment, Foam | 0.05% |

| | | |
|---|---|---|
| **High Potency (group 2)** | | |
| Amcinonide (Amcort) | Ointment | 0.1% |
| Augmented betamethasone dipropionate (Diprolene, Diprolene AF) | Cream, Lotion, Ointment | 0.05% |
| Betamethasone dipropionate | Lotion, Ointment | 0.05% |
| Clobetasol propionate (Impoyz) | Cream | 0.025% |
| Desoximetasone (Topicort) | Cream, Ointment, Spray | 0.25%, |
| | Gel | 0.05% |
| Diflorasone diacetate (Psorcon) | Cream, Ointment | 0.05% |
| Fluocinonide (Lidex, Lidex E) | Cream, Gel, Ointment, Solution | 0.05% |
| Halcinonide (Halog) | Cream, Ointment, Solution | 0.1% |
| Halobetasol propionate (Bryhali) | Lotion | 0.01% |
| | | |
| **High Potency (group 3)** | | |
| Amcinonide (Amcort) | Cream, Lotion | 0.1% |
| Betamethasone valerate (Valisone) | Ointment | 0.1% |
| Desoximetasone (Topicort) | Cream, ointment | 0.05% |
| Diflorasone diacetate (Florone, Psorcon) | Cream | 0.05% |
| Fluocinonide (Lidex-E) | Cream | 0.05% |
| Fluticasone propionate (Cutivate) | Ointment | 0.005% |
| Mometasone furoate (Elocon) | Ointment | 0.1% |
| Triamcinolone acetonide (Aristocort HP, Kenalog, Triderm) | Cream, ointment | 0.5% |

| | | |
|---|---|---|
| **Medium Potency (group 4)** | | |
| Betamethasone dipropionate (sernivo) | Spray | 0.05% |
| Clocortolone pivalate (Cloderm) | Cream | 0.1% |
| Fluocinolone acetonide (Synalar) | Cream, Ointment | 0.025% |
| Flurandrenolide (Cordran) | Ointment | 0.05% |
| Fluticasone propionate (Cutivate) | Cream, Lotion | 0.05% |
| Hydrocortisone valerate (Westcort) | Ointment | 0.2% |
| Mometasone furoate (Elocon) | Cream, lotion, Solution | 0.1% |
| Triamcinolone acetonide (Aristocort, Kenalog) | Cream, Lotion Ointment | 0.1% |
| | Ointment | 0.05% |

Antipsychotics

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-148167 |
| **Guideline Name** | Antipsychotics |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| CAPLYTA | LUMATEPERONE TOSYLATE CAP 10.5 MG | 59400022400110 | Brand |
| CAPLYTA | LUMATEPERONE TOSYLATE CAP 21 MG | 59400022400115 | Brand |
| CAPLYTA | LUMATEPERONE TOSYLATE CAP 42 MG | 59400022400120 | Brand |
| ARIPIPRAZOLE ODT | ARIPIPRAZOLE ORALLY DISINTEGRATING TAB 10 MG | 59250015007220 | Generic |
| ARIPIPRAZOLE ODT | ARIPIPRAZOLE ORALLY DISINTEGRATING TAB 15 MG | 59250015007230 | Generic |
| ARIPIPRAZOLE | ARIPIPRAZOLE ORAL SOLUTION 1 MG/ML | 59250015002020 | Generic |
| ABILIFY MAINTENA | ARIPIPRAZOLE IM FOR ER SUSP PREFILLED SYRINGE 300 MG | 5925001500E430 | Brand |
| ABILIFY MAINTENA | ARIPIPRAZOLE IM FOR ER SUSP PREFILLED SYRINGE 400 MG | 5925001500E440 | Brand |
| ABILIFY MAINTENA | ARIPIPRAZOLE IM FOR EXTENDED RELEASE SUSP 300 MG | 5925001500G230 | Brand |
| ABILIFY MAINTENA | ARIPIPRAZOLE IM FOR EXTENDED RELEASE SUSP 400 MG | 5925001500G240 | Brand |
| ABILIFY | ARIPIPRAZOLE TAB 2 MG | 59250015000305 | Brand |
| ARIPIPRAZOLE | ARIPIPRAZOLE TAB 2 MG | 59250015000305 | Generic |
| ABILIFY | ARIPIPRAZOLE TAB 5 MG | 59250015000310 | Brand |
| ARIPIPRAZOLE | ARIPIPRAZOLE TAB 5 MG | 59250015000310 | Generic |
| ABILIFY | ARIPIPRAZOLE TAB 10 MG | 59250015000320 | Brand |
| ARIPIPRAZOLE | ARIPIPRAZOLE TAB 10 MG | 59250015000320 | Generic |
| ABILIFY | ARIPIPRAZOLE TAB 15 MG | 59250015000330 | Brand |
| ARIPIPRAZOLE | ARIPIPRAZOLE TAB 15 MG | 59250015000330 | Generic |
| ABILIFY | ARIPIPRAZOLE TAB 20 MG | 59250015000340 | Brand |
| ARIPIPRAZOLE | ARIPIPRAZOLE TAB 20 MG | 59250015000340 | Generic |
| ABILIFY | ARIPIPRAZOLE TAB 30 MG | 59250015000350 | Brand |
| ARIPIPRAZOLE | ARIPIPRAZOLE TAB 30 MG | 59250015000350 | Generic |
| ABILIFY ASIMTUFII | ARIPIPRAZOLE IM ER SUSP PREFILLED SYRINGE 720 MG/2.4ML | 5925001500E455 | Brand |
| ABILIFY ASIMTUFII | ARIPIPRAZOLE IM ER SUSP PREFILLED SYRINGE 960 MG/3.2ML | 5925001500E465 | Brand |
| ARISTADA | ARIPIPRAZOLE LAUROXIL IM ER SUSP PREFILLED SYR 441 MG/1.6ML | 5925001520E420 | Brand |
| ARISTADA | ARIPIPRAZOLE LAUROXIL IM ER SUSP PREFILLED SYR 662 MG/2.4ML | 5925001520E430 | Brand |
| ARISTADA | ARIPIPRAZOLE LAUROXIL IM ER SUSP PREFILLED SYR 882 MG/3.2ML | 5925001520E440 | Brand |

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| ARISTADA | ARIPIPRAZOLE LAUROXIL IM ER SUSP PREFILLED SYR 1064 MG/3.9ML | 5925001520E450 | Brand |
| ARISTADA INITIO | ARIPIPRAZOLE LAUROXIL IM ER SUSP PREFILLED SYR 675 MG/2.4ML | 5925001520E435 | Brand |
| CLOZAPINE | CLOZAPINE TAB 25 MG | 59152020000320 | Generic |
| CLOZARIL | CLOZAPINE TAB 25 MG | 59152020000320 | Brand |
| CLOZAPINE | CLOZAPINE TAB 50 MG | 59152020000325 | Generic |
| CLOZARIL | CLOZAPINE TAB 50 MG | 59152020000325 | Brand |
| CLOZAPINE | CLOZAPINE TAB 100 MG | 59152020000330 | Generic |
| CLOZARIL | CLOZAPINE TAB 100 MG | 59152020000330 | Brand |
| CLOZAPINE | CLOZAPINE TAB 200 MG | 59152020000340 | Generic |
| CLOZARIL | CLOZAPINE TAB 200 MG | 59152020000340 | Brand |
| CLOZAPINE ODT | CLOZAPINE ORALLY DISINTEGRATING TAB 12.5 MG | 59152020007210 | Generic |
| CLOZAPINE ODT | CLOZAPINE ORALLY DISINTEGRATING TAB 25 MG | 59152020007220 | Generic |
| CLOZAPINE ODT | CLOZAPINE ORALLY DISINTEGRATING TAB 100 MG | 59152020007230 | Generic |
| CLOZAPINE ODT | CLOZAPINE ORALLY DISINTEGRATING TAB 150 MG | 59152020007240 | Generic |
| CLOZAPINE ODT | CLOZAPINE ORALLY DISINTEGRATING TAB 200 MG | 59152020007250 | Generic |
| FANAPT | ILOPERIDONE TAB 1 MG | 59070035000310 | Brand |
| FANAPT | ILOPERIDONE TAB 2 MG | 59070035000320 | Brand |
| FANAPT | ILOPERIDONE TAB 4 MG | 59070035000340 | Brand |
| FANAPT | ILOPERIDONE TAB 6 MG | 59070035000360 | Brand |
| FANAPT | ILOPERIDONE TAB 8 MG | 59070035000380 | Brand |
| FANAPT | ILOPERIDONE TAB 10 MG | 59070035000385 | Brand |
| FANAPT | ILOPERIDONE TAB 12 MG | 59070035000390 | Brand |
| FANAPT TITRATION PACK | ILOPERIDONE TAB 1 MG & 2 MG & 4 MG & 6 MG TITRATION PAK | 59070035006320 | Brand |
| ZIPRASIDONE HYDROCHLORIDE | ZIPRASIDONE HCL CAP 20 MG | 59400085100120 | Generic |
| GEODON | ZIPRASIDONE HCL CAP 20 MG | 59400085100120 | Brand |
| ZIPRASIDONE HCL | ZIPRASIDONE HCL CAP 20 MG | 59400085100120 | Generic |
| ZIPRASIDONE HYDROCHLORIDE | ZIPRASIDONE HCL CAP 40 MG | 59400085100130 | Generic |
| GEODON | ZIPRASIDONE HCL CAP 40 MG | 59400085100130 | Brand |

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| ZIPRASIDONE HCL | ZIPRASIDONE HCL CAP 40 MG | 59400085100130 | Generic |
| ZIPRASIDONE HYDROCHLORIDE | ZIPRASIDONE HCL CAP 60 MG | 59400085100140 | Generic |
| GEODON | ZIPRASIDONE HCL CAP 60 MG | 59400085100140 | Brand |
| ZIPRASIDONE HCL | ZIPRASIDONE HCL CAP 60 MG | 59400085100140 | Generic |
| ZIPRASIDONE HYDROCHLORIDE | ZIPRASIDONE HCL CAP 80 MG | 59400085100150 | Generic |
| GEODON | ZIPRASIDONE HCL CAP 80 MG | 59400085100150 | Brand |
| ZIPRASIDONE HCL | ZIPRASIDONE HCL CAP 80 MG | 59400085100150 | Generic |
| PALIPERIDONE ER | PALIPERIDONE TAB ER 24HR 3 MG | 59070050007510 | Generic |
| INVEGA | PALIPERIDONE TAB ER 24HR 3 MG | 59070050007510 | Brand |
| PALIPERIDONE ER | PALIPERIDONE TAB ER 24HR 6 MG | 59070050007520 | Generic |
| INVEGA | PALIPERIDONE TAB ER 24HR 6 MG | 59070050007520 | Brand |
| PALIPERIDONE ER | PALIPERIDONE TAB ER 24HR 9 MG | 59070050007530 | Generic |
| INVEGA | PALIPERIDONE TAB ER 24HR 9 MG | 59070050007530 | Brand |
| INVEGA SUSTENNA | PALIPERIDONE PALMITATE ER SUSP PREF SYR 39 MG/0.25ML | 5907005010E626 | Brand |
| INVEGA SUSTENNA | PALIPERIDONE PALMITATE ER SUSP PREF SYR 78 MG/0.5ML | 5907005010E629 | Brand |
| INVEGA SUSTENNA | PALIPERIDONE PALMITATE ER SUSP PREF SYR 117 MG/0.75ML | 5907005010E632 | Brand |
| INVEGA SUSTENNA | PALIPERIDONE PALMITATE ER SUSP PREF SYR 156 MG/ML | 5907005010E635 | Brand |
| INVEGA SUSTENNA | PALIPERIDONE PALMITATE ER SUSP PREF SYR 234 MG/1.5ML | 5907005010E638 | Brand |
| INVEGA TRINZA | PALIPERIDONE PALMITATE ER SUSP PREF SYR 273 MG/0.88ML | 5907005010E643 | Brand |
| INVEGA TRINZA | PALIPERIDONE PALMITATE ER SUSP PREF SYR 410 MG/1.32ML | 5907005010E647 | Brand |
| INVEGA TRINZA | PALIPERIDONE PALMITATE ER SUSP PREF SYR 546 MG/1.75ML | 5907005010E651 | Brand |
| INVEGA TRINZA | PALIPERIDONE PALMITATE ER SUSP PREF SYR 819 MG/2.63ML | 5907005010E655 | Brand |
| INVEGA HAFYERA | PALIPERIDONE PALMITATE ER SUSP PREF SYR 1,092 MG/3.5ML | 5907005010E670 | Brand |
| INVEGA HAFYERA | PALIPERIDONE PALMITATE ER SUSP PREF SYR 1,560 MG/5ML | 5907005010E675 | Brand |

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|---|---|---|---|
| LURASIDONE HYDROCHLORIDE | LURASIDONE HCL TAB 20 MG | 59400023100310 | Generic |
| LATUDA | LURASIDONE HCL TAB 20 MG | 59400023100310 | Brand |
| LURASIDONE HYDROCHLORIDE | LURASIDONE HCL TAB 40 MG | 59400023100320 | Generic |
| LATUDA | LURASIDONE HCL TAB 40 MG | 59400023100320 | Brand |
| LURASIDONE HYDROCHLORIDE | LURASIDONE HCL TAB 60 MG | 59400023100330 | Generic |
| LATUDA | LURASIDONE HCL TAB 60 MG | 59400023100330 | Brand |
| LURASIDONE HYDROCHLORIDE | LURASIDONE HCL TAB 80 MG | 59400023100340 | Generic |
| LATUDA | LURASIDONE HCL TAB 80 MG | 59400023100340 | Brand |
| LURASIDONE HYDROCHLORIDE | LURASIDONE HCL TAB 120 MG | 59400023100350 | Generic |
| LATUDA | LURASIDONE HCL TAB 120 MG | 59400023100350 | Brand |
| LYBALVI | OLANZAPINE-SAMIDORPHAN L-MALATE TAB 5-10 MG | 62994802500310 | Brand |
| LYBALVI | OLANZAPINE-SAMIDORPHAN L-MALATE TAB 10-10 MG | 62994802500320 | Brand |
| LYBALVI | OLANZAPINE-SAMIDORPHAN L-MALATE TAB 15-10 MG | 62994802500330 | Brand |
| LYBALVI | OLANZAPINE-SAMIDORPHAN L-MALATE TAB 20-10 MG | 62994802500340 | Brand |
| MOLINDONE HYDROCHLORIDE | MOLINDONE HCL TAB 5 MG | 59160050100305 | Generic |
| MOLINDONE HYDROCHLORIDE | MOLINDONE HCL TAB 10 MG | 59160050100310 | Generic |
| MOLINDONE HYDROCHLORIDE | MOLINDONE HCL TAB 25 MG | 59160050100315 | Generic |
| PERSERIS | RISPERIDONE SUBCUTANEOUS FOR ER SUSP PREFILLED SYR 90 MG | 5907007000E420 | Brand |
| PERSERIS | RISPERIDONE SUBCUTANEOUS FOR ER SUSP PREFILLED SYR 120 MG | 5907007000E430 | Brand |
| REXULTI | BREXPIPRAZOLE TAB 0.25 MG | 59250020000310 | Brand |
| REXULTI | BREXPIPRAZOLE TAB 0.5 MG | 59250020000320 | Brand |
| REXULTI | BREXPIPRAZOLE TAB 1 MG | 59250020000330 | Brand |
| REXULTI | BREXPIPRAZOLE TAB 2 MG | 59250020000340 | Brand |
| REXULTI | BREXPIPRAZOLE TAB 3 MG | 59250020000350 | Brand |
| REXULTI | BREXPIPRAZOLE TAB 4 MG | 59250020000360 | Brand |
| RISPERIDONE | RISPERIDONE TAB 0.5 MG | 59070070000306 | Generic |

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|---|---|---|---|
| RISPERDAL | RISPERIDONE TAB 0.5 MG | 59070070000306 | Brand |
| RISPERIDONE | RISPERIDONE TAB 1 MG | 59070070000310 | Generic |
| RISPERDAL | RISPERIDONE TAB 1 MG | 59070070000310 | Brand |
| RISPERIDONE | RISPERIDONE TAB 2 MG | 59070070000320 | Generic |
| RISPERDAL | RISPERIDONE TAB 2 MG | 59070070000320 | Brand |
| RISPERIDONE | RISPERIDONE TAB 3 MG | 59070070000330 | Generic |
| RISPERDAL | RISPERIDONE TAB 3 MG | 59070070000330 | Brand |
| RISPERIDONE | RISPERIDONE TAB 4 MG | 59070070000340 | Generic |
| RISPERDAL | RISPERIDONE TAB 4 MG | 59070070000340 | Brand |
| RISPERIDONE | RISPERIDONE SOLN 1 MG/ML | 59070070002010 | Generic |
| RISPERDAL | RISPERIDONE SOLN 1 MG/ML | 59070070002010 | Brand |
| RISPERIDONE ODT | RISPERIDONE ORALLY DISINTEGRATING TAB 0.25 MG | 59070070007210 | Generic |
| RISPERIDONE ODT | RISPERIDONE ORALLY DISINTEGRATING TAB 0.5 MG | 59070070007220 | Generic |
| RISPERIDONE ODT | RISPERIDONE ORALLY DISINTEGRATING TAB 1 MG | 59070070007230 | Generic |
| RISPERIDONE ODT | RISPERIDONE ORALLY DISINTEGRATING TAB 2 MG | 59070070007240 | Generic |
| RISPERIDONE ODT | RISPERIDONE ORALLY DISINTEGRATING TAB 3 MG | 59070070007250 | Generic |
| RISPERIDONE ODT | RISPERIDONE ORALLY DISINTEGRATING TAB 4 MG | 59070070007260 | Generic |
| RISPERDAL CONSTA | RISPERIDONE MICROSPHERES FOR IM EXTENDED REL SUSP 12.5 MG | 5907007010G210 | Brand |
| RISPERIDONE ER | RISPERIDONE MICROSPHERES FOR IM EXTENDED REL SUSP 12.5 MG | 5907007010G210 | Generic |
| RISPERDAL CONSTA | RISPERIDONE MICROSPHERES FOR IM EXTENDED REL SUSP 25 MG | 5907007010G220 | Brand |
| RISPERIDONE ER | RISPERIDONE MICROSPHERES FOR IM EXTENDED REL SUSP 25 MG | 5907007010G220 | Generic |
| RISPERDAL CONSTA | RISPERIDONE MICROSPHERES FOR IM EXTENDED REL SUSP 37.5 MG | 5907007010G230 | Brand |
| RISPERIDONE ER | RISPERIDONE MICROSPHERES FOR IM EXTENDED REL SUSP 37.5 MG | 5907007010G230 | Generic |
| RISPERDAL CONSTA | RISPERIDONE MICROSPHERES FOR IM EXTENDED REL SUSP 50 MG | 5907007010G240 | Brand |
| RISPERIDONE ER | RISPERIDONE MICROSPHERES FOR IM EXTENDED REL SUSP 50 MG | 5907007010G240 | Generic |
| RYKINDO | RISPERIDONE FOR IM EXTENDED RELEASE SUSPENSION 25 MG | 5907007000G220 | Brand |

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|---|---|---|---|
| RYKINDO | RISPERIDONE FOR IM EXTENDED RELEASE SUSPENSION 37.5 MG | 5907007000G230 | Brand |
| RYKINDO | RISPERIDONE FOR IM EXTENDED RELEASE SUSPENSION 50 MG | 5907007000G240 | Brand |
| SAPHRIS | ASENAPINE MALEATE SL TAB 2.5 MG (BASE EQUIV) | 59155015100710 | Brand |
| ASENAPINE MALEATE SL | ASENAPINE MALEATE SL TAB 2.5 MG (BASE EQUIV) | 59155015100710 | Generic |
| SAPHRIS | ASENAPINE MALEATE SL TAB 5 MG (BASE EQUIV) | 59155015100720 | Brand |
| ASENAPINE MALEATE SL | ASENAPINE MALEATE SL TAB 5 MG (BASE EQUIV) | 59155015100720 | Generic |
| SAPHRIS | ASENAPINE MALEATE SL TAB 10 MG (BASE EQUIV) | 59155015100730 | Brand |
| ASENAPINE MALEATE SL | ASENAPINE MALEATE SL TAB 10 MG (BASE EQUIV) | 59155015100730 | Generic |
| SECUADO | ASENAPINE TD PATCH 24 HR 3.8 MG/24HR | 59155015008520 | Brand |
| SECUADO | ASENAPINE TD PATCH 24 HR 5.7 MG/24HR | 59155015008530 | Brand |
| SECUADO | ASENAPINE TD PATCH 24 HR 7.6 MG/24HR | 59155015008540 | Brand |
| QUETIAPINE FUMARATE | QUETIAPINE FUMARATE TAB 25 MG | 59153070100310 | Generic |
| SEROQUEL | QUETIAPINE FUMARATE TAB 25 MG | 59153070100310 | Brand |
| QUETIAPINE FUMARATE | QUETIAPINE FUMARATE TAB 50 MG | 59153070100314 | Generic |
| SEROQUEL | QUETIAPINE FUMARATE TAB 50 MG | 59153070100314 | Brand |
| QUETIAPINE FUMARATE | QUETIAPINE FUMARATE TAB 100 MG | 59153070100320 | Generic |
| SEROQUEL | QUETIAPINE FUMARATE TAB 100 MG | 59153070100320 | Brand |
| QUETIAPINE FUMARATE | QUETIAPINE FUMARATE TAB 200 MG | 59153070100330 | Generic |
| SEROQUEL | QUETIAPINE FUMARATE TAB 200 MG | 59153070100330 | Brand |
| QUETIAPINE FUMARATE | QUETIAPINE FUMARATE TAB 300 MG | 59153070100340 | Generic |
| SEROQUEL | QUETIAPINE FUMARATE TAB 300 MG | 59153070100340 | Brand |
| QUETIAPINE FUMARATE | QUETIAPINE FUMARATE TAB 400 MG | 59153070100350 | Generic |
| SEROQUEL | QUETIAPINE FUMARATE TAB 400 MG | 59153070100350 | Brand |
| UZEDY | RISPERIDONE SUBCUTANEOUS ER SUSP PREF SYR 50 MG/0.14ML | 5907007000E610 | Brand |
| UZEDY | RISPERIDONE SUBCUTANEOUS ER SUSP PREF SYR 75 MG/0.21ML | 5907007000E618 | Brand |

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|---|---|---|---|
| UZEDY | RISPERIDONE SUBCUTANEOUS ER SUSP PREF SYR 100 MG/0.28ML | 5907007000E626 | Brand |
| UZEDY | RISPERIDONE SUBCUTANEOUS ER SUSP PREF SYR 125 MG/0.35ML | 5907007000E634 | Brand |
| UZEDY | RISPERIDONE SUBCUTANEOUS ER SUSP PREF SYR 150 MG/0.42ML | 5907007000E642 | Brand |
| UZEDY | RISPERIDONE SUBCUTANEOUS ER SUSP PREF SYR 200 MG/0.56ML | 5907007000E658 | Brand |
| UZEDY | RISPERIDONE SUBCUTANEOUS ER SUSP PREF SYR 250 MG/0.7ML | 5907007000E674 | Brand |
| VRAYLAR | CARIPRAZINE HCL CAP 1.5 MG (BASE EQUIVALENT) | 59400018100120 | Brand |
| VRAYLAR | CARIPRAZINE HCL CAP 3 MG (BASE EQUIVALENT) | 59400018100130 | Brand |
| VRAYLAR | CARIPRAZINE HCL CAP 4.5 MG (BASE EQUIVALENT) | 59400018100140 | Brand |
| VRAYLAR | CARIPRAZINE HCL CAP 6 MG (BASE EQUIVALENT) | 59400018100150 | Brand |
| ZYPREXA | OLANZAPINE TAB 2.5 MG | 59157060000305 | Brand |
| OLANZAPINE | OLANZAPINE TAB 2.5 MG | 59157060000305 | Generic |
| ZYPREXA | OLANZAPINE TAB 5 MG | 59157060000310 | Brand |
| OLANZAPINE | OLANZAPINE TAB 5 MG | 59157060000310 | Generic |
| ZYPREXA | OLANZAPINE TAB 7.5 MG | 59157060000315 | Brand |
| OLANZAPINE | OLANZAPINE TAB 7.5 MG | 59157060000315 | Generic |
| ZYPREXA | OLANZAPINE TAB 10 MG | 59157060000320 | Brand |
| OLANZAPINE | OLANZAPINE TAB 10 MG | 59157060000320 | Generic |
| ZYPREXA | OLANZAPINE TAB 15 MG | 59157060000330 | Brand |
| OLANZAPINE | OLANZAPINE TAB 15 MG | 59157060000330 | Generic |
| ZYPREXA | OLANZAPINE TAB 20 MG | 59157060000340 | Brand |
| OLANZAPINE | OLANZAPINE TAB 20 MG | 59157060000340 | Generic |
| OLANZAPINE ODT | OLANZAPINE ORALLY DISINTEGRATING TAB 5 MG | 59157060007210 | Generic |
| ZYPREXA ZYDIS | OLANZAPINE ORALLY DISINTEGRATING TAB 5 MG | 59157060007210 | Brand |
| OLANZAPINE ODT | OLANZAPINE ORALLY DISINTEGRATING TAB 10 MG | 59157060007220 | Generic |
| ZYPREXA ZYDIS | OLANZAPINE ORALLY DISINTEGRATING TAB 10 MG | 59157060007220 | Brand |
| OLANZAPINE ODT | OLANZAPINE ORALLY DISINTEGRATING TAB 15 MG | 59157060007230 | Generic |

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|---|---|---|---|
| ZYPREXA ZYDIS | OLANZAPINE ORALLY DISINTEGRATING TAB 15 MG | 59157060007230 | Brand |
| OLANZAPINE ODT | OLANZAPINE ORALLY DISINTEGRATING TAB 20 MG | 59157060007240 | Generic |
| ZYPREXA ZYDIS | OLANZAPINE ORALLY DISINTEGRATING TAB 20 MG | 59157060007240 | Brand |
| VERSACLOZ | CLOZAPINE SUSP 50 MG/ML | 59152020001820 | Brand |
| ABILIFY MYCITE STARTER KIT | ARIPIPRAZOLE TAB 2 MG WITH SENSOR, STRIPS & POD STARTER PAK | 5925001503B705 | Brand |
| ABILIFY MYCITE MAINTENANCE KIT | ARIPIPRAZOLE TAB 2 MG WITH SENSOR&STRIPS (FOR POD) MAINT PAK | 5925001503B706 | Brand |
| ABILIFY MYCITE STARTER KIT | ARIPIPRAZOLE TAB 5 MG WITH SENSOR, STRIPS & POD STARTER PAK | 5925001503B710 | Brand |
| ABILIFY MYCITE MAINTENANCE KIT | ARIPIPRAZOLE TAB 5 MG WITH SENSOR&STRIPS (FOR POD) MAINT PAK | 5925001503B711 | Brand |
| ABILIFY MYCITE STARTER KIT | ARIPIPRAZOLE TAB 10 MG WITH SENSOR, STRIPS & POD STARTER PAK | 5925001503B720 | Brand |
| ABILIFY MYCITE MAINTENANCE KIT | ARIPIPRAZOLE TAB 10 MG WITH SENSOR&STRIPS(FOR POD) MAINT PAK | 5925001503B721 | Brand |
| ABILIFY MYCITE STARTER KIT | ARIPIPRAZOLE TAB 15 MG WITH SENSOR, STRIPS & POD STARTER PAK | 5925001503B730 | Brand |
| ABILIFY MYCITE MAINTENANCE KIT | ARIPIPRAZOLE TAB 15 MG WITH SENSOR&STRIPS(FOR POD) MAINT PAK | 5925001503B731 | Brand |
| ABILIFY MYCITE STARTER KIT | ARIPIPRAZOLE TAB 20 MG WITH SENSOR, STRIPS & POD STARTER PAK | 5925001503B740 | Brand |
| ABILIFY MYCITE MAINTENANCE KIT | ARIPIPRAZOLE TAB 20 MG WITH SENSOR&STRIPS(FOR POD) MAINT PAK | 5925001503B741 | Brand |
| ABILIFY MYCITE STARTER KIT | ARIPIPRAZOLE TAB 30 MG WITH SENSOR, STRIPS & POD STARTER PAK | 5925001503B750 | Brand |
| ABILIFY MYCITE MAINTENANCE KIT | ARIPIPRAZOLE TAB 30 MG WITH SENSOR&STRIPS(FOR POD) MAINT PAK | 5925001503B751 | Brand |
| RISPERIDONE | RISPERIDONE TAB 0.25 MG | 59070070000303 | Generic |
| PALIPERIDONE ER | PALIPERIDONE TAB ER 24HR 1.5 MG | 59070050007505 | Generic |
| QUETIAPINE FUMARATE ER | QUETIAPINE FUMARATE TAB ER 24HR 50 MG | 59153070107505 | Generic |
| SEROQUEL XR | QUETIAPINE FUMARATE TAB ER 24HR 50 MG | 59153070107505 | Brand |
| QUETIAPINE FUMARATE ER | QUETIAPINE FUMARATE TAB ER 24HR 150 MG | 59153070107515 | Generic |

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|---|---|---|---|
| SEROQUEL XR | QUETIAPINE FUMARATE TAB ER 24HR 150 MG | 59153070107515 | Brand |
| QUETIAPINE FUMARATE ER | QUETIAPINE FUMARATE TAB ER 24HR 200 MG | 59153070107520 | Generic |
| SEROQUEL XR | QUETIAPINE FUMARATE TAB ER 24HR 200 MG | 59153070107520 | Brand |
| QUETIAPINE FUMARATE ER | QUETIAPINE FUMARATE TAB ER 24HR 300 MG | 59153070107530 | Generic |
| SEROQUEL XR | QUETIAPINE FUMARATE TAB ER 24HR 300 MG | 59153070107530 | Brand |
| QUETIAPINE FUMARATE ER | QUETIAPINE FUMARATE TAB ER 24HR 400 MG | 59153070107540 | Generic |
| SEROQUEL XR | QUETIAPINE FUMARATE TAB ER 24HR 400 MG | 59153070107540 | Brand |
| QUETIAPINE FUMARATE | QUETIAPINE FUMARATE TAB 150 MG | 59153070100325 | Generic |

**Approval Criteria**

**1** - ALL of the following:

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

**AND**

**1.2** 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**

**1.3** ONE of the following:

**1.3.1** Patient has ONE of the following diagnoses:

- Schizophrenia or schizoaffective disorder
- Autism
- Bipolar disorder

**OR**

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

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|---|---|
| Notes | *See Table 1 in the Background section for UHC C&S Plan Minimum Age Edits<br>**PDL link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |

| Product Name: Caplyta | |
|---|---|
| Diagnosis | Caplyta Requests Exceeding Quantity Limit |
| Approval Length | 12 month(s) |
| Guideline Type | Quantity Limit |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CAPLYTA | LUMATEPERONE TOSYLATE CAP 10.5 MG | 59400022400110 | Brand |
| CAPLYTA | LUMATEPERONE TOSYLATE CAP 21 MG | 59400022400115 | Brand |
| CAPLYTA | LUMATEPERONE TOSYLATE CAP 42 MG | 59400022400120 | Brand |

**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 (NOTE: The treatment effect of Caplyta at doses higher than 42 mg daily versus placebo was NOT statistically significant in clinical trials)

## 2 . Background

| Benefit/Coverage/Program Information |
| --- |
| **Table 1: UHC C&S Plan Minimum Age Edits: Based on FDA-approved uses, prior authorization is required for antipsychotic medications for members less than the following ages:**<br>• Abilify Discmelt, Abilify oral solution – 6 years of age<br>• Abilify Maintena – 18 years of age<br>• Abilify MyCite – 18 years of age<br>• Abilify oral tablets – 6 years of age<br>• Abilify Asimtufii – 18 years of age<br>• Aristada – 18 years of age<br>• Caplyta – 18 years of age<br>• Clozaril – 18 years of age<br>• Fanapt – 18 years of age<br>• Geodon – 18 years of age<br>• Invega – 12 years of age<br>• Invega Sustenna – 18 years of age<br>• Invega Trinza – 18 years of age<br>• Invega Hafyera – 18 years of age<br>• Latuda – 10 years of age<br>• Lybalvi – 18 years of age<br>• Molindone – 12 years of age<br>• Perseris – 18 years of age<br>• Rexulti – 18 years of age<br>• Risperdal – 5 years of age<br>• Risperdal Consta – 18 years of age<br>• Rykindo – 18 years of age<br>• Saphris – 10 years of age<br>• Secuado – 18 years of age<br>• Seroquel, Seroquel XR – 10 years of age<br>• Uzedy – 18 years of age<br>• Vraylar – 18 years of age<br>• Zyprexa – 13 years of age<br>• Zyprexa Zydis – 6 years of age |

## 3 . Revision History

| Date | Notes |
| --- | --- |
| 6/7/2024 | New program. |

Apokyn

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146471 |
| **Guideline Name** | Apokyn |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Brand Apokyn, generic apomorphine hcl | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| APOKYN | APOMORPHINE HCL SOLN CARTRIDGE 30 MG/3ML | 7320301010E220 | Brand |
| APOMORPHINE HYDROCHLORIDE | APOMORPHINE HCL SOLN CARTRIDGE 30 MG/3ML | 7320301010E220 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| APOKYN | APOMORPHINE HCL SOLN CARTRIDGE 30 MG/3ML | 7320301010E220 | Brand |
| APOMORPHINE HYDROCHLORIDE | APOMORPHINE HCL SOLN CARTRIDGE 30 MG/3ML | 7320301010E220 | Generic |

**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

Arcalyst

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146472 |
| **Guideline Name** | Arcalyst |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Arcalyst | |
|---|---|
| Diagnosis | Cryopyrin-Associated Periodic Syndromes (CAPS) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ARCALYST | RILONACEPT FOR INJ 220 MG | 66450060002120 | Brand |

**Approval Criteria**

**1** - Diagnosis of Cryopyrin-Associated Periodic Syndromes (CAPS), including Familial Cold Auto-inflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS)

| Product Name: Arcalyst | |
|---|---|
| Diagnosis | Deficiency of Interleukin-1 Receptor Antagonist (DIRA) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ARCALYST | RILONACEPT FOR INJ 220 MG | 66450060002120 | Brand |

**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)

| Product Name: Arcalyst | |
|---|---|
| Diagnosis | Pericarditis |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ARCALYST | RILONACEPT FOR INJ 220 MG | 66450060002120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ARCALYST | RILONACEPT FOR INJ 220 MG | 66450060002120 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Arcalyst therapy

Arikayce

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146473 |
| **Guideline Name** | Arikayce |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ARIKAYCE | AMIKACIN SULFATE LIPOSOME INHAL SUSP 590 MG/8.4ML (BASE EQ) | 07000010121830 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ARIKAYCE | AMIKACIN SULFATE LIPOSOME INHAL SUSP 590 MG/8.4ML (BASE EQ) | 07000010121830 | Brand |

**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

Augtyro

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-155867 |
| **Guideline Name** | Augtyro |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 11/1/2024 |

## 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AUGTYRO | REPOTRECTINIB CAP 40 MG | 21533865000120 | Brand |

**Approval Criteria**

**1** - Diagnosis of non-small cell lung cancer (NSCLC)

**AND**

**2** - Disease is ONE of the following:

- Advanced
- Metastatic

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AUGTYRO | REPOTRECTINIB CAP 40 MG | 21533865000120 | Brand |

**Approval Criteria**

**1** - Presence of solid tumor(s)

**AND**

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

**AND**

**2** - 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AUGTYRO | REPOTRECTINIB CAP 40 MG | 21533865000120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AUGTYRO | REPOTRECTINIB CAP 40 MG | 21533865000120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AUGTYRO | REPOTRECTINIB CAP 40 MG | 21533865000120 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Augtyro therapy

## 2 . Revision History

| Date | Notes |
|---|---|
| 9/24/2024 | Added criteria for Solid Tumors. |

Austedo

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-159281 |
| **Guideline Name** | Austedo |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 1 . Criteria

| Product Name: Austedo* | |
|---|---|
| Diagnosis | Tardive Dyskinesia |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AUSTEDO PATIENT TITRATION KIT | DEUTETRABENAZINE TAB TITRATION PACK 6 MG & 9 MG & 12 MG | 6238003000B720 | Brand |
| AUSTEDO | DEUTETRABENAZINE TAB 6 MG | 62380030000310 | Brand |

| | | | |
|---|---|---|---|
| AUSTEDO | DEUTETRABENAZINE TAB 9 MG | 62380030000320 | Brand |
| AUSTEDO | DEUTETRABENAZINE TAB 12 MG | 62380030000330 | Brand |

**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

| | |
|---|---|
| Notes | *Austedo XR not applicable to this guideline |

| Product Name: Austedo* | |
|---|---|
| Diagnosis | Tardive Dyskinesia |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AUSTEDO PATIENT TITRATION KIT | DEUTETRABENAZINE TAB TITRATION PACK 6 MG & 9 MG & 12 MG | 6238003000B720 | Brand |
| AUSTEDO | DEUTETRABENAZINE TAB 6 MG | 62380030000310 | Brand |
| AUSTEDO | DEUTETRABENAZINE TAB 9 MG | 62380030000320 | Brand |
| AUSTEDO | DEUTETRABENAZINE TAB 12 MG | 62380030000330 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Austedo therapy

| Notes | *Austedo XR not applicable to this guideline |
|---|---|

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AUSTEDO PATIENT TITRATION KIT | DEUTETRABENAZINE TAB TITRATION PACK 6 MG & 9 MG & 12 MG | 6238003000B720 | Brand |
| AUSTEDO | DEUTETRABENAZINE TAB 6 MG | 62380030000310 | Brand |
| AUSTEDO | DEUTETRABENAZINE TAB 9 MG | 62380030000320 | Brand |
| AUSTEDO | DEUTETRABENAZINE TAB 12 MG | 62380030000330 | Brand |

**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

| Notes | *Austedo XR not applicable to this guideline |
|---|---|

| Product Name: Austedo* | |
|---|---|
| Diagnosis | Chorea associated with Huntington's Disease |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AUSTEDO PATIENT TITRATION KIT | DEUTETRABENAZINE TAB TITRATION PACK 6 MG & 9 MG & 12 MG | 6238003000B720 | Brand |
| AUSTEDO | DEUTETRABENAZINE TAB 6 MG | 62380030000310 | Brand |
| AUSTEDO | DEUTETRABENAZINE TAB 9 MG | 62380030000320 | Brand |
| AUSTEDO | DEUTETRABENAZINE TAB 12 MG | 62380030000330 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Austedo therapy

| Notes | *Austedo XR not applicable to this guideline |
|---|---|

## 2 . Revision History

| Date | Notes |
|---|---|

| | |
|---|---|
| 11/5/2024 | For Huntington's disease: Removed step through tetrabenazine and updated prescriber requirement to allow psychiatrist. Clarified that Au stedo XR is not applicable to this guideline |

Ayvakit

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-154695 |
| **Guideline Name** | Ayvakit |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 10/1/2024 |

## 1 . Criteria

| Product Name: Ayvakit | |
|---|---|
| Diagnosis | Gastrointestinal Stromal Tumor (GIST) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AYVAKIT | AVAPRITINIB TAB 25 MG | 21490009000310 | Brand |
| AYVAKIT | AVAPRITINIB TAB 50 MG | 21490009000315 | Brand |
| AYVAKIT | AVAPRITINIB TAB 100 MG | 21490009000320 | Brand |
| AYVAKIT | AVAPRITINIB TAB 200 MG | 21490009000330 | Brand |

| AYVAKIT | AVAPRITINIB TAB 300 MG | 21490009000340 | Brand |
|---|---|---|---|

**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, dasatinib, 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 |
|---|---|

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AYVAKIT | AVAPRITINIB TAB 25 MG | 21490009000310 | Brand |
| AYVAKIT | AVAPRITINIB TAB 50 MG | 21490009000315 | Brand |
| AYVAKIT | AVAPRITINIB TAB 100 MG | 21490009000320 | Brand |
| AYVAKIT | AVAPRITINIB TAB 200 MG | 21490009000330 | Brand |
| AYVAKIT | AVAPRITINIB TAB 300 MG | 21490009000340 | Brand |

**Approval Criteria**

**1** - Diagnosis of myeloid/lymphoid neoplasms with eosinophilia

**AND**

**2** - Presence of a FIP1L1-PDGFRA (platelet-derived growth factor receptor alpha) rearrangement

**AND**

**3** - Presence of a PDGFRA D842V mutation

| Product Name: Ayvakit | |
|---|---|
| Diagnosis | Systemic Mastocytosis |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AYVAKIT | AVAPRITINIB TAB 25 MG | 21490009000310 | Brand |
| AYVAKIT | AVAPRITINIB TAB 50 MG | 21490009000315 | Brand |
| AYVAKIT | AVAPRITINIB TAB 100 MG | 21490009000320 | Brand |

| | | | |
|---|---|---|---|
| AYVAKIT | AVAPRITINIB TAB 200 MG | 21490009000330 | Brand |
| AYVAKIT | AVAPRITINIB TAB 300 MG | 21490009000340 | Brand |

**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 x 10^9/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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AYVAKIT | AVAPRITINIB TAB 25 MG | 21490009000310 | Brand |
| AYVAKIT | AVAPRITINIB TAB 50 MG | 21490009000315 | Brand |
| AYVAKIT | AVAPRITINIB TAB 100 MG | 21490009000320 | Brand |
| AYVAKIT | AVAPRITINIB TAB 200 MG | 21490009000330 | Brand |
| AYVAKIT | AVAPRITINIB TAB 300 MG | 21490009000340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AYVAKIT | AVAPRITINIB TAB 25 MG | 21490009000310 | Brand |
| AYVAKIT | AVAPRITINIB TAB 50 MG | 21490009000315 | Brand |
| AYVAKIT | AVAPRITINIB TAB 100 MG | 21490009000320 | Brand |
| AYVAKIT | AVAPRITINIB TAB 200 MG | 21490009000330 | Brand |
| AYVAKIT | AVAPRITINIB TAB 300 MG | 21490009000340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AYVAKIT | AVAPRITINIB TAB 25 MG | 21490009000310 | Brand |
| AYVAKIT | AVAPRITINIB TAB 50 MG | 21490009000315 | Brand |
| AYVAKIT | AVAPRITINIB TAB 100 MG | 21490009000320 | Brand |
| AYVAKIT | AVAPRITINIB TAB 200 MG | 21490009000330 | Brand |
| AYVAKIT | AVAPRITINIB TAB 300 MG | 21490009000340 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Ayvakit therapy

## 2 . Revision History

| Date | Notes |
|---|---|
| 9/10/2024 | Updated wording of systemic mastocytosis criteria per NCCN without change to clinical intent. |

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-147444 |
| **Guideline Name** | Azole Antifungals |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Brand Sporanox capsules, generic itraconazole capsules | |
|---|---|
| Diagnosis | Systemic Fungal Infections |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ITRACONAZOLE | ITRACONAZOLE CAP 100 MG | 11407035000120 | Generic |
| SPORANOX | ITRACONAZOLE CAP 100 MG | 11407035000120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ITRACONAZOLE | ITRACONAZOLE CAP 100 MG | 11407035000120 | Generic |
| SPORANOX | ITRACONAZOLE CAP 100 MG | 11407035000120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ITRACONAZOLE | ITRACONAZOLE CAP 100 MG | 11407035000120 | Generic |
| SPORANOX | ITRACONAZOLE CAP 100 MG | 11407035000120 | Brand |

**Approval Criteria**

**1** - Three months have elapsed since completion of initial therapy for fingernail onychomycosis

**AND**

**2** - Documentation of positive clinical response to therapy

| Product Name: Brand Sporanox capsules, generic itraconazole capsules | |
|---|---|
| Diagnosis | Onychomycosis Toenails |
| Approval Length | 3 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ITRACONAZOLE | ITRACONAZOLE CAP 100 MG | 11407035000120 | Generic |
| SPORANOX | ITRACONAZOLE CAP 100 MG | 11407035000120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ITRACONAZOLE | ITRACONAZOLE CAP 100 MG | 11407035000120 | Generic |
| SPORANOX | ITRACONAZOLE CAP 100 MG | 11407035000120 | Brand |

**Approval Criteria**

**1** - Nine months have elapsed since completion of initial therapy for toenail onychomycosis

**AND**

**2** - Documentation of positive clinical response to therapy

| Product Name: Brand Sporanox oral solution, generic itraconazole oral solution |
|---|

| Approval Length | 12 month(s) |
|---|---|
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ITRACONAZOLE | ITRACONAZOLE ORAL SOLN 10 MG/ML | 11407035002020 | Generic |
| SPORANOX | ITRACONAZOLE ORAL SOLN 10 MG/ML | 11407035002020 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VORICONAZOLE | VORICONAZOLE TAB 50 MG | 11407080000320 | Generic |
| VFEND | VORICONAZOLE TAB 50 MG | 11407080000320 | Brand |
| VORICONAZOLE | VORICONAZOLE TAB 200 MG | 11407080000340 | Generic |
| VFEND | VORICONAZOLE TAB 200 MG | 11407080000340 | Brand |

**Approval Criteria**

**1** - Diagnosis of invasive aspergillosis including Aspergillus fumigatus

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VFEND | VORICONAZOLE FOR SUSP 40 MG/ML | 11407080001920 | Brand |
| VORICONAZOLE | VORICONAZOLE FOR SUSP 40 MG/ML | 11407080001920 | Generic |

**Approval Criteria**

**1** - ONE of the following:

**1.1** Diagnosis of invasive aspergillosis including Aspergillus fumigatus

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| NOXAFIL | POSACONAZOLE TAB DELAYED RELEASE 100 MG | 11407060000620 | Brand |
| POSACONAZOLE DR | POSACONAZOLE TAB DELAYED RELEASE 100 MG | 11407060000620 | Generic |

**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 | 84 Day(s) | | |
| Guideline Type | Prior Authorization | | |
| Product Name | Generic Name | GPI | Brand/Generic |

| | | | |
|---|---|---|---|
| NOXAFIL | POSACONAZOLE TAB DELAYED RELEASE 100 MG | 11407060000620 | Brand |
| POSACONAZOLE DR | POSACONAZOLE TAB DELAYED RELEASE 100 MG | 11407060000620 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NOXAFIL | POSACONAZOLE SUSP 40 MG/ML | 11407060001820 | Brand |
| NOXAFIL | POSACONAZOLE FOR DELAYED RELEASE SUSP PACKET 300 MG | 11407060003020 | Brand |
| POSACONAZOLE | POSACONAZOLE SUSP 40 MG/ML | 11407060001820 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NOXAFIL | POSACONAZOLE SUSP 40 MG/ML | 11407060001820 | Brand |
| POSACONAZOLE | POSACONAZOLE SUSP 40 MG/ML | 11407060001820 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CRESEMBA | ISAVUCONAZONIUM SULFATE CAP 186 MG (ISAVUCONAZOLE 100 MG) | 11407030100120 | Brand |
| CRESEMBA | ISAVUCONAZONIUM SULFATE CAP 74.5 MG (ISAVUCONAZOLE 40 MG) | 11407030100105 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TOLSURA | ITRACONAZOLE CAP 65 MG | 11407035000113 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ITRACONAZOLE | ITRACONAZOLE CAP 100 MG | 11407035000120 | Generic |
| SPORANOX | ITRACONAZOLE CAP 100 MG | 11407035000120 | Brand |
| ITRACONAZOLE | ITRACONAZOLE ORAL SOLN 10 MG/ML | 11407035002020 | Generic |
| SPORANOX | ITRACONAZOLE ORAL SOLN 10 MG/ML | 11407035002020 | Brand |
| VORICONAZOLE | VORICONAZOLE TAB 50 MG | 11407080000320 | Generic |
| VFEND | VORICONAZOLE TAB 50 MG | 11407080000320 | Brand |
| VORICONAZOLE | VORICONAZOLE TAB 200 MG | 11407080000340 | Generic |
| VFEND | VORICONAZOLE TAB 200 MG | 11407080000340 | Brand |
| VORICONAZOLE | VORICONAZOLE FOR SUSP 40 MG/ML | 11407080001920 | Generic |
| VFEND | VORICONAZOLE FOR SUSP 40 MG/ML | 11407080001920 | Brand |
| NOXAFIL | POSACONAZOLE TAB DELAYED RELEASE 100 MG | 11407060000620 | Brand |
| POSACONAZOLE DR | POSACONAZOLE TAB DELAYED RELEASE 100 MG | 11407060000620 | Generic |
| NOXAFIL | POSACONAZOLE SUSP 40 MG/ML | 11407060001820 | Brand |
| NOXAFIL | POSACONAZOLE FOR DELAYED RELEASE SUSP PACKET 300 MG | 11407060003020 | Brand |
| CRESEMBA | ISAVUCONAZONIUM SULFATE CAP 186 MG (ISAVUCONAZOLE 100 MG) | 11407030100120 | Brand |

| | | | |
|---|---|---|---|
| TOLSURA | ITRACONAZOLE CAP 65 MG | 11407035000113 | Brand |
| POSACONAZOLE | POSACONAZOLE SUSP 40 MG/ML | 11407060001820 | Generic |
| CRESEMBA | ISAVUCONAZONIUM SULFATE CAP 74.5 MG (ISAVUCONAZOLE 40 MG) | 11407030100105 | Brand |

**Approval Criteria**

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

## 2 . Revision History

| Date | Notes |
|---|---|
| 5/16/2024 | Updated GPIs (removed obsolete posaconazole tab; added new Cre semba 74.5mg) |

Balversa

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-150796 |
| **Guideline Name** | Balversa |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 8/2/2024 |

## 1 . Criteria

| Product Name: Balversa | |
|---|---|
| Diagnosis | Urothelial Carcinoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BALVERSA | ERDAFITINIB TAB 3 MG | 21532225000320 | Brand |
| BALVERSA | ERDAFITINIB TAB 4 MG | 21532225000325 | Brand |
| BALVERSA | ERDAFITINIB TAB 5 MG | 21532225000330 | Brand |

**Approval Criteria**

**1** - Diagnosis of urothelial carcinoma

**AND**

**2** - 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:

**5.1** Patient has received prior systemic therapy containing an immune checkpoint inhibitor (e.g., pembrolizumab, nivolumab, avelumab)

**OR**

**5.2** Patient is not eligible for immune checkpoint inhibitor therapy (e.g., pembrolizumab, nivolumab, avelumab)

Product Name: Balversa

| | |
|---|---|
| Diagnosis | Urothelial Carcinoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BALVERSA | ERDAFITINIB TAB 3 MG | 21532225000320 | Brand |
| BALVERSA | ERDAFITINIB TAB 4 MG | 21532225000325 | Brand |
| BALVERSA | ERDAFITINIB TAB 5 MG | 21532225000330 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BALVERSA | ERDAFITINIB TAB 3 MG | 21532225000320 | Brand |
| BALVERSA | ERDAFITINIB TAB 4 MG | 21532225000325 | Brand |
| BALVERSA | ERDAFITINIB TAB 5 MG | 21532225000330 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BALVERSA | ERDAFITINIB TAB 3 MG | 21532225000320 | Brand |
| BALVERSA | ERDAFITINIB TAB 4 MG | 21532225000325 | Brand |
| BALVERSA | ERDAFITINIB TAB 5 MG | 21532225000330 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Balversa therapy

## 2 . Revision History

| Date | Notes |
|---|---|
| 8/1/2024 | Copy of core |

Baxdela

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146295 |
| **Guideline Name** | Baxdela |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Baxdela | |
|---|---|
| Diagnosis | Community-Acquired Bacterial Pneumonia |
| Approval Length | 10 Day(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BAXDELA | DELAFLOXACIN MEGLUMINE TAB 450 MG (BASE EQUIV) | 05000025100320 | Brand |

**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 | |
|---|---|
| Diagnosis | Acute Bacterial Skin and Skin Structure Infections |
| Approval Length | 14 Day(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BAXDELA | DELAFLOXACIN MEGLUMINE TAB 450 MG (BASE EQUIV) | 05000025100320 | Brand |

**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 | |
|---|---|
| Diagnosis | Off-Label Uses |
| Approval Length | Based on provider and IDSA recommended treatment durations, up to 6 months. |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BAXDELA | DELAFLOXACIN MEGLUMINE TAB 450 MG (BASE EQUIV) | 05000025100320 | Brand |

**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)

Belbuca_Butrans

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-161157 |
| **Guideline Name** | Belbuca_Butrans |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 1 . Criteria

| Product Name: Belbuca, generic buprenorphine patches, Brand Butrans | |
|---|---|
| Diagnosis | DUR: Opioid Naïve (Not having filled an opioid in the past 60 days) exceeding the 7 day supply limit* |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 75 MCG (BASE EQUIVALENT) | 65200010108210 | Brand |
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 150 MCG (BASE EQUIVALENT) | 65200010108220 | Brand |
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 300 MCG (BASE EQUIVALENT) | 65200010108230 | Brand |
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 450 MCG (BASE EQUIVALENT) | 65200010108240 | Brand |

| | | | |
|---|---|---|---|
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 600 MCG (BASE EQUIVALENT) | 65200010108250 | Brand |
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 750 MCG (BASE EQUIVALENT) | 65200010108260 | Brand |
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 900 MCG (BASE EQUIVALENT) | 65200010108270 | Brand |
| BUTRANS | BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR | 65200010008820 | Brand |
| BUPRENORPHINE | BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR | 65200010008820 | Generic |
| BUTRANS | BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR | 65200010008825 | Brand |
| BUPRENORPHINE | BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR | 65200010008825 | Generic |
| BUTRANS | BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR | 65200010008830 | Brand |
| BUPRENORPHINE | BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR | 65200010008830 | Generic |
| BUTRANS | BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR | 65200010008835 | Brand |
| BUPRENORPHINE | BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR | 65200010008835 | Generic |
| BUTRANS | BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR | 65200010008840 | Brand |
| BUPRENORPHINE | BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR | 65200010008840 | Generic |

**Approval Criteria**

**1** - Patient meets 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)
- End of life care, including hospice care
- Palliative care
- Sickle cell anemia

**OR**

**2** - Prescriber attests that the patient has received an opioid within the past 60 days

| Notes | *Approval length for cancer related pain, end of life, palliative care, or sickle cell pain will be issued for 12 months. All other approvals will be issued for the requested duration, not to exceed one month. |
|---|---|

| Product Name: Belbuca, generic buprenorphine patches, Brand Butrans | |
|---|---|
| Diagnosis | Cancer-related pain/Hospice/Sickle Cell Anemia/End of Life related pain |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 75 MCG (BASE EQUIVALENT) | 65200010108210 | Brand |
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 150 MCG (BASE EQUIVALENT) | 65200010108220 | Brand |
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 300 MCG (BASE EQUIVALENT) | 65200010108230 | Brand |
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 450 MCG (BASE EQUIVALENT) | 65200010108240 | Brand |
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 600 MCG (BASE EQUIVALENT) | 65200010108250 | Brand |
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 750 MCG (BASE EQUIVALENT) | 65200010108260 | Brand |
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 900 MCG (BASE EQUIVALENT) | 65200010108270 | Brand |
| BUTRANS | BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR | 65200010008820 | Brand |
| BUPRENORPHINE | BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR | 65200010008820 | Generic |
| BUTRANS | BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR | 65200010008825 | Brand |
| BUPRENORPHINE | BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR | 65200010008825 | Generic |
| BUTRANS | BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR | 65200010008830 | Brand |
| BUPRENORPHINE | BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR | 65200010008830 | Generic |
| BUTRANS | BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR | 65200010008835 | Brand |
| BUPRENORPHINE | BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR | 65200010008835 | Generic |
| BUTRANS | BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR | 65200010008840 | Brand |

| | | | |
|---|---|---|---|
| BUPRENORPHINE | BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR | 65200010008840 | Generic |

**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
- Sickle cell anemia
- 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 c riteria requirements for treatment with an opioid, a denial should be is sued and a maximum 60-day authorization may be authorized one tim e for the requested drug/strength combination up to the requested qua ntity for transition to an alternative treatment.<br><br>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 bu prenorphine patches, a denial should be issued and a maximum 60-d ay authorization may be authorized one time for the requested drug/st rength combination up to the requested quantity for transition to an alt ernative treatment. Additionally, a 12-month authorization should be e ntered for generic buprenorphine patches. |

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 75 MCG (BASE EQUIVALENT) | 65200010108210 | Brand |
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 150 MCG (BASE EQUIVALENT) | 65200010108220 | Brand |
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 300 MCG (BASE EQUIVALENT) | 65200010108230 | Brand |
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 450 MCG (BASE EQUIVALENT) | 65200010108240 | Brand |
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 600 MCG (BASE EQUIVALENT) | 65200010108250 | Brand |
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 750 MCG (BASE EQUIVALENT) | 65200010108260 | Brand |
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 900 MCG (BASE EQUIVALENT) | 65200010108270 | Brand |
| BUTRANS | BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR | 65200010008820 | Brand |
| BUPRENORPHINE | BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR | 65200010008820 | Generic |
| BUTRANS | BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR | 65200010008825 | Brand |
| BUPRENORPHINE | BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR | 65200010008825 | Generic |
| BUTRANS | BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR | 65200010008830 | Brand |
| BUPRENORPHINE | BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR | 65200010008830 | Generic |
| BUTRANS | BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR | 65200010008835 | Brand |
| BUPRENORPHINE | BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR | 65200010008835 | Generic |
| BUTRANS | BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR | 65200010008840 | Brand |
| BUPRENORPHINE | BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR | 65200010008840 | Generic |

**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), BOTH of the following:

**5.1** 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**

**5.2** 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)

**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 c riteria requirements for treatment with an opioid, a denial should be is sued and a maximum 60-day authorization may be authorized one tim e for the requested drug/strength combination up to the requested qua ntity for transition to an alternative treatment.<br><br>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 bu prenorphine patches, a denial should be issued and a maximum 60-d ay authorization may be authorized one time for the requested drug/st |

| | |
|---|---|
| | rength combination up to the requested quantity for transition to an alt ernative treatment. Additionally, a 6 month authorization should be ent ered for generic buprenorphine patches. |

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 75 MCG (BASE EQUIVALENT) | 65200010108210 | Brand |
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 150 MCG (BASE EQUIVALENT) | 65200010108220 | Brand |
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 300 MCG (BASE EQUIVALENT) | 65200010108230 | Brand |
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 450 MCG (BASE EQUIVALENT) | 65200010108240 | Brand |
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 600 MCG (BASE EQUIVALENT) | 65200010108250 | Brand |
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 750 MCG (BASE EQUIVALENT) | 65200010108260 | Brand |
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 900 MCG (BASE EQUIVALENT) | 65200010108270 | Brand |
| BUTRANS | BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR | 65200010008820 | Brand |
| BUPRENORPHINE | BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR | 65200010008820 | Generic |
| BUTRANS | BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR | 65200010008825 | Brand |
| BUPRENORPHINE | BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR | 65200010008825 | Generic |
| BUTRANS | BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR | 65200010008830 | Brand |
| BUPRENORPHINE | BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR | 65200010008830 | Generic |
| BUTRANS | BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR | 65200010008835 | Brand |
| BUPRENORPHINE | BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR | 65200010008835 | Generic |

| | | | |
|---|---|---|---|
| BUTRANS | BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR | 65200010008840 | Brand |
| BUPRENORPHINE | BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR | 65200010008840 | Generic |

**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 c riteria requirements for treatment with an opioid, a denial should be is sued and a maximum 60-day authorization may be authorized one tim e for the requested drug/strength combination up to the requested qua ntity for transition to an alternative treatment.<br><br>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 bu prenorphine patches, a denial should be issued and a maximum 60-d ay authorization may be authorized one time for the requested drug/st rength combination up to the requested quantity for transition to an alt ernative treatment. Additionally, a 6 month authorization should be ent ered for generic buprenorphine patches. |

| Product Name: Belbuca, generic buprenorphine patches, Brand Butrans | | | |
|---|---|---|---|
| Guideline Type | Quantity Limit | | |
| Product Name | Generic Name | GPI | Brand/Generic |
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 75 MCG (BASE EQUIVALENT) | 65200010108210 | Brand |
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 150 MCG (BASE EQUIVALENT) | 65200010108220 | Brand |
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 300 MCG (BASE EQUIVALENT) | 65200010108230 | Brand |
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 450 MCG (BASE EQUIVALENT) | 65200010108240 | Brand |
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 600 MCG (BASE EQUIVALENT) | 65200010108250 | Brand |
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 750 MCG (BASE EQUIVALENT) | 65200010108260 | Brand |
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 900 MCG (BASE EQUIVALENT) | 65200010108270 | Brand |
| BUTRANS | BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR | 65200010008820 | Brand |
| BUPRENORPHINE | BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR | 65200010008820 | Generic |
| BUTRANS | BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR | 65200010008825 | Brand |
| BUPRENORPHINE | BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR | 65200010008825 | Generic |
| BUTRANS | BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR | 65200010008830 | Brand |
| BUPRENORPHINE | BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR | 65200010008830 | Generic |
| BUTRANS | BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR | 65200010008835 | Brand |
| BUPRENORPHINE | BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR | 65200010008835 | Generic |
| BUTRANS | BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR | 65200010008840 | Brand |

| | | | |
|---|---|---|---|
| BUPRENORPHINE | BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR | 65200010008840 | Generic |

**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:<br>12 months for cancer related pain/hospice/sickle cell anemia related p ain/end of life related pain.<br>6 months for non-cancer related pain/non-hospice/non-sickle cell ane mia related pain/non-end of life related pain. |

| Product Name: Belbuca, generic buprenorphine patches, Brand Butrans | |
|---|---|
| Diagnosis | Cancer-related pain/Hospice/End of Life Related Pain/Sickle Cell Anemia Related Pain |
| Approval Length | 12 month(s) |
| Guideline Type | Morphine Milligram Equivalents (MME) |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 75 MCG (BASE EQUIVALENT) | 65200010108210 | Brand |
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 150 MCG (BASE EQUIVALENT) | 65200010108220 | Brand |
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 300 MCG (BASE EQUIVALENT) | 65200010108230 | Brand |
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 450 MCG (BASE EQUIVALENT) | 65200010108240 | Brand |
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 600 MCG (BASE EQUIVALENT) | 65200010108250 | Brand |
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 750 MCG (BASE EQUIVALENT) | 65200010108260 | Brand |
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 900 MCG (BASE EQUIVALENT) | 65200010108270 | Brand |
| BUTRANS | BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR | 65200010008820 | Brand |

| | | | |
|---|---|---|---|
| BUPRENORPHINE | BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR | 65200010008820 | Generic |
| BUTRANS | BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR | 65200010008825 | Brand |
| BUPRENORPHINE | BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR | 65200010008825 | Generic |
| BUTRANS | BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR | 65200010008830 | Brand |
| BUPRENORPHINE | BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR | 65200010008830 | Generic |
| BUTRANS | BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR | 65200010008835 | Brand |
| BUPRENORPHINE | BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR | 65200010008835 | Generic |
| BUTRANS | BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR | 65200010008840 | Brand |
| BUPRENORPHINE | BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR | 65200010008840 | Generic |

**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
- An end of life diagnosis
- Sickle cell anemia related pain

| | |
|---|---|
| Notes | The authorization should be entered for an MME of 9999 so as to prev ent 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/Non-Sickle Cell Anemia Related Pain |
| Approval Length | 6 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Morphine Milligram Equivalents (MME) |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 75 MCG (BASE EQUIVALENT) | 65200010108210 | Brand |
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 150 MCG (BASE EQUIVALENT) | 65200010108220 | Brand |
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 300 MCG (BASE EQUIVALENT) | 65200010108230 | Brand |
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 450 MCG (BASE EQUIVALENT) | 65200010108240 | Brand |
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 600 MCG (BASE EQUIVALENT) | 65200010108250 | Brand |
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 750 MCG (BASE EQUIVALENT) | 65200010108260 | Brand |
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 900 MCG (BASE EQUIVALENT) | 65200010108270 | Brand |
| BUTRANS | BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR | 65200010008820 | Brand |
| BUPRENORPHINE | BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR | 65200010008820 | Generic |
| BUTRANS | BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR | 65200010008825 | Brand |
| BUPRENORPHINE | BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR | 65200010008825 | Generic |
| BUTRANS | BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR | 65200010008830 | Brand |
| BUPRENORPHINE | BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR | 65200010008830 | Generic |
| BUTRANS | BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR | 65200010008835 | Brand |
| BUPRENORPHINE | BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR | 65200010008835 | Generic |
| BUTRANS | BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR | 65200010008840 | Brand |
| BUPRENORPHINE | BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR | 65200010008840 | Generic |

**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-sickle cell anemia related pain/non-end of life related pain up to the current requested MME plus 90 MME.<br><br>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/Non-hospice/Non-End of Life Related Pain/Non-Sickle Cell Anemia Related Pain |

| | |
|---|---|
| Approval Length | 6 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Morphine Milligram Equivalents (MME) |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 75 MCG (BASE EQUIVALENT) | 65200010108210 | Brand |
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 150 MCG (BASE EQUIVALENT) | 65200010108220 | Brand |
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 300 MCG (BASE EQUIVALENT) | 65200010108230 | Brand |
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 450 MCG (BASE EQUIVALENT) | 65200010108240 | Brand |
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 600 MCG (BASE EQUIVALENT) | 65200010108250 | Brand |
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 750 MCG (BASE EQUIVALENT) | 65200010108260 | Brand |
| BELBUCA | BUPRENORPHINE HCL BUCCAL FILM 900 MCG (BASE EQUIVALENT) | 65200010108270 | Brand |
| BUTRANS | BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR | 65200010008820 | Brand |
| BUPRENORPHINE | BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR | 65200010008820 | Generic |
| BUTRANS | BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR | 65200010008825 | Brand |
| BUPRENORPHINE | BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR | 65200010008825 | Generic |
| BUTRANS | BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR | 65200010008830 | Brand |
| BUPRENORPHINE | BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR | 65200010008830 | Generic |
| BUTRANS | BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR | 65200010008835 | Brand |
| BUPRENORPHINE | BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR | 65200010008835 | Generic |
| BUTRANS | BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR | 65200010008840 | Brand |
| BUPRENORPHINE | BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR | 65200010008840 | Generic |

**Approval Criteria**

| | |
|---|---|
| **1** - Prescriber attests that the patient has been screened for substance abuse/opioid dependence<br><br>**AND**<br><br>**2** - Documented rationale for not tapering and discontinuing opioid if treatment goals are not being met<br><br>**AND**<br><br>**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-sickle cell anemia related pain/non-end of life related pain up to the current requested MME plus 90 MME<br><br>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 |
|---|---|
| 11/21/2024 | Updated language to clarify "cancer" is Cancer-related pain |

Benefit Determination Mifeprex

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146297 |
| **Guideline Name** | Benefit Determination Mifeprex |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Brand Mifeprex, generic mifepristone | |
|---|---|
| Approval Length | 1 month(s) |
| Guideline Type | Benefit Determination |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MIFEPREX | MIFEPRISTONE TAB 200 MG | 30502060000320 | Brand |
| MIFEPRISTONE | MIFEPRISTONE TAB 200 MG | 30502060000320 | Generic |

**Approval Criteria**

**1** - Provider attests patient requires treatment for purposes identified in the Hyde amendment and any applicable state laws and regulations.

Benlysta

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146478 |
| **Guideline Name** | Benlysta |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Benlysta SQ | |
|---|---|
| Diagnosis | Systemic Lupus Erythematosus |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BENLYSTA | BELIMUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/ML | 9942201500D520 | Brand |
| BENLYSTA | BELIMUMAB SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/ML | 9942201500E520 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BENLYSTA | BELIMUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/ML | 9942201500D520 | Brand |
| BENLYSTA | BELIMUMAB SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/ML | 9942201500E520 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BENLYSTA | BELIMUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/ML | 9942201500D520 | Brand |
| BENLYSTA | BELIMUMAB SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/ML | 9942201500E520 | Brand |

**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)

Benznidazole

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146298 |
| **Guideline Name** | Benznidazole |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Benznidazole | |
|---|---|
| Approval Length | 60 Day(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BENZNIDAZOLE | BENZNIDAZOLE TAB 12.5 MG | 15000003000320 | Brand |
| BENZNIDAZOLE | BENZNIDAZOLE TAB 100 MG | 15000003000340 | Brand |

**Approval Criteria**

**1** - Diagnosis of Chagas disease (American trypanosomiasis) due to Trypanosoma cruzi

Berinert

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-147728 |
| **Guideline Name** | Berinert |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BERINERT | C1 ESTERASE INHIBITOR (HUMAN) FOR IV INJ KIT 500 UNIT | 85802022006420 | Brand |

**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., 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BERINERT | C1 ESTERASE INHIBITOR (HUMAN) FOR IV INJ KIT 500 UNIT | 85802022006420 | Brand |

**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 |
|---|---|
| 5/23/2024 | Update to types of genetic variant(s) and diagnostic criteria with normal C1 inhibitor levels in initial auth section and minor update in reauth section. |

Besremi

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-159223 |
| **Guideline Name** | Besremi |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 1 . Criteria

| Product Name: Besremi | |
|---|---|
| Diagnosis | Polycythemia Vera |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BESREMI | ROPEGINTERFERON ALFA-2B-NJFT SOLN PREFILLED SYR 500 MCG/ML | 2170007750E520 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BESREMI | ROPEGINTERFERON ALFA-2B-NJFT SOLN PREFILLED SYR 500 MCG/ML | 2170007750E520 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BESREMI | ROPEGINTERFERON ALFA-2B-NJFT SOLN PREFILLED SYR 500 MCG/ML | 2170007750E520 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Besremi therapy

## 2 . Revision History

| Date | Notes |
| --- | --- |
| 11/4/2024 | New program |

Biktarvy

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-161622 |
| **Guideline Name** | Biktarvy |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 1 . Criteria

| Product Name: Biktarvy | |
|---|---|
| Diagnosis | Human Immunodeficiency Virus (HIV) |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BIKTARVY | BICTEGRAVIR-EMTRICITABINE-TENOFOVIR AF TAB 30-120-15 MG | 12109903240320 | Brand |
| BIKTARVY | BICTEGRAVIR-EMTRICITABINE-TENOFOVIR AF TAB 50-200-25 MG | 12109903240330 | Brand |

**Approval Criteria**

**1** - Diagnosis of human immunodeficiency virus (HIV)

**AND**

**2** - ONE of the following:

**2.1** Patient is not an appropriate candidate for all of the following (please specify why patient is not a candidate):

- efavirenz/emtricitabine/tenofovir disoproxil (generic Atripla)
- Triumeq (abacavir/dolutegravir/lamivudine)
- Juluca (dolutegravir/rilpivirine)
- Dovato (dolutegravir/lamivudine)

**OR**

**2.2** Patient is currently on Biktarvy therapy

| Product Name: Biktarvy | |
|---|---|
| Diagnosis | Post-Exposure Prophylaxis |
| Approval Length | 4 Week(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BIKTARVY | BICTEGRAVIR-EMTRICITABINE-TENOFOVIR AF TAB 30-120-15 MG | 12109903240320 | Brand |
| BIKTARVY | BICTEGRAVIR-EMTRICITABINE-TENOFOVIR AF TAB 50-200-25 MG | 12109903240330 | Brand |

**Approval Criteria**

**1** - Diagnosis of post-exposure prophylaxis

## 2 . Revision History

| Date | Notes |
| --- | --- |
| 12/4/2024 | Updated HIV criteria |

Biltricide

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146300 |
| **Guideline Name** | Biltricide |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Brand Biltricide, generic praziquantel | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BILTRICIDE | PRAZIQUANTEL TAB 600 MG | 15000050000305 | Brand |
| PRAZIQUANTEL | PRAZIQUANTEL TAB 600 MG | 15000050000305 | Generic |

**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)

Bimzelx

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-161214 |
| **Guideline Name** | Bimzelx |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BIMZELX | BIMEKIZUMAB-BKZX SUBCUTANEOUS SOLN AUTO-INJECTOR 160 MG/ML | 9025051800D520 | Brand |
| BIMZELX | BIMEKIZUMAB-BKZX SUBCUTANEOUS SOLN PREFILLED SYR 160 MG/ML | 9025051800E520 | Brand |

**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), Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Otezla (apremilast)]

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

**AND**

**1.4** ONE of the following:

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

**1.4.1.1** One of the preferred adalimumab products*

**AND**

**1.4.1.2** ONE of the following:

- Enbrel (etanercept)
- Ilumya (tildrakizumab)

**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)
- Ilumya (tildrakizumab)

**AND**

**1.5** ONE of the following:

**1.5.1** Failure to a 6 month trial of Cosentyx (secukinumab) with moderate clinical response yet residual disease activity confirmed by claims history or submitted medical records

**OR**

**1.5.2** BOTH of the following:

**1.5.2.1** History of intolerance or adverse event to Cosentyx (please specify intolerance or contraindication)

**AND**

**1.5.2.2** Physician attests that in their clinical opinion the same intolerance or adverse event would not be expected to occur with Bimzelx

**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, Stelara (ustekinumab), 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

| Notes | *PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |
|---|---|

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BIMZELX | BIMEKIZUMAB-BKZX SUBCUTANEOUS SOLN AUTO-INJECTOR 160 MG/ML | 9025051800D520 | Brand |
| BIMZELX | BIMEKIZUMAB-BKZX SUBCUTANEOUS SOLN PREFILLED SYR 160 MG/ML | 9025051800E520 | Brand |

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

## 2 . Revision History

| Date | Notes |
|---|---|
| 11/25/2024 | Added PDL link |

Bonjesta and Diclegis

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146301 |
| **Guideline Name** | Bonjesta and Diclegis |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DOXYLAMINE SUCCINATE/PYRIDOXINE HYDROCHLORIDE | DOXYLAMINE-PYRIDOXINE TAB DELAYED RELEASE 10-10 MG | 50309902100620 | Generic |
| DICLEGIS | DOXYLAMINE-PYRIDOXINE TAB DELAYED RELEASE 10-10 MG | 50309902100620 | Brand |
| BONJESTA | DOXYLAMINE-PYRIDOXINE TAB ER 20-20 MG | 50309902100430 | Brand |

**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)

Bosulif

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146480 |
| **Guideline Name** | Bosulif |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Bosulif | |
|---|---|
| Diagnosis | Chronic Myelogenuous/Myeloid Leukemia |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BOSULIF | BOSUTINIB TAB 100 MG | 21531812000320 | Brand |
| BOSULIF | BOSUTINIB TAB 400 MG | 21531812000327 | Brand |
| BOSULIF | BOSUTINIB TAB 500 MG | 21531812000340 | Brand |
| BOSULIF | BOSUTINIB CAP 50 MG | 21531812000120 | Brand |

| | | | |
|---|---|---|---|
| BOSULIF | BOSUTINIB CAP 100 MG | 21531812000130 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BOSULIF | BOSUTINIB TAB 100 MG | 21531812000320 | Brand |
| BOSULIF | BOSUTINIB TAB 400 MG | 21531812000327 | Brand |
| BOSULIF | BOSUTINIB TAB 500 MG | 21531812000340 | Brand |
| BOSULIF | BOSUTINIB CAP 50 MG | 21531812000120 | Brand |
| BOSULIF | BOSUTINIB CAP 100 MG | 21531812000130 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BOSULIF | BOSUTINIB TAB 100 MG | 21531812000320 | Brand |
| BOSULIF | BOSUTINIB TAB 400 MG | 21531812000327 | Brand |
| BOSULIF | BOSUTINIB TAB 500 MG | 21531812000340 | Brand |
| BOSULIF | BOSUTINIB CAP 50 MG | 21531812000120 | Brand |
| BOSULIF | BOSUTINIB CAP 100 MG | 21531812000130 | Brand |

**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 Myelogenuous/Myeloid Leukemia, Philadelphia Chromosome-Positive Acute Lymphoblastic Leukemia, Myeloid/Lymphoid Neoplasms |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BOSULIF | BOSUTINIB TAB 100 MG | 21531812000320 | Brand |

| | | | |
|---|---|---|---|
| BOSULIF | BOSUTINIB TAB 400 MG | 21531812000327 | Brand |
| BOSULIF | BOSUTINIB TAB 500 MG | 21531812000340 | Brand |
| BOSULIF | BOSUTINIB CAP 50 MG | 21531812000120 | Brand |
| BOSULIF | BOSUTINIB CAP 100 MG | 21531812000130 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BOSULIF | BOSUTINIB TAB 100 MG | 21531812000320 | Brand |
| BOSULIF | BOSUTINIB TAB 400 MG | 21531812000327 | Brand |
| BOSULIF | BOSUTINIB TAB 500 MG | 21531812000340 | Brand |
| BOSULIF | BOSUTINIB CAP 50 MG | 21531812000120 | Brand |
| BOSULIF | BOSUTINIB CAP 100 MG | 21531812000130 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BOSULIF | BOSUTINIB TAB 100 MG | 21531812000320 | Brand |
| BOSULIF | BOSUTINIB TAB 400 MG | 21531812000327 | Brand |
| BOSULIF | BOSUTINIB TAB 500 MG | 21531812000340 | Brand |
| BOSULIF | BOSUTINIB CAP 50 MG | 21531812000120 | Brand |
| BOSULIF | BOSUTINIB CAP 100 MG | 21531812000130 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Bosulif therapy

Braftovi

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-156254 |
| **Guideline Name** | Braftovi |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 11/1/2024 |

## 1 . Criteria

| Product Name: Braftovi | |
|---|---|
| Diagnosis | Melanoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BRAFTOVI | ENCORAFENIB CAP 75 MG | 21532040000130 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BRAFTOVI | ENCORAFENIB CAP 75 MG | 21532040000130 | Brand |

**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 Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BRAFTOVI | ENCORAFENIB CAP 75 MG | 21532040000130 | Brand |

**Approval Criteria**

**1** - Diagnosis of colon cancer

**AND**

**2** - Presence of BRAF V600E mutation

**AND**

**3** - Disease is one of the following:

- Advanced
- Metastatic

**AND**

**4** - Patient has received prior therapy

**AND**

**5** - Used in combination with ONE of the following:

- Erbitux (cetuximab)
- Vectibix (panitumumab)

| Product Name: Braftovi | |
|---|---|
| Diagnosis | Colon Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BRAFTOVI | ENCORAFENIB CAP 75 MG | 21532040000130 | Brand |

**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)

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BRAFTOVI | ENCORAFENIB CAP 75 MG | 21532040000130 | Brand |

**Approval Criteria**

**1** - Diagnosis of rectal cancer

**AND**

**2** - Presence of BRAF V600E mutation

**AND**

**3** - Disease is one of the following:

- Advanced
- Metastatic

**AND**

**4** - Patient has received prior therapy

**AND**

**5** - Used in combination with ONE of the following:

- Erbitux (cetuximab)
- Vectibix (panitumumab)

| Product Name: Braftovi | |
|---|---|
| Diagnosis | Rectal Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BRAFTOVI | ENCORAFENIB CAP 75 MG | 21532040000130 | Brand |

**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)

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BRAFTOVI | ENCORAFENIB CAP 75 MG | 21532040000130 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BRAFTOVI | ENCORAFENIB CAP 75 MG | 21532040000130 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BRAFTOVI | ENCORAFENIB CAP 75 MG | 21532040000130 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BRAFTOVI | ENCORAFENIB CAP 75 MG | 21532040000130 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Braftovi therapy

## 2 . Revision History

| Date | Notes |
|---|---|
| 9/25/2024 | Add step thru section for melanoma and NSCLC |

Brexafemme

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146302 |
| **Guideline Name** | Brexafemme |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BREXAFEMME | IBREXAFUNGERP CITRATE TAB 150 MG | 11507040100320 | Brand |

**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:

**2.2.1** Other causes (including but not limited to bacterial vaginosis or trichomoniasis) have been ruled out

**AND**

**2.2.2** Failure of a 7-day course of oral fluconazole therapy defined as 100 mg (milligrams), 150 mg, or 200 mg taken orally every third day for a total of 3 doses (days 1,4, and 7), confirmed by claims history or submission of medical records, 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BREXAFEMME | IBREXAFUNGERP CITRATE TAB 150 MG | 11507040100320 | Brand |

**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:

**2.2.1** Other causes (including but not limited to bacterial vaginosis or trichomoniasis) have been ruled out

**AND**

**2.2.2** 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

Brilinta and Effient

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146303 |
| **Guideline Name** | Brilinta and Effient |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Brilinta | |
|---|---|
| Diagnosis | Acute coronary syndrome (ACS) |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BRILINTA | TICAGRELOR TAB 60 MG | 85158470000315 | Brand |
| BRILINTA | TICAGRELOR TAB 90 MG | 85158470000320 | Brand |

**Approval Criteria**

**1** - Diagnosis of acute coronary syndrome (ACS) [e.g., unstable angina (UA), non-ST elevation myocardial infarction (NSTEMI) or ST-segment elevation myocardial infarction (STEMI)]

**OR**

**2** - The medication is being used to reduce the risk of a first myocardial infarction (MI) or stroke in a patient with coronary artery disease (CAD) at high risk for such events [e.g., type 2 diabetes mellitus, hypertension, dyslipidemia, multi-vessel CAD, obesity, heart failure, current smoker or chronic kidney disease]

**OR**

**3** - The medication is being used to reduce the risk of stroke in patients with acute ischemic stroke (NIH Stroke Scale score less than or equal to 5) or high-risk transient ischemic attack (TIA)

| Product Name: Brand Effient, generic prasugrel | |
|---|---|
| Diagnosis | Acute coronary syndrome (ACS) |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| EFFIENT | PRASUGREL HCL TAB 5 MG (BASE EQUIV) | 85158060100320 | Brand |
| PRASUGREL | PRASUGREL HCL TAB 5 MG (BASE EQUIV) | 85158060100320 | Generic |
| EFFIENT | PRASUGREL HCL TAB 10 MG (BASE EQUIV) | 85158060100330 | Brand |
| PRASUGREL | PRASUGREL HCL TAB 10 MG (BASE EQUIV) | 85158060100330 | Generic |

**Approval Criteria**

**1** - Diagnosis of acute coronary syndrome (ACS) [e.g., unstable angina (UA), non-ST elevation myocardial infarction (NSTEMI) or ST-segment elevation myocardial infarction (STEMI)]

**AND**

**2** - The patient must be managed with percutaneous coronary intervention (PCI)

Bronchitol

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146304 |
| **Guideline Name** | Bronchitol |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BRONCHITOL TOLERANCE TEST | MANNITOL INHAL CAP 40 MG | 45307060000140 | Brand |
| BRONCHITOL | MANNITOL INHAL CAP 40 MG | 45307060000140 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BRONCHITOL TOLERANCE TEST | MANNITOL INHAL CAP 40 MG | 45307060000140 | Brand |
| BRONCHITOL | MANNITOL INHAL CAP 40 MG | 45307060000140 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Bronchitol therapy

Brukinsa

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-154623 |
| **Guideline Name** | Brukinsa |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 10/1/2024 |

## 1 . Criteria

| Product Name: Brukinsa | |
|---|---|
| Diagnosis | B-Cell Lymphomas |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BRUKINSA | ZANUBRUTINIB CAP 80 MG | 21532195000120 | Brand |

**Approval Criteria**

**1** - ALL of the following:

- Diagnosis of follicular lymphoma (FL)
- Disease is relapsed or refractory
- Patient has received at least two or more lines of systemic therapy
- 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BRUKINSA | ZANUBRUTINIB CAP 80 MG | 21532195000120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BRUKINSA | ZANUBRUTINIB CAP 80 MG | 21532195000120 | Brand |

**Approval Criteria**

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

| Product Name: Brukinsa | |
|---|---|
| Diagnosis | B-Cell Lymphomas, Waldenström's Macroglobulinemia (WM), Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma (CLL/SLL) |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BRUKINSA | ZANUBRUTINIB CAP 80 MG | 21532195000120 | Brand |

**Approval Criteria**

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

| Product Name: Brukinsa | |
|---|---|
| Diagnosis | Hairy Cell Leukemia |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BRUKINSA | ZANUBRUTINIB CAP 80 MG | 21532195000120 | Brand |

**Approval Criteria**

**1** - Diagnosis of hairy cell leukemia

**AND**

**2** - Disease is relapsed, refractory, or progressive

| Product Name: Brukinsa | |
|---|---|
| Diagnosis | Hairy Cell Leukemia |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BRUKINSA | ZANUBRUTINIB CAP 80 MG | 21532195000120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BRUKINSA | ZANUBRUTINIB CAP 80 MG | 21532195000120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BRUKINSA | ZANUBRUTINIB CAP 80 MG | 21532195000120 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Brukinsa therapy

## 2 . Revision History

| Date | Notes |
|---|---|
| 9/9/2024 | Annual review. Clinical coverage criteria added for follicular lymphoma and hairy cell leukemia. Updated B-cell lymphoma formatting. Updated background and reference. |

Buphenyl

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146483 |
| **Guideline Name** | Buphenyl |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BUPHENYL | SODIUM PHENYLBUTYRATE ORAL POWDER 3 GM/TEASPOONFUL | 30908060002950 | Brand |
| SODIUM PHENYLBUTYRATE | SODIUM PHENYLBUTYRATE ORAL POWDER 3 GM/TEASPOONFUL | 30908060002950 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BUPHENYL | SODIUM PHENYLBUTYRATE TAB 500 MG | 30908060000320 | Brand |
| SODIUM PHENYLBUTYRATE | SODIUM PHENYLBUTYRATE TAB 500 MG | 30908060000320 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BUPHENYL | SODIUM PHENYLBUTYRATE TAB 500 MG | 30908060000320 | Brand |
| SODIUM PHENYLBUTYRATE | SODIUM PHENYLBUTYRATE TAB 500 MG | 30908060000320 | Generic |

| **Approval Criteria** |
| --- |
| **1** - Documentation of positive clinical response to Buphenyl (sodium phenylbutyrate) tablets |

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146305 |
| **Guideline Name** | Buprenorphine for Opioid Dependence |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: generic buprenorphine/naloxone SL film, buprenorphine/naloxone SL tabs, buprenorphine SL tabs | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE | BUPRENORPHINE HCL-NALOXONE HCL SL FILM 2-0.5 MG (BASE EQUIV) | 65200010208220 | Generic |
| BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE | BUPRENORPHINE HCL-NALOXONE HCL SL FILM 8-2 MG (BASE EQUIV) | 65200010208240 | Generic |
| BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE | BUPRENORPHINE HCL-NALOXONE HCL SL FILM 4-1 MG (BASE EQUIV) | 65200010208230 | Generic |

| | | | |
|---|---|---|---|
| BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE | BUPRENORPHINE HCL-NALOXONE HCL SL FILM 12-3 MG (BASE EQUIV) | 65200010208250 | Generic |
| BUPRENORPHINE HCL/NALOXONE HCL | BUPRENORPHINE HCL-NALOXONE HCL SL TAB 2-0.5 MG (BASE EQUIV) | 65200010200720 | Generic |
| BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE | BUPRENORPHINE HCL-NALOXONE HCL SL TAB 2-0.5 MG (BASE EQUIV) | 65200010200720 | Generic |
| BUPRENORPHINE HCL/NALOXONE HCL | BUPRENORPHINE HCL-NALOXONE HCL SL TAB 8-2 MG (BASE EQUIV) | 65200010200740 | Generic |
| BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE | BUPRENORPHINE HCL-NALOXONE HCL SL TAB 8-2 MG (BASE EQUIV) | 65200010200740 | Generic |
| BUPRENORPHINE HYDROCHLORIDE | BUPRENORPHINE HCL SL TAB 2 MG (BASE EQUIV) | 65200010100760 | Generic |
| BUPRENORPHINE HCL | BUPRENORPHINE HCL SL TAB 2 MG (BASE EQUIV) | 65200010100760 | Generic |
| BUPRENORPHINE HYDROCHLORIDE | BUPRENORPHINE HCL SL TAB 8 MG (BASE EQUIV) | 65200010100780 | Generic |
| BUPRENORPHINE HCL | BUPRENORPHINE HCL SL TAB 8 MG (BASE EQUIV) | 65200010100780 | Generic |

**Approval Criteria**

**1** - The patient has a DSM-V-TR (diagnostic and statistical manual, fifth edition, text revision) diagnosis of opioid use disorder

| | |
|---|---|
| Notes | *Up to 24 mg per day of buprenorphine, or equivalent dosing of an alt ernative medication, will be authorized. |

| Product Name: Brand Suboxone, Zubsolv, Bunavail | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SUBOXONE | BUPRENORPHINE HCL-NALOXONE HCL SL FILM 2-0.5 MG (BASE EQUIV) | 65200010208220 | Brand |
| SUBOXONE | BUPRENORPHINE HCL-NALOXONE HCL SL FILM 8-2 MG (BASE EQUIV) | 65200010208240 | Brand |

| | | | |
|---|---|---|---|
| SUBOXONE | BUPRENORPHINE HCL-NALOXONE HCL SL FILM 4-1 MG (BASE EQUIV) | 65200010208230 | Brand |
| SUBOXONE | BUPRENORPHINE HCL-NALOXONE HCL SL FILM 12-3 MG (BASE EQUIV) | 65200010208250 | Brand |
| ZUBSOLV | BUPRENORPHINE HCL-NALOXONE HCL SL TAB 0.7-0.18 MG (BASE EQ) | 65200010200710 | Brand |
| ZUBSOLV | BUPRENORPHINE HCL-NALOXONE HCL SL TAB 1.4-0.36 MG (BASE EQ) | 65200010200715 | Brand |
| ZUBSOLV | BUPRENORPHINE HCL-NALOXONE HCL SL TAB 2.9-0.71 MG (BASE EQ) | 65200010200725 | Brand |
| ZUBSOLV | BUPRENORPHINE HCL-NALOXONE HCL SL TAB 5.7-1.4 MG (BASE EQ) | 65200010200732 | Brand |
| ZUBSOLV | BUPRENORPHINE HCL-NALOXONE HCL SL TAB 8.6-2.1 MG (BASE EQ) | 65200010200745 | Brand |
| ZUBSOLV | BUPRENORPHINE HCL-NALOXONE HCL SL TAB 11.4-2.9 MG (BASE EQ) | 65200010200760 | Brand |
| BUNAVAIL | BUPRENORPHINE-NALOXONE BUCCAL FILM 4.2-0.7 MG (BASE EQUIV) | 65200010208270 | Brand |
| BUNAVAIL | BUPRENORPHINE-NALOXONE BUCCAL FILM 6.3-1 MG (BASE EQUIV) | 65200010208280 | Brand |

**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 24 mg per day of buprenorphine, or equivalent dosing of an alt ernative medication, will be authorized. |

| Product Name: Brand Suboxone, Zubsolv, Bunavail | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |

| Guideline Type | Prior Authorization |
|---|---|

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SUBOXONE | BUPRENORPHINE HCL-NALOXONE HCL SL FILM 2-0.5 MG (BASE EQUIV) | 65200010208220 | Brand |
| SUBOXONE | BUPRENORPHINE HCL-NALOXONE HCL SL FILM 8-2 MG (BASE EQUIV) | 65200010208240 | Brand |
| SUBOXONE | BUPRENORPHINE HCL-NALOXONE HCL SL FILM 4-1 MG (BASE EQUIV) | 65200010208230 | Brand |
| SUBOXONE | BUPRENORPHINE HCL-NALOXONE HCL SL FILM 12-3 MG (BASE EQUIV) | 65200010208250 | Brand |
| ZUBSOLV | BUPRENORPHINE HCL-NALOXONE HCL SL TAB 0.7-0.18 MG (BASE EQ) | 65200010200710 | Brand |
| ZUBSOLV | BUPRENORPHINE HCL-NALOXONE HCL SL TAB 1.4-0.36 MG (BASE EQ) | 65200010200715 | Brand |
| ZUBSOLV | BUPRENORPHINE HCL-NALOXONE HCL SL TAB 2.9-0.71 MG (BASE EQ) | 65200010200725 | Brand |
| ZUBSOLV | BUPRENORPHINE HCL-NALOXONE HCL SL TAB 5.7-1.4 MG (BASE EQ) | 65200010200732 | Brand |
| ZUBSOLV | BUPRENORPHINE HCL-NALOXONE HCL SL TAB 8.6-2.1 MG (BASE EQ) | 65200010200745 | Brand |
| ZUBSOLV | BUPRENORPHINE HCL-NALOXONE HCL SL TAB 11.4-2.9 MG (BASE EQ) | 65200010200760 | Brand |
| BUNAVAIL | BUPRENORPHINE-NALOXONE BUCCAL FILM 4.2-0.7 MG (BASE EQUIV) | 65200010208270 | Brand |
| BUNAVAIL | BUPRENORPHINE-NALOXONE BUCCAL FILM 6.3-1 MG (BASE EQUIV) | 65200010208280 | Brand |

**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 24 mg per day of buprenorphine, or equivalent dosing of an alt ernative medication, will be authorized. |
|---|---|

| Product Name: generic buprenorphine/naloxone SL film, Brand Suboxone, buprenorphine/naloxone SL tabs, Zubsolv, buprenorphine SL tabs, Bunavail | |
|---|---|
| Diagnosis | Exceeding 24 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE | BUPRENORPHINE HCL-NALOXONE HCL SL FILM 2-0.5 MG (BASE EQUIV) | 65200010208220 | Generic |
| SUBOXONE | BUPRENORPHINE HCL-NALOXONE HCL SL FILM 2-0.5 MG (BASE EQUIV) | 65200010208220 | Brand |
| BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE | BUPRENORPHINE HCL-NALOXONE HCL SL FILM 8-2 MG (BASE EQUIV) | 65200010208240 | Generic |
| SUBOXONE | BUPRENORPHINE HCL-NALOXONE HCL SL FILM 8-2 MG (BASE EQUIV) | 65200010208240 | Brand |
| BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE | BUPRENORPHINE HCL-NALOXONE HCL SL FILM 4-1 MG (BASE EQUIV) | 65200010208230 | Generic |
| SUBOXONE | BUPRENORPHINE HCL-NALOXONE HCL SL FILM 4-1 MG (BASE EQUIV) | 65200010208230 | Brand |
| BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE | BUPRENORPHINE HCL-NALOXONE HCL SL FILM 12-3 MG (BASE EQUIV) | 65200010208250 | Generic |
| SUBOXONE | BUPRENORPHINE HCL-NALOXONE HCL SL FILM 12-3 MG (BASE EQUIV) | 65200010208250 | Brand |
| BUPRENORPHINE HCL/NALOXONE HCL | BUPRENORPHINE HCL-NALOXONE HCL SL TAB 2-0.5 MG (BASE EQUIV) | 65200010200720 | Generic |
| BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE | BUPRENORPHINE HCL-NALOXONE HCL SL TAB 2-0.5 MG (BASE EQUIV) | 65200010200720 | Generic |
| BUPRENORPHINE HCL/NALOXONE HCL | BUPRENORPHINE HCL-NALOXONE HCL SL TAB 8-2 MG (BASE EQUIV) | 65200010200740 | Generic |
| BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE | BUPRENORPHINE HCL-NALOXONE HCL SL TAB 8-2 MG (BASE EQUIV) | 65200010200740 | Generic |

| | | | |
|---|---|---|---|
| ZUBSOLV | BUPRENORPHINE HCL-NALOXONE HCL SL TAB 0.7-0.18 MG (BASE EQ) | 65200010200710 | Brand |
| ZUBSOLV | BUPRENORPHINE HCL-NALOXONE HCL SL TAB 1.4-0.36 MG (BASE EQ) | 65200010200715 | Brand |
| ZUBSOLV | BUPRENORPHINE HCL-NALOXONE HCL SL TAB 2.9-0.71 MG (BASE EQ) | 65200010200725 | Brand |
| ZUBSOLV | BUPRENORPHINE HCL-NALOXONE HCL SL TAB 5.7-1.4 MG (BASE EQ) | 65200010200732 | Brand |
| ZUBSOLV | BUPRENORPHINE HCL-NALOXONE HCL SL TAB 8.6-2.1 MG (BASE EQ) | 65200010200745 | Brand |
| ZUBSOLV | BUPRENORPHINE HCL-NALOXONE HCL SL TAB 11.4-2.9 MG (BASE EQ) | 65200010200760 | Brand |
| BUPRENORPHINE HYDROCHLORIDE | BUPRENORPHINE HCL SL TAB 2 MG (BASE EQUIV) | 65200010100760 | Generic |
| BUPRENORPHINE HCL | BUPRENORPHINE HCL SL TAB 2 MG (BASE EQUIV) | 65200010100760 | Generic |
| BUPRENORPHINE HYDROCHLORIDE | BUPRENORPHINE HCL SL TAB 8 MG (BASE EQUIV) | 65200010100780 | Generic |
| BUPRENORPHINE HCL | BUPRENORPHINE HCL SL TAB 8 MG (BASE EQUIV) | 65200010100780 | Generic |
| BUNAVAIL | BUPRENORPHINE-NALOXONE BUCCAL FILM 4.2-0.7 MG (BASE EQUIV) | 65200010208270 | Brand |
| BUNAVAIL | BUPRENORPHINE-NALOXONE BUCCAL FILM 6.3-1 MG (BASE EQUIV) | 65200010208280 | Brand |

**Approval Criteria**

**1** - Physician has provided rationale for needing to exceed the 24 mg (milligrams) buprenorphine daily limit

| Product Name: generic buprenorphine/naloxone SL film, Brand Suboxone, buprenorphine/naloxone SL tabs, Zubsolv, buprenorphine SL tabs, Bunavail | |
|---|---|
| Approval Length | Authorization length will be issued for requested duration of therapy, not to exceed 12 months |
| Guideline Type | Quantity Limit |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE | BUPRENORPHINE HCL-NALOXONE HCL SL FILM 2-0.5 MG (BASE EQUIV) | 65200010208220 | Generic |
| SUBOXONE | BUPRENORPHINE HCL-NALOXONE HCL SL FILM 2-0.5 MG (BASE EQUIV) | 65200010208220 | Brand |
| BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE | BUPRENORPHINE HCL-NALOXONE HCL SL FILM 8-2 MG (BASE EQUIV) | 65200010208240 | Generic |
| SUBOXONE | BUPRENORPHINE HCL-NALOXONE HCL SL FILM 8-2 MG (BASE EQUIV) | 65200010208240 | Brand |
| BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE | BUPRENORPHINE HCL-NALOXONE HCL SL FILM 4-1 MG (BASE EQUIV) | 65200010208230 | Generic |
| SUBOXONE | BUPRENORPHINE HCL-NALOXONE HCL SL FILM 4-1 MG (BASE EQUIV) | 65200010208230 | Brand |
| BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE | BUPRENORPHINE HCL-NALOXONE HCL SL FILM 12-3 MG (BASE EQUIV) | 65200010208250 | Generic |
| SUBOXONE | BUPRENORPHINE HCL-NALOXONE HCL SL FILM 12-3 MG (BASE EQUIV) | 65200010208250 | Brand |
| BUPRENORPHINE HCL/NALOXONE HCL | BUPRENORPHINE HCL-NALOXONE HCL SL TAB 2-0.5 MG (BASE EQUIV) | 65200010200720 | Generic |
| BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE | BUPRENORPHINE HCL-NALOXONE HCL SL TAB 2-0.5 MG (BASE EQUIV) | 65200010200720 | Generic |
| BUPRENORPHINE HCL/NALOXONE HCL | BUPRENORPHINE HCL-NALOXONE HCL SL TAB 8-2 MG (BASE EQUIV) | 65200010200740 | Generic |
| BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE | BUPRENORPHINE HCL-NALOXONE HCL SL TAB 8-2 MG (BASE EQUIV) | 65200010200740 | Generic |
| ZUBSOLV | BUPRENORPHINE HCL-NALOXONE HCL SL TAB 0.7-0.18 MG (BASE EQ) | 65200010200710 | Brand |
| ZUBSOLV | BUPRENORPHINE HCL-NALOXONE HCL SL TAB 1.4-0.36 MG (BASE EQ) | 65200010200715 | Brand |
| ZUBSOLV | BUPRENORPHINE HCL-NALOXONE HCL SL TAB 2.9-0.71 MG (BASE EQ) | 65200010200725 | Brand |
| ZUBSOLV | BUPRENORPHINE HCL-NALOXONE HCL SL TAB 5.7-1.4 MG (BASE EQ) | 65200010200732 | Brand |

| | | | |
|---|---|---|---|
| ZUBSOLV | BUPRENORPHINE HCL-NALOXONE HCL SL TAB 8.6-2.1 MG (BASE EQ) | 65200010200745 | Brand |
| ZUBSOLV | BUPRENORPHINE HCL-NALOXONE HCL SL TAB 11.4-2.9 MG (BASE EQ) | 65200010200760 | Brand |
| BUPRENORPHINE HYDROCHLORIDE | BUPRENORPHINE HCL SL TAB 2 MG (BASE EQUIV) | 65200010100760 | Generic |
| BUPRENORPHINE HCL | BUPRENORPHINE HCL SL TAB 2 MG (BASE EQUIV) | 65200010100760 | Generic |
| BUPRENORPHINE HYDROCHLORIDE | BUPRENORPHINE HCL SL TAB 8 MG (BASE EQUIV) | 65200010100780 | Generic |
| BUPRENORPHINE HCL | BUPRENORPHINE HCL SL TAB 8 MG (BASE EQUIV) | 65200010100780 | Generic |
| BUNAVAIL | BUPRENORPHINE-NALOXONE BUCCAL FILM 4.2-0.7 MG (BASE EQUIV) | 65200010208270 | Brand |
| BUNAVAIL | BUPRENORPHINE-NALOXONE BUCCAL FILM 6.3-1 MG (BASE EQUIV) | 65200010208280 | Brand |

**Approval Criteria**

**1** - The requested dosage cannot be achieved using the plan accepted quantity limit of a different dose or formulation

**OR**

**2** - Physician has provided rationale for requiring the specific quantity requested

Bylvay

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-156302 |
| **Guideline Name** | Bylvay |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 11/1/2024 |

## 1 . Criteria

| Product Name: Bylvay | |
|---|---|
| Diagnosis | Progressive Familial Intrahepatic Cholestasis |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BYLVAY | ODEVIXIBAT CAP 400 MCG | 52350060000120 | Brand |
| BYLVAY | ODEVIXIBAT CAP 1200 MCG | 52350060000140 | Brand |
| BYLVAY (PELLETS) | ODEVIXIBAT PELLETS CAP SPRINKLE 200 MCG | 52350060006810 | Brand |

| | | | |
|---|---|---|---|
| BYLVAY (PELLETS) | ODEVIXIBAT PELLETS CAP SPRINKLE 600 MCG | 52350060006830 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BYLVAY | ODEVIXIBAT CAP 400 MCG | 52350060000120 | Brand |
| BYLVAY | ODEVIXIBAT CAP 1200 MCG | 52350060000140 | Brand |
| BYLVAY (PELLETS) | ODEVIXIBAT PELLETS CAP SPRINKLE 200 MCG | 52350060006810 | Brand |
| BYLVAY (PELLETS) | ODEVIXIBAT PELLETS CAP SPRINKLE 600 MCG | 52350060006830 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BYLVAY | ODEVIXIBAT CAP 400 MCG | 52350060000120 | Brand |
| BYLVAY | ODEVIXIBAT CAP 1200 MCG | 52350060000140 | Brand |
| BYLVAY (PELLETS) | ODEVIXIBAT PELLETS CAP SPRINKLE 200 MCG | 52350060006810 | Brand |
| BYLVAY (PELLETS) | ODEVIXIBAT PELLETS CAP SPRINKLE 600 MCG | 52350060006830 | Brand |

**Approval Criteria**

**1** - Diagnosis 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| BYLVAY | ODEVIXIBAT CAP 400 MCG | 52350060000120 | Brand |
| BYLVAY | ODEVIXIBAT CAP 1200 MCG | 52350060000140 | Brand |
| BYLVAY (PELLETS) | ODEVIXIBAT PELLETS CAP SPRINKLE 200 MCG | 52350060006810 | Brand |
| BYLVAY (PELLETS) | ODEVIXIBAT PELLETS CAP SPRINKLE 600 MCG | 52350060006830 | Brand |

**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

| Date | Notes |
|---|---|
| 9/25/2024 | Updated examples of conventional treatment and initial authorization durations |

Cablivi

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146485 |
| **Guideline Name** | Cablivi |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Cablivi | |
|---|---|
| Diagnosis | Acquired thrombotic thrombocytopenic purpura (aTTP) |
| Approval Length | 2 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CABLIVI | CAPLACIZUMAB-YHDP FOR INJ KIT 11 MG | 85151020806420 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CABLIVI | CAPLACIZUMAB-YHDP FOR INJ KIT 11 MG | 85151020806420 | Brand |

**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)

Cabometyx

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146486 |
| **Guideline Name** | Cabometyx |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Cabometyx | |
|---|---|
| Diagnosis | Renal Cell Carcinoma (RCC) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CABOMETYX | CABOZANTINIB S-MALATE TAB 20 MG (BASE EQUIVALENT) | 21533010100320 | Brand |
| CABOMETYX | CABOZANTINIB S-MALATE TAB 40 MG (BASE EQUIVALENT) | 21533010100330 | Brand |
| CABOMETYX | CABOZANTINIB S-MALATE TAB 60 MG (BASE EQUIVALENT) | 21533010100340 | Brand |

**Approval Criteria**

**1** - Diagnosis of advanced renal cell carcinoma

| Product Name: Cabometyx | |
|---|---|
| Diagnosis | Non-Small Cell Lung Cancer (NSCLC) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CABOMETYX | CABOZANTINIB S-MALATE TAB 20 MG (BASE EQUIVALENT) | 21533010100320 | Brand |
| CABOMETYX | CABOZANTINIB S-MALATE TAB 40 MG (BASE EQUIVALENT) | 21533010100330 | Brand |
| CABOMETYX | CABOZANTINIB S-MALATE TAB 60 MG (BASE EQUIVALENT) | 21533010100340 | Brand |

**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

| Product Name: Cabometyx | |
|---|---|
| Diagnosis | Hepatocellular Carcinoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CABOMETYX | CABOZANTINIB S-MALATE TAB 20 MG (BASE EQUIVALENT) | 21533010100320 | Brand |
| CABOMETYX | CABOZANTINIB S-MALATE TAB 40 MG (BASE EQUIVALENT) | 21533010100330 | Brand |
| CABOMETYX | CABOZANTINIB S-MALATE TAB 60 MG (BASE EQUIVALENT) | 21533010100340 | Brand |

**Approval Criteria**

**1** - Diagnosis of hepatocellular carcinoma

**AND**

**2** - ONE of the following:

**2.1** Failure to Nexavar (sorafenib), as confirmed by claims history or submission of medical records

**OR**

**2.2** History of contraindication or intolerance to Nexavar (sorafenib) (please specify contraindication or intolerance)

**OR**

**2.3** BOTH of the following:

**2.3.1** Disease is Child-Pugh class A

**AND**

**2.3.2** Patient has unresectable disease and is not a transplant candidate

**OR**

**2.4** BOTH of the following:

**2.4.1** Disease is Child-Pugh class A

**AND**

**2.4.2** Patient has metastatic disease or extensive liver tumor burden

**OR**

**2.5** BOTH of the following:

**2.5.1** Disease is Child-Pugh class A

**AND**

**2.5.2** Patient has liver-confined disease and it is inoperable by performance status, comorbidity, or with minimal or uncertain extrahepatic disease

| Product Name: Cabometyx | |
|---|---|
| Diagnosis | Osteosarcoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| CABOMETYX | CABOZANTINIB S-MALATE TAB 20 MG (BASE EQUIVALENT) | 21533010100320 | Brand |
| CABOMETYX | CABOZANTINIB S-MALATE TAB 40 MG (BASE EQUIVALENT) | 21533010100330 | Brand |
| CABOMETYX | CABOZANTINIB S-MALATE TAB 60 MG (BASE EQUIVALENT) | 21533010100340 | Brand |

**Approval Criteria**

**1** - Diagnosis of osteosarcoma

**AND**

**2** - Patient's disease has progressed on prior treatment

**AND**

**3** - ONE of the following:

**3.1** Patient has relapsed/refractory disease

**OR**

**3.2** Patient has metastatic disease

| Product Name: Cabometyx | |
|---|---|
| Diagnosis | Ewing Sarcoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CABOMETYX | CABOZANTINIB S-MALATE TAB 20 MG (BASE EQUIVALENT) | 21533010100320 | Brand |

| | | | |
|---|---|---|---|
| CABOMETYX | CABOZANTINIB S-MALATE TAB 40 MG (BASE EQUIVALENT) | 21533010100330 | Brand |
| CABOMETYX | CABOZANTINIB S-MALATE TAB 60 MG (BASE EQUIVALENT) | 21533010100340 | Brand |

**Approval Criteria**

**1** - Diagnosis of Ewing sarcoma (including mesenchymal chondrosarcoma)

**AND**

**2** - Patient has relapsed, progressive, or metastatic disease

| Product Name: Cabometyx | |
|---|---|
| Diagnosis | Gastrointestinal Stromal Tumors (GIST) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CABOMETYX | CABOZANTINIB S-MALATE TAB 20 MG (BASE EQUIVALENT) | 21533010100320 | Brand |
| CABOMETYX | CABOZANTINIB S-MALATE TAB 40 MG (BASE EQUIVALENT) | 21533010100330 | Brand |
| CABOMETYX | CABOZANTINIB S-MALATE TAB 60 MG (BASE EQUIVALENT) | 21533010100340 | Brand |

**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 | Kidney Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CABOMETYX | CABOZANTINIB S-MALATE TAB 20 MG (BASE EQUIVALENT) | 21533010100320 | Brand |
| CABOMETYX | CABOZANTINIB S-MALATE TAB 40 MG (BASE EQUIVALENT) | 21533010100330 | Brand |
| CABOMETYX | CABOZANTINIB S-MALATE TAB 60 MG (BASE EQUIVALENT) | 21533010100340 | Brand |

**Approval Criteria**

**1** - Diagnosis of kidney cancer

**AND**

**2** - ONE of the following:

**2.1** Patient has relapsed disease

**OR**

**2.2** Patient has metastatic disease

| Product Name: Cabometyx | |
|---|---|
| Diagnosis | Endometrial Carcinoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CABOMETYX | CABOZANTINIB S-MALATE TAB 20 MG (BASE EQUIVALENT) | 21533010100320 | Brand |
| CABOMETYX | CABOZANTINIB S-MALATE TAB 40 MG (BASE EQUIVALENT) | 21533010100330 | Brand |
| CABOMETYX | CABOZANTINIB S-MALATE TAB 60 MG (BASE EQUIVALENT) | 21533010100340 | Brand |

**Approval Criteria**

**1** - Diagnosis of endometrial carcinoma

**AND**

**2** - Disease is recurrent, high-risk, or metastatic

**AND**

**3** - Used as second-line treatment

Product Name: Cabometyx

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CABOMETYX | CABOZANTINIB S-MALATE TAB 20 MG (BASE EQUIVALENT) | 21533010100320 | Brand |
| CABOMETYX | CABOZANTINIB S-MALATE TAB 40 MG (BASE EQUIVALENT) | 21533010100330 | Brand |
| CABOMETYX | CABOZANTINIB S-MALATE TAB 60 MG (BASE EQUIVALENT) | 21533010100340 | Brand |

**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 | Renal Cell Carcinoma (RCC), Non-Small Cell Lung Cancer (NSCLC), Hepatocellular Carcinoma, Osteosarcoma, Ewing Sarcoma, Gastrointestinal Stromal Tumors (GIST), Kidney Cancer, Endometrial Carcinoma, Thyroid Cancer |
| Approval Length | 12 month(s) |

| Therapy Stage | Reauthorization |
|---|---|
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CABOMETYX | CABOZANTINIB S-MALATE TAB 20 MG (BASE EQUIVALENT) | 21533010100320 | Brand |
| CABOMETYX | CABOZANTINIB S-MALATE TAB 40 MG (BASE EQUIVALENT) | 21533010100330 | Brand |
| CABOMETYX | CABOZANTINIB S-MALATE TAB 60 MG (BASE EQUIVALENT) | 21533010100340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CABOMETYX | CABOZANTINIB S-MALATE TAB 20 MG (BASE EQUIVALENT) | 21533010100320 | Brand |
| CABOMETYX | CABOZANTINIB S-MALATE TAB 40 MG (BASE EQUIVALENT) | 21533010100330 | Brand |
| CABOMETYX | CABOZANTINIB S-MALATE TAB 60 MG (BASE EQUIVALENT) | 21533010100340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CABOMETYX | CABOZANTINIB S-MALATE TAB 20 MG (BASE EQUIVALENT) | 21533010100320 | Brand |
| CABOMETYX | CABOZANTINIB S-MALATE TAB 40 MG (BASE EQUIVALENT) | 21533010100330 | Brand |
| CABOMETYX | CABOZANTINIB S-MALATE TAB 60 MG (BASE EQUIVALENT) | 21533010100340 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Cabometyx therapy

Calquence

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146487 |
| **Guideline Name** | Calquence |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Calquence | |
|---|---|
| Diagnosis | Mantle cell lymphoma (MCL) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CALQUENCE | ACALABRUTINIB CAP 100 MG | 21532103000120 | Brand |
| CALQUENCE | ACALABRUTINIB MALEATE TAB 100 MG | 21532103500320 | Brand |

**Approval Criteria**

**1** - Diagnosis of mantle cell lymphoma (MCL)

**AND**

**2** - Patient has received at least one prior therapy for MCL [e.g., Rituxan (rituximab)]

| Product Name: Calquence | |
|---|---|
| Diagnosis | Chronic lymphocytic leukemia/small lymphocytic lymphoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CALQUENCE | ACALABRUTINIB CAP 100 MG | 21532103000120 | Brand |
| CALQUENCE | ACALABRUTINIB MALEATE TAB 100 MG | 21532103500320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CALQUENCE | ACALABRUTINIB CAP 100 MG | 21532103000120 | Brand |
| CALQUENCE | ACALABRUTINIB MALEATE TAB 100 MG | 21532103500320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CALQUENCE | ACALABRUTINIB CAP 100 MG | 21532103000120 | Brand |
| CALQUENCE | ACALABRUTINIB MALEATE TAB 100 MG | 21532103500320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CALQUENCE | ACALABRUTINIB CAP 100 MG | 21532103000120 | Brand |
| CALQUENCE | ACALABRUTINIB MALEATE TAB 100 MG | 21532103500320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CALQUENCE | ACALABRUTINIB CAP 100 MG | 21532103000120 | Brand |
| CALQUENCE | ACALABRUTINIB MALEATE TAB 100 MG | 21532103500320 | Brand |

**Approval Criteria**

**1** - Use 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CALQUENCE | ACALABRUTINIB CAP 100 MG | 21532103000120 | Brand |
| CALQUENCE | ACALABRUTINIB MALEATE TAB 100 MG | 21532103500320 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Calquence therapy

Camzyos

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146488 |
| **Guideline Name** | Camzyos |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CAMZYOS | MAVACAMTEN CAP 2.5 MG | 40190050000110 | Brand |
| CAMZYOS | MAVACAMTEN CAP 5 MG | 40190050000120 | Brand |
| CAMZYOS | MAVACAMTEN CAP 10 MG | 40190050000130 | Brand |
| CAMZYOS | MAVACAMTEN CAP 15 MG | 40190050000140 | Brand |

**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** - Patient has a left ventricular ejection fraction of greater than or equal to 55%

**AND**

**4** - Patient has 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 TWO 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)
- Disopyramide

**OR**

**5.2** History of contraindication or intolerance to ALL 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)
- Disopyramide

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CAMZYOS | MAVACAMTEN CAP 2.5 MG | 40190050000110 | Brand |
| CAMZYOS | MAVACAMTEN CAP 5 MG | 40190050000120 | Brand |
| CAMZYOS | MAVACAMTEN CAP 10 MG | 40190050000130 | Brand |
| CAMZYOS | MAVACAMTEN CAP 15 MG | 40190050000140 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to therapy as supported by ONE of the following:

- Reduction in NYHA (New York Heart Association) 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 prescribed by, or in consultation with, a cardiologist |

Caprelsa

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-159297 |
| **Guideline Name** | Caprelsa |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 1 . Criteria

| Product Name: Caprelsa | |
|---|---|
| Diagnosis | Thyroid Carcinoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CAPRELSA | VANDETANIB TAB 100 MG | 21533085000320 | Brand |
| CAPRELSA | VANDETANIB TAB 300 MG | 21533085000340 | Brand |

**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
- Oncocytic carcinoma
- Papillary carcinoma

**AND**

**2.2** ONE of the following:

- Unresectable recurrent disease
- Persistent locoregional 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

| Product Name: Caprelsa | |
|---|---|
| Diagnosis | Thyroid Carcinoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CAPRELSA | VANDETANIB TAB 100 MG | 21533085000320 | Brand |
| CAPRELSA | VANDETANIB TAB 300 MG | 21533085000340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CAPRELSA | VANDETANIB TAB 100 MG | 21533085000320 | Brand |
| CAPRELSA | VANDETANIB TAB 300 MG | 21533085000340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CAPRELSA | VANDETANIB TAB 100 MG | 21533085000320 | Brand |
| CAPRELSA | VANDETANIB TAB 300 MG | 21533085000340 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Caprelsa therapy

## 2 . Revision History

| Date | Notes |
|---|---|
| 11/5/2024 | Updated criteria for medullary thyroid carcinoma |

Carbaglu

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146490 |
| **Guideline Name** | Carbaglu |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Brand Carbaglu, generic carglumic acid | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CARBAGLU | CARGLUMIC ACID SOLUBLE TAB 200 MG | 30908230007320 | Brand |
| CARGLUMIC ACID | CARGLUMIC ACID SOLUBLE TAB 200 MG | 30908230007320 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CARBAGLU | CARGLUMIC ACID SOLUBLE TAB 200 MG | 30908230007320 | Brand |
| CARGLUMIC ACID | CARGLUMIC ACID SOLUBLE TAB 200 MG | 30908230007320 | Generic |

**Approval Criteria**

**1** - Documentation of positive clinical response to the requested therapy

Cayston

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146491 |
| **Guideline Name** | Cayston |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Cayston | |
|---|---|
| Diagnosis | Cystic Fibrosis (CF) |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CAYSTON | AZTREONAM LYSINE FOR INHAL SOLN 75 MG (BASE EQUIVALENT) | 16140010402120 | Brand |

**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)

Cerdelga and Zavesca

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146492 |
| **Guideline Name** | Cerdelga and Zavesca |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Cerdelga | |
|---|---|
| Diagnosis | Gaucher Disease Type 1 |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CERDELGA | ELIGLUSTAT TARTRATE CAP 84 MG (BASE EQUIVALENT) | 82700040600120 | Brand |

**Approval Criteria**

**1** - Diagnosis of Gaucher disease type 1

**AND**

**2** - Patient is ONE of the following as detected by a Food and Drug Administration (FDA)-cleared test:

- CYP2D6 extensive metabolizer
- CYP2D6 intermediate metabolizer
- CYP2D6 poor metabolizer

| Product Name: Cerdelga | |
|---|---|
| Diagnosis | Gaucher Disease Type 1 |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CERDELGA | ELIGLUSTAT TARTRATE CAP 84 MG (BASE EQUIVALENT) | 82700040600120 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to therapy

| Product Name: Brand Zavesca, generic miglustat, Yargesa | |
|---|---|
| Diagnosis | Mild to Moderate Type 1 Gaucher Disease |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MIGLUSTAT | MIGLUSTAT CAP 100 MG | 82700070000120 | Generic |

| | | | |
|---|---|---|---|
| ZAVESCA | MIGLUSTAT CAP 100 MG | 82700070000120 | Brand |
| YARGESA | MIGLUSTAT CAP 100 MG | 82700070000120 | Generic |

**Approval Criteria**

**1** - Diagnosis of mild to moderate type 1 Gaucher disease

**AND**

**2** - Patient is unable to receive enzyme replacement therapy due to ONE of the following conditions:

**2.1** Allergy or hypersensitivity to enzyme replacement therapy

**OR**

**2.2** Poor venous access

**OR**

**2.3** Unavailability of enzyme replacement therapy (e.g., Cerezyme, VPRIV)

| Product Name: Brand Zavesca, generic miglustat, Yargesa | |
|---|---|
| Diagnosis | Mild to Moderate Type 1 Gaucher Disease |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MIGLUSTAT | MIGLUSTAT CAP 100 MG | 82700070000120 | Generic |
| ZAVESCA | MIGLUSTAT CAP 100 MG | 82700070000120 | Brand |
| YARGESA | MIGLUSTAT CAP 100 MG | 82700070000120 | Generic |

**Approval Criteria**

**1** - Documentation of positive clinical response to therapy

CGRP

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-147271 |
| **Guideline Name** | CGRP |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AJOVY | FREMANEZUMAB-VFRM SUBCUTANEOUS SOLN AUTO-INJ 225 MG/1.5ML | 6770203020D520 | Brand |
| AJOVY | FREMANEZUMAB-VFRM SUBCUTANEOUS SOLN PREF SYR 225 MG/1.5ML | 6770203020E520 | Brand |
| EMGALITY | GALCANEZUMAB-GNLM SUBCUTANEOUS SOLN AUTO-INJECTOR 120 MG/ML | 6770203530D520 | Brand |

| | | | |
|---|---|---|---|
| EMGALITY | GALCANEZUMAB-GNLM SUBCUTANEOUS SOLN PREFILLED SYR 120 MG/ML | 6770203530E520 | Brand |

**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:

- Amitriptyline (generic Elavil)
- 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)**
- Topiramate (generic Topamax)
- Venlafaxine [generic Effexor/Effexor XR (extended-release)]

**OR**

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

- Amitriptyline (generic Elavil)
- 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)**
- Topiramate (generic Topamax)
- Venlafaxine [generic Effexor/Effexor XR (extended-release)]

**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 include d in denial to provider.<br>**OnabotulinumtoxinA (generic Botox) might not be covered on your p harmacy prescription drug benefit. Coverage might be available on yo ur medical benefit. |

| Product Name: Aimovig | |
|---|---|
| Diagnosis | Migraines |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AIMOVIG | ERENUMAB-AOOE SUBCUTANEOUS SOLN AUTO-INJECTOR 70 MG/ML | 6770202010D520 | Brand |
| AIMOVIG | ERENUMAB-AOOE SUBCUTANEOUS SOLN AUTO-INJECTOR 140 MG/ML | 6770202010D540 | Brand |

**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:

- Amitriptyline (generic Elavil)
- 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)**
- Topiramate (generic Topamax)
- Venlafaxine [generic Effexor/Effexor XR (extended-release)]

**OR**

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

- Amitriptyline (generic Elavil)
- 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)**
- Topiramate (generic Topamax)

- Venlafaxine [generic Effexor/Effexor XR (extended-release)]

**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 include d in denial to provider.<br>**OnabotulinumtoxinA (generic Botox) might not be covered on your p harmacy prescription drug benefit. Coverage might be available on yo ur medical benefit. |
|---|---|

| Product Name: Aimovig, Ajovy, Emgality 120mg | |
|---|---|
| Diagnosis | Migraines |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| AIMOVIG | ERENUMAB-AOOE SUBCUTANEOUS SOLN AUTO-INJECTOR 70 MG/ML | 6770202010D520 | Brand |
| AIMOVIG | ERENUMAB-AOOE SUBCUTANEOUS SOLN AUTO-INJECTOR 140 MG/ML | 6770202010D540 | Brand |
| AJOVY | FREMANEZUMAB-VFRM SUBCUTANEOUS SOLN AUTO-INJ 225 MG/1.5ML | 6770203020D520 | Brand |
| AJOVY | FREMANEZUMAB-VFRM SUBCUTANEOUS SOLN PREF SYR 225 MG/1.5ML | 6770203020E520 | Brand |
| EMGALITY | GALCANEZUMAB-GNLM SUBCUTANEOUS SOLN AUTO-INJECTOR 120 MG/ML | 6770203530D520 | Brand |
| EMGALITY | GALCANEZUMAB-GNLM SUBCUTANEOUS SOLN PREFILLED SYR 120 MG/ML | 6770203530E520 | Brand |

**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 | |
|---|---|
| Diagnosis | Episodic Cluster Headache |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| EMGALITY | GALCANEZUMAB-GNLM SUBCUTANEOUS SOLN PREFILLED SYR 100 MG/ML | 6770203530E515 | Brand |

**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 used for the preventive treatment of migraines [e.g., Aimovig, Ajovy, Nurtec ODT (orally disintegrating tablet), Qulipta, Vyepti]

| Product Name: Emgality 100mg | |
|---|---|
| Diagnosis | Episodic Cluster Headache |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| EMGALITY | GALCANEZUMAB-GNLM SUBCUTANEOUS SOLN PREFILLED SYR 100 MG/ML | 6770203530E515 | Brand |

**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., Aimovig, Ajovy, Nurtec ODT (orally disintegrating tablet), Qulipta, Vyepti]

## 2 . Revision History

| Date | Notes |
| --- | --- |
| 5/13/2024 | Updated note regarding medical coverage of generic Botox. Added e pisodic to header of cluster headaches section. |

Cholbam

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146493 |
| **Guideline Name** | Cholbam |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Cholbam | |
|---|---|
| Approval Length | 3 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CHOLBAM | CHOLIC ACID CAP 50 MG | 52700025000120 | Brand |
| CHOLBAM | CHOLIC ACID CAP 250 MG | 52700025000140 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CHOLBAM | CHOLIC ACID CAP 50 MG | 52700025000120 | Brand |
| CHOLBAM | CHOLIC ACID CAP 250 MG | 52700025000140 | Brand |

**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

Cialis and Chewtadzy for BPH

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-156306 |
| **Guideline Name** | Cialis and Chewtadzy for BPH |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 11/1/2024 |

## 1 . Criteria

| Product Name: Chewtadzy 5mg, Brand Cialis 5 mg, generic tadalafil 5 mg | |
|---|---|
| Diagnosis | Benign prostatic hyperplasia (BPH) |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CIALIS | TADALAFIL TAB 5 MG | 40304080000305 | Brand |
| TADALAFIL | TADALAFIL TAB 5 MG | 40304080000305 | Generic |
| CHEWTADZY | | | |

**Approval Criteria**

**1** - The patient has a 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 |
| --- | --- |
| 9/26/2024 | Added Chewtadzy |

Cibinqo

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-147335 |
| **Guideline Name** | Cibinqo |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Cibinqo | |
|---|---|
| Diagnosis | Atopic Dermatitis |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CIBINQO | ABROCITINIB TAB 50 MG | 90272005000320 | Brand |
| CIBINQO | ABROCITINIB TAB 100 MG | 90272005000325 | Brand |
| CIBINQO | ABROCITINIB TAB 200 MG | 90272005000330 | Brand |

**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:

**2.1.2.1.1** 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), cyclosporine, azathioprine, methotrexate, mycophenolate mofetil, etc.]

**AND**

**2.1.2.1.2** 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 BOTH of the following FDA (Food and Drug Administration)-approved chronic atopic dermatitis therapies is inadvisable (document drug and contraindication rationale):

- Adbry (tralokinumab-ldrm)
- Dupixent (dupilumab)

**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:

- Biologic immunomodulator [e.g., Adbry (tralokinumab-ldrm), Dupixent (dupilumab)]
- Janus kinase inhibitor [e.g., Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib), Olumiant (baricitinib), Opzelura (topical ruxolitinib)]

- 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 | |
|---|---|
| Diagnosis | Atopic Dermatitis |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CIBINQO | ABROCITINIB TAB 50 MG | 90272005000320 | Brand |
| CIBINQO | ABROCITINIB TAB 100 MG | 90272005000325 | Brand |
| CIBINQO | ABROCITINIB TAB 200 MG | 90272005000330 | Brand |

**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:

- Biologic immunomodulator [e.g., Adbry (tralokinumab-ldrm), Dupixent (dupilumab)]
- Janus kinase inhibitor [e.g., Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib), Olumiant (baricitinib), Opzelura (topical ruxolitinib)]

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

## 3 . Revision History

| Date | Notes |
| --- | --- |
| 5/13/2024 | Copy NY |

Cimzia

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-159342 |
| **Guideline Name** | Cimzia |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CIMZIA | CERTOLIZUMAB PEGOL PREFILLED SYRINGE KIT 200 MG/ML | 5250502010F840 | Brand |
| CIMZIA STARTER KIT | CERTOLIZUMAB PEGOL PREFILLED SYRINGE KIT 200 MG/ML | 5250502010F840 | Brand |
| CIMZIA | CERTOLIZUMAB PEGOL FOR INJ KIT 2 X 200 MG | 52505020106420 | Brand |

**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 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, Stelara (ustekinumab), Skyrizi (risankizumab)]

**AND**

**1.3** ONE of the following:

- Failure to one of the preferred adalimumab products* as confirmed by claims history or submitted medical records
- History of contraindication or intolerance to one of the preferred adalimumab products* (please specify contraindication or intolerance)

**AND**

**1.4** Patient is NOT receiving Cimzia in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Stelara (ustekinumab), Skyrizi (risankizumab)]

**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 targeted immunomodulator [e.g., Enbrel (etanercept), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Stelara (ustekinumab), Skyrizi (risankizumab)]

**AND**

| **2.4** Prescribed by or in consultation with a gastroenterologist | |
|---|---|
| Notes | *For a list of preferred adalimumab products please reference drug co verage tools. |

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CIMZIA | CERTOLIZUMAB PEGOL PREFILLED SYRINGE KIT 200 MG/ML | 5250502010F840 | Brand |
| CIMZIA STARTER KIT | CERTOLIZUMAB PEGOL PREFILLED SYRINGE KIT 200 MG/ML | 5250502010F840 | Brand |
| CIMZIA | CERTOLIZUMAB PEGOL FOR INJ KIT 2 X 200 MG | 52505020106420 | Brand |

**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 targeted immunomodulator FDA-approved for the treatment of rheumatoid arthritis as confirmed by claims history or submission of medical records [e.g., Enbrel (etanercept), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

**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 targeted immunomodulator [e.g., Enbrel (etanercept), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

**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 targeted immunomodulator [e.g., Enbrel (etanercept), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

**AND**

**2.4** Prescribed by or in consultation with a rheumatologist

| Notes | *For a list of preferred adalimumab products please reference drug co verage tools. |
|---|---|

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CIMZIA | CERTOLIZUMAB PEGOL PREFILLED SYRINGE KIT 200 MG/ML | 5250502010F840 | Brand |
| CIMZIA STARTER KIT | CERTOLIZUMAB PEGOL PREFILLED SYRINGE KIT 200 MG/ML | 5250502010F840 | Brand |

| CIMZIA | CERTOLIZUMAB PEGOL FOR INJ KIT 2 X 200 MG | 52505020106420 | Brand |
|---|---|---|---|

**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 targeted immunomodulator FDA-approved for the treatment of psoriatic arthritis as confirmed by claims history or submission of medical records [e.g., Enbrel (etanercept), adalimumab, Simponi (golimumab), Orencia (abatacept), Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

**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 targeted immunomodulator [e.g., Enbrel (etanercept), adalimumab, Simponi (golimumab), Orencia (abatacept), Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

**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 targeted immunomodulator [e.g., Enbrel (etanercept), adalimumab, Simponi (golimumab), Orencia (abatacept), Stelara (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 | *For a list of preferred adalimumab products please reference drug co verage tools. |
|---|---|

| Product Name: Cimzia | |
|---|---|
| Diagnosis | Ankylosing Spondylitis |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CIMZIA | CERTOLIZUMAB PEGOL PREFILLED SYRINGE KIT 200 MG/ML | 5250502010F840 | Brand |
| CIMZIA STARTER KIT | CERTOLIZUMAB PEGOL PREFILLED SYRINGE KIT 200 MG/ML | 5250502010F840 | Brand |
| CIMZIA | CERTOLIZUMAB PEGOL FOR INJ KIT 2 X 200 MG | 52505020106420 | Brand |

**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 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)]

**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 targeted immunomodulator [e.g., Enbrel (etanercept), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

**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 targeted immunomodulator [e.g., Enbrel (etanercept), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

**AND**

**2.4** Prescribed by or in consultation with a rheumatologist

| Notes | *For a list of preferred adalimumab products please reference drug co verage tools. |
|---|---|

| Product Name: Cimzia |
|---|

| | |
|---|---|
| Diagnosis | Plaque Psoriasis |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CIMZIA | CERTOLIZUMAB PEGOL PREFILLED SYRINGE KIT 200 MG/ML | 5250502010F840 | Brand |
| CIMZIA STARTER KIT | CERTOLIZUMAB PEGOL PREFILLED SYRINGE KIT 200 MG/ML | 5250502010F840 | Brand |
| CIMZIA | CERTOLIZUMAB PEGOL FOR INJ KIT 2 X 200 MG | 52505020106420 | Brand |

**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 targeted immunomodulator FDA-approved for the treatment of plaque psoriasis as confirmed by claims history or submission of medical records [e.g., adalimumab, Otezla (apremilast), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Tremfya (guselkumab)]

**AND**

**1.3** ONE of the following:

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

- One of the preferred adalimumab products*
- One of the following: Enbrel (etanercept) or Ilumya (tildrakizumab)

**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)
- Ilumya (tildrakizumab)

**AND**

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

**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 targeted immunomodulator [e.g., Enbrel (etanercept), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), 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

| | |
|---|---|
| Notes | *For a list of preferred adalimumab products please reference drug co verage tools. |

| Product Name: Cimzia | |
|---|---|
| Diagnosis | Non-Radiographic Axial Spondyloarthritis |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CIMZIA | CERTOLIZUMAB PEGOL PREFILLED SYRINGE KIT 200 MG/ML | 5250502010F840 | Brand |
| CIMZIA STARTER KIT | CERTOLIZUMAB PEGOL PREFILLED SYRINGE KIT 200 MG/ML | 5250502010F840 | Brand |
| CIMZIA | CERTOLIZUMAB PEGOL FOR INJ KIT 2 X 200 MG | 52505020106420 | Brand |

**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 targeted immunomodulator FDA-approved for the treatment of non-radiographic axial spondyloarthritis as confirmed by claims history or submission of medical records [e.g., Cosentyx (secukinumab), 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 targeted immunomodulator [e.g., Cosentyx (secukinumab), Rinvoq (upadacitinib), Taltz (ixekizumab)]

**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 targeted immunomodulator [e.g., Cosentyx (secukinumab), Rinvoq (upadacitinib), Taltz (ixekizumab)]

**AND**

**2.4** Prescribed by or in consultation with a rheumatologist

| Product Name: Cimzia | |
|---|---|
| Diagnosis | Crohn's Disease, Rheumatoid Arthritis (RA), Psoriatic Arthritis, Ankylosing Spondylitis, Plaque Psoriasis, Non-Radiographic Axial Spondyloarthritis |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CIMZIA | CERTOLIZUMAB PEGOL PREFILLED SYRINGE KIT 200 MG/ML | 5250502010F840 | Brand |
| CIMZIA STARTER KIT | CERTOLIZUMAB PEGOL PREFILLED SYRINGE KIT 200 MG/ML | 5250502010F840 | Brand |
| CIMZIA | CERTOLIZUMAB PEGOL FOR INJ KIT 2 X 200 MG | 52505020106420 | Brand |

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

## 2 . Background

| **Benefit/Coverage/Program Information** |
|---|
| **PDL Links**<br><br>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 |
|---|---|
| 11/6/2024 | Updated GPIs and formularies. Updated step through agents. Updat ed safety language. Moved non-radiographic axial spondyloarthritis i nto separate criteria |

Cinryze

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-147161 |
| **Guideline Name** | Cinryze |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Cinryze | |
|---|---|
| Diagnosis | Hereditary angioedema (HAE) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CINRYZE | C1 ESTERASE INHIBITOR (HUMAN) FOR IV INJ 500 UNIT | 85802022002120 | Brand |

**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., 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 | |
|---|---|
| Diagnosis | Hereditary angioedema (HAE) |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CINRYZE | C1 ESTERASE INHIBITOR (HUMAN) FOR IV INJ 500 UNIT | 85802022002120 | Brand |

**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, Firazyr, 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., Haegarda, Orladeyo, Takhzyro)

**AND**

**5** - Prescribed by ONE of the following:

- Immunologist
- Allergist

## 2 . Revision History

| Date | Notes |
|---|---|
| 5/8/2024 | Update to diagnostic criteria for HAE with normal C1 inhibitor levels. Simplified reauthorization criteria. |

Ciprodex

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146308 |
| **Guideline Name** | Ciprodex |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Brand Ciprodex, generic ciprofloxacin/dexamethasone | |
|---|---|
| Approval Length | 1 Month |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CIPRODEX | CIPROFLOXACIN-DEXAMETHASONE OTIC SUSP 0.3-0.1% | 87991002361820 | Brand |
| CIPROFLOXACIN/DEXAMETHASONE | CIPROFLOXACIN-DEXAMETHASONE OTIC SUSP 0.3-0.1% | 87991002361820 | Generic |

**Approval Criteria**

**1** - ONE of the following:

**1.1** The patient has a perforated tympanic membrane or tympanostomy tubes

**OR**

**1.2** The patient has had an inadequate response, intolerance or contraindication to ONE preferred alternative confirmed by claims history or submission of medical records (please specify intolerance or contraindication if applicable).

Colony Stimulating Factors

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146497 |
| **Guideline Name** | Colony Stimulating Factors |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Leukine, Zarxio | |
|---|---|
| Diagnosis | Bone Marrow/Stem Cell Transplant |
| Approval Length | 3 months or duration of therapy |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LEUKINE | SARGRAMOSTIM LYOPHILIZED FOR INJ 250 MCG | 82402050002120 | Brand |
| ZARXIO | FILGRASTIM-SNDZ SOLN PREFILLED SYRINGE 300 MCG/0.5ML | 8240152060E530 | Brand |
| ZARXIO | FILGRASTIM-SNDZ SOLN PREFILLED SYRINGE 480 MCG/0.8ML | 8240152060E540 | Brand |

**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, Releuko | |
|---|---|
| Diagnosis | Bone Marrow/Stem Cell Transplant |
| Approval Length | 3 months or duration of therapy |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NEUPOGEN | FILGRASTIM INJ 300 MCG/ML | 82401520002010 | Brand |
| NEUPOGEN | FILGRASTIM INJ 480 MCG/1.6ML (300 MCG/ML) | 82401520002012 | Brand |
| NEUPOGEN | FILGRASTIM SOLN PREFILLED SYRINGE 300 MCG/0.5ML | 8240152000E545 | Brand |
| NEUPOGEN | FILGRASTIM SOLN PREFILLED SYRINGE 480 MCG/0.8ML (600 MCG/ML) | 8240152000E550 | Brand |

| | | | |
|---|---|---|---|
| NIVESTYM | FILGRASTIM-AAFI SOLN PREFILLED SYRINGE 300 MCG/0.5ML | 8240152010E520 | Brand |
| NIVESTYM | FILGRASTIM-AAFI SOLN PREFILLED SYRINGE 480 MCG/0.8ML | 8240152010E530 | Brand |
| NIVESTYM | FILGRASTIM-AAFI INJ 300 MCG/ML | 82401520102020 | Brand |
| NIVESTYM | FILGRASTIM-AAFI INJ 480 MCG/1.6ML (300 MCG/ML) | 82401520102030 | Brand |
| RELEUKO | FILGRASTIM-AYOW SOLN PREFILLED SYRINGE 300 MCG/0.5ML | 8240152015E520 | Brand |
| RELEUKO | FILGRASTIM-AYOW SOLN PREFILLED SYRINGE 480 MCG/0.8ML | 8240152015E530 | Brand |
| RELEUKO | FILGRASTIM-AYOW INJ SOLN 300 MCG/ML | 82401520152020 | Brand |
| RELEUKO | FILGRASTIM-AYOW INJ SOLN 480 MCG/1.6ML (300 MCG/ML) | 82401520152030 | Brand |

**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, or Nivestym, 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LEUKINE | SARGRAMOSTIM LYOPHILIZED FOR INJ 250 MCG | 82402050002120 | Brand |
| ZARXIO | FILGRASTIM-SNDZ SOLN PREFILLED SYRINGE 300 MCG/0.5ML | 8240152060E530 | Brand |
| ZARXIO | FILGRASTIM-SNDZ SOLN PREFILLED SYRINGE 480 MCG/0.8ML | 8240152060E540 | Brand |

**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, Releuko | |
|---|---|
| Diagnosis | AML Induction or Consolidation Therapy |
| Approval Length | 3 months or duration of therapy |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NEUPOGEN | FILGRASTIM INJ 300 MCG/ML | 82401520002010 | Brand |
| NEUPOGEN | FILGRASTIM INJ 480 MCG/1.6ML (300 MCG/ML) | 82401520002012 | Brand |

| | | | |
|---|---|---|---|
| NEUPOGEN | FILGRASTIM SOLN PREFILLED SYRINGE 300 MCG/0.5ML | 8240152000E545 | Brand |
| NEUPOGEN | FILGRASTIM SOLN PREFILLED SYRINGE 480 MCG/0.8ML (600 MCG/ML) | 8240152000E550 | Brand |
| NIVESTYM | FILGRASTIM-AAFI SOLN PREFILLED SYRINGE 300 MCG/0.5ML | 8240152010E520 | Brand |
| NIVESTYM | FILGRASTIM-AAFI SOLN PREFILLED SYRINGE 480 MCG/0.8ML | 8240152010E530 | Brand |
| NIVESTYM | FILGRASTIM-AAFI INJ 300 MCG/ML | 82401520102020 | Brand |
| NIVESTYM | FILGRASTIM-AAFI INJ 480 MCG/1.6ML (300 MCG/ML) | 82401520102030 | Brand |
| RELEUKO | FILGRASTIM-AYOW SOLN PREFILLED SYRINGE 300 MCG/0.5ML | 8240152015E520 | Brand |
| RELEUKO | FILGRASTIM-AYOW SOLN PREFILLED SYRINGE 480 MCG/0.8ML | 8240152015E530 | Brand |
| RELEUKO | FILGRASTIM-AYOW INJ SOLN 300 MCG/ML | 82401520152020 | Brand |
| RELEUKO | FILGRASTIM-AYOW INJ SOLN 480 MCG/1.6ML (300 MCG/ML) | 82401520152030 | Brand |

**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, or Nivestym, 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NEULASTA | PEGFILGRASTIM SOLN PREFILLED SYRINGE 6 MG/0.6ML | 8240157000E520 | Brand |
| NEULASTA ONPRO KIT | PEGFILGRASTIM SOLN PREFILLED SYRINGE KIT 6 MG/0.6ML | 8240157000F820 | Brand |
| LEUKINE | SARGRAMOSTIM LYOPHILIZED FOR INJ 250 MCG | 82402050002120 | Brand |
| ZARXIO | FILGRASTIM-SNDZ SOLN PREFILLED SYRINGE 300 MCG/0.5ML | 8240152060E530 | Brand |
| ZARXIO | FILGRASTIM-SNDZ SOLN PREFILLED SYRINGE 480 MCG/0.8ML | 8240152060E540 | Brand |
| UDENYCA | PEGFILGRASTIM-CBQV SOLN AUTO-INJECTOR 6 MG/0.6ML | 8240157010D520 | Brand |
| UDENYCA | PEGFILGRASTIM-CBQV SOLN PREFILLED SYRINGE 6 MG/0.6ML | 8240157010E520 | Brand |
| UDENYCA ONBODY | PEGFILGRASTIM-CBQV SOLN PREFILL SYR/INFUSION DEV 6 MG/0.6ML | 8240157010E525 | Brand |

**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, Releuko | |
|---|---|
| Diagnosis | Primary Prophylaxis of Chemotherapy-Induced Febrile Neutropenia (FN) |
| Approval Length | 3 months or duration of therapy. |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NEUPOGEN | FILGRASTIM SOLN PREFILLED SYRINGE 300 MCG/0.5ML | 8240152000E545 | Brand |
| NEUPOGEN | FILGRASTIM SOLN PREFILLED SYRINGE 480 MCG/0.8ML (600 MCG/ML) | 8240152000E550 | Brand |
| NEUPOGEN | FILGRASTIM INJ 300 MCG/ML | 82401520002010 | Brand |
| NEUPOGEN | FILGRASTIM INJ 480 MCG/1.6ML (300 MCG/ML) | 82401520002012 | Brand |
| GRANIX | TBO-FILGRASTIM SOLN PREFILLED SYRINGE 300 MCG/0.5ML | 8240152070E530 | Brand |
| GRANIX | TBO-FILGRASTIM SOLN PREFILLED SYRINGE 480 MCG/0.8ML | 8240152070E540 | Brand |
| GRANIX | TBO-FILGRASTIM SUBCUTANEOUS INJ 300 MCG/ML | 82401520702020 | Brand |
| GRANIX | TBO-FILGRASTIM SUBCUTANEOUS INJ 480 MCG/1.6ML (300 MCG/ML) | 82401520702030 | Brand |

| | | | |
|---|---|---|---|
| NIVESTYM | FILGRASTIM-AAFI SOLN PREFILLED SYRINGE 300 MCG/0.5ML | 8240152010E520 | Brand |
| NIVESTYM | FILGRASTIM-AAFI SOLN PREFILLED SYRINGE 480 MCG/0.8ML | 8240152010E530 | Brand |
| NIVESTYM | FILGRASTIM-AAFI INJ 300 MCG/ML | 82401520102020 | Brand |
| NIVESTYM | FILGRASTIM-AAFI INJ 480 MCG/1.6ML (300 MCG/ML) | 82401520102030 | Brand |
| RELEUKO | FILGRASTIM-AYOW SOLN PREFILLED SYRINGE 300 MCG/0.5ML | 8240152015E520 | Brand |
| RELEUKO | FILGRASTIM-AYOW SOLN PREFILLED SYRINGE 480 MCG/0.8ML | 8240152015E530 | Brand |
| RELEUKO | FILGRASTIM-AYOW INJ SOLN 300 MCG/ML | 82401520152020 | Brand |
| RELEUKO | FILGRASTIM-AYOW INJ SOLN 480 MCG/1.6ML (300 MCG/ML) | 82401520152030 | Brand |

**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, 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, Stimufend, Ziextenzo | |
|---|---|
| Diagnosis | Primary Prophylaxis of Chemotherapy-Induced Febrile Neutropenia (FN) |

| Approval Length | 3 months or duration of therapy |
|---|---|
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| FULPHILA | PEGFILGRASTIM-JMDB SOLN PREFILLED SYRINGE 6 MG/0.6ML | 8240157020E520 | Brand |
| NYVEPRIA | PEGFILGRASTIM-APGF SOLN PREFILLED SYRINGE 6 MG/0.6ML | 8240157002E520 | Brand |
| FYLNETRA | PEGFILGRASTIM-PBBK SOLN PREFILLED SYRINGE 6 MG/0.6ML | 8240157060E520 | Brand |
| ROLVEDON | EFLAPEGRASTIM-XNST SOLN PREFILLED SYRINGE 13.2 MG/0.6ML | 8240151880E520 | Brand |
| STIMUFEND | PEGFILGRASTIM-FPGK SOLN PREFILLED SYRINGE 6 MG/0.6ML | 8240157015E520 | Brand |
| ZIEXTENZO | PEGFILGRASTIM-BMEZ SOLN PREFILLED SYRINGE 6 MG/0.6ML | 8240157005E520 | Brand |

**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 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 Fulphila, Fylnetra, Nyvepria, Rolvedon, Stimufend or Ziextenzo 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NEULASTA | PEGFILGRASTIM SOLN PREFILLED SYRINGE 6 MG/0.6ML | 8240157000E520 | Brand |

| | | | |
|---|---|---|---|
| NEULASTA ONPRO KIT | PEGFILGRASTIM SOLN PREFILLED SYRINGE KIT 6 MG/0.6ML | 8240157000F820 | Brand |
| LEUKINE | SARGRAMOSTIM LYOPHILIZED FOR INJ 250 MCG | 82402050002120 | Brand |
| ZARXIO | FILGRASTIM-SNDZ SOLN PREFILLED SYRINGE 300 MCG/0.5ML | 8240152060E530 | Brand |
| ZARXIO | FILGRASTIM-SNDZ SOLN PREFILLED SYRINGE 480 MCG/0.8ML | 8240152060E540 | Brand |
| UDENYCA | PEGFILGRASTIM-CBQV SOLN AUTO-INJECTOR 6 MG/0.6ML | 8240157010D520 | Brand |
| UDENYCA | PEGFILGRASTIM-CBQV SOLN PREFILLED SYRINGE 6 MG/0.6ML | 8240157010E520 | Brand |
| UDENYCA ONBODY | PEGFILGRASTIM-CBQV SOLN PREFILL SYR/INFUSION DEV 6 MG/0.6ML | 8240157010E525 | Brand |

**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, Releuko | |
|---|---|
| Diagnosis | Secondary Prophylaxis of Febrile Neutropenia (FN) |

| Approval Length | 3 months or duration of therapy |
|---|---|
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NEUPOGEN | FILGRASTIM SOLN PREFILLED SYRINGE 300 MCG/0.5ML | 8240152000E545 | Brand |
| NEUPOGEN | FILGRASTIM SOLN PREFILLED SYRINGE 480 MCG/0.8ML (600 MCG/ML) | 8240152000E550 | Brand |
| NEUPOGEN | FILGRASTIM INJ 300 MCG/ML | 82401520002010 | Brand |
| NEUPOGEN | FILGRASTIM INJ 480 MCG/1.6ML (300 MCG/ML) | 82401520002012 | Brand |
| GRANIX | TBO-FILGRASTIM SOLN PREFILLED SYRINGE 300 MCG/0.5ML | 8240152070E530 | Brand |
| GRANIX | TBO-FILGRASTIM SOLN PREFILLED SYRINGE 480 MCG/0.8ML | 8240152070E540 | Brand |
| GRANIX | TBO-FILGRASTIM SUBCUTANEOUS INJ 300 MCG/ML | 82401520702020 | Brand |
| GRANIX | TBO-FILGRASTIM SUBCUTANEOUS INJ 480 MCG/1.6ML (300 MCG/ML) | 82401520702030 | Brand |
| NIVESTYM | FILGRASTIM-AAFI SOLN PREFILLED SYRINGE 300 MCG/0.5ML | 8240152010E520 | Brand |
| NIVESTYM | FILGRASTIM-AAFI SOLN PREFILLED SYRINGE 480 MCG/0.8ML | 8240152010E530 | Brand |
| NIVESTYM | FILGRASTIM-AAFI INJ 300 MCG/ML | 82401520102020 | Brand |
| NIVESTYM | FILGRASTIM-AAFI INJ 480 MCG/1.6ML (300 MCG/ML) | 82401520102030 | Brand |
| RELEUKO | FILGRASTIM-AYOW SOLN PREFILLED SYRINGE 300 MCG/0.5ML | 8240152015E520 | Brand |
| RELEUKO | FILGRASTIM-AYOW SOLN PREFILLED SYRINGE 480 MCG/0.8ML | 8240152015E530 | Brand |
| RELEUKO | FILGRASTIM-AYOW INJ SOLN 300 MCG/ML | 82401520152020 | Brand |
| RELEUKO | FILGRASTIM-AYOW INJ SOLN 480 MCG/1.6ML (300 MCG/ML) | 82401520152030 | Brand |

**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 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, Stimufend, Ziextenzo

| Diagnosis | Secondary Prophylaxis of Febrile Neutropenia (FN) |
|---|---|
| Approval Length | 3 months or duration of therapy |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| FULPHILA | PEGFILGRASTIM-JMDB SOLN PREFILLED SYRINGE 6 MG/0.6ML | 8240157020E520 | Brand |
| NYVEPRIA | PEGFILGRASTIM-APGF SOLN PREFILLED SYRINGE 6 MG/0.6ML | 8240157002E520 | Brand |
| FYLNETRA | PEGFILGRASTIM-PBBK SOLN PREFILLED SYRINGE 6 MG/0.6ML | 8240157060E520 | Brand |
| ROLVEDON | EFLAPEGRASTIM-XNST SOLN PREFILLED SYRINGE 13.2 MG/0.6ML | 8240151880E520 | Brand |
| STIMUFEND | PEGFILGRASTIM-FPGK SOLN PREFILLED SYRINGE 6 MG/0.6ML | 8240157015E520 | Brand |
| ZIEXTENZO | PEGFILGRASTIM-BMEZ SOLN PREFILLED SYRINGE 6 MG/0.6ML | 8240157005E520 | Brand |

**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 Fulphila, Fylnetra, Nyvepria, Rolvedon, Stimufend or Ziextenzo 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NEULASTA | PEGFILGRASTIM SOLN PREFILLED SYRINGE 6 MG/0.6ML | 8240157000E520 | Brand |
| NEULASTA ONPRO KIT | PEGFILGRASTIM SOLN PREFILLED SYRINGE KIT 6 MG/0.6ML | 8240157000F820 | Brand |
| LEUKINE | SARGRAMOSTIM LYOPHILIZED FOR INJ 250 MCG | 82402050002120 | Brand |
| ZARXIO | FILGRASTIM-SNDZ SOLN PREFILLED SYRINGE 300 MCG/0.5ML | 8240152060E530 | Brand |
| ZARXIO | FILGRASTIM-SNDZ SOLN PREFILLED SYRINGE 480 MCG/0.8ML | 8240152060E540 | Brand |
| UDENYCA | PEGFILGRASTIM-CBQV SOLN AUTO-INJECTOR 6 MG/0.6ML | 8240157010D520 | Brand |
| UDENYCA | PEGFILGRASTIM-CBQV SOLN PREFILLED SYRINGE 6 MG/0.6ML | 8240157010E520 | Brand |

| | | | |
|---|---|---|---|
| UDENYCA ONBODY | PEGFILGRASTIM-CBQV SOLN PREFILL SYR/INFUSION DEV 6 MG/0.6ML | 8240157010E525 | Brand |

**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 or 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, Releuko | |
|---|---|
| Diagnosis | Treatment of Febrile Neutropenia (FN) |
| Approval Length | 1 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NEUPOGEN | FILGRASTIM INJ 300 MCG/ML | 82401520002010 | Brand |

| | | | |
|---|---|---|---|
| NEUPOGEN | FILGRASTIM INJ 480 MCG/1.6ML (300 MCG/ML) | 82401520002012 | Brand |
| NEUPOGEN | FILGRASTIM SOLN PREFILLED SYRINGE 300 MCG/0.5ML | 8240152000E545 | Brand |
| NEUPOGEN | FILGRASTIM SOLN PREFILLED SYRINGE 480 MCG/0.8ML (600 MCG/ML) | 8240152000E550 | Brand |
| NIVESTYM | FILGRASTIM-AAFI SOLN PREFILLED SYRINGE 300 MCG/0.5ML | 8240152010E520 | Brand |
| NIVESTYM | FILGRASTIM-AAFI SOLN PREFILLED SYRINGE 480 MCG/0.8ML | 8240152010E530 | Brand |
| NIVESTYM | FILGRASTIM-AAFI INJ 300 MCG/ML | 82401520102020 | Brand |
| NIVESTYM | FILGRASTIM-AAFI INJ 480 MCG/1.6ML (300 MCG/ML) | 82401520102030 | Brand |
| RELEUKO | FILGRASTIM-AYOW SOLN PREFILLED SYRINGE 300 MCG/0.5ML | 8240152015E520 | Brand |
| RELEUKO | FILGRASTIM-AYOW SOLN PREFILLED SYRINGE 480 MCG/0.8ML | 8240152015E530 | Brand |
| RELEUKO | FILGRASTIM-AYOW INJ SOLN 300 MCG/ML | 82401520152020 | Brand |
| RELEUKO | FILGRASTIM-AYOW INJ SOLN 480 MCG/1.6ML (300 MCG/ML) | 82401520152030 | Brand |
| UDENYCA ONBODY | PEGFILGRASTIM-CBQV SOLN PREFILL SYR/INFUSION DEV 6 MG/0.6ML | 8240157010E525 | Brand |

**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 or 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 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, Stimufend, Ziextenzo | |
|---|---|
| Diagnosis | Treatment of Febrile Neutropenia (FN) |
| Approval Length | 1 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| FULPHILA | PEGFILGRASTIM-JMDB SOLN PREFILLED SYRINGE 6 MG/0.6ML | 8240157020E520 | Brand |
| NYVEPRIA | PEGFILGRASTIM-APGF SOLN PREFILLED SYRINGE 6 MG/0.6ML | 8240157002E520 | Brand |
| FYLNETRA | PEGFILGRASTIM-PBBK SOLN PREFILLED SYRINGE 6 MG/0.6ML | 8240157060E520 | Brand |
| ROLVEDON | EFLAPEGRASTIM-XNST SOLN PREFILLED SYRINGE 13.2 MG/0.6ML | 8240151880E520 | Brand |
| STIMUFEND | PEGFILGRASTIM-FPGK SOLN PREFILLED SYRINGE 6 MG/0.6ML | 8240157015E520 | Brand |
| ZIEXTENZO | PEGFILGRASTIM-BMEZ SOLN PREFILLED SYRINGE 6 MG/0.6ML | 8240157005E520 | Brand |

**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 or 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 Fulphila, Fylnetra, Nyvepria, Rolvedon, Stimufend or Ziextenzo 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZARXIO | FILGRASTIM-SNDZ SOLN PREFILLED SYRINGE 300 MCG/0.5ML | 8240152060E530 | Brand |
| ZARXIO | FILGRASTIM-SNDZ SOLN PREFILLED SYRINGE 480 MCG/0.8ML | 8240152060E540 | Brand |
| UDENYCA ONBODY | PEGFILGRASTIM-CBQV SOLN PREFILL SYR/INFUSION DEV 6 MG/0.6ML | 8240157010E525 | Brand |

**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, Releuko | |
|---|---|
| Diagnosis | Severe Chronic Neutropenia (SCN) |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NEUPOGEN | FILGRASTIM INJ 300 MCG/ML | 82401520002010 | Brand |
| NEUPOGEN | FILGRASTIM INJ 480 MCG/1.6ML (300 MCG/ML) | 82401520002012 | Brand |
| NEUPOGEN | FILGRASTIM SOLN PREFILLED SYRINGE 300 MCG/0.5ML | 8240152000E545 | Brand |
| NEUPOGEN | FILGRASTIM SOLN PREFILLED SYRINGE 480 MCG/0.8ML (600 MCG/ML) | 8240152000E550 | Brand |
| NIVESTYM | FILGRASTIM-AAFI SOLN PREFILLED SYRINGE 300 MCG/0.5ML | 8240152010E520 | Brand |
| NIVESTYM | FILGRASTIM-AAFI SOLN PREFILLED SYRINGE 480 MCG/0.8ML | 8240152010E530 | Brand |
| NIVESTYM | FILGRASTIM-AAFI INJ 300 MCG/ML | 82401520102020 | Brand |
| NIVESTYM | FILGRASTIM-AAFI INJ 480 MCG/1.6ML (300 MCG/ML) | 82401520102030 | Brand |
| RELEUKO | FILGRASTIM-AYOW SOLN PREFILLED SYRINGE 300 MCG/0.5ML | 8240152015E520 | Brand |
| RELEUKO | FILGRASTIM-AYOW SOLN PREFILLED SYRINGE 480 MCG/0.8ML | 8240152015E530 | Brand |
| RELEUKO | FILGRASTIM-AYOW INJ SOLN 300 MCG/ML | 82401520152020 | Brand |
| RELEUKO | FILGRASTIM-AYOW INJ SOLN 480 MCG/1.6ML (300 MCG/ML) | 82401520152030 | Brand |
| UDENYCA ONBODY | PEGFILGRASTIM-CBQV SOLN PREFILL SYR/INFUSION DEV 6 MG/0.6ML | 8240157010E525 | Brand |

**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 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| NEULASTA | PEGFILGRASTIM SOLN PREFILLED SYRINGE 6 MG/0.6ML | 8240157000E520 | Brand |
| LEUKINE | SARGRAMOSTIM LYOPHILIZED FOR INJ 250 MCG | 82402050002120 | Brand |
| ZARXIO | FILGRASTIM-SNDZ SOLN PREFILLED SYRINGE 300 MCG/0.5ML | 8240152060E530 | Brand |
| ZARXIO | FILGRASTIM-SNDZ SOLN PREFILLED SYRINGE 480 MCG/0.8ML | 8240152060E540 | Brand |
| UDENYCA | PEGFILGRASTIM-CBQV SOLN AUTO-INJECTOR 6 MG/0.6ML | 8240157010D520 | Brand |
| UDENYCA | PEGFILGRASTIM-CBQV SOLN PREFILLED SYRINGE 6 MG/0.6ML | 8240157010E520 | Brand |
| UDENYCA ONBODY | PEGFILGRASTIM-CBQV SOLN PREFILL SYR/INFUSION DEV 6 MG/0.6ML | 8240157010E525 | Brand |

**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, Releuko | |
|---|---|
| Diagnosis | Hematopoietic Syndrome of Acute Radiation Syndrome |
| Approval Length | 3 months or duration of therapy |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NEUPOGEN | FILGRASTIM INJ 300 MCG/ML | 82401520002010 | Brand |
| NEUPOGEN | FILGRASTIM INJ 480 MCG/1.6ML (300 MCG/ML) | 82401520002012 | Brand |
| NEUPOGEN | FILGRASTIM SOLN PREFILLED SYRINGE 300 MCG/0.5ML | 8240152000E545 | Brand |
| NEUPOGEN | FILGRASTIM SOLN PREFILLED SYRINGE 480 MCG/0.8ML (600 MCG/ML) | 8240152000E550 | Brand |
| NIVESTYM | FILGRASTIM-AAFI SOLN PREFILLED SYRINGE 300 MCG/0.5ML | 8240152010E520 | Brand |
| NIVESTYM | FILGRASTIM-AAFI SOLN PREFILLED SYRINGE 480 MCG/0.8ML | 8240152010E530 | Brand |

| | | | |
|---|---|---|---|
| NIVESTYM | FILGRASTIM-AAFI INJ 300 MCG/ML | 82401520102020 | Brand |
| NIVESTYM | FILGRASTIM-AAFI INJ 480 MCG/1.6ML (300 MCG/ML) | 82401520102030 | Brand |
| RELEUKO | FILGRASTIM-AYOW SOLN PREFILLED SYRINGE 300 MCG/0.5ML | 8240152015E520 | Brand |
| RELEUKO | FILGRASTIM-AYOW SOLN PREFILLED SYRINGE 480 MCG/0.8ML | 8240152015E530 | Brand |
| RELEUKO | FILGRASTIM-AYOW INJ SOLN 300 MCG/ML | 82401520152020 | Brand |
| RELEUKO | FILGRASTIM-AYOW INJ SOLN 480 MCG/1.6ML (300 MCG/ML) | 82401520152030 | Brand |
| UDENYCA ONBODY | PEGFILGRASTIM-CBQV SOLN PREFILL SYR/INFUSION DEV 6 MG/0.6ML | 8240157010E525 | Brand |

**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 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, Stimufend, Ziextenzo | |
|---|---|
| Diagnosis | Hematopoietic Syndrome of Acute Radiation Syndrome |
| Approval Length | 3 months or duration of therapy |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| FULPHILA | PEGFILGRASTIM-JMDB SOLN PREFILLED SYRINGE 6 MG/0.6ML | 8240157020E520 | Brand |
| NYVEPRIA | PEGFILGRASTIM-APGF SOLN PREFILLED SYRINGE 6 MG/0.6ML | 8240157002E520 | Brand |
| FYLNETRA | PEGFILGRASTIM-PBBK SOLN PREFILLED SYRINGE 6 MG/0.6ML | 8240157060E520 | Brand |
| ROLVEDON | EFLAPEGRASTIM-XNST SOLN PREFILLED SYRINGE 13.2 MG/0.6ML | 8240151880E520 | Brand |
| STIMUFEND | PEGFILGRASTIM-FPGK SOLN PREFILLED SYRINGE 6 MG/0.6ML | 8240157015E520 | Brand |
| ZIEXTENZO | PEGFILGRASTIM-BMEZ SOLN PREFILLED SYRINGE 6 MG/0.6ML | 8240157005E520 | Brand |

**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 Fulphila, Fylnetra, Nyvepria, Rolvedon, Stimufend or Ziextenzo 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)

Combination Basal Insulin/GLP-1 Receptor Agonist

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-147277 |
| **Guideline Name** | Combination Basal Insulin/GLP-1 Receptor Agonist |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Soliqua | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Step Therapy |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SOLIQUA 100/33 | INSULIN GLARGINE-LIXISENATIDE SOL PEN-INJ 100-33 UNIT-MCG/ML | 2799100235D220 | Brand |

**Approval Criteria**

**1** - Inadequately controlled on ONE of the following as confirmed by claims history or submission of medical records:

- GLP-1 (glucagon-like peptide-1) receptor agonist [e.g. Trulicity (dulaglutide), Victoza (liraglutide), Bydureon BCise (exenatide extended-release), Byetta (exenatide), 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XULTOPHY 100/3.6 | INSULIN DEGLUDEC-LIRAGLUTIDE SOL PEN-INJ 100-3.6 UNIT-MG/ML | 2799100225D220 | Brand |

**Approval Criteria**

**1** - Diagnosis of type 2 diabetes mellitus

**AND**

**2** - Inadequately controlled on ONE of the following 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:

**3.1** Failure to Soliqua as confirmed by claims history or submission of medical records

**OR**

**3.2** History of contraindication or intolerance to Soliqua (please specify contraindication or intolerance)

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XULTOPHY 100/3.6 | INSULIN DEGLUDEC-LIRAGLUTIDE SOL PEN-INJ 100-3.6 UNIT-MG/ML | 2799100225D220 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Xultophy therapy

## 2 . Revision History

| Date | Notes |
|---|---|
| 5/13/2024 | New; copy core |

Cometriq

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146498 |
| **Guideline Name** | Cometriq |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Cometriq | |
|---|---|
| Diagnosis | Thyroid Carcinoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| COMETRIQ | CABOZANTINIB S-MALATE CAP 3 X 20 MG (60 MG DOSE) KIT | 21533010106460 | Brand |
| COMETRIQ | CABOZANTINIB S-MAL CAP 1 X 80 MG & 1 X 20 MG (100 DOSE) KIT | 21533010106470 | Brand |
| COMETRIQ | CABOZANTINIB S-MAL CAP 1 X 80 MG & 3 X 20 MG (140 DOSE) KIT | 21533010106480 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| COMETRIQ | CABOZANTINIB S-MALATE CAP 3 X 20 MG (60 MG DOSE) KIT | 21533010106460 | Brand |
| COMETRIQ | CABOZANTINIB S-MAL CAP 1 X 80 MG & 1 X 20 MG (100 DOSE) KIT | 21533010106470 | Brand |
| COMETRIQ | CABOZANTINIB S-MAL CAP 1 X 80 MG & 3 X 20 MG (140 DOSE) KIT | 21533010106480 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| COMETRIQ | CABOZANTINIB S-MALATE CAP 3 X 20 MG (60 MG DOSE) KIT | 21533010106460 | Brand |
| COMETRIQ | CABOZANTINIB S-MAL CAP 1 X 80 MG & 1 X 20 MG (100 DOSE) KIT | 21533010106470 | Brand |
| COMETRIQ | CABOZANTINIB S-MAL CAP 1 X 80 MG & 3 X 20 MG (140 DOSE) KIT | 21533010106480 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| COMETRIQ | CABOZANTINIB S-MALATE CAP 3 X 20 MG (60 MG DOSE) KIT | 21533010106460 | Brand |
| COMETRIQ | CABOZANTINIB S-MAL CAP 1 X 80 MG & 1 X 20 MG (100 DOSE) KIT | 21533010106470 | Brand |
| COMETRIQ | CABOZANTINIB S-MAL CAP 1 X 80 MG & 3 X 20 MG (140 DOSE) KIT | 21533010106480 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| COMETRIQ | CABOZANTINIB S-MALATE CAP 3 X 20 MG (60 MG DOSE) KIT | 21533010106460 | Brand |
| COMETRIQ | CABOZANTINIB S-MAL CAP 1 X 80 MG & 1 X 20 MG (100 DOSE) KIT | 21533010106470 | Brand |
| COMETRIQ | CABOZANTINIB S-MAL CAP 1 X 80 MG & 3 X 20 MG (140 DOSE) KIT | 21533010106480 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| COMETRIQ | CABOZANTINIB S-MALATE CAP 3 X 20 MG (60 MG DOSE) KIT | 21533010106460 | Brand |
| COMETRIQ | CABOZANTINIB S-MAL CAP 1 X 80 MG & 1 X 20 MG (100 DOSE) KIT | 21533010106470 | Brand |
| COMETRIQ | CABOZANTINIB S-MAL CAP 1 X 80 MG & 3 X 20 MG (140 DOSE) KIT | 21533010106480 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Cometriq therapy

Complera

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146310 |
| **Guideline Name** | Complera |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Complera | |
|---|---|
| Diagnosis | HIV |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| COMPLERA | EMTRICITABINE-RILPIVIRINE-TENOFOVIR DF TAB 200-25-300 MG | 12109903400320 | Brand |

**Approval Criteria**

**1** - Diagnosis of human immunodeficiency virus (HIV)

**AND**

**2** - ONE of the following:

**2.1** Patient is NOT an appropriate candidate for ALL of the following (please specify why patient is not a candidate):

- efavirenz/lamivudine/tenofovir disoproxil (generic Symfi or generic Symfi Lo)
- efavirenz/emtricitabine/tenofovir disoproxil (generic Atripla)
- Triumeq (abacavir/dolutegravir/lamivudine)
- Juluca (dolutegravir/rilpivirine)
- Dovato (dolutegravir/lamivudine)

**OR**

**2.2** Patient is currently on Complera therapy

| Product Name: Complera | |
|---|---|
| Diagnosis | Post-Exposure Prophylaxis |
| Approval Length | 4 Week(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| COMPLERA | EMTRICITABINE-RILPIVIRINE-TENOFOVIR DF TAB 200-25-300 MG | 12109903400320 | Brand |

**Approval Criteria**

**1** - Diagnosis of post-exposure prophylaxis

Compounds and Bulk Powders

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146311 |
| **Guideline Name** | Compounds and Bulk Powders |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Compounds or Bulk Powders | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Administrative |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| Bulk Powders | | | |
| Compound Preparation | | | |

**Approval Criteria**

**1** - The requested drug component is a covered medication

**AND**

**2** - ONE of the following:

**2.1** The requested drug component is to be administered for an FDA (Food and Drug Administration)-approved indication

**OR**

**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**

**3** - If a drug included in the compound requires prior authorization and/or step therapy, all drug specific clinical criteria must also be met

**AND**

**4** - If the drug component is no longer available commercially, it must not have been withdrawn for safety reasons

**AND**

**5** - ONE of the following:

**5.1** A unique vehicle is required

**OR**

**5.2** A unique dosage form is required for a commercially available product due to patient's age, weight, or inability to take a solid dosage form

**OR**

**5.3** A unique formulation is required for a commercially available product due to an allergy or intolerance to an inactive ingredient in the commercially available product

**OR**

**5.4** There is a shortage of the commercially available product per the FDA Drug Shortage database or the ASHP (American Society of Health-System Pharmacists) Current Drug Shortages tracking log

**AND**

**6** - Coverage for compounds and bulk powders will NOT be approved for any of the following:

**6.1** For topical compound preparations (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**

**6.2** If the requested compound contains topical fluticasone, topical fluticasone will NOT be approved unless both of the following are met:

**6.2.1** Topical fluticasone is intended to treat a dermatologic condition (scar treatments are considered cosmetic and will not be covered)

**AND**

**6.2.2** Patient has a contraindication to all commercially available topical fluticasone formulations

**OR**

**6.3** Requested compound contains any ingredients when used for cosmetic purposes (see Table 2 in Background section)

**OR**

**6.4** Requested compound contains any ingredient(s) which are on the FDA's Do Not Compound List (see Table 3 in Background section)

## 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:**<br>(1) Ketamine<br>(2) Gabapentin<br>(3) Flurbiprofen (topical ophthalmic use not included)<br>(4) Ketoprofen<br>(5) Morphine<br>(6) Nabumetone<br>(7) Oxycodone<br>(8) Cyclobenzaprine<br>(9) Baclofen |

(10) Tramadol

(11) Hydrocodone

(12) Meloxicam

(13) Amitriptyline

(14) Pentoxifylline

(15) Orphenadrine

(16) Piroxicam

(17) Levocetirizine

(18) Amantadine

(19) Oxytocin

(20) Sumatriptan

(21) Chorionic gonadotropin (human)

(22) Clomipramine

(23) Dexamethasone

(24) Hydromorphone

(25) Methadone

(26) Papaverine

(27) Mefenamic acid

(28) Promethazine

(29) Succimer DMSA

(30) Tizanidine

(31) Apomorphine

(32) Carbamazepine

(33) Ketorolac

(34) Dimercaptopropane-sulfonate

(35) Dimercaptosuccinic acid

(36) Duloxetine

(37) Fluoxetine

(38) Bromfenac (topical ophthalmic use not included)

(39) Nepafenac (topical ophthalmic use not included)

**Table 2: Example compounds that contain ingredients for cosmetic purposes:**

(1) Hydroquinone

(2) Acetyl hexapeptide-8

(3) Tocopheryl Acid Succinate

(4) PracaSil TM-Plus

(5) Chrysaderm Day Cream

(6) Chrysaderm Night Cream

(7) PCCA Spira-Wash

(8) Lipopen Ultra

(9) Versapro

(10) Fluticasone

(11) Mometasone

(12) Halobetasol

(13) Betamethasone

(14) Clobetasol

(15) Triamcinolone

(16) Minoxidil

(17) Tretinoin

(18) Dexamethasone

(19) Spironolactone

(20) Cycloserine

(21) Tamoxifen

(22) Sermorelin

(23) Mederma Cream

(24) PCCA Cosmetic HRT Base

(25) Sanare Scar Therapy Cream

(26) Scarcin Cream

(27) Apothederm

(28) Stera Cream

(29) Copasil

(30) Collagenase

(31) Arbutin Alpha

(32) Nourisil

(33) Freedom Cepapro

(34) Freedom Silomac Andydrous

(35) Retinaldehyde

(36) Apothederm

**Table 3: Example ingredients on the FDA's Do Not Compound List:**

(1) 3,3′,4′,5-tetrachlorosalicylanilide

(2) Adenosine phosphate

(3) Adrenal cortex

(4) Alatrofloxacin mesylate

(5) Aminopyrine

(6) Astemizole

(7) Azaribine

(8) Benoxaprofen

(9) Bithionol

(10) Camphorated oil

(11) Carbetapentane citrate

(12) Casein, iodinated

(13) Cerivastatin sodium

(14) Chlormadinone acetate

(15) Chloroform

(16) Cisapride

(17) Defenfluramine hydrochloride

(18) Diamthazole dihydrochloride

(19) Dibromsalan

(20) Dihydrostreptomycin sulfate

(21) Dipyrone

(22) Encainide hydrochloride

(23) Etretinate

(24) Fenfluramine hydrochloride

(25) Flosequinan

(26) Glycerol, iodinated

(27) Grepafloxacin

(28) Mepazine

(29) Metabromsalan

(30) Methapyrilene

(31) Methopholine

(32) Methoxyflurane

(33) Mibefradil dihydrochloride

(34) Nomifensine maleate

(35) Novobiocin sodium

(36) Oxyphenisatin acetate

(37) Oxyphenisatin

(38) Pemoline

(39) Pergolide mesylate

(40) Phenacetin

(41) Phenformin hydrochloride

(42) Phenylpropanolamine

(43) Pipamazine

(44) Potassium arsenite

(45) Propoxyphene

(46) Rapacuronium bromide

(47) Rofecoxib

(48) Sibutramine hydrochloride

(49) Sparteine sulfate

(50) Sulfadimethoxine

(51) Sweet spirits of nitre

(52) Tegaserod maleate

(53) Temafloxacin hydrochloride

(54) Terfenadine

(55) Ticrynafen

(56) Tribromsalan

(57) Trichloroethane

(58) Troglitazone

(59) Trovafloxacin mesylate:

(60) Urethane

(61) Valdecoxib

(62) Zomepirac sodium

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146312 |
| **Guideline Name** | Constipation Agents |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: generic lubiprostone | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LUBIPROSTONE | LUBIPROSTONE CAP 8 MCG | 52450045000110 | Generic |
| LUBIPROSTONE | LUBIPROSTONE CAP 24 MCG | 52450045000120 | Generic |

**Approval Criteria**

**1** - BOTH of the following:

**1.1** ONE of the following:

**1.1.1** Diagnosis of opioid-induced constipation in an adult with chronic, non-cancer pain

**OR**

**1.1.2** Diagnosis of opioid-induced constipation 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**

**1.2** ONE of the following:

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

- Lactulose
- Polyethylene glycol (Miralax)

**OR**

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

- Lactulose
- Polyethylene glycol (Miralax)

**OR**

**2** - BOTH of the following:

**2.1** Diagnosis of chronic idiopathic constipation

**AND**

**2.2** ONE of the following:

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

- Lactulose
- Polyethylene glycol (Miralax)

**OR**

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

- Lactulose
- Polyethylene glycol (Miralax)

**OR**

**3** - ALL of the following:

**3.1** Diagnosis of irritable bowel syndrome with constipation

**AND**

**3.2** Patient was female at birth

**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:

- Lactulose
- Polyethylene glycol (Miralax)

**OR**

**3.3.2** 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AMITIZA | LUBIPROSTONE CAP 8 MCG | 52450045000110 | Brand |
| AMITIZA | LUBIPROSTONE CAP 24 MCG | 52450045000120 | Brand |

**Approval Criteria**

**1** - ALL of the following:

**1.1** ONE of the following:

**1.1.1** Diagnosis of opioid-induced constipation in an adult with chronic, non-cancer pain

**OR**

**1.1.2** Diagnosis of opioid-induced constipation 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**

**1.2** ONE of the following:

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

- Lactulose
- Polyethylene glycol (Miralax)

**OR**

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

- Lactulose
- Polyethylene glycol (Miralax)

**AND**

**1.3** ONE of the following:

**1.3.1** Failure to Movantik as confirmed by claims history or submission of medical records

**OR**

**1.3.2** History of intolerance or contraindication to Movantik (please specify intolerance or contraindication)

**AND**

**1.4** ONE of the following:

**1.4.1** Failure to lubiprostone (generic of Amitiza) as confirmed by claims history or submission of medical records

**OR**

**1.4.2** History of intolerance or contraindication to lubiprostone (generic of Amitiza) (please specify intolerance or contraindication)

**OR**

**2** - ALL of the following:

**2.1** Diagnosis of chronic idiopathic constipation

**AND**

**2.2** ONE of the following:

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

- Lactulose
- Polyethylene glycol (Miralax)

**OR**

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

- Lactulose
- Polyethylene glycol (Miralax)

**AND**

**2.3** ONE of the following:

**2.3.1** Failure to Motegrity as confirmed by claims history or submission of medical records

**OR**

**2.3.2** History of intolerance or contraindication to Motegrity (please specify intolerance or contraindication)

**AND**

**2.4** ONE of the following:

**2.4.1** Failure to lubiprostone (generic of Amitiza) as confirmed by claims history or submission of medical records

**OR**

**2.4.2** History of intolerance or contraindication to lubiprostone (generic of Amitiza) (please specify intolerance or contraindication)

**OR**

**3** - ALL of the following:

**3.1** Diagnosis of irritable bowel syndrome with constipation

**AND**

**3.2** Patient was female at birth

**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:

- Lactulose
- Polyethylene glycol (Miralax)

**OR**

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

- Lactulose
- Polyethylene glycol (Miralax)

**AND**

**3.4** ONE of the following:

**3.4.1** Failure to lubiprostone (generic of Amitiza) as confirmed by claims history or submission of medical records

**OR**

**3.4.2** History of intolerance or contraindication to lubiprostone (generic of Amitiza) (please specify intolerance or contraindication)

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LINZESS | LINACLOTIDE CAP 72 MCG | 52557050000110 | Brand |
| LINZESS | LINACLOTIDE CAP 145 MCG | 52557050000120 | Brand |
| LINZESS | LINACLOTIDE CAP 290 MCG | 52557050000140 | Brand |

**Approval Criteria**

**1** - ALL of the following:

**1.1** Diagnosis of chronic idiopathic constipation

**AND**

**1.2** ONE of the following:

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

- Lactulose
- Polyethylene glycol (Miralax)

**OR**

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

- Lactulose
- Polyethylene glycol (Miralax)

**AND**

**1.3** ONE of the following:

**1.3.1** Failure to lubiprostone (generic of Amitiza) as confirmed by claims history or submission of medical records

**OR**

**1.3.2** History of intolerance or contraindication to lubiprostone (generic of Amitiza) (please specify intolerance or contraindication)

**AND**

**1.4** ONE of the following:

**1.4.1** Failure to Motegrity as confirmed by claims history or submission of medical records

**OR**

**1.4.2** History of intolerance or contraindication to Motegrity (please specify intolerance or contraindication)

**OR**

**2** - ALL of the following:

**2.1** Diagnosis of irritable bowel syndrome with constipation

**AND**

**2.2** ONE of the following:

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

- Lactulose
- Polyethylene glycol (Miralax)

**OR**

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

- Lactulose
- Polyethylene glycol (Miralax)

**AND**

**2.3** ONE of the following:

**2.3.1** Failure to lubiprostone (generic of Amitiza) as confirmed by claims history or submission of medical records

**OR**

**2.3.2** History of intolerance or contraindication to lubiprostone (generic of Amitiza) (please specify intolerance or contraindication)

**OR**

**3** - BOTH of the following:

**3.1** Diagnosis of functional constipation

**AND**

**3.2** ONE of the following:

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

- Lactulose
- Polyethylene glycol (Miralax)

**OR**

**3.2.2** 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TRULANCE | PLECANATIDE TAB 3 MG | 52543060000320 | Brand |

**Approval Criteria**

**1** - ALL of the following:

**1.1** Diagnosis of chronic idiopathic constipation

**AND**

**1.2** ONE of the following:

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

- Lactulose
- Polyethylene glycol (Miralax)

**OR**

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

- Lactulose
- Polyethylene glycol (Miralax)

**AND**

**1.3** ONE of the following:

**1.3.1** Failure to lubiprostone (generic of Amitiza) as confirmed by claims history or submission of medical records

**OR**

**1.3.2** History of intolerance or contraindication to lubiprostone (generic of Amitiza) (please specify intolerance or contraindication)

**AND**

**1.4** ONE of the following:

**1.4.1** Failure to Motegrity as confirmed by claims history or submission of medical records

**OR**

**1.4.2** History of intolerance or contraindication to Motegrity (please specify intolerance or contraindication)

**OR**

**2** - ALL of the following:

**2.1** Diagnosis of irritable bowel syndrome with constipation

**AND**

**2.2** ONE of the following:

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

- Lactulose
- Polyethylene glycol (Miralax)

**OR**

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

- Lactulose
- Polyethylene glycol (Miralax)

**AND**

**2.3** ONE of the following:

**2.3.1** Failure to lubiprostone (generic of Amitiza) as confirmed by claims history or submission of medical records

**OR**

**2.3.2** History of intolerance or contraindication to lubiprostone (generic of Amitiza) (please specify intolerance or contraindication)

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MOTEGRITY | PRUCALOPRIDE SUCCINATE TAB 1 MG (BASE EQUIVALENT) | 52560060200320 | Brand |
| MOTEGRITY | PRUCALOPRIDE SUCCINATE TAB 2 MG (BASE EQUIVALENT) | 52560060200330 | Brand |

**Approval Criteria**

**1** - Diagnosis of chronic idiopathic constipation

**AND**

**2** - ONE of the following:

**2.1** Failure to ONE 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)

**AND**

**3** - ONE of the following:

**3.1** Failure to lubiprostone (generic of Amitiza) as confirmed by claims history or submission of medical records

**OR**

**3.2** History of intolerance or contraindication to lubiprostone (generic of Amitiza) (please specify intolerance or contraindication)

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MOVANTIK | NALOXEGOL OXALATE TAB 12.5 MG (BASE EQUIVALENT) | 52580060300320 | Brand |
| MOVANTIK | NALOXEGOL OXALATE TAB 25 MG (BASE EQUIVALENT) | 52580060300330 | Brand |

**Approval Criteria**

**1** - ONE of the following:

**1.1** Diagnosis of opioid-induced constipation in a patient being treated for chronic, non-cancer pain

**OR**

**1.2** Diagnosis of opioid-induced constipation 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** - ONE of the following:

**2.1** Failure to ONE 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)

**AND**

**3** - ONE of the following:

**3.1** Failure to lubiprostone (generic of Amitiza) as confirmed by claims history or submission of medical records

**OR**

**3.2** History of intolerance or contraindication to lubiprostone (generic of Amitiza) (please specify intolerance or contraindication)

| Product Name: Symproic | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |

| Guideline Type | Prior Authorization |
|---|---|

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SYMPROIC | NALDEMEDINE TOSYLATE TAB 0.2 MG (BASE EQUIVALENT) | 52580057200320 | Brand |

**Approval Criteria**

**1** - ONE of the following:

**1.1** Diagnosis of opioid-induced constipation in a patient being treated for chronic, non-cancer pain

**OR**

**1.2** Diagnosis of opioid-induced constipation 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** - ONE of the following:

**2.1** Failure to ONE 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)

**AND**

**3** - ONE of the following:

**3.1** Failure to lubiprostone (generic of Amitiza) as confirmed by claims history or submission of medical records

**OR**

**3.2** History of intolerance or contraindication to lubiprostone (generic of Amitiza) (please specify intolerance or contraindication)

**AND**

**4** - ONE of the following:

**4.1** Failure to Movantik as confirmed by claims history or submission of medical records

**OR**

**4.2** History of intolerance or contraindication to Movantik (please specify intolerance or contraindication)

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZELNORM | TEGASEROD MALEATE TAB 6 MG (BASE EQUIVALENT) | 52555060200320 | Brand |

**Approval Criteria**

**1** - Diagnosis of irritable bowel syndrome with constipation

**AND**

**2** - Patient was female at birth

**AND**

**3** - ONE of the following:

**3.1** Failure to ONE 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)

**AND**

**4** - ONE of the following:

**4.1** Failure to lubiprostone (generic of Amitiza) as confirmed by claims history or submission of medical records

**OR**

**4.2** History of intolerance or contraindication to lubiprostone (generic of Amitiza) (please specify intolerance or contraindication)

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| IBSRELA | TENAPANOR HCL TAB 50 MG | 52558580100320 | Brand |

**Approval Criteria**

**1** - Diagnosis of irritable bowel syndrome with constipation

**AND**

**2** - ONE of the following:

**2.1** Failure to ONE 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)

**AND**

**3** - ONE of the following:

**3.1** Failure to lubiprostone (generic of Amitiza) as confirmed by claims history or submission of medical records

**OR**

**3.2** History of intolerance or contraindication to lubiprostone (generic of Amitiza) (please specify intolerance or contraindication)

| Product Name: Brand Amitiza, generic lubiprostone, Ibsrela, Linzess, Motegrity, Movantik, Symproic, Trulance, Zelnorm | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AMITIZA | LUBIPROSTONE CAP 8 MCG | 52450045000110 | Brand |
| LUBIPROSTONE | LUBIPROSTONE CAP 8 MCG | 52450045000110 | Generic |
| AMITIZA | LUBIPROSTONE CAP 24 MCG | 52450045000120 | Brand |
| LUBIPROSTONE | LUBIPROSTONE CAP 24 MCG | 52450045000120 | Generic |
| IBSRELA | TENAPANOR HCL TAB 50 MG | 52558580100320 | Brand |
| LINZESS | LINACLOTIDE CAP 72 MCG | 52557050000110 | Brand |
| LINZESS | LINACLOTIDE CAP 145 MCG | 52557050000120 | Brand |
| LINZESS | LINACLOTIDE CAP 290 MCG | 52557050000140 | Brand |
| MOTEGRITY | PRUCALOPRIDE SUCCINATE TAB 1 MG (BASE EQUIVALENT) | 52560060200320 | Brand |
| MOTEGRITY | PRUCALOPRIDE SUCCINATE TAB 2 MG (BASE EQUIVALENT) | 52560060200330 | Brand |
| MOVANTIK | NALOXEGOL OXALATE TAB 12.5 MG (BASE EQUIVALENT) | 52580060300320 | Brand |
| MOVANTIK | NALOXEGOL OXALATE TAB 25 MG (BASE EQUIVALENT) | 52580060300330 | Brand |
| SYMPROIC | NALDEMEDINE TOSYLATE TAB 0.2 MG (BASE EQUIVALENT) | 52580057200320 | Brand |
| TRULANCE | PLECANATIDE TAB 3 MG | 52543060000320 | Brand |
| ZELNORM | TEGASEROD MALEATE TAB 6 MG (BASE EQUIVALENT) | 52555060200320 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to therapy

Continuous Glucose Monitors

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-156368 |
| **Guideline Name** | Continuous Glucose Monitors |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 10/1/2024 |

## 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DEXCOM G6 RECEIVER | *CONTINUOUS GLUCOSE SYSTEM RECEIVER*** | 97202012026200 | Brand |
| DEXCOM G7 RECEIVER | *CONTINUOUS GLUCOSE SYSTEM RECEIVER*** | 97202012026200 | Brand |
| FREESTYLE LIBRE 14 DAY/READER/FLASH MONITORING SYSTEM | *CONTINUOUS GLUCOSE SYSTEM RECEIVER*** | 97202012026200 | Brand |

| | | | |
|---|---|---|---|
| FREESTYLE LIBRE 2/READER/FLASH GLUCOSE MONITORING SYSTEM | *CONTINUOUS GLUCOSE SYSTEM RECEIVER*** | 97202012026200 | Brand |
| FREESTYLE LIBRE 3/READER/GLUCOSE MONITORING SYSTEM | *CONTINUOUS GLUCOSE SYSTEM RECEIVER*** | 97202012026200 | Brand |
| FREESTYLE LIBRE/READER/FLASH MONITORING SYSTEM | *CONTINUOUS GLUCOSE SYSTEM RECEIVER*** | 97202012026200 | Brand |
| GUARDIAN REAL-TIME REPLACEMENT MONITOR PEDIATRIC | *CONTINUOUS GLUCOSE SYSTEM RECEIVER*** | 97202012026200 | Brand |
| DEXCOM G6 SENSOR | *CONTINUOUS GLUCOSE SYSTEM SENSOR*** | 97202012046300 | Brand |
| DEXCOM G7 SENSOR | *CONTINUOUS GLUCOSE SYSTEM SENSOR*** | 97202012046300 | Brand |
| ENLITE GLUCOSE SENSOR | *CONTINUOUS GLUCOSE SYSTEM SENSOR*** | 97202012046300 | Brand |
| EVERSENSE E3 SENSOR/HOLDER | *CONTINUOUS GLUCOSE SYSTEM SENSOR*** | 97202012046300 | Brand |
| EVERSENSE SENSOR/HOLDER | *CONTINUOUS GLUCOSE SYSTEM SENSOR*** | 97202012046300 | Brand |
| FREESTYLE LIBRE 14 DAY/SENSOR/FLASH MONITORING SYSTEM | *CONTINUOUS GLUCOSE SYSTEM SENSOR*** | 97202012046300 | Brand |
| FREESTYLE LIBRE 2/SENSOR/FLASH GLUCOSE MONITORING SYSTEM | *CONTINUOUS GLUCOSE SYSTEM SENSOR*** | 97202012046300 | Brand |
| FREESTYLE LIBRE 3 PLUS/SENSOR/GLUCOSE MONITORING SYSTEM | *CONTINUOUS GLUCOSE SYSTEM SENSOR*** | 97202012046300 | Brand |
| FREESTYLE LIBRE 3/SENSOR/GLUCOSE MONITORING SYSTEM | *CONTINUOUS GLUCOSE SYSTEM SENSOR*** | 97202012046300 | Brand |
| GUARDIAN SENSOR (3) | *CONTINUOUS GLUCOSE SYSTEM SENSOR*** | 97202012046300 | Brand |
| GUARDIAN SENSOR 3 | *CONTINUOUS GLUCOSE SYSTEM SENSOR*** | 97202012046300 | Brand |
| GUARDIAN 4 GLUCOSE SENSOR | *CONTINUOUS GLUCOSE SYSTEM SENSOR*** | 97202012046300 | Brand |
| DEXCOM G6 TRANSMITTER | *CONTINUOUS GLUCOSE SYSTEM TRANSMITTER*** | 97202012066300 | Brand |
| EVERSENSE E3 SMART TRANSMITTER | *CONTINUOUS GLUCOSE SYSTEM TRANSMITTER*** | 97202012066300 | Brand |
| EVERSENSE SMART TRANSMITTER | *CONTINUOUS GLUCOSE SYSTEM TRANSMITTER*** | 97202012066300 | Brand |

| | | | |
|---|---|---|---|
| GUARDIAN CONNECT TRANSMITTER | *CONTINUOUS GLUCOSE SYSTEM TRANSMITTER*** | 97202012066300 | Brand |
| GUARDIAN CONNECT TRANSMITTER KIT | *CONTINUOUS GLUCOSE SYSTEM TRANSMITTER*** | 97202012066300 | Brand |
| GUARDIAN LINK 3 TRANSMITTER KIT | *CONTINUOUS GLUCOSE SYSTEM TRANSMITTER*** | 97202012066300 | Brand |
| GUARDIAN 4 TRANSMITTER KIT | *CONTINUOUS GLUCOSE SYSTEM TRANSMITTER*** | 97202012066300 | Brand |
| MINILINK REAL-TIME TRANSMITTER | *CONTINUOUS GLUCOSE SYSTEM TRANSMITTER*** | 97202012066300 | Brand |
| MINIMED 630G GUARDIAN PRESS STARTER TRANSMITTER KIT | *CONTINUOUS GLUCOSE SYSTEM TRANSMITTER*** | 97202012066300 | Brand |
| PARADIGM REAL-TIME TRANSMITTER | *CONTINUOUS GLUCOSE SYSTEM TRANSMITTER*** | 97202012066300 | Brand |

**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:

- Patient has a history of a level 3 hypoglycemic event
- Patient has a history of more than one level 2 hypoglycemia events 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 Guardian Connect (all components), Guardian 3 (all components), Guardian 4 (all components), or Freestyle Libre 3 (all components), ONE of the following:

**4.1** BOTH of the following:

**4.1.1** Patient has a physical or mental limitation that makes utilization of Dexcom G6 and Dexcom G7 unsafe, inaccurate, or otherwise not feasible (e.g., manual dexterity; document limitation)

**AND**

**4.1.2** 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 the Guardian Connect, Guardian 3, Guardian 4, or Freestyle Libre 3 for treatment of diabetes

| Product Name: Continuous Glucose Monitors, sensors, and transmitters (all brands) | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DEXCOM G6 RECEIVER | *CONTINUOUS GLUCOSE SYSTEM RECEIVER*** | 97202012026200 | Brand |
| DEXCOM G7 RECEIVER | *CONTINUOUS GLUCOSE SYSTEM RECEIVER*** | 97202012026200 | Brand |
| FREESTYLE LIBRE 14 DAY/READER/FLASH MONITORING SYSTEM | *CONTINUOUS GLUCOSE SYSTEM RECEIVER*** | 97202012026200 | Brand |
| FREESTYLE LIBRE 2/READER/FLASH GLUCOSE MONITORING SYSTEM | *CONTINUOUS GLUCOSE SYSTEM RECEIVER*** | 97202012026200 | Brand |

| | | | |
|---|---|---|---|
| FREESTYLE LIBRE 3/READER/GLUCOSE MONITORING SYSTEM | *CONTINUOUS GLUCOSE SYSTEM RECEIVER*** | 97202012026200 | Brand |
| FREESTYLE LIBRE/READER/FLASH MONITORING SYSTEM | *CONTINUOUS GLUCOSE SYSTEM RECEIVER*** | 97202012026200 | Brand |
| GUARDIAN REAL-TIME REPLACEMENT MONITOR PEDIATRIC | *CONTINUOUS GLUCOSE SYSTEM RECEIVER*** | 97202012026200 | Brand |
| DEXCOM G6 SENSOR | *CONTINUOUS GLUCOSE SYSTEM SENSOR*** | 97202012046300 | Brand |
| DEXCOM G7 SENSOR | *CONTINUOUS GLUCOSE SYSTEM SENSOR*** | 97202012046300 | Brand |
| ENLITE GLUCOSE SENSOR | *CONTINUOUS GLUCOSE SYSTEM SENSOR*** | 97202012046300 | Brand |
| EVERSENSE E3 SENSOR/HOLDER | *CONTINUOUS GLUCOSE SYSTEM SENSOR*** | 97202012046300 | Brand |
| EVERSENSE SENSOR/HOLDER | *CONTINUOUS GLUCOSE SYSTEM SENSOR*** | 97202012046300 | Brand |
| FREESTYLE LIBRE 14 DAY/SENSOR/FLASH MONITORING SYSTEM | *CONTINUOUS GLUCOSE SYSTEM SENSOR*** | 97202012046300 | Brand |
| FREESTYLE LIBRE 2/SENSOR/FLASH GLUCOSE MONITORING SYSTEM | *CONTINUOUS GLUCOSE SYSTEM SENSOR*** | 97202012046300 | Brand |
| FREESTYLE LIBRE 3 PLUS/SENSOR/GLUCOSE MONITORING SYSTEM | *CONTINUOUS GLUCOSE SYSTEM SENSOR*** | 97202012046300 | Brand |
| FREESTYLE LIBRE 3/SENSOR/GLUCOSE MONITORING SYSTEM | *CONTINUOUS GLUCOSE SYSTEM SENSOR*** | 97202012046300 | Brand |
| GUARDIAN SENSOR (3) | *CONTINUOUS GLUCOSE SYSTEM SENSOR*** | 97202012046300 | Brand |
| GUARDIAN SENSOR 3 | *CONTINUOUS GLUCOSE SYSTEM SENSOR*** | 97202012046300 | Brand |
| GUARDIAN 4 GLUCOSE SENSOR | *CONTINUOUS GLUCOSE SYSTEM SENSOR*** | 97202012046300 | Brand |
| DEXCOM G6 TRANSMITTER | *CONTINUOUS GLUCOSE SYSTEM TRANSMITTER*** | 97202012066300 | Brand |
| EVERSENSE E3 SMART TRANSMITTER | *CONTINUOUS GLUCOSE SYSTEM TRANSMITTER*** | 97202012066300 | Brand |
| EVERSENSE SMART TRANSMITTER | *CONTINUOUS GLUCOSE SYSTEM TRANSMITTER*** | 97202012066300 | Brand |
| GUARDIAN CONNECT TRANSMITTER | *CONTINUOUS GLUCOSE SYSTEM TRANSMITTER*** | 97202012066300 | Brand |
| GUARDIAN CONNECT TRANSMITTER KIT | *CONTINUOUS GLUCOSE SYSTEM TRANSMITTER*** | 97202012066300 | Brand |

| | | | |
|---|---|---|---|
| GUARDIAN LINK 3 TRANSMITTER KIT | *CONTINUOUS GLUCOSE SYSTEM TRANSMITTER*** | 97202012066300 | Brand |
| GUARDIAN 4 TRANSMITTER KIT | *CONTINUOUS GLUCOSE SYSTEM TRANSMITTER*** | 97202012066300 | Brand |
| MINILINK REAL-TIME TRANSMITTER | *CONTINUOUS GLUCOSE SYSTEM TRANSMITTER*** | 97202012066300 | Brand |
| MINIMED 630G GUARDIAN PRESS STARTER TRANSMITTER KIT | *CONTINUOUS GLUCOSE SYSTEM TRANSMITTER*** | 97202012066300 | Brand |
| PARADIGM REAL-TIME TRANSMITTER | *CONTINUOUS GLUCOSE SYSTEM TRANSMITTER*** | 97202012066300 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response

## 2 . Revision History

| Date | Notes |
|---|---|
| 9/26/2024 | Clarified nonpreferred CGM criteria |

Copiktra

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146499 |
| **Guideline Name** | Copiktra |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| COPIKTRA | DUVELISIB CAP 15 MG | 21538030000120 | Brand |
| COPIKTRA | DUVELISIB CAP 25 MG | 21538030000130 | Brand |

**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 | Chronic Lymphocytic Leukemia (CLL) / Small Lymphocytic Lymphoma (SLL) |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| COPIKTRA | DUVELISIB CAP 15 MG | 21538030000120 | Brand |

| | | | |
|---|---|---|---|
| COPIKTRA | DUVELISIB CAP 25 MG | 21538030000130 | Brand |

**Approval Criteria**

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

| Product Name: Copiktra | |
|---|---|
| Diagnosis | T-cell Lymphomas |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| COPIKTRA | DUVELISIB CAP 15 MG | 21538030000120 | Brand |
| COPIKTRA | DUVELISIB CAP 25 MG | 21538030000130 | Brand |

**Approval Criteria**

**1** - Diagnosis of ONE of the following:

- Hepatosplenic T-cell lymphoma
- Breast implant-associated anaplastic large cell lymphoma
- Peripheral T-cell lymphomas

**AND**

**2** - Disease is relapsed or refractory

**AND**

**3** - ONE of the following:

**3.1** Failure to at least TWO prior systemic therapies confirmed by claims history or submitted medical records

**OR**

**3.2** History of intolerance or contraindication to at least TWO prior systemic therapies (please specify intolerance or contraindication)

| Product Name: Copiktra | |
|---|---|
| Diagnosis | T-cell Lymphomas |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| COPIKTRA | DUVELISIB CAP 15 MG | 21538030000120 | Brand |
| COPIKTRA | DUVELISIB CAP 25 MG | 21538030000130 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| COPIKTRA | DUVELISIB CAP 15 MG | 21538030000120 | Brand |
| COPIKTRA | DUVELISIB CAP 25 MG | 21538030000130 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| COPIKTRA | DUVELISIB CAP 15 MG | 21538030000120 | Brand |
| COPIKTRA | DUVELISIB CAP 25 MG | 21538030000130 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Copiktra therapy

Copper Chelating Agents

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-149088 |
| **Guideline Name** | Copper Chelating Agents |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DEPEN TITRATABS | PENICILLAMINE TAB 250 MG | 99200030000305 | Brand |
| PENICILLAMINE | PENICILLAMINE TAB 250 MG | 99200030000305 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DEPEN TITRATABS | PENICILLAMINE TAB 250 MG | 99200030000305 | Brand |
| PENICILLAMINE | PENICILLAMINE TAB 250 MG | 99200030000305 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DEPEN TITRATABS | PENICILLAMINE TAB 250 MG | 99200030000305 | Brand |
| PENICILLAMINE | PENICILLAMINE TAB 250 MG | 99200030000305 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| PENICILLAMINE | PENICILLAMINE CAP 250 MG | 99200030000110 | Generic |
| CUPRIMINE | PENICILLAMINE CAP 250 MG | 99200030000110 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| PENICILLAMINE | PENICILLAMINE CAP 250 MG | 99200030000110 | Generic |
| CUPRIMINE | PENICILLAMINE CAP 250 MG | 99200030000110 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| PENICILLAMINE | PENICILLAMINE CAP 250 MG | 99200030000110 | Generic |
| CUPRIMINE | PENICILLAMINE CAP 250 MG | 99200030000110 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TRIENTINE HYDROCHLORIDE | TRIENTINE HCL CAP 250 MG | 99200020100110 | Generic |
| SYPRINE | TRIENTINE HCL CAP 250 MG | 99200020100110 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TRIENTINE HYDROCHLORIDE | TRIENTINE HCL CAP 250 MG | 99200020100110 | Generic |
| SYPRINE | TRIENTINE HCL CAP 250 MG | 99200020100110 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TRIENTINE HYDROCHLORIDE | TRIENTINE HCL CAP 500 MG | 99200020100130 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TRIENTINE HYDROCHLORIDE | TRIENTINE HCL CAP 500 MG | 99200020100130 | Generic |

**Approval Criteria**

**1** - Documentation of positive clinical response to therapy

## 2 . Revision History

| Date | Notes |
|---|---|
| 6/28/2024 | Updated trial/failure requirements for Cuprimine, Syprine, and trientin e 500 mg capsules. |

Corlanor

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-158165 |
| **Guideline Name** | Corlanor |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 12/1/2024 |

## 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CORLANOR | IVABRADINE HCL TAB 5 MG (BASE EQUIV) | 40700035100320 | Brand |
| CORLANOR | IVABRADINE HCL TAB 7.5 MG (BASE EQUIV) | 40700035100330 | Brand |
| CORLANOR | IVABRADINE HCL ORAL SOLN 5 MG/5ML (BASE EQUIV) | 40700035102020 | Brand |
| IVABRADINE HYDROCHLORIDE | IVABRADINE HCL TAB 5 MG (BASE EQUIV) | 40700035100320 | Generic |

| IVABRADINE HYDROCHLORIDE | IVABRADINE HCL TAB 7.5 MG (BASE EQUIV) | 40700035100330 | Generic |
|---|---|---|---|

**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 Farxiga (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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CORLANOR | IVABRADINE HCL TAB 5 MG (BASE EQUIV) | 40700035100320 | Brand |
| CORLANOR | IVABRADINE HCL TAB 7.5 MG (BASE EQUIV) | 40700035100330 | Brand |
| CORLANOR | IVABRADINE HCL ORAL SOLN 5 MG/5ML (BASE EQUIV) | 40700035102020 | Brand |
| IVABRADINE HYDROCHLORIDE | IVABRADINE HCL TAB 5 MG (BASE EQUIV) | 40700035100320 | Generic |
| IVABRADINE HYDROCHLORIDE | IVABRADINE HCL TAB 7.5 MG (BASE EQUIV) | 40700035100330 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CORLANOR | IVABRADINE HCL TAB 5 MG (BASE EQUIV) | 40700035100320 | Brand |
| CORLANOR | IVABRADINE HCL TAB 7.5 MG (BASE EQUIV) | 40700035100330 | Brand |
| CORLANOR | IVABRADINE HCL ORAL SOLN 5 MG/5ML (BASE EQUIV) | 40700035102020 | Brand |
| IVABRADINE HYDROCHLORIDE | IVABRADINE HCL TAB 5 MG (BASE EQUIV) | 40700035100320 | Generic |
| IVABRADINE HYDROCHLORIDE | IVABRADINE HCL TAB 7.5 MG (BASE EQUIV) | 40700035100330 | Generic |

**Approval Criteria**

**1** - Documentation of positive clinical response to Corlanor therapy

## 2 . Revision History

| Date | Notes |
|---|---|
| 10/29/2024 | Added generic ivabradine. Updated product names. |

Cosentyx

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-159406 |
| **Guideline Name** | Cosentyx |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| COSENTYX | SECUKINUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/ML | 9025057500E520 | Brand |
| COSENTYX SENSOREADY PEN | SECUKINUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 150 MG/ML | 9025057500D520 | Brand |

| | | | |
|---|---|---|---|
| COSENTYX SENSOREADY PEN | SECUKINUMAB SUBCUTANEOUS AUTO-INJ 150 MG/ML (300 MG DOSE) | 9025057500D530 | Brand |
| COSENTYX | SECUKINUMAB SUBCUTANEOUS PREF SYR 150 MG/ML (300 MG DOSE) | 9025057500E530 | Brand |
| COSENTYX | SECUKINUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 75 MG/0.5ML | 9025057500E510 | Brand |
| COSENTYX UNOREADY | SECUKINUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML | 9025057500D550 | Brand |

**Approval Criteria**

**1** - Diagnosis of moderate to severe plaque psoriasis

**AND**

**2** - Patient is NOT receiving Cosentyx in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Taltz (ixekizumab), Siliq (brodalumab), 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 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 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), Stelara (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, 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 of BOTH of the following preferred products confirmed by claims history or submitted medical records:

- One of the preferred adalimumab products*
- One of the following: Enbrel (etanercept) or Ilumya (tildrakizumab)

**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)
- Ilumya (tildrakizumab)

| Notes | *For a list of preferred adalimumab products please reference drug co verage tools |
|---|---|

| Product Name: Cosentyx | |
|---|---|
| Diagnosis | Ankylosing Spondylitis |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| COSENTYX | SECUKINUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/ML | 9025057500E520 | Brand |
| COSENTYX SENSOREADY PEN | SECUKINUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 150 MG/ML | 9025057500D520 | Brand |
| COSENTYX SENSOREADY PEN | SECUKINUMAB SUBCUTANEOUS AUTO-INJ 150 MG/ML (300 MG DOSE) | 9025057500D530 | Brand |
| COSENTYX | SECUKINUMAB SUBCUTANEOUS PREF SYR 150 MG/ML (300 MG DOSE) | 9025057500E530 | Brand |
| COSENTYX | SECUKINUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 75 MG/0.5ML | 9025057500E510 | Brand |
| COSENTYX UNOREADY | SECUKINUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML | 9025057500D550 | Brand |

**Approval Criteria**

**1** - Diagnosis of active ankylosing spondylitis

**AND**

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

**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 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 | *For a list of preferred adalimumab products please reference drug co verage tools |
|---|---|

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| COSENTYX | SECUKINUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/ML | 9025057500E520 | Brand |
| COSENTYX SENSOREADY PEN | SECUKINUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 150 MG/ML | 9025057500D520 | Brand |
| COSENTYX SENSOREADY PEN | SECUKINUMAB SUBCUTANEOUS AUTO-INJ 150 MG/ML (300 MG DOSE) | 9025057500D530 | Brand |
| COSENTYX | SECUKINUMAB SUBCUTANEOUS PREF SYR 150 MG/ML (300 MG DOSE) | 9025057500E530 | Brand |
| COSENTYX | SECUKINUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 75 MG/0.5ML | 9025057500E510 | Brand |
| COSENTYX UNOREADY | SECUKINUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML | 9025057500D550 | Brand |

**Approval Criteria**

**1** - Diagnosis of active psoriatic arthritis

**AND**

**2** - Patient is NOT receiving Cosentyx in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

**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:

**4.2.1.1** Failure of a 3 month trial of methotrexate at the 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 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), Stelara (ustekinumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), Otezla (apremilast), Skyrizi (risankizumab-rzaa), 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 | *For a list of preferred adalimumab products please reference drug co verage tools |
|---|---|

| Product Name: Cosentyx | |
|---|---|
| Diagnosis | Non-radiographic axial spondyloarthritis |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| COSENTYX | SECUKINUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/ML | 9025057500E520 | Brand |
| COSENTYX SENSOREADY PEN | SECUKINUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 150 MG/ML | 9025057500D520 | Brand |
| COSENTYX SENSOREADY PEN | SECUKINUMAB SUBCUTANEOUS AUTO-INJ 150 MG/ML (300 MG DOSE) | 9025057500D530 | Brand |
| COSENTYX | SECUKINUMAB SUBCUTANEOUS PREF SYR 150 MG/ML (300 MG DOSE) | 9025057500E530 | Brand |

| | | | |
|---|---|---|---|
| COSENTYX | SECUKINUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 75 MG/0.5ML | 9025057500E510 | Brand |
| COSENTYX UNOREADY | SECUKINUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML | 9025057500D550 | Brand |

**Approval Criteria**

**1** - Diagnosis of active non-radiographic axial spondyloarthritis

**AND**

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

**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 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, Cimzia (certolizumab), Simponi (golimumab)]

| Product Name: Cosentyx | |
|---|---|
| Diagnosis | Enthesitis-Related Arthritis |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| COSENTYX | SECUKINUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/ML | 9025057500E520 | Brand |
| COSENTYX SENSOREADY PEN | SECUKINUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 150 MG/ML | 9025057500D520 | Brand |
| COSENTYX SENSOREADY PEN | SECUKINUMAB SUBCUTANEOUS AUTO-INJ 150 MG/ML (300 MG DOSE) | 9025057500D530 | Brand |
| COSENTYX | SECUKINUMAB SUBCUTANEOUS PREF SYR 150 MG/ML (300 MG DOSE) | 9025057500E530 | Brand |
| COSENTYX | SECUKINUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 75 MG/0.5ML | 9025057500E510 | Brand |
| COSENTYX UNOREADY | SECUKINUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML | 9025057500D550 | Brand |

**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 targeted immunomodulator [e.g., Enbrel (etanercept), adalimumab, Cimzia (certolizumab), Simponi (golimumab), Xeljanz (tofacitinib), Rinvoq (upadacitinib)]

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| COSENTYX | SECUKINUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/ML | 9025057500E520 | Brand |

| | | | |
|---|---|---|---|
| COSENTYX SENSOREADY PEN | SECUKINUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 150 MG/ML | 9025057500D520 | Brand |
| COSENTYX SENSOREADY PEN | SECUKINUMAB SUBCUTANEOUS AUTO-INJ 150 MG/ML (300 MG DOSE) | 9025057500D530 | Brand |
| COSENTYX | SECUKINUMAB SUBCUTANEOUS PREF SYR 150 MG/ML (300 MG DOSE) | 9025057500E530 | Brand |
| COSENTYX | SECUKINUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 75 MG/0.5ML | 9025057500E510 | Brand |
| COSENTYX UNOREADY | SECUKINUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML | 9025057500D550 | Brand |

**Approval Criteria**

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

**AND**

**2** - ONE of the following:

**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**

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

**OR**

**2.3** Patient is currently on Cosentyx therapy as confirmed by claims history or submission of medical records

**AND**

**3** - ONE of the following:

**3.1** Failure to at least one of the preferred adalimumab products* as confirmed by claims history or submission of medical records

**OR**

**3.2** History of contraindication or intolerance to one of the preferred adalimumab products* (please specify contraindication or intolerance)

**AND**

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

**AND**

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

| Notes | *For a list of preferred adalimumab products please reference drug co verage tools |
|---|---|

| 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| COSENTYX | SECUKINUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/ML | 9025057500E520 | Brand |
| COSENTYX SENSOREADY PEN | SECUKINUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 150 MG/ML | 9025057500D520 | Brand |
| COSENTYX SENSOREADY PEN | SECUKINUMAB SUBCUTANEOUS AUTO-INJ 150 MG/ML (300 MG DOSE) | 9025057500D530 | Brand |

| | | | |
|---|---|---|---|
| COSENTYX | SECUKINUMAB SUBCUTANEOUS PREF SYR 150 MG/ML (300 MG DOSE) | 9025057500E530 | Brand |
| COSENTYX | SECUKINUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 75 MG/0.5ML | 9025057500E510 | Brand |
| COSENTYX UNOREADY | SECUKINUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML | 9025057500D550 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Cosentyx therapy

**AND**

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

| | |
|---|---|
| Notes | * Examples of drug(s) may not be applicable based on the requested i ndication. |

## 2 . Background

| **Benefit/Coverage/Program Information** |
|---|
| **PDL Links:**<br>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 |
|---|---|
| 11/7/2024 | Updated safety language. Removed Cimzia as step thru agent. |

Cotellic

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146502 |
| **Guideline Name** | Cotellic |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Cotellic | |
|---|---|
| Diagnosis | Melanoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| COTELLIC | COBIMETINIB FUMARATE TAB 20 MG (BASE EQUIVALENT) | 21533530200320 | Brand |

**Approval Criteria**

**1** - Diagnosis of melanoma

**AND**

**2** - Disease is ONE of the following:

- 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| COTELLIC | COBIMETINIB FUMARATE TAB 20 MG (BASE EQUIVALENT) | 21533530200320 | Brand |

**Approval Criteria**

**1** - Diagnosis of Central Nervous System (CNS) Cancer

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| COTELLIC | COBIMETINIB FUMARATE TAB 20 MG (BASE EQUIVALENT) | 21533530200320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| COTELLIC | COBIMETINIB FUMARATE TAB 20 MG (BASE EQUIVALENT) | 21533530200320 | Brand |

**Approval Criteria**

**1** - Diagnosis of histiocytic neoplasms

| Product Name: Cotellic | |
|---|---|
| Diagnosis | Histiocytic Neoplasms |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| COTELLIC | COBIMETINIB FUMARATE TAB 20 MG (BASE EQUIVALENT) | 21533530200320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| COTELLIC | COBIMETINIB FUMARATE TAB 20 MG (BASE EQUIVALENT) | 21533530200320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| COTELLIC | COBIMETINIB FUMARATE TAB 20 MG (BASE EQUIVALENT) | 21533530200320 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Cotellic therapy

Cuvrior

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-148965 |
| **Guideline Name** | Cuvrior |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CUVRIOR | TRIENTINE TETRAHYDROCHLORIDE TAB 300 MG | 99200020200330 | Brand |

**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 |
|---|---|

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CUVRIOR | TRIENTINE TETRAHYDROCHLORIDE TAB 300 MG | 99200020200330 | Brand |

**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 |
|---|---|
| 6/26/2024 | Updated language on why pt must switch from preferred penicillamin e agent, added step through trientine 250 mg capsules, added prescr iber requirement, and updated initial/reauth durations to 12 months. |

Cystaran, Cystadrops

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146504 |
| **Guideline Name** | Cystaran, Cystadrops |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Cystaran, Cystadrops | |
|---|---|
| Diagnosis | Cystinosis |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CYSTARAN | CYSTEAMINE HCL OPHTH SOLN 0.44% (BASE EQUIVALENT) | 86805525102020 | Brand |
| CYSTADROPS | CYSTEAMINE HCL OPHTH SOLN 0.37% (BASE EQUIVALENT) | 86805525102015 | Brand |

**Approval Criteria**

**1** - Diagnosis of cystinosis

Daliresp (roflumilast)

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146315 |
| **Guideline Name** | Daliresp (roflumilast) |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Brand Daliresp, generic roflumilast | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DALIRESP | ROFLUMILAST TAB 250 MCG | 44450065000310 | Brand |
| DALIRESP | ROFLUMILAST TAB 500 MCG | 44450065000320 | Brand |
| ROFLUMILAST | ROFLUMILAST TAB 250 MCG | 44450065000310 | Generic |
| ROFLUMILAST | ROFLUMILAST TAB 500 MCG | 44450065000320 | Generic |

**Approval Criteria**

**1** - Diagnosis of severe to very severe chronic obstructive pulmonary disease (COPD) (i.e., FEV1 less than or equal to 50% of predicted)

**AND**

**2** - COPD is associated with chronic bronchitis

**AND**

**3** - History of COPD exacerbation(s)

| Product Name: Brand Daliresp, generic roflumilast | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DALIRESP | ROFLUMILAST TAB 250 MCG | 44450065000310 | Brand |
| DALIRESP | ROFLUMILAST TAB 500 MCG | 44450065000320 | Brand |
| ROFLUMILAST | ROFLUMILAST TAB 250 MCG | 44450065000310 | Generic |
| ROFLUMILAST | ROFLUMILAST TAB 500 MCG | 44450065000320 | Generic |

**Approval Criteria**

**1** - Documentation of positive clinical response to therapy

Daraprim

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146505 |
| **Guideline Name** | Daraprim |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Brand Daraprim, generic pyrimethamine | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DARAPRIM | PYRIMETHAMINE TAB 25 MG | 13000040000310 | Brand |
| PYRIMETHAMINE | PYRIMETHAMINE TAB 25 MG | 13000040000310 | Generic |

**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:

**1.4.3.1** Patient has been re-challenged with trimethoprim-sulfamethoxazole (TMP-SMX) using a desensitization protocol and is still unable to tolerate

**OR**

**1.4.3.2** Evidence of moderately severe or life threatening-reaction to trimethoprim-sulfamethoxazole (TMP-SMX) in the past [e.g., toxic epidermal necrolysis (TEN), Stevens-Johnson syndrome]

**OR**

**1.5** ALL of the following:

**1.5.1** Primary prophylaxis of toxoplasmic encephalitis

**AND**

**1.5.2** Toxoplasma immunoglobulin G (IgG) positive

**AND**

**1.5.3** CD4 (cluster of differentiation 4) less than or equal to 100 cells per mm^3 if initiating prophylaxis or CD4 100-200 cells per mm^3 if reinstituting prophylaxis*

**AND**

**1.5.4** Will be used in combination with dapsone or atovaquone

**AND**

**1.5.5** Patient has experienced intolerance to prior prophylaxis with trimethoprim-sulfamethoxazole (TMP-SMX)

**AND**

**1.5.6** ONE of the following:

**1.5.6.1** Patient has been re-challenged with trimethoprim-sulfamethoxazole (TMP-SMX) using a desensitization protocol and is still unable to tolerate

**OR**

**1.5.6.2** Evidence of moderately severe or life threatening-reaction to trimethoprim-

| | |
|---|---|
| sulfamethoxazole (TMP-SMX) in the past [e.g., toxic epidermal necrolysis (TEN), Stevens-Johnson syndrome] | |
| Notes | *Consider discontinuation of primary prophylaxis if CD4 > 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DARAPRIM | PYRIMETHAMINE TAB 25 MG | 13000040000310 | Brand |
| PYRIMETHAMINE | PYRIMETHAMINE TAB 25 MG | 13000040000310 | Generic |

**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) |

Daurismo

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146506 |
| **Guideline Name** | Daurismo |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Daurismo | |
|---|---|
| Diagnosis | Acute Myeloid Leukemia |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DAURISMO | GLASDEGIB MALEATE TAB 25 MG (BASE EQUIVALENT) | 21370030300320 | Brand |
| DAURISMO | GLASDEGIB MALEATE TAB 100 MG (BASE EQUIVALENT) | 21370030300335 | Brand |

**Approval Criteria**

**1** - ONE of the following:

**1.1** Diagnosis of newly-diagnosed acute myeloid leukemia (AML)

**OR**

**1.2** Relapsed/refractory disease with ALL of the following:

**1.2.1** Given as a component of repeating the initial successful induction regimen

**AND**

**1.2.2** Late relapse (greater than or equal to 12 months since induction regimen)

**AND**

**1.2.3** Initial therapy was not administered continuously

**AND**

**1.2.4** Initial therapy was not stopped due to development of clinical resistance

**AND**

**2** - Daurismo therapy to be given in combination with low-dose cytarabine

**AND**

**3** - ONE of the following:

**3.1** Patient is at least 75 years old

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DAURISMO | GLASDEGIB MALEATE TAB 25 MG (BASE EQUIVALENT) | 21370030300320 | Brand |
| DAURISMO | GLASDEGIB MALEATE TAB 100 MG (BASE EQUIVALENT) | 21370030300335 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DAURISMO | GLASDEGIB MALEATE TAB 25 MG (BASE EQUIVALENT) | 21370030300320 | Brand |
| DAURISMO | GLASDEGIB MALEATE TAB 100 MG (BASE EQUIVALENT) | 21370030300335 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DAURISMO | GLASDEGIB MALEATE TAB 25 MG (BASE EQUIVALENT) | 21370030300320 | Brand |
| DAURISMO | GLASDEGIB MALEATE TAB 100 MG (BASE EQUIVALENT) | 21370030300335 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Daurismo therapy

Daybue

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-150913 |
| **Guideline Name** | Daybue |
| **Formulary** | • Medicaid - Community & State New Mexico |

## 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DAYBUE | TROFINETIDE ORAL SOLN 200 MG/ML | 74653075002020 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DAYBUE | TROFINETIDE ORAL SOLN 200 MG/ML | 74653075002020 | Brand |

**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. |

DEKAs Plus

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146316 |
| **Guideline Name** | DEKAs Plus |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: DEKAs Plus Ocean, DEKAs Plus | |
|---|---|
| Diagnosis | Cystic Fibrosis |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DEKAS PLUS OCEAN | *MULTIPLE VITAMINS W/ MINERALS CAP** | 78310000000100 | Brand |
| DEKAS PLUS | *MULTIPLE VITAMINS W/ MINERALS CAP** | 78310000000100 | Brand |
| DEKAS PLUS | *MULTIPLE VITAMINS W/ MINERALS CHEW TAB** | 78310000000500 | Brand |

| | | | |
|---|---|---|---|
| DEKAS PLUS | *PEDIATRIC MULTIPLE VITAMIN W/ MINERALS LIQUID** | 78420000000900 | Brand |

**Approval Criteria**

**1** - Diagnosis of cystic fibrosis

Descovy

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-150882 |
| **Guideline Name** | Descovy |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 8/2/2024 |

## 1 . Criteria

| Product Name: Descovy | |
|---|---|
| Diagnosis | Human Immunodeficiency Virus-1 (HIV-1) |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DESCOVY | EMTRICITABINE-TENOFOVIR ALAFENAMIDE FUMARATE TAB 200-25 MG | 12109902290320 | Brand |
| DESCOVY | EMTRICITABINE-TENOFOVIR ALAFENAMIDE FUMARATE TAB 120-15 MG | 12109902290310 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DESCOVY | EMTRICITABINE-TENOFOVIR ALAFENAMIDE FUMARATE TAB 200-25 MG | 12109902290320 | Brand |
| DESCOVY | EMTRICITABINE-TENOFOVIR ALAFENAMIDE FUMARATE TAB 120-15 MG | 12109902290310 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DESCOVY | EMTRICITABINE-TENOFOVIR ALAFENAMIDE FUMARATE TAB 200-25 MG | 12109902290320 | Brand |

**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 |
|---|---|
| 8/2/2024 | Minor update to specify type 1 infection for HIV diagnosis without change to clinical intent. |

Dificid

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-154718 |
| **Guideline Name** | Dificid |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 10/1/2024 |

## 1 . Criteria

| Product Name: Dificid | |
|---|---|
| Approval Length | 1 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DIFICID | FIDAXOMICIN TAB 200 MG | 03530025000320 | Brand |
| DIFICID | FIDAXOMICIN FOR SUSP 40 MG/ML | 03530025001920 | Brand |

**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:

- 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 Dificid therapy

Dojolvi

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-149530 |
| **Guideline Name** | Dojolvi |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/3/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DOJOLVI | TRIHEPTANOIN ORAL LIQUID 100% | 80200080000920 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DOJOLVI | TRIHEPTANOIN ORAL LIQUID 100% | 80200080000920 | Brand |

**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 |
|---|---|

| | |
|---|---|
| 7/3/2024 | New guideline. |

Donepezil 23mg

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146319 |
| **Guideline Name** | Donepezil 23mg |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: generic donepezil 23 mg | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Step Therapy |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DONEPEZIL HYDROCHLORIDE | DONEPEZIL HYDROCHLORIDE TAB 23 MG | 62051025100330 | Generic |
| DONEPEZIL HCL | DONEPEZIL HYDROCHLORIDE TAB 23 MG | 62051025100330 | Generic |

**Approval Criteria**

**1** - Failure to donepezil at a minimum dose of 10 mg (milligrams) daily for 90 days, as confirmed by claims history or submission of medical records

**OR**

**2** - History of contraindication or intolerance to donepezil 10 mg (please specify contraindication or intolerance)

Doptelet

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146508 |
| **Guideline Name** | Doptelet |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DOPTELET | AVATROMBOPAG MALEATE TAB 20 MG (BASE EQUIV) | 82405010200320 | Brand |

**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:

**4.1** Failure to Mulpleta (lusutrombopag) as confirmed by claims history or submission of medical records

**OR**

**4.2** 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DOPTELET | AVATROMBOPAG MALEATE TAB 20 MG (BASE EQUIV) | 82405010200320 | Brand |

**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:

**2.1.2.1** Failure to Promacta (eltrombopag) as confirmed by claims history or submission of medical records

**OR**

**2.1.2.2** History of contraindication or intolerance to Promacta (eltrombopag) (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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DOPTELET | AVATROMBOPAG MALEATE TAB 20 MG (BASE EQUIV) | 82405010200320 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Doptelet therapy

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146320 |
| **Guideline Name** | DPP-4 Inhibitors |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Nesina, Alogliptin, Kazano, Alogliptin/metformin, Oseni, Alogliptin/pioglitazone | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NESINA | ALOGLIPTIN BENZOATE TAB 6.25 MG (BASE EQUIV) | 27550010100310 | Generic |
| NESINA | ALOGLIPTIN BENZOATE TAB 12.5 MG (BASE EQUIV) | 27550010100320 | Generic |
| NESINA | ALOGLIPTIN BENZOATE TAB 25 MG (BASE EQUIV) | 27550010100330 | Generic |
| KAZANO | ALOGLIPTIN-METFORMIN HCL TAB 12.5-500 MG | 27992502100320 | Generic |

| | | | |
|---|---|---|---|
| KAZANO | ALOGLIPTIN-METFORMIN HCL TAB 12.5-1000 MG | 27992502100330 | Generic |
| OSENI | ALOGLIPTIN-PIOGLITAZONE TAB 12.5-15 MG | 27994002100320 | Generic |
| OSENI | ALOGLIPTIN-PIOGLITAZONE TAB 12.5-30 MG | 27994002100325 | Generic |
| ALOGLIPTIN/PIOGLITAZONE | ALOGLIPTIN-PIOGLITAZONE TAB 12.5-45 MG | 27994002100330 | Generic |
| OSENI | ALOGLIPTIN-PIOGLITAZONE TAB 12.5-45 MG | 27994002100330 | Generic |
| OSENI | ALOGLIPTIN-PIOGLITAZONE TAB 25-15 MG | 27994002100340 | Generic |
| OSENI | ALOGLIPTIN-PIOGLITAZONE TAB 25-30 MG | 27994002100345 | Generic |
| OSENI | ALOGLIPTIN-PIOGLITAZONE TAB 25-45 MG | 27994002100350 | Generic |
| ALOGLIPTIN | ALOGLIPTIN BENZOATE TAB 6.25 MG (BASE EQUIV) | 27550010100310 | Brand |
| ALOGLIPTIN | ALOGLIPTIN BENZOATE TAB 12.5 MG (BASE EQUIV) | 27550010100320 | Brand |
| ALOGLIPTIN | ALOGLIPTIN BENZOATE TAB 25 MG (BASE EQUIV) | 27550010100330 | Brand |
| ALOGLIPTIN/METFORMIN HCL | ALOGLIPTIN-METFORMIN HCL TAB 12.5-500 MG | 27992502100320 | Brand |
| ALOGLIPTIN/METFORMIN HYDROCHLORIDE | ALOGLIPTIN-METFORMIN HCL TAB 12.5-1000 MG | 27992502100330 | Brand |
| ALOGLIPTIN/PIOGLITAZONE | ALOGLIPTIN-PIOGLITAZONE TAB 12.5-30 MG | 27994002100325 | Brand |
| ALOGLIPTIN/PIOGLITAZONE | ALOGLIPTIN-PIOGLITAZONE TAB 25-15 MG | 27994002100340 | Brand |
| ALOGLIPTIN/PIOGLITAZONE | ALOGLIPTIN-PIOGLITAZONE TAB 25-30 MG | 27994002100345 | Brand |
| ALOGLIPTIN/PIOGLITAZONE | ALOGLIPTIN-PIOGLITAZONE TAB 25-45 MG | 27994002100350 | Brand |

**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: Januvia, Janumet, Janumet XR, Brand Onglyza, generic saxagliptin, Brand Kombiglyze XR, generic saxagliptin/metformin ER, Tradjenta, Jentadueto, Jentadueto XR, Zituvimet, Zituvio | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| KOMBIGLYZE XR | SAXAGLIPTIN-METFORMIN HCL TAB ER 24HR 5-1000 MG | 27992502607540 | Brand |
| KOMBIGLYZE XR | SAXAGLIPTIN-METFORMIN HCL TAB ER 24HR 5-500 MG | 27992502607530 | Brand |
| KOMBIGLYZE XR | SAXAGLIPTIN-METFORMIN HCL TAB ER 24HR 2.5-1000 MG | 27992502607520 | Brand |
| JANUMET | SITAGLIPTIN-METFORMIN HCL TAB 50-500 MG | 27992502700320 | Brand |
| JANUMET | SITAGLIPTIN-METFORMIN HCL TAB 50-1000 MG | 27992502700340 | Brand |
| JANUMET XR | SITAGLIPTIN-METFORMIN HCL TAB ER 24HR 50-1000 MG | 27992502707530 | Brand |
| JANUMET XR | SITAGLIPTIN-METFORMIN HCL TAB ER 24HR 100-1000 MG | 27992502707540 | Brand |
| JANUMET XR | SITAGLIPTIN-METFORMIN HCL TAB ER 24HR 50-500 MG | 27992502707520 | Brand |
| JANUVIA | SITAGLIPTIN PHOSPHATE TAB 25 MG (BASE EQUIV) | 27550070100320 | Brand |
| JANUVIA | SITAGLIPTIN PHOSPHATE TAB 50 MG (BASE EQUIV) | 27550070100330 | Brand |
| JANUVIA | SITAGLIPTIN PHOSPHATE TAB 100 MG (BASE EQUIV) | 27550070100340 | Brand |
| JENTADUETO | LINAGLIPTIN-METFORMIN HCL TAB 2.5-500 MG | 27992502400320 | Brand |
| JENTADUETO | LINAGLIPTIN-METFORMIN HCL TAB 2.5-850 MG | 27992502400330 | Brand |

| | | | |
|---|---|---|---|
| JENTADUETO | LINAGLIPTIN-METFORMIN HCL TAB 2.5-1000 MG | 27992502400340 | Brand |
| JENTADUETO XR | LINAGLIPTIN-METFORMIN HCL TAB ER 24HR 5-1000 MG | 27992502407530 | Brand |
| JENTADUETO XR | LINAGLIPTIN-METFORMIN HCL TAB ER 24HR 2.5-1000 MG | 27992502407520 | Brand |
| ONGLYZA | SAXAGLIPTIN HCL TAB 2.5 MG (BASE EQUIV) | 27550065100320 | Brand |
| ONGLYZA | SAXAGLIPTIN HCL TAB 5 MG (BASE EQUIV) | 27550065100330 | Brand |
| TRADJENTA | LINAGLIPTIN TAB 5 MG | 27550050000320 | Brand |
| SAXAGLIPTIN HYDROCHLORIDE/METFORMIN HYDROCHLORIDE ER | SAXAGLIPTIN-METFORMIN HCL TAB ER 24HR 2.5-1000 MG | 27992502607520 | Generic |
| SAXAGLIPTIN HYDROCHLORIDE/METFORMIN HYDROCHLORIDE ER | SAXAGLIPTIN-METFORMIN HCL TAB ER 24HR 5-500 MG | 27992502607530 | Generic |
| SAXAGLIPTIN HYDROCHLORIDE/METFORMIN HYDROCHLORIDE ER | SAXAGLIPTIN-METFORMIN HCL TAB ER 24HR 5-1000 MG | 27992502607540 | Generic |
| SAXAGLIPTIN HYDROCHLORIDE | SAXAGLIPTIN HCL TAB 2.5 MG (BASE EQUIV) | 27550065100320 | Generic |
| SAXAGLIPTIN HYDROCHLORIDE | SAXAGLIPTIN HCL TAB 5 MG (BASE EQUIV) | 27550065100330 | Generic |
| ZITUVIO | SITAGLIPTIN TAB 25 MG | 27550070000320 | Brand |
| ZITUVIO | SITAGLIPTIN TAB 50 MG | 27550070000330 | Brand |
| ZITUVIO | SITAGLIPTIN TAB 100 MG | 27550070000340 | Brand |
| ZITUVIMET | | | |

**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 (generic Nesina)
- Alogliptin/metformin (generic Kazano)
- Alogliptin/pioglitazone (generic Oseni)

**OR**

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

- Alogliptin (generic Nesina)
- Alogliptin/metformin (generic Kazano)
- Alogliptin/pioglitazone (generic Oseni)

Dry Eye Disease

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-154758 |
| **Guideline Name** | Dry Eye Disease |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 10/1/2024 |

## 1 . Criteria

| Product Name: Restasis Multidose, Brand Restasis, Cequa, Tyrvaya, Vevye, Miebo, Xiidra | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RESTASIS MULTIDOSE | CYCLOSPORINE (OPHTH) EMULSION 0.05% | 86720020001620 | Brand |
| RESTASIS | CYCLOSPORINE (OPHTH) EMULSION 0.05% | 86720020001620 | Brand |
| CEQUA | CYCLOSPORINE (OPHTH) SOLN 0.09% (PF) | 86720020002040 | Brand |
| TYRVAYA | VARENICLINE TARTRATE NASAL SOLN 0.03 MG/ACT | 86280080202020 | Brand |

| | | | |
|---|---|---|---|
| MIEBO | PERFLUOROHEXYLOCTANE OPHTH SOLN 1.338 GM/ML | 868070180020 | Brand |
| VEVYE | CYCLOSPORINE (OPHTH) SOLN 0.1% | 86720020002043 | Brand |
| XIIDRA | LIFITEGRAST OPHTH SOLN 5% | 86734050002020 | Brand |

**Approval Criteria**

**1** - Tear deficiency associated with ocular inflammation due to ONE of the following:

- Moderate to severe keratoconjunctivitis sicca
- Moderate to severe dry eye disease

**AND**

**2** - 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 one OTC (over-the-counter) artificial tear product (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 | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CYCLOSPORINE | CYCLOSPORINE (OPHTH) EMULSION 0.05% | 86720020001620 | Generic |

**Approval Criteria**

**1** - Tear deficiency associated with ocular inflammation due to ONE of the following:

- Moderate to severe keratoconjunctivitis sicca
- Moderate to severe dry eye disease

**AND**

**2** - 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 one OTC (over-the-counter) artificial tear product (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: Restasis Multidose, Brand Restasis, generic cyclosporine, Xiidra, Cequa, Tyrvaya, Vevye, Miebo | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RESTASIS MULTIDOSE | CYCLOSPORINE (OPHTH) EMULSION 0.05% | 86720020001620 | Brand |
| RESTASIS | CYCLOSPORINE (OPHTH) EMULSION 0.05% | 86720020001620 | Brand |
| XIIDRA | LIFITEGRAST OPHTH SOLN 5% | 86734050002020 | Brand |
| CEQUA | CYCLOSPORINE (OPHTH) SOLN 0.09% (PF) | 86720020002040 | Brand |
| TYRVAYA | VARENICLINE TARTRATE NASAL SOLN 0.03 MG/ACT | 86280080202020 | Brand |
| CYCLOSPORINE | CYCLOSPORINE (OPHTH) EMULSION 0.05% | 86720020001620 | Generic |

| | | | |
|---|---|---|---|
| MIEBO | PERFLUOROHEXYLOCTANE OPHTH SOLN 1.338 GM/ML | 86807018002020 | Brand |
| VEVYE | CYCLOSPORINE (OPHTH) SOLN 0.1% | 86720020002043 | Brand |

**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)

Duexis and Vimovo

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146887 |
| **Guideline Name** | Duexis and Vimovo |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Brand Duexis, generic ibuprofen/famotidine | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DUEXIS | IBUPROFEN-FAMOTIDINE TAB 800-26.6 MG | 66109902320340 | Brand |
| IBUPROFEN/FAMOTIDINE | IBUPROFEN-FAMOTIDINE TAB 800-26.6 MG | 66109902320340 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VIMOVO | NAPROXEN-ESOMEPRAZOLE MAGNESIUM TAB DR 375-20 MG | 66109902440620 | Brand |

| | | | |
|---|---|---|---|
| NAPROXEN/ESOMEPRAZOLE MAGNESIUM | NAPROXEN-ESOMEPRAZOLE MAGNESIUM TAB DR 375-20 MG | 66109902440620 | Generic |
| VIMOVO | NAPROXEN-ESOMEPRAZOLE MAGNESIUM TAB DR 500-20 MG | 66109902440640 | Brand |
| NAPROXEN/ESOMEPRAZOLE MAGNESIUM | NAPROXEN-ESOMEPRAZOLE MAGNESIUM TAB DR 500-20 MG | 66109902440640 | Generic |

**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**<br><br>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 |
| --- | --- |
| 4/30/2024 | Updated PDL link |

Duopa

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146323 |
| **Guideline Name** | Duopa |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Duopa | |
|---|---|
| Diagnosis | Parkinson's disease |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DUOPA | CARBIDOPA-LEVODOPA ENTERAL SUSP 4.63-20 MG/ML | 73209902101820 | Brand |

**Approval Criteria**

**1** - Diagnosis of advanced Parkinson's disease

**AND**

**2** - Patient is levodopa-responsive

**AND**

**3** - Patient experiences disabling “off” periods for a minimum of 3 hours per day

**AND**

**4** - Disabling “off" periods occur despite therapy with BOTH of the following, as confirmed by claims history or submission of medical records:

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

**AND**

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

**AND**

**6** - Prescribed by or in consultation with a neurologist

| Product Name: Duopa | |
|---|---|
| Diagnosis | Parkinson's disease |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DUOPA | CARBIDOPA-LEVODOPA ENTERAL SUSP 4.63-20 MG/ML | 73209902101820 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Duopa therapy

Dupixent

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-147442 |
| **Guideline Name** | Dupixent |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Dupixent | |
|---|---|
| Diagnosis | Atopic Dermatitis |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 200 MG/1.14ML | 9027302000D515 | Brand |
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 300 MG/2ML | 9027302000D520 | Brand |
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/0.67ML | 9027302000E510 | Brand |

| | | | |
|---|---|---|---|
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 200 MG/1.14ML | 9027302000E515 | Brand |
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML | 9027302000E520 | Brand |

**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:

- Biologic immunomodulator [e.g., Adbry (tralokinumab-ldrm)]
- 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 200 MG/1.14ML | 9027302000D515 | Brand |
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 300 MG/2ML | 9027302000D520 | Brand |
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/0.67ML | 9027302000E510 | Brand |
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 200 MG/1.14ML | 9027302000E515 | Brand |
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML | 9027302000E520 | Brand |

**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:

- Biologic immunomodulator [e.g., Adbry (tralokinumab-ldrm)]
- 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 200 MG/1.14ML | 9027302000D515 | Brand |
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 300 MG/2ML | 9027302000D520 | Brand |
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/0.67ML | 9027302000E510 | Brand |
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 200 MG/1.14ML | 9027302000E515 | Brand |
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML | 9027302000E520 | Brand |

**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:

**2.1.2.2.1** ONE maximally-dosed (appropriately adjusted for age) ICS product [e.g., ciclesonide (Alvesco), mometasone furoate (Asmanex), beclomethasone dipropionate (QVAR)] (see Table 2 in Background)

**AND**

**2.1.2.2.2** 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:

**2.1.3.1** Submission of medical records (e.g., chart notes, laboratory values, etc.) documenting that asthma is an eosinophilic phenotype as defined by a baseline (pre-dupilumab treatment) peripheral blood eosinophil level greater than or equal to 150 cells/microliter

**OR**

**2.1.3.2** 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:

**2.2.2.2.1** ONE maximally-dosed (appropriately adjusted for age) ICS product [e.g., ciclesonide (Alvesco), mometasone furoate (Asmanex), beclomethasone dipropionate (QVAR)]

**AND**

**2.2.2.2.2** 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:

- Anti-interleukin-5 therapy [e.g., Nucala (mepolizumab), Cinqair (resilizumab), 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 200 MG/1.14ML | 9027302000D515 | Brand |
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 300 MG/2ML | 9027302000D520 | Brand |
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/0.67ML | 9027302000E510 | Brand |
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 200 MG/1.14ML | 9027302000E515 | Brand |
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML | 9027302000E520 | Brand |

**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:

**2.2.1** ONE maximally-dosed (appropriately adjusted for age) ICS product [e.g., ciclesonide (Alvesco), mometasone furoate (Asmanex), beclomethasone dipropionate (QVAR)]

**AND**

**2.2.2** 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:

- Anti-interleukin-5 therapy [e.g., Nucala (mepolizumab), Cinqair (resilizumab), 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 200 MG/1.14ML | 9027302000D515 | Brand |
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 300 MG/2ML | 9027302000D520 | Brand |
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/0.67ML | 9027302000E510 | Brand |

| | | | |
|---|---|---|---|
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 200 MG/1.14ML | 9027302000E515 | Brand |
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML | 9027302000E520 | Brand |

**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:

**1.2.1** Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP)

**AND**

**1.2.2** 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:

- Anti-interleukin-5 therapy [e.g., Cinqair (resilizumab), 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 200 MG/1.14ML | 9027302000D515 | Brand |
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 300 MG/2ML | 9027302000D520 | Brand |
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/0.67ML | 9027302000E510 | Brand |
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 200 MG/1.14ML | 9027302000E515 | Brand |
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML | 9027302000E520 | Brand |

**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:

- Anti-interleukin-5 therapy [e.g., Cinqair (resilizumab), 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 | 6 month(s)* |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 200 MG/1.14ML | 9027302000D515 | Brand |
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 300 MG/2ML | 9027302000D520 | Brand |

| | | | |
|---|---|---|---|
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/0.67ML | 9027302000E510 | Brand |
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 200 MG/1.14ML | 9027302000E515 | Brand |
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML | 9027302000E520 | Brand |

**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 mm^2 (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:

- Anti-interleukin-5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab), Nucala (mepolizumab)]
- Anti-IgE therapy [e.g., Xolair (omalizumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

**AND**

**7** - Prescribed by 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 | 6 month(s)* |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 200 MG/1.14ML | 9027302000D515 | Brand |
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 300 MG/2ML | 9027302000D520 | Brand |
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/0.67ML | 9027302000E510 | Brand |
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 200 MG/1.14ML | 9027302000E515 | Brand |
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML | 9027302000E520 | Brand |

**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:

- Anti-interleukin-5 therapy [e.g., Cinqair (resilizumab), 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 | 6 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 200 MG/1.14ML | 9027302000D515 | Brand |
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 300 MG/2ML | 9027302000D520 | Brand |
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/0.67ML | 9027302000E510 | Brand |
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 200 MG/1.14ML | 9027302000E515 | Brand |

| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML | 9027302000E520 | Brand |
|---|---|---|---|

**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:

- Biologic immunomodulator [e.g., Adbry (tralokinumab-ldrm)]
- Janus kinase inhibitor [e.g., Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib), Opzelura (topical ruxolitinib), Cibinqo (abrocitinib)]

**AND**

**5** - Prescribed by 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 200 MG/1.14ML | 9027302000D515 | Brand |
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 300 MG/2ML | 9027302000D520 | Brand |
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/0.67ML | 9027302000E510 | Brand |
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 200 MG/1.14ML | 9027302000E515 | Brand |
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML | 9027302000E520 | Brand |

**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:

- Biologic immunomodulator [e.g., Adbry (tralokinumab-ldrm)]
- Janus kinase inhibitor [e.g., Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib), Opzelura (topical ruxolitinib), Cibinqo (abrocitinib)]

**AND**

**3** - Prescribed by 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 |
| 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 |

**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

| Date | Notes |
|---|---|
| 5/15/2024 | Clarified language regarding topical steroid potency in initial auth section for AD. Removed weight requirement in initial auth section for EoE. Updated example from "Adbry (tralokinumab)" to "Adbry (tralokinumab-ldrm)" where applicable. |

Duvyzat

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-155733 |
| **Guideline Name** | Duvyzat |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 10/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DUVYZAT | GIVINOSTAT HCL ORAL SUSP 8.86 MG/ML | 74603025201820 | Brand |

**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** - Patient has not received gene therapy for DMD [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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DUVYZAT | GIVINOSTAT HCL ORAL SUSP 8.86 MG/ML | 74603025201820 | Brand |

**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 has not received gene therapy for DMD [e.g., Elevidys (delandistrogene moxparvovec-rokl)]

**AND**

| |
|---|
| **6** - 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 |
|---|---|
| 9/23/2024 | New guideline. |

Egrifta

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146510 |
| **Guideline Name** | Egrifta |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Egrifta SV | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| EGRIFTA SV | TESAMORELIN ACETATE FOR INJ 2 MG (BASE EQUIV) | 30150085102130 | Brand |

**Approval Criteria**

**1** - Diagnosis of human immunodeficiency virus (HIV)-associated lipodystrophy

Elidel-Protopic

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-148510 |
| **Guideline Name** | Elidel-Protopic |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Brand Elidel, generic pimecrolimus, generic tacrolimus 0.03% | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ELIDEL | PIMECROLIMUS CREAM 1% | 90784060003720 | Brand |
| PIMECROLIMUS | PIMECROLIMUS CREAM 1% | 90784060003720 | Generic |
| TACROLIMUS | TACROLIMUS OINT 0.03% | 90784075004210 | Generic |

**Approval Criteria**

**1** - The patient is 2 years of age or older

**AND**

**2** - ONE of the following:

**2.1** Failure to one topical corticosteroid in the past 90 days as confirmed by claims history or submission of medical records

**OR**

**2.2** History of contraindication or intolerance to one topical corticosteroid (please specify contraindication or intolerance)

**OR**

**2.3** Drug is being prescribed for the facial or groin area

| Product Name: Generic tacrolimus 0.1% | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TACROLIMUS | TACROLIMUS OINT 0.1% | 90784075004230 | Generic |

**Approval Criteria**

**1** - The patient is 16 years of age or older

**AND**

**2** - ONE of the following:

**2.1** Failure to one topical corticosteroid in the past 90 days as confirmed by claims history or submission of medical records

**OR**

**2.2** History of contraindication or intolerance to one topical corticosteroid (please specify contraindication or intolerance)

**OR**

**2.3** Drug is being prescribed for the facial or groin area

## 2 . Revision History

| Date | Notes |
|---|---|
| 6/13/2024 | Removed Protopic from GPI table since it is obsolete. |

Elmiron

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146325 |
| **Guideline Name** | Elmiron |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Elmiron | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ELMIRON | PENTOSAN POLYSULFATE SODIUM CAPS 100 MG | 56500060100110 | Brand |

**Approval Criteria**

**1** - Patient has a documented diagnosis of bladder pain or discomfort associated with interstitial cystitis

Emflaza

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-161235 |
| **Guideline Name** | Emflaza |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 1 . Criteria

| Product Name: Brand Emflaza, generic deflazacort | |
|---|---|
| Diagnosis | Duchenne Muscular Dystrophy |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| EMFLAZA | DEFLAZACORT TAB 6 MG | 22100017000340 | Brand |
| EMFLAZA | DEFLAZACORT TAB 18 MG | 22100017000350 | Brand |
| EMFLAZA | DEFLAZACORT TAB 30 MG | 22100017000360 | Brand |
| EMFLAZA | DEFLAZACORT TAB 36 MG | 22100017000365 | Brand |
| EMFLAZA | DEFLAZACORT SUSP 22.75 MG/ML | 22100017001830 | Brand |
| DEFLAZACORT | DEFLAZACORT TAB 6 MG | 22100017000340 | Generic |

| | | | |
|---|---|---|---|
| DEFLAZACORT | DEFLAZACORT TAB 18 MG | 22100017000350 | Generic |
| DEFLAZACORT | DEFLAZACORT TAB 30 MG | 22100017000360 | Generic |
| DEFLAZACORT | DEFLAZACORT TAB 36 MG | 22100017000365 | Generic |
| DEFLAZACORT | DEFLAZACORT SUSP 22.75 MG/ML | 22100017001830 | Generic |

**Approval Criteria**

**1** - Published clinical evidence shows Emflaza is likely to produce equivalent therapeutic results as other available corticosteroids (e.g., prednisone); therefore, Emflaza 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 |
|---|---|
| 11/25/2024 | Updated GPIs and product list to add generic |

Empaveli

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-148077 |
| **Guideline Name** | Empaveli |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| EMPAVELI | PEGCETACOPLAN SUBCUTANEOUS SOLN 1080 MG/20ML (54 MG/ML) | 85804065002020 | Brand |

**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., Fabhalta, Soliris, Ultomiris)

**OR**

**2.2** Patient is currently receiving another complement inhibitor (e.g., Fabhalta, 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 | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| EMPAVELI | PEGCETACOPLAN SUBCUTANEOUS SOLN 1080 MG/20ML (54 MG/ML) | 85804065002020 | Brand |

**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., Fabhalta, Soliris, Ultomiris)

**AND**

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

- Hematologist
- Oncologist

## 2 . Revision History

| Date | Notes |
|---|---|
| 6/4/2024 | In initial auth section, simplified criteria language for converting to ne w complement inhibitor therapy. |

Enbrel

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-159437 |
| **Guideline Name** | Enbrel |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 1 . Criteria

| Product Name: Enbrel | |
|---|---|
| Diagnosis | Rheumatoid Arthritis (RA) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ENBREL SURECLICK | ETANERCEPT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML | 6629003000D530 | Brand |
| ENBREL MINI | ETANERCEPT SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML | 6629003000E230 | Brand |
| ENBREL | ETANERCEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 25 MG/0.5ML | 6629003000E525 | Brand |

| | | | |
|---|---|---|---|
| ENBREL | ETANERCEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 50 MG/ML | 6629003000E530 | Brand |
| ENBREL | ETANERCEPT SUBCUTANEOUS INJ 25 MG/0.5ML | 66290030002015 | Brand |

**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 targeted immunomodulator FDA (Food and Drug Administration)-approved for the treatment of rheumatoid arthritis 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 Enbrel in combination with another targeted immunomodulator [e.g., Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

**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 targeted immunomodulator [e.g., Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| ENBREL SURECLICK | ETANERCEPT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML | 6629003000D530 | Brand |
| ENBREL MINI | ETANERCEPT SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML | 6629003000E230 | Brand |
| ENBREL | ETANERCEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 25 MG/0.5ML | 6629003000E525 | Brand |
| ENBREL | ETANERCEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 50 MG/ML | 6629003000E530 | Brand |
| ENBREL | ETANERCEPT SUBCUTANEOUS INJ 25 MG/0.5ML | 66290030002015 | Brand |

**Approval Criteria**

**1** - Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis

**AND**

**2** - Patient is NOT receiving Enbrel in combination with another targeted immunomodulator [e.g., Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ENBREL SURECLICK | ETANERCEPT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML | 6629003000D530 | Brand |
| ENBREL MINI | ETANERCEPT SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML | 6629003000E230 | Brand |

| | | | |
|---|---|---|---|
| ENBREL | ETANERCEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 25 MG/0.5ML | 6629003000E525 | Brand |
| ENBREL | ETANERCEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 50 MG/ML | 6629003000E530 | Brand |
| ENBREL | ETANERCEPT SUBCUTANEOUS INJ 25 MG/0.5ML | 66290030002015 | Brand |

**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 (Food and Drug Administration)-approved for the treatment of psoriatic arthritis as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Stelara (ustekinumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), Otezla (apremilast), Skyrizi (risankizumab-rzaa)]

**AND**

**1.3** Patient is NOT receiving Enbrel in combination with another targeted immunomodulator [e.g., Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz

(ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

**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 targeted immunomodulator [e.g., Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (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

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ENBREL SURECLICK | ETANERCEPT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML | 6629003000D530 | Brand |
| ENBREL MINI | ETANERCEPT SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML | 6629003000E230 | Brand |
| ENBREL | ETANERCEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 25 MG/0.5ML | 6629003000E525 | Brand |
| ENBREL | ETANERCEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 50 MG/ML | 6629003000E530 | Brand |
| ENBREL | ETANERCEPT SUBCUTANEOUS INJ 25 MG/0.5ML | 66290030002015 | Brand |

**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 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., Cimzia (certolizumab), adalimumab, Otezla (apremilast), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Tremfya (guselkumab)]

**AND**

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

**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 targeted immunomodulator [e.g., Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), 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

| Product Name: Enbrel | |
|---|---|
| Diagnosis | Ankylosing Spondylitis |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ENBREL SURECLICK | ETANERCEPT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML | 6629003000D530 | Brand |
| ENBREL MINI | ETANERCEPT SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML | 6629003000E230 | Brand |
| ENBREL | ETANERCEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 25 MG/0.5ML | 6629003000E525 | Brand |
| ENBREL | ETANERCEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 50 MG/ML | 6629003000E530 | Brand |
| ENBREL | ETANERCEPT SUBCUTANEOUS INJ 25 MG/0.5ML | 66290030002015 | Brand |

**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 targeted immunomodulator FDA (Food and Drug Administration)-approved for the treatment of ankylosing spondylitis as confirmed by claims history or submission of medical records [e.g., adalimumab, Simponi (golimumab)]

**AND**

**1.3** Patient is NOT receiving Enbrel in combination with another targeted immunomodulator [e.g., Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

**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 targeted immunomodulator [e.g., Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ENBREL SURECLICK | ETANERCEPT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML | 6629003000D530 | Brand |
| ENBREL MINI | ETANERCEPT SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML | 6629003000E230 | Brand |
| ENBREL | ETANERCEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 25 MG/0.5ML | 6629003000E525 | Brand |
| ENBREL | ETANERCEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 50 MG/ML | 6629003000E530 | Brand |
| ENBREL | ETANERCEPT SUBCUTANEOUS INJ 25 MG/0.5ML | 66290030002015 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Enbrel therapy

**AND**

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

| Notes | * Examples of drug(s) may not be applicable based on the requested i ndication. |
|---|---|

## 2 . Revision History

| Date | Notes |
| --- | --- |
| 11/7/2024 | Updated safety language |

Endari

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146326 |
| **Guideline Name** | Endari |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Endari | |
|---|---|
| Diagnosis | Sickle cell disease |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ENDARI | GLUTAMINE (SICKLE CELL) POWD PACK 5 GM | 82801020003020 | Brand |

**Approval Criteria**

**1** - BOTH of the following:

- Diagnosis of sickle cell disease
- Used to reduce acute complications of sickle cell disease

**AND**

**2** - ONE of the following:

- Patient is using Endari with concurrent hydroxyurea therapy
- Patient is unable to take hydroxyurea due to a contraindication or intolerance (please specify contraindication or intolerance)

**AND**

**3** - Patient has had 2 or more painful sickle cell crises within the past 12 months

| Product Name: Endari | |
|---|---|
| Diagnosis | Sickle cell disease |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ENDARI | GLUTAMINE (SICKLE CELL) POWD PACK 5 GM | 82801020003020 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Endari therapy

Enspryng

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-160437 |
| **Guideline Name** | Enspryng |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ENSPRYNG | SATRALIZUMAB-MWGE SUBCUTANEOUS SOLN PREF SYRINGE 120 MG/ML | 9940507040E520 | Brand |

**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:

- Disease modifying therapies for the treatment of multiple sclerosis [e.g., Gilenya (fingolimod), Tecfidera (dimethyl fumarate), Ocrevus (ocrelizumab), etc.]
- Complement inhibitors [e.g., Soliris (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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ENSPRYNG | SATRALIZUMAB-MWGE SUBCUTANEOUS SOLN PREF SYRINGE 120 MG/ML | 9940507040E520 | Brand |

**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:

- Disease modifying therapies for the treatment of multiple sclerosis [e.g., Gilenya (fingolimod), Tecfidera (dimethyl fumarate), Ocrevus (ocrelizumab), etc.]
- Complement inhibitors [e.g., Soliris (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 |
|---|---|
| 11/11/2024 | Updated examples of complement inhibitors |

Entocort

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146327 |
| **Guideline Name** | Entocort |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: budesonide caps | |
|---|---|
| Diagnosis | Crohn's Disease |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BUDESONIDE | BUDESONIDE DELAYED RELEASE PARTICLES CAP 3 MG | 22100012006720 | Generic |

**Approval Criteria**

**1** - Used for the treatment of Crohn's disease

Entresto

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-156316 |
| **Guideline Name** | Entresto |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 11/1/2024 |

## 1 . Criteria

| Product Name: Entresto, Entresto Sprinkles | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ENTRESTO | SACUBITRIL-VALSARTAN TAB 24-26 MG | 40992002600320 | Brand |
| ENTRESTO | SACUBITRIL-VALSARTAN TAB 49-51 MG | 40992002600330 | Brand |
| ENTRESTO | SACUBITRIL-VALSARTAN TAB 97-103 MG | 40992002600340 | Brand |
| ENTRESTO | SACUBITRIL-VALSARTAN SPRINKLE CAP 6-6 MG | 40992002606820 | Brand |
| ENTRESTO | SACUBITRIL-VALSARTAN SPRINKLE CAP 15-16 MG | 40992002606830 | Brand |

**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: Entresto, Entresto Sprinkles | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ENTRESTO | SACUBITRIL-VALSARTAN TAB 24-26 MG | 40992002600320 | Brand |
| ENTRESTO | SACUBITRIL-VALSARTAN TAB 49-51 MG | 40992002600330 | Brand |
| ENTRESTO | SACUBITRIL-VALSARTAN TAB 97-103 MG | 40992002600340 | Brand |
| ENTRESTO | SACUBITRIL-VALSARTAN SPRINKLE CAP 6-6 MG | 40992002606820 | Brand |
| ENTRESTO | SACUBITRIL-VALSARTAN SPRINKLE CAP 15-16 MG | 40992002606830 | Brand |

**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 |
|---|---|
| 9/26/2024 | Added Entresto sprinkles |

Entyvio SC

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-160555 |
| **Guideline Name** | Entyvio SC |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 1 . Criteria

| Product Name: Entyvio SC | |
|---|---|
| Diagnosis | Ulcerative Colitis (UC) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ENTYVIO PEN | VEDOLIZUMAB SOLN AUTO-INJECTOR 108 MG/0.68ML | 5250308000D520 | Brand |

**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 documented by claims history or submission of medical records (Document date and duration of therapy)

**AND**

**4** - Patient is NOT receiving Entyvio for subcutaneous use in combination with another targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Omvoh (mirikizumab-mrkz), Rinvoq (upadacitinib), Simponi (golimumab), Skyrizi (risankizumab), Stelara (ustekinumab), Xeljanz (tofacitinib)]

**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 |
|---|---|

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ENTYVIO PEN | VEDOLIZUMAB SOLN AUTO-INJECTOR 108 MG/0.68ML | 5250308000D520 | Brand |

**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 documented by claims history or submission of medical records (Document date and duration of therapy)

**AND**

**4** - Patient is NOT receiving Entyvio in combination with a targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Omvoh (mirikizumab-mrkz), Rinvoq (upadacitinib), Simponi (golimumab), Skyrizi (risankizumab), Stelara (ustekinumab), Xeljanz (tofacitinib)]

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ENTYVIO PEN | VEDOLIZUMAB SOLN AUTO-INJECTOR 108 MG/0.68ML | 5250308000D520 | Brand |

**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 targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Omvoh (mirikizumab-mrkz), Rinvoq (upadacitinib), Simponi (golimumab), Skyrizi (risankizumab), Stelara (ustekinumab), Xeljanz (tofacitinib)]

## 2 . Revision History

| Date | Notes |
|---|---|
| 11/13/2024 | Updated GPI. Updated criteria for UC and CD. Combined reauth sect ions. Updated title to "Entyvio SC" to match policy |

Eohilia

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-151000 |
| **Guideline Name** | Eohilia |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 8/6/2024 |

## 1 . Criteria

| Product Name: Eohilia | |
|---|---|
| Approval Length | 12 Week(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| EOHILIA | BUDESONIDE ORAL SUSPENSION 2 MG/10ML | 22100012001820 | Brand |

**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** Failure 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

Epaned

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146329 |
| **Guideline Name** | Epaned |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: generic enalapril oral soln, Brand Epaned | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ENALAPRIL MALEATE | ENALAPRIL MALEATE ORAL SOLN 1 MG/ML | 36100020102020 | Generic |
| EPANED | ENALAPRIL MALEATE ORAL SOLN 1 MG/ML | 36100020102020 | Brand |

**Approval Criteria**

**1** - Patient is less than 8 years of age

**OR**

**2** - BOTH of the following:

**2.1** ONE of the following diagnoses:

- Hypertension
- Heart failure
- Asymptomatic left ventricular dysfunction, defined as left ventricular ejection fraction less than or equal to 35%

**AND**

**2.2** ONE of the following:

**2.2.1** Failure to TWO formulary oral anti-hypertensives [e.g., angiotensin-converting enzyme (ACE) inhibitor, ACE inhibitor combination, angiotensin-receptor blocker (ARB), ARB combination, thiazide diuretic] as confirmed by claims history or submission of medical records

**OR**

**2.2.2** History of contraindication or intolerance to ALL formulary oral anti-hypertensives (e.g., ACE inhibitor, ACE inhibitor combination, ARB, ARB combination, thiazide diuretic) (please specify contraindication or intolerance)

**OR**

**2.2.3** Patient is unable to ingest a solid dosage form (e.g., an oral tablet or capsule) due to ONE of the following:

- Oral/motor difficulties
- Dysphagia

Erivedge

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146515 |
| **Guideline Name** | Erivedge |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Erivedge | |
|---|---|
| Diagnosis | Basal Cell Carcinoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ERIVEDGE | VISMODEGIB CAP 150 MG | 21370070000120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ERIVEDGE | VISMODEGIB CAP 150 MG | 21370070000120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ERIVEDGE | VISMODEGIB CAP 150 MG | 21370070000120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ERIVEDGE | VISMODEGIB CAP 150 MG | 21370070000120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ERIVEDGE | VISMODEGIB CAP 150 MG | 21370070000120 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Erivedge therapy

Erleada

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146516 |
| **Guideline Name** | Erleada |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Erleada | |
|---|---|
| Diagnosis | Prostate Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ERLEADA | APALUTAMIDE TAB 60 MG | 21402410000320 | Brand |
| ERLEADA | APALUTAMIDE TAB 240 MG | 21402410000360 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ERLEADA | APALUTAMIDE TAB 60 MG | 21402410000320 | Brand |
| ERLEADA | APALUTAMIDE TAB 240 MG | 21402410000360 | Brand |

**Approval Criteria**

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

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ERLEADA | APALUTAMIDE TAB 60 MG | 21402410000320 | Brand |
| ERLEADA | APALUTAMIDE TAB 240 MG | 21402410000360 | Brand |

**Approval Criteria**

**1** - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

| Product Name: Erleada | |
|---|---|
| Diagnosis | NCCN Recommended Regimen |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ERLEADA | APALUTAMIDE TAB 60 MG | 21402410000320 | Brand |

| | | | |
|---|---|---|---|
| ERLEADA | APALUTAMIDE TAB 240 MG | 21402410000360 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Erleada therapy

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146517 |
| **Guideline Name** | Erythropoietic Agents |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| EPOGEN | EPOETIN ALFA INJ 2000 UNIT/ML | 82401020002010 | Brand |
| PROCRIT | EPOETIN ALFA INJ 2000 UNIT/ML | 82401020002010 | Brand |
| EPOGEN | EPOETIN ALFA INJ 3000 UNIT/ML | 82401020002015 | Brand |
| PROCRIT | EPOETIN ALFA INJ 3000 UNIT/ML | 82401020002015 | Brand |

| | | | |
|---|---|---|---|
| EPOGEN | EPOETIN ALFA INJ 4000 UNIT/ML | 82401020002020 | Brand |
| PROCRIT | EPOETIN ALFA INJ 4000 UNIT/ML | 82401020002020 | Brand |
| EPOGEN | EPOETIN ALFA INJ 10000 UNIT/ML | 82401020002040 | Brand |
| PROCRIT | EPOETIN ALFA INJ 10000 UNIT/ML | 82401020002040 | Brand |
| EPOGEN | EPOETIN ALFA INJ 20000 UNIT/ML | 82401020002050 | Brand |
| PROCRIT | EPOETIN ALFA INJ 20000 UNIT/ML | 82401020002050 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 10 MCG/0.4ML | 8240101510E510 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 25 MCG/0.42ML | 8240101510E528 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 40 MCG/0.4ML | 8240101510E543 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 60 MCG/0.3ML | 8240101510E552 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 100 MCG/0.5ML | 8240101510E560 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 150 MCG/0.3ML | 8240101510E575 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 200 MCG/0.4ML | 8240101510E582 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 300 MCG/0.6ML | 8240101510E588 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 500 MCG/ML | 8240101510E590 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN INJ 25 MCG/ML | 82401015102010 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN INJ 40 MCG/ML | 82401015102020 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN INJ 60 MCG/ML | 82401015102030 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN INJ 100 MCG/ML | 82401015102040 | Brand |

| | | | |
|---|---|---|---|
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN INJ 200 MCG/ML | 82401015102060 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 2000 UNIT/ML | 82401020042010 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 3000 UNIT/ML | 82401020042015 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 4000 UNIT/ML | 82401020042020 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 10000 UNIT/ML | 82401020042040 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 20000 UNIT/ML | 82401020042050 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 40000 UNIT/ML | 82401020042060 | Brand |
| PROCRIT | EPOETIN ALFA INJ 40000 UNIT/ML | 82401020002060 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| EPOGEN | EPOETIN ALFA INJ 2000 UNIT/ML | 82401020002010 | Brand |
| PROCRIT | EPOETIN ALFA INJ 2000 UNIT/ML | 82401020002010 | Brand |
| EPOGEN | EPOETIN ALFA INJ 3000 UNIT/ML | 82401020002015 | Brand |
| PROCRIT | EPOETIN ALFA INJ 3000 UNIT/ML | 82401020002015 | Brand |
| EPOGEN | EPOETIN ALFA INJ 4000 UNIT/ML | 82401020002020 | Brand |
| PROCRIT | EPOETIN ALFA INJ 4000 UNIT/ML | 82401020002020 | Brand |
| EPOGEN | EPOETIN ALFA INJ 10000 UNIT/ML | 82401020002040 | Brand |
| PROCRIT | EPOETIN ALFA INJ 10000 UNIT/ML | 82401020002040 | Brand |
| EPOGEN | EPOETIN ALFA INJ 20000 UNIT/ML | 82401020002050 | Brand |
| PROCRIT | EPOETIN ALFA INJ 20000 UNIT/ML | 82401020002050 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 10 MCG/0.4ML | 8240101510E510 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 25 MCG/0.42ML | 8240101510E528 | Brand |

| | | | |
|---|---|---|---|
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 40 MCG/0.4ML | 8240101510E543 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 60 MCG/0.3ML | 8240101510E552 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 100 MCG/0.5ML | 8240101510E560 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 150 MCG/0.3ML | 8240101510E575 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 200 MCG/0.4ML | 8240101510E582 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 300 MCG/0.6ML | 8240101510E588 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 500 MCG/ML | 8240101510E590 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN INJ 25 MCG/ML | 82401015102010 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN INJ 40 MCG/ML | 82401015102020 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN INJ 60 MCG/ML | 82401015102030 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN INJ 100 MCG/ML | 82401015102040 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN INJ 200 MCG/ML | 82401015102060 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 2000 UNIT/ML | 82401020042010 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 3000 UNIT/ML | 82401020042015 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 4000 UNIT/ML | 82401020042020 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 10000 UNIT/ML | 82401020042040 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 20000 UNIT/ML | 82401020042050 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 40000 UNIT/ML | 82401020042060 | Brand |
| PROCRIT | EPOETIN ALFA INJ 40000 UNIT/ML | 82401020002060 | Brand |

**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 |
|---|---|

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| EPOGEN | EPOETIN ALFA INJ 2000 UNIT/ML | 82401020002010 | Brand |
| PROCRIT | EPOETIN ALFA INJ 2000 UNIT/ML | 82401020002010 | Brand |
| EPOGEN | EPOETIN ALFA INJ 3000 UNIT/ML | 82401020002015 | Brand |
| PROCRIT | EPOETIN ALFA INJ 3000 UNIT/ML | 82401020002015 | Brand |
| EPOGEN | EPOETIN ALFA INJ 4000 UNIT/ML | 82401020002020 | Brand |
| PROCRIT | EPOETIN ALFA INJ 4000 UNIT/ML | 82401020002020 | Brand |
| EPOGEN | EPOETIN ALFA INJ 10000 UNIT/ML | 82401020002040 | Brand |
| PROCRIT | EPOETIN ALFA INJ 10000 UNIT/ML | 82401020002040 | Brand |
| EPOGEN | EPOETIN ALFA INJ 20000 UNIT/ML | 82401020002050 | Brand |
| PROCRIT | EPOETIN ALFA INJ 20000 UNIT/ML | 82401020002050 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 2000 UNIT/ML | 82401020042010 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 3000 UNIT/ML | 82401020042015 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 4000 UNIT/ML | 82401020042020 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 10000 UNIT/ML | 82401020042040 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 20000 UNIT/ML | 82401020042050 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 40000 UNIT/ML | 82401020042060 | Brand |
| PROCRIT | EPOETIN ALFA INJ 40000 UNIT/ML | 82401020002060 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| EPOGEN | EPOETIN ALFA INJ 2000 UNIT/ML | 82401020002010 | Brand |
| PROCRIT | EPOETIN ALFA INJ 2000 UNIT/ML | 82401020002010 | Brand |
| EPOGEN | EPOETIN ALFA INJ 3000 UNIT/ML | 82401020002015 | Brand |
| PROCRIT | EPOETIN ALFA INJ 3000 UNIT/ML | 82401020002015 | Brand |
| EPOGEN | EPOETIN ALFA INJ 4000 UNIT/ML | 82401020002020 | Brand |
| PROCRIT | EPOETIN ALFA INJ 4000 UNIT/ML | 82401020002020 | Brand |
| EPOGEN | EPOETIN ALFA INJ 10000 UNIT/ML | 82401020002040 | Brand |
| PROCRIT | EPOETIN ALFA INJ 10000 UNIT/ML | 82401020002040 | Brand |
| EPOGEN | EPOETIN ALFA INJ 20000 UNIT/ML | 82401020002050 | Brand |
| PROCRIT | EPOETIN ALFA INJ 20000 UNIT/ML | 82401020002050 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 2000 UNIT/ML | 82401020042010 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 3000 UNIT/ML | 82401020042015 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 4000 UNIT/ML | 82401020042020 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 10000 UNIT/ML | 82401020042040 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 20000 UNIT/ML | 82401020042050 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 40000 UNIT/ML | 82401020042060 | Brand |
| PROCRIT | EPOETIN ALFA INJ 40000 UNIT/ML | 82401020002060 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| EPOGEN | EPOETIN ALFA INJ 2000 UNIT/ML | 82401020002010 | Brand |
| PROCRIT | EPOETIN ALFA INJ 2000 UNIT/ML | 82401020002010 | Brand |
| EPOGEN | EPOETIN ALFA INJ 3000 UNIT/ML | 82401020002015 | Brand |
| PROCRIT | EPOETIN ALFA INJ 3000 UNIT/ML | 82401020002015 | Brand |
| EPOGEN | EPOETIN ALFA INJ 4000 UNIT/ML | 82401020002020 | Brand |
| PROCRIT | EPOETIN ALFA INJ 4000 UNIT/ML | 82401020002020 | Brand |

| | | | |
|---|---|---|---|
| EPOGEN | EPOETIN ALFA INJ 10000 UNIT/ML | 82401020002040 | Brand |
| PROCRIT | EPOETIN ALFA INJ 10000 UNIT/ML | 82401020002040 | Brand |
| EPOGEN | EPOETIN ALFA INJ 20000 UNIT/ML | 82401020002050 | Brand |
| PROCRIT | EPOETIN ALFA INJ 20000 UNIT/ML | 82401020002050 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 10 MCG/0.4ML | 8240101510E510 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 25 MCG/0.42ML | 8240101510E528 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 40 MCG/0.4ML | 8240101510E543 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 60 MCG/0.3ML | 8240101510E552 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 100 MCG/0.5ML | 8240101510E560 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 150 MCG/0.3ML | 8240101510E575 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 200 MCG/0.4ML | 8240101510E582 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 300 MCG/0.6ML | 8240101510E588 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 500 MCG/ML | 8240101510E590 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN INJ 25 MCG/ML | 82401015102010 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN INJ 40 MCG/ML | 82401015102020 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN INJ 60 MCG/ML | 82401015102030 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN INJ 100 MCG/ML | 82401015102040 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN INJ 200 MCG/ML | 82401015102060 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 2000 UNIT/ML | 82401020042010 | Brand |

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|---|---|---|---|
| RETACRIT | EPOETIN ALFA-EPBX INJ 3000 UNIT/ML | 82401020042015 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 4000 UNIT/ML | 82401020042020 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 10000 UNIT/ML | 82401020042040 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 20000 UNIT/ML | 82401020042050 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 40000 UNIT/ML | 82401020042060 | Brand |
| PROCRIT | EPOETIN ALFA INJ 40000 UNIT/ML | 82401020002060 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| EPOGEN | EPOETIN ALFA INJ 2000 UNIT/ML | 82401020002010 | Brand |
| PROCRIT | EPOETIN ALFA INJ 2000 UNIT/ML | 82401020002010 | Brand |
| EPOGEN | EPOETIN ALFA INJ 3000 UNIT/ML | 82401020002015 | Brand |
| PROCRIT | EPOETIN ALFA INJ 3000 UNIT/ML | 82401020002015 | Brand |
| EPOGEN | EPOETIN ALFA INJ 4000 UNIT/ML | 82401020002020 | Brand |
| PROCRIT | EPOETIN ALFA INJ 4000 UNIT/ML | 82401020002020 | Brand |
| EPOGEN | EPOETIN ALFA INJ 10000 UNIT/ML | 82401020002040 | Brand |
| PROCRIT | EPOETIN ALFA INJ 10000 UNIT/ML | 82401020002040 | Brand |
| EPOGEN | EPOETIN ALFA INJ 20000 UNIT/ML | 82401020002050 | Brand |
| PROCRIT | EPOETIN ALFA INJ 20000 UNIT/ML | 82401020002050 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 10 MCG/0.4ML | 8240101510E510 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 25 MCG/0.42ML | 8240101510E528 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 40 MCG/0.4ML | 8240101510E543 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 60 MCG/0.3ML | 8240101510E552 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 100 MCG/0.5ML | 8240101510E560 | Brand |

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|---|---|---|---|
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 150 MCG/0.3ML | 8240101510E575 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 200 MCG/0.4ML | 8240101510E582 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 300 MCG/0.6ML | 8240101510E588 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 500 MCG/ML | 8240101510E590 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN INJ 25 MCG/ML | 82401015102010 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN INJ 40 MCG/ML | 82401015102020 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN INJ 60 MCG/ML | 82401015102030 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN INJ 100 MCG/ML | 82401015102040 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN INJ 200 MCG/ML | 82401015102060 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 2000 UNIT/ML | 82401020042010 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 3000 UNIT/ML | 82401020042015 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 4000 UNIT/ML | 82401020042020 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 10000 UNIT/ML | 82401020042040 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 20000 UNIT/ML | 82401020042050 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 40000 UNIT/ML | 82401020042060 | Brand |
| PROCRIT | EPOETIN ALFA INJ 40000 UNIT/ML | 82401020002060 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| EPOGEN | EPOETIN ALFA INJ 2000 UNIT/ML | 82401020002010 | Brand |
| PROCRIT | EPOETIN ALFA INJ 2000 UNIT/ML | 82401020002010 | Brand |
| EPOGEN | EPOETIN ALFA INJ 3000 UNIT/ML | 82401020002015 | Brand |
| PROCRIT | EPOETIN ALFA INJ 3000 UNIT/ML | 82401020002015 | Brand |
| EPOGEN | EPOETIN ALFA INJ 4000 UNIT/ML | 82401020002020 | Brand |
| PROCRIT | EPOETIN ALFA INJ 4000 UNIT/ML | 82401020002020 | Brand |
| EPOGEN | EPOETIN ALFA INJ 10000 UNIT/ML | 82401020002040 | Brand |
| PROCRIT | EPOETIN ALFA INJ 10000 UNIT/ML | 82401020002040 | Brand |
| EPOGEN | EPOETIN ALFA INJ 20000 UNIT/ML | 82401020002050 | Brand |
| PROCRIT | EPOETIN ALFA INJ 20000 UNIT/ML | 82401020002050 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 2000 UNIT/ML | 82401020042010 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 3000 UNIT/ML | 82401020042015 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 4000 UNIT/ML | 82401020042020 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 10000 UNIT/ML | 82401020042040 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 20000 UNIT/ML | 82401020042050 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 40000 UNIT/ML | 82401020042060 | Brand |
| PROCRIT | EPOETIN ALFA INJ 40000 UNIT/ML | 82401020002060 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| EPOGEN | EPOETIN ALFA INJ 2000 UNIT/ML | 82401020002010 | Brand |
| PROCRIT | EPOETIN ALFA INJ 2000 UNIT/ML | 82401020002010 | Brand |
| EPOGEN | EPOETIN ALFA INJ 3000 UNIT/ML | 82401020002015 | Brand |
| PROCRIT | EPOETIN ALFA INJ 3000 UNIT/ML | 82401020002015 | Brand |
| EPOGEN | EPOETIN ALFA INJ 4000 UNIT/ML | 82401020002020 | Brand |
| PROCRIT | EPOETIN ALFA INJ 4000 UNIT/ML | 82401020002020 | Brand |

| | | | |
|---|---|---|---|
| EPOGEN | EPOETIN ALFA INJ 10000 UNIT/ML | 82401020002040 | Brand |
| PROCRIT | EPOETIN ALFA INJ 10000 UNIT/ML | 82401020002040 | Brand |
| EPOGEN | EPOETIN ALFA INJ 20000 UNIT/ML | 82401020002050 | Brand |
| PROCRIT | EPOETIN ALFA INJ 20000 UNIT/ML | 82401020002050 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 10 MCG/0.4ML | 8240101510E510 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 25 MCG/0.42ML | 8240101510E528 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 40 MCG/0.4ML | 8240101510E543 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 60 MCG/0.3ML | 8240101510E552 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 100 MCG/0.5ML | 8240101510E560 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 150 MCG/0.3ML | 8240101510E575 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 200 MCG/0.4ML | 8240101510E582 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 300 MCG/0.6ML | 8240101510E588 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 500 MCG/ML | 8240101510E590 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN INJ 25 MCG/ML | 82401015102010 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN INJ 40 MCG/ML | 82401015102020 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN INJ 60 MCG/ML | 82401015102030 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN INJ 100 MCG/ML | 82401015102040 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN INJ 200 MCG/ML | 82401015102060 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 2000 UNIT/ML | 82401020042010 | Brand |

| | | | |
|---|---|---|---|
| RETACRIT | EPOETIN ALFA-EPBX INJ 3000 UNIT/ML | 82401020042015 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 4000 UNIT/ML | 82401020042020 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 10000 UNIT/ML | 82401020042040 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 20000 UNIT/ML | 82401020042050 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 40000 UNIT/ML | 82401020042060 | Brand |
| PROCRIT | EPOETIN ALFA INJ 40000 UNIT/ML | 82401020002060 | Brand |

**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 to15% (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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| EPOGEN | EPOETIN ALFA INJ 2000 UNIT/ML | 82401020002010 | Brand |
| PROCRIT | EPOETIN ALFA INJ 2000 UNIT/ML | 82401020002010 | Brand |
| EPOGEN | EPOETIN ALFA INJ 3000 UNIT/ML | 82401020002015 | Brand |
| PROCRIT | EPOETIN ALFA INJ 3000 UNIT/ML | 82401020002015 | Brand |
| EPOGEN | EPOETIN ALFA INJ 4000 UNIT/ML | 82401020002020 | Brand |
| PROCRIT | EPOETIN ALFA INJ 4000 UNIT/ML | 82401020002020 | Brand |
| EPOGEN | EPOETIN ALFA INJ 10000 UNIT/ML | 82401020002040 | Brand |
| PROCRIT | EPOETIN ALFA INJ 10000 UNIT/ML | 82401020002040 | Brand |

| | | | |
|---|---|---|---|
| EPOGEN | EPOETIN ALFA INJ 20000 UNIT/ML | 82401020002050 | Brand |
| PROCRIT | EPOETIN ALFA INJ 20000 UNIT/ML | 82401020002050 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 10 MCG/0.4ML | 8240101510E510 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 25 MCG/0.42ML | 8240101510E528 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 40 MCG/0.4ML | 8240101510E543 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 60 MCG/0.3ML | 8240101510E552 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 100 MCG/0.5ML | 8240101510E560 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 150 MCG/0.3ML | 8240101510E575 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 200 MCG/0.4ML | 8240101510E582 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 300 MCG/0.6ML | 8240101510E588 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 500 MCG/ML | 8240101510E590 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN INJ 25 MCG/ML | 82401015102010 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN INJ 40 MCG/ML | 82401015102020 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN INJ 60 MCG/ML | 82401015102030 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN INJ 100 MCG/ML | 82401015102040 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN INJ 200 MCG/ML | 82401015102060 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 2000 UNIT/ML | 82401020042010 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 3000 UNIT/ML | 82401020042015 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 4000 UNIT/ML | 82401020042020 | Brand |

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|---|---|---|---|
| RETACRIT | EPOETIN ALFA-EPBX INJ 10000 UNIT/ML | 82401020042040 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 20000 UNIT/ML | 82401020042050 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 40000 UNIT/ML | 82401020042060 | Brand |
| PROCRIT | EPOETIN ALFA INJ 40000 UNIT/ML | 82401020002060 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| EPOGEN | EPOETIN ALFA INJ 2000 UNIT/ML | 82401020002010 | Brand |
| PROCRIT | EPOETIN ALFA INJ 2000 UNIT/ML | 82401020002010 | Brand |
| EPOGEN | EPOETIN ALFA INJ 3000 UNIT/ML | 82401020002015 | Brand |
| PROCRIT | EPOETIN ALFA INJ 3000 UNIT/ML | 82401020002015 | Brand |
| EPOGEN | EPOETIN ALFA INJ 4000 UNIT/ML | 82401020002020 | Brand |
| PROCRIT | EPOETIN ALFA INJ 4000 UNIT/ML | 82401020002020 | Brand |
| EPOGEN | EPOETIN ALFA INJ 10000 UNIT/ML | 82401020002040 | Brand |

| | | | |
|---|---|---|---|
| PROCRIT | EPOETIN ALFA INJ 10000 UNIT/ML | 82401020002040 | Brand |
| EPOGEN | EPOETIN ALFA INJ 20000 UNIT/ML | 82401020002050 | Brand |
| PROCRIT | EPOETIN ALFA INJ 20000 UNIT/ML | 82401020002050 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 10 MCG/0.4ML | 8240101510E510 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 25 MCG/0.42ML | 8240101510E528 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 40 MCG/0.4ML | 8240101510E543 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 60 MCG/0.3ML | 8240101510E552 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 100 MCG/0.5ML | 8240101510E560 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 150 MCG/0.3ML | 8240101510E575 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 200 MCG/0.4ML | 8240101510E582 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 300 MCG/0.6ML | 8240101510E588 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 500 MCG/ML | 8240101510E590 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN INJ 25 MCG/ML | 82401015102010 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN INJ 40 MCG/ML | 82401015102020 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN INJ 60 MCG/ML | 82401015102030 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN INJ 100 MCG/ML | 82401015102040 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN INJ 200 MCG/ML | 82401015102060 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 2000 UNIT/ML | 82401020042010 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 3000 UNIT/ML | 82401020042015 | Brand |

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|---|---|---|---|
| RETACRIT | EPOETIN ALFA-EPBX INJ 4000 UNIT/ML | 82401020042020 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 10000 UNIT/ML | 82401020042040 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 20000 UNIT/ML | 82401020042050 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 40000 UNIT/ML | 82401020042060 | Brand |
| PROCRIT | EPOETIN ALFA INJ 40000 UNIT/ML | 82401020002060 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| EPOGEN | EPOETIN ALFA INJ 2000 UNIT/ML | 82401020002010 | Brand |
| PROCRIT | EPOETIN ALFA INJ 2000 UNIT/ML | 82401020002010 | Brand |
| EPOGEN | EPOETIN ALFA INJ 3000 UNIT/ML | 82401020002015 | Brand |
| PROCRIT | EPOETIN ALFA INJ 3000 UNIT/ML | 82401020002015 | Brand |
| EPOGEN | EPOETIN ALFA INJ 4000 UNIT/ML | 82401020002020 | Brand |
| PROCRIT | EPOETIN ALFA INJ 4000 UNIT/ML | 82401020002020 | Brand |

| | | | |
|---|---|---|---|
| EPOGEN | EPOETIN ALFA INJ 10000 UNIT/ML | 82401020002040 | Brand |
| PROCRIT | EPOETIN ALFA INJ 10000 UNIT/ML | 82401020002040 | Brand |
| EPOGEN | EPOETIN ALFA INJ 20000 UNIT/ML | 82401020002050 | Brand |
| PROCRIT | EPOETIN ALFA INJ 20000 UNIT/ML | 82401020002050 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 10 MCG/0.4ML | 8240101510E510 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 25 MCG/0.42ML | 8240101510E528 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 40 MCG/0.4ML | 8240101510E543 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 60 MCG/0.3ML | 8240101510E552 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 100 MCG/0.5ML | 8240101510E560 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 150 MCG/0.3ML | 8240101510E575 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 200 MCG/0.4ML | 8240101510E582 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 300 MCG/0.6ML | 8240101510E588 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 500 MCG/ML | 8240101510E590 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN INJ 25 MCG/ML | 82401015102010 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN INJ 40 MCG/ML | 82401015102020 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN INJ 60 MCG/ML | 82401015102030 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN INJ 100 MCG/ML | 82401015102040 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN INJ 200 MCG/ML | 82401015102060 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 2000 UNIT/ML | 82401020042010 | Brand |

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|---|---|---|---|
| RETACRIT | EPOETIN ALFA-EPBX INJ 3000 UNIT/ML | 82401020042015 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 4000 UNIT/ML | 82401020042020 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 10000 UNIT/ML | 82401020042040 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 20000 UNIT/ML | 82401020042050 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 40000 UNIT/ML | 82401020042060 | Brand |
| PROCRIT | EPOETIN ALFA INJ 40000 UNIT/ML | 82401020002060 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| EPOGEN | EPOETIN ALFA INJ 2000 UNIT/ML | 82401020002010 | Brand |
| PROCRIT | EPOETIN ALFA INJ 2000 UNIT/ML | 82401020002010 | Brand |
| EPOGEN | EPOETIN ALFA INJ 3000 UNIT/ML | 82401020002015 | Brand |
| PROCRIT | EPOETIN ALFA INJ 3000 UNIT/ML | 82401020002015 | Brand |

| | | | |
|---|---|---|---|
| EPOGEN | EPOETIN ALFA INJ 4000 UNIT/ML | 82401020002020 | Brand |
| PROCRIT | EPOETIN ALFA INJ 4000 UNIT/ML | 82401020002020 | Brand |
| EPOGEN | EPOETIN ALFA INJ 10000 UNIT/ML | 82401020002040 | Brand |
| PROCRIT | EPOETIN ALFA INJ 10000 UNIT/ML | 82401020002040 | Brand |
| EPOGEN | EPOETIN ALFA INJ 20000 UNIT/ML | 82401020002050 | Brand |
| PROCRIT | EPOETIN ALFA INJ 20000 UNIT/ML | 82401020002050 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 2000 UNIT/ML | 82401020042010 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 3000 UNIT/ML | 82401020042015 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 4000 UNIT/ML | 82401020042020 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 10000 UNIT/ML | 82401020042040 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 20000 UNIT/ML | 82401020042050 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 40000 UNIT/ML | 82401020042060 | Brand |
| PROCRIT | EPOETIN ALFA INJ 40000 UNIT/ML | 82401020002060 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| EPOGEN | EPOETIN ALFA INJ 2000 UNIT/ML | 82401020002010 | Brand |
| PROCRIT | EPOETIN ALFA INJ 2000 UNIT/ML | 82401020002010 | Brand |
| EPOGEN | EPOETIN ALFA INJ 3000 UNIT/ML | 82401020002015 | Brand |
| PROCRIT | EPOETIN ALFA INJ 3000 UNIT/ML | 82401020002015 | Brand |
| EPOGEN | EPOETIN ALFA INJ 4000 UNIT/ML | 82401020002020 | Brand |
| PROCRIT | EPOETIN ALFA INJ 4000 UNIT/ML | 82401020002020 | Brand |
| EPOGEN | EPOETIN ALFA INJ 10000 UNIT/ML | 82401020002040 | Brand |
| PROCRIT | EPOETIN ALFA INJ 10000 UNIT/ML | 82401020002040 | Brand |
| EPOGEN | EPOETIN ALFA INJ 20000 UNIT/ML | 82401020002050 | Brand |
| PROCRIT | EPOETIN ALFA INJ 20000 UNIT/ML | 82401020002050 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 2000 UNIT/ML | 82401020042010 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 3000 UNIT/ML | 82401020042015 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 4000 UNIT/ML | 82401020042020 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 10000 UNIT/ML | 82401020042040 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 20000 UNIT/ML | 82401020042050 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 40000 UNIT/ML | 82401020042060 | Brand |
| PROCRIT | EPOETIN ALFA INJ 40000 UNIT/ML | 82401020002060 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| EPOGEN | EPOETIN ALFA INJ 2000 UNIT/ML | 82401020002010 | Brand |
| PROCRIT | EPOETIN ALFA INJ 2000 UNIT/ML | 82401020002010 | Brand |
| EPOGEN | EPOETIN ALFA INJ 3000 UNIT/ML | 82401020002015 | Brand |
| PROCRIT | EPOETIN ALFA INJ 3000 UNIT/ML | 82401020002015 | Brand |
| EPOGEN | EPOETIN ALFA INJ 4000 UNIT/ML | 82401020002020 | Brand |
| PROCRIT | EPOETIN ALFA INJ 4000 UNIT/ML | 82401020002020 | Brand |
| EPOGEN | EPOETIN ALFA INJ 10000 UNIT/ML | 82401020002040 | Brand |
| PROCRIT | EPOETIN ALFA INJ 10000 UNIT/ML | 82401020002040 | Brand |
| EPOGEN | EPOETIN ALFA INJ 20000 UNIT/ML | 82401020002050 | Brand |
| PROCRIT | EPOETIN ALFA INJ 20000 UNIT/ML | 82401020002050 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 10 MCG/0.4ML | 8240101510E510 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 25 MCG/0.42ML | 8240101510E528 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 40 MCG/0.4ML | 8240101510E543 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 60 MCG/0.3ML | 8240101510E552 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 100 MCG/0.5ML | 8240101510E560 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 150 MCG/0.3ML | 8240101510E575 | Brand |

| | | | |
|---|---|---|---|
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 200 MCG/0.4ML | 8240101510E582 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 300 MCG/0.6ML | 8240101510E588 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 500 MCG/ML | 8240101510E590 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN INJ 25 MCG/ML | 82401015102010 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN INJ 40 MCG/ML | 82401015102020 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN INJ 60 MCG/ML | 82401015102030 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN INJ 100 MCG/ML | 82401015102040 | Brand |
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA SOLN INJ 200 MCG/ML | 82401015102060 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 2000 UNIT/ML | 82401020042010 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 3000 UNIT/ML | 82401020042015 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 4000 UNIT/ML | 82401020042020 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 10000 UNIT/ML | 82401020042040 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 20000 UNIT/ML | 82401020042050 | Brand |
| RETACRIT | EPOETIN ALFA-EPBX INJ 40000 UNIT/ML | 82401020042060 | Brand |
| PROCRIT | EPOETIN ALFA INJ 40000 UNIT/ML | 82401020002060 | Brand |

**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

Esbriet, Ofev

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146518 |
| **Guideline Name** | Esbriet, Ofev |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Brand Esbriet, generic pirfenidone, Ofev | |
|---|---|
| Diagnosis | Idiopathic Pulmonary Fibrosis |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ESBRIET | PIRFENIDONE CAP 267 MG | 45550060000120 | Brand |
| ESBRIET | PIRFENIDONE TAB 267 MG | 45550060000325 | Brand |
| ESBRIET | PIRFENIDONE TAB 801 MG | 45550060000345 | Brand |

| | | | |
|---|---|---|---|
| OFEV | NINTEDANIB ESYLATE CAP 100 MG (BASE EQUIVALENT) | 45554050200120 | Brand |
| OFEV | NINTEDANIB ESYLATE CAP 150 MG (BASE EQUIVALENT) | 45554050200130 | Brand |
| PIRFENIDONE | PIRFENIDONE CAP 267 MG | 45550060000120 | Generic |
| PIRFENIDONE | PIRFENIDONE TAB 267 MG | 45550060000325 | Generic |
| PIRFENIDONE | PIRFENIDONE TAB 801 MG | 45550060000345 | Generic |
| PIRFENIDONE | PIRFENIDONE TAB 534 MG | 45550060000333 | Generic |

**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:

**2.1** If the request is for Esbriet (pirfenidone), it is not being used in combination with Ofev

**OR**

**2.2** If the request is for Ofev, it is not being used in combination with Esbriet (pirfenidone)

**AND**

**3** - The prescriber is a pulmonologist

| Product Name: Brand Esbriet, generic pirfenidone, Ofev | |
|---|---|
| Diagnosis | Idiopathic Pulmonary Fibrosis |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ESBRIET | PIRFENIDONE CAP 267 MG | 45550060000120 | Brand |
| ESBRIET | PIRFENIDONE TAB 267 MG | 45550060000325 | Brand |
| ESBRIET | PIRFENIDONE TAB 801 MG | 45550060000345 | Brand |
| OFEV | NINTEDANIB ESYLATE CAP 100 MG (BASE EQUIVALENT) | 45554050200120 | Brand |
| OFEV | NINTEDANIB ESYLATE CAP 150 MG (BASE EQUIVALENT) | 45554050200130 | Brand |
| PIRFENIDONE | PIRFENIDONE CAP 267 MG | 45550060000120 | Generic |
| PIRFENIDONE | PIRFENIDONE TAB 267 MG | 45550060000325 | Generic |
| PIRFENIDONE | PIRFENIDONE TAB 801 MG | 45550060000345 | Generic |
| PIRFENIDONE | PIRFENIDONE TAB 534 MG | 45550060000333 | Generic |

**Approval Criteria**

**1** - Documentation of positive clinical response to the requested therapy

**AND**

**2** - ONE of the following:

**2.1** If the request is for Esbriet (pirfenidone), it is not being used in combination with Ofev

**OR**

**2.2** If the request is for Ofev, it 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 | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OFEV | NINTEDANIB ESYLATE CAP 100 MG (BASE EQUIVALENT) | 45554050200120 | Brand |
| OFEV | NINTEDANIB ESYLATE CAP 150 MG (BASE EQUIVALENT) | 45554050200130 | Brand |

**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 | Chronic Fibrosing Interstitial Lung Disease with a Progressive Phenotype |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| OFEV | NINTEDANIB ESYLATE CAP 100 MG (BASE EQUIVALENT) | 45554050200120 | Brand |
| OFEV | NINTEDANIB ESYLATE CAP 150 MG (BASE EQUIVALENT) | 45554050200130 | Brand |

**Approval Criteria**

**1** - Diagnosis of chronic fibrosing interstitial lung disease (ILD) with a progressive phenotype as documented by BOTH of the following:

**1.1** Presence of fibrotic ILD as determined by finding evidence of pulmonary fibrosis on HRCT (high-resolution computed tomography), involving at least 10% of the lungs

**AND**

**1.2** Patient is presenting with clinical signs of progression as defined by ONE of the following in the previous 24 months:

**1.2.1** Forced vital capacity (FVC) decline of greater than 10%

**OR**

**1.2.2** TWO of the following:

- FVC decline of greater than or equal to 5%, but less than 10%
- Patient is experiencing worsening respiratory symptoms
- Patient is exhibiting increasing extent of fibrotic changes on chest imaging

**AND**

**2** - 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, Chronic Fibrosing Interstitial Lung Disease with a Progressive Phenotype |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OFEV | NINTEDANIB ESYLATE CAP 100 MG (BASE EQUIVALENT) | 45554050200120 | Brand |
| OFEV | NINTEDANIB ESYLATE CAP 150 MG (BASE EQUIVALENT) | 45554050200130 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Ofev therapy

**AND**

**2** - Ofev is not being used in combination with Esbriet (pirfenidone)

**AND**

**3** - The prescriber is a pulmonologist

Eucrisa

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146330 |
| **Guideline Name** | Eucrisa |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Eucrisa | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Step Therapy |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| EUCRISA | CRISABOROLE OINT 2% | 90230025004220 | Brand |

**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

Evrysdi

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-154626 |
| **Guideline Name** | Evrysdi |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 10/1/2024 |

## 1 . Criteria

| Product Name: Evrysdi | |
|---|---|
| Diagnosis | Spinal Muscular Atrophy (SMA) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| EVRYSDI | RISDIPLAM FOR SOLN 0.75 MG/ML | 74706560002120 | Brand |

**Approval Criteria**

**1** - Diagnosis of spinal muscular atrophy (SMA)

**AND**

**2** - Submission of medical records (e.g., chart notes, laboratory values) confirming the mutation or deletion of genes in chromosome 5q resulting in ONE of the following:

**2.1** Homozygous gene deletion or mutation of SMN1 gene (e.g., homozygous deletion of exon 7 at locus 5q13)

**OR**

**2.2** Compound heterozygous mutation of SMN1 gene [e.g., deletion of SMN1 exon 7 (allele 1) and mutation of SMN1 (allele 2)]

**AND**

**3** - Patient is not dependent on invasive ventilation or tracheostomy

**AND**

**4** - Patient is not dependent on the use of non-invasive ventilation beyond use for naps and nighttime sleep

**AND**

**5** - Patient is not receiving concomitant chronic survival motor neuron (SMN)-modifying therapy [e.g., Spinraza (nusinersen)]

**AND**

**6** - Patient has not previously received gene replacement therapy for the treatment of SMA [e.g., Zolgensma (onasemnogene abeparvovec-xioi)]

**AND**

**7** - Submission of medical records (e.g., chart notes, laboratory values) documenting the baseline assessment of at least ONE of the following exams (based on patient age and motor ability) to establish baseline motor ability (baseline motor function analysis could include assessments evaluated prior to receipt of previous chronic SMN-modifying therapy if transitioning therapy)*:

- Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND)
- Hammersmith Infant Neurological Exam Part 2 (HINE-2)
- Hammersmith Functional Motor Scale Expanded (HFMSE)
- 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 | |
|---|---|
| Diagnosis | Spinal Muscular Atrophy (SMA) |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| EVRYSDI | RISDIPLAM FOR SOLN 0.75 MG/ML | 74706560002120 | Brand |

**Approval Criteria**

**1** - Submission of medical records (e.g., chart notes, laboratory values) with the most recent

results documenting a positive clinical response to Evrysdi compared to pretreatment baseline status [inclusive of baseline assessments prior to receipt of previous chronic survival motor neuron (SMN)-modifying therapy] as demonstrated by at least ONE of the following exams:

**1.1** Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND) with ONE of the following:

**1.1.1** Improvement or maintenance of previous improvement of at least a 4-point increase in score from pretreatment baseline

**OR**

**1.1.2** Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so

**OR**

**1.2** Hammersmith Infant Neurological Exam Part 2 (HINE-2) with ONE of the following:

**1.2.1** Improvement or maintenance of previous improvement of at least a 2-point (or maximal score) increase in ability to kick

**OR**

**1.2.2** Improvement or maintenance of previous improvement of at least a 1-point increase in any other HINE-2 milestone (e.g., head control, rolling, sitting, crawling, etc.), excluding voluntary grasp

**OR**

**1.2.3** The patient exhibited improvement, or maintenance of previous improvement, in more HINE motor milestones than worsening, from pretreatment baseline (net positive improvement)

**OR**

**1.2.4** Patient has achieved and maintained any new motor milestones when they would otherwise be unexpected to do so

**OR**

**1.3** Hammersmith Functional Motor Scale Expanded (HFMSE) with ONE of the following:

**1.3.1** Improvement or maintenance of previous improvement of at least a 3-point increase in score from pretreatment baseline

**OR**

**1.3.2** Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so

**OR**

**1.4** Revised Upper Limb Module (RULM) with ONE of the following:

**1.4.1** Improvement or maintenance of previous improvement of at least a 2-point increase in score from pretreatment baseline

**OR**

**1.4.2** Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so

**OR**

**1.5** Motor Function Measure 32 (MFM-32) with ONE of the following:

**1.5.1** Improvement or maintenance of previous improvement of at least a 3-point increase in score from pretreatment baseline

**OR**

**1.5.2** Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so

**AND**

**2** - Patient is not dependent on invasive ventilation or tracheostomy

**AND**

**3** - Patient is not dependent on the use of non-invasive ventilation beyond use for naps and nighttime sleep

**AND**

**4** - Patient is not receiving concomitant chronic SMN-modifying therapy [e.g., Spinraza (nusinersen)]

**AND**

**5** - Patient has not previously received gene replacement therapy for the treatment of spinal muscular atrophy (SMA) [e.g., Zolgensma (onasemnogene abeparvovec-xioi)]

**AND**

**6** - Prescribed by or in consultation with a neurologist with expertise in the treatment of SMA

## 2 . Revision History

| Date | Notes |
|---|---|
| 9/9/2024 | Annual review. Revised prescriber requirement and updated Upper Limb Module to Revised Upper Limb Module test. Updated references. |

Evrysdi

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146519 |
| **Guideline Name** | Evrysdi |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Evrysdi | |
|---|---|
| Diagnosis | Spinal Muscular Atrophy (SMA) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| EVRYSDI | RISDIPLAM FOR SOLN 0.75 MG/ML | 74706560002120 | Brand |

**Approval Criteria**

**1** - Diagnosis of spinal muscular atrophy (SMA)

**AND**

**2** - Submission of medical records (e.g., chart notes, laboratory values) confirming the mutation or deletion of genes in chromosome 5q resulting in ONE of the following:

**2.1** Homozygous gene deletion or mutation of SMN1 gene (e.g., homozygous deletion of exon 7 at locus 5q13)

**OR**

**2.2** Compound heterozygous mutation of SMN1 gene [e.g., deletion of SMN1 exon 7 (allele 1) and mutation of SMN1 (allele 2)]

**AND**

**3** - Patient is not dependent on invasive ventilation or tracheostomy

**AND**

**4** - Patient is not dependent on the use of non-invasive ventilation beyond use for naps and nighttime sleep

**AND**

**5** - Patient is not receiving concomitant chronic survival motor neuron (SMN)-modifying therapy [e.g., Spinraza (nusinersen)]

**AND**

**6** - Patient has not previously received gene replacement therapy for the treatment of SMA [e.g., Zolgensma (onasemnogene abeparvovec-xioi)]

**AND**

**7** - Submission of medical records (e.g., chart notes, laboratory values) documenting the baseline assessment of at least ONE of the following exams (based on patient age and motor ability) to establish baseline motor ability (baseline motor function analysis could include assessments evaluated prior to receipt of previous chronic SMN-modifying therapy if transitioning therapy)*:

- Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND)
- Hammersmith Infant Neurological Exam Part 2 (HINE-2)
- Hammersmith Functional Motor Scale Expanded (HFMSE)
- Upper Limb Module (ULM) Test
- Motor Function Measure 32 (MFM-32) Scale

**AND**

**8** - Prescribed by a neurologist with expertise in the treatment of SMA

| | |
|---|---|
| Notes | *Baseline assessments for patients less than 2 months of age request ing Evrysdi are not necessary in order not to delay access to initial the rapy in recently diagnosed infants. Initial assessments shortly post-the rapy can serve as baseline with respect to efficacy reauthorization ass essment. |

| Product Name: Evrysdi | |
|---|---|
| Diagnosis | Spinal Muscular Atrophy (SMA) |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| EVRYSDI | RISDIPLAM FOR SOLN 0.75 MG/ML | 74706560002120 | Brand |

**Approval Criteria**

**1** - Submission of medical records (e.g., chart notes, laboratory values) with the most recent

results documenting a positive clinical response to Evrysdi compared to pretreatment baseline status [inclusive of baseline assessments prior to receipt of previous chronic survival motor neuron (SMN)-modifying therapy] as demonstrated by at least ONE of the following exams:

**1.1** Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND) with ONE of the following:

**1.1.1** Improvement or maintenance of previous improvement of at least a 4-point increase in score from pretreatment baseline

**OR**

**1.1.2** Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so

**OR**

**1.2** Hammersmith Infant Neurological Exam Part 2 (HINE-2) with ONE of the following:

**1.2.1** Improvement or maintenance of previous improvement of at least a 2-point (or maximal score) increase in ability to kick

**OR**

**1.2.2** Improvement or maintenance of previous improvement of at least a 1-point increase in any other HINE-2 milestone (e.g., head control, rolling, sitting, crawling, etc.), excluding voluntary grasp

**OR**

**1.2.3** The patient exhibited improvement, or maintenance of previous improvement, in more HINE motor milestones than worsening, from pretreatment baseline (net positive improvement)

**OR**

**1.2.4** Patient has achieved and maintained any new motor milestones when they would otherwise be unexpected to do so

**OR**

**1.3** Hammersmith Functional Motor Scale Expanded (HFMSE) with ONE of the following:

**1.3.1** Improvement or maintenance of previous improvement of at least a 3-point increase in score from pretreatment baseline

**OR**

**1.3.2** Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so

**OR**

**1.4** Upper Limb Module (ULM) with ONE of the following:

**1.4.1** Improvement or maintenance of previous improvement of at least a 2-point increase in score from pretreatment baseline

**OR**

**1.4.2** Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so

**OR**

**1.5** Motor Function Measure 32 (MFM-32) with ONE of the following:

**1.5.1** Improvement or maintenance of previous improvement of at least a 3-point increase in score from pretreatment baseline

**OR**

**1.5.2** Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so

**AND**

**2** - Patient is not dependent on invasive ventilation or tracheostomy

**AND**

**3** - Patient is not dependent on the use of non-invasive ventilation beyond use for naps and nighttime sleep

**AND**

**4** - Patient is not receiving concomitant chronic SMN-modifying therapy [e.g., Spinraza (nusinersen)]

**AND**

**5** - Patient has not previously received gene replacement therapy for the treatment of spinal muscular atrophy (SMA) [e.g., Zolgensma (onasemnogene abeparvovec-xioi)]

**AND**

**6** - Prescribed by a neurologist with expertise in the treatment of SMA

Exkivity

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146520 |
| **Guideline Name** | Exkivity |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Exkivity | |
|---|---|
| Diagnosis | Non-Small Cell Lung Cancer (NSCLC) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| EXKIVITY | MOBOCERTINIB SUCCINATE CAP 40 MG | 21360050600120 | Brand |

**Approval Criteria**

**1** - Diagnosis of non-small cell lung cancer (NSCLC)

**AND**

**2** - Disease is locally advanced or metastatic

**AND**

**3** - Disease is epidermal growth factor receptor (EGFR) exon 20 insertion mutation positive

**AND**

**4** - Subsequent therapy for disease that has progressed on or after platinum-based chemotherapy

| Product Name: Exkivity | |
|---|---|
| Diagnosis | Non-Small Cell Lung Cancer (NSCLC) |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| EXKIVITY | MOBOCERTINIB SUCCINATE CAP 40 MG | 21360050600120 | Brand |

**Approval Criteria**

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

| Product Name: Exkivity | |
|---|---|
| Diagnosis | NCCN Recommended Regimen |
| Approval Length | 12 month(s) |

| | |
|---|---|
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| EXKIVITY | MOBOCERTINIB SUCCINATE CAP 40 MG | 21360050600120 | Brand |

**Approval Criteria**

**1** - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

| Product Name: Exkivity | |
|---|---|
| Diagnosis | NCCN Recommended Regimen |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| EXKIVITY | MOBOCERTINIB SUCCINATE CAP 40 MG | 21360050600120 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Exkivity therapy

Fabhalta

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-160516 |
| **Guideline Name** | Fabhalta |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 1 . Criteria

| Product Name: Fabhalta | |
|---|---|
| Diagnosis | Paroxysmal nocturnal hemoglobinuria (PNH) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| FABHALTA | IPTACOPAN HCL CAP 200 MG | 85807535200130 | Brand |

**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, Soliris, Ultomiris)

**OR**

**2.2** Patient is currently receiving another complement inhibitor (e.g., Empaveli, PiaSky, Soliris, 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 |
|---|---|

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| FABHALTA | IPTACOPAN HCL CAP 200 MG | 85807535200130 | Brand |

**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, Soliris, 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| FABHALTA | IPTACOPAN HCL CAP 200 MG | 85807535200130 | Brand |

**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 | Primary immunoglobulin A nephropathy (IgAN) |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| FABHALTA | IPTACOPAN HCL CAP 200 MG | 85807535200130 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Fabhalta therapy demonstrated by a reduction in proteinuria

## 2 . Revision History

| Date | Notes |
|---|---|
| 11/12/2024 | Added criteria for IgAN. Updated examples for combination use requi rement for PNH. |

Fasenra

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-154990 |
| **Guideline Name** | Fasenra |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 10/1/2024 |

## 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| FASENRA PEN | BENRALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 30 MG/ML | 4460402000D520 | Brand |

**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:

**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 in 1 second (FEV1) from pretreatment baseline

**OR**

**2.4** Reduction in severity or frequency of asthma-related symptoms (e.g., wheezing, shortness of breath, coughing, etc.)

**OR**

**2.5** 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:

- Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| FASENRA PEN | BENRALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 30 MG/ML | 4460402000D520 | Brand |

**Approval Criteria**

**1** - Diagnosis of severe asthma

**AND**

**2** - Classification of asthma as uncontrolled or inadequately controlled as defined by 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** - 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:

**4.2.1** ONE maximally-dosed (appropriately adjusted for age) ICS product [e.g., ciclesonide (Alvesco), mometasone furoate (Asmanex), beclomethasone dipropionate (QVAR), Arnuity Ellipta (fluticasone furoate)]

**AND**

**4.2.2** 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:

- Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| FASENRA PEN | BENRALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 30 MG/ML | 4460402000D520 | Brand |

**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:

- Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), 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 |
|---|---|
| 9/16/2024 | Modified criteria for existing prior authorization for under the medical benefit. |

Febuxostat

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146331 |
| **Guideline Name** | Febuxostat |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: generic febuxostat | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Step Therapy |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| FEBUXOSTAT | FEBUXOSTAT TAB 40 MG | 68000030000320 | Generic |
| FEBUXOSTAT | FEBUXOSTAT TAB 80 MG | 68000030000330 | Generic |

**Approval Criteria**

**1** - Failure to allopurinol (generic Zyloprim) as confirmed by claims history or submission of medical records

**OR**

**2** - History of contraindication or intolerance to allopurinol (generic Zyloprim) (please specify contraindication or intolerance)

Fentanyl IR

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-155738 |
| **Guideline Name** | Fentanyl IR |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 10/1/2024 |

## 1 . Criteria

| Product Name: Fentanyl citrate lozenges (generic Actiq) | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| FENTANYL CITRATE ORAL TRANSMUCOSAL | FENTANYL CITRATE LOZENGE ON A HANDLE 200 MCG | 65100025108450 | Generic |
| FENTANYL CITRATE ORAL TRANSMUCOSAL | FENTANYL CITRATE LOZENGE ON A HANDLE 400 MCG | 65100025108455 | Generic |
| FENTANYL CITRATE ORAL TRANSMUCOSAL | FENTANYL CITRATE LOZENGE ON A HANDLE 600 MCG | 65100025108460 | Generic |

| | | | |
|---|---|---|---|
| FENTANYL CITRATE ORAL TRANSMUCOSAL | FENTANYL CITRATE LOZENGE ON A HANDLE 800 MCG | 65100025108465 | Generic |
| FENTANYL CITRATE ORAL TRANSMUCOSAL | FENTANYL CITRATE LOZENGE ON A HANDLE 1200 MCG | 65100025108475 | Generic |
| FENTANYL CITRATE ORAL TRANSMUCOSAL | FENTANYL CITRATE LOZENGE ON A HANDLE 1600 MCG | 65100025108485 | Generic |

**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 doses of greater than or equal to 60 milligrams per day
- Fentanyl transdermal patch at a dose of greater than or equal to 25 micrograms per hour
- Oral oxycodone at a dose of greater than or equal to 30 milligrams per day
- Oral hydromorphone at a dose of greater than or equal to 8 milligrams per day
- Oral oxymorphone at a dose of greater than or equal to 25 milligrams per day
- 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 milligrams per day)

**AND**

**3** - The patient is currently taking a long-acting opioid around the clock for cancer pain (Document drug)

**AND**

**4** - ONE of the following:

**4.1** The patient is not concurrently receiving an alternative fentanyl transmucosal product

**OR**

**4.2** BOTH of the following:

**4.2.1** The patient is currently receiving an alternative transmucosal fentanyl product

**AND**

**4.2.2** The prescriber is requesting the termination of all current authorizations for alternative transmucosal fentanyl products in order to begin treatment with the requested medication (Only one transmucosal fentanyl product will be approved at a time. If previous authorizations cannot be terminated, the PA request will be denied)

| Product Name: Brand Actiq, Brand Fentora, fentanyl citrate buccal tablet (authorized generic of Fentora) | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| FENTANYL CITRATE | FENTANYL CITRATE BUCCAL TAB 100 MCG (BASE EQUIV) | 65100025100310 | Generic |
| FENTORA | FENTANYL CITRATE BUCCAL TAB 100 MCG (BASE EQUIV) | 65100025100310 | Generic |
| FENTANYL CITRATE | FENTANYL CITRATE BUCCAL TAB 200 MCG (BASE EQUIV) | 65100025100320 | Generic |
| FENTORA | FENTANYL CITRATE BUCCAL TAB 200 MCG (BASE EQUIV) | 65100025100320 | Generic |
| FENTANYL CITRATE | FENTANYL CITRATE BUCCAL TAB 400 MCG (BASE EQUIV) | 65100025100330 | Generic |
| FENTORA | FENTANYL CITRATE BUCCAL TAB 400 MCG (BASE EQUIV) | 65100025100330 | Generic |
| FENTANYL CITRATE | FENTANYL CITRATE BUCCAL TAB 600 MCG (BASE EQUIV) | 65100025100340 | Generic |
| FENTORA | FENTANYL CITRATE BUCCAL TAB 600 MCG (BASE EQUIV) | 65100025100340 | Generic |
| FENTANYL CITRATE | FENTANYL CITRATE BUCCAL TAB 800 MCG (BASE EQUIV) | 65100025100350 | Generic |
| FENTORA | FENTANYL CITRATE BUCCAL TAB 800 MCG (BASE EQUIV) | 65100025100350 | Generic |

| | | | |
|---|---|---|---|
| ACTIQ | FENTANYL CITRATE LOZENGE ON A HANDLE 200 MCG | 65100025108450 | Brand |
| ACTIQ | FENTANYL CITRATE LOZENGE ON A HANDLE 400 MCG | 65100025108455 | Brand |
| ACTIQ | FENTANYL CITRATE LOZENGE ON A HANDLE 600 MCG | 65100025108460 | Brand |
| ACTIQ | FENTANYL CITRATE LOZENGE ON A HANDLE 800 MCG | 65100025108465 | Brand |
| ACTIQ | FENTANYL CITRATE LOZENGE ON A HANDLE 1200 MCG | 65100025108475 | Brand |
| ACTIQ | FENTANYL CITRATE LOZENGE ON A HANDLE 1600 MCG | 65100025108485 | Brand |
| FENTANYL CITRATE | FENTANYL CITRATE BUCCAL TAB 200 MCG (BASE EQUIV) | 65100025100320 | Brand |
| FENTANYL CITRATE | FENTANYL CITRATE BUCCAL TAB 400 MCG (BASE EQUIV) | 65100025100330 | Brand |
| FENTANYL CITRATE | FENTANYL CITRATE BUCCAL TAB 600 MCG (BASE EQUIV) | 65100025100340 | Brand |
| FENTANYL CITRATE | FENTANYL CITRATE BUCCAL TAB 800 MCG (BASE EQUIV) | 65100025100350 | Brand |

**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 doses of greater than or equal to 60 milligrams per day
- Fentanyl transdermal patch at a dose of greater than or equal to 25 micrograms per hour
- Oral oxycodone at a dose of greater than or equal to 30 milligrams per day
- Oral hydromorphone at a dose of greater than or equal to 8 milligrams per day
- Oral oxymorphone at a dose of greater than or equal to 25 milligrams per day
- 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 milligrams per day)

**AND**

**3** - The patient is currently taking a long-acting opioid around the clock for cancer pain (Document drug)

**AND**

**4** - ONE of the following:

**4.1** The patient is not concurrently receiving an alternative fentanyl transmucosal product

**OR**

**4.2** BOTH of the following:

**4.2.1** The patient is currently receiving an alternative transmucosal fentanyl product

**AND**

**4.2.2** The prescriber is requesting the termination of all current authorizations for alternative transmucosal fentanyl products in order to begin treatment with the requested medication (Only one transmucosal fentanyl product will be approved at a time. If previous authorizations cannot be terminated, the PA request will be denied)

**AND**

**5** - One of the following:

- Failure to fentanyl citrate lozenges (generic Actiq) confirmed by claims history or submission of medical records
- History of intolerance or contraindication to fentanyl citrate lozenges (generic Actiq) (document intolerance or contraindication)

## 2 . Revision History

| Date | Notes |
| --- | --- |
| 9/23/2024 | Removed Lazanda and Subsys as they are no longer on the market. |

Filspari

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-160472 |
| **Guideline Name** | Filspari |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| FILSPARI | SPARSENTAN TAB 200 MG | 56483065000320 | Brand |
| FILSPARI | SPARSENTAN TAB 400 MG | 56483065000340 | Brand |

**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:

**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: Filspari | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| FILSPARI | SPARSENTAN TAB 200 MG | 56483065000320 | Brand |
| FILSPARI | SPARSENTAN TAB 400 MG | 56483065000340 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response demonstrated by a reduction in proteinuria

## 2 . Revision History

| Date | Notes |
| --- | --- |
| 11/12/2024 | Updated disease progression criteria and added criteria that use is to slow kidney decline |

Filsuvez

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-147343 |
| **Guideline Name** | Filsuvez |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| FILSUVEZ | BIRCH TRITERPENES GEL 10% | 90944020004030 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| FILSUVEZ | BIRCH TRITERPENES GEL 10% | 90944020004030 | Brand |

**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 |
|---|---|
| 5/13/2024 | Copy core |

Firazyr, Sajazir

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-148035 |
| **Guideline Name** | Firazyr, Sajazir |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Sajazir, Brand Firazyr, generic icatibant | |
|---|---|
| Diagnosis | Hereditary angioedema (HAE) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SAJAZIR | ICATIBANT ACETATE SUBCUTANEOUS SOLN PREF SYR 30 MG/3ML | 8582004010E520 | Generic |
| FIRAZYR | ICATIBANT ACETATE SUBCUTANEOUS SOLN PREF SYR 30 MG/3ML | 8582004010E520 | Brand |
| ICATIBANT ACETATE | ICATIBANT ACETATE SUBCUTANEOUS SOLN PREF SYR 30 MG/3ML | 8582004010E520 | Generic |

**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, Kalbitor, or Ruconest)

**AND**

**4** - Prescribed by ONE of the following:

- Immunologist
- Allergist

| Product Name: Sajazir, Brand Firazyr, generic icatibant | |
|---|---|
| Diagnosis | Hereditary angioedema (HAE) |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SAJAZIR | ICATIBANT ACETATE SUBCUTANEOUS SOLN PREF SYR 30 MG/3ML | 8582004010E520 | Generic |
| FIRAZYR | ICATIBANT ACETATE SUBCUTANEOUS SOLN PREF SYR 30 MG/3ML | 8582004010E520 | Brand |
| ICATIBANT ACETATE | ICATIBANT ACETATE SUBCUTANEOUS SOLN PREF SYR 30 MG/3ML | 8582004010E520 | Generic |

**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, Kalbitor, or Ruconest)

**AND**

**4** - Prescribed by ONE of the following:

- Immunologist
- Allergist

## 2 . Revision History

| Date | Notes |
|---|---|
| 6/3/2024 | Update to types of genetic variant(s) and diagnostic criteria with normal C1 inhibitor levels in initial auth section and minor language update in reauth section. |

Firdapse

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146525 |
| **Guideline Name** | Firdapse |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| FIRDAPSE | AMIFAMPRIDINE PHOSPHATE TAB 10 MG (BASE EQUIVALENT) | 76000012100320 | Brand |

**Approval Criteria**

**1** - Patient has a diagnosis of Lambert-Eaton myasthenic syndrome (LEMS)

**AND**

**2** - Prescribed by or in consultation with a specialist in the treatment of LEMS (e.g., neurologist or oncologist)

**AND**

**3** - Patient is not receiving Firdapse in combination with similar potassium channel blockers [e.g., Ampyra (dalfampridine)]

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| FIRDAPSE | AMIFAMPRIDINE PHOSPHATE TAB 10 MG (BASE EQUIVALENT) | 76000012100320 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Firdapse therapy

**AND**

**2** - Patient is not receiving Firdapse in combination with similar potassium channel blockers [e.g., Ampyra (dalfampridine)]

Fortamet, Glumetza

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146333 |
| **Guideline Name** | Fortamet, Glumetza |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: generic metformin extended-release (generic Fortamet) | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| METFORMIN HYDROCHLORIDE ER | METFORMIN HCL TAB ER 24HR OSMOTIC 500 MG | 27250050007560 | Generic |
| METFORMIN HYDROCHLORIDE ER | METFORMIN HCL TAB ER 24HR OSMOTIC 1000 MG | 27250050007570 | Generic |
| Fortamet | | | |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| METFORMIN HYDROCHLORIDE ER | METFORMIN HCL TAB ER 24HR MODIFIED RELEASE 500 MG | 27250050007580 | Generic |
| METFORMIN HYDROCHLORIDE ER | METFORMIN HCL TAB ER 24HR MODIFIED RELEASE 1000 MG | 27250050007590 | Generic |
| GLUMETZA | METFORMIN HCL TAB ER 24HR MODIFIED RELEASE 500 MG | 27250050007580 | Brand |
| GLUMETZA | METFORMIN HCL TAB ER 24HR MODIFIED RELEASE 1000 MG | 27250050007590 | Brand |

**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)

Forteo

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-161184 |
| **Guideline Name** | Forteo |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 1 . Criteria

| Product Name: Brand Forteo, generic teriparatide, brand Teriparatide | |
|---|---|
| Diagnosis | Osteoporosis |
| Approval Length | 24 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TERIPARATIDE | TERIPARATIDE (RECOMBINANT) SOLN PEN-INJ 620 MCG/2.48ML | 3004407000D221 | Brand |
| FORTEO | TERIPARATIDE (RECOMBINANT) SOLN PEN-INJ 600 MCG/2.4ML | 3004407000D220 | Brand |
| TERIPARATIDE | TERIPARATIDE SOLN PEN-INJ 600 MCG/2.4ML | 3004407000D220 | Generic |

**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., 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., 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** - 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)

| Product Name: Brand Forteo, generic teriparatide, brand Teriparatide | |
|---|---|
| Diagnosis | Osteoporosis Associated with Sustained Systemic Glucocorticoid Therapy |
| Approval Length | 24 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TERIPARATIDE | TERIPARATIDE (RECOMBINANT) SOLN PEN-INJ 620 MCG/2.48ML | 3004407000D221 | Brand |
| FORTEO | TERIPARATIDE (RECOMBINANT) SOLN PEN-INJ 600 MCG/2.4ML | 3004407000D220 | Brand |
| TERIPARATIDE | TERIPARATIDE SOLN PEN-INJ 600 MCG/2.4ML | 3004407000D220 | Generic |

**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., 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., 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

| Product Name: Brand Forteo, generic teriparatide, brand Teriparatide | |
|---|---|
| Diagnosis | Osteoporosis, Osteoporosis Associated with Sustained Systemic Glucocorticoid Therapy |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TERIPARATIDE | TERIPARATIDE (RECOMBINANT) SOLN PEN-INJ 620 MCG/2.48ML | 3004407000D221 | Brand |
| FORTEO | TERIPARATIDE (RECOMBINANT) SOLN PEN-INJ 600 MCG/2.4ML | 3004407000D220 | Brand |
| TERIPARATIDE | TERIPARATIDE SOLN PEN-INJ 600 MCG/2.4ML | 3004407000D220 | Generic |

**Approval Criteria**

**1** - Treatment duration of parathyroid hormones (e.g., 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., teriparatide injection, Forteo, Tymlos)

Fotivda

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146527 |
| **Guideline Name** | Fotivda |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Fotivda | |
|---|---|
| Diagnosis | Renal Cell Carcinoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| FOTIVDA | TIVOZANIB HCL CAP 0.89 MG (BASE EQUIVALENT) | 21533076250120 | Brand |
| FOTIVDA | TIVOZANIB HCL CAP 1.34 MG (BASE EQUIVALENT) | 21533076250130 | Brand |

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| FOTIVDA | TIVOZANIB HCL CAP 0.89 MG (BASE EQUIVALENT) | 21533076250120 | Brand |
| FOTIVDA | TIVOZANIB HCL CAP 1.34 MG (BASE EQUIVALENT) | 21533076250130 | Brand |

**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 |
|---|---|

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| FOTIVDA | TIVOZANIB HCL CAP 0.89 MG (BASE EQUIVALENT) | 21533076250120 | Brand |
| FOTIVDA | TIVOZANIB HCL CAP 1.34 MG (BASE EQUIVALENT) | 21533076250130 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| FOTIVDA | TIVOZANIB HCL CAP 0.89 MG (BASE EQUIVALENT) | 21533076250120 | Brand |
| FOTIVDA | TIVOZANIB HCL CAP 1.34 MG (BASE EQUIVALENT) | 21533076250130 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Fotivda therapy

Fruzaqla

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146528 |
| **Guideline Name** | Fruzaqla |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Fruzaqla | |
|---|---|
| Diagnosis | Colorectal Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| FRUZAQLA | FRUQUINTINIB CAP 1 MG | 21335035000120 | Brand |
| FRUZAQLA | FRUQUINTINIB CAP 5 MG | 21335035000140 | Brand |

**Approval Criteria**

**1** - Diagnosis of colorectal cancer

**AND**

**2** - Disease of 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 | Colorectal Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| FRUZAQLA | FRUQUINTINIB CAP 1 MG | 21335035000120 | Brand |
| FRUZAQLA | FRUQUINTINIB CAP 5 MG | 21335035000140 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| FRUZAQLA | FRUQUINTINIB CAP 1 MG | 21335035000120 | Brand |
| FRUZAQLA | FRUQUINTINIB CAP 5 MG | 21335035000140 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| FRUZAQLA | FRUQUINTINIB CAP 1 MG | 21335035000120 | Brand |
| FRUZAQLA | FRUQUINTINIB CAP 5 MG | 21335035000140 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Fruzaqla therapy

Furoscix

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-160541 |
| **Guideline Name** | Furoscix |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 1 . Criteria

| Product Name: Furoscix | |
|---|---|
| Approval Length | 1 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| FUROSCIX | FUROSEMIDE SUBCUTANEOUS CARTRIDGE KIT 80 MG/10ML | 3720003000F720 | Brand |

**Approval Criteria**

**1** - Diagnosis of chronic heart failure

**AND**

**2** - Patient has signs or symptoms of congestion due to fluid overload

**AND**

**3** - Patient is established on background loop diuretic therapy (e.g., bumetanide, furosemide, torsemide)

**AND**

**4** - Both of the following:

**4.1** Patient does not require ongoing emergency care or hospitalization for heart failure, acute pulmonary edema, or other conditions

**AND**

**4.2** Patient is currently a candidate for parenteral diuresis outside of the hospital

**AND**

**5** - Patient has an estimated creatine clearance greater than 30ml/min

**AND**

**6** - Furoscix is prescribed by or in consultation with a cardiologist

## 2 . Revision History

| Date | Notes |
|---|---|
| 11/12/2024 | Removed criteria requiring NYHA Class II or III HF |

Galafold

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146529 |
| **Guideline Name** | Galafold |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Galafold | |
|---|---|
| Diagnosis | Fabry Disease |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| GALAFOLD | MIGALASTAT HCL CAP 123 MG (BASE EQUIVALENT) | 30903650100120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| GALAFOLD | MIGALASTAT HCL CAP 123 MG (BASE EQUIVALENT) | 30903650100120 | Brand |

**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)

Gattex

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146530 |
| **Guideline Name** | Gattex |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| GATTEX | TEDUGLUTIDE (RDNA) FOR INJ KIT 5 MG | 52533070006420 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| GATTEX | TEDUGLUTIDE (RDNA) FOR INJ KIT 5 MG | 52533070006420 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Gattex therapy

Gavreto

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146531 |
| **Guideline Name** | Gavreto |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| GAVRETO | PRALSETINIB CAP 100 MG | 21535750000120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| GAVRETO | PRALSETINIB CAP 100 MG | 21535750000120 | Brand |

**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** 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 medullary carcinoma

**AND**

**2.2** ONE of the following:

- Disease is recurrent, persistent, or progressive
- Disease is symptomatic with distant metastases

**AND**

**2.3** Disease is RET-mutation positive

**OR**

**3** - ALL of the following:

**3.1** Diagnosis of anaplastic carcinoma

**AND**

**3.2** ONE of the following:

- Disease is stage IVA or IVB (locoregional)
- Disease is metastatic

**AND**

**3.3** Disease is RET gene fusion positive

| Product Name: Gavreto | |
|---|---|
| Diagnosis | Hepatobiliary Cancers |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| GAVRETO | PRALSETINIB CAP 100 MG | 21535750000120 | Brand |

**Approval Criteria**

**1** - Diagnosis of ONE of the following:

- Gallbladder cancer
- Extrahepatic cholangiocarcinoma
- Intrahepatic cholangiocarcinoma

**AND**

**2** - Disease is ONE of the following:

- Unresectable
- Resected gross residual (R2)

- Metastatic

**AND**

**3** - Disease is RET gene fusion positive

| Product Name: Gavreto | |
|---|---|
| Diagnosis | Non-Small Cell Lung Cancer (NSCLC), Thyroid Carcinoma, Hepatobiliary Cancers |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| GAVRETO | PRALSETINIB CAP 100 MG | 21535750000120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| GAVRETO | PRALSETINIB CAP 100 MG | 21535750000120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| GAVRETO | PRALSETINIB CAP 100 MG | 21535750000120 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Gavreto therapy

Genvoya and Stribild

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146335 |
| **Guideline Name** | Genvoya and Stribild |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Genvoya, Stribild | |
|---|---|
| Diagnosis | Human Immunodeficiency Virus (HIV) |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| GENVOYA | ELVITEGRAV-COBIC-EMTRICITAB-TENOFOV AF TAB 150-150-200-10 MG | 12109904290315 | Brand |
| STRIBILD | ELVITEGRAV-COBIC-EMTRICITAB-TENOFOVDF TAB 150-150-200-300 MG | 12109904300320 | Brand |

**Approval Criteria**

**1** - Diagnosis of human immunodeficiency virus (HIV)

**AND**

**2** - ONE of the following:

**2.1** Patient is not an appropriate candidate for ALL of the following (please specify why patient is not a candidate):

- efavirenz/emtricitabine/tenofovir disoproxil (generic Atripla)
- Triumeq (abacavir/dolutegravir/lamivudine)
- Juluca (dolutegravir/rilpivirine)
- Dovato (dolutegravir/lamivudine)

**OR**

**2.2** Patient is currently on Genvoya or Stribild therapy

| Product Name: Genvoya, Stribild | |
|---|---|
| Diagnosis | Post-Exposure Prophylaxis |
| Approval Length | 4 Week(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| GENVOYA | ELVITEGRAV-COBIC-EMTRICITAB-TENOFOV AF TAB 150-150-200-10 MG | 12109904290315 | Brand |
| STRIBILD | ELVITEGRAV-COBIC-EMTRICITAB-TENOFOVDF TAB 150-150-200-300 MG | 12109904300320 | Brand |

**Approval Criteria**

**1** - Diagnosis of post-exposure prophylaxis

Gilotrif

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146532 |
| **Guideline Name** | Gilotrif |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| GILOTRIF | AFATINIB DIMALEATE TAB 20 MG (BASE EQUIVALENT) | 21360006100320 | Brand |
| GILOTRIF | AFATINIB DIMALEATE TAB 30 MG (BASE EQUIVALENT) | 21360006100330 | Brand |
| GILOTRIF | AFATINIB DIMALEATE TAB 40 MG (BASE EQUIVALENT) | 21360006100340 | Brand |

**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 | Advanced Non-Nasopharyngeal Head and Neck Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| GILOTRIF | AFATINIB DIMALEATE TAB 20 MG (BASE EQUIVALENT) | 21360006100320 | Brand |
| GILOTRIF | AFATINIB DIMALEATE TAB 30 MG (BASE EQUIVALENT) | 21360006100330 | Brand |
| GILOTRIF | AFATINIB DIMALEATE TAB 40 MG (BASE EQUIVALENT) | 21360006100340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| GILOTRIF | AFATINIB DIMALEATE TAB 20 MG (BASE EQUIVALENT) | 21360006100320 | Brand |
| GILOTRIF | AFATINIB DIMALEATE TAB 30 MG (BASE EQUIVALENT) | 21360006100330 | Brand |
| GILOTRIF | AFATINIB DIMALEATE TAB 40 MG (BASE EQUIVALENT) | 21360006100340 | Brand |

**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), Advanced Non-Nasopharyngeal Head and Neck Cancer, Brain Metastases |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| GILOTRIF | AFATINIB DIMALEATE TAB 20 MG (BASE EQUIVALENT) | 21360006100320 | Brand |
| GILOTRIF | AFATINIB DIMALEATE TAB 30 MG (BASE EQUIVALENT) | 21360006100330 | Brand |
| GILOTRIF | AFATINIB DIMALEATE TAB 40 MG (BASE EQUIVALENT) | 21360006100340 | Brand |

**Approval Criteria**

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

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| GILOTRIF | AFATINIB DIMALEATE TAB 20 MG (BASE EQUIVALENT) | 21360006100320 | Brand |
| GILOTRIF | AFATINIB DIMALEATE TAB 30 MG (BASE EQUIVALENT) | 21360006100330 | Brand |
| GILOTRIF | AFATINIB DIMALEATE TAB 40 MG (BASE EQUIVALENT) | 21360006100340 | Brand |

**Approval Criteria**

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

| Product Name: Gilotrif | |
|---|---|
| Diagnosis | NCCN Recommended Regimen |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| GILOTRIF | AFATINIB DIMALEATE TAB 20 MG (BASE EQUIVALENT) | 21360006100320 | Brand |
| GILOTRIF | AFATINIB DIMALEATE TAB 30 MG (BASE EQUIVALENT) | 21360006100330 | Brand |
| GILOTRIF | AFATINIB DIMALEATE TAB 40 MG (BASE EQUIVALENT) | 21360006100340 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Gilotrif therapy

Gleevec

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146533 |
| **Guideline Name** | Gleevec |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Brand Gleevec, generic imatinib | |
|---|---|
| Diagnosis | Chronic Myelogenous/Myeloid Leukemia |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| IMATINIB MESYLATE | IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT) | 21531835100320 | Generic |
| GLEEVEC | IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT) | 21531835100320 | Brand |
| IMATINIB MESYLATE | IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT) | 21531835100340 | Generic |

| | | | |
|---|---|---|---|
| GLEEVEC | IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT) | 21531835100340 | Brand |

**Approval Criteria**

**1** - Diagnosis of chronic myelogenous/myeloid leukemia (CML)

| Product Name: Brand Gleevec, generic imatinib | |
|---|---|
| Diagnosis | Acute Lymphoblastic Leukemia (ALL) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| IMATINIB MESYLATE | IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT) | 21531835100320 | Generic |
| GLEEVEC | IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT) | 21531835100320 | Brand |
| IMATINIB MESYLATE | IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT) | 21531835100340 | Generic |
| GLEEVEC | IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT) | 21531835100340 | Brand |

**Approval Criteria**

**1** - Diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ALL)

| Product Name: Brand Gleevec, generic imatinib | |
|---|---|
| Diagnosis | Myelodysplastic Disease (MDS)/Myeloproliferative Disease (MPD) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| IMATINIB MESYLATE | IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT) | 21531835100320 | Generic |
| GLEEVEC | IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT) | 21531835100320 | Brand |
| IMATINIB MESYLATE | IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT) | 21531835100340 | Generic |
| GLEEVEC | IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT) | 21531835100340 | Brand |

**Approval Criteria**

**1** - Diagnosis of myelodysplastic/myeloproliferative disease (MDS/MPD)

**AND**

**2** - Platelet-derived growth factor receptor (PDGFR) gene re-arrangements

| Product Name: Brand Gleevec, generic imatinib | |
|---|---|
| Diagnosis | Aggressive Systemic Mastocytosis (ASM) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| IMATINIB MESYLATE | IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT) | 21531835100320 | Generic |
| GLEEVEC | IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT) | 21531835100320 | Brand |
| IMATINIB MESYLATE | IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT) | 21531835100340 | Generic |
| GLEEVEC | IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT) | 21531835100340 | Brand |

**Approval Criteria**

**1** - Diagnosis of aggressive systemic mastocytosis (ASM)

**AND**

**2** - ONE of the following:

- Kit D816V mutation negative or unknown
- Well-differentiated SM [WDSM]
- Eosinophilia is present with FIP1L1-PDGFRA fusion gene

| Product Name: Brand Gleevec, generic imatinib | |
|---|---|
| Diagnosis | Hypereosinophilic Syndrome (HES)/Chronic Eosinophilic Leukemia (CEL) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| IMATINIB MESYLATE | IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT) | 21531835100320 | Generic |
| GLEEVEC | IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT) | 21531835100320 | Brand |
| IMATINIB MESYLATE | IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT) | 21531835100340 | Generic |
| GLEEVEC | IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT) | 21531835100340 | Brand |

**Approval Criteria**

**1** - Diagnosis of at least ONE of the following:

- Hypereosinophilic syndrome (HES)
- Chronic eosinophilic leukemia (CEL)

| Product Name: Brand Gleevec, generic imatinib | |
|---|---|
| Diagnosis | Dermatofibrosarcoma Protuberans (DFSP) |

| | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| IMATINIB MESYLATE | IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT) | 21531835100320 | Generic |
| GLEEVEC | IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT) | 21531835100320 | Brand |
| IMATINIB MESYLATE | IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT) | 21531835100340 | Generic |
| GLEEVEC | IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT) | 21531835100340 | Brand |

**Approval Criteria**

**1** - Diagnosis of dermatofibrosarcoma protuberans (DFSP)

| Product Name: Brand Gleevec, generic imatinib | |
|---|---|
| Diagnosis | Soft Tissue Sarcoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| IMATINIB MESYLATE | IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT) | 21531835100320 | Generic |
| GLEEVEC | IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT) | 21531835100320 | Brand |
| IMATINIB MESYLATE | IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT) | 21531835100340 | Generic |
| GLEEVEC | IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT) | 21531835100340 | Brand |

**Approval Criteria**

**1** - Diagnosis of ONE of the following:

- Gastrointestinal stromal tumors (GIST)
- Desmoid tumors/aggressive fibromatosis
- Pigmented villonodular synovitis (PVNS)/tenosynovial giant cell tumor (TGCT)

| Product Name: Brand Gleevec, generic imatinib | |
|---|---|
| Diagnosis | Chordoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| IMATINIB MESYLATE | IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT) | 21531835100320 | Generic |
| GLEEVEC | IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT) | 21531835100320 | Brand |
| IMATINIB MESYLATE | IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT) | 21531835100340 | Generic |
| GLEEVEC | IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT) | 21531835100340 | Brand |

**Approval Criteria**

**1** - Diagnosis of chordoma

| Product Name: Brand Gleevec, generic imatinib | |
|---|---|
| Diagnosis | Melanoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| IMATINIB MESYLATE | IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT) | 21531835100320 | Generic |
| GLEEVEC | IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT) | 21531835100320 | Brand |

| | | | |
|---|---|---|---|
| IMATINIB MESYLATE | IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT) | 21531835100340 | Generic |
| GLEEVEC | IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT) | 21531835100340 | Brand |

**Approval Criteria**

**1** - Diagnosis of melanoma

**AND**

**2** - Patient has C-KIT (gene) mutation

| Product Name: Brand Gleevec, generic imatinib | |
|---|---|
| Diagnosis | AIDS-Related Kaposi Sarcoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| IMATINIB MESYLATE | IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT) | 21531835100320 | Generic |
| GLEEVEC | IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT) | 21531835100320 | Brand |
| IMATINIB MESYLATE | IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT) | 21531835100340 | Generic |
| GLEEVEC | IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT) | 21531835100340 | Brand |

**Approval Criteria**

**1** - Diagnosis of AIDS (acquired immunodeficiency syndrome)-related Kaposi Sarcoma

**AND**

**2** - Not used as first line therapy

| Product Name: Brand Gleevec, generic imatinib | |
|---|---|
| Diagnosis | Steroid-Refractory Chronic Graft-Versus-Host Disease (GVHD) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| IMATINIB MESYLATE | IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT) | 21531835100320 | Generic |
| GLEEVEC | IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT) | 21531835100320 | Brand |
| IMATINIB MESYLATE | IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT) | 21531835100340 | Generic |
| GLEEVEC | IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT) | 21531835100340 | Brand |

**Approval Criteria**

**1** - Diagnosis of chronic graft-versus-host disease

**AND**

**2** - Patient is being treated with systemic corticosteroids

**AND**

**3** - Patient had no response to first-line therapy options

| Product Name: Brand Gleevec, generic imatinib | |
|---|---|
| Diagnosis | Myeloid/Lymphoid Neoplasms with Eosinophilia |
| Approval Length | 12 month(s) |

| Therapy Stage | Initial Authorization |
|---|---|
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| IMATINIB MESYLATE | IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT) | 21531835100320 | Generic |
| GLEEVEC | IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT) | 21531835100320 | Brand |
| IMATINIB MESYLATE | IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT) | 21531835100340 | Generic |
| GLEEVEC | IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT) | 21531835100340 | Brand |

**Approval Criteria**

**1** - Diagnosis of lymphoid, myeloid, or mixed lineage neoplasms with eosinophilia

**AND**

**2** - ONE of the following:

- FIP1L1-PDGFRA rearrangement
- PDGFRB rearrangement
- ABL1 rearrangement

| Product Name: Brand Gleevec, generic imatinib | |
|---|---|
| Diagnosis | All Indications except NCCN |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| IMATINIB MESYLATE | IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT) | 21531835100320 | Generic |
| GLEEVEC | IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT) | 21531835100320 | Brand |

| | | | |
|---|---|---|---|
| IMATINIB MESYLATE | IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT) | 21531835100340 | Generic |
| GLEEVEC | IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT) | 21531835100340 | Brand |

**Approval Criteria**

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

| Product Name: Brand Gleevec, generic imatinib | |
|---|---|
| Diagnosis | NCCN Recommended Regimen |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| IMATINIB MESYLATE | IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT) | 21531835100320 | Generic |
| GLEEVEC | IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT) | 21531835100320 | Brand |
| IMATINIB MESYLATE | IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT) | 21531835100340 | Generic |
| GLEEVEC | IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT) | 21531835100340 | Brand |

**Approval Criteria**

**1** - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

| Product Name: Brand Gleevec, generic imatinib | |
|---|---|
| Diagnosis | NCCN Recommended Regimen |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| IMATINIB MESYLATE | IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT) | 21531835100320 | Generic |
| GLEEVEC | IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT) | 21531835100320 | Brand |
| IMATINIB MESYLATE | IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT) | 21531835100340 | Generic |
| GLEEVEC | IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT) | 21531835100340 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Gleevec therapy

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-156323 |
| **Guideline Name** | GLP-1 & Dual GIP/GLP-1 Receptor Agonists |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 11/1/2024 |

## 1 . Criteria

| Product Name: Victoza 1.2mg per day (2 Pen Pack), liraglutide 1.2mg per day (2 Pen Pack), Mounjaro, Ozempic, Rybelsus | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VICTOZA | LIRAGLUTIDE SOLN PEN-INJECTOR 18 MG/3ML (6 MG/ML) | 2717005000D220 | Brand |
| MOUNJARO | TIRZEPATIDE SOLN PEN-INJECTOR 2.5 MG/0.5ML | 2717308000D510 | Brand |
| MOUNJARO | TIRZEPATIDE SOLN PEN-INJECTOR 5 MG/0.5ML | 2717308000D515 | Brand |
| MOUNJARO | TIRZEPATIDE SOLN PEN-INJECTOR 7.5 MG/0.5ML | 2717308000D520 | Brand |
| MOUNJARO | TIRZEPATIDE SOLN PEN-INJECTOR 10 MG/0.5ML | 2717308000D525 | Brand |

| | | | |
|---|---|---|---|
| MOUNJARO | TIRZEPATIDE SOLN PEN-INJECTOR 12.5 MG/0.5ML | 2717308000D530 | Brand |
| MOUNJARO | TIRZEPATIDE SOLN PEN-INJECTOR 15 MG/0.5ML | 2717308000D535 | Brand |
| OZEMPIC | SEMAGLUTIDE SOLN PEN-INJ 0.25 OR 0.5 MG/DOSE (2 MG/3ML) | 2717007000D221 | Brand |
| OZEMPIC | SEMAGLUTIDE SOLN PEN-INJ 1 MG/DOSE (4 MG/3ML) | 2717007000D222 | Brand |
| OZEMPIC | SEMAGLUTIDE SOLN PEN-INJ 2 MG/DOSE (8 MG/3ML) | 2717007000D225 | Brand |
| RYBELSUS | SEMAGLUTIDE TAB 3 MG | 27170070000310 | Brand |
| RYBELSUS | SEMAGLUTIDE TAB 7 MG | 27170070000320 | Brand |
| RYBELSUS | SEMAGLUTIDE TAB 14 MG | 27170070000330 | Brand |
| LIRAGLUTIDE | LIRAGLUTIDE SOLN PEN-INJECTOR 18 MG/3ML (6 MG/ML) | 2717005000D220 | Generic |
| VICTOZA | LIRAGLUTIDE SOLN PEN-INJECTOR 18 MG/3ML (6 MG/ML) | 2717005000D220 | Generic |
| MOUNJARO | TIRZEPATIDE SOLN AUTO-INJECTOR 2.5 MG/0.5ML | 2717308000D510 | Brand |
| MOUNJARO | TIRZEPATIDE SOLN AUTO-INJECTOR 5 MG/0.5ML | 2717308000D515 | Brand |
| MOUNJARO | TIRZEPATIDE SOLN AUTO-INJECTOR 7.5 MG/0.5ML | 2717308000D520 | Brand |
| MOUNJARO | TIRZEPATIDE SOLN AUTO-INJECTOR 10 MG/0.5ML | 2717308000D525 | Brand |
| MOUNJARO | TIRZEPATIDE SOLN AUTO-INJECTOR 12.5 MG/0.5ML | 2717308000D530 | Brand |
| MOUNJARO | TIRZEPATIDE SOLN AUTO-INJECTOR 15 MG/0.5ML | 2717308000D535 | Brand |

**Approval Criteria**

**1** - Confirmation of type 2 diabetes mellitus via medical records (i.e., medical documentation confirming type 2 diabetes mellitus, medical claims history) or prescriber attestation

**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: Victoza 1.8mg per day (3 Pen Pack), liraglutide 1.8mg per day (3 Pen Pack) | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VICTOZA | LIRAGLUTIDE SOLN PEN-INJECTOR 18 MG/3ML (6 MG/ML) | 2717005000D220 | Brand |
| LIRAGLUTIDE | LIRAGLUTIDE SOLN PEN-INJECTOR 18 MG/3ML (6 MG/ML) | 2717005000D220 | Generic |
| VICTOZA | LIRAGLUTIDE SOLN PEN-INJECTOR 18 MG/3ML (6 MG/ML) | 2717005000D220 | Generic |

**Approval Criteria**

**1** - Diagnosis of type 2 diabetes mellitus confirmed by submission of medical records (i.e., chart notes, medical claims history)

**AND**

**2** - ONE of the following:

**2.1** 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

**OR**

**2.2** History of contraindication or intolerance to metformin (please specify contraindication or intolerance)

**AND**

**3** - History of failure to achieve acceptable glycemic control with Victoza 1.2mg per day for 90 days (2 Pen Pack), as confirmed by claims history or submission of medical records

| Product Name: Bydureon BCise, Byetta, Trulicity | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BYDUREON BCISE | EXENATIDE EXTENDED RELEASE SUSP AUTO-INJECTOR 2 MG/0.85ML | 2717002000D420 | Brand |
| BYETTA | EXENATIDE SOLN PEN-INJECTOR 5 MCG/0.02ML | 2717002000D220 | Brand |
| BYETTA | EXENATIDE SOLN PEN-INJECTOR 10 MCG/0.04ML | 2717002000D240 | Brand |
| TRULICITY | DULAGLUTIDE SOLN PEN-INJECTOR 0.75 MG/0.5ML | 2717001500D520 | Brand |
| TRULICITY | DULAGLUTIDE SOLN PEN-INJECTOR 1.5 MG/0.5ML | 2717001500D530 | Brand |
| TRULICITY | DULAGLUTIDE SOLN PEN-INJECTOR 3 MG/0.5ML | 2717001500D540 | Brand |
| TRULICITY | DULAGLUTIDE SOLN PEN-INJECTOR 4.5 MG/0.5ML | 2717001500D550 | Brand |
| TRULICITY | DULAGLUTIDE SOLN AUTO-INJECTOR 0.75 MG/0.5ML | 2717001500D520 | Brand |
| TRULICITY | DULAGLUTIDE SOLN AUTO-INJECTOR 1.5 MG/0.5ML | 2717001500D530 | Brand |
| TRULICITY | DULAGLUTIDE SOLN AUTO-INJECTOR 3 MG/0.5ML | 2717001500D540 | Brand |

| TRULICITY | DULAGLUTIDE SOLN AUTO-INJECTOR 4.5 MG/0.5ML | 2717001500D550 | Brand |
|---|---|---|---|

**Approval Criteria**

**1** - Diagnosis of type 2 diabetes mellitus confirmed by submission of medical records (i.e., chart notes, medical claims history)

**AND**

**2** - ONE of the following:

**2.1** 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

**OR**

**2.2** 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 |

## 2 . Revision History

| Date | Notes |
|---|---|
| 9/26/2024 | Added liraglutide |

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-161334 |
| **Guideline Name** | Gonadotropin-Releasing Hormone Agonists |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 1 . Criteria

| Product Name: leuprolide acetate inj kit 5 mg/mL, Lupron Depot-Ped, Triptodur, Fensolvi | |
|---|---|
| Diagnosis | Central Precocious Puberty (CPP) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LUPRON DEPOT-PED (1-MONTH) | LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 7.5 MG | 30080050106420 | Brand |
| LUPRON DEPOT-PED (1-MONTH) | LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 11.25 MG | 30080050106430 | Brand |

| | | | |
|---|---|---|---|
| LUPRON DEPOT-PED (1-MONTH) | LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 15 MG | 30080050106440 | Brand |
| LUPRON DEPOT-PED (3-MONTH) | LEUPROLIDE ACETATE (3 MONTH) FOR INJ PEDIATRIC KIT 11.25 MG | 30080050156420 | Brand |
| LUPRON DEPOT-PED (3-MONTH) | LEUPROLIDE ACETATE (3 MONTH) FOR INJ PEDIATRIC KIT 30 MG | 30080050156440 | Brand |
| TRIPTODUR | TRIPTORELIN PAMOATE FOR IM ER SUSP 22.5 MG (BASE EQUIV) | 3008007040G240 | Brand |
| FENSOLVI | LEUPROLIDE ACET (6 MONTH) FOR INJ PEDIATRIC KIT 45 MG | 30080050256450 | Brand |
| LEUPROLIDE ACETATE | LEUPROLIDE ACETATE INJ KIT 1 MG/0.2ML (5 MG/ML) | 21405010106407 | Generic |
| LUPRON DEPOT-PED (6-MONTH) | LEUPROLIDE ACET (6 MONTH) FOR IM INJ PEDIATRIC KIT 45 MG | 30080050256460 | Brand |

**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: leuprolide acetate inj kit 5 mg/mL, Lupron Depot-Ped, Triptodur, Fensolvi | |
|---|---|
| Diagnosis | Central Precocious Puberty (CPP) |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LUPRON DEPOT-PED (1-MONTH) | LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 7.5 MG | 30080050106420 | Brand |
| LUPRON DEPOT-PED (1-MONTH) | LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 11.25 MG | 30080050106430 | Brand |

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|---|---|---|---|
| LUPRON DEPOT-PED (1-MONTH) | LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 15 MG | 30080050106440 | Brand |
| LUPRON DEPOT-PED (3-MONTH) | LEUPROLIDE ACETATE (3 MONTH) FOR INJ PEDIATRIC KIT 11.25 MG | 30080050156420 | Brand |
| LUPRON DEPOT-PED (3-MONTH) | LEUPROLIDE ACETATE (3 MONTH) FOR INJ PEDIATRIC KIT 30 MG | 30080050156440 | Brand |
| FENSOLVI | LEUPROLIDE ACET (6 MONTH) FOR INJ PEDIATRIC KIT 45 MG | 30080050256450 | Brand |
| TRIPTODUR | TRIPTORELIN PAMOATE FOR IM ER SUSP 22.5 MG (BASE EQUIV) | 3008007040G240 | Brand |
| LEUPROLIDE ACETATE | LEUPROLIDE ACETATE INJ KIT 1 MG/0.2ML (5 MG/ML) | 21405010106407 | Generic |
| LUPRON DEPOT-PED (6-MONTH) | LEUPROLIDE ACET (6 MONTH) FOR IM INJ PEDIATRIC KIT 45 MG | 30080050256460 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LUPRON DEPOT (1-MONTH) | LEUPROLIDE ACETATE FOR INJ KIT 3.75 MG | 21405010106405 | Brand |
| LUPRON DEPOT (3-MONTH) | LEUPROLIDE ACETATE (3 MONTH) FOR INJ KIT 11.25 MG | 21405010156420 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LUPRON DEPOT (1-MONTH) | LEUPROLIDE ACETATE FOR INJ KIT 3.75 MG | 21405010106405 | Brand |
| LUPRON DEPOT (3-MONTH) | LEUPROLIDE ACETATE (3 MONTH) FOR INJ KIT 11.25 MG | 21405010156420 | Brand |

**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 1 2 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LUPRON DEPOT (1-MONTH) | LEUPROLIDE ACETATE FOR INJ KIT 3.75 MG | 21405010106405 | Brand |
| LUPRON DEPOT (3-MONTH) | LEUPROLIDE ACETATE (3 MONTH) FOR INJ KIT 11.25 MG | 21405010156420 | Brand |

**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 |
|---|

| Diagnosis | Prostate Cancer |
|---|---|
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LUPRON DEPOT (1-MONTH) | LEUPROLIDE ACETATE FOR INJ KIT 7.5 MG | 21405010106410 | Brand |
| LUPRON DEPOT (3-MONTH) | LEUPROLIDE ACETATE (3 MONTH) FOR INJ KIT 22.5 MG | 21405010156430 | Brand |
| LUPRON DEPOT (4-MONTH) | LEUPROLIDE ACETATE (4 MONTH) FOR INJ KIT 30 MG | 21405010206430 | Brand |
| LUPRON DEPOT (6-MONTH) | LEUPROLIDE ACETATE (6 MONTH) FOR INJ KIT 45 MG | 21405010256450 | Brand |
| LEUPROLIDE ACETATE | LEUPROLIDE ACETATE (3 MONTH) FOR INJ 22.5 MG | 21405010152230 | Brand |
| LEUPROLIDE ACETATE | LEUPROLIDE ACETATE INJ KIT 1 MG/0.2ML (5 MG/ML) | 21405010106407 | Generic |

**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, Triptodur, leuprolide acetate inj kit 5 mg/mL, leuprolide acetate (3 month) 22.5 mg inj | |
|---|---|
| Diagnosis | Gender Dysphoria in Adolescents* |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LUPRON DEPOT (1-MONTH) | LEUPROLIDE ACETATE FOR INJ KIT 3.75 MG | 21405010106405 | Brand |
| LUPRON DEPOT (1-MONTH) | LEUPROLIDE ACETATE FOR INJ KIT 7.5 MG | 21405010106410 | Brand |

| | | | |
|---|---|---|---|
| LUPRON DEPOT (3-MONTH) | LEUPROLIDE ACETATE (3 MONTH) FOR INJ KIT 11.25 MG | 21405010156420 | Brand |
| LUPRON DEPOT (3-MONTH) | LEUPROLIDE ACETATE (3 MONTH) FOR INJ KIT 22.5 MG | 21405010156430 | Brand |
| LUPRON DEPOT (4-MONTH) | LEUPROLIDE ACETATE (4 MONTH) FOR INJ KIT 30 MG | 21405010206430 | Brand |
| LUPRON DEPOT (6-MONTH) | LEUPROLIDE ACETATE (6 MONTH) FOR INJ KIT 45 MG | 21405010256450 | Brand |
| LUPRON DEPOT-PED (1-MONTH) | LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 7.5 MG | 30080050106420 | Brand |
| LUPRON DEPOT-PED (1-MONTH) | LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 11.25 MG | 30080050106430 | Brand |
| LUPRON DEPOT-PED (1-MONTH) | LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 15 MG | 30080050106440 | Brand |
| LUPRON DEPOT-PED (3-MONTH) | LEUPROLIDE ACETATE (3 MONTH) FOR INJ PEDIATRIC KIT 11.25 MG | 30080050156420 | Brand |
| LUPRON DEPOT-PED (3-MONTH) | LEUPROLIDE ACETATE (3 MONTH) FOR INJ PEDIATRIC KIT 30 MG | 30080050156440 | Brand |
| FENSOLVI | LEUPROLIDE ACET (6 MONTH) FOR INJ PEDIATRIC KIT 45 MG | 30080050256450 | Brand |
| TRIPTODUR | TRIPTORELIN PAMOATE FOR IM ER SUSP 22.5 MG (BASE EQUIV) | 3008007040G240 | Brand |
| LEUPROLIDE ACETATE | LEUPROLIDE ACETATE (3 MONTH) FOR INJ 22.5 MG | 21405010152230 | Brand |
| LEUPROLIDE ACETATE | LEUPROLIDE ACETATE INJ KIT 1 MG/0.2ML (5 MG/ML) | 21405010106407 | Generic |
| LUPRON DEPOT-PED (6-MONTH) | LEUPROLIDE ACET (6 MONTH) FOR IM INJ PEDIATRIC KIT 45 MG | 30080050256460 | Brand |

**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

**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, Triptodur, leuprolide acetate inj kit 5 mg/mL, leuprolide acetate (3 month) 22.5 mg inj | |
|---|---|
| Diagnosis | Gender Dysphoria in Adolescents* |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LUPRON DEPOT (1-MONTH) | LEUPROLIDE ACETATE FOR INJ KIT 3.75 MG | 21405010106405 | Brand |
| LUPRON DEPOT (1-MONTH) | LEUPROLIDE ACETATE FOR INJ KIT 7.5 MG | 21405010106410 | Brand |
| LUPRON DEPOT (3-MONTH) | LEUPROLIDE ACETATE (3 MONTH) FOR INJ KIT 11.25 MG | 21405010156420 | Brand |
| LUPRON DEPOT (3-MONTH) | LEUPROLIDE ACETATE (3 MONTH) FOR INJ KIT 22.5 MG | 21405010156430 | Brand |
| LUPRON DEPOT (4-MONTH) | LEUPROLIDE ACETATE (4 MONTH) FOR INJ KIT 30 MG | 21405010206430 | Brand |

| | | | |
|---|---|---|---|
| LUPRON DEPOT (6-MONTH) | LEUPROLIDE ACETATE (6 MONTH) FOR INJ KIT 45 MG | 21405010256450 | Brand |
| LUPRON DEPOT-PED (1-MONTH) | LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 7.5 MG | 30080050106420 | Brand |
| LUPRON DEPOT-PED (1-MONTH) | LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 11.25 MG | 30080050106430 | Brand |
| LUPRON DEPOT-PED (1-MONTH) | LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 15 MG | 30080050106440 | Brand |
| LUPRON DEPOT-PED (3-MONTH) | LEUPROLIDE ACETATE (3 MONTH) FOR INJ PEDIATRIC KIT 11.25 MG | 30080050156420 | Brand |
| LUPRON DEPOT-PED (3-MONTH) | LEUPROLIDE ACETATE (3 MONTH) FOR INJ PEDIATRIC KIT 30 MG | 30080050156440 | Brand |
| FENSOLVI | LEUPROLIDE ACET (6 MONTH) FOR INJ PEDIATRIC KIT 45 MG | 30080050256450 | Brand |
| TRIPTODUR | TRIPTORELIN PAMOATE FOR IM ER SUSP 22.5 MG (BASE EQUIV) | 3008007040G240 | Brand |
| LEUPROLIDE ACETATE | LEUPROLIDE ACETATE (3 MONTH) FOR INJ 22.5 MG | 21405010152230 | Brand |
| LEUPROLIDE ACETATE | LEUPROLIDE ACETATE INJ KIT 1 MG/0.2ML (5 MG/ML) | 21405010106407 | Generic |
| LUPRON DEPOT-PED (6-MONTH) | LEUPROLIDE ACET (6 MONTH) FOR IM INJ PEDIATRIC KIT 45 MG | 30080050256460 | Brand |

**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, Triptodur, leuprolide acetate inj kit 5 mg/mL, leuprolide acetate (3 month) 22.5 mg inj | |
|---|---|
| Diagnosis | Adjunct for Gender-Affirming Hormonal Therapy for Transgender Adults* |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LUPRON DEPOT (1-MONTH) | LEUPROLIDE ACETATE FOR INJ KIT 3.75 MG | 21405010106405 | Brand |
| LUPRON DEPOT (1-MONTH) | LEUPROLIDE ACETATE FOR INJ KIT 7.5 MG | 21405010106410 | Brand |
| LUPRON DEPOT (3-MONTH) | LEUPROLIDE ACETATE (3 MONTH) FOR INJ KIT 11.25 MG | 21405010156420 | Brand |
| LUPRON DEPOT (3-MONTH) | LEUPROLIDE ACETATE (3 MONTH) FOR INJ KIT 22.5 MG | 21405010156430 | Brand |
| LUPRON DEPOT (4-MONTH) | LEUPROLIDE ACETATE (4 MONTH) FOR INJ KIT 30 MG | 21405010206430 | Brand |
| LUPRON DEPOT (6-MONTH) | LEUPROLIDE ACETATE (6 MONTH) FOR INJ KIT 45 MG | 21405010256450 | Brand |

| | | | |
|---|---|---|---|
| LUPRON DEPOT-PED (1-MONTH) | LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 7.5 MG | 30080050106420 | Brand |
| LUPRON DEPOT-PED (1-MONTH) | LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 11.25 MG | 30080050106430 | Brand |
| LUPRON DEPOT-PED (1-MONTH) | LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 15 MG | 30080050106440 | Brand |
| LUPRON DEPOT-PED (3-MONTH) | LEUPROLIDE ACETATE (3 MONTH) FOR INJ PEDIATRIC KIT 11.25 MG | 30080050156420 | Brand |
| LUPRON DEPOT-PED (3-MONTH) | LEUPROLIDE ACETATE (3 MONTH) FOR INJ PEDIATRIC KIT 30 MG | 30080050156440 | Brand |
| FENSOLVI | LEUPROLIDE ACET (6 MONTH) FOR INJ PEDIATRIC KIT 45 MG | 30080050256450 | Brand |
| TRIPTODUR | TRIPTORELIN PAMOATE FOR IM ER SUSP 22.5 MG (BASE EQUIV) | 3008007040G240 | Brand |
| LEUPROLIDE ACETATE | LEUPROLIDE ACETATE (3 MONTH) FOR INJ 22.5 MG | 21405010152230 | Brand |
| LEUPROLIDE ACETATE | LEUPROLIDE ACETATE INJ KIT 1 MG/0.2ML (5 MG/ML) | 21405010106407 | Generic |
| LUPRON DEPOT-PED (6-MONTH) | LEUPROLIDE ACET (6 MONTH) FOR IM INJ PEDIATRIC KIT 45 MG | 30080050256460 | Brand |

**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, Triptodur, leuprolide acetate inj kit 5 mg/mL, leuprolide acetate (3 month) 22.5 mg inj | |
|---|---|
| Diagnosis | Adjunct for Gender-Affirming Hormonal Therapy for Transgender Adults* |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LUPRON DEPOT (1-MONTH) | LEUPROLIDE ACETATE FOR INJ KIT 3.75 MG | 21405010106405 | Brand |
| LUPRON DEPOT (1-MONTH) | LEUPROLIDE ACETATE FOR INJ KIT 7.5 MG | 21405010106410 | Brand |
| LUPRON DEPOT (3-MONTH) | LEUPROLIDE ACETATE (3 MONTH) FOR INJ KIT 11.25 MG | 21405010156420 | Brand |
| LUPRON DEPOT (3-MONTH) | LEUPROLIDE ACETATE (3 MONTH) FOR INJ KIT 22.5 MG | 21405010156430 | Brand |
| LUPRON DEPOT (4-MONTH) | LEUPROLIDE ACETATE (4 MONTH) FOR INJ KIT 30 MG | 21405010206430 | Brand |
| LUPRON DEPOT (6-MONTH) | LEUPROLIDE ACETATE (6 MONTH) FOR INJ KIT 45 MG | 21405010256450 | Brand |
| LUPRON DEPOT-PED (1-MONTH) | LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 7.5 MG | 30080050106420 | Brand |

| | | | |
|---|---|---|---|
| LUPRON DEPOT-PED (1-MONTH) | LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 11.25 MG | 30080050106430 | Brand |
| LUPRON DEPOT-PED (1-MONTH) | LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 15 MG | 30080050106440 | Brand |
| LUPRON DEPOT-PED (3-MONTH) | LEUPROLIDE ACETATE (3 MONTH) FOR INJ PEDIATRIC KIT 11.25 MG | 30080050156420 | Brand |
| LUPRON DEPOT-PED (3-MONTH) | LEUPROLIDE ACETATE (3 MONTH) FOR INJ PEDIATRIC KIT 30 MG | 30080050156440 | Brand |
| FENSOLVI | LEUPROLIDE ACET (6 MONTH) FOR INJ PEDIATRIC KIT 45 MG | 30080050256450 | Brand |
| TRIPTODUR | TRIPTORELIN PAMOATE FOR IM ER SUSP 22.5 MG (BASE EQUIV) | 3008007040G240 | Brand |
| LEUPROLIDE ACETATE | LEUPROLIDE ACETATE (3 MONTH) FOR INJ 22.5 MG | 21405010152230 | Brand |
| LEUPROLIDE ACETATE | LEUPROLIDE ACETATE INJ KIT 1 MG/0.2ML (5 MG/ML) | 21405010106407 | Generic |
| LUPRON DEPOT-PED (6-MONTH) | LEUPROLIDE ACET (6 MONTH) FOR IM INJ PEDIATRIC KIT 45 MG | 30080050256460 | Brand |

**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, progesterones) 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, Triptodur, leuprolide acetate inj kit 5 mg/mL, leuprolide acetate (3 month) 22.5 mg inj | |
|---|---|
| Diagnosis | Fertility Preservation |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LUPRON DEPOT (1-MONTH) | LEUPROLIDE ACETATE FOR INJ KIT 3.75 MG | 21405010106405 | Brand |
| LUPRON DEPOT (1-MONTH) | LEUPROLIDE ACETATE FOR INJ KIT 7.5 MG | 21405010106410 | Brand |
| LUPRON DEPOT (3-MONTH) | LEUPROLIDE ACETATE (3 MONTH) FOR INJ KIT 11.25 MG | 21405010156420 | Brand |
| LUPRON DEPOT (3-MONTH) | LEUPROLIDE ACETATE (3 MONTH) FOR INJ KIT 22.5 MG | 21405010156430 | Brand |
| LUPRON DEPOT (4-MONTH) | LEUPROLIDE ACETATE (4 MONTH) FOR INJ KIT 30 MG | 21405010206430 | Brand |

| | | | |
|---|---|---|---|
| LUPRON DEPOT (6-MONTH) | LEUPROLIDE ACETATE (6 MONTH) FOR INJ KIT 45 MG | 21405010256450 | Brand |
| LUPRON DEPOT-PED (1-MONTH) | LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 7.5 MG | 30080050106420 | Brand |
| LUPRON DEPOT-PED (1-MONTH) | LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 11.25 MG | 30080050106430 | Brand |
| LUPRON DEPOT-PED (1-MONTH) | LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 15 MG | 30080050106440 | Brand |
| LUPRON DEPOT-PED (3-MONTH) | LEUPROLIDE ACETATE (3 MONTH) FOR INJ PEDIATRIC KIT 11.25 MG | 30080050156420 | Brand |
| LUPRON DEPOT-PED (3-MONTH) | LEUPROLIDE ACETATE (3 MONTH) FOR INJ PEDIATRIC KIT 30 MG | 30080050156440 | Brand |
| FENSOLVI | LEUPROLIDE ACET (6 MONTH) FOR INJ PEDIATRIC KIT 45 MG | 30080050256450 | Brand |
| TRIPTODUR | TRIPTORELIN PAMOATE FOR IM ER SUSP 22.5 MG (BASE EQUIV) | 3008007040G240 | Brand |
| LEUPROLIDE ACETATE | LEUPROLIDE ACETATE (3 MONTH) FOR INJ 22.5 MG | 21405010152230 | Brand |
| LEUPROLIDE ACETATE | LEUPROLIDE ACETATE INJ KIT 1 MG/0.2ML (5 MG/ML) | 21405010106407 | Generic |
| LUPRON DEPOT-PED (6-MONTH) | LEUPROLIDE ACET (6 MONTH) FOR IM INJ PEDIATRIC KIT 45 MG | 30080050256460 | Brand |

**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, Triptodur, leuprolide acetate inj kit 5 mg/mL, leuprolide acetate (3 month) 22.5 mg inj | |
|---|---|
| Diagnosis | Fertility Preservation |

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LUPRON DEPOT (1-MONTH) | LEUPROLIDE ACETATE FOR INJ KIT 3.75 MG | 21405010106405 | Brand |
| LUPRON DEPOT (1-MONTH) | LEUPROLIDE ACETATE FOR INJ KIT 7.5 MG | 21405010106410 | Brand |
| LUPRON DEPOT (3-MONTH) | LEUPROLIDE ACETATE (3 MONTH) FOR INJ KIT 11.25 MG | 21405010156420 | Brand |
| LUPRON DEPOT (3-MONTH) | LEUPROLIDE ACETATE (3 MONTH) FOR INJ KIT 22.5 MG | 21405010156430 | Brand |
| LUPRON DEPOT (4-MONTH) | LEUPROLIDE ACETATE (4 MONTH) FOR INJ KIT 30 MG | 21405010206430 | Brand |
| LUPRON DEPOT (6-MONTH) | LEUPROLIDE ACETATE (6 MONTH) FOR INJ KIT 45 MG | 21405010256450 | Brand |
| LUPRON DEPOT-PED (1-MONTH) | LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 7.5 MG | 30080050106420 | Brand |
| LUPRON DEPOT-PED (1-MONTH) | LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 11.25 MG | 30080050106430 | Brand |
| LUPRON DEPOT-PED (1-MONTH) | LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 15 MG | 30080050106440 | Brand |
| LUPRON DEPOT-PED (3-MONTH) | LEUPROLIDE ACETATE (3 MONTH) FOR INJ PEDIATRIC KIT 11.25 MG | 30080050156420 | Brand |
| LUPRON DEPOT-PED (3-MONTH) | LEUPROLIDE ACETATE (3 MONTH) FOR INJ PEDIATRIC KIT 30 MG | 30080050156440 | Brand |
| FENSOLVI | LEUPROLIDE ACET (6 MONTH) FOR INJ PEDIATRIC KIT 45 MG | 30080050256450 | Brand |
| TRIPTODUR | TRIPTORELIN PAMOATE FOR IM ER SUSP 22.5 MG (BASE EQUIV) | 3008007040G240 | Brand |
| LEUPROLIDE ACETATE | LEUPROLIDE ACETATE (3 MONTH) FOR INJ 22.5 MG | 21405010152230 | Brand |
| LEUPROLIDE ACETATE | LEUPROLIDE ACETATE INJ KIT 1 MG/0.2ML (5 MG/ML) | 21405010106407 | Generic |

| | | | |
|---|---|---|---|
| LUPRON DEPOT-PED (6-MONTH) | LEUPROLIDE ACET (6 MONTH) FOR IM INJ PEDIATRIC KIT 45 MG | 30080050256460 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LEUPROLIDE ACETATE | LEUPROLIDE ACETATE INJ KIT 1 MG/0.2ML (5 MG/ML) | 21405010106407 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LEUPROLIDE ACETATE | LEUPROLIDE ACETATE INJ KIT 1 MG/0.2ML (5 MG/ML) | 21405010106407 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LUPRON DEPOT (1-MONTH) | LEUPROLIDE ACETATE FOR INJ KIT 3.75 MG | 21405010106405 | Brand |
| LUPRON DEPOT (1-MONTH) | LEUPROLIDE ACETATE FOR INJ KIT 7.5 MG | 21405010106410 | Brand |
| LUPRON DEPOT (3-MONTH) | LEUPROLIDE ACETATE (3 MONTH) FOR INJ KIT 11.25 MG | 21405010156420 | Brand |
| LUPRON DEPOT (3-MONTH) | LEUPROLIDE ACETATE (3 MONTH) FOR INJ KIT 22.5 MG | 21405010156430 | Brand |
| LUPRON DEPOT (4-MONTH) | LEUPROLIDE ACETATE (4 MONTH) FOR INJ KIT 30 MG | 21405010206430 | Brand |
| LUPRON DEPOT (6-MONTH) | LEUPROLIDE ACETATE (6 MONTH) FOR INJ KIT 45 MG | 21405010256450 | Brand |
| LUPRON DEPOT-PED (1-MONTH) | LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 7.5 MG | 30080050106420 | Brand |
| LUPRON DEPOT-PED (1-MONTH) | LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 11.25 MG | 30080050106430 | Brand |
| LUPRON DEPOT-PED (1-MONTH) | LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 15 MG | 30080050106440 | Brand |
| LUPRON DEPOT-PED (3-MONTH) | LEUPROLIDE ACETATE (3 MONTH) FOR INJ PEDIATRIC KIT 11.25 MG | 30080050156420 | Brand |
| LUPRON DEPOT-PED (3-MONTH) | LEUPROLIDE ACETATE (3 MONTH) FOR INJ PEDIATRIC KIT 30 MG | 30080050156440 | Brand |

| | | | |
|---|---|---|---|
| LEUPROLIDE ACETATE | LEUPROLIDE ACETATE INJ KIT 1 MG/0.2ML (5 MG/ML) | 21405010106407 | Generic |
| LUPRON DEPOT-PED (6-MONTH) | LEUPROLIDE ACET (6 MONTH) FOR IM INJ PEDIATRIC KIT 45 MG | 30080050256460 | Brand |

**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 |
|---|---|
| 11/26/2024 | Updated GPIs. Updated step therapy in CPP section as Fensolvi was moved to preferred and Lupron Depot Ped was moved to NP |

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-161799 |
| **Guideline Name** | Growth Hormone, Growth Stimulating Agents - Managed Medicaid |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 1 . Criteria

| Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ NuSpin, Omnitrope, Saizen, Zomacton, Zorbtive, Serostim | |
|---|---|
| Diagnosis | Pediatric Growth Hormone Deficiency (GHD)* |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZOMACTON | SOMATROPIN FOR SUBCUTANEOUS INJ 5 MG | 30100020002121 | Brand |
| OMNITROPE | SOMATROPIN FOR INJ 5.8 MG | 30100020002123 | Brand |
| SAIZEN | SOMATROPIN (NON-REFRIGERATED) FOR INJ 5 MG | 30100020102120 | Brand |

| | | | |
|---|---|---|---|
| SAIZEN | SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG | 30100020102130 | Brand |
| SAIZENPREP RECONSTITUTIONKIT | SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG | 30100020102130 | Brand |
| ZOMACTON | SOMATROPIN FOR INJ 10 MG | 30100020002140 | Brand |
| ZORBTIVE | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 8.8 MG | 30100020102132 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 4 MG | 30100020102118 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 5 MG | 30100020102121 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 6 MG | 30100020102125 | Brand |
| NUTROPIN AQ NUSPIN 5 | SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/2ML | 3010002000D207 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/1.5ML | 3010002000D212 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/1.5ML | 3010002000D230 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 15 MG/1.5ML | 3010002000D240 | Brand |
| NUTROPIN AQ NUSPIN 10 | SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/2ML | 3010002000D220 | Brand |
| NUTROPIN AQ NUSPIN 20 | SOMATROPIN SOLUTION PEN-INJECTOR 20 MG/2ML | 3010002000D250 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 30 MG/3ML | 3010002000D260 | Brand |
| OMNITROPE | SOMATROPIN SOLUTION CARTRIDGE 5 MG/1.5ML | 3010002000E210 | Brand |
| OMNITROPE | SOMATROPIN SOLUTION CARTRIDGE 10 MG/1.5ML | 3010002000E213 | Brand |
| GENOTROPIN | SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 5 MG | 3010002000E159 | Brand |
| GENOTROPIN | SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 12 MG (36 UNIT) | 3010002000E188 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.2 MG | 3010002000E404 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.4 MG | 3010002000E407 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.6 MG | 3010002000E410 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.8 MG | 3010002000E413 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1 MG | 3010002000E416 | Brand |

| | | | |
|---|---|---|---|
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.2 MG | 3010002000E419 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.4 MG | 3010002000E422 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.6 MG | 3010002000E425 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.8 MG | 3010002000E428 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 2 MG | 3010002000E431 | Brand |
| HUMATROPE | SOMATROPIN FOR INJ CARTRIDGE 6 MG (18 UNIT) | 3010002000E120 | Brand |
| HUMATROPE | SOMATROPIN FOR INJ CARTRIDGE 12 MG (36 UNIT) | 3010002000E130 | Brand |
| HUMATROPE | SOMATROPIN FOR INJ CARTRIDGE 24 MG | 3010002000E140 | Brand |

**Approval Criteria**

**1** - ONE of the following:

**1.1** BOTH of the following:

**1.1.1** ONE of the following:

**1.1.1.1** All of the following:

- Infant is less than 4 months of age
- Infant has growth deficiency
- Prescribed by an endocrinologist

**OR**

**1.1.1.2** BOTH of the following:

- History of neonatal hypoglycemia associated with pituitary disease
- Prescribed by an endocrinologist

**OR**

**1.1.1.3** BOTH of the following:

- Diagnosis of panhypopituitarism
- Prescribed by an endocrinologist

**AND**

**1.1.2** 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) (See Table 1 in Background section for non-preferred products)

**OR**

**1.2** ALL of the following:

**1.2.1** Diagnosis of pediatric growth hormone (GH) deficiency as confirmed by ONE of the following:

**1.2.1.1** Projected height (as determined by extrapolating pre-treatment growth trajectory along current channel to 18-20 year mark) is greater than 2.0 standard deviations [SD] below midparental height utilizing age and gender growth charts related to height

**OR**

**1.2.1.2** Height is greater than 2.25 SD below population mean (below the 1.2 percentile for age and gender) utilizing age and gender growth charts related to height

**OR**

**1.2.1.3** Growth velocity is greater than 2 SD below mean for age and gender

**OR**

**1.2.1.4** Delayed skeletal maturation of greater than 2 SD below mean for age and gender (e.g., delayed greater than 2 years compared with chronological age)

**AND**

**1.2.2** ONE of the following:

**1.2.2.1** Patient is male and ONE of the following:

- Tanner stage less than 4
- Bone age less than 16 years measured in the past 12 months

**OR**

**1.2.2.2** Patient is female and ONE of the following:

- Tanner stage less than 4
- Bone age less than 14 years measured in the past 12 months

**AND**

**1.2.3** Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following:

**1.2.3.1** BOTH of the following:

**1.2.3.1.1** Patient has undergone TWO of the following provocative GH stimulation tests:

- Arginine
- Clonidine
- Glucagon
- Insulin
- Levodopa
- Growth hormone releasing hormone

**AND**

**1.2.3.1.2** BOTH GH response values are less than 10 micrograms per liter

**OR**

**1.2.3.2** BOTH of the following:

**1.2.3.2.1** Patient is less than 1 year of age

**AND**

**1.2.3.2.2** ONE of the following is below the age and gender adjusted normal range as provided by the physician's lab:

- Insulin-like Growth Factor 1 (IGF-1/Somatomedin-C)
- Insulin Growth Factor Binding Protein-3 (IGFBP-3)

**AND**

**1.2.4** ONE of the following:

**1.2.4.1** Request does not exceed a maximum supply limit of 0.3 milligrams per kilogram per week

**OR**

**1.2.4.2** BOTH of the following:

- Tanner Stage 3 or greater
- Request does not exceed a maximum supply limit of 0.7 milligrams per kilogram per week

**AND**

**1.2.5** Prescribed by an endocrinologist

**AND**

**1.2.6** 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) (See Table 1 in Background section for non-preferred products)

| | |
|---|---|
| Notes | *Includes children who have undergone brain radiation. If patient is a Transition Phase Adolescent or Adult who had childhood onset GH de ficiency, utilize criteria for Transition Phase Adolescent or Adult GH D eficiency. |

| Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ NuSpin, Omnitrope, Saizen, Zomacton, Zorbtive, Serostim | |
|---|---|
| Diagnosis | Pediatric Growth Hormone Deficiency (GHD)* |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZOMACTON | SOMATROPIN FOR SUBCUTANEOUS INJ 5 MG | 30100020002121 | Brand |
| OMNITROPE | SOMATROPIN FOR INJ 5.8 MG | 30100020002123 | Brand |
| SAIZEN | SOMATROPIN (NON-REFRIGERATED) FOR INJ 5 MG | 30100020102120 | Brand |
| SAIZEN | SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG | 30100020102130 | Brand |
| SAIZENPREP RECONSTITUTIONKIT | SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG | 30100020102130 | Brand |
| ZOMACTON | SOMATROPIN FOR INJ 10 MG | 30100020002140 | Brand |
| ZORBTIVE | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 8.8 MG | 30100020102132 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 4 MG | 30100020102118 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 5 MG | 30100020102121 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 6 MG | 30100020102125 | Brand |
| NUTROPIN AQ NUSPIN 5 | SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/2ML | 3010002000D207 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/1.5ML | 3010002000D212 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/1.5ML | 3010002000D230 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 15 MG/1.5ML | 3010002000D240 | Brand |
| NUTROPIN AQ NUSPIN 10 | SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/2ML | 3010002000D220 | Brand |
| NUTROPIN AQ NUSPIN 20 | SOMATROPIN SOLUTION PEN-INJECTOR 20 MG/2ML | 3010002000D250 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 30 MG/3ML | 3010002000D260 | Brand |
| OMNITROPE | SOMATROPIN SOLUTION CARTRIDGE 5 MG/1.5ML | 3010002000E210 | Brand |

| | | | |
|---|---|---|---|
| OMNITROPE | SOMATROPIN SOLUTION CARTRIDGE 10 MG/1.5ML | 3010002000E213 | Brand |
| GENOTROPIN | SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 5 MG | 3010002000E159 | Brand |
| GENOTROPIN | SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 12 MG (36 UNIT) | 3010002000E188 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.2 MG | 3010002000E404 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.4 MG | 3010002000E407 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.6 MG | 3010002000E410 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.8 MG | 3010002000E413 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1 MG | 3010002000E416 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.2 MG | 3010002000E419 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.4 MG | 3010002000E422 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.6 MG | 3010002000E425 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.8 MG | 3010002000E428 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 2 MG | 3010002000E431 | Brand |
| HUMATROPE | SOMATROPIN FOR INJ CARTRIDGE 6 MG (18 UNIT) | 3010002000E120 | Brand |
| HUMATROPE | SOMATROPIN FOR INJ CARTRIDGE 12 MG (36 UNIT) | 3010002000E130 | Brand |
| HUMATROPE | SOMATROPIN FOR INJ CARTRIDGE 24 MG | 3010002000E140 | Brand |

**Approval Criteria**

**1** - Height increase of at least 2 centimeters per year over the previous year documented by BOTH of the following:**

- Previous height and date obtained
- Current height and date obtained

**AND**

**2** - BOTH of the following:**

- Expected adult height not attained
- Documentation of expected adult height goal (e.g. genetic potential)

**AND**

**3** - Calculated height (growth) velocity over the past 12 months

**AND**

**4** - ONE of the following:

**4.1** Patient is a male and ONE of the following:

- Tanner stage less than 4
- Bone age less than 16 years measured in the past 12 months

**OR**

**4.2** Patient is a female and ONE of the following:

- Tanner stage less than 4
- Bone age less than 14 years measured in the past 12 months

**AND**

**5** - ONE of the following:

**5.1** Request does not exceed a maximum supply limit of 0.3 milligrams per kilogram per week

**OR**

**5.2** BOTH of the following:

- Tanner Stage 3 or greater

- Request does not exceed a maximum supply limit of 0.7 milligrams per kilogram per week

**AND**

**6** - Prescribed by an endocrinologist

| | |
|---|---|
| Notes | *Includes children who have undergone brain radiation. If patient is a Transition Phase Adolescent or Adult who had childhood onset GH de ficiency, utilize criteria for Transition Phase Adolescent or Adult GH D eficiency.<br><br>**Documentation of previous height, current height and goal expected adult height will be required for renewal. |

| Product Name: Skytrofa | |
|---|---|
| Diagnosis | Pediatric Growth Hormone Deficiency (GHD) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SKYTROFA | LONAPEGSOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CARTRIDGE 3 MG | 3010000380E110 | Brand |
| SKYTROFA | LONAPEGSOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CARTRIDGE 3.6 MG | 3010000380E115 | Brand |
| SKYTROFA | LONAPEGSOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CARTRIDGE 4.3 MG | 3010000380E120 | Brand |
| SKYTROFA | LONAPEGSOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CARTRIDGE 5.2 MG | 3010000380E125 | Brand |
| SKYTROFA | LONAPEGSOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CARTRIDGE 6.3 MG | 3010000380E130 | Brand |
| SKYTROFA | LONAPEGSOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CARTRIDGE 7.6 MG | 3010000380E135 | Brand |
| SKYTROFA | LONAPEGSOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CARTRIDGE 9.1 MG | 3010000380E140 | Brand |
| SKYTROFA | LONAPEGSOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CARTRIDGE 11 MG | 3010000380E145 | Brand |
| SKYTROFA | LONAPEGSOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CART 13.3 MG | 3010000380E150 | Brand |

**Approval Criteria**

**1** - ONE of the following:

**1.1** ALL of the following:

**1.1.1** ONE of the following:

- History of neonatal hypoglycemia associated with pituitary disease
- Diagnosis of panhypopituitarism

**AND**

**1.1.2** Prescribed by an endocrinologist

**AND**

**1.1.3** ONE of the following:

**1.1.3.1** Failure to ONE of the following, confirmed by claims history or submission of medical records:

- Somatropin (Norditropin)
- Somatropin (Omnitrope)

**OR**

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

- Somatropin (Norditropin)
- Somatropin (Omnitrope)

**OR**

**1.2** ALL of the following:

**1.2.1** Diagnosis of pediatric GH (growth hormone) deficiency as confirmed by ONE of the following:

**1.2.1.1** Projected height (as determined by extrapolating pre-treatment growth trajectory along current channel to 18-20 year mark) is greater than 2.0 standard deviations [SD] below midparental height utilizing age and gender growth charts related to height

**OR**

**1.2.1.2** Height is greater than 2.25 SD below population mean (below the 1.2 percentile for age and gender) utilizing age and gender growth charts related to height

**OR**

**1.2.1.3** Growth velocity is greater than 2 SD below mean for age and gender

**OR**

**1.2.1.4** Delayed skeletal maturation of greater than 2 SD below mean for age and gender (e.g., delayed greater than 2 years compared with chronological age)

**AND**

**1.2.2** ONE of the following:

**1.2.2.1** Patient is male and ONE of the following:

- Tanner stage less than 4
- Bone age less than 16 years measured in the past 12 months

**OR**

**1.2.2.2** Patient is female and ONE of the following:

- Tanner stage less than 4
- Bone age less than 14 years measured in the past 12 months

**AND**

**1.2.3** Submission of medical records (e.g., chart notes, laboratory values) documenting BOTH of the following:

**1.2.3.1** Patient has undergone TWO of the following provocative GH stimulation tests:

- Arginine
- Clonidine
- Glucagon
- Insulin
- Levodopa
- Growth hormone releasing hormone

**AND**

**1.2.3.2** Both GH response values are less than 10 micrograms per liter

**AND**

**1.2.4** One of the following:

**1.2.4.1** Failure to ONE of the following, confirmed by claims history or submission of medical records:

- Somatropin (Norditropin)
- Somatropin (Omnitrope)

**OR**

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

- Somatropin (Norditropin)
- Somatropin (Omnitrope)

**AND**

**1.2.5** Prescribed by an endocrinologist

| Product Name: Skytrofa | |
|---|---|
| Diagnosis | Pediatric Growth Hormone Deficiency (GHD) |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SKYTROFA | LONAPEGSOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CARTRIDGE 3 MG | 3010000380E110 | Brand |
| SKYTROFA | LONAPEGSOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CARTRIDGE 3.6 MG | 3010000380E115 | Brand |
| SKYTROFA | LONAPEGSOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CARTRIDGE 4.3 MG | 3010000380E120 | Brand |
| SKYTROFA | LONAPEGSOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CARTRIDGE 5.2 MG | 3010000380E125 | Brand |
| SKYTROFA | LONAPEGSOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CARTRIDGE 6.3 MG | 3010000380E130 | Brand |
| SKYTROFA | LONAPEGSOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CARTRIDGE 7.6 MG | 3010000380E135 | Brand |
| SKYTROFA | LONAPEGSOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CARTRIDGE 9.1 MG | 3010000380E140 | Brand |
| SKYTROFA | LONAPEGSOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CARTRIDGE 11 MG | 3010000380E145 | Brand |
| SKYTROFA | LONAPEGSOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CART 13.3 MG | 3010000380E150 | Brand |

**Approval Criteria**

**1** - Height increase of at least 2 centimeters per year over the previous year documented by BOTH of the following:*

- Previous height and date obtained
- Current height and date obtained

**AND**

**2** - BOTH of the following:*

- Expected adult height not attained
- Documentation of expected adult height goal (e.g. genetic potential)

**AND**

**3** - Calculated height (growth) velocity over the past 12 months

**AND**

**4** - ONE of the following:

**4.1** Patient is a male and ONE of the following:

- Tanner stage less than 4
- Bone age less than 16 years measured in the past 12 months

**OR**

**4.2** Patient is a female and ONE of the following:

- Tanner stage less than 4
- Bone age less than 14 years measured in the past 12 months

**AND**

**5** - Prescribed by an endocrinologist

| Notes | *Documentation of previous height, current height and goal expected adult height will be required for renewal. |
|---|---|

| Product Name: Sogroya, Ngenla | |
|---|---|
| Diagnosis | Pediatric Growth Hormone Deficiency (GHD) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SOGROYA | SOMAPACITAN-BECO SOLUTION PEN-INJECTOR 5 MG/1.5ML | 3010000720D210 | Brand |
| SOGROYA | SOMAPACITAN-BECO SOLUTION PEN-INJECTOR 10 MG/1.5ML | 3010000720D220 | Brand |
| SOGROYA | SOMAPACITAN-BECO SOLUTION PEN-INJECTOR 15 MG/1.5ML | 3010000720D230 | Brand |
| NGENLA | SOMATROGON-GHLA SOLUTION PEN-INJECTOR 24 MG/1.2ML (20 MG/ML) | 3010001500D220 | Brand |
| NGENLA | SOMATROGON-GHLA SOLUTION PEN-INJECTOR 60 MG/1.2ML (50 MG/ML) | 3010001500D240 | Brand |

**Approval Criteria**

**1** - ONE of the following:

**1.1** ALL of the following:

**1.1.1** Diagnosis of panhypopituitarism

**AND**

**1.1.2** Prescribed by an endocrinologist

**AND**

**1.1.3** ONE of the following:

**1.1.3.1** Failure to ONE of the following, confirmed by claims history or submission of medical records:

- Somatropin (Norditropin)
- Somatropin (Omnitrope)

**OR**

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

- Somatropin (Norditropin)
- Somatropin (Omnitrope)

**OR**

**1.2** ALL of the following:

**1.2.1** Diagnosis of pediatric GH (growth hormone) deficiency as confirmed by ONE of the following:

**1.2.1.1** Projected height (as determined by extrapolating pre-treatment growth trajectory along current channel to 18-20 year mark) is greater than 2.0 standard deviations [SD] below midparental height utilizing age and gender growth charts related to height

**OR**

**1.2.1.2** Height is greater than 2.25 SD below population mean (below the 1.2 percentile for age and gender) utilizing age and gender growth charts related to height

**OR**

**1.2.1.3** Growth velocity is greater than 2 SD below mean for age and gender

**OR**

**1.2.1.4** Delayed skeletal maturation of greater than 2 SD below mean for age and gender (e.g., delayed greater than 2 years compared with chronological age)

**AND**

**1.2.2** ONE of the following:

**1.2.2.1** Patient is male and ONE of the following:

- Tanner stage less than 4
- Bone age less than 16 years measured in the past 12 months

**OR**

**1.2.2.2** Patient is female and ONE of the following:

- Tanner stage less than 4
- Bone age less than 14 years measured in the past 12 months

**AND**

**1.2.3** Submission of medical records (e.g., chart notes, laboratory values) documenting BOTH of the following:

**1.2.3.1** Patient has undergone TWO of the following provocative GH stimulation tests:

- Arginine
- Clonidine
- Glucagon
- Insulin
- Levodopa
- Growth hormone releasing hormone

**AND**

**1.2.3.2** Both GH response values are less than 10 micrograms per liter

**AND**

**1.2.4** ONE of the following:

**1.2.4.1** If the request is for Sogroya, the patient is 2.5 years of age or older

**OR**

**1.2.4.2** If the request is for Ngenla, the patient is 3 years of age or older

**AND**

**1.2.5** ONE of the following:

**1.2.5.1** Failure to ONE of the following, confirmed by claims history or submission of medical records:

- Somatropin (Norditropin)
- Somatropin (Omnitrope)

**OR**

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

- Somatropin (Norditropin)
- Somatropin (Omnitrope)

**AND**

**1.2.6** Prescribed by an endocrinologist

| Product Name: Sogroya, Ngenla | |
|---|---|
| Diagnosis | Pediatric Growth Hormone Deficiency (GHD) |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SOGROYA | SOMAPACITAN-BECO SOLUTION PEN-INJECTOR 5 MG/1.5ML | 3010000720D210 | Brand |
| SOGROYA | SOMAPACITAN-BECO SOLUTION PEN-INJECTOR 10 MG/1.5ML | 3010000720D220 | Brand |
| SOGROYA | SOMAPACITAN-BECO SOLUTION PEN-INJECTOR 15 MG/1.5ML | 3010000720D230 | Brand |
| NGENLA | SOMATROGON-GHLA SOLUTION PEN-INJECTOR 24 MG/1.2ML (20 MG/ML) | 3010001500D220 | Brand |
| NGENLA | SOMATROGON-GHLA SOLUTION PEN-INJECTOR 60 MG/1.2ML (50 MG/ML) | 3010001500D240 | Brand |

**Approval Criteria**

**1** - Height increase of at least 2 centimeters per year over the previous year documented by BOTH of the following:*

- Previous height and date obtained
- Current height and date obtained

**AND**

**2** - BOTH of the following:*

- Expected adult height not attained
- Documentation of expected adult height goal (e.g. genetic potential)

**AND**

**3** - Calculated height (growth) velocity over the past 12 months

**AND**

**4** - ONE of the following:

**4.1** Patient is a male and ONE of the following:

- Tanner stage less than 4
- Bone age less than 16 years measured in the past 12 months

**OR**

**4.2** Patient is a female and ONE of the following:

- Tanner stage less than 4
- Bone age less than 14 years measured in the past 12 months

| **AND**<br><br>**5** - Prescribed by an endocrinologist | |
|---|---|
| Notes | *Documentation of previous height, current height and goal expected adult height will be required for renewal. |

| 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZOMACTON | SOMATROPIN FOR SUBCUTANEOUS INJ 5 MG | 30100020002121 | Brand |
| OMNITROPE | SOMATROPIN FOR INJ 5.8 MG | 30100020002123 | Brand |
| SAIZEN | SOMATROPIN (NON-REFRIGERATED) FOR INJ 5 MG | 30100020102120 | Brand |
| SAIZEN | SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG | 30100020102130 | Brand |
| SAIZENPREP RECONSTITUTIONKIT | SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG | 30100020102130 | Brand |
| ZOMACTON | SOMATROPIN FOR INJ 10 MG | 30100020002140 | Brand |
| ZORBTIVE | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 8.8 MG | 30100020102132 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 4 MG | 30100020102118 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 5 MG | 30100020102121 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 6 MG | 30100020102125 | Brand |
| NUTROPIN AQ NUSPIN 5 | SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/2ML | 3010002000D207 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/1.5ML | 3010002000D212 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/1.5ML | 3010002000D230 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 15 MG/1.5ML | 3010002000D240 | Brand |

| | | | |
|---|---|---|---|
| NUTROPIN AQ NUSPIN 10 | SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/2ML | 3010002000D220 | Brand |
| NUTROPIN AQ NUSPIN 20 | SOMATROPIN SOLUTION PEN-INJECTOR 20 MG/2ML | 3010002000D250 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 30 MG/3ML | 3010002000D260 | Brand |
| OMNITROPE | SOMATROPIN SOLUTION CARTRIDGE 5 MG/1.5ML | 3010002000E210 | Brand |
| OMNITROPE | SOMATROPIN SOLUTION CARTRIDGE 10 MG/1.5ML | 3010002000E213 | Brand |
| GENOTROPIN | SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 5 MG | 3010002000E159 | Brand |
| GENOTROPIN | SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 12 MG (36 UNIT) | 3010002000E188 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.2 MG | 3010002000E404 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.4 MG | 3010002000E407 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.6 MG | 3010002000E410 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.8 MG | 3010002000E413 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1 MG | 3010002000E416 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.2 MG | 3010002000E419 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.4 MG | 3010002000E422 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.6 MG | 3010002000E425 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.8 MG | 3010002000E428 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 2 MG | 3010002000E431 | Brand |
| HUMATROPE | SOMATROPIN FOR INJ CARTRIDGE 6 MG (18 UNIT) | 3010002000E120 | Brand |
| HUMATROPE | SOMATROPIN FOR INJ CARTRIDGE 12 MG (36 UNIT) | 3010002000E130 | Brand |
| HUMATROPE | SOMATROPIN FOR INJ CARTRIDGE 24 MG | 3010002000E140 | Brand |

**Approval Criteria**

**1** - Diagnosis of Prader-Willi Syndrome

**AND**

**2** - Prescribed by an endocrinologist

**AND**

**3** - 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) (See Table 1 in Background section for non-preferred products)

| 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZOMACTON | SOMATROPIN FOR SUBCUTANEOUS INJ 5 MG | 30100020002121 | Brand |
| OMNITROPE | SOMATROPIN FOR INJ 5.8 MG | 30100020002123 | Brand |
| SAIZEN | SOMATROPIN (NON-REFRIGERATED) FOR INJ 5 MG | 30100020102120 | Brand |
| SAIZEN | SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG | 30100020102130 | Brand |
| SAIZENPREP RECONSTITUTIONKIT | SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG | 30100020102130 | Brand |
| ZOMACTON | SOMATROPIN FOR INJ 10 MG | 30100020002140 | Brand |
| ZORBTIVE | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 8.8 MG | 30100020102132 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 4 MG | 30100020102118 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 5 MG | 30100020102121 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 6 MG | 30100020102125 | Brand |

| | | | |
|---|---|---|---|
| NUTROPIN AQ NUSPIN 5 | SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/2ML | 3010002000D207 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/1.5ML | 3010002000D212 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/1.5ML | 3010002000D230 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 15 MG/1.5ML | 3010002000D240 | Brand |
| NUTROPIN AQ NUSPIN 10 | SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/2ML | 3010002000D220 | Brand |
| NUTROPIN AQ NUSPIN 20 | SOMATROPIN SOLUTION PEN-INJECTOR 20 MG/2ML | 3010002000D250 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 30 MG/3ML | 3010002000D260 | Brand |
| OMNITROPE | SOMATROPIN SOLUTION CARTRIDGE 5 MG/1.5ML | 3010002000E210 | Brand |
| OMNITROPE | SOMATROPIN SOLUTION CARTRIDGE 10 MG/1.5ML | 3010002000E213 | Brand |
| GENOTROPIN | SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 5 MG | 3010002000E159 | Brand |
| GENOTROPIN | SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 12 MG (36 UNIT) | 3010002000E188 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.2 MG | 3010002000E404 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.4 MG | 3010002000E407 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.6 MG | 3010002000E410 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.8 MG | 3010002000E413 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1 MG | 3010002000E416 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.2 MG | 3010002000E419 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.4 MG | 3010002000E422 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.6 MG | 3010002000E425 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.8 MG | 3010002000E428 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 2 MG | 3010002000E431 | Brand |
| HUMATROPE | SOMATROPIN FOR INJ CARTRIDGE 6 MG (18 UNIT) | 3010002000E120 | Brand |
| HUMATROPE | SOMATROPIN FOR INJ CARTRIDGE 12 MG (36 UNIT) | 3010002000E130 | Brand |

| HUMATROPE | SOMATROPIN FOR INJ CARTRIDGE 24 MG | 3010002000E140 | Brand |
|---|---|---|---|

**Approval Criteria**

**1** - ONE of the following criteria:

**1.1** BOTH of the following:

**1.1.1** Evidence of positive response to therapy (e.g., increase in total lean body mass, decrease in fat mass)

**AND**

**1.1.2** Prescribed by an endocrinologist

**OR**

**1.2** ALL of the following:

**1.2.1** Height increase of at least 2 centimeters per year over the previous year of treatment as documented by BOTH of the following:

- Previous height and date obtained
- Current height and date obtained

**AND**

**1.2.2** BOTH of the following:

- Expected adult height not attained
- Documentation of expected adult height goal

**AND**

**1.2.3** Prescribed by an endocrinologist

| Product Name: Genotropin, 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZOMACTON | SOMATROPIN FOR SUBCUTANEOUS INJ 5 MG | 30100020002121 | Brand |
| OMNITROPE | SOMATROPIN FOR INJ 5.8 MG | 30100020002123 | Brand |
| SAIZEN | SOMATROPIN (NON-REFRIGERATED) FOR INJ 5 MG | 30100020102120 | Brand |
| SAIZEN | SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG | 30100020102130 | Brand |
| SAIZENPREP RECONSTITUTIONKIT | SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG | 30100020102130 | Brand |
| ZOMACTON | SOMATROPIN FOR INJ 10 MG | 30100020002140 | Brand |
| ZORBTIVE | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 8.8 MG | 30100020102132 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 4 MG | 30100020102118 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 5 MG | 30100020102121 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 6 MG | 30100020102125 | Brand |
| NUTROPIN AQ NUSPIN 5 | SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/2ML | 3010002000D207 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/1.5ML | 3010002000D212 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/1.5ML | 3010002000D230 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 15 MG/1.5ML | 3010002000D240 | Brand |
| NUTROPIN AQ NUSPIN 10 | SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/2ML | 3010002000D220 | Brand |
| NUTROPIN AQ NUSPIN 20 | SOMATROPIN SOLUTION PEN-INJECTOR 20 MG/2ML | 3010002000D250 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 30 MG/3ML | 3010002000D260 | Brand |
| OMNITROPE | SOMATROPIN SOLUTION CARTRIDGE 5 MG/1.5ML | 3010002000E210 | Brand |

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|---|---|---|---|
| OMNITROPE | SOMATROPIN SOLUTION CARTRIDGE 10 MG/1.5ML | 3010002000E213 | Brand |
| GENOTROPIN | SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 5 MG | 3010002000E159 | Brand |
| GENOTROPIN | SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 12 MG (36 UNIT) | 3010002000E188 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.2 MG | 3010002000E404 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.4 MG | 3010002000E407 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.6 MG | 3010002000E410 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.8 MG | 3010002000E413 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1 MG | 3010002000E416 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.2 MG | 3010002000E419 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.4 MG | 3010002000E422 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.6 MG | 3010002000E425 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.8 MG | 3010002000E428 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 2 MG | 3010002000E431 | Brand |
| HUMATROPE | SOMATROPIN FOR INJ CARTRIDGE 6 MG (18 UNIT) | 3010002000E120 | Brand |
| HUMATROPE | SOMATROPIN FOR INJ CARTRIDGE 12 MG (36 UNIT) | 3010002000E130 | Brand |
| HUMATROPE | SOMATROPIN FOR INJ CARTRIDGE 24 MG | 3010002000E140 | Brand |

**Approval Criteria**

**1** - Diagnosis of SGA (small for gestational age) based on demonstration of catch up growth failure in the first 24 months of life using a birth to 36 month growth chart as confirmed by BOTH of the following:

**1.1** Documentation that ONE of the following is below the third percentile for gestational age (greater than or equal to 2 standard deviations [SD] below population mean):

- Birth weight

- Birth length

**AND**

**1.2** Patient has demonstrated failure of catch up growth in the first 24 months of life

**AND**

**2** - Documentation that height remains less than or equal to third percentile (greater than or equal to 2 SD below population mean)

**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) (See Table 1 in Background section for non-preferred products)

| 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZOMACTON | SOMATROPIN FOR SUBCUTANEOUS INJ 5 MG | 30100020002121 | Brand |
| OMNITROPE | SOMATROPIN FOR INJ 5.8 MG | 30100020002123 | Brand |
| SAIZEN | SOMATROPIN (NON-REFRIGERATED) FOR INJ 5 MG | 30100020102120 | Brand |

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|---|---|---|---|
| SAIZEN | SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG | 30100020102130 | Brand |
| SAIZENPREP RECONSTITUTIONKIT | SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG | 30100020102130 | Brand |
| ZOMACTON | SOMATROPIN FOR INJ 10 MG | 30100020002140 | Brand |
| ZORBTIVE | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 8.8 MG | 30100020102132 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 4 MG | 30100020102118 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 5 MG | 30100020102121 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 6 MG | 30100020102125 | Brand |
| NUTROPIN AQ NUSPIN 5 | SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/2ML | 3010002000D207 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/1.5ML | 3010002000D212 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/1.5ML | 3010002000D230 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 15 MG/1.5ML | 3010002000D240 | Brand |
| NUTROPIN AQ NUSPIN 10 | SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/2ML | 3010002000D220 | Brand |
| NUTROPIN AQ NUSPIN 20 | SOMATROPIN SOLUTION PEN-INJECTOR 20 MG/2ML | 3010002000D250 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 30 MG/3ML | 3010002000D260 | Brand |
| OMNITROPE | SOMATROPIN SOLUTION CARTRIDGE 5 MG/1.5ML | 3010002000E210 | Brand |
| OMNITROPE | SOMATROPIN SOLUTION CARTRIDGE 10 MG/1.5ML | 3010002000E213 | Brand |
| GENOTROPIN | SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 5 MG | 3010002000E159 | Brand |
| GENOTROPIN | SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 12 MG (36 UNIT) | 3010002000E188 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.2 MG | 3010002000E404 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.4 MG | 3010002000E407 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.6 MG | 3010002000E410 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.8 MG | 3010002000E413 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1 MG | 3010002000E416 | Brand |

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|---|---|---|---|
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.2 MG | 3010002000E419 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.4 MG | 3010002000E422 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.6 MG | 3010002000E425 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.8 MG | 3010002000E428 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 2 MG | 3010002000E431 | Brand |
| HUMATROPE | SOMATROPIN FOR INJ CARTRIDGE 6 MG (18 UNIT) | 3010002000E120 | Brand |
| HUMATROPE | SOMATROPIN FOR INJ CARTRIDGE 12 MG (36 UNIT) | 3010002000E130 | Brand |
| HUMATROPE | SOMATROPIN FOR INJ CARTRIDGE 24 MG | 3010002000E140 | Brand |

**Approval Criteria**

**1** - Height increase of at least 2 centimeters per year over the previous year documented by BOTH of the following:*

- Previous height and date obtained
- Current height and date obtained

**AND**

**2** - Documentation of BOTH of the following:*

- Expected adult height not attained
- Expected adult height goal

**AND**

**3** - Prescribed by an endocrinologist

| | |
|---|---|
| Notes | *Documentation of previous height, current height and goal expected adult height will be required for renewal. |

| Product Name: Genotropin, 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZOMACTON | SOMATROPIN FOR SUBCUTANEOUS INJ 5 MG | 30100020002121 | Brand |
| OMNITROPE | SOMATROPIN FOR INJ 5.8 MG | 30100020002123 | Brand |
| SAIZEN | SOMATROPIN (NON-REFRIGERATED) FOR INJ 5 MG | 30100020102120 | Brand |
| SAIZEN | SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG | 30100020102130 | Brand |
| SAIZENPREP RECONSTITUTIONKIT | SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG | 30100020102130 | Brand |
| ZOMACTON | SOMATROPIN FOR INJ 10 MG | 30100020002140 | Brand |
| ZORBTIVE | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 8.8 MG | 30100020102132 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 4 MG | 30100020102118 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 5 MG | 30100020102121 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 6 MG | 30100020102125 | Brand |
| NUTROPIN AQ NUSPIN 5 | SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/2ML | 3010002000D207 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/1.5ML | 3010002000D212 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/1.5ML | 3010002000D230 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 15 MG/1.5ML | 3010002000D240 | Brand |
| NUTROPIN AQ NUSPIN 10 | SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/2ML | 3010002000D220 | Brand |
| NUTROPIN AQ NUSPIN 20 | SOMATROPIN SOLUTION PEN-INJECTOR 20 MG/2ML | 3010002000D250 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 30 MG/3ML | 3010002000D260 | Brand |
| OMNITROPE | SOMATROPIN SOLUTION CARTRIDGE 5 MG/1.5ML | 3010002000E210 | Brand |

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|---|---|---|---|
| OMNITROPE | SOMATROPIN SOLUTION CARTRIDGE 10 MG/1.5ML | 3010002000E213 | Brand |
| GENOTROPIN | SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 5 MG | 3010002000E159 | Brand |
| GENOTROPIN | SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 12 MG (36 UNIT) | 3010002000E188 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.2 MG | 3010002000E404 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.4 MG | 3010002000E407 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.6 MG | 3010002000E410 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.8 MG | 3010002000E413 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1 MG | 3010002000E416 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.2 MG | 3010002000E419 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.4 MG | 3010002000E422 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.6 MG | 3010002000E425 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.8 MG | 3010002000E428 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 2 MG | 3010002000E431 | Brand |
| HUMATROPE | SOMATROPIN FOR INJ CARTRIDGE 6 MG (18 UNIT) | 3010002000E120 | Brand |
| HUMATROPE | SOMATROPIN FOR INJ CARTRIDGE 12 MG (36 UNIT) | 3010002000E130 | Brand |
| HUMATROPE | SOMATROPIN FOR INJ CARTRIDGE 24 MG | 3010002000E140 | Brand |

**Approval Criteria**

**1** - Diagnosis of pediatric growth failure associated with ONE of the following:

**1.1** BOTH of the following:

**1.1.1** Turner Syndrome (Gonadal Dysgenesis)

**AND**

**1.1.2** Patient is female and ONE of the following:

- Tanner stage less than 4
- Bone age less than 14 years measured in the past 12 months

**OR**

**1.2** BOTH of the following:

**1.2.1** Noonan Syndrome

**AND**

**1.2.2** ONE of the following:

**1.2.2.1** Patient is male and ONE of the following:

- Tanner stage less than 4
- Bone age less than 16 years measured in the past 12 months

**OR**

**1.2.2.2** Patient is female and ONE of the following:

- Tanner stage less than 4
- Bone age less than 14 years measured in the past 12 months

**AND**

**2** - Height is below the fifth percentile on growth charts for age and gender

**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) (See Table 1 in Background section for non-preferred products)

| 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZOMACTON | SOMATROPIN FOR SUBCUTANEOUS INJ 5 MG | 30100020002121 | Brand |
| OMNITROPE | SOMATROPIN FOR INJ 5.8 MG | 30100020002123 | Brand |
| SAIZEN | SOMATROPIN (NON-REFRIGERATED) FOR INJ 5 MG | 30100020102120 | Brand |
| SAIZEN | SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG | 30100020102130 | Brand |
| SAIZENPREP RECONSTITUTIONKIT | SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG | 30100020102130 | Brand |
| ZOMACTON | SOMATROPIN FOR INJ 10 MG | 30100020002140 | Brand |
| ZORBTIVE | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 8.8 MG | 30100020102132 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 4 MG | 30100020102118 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 5 MG | 30100020102121 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 6 MG | 30100020102125 | Brand |
| NUTROPIN AQ NUSPIN 5 | SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/2ML | 3010002000D207 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/1.5ML | 3010002000D212 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/1.5ML | 3010002000D230 | Brand |

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|---|---|---|---|
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 15 MG/1.5ML | 3010002000D240 | Brand |
| NUTROPIN AQ NUSPIN 10 | SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/2ML | 3010002000D220 | Brand |
| NUTROPIN AQ NUSPIN 20 | SOMATROPIN SOLUTION PEN-INJECTOR 20 MG/2ML | 3010002000D250 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 30 MG/3ML | 3010002000D260 | Brand |
| OMNITROPE | SOMATROPIN SOLUTION CARTRIDGE 5 MG/1.5ML | 3010002000E210 | Brand |
| OMNITROPE | SOMATROPIN SOLUTION CARTRIDGE 10 MG/1.5ML | 3010002000E213 | Brand |
| GENOTROPIN | SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 5 MG | 3010002000E159 | Brand |
| GENOTROPIN | SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 12 MG (36 UNIT) | 3010002000E188 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.2 MG | 3010002000E404 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.4 MG | 3010002000E407 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.6 MG | 3010002000E410 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.8 MG | 3010002000E413 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1 MG | 3010002000E416 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.2 MG | 3010002000E419 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.4 MG | 3010002000E422 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.6 MG | 3010002000E425 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.8 MG | 3010002000E428 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 2 MG | 3010002000E431 | Brand |
| HUMATROPE | SOMATROPIN FOR INJ CARTRIDGE 6 MG (18 UNIT) | 3010002000E120 | Brand |
| HUMATROPE | SOMATROPIN FOR INJ CARTRIDGE 12 MG (36 UNIT) | 3010002000E130 | Brand |
| HUMATROPE | SOMATROPIN FOR INJ CARTRIDGE 24 MG | 3010002000E140 | Brand |

**Approval Criteria**

**1** - Height increase of at least 2 centimeters per year over the previous year documented by BOTH of the following:*

- Previous height and date obtained
- Current height and date obtained

**AND**

**2** - Documentation of BOTH of the following:*

- Expected adult height not attained
- Expected adult height goal

**AND**

**3** - Prescribed by an endocrinologist

| Notes | *Documentation of previous height, current height and goal expected adult height will be required for renewal. |
|---|---|

| Product Name: Genotropin, 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZOMACTON | SOMATROPIN FOR SUBCUTANEOUS INJ 5 MG | 30100020002121 | Brand |
| OMNITROPE | SOMATROPIN FOR INJ 5.8 MG | 30100020002123 | Brand |
| SAIZEN | SOMATROPIN (NON-REFRIGERATED) FOR INJ 5 MG | 30100020102120 | Brand |
| SAIZEN | SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG | 30100020102130 | Brand |
| SAIZENPREP RECONSTITUTIONKIT | SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG | 30100020102130 | Brand |
| ZOMACTON | SOMATROPIN FOR INJ 10 MG | 30100020002140 | Brand |

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|---|---|---|---|
| ZORBTIVE | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 8.8 MG | 30100020102132 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 4 MG | 30100020102118 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 5 MG | 30100020102121 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 6 MG | 30100020102125 | Brand |
| NUTROPIN AQ NUSPIN 5 | SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/2ML | 3010002000D207 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/1.5ML | 3010002000D212 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/1.5ML | 3010002000D230 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 15 MG/1.5ML | 3010002000D240 | Brand |
| NUTROPIN AQ NUSPIN 10 | SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/2ML | 3010002000D220 | Brand |
| NUTROPIN AQ NUSPIN 20 | SOMATROPIN SOLUTION PEN-INJECTOR 20 MG/2ML | 3010002000D250 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 30 MG/3ML | 3010002000D260 | Brand |
| OMNITROPE | SOMATROPIN SOLUTION CARTRIDGE 5 MG/1.5ML | 3010002000E210 | Brand |
| OMNITROPE | SOMATROPIN SOLUTION CARTRIDGE 10 MG/1.5ML | 3010002000E213 | Brand |
| GENOTROPIN | SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 5 MG | 3010002000E159 | Brand |
| GENOTROPIN | SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 12 MG (36 UNIT) | 3010002000E188 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.2 MG | 3010002000E404 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.4 MG | 3010002000E407 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.6 MG | 3010002000E410 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.8 MG | 3010002000E413 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1 MG | 3010002000E416 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.2 MG | 3010002000E419 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.4 MG | 3010002000E422 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.6 MG | 3010002000E425 | Brand |

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|---|---|---|---|
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.8 MG | 3010002000E428 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 2 MG | 3010002000E431 | Brand |
| HUMATROPE | SOMATROPIN FOR INJ CARTRIDGE 6 MG (18 UNIT) | 3010002000E120 | Brand |
| HUMATROPE | SOMATROPIN FOR INJ CARTRIDGE 12 MG (36 UNIT) | 3010002000E130 | Brand |
| HUMATROPE | SOMATROPIN FOR INJ CARTRIDGE 24 MG | 3010002000E140 | Brand |

**Approval Criteria**

**1** - Diagnosis of pediatric growth failure with short-stature homeobox (SHOX) gene deficiency as confirmed by genetic testing

**AND**

**2** - ONE of the following:

**2.1** Patient is male and ONE of the following:

- Tanner stage less than 4
- Bone age less than 16 years measured in the past 12 months

**OR**

**2.2** Patient is female and ONE of the following:

- Tanner stage less than 4
- Bone age less than 14 years measured in the past 12 months

**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) (See Table 1 in Background section for non-preferred products)

| 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZOMACTON | SOMATROPIN FOR SUBCUTANEOUS INJ 5 MG | 30100020002121 | Brand |
| OMNITROPE | SOMATROPIN FOR INJ 5.8 MG | 30100020002123 | Brand |
| SAIZEN | SOMATROPIN (NON-REFRIGERATED) FOR INJ 5 MG | 30100020102120 | Brand |
| SAIZEN | SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG | 30100020102130 | Brand |
| SAIZENPREP RECONSTITUTIONKIT | SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG | 30100020102130 | Brand |
| ZOMACTON | SOMATROPIN FOR INJ 10 MG | 30100020002140 | Brand |
| ZORBTIVE | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 8.8 MG | 30100020102132 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 4 MG | 30100020102118 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 5 MG | 30100020102121 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 6 MG | 30100020102125 | Brand |
| NUTROPIN AQ NUSPIN 5 | SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/2ML | 3010002000D207 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/1.5ML | 3010002000D212 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/1.5ML | 3010002000D230 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 15 MG/1.5ML | 3010002000D240 | Brand |
| NUTROPIN AQ NUSPIN 10 | SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/2ML | 3010002000D220 | Brand |

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|---|---|---|---|
| NUTROPIN AQ NUSPIN 20 | SOMATROPIN SOLUTION PEN-INJECTOR 20 MG/2ML | 3010002000D250 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 30 MG/3ML | 3010002000D260 | Brand |
| OMNITROPE | SOMATROPIN SOLUTION CARTRIDGE 5 MG/1.5ML | 3010002000E210 | Brand |
| OMNITROPE | SOMATROPIN SOLUTION CARTRIDGE 10 MG/1.5ML | 3010002000E213 | Brand |
| GENOTROPIN | SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 5 MG | 3010002000E159 | Brand |
| GENOTROPIN | SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 12 MG (36 UNIT) | 3010002000E188 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.2 MG | 3010002000E404 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.4 MG | 3010002000E407 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.6 MG | 3010002000E410 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.8 MG | 3010002000E413 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1 MG | 3010002000E416 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.2 MG | 3010002000E419 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.4 MG | 3010002000E422 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.6 MG | 3010002000E425 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.8 MG | 3010002000E428 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 2 MG | 3010002000E431 | Brand |
| HUMATROPE | SOMATROPIN FOR INJ CARTRIDGE 6 MG (18 UNIT) | 3010002000E120 | Brand |
| HUMATROPE | SOMATROPIN FOR INJ CARTRIDGE 12 MG (36 UNIT) | 3010002000E130 | Brand |
| HUMATROPE | SOMATROPIN FOR INJ CARTRIDGE 24 MG | 3010002000E140 | Brand |

**Approval Criteria**

**1** - Height increase of at least 2 centimeters per year over the previous year documented by BOTH of the following:*

- Previous height and date obtained
- Current height and date obtained

**AND**

**2** - Documentation of BOTH of the following:*

- Expected adult height not attained
- Expected adult height goal

**AND**

**3** - Prescribed by an endocrinologist

| Notes | *Documentation of previous height, current height and goal expected adult height will be required for renewal. |
|---|---|

| Product Name: Genotropin, 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZOMACTON | SOMATROPIN FOR SUBCUTANEOUS INJ 5 MG | 30100020002121 | Brand |
| OMNITROPE | SOMATROPIN FOR INJ 5.8 MG | 30100020002123 | Brand |
| SAIZEN | SOMATROPIN (NON-REFRIGERATED) FOR INJ 5 MG | 30100020102120 | Brand |
| SAIZEN | SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG | 30100020102130 | Brand |
| SAIZENPREP RECONSTITUTIONKIT | SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG | 30100020102130 | Brand |
| ZOMACTON | SOMATROPIN FOR INJ 10 MG | 30100020002140 | Brand |
| ZORBTIVE | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 8.8 MG | 30100020102132 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 4 MG | 30100020102118 | Brand |

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|---|---|---|---|
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 5 MG | 30100020102121 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 6 MG | 30100020102125 | Brand |
| NUTROPIN AQ NUSPIN 5 | SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/2ML | 3010002000D207 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/1.5ML | 3010002000D212 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/1.5ML | 3010002000D230 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 15 MG/1.5ML | 3010002000D240 | Brand |
| NUTROPIN AQ NUSPIN 10 | SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/2ML | 3010002000D220 | Brand |
| NUTROPIN AQ NUSPIN 20 | SOMATROPIN SOLUTION PEN-INJECTOR 20 MG/2ML | 3010002000D250 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 30 MG/3ML | 3010002000D260 | Brand |
| OMNITROPE | SOMATROPIN SOLUTION CARTRIDGE 5 MG/1.5ML | 3010002000E210 | Brand |
| OMNITROPE | SOMATROPIN SOLUTION CARTRIDGE 10 MG/1.5ML | 3010002000E213 | Brand |
| GENOTROPIN | SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 5 MG | 3010002000E159 | Brand |
| GENOTROPIN | SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 12 MG (36 UNIT) | 3010002000E188 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.2 MG | 3010002000E404 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.4 MG | 3010002000E407 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.6 MG | 3010002000E410 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.8 MG | 3010002000E413 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1 MG | 3010002000E416 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.2 MG | 3010002000E419 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.4 MG | 3010002000E422 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.6 MG | 3010002000E425 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.8 MG | 3010002000E428 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 2 MG | 3010002000E431 | Brand |

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|---|---|---|---|
| HUMATROPE | SOMATROPIN FOR INJ CARTRIDGE 6 MG (18 UNIT) | 3010002000E120 | Brand |
| HUMATROPE | SOMATROPIN FOR INJ CARTRIDGE 12 MG (36 UNIT) | 3010002000E130 | Brand |
| HUMATROPE | SOMATROPIN FOR INJ CARTRIDGE 24 MG | 3010002000E140 | Brand |

**Approval Criteria**

**1** - Diagnosis of pediatric growth failure associated with chronic renal insufficiency

**AND**

**2** - ONE of the following:

**2.1** Patient is male and ONE of the following:

- Tanner stage less than 4
- Bone age less than 16 years measured in the past 12 months

**OR**

**2.2** Patient is female and ONE of the following:

- Tanner stage less than 4
- Bone age less than 14 years measured in the past 12 months

**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) (See Table 1 in Background section for non-preferred products) |
|---|

| 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZOMACTON | SOMATROPIN FOR SUBCUTANEOUS INJ 5 MG | 30100020002121 | Brand |
| OMNITROPE | SOMATROPIN FOR INJ 5.8 MG | 30100020002123 | Brand |
| SAIZEN | SOMATROPIN (NON-REFRIGERATED) FOR INJ 5 MG | 30100020102120 | Brand |
| SAIZEN | SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG | 30100020102130 | Brand |
| SAIZENPREP RECONSTITUTIONKIT | SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG | 30100020102130 | Brand |
| ZOMACTON | SOMATROPIN FOR INJ 10 MG | 30100020002140 | Brand |
| ZORBTIVE | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 8.8 MG | 30100020102132 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 4 MG | 30100020102118 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 5 MG | 30100020102121 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 6 MG | 30100020102125 | Brand |
| NUTROPIN AQ NUSPIN 5 | SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/2ML | 3010002000D207 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/1.5ML | 3010002000D212 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/1.5ML | 3010002000D230 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 15 MG/1.5ML | 3010002000D240 | Brand |
| NUTROPIN AQ NUSPIN 10 | SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/2ML | 3010002000D220 | Brand |
| NUTROPIN AQ NUSPIN 20 | SOMATROPIN SOLUTION PEN-INJECTOR 20 MG/2ML | 3010002000D250 | Brand |

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|---|---|---|---|
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 30 MG/3ML | 3010002000D260 | Brand |
| OMNITROPE | SOMATROPIN SOLUTION CARTRIDGE 5 MG/1.5ML | 3010002000E210 | Brand |
| OMNITROPE | SOMATROPIN SOLUTION CARTRIDGE 10 MG/1.5ML | 3010002000E213 | Brand |
| GENOTROPIN | SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 5 MG | 3010002000E159 | Brand |
| GENOTROPIN | SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 12 MG (36 UNIT) | 3010002000E188 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.2 MG | 3010002000E404 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.4 MG | 3010002000E407 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.6 MG | 3010002000E410 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.8 MG | 3010002000E413 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1 MG | 3010002000E416 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.2 MG | 3010002000E419 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.4 MG | 3010002000E422 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.6 MG | 3010002000E425 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.8 MG | 3010002000E428 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 2 MG | 3010002000E431 | Brand |
| HUMATROPE | SOMATROPIN FOR INJ CARTRIDGE 6 MG (18 UNIT) | 3010002000E120 | Brand |
| HUMATROPE | SOMATROPIN FOR INJ CARTRIDGE 12 MG (36 UNIT) | 3010002000E130 | Brand |
| HUMATROPE | SOMATROPIN FOR INJ CARTRIDGE 24 MG | 3010002000E140 | Brand |

**Approval Criteria**

**1** - Height increase of at least 2 centimeters per year over the previous year documented by BOTH of the following:*

- Previous height and date obtained

- Current height and date obtained

**AND**

**2** - Documentation of BOTH of the following:*

- Expected adult height not attained
- Expected adult height goal

**AND**

**3** - Prescribed by ONE of the following:

- Endocrinologist
- Nephrologist

| Notes | *Documentation of previous height, current height and goal expected adult height will be required for renewal. |
|---|---|

| Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ NuSpin, Omnitrope, Saizen, Zomacton, Zorbtive, Serostim | |
|---|---|
| Diagnosis | Adult Growth Hormone Deficiency |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZOMACTON | SOMATROPIN FOR SUBCUTANEOUS INJ 5 MG | 30100020002121 | Brand |
| OMNITROPE | SOMATROPIN FOR INJ 5.8 MG | 30100020002123 | Brand |
| SAIZEN | SOMATROPIN (NON-REFRIGERATED) FOR INJ 5 MG | 30100020102120 | Brand |
| SAIZEN | SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG | 30100020102130 | Brand |
| SAIZENPREP RECONSTITUTIONKIT | SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG | 30100020102130 | Brand |
| ZOMACTON | SOMATROPIN FOR INJ 10 MG | 30100020002140 | Brand |
| ZORBTIVE | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 8.8 MG | 30100020102132 | Brand |

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|---|---|---|---|
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 4 MG | 30100020102118 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 5 MG | 30100020102121 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 6 MG | 30100020102125 | Brand |
| NUTROPIN AQ NUSPIN 5 | SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/2ML | 3010002000D207 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/1.5ML | 3010002000D212 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/1.5ML | 3010002000D230 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 15 MG/1.5ML | 3010002000D240 | Brand |
| NUTROPIN AQ NUSPIN 10 | SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/2ML | 3010002000D220 | Brand |
| NUTROPIN AQ NUSPIN 20 | SOMATROPIN SOLUTION PEN-INJECTOR 20 MG/2ML | 3010002000D250 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 30 MG/3ML | 3010002000D260 | Brand |
| OMNITROPE | SOMATROPIN SOLUTION CARTRIDGE 5 MG/1.5ML | 3010002000E210 | Brand |
| OMNITROPE | SOMATROPIN SOLUTION CARTRIDGE 10 MG/1.5ML | 3010002000E213 | Brand |
| GENOTROPIN | SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 5 MG | 3010002000E159 | Brand |
| GENOTROPIN | SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 12 MG (36 UNIT) | 3010002000E188 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.2 MG | 3010002000E404 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.4 MG | 3010002000E407 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.6 MG | 3010002000E410 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.8 MG | 3010002000E413 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1 MG | 3010002000E416 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.2 MG | 3010002000E419 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.4 MG | 3010002000E422 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.6 MG | 3010002000E425 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.8 MG | 3010002000E428 | Brand |

| | | | |
|---|---|---|---|
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 2 MG | 3010002000E431 | Brand |
| HUMATROPE | SOMATROPIN FOR INJ CARTRIDGE 6 MG (18 UNIT) | 3010002000E120 | Brand |
| HUMATROPE | SOMATROPIN FOR INJ CARTRIDGE 12 MG (36 UNIT) | 3010002000E130 | Brand |
| HUMATROPE | SOMATROPIN FOR INJ CARTRIDGE 24 MG | 3010002000E140 | Brand |

**Approval Criteria**

**1** - Diagnosis of adult growth hormone deficiency (GHD) as a result of ONE of the following:

**1.1** Clinical records supporting a diagnosis of childhood-onset GHD

**OR**

**1.2** BOTH of the following:

**1.2.1** Adult-onset GHD

**AND**

**1.2.2** Clinical records documenting that hormone deficiency is a result of hypothalamic-pituitary disease from organic or known causes (e.g., damage from surgery, cranial irradiation, head trauma, or subarachnoid hemorrhage)

**AND**

**2** - Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following:

**2.1** BOTH of the following:

**2.1.1** Patient has undergone ONE of the following GH (growth hormone) stimulation tests to confirm adult GH deficiency:

- Insulin tolerance test (ITT)
- ARG (Arginine) and GHRH (growth hormone releasing hormone)
- Glucagon

- ARG
- Macrilen (macimorelin)

**AND**

**2.1.2** ONE of the following peak GH values:

**2.1.2.1** ITT less than or equal to 5 micrograms per liter

**OR**

**2.1.2.2** GHRH and ARG of ONE of the following:

- Less than or equal to 11 micrograms per liter if body mass index [BMI] is less than 25 kilograms per meter squared
- Less than or equal to 8 micrograms per liter if BMI is greater than or equal to 25 and less than 30 kilograms per meter squared
- Less than or equal to 4 micrograms per liter if BMI is greater than or equal to 30 kilograms per meter squared

**OR**

**2.1.2.3** Glucagon less than or equal to 3 micrograms per liter

**OR**

**2.1.2.4** ARG less than or equal to 0.4 micrograms per liter

**OR**

**2.1.2.5** Macimorelin less than 2.8 nanograms per milliliter 30, 45, 60 and 90 minutes following macimorelin administration

**OR**

**2.2** BOTH of the following:

**2.2.1** Submission of medical records (e.g., chart notes, laboratory values) documenting deficiency of THREE of the following anterior pituitary hormones:

- Prolactin
- ACTH (adrenocorticotropic hormone)
- TSH (thyroid stimulating hormone)
- FSH/LH (follicle-stimulating hormone/luteinizing hormone)

**AND**

**2.2.2** Insulin-like Growth Factor 1 (IGF-1)/Somatomedin-C level is below the age and gender adjusted normal range as provided by the physician's lab

**AND**

**3** - ONE of the following:

**3.1** Diagnosis of panhypopituitarism

**OR**

**3.2** Other diagnosis and not used in combination with the following:

- Aromatase inhibitors [e.g., Arimidex (anastrazole),Femara (letrazole)]
- Androgens [e.g., Delatestryl (testosterone enanthate), Depo-Testosterone (testosterone cypionate)]

**AND**

**4** - Prescribed by an endocrinologist

**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) (See Table 1 in Background section for non-preferred products)

| Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ NuSpin, Omnitrope, Saizen, Zomacton, Zorbtive, Serostim | |
|---|---|
| Diagnosis | Adult Growth Hormone Deficiency |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZOMACTON | SOMATROPIN FOR SUBCUTANEOUS INJ 5 MG | 30100020002121 | Brand |
| OMNITROPE | SOMATROPIN FOR INJ 5.8 MG | 30100020002123 | Brand |
| SAIZEN | SOMATROPIN (NON-REFRIGERATED) FOR INJ 5 MG | 30100020102120 | Brand |
| SAIZEN | SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG | 30100020102130 | Brand |
| SAIZENPREP RECONSTITUTIONKIT | SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG | 30100020102130 | Brand |
| ZOMACTON | SOMATROPIN FOR INJ 10 MG | 30100020002140 | Brand |
| ZORBTIVE | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 8.8 MG | 30100020102132 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 4 MG | 30100020102118 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 5 MG | 30100020102121 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 6 MG | 30100020102125 | Brand |
| NUTROPIN AQ NUSPIN 5 | SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/2ML | 3010002000D207 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/1.5ML | 3010002000D212 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/1.5ML | 3010002000D230 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 15 MG/1.5ML | 3010002000D240 | Brand |
| NUTROPIN AQ NUSPIN 10 | SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/2ML | 3010002000D220 | Brand |
| NUTROPIN AQ NUSPIN 20 | SOMATROPIN SOLUTION PEN-INJECTOR 20 MG/2ML | 3010002000D250 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 30 MG/3ML | 3010002000D260 | Brand |
| OMNITROPE | SOMATROPIN SOLUTION CARTRIDGE 5 MG/1.5ML | 3010002000E210 | Brand |

| | | | |
|---|---|---|---|
| OMNITROPE | SOMATROPIN SOLUTION CARTRIDGE 10 MG/1.5ML | 3010002000E213 | Brand |
| GENOTROPIN | SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 5 MG | 3010002000E159 | Brand |
| GENOTROPIN | SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 12 MG (36 UNIT) | 3010002000E188 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.2 MG | 3010002000E404 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.4 MG | 3010002000E407 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.6 MG | 3010002000E410 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.8 MG | 3010002000E413 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1 MG | 3010002000E416 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.2 MG | 3010002000E419 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.4 MG | 3010002000E422 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.6 MG | 3010002000E425 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.8 MG | 3010002000E428 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 2 MG | 3010002000E431 | Brand |
| HUMATROPE | SOMATROPIN FOR INJ CARTRIDGE 6 MG (18 UNIT) | 3010002000E120 | Brand |
| HUMATROPE | SOMATROPIN FOR INJ CARTRIDGE 12 MG (36 UNIT) | 3010002000E130 | Brand |
| HUMATROPE | SOMATROPIN FOR INJ CARTRIDGE 24 MG | 3010002000E140 | Brand |

**Approval Criteria**

**1** - Documentation of Insulin-like Growth Factor 1 (IGF-1)/Somatomedin C level within the past 12 months

**AND**

**2** - ONE of the following:

**2.1** Diagnosis of panhypopituitarism

**OR**

**2.2** Other diagnosis and not used in combination with the following:

- Aromatase inhibitors [e.g., Arimidex (anastrazole), Femara (letrazole)]
- Androgens [e.g., Delatestryl (testosterone enanthate), Depo-Testosterone (testosterone cypionate)]

**AND**

**3** - Prescribed by an endocrinologist

| Product Name: Sogroya | |
|---|---|
| Diagnosis | Adult Growth Hormone Deficiency |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SOGROYA | SOMAPACITAN-BECO SOLUTION PEN-INJECTOR 5 MG/1.5ML | 3010000720D210 | Brand |
| SOGROYA | SOMAPACITAN-BECO SOLUTION PEN-INJECTOR 10 MG/1.5ML | 3010000720D220 | Brand |
| SOGROYA | SOMAPACITAN-BECO SOLUTION PEN-INJECTOR 15 MG/1.5ML | 3010000720D230 | Brand |

**Approval Criteria**

**1** - Diagnosis of adult growth hormone deficiency (GHD) as a result of ONE of the following:

**1.1** Clinical records supporting a diagnosis of childhood-onset GHD

**OR**

**1.2** BOTH of the following:

**1.2.1** Adult-onset GHD

**AND**

**1.2.2** Clinical records documenting that hormone deficiency is a result of hypothalamic-pituitary disease from organic or known causes (e.g., damage from surgery, cranial irradiation, head trauma, or subarachnoid hemorrhage)

**AND**

**2** - Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following:

**2.1** BOTH of the following:

**2.1.1** Patient has undergone ONE of the following GH (growth hormone) stimulation tests to confirm adult GH deficiency:

- Insulin tolerance test (ITT)
- ARG (Arginine) and GHRH (growth hormone releasing hormone)
- Glucagon
- ARG
- Macrilen (macimorelin)

**AND**

**2.1.2** ONE of the following peak GH values:

**2.1.2.1** ITT less than or equal to 5 micrograms per liter

**OR**

**2.1.2.2** GHRH and ARG of ONE of the following:

- Less than or equal to 11 micrograms per liter if body mass index [BMI] is less than 25 kilograms per meter squared
- Less than or equal to 8 micrograms per liter if BMI is greater than or equal to 25 and less than 30 kilograms per meter squared

- Less than or equal to 4 micrograms per liter if BMI is greater than or equal to 30 kilograms per meter squared

**OR**

**2.1.2.3** Glucagon less than or equal to 3 micrograms per liter

**OR**

**2.1.2.4** ARG less than or equal to 0.4 micrograms per liter

**OR**

**2.1.2.5** Macimorelin less than 2.8 nanograms per milliliter 30, 45, 60 and 90 minutes following macimorelin administration

**OR**

**2.2** BOTH of the following:

**2.2.1** Submission of medical records (e.g., chart notes, laboratory values) documenting deficiency of THREE of the following anterior pituitary hormones:

- Prolactin
- ACTH (adrenocorticotropic hormone)
- TSH (thyroid stimulating hormone)
- FSH/LH (follicle-stimulating hormone/luteinizing hormone)

**AND**

**2.2.2** Insulin-like Growth Factor 1 (IGF-1)/Somatomedin-C level is below the age and gender adjusted normal range as provided by the physician's lab

**AND**

**3** - ONE of the following:

**3.1** Diagnosis of panhypopituitarism

**OR**

**3.2** Other diagnosis and not used in combination with the following:

- Aromatase inhibitors [e.g., Arimidex (anastrazole),Femara (letrazole)]
- Androgens [e.g., Delatestryl (testosterone enanthate), Depo-Testosterone (testosterone cypionate)]

**AND**

**4** - Prescribed by an endocrinologist

**AND**

**5** - ONE of the following:

**5.1** Failure to ONE of the following, confirmed by claims history or submission of medical records:

- Somatropin (Norditropin)
- Somatropin (Omnitrope)

**OR**

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

- Somatropin (Norditropin)
- Somatropin (Omnitrope)

| Product Name: Sogroya | |
|---|---|
| Diagnosis | Adult Growth Hormone Deficiency |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |

| Guideline Type | Prior Authorization |
|---|---|

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SOGROYA | SOMAPACITAN-BECO SOLUTION PEN-INJECTOR 5 MG/1.5ML | 3010000720D210 | Brand |
| SOGROYA | SOMAPACITAN-BECO SOLUTION PEN-INJECTOR 10 MG/1.5ML | 3010000720D220 | Brand |
| SOGROYA | SOMAPACITAN-BECO SOLUTION PEN-INJECTOR 15 MG/1.5ML | 3010000720D230 | Brand |

**Approval Criteria**

**1** - Documentation of Insulin-like Growth Factor 1 (IGF-1)/Somatomedin C level within the past 12 months

**AND**

**2** - ONE of the following:

**2.1** Diagnosis of panhypopituitarism

**OR**

**2.2** Other diagnosis and not used in combination with the following:

- Aromatase inhibitors [e.g., Arimidex (anastrazole), Femara (letrazole)]
- 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 | Transition Phase Adolescent Patients |
| Approval Length | 12 month(s) |

| Therapy Stage | Initial Authorization |
|---|---|
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZOMACTON | SOMATROPIN FOR SUBCUTANEOUS INJ 5 MG | 30100020002121 | Brand |
| OMNITROPE | SOMATROPIN FOR INJ 5.8 MG | 30100020002123 | Brand |
| SAIZEN | SOMATROPIN (NON-REFRIGERATED) FOR INJ 5 MG | 30100020102120 | Brand |
| SAIZEN | SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG | 30100020102130 | Brand |
| SAIZENPREP RECONSTITUTIONKIT | SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG | 30100020102130 | Brand |
| ZOMACTON | SOMATROPIN FOR INJ 10 MG | 30100020002140 | Brand |
| ZORBTIVE | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 8.8 MG | 30100020102132 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 4 MG | 30100020102118 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 5 MG | 30100020102121 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 6 MG | 30100020102125 | Brand |
| NUTROPIN AQ NUSPIN 5 | SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/2ML | 3010002000D207 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/1.5ML | 3010002000D212 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/1.5ML | 3010002000D230 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 15 MG/1.5ML | 3010002000D240 | Brand |
| NUTROPIN AQ NUSPIN 10 | SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/2ML | 3010002000D220 | Brand |
| NUTROPIN AQ NUSPIN 20 | SOMATROPIN SOLUTION PEN-INJECTOR 20 MG/2ML | 3010002000D250 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 30 MG/3ML | 3010002000D260 | Brand |
| OMNITROPE | SOMATROPIN SOLUTION CARTRIDGE 5 MG/1.5ML | 3010002000E210 | Brand |
| OMNITROPE | SOMATROPIN SOLUTION CARTRIDGE 10 MG/1.5ML | 3010002000E213 | Brand |
| GENOTROPIN | SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 5 MG | 3010002000E159 | Brand |
| GENOTROPIN | SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 12 MG (36 UNIT) | 3010002000E188 | Brand |

| | | | |
|---|---|---|---|
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.2 MG | 3010002000E404 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.4 MG | 3010002000E407 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.6 MG | 3010002000E410 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.8 MG | 3010002000E413 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1 MG | 3010002000E416 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.2 MG | 3010002000E419 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.4 MG | 3010002000E422 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.6 MG | 3010002000E425 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.8 MG | 3010002000E428 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 2 MG | 3010002000E431 | Brand |
| HUMATROPE | SOMATROPIN FOR INJ CARTRIDGE 6 MG (18 UNIT) | 3010002000E120 | Brand |
| HUMATROPE | SOMATROPIN FOR INJ CARTRIDGE 12 MG (36 UNIT) | 3010002000E130 | Brand |
| HUMATROPE | SOMATROPIN FOR INJ CARTRIDGE 24 MG | 3010002000E140 | Brand |

**Approval Criteria**

**1** - Request does not exceed a maximum supply limit of 0.3 milligrams per kilogram per week

**AND**

**2** - Documentation of ONE of the following:

- Attained expected adult height
- Closed epiphyses on bone radiograph

**AND**

**3** - Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following:

**3.1** BOTH of the following:

**3.1.1** Documentation of high risk of growth hormone (GH) deficiency due to GH deficiency in childhood from ONE of the following:

**3.1.1.1** Embryopathic/congenital defects

**OR**

**3.1.1.2** Genetic mutations

**OR**

**3.1.1.3** Irreversible structural hypothalamic-pituitary disease

**OR**

**3.1.1.4** Panhypopituitarism

**OR**

**3.1.1.5** Deficiency of THREE of the following anterior pituitary hormones:

- ACTH (adrenocorticotropic hormone)
- TSH (thyroid stimulating hormone)
- Prolactin
- FSH/LH (follicle-stimulating hormone/luteinizing hormone)

**AND**

**3.1.2** ONE of the following:

**3.1.2.1** Insulin-like Growth Factor 1 (IGF-1)/Somatomedin-C level is below the age and gender adjusted normal range as provided by the physician's lab

**OR**

**3.1.2.2** ALL of the following:

**3.1.2.2.1** Patient does not have a low IGF-1/Somatomedin C level

**AND**

**3.1.2.2.2** Discontinued GH therapy for at least 1 month

**AND**

**3.1.2.2.3** Patient has undergone ONE of the following GH stimulation tests after discontinuation of therapy for at least 1 month:

- Insulin tolerance test (ITT)
- ARG (Arginine) and GHRH (growth hormone releasing hormone)
- ARG
- Glucagon

**AND**

**3.1.2.2.4** ONE of the following peak GH values:

**3.1.2.2.4.1** ITT less than or equal to 5 micrograms per liter

**OR**

**3.1.2.2.4.2** GHRH and ARG of ONE of the following:

- Less than or equal to 11 micrograms per liter if body mass index [BMI] is less than 25 kilograms per meter squared
- Less than or equal to 8 micrograms per liter if BMI is greater than or equal to 25 and less than 30 kilograms per meter squared
- Less than or equal to 4 micrograms per liter if BMI is greater than or equal to 30 kilograms per meter squared

**OR**

**3.1.2.2.4.3** Glucagon less than or equal to 3 micrograms per liter

**OR**

**3.1.2.2.4.4** ARG less than or equal to 0.4 micrograms per liter

**OR**

**3.2** ALL of the following:

**3.2.1** At low risk of severe GH deficiency (e.g., due to isolated and/or idiopathic GH deficiency)

**AND**

**3.2.2** Discontinued GH therapy for at least 1 month

**AND**

**3.2.3** BOTH of the following:

**3.2.3.1** Patient has undergone ONE of the following GH stimulation tests after discontinuation of therapy for at least 1 month:

- ITT
- GHRH and ARG
- ARG
- Glucagon

**AND**

**3.2.3.2** ONE of the following peak GH values:

**3.2.3.2.1** ITT less than or equal to 5 micrograms per liter

**OR**

**3.2.3.2.2** GHRH and ARG of ONE of the following:

- Less than or equal to 11 micrograms per liter if body mass index [BMI] is less than 25 kilograms per meter squared
- Less than or equal to 8 micrograms per liter if BMI is greater than or equal to 25 and less than 30 kilograms per meter squared
- Less than or equal to 4 micrograms per liter if BMI is greater than or equal to 30 kilograms per meter squared

**OR**

**3.2.3.2.3** Glucagon less than or equal to 3 micrograms per liter

**OR**

**3.2.3.2.4** ARG less than or equal to 0.4 micrograms per liter

**AND**

**4** - Prescribed by an endocrinologist

**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) (See Table 1 in Background section for non-preferred products)

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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZOMACTON | SOMATROPIN FOR SUBCUTANEOUS INJ 5 MG | 30100020002121 | Brand |
| OMNITROPE | SOMATROPIN FOR INJ 5.8 MG | 30100020002123 | Brand |
| SAIZEN | SOMATROPIN (NON-REFRIGERATED) FOR INJ 5 MG | 30100020102120 | Brand |
| SAIZEN | SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG | 30100020102130 | Brand |
| SAIZENPREP RECONSTITUTIONKIT | SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG | 30100020102130 | Brand |
| ZOMACTON | SOMATROPIN FOR INJ 10 MG | 30100020002140 | Brand |
| ZORBTIVE | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 8.8 MG | 30100020102132 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 4 MG | 30100020102118 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 5 MG | 30100020102121 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 6 MG | 30100020102125 | Brand |
| NUTROPIN AQ NUSPIN 5 | SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/2ML | 3010002000D207 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/1.5ML | 3010002000D212 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/1.5ML | 3010002000D230 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 15 MG/1.5ML | 3010002000D240 | Brand |
| NUTROPIN AQ NUSPIN 10 | SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/2ML | 3010002000D220 | Brand |
| NUTROPIN AQ NUSPIN 20 | SOMATROPIN SOLUTION PEN-INJECTOR 20 MG/2ML | 3010002000D250 | Brand |
| NORDITROPIN FLEXPRO | SOMATROPIN SOLUTION PEN-INJECTOR 30 MG/3ML | 3010002000D260 | Brand |
| OMNITROPE | SOMATROPIN SOLUTION CARTRIDGE 5 MG/1.5ML | 3010002000E210 | Brand |
| OMNITROPE | SOMATROPIN SOLUTION CARTRIDGE 10 MG/1.5ML | 3010002000E213 | Brand |
| GENOTROPIN | SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 5 MG | 3010002000E159 | Brand |

| | | | |
|---|---|---|---|
| GENOTROPIN | SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 12 MG (36 UNIT) | 3010002000E188 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.2 MG | 3010002000E404 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.4 MG | 3010002000E407 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.6 MG | 3010002000E410 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.8 MG | 3010002000E413 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1 MG | 3010002000E416 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.2 MG | 3010002000E419 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.4 MG | 3010002000E422 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.6 MG | 3010002000E425 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.8 MG | 3010002000E428 | Brand |
| GENOTROPIN MINIQUICK | SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 2 MG | 3010002000E431 | Brand |
| HUMATROPE | SOMATROPIN FOR INJ CARTRIDGE 6 MG (18 UNIT) | 3010002000E120 | Brand |
| HUMATROPE | SOMATROPIN FOR INJ CARTRIDGE 12 MG (36 UNIT) | 3010002000E130 | Brand |
| HUMATROPE | SOMATROPIN FOR INJ CARTRIDGE 24 MG | 3010002000E140 | Brand |

**Approval Criteria**

**1** - Documentation of positive response to therapy (e.g., increase in total lean body mass, exercise capacity or IGF-1 [Insulin-like Growth Factor 1] and IGFBP-3 [Insulin-like growth factor binding protein 3] levels)

**AND**

**2** - Request does not exceed a maximum supply limit of 0.3 milligrams per kilogram per week

**AND**

**3** - Prescribed by an endocrinologist

| Product Name: Serostim | |
|---|---|
| Diagnosis | Human Immunodeficiency Virus (HIV)-associated wasting syndrome or cachexia |
| Approval Length | 3 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 4 MG | 30100020102118 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 5 MG | 30100020102121 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 6 MG | 30100020102125 | Brand |

**Approval Criteria**

**1** - Diagnosis of human immunodeficiency virus (HIV)-associated wasting syndrome or cachexia

**AND**

**2** - Documentation of ONE of the following:

**2.1** Unintentional weight loss of greater than 10 percent over the last 12 months

**OR**

**2.2** Unintentional weight loss of greater than 7.5 percent over the last 6 months

**OR**

**2.3** Loss of 5 percent body cell mass (BCM) within 6 months

**OR**

**2.4** Body mass index (BMI) less than 20 kilograms per meter squared

**OR**

**2.5** ONE of the following:

**2.5.1** ALL of the following:

- Patient is male
- BCM less than 35 percent of total body weight
- BMI less than 27 kilograms per meter squared

**OR**

**2.5.2** ALL of the following:

- Patient is female
- BCM less than 23 percent of total body weight
- BMI less than 27 kilograms per meter squared

**AND**

**3** - A nutritional evaluation has been completed since onset of wasting first occurred

**AND**

**4** - Patient has not had weight loss as a result of other underlying treatable conditions (e.g., depression, mycobacterium avium complex, chronic infectious diarrhea, or malignancy with the exception of Kaposi's sarcoma limited to skin or mucous membranes)

**AND**

**5** - Patient's anti-retroviral therapy has been optimized to decrease the viral load

| Product Name: Serostim | |
|---|---|
| Diagnosis | Human Immunodeficiency Virus (HIV)-associated wasting syndrome or cachexia |
| Approval Length | 6 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 4 MG | 30100020102118 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 5 MG | 30100020102121 | Brand |
| SEROSTIM | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 6 MG | 30100020102125 | Brand |

**Approval Criteria**

**1** - Evidence of positive response to therapy (i.e., greater than or equal to 2 percent increase in body weight and/or body cell mass [BCM])

**AND**

**2** - ONE of the following targets or goals has not been achieved:

- Weight
- BCM
- Body Mass Index (BMI)

| Product Name: Zorbtive | |
|---|---|
| Diagnosis | Short Bowel Syndrome |
| Approval Length | *4 weeks |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZORBTIVE | SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 8.8 MG | 30100020102132 | Brand |

**Approval Criteria**

**1** - Diagnosis of Short Bowel Syndrome

**AND**

**2** - Patient is currently receiving specialized nutritional support (e.g., intravenous parenteral nutrition, fluid, and micronutrient supplements)

**AND**

**3** - Patient has not previously received 4 weeks of treatment with Zorbtive*

| | |
|---|---|
| Notes | *Treatment with Zorbtive will not be authorized beyond 4 weeks. Administration for more than 4 weeks has not been adequately studied. |

| Product Name: Increlex | |
|---|---|
| Diagnosis | Severe Primary IGF-1 Deficiency / Growth Hormone Gene Deletion |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| INCRELEX | MECASERMIN INJ 40 MG/4ML (10 MG/ML) | 30160045002020 | Brand |

**Approval Criteria**

**1** - ONE of the following criteria:

**1.1** Documentation of ALL of the following:

**1.1.1** Diagnosis of severe primary Insulin-like Growth Factor 1 (IGF-1) deficiency

**AND**

**1.1.2** Height standard deviation score less than or equal to -3.0

**AND**

**1.1.3** Basal IGF-1 standard deviation score less than or equal to -3.0

**AND**

**1.1.4** Normal or elevated growth hormone levels

**AND**

**1.1.5** Documentation of open epiphyses on last bone radiograph

**AND**

**1.1.6** The patient will not be treated with concurrent growth hormone therapy

**AND**

**1.1.7** Prescribed by an endocrinologist

**OR**

**1.2** ALL of the following:

**1.2.1** Diagnosis of growth hormone gene deletion and has developed neutralizing antibodies to growth hormone

**AND**

**1.2.2** Documentation of open epiphyses on last bone radiograph

**AND**

**1.2.3** The patient will not be treated with concurrent growth hormone therapy

**AND**

**1.2.4** Prescribed by an endocrinologist

| Product Name: Increlex | |
|---|---|
| Diagnosis | Severe Primary IGF-1 Deficiency / Growth Hormone Gene Deletion |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| INCRELEX | MECASERMIN INJ 40 MG/4ML (10 MG/ML) | 30160045002020 | Brand |

**Approval Criteria**

**1** - Height increase of at least 2 centimeters per year over the previous year of treatment as documented by BOTH of the following:*

- Previous height and date obtained
- Current height and date obtained

**AND**

**2** - Documentation of BOTH of the following:*

| | |
|---|---|
| • Expected adult height not obtained<br>• Expected adult height goal<br><br>**AND**<br><br>**3** - Patient is not treated with concurrent growth hormone therapy<br><br>**AND**<br><br>**4** - Prescribed by an endocrinologist | |
| Notes | *Documentation of previous height, current height and goal expected adult height will be required for renewal. |

## 2 . Background

| **Benefit/Coverage/Program Information** |
|---|
| **Table 1: Human Growth Hormone:**<br><br>**Preferred Agents:**<br><br>Somatropin (Norditropin®), Somatropin (Omnitrope®)<br><br>**Nonpreferred Agents:**<br><br>Somatropin (Genotropin®, Humatrope®, NordiFlex®, Nutropin AQ® NuSpin™, Saizen®, Zorbtive®, Serostim®, and Zomacton®), Skytrofa™ (lonapegsomatropin-tcgd), Ngenla (somatrogon), Sogroya (somapacitan) |

| **Growth Stimulating Products** : Mecasermin (Increlex®) |
|---|

## 3 . Revision History

| Date | Notes |
|---|---|
| 12/9/2024 | Removed Nutropin from step thru agents |

Haegarda

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-147287 |
| **Guideline Name** | Haegarda |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| HAEGARDA | C1 ESTERASE INHIBITOR (HUMAN) FOR SUBCUTANEOUS INJ 2000 UNIT | 85802022002130 | Brand |
| HAEGARDA | C1 ESTERASE INHIBITOR (HUMAN) FOR SUBCUTANEOUS INJ 3000 UNIT | 85802022002140 | Brand |

**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:

**1.2.1** 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

**OR**

**1.2.2** Recurring angioedema attacks that are refractory to high-dose antihistamines with confirmed family history of angioedema

**OR**

**1.2.3** 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, 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| HAEGARDA | C1 ESTERASE INHIBITOR (HUMAN) FOR SUBCUTANEOUS INJ 2000 UNIT | 85802022002130 | Brand |
| HAEGARDA | C1 ESTERASE INHIBITOR (HUMAN) FOR SUBCUTANEOUS INJ 3000 UNIT | 85802022002140 | Brand |

**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, Firazyr, 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., Cinryze, Orladeyo, Takhzyro)

**AND**

**5** - Prescribed by ONE of the following:

- Immunologist
- Allergist

## 2 . Revision History

| Date | Notes |
|---|---|
| 5/13/2024 | Copy core; New |

HCG

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146536 |
| **Guideline Name** | HCG |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Novarel, Chorionic Gonadotropin, Ovidrel, Pregnyl | |
|---|---|
| Diagnosis | Prepubertal Cryptorchidism |
| Approval Length | 6 Week(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NOVAREL | CHORIONIC GONADOTROPIN FOR IM INJ 5000 UNIT | 30062020002130 | Brand |
| NOVAREL | CHORIONIC GONADOTROPIN FOR IM INJ 10000 UNIT | 30062020002140 | Brand |
| CHORIONIC GONADOTROPIN | CHORIONIC GONADOTROPIN FOR IM INJ 10000 UNIT | 30062020002140 | Brand |
| OVIDREL | CHORIOGONADOTROPIN ALFA INJ 250 MCG/0.5ML | 3006202205E520 | Brand |

| | | | |
|---|---|---|---|
| PREGNYL W/DILUENT BENZYL ALCOHOL/NACL | CHORIONIC GONADOTROPIN FOR IM INJ 10000 UNIT | 30062020002140 | Brand |
| PREGNYL | CHORIONIC GONADOTROPIN FOR IM INJ 10000 UNIT | 30062020002140 | Brand |

**Approval Criteria**

**1** - Diagnosis of prepubertal cryptorchidism not due to anatomical obstruction

Hemangeol

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146337 |
| **Guideline Name** | Hemangeol |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Hemangeol | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| HEMANGEOL | PROPRANOLOL HCL ORAL SOLN 4.28 MG/ML (3.75 MG/ML BASE EQUIV) | 33100040102080 | Brand |

**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

Hemlibra

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-158193 |
| **Guideline Name** | Hemlibra |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 12/1/2024 |

## 1 . Criteria

| Product Name: Hemlibra | |
|---|---|
| Diagnosis | Hemophilia A with Inhibitors |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| HEMLIBRA | EMICIZUMAB-KXWH SUBCUTANEOUS SOLN 30 MG/ML | 85105030202010 | Brand |
| HEMLIBRA | EMICIZUMAB-KXWH SUBCUTANEOUS SOLN 60 MG/0.4ML (150 MG/ML) | 85105030202020 | Brand |
| HEMLIBRA | EMICIZUMAB-KXWH SUBCUTANEOUS SOLN 105 MG/0.7ML (150 MG/ML) | 85105030202030 | Brand |

| | | | |
|---|---|---|---|
| HEMLIBRA | EMICIZUMAB-KXWH SUBCUTANEOUS SOLN 150 MG/ML | 85105030202040 | Brand |
| HEMLIBRA | EMICIZUMAB-KXWH SUBCUTANEOUS SOLN 12 MG/0.4ML (30 MG/ML) | 85105030202007 | Brand |
| HEMLIBRA | EMICIZUMAB-KXWH SUBCUTANEOUS SOLN 300 MG/2ML (150 MG/ML) | 85105030202060 | Brand |

**Approval Criteria**

**1** - Diagnosis of hemophilia A

**AND**

**2** - Patient has developed high-titer factor VIII inhibitors [greater than 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| HEMLIBRA | EMICIZUMAB-KXWH SUBCUTANEOUS SOLN 30 MG/ML | 85105030202010 | Brand |
| HEMLIBRA | EMICIZUMAB-KXWH SUBCUTANEOUS SOLN 60 MG/0.4ML (150 MG/ML) | 85105030202020 | Brand |
| HEMLIBRA | EMICIZUMAB-KXWH SUBCUTANEOUS SOLN 105 MG/0.7ML (150 MG/ML) | 85105030202030 | Brand |
| HEMLIBRA | EMICIZUMAB-KXWH SUBCUTANEOUS SOLN 150 MG/ML | 85105030202040 | Brand |
| HEMLIBRA | EMICIZUMAB-KXWH SUBCUTANEOUS SOLN 12 MG/0.4ML (30 MG/ML) | 85105030202007 | Brand |

| | | | |
|---|---|---|---|
| HEMLIBRA | EMICIZUMAB-KXWH SUBCUTANEOUS SOLN 300 MG/2ML (150 MG/ML) | 85105030202060 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| HEMLIBRA | EMICIZUMAB-KXWH SUBCUTANEOUS SOLN 30 MG/ML | 85105030202010 | Brand |
| HEMLIBRA | EMICIZUMAB-KXWH SUBCUTANEOUS SOLN 60 MG/0.4ML (150 MG/ML) | 85105030202020 | Brand |
| HEMLIBRA | EMICIZUMAB-KXWH SUBCUTANEOUS SOLN 105 MG/0.7ML (150 MG/ML) | 85105030202030 | Brand |
| HEMLIBRA | EMICIZUMAB-KXWH SUBCUTANEOUS SOLN 150 MG/ML | 85105030202040 | Brand |
| HEMLIBRA | EMICIZUMAB-KXWH SUBCUTANEOUS SOLN 12 MG/0.4ML (30 MG/ML) | 85105030202007 | Brand |
| HEMLIBRA | EMICIZUMAB-KXWH SUBCUTANEOUS SOLN 300 MG/2ML (150 MG/ML) | 85105030202060 | Brand |

**Approval Criteria**

**1** - ONE of the following:

**1.1** BOTH of the following:

**1.1.1** Diagnosis of severe hemophilia A

**AND**

**1.1.2** Documentation of endogenous factor VIII levels less than 1% of normal factor VIII [less than 0.01 international units/milliliter (IU/mL)]

**OR**

**1.2** BOTH of the following:

**1.2.1** ONE of the following:

**1.2.1.1** BOTH of the following:

**1.2.1.1.1** Diagnosis of moderate hemophilia A

**AND**

**1.2.1.1.2** Documentation of endogenous factor VIII level greater than or equal to 1% and less than 5% (greater than or equal to 0.01 IU/mL to less than 0.05 IU/mL)

**OR**

**1.2.1.2** BOTH of the following:

**1.2.1.2.1** Diagnosis of mild hemophilia A

**AND**

**1.2.1.2.2** Documentation of endogenous factor VIII level greater than or equal to 5% (greater than or equal to 0.05 IU/mL)

**AND**

**1.2.2** Submission of medical records (e.g., chart notes, laboratory values) documenting a failure to meet clinical goals (e.g., continuation of spontaneous bleeds, inability to achieve appropriate trough level, previous history of inhibitors) after a trial of prophylactic factor VIII replacement products

**OR**

**1.3** BOTH of the following:

**1.3.1** Patient is currently on Hemlibra therapy as confirmed by claims history or submission of medical records

**AND**

**1.3.2** Diagnosis of hemophilia A

**AND**

**2** - Hemlibra is prescribed for the prevention of bleeding episodes (i.e., routine prophylaxis)

**AND**

**3** - Prescriber attestation that the patient is not to receive extended half-life factor VIII replacement products (e.g., Adynovate, Afstyla, Altuviio, Eloctate, Jivi) for the treatment of breakthrough bleeding episodes

| Product Name: Hemlibra | |
|---|---|
| Diagnosis | Hemophilia A without Inhibitors |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| HEMLIBRA | EMICIZUMAB-KXWH SUBCUTANEOUS SOLN 30 MG/ML | 85105030202010 | Brand |
| HEMLIBRA | EMICIZUMAB-KXWH SUBCUTANEOUS SOLN 60 MG/0.4ML (150 MG/ML) | 85105030202020 | Brand |
| HEMLIBRA | EMICIZUMAB-KXWH SUBCUTANEOUS SOLN 105 MG/0.7ML (150 MG/ML) | 85105030202030 | Brand |

| | | | |
|---|---|---|---|
| HEMLIBRA | EMICIZUMAB-KXWH SUBCUTANEOUS SOLN 150 MG/ML | 85105030202040 | Brand |
| HEMLIBRA | EMICIZUMAB-KXWH SUBCUTANEOUS SOLN 12 MG/0.4ML (30 MG/ML) | 85105030202007 | Brand |
| HEMLIBRA | EMICIZUMAB-KXWH SUBCUTANEOUS SOLN 300 MG/2ML (150 MG/ML) | 85105030202060 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Hemlibra therapy

**AND**

**2** - Submission of medical records (e.g., chart notes, laboratory values) documenting that the patient is not receiving Hemlibra in combination with an extended half-life factor VIII replacement product (e.g., Adynovate, Afstyla, Altuviio, Eloctate, Jivi) for the treatment of breakthrough bleeding episodes (Prescription claim history that does not show any concomitant extended half-life factor VIII replacement product claim within 60 days of reauthorization request may be used as documentation)

## 2 . Revision History

| Date | Notes |
|---|---|
| 10/29/2024 | Added new Hemlibra strengths. Updated list of examples of extende d half-life factor VIII replacement products. |

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-148186 |
| **Guideline Name** | Hepatitis C Criteria |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Harvoni, ledipasvir/sofosbuvir (authorized generic of Harvoni) | |
|---|---|
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| HARVONI | LEDIPASVIR-SOFOSBUVIR TAB 45-200 MG | 12359902400310 | Brand |
| HARVONI | LEDIPASVIR-SOFOSBUVIR TAB 90-400 MG | 12359902400320 | Generic |
| LEDIPASVIR/SOFOSBUVIR | LEDIPASVIR-SOFOSBUVIR TAB 90-400 MG | 12359902400320 | Generic |
| HARVONI | LEDIPASVIR-SOFOSBUVIR PELLET PACK 33.75-150 MG | 12359902403006 | Brand |
| HARVONI | LEDIPASVIR-SOFOSBUVIR PELLET PACK 45-200 MG | 12359902403010 | Brand |

**Approval Criteria**

**1** - Diagnosis of chronic hepatitis C genotype 1, 4, 5, or 6 infection

**AND**

**2** - Physician/provider asserts patient demonstrates treatment readiness, including the ability to adhere to the treatment regimen

**AND**

**3** - ONE of the following:

**3.1** Patient is genotype 1 or 4 and has a history of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- Sofosbuvir/velpatasvir (authorized generic of Epclusa)
- Mavyret
- Zepatier

**OR**

**3.2** Patient is genotype 5 or 6 and has a history of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Sofosbuvir/velpatasvir (authorized generic of Epclusa)
- Mavyret

**OR**

**3.3** Patient is currently on Harvoni (ledipasvir/sofosbuvir) therapy

**AND**

**4** - Patient is NOT receiving the requested medication in combination with another HCV

(hepatitis C virus) direct acting antiviral agent [e.g., Epclusa (sofosbuvir/velpatasvir), Mavyret (glecaprevir/pibrentasvir), Sovaldi (sofosbuvir), Zepatier (elbasvir/grazoprevir)]

**AND**

**5** - The requested regimen is an approvable regimen based on patient genotype and characteristics (See Table 1 in Background section)

**AND**

**6** - If brand is requested, the provider must submit explanation of medical necessity for brand versus authorized generic

| Notes | Approval length is by regimen based on patient genotype and charact eristics in Table 1. |
|---|---|

| Product Name: Sovaldi | |
|---|---|
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SOVALDI | SOFOSBUVIR TAB 200 MG | 12353080000310 | Brand |
| SOVALDI | SOFOSBUVIR TAB 400 MG | 12353080000320 | Brand |
| SOVALDI | SOFOSBUVIR PELLET PACK 150 MG | 12353080003015 | Brand |
| SOVALDI | SOFOSBUVIR PELLET PACK 200 MG | 12353080003020 | Brand |

**Approval Criteria**

**1** - Diagnosis of chronic hepatitis C genotype 1, 2, 3, or 4 infection

**AND**

**2** - Physician/provider asserts patient demonstrates treatment readiness, including the ability to adhere to the treatment regimen

**AND**

**3** - ONE of the following:

**3.1** Patient is genotype 1 or 4 and has a history of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- Sofosbuvir/velpatasvir (authorized generic of Epclusa)
- Mavyret
- Zepatier

**OR**

**3.2** Patient is genotype 2 or 3 and has a history of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Sofosbuvir/velpatasvir (authorized generic of Epclusa)
- Mavyret

**OR**

**3.3** Patient is currently on Sovaldi therapy

**AND**

**4** - Patient is NOT receiving the requested medication in combination with another HCV (hepatitis C virus) direct acting antiviral agent [e.g., Epclusa (sofosbuvir/velpatasvir), Harvoni (ledipasvir/sofosbuvir), Mavyret (glecaprevir/pibrentasvir), Zepatier (elbasvir/grazoprevir)]

**AND**

**5** - The requested regimen is an approvable regimen based on patient genotype and characteristics (see Table 2 in Background section)

| Notes | Approval length is by regimen based on patient genotype and charact eristics in Table 2. |
|---|---|

| Product Name: Vosevi | |
|---|---|
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VOSEVI | SOFOSBUVIR-VELPATASVIR-VOXILAPREVIR TAB 400-100-100 MG | 12359903800330 | Brand |

**Approval Criteria**

**1** - Diagnosis of chronic hepatitis C genotype 1, 2, 3, 4, 5, or 6 infection

**AND**

**2** - Physician/provider asserts patient demonstrates treatment readiness, including the ability to adhere to the treatment regimen

**AND**

**3** - The patient is without cirrhosis or has compensated cirrhosis (Child-Pugh A)

**AND**

**4** - ONE of the following:

**4.1** BOTH of the following:

**4.1.1** Patient is genotype 1, 2, 3, 4, 5, or 6 and had virologic failure after completing previous treatment of at least 4 weeks' duration with an HCV (hepatitis C virus) regimen containing an NS5A (nonstructural protein 5A) inhibitor as confirmed by claims history or submission of medical records

**AND**

**4.1.2** If the patient is genotype 1 and has NOT been previously treated with an NS3/4A (nonstructural protein 3/4A) inhibitor, history of intolerance or contraindication to Mavyret (please specify intolerance or contraindication)

**OR**

**4.2** ALL of the following:

**4.2.1** Patient is genotype 1a or 3 and had virologic failure after completing previous treatment of at least 4 weeks' duration with an HCV regimen containing sofosbuvir without an NS5A inhibitor as confirmed by claims history or submission of medical records

**AND**

**4.2.2** If patient is genotype 1a and has been treated with or without an NS3/4A inhibitor, history of intolerance or contraindication to Mavyret (please specify intolerance or contraindication)

**AND**

**4.2.3** If patient is genotype 3 and has NOT been treated with an NS3/4A inhibitor, history of intolerance or contraindication to Mavyret (please specify intolerance or contraindication)

**OR**

**4.3** Patient is currently on Vosevi therapy

**AND**

**5** - Patient is NOT receiving the requested medication in combination with another HCV direct acting antiviral agent [e.g., Epclusa (sofosbuvir/velpatasvir), Harvoni (ledipasvir/sofosbuvir), Mavyret (glecaprevir/pibrentasvir), Sovaldi (sofosbuvir), Zepatier (elbasvir/grazoprevir)]

**AND**

**6** - The requested regimen is an approvable regimen based on patient genotype and characteristics (See Table 3 in Background section)

| Notes | Approval length is by regimen based on patient genotype and charact eristics in Table 3. |
|---|---|

| Product Name: Zepatier | |
|---|---|
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZEPATIER | ELBASVIR-GRAZOPREVIR TAB 50-100 MG | 12359902300320 | Brand |

**Approval Criteria**

**1** - Diagnosis of chronic hepatitis C genotype 1 or 4 infection

**AND**

**2** - Physician/provider asserts patient demonstrates treatment readiness, including the ability to adhere to the treatment regimen

**AND**

**3** - Patient is NOT receiving the requested medication in combination with another HCV (hepatitis C virus) direct acting antiviral agent [e.g., Epclusa (sofosbuvir/velpatasvir), Harvoni (ledipasvir/sofosbuvir), Mavyret (glecaprevir/pibrentasvir), Sovaldi (sofosbuvir)]

**AND**

**4** - The requested regimen is an approvable regimen based on patient genotype and characteristics (See Table 4 in Background section)

| Notes | Approval length is by regimen based on patient genotype and charact eristics in Table 4. |
|---|---|

## 2 . Background

| **Benefit/Coverage/Program Information** |
|---|

**Table 1. Harvoni or ledipasvir/sofosbuvir (authorized generic of Harvoni)**

**Recommended treatment regimen and duration:**

| Genotype | Patient Population | Regimen and Duration |
|---|---|---|
| Genotype 1 | Treatment-naïve without cirrhosis or with compensated cirrhosis (Child-Pugh A) | HARVONI 12 weeks* |
| | Treatment-experienced** without cirrhosis | HARVONI 12 weeks |
| | Treatment-experienced** with compensated cirrhosis (Child-Pugh A) | HARVONI 24 weeks+ |
| | Treatment-naïve and treatment-experienced** with decompensated cirrhosis (Child-Pugh B or C) | HARVONI + ribavirin 12 weeks |
| Genotype 1 or 4 | Treatment-naïve and treatment-experienced** liver transplant recipients without cirrhosis, or with compensated cirrhosis (Child-Pugh A) | HARVONI + ribavirin 12 weeks |
| Genotype 4, 5, or 6 | Treatment-naïve and treatment-experienced** without cirrhosis or with compensated cirrhosis (Child-Pugh A) | HARVONI 12 weeks |

*HARVONI for 8 weeks can be considered in treatment-naïve genotype 1 patients without cirrhosis who have pre-treatment HCV RNA less than 6 million IU/mL

**Treatment-experienced adult and pediatric patients have failed a peginterferon alfa +/- ribavirin based regimen with or without an HCV protease inhibitor

+HARVONI + ribavirin for 12 weeks can be considered in treatment-experienced genotype 1 patients with cirrhosis who are eligible for ribavirin

**Table 2. Sovaldi**

**Recommended Adult Treatment Regimen and Duration**

| | Adult Patient Population | Regimen and Duration |
|---|---|---|
| Genotype 1 or 4 | Treatment naïve without cirrhosis or with compensated cirrhosis (Child-Pugh A) | SOVALDI + peginterferon alfa + ribavirin<br>12 weeks |
| Genotype 2 | Treatment naïve and treatment experienced* without cirrhosis or with compensated cirrhosis (Child-Pugh A) | SOVALDI + ribavirin<br>12 weeks |
| Genotype 3 | Treatment naïve and treatment experienced* without cirrhosis or with compensated cirrhosis (Child-Pugh A) | SOVALDI + ribavirin<br>24 weeks |

SOVALDI in combination with ribavirin for 24 weeks can be considered for adult patients with genotype 1 infection who are interferon ineligible.

SOVALDI should be used in combination with ribavirin for treatment of HCV in adult patients with hepatocellular carcinoma awaiting liver transplantation for up to 48 weeks or until liver transplantation, whichever occurs first.

*Treatment-experienced patients have failed an interferon based regimen with or without ribavirin

**Recommended Treatment Regimen and Duration for Pediatric Patients 3 Years of Age and Older**

| | Pediatric Patient Population 3 Years of Age and Older | Regimen and Duration |
|---|---|---|
| Genotype 2 | Treatment naïve and treatment experienced* without cirrhosis or with compensated cirrhosis (Child-Pugh A) | SOVALDI + ribavirin<br>12 weeks |
| Genotype 3 | Treatment naïve and treatment experienced* without cirrhosis or with | SOVALDI + ribavirin<br>24 weeks |

| | | |
|---|---|---|
| | compensated cirrhosis (Child-Pugh A) | |

*Treatment experienced patients have failed an interferon based regimen with or without ribavirin

**Table 3. Vosevi**

| Genotype | Patients previously treated with an HCV regimen containing: | VOSEVI Duration |
|---|---|---|
| 1, 2, 3, 4, 5, or 6 | An NS5A inhibitor[1] | 12 weeks |
| 1a or 3 | Sofosbuvir without an NS5A inhibitor[2] | 12 weeks |

1. In clinical trials, prior NS5A inhibitor experience included daclatasvir, elbasvir, ledipasvir, ombitasvir, or velpatasvir.

2. In clinical trials, prior treatment experience included sofosbuvir with or without any of the following: peginterferon alfa/ribavirin, ribavirin, HCV NS3/4A protease inhibitor (boceprevir, simeprevir or telaprevir).

**Table 4. Zepatier**

**Dosage Regimens and Durations for ZEPATIER in Patients with Genotype 1 or 4 HCV with or without Cirrhosis**

| Patient Population | Treatment | Duration |
|---|---|---|
| Genotype 1a: treatment naïve or PegIFN/RBV experienced* without baseline NS5A polymorphisms+ | ZEPATIER | 12 weeks |
| Genotype 1a: treatment naïve or PegIFN/RBV experienced* with baseline NS5A polymorphisms+ | ZEPATIER + ribavirin | 16 weeks |

| | | |
|---|---|---|
| Genotype 1b: treatment naïve or PegIFN/RBV experienced* | ZEPATIER | 12 weeks |
| Genotype 1a or 1b: PegIFN/RBV/PI experienced++ | ZEPATIER + ribavirin | 12 weeks |
| Genotype 4: treatment naïve | ZEPATIER | 12 weeks |
| Genotype 4: PegIFN/RBV experienced* | ZEPATIER + ribavirin | 16 weeks |

*Peginterferon alfa + ribavirin

+Polymorphisms at amino acid positions 28, 30, 31, or 93

++Peginterferon alfa + ribavirin + HCV NS3/4 A protease inhibitor

## 3 . Revision History

| Date | Notes |
|---|---|
| 6/13/2024 | New guideline specific to NM |

Hetlioz

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146538 |
| **Guideline Name** | Hetlioz |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Brand Hetlioz, generic tasimelteon, Hetlioz LQ | |
|---|---|
| Approval Length | 6 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TASIMELTEON | TASIMELTEON CAPSULE 20 MG | 60250070000130 | Generic |
| HETLIOZ | TASIMELTEON CAPSULE 20 MG | 60250070000130 | Brand |
| HETLIOZ LQ | TASIMELTEON ORAL SUSP 4 MG/ML | 60250070001820 | Brand |

**Approval Criteria**

**1** - ONE of the following:

**1.1** BOTH of the following:

**1.1.1** 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 hypernychthemeral syndrome)

**AND**

**1.1.2** 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:

**2.2.1** 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

**AND**

**2.2.2** 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TASIMELTEON | TASIMELTEON CAPSULE 20 MG | 60250070000130 | Generic |
| HETLIOZ | TASIMELTEON CAPSULE 20 MG | 60250070000130 | Brand |
| HETLIOZ LQ | TASIMELTEON ORAL SUSP 4 MG/ML | 60250070001820 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to therapy

HIV

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-150995 |
| **Guideline Name** | HIV |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 8/7/2024 |

## 1 . Criteria

| Product Name: Brand Viread, generic tenofovir disoproxil fumarate | |
|---|---|
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VIREAD | TENOFOVIR DISOPROXIL FUMARATE TAB 150 MG | 12108570100305 | Brand |
| VIREAD | TENOFOVIR DISOPROXIL FUMARATE TAB 200 MG | 12108570100310 | Brand |
| VIREAD | TENOFOVIR DISOPROXIL FUMARATE TAB 250 MG | 12108570100315 | Brand |
| TENOFOVIR DISOPROXIL FUMARATE | TENOFOVIR DISOPROXIL FUMARATE TAB 300 MG | 12108570100320 | Generic |
| VIREAD | TENOFOVIR DISOPROXIL FUMARATE TAB 300 MG | 12108570100320 | Brand |
| VIREAD | TENOFOVIR DISOPROXIL FUMARATE ORAL POWDER 40 MG/GM | 12108570102920 | Brand |

**Approval Criteria**

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

- HIV (human immunodeficiency virus)
- Hepatitis B
- HIV post-exposure prophylaxis (PEP)

| Notes | Approval Duration: 12 months for HIV and hepatitis B; 4 weeks for PEP. |
|---|---|

| Product Name: Brand Truvada, generic emtricitabine/tenofovir disoproxil | |
|---|---|
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| EMTRICITABINE/TENOFOVIR DISOPROXIL FUMARATE | EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE TAB 100-150 MG | 12109902300308 | Generic |
| TRUVADA | EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE TAB 100-150 MG | 12109902300308 | Brand |
| EMTRICITABINE/TENOFOVIR DISOPROXIL FUMARATE | EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE TAB 133-200 MG | 12109902300312 | Generic |
| TRUVADA | EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE TAB 133-200 MG | 12109902300312 | Brand |
| EMTRICITABINE/TENOFOVIR DISOPROXIL | EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE TAB 167-250 MG | 12109902300316 | Generic |
| TRUVADA | EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE TAB 167-250 MG | 12109902300316 | Brand |
| EMTRICITABINE/TENOFOVIR DISOPROXIL FUMARATE | EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE TAB 200-300 MG | 12109902300320 | Generic |
| TRUVADA | EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE TAB 200-300 MG | 12109902300320 | Brand |

**Approval Criteria**

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

- HIV (human immunodeficiency virus)
- Pre-exposure prophylaxis (PrEP)
- HIV post-exposure prophylaxis (PEP)

| Notes | Approval Duration: 12 months for HIV and PrEP; 4 weeks for PEP. |
|---|---|

| Product Name: Aptivus, Viracept, nevirapine, nevirapine ER | |
|---|---|
| Diagnosis | HIV |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NEVIRAPINE | NEVIRAPINE TAB 200 MG | 12109050000320 | Generic |
| NEVIRAPINE | NEVIRAPINE SUSP 50 MG/5ML | 12109050001820 | Generic |
| APTIVUS | TIPRANAVIR CAP 250 MG | 12104585000120 | Brand |
| VIRACEPT | NELFINAVIR MESYLATE TAB 250 MG | 12104545200320 | Brand |
| VIRACEPT | NELFINAVIR MESYLATE TAB 625 MG | 12104545200340 | Brand |
| NEVIRAPINE ER | NEVIRAPINE TAB ER 24HR 400 MG | 12109050007520 | Generic |

**Approval Criteria**

**1** - Diagnosis of HIV (human immunodeficiency virus)

Product Name: (All other HIV medications which do not have criteria above) brand Selzentry, generic maraviroc, Fuzeon, Tivicay, Tivicay PD, Isentress, Isentress HD, brand Reyataz, generic atazanavir, Brand Prezista, generic darunavir, brand Lexiva, generic fosamprenavir, brand Norvir, generic ritonavir, Brand Ziagen, generic abacavir, Brand Emtriva, generic emtricitabine, Brand Epivir, generic lamivudine, stavudine, Brand Retrovir, generic zidovudine, Pifeltro, Brand Sustiva, generic efavirenz, brand Intelence, generic etravirine, Edurant, Tybost, Brand Epzicom, generic abacavir/lamivudine, Evotaz, Dovato, Prezcobix, Cimduo, Brand Combivir, generic lamivudine/zidovudine, Brand Kaletra, generic lopinavir/ritonavir, Triumeq, Triumeq PD, Trizivir, Delstrigo, Brand Atripla, generic efavirenz/emtricitabine/tenofovir, Brand Symfi Lo, Brand Symfi, generic efavirenz/lamivudine/tenofovir, Odefsey, Symtuza, Juluca

| Diagnosis | Human Immunodeficiency Virus (HIV), HIV post-exposure prophylaxis (PEP) |
|---|---|
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SELZENTRY | MARAVIROC TAB 25 MG | 12102060000305 | Brand |
| SELZENTRY | MARAVIROC TAB 75 MG | 12102060000310 | Brand |
| MARAVIROC | MARAVIROC TAB 150 MG | 12102060000320 | Generic |
| SELZENTRY | MARAVIROC TAB 150 MG | 12102060000320 | Brand |
| MARAVIROC | MARAVIROC TAB 300 MG | 12102060000330 | Generic |
| SELZENTRY | MARAVIROC TAB 300 MG | 12102060000330 | Brand |
| SELZENTRY | MARAVIROC ORAL SOLN 20 MG/ML | 12102060002020 | Brand |
| FUZEON | ENFUVIRTIDE FOR INJ 90 MG | 12102530002120 | Brand |
| TIVICAY | DOLUTEGRAVIR SODIUM TAB 10 MG (BASE EQUIV) | 12103015100305 | Brand |
| TIVICAY | DOLUTEGRAVIR SODIUM TAB 25 MG (BASE EQUIV) | 12103015100310 | Brand |
| TIVICAY | DOLUTEGRAVIR SODIUM TAB 50 MG (BASE EQUIV) | 12103015100320 | Brand |
| TIVICAY PD | DOLUTEGRAVIR SODIUM TAB FOR ORAL SUSP 5 MG (BASE EQUIV) | 12103015107320 | Brand |
| ISENTRESS | RALTEGRAVIR POTASSIUM TAB 400 MG (BASE EQUIV) | 12103060100320 | Brand |
| ISENTRESS HD | RALTEGRAVIR POTASSIUM TAB 600 MG (BASE EQUIV) | 12103060100330 | Brand |
| ISENTRESS | RALTEGRAVIR POTASSIUM CHEW TAB 25 MG (BASE EQUIV) | 12103060100510 | Brand |
| ISENTRESS | RALTEGRAVIR POTASSIUM CHEW TAB 100 MG (BASE EQUIV) | 12103060100540 | Brand |

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|---|---|---|---|
| ISENTRESS | RALTEGRAVIR POTASSIUM PACKET FOR SUSP 100 MG (BASE EQUIV) | 12103060103020 | Brand |
| ATAZANAVIR | ATAZANAVIR SULFATE CAP 150 MG (BASE EQUIV) | 12104515200130 | Generic |
| ATAZANAVIR SULFATE | ATAZANAVIR SULFATE CAP 150 MG (BASE EQUIV) | 12104515200130 | Generic |
| ATAZANAVIR | ATAZANAVIR SULFATE CAP 200 MG (BASE EQUIV) | 12104515200140 | Generic |
| ATAZANAVIR SULFATE | ATAZANAVIR SULFATE CAP 200 MG (BASE EQUIV) | 12104515200140 | Generic |
| REYATAZ | ATAZANAVIR SULFATE CAP 200 MG (BASE EQUIV) | 12104515200140 | Brand |
| ATAZANAVIR SULFATE | ATAZANAVIR SULFATE CAP 300 MG (BASE EQUIV) | 12104515200150 | Generic |
| REYATAZ | ATAZANAVIR SULFATE CAP 300 MG (BASE EQUIV) | 12104515200150 | Brand |
| REYATAZ | ATAZANAVIR SULFATE ORAL POWDER PACKET 50 MG (BASE EQUIV) | 12104515203020 | Brand |
| PREZISTA | DARUNAVIR TAB 75 MG | 12104520000305 | Brand |
| PREZISTA | DARUNAVIR TAB 150 MG | 12104520000310 | Brand |
| PREZISTA | DARUNAVIR TAB 600 MG | 12104520000325 | Brand |
| PREZISTA | DARUNAVIR TAB 800 MG | 12104520000350 | Brand |
| PREZISTA | DARUNAVIR ORAL SUSP 100 MG/ML | 12104520001820 | Brand |
| FOSAMPRENAVIR CALCIUM | FOSAMPRENAVIR CALCIUM TAB 700 MG (BASE EQUIV) | 12104525100330 | Generic |
| LEXIVA | FOSAMPRENAVIR CALCIUM TAB 700 MG (BASE EQUIV) | 12104525100330 | Brand |
| LEXIVA | FOSAMPRENAVIR CALCIUM SUSP 50 MG/ML (BASE EQUIV) | 12104525101820 | Brand |

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|---|---|---|---|
| NORVIR | RITONAVIR TAB 100 MG | 12104560000320 | Brand |
| RITONAVIR | RITONAVIR TAB 100 MG | 12104560000320 | Generic |
| NORVIR | RITONAVIR POWDER PACKET 100 MG | 12104560003020 | Brand |
| ABACAVIR | ABACAVIR SULFATE TAB 300 MG (BASE EQUIV) | 12105005100320 | Generic |
| ABACAVIR SULFATE | ABACAVIR SULFATE TAB 300 MG (BASE EQUIV) | 12105005100320 | Generic |
| ZIAGEN | ABACAVIR SULFATE TAB 300 MG (BASE EQUIV) | 12105005100320 | Brand |
| ABACAVIR | ABACAVIR SULFATE SOLN 20 MG/ML (BASE EQUIV) | 12105005102020 | Generic |
| ZIAGEN | ABACAVIR SULFATE SOLN 20 MG/ML (BASE EQUIV) | 12105005102020 | Brand |
| EMTRICITABINE | EMTRICITABINE CAPS 200 MG | 12106030000120 | Generic |
| EMTRIVA | EMTRICITABINE CAPS 200 MG | 12106030000120 | Brand |
| EMTRIVA | EMTRICITABINE SOLN 10 MG/ML | 12106030002010 | Brand |
| EPIVIR | LAMIVUDINE TAB 150 MG | 12106060000320 | Brand |
| LAMIVUDINE | LAMIVUDINE TAB 150 MG | 12106060000320 | Generic |
| EPIVIR | LAMIVUDINE TAB 300 MG | 12106060000330 | Brand |
| LAMIVUDINE | LAMIVUDINE TAB 300 MG | 12106060000330 | Generic |
| EPIVIR | LAMIVUDINE ORAL SOLN 10 MG/ML | 12106060002020 | Brand |
| LAMIVUDINE | LAMIVUDINE ORAL SOLN 10 MG/ML | 12106060002020 | Generic |
| STAVUDINE | STAVUDINE CAP 15 MG | 12108070000115 | Generic |
| STAVUDINE | STAVUDINE CAP 20 MG | 12108070000120 | Generic |
| STAVUDINE | STAVUDINE CAP 30 MG | 12108070000130 | Generic |
| STAVUDINE | STAVUDINE CAP 40 MG | 12108070000140 | Generic |

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|---|---|---|---|
| RETROVIR | ZIDOVUDINE CAP 100 MG | 12108085000110 | Brand |
| ZIDOVUDINE | ZIDOVUDINE CAP 100 MG | 12108085000110 | Generic |
| ZIDOVUDINE | ZIDOVUDINE TAB 300 MG | 12108085000330 | Generic |
| RETROVIR | ZIDOVUDINE SYRUP 10 MG/ML | 12108085001210 | Brand |
| ZIDOVUDINE | ZIDOVUDINE SYRUP 10 MG/ML | 12108085001210 | Generic |
| PIFELTRO | DORAVIRINE TAB 100 MG | 12109025000320 | Brand |
| EFAVIRENZ | EFAVIRENZ CAP 50 MG | 12109030000110 | Generic |
| SUSTIVA | EFAVIRENZ CAP 50 MG | 12109030000110 | Brand |
| EFAVIRENZ | EFAVIRENZ CAP 200 MG | 12109030000140 | Generic |
| SUSTIVA | EFAVIRENZ CAP 200 MG | 12109030000140 | Brand |
| EFAVIRENZ | EFAVIRENZ TAB 600 MG | 12109030000330 | Generic |
| SUSTIVA | EFAVIRENZ TAB 600 MG | 12109030000330 | Brand |
| INTELENCE | ETRAVIRINE TAB 25 MG | 12109035000310 | Brand |
| ETRAVIRINE | ETRAVIRINE TAB 100 MG | 12109035000320 | Generic |
| INTELENCE | ETRAVIRINE TAB 100 MG | 12109035000320 | Brand |
| ETRAVIRINE | ETRAVIRINE TAB 200 MG | 12109035000340 | Generic |
| INTELENCE | ETRAVIRINE TAB 200 MG | 12109035000340 | Brand |
| EDURANT | RILPIVIRINE HCL TAB 25 MG (BASE EQUIVALENT) | 12109080100320 | Brand |
| TYBOST | COBICISTAT TAB 150 MG | 12109530000320 | Brand |
| ABACAVIR SULFATE/LAMIVUDINE | ABACAVIR SULFATE-LAMIVUDINE TAB 600-300 MG | 12109902200340 | Generic |
| EPZICOM | ABACAVIR SULFATE-LAMIVUDINE TAB 600-300 MG | 12109902200340 | Brand |

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|---|---|---|---|
| EVOTAZ | ATAZANAVIR SULFATE-COBICISTAT TAB 300-150 MG (BASE EQUIV) | 12109902220330 | Brand |
| DOVATO | DOLUTEGRAVIR SODIUM-LAMIVUDINE TAB 50-300 MG (BASE EQ) | 12109902260320 | Brand |
| PREZCOBIX | DARUNAVIR-COBICISTAT TAB 800-150 MG | 12109902270320 | Brand |
| JULUCA | DOLUTEGRAVIR SODIUM-RILPIVIRINE HCL TAB 50-25 MG (BASE EQ) | 12109902280320 | Brand |
| CIMDUO | LAMIVUDINE-TENOFOVIR DISOPROXIL FUMARATE TAB 300-300 MG | 12109902470330 | Brand |
| COMBIVIR | LAMIVUDINE-ZIDOVUDINE TAB 150-300 MG | 12109902500320 | Brand |
| LAMIVUDINE/ZIDOVUDINE | LAMIVUDINE-ZIDOVUDINE TAB 150-300 MG | 12109902500320 | Generic |
| KALETRA | LOPINAVIR-RITONAVIR TAB 100-25 MG | 12109902550310 | Brand |
| LOPINAVIR/RITONAVIR | LOPINAVIR-RITONAVIR TAB 100-25 MG | 12109902550310 | Generic |
| KALETRA | LOPINAVIR-RITONAVIR TAB 200-50 MG | 12109902550320 | Brand |
| LOPINAVIR/RITONAVIR | LOPINAVIR-RITONAVIR TAB 200-50 MG | 12109902550320 | Generic |
| KALETRA | LOPINAVIR-RITONAVIR SOLN 400-100 MG/5ML (80-20 MG/ML) | 12109902552020 | Brand |
| LOPINAVIR/RITONAVIR | LOPINAVIR-RITONAVIR SOLN 400-100 MG/5ML (80-20 MG/ML) | 12109902552020 | Generic |
| TRIUMEQ | ABACAVIR-DOLUTEGRAVIR-LAMIVUDINE TAB 600-50-300 MG | 12109903150320 | Brand |
| TRIUMEQ PD | ABACAVIR-DOLUTEGRAVIR-LAMIVUDINE TAB FOR ORAL SUS 60-5-30 MG | 12109903157320 | Brand |
| TRIZIVIR | ABACAVIR SULFATE-LAMIVUDINE- | 12109903200320 | Brand |

| | | | |
|---|---|---|---|
| | ZIDOVUDINE TAB 300-150-300 MG | | |
| DELSTRIGO | DORAVIRINE-LAMIVUDINE-TENOFOVIR DF TAB 100-300-300 MG | 12109903270320 | Brand |
| ATRIPLA | EFAVIRENZ-EMTRICITABINE-TENOFOVIR DF TAB 600-200-300 MG | 12109903300320 | Brand |
| EFAVIRENZ/EMTRICITABINE/TENOFOVIR DISOPROXIL FUMARATE | EFAVIRENZ-EMTRICITABINE-TENOFOVIR DF TAB 600-200-300 MG | 12109903300320 | Generic |
| EFAVIRENZ/LAMIVUDINE/TENOFOVIR DISOPROXIL FUMARATE | EFAVIRENZ-LAMIVUDINE-TENOFOVIR DF TAB 400-300-300 MG | 12109903330330 | Generic |
| SYMFI LO | EFAVIRENZ-LAMIVUDINE-TENOFOVIR DF TAB 400-300-300 MG | 12109903330330 | Brand |
| EFAVIRENZ/LAMIVUDINE/TENOFOVIR DISOPROXIL FUMARATE | EFAVIRENZ-LAMIVUDINE-TENOFOVIR DF TAB 600-300-300 MG | 12109903330340 | Generic |
| SYMFI | EFAVIRENZ-LAMIVUDINE-TENOFOVIR DF TAB 600-300-300 MG | 12109903330340 | Brand |
| ODEFSEY | EMTRICITABINE-RILPIVIRINE-TENOFOVIR AF TAB 200-25-25 MG | 12109903390320 | Brand |
| SYMTUZA | DARUNAVIR-COBIC-EMTRICITAB-TENOFOV AF TAB 800-150-200-10 MG | 12109904200320 | Brand |
| DARUNAVIR | DARUNAVIR TAB 600 MG | 12104520000325 | Generic |
| DARUNAVIR | DARUNAVIR TAB 800 MG | 12104520000350 | Generic |

**Approval Criteria**

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

- HIV (human immunodeficiency virus)

| | |
|---|---|
| • HIV post-exposure prophylaxis (PEP)<br><br>**AND**<br><br>**2** - If the request is non-preferred*, ONE of the following:<br><br>**2.1** History of contraindication or intolerance to THREE preferred* products<br><br>**OR**<br><br>**2.2** Continuation of current therapy | |
| Notes | This guideline does NOT include Biktarvy, Complera, Descovy, Genvoya, Rukobia, and Stribild. These medications have drug specific guidelines.<br>Approval Duration: 12 months for HIV; 4 weeks for PEP.<br>*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |

## 2 . Revision History

| Date | Notes |
|---|---|
| 8/6/2024 | Copy Core |

Hycamtin

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146539 |
| **Guideline Name** | Hycamtin |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| HYCAMTIN | TOPOTECAN HCL CAP 0.25 MG (BASE EQUIV) | 21550080100120 | Brand |
| HYCAMTIN | TOPOTECAN HCL CAP 1 MG (BASE EQUIV) | 21550080100140 | Brand |
| HYCAMTIN | TOPOTECAN HCL FOR INJ 4 MG (BASE EQUIV) | 21550080102120 | Brand |

| | | | |
|---|---|---|---|
| TOPOTECAN HCL | TOPOTECAN HCL FOR INJ 4 MG (BASE EQUIV) | 21550080102120 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| HYCAMTIN | TOPOTECAN HCL CAP 0.25 MG (BASE EQUIV) | 21550080100120 | Brand |
| HYCAMTIN | TOPOTECAN HCL CAP 1 MG (BASE EQUIV) | 21550080100140 | Brand |
| HYCAMTIN | TOPOTECAN HCL FOR INJ 4 MG (BASE EQUIV) | 21550080102120 | Brand |
| TOPOTECAN HCL | TOPOTECAN HCL FOR INJ 4 MG (BASE EQUIV) | 21550080102120 | Generic |

**Approval Criteria**

**1** - Diagnosis of Merkel cell carcinoma

**AND**

**2** - Disease is M1 disseminated

**AND**

**3** - Patient has a contraindication to or disease has progressed on anti-PD-L1 or anti-PD-1 therapy

| 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| HYCAMTIN | TOPOTECAN HCL CAP 0.25 MG (BASE EQUIV) | 21550080100120 | Brand |
| HYCAMTIN | TOPOTECAN HCL CAP 1 MG (BASE EQUIV) | 21550080100140 | Brand |
| HYCAMTIN | TOPOTECAN HCL FOR INJ 4 MG (BASE EQUIV) | 21550080102120 | Brand |
| TOPOTECAN HCL | TOPOTECAN HCL FOR INJ 4 MG (BASE EQUIV) | 21550080102120 | Generic |

**Approval Criteria**

**1** - Patient does not show evidence of progressive disease while on Hycamtin (topotecan) therapy

| Product Name: Brand Hycamtin, generic topotecan | |
|---|---|
| Diagnosis | NCCN Recommended Regimens |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| HYCAMTIN | TOPOTECAN HCL CAP 0.25 MG (BASE EQUIV) | 21550080100120 | Brand |
| HYCAMTIN | TOPOTECAN HCL CAP 1 MG (BASE EQUIV) | 21550080100140 | Brand |

| | | | |
|---|---|---|---|
| HYCAMTIN | TOPOTECAN HCL FOR INJ 4 MG (BASE EQUIV) | 21550080102120 | Brand |
| TOPOTECAN HCL | TOPOTECAN HCL FOR INJ 4 MG (BASE EQUIV) | 21550080102120 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| HYCAMTIN | TOPOTECAN HCL CAP 0.25 MG (BASE EQUIV) | 21550080100120 | Brand |
| HYCAMTIN | TOPOTECAN HCL CAP 1 MG (BASE EQUIV) | 21550080100140 | Brand |
| HYCAMTIN | TOPOTECAN HCL FOR INJ 4 MG (BASE EQUIV) | 21550080102120 | Brand |
| TOPOTECAN HCL | TOPOTECAN HCL FOR INJ 4 MG (BASE EQUIV) | 21550080102120 | Generic |

**Approval Criteria**

**1** - Documentation of positive clinical response to Hycamtin (topotecan) therapy

Hyftor

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146338 |
| **Guideline Name** | Hyftor |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Hyftor | |
|---|---|
| Approval Length | 6 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| HYFTOR | SIROLIMUS GEL 0.2% | 90784070004020 | Brand |

**Approval Criteria**

**1** - Diagnosis of tuberous sclerosis

**AND**

**2** - One of the following:

**2.1** One or more of the following major features:

- Hypomelanotic macules (At least 3; at least 5 mm diameter)
- Angiofibroma (At least 3) or fibrous cephalic plaque
- Ungual fibromas (At least 2)
- Shagreen patch
- Multiple retinal hamartomas
- Multiple cortical tubers and/or radial migration lines
- Subependymal nodule (At least 2)
- Subependymal giant cell astrocytoma
- Cardiac rhabdomyoma
- Lymphangiomyomatosis (LAM)
- Angiomyolipomas (At least 2)

**OR**

**2.2** Two or more of the following minor features:

- “Confetti” skin lesions
- Dental enamel pits (At least 3)
- Intraoral fibromas (At least 2)
- Retinal achromic patch
- Multiple renal cysts
- Nonrenal hamartomas
- Sclerotic bone lesions

**OR**

**2.3** Confirmed presence of a mutation in the TSC1 or TSC2 gene

**AND**

**3** - Patient has facial angiofibroma associated with tuberous sclerosis

**AND**

**4** - Patient is not receiving Hyftor in combination with a systemic mTOR (mechanistic target of rapamycin) inhibitor [e.g., Rapamune (sirolimus), Afinitor (everolimus)]

**AND**

**5** - Hyftor is being prescribed by, or in consultation, with a dermatologist, neurologist, or oncologist

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| HYFTOR | SIROLIMUS GEL 0.2% | 90784070004020 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to therapy (e.g., improvement in skin lesions)

**AND**

**2** - Patient is not receiving Hyftor in combination with a systemic mTOR inhibitor [e.g., Rapamune (sirolimus), Afinitor (everolimus)]

**AND**

**3** - Hyftor is being prescribed by, or in consultation, with a dermatologist, neurologist, or oncologist

Ibrance

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146540 |
| **Guideline Name** | Ibrance |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Ibrance | |
|---|---|
| Diagnosis | Breast Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| IBRANCE | PALBOCICLIB CAP 75 MG | 21531060000120 | Brand |
| IBRANCE | PALBOCICLIB CAP 100 MG | 21531060000130 | Brand |
| IBRANCE | PALBOCICLIB CAP 125 MG | 21531060000140 | Brand |
| IBRANCE | PALBOCICLIB TAB 75 MG | 21531060000320 | Brand |

| | | | |
|---|---|---|---|
| IBRANCE | PALBOCICLIB TAB 100 MG | 21531060000330 | Brand |
| IBRANCE | PALBOCICLIB TAB 125 MG | 21531060000340 | Brand |

**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)

| Product Name: Ibrance | |
|---|---|
| Diagnosis | Well-Differentiated/Dedifferentiated Liposarcoma (WD-DDLS) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| IBRANCE | PALBOCICLIB CAP 75 MG | 21531060000120 | Brand |
| IBRANCE | PALBOCICLIB CAP 100 MG | 21531060000130 | Brand |

| | | | |
|---|---|---|---|
| IBRANCE | PALBOCICLIB CAP 125 MG | 21531060000140 | Brand |
| IBRANCE | PALBOCICLIB TAB 75 MG | 21531060000320 | Brand |
| IBRANCE | PALBOCICLIB TAB 100 MG | 21531060000330 | Brand |
| IBRANCE | PALBOCICLIB TAB 125 MG | 21531060000340 | Brand |

**Approval Criteria**

**1** - Diagnosis of unresectable retroperitoneal WD-DDLS (well-differentiated/dedifferentiated liposarcoma)

| Product Name: Ibrance | |
|---|---|
| Diagnosis | Breast Cancer, Well-Differentiated/Dedifferentiated Liposarcoma (WD-DDLS) |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| IBRANCE | PALBOCICLIB CAP 75 MG | 21531060000120 | Brand |
| IBRANCE | PALBOCICLIB CAP 100 MG | 21531060000130 | Brand |
| IBRANCE | PALBOCICLIB CAP 125 MG | 21531060000140 | Brand |
| IBRANCE | PALBOCICLIB TAB 75 MG | 21531060000320 | Brand |
| IBRANCE | PALBOCICLIB TAB 100 MG | 21531060000330 | Brand |
| IBRANCE | PALBOCICLIB TAB 125 MG | 21531060000340 | Brand |

**Approval Criteria**

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

| Product Name: Ibrance | |
|---|---|
| Diagnosis | NCCN Recommended Regimen |
| Approval Length | 12 month(s) |

| Therapy Stage | Initial Authorization |
|---|---|
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| IBRANCE | PALBOCICLIB CAP 75 MG | 21531060000120 | Brand |
| IBRANCE | PALBOCICLIB CAP 100 MG | 21531060000130 | Brand |
| IBRANCE | PALBOCICLIB CAP 125 MG | 21531060000140 | Brand |
| IBRANCE | PALBOCICLIB TAB 75 MG | 21531060000320 | Brand |
| IBRANCE | PALBOCICLIB TAB 100 MG | 21531060000330 | Brand |
| IBRANCE | PALBOCICLIB TAB 125 MG | 21531060000340 | Brand |

**Approval Criteria**

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

| Product Name: Ibrance | |
|---|---|
| Diagnosis | NCCN Recommended Regimen |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| IBRANCE | PALBOCICLIB CAP 75 MG | 21531060000120 | Brand |
| IBRANCE | PALBOCICLIB CAP 100 MG | 21531060000130 | Brand |
| IBRANCE | PALBOCICLIB CAP 125 MG | 21531060000140 | Brand |
| IBRANCE | PALBOCICLIB TAB 75 MG | 21531060000320 | Brand |
| IBRANCE | PALBOCICLIB TAB 100 MG | 21531060000330 | Brand |
| IBRANCE | PALBOCICLIB TAB 125 MG | 21531060000340 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Ibrance therapy

Iclusig

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146541 |
| **Guideline Name** | Iclusig |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Iclusig | |
|---|---|
| Diagnosis | Chronic Myelogenous / Myeloid Leukemia (CML) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ICLUSIG | PONATINIB HCL TAB 10 MG (BASE EQUIV) | 21531875100315 | Brand |
| ICLUSIG | PONATINIB HCL TAB 15 MG (BASE EQUIV) | 21531875100320 | Brand |
| ICLUSIG | PONATINIB HCL TAB 30 MG (BASE EQUIV) | 21531875100330 | Brand |
| ICLUSIG | PONATINIB HCL TAB 45 MG (BASE EQUIV) | 21531875100340 | Brand |

**Approval Criteria**

**1** - Diagnosis of chronic myelogenous/ myeloid leukemia (CML)

**AND**

**2** - One of the following:

**2.1** BOTH of the following:

- Disease is in the chronic phase
- Patient has resistance or intolerance to two or more tyrosine kinase inhibitor (TKI) therapies [e.g., imatinib mesylate, Sprycel (dasatinib), or Tasigna (nilotinib)]

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| ICLUSIG | PONATINIB HCL TAB 10 MG (BASE EQUIV) | 21531875100315 | Brand |
| ICLUSIG | PONATINIB HCL TAB 15 MG (BASE EQUIV) | 21531875100320 | Brand |
| ICLUSIG | PONATINIB HCL TAB 30 MG (BASE EQUIV) | 21531875100330 | Brand |
| ICLUSIG | PONATINIB HCL TAB 45 MG (BASE EQUIV) | 21531875100340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ICLUSIG | PONATINIB HCL TAB 10 MG (BASE EQUIV) | 21531875100315 | Brand |
| ICLUSIG | PONATINIB HCL TAB 15 MG (BASE EQUIV) | 21531875100320 | Brand |
| ICLUSIG | PONATINIB HCL TAB 30 MG (BASE EQUIV) | 21531875100330 | Brand |
| ICLUSIG | PONATINIB HCL TAB 45 MG (BASE EQUIV) | 21531875100340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ICLUSIG | PONATINIB HCL TAB 10 MG (BASE EQUIV) | 21531875100315 | Brand |
| ICLUSIG | PONATINIB HCL TAB 15 MG (BASE EQUIV) | 21531875100320 | Brand |
| ICLUSIG | PONATINIB HCL TAB 30 MG (BASE EQUIV) | 21531875100330 | Brand |
| ICLUSIG | PONATINIB HCL TAB 45 MG (BASE EQUIV) | 21531875100340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ICLUSIG | PONATINIB HCL TAB 10 MG (BASE EQUIV) | 21531875100315 | Brand |
| ICLUSIG | PONATINIB HCL TAB 15 MG (BASE EQUIV) | 21531875100320 | Brand |
| ICLUSIG | PONATINIB HCL TAB 30 MG (BASE EQUIV) | 21531875100330 | Brand |
| ICLUSIG | PONATINIB HCL TAB 45 MG (BASE EQUIV) | 21531875100340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ICLUSIG | PONATINIB HCL TAB 10 MG (BASE EQUIV) | 21531875100315 | Brand |
| ICLUSIG | PONATINIB HCL TAB 15 MG (BASE EQUIV) | 21531875100320 | Brand |
| ICLUSIG | PONATINIB HCL TAB 30 MG (BASE EQUIV) | 21531875100330 | Brand |
| ICLUSIG | PONATINIB HCL TAB 45 MG (BASE EQUIV) | 21531875100340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ICLUSIG | PONATINIB HCL TAB 10 MG (BASE EQUIV) | 21531875100315 | Brand |
| ICLUSIG | PONATINIB HCL TAB 15 MG (BASE EQUIV) | 21531875100320 | Brand |
| ICLUSIG | PONATINIB HCL TAB 30 MG (BASE EQUIV) | 21531875100330 | Brand |
| ICLUSIG | PONATINIB HCL TAB 45 MG (BASE EQUIV) | 21531875100340 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Iclusig therapy

ICS.LABA Combination Products

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-158104 |
| **Guideline Name** | ICS.LABA Combination Products |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 12/1/2024 |

## 1 . Criteria

| Product Name: generic budesonide/formoterol, generic Breyna | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BREYNA | BUDESONIDE-FORMOTEROL FUMARATE DIHYD AEROSOL 80-4.5 MCG/ACT | 44209902413220 | Generic |
| BUDESONIDE/FORMOTEROL FUMARATE DIHYDRATE | BUDESONIDE-FORMOTEROL FUMARATE DIHYD AEROSOL 80-4.5 MCG/ACT | 44209902413220 | Generic |
| BREYNA | BUDESONIDE-FORMOTEROL FUMARATE DIHYD AEROSOL 160-4.5 MCG/ACT | 44209902413240 | Generic |

| | | | |
|---|---|---|---|
| BUDESONIDE/FORMOTEROL FUMARATE DIHYDRATE | BUDESONIDE-FORMOTEROL FUMARATE DIHYD AEROSOL 160-4.5 MCG/ACT | 44209902413240 | Generic |

**Approval Criteria**

**1** - One of the following:

**1.1** BOTH of the following:

**1.1.1** Diagnosis of 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| FLUTICASONE FUROATE/VILANTEROL ELLIPTA | FLUTICASONE FUROATE-VILANTEROL AERO POWD BA 100-25 MCG/ACT | 44209902758020 | Generic |
| FLUTICASONE FUROATE/VILANTEROL ELLIPTA | FLUTICASONE FUROATE-VILANTEROL AERO POWD BA 200-25 MCG/ACT | 44209902758030 | Generic |

**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 Breyna or budesonide/formoterol (generic of Symbicort) confirmed by claims history or submitted medical records

**OR**

**1.2.2.2** 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 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 |
|---|---|

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DULERA | MOMETASONE FUROATE-FORMOTEROL FUMARATE AEROSOL 50-5 MCG/ACT | 44209902903210 | Brand |
| DULERA | MOMETASONE FUROATE-FORMOTEROL FUMARATE AEROSOL 100-5 MCG/ACT | 44209902903220 | Brand |
| DULERA | MOMETASONE FUROATE-FORMOTEROL FUMARATE AEROSOL 200-5 MCG/ACT | 44209902903240 | Brand |
| AIRDUO RESPICLICK 55/14 | FLUTICASONE-SALMETEROL AER POWDER BA 55-14 MCG/ACT | 44209902708010 | Generic |
| AIRDUO RESPICLICK 113/14 | FLUTICASONE-SALMETEROL AER POWDER BA 113-14 MCG/ACT | 44209902708015 | Generic |
| AIRDUO RESPICLICK 232/14 | FLUTICASONE-SALMETEROL AER POWDER BA 232-14 MCG/ACT | 44209902708025 | Generic |
| AIRDUO DIGIHALER 55/14 | FLUTICASONE-SALMETEROL AER POWDER BA 55-14 MCG/ACT W/ SENSOR | 44209902718020 | Brand |
| AIRDUO DIGIHALER 113/14 | FLUTICASONE-SALMETEROL AER POWDER BA 113-14 MCG/ACT W/SENSOR | 44209902718030 | Brand |
| AIRDUO DIGIHALER 232/14 | FLUTICASONE-SALMETEROL AER POWDER BA 232-14 MCG/ACT W/SENSOR | 44209902718040 | Brand |
| FLUTICASONE PROPIONATE/SALMETEROL HFA | FLUTICASONE-SALMETEROL INHAL AEROSOL 45-21 MCG/ACT | 44209902703250 | Generic |
| ADVAIR HFA | FLUTICASONE-SALMETEROL INHAL AEROSOL 45-21 MCG/ACT | 44209902703250 | Generic |
| FLUTICASONE PROPIONATE/SALMETEROL HFA | FLUTICASONE-SALMETEROL INHAL AEROSOL 115-21 MCG/ACT | 44209902703260 | Generic |
| ADVAIR HFA | FLUTICASONE-SALMETEROL INHAL AEROSOL 115-21 MCG/ACT | 44209902703260 | Generic |
| FLUTICASONE PROPIONATE/SALMETEROL HFA | FLUTICASONE-SALMETEROL INHAL AEROSOL 230-21 MCG/ACT | 44209902703270 | Generic |
| ADVAIR HFA | FLUTICASONE-SALMETEROL INHAL AEROSOL 230-21 MCG/ACT | 44209902703270 | Generic |

**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 Respiclick)
- 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 Respiclick)
- 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ADVAIR DISKUS | FLUTICASONE-SALMETEROL AER POWDER BA 100-50 MCG/ACT | 44209902708020 | Brand |
| ADVAIR DISKUS | FLUTICASONE-SALMETEROL AER POWDER BA 250-50 MCG/ACT | 44209902708030 | Brand |
| ADVAIR DISKUS | FLUTICASONE-SALMETEROL AER POWDER BA 500-50 MCG/ACT | 44209902708040 | Brand |
| SYMBICORT | BUDESONIDE-FORMOTEROL FUMARATE DIHYD AEROSOL 80-4.5 MCG/ACT | 44209902413220 | Brand |
| SYMBICORT | BUDESONIDE-FORMOTEROL FUMARATE DIHYD AEROSOL 160-4.5 MCG/ACT | 44209902413240 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BREO ELLIPTA | FLUTICASONE FUROATE-VILANTEROL AERO POWD BA 100-25 MCG/ACT | 44209902758020 | Generic |
| BREO ELLIPTA | FLUTICASONE FUROATE-VILANTEROL AERO POWD BA 200-25 MCG/ACT | 44209902758030 | Generic |
| BREO ELLIPTA | FLUTICASONE FUROATE-VILANTEROL AERO POWD BA 50-25 MCG/ACT | 44209902758010 | Brand |

**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 |
|---|---|
| 10/28/2024 | Added new Breo Ellipta strength. Clarified preferred Respiclick produ ct in T/F language. |

Idhifa

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-157998 |
| **Guideline Name** | Idhifa |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 12/1/2024 |

## 1 . Criteria

| Product Name: Idhifa | |
|---|---|
| Diagnosis | Acute Myeloid Leukemia (AML) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| IDHIFA | ENASIDENIB MESYLATE TAB 50 MG (BASE EQUIVALENT) | 21535030200320 | Brand |
| IDHIFA | ENASIDENIB MESYLATE TAB 100 MG (BASE EQUIVALENT) | 21535030200340 | Brand |

**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 |
|---|---|

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| IDHIFA | ENASIDENIB MESYLATE TAB 50 MG (BASE EQUIVALENT) | 21535030200320 | Brand |
| IDHIFA | ENASIDENIB MESYLATE TAB 100 MG (BASE EQUIVALENT) | 21535030200340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| IDHIFA | ENASIDENIB MESYLATE TAB 50 MG (BASE EQUIVALENT) | 21535030200320 | Brand |
| IDHIFA | ENASIDENIB MESYLATE TAB 100 MG (BASE EQUIVALENT) | 21535030200340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| IDHIFA | ENASIDENIB MESYLATE TAB 50 MG (BASE EQUIVALENT) | 21535030200320 | Brand |
| IDHIFA | ENASIDENIB MESYLATE TAB 100 MG (BASE EQUIVALENT) | 21535030200340 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Idhifa therapy

## 2 . Revision History

| Date | Notes |
|---|---|
| 10/24/2024 | Updated initial auth criteria for AML based on NCCN recommendatio ns; Minor cosmetic updates. |

Ilaris

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146836 |
| **Guideline Name** | Ilaris |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Ilaris | |
|---|---|
| Diagnosis | Cryopyrin-Associated Periodic Syndromes (CAPS) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ILARIS | CANAKINUMAB SUBCUTANEOUS INJ 150 MG/ML | 66460020002015 | Brand |

**Approval Criteria**

**1** - Diagnosis of ONE of the following:

- Familial cold autoinflammatory syndrome (FCAS)
- Muckle-Wells Syndrome (MWS)

**AND**

**2** - Diagnosis is made by, or in consultation with, a rheumatologist or immunologist with expertise in the diagnosis of FCAS and MWS

| Product Name: Ilaris | |
|---|---|
| Diagnosis | Cryopyrin-Associated Periodic Syndromes (CAPS) |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ILARIS | CANAKINUMAB SUBCUTANEOUS INJ 150 MG/ML | 66460020002015 | Brand |

**Approval Criteria**

**1** - Patient is currently on Ilaris therapy for ONE of the following:

- Familial cold autoinflammatory syndrome (FCAS)
- Muckle-Wells Syndrome (MWS)

**AND**

**2** - 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ILARIS | CANAKINUMAB SUBCUTANEOUS INJ 150 MG/ML | 66460020002015 | Brand |

**Approval Criteria**

**1** - Diagnosis of tumor necrosis factor (TNF) receptor-associated periodic syndrome (TRAPS)

**AND**

**2** - Diagnosis is made by, or in consultation with, a rheumatologist or immunologist with expertise in the diagnosis of TRAPS

| 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ILARIS | CANAKINUMAB SUBCUTANEOUS INJ 150 MG/ML | 66460020002015 | Brand |

**Approval Criteria**

**1** - Patient is currently on Ilaris therapy for tumor necrosis factor (TNF) receptor-associated periodic syndrome (TRAPS)

**AND**

**2** - Documentation of positive clinical response to Ilaris therapy, defined as a decrease in frequency or severity of attacks

| Product Name: Ilaris | |
|---|---|
| Diagnosis | Hyperimmunoglobulin D (Hyper-IgD) Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ILARIS | CANAKINUMAB SUBCUTANEOUS INJ 150 MG/ML | 66460020002015 | Brand |

**Approval Criteria**

**1** - Diagnosis of ONE of the following

- Hyperimmunoglobulin D (Hyper-IgD) Syndrome (HIDS)
- Mevalonate Kinase Deficiency (MKD)

**AND**

**2** - Diagnosis is made by, or in consultation with, a rheumatologist or immunologist with expertise in the diagnosis of HIDS or MKD

| Product Name: Ilaris | |
|---|---|
| Diagnosis | Hyperimmunoglobulin D (Hyper-IgD) Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD) |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| ILARIS | CANAKINUMAB SUBCUTANEOUS INJ 150 MG/ML | 66460020002015 | Brand |

**Approval Criteria**

**1** - Patient is currently on Ilaris therapy for ONE of the following:

- Hyperimmunoglobulin D (Hyper-IgD) Syndrome (HIDS)
- Mevalonate Kinase Deficiency (MKD)

**AND**

**2** - 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ILARIS | CANAKINUMAB SUBCUTANEOUS INJ 150 MG/ML | 66460020002015 | Brand |

**Approval Criteria**

**1** - Diagnosis of Familial Mediterranean Fever (FMF)

**AND**

**2** - Diagnosis is made by, or in consultation with, a rheumatologist or immunologist with expertise in the diagnosis of FMF

**AND**

**3** - ONE of the following:

**3.1** Failure to colchicine as confirmed by claims history or submission of medical records

**OR**

**3.2** History of contraindication or intolerance to colchicine (please specify contraindication or intolerance)

| Product Name: Ilaris | |
|---|---|
| Diagnosis | Familial Mediterranean Fever (FMF) |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ILARIS | CANAKINUMAB SUBCUTANEOUS INJ 150 MG/ML | 66460020002015 | Brand |

**Approval Criteria**

**1** - Patient is currently on Ilaris therapy for Familial Mediterranean Fever (FMF)

**AND**

**2** - 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ILARIS | CANAKINUMAB SUBCUTANEOUS INJ 150 MG/ML | 66460020002015 | Brand |

**Approval Criteria**

**1** - Diagnosis of systemic juvenile idiopathic arthritis (SJIA)

**AND**

**2** - Diagnosis is made by, or in consultation with, a rheumatologist or immunologist with expertise in the diagnosis of SJIA

**AND**

**3** - Patient is not receiving Ilaris in combination with another biologic (e.g., Actemra)

| Product Name: Ilaris | |
|---|---|
| Diagnosis | Systemic Juvenile Idiopathic Arthritis (SJIA) |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ILARIS | CANAKINUMAB SUBCUTANEOUS INJ 150 MG/ML | 66460020002015 | Brand |

**Approval Criteria**

**1** - Patient is currently on Ilaris therapy for systemic juvenile idiopathic arthritis (SJIA)

**AND**

**2** - Documentation of positive clinical response to Ilaris therapy

**AND**

**3** - Patient is not receiving Ilaris in combination with another biologic (e.g., Actemra)

| 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ILARIS | CANAKINUMAB SUBCUTANEOUS INJ 150 MG/ML | 66460020002015 | Brand |

**Approval Criteria**

**1** - Diagnosis of Adult Onset Still's Disease (AOSD)

**AND**

**2** - Diagnosis is made by, or in consultation with, a rheumatologist or immunologist with expertise in the diagnosis of Still's Disease

**AND**

**3** - Patient is not receiving Ilaris in combination with another biologic (e.g., Actemra)

| 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ILARIS | CANAKINUMAB SUBCUTANEOUS INJ 150 MG/ML | 66460020002015 | Brand |

**Approval Criteria**

**1** - Patient is currently on Ilaris therapy for Adult Onset Still's Disease (AOSD)

**AND**

**2** - Documentation of positive clinical response to Ilaris therapy

**AND**

**3** - Patient is not receiving Ilaris in combination with another biologic (e.g., Actemra)

| Product Name: Ilaris | |
|---|---|
| Diagnosis | Gout Flare |
| Approval Length | 12 Week(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ILARIS | CANAKINUMAB SUBCUTANEOUS INJ 150 MG/ML | 66460020002015 | Brand |

**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 |
|---|---|
| 4/30/2024 | Removed "-NY CHIP" from GL name |

Ilumya

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146544 |
| **Guideline Name** | Ilumya |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ILUMYA | TILDRAKIZUMAB-ASMN SUBCUTANEOUS SOLN PREF SYRINGE 100 MG/ML | 9025058010E520 | Brand |

**Approval Criteria**

**1** - Diagnosis of chronic moderate to severe plaque psoriasis

**AND**

**2** - Patient is NOT receiving Ilumya in combination with ONE of the following:

- Biologic disease-modifying antirheumatic drug (DMARD) [e.g., adalimumab, Cimzia (certolizumab), Simponi (golimumab), Cosentyx (secukinumab), Orencia (abatacept)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g. Otezla (apremilast)]

**AND**

**3** - Prescribed by, or in consultation with, a dermatologist

**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** One of the following:

**4.2.1** Patient has been previously treated with a biologic or targeted synthetic DMARD FDA (Food and Drug Administration)-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), Stelara (ustekinumab), Tremfya (guselkumab), Enbrel (etanercept)]

**OR**

**4.2.2** All of the following:

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

**AND**

**4.2.2.2** 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**

**4.2.2.3** 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)

| Product Name: Ilumya | |
|---|---|
| Diagnosis | Plaque Psoriasis |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ILUMYA | TILDRAKIZUMAB-ASMN SUBCUTANEOUS SOLN PREF SYRINGE 100 MG/ML | 9025058010E520 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Ilumya therapy

**AND**

**2** - Patient is NOT receiving Ilumya in combination with ONE of the following:

- Biologic disease-modifying antirheumatic drug (DMARD) [e.g., adalimumab, Cimzia (certolizumab), Simponi (golimumab), Cosentyx (secukinumab), Orencia (abatacept)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g. Otezla (apremilast)]

Imbruvica

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-161251 |
| **Guideline Name** | Imbruvica |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 1 . Criteria

| Product Name: Imbruvica | |
|---|---|
| Diagnosis | B-Cell Lymphoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| IMBRUVICA | IBRUTINIB CAP 70 MG | 21532133000110 | Brand |
| IMBRUVICA | IBRUTINIB CAP 140 MG | 21532133000120 | Brand |
| IMBRUVICA | IBRUTINIB TAB 140 MG | 21532133000320 | Brand |
| IMBRUVICA | IBRUTINIB TAB 280 MG | 21532133000330 | Brand |

| | | | |
|---|---|---|---|
| IMBRUVICA | IBRUTINIB TAB 420 MG | 21532133000340 | Brand |
| IMBRUVICA | IBRUTINIB TAB 560 MG | 21532133000350 | Brand |
| IMBRUVICA | IBRUTINIB ORAL SUSP 70 MG/ML | 21532133001820 | Brand |

**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-GCB DLBCL (non-germinal center B-cell diffuse large B-cell) and non-candidate for transplant]

- Human Immunodeficiency Virus (HIV)-related B-cell lymphoma
- Post-transplant lymphoproliferative disorders
- Histologic transformation to diffuse large B-cell lymphoma
- 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| IMBRUVICA | IBRUTINIB CAP 70 MG | 21532133000110 | Brand |
| IMBRUVICA | IBRUTINIB CAP 140 MG | 21532133000120 | Brand |
| IMBRUVICA | IBRUTINIB TAB 140 MG | 21532133000320 | Brand |
| IMBRUVICA | IBRUTINIB TAB 280 MG | 21532133000330 | Brand |
| IMBRUVICA | IBRUTINIB TAB 420 MG | 21532133000340 | Brand |
| IMBRUVICA | IBRUTINIB TAB 560 MG | 21532133000350 | Brand |
| IMBRUVICA | IBRUTINIB ORAL SUSP 70 MG/ML | 21532133001820 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| IMBRUVICA | IBRUTINIB CAP 70 MG | 21532133000110 | Brand |
| IMBRUVICA | IBRUTINIB CAP 140 MG | 21532133000120 | Brand |
| IMBRUVICA | IBRUTINIB TAB 140 MG | 21532133000320 | Brand |
| IMBRUVICA | IBRUTINIB TAB 280 MG | 21532133000330 | Brand |
| IMBRUVICA | IBRUTINIB TAB 420 MG | 21532133000340 | Brand |
| IMBRUVICA | IBRUTINIB TAB 560 MG | 21532133000350 | Brand |
| IMBRUVICA | IBRUTINIB ORAL SUSP 70 MG/ML | 21532133001820 | Brand |

**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 |
|---|---|

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| IMBRUVICA | IBRUTINIB CAP 70 MG | 21532133000110 | Brand |
| IMBRUVICA | IBRUTINIB CAP 140 MG | 21532133000120 | Brand |
| IMBRUVICA | IBRUTINIB TAB 140 MG | 21532133000320 | Brand |
| IMBRUVICA | IBRUTINIB TAB 280 MG | 21532133000330 | Brand |
| IMBRUVICA | IBRUTINIB TAB 420 MG | 21532133000340 | Brand |
| IMBRUVICA | IBRUTINIB TAB 560 MG | 21532133000350 | Brand |
| IMBRUVICA | IBRUTINIB ORAL SUSP 70 MG/ML | 21532133001820 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| IMBRUVICA | IBRUTINIB CAP 70 MG | 21532133000110 | Brand |
| IMBRUVICA | IBRUTINIB CAP 140 MG | 21532133000120 | Brand |
| IMBRUVICA | IBRUTINIB TAB 140 MG | 21532133000320 | Brand |
| IMBRUVICA | IBRUTINIB TAB 280 MG | 21532133000330 | Brand |
| IMBRUVICA | IBRUTINIB TAB 420 MG | 21532133000340 | Brand |
| IMBRUVICA | IBRUTINIB TAB 560 MG | 21532133000350 | Brand |
| IMBRUVICA | IBRUTINIB ORAL SUSP 70 MG/ML | 21532133001820 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| IMBRUVICA | IBRUTINIB CAP 70 MG | 21532133000110 | Brand |
| IMBRUVICA | IBRUTINIB CAP 140 MG | 21532133000120 | Brand |
| IMBRUVICA | IBRUTINIB TAB 140 MG | 21532133000320 | Brand |
| IMBRUVICA | IBRUTINIB TAB 280 MG | 21532133000330 | Brand |
| IMBRUVICA | IBRUTINIB TAB 420 MG | 21532133000340 | Brand |
| IMBRUVICA | IBRUTINIB TAB 560 MG | 21532133000350 | Brand |
| IMBRUVICA | IBRUTINIB ORAL SUSP 70 MG/ML | 21532133001820 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| IMBRUVICA | IBRUTINIB CAP 70 MG | 21532133000110 | Brand |
| IMBRUVICA | IBRUTINIB CAP 140 MG | 21532133000120 | Brand |
| IMBRUVICA | IBRUTINIB TAB 140 MG | 21532133000320 | Brand |
| IMBRUVICA | IBRUTINIB TAB 280 MG | 21532133000330 | Brand |
| IMBRUVICA | IBRUTINIB TAB 420 MG | 21532133000340 | Brand |
| IMBRUVICA | IBRUTINIB TAB 560 MG | 21532133000350 | Brand |
| IMBRUVICA | IBRUTINIB ORAL SUSP 70 MG/ML | 21532133001820 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| IMBRUVICA | IBRUTINIB CAP 70 MG | 21532133000110 | Brand |
| IMBRUVICA | IBRUTINIB CAP 140 MG | 21532133000120 | Brand |
| IMBRUVICA | IBRUTINIB TAB 140 MG | 21532133000320 | Brand |
| IMBRUVICA | IBRUTINIB TAB 280 MG | 21532133000330 | Brand |
| IMBRUVICA | IBRUTINIB TAB 420 MG | 21532133000340 | Brand |
| IMBRUVICA | IBRUTINIB TAB 560 MG | 21532133000350 | Brand |
| IMBRUVICA | IBRUTINIB ORAL SUSP 70 MG/ML | 21532133001820 | Brand |

**Approval Criteria**

| |
|---|
| **1** - Documentation of positive clinical response to Imbruvica therapy |

## 2 . Revision History

| Date | Notes |
|---|---|
| 11/25/2024 | Added rituximab to RHyperCVAD and minor formatting changes |

Impavido

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146340 |
| **Guideline Name** | Impavido |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Impavido | |
|---|---|
| Approval Length | 28 Day(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| IMPAVIDO | MILTEFOSINE CAP 50 MG | 16000036000120 | Brand |

**Approval Criteria**

**1** - Patient has a diagnosis of ONE of the following:

- Visceral leishmaniasis due to Leishmania donovani
- Cutaneous leishmaniasis due to Leishmania braziliensis, Leishmania guyanensis, or Leishmania panamensis
- Mucosal leishmaniasis due to Leishmania braziliensis
- Primary Amebic Meningoencephalitis (PAM)
- Keratitis due to Acanthamoeba
- Amebic encephalitis due to Balamuthia mandrillaris

Inbrija

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146342 |
| **Guideline Name** | Inbrija |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| INBRIJA | LEVODOPA INHAL POWDER CAP 42 MG | 73200040000160 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| INBRIJA | LEVODOPA INHAL POWDER CAP 42 MG | 73200040000160 | Brand |

**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

Ingrezza

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146546 |
| **Guideline Name** | Ingrezza |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Ingrezza | |
|---|---|
| Diagnosis | Tardive Dyskinesia |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| INGREZZA | VALBENAZINE TOSYLATE CAP THERAPY PACK 40 MG (7) & 80 MG (21) | 6238008020B220 | Brand |
| INGREZZA | VALBENAZINE TOSYLATE CAP 40 MG (BASE EQUIV) | 62380080200120 | Brand |
| INGREZZA | VALBENAZINE TOSYLATE CAP 60 MG (BASE EQUIV) | 62380080200130 | Brand |

| | | | |
|---|---|---|---|
| INGREZZA | VALBENAZINE TOSYLATE CAP 80 MG (BASE EQUIV) | 62380080200140 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| INGREZZA | VALBENAZINE TOSYLATE CAP THERAPY PACK 40 MG (7) & 80 MG (21) | 6238008020B220 | Brand |

| | | | |
|---|---|---|---|
| INGREZZA | VALBENAZINE TOSYLATE CAP 40 MG (BASE EQUIV) | 62380080200120 | Brand |
| INGREZZA | VALBENAZINE TOSYLATE CAP 60 MG (BASE EQUIV) | 62380080200130 | Brand |
| INGREZZA | VALBENAZINE TOSYLATE CAP 80 MG (BASE EQUIV) | 62380080200140 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| INGREZZA | VALBENAZINE TOSYLATE CAP THERAPY PACK 40 MG (7) & 80 MG (21) | 6238008020B220 | Brand |
| INGREZZA | VALBENAZINE TOSYLATE CAP 40 MG (BASE EQUIV) | 62380080200120 | Brand |
| INGREZZA | VALBENAZINE TOSYLATE CAP 60 MG (BASE EQUIV) | 62380080200130 | Brand |
| INGREZZA | VALBENAZINE TOSYLATE CAP 80 MG (BASE EQUIV) | 62380080200140 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Ingrezza therapy

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-149518 |
| **Guideline Name** | Inhaled Corticosteroids |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/4/2024 |

## 1 . Criteria

| Product Name: Asmanex HFA, Asmanex Twisthaler | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ASMANEX HFA | MOMETASONE FUROATE INHAL AEROSOL SUSPENSION 100 MCG/ACT | 44400036203220 | Brand |
| ASMANEX HFA | MOMETASONE FUROATE INHAL AEROSOL SUSPENSION 200 MCG/ACT | 44400036203230 | Brand |
| ASMANEX HFA | MOMETASONE FUROATE INHAL AEROSOL SUSPENSION 50 MCG/ACT | 44400036203210 | Brand |
| ASMANEX TWISTHALER | MOMETASONE FUROATE INHAL POWD 110 MCG/ACT (BREATH ACTIVATED) | 44400036208010 | Brand |

| | | | |
|---|---|---|---|
| 30 METERED DOSES | | | |
| ASMANEX TWISTHALER 14 METERED DOSES | MOMETASONE FUROATE INHAL POWD 220 MCG/ACT (BREATH ACTIVATED) | 44400036208020 | Brand |
| ASMANEX TWISTHALER 60 METERED DOSES | MOMETASONE FUROATE INHAL POWD 220 MCG/ACT (BREATH ACTIVATED) | 44400036208020 | Brand |
| ASMANEX TWISTHALER 120 METERED DOSES | MOMETASONE FUROATE INHAL POWD 220 MCG/ACT (BREATH ACTIVATED) | 44400036208020 | Brand |
| ASMANEX TWISTHALER 30 METERED DOSES | MOMETASONE FUROATE INHAL POWD 220 MCG/ACT (BREATH ACTIVATED) | 44400036208020 | Brand |

**Approval Criteria**

**1** - Diagnosis of asthma

**AND**

**2** - ONE of the following:

**2.1** Failure of Brand Fluticasone propionate HFA confirmed by claims history or submitted medical records

**OR**

**2.2** History of intolerance or contraindication to Brand Fluticasone propionate HFA (please specify intolerance or contraindication)

| Product Name: Alvesco, ArmonAir Digihaler, Arnuity Ellipta, Flovent Diskus, Brand Flovent HFA, Pulmicort Flexhaler, Qvar RediHaler | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| FLOVENT DISKUS | FLUTICASONE PROPIONATE AER POW BA 50 MCG/BLISTER | 44400033208010 | Brand |
| FLOVENT DISKUS | FLUTICASONE PROPIONATE AER POW BA 100 MCG/BLISTER | 44400033208020 | Brand |
| FLOVENT DISKUS | FLUTICASONE PROPIONATE AER POW BA 250 MCG/BLISTER | 44400033208030 | Brand |
| PULMICORT FLEXHALER | BUDESONIDE INHAL AERO POWD 90 MCG/ACT (BREATH ACTIVATED) | 44400015008009 | Brand |
| PULMICORT FLEXHALER | BUDESONIDE INHAL AERO POWD 180 MCG/ACT (BREATH ACTIVATED) | 44400015008018 | Brand |
| ALVESCO | CICLESONIDE INHAL AEROSOL 80 MCG/ACT | 44400017003420 | Brand |
| ALVESCO | CICLESONIDE INHAL AEROSOL 160 MCG/ACT | 44400017003440 | Brand |
| ARMONAIR DIGIHALER | FLUTICASONE PROPIONATE AER POW BA 55 MCG/ACT WITH SENSOR | 44400033218020 | Brand |
| ARMONAIR DIGIHALER | FLUTICASONE PROPIONATE AER POW BA 113 MCG/ACT WITH SENSOR | 44400033218030 | Brand |
| ARMONAIR DIGIHALER | FLUTICASONE PROPIONATE AER POW BA 232 MCG/ACT WITH SENSOR | 44400033218040 | Brand |
| ARNUITY ELLIPTA | FLUTICASONE FUROATE AEROSOL POWDER BREATH ACTIV 50 MCG/ACT | 44400033108010 | Brand |
| ARNUITY ELLIPTA | FLUTICASONE FUROATE AEROSOL POWDER BREATH ACTIV 100 MCG/ACT | 44400033108020 | Brand |
| ARNUITY ELLIPTA | FLUTICASONE FUROATE AEROSOL POWDER BREATH ACTIV 200 MCG/ACT | 44400033108030 | Brand |
| FLOVENT HFA | FLUTICASONE PROPIONATE HFA INHAL AERO 44 MCG/ACT (50/VALVE) | 44400033223220 | Generic |
| FLOVENT HFA | FLUTICASONE PROPIONATE HFA INHAL AER 110 MCG/ACT (125/VALVE) | 44400033223230 | Generic |
| FLOVENT HFA | FLUTICASONE PROPIONATE HFA INHAL AER 220 MCG/ACT (250/VALVE) | 44400033223240 | Generic |
| QVAR REDIHALER | BECLOMETHASONE DIPROP HFA BREATH ACT INH AER 40 MCG/ACT | 44400010128120 | Brand |
| QVAR REDIHALER | BECLOMETHASONE DIPROP HFA BREATH ACT INH AER 80 MCG/ACT | 44400010128140 | Brand |

**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:

- Brand 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):

- Brand Fluticasone propionate HFA
- Asmanex HFA or Asmanex Twisthaler

Inlyta

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-158209 |
| **Guideline Name** | Inlyta |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 12/1/2024 |

## 1 . Criteria

| Product Name: Inlyta | |
|---|---|
| Diagnosis | Renal Cell Carcinoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| INLYTA | AXITINIB TAB 1 MG | 21335013000320 | Brand |
| INLYTA | AXITINIB TAB 5 MG | 21335013000340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| INLYTA | AXITINIB TAB 1 MG | 21335013000320 | Brand |
| INLYTA | AXITINIB TAB 5 MG | 21335013000340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| INLYTA | AXITINIB TAB 1 MG | 21335013000320 | Brand |
| INLYTA | AXITINIB TAB 5 MG | 21335013000340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| INLYTA | AXITINIB TAB 1 MG | 21335013000320 | Brand |
| INLYTA | AXITINIB TAB 5 MG | 21335013000340 | Brand |

**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 | Renal Cell Carcinoma, Thyroid Carcinoma, Salivary Gland Tumor, Soft Tissue Sarcoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| INLYTA | AXITINIB TAB 1 MG | 21335013000320 | Brand |
| INLYTA | AXITINIB TAB 5 MG | 21335013000340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| INLYTA | AXITINIB TAB 1 MG | 21335013000320 | Brand |
| INLYTA | AXITINIB TAB 5 MG | 21335013000340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| INLYTA | AXITINIB TAB 1 MG | 21335013000320 | Brand |
| INLYTA | AXITINIB TAB 5 MG | 21335013000340 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Inlyta therapy

## 2 . Revision History

| Date | Notes |
|---|---|

| | |
|---|---|
| 10/29/2024 | Updated initial auth criteria for RCC. Updated diagnosis header for R CC in reauth section. Minor update to initial auth criteria for NCCN R ecommended Regimens with no changes to clinical intent; Minor cos metic updates. |

Inqovi

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146548 |
| **Guideline Name** | Inqovi |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Inqovi | |
|---|---|
| Diagnosis | Myelodysplastic Syndrome (MDS), Chronic Myelomonocytic Leukemia (CMML) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| INQOVI | DECITABINE-CEDAZURIDINE TAB 35-100 MG | 21990002250320 | Brand |

**Approval Criteria**

**1** - BOTH of the following:

**1.1** Diagnosis of myelodysplastic syndrome (MDS)

**AND**

**1.2** Patient is intermediate-1, intermediate-2, or high-risk per the International Prognostic Scoring System (IPSS)

**OR**

**2** - Diagnosis of chronic myelomonocytic leukemia (CMML)

| Product Name: Inqovi | |
|---|---|
| Diagnosis | Myelodysplastic Syndrome (MDS), Chronic Myelomonocytic Leukemia (CMML) |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| INQOVI | DECITABINE-CEDAZURIDINE TAB 35-100 MG | 21990002250320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| INQOVI | DECITABINE-CEDAZURIDINE TAB 35-100 MG | 21990002250320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| INQOVI | DECITABINE-CEDAZURIDINE TAB 35-100 MG | 21990002250320 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Inqovi therapy

Inrebic

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146549 |
| **Guideline Name** | Inrebic |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Inrebic | |
|---|---|
| Diagnosis | Myelofibrosis |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| INREBIC | FEDRATINIB HCL CAP 100 MG | 21537520200120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| INREBIC | FEDRATINIB HCL CAP 100 MG | 21537520200120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| INREBIC | FEDRATINIB HCL CAP 100 MG | 21537520200120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| INREBIC | FEDRATINIB HCL CAP 100 MG | 21537520200120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| INREBIC | FEDRATINIB HCL CAP 100 MG | 21537520200120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| INREBIC | FEDRATINIB HCL CAP 100 MG | 21537520200120 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Inrebic therapy

Insulin Pen Needles and Syringes

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-158147 |
| **Guideline Name** | Insulin Pen Needles and Syringes |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 12/1/2024 |

## 1 . Criteria

| Product Name: Non-preferred insulin pen needles and insulin syringes | |
|---|---|
| Diagnosis | Non-Preferred |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| EASY TOUCH SAFETY PEN NEEDLES/29G X 5MM | INSULIN PEN NEEDLE 29 G X 5 MM (1/5" OR 3/16") | 97051050146318 | Brand |
| MAXI-COMFORT SAFETY PEN NEEDLE/29G X 3/16" | INSULIN PEN NEEDLE 29 G X 5 MM (1/5" OR 3/16") | 97051050146318 | Brand |
| EASY TOUCH SAFETY PEN NEEDLES/29G X 8MM | INSULIN PEN NEEDLE 29 G X 8 MM (1/3" OR 5/16") | 97051050146322 | Brand |
| MAXI-COMFORT SAFETY PEN NEEDLE/29G X 5/16" | INSULIN PEN NEEDLE 29 G X 8 MM (1/3" OR 5/16") | 97051050146322 | Brand |

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|---|---|---|---|
| DROPLET PEN NEEDLES 29GX10MM | INSULIN PEN NEEDLE 29 G X 10 MM | 97051050146326 | Brand |
| TECHLITE PEN NEEDLES 29G X 10MM | INSULIN PEN NEEDLE 29 G X 10 MM | 97051050146326 | Brand |
| AURORA PEN NEEDLES 29GX12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| CAREFINE PEN NEEDLES 29GX1/2" | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| CAREONE UNIFINE PENTIPS PLUS PEN NEEDLES 29GX12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| CAREONE UNIFINE PENTIPS 29GX12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| CARETOUCH PEN NEEDLE 29GX1/2" | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| CLEVER CHOICE COMFORT EZ PEN NEEDLES 29GX12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| DROPLET PEN NEEDLES 29G X1/2" | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| DROPLET PEN NEEDLES 29GX12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| DRUG MART UNIFINE PENTIPS29G X 12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| EASY TOUCH PEN NEEDLES 29GX1/2" | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| EXEL COMFORT POINT INSULIN PEN NEEDLES 29G X 12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| GLOBAL EASE INJECT PEN NEEDLES 29GX12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| H-E-B INCONTROL PEN NEEDLES 29GX12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| HEALTHWISE PEN NEEDLES 29GX12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| HEALTHY ACCENTS UNIFINE PENTIPS PEN NEEDLES 29GX12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| INSUPEN 29G X 12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| KROGER PEN NEEDLES 29G X 12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| MARATHON MEDICAL PENTIPS 29GX12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| MEDICINE SHOPPE PEN NEEDLES 29G X 12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| MEIJER PEN NEEDLES 29G X 12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| PC UNIFINE PENTIPS 29G X 1/2" | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |

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|---|---|---|---|
| PEN NEEDLES 29GX12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| PEN NEEDLES/29G X 1/2" | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| PENTIPS 29G X 12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| PENTIPS 29GX12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| PREFERRED PLUS UNIFINE PENTIPS 29G X 12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| PX PEN NEEDLE 29GX12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| QC PEN NEEDLES 29G X 12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| RAYA SURE PEN NEEDLE 29G X 12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| RELION PEN NEEDLES 29GX12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| SHOPKO UNIFINE PENTIPS PEN NEEDLES/ORIGINAL/29GX12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| SHOPKO UNIFINE PENTIPS PLUS PEN NEEDLES/REMOVER/29GX12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| TECHLITE PEN NEEDLES 29G X 12 MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| TODAYS HEALTH ORIGINAL PEN NEEDLES 29G X 1/2" | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| TRUEPLUS PEN NEEDLES 29GX12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| ULTRA FLO INSULIN PEN NEEDLES | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| UNIFINE PENTIPS PLUS 29GX12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| UNIFINE PENTIPS 29GX12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| VALUMARK PEN NEEDLES 29GX12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| VIDA MIA UNIFINE PENTIPS ORIGINAL 29GX12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| 1ST TIER UNIFINE PENTIPS PLUS/ORIGINAL/29GX12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| 1ST TIER UNIFINE PENTIPS 29GX12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| ADVOCATE INSULIN PEN NEEDLES 29GX12.7MM | INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2") | 97051050146331 | Brand |

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|---|---|---|---|
| BD PEN NEEDLE/ORIGINAL/ULTRA-FINE/29G X 12.7MM | INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2") | 97051050146331 | Brand |
| LITETOUCH PEN NEEDLES 29GX12.7MM | INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2") | 97051050146331 | Brand |
| SURE COMFORT PEN NEEDLES 29GX1/2" 12.7MM | INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2") | 97051050146331 | Brand |
| TRUEPLUS 5-BEVEL PEN NEEDLES 29GX12.7MM | INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2") | 97051050146331 | Brand |
| ULTICARE ORIGINAL PEN NEEDLES ULTI-FINE | INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2") | 97051050146331 | Brand |
| ULTICARE PEN NEEDLES/29G X 12.7MM | INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2") | 97051050146331 | Brand |
| ULTIGUARD SAFEPACK PEN NEEDLE/29G X 1/2"/SHARPS CONTAINER | INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2") | 97051050146331 | Brand |
| ULTILET PEN NEEDLE 29GX12.7MM | INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2") | 97051050146331 | Brand |
| ULTRA-THIN II PEN NEEDLES 29GX1/2" | INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2") | 97051050146331 | Brand |
| BD AUTOSHIELD DUO 30G X 5MM | INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16") | 97051050146340 | Brand |
| EASY TOUCH PEN NEEDLE/30 G X 3/16" | INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16") | 97051050146340 | Brand |
| PEN NEEDLES 30GX5MM | INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16") | 97051050146340 | Brand |
| SAFETY PEN NEEDLES/30G X 3/16" | INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16") | 97051050146340 | Brand |
| ULTICARE MINI SAFETY PEN NEEDLES 30G X 3/16" | INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16") | 97051050146340 | Brand |
| UNIFINE PENTIPS PLUS/30G X 3/16" | INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16") | 97051050146340 | Brand |
| UNIFINE PENTIPS/30G X 3/16" | INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16") | 97051050146340 | Brand |
| UNIFINE SAFECONTROL PEN NEEDLE/30G X 3/16" | INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16") | 97051050146340 | Brand |
| EASY TOUCH SAFETY PEN NEEDLES/30G X 1/4" | INSULIN PEN NEEDLE 30 G X 6 MM (1/4" OR 15/64") | 97051050146341 | Brand |
| ABOUTTIME PEN NEEDLES 30GX 5/16" | INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16") | 97051050146344 | Brand |
| ASSURE ID SAFETY PEN NEEDLES 30G X 5/16" | INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16") | 97051050146344 | Brand |
| CAREFINE PEN NEEDLES 30GX5/16" | INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16") | 97051050146344 | Brand |
| DROPLET PEN NEEDLES 30G X 5/16" | INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16") | 97051050146344 | Brand |

| | | | |
|---|---|---|---|
| EASY TOUCH PEN NEEDLE 30 G X 5/16" | INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16") | 97051050146344 | Brand |
| EASY TOUCH SAFETY PEN NEEDLES/30G X 5/16" | INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16") | 97051050146344 | Brand |
| INSUPEN ULTRAFIN 30GX8MM | INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16") | 97051050146344 | Brand |
| NOVOFINE AUTOCOVER PEN NEEDLE 30G X 8MM | INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16") | 97051050146344 | Brand |
| PEN NEEDLES 30GX8MM | INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16") | 97051050146344 | Brand |
| SAFETY PEN NEEDLES/30G X 5/16" | INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16") | 97051050146344 | Brand |
| SECURESAFE SAFETY PEN NEEDLES/30G X 5/16" | INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16") | 97051050146344 | Brand |
| SURE COMFORT PEN NEEDLES 30GX5/16" SHORT | INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16") | 97051050146344 | Brand |
| ULTICARE SHORT SAFETY PEN NEEDLES 30G X 5/16" | INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16") | 97051050146344 | Brand |
| UNIFINE SAFECONTROL PEN NEEDLE/30G X 5/16" | INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16") | 97051050146344 | Brand |
| AUM SAFETY PEN NEEDLE/31 G X 4MM | INSULIN PEN NEEDLE 31 G X 4 MM (1/6" OR 5/32") | 97051050146354 | Brand |
| COMFORT TOUCH PEN NEEDLES/31G X 4MM | INSULIN PEN NEEDLE 31 G X 4 MM (1/6" OR 5/32") | 97051050146354 | Brand |
| RAYA SURE PEN NEEDLE 31G X 4MM | INSULIN PEN NEEDLE 31 G X 4 MM (1/6" OR 5/32") | 97051050146354 | Brand |
| ABOUTTIME PEN NEEDLES 31G X 3/16" | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| ADVOCATE INSULIN PEN NEEDLES 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| AUM SAFETY PEN NEEDLE/31 G X 5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| AURORA UNIFINE PENTIPS/MINI/31GX3/16" | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| BD PEN NEEDLE/MINI/ULTRA-FINE/31G X 5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| CAREONE UNIFINE PENTIPS PLUS PEN NEEDLES 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| CAREONE UNIFINE PENTIPS 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| CARETOUCH PEN NEEDLES 31GX 5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| CLEVER CHOICE COMFORT EZ PEN NEEDLES 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| CLICKFINE PEN NEEDLES 31G X 3/16" | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |

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|---|---|---|---|
| COMFORT EZ/31G X 5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| COMFORT TOUCH PEN NEEDLES/31G X 5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| DIATHRIVE PEN NEEDLE/31G X 5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| DROPLET PEN NEEDLES 31G X3/16" | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| DROPLET PEN NEEDLES 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| DROPSAFE SAFETY PEN NEEDLE/31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| DRUG MART UNIFINE PENTIPS 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| EASY COMFORT PEN NEEDLES 31GX3/16" | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| EASY TOUCH PEN NEEDLES/31G X 3/16" | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| FIFTY50 PEN NEEDLES 31G X3/16" (5MM) | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| FIFTY50 PEN NEEDLES 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| FREDS PHARMACY UNIFINE PENTIPS PLUS 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| GLOBAL EASE INJECT PEN NEEEDLES 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| GNP ULTICARE PEN NEEDLES 31G X 5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| GNP ULTIGUARD SAFEPACK/MINI PEN NEEDLE/31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| GOODSENSE CLICKFINE SAFETY PEN NEEDLE/31G X 3/16" | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| GOODSENSE PEN NEEDLE/PENFINE CLASSIC/31G X 3/16" | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| H-E-B IN CONTROL PEN NEEDLE 31GX3/16" | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| H-E-B IN CONTROL PEN NEEDLES 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| H-E-B IN CONTROL UNIFINE PENTIPS PLUS 31GX3/16" | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| H-E-B IN CONTROL UNIFINE PENTIPS PLUS 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| HEALTHWISE SHORT PEN NEEDLES/31G X 3/16" | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |

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| HEALTHY ACCENTS UNIFINE PENTIPS PEN NEEDLES 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| HM ULTICARE MINI PEN NEEDLES/31G X 5MM (3/16") | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| INSUPEN 31G X 5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| KROGER PEN NEEDLES/31G X 3/16" | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| LEADER UNIFINE PENTIPS PLUS/MINI/31GX3/16" | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| LEADER UNIFINE PENTIPS/MINI/31GX3/16" | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| LITETOUCH PEN NEEDLES/31 G X 3/16" | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| LITETOUCH PEN NEEDLES/31G X 5MM/MINI | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| MARATHON MEDICAL PENTIPS 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| MM PEN NEEDLES 31G X 3/16" | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| PC UNIFINE PENTIPS 31G X 5MM MINI | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| PEN NEEDLES 31G X 3/16" | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| PEN NEEDLES 31G X 5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| PEN NEEDLES/31G X 3/16" | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| PENTIPS 31G X 5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| PENTIPS 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| PREFERRED PLUS UNIFINE PENTIPS/MINI/31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| PX MINI PEN NEEDLES 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| RA PEN NEEDLES 31G X 5MM 3/16" | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| RAYA SURE PEN NEEDLE 31G X 5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| SHOPKO UNIFINE PENTIPS PEN NEEDLES/MINI/31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| SHOPKO UNIFINE PENTIPS PLUS PEN NEEDLES/MINI/REMOVER/31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |

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| SURE COMFORT PEN NEEDLES 31GX3/16" (5MM) | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| TECHLITE PEN NEEDLES 31G X 5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| TECHLITE PEN NEEDLES/31G X 5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| TRUE COMFORT PEN NEEDLES 31G X 5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| TRUE COMFORT PRO PEN NEEDLES 31G X 5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| TRUEPLUS PEN NEEDLES 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| TRUEPLUS 5-BEVEL PEN NEEDLES 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| ULTICARE PEN NEEDLES 31G X 5MM/MINI | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| ULTIGUARD SAFEPACK MINI PEN NEEDLE/31G X 3/16"/SHARPS CONTAI | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| ULTIGUARD SAFEPACK/MINI PEN NEEDLE/31G X 3/16"/SHARPS CONTAI | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| ULTILET PEN NEEDLE 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| ULTILET SHORT PEN NEEDLES31GX3/16" | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| ULTRA FLO INSULIN PEN NEEDLE 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| ULTRA-THIN II MINI PEN NEEEDLES/31GX3/16" | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| ULTRACARE PEN NEEDLES/31G X 3/16" | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| UNIFINE PENTIPS PLUS 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| UNIFINE PENTIPS 31G X 3/16" | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| UNIFINE PENTIPS 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| UNIFINE ULTRA PEN NEEDLE/31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| WEGMANS UNIFINE PENTIPS PLUS/MINI/31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| ZEVRX PEN NEEDLES 31G X 5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| 1ST TIER UNIFINE PENTIPS /MINI/31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |

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| 1ST TIER UNIFINE PENTIPS PLUS/MINI/31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| AURORA PEN NEEDLES 31G X 6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| CAREFINE PEN NEEDLES 31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| CAREONE UNIFINE PENTIPS PLUS PEN NEEDLES 31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| CAREONE UNIFINE PENTIPS 31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| CARETOUCH PEN NEEDLES 31 G X 6 MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| CLEVER CHOICE COMFORT EZ PEN NEEDLES 31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| CLICKFINE PEN NEEDLE UNIVERSAL/31GX1/4" | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| CLICKFINE PEN NEEDLES 31G X 1/4" | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| COMFORT EZ/31G X 6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| COMFORT TOUCH PEN NEEDLES/31G X 6 MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| DIATHRIVE PEN NEEDLE/31 G X 6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| DROPLET PEN NEEDLES 31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| DROPSAFE SAFTEY PEN NEEDLES/31G X 1/4" | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| DRUG MART UNIFINE PENTIPS31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| EASY COMFORT PEN NEEDLES 31GX1/4" | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| EASY TOUCH PEN NEEDLES 31GX1/4" | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| EXEL COMFORT POINT INSULIN PEN NEEDLES 31G X 6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| GNP CLICKFINE UNIVERSAL PEN NEEDLES 31GX1/4" | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| H-E-B IN CONTROL PEN NEEDLES 31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| H-E-B IN CONTROL UNIFINE PENTIPS PLUS 31GX1/4" | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| HEALTHWISE MINI PEN NEEDLES 31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| HEALTHY ACCENTS UNIFINE PENTIPS PEN NEEDLES 31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |

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|---|---|---|---|
| INCONTROL ULTICARE MINI PEN NEEDLES/31G X 6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| INSUPEN ULTRAFIN 31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| KROGER PEN NEEDLES 31GX1/4" | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| KROGER PEN NEEDLES/31G X 1/4" | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| LITETOUCH PEN NEEDLES 31G X 6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| LITETOUCH PEN NEEDLES 31G X 6MM/ULTRA SHORT | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| MAXICOMFORT II PEN NEEDLES/31G X 1/4" | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| MEDICINE SHOPPE PEN NEEDLES 31G X 6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| MEIJER PEN NEEDLES 31G X 6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| MICRODOT PEN NEEDLE/31G X 6 MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| MM PEN NEEDLES 31G X 1/4" | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| PC UNIFINE PENTIPS 31G X 6MM ULTRA SHORT | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| PEN NEEDLES 31G X 6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| PEN NEEDLES 31GX6MM (1/4") | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| BD INSULIN SYRINGE/U-500/0.5ML/31G X 6MM | INSULIN SYRINGE/NEEDLE U-500 0.5 ML 31G X 6MM (15/64") | 97051030956330 | Brand |
| ADVOCATE INSULIN SYRINGE/U-100/0.3ML/29GX1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| BD INSULIN SYRINGE ULTRAFINE/U-100/0.3ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| BD INSULIN SYRINGE/0.3ML/29G X 12.7MM | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| BD SAFETYGLIDE INSULIN SYRINGE/0.3ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.3ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| DROPLET INSULIN SYRINGE 0.3ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| EQL INSULIN SYRINGE/0.3ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |

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|---|---|---|---|
| EXEL COMFORT POINT INSULIN SYRINGE/0.3ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.3ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| GNP INSULIN SYRINGE/0.3ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| INSULIN SYRINGE/U-100/0.3ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| KROGER INSULIN SYRINGE/0.3ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| LEADER INSULIN SYRINGE/0.3ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| LITETOUCH INSULIN SYRINGE/0.3ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| MAGELLAN INSULIN SAFETY SYRINGE/U-100/0.3ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| MONOJECT INSULIN SYRINGE/SAFETY/PERM NEEDLE/0.3ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| MONOJECT INSULIN SYRINGE/SAFETY/PERM NEEDLE/0.3ML/29GX1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.3ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| PREFERRED PLUS INSULIN SYRINGE/U-100/0.3ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| SURE COMFORT INSULIN SYRINGE/U-100/0.3ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| TECHLITE INSULIN SYRINGE U-100/0.3ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| TOPCARE ULTRA COMFORT INSULIN SYRINGE/U-100/0.3ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| TRUEPLUS INSULIN SYRINGE/U-100/0.3ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| ULTICARE INSULIN SYRINGE/0.3ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| ULTRA FLO INSULIN SYRINGE 0.3ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| VP INSULIN SYRINGE/U-100/0.3ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| ADVOCATE INSULIN SYRINGE/U-100/0.3ML/30GX5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |

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| DROPLET INSULIN SYRINGE U-100/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| EASY TOUCH INSULIN SYRINGE/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| EQL INSULIN SYRINGE/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| EXEL COMFORT POINT INSULIN SYRINGE/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| GLOBAL INSULIN SYRINGES/U-100/0.3ML/30GX5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| GLUCOPRO INSULIN SYRINGE/U-100/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| GNP INSULIN SYRINGE/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| GNP INSULIN SYRINGES/0.3ML/30GX5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| HEALTHWISE INSULIN SYRINGE/U-100/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| INSULIN SYRINGE/NEEDLE 0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| INSULIN SYRINGE/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| KROGER INSULIN SYRINGE/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| LEADER INSULIN SYRINGE/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| LITETOUCH INSULIN SYRINGE/U-100/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| LITETOUCH INSULIN SYRINGE/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| MAGELLAN INSULIN SAFETY SYRINGE/U-100/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| MEDIC INSULIN SYRINGE/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| MM INSULIN SYRINGE/U-100/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| MONOJECT INSULIN SYRINGE/U-100/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| PRECISION SURE-DOSE INSULIN SYRINGE/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |

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|---|---|---|---|
| PREFERRED PLUS INSULIN SYRINGE/U-100/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| SURE COMFORT INSULIN SYRINGE/U-100/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| TECHLITE INSULIN SYRINGE U-100/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| TOPCARE ULTRA COMFORT INSULIN SYRINGE/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| TRUEPLUS INSULIN SYRINGE/U-100/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| ULTICARE INSULIN SYRINGE/SHORT/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| ULTICARE INSULIN SYRINGE/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| ULTRA COMFORT INSULIN SYRINGE/U-100/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| ULTRA FLO INSULIN SYRINGE 0.3ML/30GX5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| ULTRA FLO INSULIN SYRINGE 1/2 UNIT/0.3ML/30GX5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| ULTRA-THIN II INSULIN SYRINGE SHORT/U-100/0.3ML/30GX5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| ULTRACARE INSULIN SYRINGE/U-100/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| B-D INSULIN SYRINGE ULTRAFINE/0.3ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2" | 97051030906308 | Brand |
| BD INSULIN SYRINGE ULTRA-FINE/0.3ML/30G X 12.7MM | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2" | 97051030906308 | Brand |
| BD INSULIN SYRINGE ULTRAFINE/0.3ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2" | 97051030906308 | Brand |
| CAREONE INSULIN SYRINGES/0.3ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2" | 97051030906308 | Brand |
| CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.3ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2" | 97051030906308 | Brand |
| DROPLET INSULIN SYRINGE U-100/0.3ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2" | 97051030906308 | Brand |
| EASY TOUCH INSULIN SYRINGE/U-100/0.3ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2" | 97051030906308 | Brand |
| GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.3ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2" | 97051030906308 | Brand |
| GLOBAL INSULIN SYRINGE/U-100/0.3ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2" | 97051030906308 | Brand |
| GLUCOPRO INSULIN SYRINGE/U-100/0.3ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2" | 97051030906308 | Brand |

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|---|---|---|---|
| SURE COMFORT INSULIN SYRINGE/U-100/0.3ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2" | 97051030906308 | Brand |
| ULTICARE INSULIN SYRINGE/U-100/0.3ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2" | 97051030906308 | Brand |
| ULTICARE INSULIN SYRINGE/0.3ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2" | 97051030906308 | Brand |
| ULTIGUARD SAFEPACK INSULIN SYRINGE 0.3ML/30G X 1/2"/SHARPS C | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2" | 97051030906308 | Brand |
| ULTIGUARD SAFEPACK INSULIN SYRINGE/0.3ML/30G X 1/2"/SHARPS C | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2" | 97051030906308 | Brand |
| ULTRA FLO INSULIN SYRINGE 0.3ML/30GX1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2" | 97051030906308 | Brand |
| ULTRA FLO INSULIN SYRINGE 1/2 UNIT/0.3ML/30GX1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2" | 97051030906308 | Brand |
| EASY TOUCH INSULIN SYRINGE/U-100/0.5ML/27G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 27 X 1/2" | 97051030906310 | Brand |
| INSULIN SYRINGES/0.5ML/27GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 27 X 1/2" | 97051030906310 | Brand |
| MAXICOMFORT INSULIN SYRINGES 27G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 27 X 1/2" | 97051030906310 | Brand |
| ADVOCATE INSULIN SYRINGE/U-100/0.5ML/31GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| B-D INSULIN SYRINGE ULTRAFINE II/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| BD INSULIN SYRINGE ULTRA-FINE/0.5ML/31G X 8MM | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| BD INSULIN SYRINGE ULTRAFINE/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| CAREONE INSULIN SYRINGES/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| CARETOUCH INSULIN SYRINGE/0.5ML/31GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| COMFORT EZ INSULIN SYRINGE/U-100/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| DROPLET INSULIN SYRINGE U-100/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| DROPLET INSULIN SYRINGE/U-100/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| EASY COMFORT INSULIN SYRINGE/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |

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|---|---|---|---|
| EASY TOUCH INSULIN SYRINGE/U-100/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| EQL INSULIN SYRINGE/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| FIFTY50 SUPERIOR COMFORT INSULIN SYRINGE/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| GLUCOPRO INSULIN SYRINGE/U-100/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| GNP INSULIN SYRINGE/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| HEALTHWISE INSULIN SYRINGE/U-100/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| INSULIN SYRINGE/NEEDLE 0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| INSULIN SYRINGE/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| INSULIN SYRINGES/0.5ML/31GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| KINRAY INSULIN SYRINGE PREFERRED PLUS/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| KROGER INSULIN SYRINGE/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| LEADER INSULIN SYRINGE/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| LITETOUCH INSULIN SYRINGE/U-100/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| LITETOUCH INSULIN SYRINGE/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| LONGS INSULIN SYRINGE/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| MM INSULIN SYRINGE/U-100/1/2ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| MS INSULIN SYRINGE/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| PRO COMFORT INSULIN SYRINGES/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| PRODIGY INSULIN SYRINGE/1/2ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |

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| RELION INSULIN SYRINGE/U-100/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| SURE COMFORT INSULIN SYRINGE/U-100/0.5ML/31G X 5/16 | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| TECHLITE INSULIN SYRINGE U-100/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| TOPCARE ULTRA COMFORT INSULIN SYRINGE/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| TRUE COMFORT INSULIN SYRINGE/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| TRUE COMFORT PRO INSULIN SYRINGE/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| TRUEPLUS INSULIN SYRINGE/U-100/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| ULTICARE INSULIN SYRINGE ULTRAFINE U-100/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| ULTICARE INSULIN SYRINGE/SHORT/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| ULTICARE INSULIN SYRINGE/U-100/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| ULTIGUARD SAFEPACK/SYRINGE/NEEDLE/31G X 5/16"/SHARPS CONTAIN | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| ULTRA FLO INSULIN SYRINGE 0.5ML/31GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| ULTRA-THIN II INSULIN SYRINGE SHORT/U-100/0.5ML/31GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| ULTRACARE INSULIN SYRINGE/U-100/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| BD LO-DOSE INSULIN SYRINGE MICROFINE IV/0.5ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2" | 97051030906320 | Brand |
| BD INSULIN SYRINGE MICROFINE IV/U-100/0.5ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2" | 97051030906320 | Brand |
| CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.5ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2" | 97051030906320 | Brand |
| EASY TOUCH INSULIN SYRINGE/U-100/0.5ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2" | 97051030906320 | Brand |
| EXEL COMFORT POINT INSULIN SYRINGE/0.5ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2" | 97051030906320 | Brand |
| GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.5ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2" | 97051030906320 | Brand |
| GNP INSULIN SYRINGE/0.5ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2" | 97051030906320 | Brand |
| INSULIN SYRINGE/0.5ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2" | 97051030906320 | Brand |

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| INSULIN SYRINGES/0.5ML/28GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2" | 97051030906320 | Brand |
| LEADER INSULIN SYRINGE/0.5ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2" | 97051030906320 | Brand |
| LITETOUCH INSULIN SYRINGE/U-100/0.5ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2" | 97051030906320 | Brand |
| MAXI-COMFORT INSULIN SYRINGE/U-100/0.5ML/28GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2" | 97051030906320 | Brand |
| MONOJECT INSULIN SYRINGE/PERM NEEDLE/U-100/0.5ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2" | 97051030906320 | Brand |
| MONOJECT INSULIN SYRINGE/SOFTPACK/U-100/0.5ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2" | 97051030906320 | Brand |
| MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.5ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2" | 97051030906320 | Brand |
| PREFERRED PLUS INSULIN SYRINGE/U-100/0.5ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2" | 97051030906320 | Brand |
| REALITY INSULIN SYRINGE/U-100/0.5ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2" | 97051030906320 | Brand |
| SURE COMFORT INSULIN SYRINGE/U-100/0.5ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2" | 97051030906320 | Brand |
| TRUEPLUS INSULIN SYRINGE/U-100/0.5ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2" | 97051030906320 | Brand |
| ULTICARE INSULIN SYRINGE/0.5ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2" | 97051030906320 | Brand |
| ADVOCATE INSULIN SYRINGE/U-100/0.5ML/29GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| BD INSULIN SYRINGE ULTRAFINE/U-100/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| BD INSULIN SYRINGE/0.5ML/29G X 12.7MM | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| BD SAFETY-GLIDE INSULIN SYRINGE/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| BD SAFETYGLIDE INSULIN SYRINGE/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| DROPLET INSULIN SYRINGE 0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| EASY TOUCH INSULIN SYRINGE/SAFETY/U-100/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| EASY TOUCH INSULIN SYRINGE/U-100/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |

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|---|---|---|---|
| EASY TOUCH INSULIN SYRINGE/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| EQL INSULIN SYRINGE/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| EXEL COMFORT POINT INSULIN SYRINGE/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| GNP INSULIN SYRINGE/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| GNP INSULIN SYRINGES/1/2ML/29GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| INSULIN SYRINGE/NEEDLE 0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| INSULIN SYRINGE/U-100/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| INSULIN SYRINGES/0.5ML/29GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| KINRAY INSULIN SYRINGE/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| KROGER INSULIN SYRINGE/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| LEADER INSULIN SYRINGE/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| LITETOUCH INSULIN SYRINGE/U-100/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| MAGELLAN INSULIN SAFETY SYRINGE/U-100/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| MONOJECT INSULIN SYRINGE/SAFETY/PERM NEEDLE/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| PREFERRED PLUS INSULIN SYRINGE/U-100/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| RA INSULIN SYRINGE/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| REALITY INSULIN SYRINGE/U-100/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| RELION INSULIN SYRINGE/U-100/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| SB INSULIN SYRINGE/U-100/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| SECURESAFE SAFETY INSULIN SYRINGES/U-100/0.5ML/29GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |

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|---|---|---|---|
| SURE COMFORT INSULIN SYRINGE/U-100/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| TECHLITE INSULIN SYRINGE U-100/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| TOPCARE ULTRA COMFORT INSULIN SYRINGE/U-100/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| TRUEPLUS INSULIN SYRINGE/U-100/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| ULTICARE INSULIN SAFETY SYRINGE/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| ULTICARE INSULIN SYRINGE/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| ULTRA FLO INSULIN SYRINGE 0.5ML/29GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| ULTRA-THIN II INSULIN SYRINGE/U-100/0.5ML/29GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| VALUE HEALTH INSULIN SYRINGE/U-100/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| ADVOCATE INSULIN SYRINGE/U-100/0.5ML/30GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| BD SAFETYGLIDE INSULIN SYSYRINGE/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| CARETOUCH INSULIN SYRINGE0.5ML/30GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| DROPLET INSULIN SYRINGE U-100/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| EASY COMFORT INSULIN SYRINGE/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| EASY TOUCH INSULIN SYRINGE/SAFETY/U-100/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| EASY TOUCH INSULIN SYRINGE/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| EQL INSULIN SYRINGE/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| EXEL COMFORT POINT INSULIN SYRINGE/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| KMART VALU PLUS INSULIN SYRINGE/0.3ML/30G | INSULIN SYRINGE (DISP) U-100 0.3 ML | 97051030056305 | Brand |

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|---|---|---|---|
| KMART VALU PLUS INSULIN SYRINGE/0.5ML/29G | INSULIN SYRINGE (DISP) U-100 1/2 ML | 97051030056310 | Brand |
| KMART VALU PLUS INSULIN SYRINGE/0.5ML/30G | INSULIN SYRINGE (DISP) U-100 1/2 ML | 97051030056310 | Brand |
| BD INSULIN SYRINGE LUER-LOK/U-100/1ML | INSULIN SYRINGE (DISP) U-100 1 ML | 97051030056320 | Brand |
| BD INSULIN SYRINGE SLIP TIP/U-100/1ML | INSULIN SYRINGE (DISP) U-100 1 ML | 97051030056320 | Brand |
| KMART VALU PLUS INSULIN SYRINGE/1ML/29G | INSULIN SYRINGE (DISP) U-100 1 ML | 97051030056320 | Brand |
| KMART VALU PLUS INSULIN SYRINGE/1ML/30G | INSULIN SYRINGE (DISP) U-100 1 ML | 97051030056320 | Brand |
| MONOJECT INSULIN SYRINGE REGULAR LUER TIP/SOFTPACK/1ML | INSULIN SYRINGE (DISP) U-100 1 ML | 97051030056320 | Brand |
| MONOJECT INSULIN SYRINGE/1ML | INSULIN SYRINGE (DISP) U-100 1 ML | 97051030056320 | Brand |
| DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 31GX8MM 0.5ML | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| INSULIN SYRINGES/U-100/0.5ML/31GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| VERIFINE INSULIN SYRINGE 0.5ML/31G X 8MM | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| INSULIN SYRINGES/U-100/0.5ML/28GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2" | 97051030906320 | Brand |
| INSULIN SYRINGES/U-100/0.5ML/29GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| VERIFINE INSULIN SYRINGE 0.5ML/29G X 12MM | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| AQ INSULIN SYRINGE/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| GLUCOPRO INSULIN SYRINGE/U-100/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| GNP INSULIN SYRINGE/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| HEALTHWISE INSULIN SYRINGE/U-100/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| INSULIN SYRINGE/NEEDLE 0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| INSULIN SYRINGE/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| INSULIN SYRINGES/U-100/0.5ML/30GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| KROGER INSULIN SYRINGE/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |

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|---|---|---|---|
| LEADER INSULIN SYRINGE/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| LITETOUCH INSULIN SYRINGE/U-100/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| LITETOUCH INSULIN SYRINGE/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| MAGELLAN INSULIN SAFETY SYRINGE/U-100/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| MEDIC INSULIN SYRINGE/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| MM INSULIN SYRINGE/U-100/1/2ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| MONOJECT INSULIN SYRINGE/U-100/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| PREFERRED PLUS INSULIN SYRINGE/U-100/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| PRO COMFORT INSULIN SYRINGES/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| RA INSULIN SYRINGE/U-100/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| SB INSULIN SYRINGE/U-100/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| SURE COMFORT INSULIN SYRINGE/U-100/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| TECHLITE INSULIN SYRINGE U-100/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| TOPCARE ULTRA COMFORT INSULIN SYRINGE/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| TRUE COMFORT PRO INSULIN SYRINGE/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| TRUEPLUS INSULIN SYRINGE/U-100/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| ULTICARE INSULIN SYRINGE/SHORT/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| ULTICARE INSULIN SYRINGE/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| ULTRA FLO INSULIN SYRINGE 0.5ML/30GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| ULTRA-THIN II INSULIN SYRINGE SHORT/U-100/0.5ML/30GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| ULTRACARE INSULIN SYRINGE/U-100/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |

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| VANISHPOINT INSULIN SYRINGE/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| ZEVRX INSULIN SYRINGE/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| CAREONE INSULIN SYRINGES/0.5ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2" | 97051030906329 | Brand |
| CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.5ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2" | 97051030906329 | Brand |
| DROPLET INSULIN SYRINGE U-100/0.5ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2" | 97051030906329 | Brand |
| DROPLET INSULIN SYRINGE/U-100/0.5ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2" | 97051030906329 | Brand |
| EASY COMFORT INSULIN SYRINGE/U-100/0.5ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2" | 97051030906329 | Brand |
| EASY TOUCH INSULIN SYRINGE/U-100/0.5ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2" | 97051030906329 | Brand |
| GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.5ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2" | 97051030906329 | Brand |
| GLUCOPRO INSULIN SYRINGE/U-100/0.5ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2" | 97051030906329 | Brand |
| PRO COMFORT INSULIN SYRINGES/0.5ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2" | 97051030906329 | Brand |
| PX INSULIN SYRINGE/U-100/0.5ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2" | 97051030906329 | Brand |
| SURE COMFORT INSULIN SYRINGE/U-100/0.5ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2" | 97051030906329 | Brand |
| TECHLITE INSULIN SYRINGE U-100/0.5ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2" | 97051030906329 | Brand |
| TRUE COMFORT PRO INSULIN SYRINGE/U-100/0.5ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2" | 97051030906329 | Brand |
| ULTICARE INSULIN SYRINGE/U-100/0.5ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2" | 97051030906329 | Brand |
| ULTICARE INSULIN SYRINGE/0.5ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2" | 97051030906329 | Brand |
| ULTIGUARD SAFEPACK INSULIN SYRINGE 1/2ML 30G X 1/2"/SHARPS C | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2" | 97051030906329 | Brand |
| ULTIGUARD SAFEPACK INSULIN SYRINGE/0.5ML/30G X 1/2"/SHARPS C | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2" | 97051030906329 | Brand |
| ULTRA FLO INSULIN SYRINGE 0.5ML/30GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2" | 97051030906329 | Brand |
| ULTRACARE INSULIN SYRINGE/U-100/0.5ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2" | 97051030906329 | Brand |
| VANISHPOINT INSULIN SYRINGE/0.5ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2" | 97051030906329 | Brand |

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| ZEVRX INSULIN SYRINGE/0.5ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2" | 97051030906329 | Brand |
| MONOJECT INSULIN SYRINGE/DETACH NEEDLE/1ML/25G X 5/8" | INSULIN SYRINGE/NEEDLE U-100 1 ML 25 X 5/8" | 97051030906330 | Brand |
| BD SAFETYGLIDE INSULIN SYRINGE/0.3ML/31G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64" | 97051030906333 | Brand |
| BD VEO INSULIN SYRINGE ULTRA-FINE/U-100/0.3ML/31G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64" | 97051030906333 | Brand |
| BD VEO INSULIN SYRINGE ULTRA-FINE/0.3ML/31G X 6MM | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64" | 97051030906333 | Brand |
| BD VEO INSULIN SYRINGE ULTRA-FINE/1/2 UNIT/0.3ML/31G X 6MM | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64" | 97051030906333 | Brand |
| DROPLET INSULIN SYRINGE U-100/0.3ML/31G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64" | 97051030906333 | Brand |
| DROPLET INSULIN SYRINGE/U-100/0.3ML/31G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64" | 97051030906333 | Brand |
| DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 31GX6MM 0.3ML | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64" | 97051030906333 | Brand |
| GLOBAL EASY GLIDE INSULIN SYRINGE/0.3ML/31G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64" | 97051030906333 | Brand |
| RELION INSULIN SYRINGE/U-100/0.3ML/31G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64" | 97051030906333 | Brand |
| TECHLITE INSULIN SYRINGE U-100/0.3ML/31G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64" | 97051030906333 | Brand |
| INSULIN SYRINGES 0.3ML/31G X 1/4" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 1/4" (6 MM) | 97051030906334 | Brand |
| SURE COMFORT INSULIN SYRINGE/U-100/0.3ML/31GX1/4" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 1/4" (6 MM) | 97051030906334 | Brand |
| ULTICARE U-100 INSULIN SYRINGES/HALF UNIT/0.3ML/31G X1/4" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 1/4" (6 MM) | 97051030906334 | Brand |
| ULTICARE U-100 INSULIN SYRINGES/0.3ML/31G X 1/4" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 1/4" (6 MM) | 97051030906334 | Brand |
| ULTICARE U-100 INSULIN SYRINGES/0.3ML/31G X1/4" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 1/4" (6 MM) | 97051030906334 | Brand |
| INSULIN SYRINGES 0.5ML/31G X 1/4" | INSULIN SYRINGE/NEEDLE U-100 0.5 ML 31 X 1/4" (6 MM) | 97051030906336 | Brand |
| SURE COMFORT INSULIN SYRINGES/0.5ML/31G X 6MM | INSULIN SYRINGE/NEEDLE U-100 0.5 ML 31 X 1/4" (6 MM) | 97051030906336 | Brand |

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| ULTICARE U-100 INSULIN SYRINGES/0.5ML/31G X 1/4" | INSULIN SYRINGE/NEEDLE U-100 0.5 ML 31 X 1/4" (6 MM) | 97051030906336 | Brand |
| INSULIN SYRINGE 1ML/31G X1/4" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 1/4" (6 MM) | 97051030906337 | Brand |
| SURE COMFORT INSULIN SYRINGES/U-100/1ML/31GX6MM | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 1/4" (6 MM) | 97051030906337 | Brand |
| ULTICARE U-100 INSULIN SYRINGES/1ML/31G X 1/4" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 1/4" (6 MM) | 97051030906337 | Brand |
| VANISHPOINT INSULIN SYRINGE/1ML/30G X 3/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 3/16" (5 MM) | 97051030906338 | Brand |
| EASY COMFORT INSULIN SYRINGE/0.3ML/31G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 1/2" | 97051030906341 | Brand |
| EASY COMFORT INSULIN SYRINGES/0.5ML/32GX5/16" | INSULIN SYRINGE/NEEDLE U-100 0.5 ML 32 X 5/16" | 97051030906343 | Brand |
| TRUE COMFORT PRO INSULIN SYRINGE/0.5ML/32G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.5 ML 32 X 5/16" | 97051030906343 | Brand |
| EASY COMFORT INSULIN SYRINGE/1ML/32GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 32 X 5/16" | 97051030906344 | Brand |
| TRUE COMFORT PRO INSULIN SYRINGE/1ML/32GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 32 X 5/16" | 97051030906344 | Brand |
| EASY TOUCH INSULIN SYRINGE/U-100/1ML/27G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 1/2" | 97051030906350 | Brand |
| INSULIN SYRINGES/U-100/1ML/27GX/1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 1/2" | 97051030906350 | Brand |
| MAXICOMFORT INSULIN SYRINGES 27G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 1/2" | 97051030906350 | Brand |
| MONOJECT INSULIN SYRINGE/DETACH NEEDLE/1ML/27G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 1/2" | 97051030906350 | Brand |
| MONOJECT INSULIN SYRINGE/SOFTPACK/1ML/27G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 1/2" | 97051030906350 | Brand |
| VANISHPOINT INSULIN SYRINGE/0.5ML/30G X 3/16" | INSULIN SYRINGE/NEEDLE U-100 0.5 ML 30 X 3/16" (5 MM) | 97051030906355 | Brand |
| DROPLET INSULIN SYRINGE U-100/0.3ML/30G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 15/64" | 97051030906359 | Brand |
| EASY TOUCH INSULIN SYRINGE/U-100/1ML/27G X 5/8" | INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 5/8" | 97051030906360 | Brand |
| DROPLET INSULIN SYRINGE U-100/0.5ML/30G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 0.5 ML 30 X 15/64" | 97051030906361 | Brand |
| DROPLET INSULIN SYRINGE U-100/1ML/30G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 15/64" | 97051030906362 | Brand |
| CARETOUCH INSULIN SYRINGE/U-100/1ML/28G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 5/16" | 97051030906368 | Brand |

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|---|---|---|---|
| BD INSULIN SYRINGE MICROFINE/U-100/1ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2" | 97051030906370 | Brand |
| CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/1ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2" | 97051030906370 | Brand |
| EASY TOUCH INSULIN SYRINGE/U-100/1ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2" | 97051030906370 | Brand |
| GLOBAL INJECT EASE INSULIN SYRINGE/U-100/1ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2" | 97051030906370 | Brand |
| GNP INSULIN SYRINGES/1ML/28GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2" | 97051030906370 | Brand |
| GNP ULTRA COMFORT INSULIN SYRINGE/1ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2" | 97051030906370 | Brand |
| INSULIN SYRINGES/U-100/1ML/28GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2" | 97051030906370 | Brand |
| LEADER INSULIN SYRINGE/1ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2" | 97051030906370 | Brand |
| LITETOUCH INSULIN SYRINGE/U-100/1ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2" | 97051030906370 | Brand |
| MAXI-COMFORT INSULIN SYRINGE/U-100/1ML/28GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2" | 97051030906370 | Brand |
| MONOJECT INSULIN SYRINGE/PERM NEEDLE/1ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2" | 97051030906370 | Brand |
| MONOJECT INSULIN SYRINGE/U-100/1ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2" | 97051030906370 | Brand |
| MONOJECT ULTRA COMFORT INSULIN SYRINGE/1ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2" | 97051030906370 | Brand |
| PREFERRED PLUS INSULIN SYRINGE/U-100/1ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2" | 97051030906370 | Brand |
| PRODIGY INSULIN SYRINGE/1ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2" | 97051030906370 | Brand |
| REALITY INSULIN SYRINGE/U-100/1ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2" | 97051030906370 | Brand |
| SURE COMFORT INSULIN SYRINGE/U-100/1ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2" | 97051030906370 | Brand |
| TRUEPLUS INSULIN SYRINGE/U-100/1ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2" | 97051030906370 | Brand |
| ULTICARE INSULIN SYRINGE/1ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2" | 97051030906370 | Brand |
| ADVOCATE INSULIN SYRINGE/U-100/1ML/29GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| AQ INSULIN SYRINGE/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |

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|---|---|---|---|
| DROPLET INSULIN SYRINGE 1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 29GX12.5MM 1ML | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| EASY TOUCH FLIPLOCK SAFETY INSULIN SYRINGE 1ML/29GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| EASY TOUCH INSULIN SYRINGE/SAFETY/U-100/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| EASY TOUCH INSULIN SYRINGE/U-100/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| EASY TOUCH SHEATHLOCK SAFETY INSULIN SYRINGE 1ML/29GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| EQL INSULIN SYRINGE/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| GLOBAL INJECT EASE INSULIN SYRINGE/U-100/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| GNP INSULIN SYRINGE/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| GNP INSULIN SYRINGES/1ML/29GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| INSULIN SYRINGE/NEEDLE 1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| INSULIN SYRINGE/U-100/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| INSULIN SYRINGE/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| INSULIN SYRINGES/U-100/1ML/29GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| KROGER INSULIN SYRINGE/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| LEADER INSULIN SYRINGE/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| LITETOUCH INSULIN SYRINGE/U-100/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| MAGELLAN INSULIN SAFETY SYRINGE/U-100/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| MONOJECT INSULIN SYRINGE/SAFETY/PERM NEEDLE/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| MONOJECT ULTRA COMFORT INSULIN SYRINGE/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| PREFERRED PLUS INSULIN SYRINGE/U-100/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |

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|---|---|---|---|
| RA INSULIN SYRINGE/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| REALITY INSULIN SYRINGE/U-100/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| SB INSULIN SYRINGE/U-100/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| SECURESAFE SAFETY INSULIN SYRINGES/U-100/1ML/29GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| SURE COMFORT INSULIN SYRINGE/U-100/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| TECHLITE INSULIN SYRINGE U-100/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| TOPCARE ULTRA COMFORT INSULIN SYRINGE/U-100/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| TRUEPLUS INSULIN SYRINGE /U-100/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| ULTICARE INSULIN SAFETY SYRINGE/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| ULTICARE INSULIN SYRINGE/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| ULTRA FLO INSULIN SYRINGE 1M/29GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| ULTRA-THIN II INSULIN SYRINGE/U-100/1ML/29GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| VALUE HEALTH INSULIN SYRINGE/U-100/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| VANISHPOINT INSULIN SYRINGE/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| VERIFINE INSULIN SYRINGE 1ML/29G X 12MM | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| CARETOUCH INSULIN SYRINGE/U-100/1ML/29G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 5/16" | 97051030906382 | Brand |
| VANISHPOINT INSULIN SYRINGE/1ML/29G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 5/16" | 97051030906382 | Brand |
| ADVOCATE INSULIN SYRINGE/U-100/1ML/30GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| CARETOUCH INSULIN SYRINGE/1ML/30GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| DROPLET INSULIN SYRINGE U-100/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| EASY COMFORT INSULIN SYRINGE/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |

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|---|---|---|---|
| EASY TOUCH FLIPLOCK SAFETY INSULIN SYRINGE 1ML/30GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| EASY TOUCH INSULIN SYRINGE/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| EASY TOUCH SHEATHLOCK SAFETY INSULIN SYRINGE 1ML/30GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| EQL INSULIN SYRINGE/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| GLOBAL INJECT EASE INSULIN SYRINGE/U-100/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| GLUCOPRO INSULIN SYRINGE/U-100/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| GNP INSULIN SYRINGE/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| GNP INSULIN SYRINGES/1ML/30GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| HEALTHWISE INSULIN SYRINGE/U-100/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| INSULIN SYRINGE/NEEDLE 1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| INSULIN SYRINGE/U-100/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| INSULIN SYRINGE/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| KROGER INSULIN SYRINGE/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| LEADER INSULIN SYRINGE/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| LITETOUCH INSULIN SYRINGE/U-100/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| LITETOUCH INSULIN SYRINGE/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| MAGELLAN INSULIN SAFETY SYRINGE/U-100/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| MM INSULIN SYRINGE/U-100/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| MONOJECT INSULIN SYRINGE/U-100/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| PREFERRED PLUS INSULIN SYRINGE/U-100/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| PRO COMFORT INSULIN SYRINGES/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| RA INSULIN SYRINGE/U-100/1 ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |

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|---|---|---|---|
| SB INSULIN SYRINGE/U-100/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| SURE COMFORT INSULIN SYRINGE/U-100/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| TOPCARE ULTRA COMFORT INSULIN SYRINGE/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| TRUE COMFORT PRO INSULIN SYRINGE/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| TRUEPLUS INSULIN SYRINGE/U-100/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| ULTICARE INSULIN SYRINGE/SHORT/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| ULTICARE INSULIN SYRINGE/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| ULTRA FLO INSULIN SYRINGE 1ML/30GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| ULTRA-THIN II INSULIN SYRINGE SHORT/U-100/1ML/30GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| ULTRACARE INSULIN SYRINGE/U-100/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| VANISHPOINT INSULIN SYRINGE/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| ZEVRX INSULIN SYRINGE/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| BD INSULIN SYRINGE ULTRA FINE/1ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| BD INSULIN SYRINGE ULTRA-FINE/1ML/30G X 12.7MM | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| BD INSULIN SYRINGE ULTRAFINE/1ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| CAREONE INSULIN SYRINGES/1ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/1.0ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| DROPLET INSULIN SYRINGE U-100/1ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| DROPLET INSULIN SYRINGE/U-100/1ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| EASY COMFORT INSULIN SYRINGE/U-100/1ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| EASY TOUCH FLIPLOCK SAFETY INSULIN SYRINGE 1ML/30GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| EASY TOUCH INSULIN SYRINGE/SAFETY/U-100/1ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |

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| EASY TOUCH INSULIN SYRINGE/U-100/1ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| EASY TOUCH SHEATHLOCK SAFETY SYRINGE 1ML/30GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| GLOBAL INJECT EASE INSULIN SYRINGE/U-100/1ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| GLUCOPRO INSULIN SYRINGE/U-100/1ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| HM ULTICARE INSULIN SYRINGE/1ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| INSULIN SYRINGES/U-100/1ML/30GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| PRO COMFORT INSULIN SYRINGES/1ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| SURE COMFORT INSULIN SYRINGE/U-100/1ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| TECHLITE INSULIN SYRINGE U-100/1ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| TRUE COMFORT PRO INSULIN SYRINGE/U-100/1ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| ULTICARE INSULIN SYRINGE/U-100/1ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| ULTICARE INSULIN SYRINGE/1ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| ULTIGUARD SAFEPACK INSULIN SYRINGE 1ML 30G X 1/2"/SHARPS CON | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| ULTRA FLO INSULIN SYRINGE 1ML/30GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| ULTRACARE INSULIN SYRINGE/U-100/1ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| ZEVRX INSULIN SYRINGE/1ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| ADVOCATE INSULIN SYRINGE/U-100/1ML/31GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| AQ INSULIN SYRINGE/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| BD INSULIN SYRINGE ULTRA-FINE/1ML/31G X 8MM | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| BD INSULIN SYRINGE ULTRAFINE/U-100/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| CAREONE INSULIN SYRINGES/1ML/31GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| CARETOUCH INSULIN SYRINGE/1ML/31GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |

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|---|---|---|---|
| CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/U-100/1ML/31GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| COMFORT EZ INSULIN SYRINGE/U-100/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| DROPLET INSULIN SYRINGE U-100/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| DROPLET INSULIN SYRINGE/U-100/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 31GX8MM 1ML | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| EASY COMFORT INSULIN SYRINGE/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| EASY TOUCH FLIPLOCK SAFETY INSULIN SYRINGE 1ML/31GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| EASY TOUCH INSULIN SYRINGE/U-100/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| EASY TOUCH SHEATHLOCK SAFETY INSULIN SYRINGE 1ML/31GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| EQL INSULIN SYRINGE/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| FIFTY50 SUPERIOR COMFORT INSULIN SYRINGE/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| GLOBAL INJECT EASE INSULIN SYRINGE/U-100/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| GLUCOPRO INSULIN SYRINGE/U-100/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| GNP INSULIN SYRINGE/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| HEALTHWISE INSULIN SYRINGE/U-100/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| INSULIN SYRINGE/NEEDLE 1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| INSULIN SYRINGE/U-100/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| INSULIN SYRINGES/U-100/1ML/31GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| KINRAY INSULIN SYRINGE PREFERRED PLUS/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| KROGER INSULIN SYRINGE/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| LEADER INSULIN SYRINGE/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |

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|---|---|---|---|
| LITETOUCH INSULIN SYRINGE/U-100/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| MM INSULIN SYRINGE/U-100/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| MONOJECT INSULIN SYRINGE/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| MS INSULIN SYRINGE/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| PRO COMFORT INSULIN SYRINGES/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| RELION INSULIN SYRINGE/U-100/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| SB INSULIN SYRINGE/U-100/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| SURE COMFORT INSULIN SYRINGE/U-100/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| TECHLITE INSULIN SYRINGE U-100/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| TOPCARE ULTRA COMFORT INSULIN SYRINGE/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| TRUE COMFORT INSULIN SYRINGE/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| TRUE COMFORT PRO INSULIN SYRINGE/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| TRUEPLUS INSULIN SYRINGE/U-100/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| ULTICARE INSULIN SYRINGE ULTRAFINE U-100/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| ULTICARE INSULIN SYRINGE/SHORT/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| ULTICARE INSULIN SYRINGE/U-100/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| ULTIGUARD SAFEPACK INSULIN SYRINGE 1ML 31G X 5/16"/SHARPS CO | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| ULTRA FLO INSULIN SYRINGE 1ML/31GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| ULTRA-THIN II INSULIN SYRINGE SHORT/U-100/1ML/31GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| ULTRACARE INSULIN SYRINGE/U-100/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| VERIFINE INSULIN SYRINGE 1ML/31G X 8MM | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| ADVOCATE INSULIN SYRINGE/U-100/0.3ML/31GX5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |

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|---|---|---|---|
| CAREONE INSULIN SYRINGES/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| CARETOUCH INSULIN SYRINGE/0.3ML/31GX5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| COMFORT ASSIST INSULIN SYRINGE/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| DROPLET INSULIN SYRINGE U-100/0.3/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| DROPLET INSULIN SYRINGE/U-100/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 31GX8MM 0.3ML | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| EASY COMFORT INSULIN SYRINGE/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| EASY TOUCH INSULIN SYRINGE/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| EQL INSULIN SYRINGE/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| FIFTY50 SUPERIOR COMFORT INSULIN SYRINGE/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| GLOBAL EASY GLIDE INSULINSYRINGE/U-100/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| GLUCOPRO INSULIN SYRINGE/U-100/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| GNP INSULIN SYRINGE/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| GNP INSULIN SYRINGES/3ML/31GX5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| HEALTHWISE INSULIN SYRINGE/U-100/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| HM ULTICARE INSULIN SYRINGE/U-100/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| INSULIN SYRINGE/NEEDLE 0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| INSULIN SYRINGE/U-100/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| INSULIN SYRINGE/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |

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|---|---|---|---|
| KINRAY INSULIN SYRINGE PREFERRED PLUS/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| KROGER INSULIN SYRINGE/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| LEADER INSULIN SYRINGE/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| LITETOUCH INSULIN SYRINGE/U-100/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| LITETOUCH INSULIN SYRINGE/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| MM INSULIN SYRINGE/U-100/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| MS INSULIN SYRINGE/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| PRODIGY INSULIN SYRING/U-100/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| RELION INSULIN SYRINGE/U-100/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| SURE COMFORT INSULIN SYRINGE/U-100/0.3ML/31G X 5/16 | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| SURE COMFORT INSULIN SYRINGE/U-100/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| TECHLITE INSULIN SYRINGE U-100/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| TOPCARE ULTRA COMFORT INSULIN SYRINGE/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| TRUEPLUS INSULIN SYRINGE/U-100/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| ULTICARE INSULIN SYRINGE ULTRAFINE U-100/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| ULTICARE INSULIN SYRINGE/SHORT/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| ULTICARE INSULIN SYRINGE/U-100/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| ULTIGUARD SAFEPACK INSULIN SYRINGE/0.3ML/31G X 5/16"/SHARPS | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| ULTRA FLO INSULIN SYRINGE 0.3ML/31GX5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| ULTRA FLO INSULIN SYRINGE 1/2 UNIT/0.3ML/31GX5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |

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|---|---|---|---|
| ULTRA-THIN II INSULIN SYRINGE SHORT/U-100/0.3ML/31GX5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| ULTRACARE INSULIN SYRINGE/U-100/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| VERIFINE INSULIN SYRINGE 0.3ML/31G X 8MM | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| ASSURE ID INSULIN SAFETY SYRINGE U-100/0.5ML/31G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64" | 97051030906391 | Brand |
| DROPLET INSULIN SYRINGE/U-100/0.5ML/31G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64" | 97051030906391 | Brand |
| DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 31GX6MM 0.5ML | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64" | 97051030906391 | Brand |
| GLOBAL EASY GLIDE INSULIN SYRINGE/0.5ML/31G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64" | 97051030906391 | Brand |
| RELION INSULIN SYRINGE 0.5ML/31G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64" | 97051030906391 | Brand |
| TECHLITE INSULIN SYRINGE U-100/0.5ML/31G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64" | 97051030906391 | Brand |
| ASSURE ID INSULIN SAFETY SYRINGE/1ML/31G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64" | 97051030906399 | Brand |
| DROPLET INSULIN SYRINGE U-100/1ML/31G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64" | 97051030906399 | Brand |
| DROPLET INSULIN SYRINGE/U-100/1ML/31G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64" | 97051030906399 | Brand |
| DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 31GX6MM 1ML | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64" | 97051030906399 | Brand |
| GLOBAL EASY GLIDE INSULIN SYRINGE/1ML/31G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64" | 97051030906399 | Brand |
| RELION INSULIN SYRINGE 1ML/31GX15/64" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64" | 97051030906399 | Brand |
| RELION INSULIN SYRINGE/U-100/1ML/31G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64" | 97051030906399 | Brand |
| TECHLITE INSULIN SYRINGE U-100/1ML/31G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64" | 97051030906399 | Brand |
| EMBRACE PEN NEEDLES/29G X 12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| VERIFINE INSULIN PEN NEEDLE 29G X 12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| EMBRACE PEN NEEDLES/30G X 5MM | INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16") | 97051050146340 | Brand |
| COMFORT EZ PRO SAFETY PEN NEEDLES 30G X 8MM | INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16") | 97051050146344 | Brand |
| EMBRACE PEN NEEDLES/30G X 8MM | INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16") | 97051050146344 | Brand |

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|---|---|---|---|
| PEN NEEDLES | INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16") | 97051050146344 | Brand |
| AUM INSULIN SAFETY PEN NEEDLE/31GX4MM | INSULIN PEN NEEDLE 31 G X 4 MM (1/6" OR 5/32") | 97051050146354 | Brand |
| COMFORT EZ PRO SAFETY PEN NEEDLES 31G X 4MM | INSULIN PEN NEEDLE 31 G X 4 MM (1/6" OR 5/32") | 97051050146354 | Brand |
| AQINJECT PEN NEEDLE/31G X 3/16" | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| AUM INSULIN SAFETY PEN NEEDLE/31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| COMFORT EZ PRO SAFETY PEN NEEDLES 31G X 5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| EMBRACE PEN NEEDLES/31G X 5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| PEN NEEDLES 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| PIP PEN NEEDLES 31G X 5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| PURE COMFORT SAFETY PEN NEEDLE 31G X 5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| TRUE COMFORT SAFETY PEN NEEDLES 31G X 5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| VERIFINE INSULIN PEN NEEDLE 31G X 5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| VERIFINE PLUS INSULIN PEN NEEDLE 31G X 5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| EMBRACE PEN NEEDLES/31G X 6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| PEN NEEDLES/31G X 1/4" | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| PEN NEEDLES/31G X 6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| PENTIPS 31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| PREVENT DROPSAFE SAFETY PEN NEEDLES 31GX1/4" | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| PREVENT SAFETY PEN NEEDLES 31GX1/4" | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| PURE COMFORT SAFETY PEN NEEDLE 31G X 6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| PX EXTRA SHORT PEN NEEDLES 31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| QC PEN NEEDLES 31G X 6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| RAYA SURE PEN NEEDLE 31G X 6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |

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|---|---|---|---|
| RELION MINI PEN NEEDLES 31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| RELION PEN NEEDLES 31G X 6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| RELION PEN NEEDLES 31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| RELION PEN NEEDLES/31G X 1/4" | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| SURE COMFORT AUTOKEEPER SAFETY PEN NEEDLES 31GX1/4" | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| TECHLITE PEN NEEDLES/31G X 6 MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| TOPCARE CLICKFINE UNIVERSAL PEN EEDLES 31GX1/4" | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| TRUE COMFORT PEN NEEDLES 31G X 6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| TRUE COMFORT PRO PEN NEEDLES 31G X 6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| TRUE COMFORT SAFETY PEN NEEDLES 31G X 6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| TRUEPLUS PEN NEEDLES 31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| TRUEPLUS 5-BEVEL PEN NEEDLES 31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| ULTICARE MICRO PEN NEEDLES/31G X 1/4" | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| ULTICARE MINI PEN NEEDLES ULTI-FINE IV | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| ULTICARE MINI PEN NEEDLES 31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| ULTICARE MINI PEN NEEDLES/31G X 6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| ULTICARE MINI PEN NEEDLES31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| ULTIGUARD SAFEPACK/MINI PEN NEEDLE/31G X 1/4"/SHARPS CONTAIN | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| ULTIGUARD SAFEPACK/MINI PEN NEEDLE/31G X 6MM/SHARPS CONTAIN | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| ULTRACARE PEN NEEDLES/31G X 1/4" | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| UNIFINE PENTIPS PLUS 31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| UNIFINE PENTIPS 31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |

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| UNIFINE ULTRA PEN NEEDLE/31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| WEGMANS UNIFINE PENTIPS PLUS/ULTRA SHORT/31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| ZEVRX PEN NEEDLES 31G X 6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| 1ST TIER UNIFINE PENTIPS PLUS/ULTRA SHORT/31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| 1ST TIER UNIFINE PENTIPS 31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| ABOUTTIME PEN NEEDLES 31G X 5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| ADVOCATE INSULIN PEN NEEDLES 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| AURORA PEN NEEDLES 31G X 8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| CAREFINE PEN NEEDLES 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| CAREONE UNIFINE PENTIPS PLUS PEN NEEDLES 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| CARETOUCH PEN NEEDLES 31GX 8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| CLEVER CHOICE COMFORT EZ INSULIN PEN NEEDLES 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| CLEVER CHOICE COMFORT EZ PEN NEEDLES 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| CLICKFINE PEN NEEDLE UNIVERSAL/31GX5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| CLICKFINE PEN NEEDLES 31G X 5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| CLICKFINE PEN NEEDLES 31G X 8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| CLICKFINE UNIVERSAL PEN NEEDLES 31GX5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| COMFORT EZ SHORT/31G X 8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| COMFORT TOUCH PEN NEEDLES/31G X 8 MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| DIATHRIVE PEN NEEDLE/31 GX 8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| DROPLET PEN NEEDLES 31G X5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| DROPLET PEN NEEDLES 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| DROPSAFE SAFETY PEN NEEDLES/31G X 5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |

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|---|---|---|---|
| DRUG MART UNIFINE PENTIPS31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| EASY COMFORT PEN NEEDLES 31GX5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| EASY TOUCH PEN NEEDLES 31GX5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| EMBRACE PEN NEEDLES/31G X 8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| FIFTY50 PEN NEEDLES 31G X5/16" (8MM) | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| FIFTY50 PEN NEEDLES/31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| GLOBAL EASE INJECT PEN NEEDLES 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| GNP CLICKFINE UNIVERSAL PEN NEEDLES 31GX5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| GNP ULTICARE PEN NEEDLES /31GX5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| GNP ULTIGUARD SAFEPACK/SHORT PEN NEEDLE/31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| GOODSENSE PEN NEEDLE/PENFINE CLASSIC/31G X 5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| H-E-B IN CONTROL PEN NEEDLES 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| H-E-B IN CONTROL UNIFINE PENTIPS PLUS 31GX5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| HEALTHWISE SHORT PEN NEEDLES/31G X 5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| HM ULTICARE SHORT PEN NEEDLES 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| INCONTROL ULTICARE MINI PEN NEEDLES/31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| INSUPEN ULTRAFIN 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| INSUPEN 31G X 8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| KROGER PEN NEEDLES 31G X 8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| KROGER PEN NEEDLES/31G X 5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| LEADER UNIFINE PENTIPS PLUS/SHORT/31GX5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| LITETOUCH PEN NEEDLES 31GX8MM SHORT | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |

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|---|---|---|---|
| LITETOUCH PEN NEEDLES/31G X 8MM/SHORT | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| MARATHON MEDICAL PENTIPS 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| MEDICINE SHOPPE PEN NEEDLES 31G X 8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| MEIJER PEN NEEDLES 31G X 8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| MM PEN NEEDLES 31G X 5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| PC UNIFINE PENTIPS 31G X 8MM SHORT | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| PEN NEEDLES 31G X 8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| PEN NEEDLES 31GX5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| PEN NEEDLES 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| PEN NEEDLES 31GX8MM (5/16") | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| PEN NEEDLES/31G X 5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| PENTIPS 31G X 8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| PENTIPS 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| PREVENT DROPSAFE SAFETY PEN NEEDLES 31GX5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| PREVENT SAFETY PEN NEEDLES 31GX5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| PRO COMFORT PEN NEEDLES/ 31G X 8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| PX PEN NEEDLE 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| PX SHORTLENGTH PEN NEEDLES/31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| QC PEN NEEDLES 31G X 8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| RA PEN NEEDLES 31G X 8MM 5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| RAYA SURE PEN NEEDLE 31G X 8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| RELION PEN NEEDLES 31G X 8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| RELION PEN NEEDLES 31GX5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |

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| RELION PEN NEEDLES 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| RELION SHORT PEN NEEDLES 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| SURE COMFORT PEN NEEDLES 31GX5/16" (8MM) | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| TECHLITE PEN NEEDLES/31G X 8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| TODAYS HEALTH SHORT PEN NEEDLES 31G X 5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| TOPCARE CLICKFINE UNIVERSAL PEN EEDLES 31GX5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| TRUE COMFORT PRO PEN NEEDLES 31G X 8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| TRUEPLUS PEN NEEDLES 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| TRUEPLUS 5-BEVEL PEN NEEDLES 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| ULTICARE MICRO PEN NEEDLES 31G X 8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| ULTICARE MICRO PEN NEEDLES/31G X 5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| ULTICARE SHORT PEN NEEDLES ULTI-FINE IV | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| ULTICARE SHORT PEN NEEDLES 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| ULTICARE SHORT PEN NEEDLES/31G X 8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| ULTIGUARD SAFEPACK/SHORT PEN NEEDLE/31G X 5/16"/SHARPS CONTA | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| ULTIGUARD SAFEPACK/SHORT PEN NEEDLE/31G X 8MM/SHARPS CONTAIN | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| ULTILET PEN NEEDLE 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| ULTILET SHORT PEN NEEDLES 31GX5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| ULTRA FLO INSULIN PEN NEELE 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| ULTRA-THIN II PEN NEEDLES/SHORT/31GX5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| ULTRACARE PEN NEEDLES/31G X 5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| UNIFINE PENTIPS PLUS 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |

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| UNIFINE PENTIPS 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| UNIFINE ULTRA PEN NEEDLE/31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| VERIFINE INSULIN PEN NEEDLE 31G X 8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| VERIFINE PLUS INSULIN PEN NEEDLE 31G X 8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| WEGMANS UNIFINE PENTIPS PLUS/SHORT/31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| ZEVRX PEN NEEDLES 31G X 8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| 1ST TIER UNIFINE PENTIPS PLUS 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| 1ST TIER UNIFINE PENTIPS 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| ABOUTTIME PEN NEEDLE 32G X 5/32" | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| AQINJECT PEN NEEDLE/32G X 5/32" | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| AUM MINI INSULIN PEN NEEDLE/32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| AUM PEN NEEDLE/32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| AUM READYGARD DUO SAFETY PEN NEEDLE/32GX4MM/DUAL AUTO PROTEC | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| CAREFINE PEN NEEDLE 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| CAREONE UNIFINE PENTIPS PLUS PEN NEEDLES 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| CARETOUCH PEN NEEDLES 32GX 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| CLEVER CHOICE COMFORT EZ PEN NEEDLES 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| CLICKFINE PEN NEEDLE 32GX5/32" | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| CLICKFINE PEN NEEDLES 32G X 5/32" | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| COMFORT EZ MICRO/32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| COMFORT TOUCH PEN NEEDLES/32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| DIATHRIVE PEN NEEDLE/32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |

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| DROPLET PEN NEEDLES 32G X 5/32" | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| DROPLET PEN NEEDLES 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| DRUG MART UNIFINE PENTIPSPLUS 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| DRUG MART UNIFINE PENTIPS32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| EASY COMFORT PEN NEEDLES 32GX5/32" | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| EASY TOUCH PEN NEEDLES 32GX5/32" | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| EMBRACE PEN NEEDLES/32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| FIFTY50 PEN NEEDLES/32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| GLOBAL EASE INJECT PEN NEEDLES 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| GLOBAL EASY GLIDE PEN NEEDLES 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| GNP ULTICARE PEN NEEDLES/32GX 5/32" | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| GNP ULTIGUARD SAFEPACK/MICRO PEN NEEDLE/32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| GOODSENSE PEN NEEDLE/PENFINE CLASSIC/32G X 5/32" | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| H-E-B IN CONTROL PEN NEEDLES/NANO/32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| H-E-B IN CONTROL UNIFINE PENTIPS PLUS 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| H-E-B IN CONTROL UNIFINE PENTIPS PLUS 32GX5/32" | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| HEALTHWISE MICRON PEN NEEDLES/32G X 5/32" | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| INCONTROL ULTICARE MINI PEN NEEDLES/32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| INSUPEN PEN NEEDLES 32G X4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| INSUPEN 32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| KROGER PEN NEEDLES/32G X 5/32" | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| LEADER UNIFINE PENTIPS/NANO/32GX5/32" | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |

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| LEADER UNIFINE PENTIPS/PLUS/32GX5/32" | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| LITETOUCH INSULIN PEN NEEDLES/32G X 4MM/MINI | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| MARATHON MEDICAL PENTIPS 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| MICRODOT PEN NEEDLE/32G X 4 MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| MM PEN NEEDLES 32G X 5/32" | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| NOVOFINE PLUS PEN NEEDLE 32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| PEN NEEDLES 32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| PEN NEEDLES 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| PEN NEEDLES/32G X 5/32" | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| PENTIPS 32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| PENTIPS 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| PIP PEN NEEDLES 32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| PRO COMFORT PEN NEEDLES/ 32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| PURE COMFORT PEN NEEDLE/32G X4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| PURE COMFORT SAFETY PEN NEEDLE 32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| QC UNIFINE PENTIPS 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| RELION PEN NEEDLES 32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| RELION PEN NEEDLES 32G X 5/32" | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| RELION PEN NEEDLES 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| SURE COMFORT AUTOKEEPER SAFETY PEN NEEDLES 32GX5/32" | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| SURE COMFORT PEN NEEDLES 32GX5/32" | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| SURE COMFORT PEN NEEDLES 32GX5/32" (4MM) | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| TECHLITE PEN NEEDLES/32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |

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| TRUE COMFORT PEN NEEDLES 32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| TRUE COMFORT PRO PEN NEEDLES 32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| TRUE COMFORT SAFETY PEN NEEDLES 32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| TRUEPLUS PEN NEEDLES 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| TRUEPLUS 5-BEVEL PEN NEEDLES 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| ULTICARE MICRO PEN NEEDLES 32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| ULTICARE MICRO PEN NEEDLES/32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| ULTICARE MICRO PEN NEEDLES/32G X 5/32" | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| ULTIGUARD SAFEPACK/MICRO PEN NEEDLE/32G X 4 MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| ULTIGUARD SAFEPACK/MICRO PEN NEEDLE/32G X 4MM/SHARPS CONTAIN | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| ULTIGUARD SAFEPACK/MICRO PEN NEEDLE/32G X 5/32" | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| ULTIGUARD SAFEPACK/MICRO PEN NEEDLE/32G X 5/32"/SHARPS CNTR | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| ULTIGUARD SAFEPACK/MICRO PEN NEEDLE/32G X 5/32"/SHARPS CONTA | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| ULTILET PEN NEEDLE 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| ULTILET PEN NEEDLE 32GX4MM/SHORT | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| ULTRA FLO INSULIN PEN NEEDLE 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| ULTRA THIN PEN NEEDLES 32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| ULTRACARE PEN NEEDLES/32G X 5/32" | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| UNIFINE PENTIPS PLUS 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| UNIFINE PENTIPS 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| UNIFINE SAFECONTROL PEN NEEDLE 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| UNIFINE ULTRA PEN NEEDLE/32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |

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|---|---|---|---|
| VERIFINE INSULIN PEN NEEDLE 32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| VERIFINE PLUS INSULIN PEN NEEDLES 32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| WEGMANS UNIFINE PENTIPS PLUS 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| ZEVRX PEN NEEDLES 32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| 1ST TIER UNIFINE PENTIPS PLUS 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| 1ST TIER UNIFINE PENTIPS 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| AUM MINI INSULIN PEN NEEDLE/32GX5MM | INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16") | 97051050146367 | Brand |
| AUM PEN NEEDLE/32GX5MM | INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16") | 97051050146367 | Brand |
| CAREFINE PEN NEEDLES 32GX5MM | INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16") | 97051050146367 | Brand |
| CARETOUCH PEN NEEDLES 32GX 5MM | INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16") | 97051050146367 | Brand |
| CLEVER CHOICE COMFORT EZ PEN NEEDLES 32GX5MM | INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16") | 97051050146367 | Brand |
| COMFORT TOUCH PEN NEEDLES/32G X 5MM | INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16") | 97051050146367 | Brand |
| DROPLET PEN NEEDLES 32G X 3/16" | INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16") | 97051050146367 | Brand |
| DROPLET PEN NEEDLES 32GX5MM | INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16") | 97051050146367 | Brand |
| EASY TOUCH PEN NEEDLES 32GX3/16" | INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16") | 97051050146367 | Brand |
| EASY TOUCH 32GX5MM | INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16") | 97051050146367 | Brand |
| PEN NEEDLES 32G X 5MM | INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16") | 97051050146367 | Brand |
| PRO COMFORT PEN NEEDLES/ 32G X 5MM | INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16") | 97051050146367 | Brand |
| PURE COMFORT PEN NEEDLE/32G X 5MM | INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16") | 97051050146367 | Brand |
| TRUE COMFORT PRO PEN NEEDLES 32G X 5MM | INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16") | 97051050146367 | Brand |
| ULTRACARE PEN NEEDLES/32G X 3/16" | INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16") | 97051050146367 | Brand |
| AUM MINI INSULIN PEN NEEDLE/32GX6MM | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| AUM PEN NEEDLE/32GX6MM | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |

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| CAREFINE PEN NEEDLES 32GX6MM | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| CLEVER CHOICE COMFORT EZ PEN NEEDLES 32GX6MM | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| COMFORT TOUCH PEN NEEDLES/32G X 6MM | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| DROPLET PEN NEEDLES 32G X 1/4" | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| DROPLET PEN NEEDLES 32GX6MM | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| EASY TOUCH PEN NEEDLES 32GX1/4" | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| EASY TOUCH 32GX6MM | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| FIFTY50 PEN NEEDLES/32GX6MM | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| GNP ULTICARE PEN NEEDLES/32GX1/4" | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| GNP ULTIGUARD SAFEPACK/MINI PEN NEEDLE/32GX6MM | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| GOODSENSE PEN NEEDLE/PENFINE CLASSIC/32G X 1/4" | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| INSUPEN SENSITIVE 32GX6MM | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| NOVOFINE PEN NEEDLE 32G X 6MM | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| PEN NEEDLES 32G X 6MM | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| PENTIPS 32GX6MM | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| PRO COMFORT PEN NEEDLES/ 32G X 6MM | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| PURE COMFORT PEN NEEDLE 32G X6MM | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| SURE COMFORT PEN NEEDLES 32GX6MM | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| TECHLITE PEN NEEDLES/32G X 6MM | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| TRUE COMFORT PRO PEN NEEDLES 32G X 6MM | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| ULTICARE MINI PEN NEEDLES/32G X 1/4" | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| ULTIGUARD SAFEPACK/MINI PEN NEEDLE/32G X 1/4"/SHARPS CONTAIN | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |

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|---|---|---|---|
| ULTRACARE PEN NEEDLES/32G X 1/14" | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| UNIFINE PENTIPS 32GX6MM | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| VERIFINE INSULIN PEN NEEDLE 32G X 6MM | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| BD PEN NEEDLE/MICRO/ULTRA-FINE/32G X 6MM | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| 1ST TIER UNIFINE PENTIPS 32GX6MM | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| AUM MINI INSULIN PEN NEEDLE/32GX8MM | INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16") | 97051050146372 | Brand |
| CLEVER CHOICE COMFORT EZ PEN NEEDLES 32GX8MM | INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16") | 97051050146372 | Brand |
| COMFORT TOUCH PEN NEEDLES/32G X 8MM | INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16") | 97051050146372 | Brand |
| DROPLET PEN NEEDLES 32G X 5/16" | INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16") | 97051050146372 | Brand |
| DROPLET PEN NEEDLES 32GX8MM | INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16") | 97051050146372 | Brand |
| INSUPEN SENSITIVE 32GX8MM | INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16") | 97051050146372 | Brand |
| PURE COMFORT PEN NEEDLE 32G X8MM | INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16") | 97051050146372 | Brand |
| TECHLITE PEN NEEDLES/32G X 8MM | INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16") | 97051050146372 | Brand |
| ADVOCATE INSULIN PEN NEEDLES | INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32") | 97051050146376 | Brand |
| AUM MINI INSULIN PEN NEEDLE/33GX4MM | INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32") | 97051050146376 | Brand |
| AUM PEN NEEDLE/33GX4MM | INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32") | 97051050146376 | Brand |
| CAREONE UNIFINE PENTIPS PLUS PEN NEEDLES/33G X 5/32" | INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32") | 97051050146376 | Brand |
| CARETOUCH PEN NEEDLE 33GX5/32" | INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32") | 97051050146376 | Brand |
| CLEVER CHOICE COMFORT EZ INSULIN PEN NEEDLES 33GX4MM | INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32") | 97051050146376 | Brand |
| CLEVER CHOICE COMFORT EZ PEN NEEDLES 33GX4MM | INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32") | 97051050146376 | Brand |
| COMFORT TOUCH PEN NEEDLES/33G X 5/32" | INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32") | 97051050146376 | Brand |
| EASY COMFORT PEN NEEDLES 33G X 4MM | INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32") | 97051050146376 | Brand |
| EASY GLIDE PEN NEEDLES 33G X 5/32" | INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32") | 97051050146376 | Brand |

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| H-E-B IN CONTROL UNIFINE PENTIPS PLUS 33GX5/32" | INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32") | 97051050146376 | Brand |
| INSUPEN 33GX4MM | INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32") | 97051050146376 | Brand |
| KROGER PEN NEEDLES/33G X 5/32" | INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32") | 97051050146376 | Brand |
| MICRODOT PEN NEEDLE/33G X 4 MM | INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32") | 97051050146376 | Brand |
| PEN NEEDLES 33G X 5/32" | INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32") | 97051050146376 | Brand |
| TRUE COMFORT PRO PEN NEEDLES 33G X 4MM | INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32") | 97051050146376 | Brand |
| ULTRA FLO INSULIN PEN NEEDLE 33GX4MM | INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32") | 97051050146376 | Brand |
| ULTRACARE PEN NEEDLES/33G X 5/32" | INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32") | 97051050146376 | Brand |
| UNIFINE PENTIPS PLUS 33G X 5/32" | INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32") | 97051050146376 | Brand |
| UNIFINE PENTIPS PLUS 33GX4MM | INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32") | 97051050146376 | Brand |
| UNIFINE PENTIPS 33GX4MM | INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32") | 97051050146376 | Brand |
| 1ST TIER UNIFINE PENTIPS PLUS 33GX4MM | INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32") | 97051050146376 | Brand |
| 1ST TIER UNIFINE PENTIPS 33GX4MM | INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32") | 97051050146376 | Brand |
| AUM MINI INSULIN PEN NEEDLE/33GX5MM | INSULIN PEN NEEDLE 33 G X 5 MM (1/5" OR 3/16") | 97051050146377 | Brand |
| AUM PEN NEEDLE/33GX5MM | INSULIN PEN NEEDLE 33 G X 5 MM (1/5" OR 3/16") | 97051050146377 | Brand |
| CLEVER CHOICE COMFORT EZ PEN NEEDLES 33GX5MM | INSULIN PEN NEEDLE 33 G X 5 MM (1/5" OR 3/16") | 97051050146377 | Brand |
| COMFORT TOUCH PEN NEEDLES/33GX 3/16" | INSULIN PEN NEEDLE 33 G X 5 MM (1/5" OR 3/16") | 97051050146377 | Brand |
| EASY COMFORT PEN NEEDLES 33G X 5MM | INSULIN PEN NEEDLE 33 G X 5 MM (1/5" OR 3/16") | 97051050146377 | Brand |
| TRUE COMFORT PRO PEN NEEDLES 33G X 5MM | INSULIN PEN NEEDLE 33 G X 5 MM (1/5" OR 3/16") | 97051050146377 | Brand |
| AUM MINI INSULIN PEN NEEDLE/33GX6MM | INSULIN PEN NEEDLE 33 G X 6 MM (1/4" OR 15/64") | 97051050146378 | Brand |
| AUM PEN NEEDLE/33GX6MM | INSULIN PEN NEEDLE 33 G X 6 MM (1/4" OR 15/64") | 97051050146378 | Brand |
| CLEVER CHOICE COMFORT EZ PEN NEEDLES 33GX6MM | INSULIN PEN NEEDLE 33 G X 6 MM (1/4" OR 15/64") | 97051050146378 | Brand |
| COMFORT TOUCH PEN NEEDLES/33GX1/4" | INSULIN PEN NEEDLE 33 G X 6 MM (1/4" OR 15/64") | 97051050146378 | Brand |

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|---|---|---|---|
| EASY COMFORT PEN NEEDLES 33G X 6MM | INSULIN PEN NEEDLE 33 G X 6 MM (1/4" OR 15/64") | 97051050146378 | Brand |
| TRUE COMFORT PRO PEN NEEDLES 33G X 6MM | INSULIN PEN NEEDLE 33 G X 6 MM (1/4" OR 15/64") | 97051050146378 | Brand |
| CLEVER CHOICE COMFORT EZ PEN NEEDLES 33GX8MM | INSULIN PEN NEEDLE 33 G X 8 MM (1/3" OR 5/16") | 97051050146380 | Brand |
| DROPLET MICRON 34G X 9/64" | INSULIN PEN NEEDLE 34 G X 3.5 MM (9/64") | 97051050146385 | Brand |
| B-D INSULIN SYRINGE ULTRAFINE/0.5ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2" | 97051030906329 | Brand |
| BD INSULIN SYRINGE ULTRA-FINE/0.5ML/30G X 12.7MM | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2" | 97051030906329 | Brand |
| BD INSULIN SYRINGE ULTRAFINE/0.5ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2" | 97051030906329 | Brand |
| BD INSULIN SYRINGE MICROFINE IV/U-100/1ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2" | 97051030906370 | Brand |
| B-D INSULIN SYRINGE ULTRAFINE II/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| BD INSULIN SYRINGE ULTRA-FINE/0.3ML/31G X 8MM | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| BD INSULIN SYRINGE ULTRA-FINE/1/2 UNIT/0.3ML/31G X 8MM | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| BD INSULIN SYRINGE ULTRAFINE HALF-UNIT/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| BD INSULIN SYRINGE ULTRAFINE/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| BD SAFETYGLIDE INSULIN SYRINGE/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| BD INSULIN SYRINGE/U-100/1ML/27G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 1/2" | 97051030906350 | Brand |
| BD INSULIN SYRINGE/1ML/27G X 12.7MM | INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 1/2" | 97051030906350 | Brand |
| BD INSULIN SYRINGE MICROFINE IV/U-100/1ML/27G X 5/8" | INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 5/8" | 97051030906360 | Brand |
| BD INSULIN SYRINGE MICROFINE/U-100/1ML/27G X 5/8" | INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 5/8" | 97051030906360 | Brand |
| BD INSULIN SYRINGE SAFETYGLIDE/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| BD INSULIN SYRINGE/1ML/29G X 12.7MM | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| BD INSULIN SYRINGE/U-100/2ML/27.5G X 5/8" | INSULIN SYRINGE/NEEDLE U-100 2 ML 27.5 X 5/8" | 97051030906390 | Brand |
| BD SAFETYGLIDE INSULIN SYRINGE/0.5ML/31G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64" | 97051030906391 | Brand |
| BD VEO INSULIN SYRINGE ULTR-FINE/U-100/0.5ML/31G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64" | 97051030906391 | Brand |

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|---|---|---|---|
| BD VEO INSULIN SYRINGE ULTRA-FINE/0.5ML/31G X 6MM | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64" | 97051030906391 | Brand |
| BD SAFETYGLIDE INSULIN SYRINGE/1ML/31G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64" | 97051030906399 | Brand |
| BD VEO INSULIN SYRINGE ULTRA-FINE/U-100/1ML/31G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64" | 97051030906399 | Brand |
| BD VEO INSULIN SYRINGE ULTRA-FINE/1ML/31G X 6MM | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64" | 97051030906399 | Brand |
| BD PEN NEEDLE/SHORT/ULTRA-FINE/31G X 8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| BD PEN NEEDLE/NANO 2ND GEN/32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| BD PEN NEEDLE/NANO 2ND GEN/32G X 5/32" | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| BD PEN NEEDLE/NANO/ULTRA - FINE/32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| ASSURE ID DUO PRO SAFETY PEN NEEDLES 31G X 5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| EASY COMFORT SAFETY PEN NEEDLES 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| PENTIPS GENERIC PEN NEEDLES 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| UNIFINE SAFECONTROL PEN NEEDLE 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| PENTIPS GENERIC PEN NEEDLES 29GX12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| EASY COMFORT SAFETY PEN NEEDLES 31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| PENTIPS GENERIC PEN NEEDLES 31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| UNIFINE SAFECONTROL PEN NEEDLE 31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| PENTIPS GENERIC PEN NEEDLES 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| UNIFINE SAFECONTROL PEN NEEDLE 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| ADVOCATE INSULIN PEN NEEDLE/32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| EASY COMFORT SAFETY PEN NEEDLES 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| PENTIPS GENERIC PEN NEEDLES 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| TECHLITE PLUS PEN NEEDLES32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |

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|---|---|---|---|
| ULTIGUARD SAFEPACK/TINY PEN NEEDLE/32G X 4MM/SHARPS CONTAINE | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| UNIFINE PROTECT SAFETY PEN NEEDLE 32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| VERIFINE PLUS PEN NEEDLE/32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| PENTIPS GENERIC PEN NEEDLES 32GX6MM | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| ULTIGUARD SAFEPACK/TINY PEN NEEDLE/32G X 6MM/SHARPS CONTAINE | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| UNIFINE PROTECT SAFETY PEN NEEDLE 30G X 8MM | INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16") | 97051050146344 | Brand |
| VERIFINE INSULIN SYRINGE/0.5ML/29G X 12MM | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| VERIFINE INSULIN SYRINGE/0.3ML/31G X 8MM | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |

**Approval Criteria**

**1** - If the request is non-preferred*, history of failure to a preferred* BD (Becton Dickinson) 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* BD product (document rationale)

| | |
|---|---|
| Notes | *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |

| 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| EASY TOUCH SAFETY PEN NEEDLES/29G X 5MM | INSULIN PEN NEEDLE 29 G X 5 MM (1/5" OR 3/16") | 97051050146318 | Brand |

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|---|---|---|---|
| MAXI-COMFORT SAFETY PEN NEEDLE/29G X 3/16" | INSULIN PEN NEEDLE 29 G X 5 MM (1/5" OR 3/16") | 97051050146318 | Brand |
| EASY TOUCH SAFETY PEN NEEDLES/29G X 8MM | INSULIN PEN NEEDLE 29 G X 8 MM (1/3" OR 5/16") | 97051050146322 | Brand |
| MAXI-COMFORT SAFETY PEN NEEDLE/29G X 5/16" | INSULIN PEN NEEDLE 29 G X 8 MM (1/3" OR 5/16") | 97051050146322 | Brand |
| DROPLET PEN NEEDLES 29GX10MM | INSULIN PEN NEEDLE 29 G X 10 MM | 97051050146326 | Brand |
| TECHLITE PEN NEEDLES 29G X 10MM | INSULIN PEN NEEDLE 29 G X 10 MM | 97051050146326 | Brand |
| AURORA PEN NEEDLES 29GX12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| CAREFINE PEN NEEDLES 29GX1/2" | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| CAREONE UNIFINE PENTIPS PLUS PEN NEEDLES 29GX12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| CAREONE UNIFINE PENTIPS 29GX12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| CARETOUCH PEN NEEDLE 29GX1/2" | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| CLEVER CHOICE COMFORT EZ PEN NEEDLES 29GX12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| DROPLET PEN NEEDLES 29G X1/2" | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| DROPLET PEN NEEDLES 29GX12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| DRUG MART UNIFINE PENTIPS29G X 12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| EASY TOUCH PEN NEEDLES 29GX1/2" | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| EXEL COMFORT POINT INSULIN PEN NEEDLES 29G X 12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| GLOBAL EASE INJECT PEN NEEDLES 29GX12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| H-E-B INCONTROL PEN NEEDLES 29GX12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| HEALTHWISE PEN NEEDLES 29GX12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| HEALTHY ACCENTS UNIFINE PENTIPS PEN NEEDLES 29GX12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| INSUPEN 29G X 12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| KROGER PEN NEEDLES 29G X 12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| MARATHON MEDICAL PENTIPS 29GX12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |

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|---|---|---|---|
| MEDICINE SHOPPE PEN NEEDLES 29G X 12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| MEIJER PEN NEEDLES 29G X 12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| PC UNIFINE PENTIPS 29G X 1/2" | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| PEN NEEDLES 29GX12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| PEN NEEDLES/29G X 1/2" | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| PENTIPS 29G X 12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| PENTIPS 29GX12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| PREFERRED PLUS UNIFINE PENTIPS 29G X 12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| PX PEN NEEDLE 29GX12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| QC PEN NEEDLES 29G X 12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| RAYA SURE PEN NEEDLE 29G X 12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| RELION PEN NEEDLES 29GX12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| SHOPKO UNIFINE PENTIPS PEN NEEDLES/ORIGINAL/29GX12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| SHOPKO UNIFINE PENTIPS PLUS PEN NEEDLES/REMOVER/29GX12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| TECHLITE PEN NEEDLES 29G X 12 MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| TODAYS HEALTH ORIGINAL PEN NEEDLES 29G X 1/2" | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| TRUEPLUS PEN NEEDLES 29GX12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| ULTRA FLO INSULIN PEN NEEDLES | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| UNIFINE PENTIPS PLUS 29GX12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| UNIFINE PENTIPS 29GX12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| VALUMARK PEN NEEDLES 29GX12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| VIDA MIA UNIFINE PENTIPS ORIGINAL 29GX12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |

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|---|---|---|---|
| 1ST TIER UNIFINE PENTIPS PLUS/ORIGINAL/29GX12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| 1ST TIER UNIFINE PENTIPS 29GX12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| ADVOCATE INSULIN PEN NEEDLES 29GX12.7MM | INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2") | 97051050146331 | Brand |
| BD PEN NEEDLE/ORIGINAL/ULTRA-FINE/29G X 12.7MM | INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2") | 97051050146331 | Brand |
| LITETOUCH PEN NEEDLES 29GX12.7MM | INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2") | 97051050146331 | Brand |
| SURE COMFORT PEN NEEDLES 29GX1/2" 12.7MM | INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2") | 97051050146331 | Brand |
| TRUEPLUS 5-BEVEL PEN NEEDLES 29GX12.7MM | INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2") | 97051050146331 | Brand |
| ULTICARE ORIGINAL PEN NEEDLES ULTI-FINE | INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2") | 97051050146331 | Brand |
| ULTICARE PEN NEEDLES/29G X 12.7MM | INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2") | 97051050146331 | Brand |
| ULTIGUARD SAFEPACK PEN NEEDLE/29G X 1/2"/SHARPS CONTAINER | INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2") | 97051050146331 | Brand |
| ULTILET PEN NEEDLE 29GX12.7MM | INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2") | 97051050146331 | Brand |
| ULTRA-THIN II PEN NEEDLES 29GX1/2" | INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2") | 97051050146331 | Brand |
| BD AUTOSHIELD DUO 30G X 5MM | INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16") | 97051050146340 | Brand |
| EASY TOUCH PEN NEEDLE/30 G X 3/16" | INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16") | 97051050146340 | Brand |
| PEN NEEDLES 30GX5MM | INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16") | 97051050146340 | Brand |
| SAFETY PEN NEEDLES/30G X 3/16" | INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16") | 97051050146340 | Brand |
| ULTICARE MINI SAFETY PEN NEEDLES 30G X 3/16" | INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16") | 97051050146340 | Brand |
| UNIFINE PENTIPS PLUS/30G X 3/16" | INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16") | 97051050146340 | Brand |
| UNIFINE PENTIPS/30G X 3/16" | INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16") | 97051050146340 | Brand |
| UNIFINE SAFECONTROL PEN NEEDLE/30G X 3/16" | INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16") | 97051050146340 | Brand |
| EASY TOUCH SAFETY PEN NEEDLES/30G X 1/4" | INSULIN PEN NEEDLE 30 G X 6 MM (1/4" OR 15/64") | 97051050146341 | Brand |
| ABOUTTIME PEN NEEDLES 30GX 5/16" | INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16") | 97051050146344 | Brand |

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|---|---|---|---|
| ASSURE ID SAFETY PEN NEEDLES 30G X 5/16" | INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16") | 97051050146344 | Brand |
| CAREFINE PEN NEEDLES 30GX5/16" | INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16") | 97051050146344 | Brand |
| DROPLET PEN NEEDLES 30G X 5/16" | INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16") | 97051050146344 | Brand |
| EASY TOUCH PEN NEEDLE 30 G X 5/16" | INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16") | 97051050146344 | Brand |
| EASY TOUCH SAFETY PEN NEEDLES/30G X 5/16" | INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16") | 97051050146344 | Brand |
| INSUPEN ULTRAFIN 30GX8MM | INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16") | 97051050146344 | Brand |
| NOVOFINE AUTOCOVER PEN NEEDLE 30G X 8MM | INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16") | 97051050146344 | Brand |
| PEN NEEDLES 30GX8MM | INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16") | 97051050146344 | Brand |
| SAFETY PEN NEEDLES/30G X 5/16" | INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16") | 97051050146344 | Brand |
| SECURESAFE SAFETY PEN NEEDLES/30G X 5/16" | INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16") | 97051050146344 | Brand |
| SURE COMFORT PEN NEEDLES 30GX5/16" SHORT | INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16") | 97051050146344 | Brand |
| ULTICARE SHORT SAFETY PEN NEEDLES 30G X 5/16" | INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16") | 97051050146344 | Brand |
| UNIFINE SAFECONTROL PEN NEEDLE/30G X 5/16" | INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16") | 97051050146344 | Brand |
| AUM SAFETY PEN NEEDLE/31 G X 4MM | INSULIN PEN NEEDLE 31 G X 4 MM (1/6" OR 5/32") | 97051050146354 | Brand |
| COMFORT TOUCH PEN NEEDLES/31G X 4MM | INSULIN PEN NEEDLE 31 G X 4 MM (1/6" OR 5/32") | 97051050146354 | Brand |
| RAYA SURE PEN NEEDLE 31G X 4MM | INSULIN PEN NEEDLE 31 G X 4 MM (1/6" OR 5/32") | 97051050146354 | Brand |
| ABOUTTIME PEN NEEDLES 31G X 3/16" | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| ADVOCATE INSULIN PEN NEEDLES 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| AUM SAFETY PEN NEEDLE/31 G X 5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| AURORA UNIFINE PENTIPS/MINI/31GX3/16" | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| BD PEN NEEDLE/MINI/ULTRA-FINE/31G X 5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| CAREONE UNIFINE PENTIPS PLUS PEN NEEDLES 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| CAREONE UNIFINE PENTIPS 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |

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| CARETOUCH PEN NEEDLES 31GX 5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| CLEVER CHOICE COMFORT EZ PEN NEEDLES 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| CLICKFINE PEN NEEDLES 31G X 3/16" | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| COMFORT EZ/31G X 5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| COMFORT TOUCH PEN NEEDLES/31G X 5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| DIATHRIVE PEN NEEDLE/31G X 5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| DROPLET PEN NEEDLES 31G X3/16" | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| DROPLET PEN NEEDLES 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| DROPSAFE SAFETY PEN NEEDLE/31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| DRUG MART UNIFINE PENTIPS 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| EASY COMFORT PEN NEEDLES 31GX3/16" | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| EASY TOUCH PEN NEEDLES/31G X 3/16" | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| FIFTY50 PEN NEEDLES 31G X3/16" (5MM) | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| FIFTY50 PEN NEEDLES 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| FREDS PHARMACY UNIFINE PENTIPS PLUS 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| GLOBAL EASE INJECT PEN NEEEDLES 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| GNP ULTICARE PEN NEEDLES 31G X 5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| GNP ULTIGUARD SAFEPACK/MINI PEN NEEDLE/31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| GOODSENSE CLICKFINE SAFETY PEN NEEDLE/31G X 3/16" | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| GOODSENSE PEN NEEDLE/PENFINE CLASSIC/31G X 3/16" | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| H-E-B IN CONTROL PEN NEEDLE 31GX3/16" | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| H-E-B IN CONTROL PEN NEEDLES 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |

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| H-E-B IN CONTROL UNIFINE PENTIPS PLUS 31GX3/16" | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| H-E-B IN CONTROL UNIFINE PENTIPS PLUS 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| HEALTHWISE SHORT PEN NEEDLES/31G X 3/16" | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| HEALTHY ACCENTS UNIFINE PENTIPS PEN NEEDLES 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| HM ULTICARE MINI PEN NEEDLES/31G X 5MM (3/16") | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| INSUPEN 31G X 5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| KROGER PEN NEEDLES/31G X 3/16" | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| LEADER UNIFINE PENTIPS PLUS/MINI/31GX3/16" | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| LEADER UNIFINE PENTIPS/MINI/31GX3/16" | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| LITETOUCH PEN NEEDLES/31 G X 3/16" | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| LITETOUCH PEN NEEDLES/31G X 5MM/MINI | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| MARATHON MEDICAL PENTIPS 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| MM PEN NEEDLES 31G X 3/16" | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| PC UNIFINE PENTIPS 31G X 5MM MINI | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| PEN NEEDLES 31G X 3/16" | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| PEN NEEDLES 31G X 5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| PEN NEEDLES/31G X 3/16" | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| PENTIPS 31G X 5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| PENTIPS 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| PREFERRED PLUS UNIFINE PENTIPS/MINI/31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| PX MINI PEN NEEDLES 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| RA PEN NEEDLES 31G X 5MM 3/16" | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| RAYA SURE PEN NEEDLE 31G X 5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |

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| SHOPKO UNIFINE PENTIPS PEN NEEDLES/MINI/31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| SHOPKO UNIFINE PENTIPS PLUS PEN NEEDLES/MINI/REMOVER/31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| SURE COMFORT PEN NEEDLES 31GX3/16" (5MM) | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| TECHLITE PEN NEEDLES 31G X 5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| TECHLITE PEN NEEDLES/31G X 5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| TRUE COMFORT PEN NEEDLES 31G X 5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| TRUE COMFORT PRO PEN NEEDLES 31G X 5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| TRUEPLUS PEN NEEDLES 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| TRUEPLUS 5-BEVEL PEN NEEDLES 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| ULTICARE PEN NEEDLES 31G X 5MM/MINI | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| ULTIGUARD SAFEPACK MINI PEN NEEDLE/31G X 3/16"/SHARPS CONTAI | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| ULTIGUARD SAFEPACK/MINI PEN NEEDLE/31G X 3/16"/SHARPS CONTAI | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| ULTILET PEN NEEDLE 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| ULTILET SHORT PEN NEEDLES31GX3/16" | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| ULTRA FLO INSULIN PEN NEEDLE 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| ULTRA-THIN II MINI PEN NEEEDLES/31GX3/16" | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| ULTRACARE PEN NEEDLES/31G X 3/16" | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| UNIFINE PENTIPS PLUS 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| UNIFINE PENTIPS 31G X 3/16" | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| UNIFINE PENTIPS 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| UNIFINE ULTRA PEN NEEDLE/31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |

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| WEGMANS UNIFINE PENTIPS PLUS/MINI/31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| ZEVRX PEN NEEDLES 31G X 5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| 1ST TIER UNIFINE PENTIPS /MINI/31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| 1ST TIER UNIFINE PENTIPS PLUS/MINI/31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| AURORA PEN NEEDLES 31G X 6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| CAREFINE PEN NEEDLES 31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| CAREONE UNIFINE PENTIPS PLUS PEN NEEDLES 31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| CAREONE UNIFINE PENTIPS 31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| CARETOUCH PEN NEEDLES 31 G X 6 MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| CLEVER CHOICE COMFORT EZ PEN NEEDLES 31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| CLICKFINE PEN NEEDLE UNIVERSAL/31GX1/4" | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| CLICKFINE PEN NEEDLES 31G X 1/4" | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| COMFORT EZ/31G X 6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| COMFORT TOUCH PEN NEEDLES/31G X 6 MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| DIATHRIVE PEN NEEDLE/31 G X 6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| DROPLET PEN NEEDLES 31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| DROPSAFE SAFTEY PEN NEEDLES/31G X 1/4" | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| DRUG MART UNIFINE PENTIPS31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| EASY COMFORT PEN NEEDLES 31GX1/4" | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| EASY TOUCH PEN NEEDLES 31GX1/4" | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| EXEL COMFORT POINT INSULIN PEN NEEDLES 31G X 6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| GNP CLICKFINE UNIVERSAL PEN NEEDLES 31GX1/4" | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| H-E-B IN CONTROL PEN NEEDLES 31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |

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| H-E-B IN CONTROL UNIFINE PENTIPS PLUS 31GX1/4" | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| HEALTHWISE MINI PEN NEEDLES 31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| HEALTHY ACCENTS UNIFINE PENTIPS PEN NEEDLES 31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| INCONTROL ULTICARE MINI PEN NEEDLES/31G X 6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| INSUPEN ULTRAFIN 31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| KROGER PEN NEEDLES 31GX1/4" | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| KROGER PEN NEEDLES/31G X 1/4" | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| LITETOUCH PEN NEEDLES 31G X 6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| LITETOUCH PEN NEEDLES 31G X 6MM/ULTRA SHORT | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| MAXICOMFORT II PEN NEEDLES/31G X 1/4" | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| MEDICINE SHOPPE PEN NEEDLES 31G X 6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| MEIJER PEN NEEDLES 31G X 6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| MICRODOT PEN NEEDLE/31G X 6 MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| MM PEN NEEDLES 31G X 1/4" | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| PC UNIFINE PENTIPS 31G X 6MM ULTRA SHORT | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| PEN NEEDLES 31G X 6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| PEN NEEDLES 31GX6MM (1/4") | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| BD INSULIN SYRINGE/U-500/0.5ML/31G X 6MM | INSULIN SYRINGE/NEEDLE U-500 0.5 ML 31G X 6MM (15/64") | 97051030956330 | Brand |
| ADVOCATE INSULIN SYRINGE/U-100/0.3ML/29GX1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| BD INSULIN SYRINGE ULTRAFINE/U-100/0.3ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| BD INSULIN SYRINGE/0.3ML/29G X 12.7MM | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| BD SAFETYGLIDE INSULIN SYRINGE/0.3ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |

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| CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.3ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| DROPLET INSULIN SYRINGE 0.3ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| EQL INSULIN SYRINGE/0.3ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| EXEL COMFORT POINT INSULIN SYRINGE/0.3ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.3ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| GNP INSULIN SYRINGE/0.3ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| INSULIN SYRINGE/U-100/0.3ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| KROGER INSULIN SYRINGE/0.3ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| LEADER INSULIN SYRINGE/0.3ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| LITETOUCH INSULIN SYRINGE/0.3ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| MAGELLAN INSULIN SAFETY SYRINGE/U-100/0.3ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| MONOJECT INSULIN SYRINGE/SAFETY/PERM NEEDLE/0.3ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| MONOJECT INSULIN SYRINGE/SAFETY/PERM NEEDLE/0.3ML/29GX1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.3ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| PREFERRED PLUS INSULIN SYRINGE/U-100/0.3ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| SURE COMFORT INSULIN SYRINGE/U-100/0.3ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| TECHLITE INSULIN SYRINGE U-100/0.3ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| TOPCARE ULTRA COMFORT INSULIN SYRINGE/U-100/0.3ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| TRUEPLUS INSULIN SYRINGE/U-100/0.3ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| ULTICARE INSULIN SYRINGE/0.3ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| ULTRA FLO INSULIN SYRINGE 0.3ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |

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| VP INSULIN SYRINGE/U-100/0.3ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2" | 97051030906305 | Brand |
| ADVOCATE INSULIN SYRINGE/U-100/0.3ML/30GX5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| DROPLET INSULIN SYRINGE U-100/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| EASY TOUCH INSULIN SYRINGE/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| EQL INSULIN SYRINGE/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| EXEL COMFORT POINT INSULIN SYRINGE/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| GLOBAL INSULIN SYRINGES/U-100/0.3ML/30GX5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| GLUCOPRO INSULIN SYRINGE/U-100/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| GNP INSULIN SYRINGE/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| GNP INSULIN SYRINGES/0.3ML/30GX5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| HEALTHWISE INSULIN SYRINGE/U-100/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| INSULIN SYRINGE/NEEDLE 0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| INSULIN SYRINGE/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| KROGER INSULIN SYRINGE/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| LEADER INSULIN SYRINGE/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| LITETOUCH INSULIN SYRINGE/U-100/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| LITETOUCH INSULIN SYRINGE/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| MAGELLAN INSULIN SAFETY SYRINGE/U-100/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| MEDIC INSULIN SYRINGE/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| MM INSULIN SYRINGE/U-100/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |

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|---|---|---|---|
| MONOJECT INSULIN SYRINGE/U-100/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| PRECISION SURE-DOSE INSULIN SYRINGE/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| PREFERRED PLUS INSULIN SYRINGE/U-100/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| SURE COMFORT INSULIN SYRINGE/U-100/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| TECHLITE INSULIN SYRINGE U-100/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| TOPCARE ULTRA COMFORT INSULIN SYRINGE/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| TRUEPLUS INSULIN SYRINGE/U-100/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| ULTICARE INSULIN SYRINGE/SHORT/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| ULTICARE INSULIN SYRINGE/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| ULTRA COMFORT INSULIN SYRINGE/U-100/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| ULTRA FLO INSULIN SYRINGE 0.3ML/30GX5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| ULTRA FLO INSULIN SYRINGE 1/2 UNIT/0.3ML/30GX5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| ULTRA-THIN II INSULIN SYRINGE SHORT/U-100/0.3ML/30GX5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| ULTRACARE INSULIN SYRINGE/U-100/0.3ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16" | 97051030906307 | Brand |
| B-D INSULIN SYRINGE ULTRAFINE/0.3ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2" | 97051030906308 | Brand |
| BD INSULIN SYRINGE ULTRA-FINE/0.3ML/30G X 12.7MM | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2" | 97051030906308 | Brand |
| BD INSULIN SYRINGE ULTRAFINE/0.3ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2" | 97051030906308 | Brand |
| CAREONE INSULIN SYRINGES/0.3ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2" | 97051030906308 | Brand |
| CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.3ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2" | 97051030906308 | Brand |
| DROPLET INSULIN SYRINGE U-100/0.3ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2" | 97051030906308 | Brand |
| EASY TOUCH INSULIN SYRINGE/U-100/0.3ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2" | 97051030906308 | Brand |

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|---|---|---|---|
| GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.3ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2" | 97051030906308 | Brand |
| GLOBAL INSULIN SYRINGE/U-100/0.3ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2" | 97051030906308 | Brand |
| GLUCOPRO INSULIN SYRINGE/U-100/0.3ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2" | 97051030906308 | Brand |
| SURE COMFORT INSULIN SYRINGE/U-100/0.3ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2" | 97051030906308 | Brand |
| ULTICARE INSULIN SYRINGE/U-100/0.3ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2" | 97051030906308 | Brand |
| ULTICARE INSULIN SYRINGE/0.3ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2" | 97051030906308 | Brand |
| ULTIGUARD SAFEPACK INSULIN SYRINGE 0.3ML/30G X 1/2"/SHARPS C | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2" | 97051030906308 | Brand |
| ULTIGUARD SAFEPACK INSULIN SYRINGE/0.3ML/30G X 1/2"/SHARPS C | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2" | 97051030906308 | Brand |
| ULTRA FLO INSULIN SYRINGE 0.3ML/30GX1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2" | 97051030906308 | Brand |
| ULTRA FLO INSULIN SYRINGE 1/2 UNIT/0.3ML/30GX1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2" | 97051030906308 | Brand |
| EASY TOUCH INSULIN SYRINGE/U-100/0.5ML/27G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 27 X 1/2" | 97051030906310 | Brand |
| INSULIN SYRINGES/0.5ML/27GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 27 X 1/2" | 97051030906310 | Brand |
| MAXICOMFORT INSULIN SYRINGES 27G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 27 X 1/2" | 97051030906310 | Brand |
| ADVOCATE INSULIN SYRINGE/U-100/0.5ML/31GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| B-D INSULIN SYRINGE ULTRAFINE II/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| BD INSULIN SYRINGE ULTRA-FINE/0.5ML/31G X 8MM | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| BD INSULIN SYRINGE ULTRAFINE/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| CAREONE INSULIN SYRINGES/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| CARETOUCH INSULIN SYRINGE/0.5ML/31GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| COMFORT EZ INSULIN SYRINGE/U-100/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |

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|---|---|---|---|
| DROPLET INSULIN SYRINGE U-100/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| DROPLET INSULIN SYRINGE/U-100/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| EASY COMFORT INSULIN SYRINGE/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| EASY TOUCH INSULIN SYRINGE/U-100/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| EQL INSULIN SYRINGE/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| FIFTY50 SUPERIOR COMFORT INSULIN SYRINGE/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| GLUCOPRO INSULIN SYRINGE/U-100/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| GNP INSULIN SYRINGE/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| HEALTHWISE INSULIN SYRINGE/U-100/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| INSULIN SYRINGE/NEEDLE 0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| INSULIN SYRINGE/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| INSULIN SYRINGES/0.5ML/31GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| KINRAY INSULIN SYRINGE PREFERRED PLUS/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| KROGER INSULIN SYRINGE/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| LEADER INSULIN SYRINGE/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| LITETOUCH INSULIN SYRINGE/U-100/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| LITETOUCH INSULIN SYRINGE/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| LONGS INSULIN SYRINGE/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| MM INSULIN SYRINGE/U-100/1/2ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |

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| MS INSULIN SYRINGE/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| PRO COMFORT INSULIN SYRINGES/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| PRODIGY INSULIN SYRINGE/1/2ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| RELION INSULIN SYRINGE/U-100/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| SURE COMFORT INSULIN SYRINGE/U-100/0.5ML/31G X 5/16 | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| TECHLITE INSULIN SYRINGE U-100/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| TOPCARE ULTRA COMFORT INSULIN SYRINGE/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| TRUE COMFORT INSULIN SYRINGE/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| TRUE COMFORT PRO INSULIN SYRINGE/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| TRUEPLUS INSULIN SYRINGE/U-100/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| ULTICARE INSULIN SYRINGE ULTRAFINE U-100/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| ULTICARE INSULIN SYRINGE/SHORT/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| ULTICARE INSULIN SYRINGE/U-100/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| ULTIGUARD SAFEPACK/SYRINGE/NEEDLE/31G X 5/16"/SHARPS CONTAIN | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| ULTRA FLO INSULIN SYRINGE 0.5ML/31GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| ULTRA-THIN II INSULIN SYRINGE SHORT/U-100/0.5ML/31GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| ULTRACARE INSULIN SYRINGE/U-100/0.5ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| BD LO-DOSE INSULIN SYRINGE MICROFINE IV/0.5ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2" | 97051030906320 | Brand |
| BD INSULIN SYRINGE MICROFINE IV/U-100/0.5ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2" | 97051030906320 | Brand |
| CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.5ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2" | 97051030906320 | Brand |
| EASY TOUCH INSULIN SYRINGE/U-100/0.5ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2" | 97051030906320 | Brand |
| EXEL COMFORT POINT INSULIN SYRINGE/0.5ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2" | 97051030906320 | Brand |

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| GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.5ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2" | 97051030906320 | Brand |
| GNP INSULIN SYRINGE/0.5ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2" | 97051030906320 | Brand |
| INSULIN SYRINGE/0.5ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2" | 97051030906320 | Brand |
| INSULIN SYRINGES/0.5ML/28GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2" | 97051030906320 | Brand |
| LEADER INSULIN SYRINGE/0.5ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2" | 97051030906320 | Brand |
| LITETOUCH INSULIN SYRINGE/U-100/0.5ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2" | 97051030906320 | Brand |
| MAXI-COMFORT INSULIN SYRINGE/U-100/0.5ML/28GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2" | 97051030906320 | Brand |
| MONOJECT INSULIN SYRINGE/PERM NEEDLE/U-100/0.5ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2" | 97051030906320 | Brand |
| MONOJECT INSULIN SYRINGE/SOFTPACK/U-100/0.5ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2" | 97051030906320 | Brand |
| MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.5ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2" | 97051030906320 | Brand |
| PREFERRED PLUS INSULIN SYRINGE/U-100/0.5ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2" | 97051030906320 | Brand |
| REALITY INSULIN SYRINGE/U-100/0.5ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2" | 97051030906320 | Brand |
| SURE COMFORT INSULIN SYRINGE/U-100/0.5ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2" | 97051030906320 | Brand |
| TRUEPLUS INSULIN SYRINGE/U-100/0.5ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2" | 97051030906320 | Brand |
| ULTICARE INSULIN SYRINGE/0.5ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2" | 97051030906320 | Brand |
| ADVOCATE INSULIN SYRINGE/U-100/0.5ML/29GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| BD INSULIN SYRINGE ULTRAFINE/U-100/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| BD INSULIN SYRINGE/0.5ML/29G X 12.7MM | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| BD SAFETY-GLIDE INSULIN SYRINGE/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| BD SAFETYGLIDE INSULIN SYRINGE/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| DROPLET INSULIN SYRINGE 0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |

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| EASY TOUCH INSULIN SYRINGE/SAFETY/U-100/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| EASY TOUCH INSULIN SYRINGE/U-100/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| EASY TOUCH INSULIN SYRINGE/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| EQL INSULIN SYRINGE/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| EXEL COMFORT POINT INSULIN SYRINGE/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| GNP INSULIN SYRINGE/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| GNP INSULIN SYRINGES/1/2ML/29GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| INSULIN SYRINGE/NEEDLE 0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| INSULIN SYRINGE/U-100/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| INSULIN SYRINGES/0.5ML/29GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| KINRAY INSULIN SYRINGE/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| KROGER INSULIN SYRINGE/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| LEADER INSULIN SYRINGE/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| LITETOUCH INSULIN SYRINGE/U-100/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| MAGELLAN INSULIN SAFETY SYRINGE/U-100/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| MONOJECT INSULIN SYRINGE/SAFETY/PERM NEEDLE/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| PREFERRED PLUS INSULIN SYRINGE/U-100/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| RA INSULIN SYRINGE/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| REALITY INSULIN SYRINGE/U-100/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| RELION INSULIN SYRINGE/U-100/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |

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|---|---|---|---|
| SB INSULIN SYRINGE/U-100/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| SECURESAFE SAFETY INSULIN SYRINGES/U-100/0.5ML/29GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| SURE COMFORT INSULIN SYRINGE/U-100/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| TECHLITE INSULIN SYRINGE U-100/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| TOPCARE ULTRA COMFORT INSULIN SYRINGE/U-100/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| TRUEPLUS INSULIN SYRINGE/U-100/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| ULTICARE INSULIN SAFETY SYRINGE/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| ULTICARE INSULIN SYRINGE/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| ULTRA FLO INSULIN SYRINGE 0.5ML/29GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| ULTRA-THIN II INSULIN SYRINGE/U-100/0.5ML/29GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| VALUE HEALTH INSULIN SYRINGE/U-100/0.5ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| ADVOCATE INSULIN SYRINGE/U-100/0.5ML/30GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| BD SAFETYGLIDE INSULIN SYSYRINGE/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| CARETOUCH INSULIN SYRINGE0.5ML/30GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| DROPLET INSULIN SYRINGE U-100/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| EASY COMFORT INSULIN SYRINGE/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| EASY TOUCH INSULIN SYRINGE/SAFETY/U-100/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| EASY TOUCH INSULIN SYRINGE/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| EQL INSULIN SYRINGE/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| EXEL COMFORT POINT INSULIN SYRINGE/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |

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|---|---|---|---|
| GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| KMART VALU PLUS INSULIN SYRINGE/0.3ML/30G | INSULIN SYRINGE (DISP) U-100 0.3 ML | 97051030056305 | Brand |
| KMART VALU PLUS INSULIN SYRINGE/0.5ML/29G | INSULIN SYRINGE (DISP) U-100 1/2 ML | 97051030056310 | Brand |
| KMART VALU PLUS INSULIN SYRINGE/0.5ML/30G | INSULIN SYRINGE (DISP) U-100 1/2 ML | 97051030056310 | Brand |
| BD INSULIN SYRINGE LUER-LOK/U-100/1ML | INSULIN SYRINGE (DISP) U-100 1 ML | 97051030056320 | Brand |
| BD INSULIN SYRINGE SLIP TIP/U-100/1ML | INSULIN SYRINGE (DISP) U-100 1 ML | 97051030056320 | Brand |
| KMART VALU PLUS INSULIN SYRINGE/1ML/29G | INSULIN SYRINGE (DISP) U-100 1 ML | 97051030056320 | Brand |
| KMART VALU PLUS INSULIN SYRINGE/1ML/30G | INSULIN SYRINGE (DISP) U-100 1 ML | 97051030056320 | Brand |
| MONOJECT INSULIN SYRINGE REGULAR LUER TIP/SOFTPACK/1ML | INSULIN SYRINGE (DISP) U-100 1 ML | 97051030056320 | Brand |
| MONOJECT INSULIN SYRINGE/1ML | INSULIN SYRINGE (DISP) U-100 1 ML | 97051030056320 | Brand |
| DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 31GX8MM 0.5ML | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| INSULIN SYRINGES/U-100/0.5ML/31GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| VERIFINE INSULIN SYRINGE 0.5ML/31G X 8MM | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16" | 97051030906318 | Brand |
| INSULIN SYRINGES/U-100/0.5ML/28GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2" | 97051030906320 | Brand |
| INSULIN SYRINGES/U-100/0.5ML/29GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| VERIFINE INSULIN SYRINGE 0.5ML/29G X 12MM | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |
| AQ INSULIN SYRINGE/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| GLUCOPRO INSULIN SYRINGE/U-100/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| GNP INSULIN SYRINGE/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| HEALTHWISE INSULIN SYRINGE/U-100/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| INSULIN SYRINGE/NEEDLE 0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| INSULIN SYRINGE/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |

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|---|---|---|---|
| INSULIN SYRINGES/U-100/0.5ML/30GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| KROGER INSULIN SYRINGE/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| LEADER INSULIN SYRINGE/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| LITETOUCH INSULIN SYRINGE/U-100/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| LITETOUCH INSULIN SYRINGE/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| MAGELLAN INSULIN SAFETY SYRINGE/U-100/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| MEDIC INSULIN SYRINGE/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| MM INSULIN SYRINGE/U-100/1/2ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| MONOJECT INSULIN SYRINGE/U-100/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| PREFERRED PLUS INSULIN SYRINGE/U-100/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| PRO COMFORT INSULIN SYRINGES/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| RA INSULIN SYRINGE/U-100/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| SB INSULIN SYRINGE/U-100/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| SURE COMFORT INSULIN SYRINGE/U-100/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| TECHLITE INSULIN SYRINGE U-100/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| TOPCARE ULTRA COMFORT INSULIN SYRINGE/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| TRUE COMFORT PRO INSULIN SYRINGE/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| TRUEPLUS INSULIN SYRINGE/U-100/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| ULTICARE INSULIN SYRINGE/SHORT/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| ULTICARE INSULIN SYRINGE/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| ULTRA FLO INSULIN SYRINGE 0.5ML/30GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |

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|---|---|---|---|
| ULTRA-THIN II INSULIN SYRINGE SHORT/U-100/0.5ML/30GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| ULTRACARE INSULIN SYRINGE/U-100/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| VANISHPOINT INSULIN SYRINGE/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| ZEVRX INSULIN SYRINGE/0.5ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16" | 97051030906328 | Brand |
| CAREONE INSULIN SYRINGES/0.5ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2" | 97051030906329 | Brand |
| CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.5ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2" | 97051030906329 | Brand |
| DROPLET INSULIN SYRINGE U-100/0.5ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2" | 97051030906329 | Brand |
| DROPLET INSULIN SYRINGE/U-100/0.5ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2" | 97051030906329 | Brand |
| EASY COMFORT INSULIN SYRINGE/U-100/0.5ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2" | 97051030906329 | Brand |
| EASY TOUCH INSULIN SYRINGE/U-100/0.5ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2" | 97051030906329 | Brand |
| GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.5ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2" | 97051030906329 | Brand |
| GLUCOPRO INSULIN SYRINGE/U-100/0.5ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2" | 97051030906329 | Brand |
| PRO COMFORT INSULIN SYRINGES/0.5ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2" | 97051030906329 | Brand |
| PX INSULIN SYRINGE/U-100/0.5ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2" | 97051030906329 | Brand |
| SURE COMFORT INSULIN SYRINGE/U-100/0.5ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2" | 97051030906329 | Brand |
| TECHLITE INSULIN SYRINGE U-100/0.5ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2" | 97051030906329 | Brand |
| TRUE COMFORT PRO INSULIN SYRINGE/U-100/0.5ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2" | 97051030906329 | Brand |
| ULTICARE INSULIN SYRINGE/U-100/0.5ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2" | 97051030906329 | Brand |
| ULTICARE INSULIN SYRINGE/0.5ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2" | 97051030906329 | Brand |
| ULTIGUARD SAFEPACK INSULIN SYRINGE 1/2ML 30G X 1/2"/SHARPS C | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2" | 97051030906329 | Brand |
| ULTIGUARD SAFEPACK INSULIN SYRINGE/0.5ML/30G X 1/2"/SHARPS C | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2" | 97051030906329 | Brand |
| ULTRA FLO INSULIN SYRINGE 0.5ML/30GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2" | 97051030906329 | Brand |

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| ULTRACARE INSULIN SYRINGE/U-100/0.5ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2" | 97051030906329 | Brand |
| VANISHPOINT INSULIN SYRINGE/0.5ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2" | 97051030906329 | Brand |
| ZEVRX INSULIN SYRINGE/0.5ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2" | 97051030906329 | Brand |
| MONOJECT INSULIN SYRINGE/DETACH NEEDLE/1ML/25G X 5/8" | INSULIN SYRINGE/NEEDLE U-100 1 ML 25 X 5/8" | 97051030906330 | Brand |
| BD SAFETYGLIDE INSULIN SYRINGE/0.3ML/31G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64" | 97051030906333 | Brand |
| BD VEO INSULIN SYRINGE ULTRA-FINE/U-100/0.3ML/31G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64" | 97051030906333 | Brand |
| BD VEO INSULIN SYRINGE ULTRA-FINE/0.3ML/31G X 6MM | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64" | 97051030906333 | Brand |
| BD VEO INSULIN SYRINGE ULTRA-FINE/1/2 UNIT/0.3ML/31G X 6MM | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64" | 97051030906333 | Brand |
| DROPLET INSULIN SYRINGE U-100/0.3ML/31G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64" | 97051030906333 | Brand |
| DROPLET INSULIN SYRINGE/U-100/0.3ML/31G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64" | 97051030906333 | Brand |
| DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 31GX6MM 0.3ML | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64" | 97051030906333 | Brand |
| GLOBAL EASY GLIDE INSULIN SYRINGE/0.3ML/31G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64" | 97051030906333 | Brand |
| RELION INSULIN SYRINGE/U-100/0.3ML/31G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64" | 97051030906333 | Brand |
| TECHLITE INSULIN SYRINGE U-100/0.3ML/31G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64" | 97051030906333 | Brand |
| INSULIN SYRINGES 0.3ML/31G X 1/4" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 1/4" (6 MM) | 97051030906334 | Brand |
| SURE COMFORT INSULIN SYRINGE/U-100/0.3ML/31GX1/4" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 1/4" (6 MM) | 97051030906334 | Brand |
| ULTICARE U-100 INSULIN SYRINGES/HALF UNIT/0.3ML/31G X1/4" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 1/4" (6 MM) | 97051030906334 | Brand |
| ULTICARE U-100 INSULIN SYRINGES/0.3ML/31G X 1/4" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 1/4" (6 MM) | 97051030906334 | Brand |
| ULTICARE U-100 INSULIN SYRINGES/0.3ML/31G X1/4" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 1/4" (6 MM) | 97051030906334 | Brand |
| INSULIN SYRINGES 0.5ML/31G X 1/4" | INSULIN SYRINGE/NEEDLE U-100 0.5 ML 31 X 1/4" (6 MM) | 97051030906336 | Brand |

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|---|---|---|---|
| SURE COMFORT INSULIN SYRINGES/0.5ML/31G X 6MM | INSULIN SYRINGE/NEEDLE U-100 0.5 ML 31 X 1/4" (6 MM) | 97051030906336 | Brand |
| ULTICARE U-100 INSULIN SYRINGES/0.5ML/31G X 1/4" | INSULIN SYRINGE/NEEDLE U-100 0.5 ML 31 X 1/4" (6 MM) | 97051030906336 | Brand |
| INSULIN SYRINGE 1ML/31G X1/4" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 1/4" (6 MM) | 97051030906337 | Brand |
| SURE COMFORT INSULIN SYRINGES/U-100/1ML/31GX6MM | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 1/4" (6 MM) | 97051030906337 | Brand |
| ULTICARE U-100 INSULIN SYRINGES/1ML/31G X 1/4" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 1/4" (6 MM) | 97051030906337 | Brand |
| VANISHPOINT INSULIN SYRINGE/1ML/30G X 3/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 3/16" (5 MM) | 97051030906338 | Brand |
| EASY COMFORT INSULIN SYRINGE/0.3ML/31G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 1/2" | 97051030906341 | Brand |
| EASY COMFORT INSULIN SYRINGES/0.5ML/32GX5/16" | INSULIN SYRINGE/NEEDLE U-100 0.5 ML 32 X 5/16" | 97051030906343 | Brand |
| TRUE COMFORT PRO INSULIN SYRINGE/0.5ML/32G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.5 ML 32 X 5/16" | 97051030906343 | Brand |
| EASY COMFORT INSULIN SYRINGE/1ML/32GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 32 X 5/16" | 97051030906344 | Brand |
| TRUE COMFORT PRO INSULIN SYRINGE/1ML/32GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 32 X 5/16" | 97051030906344 | Brand |
| EASY TOUCH INSULIN SYRINGE/U-100/1ML/27G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 1/2" | 97051030906350 | Brand |
| INSULIN SYRINGES/U-100/1ML/27GX/1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 1/2" | 97051030906350 | Brand |
| MAXICOMFORT INSULIN SYRINGES 27G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 1/2" | 97051030906350 | Brand |
| MONOJECT INSULIN SYRINGE/DETACH NEEDLE/1ML/27G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 1/2" | 97051030906350 | Brand |
| MONOJECT INSULIN SYRINGE/SOFTPACK/1ML/27G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 1/2" | 97051030906350 | Brand |
| VANISHPOINT INSULIN SYRINGE/0.5ML/30G X 3/16" | INSULIN SYRINGE/NEEDLE U-100 0.5 ML 30 X 3/16" (5 MM) | 97051030906355 | Brand |
| DROPLET INSULIN SYRINGE U-100/0.3ML/30G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 15/64" | 97051030906359 | Brand |
| EASY TOUCH INSULIN SYRINGE/U-100/1ML/27G X 5/8" | INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 5/8" | 97051030906360 | Brand |
| DROPLET INSULIN SYRINGE U-100/0.5ML/30G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 0.5 ML 30 X 15/64" | 97051030906361 | Brand |

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|---|---|---|---|
| DROPLET INSULIN SYRINGE U-100/1ML/30G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 15/64" | 97051030906362 | Brand |
| CARETOUCH INSULIN SYRINGE/U-100/1ML/28G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 5/16" | 97051030906368 | Brand |
| BD INSULIN SYRINGE MICROFINE/U-100/1ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2" | 97051030906370 | Brand |
| CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/1ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2" | 97051030906370 | Brand |
| EASY TOUCH INSULIN SYRINGE/U-100/1ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2" | 97051030906370 | Brand |
| GLOBAL INJECT EASE INSULIN SYRINGE/U-100/1ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2" | 97051030906370 | Brand |
| GNP INSULIN SYRINGES/1ML/28GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2" | 97051030906370 | Brand |
| GNP ULTRA COMFORT INSULIN SYRINGE/1ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2" | 97051030906370 | Brand |
| INSULIN SYRINGES/U-100/1ML/28GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2" | 97051030906370 | Brand |
| LEADER INSULIN SYRINGE/1ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2" | 97051030906370 | Brand |
| LITETOUCH INSULIN SYRINGE/U-100/1ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2" | 97051030906370 | Brand |
| MAXI-COMFORT INSULIN SYRINGE/U-100/1ML/28GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2" | 97051030906370 | Brand |
| MONOJECT INSULIN SYRINGE/PERM NEEDLE/1ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2" | 97051030906370 | Brand |
| MONOJECT INSULIN SYRINGE/U-100/1ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2" | 97051030906370 | Brand |
| MONOJECT ULTRA COMFORT INSULIN SYRINGE/1ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2" | 97051030906370 | Brand |
| PREFERRED PLUS INSULIN SYRINGE/U-100/1ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2" | 97051030906370 | Brand |
| PRODIGY INSULIN SYRINGE/1ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2" | 97051030906370 | Brand |
| REALITY INSULIN SYRINGE/U-100/1ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2" | 97051030906370 | Brand |
| SURE COMFORT INSULIN SYRINGE/U-100/1ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2" | 97051030906370 | Brand |
| TRUEPLUS INSULIN SYRINGE/U-100/1ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2" | 97051030906370 | Brand |
| ULTICARE INSULIN SYRINGE/1ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2" | 97051030906370 | Brand |
| ADVOCATE INSULIN SYRINGE/U-100/1ML/29GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |

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|---|---|---|---|
| AQ INSULIN SYRINGE/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| DROPLET INSULIN SYRINGE 1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 29GX12.5MM 1ML | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| EASY TOUCH FLIPLOCK SAFETY INSULIN SYRINGE 1ML/29GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| EASY TOUCH INSULIN SYRINGE/SAFETY/U-100/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| EASY TOUCH INSULIN SYRINGE/U-100/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| EASY TOUCH SHEATHLOCK SAFETY INSULIN SYRINGE 1ML/29GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| EQL INSULIN SYRINGE/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| GLOBAL INJECT EASE INSULIN SYRINGE/U-100/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| GNP INSULIN SYRINGE/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| GNP INSULIN SYRINGES/1ML/29GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| INSULIN SYRINGE/NEEDLE 1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| INSULIN SYRINGE/U-100/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| INSULIN SYRINGE/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| INSULIN SYRINGES/U-100/1ML/29GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| KROGER INSULIN SYRINGE/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| LEADER INSULIN SYRINGE/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| LITETOUCH INSULIN SYRINGE/U-100/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| MAGELLAN INSULIN SAFETY SYRINGE/U-100/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| MONOJECT INSULIN SYRINGE/SAFETY/PERM NEEDLE/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |

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|---|---|---|---|
| MONOJECT ULTRA COMFORT INSULIN SYRINGE/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| PREFERRED PLUS INSULIN SYRINGE/U-100/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| RA INSULIN SYRINGE/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| REALITY INSULIN SYRINGE/U-100/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| SB INSULIN SYRINGE/U-100/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| SECURESAFE SAFETY INSULIN SYRINGES/U-100/1ML/29GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| SURE COMFORT INSULIN SYRINGE/U-100/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| TECHLITE INSULIN SYRINGE U-100/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| TOPCARE ULTRA COMFORT INSULIN SYRINGE/U-100/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| TRUEPLUS INSULIN SYRINGE /U-100/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| ULTICARE INSULIN SAFETY SYRINGE/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| ULTICARE INSULIN SYRINGE/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| ULTRA FLO INSULIN SYRINGE 1M/29GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| ULTRA-THIN II INSULIN SYRINGE/U-100/1ML/29GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| VALUE HEALTH INSULIN SYRINGE/U-100/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| VANISHPOINT INSULIN SYRINGE/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| VERIFINE INSULIN SYRINGE 1ML/29G X 12MM | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| CARETOUCH INSULIN SYRINGE/U-100/1ML/29G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 5/16" | 97051030906382 | Brand |
| VANISHPOINT INSULIN SYRINGE/1ML/29G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 5/16" | 97051030906382 | Brand |
| ADVOCATE INSULIN SYRINGE/U-100/1ML/30GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| CARETOUCH INSULIN SYRINGE/1ML/30GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |

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|---|---|---|---|
| DROPLET INSULIN SYRINGE U-100/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| EASY COMFORT INSULIN SYRINGE/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| EASY TOUCH FLIPLOCK SAFETY INSULIN SYRINGE 1ML/30GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| EASY TOUCH INSULIN SYRINGE/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| EASY TOUCH SHEATHLOCK SAFETY INSULIN SYRINGE 1ML/30GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| EQL INSULIN SYRINGE/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| GLOBAL INJECT EASE INSULIN SYRINGE/U-100/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| GLUCOPRO INSULIN SYRINGE/U-100/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| GNP INSULIN SYRINGE/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| GNP INSULIN SYRINGES/1ML/30GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| HEALTHWISE INSULIN SYRINGE/U-100/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| INSULIN SYRINGE/NEEDLE 1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| INSULIN SYRINGE/U-100/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| INSULIN SYRINGE/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| KROGER INSULIN SYRINGE/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| LEADER INSULIN SYRINGE/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| LITETOUCH INSULIN SYRINGE/U-100/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| LITETOUCH INSULIN SYRINGE/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| MAGELLAN INSULIN SAFETY SYRINGE/U-100/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| MM INSULIN SYRINGE/U-100/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| MONOJECT INSULIN SYRINGE/U-100/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| PREFERRED PLUS INSULIN SYRINGE/U-100/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |

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|---|---|---|---|
| PRO COMFORT INSULIN SYRINGES/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| RA INSULIN SYRINGE/U-100/1 ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| SB INSULIN SYRINGE/U-100/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| SURE COMFORT INSULIN SYRINGE/U-100/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| TOPCARE ULTRA COMFORT INSULIN SYRINGE/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| TRUE COMFORT PRO INSULIN SYRINGE/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| TRUEPLUS INSULIN SYRINGE/U-100/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| ULTICARE INSULIN SYRINGE/SHORT/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| ULTICARE INSULIN SYRINGE/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| ULTRA FLO INSULIN SYRINGE 1ML/30GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| ULTRA-THIN II INSULIN SYRINGE SHORT/U-100/1ML/30GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| ULTRACARE INSULIN SYRINGE/U-100/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| VANISHPOINT INSULIN SYRINGE/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| ZEVRX INSULIN SYRINGE/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16" | 97051030906384 | Brand |
| BD INSULIN SYRINGE ULTRA FINE/1ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| BD INSULIN SYRINGE ULTRA-FINE/1ML/30G X 12.7MM | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| BD INSULIN SYRINGE ULTRAFINE/1ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| CAREONE INSULIN SYRINGES/1ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/1.0ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| DROPLET INSULIN SYRINGE U-100/1ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| DROPLET INSULIN SYRINGE/U-100/1ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| EASY COMFORT INSULIN SYRINGE/U-100/1ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| EASY TOUCH FLIPLOCK SAFETY INSULIN SYRINGE 1ML/30GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |

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|---|---|---|---|
| EASY TOUCH INSULIN SYRINGE/SAFETY/U-100/1ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| EASY TOUCH INSULIN SYRINGE/U-100/1ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| EASY TOUCH SHEATHLOCK SAFETY SYRINGE 1ML/30GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| GLOBAL INJECT EASE INSULIN SYRINGE/U-100/1ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| GLUCOPRO INSULIN SYRINGE/U-100/1ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| HM ULTICARE INSULIN SYRINGE/1ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| INSULIN SYRINGES/U-100/1ML/30GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| PRO COMFORT INSULIN SYRINGES/1ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| SURE COMFORT INSULIN SYRINGE/U-100/1ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| TECHLITE INSULIN SYRINGE U-100/1ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| TRUE COMFORT PRO INSULIN SYRINGE/U-100/1ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| ULTICARE INSULIN SYRINGE/U-100/1ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| ULTICARE INSULIN SYRINGE/1ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| ULTIGUARD SAFEPACK INSULIN SYRINGE 1ML 30G X 1/2"/SHARPS CON | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| ULTRA FLO INSULIN SYRINGE 1ML/30GX1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| ULTRACARE INSULIN SYRINGE/U-100/1ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| ZEVRX INSULIN SYRINGE/1ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2" | 97051030906386 | Brand |
| ADVOCATE INSULIN SYRINGE/U-100/1ML/31GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| AQ INSULIN SYRINGE/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| BD INSULIN SYRINGE ULTRA-FINE/1ML/31G X 8MM | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| BD INSULIN SYRINGE ULTRAFINE/U-100/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| CAREONE INSULIN SYRINGES/1ML/31GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |

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|---|---|---|---|
| CARETOUCH INSULIN SYRINGE/1ML/31GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/U-100/1ML/31GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| COMFORT EZ INSULIN SYRINGE/U-100/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| DROPLET INSULIN SYRINGE U-100/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| DROPLET INSULIN SYRINGE/U-100/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 31GX8MM 1ML | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| EASY COMFORT INSULIN SYRINGE/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| EASY TOUCH FLIPLOCK SAFETY INSULIN SYRINGE 1ML/31GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| EASY TOUCH INSULIN SYRINGE/U-100/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| EASY TOUCH SHEATHLOCK SAFETY INSULIN SYRINGE 1ML/31GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| EQL INSULIN SYRINGE/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| FIFTY50 SUPERIOR COMFORT INSULIN SYRINGE/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| GLOBAL INJECT EASE INSULIN SYRINGE/U-100/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| GLUCOPRO INSULIN SYRINGE/U-100/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| GNP INSULIN SYRINGE/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| HEALTHWISE INSULIN SYRINGE/U-100/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| INSULIN SYRINGE/NEEDLE 1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| INSULIN SYRINGE/U-100/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| INSULIN SYRINGES/U-100/1ML/31GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| KINRAY INSULIN SYRINGE PREFERRED PLUS/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| KROGER INSULIN SYRINGE/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |

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|---|---|---|---|
| LEADER INSULIN SYRINGE/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| LITETOUCH INSULIN SYRINGE/U-100/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| MM INSULIN SYRINGE/U-100/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| MONOJECT INSULIN SYRINGE/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| MS INSULIN SYRINGE/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| PRO COMFORT INSULIN SYRINGES/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| RELION INSULIN SYRINGE/U-100/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| SB INSULIN SYRINGE/U-100/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| SURE COMFORT INSULIN SYRINGE/U-100/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| TECHLITE INSULIN SYRINGE U-100/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| TOPCARE ULTRA COMFORT INSULIN SYRINGE/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| TRUE COMFORT INSULIN SYRINGE/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| TRUE COMFORT PRO INSULIN SYRINGE/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| TRUEPLUS INSULIN SYRINGE/U-100/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| ULTICARE INSULIN SYRINGE ULTRAFINE U-100/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| ULTICARE INSULIN SYRINGE/SHORT/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| ULTICARE INSULIN SYRINGE/U-100/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| ULTIGUARD SAFEPACK INSULIN SYRINGE 1ML 31G X 5/16"/SHARPS CO | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| ULTRA FLO INSULIN SYRINGE 1ML/31GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| ULTRA-THIN II INSULIN SYRINGE SHORT/U-100/1ML/31GX5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| ULTRACARE INSULIN SYRINGE/U-100/1ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |
| VERIFINE INSULIN SYRINGE 1ML/31G X 8MM | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16" | 97051030906387 | Brand |

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|---|---|---|---|
| ADVOCATE INSULIN SYRINGE/U-100/0.3ML/31GX5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| CAREONE INSULIN SYRINGES/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| CARETOUCH INSULIN SYRINGE/0.3ML/31GX5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| COMFORT ASSIST INSULIN SYRINGE/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| DROPLET INSULIN SYRINGE U-100/0.3/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| DROPLET INSULIN SYRINGE/U-100/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 31GX8MM 0.3ML | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| EASY COMFORT INSULIN SYRINGE/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| EASY TOUCH INSULIN SYRINGE/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| EQL INSULIN SYRINGE/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| FIFTY50 SUPERIOR COMFORT INSULIN SYRINGE/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| GLOBAL EASY GLIDE INSULINSYRINGE/U-100/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| GLUCOPRO INSULIN SYRINGE/U-100/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| GNP INSULIN SYRINGE/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| GNP INSULIN SYRINGES/3ML/31GX5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| HEALTHWISE INSULIN SYRINGE/U-100/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| HM ULTICARE INSULIN SYRINGE/U-100/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| INSULIN SYRINGE/NEEDLE 0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| INSULIN SYRINGE/U-100/1ML/30G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |

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|---|---|---|---|
| INSULIN SYRINGE/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| KINRAY INSULIN SYRINGE PREFERRED PLUS/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| KROGER INSULIN SYRINGE/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| LEADER INSULIN SYRINGE/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| LITETOUCH INSULIN SYRINGE/U-100/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| LITETOUCH INSULIN SYRINGE/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| MM INSULIN SYRINGE/U-100/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| MS INSULIN SYRINGE/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| PRODIGY INSULIN SYRING/U-100/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| RELION INSULIN SYRINGE/U-100/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| SURE COMFORT INSULIN SYRINGE/U-100/0.3ML/31G X 5/16 | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| SURE COMFORT INSULIN SYRINGE/U-100/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| TECHLITE INSULIN SYRINGE U-100/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| TOPCARE ULTRA COMFORT INSULIN SYRINGE/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| TRUEPLUS INSULIN SYRINGE/U-100/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| ULTICARE INSULIN SYRINGE ULTRAFINE U-100/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| ULTICARE INSULIN SYRINGE/SHORT/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| ULTICARE INSULIN SYRINGE/U-100/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| ULTIGUARD SAFEPACK INSULIN SYRINGE/0.3ML/31G X 5/16"/SHARPS | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| ULTRA FLO INSULIN SYRINGE 0.3ML/31GX5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |

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| ULTRA FLO INSULIN SYRINGE 1/2 UNIT/0.3ML/31GX5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| ULTRA-THIN II INSULIN SYRINGE SHORT/U-100/0.3ML/31GX5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| ULTRACARE INSULIN SYRINGE/U-100/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| VERIFINE INSULIN SYRINGE 0.3ML/31G X 8MM | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| ASSURE ID INSULIN SAFETY SYRINGE U-100/0.5ML/31G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64" | 97051030906391 | Brand |
| DROPLET INSULIN SYRINGE/U-100/0.5ML/31G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64" | 97051030906391 | Brand |
| DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 31GX6MM 0.5ML | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64" | 97051030906391 | Brand |
| GLOBAL EASY GLIDE INSULIN SYRINGE/0.5ML/31G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64" | 97051030906391 | Brand |
| RELION INSULIN SYRINGE 0.5ML/31G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64" | 97051030906391 | Brand |
| TECHLITE INSULIN SYRINGE U-100/0.5ML/31G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64" | 97051030906391 | Brand |
| ASSURE ID INSULIN SAFETY SYRINGE/1ML/31G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64" | 97051030906399 | Brand |
| DROPLET INSULIN SYRINGE U-100/1ML/31G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64" | 97051030906399 | Brand |
| DROPLET INSULIN SYRINGE/U-100/1ML/31G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64" | 97051030906399 | Brand |
| DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 31GX6MM 1ML | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64" | 97051030906399 | Brand |
| GLOBAL EASY GLIDE INSULIN SYRINGE/1ML/31G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64" | 97051030906399 | Brand |
| RELION INSULIN SYRINGE 1ML/31GX15/64" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64" | 97051030906399 | Brand |
| RELION INSULIN SYRINGE/U-100/1ML/31G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64" | 97051030906399 | Brand |
| TECHLITE INSULIN SYRINGE U-100/1ML/31G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64" | 97051030906399 | Brand |
| EMBRACE PEN NEEDLES/29G X 12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| VERIFINE INSULIN PEN NEEDLE 29G X 12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| EMBRACE PEN NEEDLES/30G X 5MM | INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16") | 97051050146340 | Brand |
| COMFORT EZ PRO SAFETY PEN NEEDLES 30G X 8MM | INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16") | 97051050146344 | Brand |

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| EMBRACE PEN NEEDLES/30G X 8MM | INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16") | 97051050146344 | Brand |
| PEN NEEDLES | INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16") | 97051050146344 | Brand |
| AUM INSULIN SAFETY PEN NEEDLE/31GX4MM | INSULIN PEN NEEDLE 31 G X 4 MM (1/6" OR 5/32") | 97051050146354 | Brand |
| COMFORT EZ PRO SAFETY PEN NEEDLES 31G X 4MM | INSULIN PEN NEEDLE 31 G X 4 MM (1/6" OR 5/32") | 97051050146354 | Brand |
| AQINJECT PEN NEEDLE/31G X 3/16" | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| AUM INSULIN SAFETY PEN NEEDLE/31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| COMFORT EZ PRO SAFETY PEN NEEDLES 31G X 5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| EMBRACE PEN NEEDLES/31G X 5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| PEN NEEDLES 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| PIP PEN NEEDLES 31G X 5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| PURE COMFORT SAFETY PEN NEEDLE 31G X 5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| TRUE COMFORT SAFETY PEN NEEDLES 31G X 5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| VERIFINE INSULIN PEN NEEDLE 31G X 5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| VERIFINE PLUS INSULIN PEN NEEDLE 31G X 5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| EMBRACE PEN NEEDLES/31G X 6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| PEN NEEDLES/31G X 1/4" | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| PEN NEEDLES/31G X 6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| PENTIPS 31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| PREVENT DROPSAFE SAFETY PEN NEEDLES 31GX1/4" | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| PREVENT SAFETY PEN NEEDLES 31GX1/4" | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| PURE COMFORT SAFETY PEN NEEDLE 31G X 6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| PX EXTRA SHORT PEN NEEDLES 31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| QC PEN NEEDLES 31G X 6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |

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|---|---|---|---|
| RAYA SURE PEN NEEDLE 31G X 6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| RELION MINI PEN NEEDLES 31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| RELION PEN NEEDLES 31G X 6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| RELION PEN NEEDLES 31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| RELION PEN NEEDLES/31G X 1/4" | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| SURE COMFORT AUTOKEEPER SAFETY PEN NEEDLES 31GX1/4" | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| TECHLITE PEN NEEDLES/31G X 6 MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| TOPCARE CLICKFINE UNIVERSAL PEN EEDLES 31GX1/4" | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| TRUE COMFORT PEN NEEDLES 31G X 6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| TRUE COMFORT PRO PEN NEEDLES 31G X 6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| TRUE COMFORT SAFETY PEN NEEDLES 31G X 6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| TRUEPLUS PEN NEEDLES 31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| TRUEPLUS 5-BEVEL PEN NEEDLES 31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| ULTICARE MICRO PEN NEEDLES/31G X 1/4" | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| ULTICARE MINI PEN NEEDLES ULTI-FINE IV | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| ULTICARE MINI PEN NEEDLES 31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| ULTICARE MINI PEN NEEDLES/31G X 6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| ULTICARE MINI PEN NEEDLES31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| ULTIGUARD SAFEPACK/MINI PEN NEEDLE/31G X 1/4"/SHARPS CONTAIN | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| ULTIGUARD SAFEPACK/MINI PEN NEEDLE/31G X 6MM/SHARPS CONTAIN | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| ULTRACARE PEN NEEDLES/31G X 1/4" | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| UNIFINE PENTIPS PLUS 31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |

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| UNIFINE PENTIPS 31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| UNIFINE ULTRA PEN NEEDLE/31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| WEGMANS UNIFINE PENTIPS PLUS/ULTRA SHORT/31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| ZEVRX PEN NEEDLES 31G X 6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| 1ST TIER UNIFINE PENTIPS PLUS/ULTRA SHORT/31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| 1ST TIER UNIFINE PENTIPS 31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| ABOUTTIME PEN NEEDLES 31G X 5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| ADVOCATE INSULIN PEN NEEDLES 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| AURORA PEN NEEDLES 31G X 8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| CAREFINE PEN NEEDLES 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| CAREONE UNIFINE PENTIPS PLUS PEN NEEDLES 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| CARETOUCH PEN NEEDLES 31GX 8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| CLEVER CHOICE COMFORT EZ INSULIN PEN NEEDLES 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| CLEVER CHOICE COMFORT EZ PEN NEEDLES 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| CLICKFINE PEN NEEDLE UNIVERSAL/31GX5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| CLICKFINE PEN NEEDLES 31G X 5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| CLICKFINE PEN NEEDLES 31G X 8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| CLICKFINE UNIVERSAL PEN NEEDLES 31GX5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| COMFORT EZ SHORT/31G X 8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| COMFORT TOUCH PEN NEEDLES/31G X 8 MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| DIATHRIVE PEN NEEDLE/31 GX 8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| DROPLET PEN NEEDLES 31G X5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| DROPLET PEN NEEDLES 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |

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| DROPSAFE SAFETY PEN NEEDLES/31G X 5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| DRUG MART UNIFINE PENTIPS31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| EASY COMFORT PEN NEEDLES 31GX5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| EASY TOUCH PEN NEEDLES 31GX5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| EMBRACE PEN NEEDLES/31G X 8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| FIFTY50 PEN NEEDLES 31G X5/16" (8MM) | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| FIFTY50 PEN NEEDLES/31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| GLOBAL EASE INJECT PEN NEEDLES 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| GNP CLICKFINE UNIVERSAL PEN NEEDLES 31GX5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| GNP ULTICARE PEN NEEDLES /31GX5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| GNP ULTIGUARD SAFEPACK/SHORT PEN NEEDLE/31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| GOODSENSE PEN NEEDLE/PENFINE CLASSIC/31G X 5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| H-E-B IN CONTROL PEN NEEDLES 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| H-E-B IN CONTROL UNIFINE PENTIPS PLUS 31GX5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| HEALTHWISE SHORT PEN NEEDLES/31G X 5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| HM ULTICARE SHORT PEN NEEDLES 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| INCONTROL ULTICARE MINI PEN NEEDLES/31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| INSUPEN ULTRAFIN 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| INSUPEN 31G X 8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| KROGER PEN NEEDLES 31G X 8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| KROGER PEN NEEDLES/31G X 5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| LEADER UNIFINE PENTIPS PLUS/SHORT/31GX5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |

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|---|---|---|---|
| LITETOUCH PEN NEEDLES 31GX8MM SHORT | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| LITETOUCH PEN NEEDLES/31G X 8MM/SHORT | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| MARATHON MEDICAL PENTIPS 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| MEDICINE SHOPPE PEN NEEDLES 31G X 8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| MEIJER PEN NEEDLES 31G X 8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| MM PEN NEEDLES 31G X 5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| PC UNIFINE PENTIPS 31G X 8MM SHORT | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| PEN NEEDLES 31G X 8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| PEN NEEDLES 31GX5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| PEN NEEDLES 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| PEN NEEDLES 31GX8MM (5/16") | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| PEN NEEDLES/31G X 5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| PENTIPS 31G X 8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| PENTIPS 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| PREVENT DROPSAFE SAFETY PEN NEEDLES 31GX5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| PREVENT SAFETY PEN NEEDLES 31GX5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| PRO COMFORT PEN NEEDLES/ 31G X 8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| PX PEN NEEDLE 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| PX SHORTLENGTH PEN NEEDLES/31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| QC PEN NEEDLES 31G X 8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| RA PEN NEEDLES 31G X 8MM 5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| RAYA SURE PEN NEEDLE 31G X 8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| RELION PEN NEEDLES 31G X 8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |

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| RELION PEN NEEDLES 31GX5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| RELION PEN NEEDLES 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| RELION SHORT PEN NEEDLES 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| SURE COMFORT PEN NEEDLES 31GX5/16" (8MM) | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| TECHLITE PEN NEEDLES/31G X 8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| TODAYS HEALTH SHORT PEN NEEDLES 31G X 5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| TOPCARE CLICKFINE UNIVERSAL PEN EEDLES 31GX5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| TRUE COMFORT PRO PEN NEEDLES 31G X 8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| TRUEPLUS PEN NEEDLES 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| TRUEPLUS 5-BEVEL PEN NEEDLES 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| ULTICARE MICRO PEN NEEDLES 31G X 8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| ULTICARE MICRO PEN NEEDLES/31G X 5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| ULTICARE SHORT PEN NEEDLES ULTI-FINE IV | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| ULTICARE SHORT PEN NEEDLES 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| ULTICARE SHORT PEN NEEDLES/31G X 8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| ULTIGUARD SAFEPACK/SHORT PEN NEEDLE/31G X 5/16"/SHARPS CONTA | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| ULTIGUARD SAFEPACK/SHORT PEN NEEDLE/31G X 8MM/SHARPS CONTAIN | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| ULTILET PEN NEEDLE 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| ULTILET SHORT PEN NEEDLES 31GX5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| ULTRA FLO INSULIN PEN NEELE 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| ULTRA-THIN II PEN NEEDLES/SHORT/31GX5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| ULTRACARE PEN NEEDLES/31G X 5/16" | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |

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|---|---|---|---|
| UNIFINE PENTIPS PLUS 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| UNIFINE PENTIPS 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| UNIFINE ULTRA PEN NEEDLE/31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| VERIFINE INSULIN PEN NEEDLE 31G X 8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| VERIFINE PLUS INSULIN PEN NEEDLE 31G X 8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| WEGMANS UNIFINE PENTIPS PLUS/SHORT/31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| ZEVRX PEN NEEDLES 31G X 8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| 1ST TIER UNIFINE PENTIPS PLUS 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| 1ST TIER UNIFINE PENTIPS 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| ABOUTTIME PEN NEEDLE 32G X 5/32" | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| AQINJECT PEN NEEDLE/32G X 5/32" | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| AUM MINI INSULIN PEN NEEDLE/32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| AUM PEN NEEDLE/32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| AUM READYGARD DUO SAFETY PEN NEEDLE/32GX4MM/DUAL AUTO PROTEC | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| CAREFINE PEN NEEDLE 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| CAREONE UNIFINE PENTIPS PLUS PEN NEEDLES 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| CARETOUCH PEN NEEDLES 32GX 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| CLEVER CHOICE COMFORT EZ PEN NEEDLES 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| CLICKFINE PEN NEEDLE 32GX5/32" | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| CLICKFINE PEN NEEDLES 32G X 5/32" | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| COMFORT EZ MICRO/32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| COMFORT TOUCH PEN NEEDLES/32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |

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|---|---|---|---|
| DIATHRIVE PEN NEEDLE/32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| DROPLET PEN NEEDLES 32G X 5/32" | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| DROPLET PEN NEEDLES 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| DRUG MART UNIFINE PENTIPSPLUS 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| DRUG MART UNIFINE PENTIPS32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| EASY COMFORT PEN NEEDLES 32GX5/32" | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| EASY TOUCH PEN NEEDLES 32GX5/32" | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| EMBRACE PEN NEEDLES/32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| FIFTY50 PEN NEEDLES/32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| GLOBAL EASE INJECT PEN NEEDLES 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| GLOBAL EASY GLIDE PEN NEEDLES 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| GNP ULTICARE PEN NEEDLES/32GX 5/32" | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| GNP ULTIGUARD SAFEPACK/MICRO PEN NEEDLE/32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| GOODSENSE PEN NEEDLE/PENFINE CLASSIC/32G X 5/32" | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| H-E-B IN CONTROL PEN NEEDLES/NANO/32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| H-E-B IN CONTROL UNIFINE PENTIPS PLUS 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| H-E-B IN CONTROL UNIFINE PENTIPS PLUS 32GX5/32" | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| HEALTHWISE MICRON PEN NEEDLES/32G X 5/32" | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| INCONTROL ULTICARE MINI PEN NEEDLES/32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| INSUPEN PEN NEEDLES 32G X4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| INSUPEN 32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| KROGER PEN NEEDLES/32G X 5/32" | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |

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|---|---|---|---|
| LEADER UNIFINE PENTIPS/NANO/32GX5/32" | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| LEADER UNIFINE PENTIPS/PLUS/32GX5/32" | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| LITETOUCH INSULIN PEN NEEDLES/32G X 4MM/MINI | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| MARATHON MEDICAL PENTIPS 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| MICRODOT PEN NEEDLE/32G X 4 MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| MM PEN NEEDLES 32G X 5/32" | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| NOVOFINE PLUS PEN NEEDLE 32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| PEN NEEDLES 32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| PEN NEEDLES 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| PEN NEEDLES/32G X 5/32" | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| PENTIPS 32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| PENTIPS 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| PIP PEN NEEDLES 32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| PRO COMFORT PEN NEEDLES/ 32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| PURE COMFORT PEN NEEDLE/32G X4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| PURE COMFORT SAFETY PEN NEEDLE 32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| QC UNIFINE PENTIPS 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| RELION PEN NEEDLES 32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| RELION PEN NEEDLES 32G X 5/32" | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| RELION PEN NEEDLES 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| SURE COMFORT AUTOKEEPER SAFETY PEN NEEDLES 32GX5/32" | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| SURE COMFORT PEN NEEDLES 32GX5/32" | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| SURE COMFORT PEN NEEDLES 32GX5/32" (4MM) | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |

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|---|---|---|---|
| TECHLITE PEN NEEDLES/32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| TRUE COMFORT PEN NEEDLES 32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| TRUE COMFORT PRO PEN NEEDLES 32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| TRUE COMFORT SAFETY PEN NEEDLES 32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| TRUEPLUS PEN NEEDLES 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| TRUEPLUS 5-BEVEL PEN NEEDLES 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| ULTICARE MICRO PEN NEEDLES 32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| ULTICARE MICRO PEN NEEDLES/32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| ULTICARE MICRO PEN NEEDLES/32G X 5/32" | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| ULTIGUARD SAFEPACK/MICRO PEN NEEDLE/32G X 4 MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| ULTIGUARD SAFEPACK/MICRO PEN NEEDLE/32G X 4MM/SHARPS CONTAIN | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| ULTIGUARD SAFEPACK/MICRO PEN NEEDLE/32G X 5/32" | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| ULTIGUARD SAFEPACK/MICRO PEN NEEDLE/32G X 5/32"/SHARPS CNTR | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| ULTIGUARD SAFEPACK/MICRO PEN NEEDLE/32G X 5/32"/SHARPS CONTA | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| ULTILET PEN NEEDLE 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| ULTILET PEN NEEDLE 32GX4MM/SHORT | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| ULTRA FLO INSULIN PEN NEEDLE 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| ULTRA THIN PEN NEEDLES 32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| ULTRACARE PEN NEEDLES/32G X 5/32" | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| UNIFINE PENTIPS PLUS 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| UNIFINE PENTIPS 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| UNIFINE SAFECONTROL PEN NEEDLE 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |

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|---|---|---|---|
| UNIFINE ULTRA PEN NEEDLE/32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| VERIFINE INSULIN PEN NEEDLE 32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| VERIFINE PLUS INSULIN PEN NEEDLES 32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| WEGMANS UNIFINE PENTIPS PLUS 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| ZEVRX PEN NEEDLES 32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| 1ST TIER UNIFINE PENTIPS PLUS 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| 1ST TIER UNIFINE PENTIPS 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| AUM MINI INSULIN PEN NEEDLE/32GX5MM | INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16") | 97051050146367 | Brand |
| AUM PEN NEEDLE/32GX5MM | INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16") | 97051050146367 | Brand |
| CAREFINE PEN NEEDLES 32GX5MM | INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16") | 97051050146367 | Brand |
| CARETOUCH PEN NEEDLES 32GX 5MM | INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16") | 97051050146367 | Brand |
| CLEVER CHOICE COMFORT EZ PEN NEEDLES 32GX5MM | INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16") | 97051050146367 | Brand |
| COMFORT TOUCH PEN NEEDLES/32G X 5MM | INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16") | 97051050146367 | Brand |
| DROPLET PEN NEEDLES 32G X 3/16" | INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16") | 97051050146367 | Brand |
| DROPLET PEN NEEDLES 32GX5MM | INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16") | 97051050146367 | Brand |
| EASY TOUCH PEN NEEDLES 32GX3/16" | INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16") | 97051050146367 | Brand |
| EASY TOUCH 32GX5MM | INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16") | 97051050146367 | Brand |
| PEN NEEDLES 32G X 5MM | INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16") | 97051050146367 | Brand |
| PRO COMFORT PEN NEEDLES/ 32G X 5MM | INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16") | 97051050146367 | Brand |
| PURE COMFORT PEN NEEDLE/32G X 5MM | INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16") | 97051050146367 | Brand |
| TRUE COMFORT PRO PEN NEEDLES 32G X 5MM | INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16") | 97051050146367 | Brand |
| ULTRACARE PEN NEEDLES/32G X 3/16" | INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16") | 97051050146367 | Brand |
| AUM MINI INSULIN PEN NEEDLE/32GX6MM | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |

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|---|---|---|---|
| AUM PEN NEEDLE/32GX6MM | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| CAREFINE PEN NEEDLES 32GX6MM | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| CLEVER CHOICE COMFORT EZ PEN NEEDLES 32GX6MM | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| COMFORT TOUCH PEN NEEDLES/32G X 6MM | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| DROPLET PEN NEEDLES 32G X 1/4" | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| DROPLET PEN NEEDLES 32GX6MM | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| EASY TOUCH PEN NEEDLES 32GX1/4" | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| EASY TOUCH 32GX6MM | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| FIFTY50 PEN NEEDLES/32GX6MM | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| GNP ULTICARE PEN NEEDLES/32GX1/4" | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| GNP ULTIGUARD SAFEPACK/MINI PEN NEEDLE/32GX6MM | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| GOODSENSE PEN NEEDLE/PENFINE CLASSIC/32G X 1/4" | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| INSUPEN SENSITIVE 32GX6MM | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| NOVOFINE PEN NEEDLE 32G X 6MM | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| PEN NEEDLES 32G X 6MM | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| PENTIPS 32GX6MM | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| PRO COMFORT PEN NEEDLES/ 32G X 6MM | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| PURE COMFORT PEN NEEDLE 32G X6MM | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| SURE COMFORT PEN NEEDLES 32GX6MM | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| TECHLITE PEN NEEDLES/32G X 6MM | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| TRUE COMFORT PRO PEN NEEDLES 32G X 6MM | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| ULTICARE MINI PEN NEEDLES/32G X 1/4" | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |

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|---|---|---|---|
| ULTIGUARD SAFEPACK/MINI PEN NEEDLE/32G X 1/4"/SHARPS CONTAIN | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| ULTRACARE PEN NEEDLES/32G X 1/14" | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| UNIFINE PENTIPS 32GX6MM | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| VERIFINE INSULIN PEN NEEDLE 32G X 6MM | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| BD PEN NEEDLE/MICRO/ULTRA-FINE/32G X 6MM | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| 1ST TIER UNIFINE PENTIPS 32GX6MM | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| AUM MINI INSULIN PEN NEEDLE/32GX8MM | INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16") | 97051050146372 | Brand |
| CLEVER CHOICE COMFORT EZ PEN NEEDLES 32GX8MM | INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16") | 97051050146372 | Brand |
| COMFORT TOUCH PEN NEEDLES/32G X 8MM | INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16") | 97051050146372 | Brand |
| DROPLET PEN NEEDLES 32G X 5/16" | INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16") | 97051050146372 | Brand |
| DROPLET PEN NEEDLES 32GX8MM | INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16") | 97051050146372 | Brand |
| INSUPEN SENSITIVE 32GX8MM | INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16") | 97051050146372 | Brand |
| PURE COMFORT PEN NEEDLE 32G X8MM | INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16") | 97051050146372 | Brand |
| TECHLITE PEN NEEDLES/32G X 8MM | INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16") | 97051050146372 | Brand |
| ADVOCATE INSULIN PEN NEEDLES | INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32") | 97051050146376 | Brand |
| AUM MINI INSULIN PEN NEEDLE/33GX4MM | INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32") | 97051050146376 | Brand |
| AUM PEN NEEDLE/33GX4MM | INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32") | 97051050146376 | Brand |
| CAREONE UNIFINE PENTIPS PLUS PEN NEEDLES/33G X 5/32" | INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32") | 97051050146376 | Brand |
| CARETOUCH PEN NEEDLE 33GX5/32" | INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32") | 97051050146376 | Brand |
| CLEVER CHOICE COMFORT EZ INSULIN PEN NEEDLES 33GX4MM | INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32") | 97051050146376 | Brand |
| CLEVER CHOICE COMFORT EZ PEN NEEDLES 33GX4MM | INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32") | 97051050146376 | Brand |
| COMFORT TOUCH PEN NEEDLES/33G X 5/32" | INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32") | 97051050146376 | Brand |

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|---|---|---|---|
| EASY COMFORT PEN NEEDLES 33G X 4MM | INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32") | 97051050146376 | Brand |
| EASY GLIDE PEN NEEDLES 33G X 5/32" | INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32") | 97051050146376 | Brand |
| H-E-B IN CONTROL UNIFINE PENTIPS PLUS 33GX5/32" | INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32") | 97051050146376 | Brand |
| INSUPEN 33GX4MM | INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32") | 97051050146376 | Brand |
| KROGER PEN NEEDLES/33G X 5/32" | INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32") | 97051050146376 | Brand |
| MICRODOT PEN NEEDLE/33G X 4 MM | INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32") | 97051050146376 | Brand |
| PEN NEEDLES 33G X 5/32" | INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32") | 97051050146376 | Brand |
| TRUE COMFORT PRO PEN NEEDLES 33G X 4MM | INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32") | 97051050146376 | Brand |
| ULTRA FLO INSULIN PEN NEEDLE 33GX4MM | INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32") | 97051050146376 | Brand |
| ULTRACARE PEN NEEDLES/33G X 5/32" | INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32") | 97051050146376 | Brand |
| UNIFINE PENTIPS PLUS 33G X 5/32" | INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32") | 97051050146376 | Brand |
| UNIFINE PENTIPS PLUS 33GX4MM | INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32") | 97051050146376 | Brand |
| UNIFINE PENTIPS 33GX4MM | INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32") | 97051050146376 | Brand |
| 1ST TIER UNIFINE PENTIPS PLUS 33GX4MM | INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32") | 97051050146376 | Brand |
| 1ST TIER UNIFINE PENTIPS 33GX4MM | INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32") | 97051050146376 | Brand |
| AUM MINI INSULIN PEN NEEDLE/33GX5MM | INSULIN PEN NEEDLE 33 G X 5 MM (1/5" OR 3/16") | 97051050146377 | Brand |
| AUM PEN NEEDLE/33GX5MM | INSULIN PEN NEEDLE 33 G X 5 MM (1/5" OR 3/16") | 97051050146377 | Brand |
| CLEVER CHOICE COMFORT EZ PEN NEEDLES 33GX5MM | INSULIN PEN NEEDLE 33 G X 5 MM (1/5" OR 3/16") | 97051050146377 | Brand |
| COMFORT TOUCH PEN NEEDLES/33GX 3/16" | INSULIN PEN NEEDLE 33 G X 5 MM (1/5" OR 3/16") | 97051050146377 | Brand |
| EASY COMFORT PEN NEEDLES 33G X 5MM | INSULIN PEN NEEDLE 33 G X 5 MM (1/5" OR 3/16") | 97051050146377 | Brand |
| TRUE COMFORT PRO PEN NEEDLES 33G X 5MM | INSULIN PEN NEEDLE 33 G X 5 MM (1/5" OR 3/16") | 97051050146377 | Brand |
| AUM MINI INSULIN PEN NEEDLE/33GX6MM | INSULIN PEN NEEDLE 33 G X 6 MM (1/4" OR 15/64") | 97051050146378 | Brand |
| AUM PEN NEEDLE/33GX6MM | INSULIN PEN NEEDLE 33 G X 6 MM (1/4" OR 15/64") | 97051050146378 | Brand |

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|---|---|---|---|
| CLEVER CHOICE COMFORT EZ PEN NEEDLES 33GX6MM | INSULIN PEN NEEDLE 33 G X 6 MM (1/4" OR 15/64") | 97051050146378 | Brand |
| COMFORT TOUCH PEN NEEDLES/33GX1/4" | INSULIN PEN NEEDLE 33 G X 6 MM (1/4" OR 15/64") | 97051050146378 | Brand |
| EASY COMFORT PEN NEEDLES 33G X 6MM | INSULIN PEN NEEDLE 33 G X 6 MM (1/4" OR 15/64") | 97051050146378 | Brand |
| TRUE COMFORT PRO PEN NEEDLES 33G X 6MM | INSULIN PEN NEEDLE 33 G X 6 MM (1/4" OR 15/64") | 97051050146378 | Brand |
| CLEVER CHOICE COMFORT EZ PEN NEEDLES 33GX8MM | INSULIN PEN NEEDLE 33 G X 8 MM (1/3" OR 5/16") | 97051050146380 | Brand |
| DROPLET MICRON 34G X 9/64" | INSULIN PEN NEEDLE 34 G X 3.5 MM (9/64") | 97051050146385 | Brand |
| B-D INSULIN SYRINGE ULTRAFINE/0.5ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2" | 97051030906329 | Brand |
| BD INSULIN SYRINGE ULTRA-FINE/0.5ML/30G X 12.7MM | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2" | 97051030906329 | Brand |
| BD INSULIN SYRINGE ULTRAFINE/0.5ML/30G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2" | 97051030906329 | Brand |
| BD INSULIN SYRINGE MICROFINE IV/U-100/1ML/28G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2" | 97051030906370 | Brand |
| B-D INSULIN SYRINGE ULTRAFINE II/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| BD INSULIN SYRINGE ULTRA-FINE/0.3ML/31G X 8MM | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| BD INSULIN SYRINGE ULTRA-FINE/1/2 UNIT/0.3ML/31G X 8MM | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| BD INSULIN SYRINGE ULTRAFINE HALF-UNIT/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| BD INSULIN SYRINGE ULTRAFINE/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| BD SAFETYGLIDE INSULIN SYRINGE/0.3ML/31G X 5/16" | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| BD INSULIN SYRINGE/U-100/1ML/27G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 1/2" | 97051030906350 | Brand |
| BD INSULIN SYRINGE/1ML/27G X 12.7MM | INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 1/2" | 97051030906350 | Brand |
| BD INSULIN SYRINGE MICROFINE IV/U-100/1ML/27G X 5/8" | INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 5/8" | 97051030906360 | Brand |
| BD INSULIN SYRINGE MICROFINE/U-100/1ML/27G X 5/8" | INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 5/8" | 97051030906360 | Brand |
| BD INSULIN SYRINGE SAFETYGLIDE/1ML/29G X 1/2" | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| BD INSULIN SYRINGE/1ML/29G X 12.7MM | INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2" | 97051030906380 | Brand |
| BD INSULIN SYRINGE/U-100/2ML/27.5G X 5/8" | INSULIN SYRINGE/NEEDLE U-100 2 ML 27.5 X 5/8" | 97051030906390 | Brand |

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|---|---|---|---|
| BD SAFETYGLIDE INSULIN SYRINGE/0.5ML/31G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64" | 97051030906391 | Brand |
| BD VEO INSULIN SYRINGE ULTR-FINE/U-100/0.5ML/31G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64" | 97051030906391 | Brand |
| BD VEO INSULIN SYRINGE ULTRA-FINE/0.5ML/31G X 6MM | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64" | 97051030906391 | Brand |
| BD SAFETYGLIDE INSULIN SYRINGE/1ML/31G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64" | 97051030906399 | Brand |
| BD VEO INSULIN SYRINGE ULTRA-FINE/U-100/1ML/31G X 15/64" | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64" | 97051030906399 | Brand |
| BD VEO INSULIN SYRINGE ULTRA-FINE/1ML/31G X 6MM | INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64" | 97051030906399 | Brand |
| BD PEN NEEDLE/SHORT/ULTRA-FINE/31G X 8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| BD PEN NEEDLE/NANO 2ND GEN/32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| BD PEN NEEDLE/NANO 2ND GEN/32G X 5/32" | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| BD PEN NEEDLE/NANO/ULTRA - FINE/32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| ASSURE ID DUO PRO SAFETY PEN NEEDLES 31G X 5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| EASY COMFORT SAFETY PEN NEEDLES 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| PENTIPS GENERIC PEN NEEDLES 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| UNIFINE SAFECONTROL PEN NEEDLE 31GX5MM | INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16") | 97051050146358 | Brand |
| PENTIPS GENERIC PEN NEEDLES 29GX12MM | INSULIN PEN NEEDLE 29 G X 12 MM (1/2") | 97051050146330 | Brand |
| EASY COMFORT SAFETY PEN NEEDLES 31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| PENTIPS GENERIC PEN NEEDLES 31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| UNIFINE SAFECONTROL PEN NEEDLE 31GX6MM | INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64") | 97051050146361 | Brand |
| PENTIPS GENERIC PEN NEEDLES 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| UNIFINE SAFECONTROL PEN NEEDLE 31GX8MM | INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16") | 97051050146364 | Brand |
| ADVOCATE INSULIN PEN NEEDLE/32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| EASY COMFORT SAFETY PEN NEEDLES 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| PENTIPS GENERIC PEN NEEDLES 32GX4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |

| | | | |
|---|---|---|---|
| TECHLITE PLUS PEN NEEDLES32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| ULTIGUARD SAFEPACK/TINY PEN NEEDLE/32G X 4MM/SHARPS CONTAINE | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| UNIFINE PROTECT SAFETY PEN NEEDLE 32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| VERIFINE PLUS PEN NEEDLE/32G X 4MM | INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32") | 97051050146366 | Brand |
| PENTIPS GENERIC PEN NEEDLES 32GX6MM | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| ULTIGUARD SAFEPACK/TINY PEN NEEDLE/32G X 6MM/SHARPS CONTAINE | INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64") | 97051050146368 | Brand |
| UNIFINE PROTECT SAFETY PEN NEEDLE 30G X 8MM | INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16") | 97051050146344 | Brand |
| VERIFINE INSULIN SYRINGE/0.3ML/31G X 8MM | INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16" | 97051030906388 | Brand |
| VERIFINE INSULIN SYRINGE/0.5ML/29G X 12MM | INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2" | 97051030906327 | Brand |

**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 . Revision History

| Date | Notes |
|---|---|
| 10/29/2024 | Updated GPIs and moved PDL link. |

Insulins

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146815 |
| **Guideline Name** | Insulins |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| APIDRA | INSULIN GLULISINE INJ 100 UNIT/ML | 27104004002022 | Brand |
| INSULIN ASPART | INSULIN ASPART INJ SOLN 100 UNIT/ML | 27104002002022 | Brand |
| ADMELOG | INSULIN LISPRO INJ SOLN 100 UNIT/ML | 27104005002022 | Brand |
| HUMALOG | INSULIN LISPRO INJ SOLN 100 UNIT/ML | 27104005002022 | Brand |
| LYUMJEV | INSULIN LISPRO-AABC INJ 100 UNIT/ML | 27104005052020 | Brand |

**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 | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NOVOLOG | INSULIN ASPART INJ SOLN 100 UNIT/ML | 27104002002022 | Brand |
| FIASP | INSULIN ASPART (WITH NIACINAMIDE) INJ 100 UNIT/ML | 27104002202020 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NOVOLOG MIX 70/30 | INSULIN ASPART PROT & ASPART (HUMAN) INJ 100 UNIT/ML (70-30) | 27104070001820 | Brand |
| NOVOLOG MIX 70/30 RELION | INSULIN ASPART PROT & ASPART (HUMAN) INJ 100 UNIT/ML (70-30) | 27104070001820 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| HUMALOG MIX 75/25 | INSULIN LISPRO PROT & LISPRO INJ 100 UNIT/ML (75-25) | 27104080001820 | Brand |

**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 | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| HUMULIN R U-500 (CONCENTRATED) | INSULIN REGULAR (HUMAN) INJ 500 UNIT/ML | 27104010002015 | Brand |

**Approval Criteria**

**1** - Patient requires more than 200 units of insulin per day

| Product Name: Insulin Lispro Kwikpen, Insulin Lispro Junior Kwikpen | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| INSULIN LISPRO JUNIOR KWIKPEN | INSULIN LISPRO SOLN PEN-INJECTOR 100 UNIT/ML (0.5 UNIT DIAL) | 2710400500D221 | Brand |
| INSULIN LISPRO KWIKPEN | INSULIN LISPRO SOLN PEN-INJECTOR 100 UNIT/ML (1 UNIT DIAL) | 2710400500D222 | Brand |

**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 | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| APIDRA SOLOSTAR | INSULIN GLULISINE SOLN PEN-INJECTOR INJ 100 UNIT/ML | 2710400400D220 | Brand |
| INSULIN ASPART FLEXPEN | INSULIN ASPART SOLN PEN-INJECTOR 100 UNIT/ML | 2710400200D220 | Brand |

| | | | |
|---|---|---|---|
| INSULIN ASPART PENFILL | INSULIN ASPART SOLN CARTRIDGE 100 UNIT/ML | 2710400200E220 | Brand |
| ADMELOG SOLOSTAR | INSULIN LISPRO SOLN PEN-INJECTOR 100 UNIT/ML (1 UNIT DIAL) | 2710400500D222 | Brand |
| HUMALOG JUNIOR KWIKPEN | INSULIN LISPRO SOLN PEN-INJECTOR 100 UNIT/ML (0.5 UNIT DIAL) | 2710400500D221 | Brand |
| HUMALOG KWIKPEN | INSULIN LISPRO SOLN PEN-INJECTOR 100 UNIT/ML (1 UNIT DIAL) | 2710400500D222 | Brand |
| HUMALOG KWIKPEN | INSULIN LISPRO SOLN PEN-INJECTOR 200 UNIT/ML | 2710400500D230 | Brand |
| HUMALOG | INSULIN LISPRO SOLN CARTRIDGE 100 UNIT/ML | 2710400500E220 | Brand |
| LYUMJEV KWIKPEN | INSULIN LISPRO-AABC SOLN PEN-INJ 100 UNIT/ML (1 UNIT DIAL) | 2710400505D222 | Brand |
| LYUMJEV KWIKPEN | INSULIN LISPRO-AABC SOLN PEN-INJECTOR 200 UNIT/ML | 2710400505D230 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| HUMALOG TEMPO PEN | INSULIN LISPRO SOLN PEN-INJ W/TRANSMITTER PORT 100 UNIT/ML | 2710400500D224 | Brand |
| LYUMJEV TEMPO PEN | INSULIN LISPRO-AABC SOLN PEN-INJ W/TRANSMIT PORT 100 UNIT/ML | 2710400505D224 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NOVOLOG FLEXPEN | INSULIN ASPART SOLN PEN-INJECTOR 100 UNIT/ML | 2710400200D220 | Brand |
| NOVOLOG PENFILL | INSULIN ASPART SOLN CARTRIDGE 100 UNIT/ML | 2710400200E220 | Brand |
| FIASP FLEXTOUCH | INSULIN ASPART (WITH NIACINAMIDE) SOL PEN-INJ 100 UNIT/ML | 2710400220D220 | Brand |
| FIASP PENFILL | INSULIN ASPART (WITH NIACINAMIDE) SOLN CARTRIDGE 100 UNIT/ML | 2710400220E220 | Brand |
| FIASP PUMPCART | INSULIN ASPART (WITH NIACINAMIDE) SOLN CARTRIDGE 100 UNIT/ML | 2710400220E220 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NOVOLIN R FLEXPEN RELION | INSULIN REGULAR (HUMAN) SOLN PEN-INJECTOR 100 UNIT/ML | 2710401000D220 | Brand |
| NOVOLIN R FLEXPEN | INSULIN REGULAR (HUMAN) SOLN PEN-INJECTOR 100 UNIT/ML | 2710401000D220 | Brand |

**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 R U-500 Kwikpen | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| HUMULIN R U-500 KWIKPEN | INSULIN REGULAR (HUMAN) SOLN PEN-INJECTOR 500 UNIT/ML | 2710401000D250 | Brand |

**Approval Criteria**

**1** - BOTH of the following:

**1.1** Patient requires more than 200 units of insulin per day

**AND**

**1.2** ONE of the following:

**1.2.1** Failure to Humulin R U-500 vial confirmed by claims history or submission of medical records

**OR**

**1.2.2** History of contraindication or intolerance to Humulin R U-500 vial (please specify intolerance or contraindication)

**OR**

**2** - BOTH of the following:

**2.1** Patient requires more than 200 units of insulin per day

**AND**

**2.2** ONE of the following:

**2.2.1** A visual impairment that prevents the patient from using a vial and syringe to accurately draw up the dose of insulin

**OR**

**2.2.2** 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**

**2.2.3** 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| HUMULIN N KWIKPEN | INSULIN NPH (HUMAN) (ISOPHANE) SUSP PEN-INJECTOR 100 UNIT/ML | 2710402000D320 | Brand |
| NOVOLIN N FLEXPEN RELION | INSULIN NPH (HUMAN) (ISOPHANE) SUSP PEN-INJECTOR 100 UNIT/ML | 2710402000D320 | Brand |

| | | | |
|---|---|---|---|
| NOVOLIN N FLEXPEN | INSULIN NPH (HUMAN) (ISOPHANE) SUSP PEN-INJECTOR 100 UNIT/ML | 2710402000D320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| HUMALOG MIX 50/50 KWIKPEN | INSULIN LISPRO PROT & LISPRO SUS PEN-INJ 100 UNIT/ML (50-50) | 2710408000D340 | Brand |
| INSULIN ASPART PROTAMINE/INSULIN ASPART FLEXPEN | INSULIN ASPART PROT & ASPART SUS PEN-INJ 100 UNIT/ML (70-30) | 2710407000D320 | Brand |
| HUMULIN 70/30 KWIKPEN | INSULIN NPH & REGULAR SUSP PEN-INJ 100 UNIT/ML (70-30) | 2710409000D320 | Brand |
| NOVOLIN 70/30 FLEXPEN | INSULIN NPH & REGULAR SUSP PEN-INJ 100 UNIT/ML (70-30) | 2710409000D320 | Brand |
| NOVOLIN 70/30 FLEXPEN RELION | INSULIN NPH & REGULAR SUSP PEN-INJ 100 UNIT/ML (70-30) | 2710409000D320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NOVOLOG MIX 70/30 PREFILLED FLEXPEN | INSULIN ASPART PROT & ASPART SUS PEN-INJ 100 UNIT/ML (70-30) | 2710407000D320 | Brand |
| NOVOLOG MIX 70/30 PREFILLED FLEXPEN RELION | INSULIN ASPART PROT & ASPART SUS PEN-INJ 100 UNIT/ML (70-30) | 2710407000D320 | Brand |

**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 72/25 | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| HUMALOG MIX 75/25 KWIKPEN | INSULIN LISPRO PROT & LISPRO SUS PEN-INJ 100 UNIT/ML (75-25) | 2710408000D320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SEMGLEE | INSULIN GLARGINE-YFGN SOLN PEN-INJECTOR 100 UNIT/ML | 2710400390D220 | Brand |
| INSULIN GLARGINE SOLOSTAR | INSULIN GLARGINE SOLN PEN-INJECTOR 100 UNIT/ML | 2710400300D220 | Brand |
| BASAGLAR KWIKPEN | INSULIN GLARGINE SOLN PEN-INJECTOR 100 UNIT/ML | 2710400300D220 | Brand |
| INSULIN GLARGINE-YFGN | INSULIN GLARGINE-YFGN SOLN PEN-INJECTOR 100 UNIT/ML | 2710400390D220 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BASAGLAR TEMPO PEN | INSULIN GLARGINE PEN-INJ WITH TRANSMITTER PORT 100 UNIT/ML | 2710400300D222 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TOUJEO SOLOSTAR | INSULIN GLARGINE SOLN PEN-INJECTOR 300 UNIT/ML (1 UNIT DIAL) | 2710400300D233 | Brand |
| TOUJEO MAX SOLOSTAR | INSULIN GLARGINE SOLN PEN-INJECTOR 300 UNIT/ML (2 UNIT DIAL) | 2710400300D236 | Brand |
| INSULIN GLARGINE SOLOSTAR | INSULIN GLARGINE SOLN PEN-INJECTOR 300 UNIT/ML (1 UNIT DIAL) | 2710400300D233 | Brand |
| INSULIN GLARGINE MAX SOLOSTAR | INSULIN GLARGINE SOLN PEN-INJECTOR 300 UNIT/ML (2 UNIT DIAL) | 2710400300D236 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| INSULIN DEGLUDEC FLEXTOUCH | INSULIN DEGLUDEC SOLN PEN-INJECTOR 100 UNIT/ML | 2710400700D210 | Brand |
| LEVEMIR FLEXPEN | INSULIN DETEMIR SOLN PEN-INJECTOR 100 UNIT/ML | 2710400600D220 | Brand |

**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 |
|---|---|

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TRESIBA FLEXTOUCH | INSULIN DEGLUDEC SOLN PEN-INJECTOR 100 UNIT/ML | 2710400700D210 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| INSULIN DEGLUDEC FLEXTOUCH | INSULIN DEGLUDEC SOLN PEN-INJECTOR 200 UNIT/ML | 2710400700D220 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TRESIBA FLEXTOUCH | INSULIN DEGLUDEC SOLN PEN-INJECTOR 200 UNIT/ML | 2710400700D220 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SEMGLEE | INSULIN GLARGINE-YFGN INJ 100 UNIT/ML | 27104003902020 | Brand |
| INSULIN GLARGINE | INSULIN GLARGINE INJ 100 UNIT/ML | 27104003002020 | Brand |
| INSULIN GLARGINE-YFGN | INSULIN GLARGINE-YFGN INJ 100 UNIT/ML | 27104003902020 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LEVEMIR | INSULIN DETEMIR INJ 100 UNIT/ML | 27104006002020 | Brand |
| INSULIN DEGLUDEC | INSULIN DEGLUDEC INJ 100 UNIT/ML | 27104007002020 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TRESIBA | INSULIN DEGLUDEC INJ 100 UNIT/ML | 27104007002020 | Brand |

**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 72/25, 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

| | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Quantity Limit |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ADMELOG SOLOSTAR | INSULIN LISPRO SOLN PEN-INJECTOR 100 UNIT/ML (1 UNIT DIAL) | 2710400500D222 | Brand |
| APIDRA | INSULIN GLULISINE INJ 100 UNIT/ML | 27104004002022 | Brand |
| INSULIN ASPART | INSULIN ASPART INJ SOLN 100 UNIT/ML | 27104002002022 | Brand |
| INSULIN LISPRO | INSULIN LISPRO INJ SOLN 100 UNIT/ML | 27104005002022 | Brand |
| HUMALOG | INSULIN LISPRO INJ SOLN 100 UNIT/ML | 27104005002022 | Brand |
| NOVOLOG | INSULIN ASPART INJ SOLN 100 UNIT/ML | 27104002002022 | Brand |
| FIASP | INSULIN ASPART (WITH NIACINAMIDE) INJ 100 UNIT/ML | 27104002202020 | Brand |
| LYUMJEV | INSULIN LISPRO-AABC INJ 100 UNIT/ML | 27104005052020 | Brand |
| NOVOLOG MIX 70/30 | INSULIN ASPART PROT & ASPART (HUMAN) INJ 100 UNIT/ML (70-30) | 27104070001820 | Brand |

| | | | |
|---|---|---|---|
| HUMULIN R U-500 (CONCENTRATED) | INSULIN REGULAR (HUMAN) INJ 500 UNIT/ML | 27104010002015 | Brand |
| APIDRA SOLOSTAR | INSULIN GLULISINE SOLN PEN-INJECTOR INJ 100 UNIT/ML | 2710400400D220 | Brand |
| INSULIN ASPART FLEXPEN | INSULIN ASPART SOLN PEN-INJECTOR 100 UNIT/ML | 2710400200D220 | Brand |
| INSULIN ASPART PENFILL | INSULIN ASPART SOLN CARTRIDGE 100 UNIT/ML | 2710400200E220 | Brand |
| INSULIN LISPRO JUNIOR KWIKPEN | INSULIN LISPRO SOLN PEN-INJECTOR 100 UNIT/ML (0.5 UNIT DIAL) | 2710400500D221 | Brand |
| INSULIN LISPRO KWIKPEN | INSULIN LISPRO SOLN PEN-INJECTOR 100 UNIT/ML (1 UNIT DIAL) | 2710400500D222 | Brand |
| HUMALOG JUNIOR KWIKPEN | INSULIN LISPRO SOLN PEN-INJECTOR 100 UNIT/ML (0.5 UNIT DIAL) | 2710400500D221 | Brand |
| HUMALOG KWIKPEN | INSULIN LISPRO SOLN PEN-INJECTOR 100 UNIT/ML (1 UNIT DIAL) | 2710400500D222 | Brand |
| HUMALOG KWIKPEN | INSULIN LISPRO SOLN PEN-INJECTOR 200 UNIT/ML | 2710400500D230 | Brand |
| HUMALOG | INSULIN LISPRO SOLN CARTRIDGE 100 UNIT/ML | 2710400500E220 | Brand |
| NOVOLOG FLEXPEN | INSULIN ASPART SOLN PEN-INJECTOR 100 UNIT/ML | 2710400200D220 | Brand |
| NOVOLOG PENFILL | INSULIN ASPART SOLN CARTRIDGE 100 UNIT/ML | 2710400200E220 | Brand |
| FIASP FLEXTOUCH | INSULIN ASPART (WITH NIACINAMIDE) SOL PEN-INJ 100 UNIT/ML | 2710400220D220 | Brand |
| FIASP PENFILL | INSULIN ASPART (WITH NIACINAMIDE) SOLN CARTRIDGE 100 UNIT/ML | 2710400220E220 | Brand |
| LYUMJEV KWIKPEN | INSULIN LISPRO-AABC SOLN PEN-INJ 100 UNIT/ML (1 UNIT DIAL) | 2710400505D222 | Brand |
| LYUMJEV KWIKPEN | INSULIN LISPRO-AABC SOLN PEN-INJECTOR 200 UNIT/ML | 2710400505D230 | Brand |
| NOVOLIN R FLEXPEN RELION | INSULIN REGULAR (HUMAN) SOLN PEN-INJECTOR 100 UNIT/ML | 2710401000D220 | Brand |
| NOVOLIN R FLEXPEN | INSULIN REGULAR (HUMAN) SOLN PEN-INJECTOR 100 UNIT/ML | 2710401000D220 | Brand |
| HUMULIN R U-500 KWIKPEN | INSULIN REGULAR (HUMAN) SOLN PEN-INJECTOR 500 UNIT/ML | 2710401000D250 | Brand |
| HUMULIN N KWIKPEN | INSULIN NPH (HUMAN) (ISOPHANE) SUSP PEN-INJECTOR 100 UNIT/ML | 2710402000D320 | Brand |
| NOVOLIN N FLEXPEN RELION | INSULIN NPH (HUMAN) (ISOPHANE) SUSP PEN-INJECTOR 100 UNIT/ML | 2710402000D320 | Brand |
| NOVOLIN N FLEXPEN | INSULIN NPH (HUMAN) (ISOPHANE) SUSP PEN-INJECTOR 100 UNIT/ML | 2710402000D320 | Brand |
| HUMALOG MIX 75/25 KWIKPEN | INSULIN LISPRO PROT & LISPRO SUS PEN-INJ 100 UNIT/ML (75-25) | 2710408000D320 | Brand |

| | | | |
|---|---|---|---|
| HUMALOG MIX 50/50 KWIKPEN | INSULIN LISPRO PROT & LISPRO SUS PEN-INJ 100 UNIT/ML (50-50) | 2710408000D340 | Brand |
| INSULIN ASPART PROTAMINE/INSULIN ASPART FLEXPEN | INSULIN ASPART PROT & ASPART SUS PEN-INJ 100 UNIT/ML (70-30) | 2710407000D320 | Brand |
| HUMULIN 70/30 KWIKPEN | INSULIN NPH & REGULAR SUSP PEN-INJ 100 UNIT/ML (70-30) | 2710409000D320 | Brand |
| NOVOLIN 70/30 FLEXPEN | INSULIN NPH & REGULAR SUSP PEN-INJ 100 UNIT/ML (70-30) | 2710409000D320 | Brand |
| NOVOLOG MIX 70/30 PREFILLED FLEXPEN | INSULIN ASPART PROT & ASPART SUS PEN-INJ 100 UNIT/ML (70-30) | 2710407000D320 | Brand |
| LANTUS SOLOSTAR | INSULIN GLARGINE SOLN PEN-INJECTOR 100 UNIT/ML | 2710400300D220 | Brand |
| TOUJEO SOLOSTAR | INSULIN GLARGINE SOLN PEN-INJECTOR 300 UNIT/ML (1 UNIT DIAL) | 2710400300D233 | Brand |
| TOUJEO MAX SOLOSTAR | INSULIN GLARGINE SOLN PEN-INJECTOR 300 UNIT/ML (2 UNIT DIAL) | 2710400300D236 | Brand |
| SEMGLEE | INSULIN GLARGINE-YFGN SOLN PEN-INJECTOR 100 UNIT/ML | 2710400390D220 | Brand |
| TRESIBA FLEXTOUCH | INSULIN DEGLUDEC SOLN PEN-INJECTOR 100 UNIT/ML | 2710400700D210 | Brand |
| TRESIBA FLEXTOUCH | INSULIN DEGLUDEC SOLN PEN-INJECTOR 200 UNIT/ML | 2710400700D220 | Brand |
| LANTUS | INSULIN GLARGINE INJ 100 UNIT/ML | 27104003002020 | Brand |
| SEMGLEE | INSULIN GLARGINE-YFGN INJ 100 UNIT/ML | 27104003902020 | Brand |
| LEVEMIR | INSULIN DETEMIR INJ 100 UNIT/ML | 27104006002020 | Brand |
| TRESIBA | INSULIN DEGLUDEC INJ 100 UNIT/ML | 27104007002020 | Brand |
| BASAGLAR KWIKPEN | INSULIN GLARGINE SOLN PEN-INJECTOR 100 UNIT/ML | 2710400300D220 | Brand |
| HUMULIN R | INSULIN REGULAR (HUMAN) INJ 100 UNIT/ML | 27104010002005 | Brand |
| NOVOLIN R | INSULIN REGULAR (HUMAN) INJ 100 UNIT/ML | 27104010002005 | Brand |
| NOVOLIN R RELION | INSULIN REGULAR (HUMAN) INJ 100 UNIT/ML | 27104010002005 | Brand |
| HUMULIN N | INSULIN NPH (HUMAN) (ISOPHANE) INJ 100 UNIT/ML | 27104020001805 | Brand |
| NOVOLIN N RELION | INSULIN NPH (HUMAN) (ISOPHANE) INJ 100 UNIT/ML | 27104020001805 | Brand |
| NOVOLIN N | INSULIN NPH (HUMAN) (ISOPHANE) INJ 100 UNIT/ML | 27104020001805 | Brand |
| INSULIN ASPART PROTAMINE/INSULIN ASPART | INSULIN ASPART PROT & ASPART (HUMAN) INJ 100 UNIT/ML (70-30) | 27104070001820 | Brand |

| | | | |
|---|---|---|---|
| HUMALOG MIX 75/25 | INSULIN LISPRO PROT & LISPRO INJ 100 UNIT/ML (75-25) | 27104080001820 | Brand |
| HUMALOG MIX 50/50 | INSULIN LISPRO PROTAMINE & LISPRO INJ 100 UNIT/ML (50-50) | 27104080001840 | Brand |
| HUMULIN 70/30 | INSULIN NPH ISOPHANE & REGULAR HUMAN INJ 100 UNIT/ML (70-30) | 27104090001810 | Brand |
| NOVOLIN 70/30 RELION | INSULIN NPH ISOPHANE & REGULAR HUMAN INJ 100 UNIT/ML (70-30) | 27104090001810 | Brand |
| NOVOLIN 70/30 | INSULIN NPH ISOPHANE & REGULAR HUMAN INJ 100 UNIT/ML (70-30) | 27104090001810 | Brand |
| ADMELOG | INSULIN LISPRO INJ SOLN 100 UNIT/ML | 27104005002022 | Brand |
| INSULIN GLARGINE SOLOSTAR | INSULIN GLARGINE SOLN PEN-INJECTOR 100 UNIT/ML | 2710400300D220 | Brand |
| INSULIN GLARGINE | INSULIN GLARGINE INJ 100 UNIT/ML | 27104003002020 | Brand |
| SEMGLEE | INSULIN GLARGINE INJ 100 UNIT/ML | 27104003002020 | Brand |
| NOVOLOG MIX 70/30 RELION | INSULIN ASPART PROT & ASPART (HUMAN) INJ 100 UNIT/ML (70-30) | 27104070001820 | Brand |
| HUMALOG TEMPO PEN | INSULIN LISPRO SOLN PEN-INJ W/TRANSMITTER PORT 100 UNIT/ML | 2710400500D224 | Brand |
| LYUMJEV TEMPO PEN | INSULIN LISPRO-AABC SOLN PEN-INJ W/TRANSMIT PORT 100 UNIT/ML | 2710400505D224 | Brand |
| NOVOLOG FLEXPEN RELION | INSULIN ASPART SOLN PEN-INJECTOR 100 UNIT/ML | 2710400200D220 | Brand |
| BASAGLAR TEMPO PEN | INSULIN GLARGINE PEN-INJ WITH TRANSMITTER PORT 100 UNIT/ML | 2710400300D222 | Brand |
| LEVEMIR FLEXPEN | INSULIN DETEMIR SOLN PEN-INJECTOR 100 UNIT/ML | 2710400600D220 | Brand |
| INSULIN DEGLUDEC FLEXTOUCH | INSULIN DEGLUDEC SOLN PEN-INJECTOR 100 UNIT/ML | 2710400700D210 | Brand |
| INSULIN DEGLUDEC FLEXTOUCH | INSULIN DEGLUDEC SOLN PEN-INJECTOR 200 UNIT/ML | 2710400700D220 | Brand |
| INSULIN DEGLUDEC | INSULIN DEGLUDEC INJ 100 UNIT/ML | 27104007002020 | Brand |
| NOVOLOG RELION | INSULIN ASPART INJ SOLN 100 UNIT/ML | 27104002002022 | Brand |
| NOVOLOG MIX 70/30 PREFILLED FLEXPEN RELION | INSULIN ASPART PROT & ASPART SUS PEN-INJ 100 UNIT/ML (70-30) | 2710407000D320 | Brand |
| INSULIN LISPRO PROTAMINE/INSULIN LISPRO KWIKPEN | INSULIN LISPRO PROT & LISPRO SUS PEN-INJ 100 UNIT/ML (75-25) | 2710408000D320 | Brand |
| NOVOLIN 70/30 FLEXPEN RELION | INSULIN NPH & REGULAR SUSP PEN-INJ 100 UNIT/ML (70-30) | 2710409000D320 | Brand |
| REZVOGLAR KWIKPEN | INSULIN GLARGINE-AGLR SOLN PEN-INJECTOR 100 UNIT/ML | 2710400305D220 | Brand |

| | | | |
|---|---|---|---|
| FIASP PUMPCART | INSULIN ASPART (WITH NIACINAMIDE) SOLN CARTRIDGE 100 UNIT/ML | 2710400220E220 | Brand |
| INSULIN GLARGINE-YFGN | INSULIN GLARGINE-YFGN INJ 100 UNIT/ML | 27104003902020 | Brand |
| INSULIN GLARGINE-YFGN | INSULIN GLARGINE-YFGN SOLN PEN-INJECTOR 100 UNIT/ML | 2710400390D220 | Brand |
| INSULIN GLARGINE SOLOSTAR | INSULIN GLARGINE SOLN PEN-INJECTOR 300 UNIT/ML (1 UNIT DIAL) | 2710400300D233 | Brand |
| INSULIN GLARGINE MAX SOLOSTAR | INSULIN GLARGINE SOLN PEN-INJECTOR 300 UNIT/ML (2 UNIT DIAL) | 2710400300D236 | Brand |

**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** |
|---|
| **PDL Link:**<br><br>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 |
|---|---|
| 4/30/2024 | Removed PDL links for CORE markets and added PDL link for NM in background section. |

Iqirvo

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-158160 |
| **Guideline Name** | Iqirvo |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 12/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| IQIRVO | ELAFIBRANOR TAB 80 MG | 52780020000320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| IQIRVO | ELAFIBRANOR TAB 80 MG | 52780020000320 | Brand |

**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 |
|---|---|

| | |
|---|---|
| 10/29/2024 | New |

Iressa

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146550 |
| **Guideline Name** | Iressa |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Brand Iressa, generic gefitinib | |
|---|---|
| Diagnosis | Non-Small Cell Lung Cancer (NSCLC) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| IRESSA | GEFITINIB TAB 250 MG | 21360030000320 | Brand |
| GEFITINIB | GEFITINIB TAB 250 MG | 21360030000320 | Generic |

**Approval Criteria**

**1** - Diagnosis of metastatic non-small cell lung cancer (NSCLC)

**AND**

**2** - ONE of the following:

**2.1** Tumors are positive for epidermal growth factor receptor (EGFR) exon 19 deletions

**OR**

**2.2** Tumors are positive for exon 21 (L858R) substitution mutations

**OR**

**2.3** Tumors are positive for a known sensitizing EGFR mutation (e.g, exon 20 S7681 mutation, exon 18 G719X mutation, exon 21 L861Q mutation)

| Product Name: Brand Iressa, generic gefitinib | |
|---|---|
| Diagnosis | Non-Small Cell Lung Cancer (NSCLC) |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| IRESSA | GEFITINIB TAB 250 MG | 21360030000320 | Brand |
| GEFITINIB | GEFITINIB TAB 250 MG | 21360030000320 | Generic |

**Approval Criteria**

**1** - Documentation of positive clinical response to Iressa therapy

Product Name: Brand Iressa, generic gefitinib

| | |
|---|---|
| Diagnosis | Central Nervous System (CNS) Cancers |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| IRESSA | GEFITINIB TAB 250 MG | 21360030000320 | Brand |
| GEFITINIB | GEFITINIB TAB 250 MG | 21360030000320 | Generic |

**Approval Criteria**

**1** - Diagnosis of central nervous system (CNS) cancer with metastatic lesions

**AND**

**2** - Iressa is active against primary (NSCLC) tumor with a known epidermal growth factor receptor (EGFR) sensitizing mutation

| Product Name: Brand Iressa, generic gefitinib | |
|---|---|
| Diagnosis | Central Nervous System (CNS) Cancers |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| IRESSA | GEFITINIB TAB 250 MG | 21360030000320 | Brand |
| GEFITINIB | GEFITINIB TAB 250 MG | 21360030000320 | Generic |

**Approval Criteria**

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

| Product Name: Brand Iressa, generic gefitinib | |
|---|---|
| Diagnosis | NCCN Recommended Regimens |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| IRESSA | GEFITINIB TAB 250 MG | 21360030000320 | Brand |
| GEFITINIB | GEFITINIB TAB 250 MG | 21360030000320 | Generic |

**Approval Criteria**

**1** - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

| Product Name: Brand Iressa, generic gefitinib | |
|---|---|
| Diagnosis | NCCN Recommended Regimens |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| IRESSA | GEFITINIB TAB 250 MG | 21360030000320 | Brand |
| GEFITINIB | GEFITINIB TAB 250 MG | 21360030000320 | Generic |

**Approval Criteria**

**1** - Documentation of positive clinical response to Iressa therapy

Iron Chelators

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146551 |
| **Guideline Name** | Iron Chelators |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Brand Exjade, Brand Jadenu, generic deferasirox | |
|---|---|
| Diagnosis | Chronic Iron Overload due to Blood Transfusion |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DEFERASIROX | DEFERASIROX TAB FOR ORAL SUSP 125 MG | 93100025007320 | Generic |
| EXJADE | DEFERASIROX TAB FOR ORAL SUSP 125 MG | 93100025007320 | Brand |
| DEFERASIROX | DEFERASIROX TAB FOR ORAL SUSP 250 MG | 93100025007330 | Generic |
| EXJADE | DEFERASIROX TAB FOR ORAL SUSP 250 MG | 93100025007330 | Brand |

| | | | |
|---|---|---|---|
| DEFERASIROX | DEFERASIROX TAB FOR ORAL SUSP 500 MG | 93100025007340 | Generic |
| EXJADE | DEFERASIROX TAB FOR ORAL SUSP 500 MG | 93100025007340 | Brand |
| DEFERASIROX | DEFERASIROX TAB 90 MG | 93100025000320 | Generic |
| JADENU | DEFERASIROX TAB 90 MG | 93100025000320 | Brand |
| DEFERASIROX | DEFERASIROX TAB 180 MG | 93100025000330 | Generic |
| JADENU | DEFERASIROX TAB 180 MG | 93100025000330 | Brand |
| DEFERASIROX | DEFERASIROX TAB 360 MG | 93100025000340 | Generic |
| JADENU | DEFERASIROX TAB 360 MG | 93100025000340 | Brand |
| DEFERASIROX | DEFERASIROX GRANULES PACKET 90 MG | 93100025003020 | Generic |
| JADENU SPRINKLE | DEFERASIROX GRANULES PACKET 90 MG | 93100025003020 | Brand |
| DEFERASIROX | DEFERASIROX GRANULES PACKET 180 MG | 93100025003030 | Generic |
| JADENU SPRINKLE | DEFERASIROX GRANULES PACKET 180 MG | 93100025003030 | Brand |
| DEFERASIROX | DEFERASIROX GRANULES PACKET 360 MG | 93100025003040 | Generic |
| JADENU SPRINKLE | DEFERASIROX GRANULES PACKET 360 MG | 93100025003040 | Brand |

**Approval Criteria**

**1** - Diagnosis of chronic iron overload (e.g., sickle cell anemia, thalassemia, etc.) due to blood transfusion

| Product Name: Brand Exjade, Brand Jadenu, generic deferasirox | |
|---|---|
| Diagnosis | Chronic Iron Overload due to Blood Transfusion |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DEFERASIROX | DEFERASIROX TAB FOR ORAL SUSP 125 MG | 93100025007320 | Generic |
| EXJADE | DEFERASIROX TAB FOR ORAL SUSP 125 MG | 93100025007320 | Brand |
| DEFERASIROX | DEFERASIROX TAB FOR ORAL SUSP 250 MG | 93100025007330 | Generic |
| EXJADE | DEFERASIROX TAB FOR ORAL SUSP 250 MG | 93100025007330 | Brand |

| | | | |
|---|---|---|---|
| DEFERASIROX | DEFERASIROX TAB FOR ORAL SUSP 500 MG | 93100025007340 | Generic |
| EXJADE | DEFERASIROX TAB FOR ORAL SUSP 500 MG | 93100025007340 | Brand |
| DEFERASIROX | DEFERASIROX TAB 90 MG | 93100025000320 | Generic |
| JADENU | DEFERASIROX TAB 90 MG | 93100025000320 | Brand |
| DEFERASIROX | DEFERASIROX TAB 180 MG | 93100025000330 | Generic |
| JADENU | DEFERASIROX TAB 180 MG | 93100025000330 | Brand |
| DEFERASIROX | DEFERASIROX TAB 360 MG | 93100025000340 | Generic |
| JADENU | DEFERASIROX TAB 360 MG | 93100025000340 | Brand |
| DEFERASIROX | DEFERASIROX GRANULES PACKET 90 MG | 93100025003020 | Generic |
| JADENU SPRINKLE | DEFERASIROX GRANULES PACKET 90 MG | 93100025003020 | Brand |
| DEFERASIROX | DEFERASIROX GRANULES PACKET 180 MG | 93100025003030 | Generic |
| JADENU SPRINKLE | DEFERASIROX GRANULES PACKET 180 MG | 93100025003030 | Brand |
| DEFERASIROX | DEFERASIROX GRANULES PACKET 360 MG | 93100025003040 | Generic |
| JADENU SPRINKLE | DEFERASIROX GRANULES PACKET 360 MG | 93100025003040 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to therapy

| Product Name: Brand Ferriprox, generic deferiprone | |
|---|---|
| Diagnosis | Chronic Iron Overload due to Blood Transfusion |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DEFERIPRONE | DEFERIPRONE TAB 500 MG | 93100028000320 | Generic |
| FERRIPROX | DEFERIPRONE TAB 500 MG | 93100028000320 | Brand |
| FERRIPROX | DEFERIPRONE ORAL SOLN 100 MG/ML | 93100028002020 | Brand |
| FERRIPROX | DEFERIPRONE TAB 1000 MG | 93100028000340 | Brand |

| | | | |
|---|---|---|---|
| FERRIPROX TWICE-A-DAY | DEFERIPRONE (TWICE DAILY) TAB 1000 MG | 93100028000345 | Brand |
| DEFERIPRONE | DEFERIPRONE TAB 1000 MG | 93100028000340 | Generic |

**Approval Criteria**

**1** - BOTH of the following

**1.1** Diagnosis of transfusional iron overload due to thalassemia syndromes, sickle cell disease or other anemias

**AND**

**1.2** Ferriprox (deferiprone) will not be used for the treatment of transfusional iron overload due to myelodysplastic syndrome or Diamond Blackfan anemia

| Product Name: Brand Ferriprox, generic deferiprone | |
|---|---|
| Diagnosis | Chronic Iron Overload due to Blood Transfusion |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DEFERIPRONE | DEFERIPRONE TAB 500 MG | 93100028000320 | Generic |
| FERRIPROX | DEFERIPRONE TAB 500 MG | 93100028000320 | Brand |
| FERRIPROX | DEFERIPRONE ORAL SOLN 100 MG/ML | 93100028002020 | Brand |
| FERRIPROX | DEFERIPRONE TAB 1000 MG | 93100028000340 | Brand |
| FERRIPROX TWICE-A-DAY | DEFERIPRONE (TWICE DAILY) TAB 1000 MG | 93100028000345 | Brand |
| DEFERIPRONE | DEFERIPRONE TAB 1000 MG | 93100028000340 | Generic |

**Approval Criteria**

**1** - Documentation of positive clinical response to therapy

| Product Name: Brand Exjade, Brand Jadenu, generic deferasirox | |
|---|---|
| Diagnosis | Chronic Iron Overload in Non-Transfusion Dependent Thalassemia Syndrome |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DEFERASIROX | DEFERASIROX TAB FOR ORAL SUSP 125 MG | 93100025007320 | Generic |
| EXJADE | DEFERASIROX TAB FOR ORAL SUSP 125 MG | 93100025007320 | Brand |
| DEFERASIROX | DEFERASIROX TAB FOR ORAL SUSP 250 MG | 93100025007330 | Generic |
| EXJADE | DEFERASIROX TAB FOR ORAL SUSP 250 MG | 93100025007330 | Brand |
| DEFERASIROX | DEFERASIROX TAB FOR ORAL SUSP 500 MG | 93100025007340 | Generic |
| EXJADE | DEFERASIROX TAB FOR ORAL SUSP 500 MG | 93100025007340 | Brand |
| DEFERASIROX | DEFERASIROX TAB 90 MG | 93100025000320 | Generic |
| JADENU | DEFERASIROX TAB 90 MG | 93100025000320 | Brand |
| DEFERASIROX | DEFERASIROX TAB 180 MG | 93100025000330 | Generic |
| JADENU | DEFERASIROX TAB 180 MG | 93100025000330 | Brand |
| DEFERASIROX | DEFERASIROX TAB 360 MG | 93100025000340 | Generic |
| JADENU | DEFERASIROX TAB 360 MG | 93100025000340 | Brand |
| DEFERASIROX | DEFERASIROX GRANULES PACKET 90 MG | 93100025003020 | Generic |
| JADENU SPRINKLE | DEFERASIROX GRANULES PACKET 90 MG | 93100025003020 | Brand |
| DEFERASIROX | DEFERASIROX GRANULES PACKET 180 MG | 93100025003030 | Generic |
| JADENU SPRINKLE | DEFERASIROX GRANULES PACKET 180 MG | 93100025003030 | Brand |
| DEFERASIROX | DEFERASIROX GRANULES PACKET 360 MG | 93100025003040 | Generic |
| JADENU SPRINKLE | DEFERASIROX GRANULES PACKET 360 MG | 93100025003040 | Brand |

**Approval Criteria**

**1** - ALL of the following:

**1.1** Diagnosis of chronic iron overload in non-transfusion dependent thalassemia (NTDT) syndrome

**AND**

**1.2** Patient has liver iron (Fe) concentration (LIC) levels consistently greater than or equal to 5 mg Fe per gram of dry weight prior to initiation of treatment with Exjade (deferasirox) or Jadenu (deferasirox)

**AND**

**1.3** Patient has serum ferritin levels consistently greater than 300 micrograms per liter prior to initiation of treatment with Exjade (deferasirox) or Jadenu (deferasirox)

| Product Name: Brand Exjade, Brand Jadenu, generic deferasirox | |
|---|---|
| Diagnosis | Chronic Iron Overload in Non-Transfusion Dependent Thalassemia Syndrome |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DEFERASIROX | DEFERASIROX TAB FOR ORAL SUSP 125 MG | 93100025007320 | Generic |
| EXJADE | DEFERASIROX TAB FOR ORAL SUSP 125 MG | 93100025007320 | Brand |
| DEFERASIROX | DEFERASIROX TAB FOR ORAL SUSP 250 MG | 93100025007330 | Generic |
| EXJADE | DEFERASIROX TAB FOR ORAL SUSP 250 MG | 93100025007330 | Brand |
| DEFERASIROX | DEFERASIROX TAB FOR ORAL SUSP 500 MG | 93100025007340 | Generic |
| EXJADE | DEFERASIROX TAB FOR ORAL SUSP 500 MG | 93100025007340 | Brand |
| DEFERASIROX | DEFERASIROX TAB 90 MG | 93100025000320 | Generic |
| JADENU | DEFERASIROX TAB 90 MG | 93100025000320 | Brand |
| DEFERASIROX | DEFERASIROX TAB 180 MG | 93100025000330 | Generic |
| JADENU | DEFERASIROX TAB 180 MG | 93100025000330 | Brand |
| DEFERASIROX | DEFERASIROX TAB 360 MG | 93100025000340 | Generic |

| | | | |
|---|---|---|---|
| JADENU | DEFERASIROX TAB 360 MG | 93100025000340 | Brand |
| DEFERASIROX | DEFERASIROX GRANULES PACKET 90 MG | 93100025003020 | Generic |
| JADENU SPRINKLE | DEFERASIROX GRANULES PACKET 90 MG | 93100025003020 | Brand |
| DEFERASIROX | DEFERASIROX GRANULES PACKET 180 MG | 93100025003030 | Generic |
| JADENU SPRINKLE | DEFERASIROX GRANULES PACKET 180 MG | 93100025003030 | Brand |
| DEFERASIROX | DEFERASIROX GRANULES PACKET 360 MG | 93100025003040 | Generic |
| JADENU SPRINKLE | DEFERASIROX GRANULES PACKET 360 MG | 93100025003040 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to therapy

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146347 |
| **Guideline Name** | Irritable Bowel Syndrome - Diarrhea |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: generic alosetron, Brand Lotronex | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ALOSETRON HYDROCHLORIDE | ALOSETRON HCL TAB 0.5 MG (BASE EQUIV) | 52554015100310 | Generic |
| LOTRONEX | ALOSETRON HCL TAB 0.5 MG (BASE EQUIV) | 52554015100310 | Brand |
| ALOSETRON HYDROCHLORIDE | ALOSETRON HCL TAB 1 MG (BASE EQUIV) | 52554015100320 | Generic |
| LOTRONEX | ALOSETRON HCL TAB 1 MG (BASE EQUIV) | 52554015100320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ALOSETRON HYDROCHLORIDE | ALOSETRON HCL TAB 0.5 MG (BASE EQUIV) | 52554015100310 | Generic |

| | | | |
|---|---|---|---|
| LOTRONEX | ALOSETRON HCL TAB 0.5 MG (BASE EQUIV) | 52554015100310 | Brand |
| ALOSETRON HYDROCHLORIDE | ALOSETRON HCL TAB 1 MG (BASE EQUIV) | 52554015100320 | Generic |
| LOTRONEX | ALOSETRON HCL TAB 1 MG (BASE EQUIV) | 52554015100320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VIBERZI | ELUXADOLINE TAB 75 MG | 52558020000330 | Brand |
| VIBERZI | ELUXADOLINE TAB 100 MG | 52558020000340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VIBERZI | ELUXADOLINE TAB 75 MG | 52558020000330 | Brand |
| VIBERZI | ELUXADOLINE TAB 100 MG | 52558020000340 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Viberzi therapy

Isotretinoin

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146823 |
| **Guideline Name** | Isotretinoin |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Accutane, Myorisan, generic isotretinoin, Claravis, Amnesteem, Zenatane, Brand Absorica, Absorica LD | |
|---|---|
| Diagnosis | Oncology Uses (Off Label) |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MYORISAN | ISOTRETINOIN CAP 10 MG | 90050013000110 | Generic |
| ISOTRETINOIN | ISOTRETINOIN CAP 10 MG | 90050013000110 | Generic |
| MYORISAN | ISOTRETINOIN CAP 20 MG | 90050013000120 | Generic |
| ISOTRETINOIN | ISOTRETINOIN CAP 20 MG | 90050013000120 | Generic |

| | | | |
|---|---|---|---|
| MYORISAN | ISOTRETINOIN CAP 30 MG | 90050013000130 | Generic |
| ISOTRETINOIN | ISOTRETINOIN CAP 30 MG | 90050013000130 | Generic |
| MYORISAN | ISOTRETINOIN CAP 40 MG | 90050013000140 | Generic |
| ISOTRETINOIN | ISOTRETINOIN CAP 40 MG | 90050013000140 | Generic |
| CLARAVIS | ISOTRETINOIN CAP 10 MG | 90050013000110 | Generic |
| CLARAVIS | ISOTRETINOIN CAP 20 MG | 90050013000120 | Generic |
| CLARAVIS | ISOTRETINOIN CAP 30 MG | 90050013000130 | Generic |
| CLARAVIS | ISOTRETINOIN CAP 40 MG | 90050013000140 | Generic |
| AMNESTEEM | ISOTRETINOIN CAP 10 MG | 90050013000110 | Generic |
| AMNESTEEM | ISOTRETINOIN CAP 20 MG | 90050013000120 | Generic |
| AMNESTEEM | ISOTRETINOIN CAP 40 MG | 90050013000140 | Generic |
| ZENATANE | ISOTRETINOIN CAP 10 MG | 90050013000110 | Generic |
| ZENATANE | ISOTRETINOIN CAP 20 MG | 90050013000120 | Generic |
| ZENATANE | ISOTRETINOIN CAP 30 MG | 90050013000130 | Generic |
| ZENATANE | ISOTRETINOIN CAP 40 MG | 90050013000140 | Generic |
| ABSORICA | ISOTRETINOIN CAP 10 MG | 90050013000110 | Brand |
| ABSORICA | ISOTRETINOIN CAP 20 MG | 90050013000120 | Brand |
| ABSORICA | ISOTRETINOIN CAP 25 MG | 90050013000125 | Brand |
| ISOTRETINOIN | ISOTRETINOIN CAP 25 MG | 90050013000125 | Generic |
| ABSORICA | ISOTRETINOIN CAP 30 MG | 90050013000130 | Brand |
| ABSORICA | ISOTRETINOIN CAP 35 MG | 90050013000135 | Brand |
| ISOTRETINOIN | ISOTRETINOIN CAP 35 MG | 90050013000135 | Generic |
| ABSORICA | ISOTRETINOIN CAP 40 MG | 90050013000140 | Brand |
| ABSORICA LD | ISOTRETINOIN MICRONIZED CAP 8 MG | 90050013100110 | Brand |
| ABSORICA LD | ISOTRETINOIN MICRONIZED CAP 16 MG | 90050013100115 | Brand |
| ABSORICA LD | ISOTRETINOIN MICRONIZED CAP 24 MG | 90050013100125 | Brand |
| ABSORICA LD | ISOTRETINOIN MICRONIZED CAP 32 MG | 90050013100135 | Brand |
| ACCUTANE | ISOTRETINOIN CAP 10 MG | 90050013000110 | Generic |
| ACCUTANE | ISOTRETINOIN CAP 20 MG | 90050013000120 | Generic |
| ACCUTANE | ISOTRETINOIN CAP 30 MG | 90050013000130 | Generic |
| ACCUTANE | ISOTRETINOIN CAP 40 MG | 90050013000140 | Generic |

**Approval Criteria**

**1** - Use is supported by The National Comprehensive Cancer Network (NCCN)

**OR**

**2** - Use 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)

| Product Name: Accutane, Myorisan, generic isotretinoin, Claravis, Amnesteem, Zenatane, Brand Absorica, Absorica LD | |
|---|---|
| Diagnosis | Acne |
| Approval Length | 6 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MYORISAN | ISOTRETINOIN CAP 10 MG | 90050013000110 | Generic |
| ISOTRETINOIN | ISOTRETINOIN CAP 10 MG | 90050013000110 | Generic |
| MYORISAN | ISOTRETINOIN CAP 20 MG | 90050013000120 | Generic |
| ISOTRETINOIN | ISOTRETINOIN CAP 20 MG | 90050013000120 | Generic |
| MYORISAN | ISOTRETINOIN CAP 30 MG | 90050013000130 | Generic |
| ISOTRETINOIN | ISOTRETINOIN CAP 30 MG | 90050013000130 | Generic |
| MYORISAN | ISOTRETINOIN CAP 40 MG | 90050013000140 | Generic |
| ISOTRETINOIN | ISOTRETINOIN CAP 40 MG | 90050013000140 | Generic |
| CLARAVIS | ISOTRETINOIN CAP 10 MG | 90050013000110 | Generic |
| CLARAVIS | ISOTRETINOIN CAP 20 MG | 90050013000120 | Generic |
| CLARAVIS | ISOTRETINOIN CAP 30 MG | 90050013000130 | Generic |

| | | | |
|---|---|---|---|
| CLARAVIS | ISOTRETINOIN CAP 40 MG | 90050013000140 | Generic |
| AMNESTEEM | ISOTRETINOIN CAP 10 MG | 90050013000110 | Generic |
| AMNESTEEM | ISOTRETINOIN CAP 20 MG | 90050013000120 | Generic |
| AMNESTEEM | ISOTRETINOIN CAP 40 MG | 90050013000140 | Generic |
| ZENATANE | ISOTRETINOIN CAP 10 MG | 90050013000110 | Generic |
| ZENATANE | ISOTRETINOIN CAP 20 MG | 90050013000120 | Generic |
| ZENATANE | ISOTRETINOIN CAP 30 MG | 90050013000130 | Generic |
| ZENATANE | ISOTRETINOIN CAP 40 MG | 90050013000140 | Generic |
| ABSORICA | ISOTRETINOIN CAP 10 MG | 90050013000110 | Brand |
| ABSORICA | ISOTRETINOIN CAP 20 MG | 90050013000120 | Brand |
| ABSORICA | ISOTRETINOIN CAP 25 MG | 90050013000125 | Brand |
| ISOTRETINOIN | ISOTRETINOIN CAP 25 MG | 90050013000125 | Generic |
| ABSORICA | ISOTRETINOIN CAP 30 MG | 90050013000130 | Brand |
| ABSORICA | ISOTRETINOIN CAP 35 MG | 90050013000135 | Brand |
| ISOTRETINOIN | ISOTRETINOIN CAP 35 MG | 90050013000135 | Generic |
| ABSORICA | ISOTRETINOIN CAP 40 MG | 90050013000140 | Brand |
| ABSORICA LD | ISOTRETINOIN MICRONIZED CAP 8 MG | 90050013100110 | Brand |
| ABSORICA LD | ISOTRETINOIN MICRONIZED CAP 16 MG | 90050013100115 | Brand |
| ABSORICA LD | ISOTRETINOIN MICRONIZED CAP 24 MG | 90050013100125 | Brand |
| ABSORICA LD | ISOTRETINOIN MICRONIZED CAP 32 MG | 90050013100135 | Brand |
| ACCUTANE | ISOTRETINOIN CAP 10 MG | 90050013000110 | Generic |
| ACCUTANE | ISOTRETINOIN CAP 20 MG | 90050013000120 | Generic |
| ACCUTANE | ISOTRETINOIN CAP 30 MG | 90050013000130 | Generic |
| ACCUTANE | ISOTRETINOIN CAP 40 MG | 90050013000140 | Generic |

**Approval Criteria**

**1** - ONE of the following:

**1.1** Diagnosis of severe recalcitrant nodular acne unresponsive to conventional therapy

**OR**

**1.2** Diagnosis of treatment resistant acne

**AND**

**2** - 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*, there must be a reason or special circumstance that the patient must be treated with a non-preferred medication (please specify reason or special circumstance)

| | |
|---|---|
| Notes | *PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |

| Product Name: Accutane, Myorisan, generic isotretinoin, Claravis, Amnesteem, Zenatane, Brand Absorica, Absorica LD | |
|---|---|
| Diagnosis | Acne |

| | |
|---|---|
| Approval Length | 6 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MYORISAN | ISOTRETINOIN CAP 10 MG | 90050013000110 | Generic |
| ISOTRETINOIN | ISOTRETINOIN CAP 10 MG | 90050013000110 | Generic |
| MYORISAN | ISOTRETINOIN CAP 20 MG | 90050013000120 | Generic |
| ISOTRETINOIN | ISOTRETINOIN CAP 20 MG | 90050013000120 | Generic |
| MYORISAN | ISOTRETINOIN CAP 30 MG | 90050013000130 | Generic |
| ISOTRETINOIN | ISOTRETINOIN CAP 30 MG | 90050013000130 | Generic |
| MYORISAN | ISOTRETINOIN CAP 40 MG | 90050013000140 | Generic |
| ISOTRETINOIN | ISOTRETINOIN CAP 40 MG | 90050013000140 | Generic |
| CLARAVIS | ISOTRETINOIN CAP 10 MG | 90050013000110 | Generic |
| CLARAVIS | ISOTRETINOIN CAP 20 MG | 90050013000120 | Generic |
| CLARAVIS | ISOTRETINOIN CAP 30 MG | 90050013000130 | Generic |
| CLARAVIS | ISOTRETINOIN CAP 40 MG | 90050013000140 | Generic |
| AMNESTEEM | ISOTRETINOIN CAP 10 MG | 90050013000110 | Generic |
| AMNESTEEM | ISOTRETINOIN CAP 20 MG | 90050013000120 | Generic |
| AMNESTEEM | ISOTRETINOIN CAP 40 MG | 90050013000140 | Generic |
| ZENATANE | ISOTRETINOIN CAP 10 MG | 90050013000110 | Generic |
| ZENATANE | ISOTRETINOIN CAP 20 MG | 90050013000120 | Generic |
| ZENATANE | ISOTRETINOIN CAP 30 MG | 90050013000130 | Generic |
| ZENATANE | ISOTRETINOIN CAP 40 MG | 90050013000140 | Generic |
| ABSORICA | ISOTRETINOIN CAP 10 MG | 90050013000110 | Brand |
| ABSORICA | ISOTRETINOIN CAP 20 MG | 90050013000120 | Brand |
| ABSORICA | ISOTRETINOIN CAP 25 MG | 90050013000125 | Brand |
| ISOTRETINOIN | ISOTRETINOIN CAP 25 MG | 90050013000125 | Generic |
| ABSORICA | ISOTRETINOIN CAP 30 MG | 90050013000130 | Brand |
| ABSORICA | ISOTRETINOIN CAP 35 MG | 90050013000135 | Brand |
| ISOTRETINOIN | ISOTRETINOIN CAP 35 MG | 90050013000135 | Generic |
| ABSORICA | ISOTRETINOIN CAP 40 MG | 90050013000140 | Brand |

| | | | |
|---|---|---|---|
| ABSORICA LD | ISOTRETINOIN MICRONIZED CAP 8 MG | 90050013100110 | Brand |
| ABSORICA LD | ISOTRETINOIN MICRONIZED CAP 16 MG | 90050013100115 | Brand |
| ABSORICA LD | ISOTRETINOIN MICRONIZED CAP 24 MG | 90050013100125 | Brand |
| ABSORICA LD | ISOTRETINOIN MICRONIZED CAP 32 MG | 90050013100135 | Brand |
| ACCUTANE | ISOTRETINOIN CAP 10 MG | 90050013000110 | Generic |
| ACCUTANE | ISOTRETINOIN CAP 20 MG | 90050013000120 | Generic |
| ACCUTANE | ISOTRETINOIN CAP 30 MG | 90050013000130 | Generic |
| ACCUTANE | ISOTRETINOIN CAP 40 MG | 90050013000140 | Generic |

**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 milligrams/kilogram (mg/kg) (will be approved up to a total of 150 mg/kg)

## 2 . Revision History

| Date | Notes |
|---|---|
| 4/30/2024 | Removed PDL links for CORE markets in background section and ad ded PDL link for NM in notes section, where applicable. |

Isturisa

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146552 |
| **Guideline Name** | Isturisa |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ISTURISA | OSILODROSTAT PHOSPHATE TAB 1 MG | 30022060600320 | Brand |
| ISTURISA | OSILODROSTAT PHOSPHATE TAB 5 MG | 30022060600330 | Brand |
| ISTURISA | OSILODROSTAT PHOSPHATE TAB 10 MG | 30022060600340 | Brand |

**Approval Criteria**

**1** - Diagnosis of Cushing's disease

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ISTURISA | OSILODROSTAT PHOSPHATE TAB 1 MG | 30022060600320 | Brand |
| ISTURISA | OSILODROSTAT PHOSPHATE TAB 5 MG | 30022060600330 | Brand |
| ISTURISA | OSILODROSTAT PHOSPHATE TAB 10 MG | 30022060600340 | Brand |

**Approval Criteria**

**1** - Documentation of positive response to Isturisa therapy

Iwilfin

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146553 |
| **Guideline Name** | Iwilfin |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Iwilfin | |
|---|---|
| Diagnosis | High-Risk Neuroblastoma (HRNB) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| IWILFIN | EFLORNITHINE HCL TAB 192 MG | 21757220300320 | Brand |

**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: Iwilfin | |
|---|---|
| Diagnosis | High-Risk Neuroblastoma (HRNB) |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| IWILFIN | EFLORNITHINE HCL TAB 192 MG | 21757220300320 | Brand |

**Approval Criteria**

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

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| IWILFIN | EFLORNITHINE HCL TAB 192 MG | 21757220300320 | Brand |

**Approval Criteria**

**1** - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

| Product Name: Iwilfin | |
|---|---|
| Diagnosis | NCCN Recommended Regimens |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| IWILFIN | EFLORNITHINE HCL TAB 192 MG | 21757220300320 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Iwilfin therapy

Jakafi

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146554 |
| **Guideline Name** | Jakafi |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Jakafi | |
|---|---|
| Diagnosis | Myelofibrosis |
| Approval Length | 6 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 5 MG (BASE EQUIVALENT) | 21537560200310 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 15 MG (BASE EQUIVALENT) | 21537560200325 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 20 MG (BASE EQUIVALENT) | 21537560200330 | Brand |

| | | | |
|---|---|---|---|
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 25 MG (BASE EQUIVALENT) | 21537560200335 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 10 MG (BASE EQUIVALENT) | 21537560200320 | Brand |

**Approval Criteria**

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

**1.1** Primary myelofibrosis

**OR**

**1.2** Post-polycythemia vera myelofibrosis

**OR**

**1.3** Post-essential thrombocythemia myelofibrosis

| Product Name: Jakafi | |
|---|---|
| Diagnosis | Polycythemia Vera |
| Approval Length | 6 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 5 MG (BASE EQUIVALENT) | 21537560200310 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 15 MG (BASE EQUIVALENT) | 21537560200325 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 20 MG (BASE EQUIVALENT) | 21537560200330 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 25 MG (BASE EQUIVALENT) | 21537560200335 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 10 MG (BASE EQUIVALENT) | 21537560200320 | Brand |

**Approval Criteria**

**1** - Diagnosis of 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., Intron A, Pegasys)

**OR**

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

- Hydroxyurea
- Interferon therapy (e.g., Intron A, Pegasys)

| Product Name: Jakafi | |
|---|---|
| Diagnosis | Essential Thrombocythemia |
| Approval Length | 6 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 5 MG (BASE EQUIVALENT) | 21537560200310 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 10 MG (BASE EQUIVALENT) | 21537560200320 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 15 MG (BASE EQUIVALENT) | 21537560200325 | Brand |

| | | | |
|---|---|---|---|
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 20 MG (BASE EQUIVALENT) | 21537560200330 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 25 MG (BASE EQUIVALENT) | 21537560200335 | Brand |

**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 | Myelofibrosis, Polycythemia Vera, Essential Thrombocythemia |
| Approval Length | 6 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 5 MG (BASE EQUIVALENT) | 21537560200310 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 15 MG (BASE EQUIVALENT) | 21537560200325 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 20 MG (BASE EQUIVALENT) | 21537560200330 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 25 MG (BASE EQUIVALENT) | 21537560200335 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 10 MG (BASE EQUIVALENT) | 21537560200320 | Brand |

**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 improvemen t or reduction in spleen volume while on Jakafi, authorization will be is sued for 2 months to allow for dose titration with discontinuation of the rapy. |

| Product Name: Jakafi | |
|---|---|
| Diagnosis | Graft versus host disease (GVHD) |
| Approval Length | 6 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 5 MG (BASE EQUIVALENT) | 21537560200310 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 15 MG (BASE EQUIVALENT) | 21537560200325 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 20 MG (BASE EQUIVALENT) | 21537560200330 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 25 MG (BASE EQUIVALENT) | 21537560200335 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 10 MG (BASE EQUIVALENT) | 21537560200320 | Brand |

**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 | 6 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 5 MG (BASE EQUIVALENT) | 21537560200310 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 15 MG (BASE EQUIVALENT) | 21537560200325 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 20 MG (BASE EQUIVALENT) | 21537560200330 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 25 MG (BASE EQUIVALENT) | 21537560200335 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 10 MG (BASE EQUIVALENT) | 21537560200320 | Brand |

**Approval Criteria**

**1** - Documentation that patient has symptom improvement while on Jakafi

| Product Name: Jakafi | |
|---|---|
| Diagnosis | Myeloid/Lymphoid Neoplasms |
| Approval Length | 6 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 5 MG (BASE EQUIVALENT) | 21537560200310 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 15 MG (BASE EQUIVALENT) | 21537560200325 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 20 MG (BASE EQUIVALENT) | 21537560200330 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 25 MG (BASE EQUIVALENT) | 21537560200335 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 10 MG (BASE EQUIVALENT) | 21537560200320 | Brand |

**Approval Criteria**

**1** - Diagnosis of lymphoid, myeloid, or mixed lineage neoplasms with eosinophilia

**AND**

**2** - Patient has a JAK2 rearrangement

| Product Name: Jakafi | |
|---|---|
| Diagnosis | Myelodysplastic Syndromes |
| Approval Length | 6 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 5 MG (BASE EQUIVALENT) | 21537560200310 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 15 MG (BASE EQUIVALENT) | 21537560200325 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 20 MG (BASE EQUIVALENT) | 21537560200330 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 25 MG (BASE EQUIVALENT) | 21537560200335 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 10 MG (BASE EQUIVALENT) | 21537560200320 | Brand |

**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** - Diagnosis of BCR-ABL negative atypical chronic myeloid leukemia (aCML)

| Product Name: Jakafi | |
|---|---|
| Diagnosis | T-Cell Lymphomas |
| Approval Length | 6 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 5 MG (BASE EQUIVALENT) | 21537560200310 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 10 MG (BASE EQUIVALENT) | 21537560200320 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 15 MG (BASE EQUIVALENT) | 21537560200325 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 20 MG (BASE EQUIVALENT) | 21537560200330 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 25 MG (BASE EQUIVALENT) | 21537560200335 | Brand |

**Approval Criteria**

**1** - Diagnosis of ONE of the following:

**1.1** Peripheral T-Cell Lymphoma not otherwise specified (PTCL-NOS)

**OR**

**1.2** Enteropathy-associated T-cell lymphoma (EATL)

**OR**

**1.3** Monomorphic epitheliotropic intestinal T-cell lymphoma (MEITL)

**OR**

**1.4** Angioimmunoblastic T-cell lymphoma (AITL)

**OR**

**1.5** Nodal peripheral T-cell lymphoma with T-follicular helper phenotype (PTCL, TFH)

**OR**

**1.6** Follicular T-cell lymphoma (FTCL)

**OR**

**1.7** Anaplastic large cell lymphoma (ALCL)

**OR**

**1.8** Hepatosplenic T-cell lymphoma

**AND**

**2** - Used as initial palliative intent therapy or second-line and subsequent therapy for relapsed/refractory disease

| Product Name: Jakafi | |
|---|---|
| Diagnosis | Myeloid/Lymphoid Neoplasms, Myelodysplastic Syndromes, T-Cell Lymphomas |
| Approval Length | 6 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 5 MG (BASE EQUIVALENT) | 21537560200310 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 15 MG (BASE EQUIVALENT) | 21537560200325 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 20 MG (BASE EQUIVALENT) | 21537560200330 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 25 MG (BASE EQUIVALENT) | 21537560200335 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 10 MG (BASE EQUIVALENT) | 21537560200320 | Brand |

**Approval Criteria**

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

| Product Name: Jakafi | |
|---|---|
| Diagnosis | Pediatric Acute Lymphoblastic Leukemia |
| Approval Length | 6 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 5 MG (BASE EQUIVALENT) | 21537560200310 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 15 MG (BASE EQUIVALENT) | 21537560200325 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 20 MG (BASE EQUIVALENT) | 21537560200330 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 25 MG (BASE EQUIVALENT) | 21537560200335 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 10 MG (BASE EQUIVALENT) | 21537560200320 | Brand |

**Approval Criteria**

**1** - Diagnosis of pediatric acute lymphoblastic leukemia

**AND**

**2** - Used as a component of induction therapy

| Product Name: Jakafi | |
|---|---|
| Diagnosis | Immunotherapy-Related Toxicities |
| Approval Length | 6 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 5 MG (BASE EQUIVALENT) | 21537560200310 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 15 MG (BASE EQUIVALENT) | 21537560200325 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 20 MG (BASE EQUIVALENT) | 21537560200330 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 25 MG (BASE EQUIVALENT) | 21537560200335 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 10 MG (BASE EQUIVALENT) | 21537560200320 | Brand |

**Approval Criteria**

**1** - Diagnosis of CAR-T induced G4 cytokine release syndrome

**AND**

**2** - Disease is refractory to high-dose corticosteroids and anti-IL-6 therapy [e.g., Actemra (tocilizumab)]

| Product Name: Jakafi | |
|---|---|
| Diagnosis | NCCN Recommended Regimens |
| Approval Length | 6 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 5 MG (BASE EQUIVALENT) | 21537560200310 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 15 MG (BASE EQUIVALENT) | 21537560200325 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 20 MG (BASE EQUIVALENT) | 21537560200330 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 25 MG (BASE EQUIVALENT) | 21537560200335 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 10 MG (BASE EQUIVALENT) | 21537560200320 | Brand |

**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 | 6 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 5 MG (BASE EQUIVALENT) | 21537560200310 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 15 MG (BASE EQUIVALENT) | 21537560200325 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 20 MG (BASE EQUIVALENT) | 21537560200330 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 25 MG (BASE EQUIVALENT) | 21537560200335 | Brand |
| JAKAFI | RUXOLITINIB PHOSPHATE TAB 10 MG (BASE EQUIVALENT) | 21537560200320 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Jakafi therapy

Jaypirca

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146555 |
| **Guideline Name** | Jaypirca |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Jaypirca | |
|---|---|
| Diagnosis | Mantle Cell Lymphoma (MCL) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| JAYPIRCA | PIRTOBRUTINIB TAB 50 MG | 21532165000320 | Brand |
| JAYPIRCA | PIRTOBRUTINIB TAB 100 MG | 21532165000330 | Brand |

**Approval Criteria**

**1** - Diagnosis of mantle cell lymphoma (MCL)

**AND**

**2** - Disease is relapsed or refractory

**AND**

**3** - Both of the following:

**3.1** Patient has received at least two prior systemic therapies for MCL [e.g., Rituxan (rituximab)]

**AND**

**3.2** Patient has received at least one Bruton Tyrosine Kinase (BTK) inhibitor therapy for MCL [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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| JAYPIRCA | PIRTOBRUTINIB TAB 50 MG | 21532165000320 | Brand |
| JAYPIRCA | PIRTOBRUTINIB TAB 100 MG | 21532165000330 | Brand |

**Approval Criteria**

**1** - Diagnosis of chronic lymphocytic leukemia or small lymphocytic lymphoma

**AND**

**2** - Patient has been previously treated with both of the following:

**2.1** Bruton Tyrosine Kinase (BTK) inhibitor therapy [e.g., Imbruvica (ibrutinib), Calquence (acalabrutinib), Brukinsa (zanubrutinib)]

**AND**

**2.2** B-cell lymphoma 2 (BCL-2) inhibitor therapy [e.g., Venclexta (venetoclax)]

| Product Name: Jaypirca | |
|---|---|
| Diagnosis | Mantle Cell Lymphoma (MCL), Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| JAYPIRCA | PIRTOBRUTINIB TAB 50 MG | 21532165000320 | Brand |
| JAYPIRCA | PIRTOBRUTINIB TAB 100 MG | 21532165000330 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| JAYPIRCA | PIRTOBRUTINIB TAB 50 MG | 21532165000320 | Brand |
| JAYPIRCA | PIRTOBRUTINIB TAB 100 MG | 21532165000330 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| JAYPIRCA | PIRTOBRUTINIB TAB 50 MG | 21532165000320 | Brand |
| JAYPIRCA | PIRTOBRUTINIB TAB 100 MG | 21532165000330 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Jaypirca therapy

Jesduvroq

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146350 |
| **Guideline Name** | Jesduvroq |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| JESDUVROQ | DAPRODUSTAT TAB 1 MG | 82402520000310 | Brand |
| JESDUVROQ | DAPRODUSTAT TAB 2 MG | 82402520000315 | Brand |
| JESDUVROQ | DAPRODUSTAT TAB 4 MG | 82402520000320 | Brand |
| JESDUVROQ | DAPRODUSTAT TAB 6 MG | 82402520000325 | Brand |
| JESDUVROQ | DAPRODUSTAT TAB 8 MG | 82402520000330 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| JESDUVROQ | DAPRODUSTAT TAB 1 MG | 82402520000310 | Brand |
| JESDUVROQ | DAPRODUSTAT TAB 2 MG | 82402520000315 | Brand |
| JESDUVROQ | DAPRODUSTAT TAB 4 MG | 82402520000320 | Brand |
| JESDUVROQ | DAPRODUSTAT TAB 6 MG | 82402520000325 | Brand |
| JESDUVROQ | DAPRODUSTAT TAB 8 MG | 82402520000330 | Brand |

**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

Joenja

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-150145 |
| **Guideline Name** | Joenja |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 8/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| JOENJA | LENIOLISIB PHOSPHATE TAB 70 MG | 99391540600320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| JOENJA | LENIOLISIB PHOSPHATE TAB 70 MG | 99391540600320 | Brand |

**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. |

Juxtapid

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146557 |
| **Guideline Name** | Juxtapid |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| JUXTAPID | LOMITAPIDE MESYLATE CAP 5 MG (BASE EQUIV) | 39480050200120 | Brand |
| JUXTAPID | LOMITAPIDE MESYLATE CAP 10 MG (BASE EQUIV) | 39480050200130 | Brand |
| JUXTAPID | LOMITAPIDE MESYLATE CAP 20 MG (BASE EQUIV) | 39480050200140 | Brand |
| JUXTAPID | LOMITAPIDE MESYLATE CAP 30 MG (BASE EQUIV) | 39480050200150 | Brand |

**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 two mutant alleles at the LDLR, APOB, PCSK9, or LDLRAP1 gene locus

**OR**

**1.2** BOTH of the following:

**1.2.1** Pre-treatment low density lipoprotein cholesterol (LDL-C) greater than 400 mg/dL (milligrams per deciliter)

**AND**

**1.2.2** ONE of the following:

- Xanthoma before 10 years of age
- Evidence of heterozygous familial hypercholesterolemia (HeFH) in both parents

**AND**

**2** - Patient has received comprehensive counseling regarding appropriate 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)]

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| JUXTAPID | LOMITAPIDE MESYLATE CAP 5 MG (BASE EQUIV) | 39480050200120 | Brand |
| JUXTAPID | LOMITAPIDE MESYLATE CAP 10 MG (BASE EQUIV) | 39480050200130 | Brand |
| JUXTAPID | LOMITAPIDE MESYLATE CAP 20 MG (BASE EQUIV) | 39480050200140 | Brand |
| JUXTAPID | LOMITAPIDE MESYLATE CAP 30 MG (BASE EQUIV) | 39480050200150 | Brand |

**Approval Criteria**

**1** - Patient continues to receive comprehensive counseling regarding appropriate 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)]

Jynarque

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146558 |
| **Guideline Name** | Jynarque |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Jynarque, Jynarque Pak | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| JYNARQUE | TOLVAPTAN TAB THERAPY PACK 15 MG | 3045406000B710 | Brand |
| JYNARQUE | TOLVAPTAN TAB THERAPY PACK 30 & 15 MG | 3045406000B720 | Brand |
| JYNARQUE | TOLVAPTAN TAB THERAPY PACK 45 & 15 MG | 3045406000B725 | Brand |
| JYNARQUE | TOLVAPTAN TAB THERAPY PACK 60 & 30 MG | 3045406000B735 | Brand |
| JYNARQUE | TOLVAPTAN TAB THERAPY PACK 90 & 30 MG | 3045406000B745 | Brand |

| | | | |
|---|---|---|---|
| JYNARQUE | TOLVAPTAN TAB 15 MG | 30454060000320 | Brand |
| JYNARQUE | TOLVAPTAN TAB 30 MG | 30454060000330 | Brand |

**Approval Criteria**

**1** - Diagnosis of autosomal dominant polycystic kidney disease (ADPKD)

| Product Name: Jynarque, Jynarque Pak | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| JYNARQUE | TOLVAPTAN TAB THERAPY PACK 15 MG | 3045406000B710 | Brand |
| JYNARQUE | TOLVAPTAN TAB THERAPY PACK 30 & 15 MG | 3045406000B720 | Brand |
| JYNARQUE | TOLVAPTAN TAB THERAPY PACK 45 & 15 MG | 3045406000B725 | Brand |
| JYNARQUE | TOLVAPTAN TAB THERAPY PACK 60 & 30 MG | 3045406000B735 | Brand |
| JYNARQUE | TOLVAPTAN TAB THERAPY PACK 90 & 30 MG | 3045406000B745 | Brand |
| JYNARQUE | TOLVAPTAN TAB 15 MG | 30454060000320 | Brand |
| JYNARQUE | TOLVAPTAN TAB 30 MG | 30454060000330 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Jynarque therapy

Kalydeco

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-151780 |
| **Guideline Name** | Kalydeco |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 9/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| KALYDECO | IVACAFTOR TAB 150 MG | 45302030000320 | Brand |
| KALYDECO | IVACAFTOR PACKET 25 MG | 45302030003010 | Brand |
| KALYDECO | IVACAFTOR PACKET 50 MG | 45302030003020 | Brand |
| KALYDECO | IVACAFTOR PACKET 75 MG | 45302030003030 | Brand |
| KALYDECO | IVACAFTOR PACKET 13.4 MG | 45302030003005 | Brand |

| | | | |
|---|---|---|---|
| KALYDECO | IVACAFTOR PACKET 5.8 MG | 45302030003002 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| KALYDECO | IVACAFTOR TAB 150 MG | 45302030000320 | Brand |
| KALYDECO | IVACAFTOR PACKET 25 MG | 45302030003010 | Brand |
| KALYDECO | IVACAFTOR PACKET 50 MG | 45302030003020 | Brand |
| KALYDECO | IVACAFTOR PACKET 75 MG | 45302030003030 | Brand |
| KALYDECO | IVACAFTOR PACKET 13.4 MG | 45302030003005 | Brand |
| KALYDECO | IVACAFTOR PACKET 5.8 MG | 45302030003002 | Brand |

**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**

| | | | | |
|---|---|---|---|---|
| 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 |
|---|---|
| 8/14/2024 | Annual review. Removed prescriber requirement from reauthorization criteria. Updated reference. |

Kerendia

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-160463 |
| **Guideline Name** | Kerendia |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| KERENDIA | FINERENONE TAB 10 MG | 30354030000310 | Brand |
| KERENDIA | FINERENONE TAB 20 MG | 30354030000320 | Brand |

**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** - ONE of the following:

- Patient is on a stabilized dose and receiving concomitant therapy with a SGLT2 inhibitor (e.g., Farxiga)
- Failure to a SGLT2 inhibitor (e.g., Farxiga) confirmed by claims history or submitted medical records
- History of intolerance or contraindication to a SGLT2 inhibitor (e.g., Farxiga) (please specify intolerance or contraindication)

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| KERENDIA | FINERENONE TAB 10 MG | 30354030000310 | Brand |
| KERENDIA | FINERENONE TAB 20 MG | 30354030000320 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to therapy

## 2 . Revision History

| Date | Notes |
| --- | --- |
| 11/11/2024 | Updated auth durations. Updated diagnosis to CDK associated with T2D |

Keveyis

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146560 |
| **Guideline Name** | Keveyis |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Brand Keveyis, generic dichlorphenamide | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| KEVEYIS | DICHLORPHENAMIDE TAB 50 MG | 37100020000305 | Brand |
| DICHLORPHENAMIDE | DICHLORPHENAMIDE TAB 50 MG | 37100020000305 | Generic |

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| KEVEYIS | DICHLORPHENAMIDE TAB 50 MG | 37100020000305 | Brand |
| DICHLORPHENAMIDE | DICHLORPHENAMIDE TAB 50 MG | 37100020000305 | Generic |

**Approval Criteria**

**1** - Documentation of positive clinical response to the requested therapy

Kevzara

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-156350 |
| **Guideline Name** | Kevzara |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 11/1/2024 |

## 1 . Criteria

| Product Name: Kevzara | |
|---|---|
| Diagnosis | Rheumatoid Arthritis |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| KEVZARA | SARILUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML | 6650006000D520 | Brand |
| KEVZARA | SARILUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.14ML | 6650006000D530 | Brand |
| KEVZARA | SARILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/1.14ML | 6650006000E520 | Brand |

| KEVZARA | SARILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 200 MG/1.14ML | 6650006000E530 | Brand |
|---|---|---|---|

**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:

**2.1.1.1** 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**

**2.1.1.2** 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**

**2.1.1.3** Patient has been previously treated with a biologic or targeted synthetic DMARD 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**

**2.1.2** One of the following:

**2.1.2.1** Failure of one preferred adalimumab product* confirmed by claims history or submitted medical records

**OR**

**2.1.2.2** History of intolerance or contraindication to all preferred adalimumab products* (please specify intolerance or contraindication)

**AND**

**2.1.3** One of the following:

**2.1.3.1** Failure of Tyenne (tocilizumab-aazg) confirmed by claims history or submitted medical records

**OR**

**2.1.3.2** History of intolerance or contraindication to Tyenne (tocilizumab-aazg) (please specify intolerance or contraindication)

**OR**

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

**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 | *PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |
|---|---|

| Product Name: Kevzara | |
|---|---|
| Diagnosis | Rheumatoid Arthritis |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| KEVZARA | SARILUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML | 6650006000D520 | Brand |
| KEVZARA | SARILUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.14ML | 6650006000D530 | Brand |
| KEVZARA | SARILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/1.14ML | 6650006000E520 | Brand |
| KEVZARA | SARILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 200 MG/1.14ML | 6650006000E530 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| KEVZARA | SARILUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML | 6650006000D520 | Brand |

| | | | |
|---|---|---|---|
| KEVZARA | SARILUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.14ML | 6650006000D530 | Brand |
| KEVZARA | SARILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/1.14ML | 6650006000E520 | Brand |
| KEVZARA | SARILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 200 MG/1.14ML | 6650006000E530 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| KEVZARA | SARILUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML | 6650006000D520 | Brand |
| KEVZARA | SARILUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.14ML | 6650006000D530 | Brand |
| KEVZARA | SARILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/1.14ML | 6650006000E520 | Brand |
| KEVZARA | SARILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 200 MG/1.14ML | 6650006000E530 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| KEVZARA | SARILUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML | 6650006000D520 | Brand |
| KEVZARA | SARILUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.14ML | 6650006000D530 | Brand |
| KEVZARA | SARILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/1.14ML | 6650006000E520 | Brand |
| KEVZARA | SARILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 200 MG/1.14ML | 6650006000E530 | Brand |

**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 | *PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |

| Product Name: Kevzara | |
|---|---|
| Diagnosis | Polyarticular Juvenile Idiopathic Arthritis (pJIA) |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| KEVZARA | SARILUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML | 6650006000D520 | Brand |

| | | | |
|---|---|---|---|
| KEVZARA | SARILUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.14ML | 6650006000D530 | Brand |
| KEVZARA | SARILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/1.14ML | 6650006000E520 | Brand |
| KEVZARA | SARILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 200 MG/1.14ML | 6650006000E530 | Brand |

**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 . Revision History

| Date | Notes |
|---|---|
| 9/26/2024 | Added criteria for pJIA. Updated safety language |

Kineret

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-160487 |
| **Guideline Name** | Kineret |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 1 . Criteria

| Product Name: Kineret | |
|---|---|
| Diagnosis | Rheumatoid Arthritis (RA) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| KINERET | ANAKINRA SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/0.67ML | 6626001000E520 | Brand |

**Approval Criteria**

**1** - Diagnosis of moderately to severely active rheumatoid arthritis (RA)

**AND**

**2** - Patient is NOT receiving Kineret in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

**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 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 (tofacitinib)]

**OR**

**4.2.1.2** 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

**OR**

**4.2.1.3** History of intolerance or contraindication to one non-biologic 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 | * For a list of preferred adalimumab products please reference drug c overage tools. |

| Product Name: Kineret | |
|---|---|
| Diagnosis | Neonatal-Onset Multisystem Inflammatory Disease (NOMID) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| KINERET | ANAKINRA SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/0.67ML | 6626001000E520 | Brand |

**Approval Criteria**

**1** - Diagnosis of neonatal-onset multisystem inflammatory disease (NOMID)

**AND**

**2** - Patient is NOT receiving Kineret in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| KINERET | ANAKINRA SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/0.67ML | 6626001000E520 | Brand |

**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 targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| KINERET | ANAKINRA SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/0.67ML | 6626001000E520 | Brand |

**Approval Criteria**

**1** - Diagnosis of adult onset Still's Disease

**AND**

**2** - Patient is NOT receiving Kineret in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| KINERET | ANAKINRA SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/0.67ML | 6626001000E520 | Brand |

**Approval Criteria**

**1** - Diagnosis of deficiency of Interleukin-1 Receptor Antagonist (DIRA)

**AND**

**2** - Patient is NOT receiving Kineret in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| KINERET | ANAKINRA SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/0.67ML | 6626001000E520 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Kineret therapy

**AND**

**2** - Patient is NOT receiving Kineret in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

## 2 . Revision History

| Date | Notes |
| --- | --- |
| 11/12/2024 | Removed Cimzia as an alternative in RA section |

Kisqali

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146563 |
| **Guideline Name** | Kisqali |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Kisqali | |
|---|---|
| Diagnosis | Breast Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| KISQALI | RIBOCICLIB SUCCINATE TAB PACK 200 MG DAILY DOSE | 2153107050B720 | Brand |
| KISQALI | RIBOCICLIB SUCCINATE TAB PACK 400 MG DAILY DOSE (200 MG TAB) | 2153107050B740 | Brand |
| KISQALI | RIBOCICLIB SUCCINATE TAB PACK 600 MG DAILY DOSE (200 MG TAB) | 2153107050B760 | Brand |

**Approval Criteria**

**1** - Diagnosis of advanced, recurrent, or metastatic breast cancer

**AND**

**2** - BOTH of the following:

- Disease is hormone receptor (HR)-positive
- Disease is human epidermal growth factor receptor 2 (HER2)-negative

**AND**

**3** - ONE of the following:

- Used in combination with an aromatase inhibitor (e.g., anastrozole, letrozole, exemestane)
- Used in combination with Faslodex (fulvestrant)

**AND**

**4** - ONE of the following:

**4.1** One of the following:

**4.1.1** Failure to Verzenio (abemaciclib) confirmed by claims history or submission of medical records

**OR**

**4.1.2** History of contraindication or intolerance to Verzenio (abemaciclib) (please specify intolerance or contraindication)

**OR**

**4.2** 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| KISQALI | RIBOCICLIB SUCCINATE TAB PACK 200 MG DAILY DOSE | 2153107050B720 | Brand |
| KISQALI | RIBOCICLIB SUCCINATE TAB PACK 400 MG DAILY DOSE (200 MG TAB) | 2153107050B740 | Brand |
| KISQALI | RIBOCICLIB SUCCINATE TAB PACK 600 MG DAILY DOSE (200 MG TAB) | 2153107050B760 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| KISQALI | RIBOCICLIB SUCCINATE TAB PACK 200 MG DAILY DOSE | 2153107050B720 | Brand |
| KISQALI | RIBOCICLIB SUCCINATE TAB PACK 400 MG DAILY DOSE (200 MG TAB) | 2153107050B740 | Brand |
| KISQALI | RIBOCICLIB SUCCINATE TAB PACK 600 MG DAILY DOSE (200 MG TAB) | 2153107050B760 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| KISQALI | RIBOCICLIB SUCCINATE TAB PACK 200 MG DAILY DOSE | 2153107050B720 | Brand |
| KISQALI | RIBOCICLIB SUCCINATE TAB PACK 400 MG DAILY DOSE (200 MG TAB) | 2153107050B740 | Brand |
| KISQALI | RIBOCICLIB SUCCINATE TAB PACK 600 MG DAILY DOSE (200 MG TAB) | 2153107050B760 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| KISQALI | RIBOCICLIB SUCCINATE TAB PACK 200 MG DAILY DOSE | 2153107050B720 | Brand |
| KISQALI | RIBOCICLIB SUCCINATE TAB PACK 400 MG DAILY DOSE (200 MG TAB) | 2153107050B740 | Brand |
| KISQALI | RIBOCICLIB SUCCINATE TAB PACK 600 MG DAILY DOSE (200 MG TAB) | 2153107050B760 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Kisqali therapy

Kisqali Femara Co-Pack

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146564 |
| **Guideline Name** | Kisqali Femara Co-Pack |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Kisqali Femara Co-Pack | |
|---|---|
| Diagnosis | Breast Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| KISQALI FEMARA 200 DOSE | RIBOCICLIB 200 MG DOSE (200 MG TAB) & LETROZOLE 2.5 MG TBPK | 2199000260B730 | Brand |
| KISQALI FEMARA 400 DOSE | RIBOCICLIB 400 MG DOSE (200 MG TAB) & LETROZOLE 2.5 MG TBPK | 2199000260B740 | Brand |

| KISQALI FEMARA 600 DOSE | RIBOCICLIB 600 MG DOSE (200 MG TAB) & LETROZOLE 2.5 MG TBPK | 2199000260B760 | Brand |
|---|---|---|---|

**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:

**4.1** Failure to Verzenio (abemaciclib) plus an aromatase inhibitor (e.g., anastrozole, letrozole) confirmed by claims history or submission of medical records

**OR**

**4.2** History of contraindication or intolerance to Verzenio (abemaciclib) plus an aromatase inhibitor (e.g., anastrozole, letrozole) (please specify intolerance or contraindication)

**OR**

**4.3** 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| KISQALI FEMARA 200 DOSE | RIBOCICLIB 200 MG DOSE (200 MG TAB) & LETROZOLE 2.5 MG TBPK | 2199000260B730 | Brand |
| KISQALI FEMARA 400 DOSE | RIBOCICLIB 400 MG DOSE (200 MG TAB) & LETROZOLE 2.5 MG TBPK | 2199000260B740 | Brand |
| KISQALI FEMARA 600 DOSE | RIBOCICLIB 600 MG DOSE (200 MG TAB) & LETROZOLE 2.5 MG TBPK | 2199000260B760 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| KISQALI FEMARA 200 DOSE | RIBOCICLIB 200 MG DOSE (200 MG TAB) & LETROZOLE 2.5 MG TBPK | 2199000260B730 | Brand |
| KISQALI FEMARA 400 DOSE | RIBOCICLIB 400 MG DOSE (200 MG TAB) & LETROZOLE 2.5 MG TBPK | 2199000260B740 | Brand |

| | | | |
|---|---|---|---|
| KISQALI FEMARA 600 DOSE | RIBOCICLIB 600 MG DOSE (200 MG TAB) & LETROZOLE 2.5 MG TBPK | 2199000260B760 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| KISQALI FEMARA 200 DOSE | RIBOCICLIB 200 MG DOSE (200 MG TAB) & LETROZOLE 2.5 MG TBPK | 2199000260B730 | Brand |
| KISQALI FEMARA 400 DOSE | RIBOCICLIB 400 MG DOSE (200 MG TAB) & LETROZOLE 2.5 MG TBPK | 2199000260B740 | Brand |
| KISQALI FEMARA 600 DOSE | RIBOCICLIB 600 MG DOSE (200 MG TAB) & LETROZOLE 2.5 MG TBPK | 2199000260B760 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| KISQALI FEMARA 200 DOSE | RIBOCICLIB 200 MG DOSE (200 MG TAB) & LETROZOLE 2.5 MG TBPK | 2199000260B730 | Brand |
| KISQALI FEMARA 400 DOSE | RIBOCICLIB 400 MG DOSE (200 MG TAB) & LETROZOLE 2.5 MG TBPK | 2199000260B740 | Brand |
| KISQALI FEMARA 600 DOSE | RIBOCICLIB 600 MG DOSE (200 MG TAB) & LETROZOLE 2.5 MG TBPK | 2199000260B760 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Kisqali Femara Co-Pack therapy

Korlym

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-147303 |
| **Guideline Name** | Korlym |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Brand Korlym, generic mifepristone | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| KORLYM | MIFEPRISTONE TAB 300 MG | 27304050000330 | Brand |
| MIFEPRISTONE | MIFEPRISTONE TAB 300 MG | 27304050000330 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| KORLYM | MIFEPRISTONE TAB 300 MG | 27304050000330 | Brand |
| MIFEPRISTONE | MIFEPRISTONE TAB 300 MG | 27304050000330 | Generic |

**Approval Criteria**

**1** - Documentation of a positive clinical response while on the requested therapy

## 2 . Revision History

| Date | Notes |
| --- | --- |
| 5/13/2024 | Updated reauthorization criteria and added generic mifepristone as a target. Updated product name lists and GPI tables accordingly. |

Koselugo

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-158111 |
| **Guideline Name** | Koselugo |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 12/1/2024 |

## 1 . Criteria

| Product Name: Koselugo | |
|---|---|
| Diagnosis | Neurofibromatosis Type 1 |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| KOSELUGO | SELUMETINIB SULFATE CAP 10 MG | 21533565500110 | Brand |
| KOSELUGO | SELUMETINIB SULFATE CAP 25 MG | 21533565500125 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| KOSELUGO | SELUMETINIB SULFATE CAP 10 MG | 21533565500110 | Brand |
| KOSELUGO | SELUMETINIB SULFATE CAP 25 MG | 21533565500125 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| KOSELUGO | SELUMETINIB SULFATE CAP 10 MG | 21533565500110 | Brand |
| KOSELUGO | SELUMETINIB SULFATE CAP 25 MG | 21533565500125 | Brand |

**Approval Criteria**

**1** - Diagnosis of Langerhans cell histiocytosis

**AND**

**2** - ONE of the following:

- Presence of 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| KOSELUGO | SELUMETINIB SULFATE CAP 10 MG | 21533565500110 | Brand |
| KOSELUGO | SELUMETINIB SULFATE CAP 25 MG | 21533565500125 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| KOSELUGO | SELUMETINIB SULFATE CAP 10 MG | 21533565500110 | Brand |
| KOSELUGO | SELUMETINIB SULFATE CAP 25 MG | 21533565500125 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| KOSELUGO | SELUMETINIB SULFATE CAP 10 MG | 21533565500110 | Brand |
| KOSELUGO | SELUMETINIB SULFATE CAP 25 MG | 21533565500125 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Koselugo therapy

## 2 . Revision History

| Date | Notes |
|---|---|
| 10/28/2024 | Updated diagnosis header in reauth section to remove reference to p ilocytic astrocytoma and added glioma. |

Krazati

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-156450 |
| **Guideline Name** | Krazati |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 11/1/2024 |

## 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| KRAZATI | ADAGRASIB TAB 200 MG | 21532410000320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| KRAZATI | ADAGRASIB TAB 200 MG | 21532410000320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| KRAZATI | ADAGRASIB TAB 200 MG | 21532410000320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| KRAZATI | ADAGRASIB TAB 200 MG | 21532410000320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| KRAZATI | ADAGRASIB TAB 200 MG | 21532410000320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| KRAZATI | ADAGRASIB TAB 200 MG | 21532410000320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| KRAZATI | ADAGRASIB TAB 200 MG | 21532410000320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| KRAZATI | ADAGRASIB TAB 200 MG | 21532410000320 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Krazati therapy

## 2 . Revision History

| Date | Notes |
|---|---|
| 9/30/2024 | Combined criteria for colon and rectal cancer in one section – Colorectal Cancer. Added criteria for NCCN recommended use of Krazati in biliary tract cancer. |

Kuvan

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146568 |
| **Guideline Name** | Kuvan |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: generic sapropterin, Brand Kuvan | |
|---|---|
| Diagnosis | Phenylketonuria (PKU) |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SAPROPTERIN DIHYDROCHLORIDE | SAPROPTERIN DIHYDROCHLORIDE TAB 100 MG | 30908565100320 | Generic |
| KUVAN | SAPROPTERIN DIHYDROCHLORIDE TAB 100 MG | 30908565100320 | Brand |
| SAPROPTERIN DIHYDROCHLORIDE | SAPROPTERIN DIHYDROCHLORIDE POWDER PACKET 100 MG | 30908565103020 | Generic |
| KUVAN | SAPROPTERIN DIHYDROCHLORIDE POWDER PACKET 100 MG | 30908565103020 | Brand |

| | | | |
|---|---|---|---|
| SAPROPTERIN DIHYDROCHLORIDE | SAPROPTERIN DIHYDROCHLORIDE POWDER PACKET 500 MG | 30908565103040 | Generic |
| KUVAN | SAPROPTERIN DIHYDROCHLORIDE POWDER PACKET 500 MG | 30908565103040 | Brand |

**Approval Criteria**

**1** - Diagnosis of phenylketonuria (PKU)

Kynmobi

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146569 |
| **Guideline Name** | Kynmobi |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Kynmobi | |
|---|---|
| Approval Length | 6 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| KYNMOBI TITRATION KIT | APOMORPHINE HCL FILM 10/15/20/25/30 MG TITRATION KIT | 73203010106420 | Brand |
| KYNMOBI | APOMORPHINE HYDROCHLORIDE FILM 10 MG | 73203010108210 | Brand |
| KYNMOBI | APOMORPHINE HYDROCHLORIDE FILM 15 MG | 73203010108215 | Brand |
| KYNMOBI | APOMORPHINE HYDROCHLORIDE FILM 20 MG | 73203010108220 | Brand |

| | | | |
|---|---|---|---|
| KYNMOBI | APOMORPHINE HYDROCHLORIDE FILM 25 MG | 73203010108225 | Brand |
| KYNMOBI | APOMORPHINE HYDROCHLORIDE FILM 30 MG | 73203010108230 | Brand |

**Approval Criteria**

**1** - Diagnosis of Parkinson's disease

**AND**

**2** - Kynmobi 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:

**5.1** 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

**AND**

**5.2** 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) 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**

**6.2** Contraindication or intolerance to ALL anti-Parkinson's disease therapies from the following adjunctive pharmacotherapy classes (please specify contraindication or intolerance):

- 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: Kynmobi | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| KYNMOBI TITRATION KIT | APOMORPHINE HCL FILM 10/15/20/25/30 MG TITRATION KIT | 73203010106420 | Brand |
| KYNMOBI | APOMORPHINE HYDROCHLORIDE FILM 10 MG | 73203010108210 | Brand |
| KYNMOBI | APOMORPHINE HYDROCHLORIDE FILM 15 MG | 73203010108215 | Brand |
| KYNMOBI | APOMORPHINE HYDROCHLORIDE FILM 20 MG | 73203010108220 | Brand |
| KYNMOBI | APOMORPHINE HYDROCHLORIDE FILM 25 MG | 73203010108225 | Brand |
| KYNMOBI | APOMORPHINE HYDROCHLORIDE FILM 30 MG | 73203010108230 | Brand |

**Approval Criteria**

**1** - Documentation of a positive clinical response to Kynmobi therapy

**AND**

**2** - Patient will continue to receive treatment with a carbidopa/levodopa-containing medication

Lampit

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146352 |
| **Guideline Name** | Lampit |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Lampit | |
|---|---|
| Diagnosis | Chagas disease (American trypanosomiasis) |
| Approval Length | 60 Day(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LAMPIT | NIFURTIMOX TAB 30 MG | 16400055000320 | Brand |
| LAMPIT | NIFURTIMOX TAB 120 MG | 16400055000340 | Brand |

**Approval Criteria**

**1** - Diagnosis of Chagas disease (American trypanosomiasis) caused by Trypanosoma cruzi

Lazcluze

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-160564 |
| **Guideline Name** | Lazcluze |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LAZCLUZE | LAZERTINIB MESYLATE TAB 80 MG | 21360048300320 | Brand |
| LAZCLUZE | LAZERTINIB MESYLATE TAB 240 MG | 21360048300340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LAZCLUZE | LAZERTINIB MESYLATE TAB 80 MG | 21360048300320 | Brand |
| LAZCLUZE | LAZERTINIB MESYLATE TAB 240 MG | 21360048300340 | Brand |

**Approval Criteria**

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

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LAZCLUZE | LAZERTINIB MESYLATE TAB 80 MG | 21360048300320 | Brand |
| LAZCLUZE | LAZERTINIB MESYLATE TAB 240 MG | 21360048300340 | Brand |

**Approval Criteria**

**1** - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

| Product Name: Lazcluze | |
|---|---|
| Diagnosis | NCCN Recommended Regimen |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LAZCLUZE | LAZERTINIB MESYLATE TAB 80 MG | 21360048300320 | Brand |
| LAZCLUZE | LAZERTINIB MESYLATE TAB 240 MG | 21360048300340 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Lazcluze therapy

## 2 . Revision History

| Date | Notes |
|---|---|
| 11/13/2024 | New program |

Lenvima

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146570 |
| **Guideline Name** | Lenvima |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Lenvima | |
|---|---|
| Diagnosis | Renal Cell Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LENVIMA 4 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 4 MG (4 MG DAILY DOSE) | 2133505420B210 | Brand |
| LENVIMA 8 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 2 X 4 MG (8 MG DAILY DOSE) | 2133505420B215 | Brand |

| | | | |
|---|---|---|---|
| LENVIMA 10 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 10 MG (10 MG DAILY DOSE) | 2133505420B220 | Brand |
| LENVIMA 12MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 3 X 4 MG (12 MG DAILY DOSE) | 2133505420B223 | Brand |
| LENVIMA 20 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 2 X 10 MG (20 MG DAILY DOSE) | 2133505420B230 | Brand |
| LENVIMA 14 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 10 & 4 MG (14 MG DAILY DOSE) | 2133505420B240 | Brand |
| LENVIMA 18 MG DAILY DOSE | LENVATINIB CAP THER PACK 10 MG & 2 X 4 MG (18 MG DAILY DOSE) | 2133505420B244 | Brand |
| LENVIMA 24 MG DAILY DOSE | LENVATINIB CAP THER PACK 2 X 10 MG & 4 MG (24 MG DAILY DOSE) | 2133505420B250 | Brand |

**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:

**2.1.1.1** 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)]

**OR**

**2.1.1.2** 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)

| Product Name: Lenvima | |
|---|---|
| Diagnosis | Renal Cell Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LENVIMA 4 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 4 MG (4 MG DAILY DOSE) | 2133505420B210 | Brand |
| LENVIMA 8 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 2 X 4 MG (8 MG DAILY DOSE) | 2133505420B215 | Brand |
| LENVIMA 10 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 10 MG (10 MG DAILY DOSE) | 2133505420B220 | Brand |
| LENVIMA 12MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 3 X 4 MG (12 MG DAILY DOSE) | 2133505420B223 | Brand |
| LENVIMA 20 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 2 X 10 MG (20 MG DAILY DOSE) | 2133505420B230 | Brand |
| LENVIMA 14 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 10 & 4 MG (14 MG DAILY DOSE) | 2133505420B240 | Brand |

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|---|---|---|---|
| LENVIMA 18 MG DAILY DOSE | LENVATINIB CAP THER PACK 10 MG & 2 X 4 MG (18 MG DAILY DOSE) | 2133505420B244 | Brand |
| LENVIMA 24 MG DAILY DOSE | LENVATINIB CAP THER PACK 2 X 10 MG & 4 MG (24 MG DAILY DOSE) | 2133505420B250 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LENVIMA 4 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 4 MG (4 MG DAILY DOSE) | 2133505420B210 | Brand |
| LENVIMA 8 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 2 X 4 MG (8 MG DAILY DOSE) | 2133505420B215 | Brand |
| LENVIMA 10 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 10 MG (10 MG DAILY DOSE) | 2133505420B220 | Brand |
| LENVIMA 12MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 3 X 4 MG (12 MG DAILY DOSE) | 2133505420B223 | Brand |
| LENVIMA 20 MG | LENVATINIB CAP THERAPY PACK 2 X 10 MG (20 MG DAILY DOSE) | 2133505420B230 | Brand |

| | | | |
|---|---|---|---|
| DAILY DOSE | | | |
| LENVIMA 14 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 10 & 4 MG (14 MG DAILY DOSE) | 2133505420B240 | Brand |
| LENVIMA 18 MG DAILY DOSE | LENVATINIB CAP THER PACK 10 MG & 2 X 4 MG (18 MG DAILY DOSE) | 2133505420B244 | Brand |
| LENVIMA 24 MG DAILY DOSE | LENVATINIB CAP THER PACK 2 X 10 MG & 4 MG (24 MG DAILY DOSE) | 2133505420B250 | Brand |

**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 | Hepatobiliary Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LENVIMA 4 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 4 MG (4 MG DAILY DOSE) | 2133505420B210 | Brand |

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|---|---|---|---|
| LENVIMA 8 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 2 X 4 MG (8 MG DAILY DOSE) | 2133505420B215 | Brand |
| LENVIMA 10 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 10 MG (10 MG DAILY DOSE) | 2133505420B220 | Brand |
| LENVIMA 12MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 3 X 4 MG (12 MG DAILY DOSE) | 2133505420B223 | Brand |
| LENVIMA 20 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 2 X 10 MG (20 MG DAILY DOSE) | 2133505420B230 | Brand |
| LENVIMA 14 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 10 & 4 MG (14 MG DAILY DOSE) | 2133505420B240 | Brand |
| LENVIMA 18 MG DAILY DOSE | LENVATINIB CAP THER PACK 10 MG & 2 X 4 MG (18 MG DAILY DOSE) | 2133505420B244 | Brand |
| LENVIMA 24 MG DAILY DOSE | LENVATINIB CAP THER PACK 2 X 10 MG & 4 MG (24 MG DAILY DOSE) | 2133505420B250 | Brand |

**Approval Criteria**

**1** - ONE of the following:

**1.1** BOTH of the following:

**1.1.1** Diagnosis of hepatocellular carcinoma

**AND**

**1.1.2** Disease is ONE of the following:

- Unresectable
- Metastatic

**OR**

**1.2** ALL of the following:

**1.2.1** Diagnosis of biliary tract cancer

**AND**

**1.2.2** Disease is ONE of the following:

- Unresectable or resected gross residual (R2) disease
- Metastatic

**AND**

**1.2.3** Disease has progressed on or after systemic treatment

**AND**

**1.2.4** Used in combination with Keytruda (pembrolizumab)

| Product Name: Lenvima | |
|---|---|
| Diagnosis | Adenoid Cystic Carcinoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LENVIMA 4 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 4 MG (4 MG DAILY DOSE) | 2133505420B210 | Brand |
| LENVIMA 8 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 2 X 4 MG (8 MG DAILY DOSE) | 2133505420B215 | Brand |
| LENVIMA 10 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 10 MG (10 MG DAILY DOSE) | 2133505420B220 | Brand |

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|---|---|---|---|
| LENVIMA 12MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 3 X 4 MG (12 MG DAILY DOSE) | 2133505420B223 | Brand |
| LENVIMA 20 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 2 X 10 MG (20 MG DAILY DOSE) | 2133505420B230 | Brand |
| LENVIMA 14 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 10 & 4 MG (14 MG DAILY DOSE) | 2133505420B240 | Brand |
| LENVIMA 18 MG DAILY DOSE | LENVATINIB CAP THER PACK 10 MG & 2 X 4 MG (18 MG DAILY DOSE) | 2133505420B244 | Brand |
| LENVIMA 24 MG DAILY DOSE | LENVATINIB CAP THER PACK 2 X 10 MG & 4 MG (24 MG DAILY DOSE) | 2133505420B250 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LENVIMA 4 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 4 MG (4 MG DAILY DOSE) | 2133505420B210 | Brand |
| LENVIMA 8 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 2 X 4 MG (8 MG DAILY DOSE) | 2133505420B215 | Brand |
| LENVIMA 10 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 10 MG (10 MG DAILY DOSE) | 2133505420B220 | Brand |
| LENVIMA 12MG | LENVATINIB CAP THERAPY PACK 3 X 4 MG (12 MG DAILY DOSE) | 2133505420B223 | Brand |

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|---|---|---|---|
| DAILY DOSE | | | |
| LENVIMA 20 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 2 X 10 MG (20 MG DAILY DOSE) | 2133505420B230 | Brand |
| LENVIMA 14 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 10 & 4 MG (14 MG DAILY DOSE) | 2133505420B240 | Brand |
| LENVIMA 18 MG DAILY DOSE | LENVATINIB CAP THER PACK 10 MG & 2 X 4 MG (18 MG DAILY DOSE) | 2133505420B244 | Brand |
| LENVIMA 24 MG DAILY DOSE | LENVATINIB CAP THER PACK 2 X 10 MG & 4 MG (24 MG DAILY DOSE) | 2133505420B250 | Brand |

**Approval Criteria**

**1** - Diagnosis of thymic carcinoma

**AND**

**2** - ONE of the following:

**2.1** Used as a single agent for those who cannot tolerate first-line combination regimens

**OR**

**2.2** Used as a second line therapy in unresectable locally advanced disease, solitary metastasis or ipsilateral pleural metastasis, or extrathoracic metastatic disease

| Product Name: Lenvima | |
|---|---|
| Diagnosis | Thyroid Cancer, Hepatobiliary Cancer, Adenoid Cystic Carcinoma, Thymic Carcinoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LENVIMA 4 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 4 MG (4 MG DAILY DOSE) | 2133505420B210 | Brand |
| LENVIMA 8 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 2 X 4 MG (8 MG DAILY DOSE) | 2133505420B215 | Brand |
| LENVIMA 10 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 10 MG (10 MG DAILY DOSE) | 2133505420B220 | Brand |
| LENVIMA 12MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 3 X 4 MG (12 MG DAILY DOSE) | 2133505420B223 | Brand |
| LENVIMA 20 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 2 X 10 MG (20 MG DAILY DOSE) | 2133505420B230 | Brand |
| LENVIMA 14 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 10 & 4 MG (14 MG DAILY DOSE) | 2133505420B240 | Brand |
| LENVIMA 18 MG DAILY DOSE | LENVATINIB CAP THER PACK 10 MG & 2 X 4 MG (18 MG DAILY DOSE) | 2133505420B244 | Brand |
| LENVIMA 24 MG DAILY DOSE | LENVATINIB CAP THER PACK 2 X 10 MG & 4 MG (24 MG DAILY DOSE) | 2133505420B250 | Brand |

**Approval Criteria**

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

| Product Name: Lenvima | |
|---|---|
| Diagnosis | Endometrial Carcinoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LENVIMA 4 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 4 MG (4 MG DAILY DOSE) | 2133505420B210 | Brand |
| LENVIMA 8 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 2 X 4 MG (8 MG DAILY DOSE) | 2133505420B215 | Brand |
| LENVIMA 10 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 10 MG (10 MG DAILY DOSE) | 2133505420B220 | Brand |
| LENVIMA 12MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 3 X 4 MG (12 MG DAILY DOSE) | 2133505420B223 | Brand |
| LENVIMA 20 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 2 X 10 MG (20 MG DAILY DOSE) | 2133505420B230 | Brand |
| LENVIMA 14 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 10 & 4 MG (14 MG DAILY DOSE) | 2133505420B240 | Brand |
| LENVIMA 18 MG DAILY DOSE | LENVATINIB CAP THER PACK 10 MG & 2 X 4 MG (18 MG DAILY DOSE) | 2133505420B244 | Brand |
| LENVIMA 24 MG DAILY DOSE | LENVATINIB CAP THER PACK 2 X 10 MG & 4 MG (24 MG DAILY DOSE) | 2133505420B250 | Brand |

**Approval Criteria**

**1** - Diagnosis of endometrial carcinoma

**AND**

**2** - Used in combination with Keytruda (pembrolizumab)

| Product Name: Lenvima | |
|---|---|
| Diagnosis | Cutaneous Melanoma |

| | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LENVIMA 4 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 4 MG (4 MG DAILY DOSE) | 2133505420B210 | Brand |
| LENVIMA 8 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 2 X 4 MG (8 MG DAILY DOSE) | 2133505420B215 | Brand |
| LENVIMA 10 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 10 MG (10 MG DAILY DOSE) | 2133505420B220 | Brand |
| LENVIMA 12MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 3 X 4 MG (12 MG DAILY DOSE) | 2133505420B223 | Brand |
| LENVIMA 20 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 2 X 10 MG (20 MG DAILY DOSE) | 2133505420B230 | Brand |
| LENVIMA 14 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 10 & 4 MG (14 MG DAILY DOSE) | 2133505420B240 | Brand |
| LENVIMA 18 MG DAILY DOSE | LENVATINIB CAP THER PACK 10 MG & 2 X 4 MG (18 MG DAILY DOSE) | 2133505420B244 | Brand |
| LENVIMA 24 MG DAILY DOSE | LENVATINIB CAP THER PACK 2 X 10 MG & 4 MG (24 MG DAILY DOSE) | 2133505420B250 | Brand |

**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 | Endometrial Carcinoma, Cutaneous Melanoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LENVIMA 4 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 4 MG (4 MG DAILY DOSE) | 2133505420B210 | Brand |
| LENVIMA 8 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 2 X 4 MG (8 MG DAILY DOSE) | 2133505420B215 | Brand |
| LENVIMA 10 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 10 MG (10 MG DAILY DOSE) | 2133505420B220 | Brand |
| LENVIMA 12MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 3 X 4 MG (12 MG DAILY DOSE) | 2133505420B223 | Brand |
| LENVIMA 20 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 2 X 10 MG (20 MG DAILY DOSE) | 2133505420B230 | Brand |
| LENVIMA 14 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 10 & 4 MG (14 MG DAILY DOSE) | 2133505420B240 | Brand |
| LENVIMA 18 MG DAILY DOSE | LENVATINIB CAP THER PACK 10 MG & 2 X 4 MG (18 MG DAILY DOSE) | 2133505420B244 | Brand |
| LENVIMA 24 MG | LENVATINIB CAP THER PACK 2 X 10 MG & 4 MG (24 MG DAILY DOSE) | 2133505420B250 | Brand |

| | | | |
|---|---|---|---|
| DAILY DOSE | | | |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LENVIMA 4 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 4 MG (4 MG DAILY DOSE) | 2133505420B210 | Brand |
| LENVIMA 8 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 2 X 4 MG (8 MG DAILY DOSE) | 2133505420B215 | Brand |
| LENVIMA 10 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 10 MG (10 MG DAILY DOSE) | 2133505420B220 | Brand |
| LENVIMA 12MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 3 X 4 MG (12 MG DAILY DOSE) | 2133505420B223 | Brand |
| LENVIMA 20 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 2 X 10 MG (20 MG DAILY DOSE) | 2133505420B230 | Brand |
| LENVIMA 14 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 10 & 4 MG (14 MG DAILY DOSE) | 2133505420B240 | Brand |

| | | | |
|---|---|---|---|
| LENVIMA 18 MG DAILY DOSE | LENVATINIB CAP THER PACK 10 MG & 2 X 4 MG (18 MG DAILY DOSE) | 2133505420B244 | Brand |
| LENVIMA 24 MG DAILY DOSE | LENVATINIB CAP THER PACK 2 X 10 MG & 4 MG (24 MG DAILY DOSE) | 2133505420B250 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LENVIMA 4 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 4 MG (4 MG DAILY DOSE) | 2133505420B210 | Brand |
| LENVIMA 8 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 2 X 4 MG (8 MG DAILY DOSE) | 2133505420B215 | Brand |
| LENVIMA 10 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 10 MG (10 MG DAILY DOSE) | 2133505420B220 | Brand |
| LENVIMA 12MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 3 X 4 MG (12 MG DAILY DOSE) | 2133505420B223 | Brand |
| LENVIMA 20 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 2 X 10 MG (20 MG DAILY DOSE) | 2133505420B230 | Brand |
| LENVIMA 14 MG DAILY DOSE | LENVATINIB CAP THERAPY PACK 10 & 4 MG (14 MG DAILY DOSE) | 2133505420B240 | Brand |

| | | | |
|---|---|---|---|
| LENVIMA 18 MG DAILY DOSE | LENVATINIB CAP THER PACK 10 MG & 2 X 4 MG (18 MG DAILY DOSE) | 2133505420B244 | Brand |
| LENVIMA 24 MG DAILY DOSE | LENVATINIB CAP THER PACK 2 X 10 MG & 4 MG (24 MG DAILY DOSE) | 2133505420B250 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Lenvima therapy

Lidoderm

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146353 |
| **Guideline Name** | Lidoderm |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: generic lidocaine 5% patch, Brand Lidocan III, Brand Lidoderm, Brand Lidocan | |
|---|---|
| Diagnosis | Post-Herpetic Neuralgia |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LIDOCAINE | LIDOCAINE PATCH 5% | 90850060005930 | Generic |
| LIDOCAN III | LIDOCAINE PATCH 5% | 90850060005930 | Brand |
| LIDODERM | LIDOCAINE PATCH 5% | 90850060005930 | Brand |
| LIDOCAN | LIDOCAINE PATCH 5% | 90850060005930 | Brand |

| | | | |
|---|---|---|---|
| LIDOCAINE PATCH 5% | LIDOCAINE PATCH 5% | 90850060005930 | Generic |

**Approval Criteria**

**1** - Diagnosis of post-herpetic neuralgia

| Product Name: generic lidocaine 5% patch, Brand Lidocan III, Brand Lidoderm, Brand Lidocan | |
|---|---|
| Diagnosis | Neuropathic Pain |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LIDOCAINE | LIDOCAINE PATCH 5% | 90850060005930 | Generic |
| LIDOCAN III | LIDOCAINE PATCH 5% | 90850060005930 | Brand |
| LIDODERM | LIDOCAINE PATCH 5% | 90850060005930 | Brand |
| LIDOCAN | LIDOCAINE PATCH 5% | 90850060005930 | Brand |
| LIDOCAINE PATCH 5% | LIDOCAINE PATCH 5% | 90850060005930 | Generic |

**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 Lidocan III, Brand Lidoderm, Brand Lidocan | |
|---|---|
| Diagnosis | Neuropathic Pain |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LIDOCAINE | LIDOCAINE PATCH 5% | 90850060005930 | Generic |
| LIDOCAN III | LIDOCAINE PATCH 5% | 90850060005930 | Brand |
| LIDODERM | LIDOCAINE PATCH 5% | 90850060005930 | Brand |
| LIDOCAN | LIDOCAINE PATCH 5% | 90850060005930 | Brand |
| LIDOCAINE PATCH 5% | LIDOCAINE PATCH 5% | 90850060005930 | Generic |

**Approval Criteria**

**1** - Documentation of positive clinical response to the requested therapy

Litfulo

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146284 |
| **Guideline Name** | Litfulo |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LITFULO | RITLECITINIB TOSYLATE CAP 50 MG (BASE EQUIV) | 90731060100120 | Brand |

**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 has a current episode of alopecia areata with at least 50% scalp hair loss

**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 any of the following:

- Biologic DMARD (disease modifying anti-rheumatic drug) [e.g., Enbrel (etanercept), adalimumab, Cimzia (certolizumab), Simponi (golimumab)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]
- Janus kinase inhibitor [e.g., Xeljanz/Xeljanz XR (tofacitinib), Rinvoq (upadacitinib]

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LITFULO | RITLECITINIB TOSYLATE CAP 50 MG (BASE EQUIV) | 90731060100120 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Litfulo therapy

**AND**

**2** - Patient is not receiving Litfulo in combination with any of the following:

- Biologic DMARD [e.g., Enbrel (etanercept), adalimumab, Cimzia (certolizumab), Simponi (golimumab)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]
- Janus kinase inhibitor [e.g., Xeljanz/Xeljanz XR (tofacitinib), Rinvoq (upadacitinib]

Livmarli

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-158235 |
| **Guideline Name** | Livmarli |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 12/1/2024 |

## 1 . Criteria

| Product Name: Livmarli | |
|---|---|
| Diagnosis | Progressive Familial Intrahepatic Cholestasis (PFIC) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LIVMARLI | MARALIXIBAT CHLORIDE ORAL SOLN 9.5 MG/ML | 52350050102020 | Brand |
| LIVMARLI | MARALIXIBAT CHLORIDE ORAL SOLN 19 MG/ML | 52350050102040 | Brand |

**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 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 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LIVMARLI | MARALIXIBAT CHLORIDE ORAL SOLN 9.5 MG/ML | 52350050102020 | Brand |
| LIVMARLI | MARALIXIBAT CHLORIDE ORAL SOLN 19 MG/ML | 52350050102040 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Livmarli therapy (e.g., reduced serum bile acids, improved pruritis 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LIVMARLI | MARALIXIBAT CHLORIDE ORAL SOLN 9.5 MG/ML | 52350050102020 | Brand |
| LIVMARLI | MARALIXIBAT CHLORIDE ORAL SOLN 19 MG/ML | 52350050102040 | Brand |

**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 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LIVMARLI | MARALIXIBAT CHLORIDE ORAL SOLN 9.5 MG/ML | 52350050102020 | Brand |
| LIVMARLI | MARALIXIBAT CHLORIDE ORAL SOLN 19 MG/ML | 52350050102040 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Livmarli therapy (e.g., reduced serum bile acids, improved pruritis)

**AND**

**2** - Prescribed by a gastroenterologist or hepatologist.

## 2 . Revision History

| Date | Notes |
|---|---|
| 10/30/2024 | Updated examples of conventional treatment within initial authorizati on criteria for both PFIC and ALGS. Corrected spelling of pruritus. |

Livtencity

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146572 |
| **Guideline Name** | Livtencity |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Livtencity | |
|---|---|
| Approval Length | 2 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LIVTENCITY | MARIBAVIR TAB 200 MG | 12200050000320 | Brand |

**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 the requested medication in combination with ganciclovir or valganciclovir

Lokelma, Veltassa

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-154650 |
| **Guideline Name** | Lokelma, Veltassa |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 10/1/2024 |

## 1 . Criteria

| Product Name: Lokelma, Veltassa | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LOKELMA | SODIUM ZIRCONIUM CYCLOSILICATE FOR SUSP PACKET 5 GM | 99450020003020 | Brand |
| LOKELMA | SODIUM ZIRCONIUM CYCLOSILICATE FOR SUSP PACKET 10 GM | 99450020003040 | Brand |
| VELTASSA | PATIROMER SORBITEX CALCIUM FOR SUSP PACKET 8.4 GM (BASE EQ) | 99450060203020 | Brand |

| | | | |
|---|---|---|---|
| VELTASSA | PATIROMER SORBITEX CALCIUM FOR SUSP PACKET 16.8 GM (BASE EQ) | 99450060203030 | Brand |
| VELTASSA | PATIROMER SORBITEX CALCIUM FOR SUSP PACKET 25.2 GM (BASE EQ) | 99450060203040 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LOKELMA | SODIUM ZIRCONIUM CYCLOSILICATE FOR SUSP PACKET 5 GM | 99450020003020 | Brand |
| LOKELMA | SODIUM ZIRCONIUM CYCLOSILICATE FOR SUSP PACKET 10 GM | 99450020003040 | Brand |
| VELTASSA | PATIROMER SORBITEX CALCIUM FOR SUSP PACKET 8.4 GM (BASE EQ) | 99450060203020 | Brand |
| VELTASSA | PATIROMER SORBITEX CALCIUM FOR SUSP PACKET 16.8 GM (BASE EQ) | 99450060203030 | Brand |
| VELTASSA | PATIROMER SORBITEX CALCIUM FOR SUSP PACKET 25.2 GM (BASE EQ) | 99450060203040 | Brand |

| **Approval Criteria** |
|---|
| **1** - Patient has a positive clinical response to Lokelma or Veltassa therapy<br><br>**AND**<br><br>**2** - Patient continues to require treatment for hyperkalemia<br><br>**AND**<br><br>**3** - Patient follows a low potassium diet (less than or equal to 3 grams per day) |

## 2 . Revision History

| Date | Notes |
|---|---|
| 9/9/2024 | Removed requirement to adjust medications. |

Long-Acting Opioid Products

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-162060 |
| **Guideline Name** | Long-Acting Opioid Products |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 1 . Criteria

| 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 tabs/soln, generic methadone conc, Brand Methadose conc, tramadol ER, Conzip, Brand Zohydro ER | |
|---|---|
| Diagnosis | DUR: Opioid Naïve (Not having filled an opioid in the past 60 days) exceeding the 7 day supply limit* |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MORPHINE SULFATE ER | MORPHINE SULFATE TAB ER 15 MG | 65100055100415 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE TAB ER 30 MG | 65100055100432 | Generic |

| | | | |
|---|---|---|---|
| MORPHINE SULFATE ER | MORPHINE SULFATE TAB ER 60 MG | 65100055100445 | Generic |
| MORPHINE SULFATE CR | MORPHINE SULFATE TAB ER 60 MG | 65100055100445 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE TAB ER 100 MG | 65100055100460 | Generic |
| MORPHINE SULFATE CR | MORPHINE SULFATE TAB ER 100 MG | 65100055100460 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE TAB ER 200 MG | 65100055100480 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 12 MCG/HR | 65100025008610 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 25 MCG/HR | 65100025008620 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 50 MCG/HR | 65100025008630 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 75 MCG/HR | 65100025008640 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 100 MCG/HR | 65100025008650 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE CAP ER 12HR 10 MG | 65100030106910 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE CAP ER 12HR 15 MG | 65100030106915 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE CAP ER 12HR 20 MG | 65100030106920 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE CAP ER 12HR 30 MG | 65100030106930 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE CAP ER 12HR 40 MG | 65100030106940 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE CAP ER 12HR 50 MG | 65100030106950 | Generic |
| OXYMORPHONE HYDROCHLORIDE ER | OXYMORPHONE HCL TAB ER 12HR 5 MG | 65100080107405 | Generic |
| OXYMORPHONE HYDROCHLORIDE ER | OXYMORPHONE HCL TAB ER 12HR 7.5 MG | 65100080107407 | Generic |
| OXYMORPHONE HYDROCHLORIDE ER | OXYMORPHONE HCL TAB ER 12HR 10 MG | 65100080107410 | Generic |
| OXYMORPHONE HYDROCHLORIDE ER | OXYMORPHONE HCL TAB ER 12HR 15 MG | 65100080107415 | Generic |
| OXYMORPHONE HYDROCHLORIDE ER | OXYMORPHONE HCL TAB ER 12HR 20 MG | 65100080107420 | Generic |
| OXYMORPHONE HYDROCHLORIDE ER | OXYMORPHONE HCL TAB ER 12HR 30 MG | 65100080107430 | Generic |

| | | | |
|---|---|---|---|
| OXYMORPHONE HYDROCHLORIDEER | OXYMORPHONE HCL TAB ER 12HR 40 MG | 65100080107440 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 10 MG | 65100055107010 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 20 MG | 65100055107020 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 30 MG | 65100055107030 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 50 MG | 65100055107040 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 60 MG | 65100055107045 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 80 MG | 65100055107050 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 100 MG | 65100055107060 | Generic |
| HYDROMORPHONE HYDROCHLORIDE ER | HYDROMORPHONE HCL TAB ER 24HR 8 MG | 65100035107521 | Generic |
| HYDROMORPHONE HCL ER | HYDROMORPHONE HCL TAB ER 24HR 8 MG | 65100035107521 | Generic |
| HYDROMORPHONE HYDROCHLORIDE ER | HYDROMORPHONE HCL TAB ER 24HR 12 MG | 65100035107531 | Generic |
| HYDROMORPHONE HCL ER | HYDROMORPHONE HCL TAB ER 24HR 12 MG | 65100035107531 | Generic |
| HYDROMORPHONE HYDROCHLORIDE ER | HYDROMORPHONE HCL TAB ER 24HR 16 MG | 65100035107541 | Generic |
| HYDROMORPHONE HCL ER | HYDROMORPHONE HCL TAB ER 24HR 16 MG | 65100035107541 | Generic |
| HYDROMORPHONE HYDROCHLORIDE ER | HYDROMORPHONE HCL TAB ER 24HR 32 MG | 65100035107556 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG | 6510003010A810 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG | 6510003010A810 | Brand |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG | 6510003010A820 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG | 6510003010A820 | Brand |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG | 6510003010A830 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG | 6510003010A830 | Brand |

| | | | |
|---|---|---|---|
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG | 6510003010A840 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG | 6510003010A840 | Brand |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG | 6510003010A850 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG | 6510003010A850 | Brand |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG | 6510003010A860 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG | 6510003010A860 | Brand |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG | 6510003010A870 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG | 6510003010A870 | Brand |
| MS CONTIN | MORPHINE SULFATE TAB ER 15 MG | 65100055100415 | Brand |
| MS CONTIN | MORPHINE SULFATE TAB ER 30 MG | 65100055100432 | Brand |
| MS CONTIN | MORPHINE SULFATE TAB ER 60 MG | 65100055100445 | Brand |
| MS CONTIN | MORPHINE SULFATE TAB ER 100 MG | 65100055100460 | Brand |
| MS CONTIN | MORPHINE SULFATE TAB ER 200 MG | 65100055100480 | Brand |
| NUCYNTA ER | TAPENTADOL HCL TAB ER 12HR 50 MG | 65100091107420 | Brand |
| NUCYNTA ER | TAPENTADOL HCL TAB ER 12HR 100 MG | 65100091107430 | Brand |
| NUCYNTA ER | TAPENTADOL HCL TAB ER 12HR 150 MG | 65100091107440 | Brand |
| NUCYNTA ER | TAPENTADOL HCL TAB ER 12HR 200 MG | 65100091107450 | Brand |
| NUCYNTA ER | TAPENTADOL HCL TAB ER 12HR 250 MG | 65100091107460 | Brand |
| OXYCODONE HYDROCHLORIDE ER | OXYCODONE HCL TAB ER 12HR DETER 10 MG | 6510007510A710 | Generic |
| OXYCODONE HCL ER | OXYCODONE HCL TAB ER 12HR DETER 10 MG | 6510007510A710 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 10 MG | 6510007510A710 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 15 MG | 6510007510A715 | Brand |
| OXYCODONE HYDROCHLORIDE ER | OXYCODONE HCL TAB ER 12HR DETER 20 MG | 6510007510A720 | Generic |
| OXYCODONE HCL ER | OXYCODONE HCL TAB ER 12HR DETER 20 MG | 6510007510A720 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 20 MG | 6510007510A720 | Generic |

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|---|---|---|---|
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 30 MG | 6510007510A730 | Brand |
| OXYCODONE HYDROCHLORIDE ER | OXYCODONE HCL TAB ER 12HR DETER 40 MG | 6510007510A740 | Generic |
| OXYCODONE HCL ER | OXYCODONE HCL TAB ER 12HR DETER 40 MG | 6510007510A740 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 40 MG | 6510007510A740 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 60 MG | 6510007510A760 | Brand |
| OXYCODONE HYDROCHLORIDE ER | OXYCODONE HCL TAB ER 12HR DETER 80 MG | 6510007510A780 | Generic |
| OXYCODONE HCL ER | OXYCODONE HCL TAB ER 12HR DETER 80 MG | 6510007510A780 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 80 MG | 6510007510A780 | Generic |
| XTAMPZA ER | OXYCODONE CAP ER 12HR ABUSE-DETERRENT 9 MG | 6510007500A310 | Brand |
| XTAMPZA ER | OXYCODONE CAP ER 12HR ABUSE-DETERRENT 13.5 MG | 6510007500A315 | Brand |
| XTAMPZA ER | OXYCODONE CAP ER 12HR ABUSE-DETERRENT 18 MG | 6510007500A320 | Brand |
| XTAMPZA ER | OXYCODONE CAP ER 12HR ABUSE-DETERRENT 27 MG | 6510007500A330 | Brand |
| XTAMPZA ER | OXYCODONE CAP ER 12HR ABUSE-DETERRENT 36 MG | 6510007500A340 | Brand |
| FENTANYL | FENTANYL TD PATCH 72HR 37.5 MCG/HR | 65100025008626 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 62.5 MCG/HR | 65100025008635 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 87.5 MCG/HR | 65100025008645 | Generic |
| METHADONE HCL | METHADONE HCL TAB 5 MG | 65100050100305 | Generic |
| METHADONE HYDROCHLORIDE | METHADONE HCL TAB 5 MG | 65100050100305 | Generic |
| METHADONE HCL | METHADONE HCL TAB 10 MG | 65100050100310 | Generic |
| METHADONE HYDROCHLORIDE | METHADONE HCL TAB 10 MG | 65100050100310 | Generic |
| METHADONE HYDROCHLORIDE INTENSOL | METHADONE HCL CONC 10 MG/ML | 65100050101310 | Generic |
| METHADOSE SUGAR-FREE | METHADONE HCL CONC 10 MG/ML | 65100050101310 | Brand |
| METHADONE HYDROCHLORIDE | METHADONE HCL CONC 10 MG/ML | 65100050101310 | Generic |

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|---|---|---|---|
| METHADOSE | METHADONE HCL CONC 10 MG/ML | 65100050101310 | Brand |
| METHADONE HCL | METHADONE HCL SOLN 5 MG/5ML | 65100050102010 | Generic |
| METHADONE HYDROCHLORIDE | METHADONE HCL SOLN 5 MG/5ML | 65100050102010 | Generic |
| METHADONE HCL | METHADONE HCL SOLN 10 MG/5ML | 65100050102015 | Generic |
| METHADONE HYDROCHLORIDE | METHADONE HCL SOLN 10 MG/5ML | 65100050102015 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 100 MG | 65100095107070 | Generic |
| CONZIP | TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 100 MG | 65100095107070 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 200 MG | 65100095107080 | Generic |
| CONZIP | TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 200 MG | 65100095107080 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 300 MG | 65100095107090 | Generic |
| CONZIP | TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 300 MG | 65100095107090 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL TAB ER 24HR 100 MG | 65100095107520 | Generic |
| TRAMADOL HYDROCHLORIDE ER | TRAMADOL HCL TAB ER 24HR 100 MG | 65100095107520 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL TAB ER 24HR 200 MG | 65100095107530 | Generic |
| TRAMADOL HYDROCHLORIDE ER | TRAMADOL HCL TAB ER 24HR 200 MG | 65100095107530 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL TAB ER 24HR 300 MG | 65100095107540 | Generic |
| TRAMADOL HYDROCHLORIDE ER | TRAMADOL HCL TAB ER 24HR 300 MG | 65100095107540 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 100 MG | 65100095107560 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 200 MG | 65100095107570 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 300 MG | 65100095107580 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE BEADS CAP ER 24HR 30 MG | 65100055207020 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE BEADS CAP ER 24HR 45 MG | 65100055207025 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE BEADS CAP ER 24HR 60 MG | 65100055207030 | Generic |

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|---|---|---|---|
| MORPHINE SULFATE ER | MORPHINE SULFATE BEADS CAP ER 24HR 75 MG | 65100055207035 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE BEADS CAP ER 24HR 90 MG | 65100055207040 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE BEADS CAP ER 24HR 120 MG | 65100055207050 | Generic |
| ZOHYDRO ER | HYDROCODONE BITARTRATE CAP ER 12HR 10 MG | 65100030106910 | Brand |
| ZOHYDRO ER | HYDROCODONE BITARTRATE CAP ER 12HR 15 MG | 65100030106915 | Brand |
| ZOHYDRO ER | HYDROCODONE BITARTRATE CAP ER 12HR 20 MG | 65100030106920 | Brand |
| ZOHYDRO ER | HYDROCODONE BITARTRATE CAP ER 12HR 30 MG | 65100030106930 | Brand |
| ZOHYDRO ER | HYDROCODONE BITARTRATE CAP ER 12HR 40 MG | 65100030106940 | Brand |
| ZOHYDRO ER | HYDROCODONE BITARTRATE CAP ER 12HR 50 MG | 65100030106950 | Brand |

**Approval Criteria**

**1** - 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)
- End of life care, including hospice care
- Palliative care
- Sickle cell anemia

**OR**

**2** - Prescriber attests that the patient has received an opioid within the past 60 days

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|---|---|
| Notes | *Approval length for cancer-related pain, end of life, palliative care, or sickle cell pain will be issued for 12 months. All other approvals will be issued for the requested duration, not to exceed one month. |

| Product Name: generic morphine sulfate ER/CR tabs, fentanyl 12, 25, 50, 75, 100 mcg/hr patches | |
|---|---|
| Diagnosis | Cancer-related pain/Hospice/Sickle Cell Anemia/End of Life Related Pain* |

| Approval Length | 12 month(s) |
|---|---|
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MORPHINE SULFATE ER | MORPHINE SULFATE TAB ER 15 MG | 65100055100415 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE TAB ER 30 MG | 65100055100432 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE TAB ER 60 MG | 65100055100445 | Generic |
| MORPHINE SULFATE CR | MORPHINE SULFATE TAB ER 60 MG | 65100055100445 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE TAB ER 100 MG | 65100055100460 | Generic |
| MORPHINE SULFATE CR | MORPHINE SULFATE TAB ER 100 MG | 65100055100460 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE TAB ER 200 MG | 65100055100480 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 12 MCG/HR | 65100025008610 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 25 MCG/HR | 65100025008620 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 50 MCG/HR | 65100025008630 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 75 MCG/HR | 65100025008640 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 100 MCG/HR | 65100025008650 | Generic |

**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

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|---|---|
| **OR**<br><br>**3** - Patient is being treated for sickle cell anemia related pain | |
| 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, oxymorphone ER | |
|---|---|
| Diagnosis | Cancer-related pain/Hospice/Sickle Cell Anemia/End of Life Related Pain* |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OXYMORPHONE HYDROCHLORIDE ER | OXYMORPHONE HCL TAB ER 12HR 5 MG | 65100080107405 | Generic |
| OXYMORPHONE HYDROCHLORIDE ER | OXYMORPHONE HCL TAB ER 12HR 7.5 MG | 65100080107407 | Generic |
| OXYMORPHONE HYDROCHLORIDE ER | OXYMORPHONE HCL TAB ER 12HR 10 MG | 65100080107410 | Generic |
| OXYMORPHONE HYDROCHLORIDE ER | OXYMORPHONE HCL TAB ER 12HR 15 MG | 65100080107415 | Generic |
| OXYMORPHONE HYDROCHLORIDE ER | OXYMORPHONE HCL TAB ER 12HR 20 MG | 65100080107420 | Generic |
| OXYMORPHONE HYDROCHLORIDE ER | OXYMORPHONE HCL TAB ER 12HR 30 MG | 65100080107430 | Generic |
| OXYMORPHONE HYDROCHLORIDEER | OXYMORPHONE HCL TAB ER 12HR 40 MG | 65100080107440 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE CAP ER 12HR 10 MG | 65100030106910 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE CAP ER 12HR 15 MG | 65100030106915 | Generic |

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| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE CAP ER 12HR 20 MG | 65100030106920 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE CAP ER 12HR 30 MG | 65100030106930 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE CAP ER 12HR 40 MG | 65100030106940 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE CAP ER 12HR 50 MG | 65100030106950 | Generic |

**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

**OR**

**1.3** Patient is being treated for sickle cell anemia related pain

**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 (document drugs and date of trials):

- 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 hospice related pain, sickle cell anemia related pain, end of life care related pain, or 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)

**AND**

**2.3.2** The medication is not a new regimen for treatment of cancer-related pain, hospice, sickle cell anemia related pain, 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.<br>If the request is for oxymorphone ER-non crush resistant (generic) or hydrocodone extended-release capsules (generic Zohydro ER) 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, Xtampza ER, fentanyl 37.5, 62.5, 87.5 mcg/hr patches, methadone tabs/soln, generic methadone conc, Brand Methadose conc, Brand Zohydro ER

| | |
|---|---|
| Diagnosis | Cancer-related pain /Hospice/Sickle Cell Anemia/End of Life Related Pain* |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 10 MG | 65100055107010 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 20 MG | 65100055107020 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 30 MG | 65100055107030 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 50 MG | 65100055107040 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 60 MG | 65100055107045 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 80 MG | 65100055107050 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 100 MG | 65100055107060 | Generic |
| HYDROMORPHONE HYDROCHLORIDE ER | HYDROMORPHONE HCL TAB ER 24HR 8 MG | 65100035107521 | Generic |
| HYDROMORPHONE HCL ER | HYDROMORPHONE HCL TAB ER 24HR 8 MG | 65100035107521 | Generic |
| HYDROMORPHONE HYDROCHLORIDE ER | HYDROMORPHONE HCL TAB ER 24HR 12 MG | 65100035107531 | Generic |
| HYDROMORPHONE HCL ER | HYDROMORPHONE HCL TAB ER 24HR 12 MG | 65100035107531 | Generic |
| HYDROMORPHONE HYDROCHLORIDE ER | HYDROMORPHONE HCL TAB ER 24HR 16 MG | 65100035107541 | Generic |
| HYDROMORPHONE HCL ER | HYDROMORPHONE HCL TAB ER 24HR 16 MG | 65100035107541 | Generic |
| HYDROMORPHONE HYDROCHLORIDE ER | HYDROMORPHONE HCL TAB ER 24HR 32 MG | 65100035107556 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG | 6510003010A810 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG | 6510003010A810 | Brand |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG | 6510003010A820 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG | 6510003010A820 | Brand |

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|---|---|---|---|
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG | 6510003010A830 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG | 6510003010A830 | Brand |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG | 6510003010A840 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG | 6510003010A840 | Brand |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG | 6510003010A850 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG | 6510003010A850 | Brand |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG | 6510003010A860 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG | 6510003010A860 | Brand |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG | 6510003010A870 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG | 6510003010A870 | Brand |
| MS CONTIN | MORPHINE SULFATE TAB ER 15 MG | 65100055100415 | Brand |
| MS CONTIN | MORPHINE SULFATE TAB ER 30 MG | 65100055100432 | Brand |
| MS CONTIN | MORPHINE SULFATE TAB ER 60 MG | 65100055100445 | Brand |
| MS CONTIN | MORPHINE SULFATE TAB ER 100 MG | 65100055100460 | Brand |
| MS CONTIN | MORPHINE SULFATE TAB ER 200 MG | 65100055100480 | Brand |
| NUCYNTA ER | TAPENTADOL HCL TAB ER 12HR 50 MG | 65100091107420 | Brand |
| NUCYNTA ER | TAPENTADOL HCL TAB ER 12HR 100 MG | 65100091107430 | Brand |
| NUCYNTA ER | TAPENTADOL HCL TAB ER 12HR 150 MG | 65100091107440 | Brand |
| NUCYNTA ER | TAPENTADOL HCL TAB ER 12HR 200 MG | 65100091107450 | Brand |
| NUCYNTA ER | TAPENTADOL HCL TAB ER 12HR 250 MG | 65100091107460 | Brand |
| OXYCODONE HYDROCHLORIDE ER | OXYCODONE HCL TAB ER 12HR DETER 10 MG | 6510007510A710 | Generic |
| OXYCODONE HCL ER | OXYCODONE HCL TAB ER 12HR DETER 10 MG | 6510007510A710 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 10 MG | 6510007510A710 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 15 MG | 6510007510A715 | Brand |
| OXYCODONE HYDROCHLORIDE ER | OXYCODONE HCL TAB ER 12HR DETER 20 MG | 6510007510A720 | Generic |

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|---|---|---|---|
| OXYCODONE HCL ER | OXYCODONE HCL TAB ER 12HR DETER 20 MG | 6510007510A720 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 20 MG | 6510007510A720 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 30 MG | 6510007510A730 | Brand |
| OXYCODONE HYDROCHLORIDE ER | OXYCODONE HCL TAB ER 12HR DETER 40 MG | 6510007510A740 | Generic |
| OXYCODONE HCL ER | OXYCODONE HCL TAB ER 12HR DETER 40 MG | 6510007510A740 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 40 MG | 6510007510A740 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 60 MG | 6510007510A760 | Brand |
| OXYCODONE HYDROCHLORIDE ER | OXYCODONE HCL TAB ER 12HR DETER 80 MG | 6510007510A780 | Generic |
| OXYCODONE HCL ER | OXYCODONE HCL TAB ER 12HR DETER 80 MG | 6510007510A780 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 80 MG | 6510007510A780 | Generic |
| XTAMPZA ER | OXYCODONE CAP ER 12HR ABUSE-DETERRENT 9 MG | 6510007500A310 | Brand |
| XTAMPZA ER | OXYCODONE CAP ER 12HR ABUSE-DETERRENT 13.5 MG | 6510007500A315 | Brand |
| XTAMPZA ER | OXYCODONE CAP ER 12HR ABUSE-DETERRENT 18 MG | 6510007500A320 | Brand |
| XTAMPZA ER | OXYCODONE CAP ER 12HR ABUSE-DETERRENT 27 MG | 6510007500A330 | Brand |
| XTAMPZA ER | OXYCODONE CAP ER 12HR ABUSE-DETERRENT 36 MG | 6510007500A340 | Brand |
| FENTANYL | FENTANYL TD PATCH 72HR 37.5 MCG/HR | 65100025008626 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 62.5 MCG/HR | 65100025008635 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 87.5 MCG/HR | 65100025008645 | Generic |
| METHADONE HCL | METHADONE HCL TAB 5 MG | 65100050100305 | Generic |
| METHADONE HYDROCHLORIDE | METHADONE HCL TAB 5 MG | 65100050100305 | Generic |
| METHADONE HCL | METHADONE HCL TAB 10 MG | 65100050100310 | Generic |
| METHADONE HYDROCHLORIDE | METHADONE HCL TAB 10 MG | 65100050100310 | Generic |
| METHADONE HYDROCHLORIDE INTENSOL | METHADONE HCL CONC 10 MG/ML | 65100050101310 | Generic |

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|---|---|---|---|
| METHADOSE SUGAR-FREE | METHADONE HCL CONC 10 MG/ML | 65100050101310 | Brand |
| METHADONE HYDROCHLORIDE | METHADONE HCL CONC 10 MG/ML | 65100050101310 | Generic |
| METHADOSE | METHADONE HCL CONC 10 MG/ML | 65100050101310 | Brand |
| METHADONE HCL | METHADONE HCL SOLN 5 MG/5ML | 65100050102010 | Generic |
| METHADONE HYDROCHLORIDE | METHADONE HCL SOLN 5 MG/5ML | 65100050102010 | Generic |
| METHADONE HCL | METHADONE HCL SOLN 10 MG/5ML | 65100050102015 | Generic |
| METHADONE HYDROCHLORIDE | METHADONE HCL SOLN 10 MG/5ML | 65100050102015 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE BEADS CAP ER 24HR 30 MG | 65100055207020 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE BEADS CAP ER 24HR 45 MG | 65100055207025 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE BEADS CAP ER 24HR 60 MG | 65100055207030 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE BEADS CAP ER 24HR 75 MG | 65100055207035 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE BEADS CAP ER 24HR 90 MG | 65100055207040 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE BEADS CAP ER 24HR 120 MG | 65100055207050 | Generic |
| ZOHYDRO ER | HYDROCODONE BITARTRATE CAP ER 12HR 10 MG | 65100030106910 | Brand |
| ZOHYDRO ER | HYDROCODONE BITARTRATE CAP ER 12HR 15 MG | 65100030106915 | Brand |
| ZOHYDRO ER | HYDROCODONE BITARTRATE CAP ER 12HR 20 MG | 65100030106920 | Brand |
| ZOHYDRO ER | HYDROCODONE BITARTRATE CAP ER 12HR 30 MG | 65100030106930 | Brand |
| ZOHYDRO ER | HYDROCODONE BITARTRATE CAP ER 12HR 40 MG | 65100030106940 | Brand |
| ZOHYDRO ER | HYDROCODONE BITARTRATE CAP ER 12HR 50 MG | 65100030106950 | Brand |

**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

**OR**

**1.3** Patient is being treated for sickle cell anemia related pain

**AND**

**2** - ONE of the following:

**2.1** The patient has failed a trial of at least THREE of the following, as confirmed by claims history or submission of medical records (document drugs and date of trials):

- morphine sulfate controlled release tablets (generic MS Contin)
- preferred fentanyl transdermal
- oxymorphone ER non-crush resistant (generic)
- 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
- oxymorphone ER non-crush resistant (generic)
- 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 hospice related pain, sickle cell anemia related pain, end of life care related pain, or 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)<br><br>**AND**<br><br>**2.3.2** The medication is not a new regimen for treatment of cancer-related pain, hospice, sickle cell anemia related pain, 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.<br>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:<br>• If the patient has tried morphine sulfate controlled release tablets (generic MS Contin) or preferred fentanyl transdermal, an authorization should be entered for oxymorphone ER-non crush resistant (generic) and hydrocodone extended-release capsules (generic Zohydro ER).<br>• If the patient has not tried any of the preferred products [morphine sulfate controlled release tablets (generic MS Contin), preferred fentanyl transdermal, oxymorphone ER-non crush resistant (generic) or hydrocodone extended-release capsules (generic Zohydro ER)], 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 related pain/Non-hospice/Non-sickle cell anemia/Non-end of life care pain* |
| Approval Length | 6 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

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|---|---|---|---|
| MORPHINE SULFATE ER | MORPHINE SULFATE TAB ER 15 MG | 65100055100415 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE TAB ER 30 MG | 65100055100432 | Generic |
| MORPHINE SULFATE CR | MORPHINE SULFATE TAB ER 60 MG | 65100055100445 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE TAB ER 60 MG | 65100055100445 | Generic |
| MORPHINE SULFATE CR | MORPHINE SULFATE TAB ER 100 MG | 65100055100460 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE TAB ER 100 MG | 65100055100460 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE TAB ER 200 MG | 65100055100480 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 12 MCG/HR | 65100025008610 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 25 MCG/HR | 65100025008620 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 50 MCG/HR | 65100025008630 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 75 MCG/HR | 65100025008640 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 100 MCG/HR | 65100025008650 | Generic |

**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

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|---|---|
| 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, oxymorphone ER | |
|---|---|
| Diagnosis | Non-cancer related pain/Non-hospice/Non-sickle cell anemia/Non-end of life care pain* |
| Approval Length | 6 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| OXYMORPHONE HYDROCHLORIDE ER | OXYMORPHONE HCL TAB ER 12HR 5 MG | 65100080107405 | Generic |
| OXYMORPHONE HYDROCHLORIDE ER | OXYMORPHONE HCL TAB ER 12HR 7.5 MG | 65100080107407 | Generic |
| OXYMORPHONE HYDROCHLORIDE ER | OXYMORPHONE HCL TAB ER 12HR 10 MG | 65100080107410 | Generic |
| OXYMORPHONE HYDROCHLORIDE ER | OXYMORPHONE HCL TAB ER 12HR 15 MG | 65100080107415 | Generic |
| OXYMORPHONE HYDROCHLORIDE ER | OXYMORPHONE HCL TAB ER 12HR 20 MG | 65100080107420 | Generic |
| OXYMORPHONE HYDROCHLORIDE ER | OXYMORPHONE HCL TAB ER 12HR 30 MG | 65100080107430 | Generic |
| OXYMORPHONE HYDROCHLORIDEER | OXYMORPHONE HCL TAB ER 12HR 40 MG | 65100080107440 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE CAP ER 12HR 10 MG | 65100030106910 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE CAP ER 12HR 15 MG | 65100030106915 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE CAP ER 12HR 20 MG | 65100030106920 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE CAP ER 12HR 30 MG | 65100030106930 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE CAP ER 12HR 40 MG | 65100030106940 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE CAP ER 12HR 50 MG | 65100030106950 | Generic |

**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 (document drugs and date of trials):

- 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.<br>If the request is for oxymorphone ER-non crush resistant (generic) or hydrocodone extended-release capsules (generic Zohydro ER) 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, Xtampza ER, fentanyl 37.5, 62.5, 87.5 mcg/hr patches, methadone tabs/soln, generic methadone conc, Brand Methadose conc, Brand Zohydro ER

| | |
|---|---|
| Diagnosis | Non-cancer related pain/Non-hospice/Non-sickle cell anemia/Non-end of life care pain* |
| Approval Length | 6 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 10 MG | 65100055107010 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 20 MG | 65100055107020 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 30 MG | 65100055107030 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 50 MG | 65100055107040 | Generic |

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|---|---|---|---|
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 60 MG | 65100055107045 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 80 MG | 65100055107050 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 100 MG | 65100055107060 | Generic |
| HYDROMORPHONE HYDROCHLORIDE ER | HYDROMORPHONE HCL TAB ER 24HR 8 MG | 65100035107521 | Generic |
| HYDROMORPHONE HCL ER | HYDROMORPHONE HCL TAB ER 24HR 8 MG | 65100035107521 | Generic |
| HYDROMORPHONE HYDROCHLORIDE ER | HYDROMORPHONE HCL TAB ER 24HR 12 MG | 65100035107531 | Generic |
| HYDROMORPHONE HCL ER | HYDROMORPHONE HCL TAB ER 24HR 12 MG | 65100035107531 | Generic |
| HYDROMORPHONE HYDROCHLORIDE ER | HYDROMORPHONE HCL TAB ER 24HR 16 MG | 65100035107541 | Generic |
| HYDROMORPHONE HCL ER | HYDROMORPHONE HCL TAB ER 24HR 16 MG | 65100035107541 | Generic |
| HYDROMORPHONE HYDROCHLORIDE ER | HYDROMORPHONE HCL TAB ER 24HR 32 MG | 65100035107556 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG | 6510003010A810 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG | 6510003010A810 | Brand |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG | 6510003010A820 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG | 6510003010A820 | Brand |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG | 6510003010A830 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG | 6510003010A830 | Brand |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG | 6510003010A840 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG | 6510003010A840 | Brand |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG | 6510003010A850 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG | 6510003010A850 | Brand |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG | 6510003010A860 | Generic |

| | | | |
|---|---|---|---|
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG | 6510003010A860 | Brand |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG | 6510003010A870 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG | 6510003010A870 | Brand |
| MS CONTIN | MORPHINE SULFATE TAB ER 15 MG | 65100055100415 | Brand |
| MS CONTIN | MORPHINE SULFATE TAB ER 30 MG | 65100055100432 | Brand |
| MS CONTIN | MORPHINE SULFATE TAB ER 60 MG | 65100055100445 | Brand |
| MS CONTIN | MORPHINE SULFATE TAB ER 100 MG | 65100055100460 | Brand |
| MS CONTIN | MORPHINE SULFATE TAB ER 200 MG | 65100055100480 | Brand |
| NUCYNTA ER | TAPENTADOL HCL TAB ER 12HR 50 MG | 65100091107420 | Brand |
| NUCYNTA ER | TAPENTADOL HCL TAB ER 12HR 100 MG | 65100091107430 | Brand |
| NUCYNTA ER | TAPENTADOL HCL TAB ER 12HR 150 MG | 65100091107440 | Brand |
| NUCYNTA ER | TAPENTADOL HCL TAB ER 12HR 200 MG | 65100091107450 | Brand |
| NUCYNTA ER | TAPENTADOL HCL TAB ER 12HR 250 MG | 65100091107460 | Brand |
| OXYCODONE HYDROCHLORIDE ER | OXYCODONE HCL TAB ER 12HR DETER 10 MG | 6510007510A710 | Generic |
| OXYCODONE HCL ER | OXYCODONE HCL TAB ER 12HR DETER 10 MG | 6510007510A710 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 10 MG | 6510007510A710 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 15 MG | 6510007510A715 | Brand |
| OXYCODONE HYDROCHLORIDE ER | OXYCODONE HCL TAB ER 12HR DETER 20 MG | 6510007510A720 | Generic |
| OXYCODONE HCL ER | OXYCODONE HCL TAB ER 12HR DETER 20 MG | 6510007510A720 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 20 MG | 6510007510A720 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 30 MG | 6510007510A730 | Brand |
| OXYCODONE HYDROCHLORIDE ER | OXYCODONE HCL TAB ER 12HR DETER 40 MG | 6510007510A740 | Generic |
| OXYCODONE HCL ER | OXYCODONE HCL TAB ER 12HR DETER 40 MG | 6510007510A740 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 40 MG | 6510007510A740 | Generic |

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|---|---|---|---|
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 60 MG | 6510007510A760 | Brand |
| OXYCODONE HYDROCHLORIDE ER | OXYCODONE HCL TAB ER 12HR DETER 80 MG | 6510007510A780 | Generic |
| OXYCODONE HCL ER | OXYCODONE HCL TAB ER 12HR DETER 80 MG | 6510007510A780 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 80 MG | 6510007510A780 | Generic |
| XTAMPZA ER | OXYCODONE CAP ER 12HR ABUSE-DETERRENT 9 MG | 6510007500A310 | Brand |
| XTAMPZA ER | OXYCODONE CAP ER 12HR ABUSE-DETERRENT 13.5 MG | 6510007500A315 | Brand |
| XTAMPZA ER | OXYCODONE CAP ER 12HR ABUSE-DETERRENT 18 MG | 6510007500A320 | Brand |
| XTAMPZA ER | OXYCODONE CAP ER 12HR ABUSE-DETERRENT 27 MG | 6510007500A330 | Brand |
| XTAMPZA ER | OXYCODONE CAP ER 12HR ABUSE-DETERRENT 36 MG | 6510007500A340 | Brand |
| FENTANYL | FENTANYL TD PATCH 72HR 37.5 MCG/HR | 65100025008626 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 62.5 MCG/HR | 65100025008635 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 87.5 MCG/HR | 65100025008645 | Generic |
| METHADONE HCL | METHADONE HCL TAB 5 MG | 65100050100305 | Generic |
| METHADONE HYDROCHLORIDE | METHADONE HCL TAB 5 MG | 65100050100305 | Generic |
| METHADONE HCL | METHADONE HCL TAB 10 MG | 65100050100310 | Generic |
| METHADONE HYDROCHLORIDE | METHADONE HCL TAB 10 MG | 65100050100310 | Generic |
| METHADONE HYDROCHLORIDE INTENSOL | METHADONE HCL CONC 10 MG/ML | 65100050101310 | Generic |
| METHADOSE SUGAR-FREE | METHADONE HCL CONC 10 MG/ML | 65100050101310 | Brand |
| METHADONE HYDROCHLORIDE | METHADONE HCL CONC 10 MG/ML | 65100050101310 | Generic |
| METHADOSE | METHADONE HCL CONC 10 MG/ML | 65100050101310 | Brand |
| METHADONE HCL | METHADONE HCL SOLN 5 MG/5ML | 65100050102010 | Generic |
| METHADONE HYDROCHLORIDE | METHADONE HCL SOLN 5 MG/5ML | 65100050102010 | Generic |
| METHADONE HCL | METHADONE HCL SOLN 10 MG/5ML | 65100050102015 | Generic |
| METHADONE HYDROCHLORIDE | METHADONE HCL SOLN 10 MG/5ML | 65100050102015 | Generic |

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|---|---|---|---|
| MORPHINE SULFATE ER | MORPHINE SULFATE BEADS CAP ER 24HR 30 MG | 65100055207020 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE BEADS CAP ER 24HR 45 MG | 65100055207025 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE BEADS CAP ER 24HR 60 MG | 65100055207030 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE BEADS CAP ER 24HR 75 MG | 65100055207035 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE BEADS CAP ER 24HR 90 MG | 65100055207040 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE BEADS CAP ER 24HR 120 MG | 65100055207050 | Generic |
| ZOHYDRO ER | HYDROCODONE BITARTRATE CAP ER 12HR 10 MG | 65100030106910 | Brand |
| ZOHYDRO ER | HYDROCODONE BITARTRATE CAP ER 12HR 15 MG | 65100030106915 | Brand |
| ZOHYDRO ER | HYDROCODONE BITARTRATE CAP ER 12HR 20 MG | 65100030106920 | Brand |
| ZOHYDRO ER | HYDROCODONE BITARTRATE CAP ER 12HR 30 MG | 65100030106930 | Brand |
| ZOHYDRO ER | HYDROCODONE BITARTRATE CAP ER 12HR 40 MG | 65100030106940 | Brand |
| ZOHYDRO ER | HYDROCODONE BITARTRATE CAP ER 12HR 50 MG | 65100030106950 | Brand |

**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 THREE of the following, as confirmed by claims history or submission of medical records (document drugs and date of trials):

- morphine sulfate controlled release tablets (generic MS Contin)
- preferred fentanyl transdermal
- oxymorphone ER non-crush resistant (generic)
- 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
- oxymorphone ER non-crush resistant (generic)

| | |
|---|---|
| • 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.<br>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:<br>• If the patient has tried morphine sulfate controlled release tablets (generic MS Contin) or preferred fentanyl transdermal, an authorization should be entered for oxymorphone ER-non crush resistant (generic) and hydrocodone extended-release capsules (generic Zohydro ER).<br>• If the patient has not tried any of the preferred products [morphine sulfate controlled release tablets (generic MS Contin), preferred fentanyl transdermal, oxymorphone ER-non crush resistant (generic) or hydrocodone extended-release capsules (generic Zohydro ER)], 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 related pain/Non-hospice/Non-sickle cell anemia/Non-end of life care pain* |
| Approval Length | 6 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MORPHINE SULFATE ER | MORPHINE SULFATE TAB ER 15 MG | 65100055100415 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE TAB ER 30 MG | 65100055100432 | Generic |

| | | | |
|---|---|---|---|
| MORPHINE SULFATE CR | MORPHINE SULFATE TAB ER 60 MG | 65100055100445 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE TAB ER 60 MG | 65100055100445 | Generic |
| MORPHINE SULFATE CR | MORPHINE SULFATE TAB ER 100 MG | 65100055100460 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE TAB ER 100 MG | 65100055100460 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE TAB ER 200 MG | 65100055100480 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 12 MCG/HR | 65100025008610 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 25 MCG/HR | 65100025008620 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 50 MCG/HR | 65100025008630 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 75 MCG/HR | 65100025008640 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 100 MCG/HR | 65100025008650 | Generic |

**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, oxymorphone ER | |
|---|---|
| Diagnosis | Non-cancer related pain/Non-hospice/Non-sickle cell anemia/Non-end of life care pain* |
| Approval Length | 6 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OXYMORPHONE HYDROCHLORIDE ER | OXYMORPHONE HCL TAB ER 12HR 5 MG | 65100080107405 | Generic |
| OXYMORPHONE HYDROCHLORIDE ER | OXYMORPHONE HCL TAB ER 12HR 7.5 MG | 65100080107407 | Generic |
| OXYMORPHONE HYDROCHLORIDE ER | OXYMORPHONE HCL TAB ER 12HR 10 MG | 65100080107410 | Generic |
| OXYMORPHONE HYDROCHLORIDE ER | OXYMORPHONE HCL TAB ER 12HR 15 MG | 65100080107415 | Generic |
| OXYMORPHONE HYDROCHLORIDE ER | OXYMORPHONE HCL TAB ER 12HR 20 MG | 65100080107420 | Generic |
| OXYMORPHONE HYDROCHLORIDE ER | OXYMORPHONE HCL TAB ER 12HR 30 MG | 65100080107430 | Generic |
| OXYMORPHONE HYDROCHLORIDEER | OXYMORPHONE HCL TAB ER 12HR 40 MG | 65100080107440 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE CAP ER 12HR 10 MG | 65100030106910 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE CAP ER 12HR 15 MG | 65100030106915 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE CAP ER 12HR 20 MG | 65100030106920 | Generic |

| | | | |
|---|---|---|---|
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE CAP ER 12HR 30 MG | 65100030106930 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE CAP ER 12HR 40 MG | 65100030106940 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE CAP ER 12HR 50 MG | 65100030106950 | Generic |

**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 (document drugs and date of trials):

- morphine sulfate controlled release tablets (generic MS Contin)
- preferred fentanyl transdermal

**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

| | |
|---|---|
| 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.<br>If the request is for oxymorphone ER-non crush resistant (generic) or hydrocodone extended-release capsules (generic Zohydro ER) 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, Xtampza ER, fentanyl 37.5, 62.5, 87.5 mcg/hr patches, methadone tabs/soln, generic methadone conc, Brand Methadose conc, Brand Zohydro ER | |
|---|---|
| Diagnosis | Non-cancer related pain/Non-hospice/Non-sickle cell anemia/Non-end of life care pain* |
| Approval Length | 6 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 10 MG | 65100055107010 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 20 MG | 65100055107020 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 30 MG | 65100055107030 | Generic |

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|---|---|---|---|
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 50 MG | 65100055107040 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 60 MG | 65100055107045 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 80 MG | 65100055107050 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 100 MG | 65100055107060 | Generic |
| HYDROMORPHONE HYDROCHLORIDE ER | HYDROMORPHONE HCL TAB ER 24HR 8 MG | 65100035107521 | Generic |
| HYDROMORPHONE HCL ER | HYDROMORPHONE HCL TAB ER 24HR 8 MG | 65100035107521 | Generic |
| HYDROMORPHONE HYDROCHLORIDE ER | HYDROMORPHONE HCL TAB ER 24HR 12 MG | 65100035107531 | Generic |
| HYDROMORPHONE HCL ER | HYDROMORPHONE HCL TAB ER 24HR 12 MG | 65100035107531 | Generic |
| HYDROMORPHONE HYDROCHLORIDE ER | HYDROMORPHONE HCL TAB ER 24HR 16 MG | 65100035107541 | Generic |
| HYDROMORPHONE HCL ER | HYDROMORPHONE HCL TAB ER 24HR 16 MG | 65100035107541 | Generic |
| HYDROMORPHONE HYDROCHLORIDE ER | HYDROMORPHONE HCL TAB ER 24HR 32 MG | 65100035107556 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG | 6510003010A810 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG | 6510003010A810 | Brand |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG | 6510003010A820 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG | 6510003010A820 | Brand |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG | 6510003010A830 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG | 6510003010A830 | Brand |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG | 6510003010A840 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG | 6510003010A840 | Brand |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG | 6510003010A850 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG | 6510003010A850 | Brand |

| | | | |
|---|---|---|---|
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG | 6510003010A860 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG | 6510003010A860 | Brand |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG | 6510003010A870 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG | 6510003010A870 | Brand |
| MS CONTIN | MORPHINE SULFATE TAB ER 15 MG | 65100055100415 | Brand |
| MS CONTIN | MORPHINE SULFATE TAB ER 30 MG | 65100055100432 | Brand |
| MS CONTIN | MORPHINE SULFATE TAB ER 60 MG | 65100055100445 | Brand |
| MS CONTIN | MORPHINE SULFATE TAB ER 100 MG | 65100055100460 | Brand |
| MS CONTIN | MORPHINE SULFATE TAB ER 200 MG | 65100055100480 | Brand |
| NUCYNTA ER | TAPENTADOL HCL TAB ER 12HR 50 MG | 65100091107420 | Brand |
| NUCYNTA ER | TAPENTADOL HCL TAB ER 12HR 100 MG | 65100091107430 | Brand |
| NUCYNTA ER | TAPENTADOL HCL TAB ER 12HR 150 MG | 65100091107440 | Brand |
| NUCYNTA ER | TAPENTADOL HCL TAB ER 12HR 200 MG | 65100091107450 | Brand |
| NUCYNTA ER | TAPENTADOL HCL TAB ER 12HR 250 MG | 65100091107460 | Brand |
| OXYCODONE HYDROCHLORIDE ER | OXYCODONE HCL TAB ER 12HR DETER 10 MG | 6510007510A710 | Generic |
| OXYCODONE HCL ER | OXYCODONE HCL TAB ER 12HR DETER 10 MG | 6510007510A710 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 10 MG | 6510007510A710 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 15 MG | 6510007510A715 | Brand |
| OXYCODONE HYDROCHLORIDE ER | OXYCODONE HCL TAB ER 12HR DETER 20 MG | 6510007510A720 | Generic |
| OXYCODONE HCL ER | OXYCODONE HCL TAB ER 12HR DETER 20 MG | 6510007510A720 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 20 MG | 6510007510A720 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 30 MG | 6510007510A730 | Brand |
| OXYCODONE HYDROCHLORIDE ER | OXYCODONE HCL TAB ER 12HR DETER 40 MG | 6510007510A740 | Generic |
| OXYCODONE HCL ER | OXYCODONE HCL TAB ER 12HR DETER 40 MG | 6510007510A740 | Generic |

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|---|---|---|---|
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 40 MG | 6510007510A740 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 60 MG | 6510007510A760 | Brand |
| OXYCODONE HYDROCHLORIDE ER | OXYCODONE HCL TAB ER 12HR DETER 80 MG | 6510007510A780 | Generic |
| OXYCODONE HCL ER | OXYCODONE HCL TAB ER 12HR DETER 80 MG | 6510007510A780 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 80 MG | 6510007510A780 | Generic |
| XTAMPZA ER | OXYCODONE CAP ER 12HR ABUSE-DETERRENT 9 MG | 6510007500A310 | Brand |
| XTAMPZA ER | OXYCODONE CAP ER 12HR ABUSE-DETERRENT 13.5 MG | 6510007500A315 | Brand |
| XTAMPZA ER | OXYCODONE CAP ER 12HR ABUSE-DETERRENT 18 MG | 6510007500A320 | Brand |
| XTAMPZA ER | OXYCODONE CAP ER 12HR ABUSE-DETERRENT 27 MG | 6510007500A330 | Brand |
| XTAMPZA ER | OXYCODONE CAP ER 12HR ABUSE-DETERRENT 36 MG | 6510007500A340 | Brand |
| FENTANYL | FENTANYL TD PATCH 72HR 37.5 MCG/HR | 65100025008626 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 62.5 MCG/HR | 65100025008635 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 87.5 MCG/HR | 65100025008645 | Generic |
| METHADONE HCL | METHADONE HCL TAB 5 MG | 65100050100305 | Generic |
| METHADONE HYDROCHLORIDE | METHADONE HCL TAB 5 MG | 65100050100305 | Generic |
| METHADONE HCL | METHADONE HCL TAB 10 MG | 65100050100310 | Generic |
| METHADONE HYDROCHLORIDE | METHADONE HCL TAB 10 MG | 65100050100310 | Generic |
| METHADONE HYDROCHLORIDE INTENSOL | METHADONE HCL CONC 10 MG/ML | 65100050101310 | Generic |
| METHADOSE SUGAR-FREE | METHADONE HCL CONC 10 MG/ML | 65100050101310 | Brand |
| METHADONE HYDROCHLORIDE | METHADONE HCL CONC 10 MG/ML | 65100050101310 | Generic |
| METHADOSE | METHADONE HCL CONC 10 MG/ML | 65100050101310 | Brand |
| METHADONE HCL | METHADONE HCL SOLN 5 MG/5ML | 65100050102010 | Generic |
| METHADONE HYDROCHLORIDE | METHADONE HCL SOLN 5 MG/5ML | 65100050102010 | Generic |
| METHADONE HCL | METHADONE HCL SOLN 10 MG/5ML | 65100050102015 | Generic |

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|---|---|---|---|
| METHADONE HYDROCHLORIDE | METHADONE HCL SOLN 10 MG/5ML | 65100050102015 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE BEADS CAP ER 24HR 30 MG | 65100055207020 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE BEADS CAP ER 24HR 45 MG | 65100055207025 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE BEADS CAP ER 24HR 60 MG | 65100055207030 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE BEADS CAP ER 24HR 75 MG | 65100055207035 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE BEADS CAP ER 24HR 90 MG | 65100055207040 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE BEADS CAP ER 24HR 120 MG | 65100055207050 | Generic |
| ZOHYDRO ER | HYDROCODONE BITARTRATE CAP ER 12HR 10 MG | 65100030106910 | Brand |
| ZOHYDRO ER | HYDROCODONE BITARTRATE CAP ER 12HR 15 MG | 65100030106915 | Brand |
| ZOHYDRO ER | HYDROCODONE BITARTRATE CAP ER 12HR 20 MG | 65100030106920 | Brand |
| ZOHYDRO ER | HYDROCODONE BITARTRATE CAP ER 12HR 30 MG | 65100030106930 | Brand |
| ZOHYDRO ER | HYDROCODONE BITARTRATE CAP ER 12HR 40 MG | 65100030106940 | Brand |
| ZOHYDRO ER | HYDROCODONE BITARTRATE CAP ER 12HR 50 MG | 65100030106950 | Brand |

**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 THREE of the following, as confirmed by claims history or submission of medical records (document drugs and date of trials):

- morphine sulfate controlled release tablets (generic MS Contin)
- preferred fentanyl transdermal
- oxymorphone ER non-crush resistant (generic)
- 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
- oxymorphone ER non-crush resistant (generic)
- 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.<br>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. Additionall |

| | |
|---|---|
| | y, a 6 month authorization should be entered for preferred products, d epending on what the patient has already tried:<br>• If the patient has tried morphine sulfate controlled release tablets (ge neric MS Contin) or preferred fentanyl transdermal, an authorization s hould be entered for oxymorphone ER-non crush resistant (generic) a nd hydrocodone extended-release capsules (generic Zohydro ER).<br>• If the patient has not tried any of the preferred products [morphine s ulfate controlled release tablets (generic MS Contin), preferred fentan yl transdermal, oxymorphone ER-non crush resistant (generic) or hydr ocodone extended-release capsules (generic Zohydro ER)], an author ization should be entered for morphine sulfate controlled release table ts (generic MS Contin) and preferred fentanyl transdermal. |

| Product Name: tramadol ER, Conzip | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CONZIP | TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 100 MG | 65100095107070 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 100 MG | 65100095107070 | Generic |
| CONZIP | TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 200 MG | 65100095107080 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 200 MG | 65100095107080 | Generic |
| CONZIP | TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 300 MG | 65100095107090 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 300 MG | 65100095107090 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL TAB ER 24HR 100 MG | 65100095107520 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL TAB ER 24HR 200 MG | 65100095107530 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL TAB ER 24HR 300 MG | 65100095107540 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 100 MG | 65100095107560 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 200 MG | 65100095107570 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 300 MG | 65100095107580 | Generic |
| TRAMADOL HYDROCHLORIDE ER | TRAMADOL HCL TAB ER 24HR 100 MG | 65100095107520 | Generic |

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|---|---|---|---|
| TRAMADOL HYDROCHLORIDE ER | TRAMADOL HCL TAB ER 24HR 200 MG | 65100095107530 | Generic |
| TRAMADOL HYDROCHLORIDE ER | TRAMADOL HCL TAB ER 24HR 300 MG | 65100095107540 | Generic |

**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

**OR**

**2.1.3** Patient is being treated for sickle cell anemia related pain

**AND**

**2.2** BOTH of the following:

**2.2.1** Patient is established on pain therapy with the requested medication for hospice related pain, sickle cell anemia related pain, end of life care related pain, or 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)

**AND**

**2.2.2** The medication is not a new regimen for treatment of cancer-related pain, hospice, sickle cell anemia related pain, 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 tabs/soln, generic methadone conc, Brand Methadose conc, tramadol ER, Conzip, Brand Zohydro ER

| Guideline Type | Quantity Limit |
|---|---|

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MORPHINE SULFATE ER | MORPHINE SULFATE TAB ER 15 MG | 65100055100415 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE TAB ER 30 MG | 65100055100432 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE TAB ER 60 MG | 65100055100445 | Generic |
| MORPHINE SULFATE CR | MORPHINE SULFATE TAB ER 60 MG | 65100055100445 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE TAB ER 100 MG | 65100055100460 | Generic |
| MORPHINE SULFATE CR | MORPHINE SULFATE TAB ER 100 MG | 65100055100460 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE TAB ER 200 MG | 65100055100480 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 12 MCG/HR | 65100025008610 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 25 MCG/HR | 65100025008620 | Generic |

| | | | |
|---|---|---|---|
| FENTANYL | FENTANYL TD PATCH 72HR 50 MCG/HR | 65100025008630 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 75 MCG/HR | 65100025008640 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 100 MCG/HR | 65100025008650 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE CAP ER 12HR 10 MG | 65100030106910 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE CAP ER 12HR 15 MG | 65100030106915 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE CAP ER 12HR 20 MG | 65100030106920 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE CAP ER 12HR 30 MG | 65100030106930 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE CAP ER 12HR 40 MG | 65100030106940 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE CAP ER 12HR 50 MG | 65100030106950 | Generic |
| OXYMORPHONE HYDROCHLORIDE ER | OXYMORPHONE HCL TAB ER 12HR 5 MG | 65100080107405 | Generic |
| OXYMORPHONE HYDROCHLORIDE ER | OXYMORPHONE HCL TAB ER 12HR 7.5 MG | 65100080107407 | Generic |
| OXYMORPHONE HYDROCHLORIDE ER | OXYMORPHONE HCL TAB ER 12HR 10 MG | 65100080107410 | Generic |
| OXYMORPHONE HYDROCHLORIDE ER | OXYMORPHONE HCL TAB ER 12HR 15 MG | 65100080107415 | Generic |
| OXYMORPHONE HYDROCHLORIDE ER | OXYMORPHONE HCL TAB ER 12HR 20 MG | 65100080107420 | Generic |
| OXYMORPHONE HYDROCHLORIDE ER | OXYMORPHONE HCL TAB ER 12HR 30 MG | 65100080107430 | Generic |
| OXYMORPHONE HYDROCHLORIDEER | OXYMORPHONE HCL TAB ER 12HR 40 MG | 65100080107440 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 10 MG | 65100055107010 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 20 MG | 65100055107020 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 30 MG | 65100055107030 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 50 MG | 65100055107040 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 60 MG | 65100055107045 | Generic |

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|---|---|---|---|
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 80 MG | 65100055107050 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 100 MG | 65100055107060 | Generic |
| HYDROMORPHONE HYDROCHLORIDE ER | HYDROMORPHONE HCL TAB ER 24HR 8 MG | 65100035107521 | Generic |
| HYDROMORPHONE HCL ER | HYDROMORPHONE HCL TAB ER 24HR 8 MG | 65100035107521 | Generic |
| HYDROMORPHONE HYDROCHLORIDE ER | HYDROMORPHONE HCL TAB ER 24HR 12 MG | 65100035107531 | Generic |
| HYDROMORPHONE HCL ER | HYDROMORPHONE HCL TAB ER 24HR 12 MG | 65100035107531 | Generic |
| HYDROMORPHONE HYDROCHLORIDE ER | HYDROMORPHONE HCL TAB ER 24HR 16 MG | 65100035107541 | Generic |
| HYDROMORPHONE HCL ER | HYDROMORPHONE HCL TAB ER 24HR 16 MG | 65100035107541 | Generic |
| HYDROMORPHONE HYDROCHLORIDE ER | HYDROMORPHONE HCL TAB ER 24HR 32 MG | 65100035107556 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG | 6510003010A810 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG | 6510003010A810 | Brand |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG | 6510003010A820 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG | 6510003010A820 | Brand |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG | 6510003010A830 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG | 6510003010A830 | Brand |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG | 6510003010A840 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG | 6510003010A840 | Brand |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG | 6510003010A850 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG | 6510003010A850 | Brand |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG | 6510003010A860 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG | 6510003010A860 | Brand |

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|---|---|---|---|
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG | 6510003010A870 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG | 6510003010A870 | Brand |
| MS CONTIN | MORPHINE SULFATE TAB ER 15 MG | 65100055100415 | Brand |
| MS CONTIN | MORPHINE SULFATE TAB ER 30 MG | 65100055100432 | Brand |
| MS CONTIN | MORPHINE SULFATE TAB ER 60 MG | 65100055100445 | Brand |
| MS CONTIN | MORPHINE SULFATE TAB ER 100 MG | 65100055100460 | Brand |
| MS CONTIN | MORPHINE SULFATE TAB ER 200 MG | 65100055100480 | Brand |
| NUCYNTA ER | TAPENTADOL HCL TAB ER 12HR 50 MG | 65100091107420 | Brand |
| NUCYNTA ER | TAPENTADOL HCL TAB ER 12HR 100 MG | 65100091107430 | Brand |
| NUCYNTA ER | TAPENTADOL HCL TAB ER 12HR 150 MG | 65100091107440 | Brand |
| NUCYNTA ER | TAPENTADOL HCL TAB ER 12HR 200 MG | 65100091107450 | Brand |
| NUCYNTA ER | TAPENTADOL HCL TAB ER 12HR 250 MG | 65100091107460 | Brand |
| OXYCODONE HYDROCHLORIDE ER | OXYCODONE HCL TAB ER 12HR DETER 10 MG | 6510007510A710 | Generic |
| OXYCODONE HCL ER | OXYCODONE HCL TAB ER 12HR DETER 10 MG | 6510007510A710 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 10 MG | 6510007510A710 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 15 MG | 6510007510A715 | Brand |
| OXYCODONE HYDROCHLORIDE ER | OXYCODONE HCL TAB ER 12HR DETER 20 MG | 6510007510A720 | Generic |
| OXYCODONE HCL ER | OXYCODONE HCL TAB ER 12HR DETER 20 MG | 6510007510A720 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 20 MG | 6510007510A720 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 30 MG | 6510007510A730 | Brand |
| OXYCODONE HYDROCHLORIDE ER | OXYCODONE HCL TAB ER 12HR DETER 40 MG | 6510007510A740 | Generic |
| OXYCODONE HCL ER | OXYCODONE HCL TAB ER 12HR DETER 40 MG | 6510007510A740 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 40 MG | 6510007510A740 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 60 MG | 6510007510A760 | Brand |

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|---|---|---|---|
| OXYCODONE HYDROCHLORIDE ER | OXYCODONE HCL TAB ER 12HR DETER 80 MG | 6510007510A780 | Generic |
| OXYCODONE HCL ER | OXYCODONE HCL TAB ER 12HR DETER 80 MG | 6510007510A780 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 80 MG | 6510007510A780 | Generic |
| XTAMPZA ER | OXYCODONE CAP ER 12HR ABUSE-DETERRENT 9 MG | 6510007500A310 | Brand |
| XTAMPZA ER | OXYCODONE CAP ER 12HR ABUSE-DETERRENT 13.5 MG | 6510007500A315 | Brand |
| XTAMPZA ER | OXYCODONE CAP ER 12HR ABUSE-DETERRENT 18 MG | 6510007500A320 | Brand |
| XTAMPZA ER | OXYCODONE CAP ER 12HR ABUSE-DETERRENT 27 MG | 6510007500A330 | Brand |
| XTAMPZA ER | OXYCODONE CAP ER 12HR ABUSE-DETERRENT 36 MG | 6510007500A340 | Brand |
| FENTANYL | FENTANYL TD PATCH 72HR 37.5 MCG/HR | 65100025008626 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 62.5 MCG/HR | 65100025008635 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 87.5 MCG/HR | 65100025008645 | Generic |
| METHADONE HCL | METHADONE HCL TAB 5 MG | 65100050100305 | Generic |
| METHADONE HYDROCHLORIDE | METHADONE HCL TAB 5 MG | 65100050100305 | Generic |
| METHADONE HCL | METHADONE HCL TAB 10 MG | 65100050100310 | Generic |
| METHADONE HYDROCHLORIDE | METHADONE HCL TAB 10 MG | 65100050100310 | Generic |
| METHADONE HYDROCHLORIDE INTENSOL | METHADONE HCL CONC 10 MG/ML | 65100050101310 | Generic |
| METHADOSE SUGAR-FREE | METHADONE HCL CONC 10 MG/ML | 65100050101310 | Brand |
| METHADONE HYDROCHLORIDE | METHADONE HCL CONC 10 MG/ML | 65100050101310 | Generic |
| METHADOSE | METHADONE HCL CONC 10 MG/ML | 65100050101310 | Brand |
| METHADONE HCL | METHADONE HCL SOLN 5 MG/5ML | 65100050102010 | Generic |
| METHADONE HYDROCHLORIDE | METHADONE HCL SOLN 5 MG/5ML | 65100050102010 | Generic |
| METHADONE HCL | METHADONE HCL SOLN 10 MG/5ML | 65100050102015 | Generic |
| METHADONE HYDROCHLORIDE | METHADONE HCL SOLN 10 MG/5ML | 65100050102015 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 100 MG | 65100095107070 | Generic |

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|---|---|---|---|
| CONZIP | TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 100 MG | 65100095107070 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 200 MG | 65100095107080 | Generic |
| CONZIP | TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 200 MG | 65100095107080 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 300 MG | 65100095107090 | Generic |
| CONZIP | TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 300 MG | 65100095107090 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL TAB ER 24HR 100 MG | 65100095107520 | Generic |
| TRAMADOL HYDROCHLORIDE ER | TRAMADOL HCL TAB ER 24HR 100 MG | 65100095107520 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL TAB ER 24HR 200 MG | 65100095107530 | Generic |
| TRAMADOL HYDROCHLORIDE ER | TRAMADOL HCL TAB ER 24HR 200 MG | 65100095107530 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL TAB ER 24HR 300 MG | 65100095107540 | Generic |
| TRAMADOL HYDROCHLORIDE ER | TRAMADOL HCL TAB ER 24HR 300 MG | 65100095107540 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 100 MG | 65100095107560 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 200 MG | 65100095107570 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 300 MG | 65100095107580 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE BEADS CAP ER 24HR 30 MG | 65100055207020 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE BEADS CAP ER 24HR 45 MG | 65100055207025 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE BEADS CAP ER 24HR 60 MG | 65100055207030 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE BEADS CAP ER 24HR 75 MG | 65100055207035 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE BEADS CAP ER 24HR 90 MG | 65100055207040 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE BEADS CAP ER 24HR 120 MG | 65100055207050 | Generic |
| ZOHYDRO ER | HYDROCODONE BITARTRATE CAP ER 12HR 10 MG | 65100030106910 | Brand |
| ZOHYDRO ER | HYDROCODONE BITARTRATE CAP ER 12HR 15 MG | 65100030106915 | Brand |

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|---|---|---|---|
| ZOHYDRO ER | HYDROCODONE BITARTRATE CAP ER 12HR 20 MG | 65100030106920 | Brand |
| ZOHYDRO ER | HYDROCODONE BITARTRATE CAP ER 12HR 30 MG | 65100030106930 | Brand |
| ZOHYDRO ER | HYDROCODONE BITARTRATE CAP ER 12HR 40 MG | 65100030106940 | Brand |
| ZOHYDRO ER | HYDROCODONE BITARTRATE CAP ER 12HR 50 MG | 65100030106950 | Brand |

**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

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|---|---|
| Notes | Authorization will be issued for:<br>• 12 months for cancer-related pain/hospice/sickle cell anemia related pain/end of life related pain.<br>• 12 months for all Tramadol ER requests.<br>• 6 months for non-cancer related pain/non-hospice/non-sickle cell an emia related pain/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 tabs/soln, generic methadone conc, Brand Methadose conc, tramadol ER, Conzip, Brand Zohydro ER

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|---|---|
| Diagnosis | Cancer-related pain/Hospice/Sickle Cell Anemia/End of Life Related Pain |
| Approval Length | 12 Months* |
| Guideline Type | Morphine Milligram Equivalent (MME) |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MORPHINE SULFATE ER | MORPHINE SULFATE TAB ER 15 MG | 65100055100415 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE TAB ER 30 MG | 65100055100432 | Generic |

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|---|---|---|---|
| MORPHINE SULFATE ER | MORPHINE SULFATE TAB ER 60 MG | 65100055100445 | Generic |
| MORPHINE SULFATE CR | MORPHINE SULFATE TAB ER 60 MG | 65100055100445 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE TAB ER 100 MG | 65100055100460 | Generic |
| MORPHINE SULFATE CR | MORPHINE SULFATE TAB ER 100 MG | 65100055100460 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE TAB ER 200 MG | 65100055100480 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 12 MCG/HR | 65100025008610 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 25 MCG/HR | 65100025008620 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 50 MCG/HR | 65100025008630 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 75 MCG/HR | 65100025008640 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 100 MCG/HR | 65100025008650 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE CAP ER 12HR 10 MG | 65100030106910 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE CAP ER 12HR 15 MG | 65100030106915 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE CAP ER 12HR 20 MG | 65100030106920 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE CAP ER 12HR 30 MG | 65100030106930 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE CAP ER 12HR 40 MG | 65100030106940 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE CAP ER 12HR 50 MG | 65100030106950 | Generic |
| OXYMORPHONE HYDROCHLORIDE ER | OXYMORPHONE HCL TAB ER 12HR 5 MG | 65100080107405 | Generic |
| OXYMORPHONE HYDROCHLORIDE ER | OXYMORPHONE HCL TAB ER 12HR 7.5 MG | 65100080107407 | Generic |
| OXYMORPHONE HYDROCHLORIDE ER | OXYMORPHONE HCL TAB ER 12HR 10 MG | 65100080107410 | Generic |
| OXYMORPHONE HYDROCHLORIDE ER | OXYMORPHONE HCL TAB ER 12HR 15 MG | 65100080107415 | Generic |
| OXYMORPHONE HYDROCHLORIDE ER | OXYMORPHONE HCL TAB ER 12HR 20 MG | 65100080107420 | Generic |
| OXYMORPHONE HYDROCHLORIDE ER | OXYMORPHONE HCL TAB ER 12HR 30 MG | 65100080107430 | Generic |

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|---|---|---|---|
| OXYMORPHONE HYDROCHLORIDEER | OXYMORPHONE HCL TAB ER 12HR 40 MG | 65100080107440 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 10 MG | 65100055107010 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 20 MG | 65100055107020 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 30 MG | 65100055107030 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 50 MG | 65100055107040 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 60 MG | 65100055107045 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 80 MG | 65100055107050 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 100 MG | 65100055107060 | Generic |
| HYDROMORPHONE HYDROCHLORIDE ER | HYDROMORPHONE HCL TAB ER 24HR 8 MG | 65100035107521 | Generic |
| HYDROMORPHONE HCL ER | HYDROMORPHONE HCL TAB ER 24HR 8 MG | 65100035107521 | Generic |
| HYDROMORPHONE HYDROCHLORIDE ER | HYDROMORPHONE HCL TAB ER 24HR 12 MG | 65100035107531 | Generic |
| HYDROMORPHONE HCL ER | HYDROMORPHONE HCL TAB ER 24HR 12 MG | 65100035107531 | Generic |
| HYDROMORPHONE HYDROCHLORIDE ER | HYDROMORPHONE HCL TAB ER 24HR 16 MG | 65100035107541 | Generic |
| HYDROMORPHONE HCL ER | HYDROMORPHONE HCL TAB ER 24HR 16 MG | 65100035107541 | Generic |
| HYDROMORPHONE HYDROCHLORIDE ER | HYDROMORPHONE HCL TAB ER 24HR 32 MG | 65100035107556 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG | 6510003010A810 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG | 6510003010A810 | Brand |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG | 6510003010A820 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG | 6510003010A820 | Brand |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG | 6510003010A830 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG | 6510003010A830 | Brand |

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|---|---|---|---|
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG | 6510003010A840 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG | 6510003010A840 | Brand |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG | 6510003010A850 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG | 6510003010A850 | Brand |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG | 6510003010A860 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG | 6510003010A860 | Brand |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG | 6510003010A870 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG | 6510003010A870 | Brand |
| MS CONTIN | MORPHINE SULFATE TAB ER 15 MG | 65100055100415 | Brand |
| MS CONTIN | MORPHINE SULFATE TAB ER 30 MG | 65100055100432 | Brand |
| MS CONTIN | MORPHINE SULFATE TAB ER 60 MG | 65100055100445 | Brand |
| MS CONTIN | MORPHINE SULFATE TAB ER 100 MG | 65100055100460 | Brand |
| MS CONTIN | MORPHINE SULFATE TAB ER 200 MG | 65100055100480 | Brand |
| NUCYNTA ER | TAPENTADOL HCL TAB ER 12HR 50 MG | 65100091107420 | Brand |
| NUCYNTA ER | TAPENTADOL HCL TAB ER 12HR 100 MG | 65100091107430 | Brand |
| NUCYNTA ER | TAPENTADOL HCL TAB ER 12HR 150 MG | 65100091107440 | Brand |
| NUCYNTA ER | TAPENTADOL HCL TAB ER 12HR 200 MG | 65100091107450 | Brand |
| NUCYNTA ER | TAPENTADOL HCL TAB ER 12HR 250 MG | 65100091107460 | Brand |
| OXYCODONE HYDROCHLORIDE ER | OXYCODONE HCL TAB ER 12HR DETER 10 MG | 6510007510A710 | Generic |
| OXYCODONE HCL ER | OXYCODONE HCL TAB ER 12HR DETER 10 MG | 6510007510A710 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 10 MG | 6510007510A710 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 15 MG | 6510007510A715 | Brand |
| OXYCODONE HYDROCHLORIDE ER | OXYCODONE HCL TAB ER 12HR DETER 20 MG | 6510007510A720 | Generic |
| OXYCODONE HCL ER | OXYCODONE HCL TAB ER 12HR DETER 20 MG | 6510007510A720 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 20 MG | 6510007510A720 | Generic |

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|---|---|---|---|
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 30 MG | 6510007510A730 | Brand |
| OXYCODONE HYDROCHLORIDE ER | OXYCODONE HCL TAB ER 12HR DETER 40 MG | 6510007510A740 | Generic |
| OXYCODONE HCL ER | OXYCODONE HCL TAB ER 12HR DETER 40 MG | 6510007510A740 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 40 MG | 6510007510A740 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 60 MG | 6510007510A760 | Brand |
| OXYCODONE HYDROCHLORIDE ER | OXYCODONE HCL TAB ER 12HR DETER 80 MG | 6510007510A780 | Generic |
| OXYCODONE HCL ER | OXYCODONE HCL TAB ER 12HR DETER 80 MG | 6510007510A780 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 80 MG | 6510007510A780 | Generic |
| XTAMPZA ER | OXYCODONE CAP ER 12HR ABUSE-DETERRENT 9 MG | 6510007500A310 | Brand |
| XTAMPZA ER | OXYCODONE CAP ER 12HR ABUSE-DETERRENT 13.5 MG | 6510007500A315 | Brand |
| XTAMPZA ER | OXYCODONE CAP ER 12HR ABUSE-DETERRENT 18 MG | 6510007500A320 | Brand |
| XTAMPZA ER | OXYCODONE CAP ER 12HR ABUSE-DETERRENT 27 MG | 6510007500A330 | Brand |
| XTAMPZA ER | OXYCODONE CAP ER 12HR ABUSE-DETERRENT 36 MG | 6510007500A340 | Brand |
| FENTANYL | FENTANYL TD PATCH 72HR 37.5 MCG/HR | 65100025008626 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 62.5 MCG/HR | 65100025008635 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 87.5 MCG/HR | 65100025008645 | Generic |
| METHADONE HCL | METHADONE HCL TAB 5 MG | 65100050100305 | Generic |
| METHADONE HYDROCHLORIDE | METHADONE HCL TAB 5 MG | 65100050100305 | Generic |
| METHADONE HCL | METHADONE HCL TAB 10 MG | 65100050100310 | Generic |
| METHADONE HYDROCHLORIDE | METHADONE HCL TAB 10 MG | 65100050100310 | Generic |
| METHADONE HYDROCHLORIDE INTENSOL | METHADONE HCL CONC 10 MG/ML | 65100050101310 | Generic |
| METHADOSE SUGAR-FREE | METHADONE HCL CONC 10 MG/ML | 65100050101310 | Brand |
| METHADONE HYDROCHLORIDE | METHADONE HCL CONC 10 MG/ML | 65100050101310 | Generic |

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|---|---|---|---|
| METHADOSE | METHADONE HCL CONC 10 MG/ML | 65100050101310 | Brand |
| METHADONE HCL | METHADONE HCL SOLN 5 MG/5ML | 65100050102010 | Generic |
| METHADONE HYDROCHLORIDE | METHADONE HCL SOLN 5 MG/5ML | 65100050102010 | Generic |
| METHADONE HCL | METHADONE HCL SOLN 10 MG/5ML | 65100050102015 | Generic |
| METHADONE HYDROCHLORIDE | METHADONE HCL SOLN 10 MG/5ML | 65100050102015 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 100 MG | 65100095107070 | Generic |
| CONZIP | TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 100 MG | 65100095107070 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 200 MG | 65100095107080 | Generic |
| CONZIP | TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 200 MG | 65100095107080 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 300 MG | 65100095107090 | Generic |
| CONZIP | TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 300 MG | 65100095107090 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL TAB ER 24HR 100 MG | 65100095107520 | Generic |
| TRAMADOL HYDROCHLORIDE ER | TRAMADOL HCL TAB ER 24HR 100 MG | 65100095107520 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL TAB ER 24HR 200 MG | 65100095107530 | Generic |
| TRAMADOL HYDROCHLORIDE ER | TRAMADOL HCL TAB ER 24HR 200 MG | 65100095107530 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL TAB ER 24HR 300 MG | 65100095107540 | Generic |
| TRAMADOL HYDROCHLORIDE ER | TRAMADOL HCL TAB ER 24HR 300 MG | 65100095107540 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 100 MG | 65100095107560 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 200 MG | 65100095107570 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 300 MG | 65100095107580 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE BEADS CAP ER 24HR 30 MG | 65100055207020 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE BEADS CAP ER 24HR 45 MG | 65100055207025 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE BEADS CAP ER 24HR 60 MG | 65100055207030 | Generic |

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| MORPHINE SULFATE ER | MORPHINE SULFATE BEADS CAP ER 24HR 75 MG | 65100055207035 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE BEADS CAP ER 24HR 90 MG | 65100055207040 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE BEADS CAP ER 24HR 120 MG | 65100055207050 | Generic |
| ZOHYDRO ER | HYDROCODONE BITARTRATE CAP ER 12HR 10 MG | 65100030106910 | Brand |
| ZOHYDRO ER | HYDROCODONE BITARTRATE CAP ER 12HR 15 MG | 65100030106915 | Brand |
| ZOHYDRO ER | HYDROCODONE BITARTRATE CAP ER 12HR 20 MG | 65100030106920 | Brand |
| ZOHYDRO ER | HYDROCODONE BITARTRATE CAP ER 12HR 30 MG | 65100030106930 | Brand |
| ZOHYDRO ER | HYDROCODONE BITARTRATE CAP ER 12HR 40 MG | 65100030106940 | Brand |
| ZOHYDRO ER | HYDROCODONE BITARTRATE CAP ER 12HR 50 MG | 65100030106950 | Brand |

**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 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
- Sickle cell anemia

| | |
|---|---|
| Notes | *Authorization will be issued for 12 months for cancer-related pain pai n/hospice/sickle cell anemia/end of life related pain. The authorization should be entered for an MME of 9999 so as to prevent future disrupti ons 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 tabs/soln, generic methadone conc, Brand Methadose conc, tramadol ER, Conzip, Brand Zohydro ER

| | |
|---|---|
| Diagnosis | Non-cancer related pain/non-hospice/non-sickle cell anemia/non-end of life related pain |
| Approval Length | 6 Months* |
| Therapy Stage | Initial Authorization |
| Guideline Type | Morphine Milligram Equivalent (MME) |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MORPHINE SULFATE ER | MORPHINE SULFATE TAB ER 15 MG | 65100055100415 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE TAB ER 30 MG | 65100055100432 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE TAB ER 60 MG | 65100055100445 | Generic |
| MORPHINE SULFATE CR | MORPHINE SULFATE TAB ER 60 MG | 65100055100445 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE TAB ER 100 MG | 65100055100460 | Generic |
| MORPHINE SULFATE CR | MORPHINE SULFATE TAB ER 100 MG | 65100055100460 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE TAB ER 200 MG | 65100055100480 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 12 MCG/HR | 65100025008610 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 25 MCG/HR | 65100025008620 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 50 MCG/HR | 65100025008630 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 75 MCG/HR | 65100025008640 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 100 MCG/HR | 65100025008650 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE CAP ER 12HR 10 MG | 65100030106910 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE CAP ER 12HR 15 MG | 65100030106915 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE CAP ER 12HR 20 MG | 65100030106920 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE CAP ER 12HR 30 MG | 65100030106930 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE CAP ER 12HR 40 MG | 65100030106940 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE CAP ER 12HR 50 MG | 65100030106950 | Generic |
| OXYMORPHONE HYDROCHLORIDE ER | OXYMORPHONE HCL TAB ER 12HR 5 MG | 65100080107405 | Generic |

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|---|---|---|---|
| OXYMORPHONE HYDROCHLORIDE ER | OXYMORPHONE HCL TAB ER 12HR 7.5 MG | 65100080107407 | Generic |
| OXYMORPHONE HYDROCHLORIDE ER | OXYMORPHONE HCL TAB ER 12HR 10 MG | 65100080107410 | Generic |
| OXYMORPHONE HYDROCHLORIDE ER | OXYMORPHONE HCL TAB ER 12HR 15 MG | 65100080107415 | Generic |
| OXYMORPHONE HYDROCHLORIDE ER | OXYMORPHONE HCL TAB ER 12HR 20 MG | 65100080107420 | Generic |
| OXYMORPHONE HYDROCHLORIDE ER | OXYMORPHONE HCL TAB ER 12HR 30 MG | 65100080107430 | Generic |
| OXYMORPHONE HYDROCHLORIDEER | OXYMORPHONE HCL TAB ER 12HR 40 MG | 65100080107440 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 10 MG | 65100055107010 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 20 MG | 65100055107020 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 30 MG | 65100055107030 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 50 MG | 65100055107040 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 60 MG | 65100055107045 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 80 MG | 65100055107050 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 100 MG | 65100055107060 | Generic |
| HYDROMORPHONE HYDROCHLORIDE ER | HYDROMORPHONE HCL TAB ER 24HR 8 MG | 65100035107521 | Generic |
| HYDROMORPHONE HCL ER | HYDROMORPHONE HCL TAB ER 24HR 8 MG | 65100035107521 | Generic |
| HYDROMORPHONE HYDROCHLORIDE ER | HYDROMORPHONE HCL TAB ER 24HR 12 MG | 65100035107531 | Generic |
| HYDROMORPHONE HCL ER | HYDROMORPHONE HCL TAB ER 24HR 12 MG | 65100035107531 | Generic |
| HYDROMORPHONE HYDROCHLORIDE ER | HYDROMORPHONE HCL TAB ER 24HR 16 MG | 65100035107541 | Generic |
| HYDROMORPHONE HCL ER | HYDROMORPHONE HCL TAB ER 24HR 16 MG | 65100035107541 | Generic |

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|---|---|---|---|
| HYDROMORPHONE HYDROCHLORIDE ER | HYDROMORPHONE HCL TAB ER 24HR 32 MG | 65100035107556 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG | 6510003010A810 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG | 6510003010A810 | Brand |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG | 6510003010A820 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG | 6510003010A820 | Brand |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG | 6510003010A830 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG | 6510003010A830 | Brand |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG | 6510003010A840 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG | 6510003010A840 | Brand |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG | 6510003010A850 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG | 6510003010A850 | Brand |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG | 6510003010A860 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG | 6510003010A860 | Brand |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG | 6510003010A870 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG | 6510003010A870 | Brand |
| MS CONTIN | MORPHINE SULFATE TAB ER 15 MG | 65100055100415 | Brand |
| MS CONTIN | MORPHINE SULFATE TAB ER 30 MG | 65100055100432 | Brand |
| MS CONTIN | MORPHINE SULFATE TAB ER 60 MG | 65100055100445 | Brand |
| MS CONTIN | MORPHINE SULFATE TAB ER 100 MG | 65100055100460 | Brand |
| MS CONTIN | MORPHINE SULFATE TAB ER 200 MG | 65100055100480 | Brand |
| NUCYNTA ER | TAPENTADOL HCL TAB ER 12HR 50 MG | 65100091107420 | Brand |
| NUCYNTA ER | TAPENTADOL HCL TAB ER 12HR 100 MG | 65100091107430 | Brand |
| NUCYNTA ER | TAPENTADOL HCL TAB ER 12HR 150 MG | 65100091107440 | Brand |
| NUCYNTA ER | TAPENTADOL HCL TAB ER 12HR 200 MG | 65100091107450 | Brand |
| NUCYNTA ER | TAPENTADOL HCL TAB ER 12HR 250 MG | 65100091107460 | Brand |

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|---|---|---|---|
| OXYCODONE HYDROCHLORIDE ER | OXYCODONE HCL TAB ER 12HR DETER 10 MG | 6510007510A710 | Generic |
| OXYCODONE HCL ER | OXYCODONE HCL TAB ER 12HR DETER 10 MG | 6510007510A710 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 10 MG | 6510007510A710 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 15 MG | 6510007510A715 | Brand |
| OXYCODONE HYDROCHLORIDE ER | OXYCODONE HCL TAB ER 12HR DETER 20 MG | 6510007510A720 | Generic |
| OXYCODONE HCL ER | OXYCODONE HCL TAB ER 12HR DETER 20 MG | 6510007510A720 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 20 MG | 6510007510A720 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 30 MG | 6510007510A730 | Brand |
| OXYCODONE HYDROCHLORIDE ER | OXYCODONE HCL TAB ER 12HR DETER 40 MG | 6510007510A740 | Generic |
| OXYCODONE HCL ER | OXYCODONE HCL TAB ER 12HR DETER 40 MG | 6510007510A740 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 40 MG | 6510007510A740 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 60 MG | 6510007510A760 | Brand |
| OXYCODONE HYDROCHLORIDE ER | OXYCODONE HCL TAB ER 12HR DETER 80 MG | 6510007510A780 | Generic |
| OXYCODONE HCL ER | OXYCODONE HCL TAB ER 12HR DETER 80 MG | 6510007510A780 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 80 MG | 6510007510A780 | Generic |
| XTAMPZA ER | OXYCODONE CAP ER 12HR ABUSE-DETERRENT 9 MG | 6510007500A310 | Brand |
| XTAMPZA ER | OXYCODONE CAP ER 12HR ABUSE-DETERRENT 13.5 MG | 6510007500A315 | Brand |
| XTAMPZA ER | OXYCODONE CAP ER 12HR ABUSE-DETERRENT 18 MG | 6510007500A320 | Brand |
| XTAMPZA ER | OXYCODONE CAP ER 12HR ABUSE-DETERRENT 27 MG | 6510007500A330 | Brand |
| XTAMPZA ER | OXYCODONE CAP ER 12HR ABUSE-DETERRENT 36 MG | 6510007500A340 | Brand |
| FENTANYL | FENTANYL TD PATCH 72HR 37.5 MCG/HR | 65100025008626 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 62.5 MCG/HR | 65100025008635 | Generic |

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|---|---|---|---|
| FENTANYL | FENTANYL TD PATCH 72HR 87.5 MCG/HR | 65100025008645 | Generic |
| METHADONE HCL | METHADONE HCL TAB 5 MG | 65100050100305 | Generic |
| METHADONE HYDROCHLORIDE | METHADONE HCL TAB 5 MG | 65100050100305 | Generic |
| METHADONE HCL | METHADONE HCL TAB 10 MG | 65100050100310 | Generic |
| METHADONE HYDROCHLORIDE | METHADONE HCL TAB 10 MG | 65100050100310 | Generic |
| METHADONE HYDROCHLORIDE INTENSOL | METHADONE HCL CONC 10 MG/ML | 65100050101310 | Generic |
| METHADOSE SUGAR-FREE | METHADONE HCL CONC 10 MG/ML | 65100050101310 | Brand |
| METHADONE HYDROCHLORIDE | METHADONE HCL CONC 10 MG/ML | 65100050101310 | Generic |
| METHADOSE | METHADONE HCL CONC 10 MG/ML | 65100050101310 | Brand |
| METHADONE HCL | METHADONE HCL SOLN 5 MG/5ML | 65100050102010 | Generic |
| METHADONE HYDROCHLORIDE | METHADONE HCL SOLN 5 MG/5ML | 65100050102010 | Generic |
| METHADONE HCL | METHADONE HCL SOLN 10 MG/5ML | 65100050102015 | Generic |
| METHADONE HYDROCHLORIDE | METHADONE HCL SOLN 10 MG/5ML | 65100050102015 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 100 MG | 65100095107070 | Generic |
| CONZIP | TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 100 MG | 65100095107070 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 200 MG | 65100095107080 | Generic |
| CONZIP | TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 200 MG | 65100095107080 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 300 MG | 65100095107090 | Generic |
| CONZIP | TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 300 MG | 65100095107090 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL TAB ER 24HR 100 MG | 65100095107520 | Generic |
| TRAMADOL HYDROCHLORIDE ER | TRAMADOL HCL TAB ER 24HR 100 MG | 65100095107520 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL TAB ER 24HR 200 MG | 65100095107530 | Generic |
| TRAMADOL HYDROCHLORIDE ER | TRAMADOL HCL TAB ER 24HR 200 MG | 65100095107530 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL TAB ER 24HR 300 MG | 65100095107540 | Generic |

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|---|---|---|---|
| TRAMADOL HYDROCHLORIDE ER | TRAMADOL HCL TAB ER 24HR 300 MG | 65100095107540 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 100 MG | 65100095107560 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 200 MG | 65100095107570 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 300 MG | 65100095107580 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE BEADS CAP ER 24HR 30 MG | 65100055207020 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE BEADS CAP ER 24HR 45 MG | 65100055207025 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE BEADS CAP ER 24HR 60 MG | 65100055207030 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE BEADS CAP ER 24HR 75 MG | 65100055207035 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE BEADS CAP ER 24HR 90 MG | 65100055207040 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE BEADS CAP ER 24HR 120 MG | 65100055207050 | Generic |
| ZOHYDRO ER | HYDROCODONE BITARTRATE CAP ER 12HR 10 MG | 65100030106910 | Brand |
| ZOHYDRO ER | HYDROCODONE BITARTRATE CAP ER 12HR 15 MG | 65100030106915 | Brand |
| ZOHYDRO ER | HYDROCODONE BITARTRATE CAP ER 12HR 20 MG | 65100030106920 | Brand |
| ZOHYDRO ER | HYDROCODONE BITARTRATE CAP ER 12HR 30 MG | 65100030106930 | Brand |
| ZOHYDRO ER | HYDROCODONE BITARTRATE CAP ER 12HR 40 MG | 65100030106940 | Brand |
| ZOHYDRO ER | HYDROCODONE BITARTRATE CAP ER 12HR 50 MG | 65100030106950 | Brand |

**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 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

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| Notes | *Authorization will be issued for 6 months for non-cancer related pain/ non-hospice/non-sickle cell anemia/non-end of life related pain up to t he current requested MME plus 90 MME.<br>If the patient has been established on the requested MME dose for at least 30 days and does not meet the medical necessity authorization c riteria requirements, a denial should be issued and a maximum 60-da y authorization may be authorized one time for the requested MME do se. |

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 tabs/soln, generic methadone conc, Brand Methadose conc, tramadol ER, Conzip, Brand Zohydro ER

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|---|---|
| Diagnosis | Non-cancer related pain/non-hospice/non-sickle cell anemia/non-end of life related pain |
| Approval Length | 6 Months* |
| Therapy Stage | Reauthorization |
| Guideline Type | Morphine Milligram Equivalent (MME) |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MORPHINE SULFATE ER | MORPHINE SULFATE TAB ER 15 MG | 65100055100415 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE TAB ER 30 MG | 65100055100432 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE TAB ER 60 MG | 65100055100445 | Generic |
| MORPHINE SULFATE CR | MORPHINE SULFATE TAB ER 60 MG | 65100055100445 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE TAB ER 100 MG | 65100055100460 | Generic |
| MORPHINE SULFATE CR | MORPHINE SULFATE TAB ER 100 MG | 65100055100460 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE TAB ER 200 MG | 65100055100480 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 12 MCG/HR | 65100025008610 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 25 MCG/HR | 65100025008620 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 50 MCG/HR | 65100025008630 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 75 MCG/HR | 65100025008640 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 100 MCG/HR | 65100025008650 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE CAP ER 12HR 10 MG | 65100030106910 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE CAP ER 12HR 15 MG | 65100030106915 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE CAP ER 12HR 20 MG | 65100030106920 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE CAP ER 12HR 30 MG | 65100030106930 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE CAP ER 12HR 40 MG | 65100030106940 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE CAP ER 12HR 50 MG | 65100030106950 | Generic |
| OXYMORPHONE HYDROCHLORIDE ER | OXYMORPHONE HCL TAB ER 12HR 5 MG | 65100080107405 | Generic |

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|---|---|---|---|
| OXYMORPHONE HYDROCHLORIDE ER | OXYMORPHONE HCL TAB ER 12HR 7.5 MG | 65100080107407 | Generic |
| OXYMORPHONE HYDROCHLORIDE ER | OXYMORPHONE HCL TAB ER 12HR 10 MG | 65100080107410 | Generic |
| OXYMORPHONE HYDROCHLORIDE ER | OXYMORPHONE HCL TAB ER 12HR 15 MG | 65100080107415 | Generic |
| OXYMORPHONE HYDROCHLORIDE ER | OXYMORPHONE HCL TAB ER 12HR 20 MG | 65100080107420 | Generic |
| OXYMORPHONE HYDROCHLORIDE ER | OXYMORPHONE HCL TAB ER 12HR 30 MG | 65100080107430 | Generic |
| OXYMORPHONE HYDROCHLORIDEER | OXYMORPHONE HCL TAB ER 12HR 40 MG | 65100080107440 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 10 MG | 65100055107010 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 20 MG | 65100055107020 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 30 MG | 65100055107030 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 50 MG | 65100055107040 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 60 MG | 65100055107045 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 80 MG | 65100055107050 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE CAP ER 24HR 100 MG | 65100055107060 | Generic |
| HYDROMORPHONE HYDROCHLORIDE ER | HYDROMORPHONE HCL TAB ER 24HR 8 MG | 65100035107521 | Generic |
| HYDROMORPHONE HCL ER | HYDROMORPHONE HCL TAB ER 24HR 8 MG | 65100035107521 | Generic |
| HYDROMORPHONE HYDROCHLORIDE ER | HYDROMORPHONE HCL TAB ER 24HR 12 MG | 65100035107531 | Generic |
| HYDROMORPHONE HCL ER | HYDROMORPHONE HCL TAB ER 24HR 12 MG | 65100035107531 | Generic |
| HYDROMORPHONE HYDROCHLORIDE ER | HYDROMORPHONE HCL TAB ER 24HR 16 MG | 65100035107541 | Generic |
| HYDROMORPHONE HCL ER | HYDROMORPHONE HCL TAB ER 24HR 16 MG | 65100035107541 | Generic |

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|---|---|---|---|
| HYDROMORPHONE HYDROCHLORIDE ER | HYDROMORPHONE HCL TAB ER 24HR 32 MG | 65100035107556 | Generic |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG | 6510003010A810 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG | 6510003010A810 | Brand |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG | 6510003010A820 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG | 6510003010A820 | Brand |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG | 6510003010A830 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG | 6510003010A830 | Brand |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG | 6510003010A840 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG | 6510003010A840 | Brand |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG | 6510003010A850 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG | 6510003010A850 | Brand |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG | 6510003010A860 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG | 6510003010A860 | Brand |
| HYDROCODONE BITARTRATE ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG | 6510003010A870 | Generic |
| HYSINGLA ER | HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG | 6510003010A870 | Brand |
| MS CONTIN | MORPHINE SULFATE TAB ER 15 MG | 65100055100415 | Brand |
| MS CONTIN | MORPHINE SULFATE TAB ER 30 MG | 65100055100432 | Brand |
| MS CONTIN | MORPHINE SULFATE TAB ER 60 MG | 65100055100445 | Brand |
| MS CONTIN | MORPHINE SULFATE TAB ER 100 MG | 65100055100460 | Brand |
| MS CONTIN | MORPHINE SULFATE TAB ER 200 MG | 65100055100480 | Brand |
| NUCYNTA ER | TAPENTADOL HCL TAB ER 12HR 50 MG | 65100091107420 | Brand |
| NUCYNTA ER | TAPENTADOL HCL TAB ER 12HR 100 MG | 65100091107430 | Brand |
| NUCYNTA ER | TAPENTADOL HCL TAB ER 12HR 150 MG | 65100091107440 | Brand |
| NUCYNTA ER | TAPENTADOL HCL TAB ER 12HR 200 MG | 65100091107450 | Brand |
| NUCYNTA ER | TAPENTADOL HCL TAB ER 12HR 250 MG | 65100091107460 | Brand |

| | | | |
|---|---|---|---|
| OXYCODONE HYDROCHLORIDE ER | OXYCODONE HCL TAB ER 12HR DETER 10 MG | 6510007510A710 | Generic |
| OXYCODONE HCL ER | OXYCODONE HCL TAB ER 12HR DETER 10 MG | 6510007510A710 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 10 MG | 6510007510A710 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 15 MG | 6510007510A715 | Brand |
| OXYCODONE HYDROCHLORIDE ER | OXYCODONE HCL TAB ER 12HR DETER 20 MG | 6510007510A720 | Generic |
| OXYCODONE HCL ER | OXYCODONE HCL TAB ER 12HR DETER 20 MG | 6510007510A720 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 20 MG | 6510007510A720 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 30 MG | 6510007510A730 | Brand |
| OXYCODONE HYDROCHLORIDE ER | OXYCODONE HCL TAB ER 12HR DETER 40 MG | 6510007510A740 | Generic |
| OXYCODONE HCL ER | OXYCODONE HCL TAB ER 12HR DETER 40 MG | 6510007510A740 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 40 MG | 6510007510A740 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 60 MG | 6510007510A760 | Brand |
| OXYCODONE HYDROCHLORIDE ER | OXYCODONE HCL TAB ER 12HR DETER 80 MG | 6510007510A780 | Generic |
| OXYCODONE HCL ER | OXYCODONE HCL TAB ER 12HR DETER 80 MG | 6510007510A780 | Generic |
| OXYCONTIN | OXYCODONE HCL TAB ER 12HR DETER 80 MG | 6510007510A780 | Generic |
| XTAMPZA ER | OXYCODONE CAP ER 12HR ABUSE-DETERRENT 9 MG | 6510007500A310 | Brand |
| XTAMPZA ER | OXYCODONE CAP ER 12HR ABUSE-DETERRENT 13.5 MG | 6510007500A315 | Brand |
| XTAMPZA ER | OXYCODONE CAP ER 12HR ABUSE-DETERRENT 18 MG | 6510007500A320 | Brand |
| XTAMPZA ER | OXYCODONE CAP ER 12HR ABUSE-DETERRENT 27 MG | 6510007500A330 | Brand |
| XTAMPZA ER | OXYCODONE CAP ER 12HR ABUSE-DETERRENT 36 MG | 6510007500A340 | Brand |
| FENTANYL | FENTANYL TD PATCH 72HR 37.5 MCG/HR | 65100025008626 | Generic |
| FENTANYL | FENTANYL TD PATCH 72HR 62.5 MCG/HR | 65100025008635 | Generic |

| | | | |
|---|---|---|---|
| FENTANYL | FENTANYL TD PATCH 72HR 87.5 MCG/HR | 65100025008645 | Generic |
| METHADONE HCL | METHADONE HCL TAB 5 MG | 65100050100305 | Generic |
| METHADONE HYDROCHLORIDE | METHADONE HCL TAB 5 MG | 65100050100305 | Generic |
| METHADONE HCL | METHADONE HCL TAB 10 MG | 65100050100310 | Generic |
| METHADONE HYDROCHLORIDE | METHADONE HCL TAB 10 MG | 65100050100310 | Generic |
| METHADONE HYDROCHLORIDE INTENSOL | METHADONE HCL CONC 10 MG/ML | 65100050101310 | Generic |
| METHADOSE SUGAR-FREE | METHADONE HCL CONC 10 MG/ML | 65100050101310 | Brand |
| METHADONE HYDROCHLORIDE | METHADONE HCL CONC 10 MG/ML | 65100050101310 | Generic |
| METHADOSE | METHADONE HCL CONC 10 MG/ML | 65100050101310 | Brand |
| METHADONE HCL | METHADONE HCL SOLN 5 MG/5ML | 65100050102010 | Generic |
| METHADONE HYDROCHLORIDE | METHADONE HCL SOLN 5 MG/5ML | 65100050102010 | Generic |
| METHADONE HCL | METHADONE HCL SOLN 10 MG/5ML | 65100050102015 | Generic |
| METHADONE HYDROCHLORIDE | METHADONE HCL SOLN 10 MG/5ML | 65100050102015 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 100 MG | 65100095107070 | Generic |
| CONZIP | TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 100 MG | 65100095107070 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 200 MG | 65100095107080 | Generic |
| CONZIP | TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 200 MG | 65100095107080 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 300 MG | 65100095107090 | Generic |
| CONZIP | TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 300 MG | 65100095107090 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL TAB ER 24HR 100 MG | 65100095107520 | Generic |
| TRAMADOL HYDROCHLORIDE ER | TRAMADOL HCL TAB ER 24HR 100 MG | 65100095107520 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL TAB ER 24HR 200 MG | 65100095107530 | Generic |
| TRAMADOL HYDROCHLORIDE ER | TRAMADOL HCL TAB ER 24HR 200 MG | 65100095107530 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL TAB ER 24HR 300 MG | 65100095107540 | Generic |

| | | | |
|---|---|---|---|
| TRAMADOL HYDROCHLORIDE ER | TRAMADOL HCL TAB ER 24HR 300 MG | 65100095107540 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 100 MG | 65100095107560 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 200 MG | 65100095107570 | Generic |
| TRAMADOL HCL ER | TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 300 MG | 65100095107580 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE BEADS CAP ER 24HR 30 MG | 65100055207020 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE BEADS CAP ER 24HR 45 MG | 65100055207025 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE BEADS CAP ER 24HR 60 MG | 65100055207030 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE BEADS CAP ER 24HR 75 MG | 65100055207035 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE BEADS CAP ER 24HR 90 MG | 65100055207040 | Generic |
| MORPHINE SULFATE ER | MORPHINE SULFATE BEADS CAP ER 24HR 120 MG | 65100055207050 | Generic |
| ZOHYDRO ER | HYDROCODONE BITARTRATE CAP ER 12HR 10 MG | 65100030106910 | Brand |
| ZOHYDRO ER | HYDROCODONE BITARTRATE CAP ER 12HR 15 MG | 65100030106915 | Brand |
| ZOHYDRO ER | HYDROCODONE BITARTRATE CAP ER 12HR 20 MG | 65100030106920 | Brand |
| ZOHYDRO ER | HYDROCODONE BITARTRATE CAP ER 12HR 30 MG | 65100030106930 | Brand |
| ZOHYDRO ER | HYDROCODONE BITARTRATE CAP ER 12HR 40 MG | 65100030106940 | Brand |
| ZOHYDRO ER | HYDROCODONE BITARTRATE CAP ER 12HR 50 MG | 65100030106950 | Brand |

**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 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<br><br>**AND**<br><br>**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 related pain/ non-hospice/non-sickle cell anemia/non-end of life related pain up to t he current requested MME plus 90 MME.<br>If the patient has been established on the requested MME dose for at least 30 days and does not meet the medical necessity authorization c riteria requirements, a denial should be issued and a maximum 60-da y authorization may be authorized one time for the requested MME do se. |

## 2 . Revision History

| Date | Notes |
|---|---|
| 12/13/2024 | Copy |

Lonhala and Yupelri

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146356 |
| **Guideline Name** | Lonhala and Yupelri |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Lonhala Magnair (Starter Kit and Refill Kit), Yupelri | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LONHALA MAGNAIR REFILL KIT | GLYCOPYRROLATE INHAL SOLUTION 25 MCG/ML | 44100020102030 | Brand |
| LONHALA MAGNAIR STARTER KIT | GLYCOPYRROLATE INHAL SOLUTION 25 MCG/ML | 44100020102030 | Brand |

| YUPELRI | REVEFENACIN INHALATION SOLUTION 175 MCG/3ML | 44100075002020 | Brand |
|---|---|---|---|

**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)

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LONHALA MAGNAIR STARTER KIT | GLYCOPYRROLATE INHAL SOLUTION 25 MCG/ML | 44100020102030 | Brand |
| LONHALA MAGNAIR REFILL KIT | GLYCOPYRROLATE INHAL SOLUTION 25 MCG/ML | 44100020102030 | Brand |
| YUPELRI | REVEFENACIN INHALATION SOLUTION 175 MCG/3ML | 44100075002020 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to therapy

Lonsurf

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-148216 |
| **Guideline Name** | Lonsurf |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Lonsurf | |
|---|---|
| Diagnosis | Colorectal Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LONSURF | TRIFLURIDINE-TIPIRACIL TAB 15-6.14 MG | 21990002750320 | Brand |
| LONSURF | TRIFLURIDINE-TIPIRACIL TAB 20-8.19 MG | 21990002750330 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LONSURF | TRIFLURIDINE-TIPIRACIL TAB 15-6.14 MG | 21990002750320 | Brand |
| LONSURF | TRIFLURIDINE-TIPIRACIL TAB 20-8.19 MG | 21990002750330 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LONSURF | TRIFLURIDINE-TIPIRACIL TAB 15-6.14 MG | 21990002750320 | Brand |
| LONSURF | TRIFLURIDINE-TIPIRACIL TAB 20-8.19 MG | 21990002750330 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LONSURF | TRIFLURIDINE-TIPIRACIL TAB 15-6.14 MG | 21990002750320 | Brand |
| LONSURF | TRIFLURIDINE-TIPIRACIL TAB 20-8.19 MG | 21990002750330 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LONSURF | TRIFLURIDINE-TIPIRACIL TAB 15-6.14 MG | 21990002750320 | Brand |
| LONSURF | TRIFLURIDINE-TIPIRACIL TAB 20-8.19 MG | 21990002750330 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Lonsurf therapy

## 2 . Revision History

| Date | Notes |
|---|---|

| | |
|---|---|
| 6/6/2024 | Updated diagnostic criteria for colorectal cancer. Updated gastric/gas troesophageal junction adenocarcinoma diagnostic criteria. |

Lorbrena

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146574 |
| **Guideline Name** | Lorbrena |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LORBRENA | LORLATINIB TAB 25 MG | 21530556000320 | Brand |
| LORBRENA | LORLATINIB TAB 100 MG | 21530556000330 | Brand |

**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:

- 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| LORBRENA | LORLATINIB TAB 25 MG | 21530556000320 | Brand |
| LORBRENA | LORLATINIB TAB 100 MG | 21530556000330 | Brand |

**Approval Criteria**

**1** - Diagnosis of Erdheim-Chester Disease (ECD)

**AND**

**2** - Disease is BOTH of the following:

- Symptomatic, relapsed, or refractory
- ALK-positive

| Product Name: Lorbrena | |
|---|---|
| Diagnosis | Soft Tissue Sarcoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LORBRENA | LORLATINIB TAB 25 MG | 21530556000320 | Brand |
| LORBRENA | LORLATINIB TAB 100 MG | 21530556000330 | Brand |

**Approval Criteria**

**1** - Diagnosis of inflammatory myofibroblastic tumor (IMT) with ALK translocation

| Product Name: Lorbrena | |
|---|---|
| Diagnosis | Uterine Sarcoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |

| Guideline Type | Prior Authorization |
|---|---|

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LORBRENA | LORLATINIB TAB 25 MG | 21530556000320 | Brand |
| LORBRENA | LORLATINIB TAB 100 MG | 21530556000330 | Brand |

**Approval Criteria**

**1** - Diagnosis of uterine sarcoma

**AND**

**2** - Disease is ONE of the following:

- Advanced
- Recurrent/metastatic
- Inoperable

**AND**

**3** - Disease is ALK - positive

| Product Name: Lorbrena | |
|---|---|
| Diagnosis | Lymphoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LORBRENA | LORLATINIB TAB 25 MG | 21530556000320 | Brand |
| LORBRENA | LORLATINIB TAB 100 MG | 21530556000330 | Brand |

**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 ALK - positive

| Product Name: Lorbrena | |
|---|---|
| Diagnosis | Non-Small Cell Lung Cancer (NSCLC), Histiocytic Neoplasms, Soft Tissue Sarcoma, Uterine Sarcoma, Lymphoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LORBRENA | LORLATINIB TAB 25 MG | 21530556000320 | Brand |
| LORBRENA | LORLATINIB TAB 100 MG | 21530556000330 | Brand |

**Approval Criteria**

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

| Product Name: Lorbrena | |
|---|---|
| Diagnosis | NCCN Recommended Regimen |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |

| Guideline Type | Prior Authorization |
|---|---|

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LORBRENA | LORLATINIB TAB 25 MG | 21530556000320 | Brand |
| LORBRENA | LORLATINIB TAB 100 MG | 21530556000330 | Brand |

**Approval Criteria**

**1** - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

| Product Name: Lorbrena | |
|---|---|
| Diagnosis | NCCN Recommended Regimen |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LORBRENA | LORLATINIB TAB 25 MG | 21530556000320 | Brand |
| LORBRENA | LORLATINIB TAB 100 MG | 21530556000330 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Lorbrena therapy

Lovenox

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146357 |
| **Guideline Name** | Lovenox |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Brand Lovenox, generic enoxaparin | |
|---|---|
| Diagnosis | Continuation of Therapy Upon Hospital Discharge |
| Approval Length | 35 Day(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML | 8310102010E520 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML | 8310102010E520 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML | 8310102010E525 | Generic |

| | | | |
|---|---|---|---|
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML | 8310102010E525 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML | 8310102010E530 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML | 8310102010E530 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML | 8310102010E535 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML | 8310102010E535 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML | 8310102010E540 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML | 8310102010E540 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML | 8310102010E560 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML | 8310102010E560 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML | 8310102010E565 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML | 8310102010E565 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ 300 MG/3ML | 83101020102050 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ 300 MG/3ML | 83101020102050 | Brand |

**Approval Criteria**

**1** - Will be approved as continuation of therapy upon hospital discharge

| Product Name: Brand Lovenox, generic enoxaparin | |
|---|---|
| Diagnosis | Prophylaxis of DVT - Orthopedic Surgery |
| Approval Length | 35 Day(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML | 8310102010E520 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML | 8310102010E520 | Brand |

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|---|---|---|---|
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML | 8310102010E525 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML | 8310102010E525 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML | 8310102010E530 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML | 8310102010E530 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML | 8310102010E535 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML | 8310102010E535 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML | 8310102010E540 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML | 8310102010E540 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML | 8310102010E560 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML | 8310102010E560 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML | 8310102010E565 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML | 8310102010E565 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ 300 MG/3ML | 83101020102050 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ 300 MG/3ML | 83101020102050 | Brand |

**Approval Criteria**

**1** - For deep vein thrombosis (DVT) prophylaxis

**AND**

**2** - Patient is undergoing ONE of the following:

- Hip fracture surgery
- Hip replacement surgery
- Knee replacement surgery

| Product Name: Brand Lovenox, generic enoxaparin | |
|---|---|
| Diagnosis | Prophylaxis of DVT - Abdominal Surgery |
| Approval Length | 2 Week(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML | 8310102010E520 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML | 8310102010E520 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML | 8310102010E525 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML | 8310102010E525 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML | 8310102010E530 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML | 8310102010E530 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML | 8310102010E535 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML | 8310102010E535 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML | 8310102010E540 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML | 8310102010E540 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML | 8310102010E560 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML | 8310102010E560 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML | 8310102010E565 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML | 8310102010E565 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ 300 MG/3ML | 83101020102050 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ 300 MG/3ML | 83101020102050 | Brand |

**Approval Criteria**

**1** - For deep vein thrombosis (DVT) prophylaxis following abdominal surgery

**AND**

**2** - Patient is at risk for thromboembolic complications

| Product Name: Brand Lovenox, generic enoxaparin | |
|---|---|
| Diagnosis | Prophylaxis of DVT - Restricted Mobility |
| Approval Length | 2 Week(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML | 8310102010E520 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML | 8310102010E520 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML | 8310102010E525 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML | 8310102010E525 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML | 8310102010E530 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML | 8310102010E530 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML | 8310102010E535 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML | 8310102010E535 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML | 8310102010E540 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML | 8310102010E540 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML | 8310102010E560 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML | 8310102010E560 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML | 8310102010E565 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML | 8310102010E565 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ 300 MG/3ML | 83101020102050 | Generic |

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|---|---|---|---|
| LOVENOX | ENOXAPARIN SODIUM INJ 300 MG/3ML | 83101020102050 | Brand |

**Approval Criteria**

**1** - For deep vein thrombosis (DVT) prophylaxis in patients at risk for thromboembolic complications due to severely restricted mobility during acute illness

| Product Name: Brand Lovenox, generic enoxaparin | |
|---|---|
| Diagnosis | DVT Treatment |
| Approval Length | 2 Week(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML | 8310102010E520 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML | 8310102010E520 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML | 8310102010E525 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML | 8310102010E525 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML | 8310102010E530 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML | 8310102010E530 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML | 8310102010E535 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML | 8310102010E535 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML | 8310102010E540 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML | 8310102010E540 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML | 8310102010E560 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML | 8310102010E560 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML | 8310102010E565 | Generic |

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|---|---|---|---|
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML | 8310102010E565 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ 300 MG/3ML | 83101020102050 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ 300 MG/3ML | 83101020102050 | Brand |

**Approval Criteria**

**1** - For the treatment of acute deep vein thrombosis (DVT)

| Product Name: Brand Lovenox, generic enoxaparin | |
|---|---|
| Diagnosis | Prophylaxis of Ischemic Complications |
| Approval Length | 2 Week(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML | 8310102010E520 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML | 8310102010E520 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML | 8310102010E525 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML | 8310102010E525 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML | 8310102010E530 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML | 8310102010E530 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML | 8310102010E535 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML | 8310102010E535 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML | 8310102010E540 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML | 8310102010E540 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML | 8310102010E560 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML | 8310102010E560 | Brand |

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|---|---|---|---|
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML | 8310102010E565 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML | 8310102010E565 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ 300 MG/3ML | 83101020102050 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ 300 MG/3ML | 83101020102050 | Brand |

**Approval Criteria**

**1** - For prophylaxis of ischemic complications in ONE of the following:

- Unstable angina
- Non-Q-Wave myocardial infarction

| Product Name: Brand Lovenox, generic enoxaparin | |
|---|---|
| Diagnosis | Acute ST-Segment Elevation Myocardial Infarction |
| Approval Length | 2 Week(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML | 8310102010E520 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML | 8310102010E520 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML | 8310102010E525 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML | 8310102010E525 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML | 8310102010E530 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML | 8310102010E530 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML | 8310102010E535 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML | 8310102010E535 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML | 8310102010E540 | Generic |

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|---|---|---|---|
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML | 8310102010E540 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML | 8310102010E560 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML | 8310102010E560 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML | 8310102010E565 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML | 8310102010E565 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ 300 MG/3ML | 83101020102050 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ 300 MG/3ML | 83101020102050 | Brand |

**Approval Criteria**

**1** - For the treatment of acute ST-segment elevation myocardial infarction (STEMI)

**AND**

**2** - ONE of the following:

- Managed medically
- Managed with subsequent percutaneous coronary intervention

| Product Name: Brand Lovenox, generic enoxaparin | |
|---|---|
| Diagnosis | Off-Label Uses |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML | 8310102010E520 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML | 8310102010E520 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML | 8310102010E525 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML | 8310102010E525 | Brand |

| | | | |
|---|---|---|---|
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML | 8310102010E530 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML | 8310102010E530 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML | 8310102010E535 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML | 8310102010E535 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML | 8310102010E540 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML | 8310102010E540 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML | 8310102010E560 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML | 8310102010E560 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML | 8310102010E565 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML | 8310102010E565 | Brand |
| ENOXAPARIN SODIUM | ENOXAPARIN SODIUM INJ 300 MG/3ML | 83101020102050 | Generic |
| LOVENOX | ENOXAPARIN SODIUM INJ 300 MG/3ML | 83101020102050 | Brand |

**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 a medically accepted indication that is recognized as a covered benefit by the applicable health plan's program

| | |
|---|---|
| Notes | Authorization will be issued for the compendia recommended duration of therapy, not to exceed 12 months. |

Lumakras

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-155016 |
| **Guideline Name** | Lumakras |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 10/1/2024 |

## 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LUMAKRAS | SOTORASIB TAB 120 MG | 21532480000320 | Brand |
| LUMAKRAS | SOTORASIB TAB 320 MG | 21532480000340 | Brand |

**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 (gene)-mutated

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LUMAKRAS | SOTORASIB TAB 120 MG | 21532480000320 | Brand |
| LUMAKRAS | SOTORASIB TAB 320 MG | 21532480000340 | Brand |

**Approval Criteria**

**1** - Diagnosis of pancreatic adenocarcinoma

**AND**

**2** - Disease is ONE of the following:

- Recurrent
- Advanced
- Metastatic

**AND**

**3** - Tumor is KRAS G12C-mutated

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LUMAKRAS | SOTORASIB TAB 120 MG | 21532480000320 | Brand |
| LUMAKRAS | SOTORASIB TAB 320 MG | 21532480000340 | Brand |

**Approval Criteria**

**1** - Diagnosis of ampullary adenocarcinoma

**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 | Colorectal Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LUMAKRAS | SOTORASIB TAB 120 MG | 21532480000320 | Brand |
| LUMAKRAS | SOTORASIB TAB 320 MG | 21532480000340 | Brand |

**Approval Criteria**

**1** - Diagnosis of ONE of the following:

- Colon Cancer
- Rectal Cancer

**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 | Non-Small Cell Lung Cancer (NSCLC), Pancreatic Adenocarcinoma, Ampullary Adenocarcinoma, Colorectal Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LUMAKRAS | SOTORASIB TAB 120 MG | 21532480000320 | Brand |
| LUMAKRAS | SOTORASIB TAB 320 MG | 21532480000340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LUMAKRAS | SOTORASIB TAB 120 MG | 21532480000320 | Brand |
| LUMAKRAS | SOTORASIB TAB 320 MG | 21532480000340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LUMAKRAS | SOTORASIB TAB 120 MG | 21532480000320 | Brand |
| LUMAKRAS | SOTORASIB TAB 320 MG | 21532480000340 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Lumakras therapy

## 2 . Revision History

| Date | Notes |
|---|---|
| 9/16/2024 | Added criteria for ampullary adenocarcinoma, colon cancer, and rect al cancer |

Lupkynis

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-152724 |
| **Guideline Name** | Lupkynis |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 9/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LUPKYNIS | VOCLOSPORIN CAP 7.9 MG | 99402080000120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LUPKYNIS | VOCLOSPORIN CAP 7.9 MG | 99402080000120 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Lupkynis therapy

**AND**

**2** - Prescribed in combination with a background immunosuppressive therapy regimen (e.g., mycophenolate mofetil and corticosteroids)

**AND**

**3** - Patient is NOT receiving Lupkynis in combination with either of the following:

- Cyclophosphamide
- Benlysta (belimumab)

**AND**

**4** - Prescribed by ONE of the following:

- Nephrologist
- Rheumatologist

**AND**

**5** - ONE of the following:

**5.1** Patient has been on Lupkynis therapy for less than 12 months

**OR**

**5.2** BOTH of the following:

**5.2.1** Patient has completed 12 or more months of Lupkynis therapy

**AND**

**5.2.2** The provider attests that the benefit of continuation of therapy exceeds the risk in light of the patient's treatment response and risk of worsening nephrotoxicity

## 2 . Revision History

| Date | Notes |
|---|---|
| 8/27/2024 | Annual review. Updated authorization lengths to 12 months. |

Lynparza

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-154725 |
| **Guideline Name** | Lynparza |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 10/1/2024 |

## 1 . Criteria

| Product Name: Lynparza | |
|---|---|
| Diagnosis | Breast Cancer (High Risk Early) |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LYNPARZA | OLAPARIB TAB 100 MG | 21535560000330 | Brand |
| LYNPARZA | OLAPARIB TAB 150 MG | 21535560000340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LYNPARZA | OLAPARIB TAB 100 MG | 21535560000330 | Brand |
| LYNPARZA | OLAPARIB TAB 150 MG | 21535560000340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LYNPARZA | OLAPARIB TAB 100 MG | 21535560000330 | Brand |
| LYNPARZA | OLAPARIB TAB 150 MG | 21535560000340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LYNPARZA | OLAPARIB TAB 100 MG | 21535560000330 | Brand |
| LYNPARZA | OLAPARIB TAB 150 MG | 21535560000340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LYNPARZA | OLAPARIB TAB 100 MG | 21535560000330 | Brand |
| LYNPARZA | OLAPARIB TAB 150 MG | 21535560000340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LYNPARZA | OLAPARIB TAB 100 MG | 21535560000330 | Brand |
| LYNPARZA | OLAPARIB TAB 150 MG | 21535560000340 | Brand |

**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 ONE of the following:

- Prednisone
- Prednisolone

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LYNPARZA | OLAPARIB TAB 100 MG | 21535560000330 | Brand |
| LYNPARZA | OLAPARIB TAB 150 MG | 21535560000340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LYNPARZA | OLAPARIB TAB 100 MG | 21535560000330 | Brand |
| LYNPARZA | OLAPARIB TAB 150 MG | 21535560000340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| LYNPARZA | OLAPARIB TAB 100 MG | 21535560000330 | Brand |
| LYNPARZA | OLAPARIB TAB 150 MG | 21535560000340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LYNPARZA | OLAPARIB TAB 100 MG | 21535560000330 | Brand |
| LYNPARZA | OLAPARIB TAB 150 MG | 21535560000340 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Lynparza therapy

Lyrica

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146358 |
| **Guideline Name** | Lyrica |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Brand Lyrica | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LYRICA | PREGABALIN CAP 25 MG | 72600057000110 | Brand |
| LYRICA | PREGABALIN CAP 50 MG | 72600057000115 | Brand |
| LYRICA | PREGABALIN CAP 75 MG | 72600057000120 | Brand |
| LYRICA | PREGABALIN CAP 100 MG | 72600057000125 | Brand |
| LYRICA | PREGABALIN CAP 150 MG | 72600057000135 | Brand |
| LYRICA | PREGABALIN CAP 200 MG | 72600057000145 | Brand |

| | | | |
|---|---|---|---|
| LYRICA | PREGABALIN CAP 225 MG | 72600057000150 | Brand |
| LYRICA | PREGABALIN CAP 300 MG | 72600057000160 | Brand |
| LYRICA | PREGABALIN SOLN 20 MG/ML | 72600057002020 | Brand |

**Approval Criteria**

**1** - Requested for the treatment of a seizure disorder

**OR**

**2** - BOTH of the following:

**2.1** Diagnosis of ONE of the following:

- Fibromyalgia
- Diabetic peripheral neuropathy (DPN)
- Post herpetic neuralgia (PHN)
- Neuropathic pain associated with spinal cord injury

**AND**

**2.2** ONE of the following:

**2.2.1** Failure to generic pregabalin at a minimum dose of 300 mg (milligrams) daily for 4 weeks as confirmed by claims history or submission of medical records

**OR**

**2.2.2** History of intolerance or contraindication to generic pregabalin (please specify intolerance or contraindication)

| Product Name: Brand Lyrica CR, generic pregabalin ER | |
|---|---|
| Diagnosis | Diabetic Peripheral Neuropathy (DPN) |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LYRICA CR | PREGABALIN TAB ER 24HR 82.5 MG | 62540060007520 | Brand |
| LYRICA CR | PREGABALIN TAB ER 24HR 165 MG | 62540060007530 | Brand |
| LYRICA CR | PREGABALIN TAB ER 24HR 330 MG | 62540060007540 | Brand |
| PREGABALIN ER | PREGABALIN TAB ER 24HR 82.5 MG | 62540060007520 | Generic |
| PREGABALIN ER | PREGABALIN TAB ER 24HR 165 MG | 62540060007530 | Generic |
| PREGABALIN ER | PREGABALIN TAB ER 24HR 330 MG | 62540060007540 | Generic |

**Approval Criteria**

**1** - Diagnosis of diabetic peripheral neuropathy (DPN)

**AND**

**2** - ONE of the following:

**2.1** Failure to gabapentin (generic Neurontin) at a minimum dose of 1800 mg daily for 4 weeks as confirmed by claims history or submission of medical records

**OR**

**2.2** History of intolerance or contraindication to gabapentin (generic Neurontin) (please specify intolerance or contraindication)

**AND**

**3** - ONE of the following:

**3.1** Failure to treatment with ONE of the following classes of medications as confirmed by claims history or submission of medical records:

- Tricyclic antidepressant at the maximum tolerated dose for 6 to 8 weeks, or intolerance to a tricyclic antidepressant

- Serotonin and norepinephrine reuptake inhibitor (SNRI) antidepressant (e.g., duloxetine, venlafaxine)

**OR**

**3.2** History of intolerance or contraindication to treatment from BOTH classes of medications (please specify intolerance or contraindication)

- Tricyclic antidepressant at the maximum tolerated dose for 6 to 8 weeks, or intolerance to a tricyclic antidepressant
- SNRI antidepressant (e.g., duloxetine, venlafaxine)

**AND**

**4** - ONE of the following:

**4.1** Failure to generic pregabalin immediate-release capsules or generic pregabalin suspension as confirmed by claims history or submission of medical records

**OR**

**4.2** History of intolerance or contraindication to generic pregabalin immediate-release capsules or generic pregabalin suspension (please specify intolerance or contraindication)

| Product Name: Brand Lyrica CR, generic pregabalin ER | |
|---|---|
| Diagnosis | Post Herpetic Neuralgia (PHN) |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LYRICA CR | PREGABALIN TAB ER 24HR 82.5 MG | 62540060007520 | Brand |
| LYRICA CR | PREGABALIN TAB ER 24HR 165 MG | 62540060007530 | Brand |
| LYRICA CR | PREGABALIN TAB ER 24HR 330 MG | 62540060007540 | Brand |
| PREGABALIN ER | PREGABALIN TAB ER 24HR 82.5 MG | 62540060007520 | Generic |
| PREGABALIN ER | PREGABALIN TAB ER 24HR 165 MG | 62540060007530 | Generic |

| | | | |
|---|---|---|---|
| PREGABALIN ER | PREGABALIN TAB ER 24HR 330 MG | 62540060007540 | Generic |

**Approval Criteria**

**1** - Diagnosis of post herpetic neuralgia (PHN)

**AND**

**2** - ONE of the following:

**2.1** Failure to gabapentin (generic Neurontin) at a minimum dose of 1800 mg daily for 4 weeks as confirmed by claims history or submission of medical records

**OR**

**2.2** History of intolerance or contraindication to gabapentin (generic Neurontin) (please specify intolerance or contraindication)

**AND**

**3** - ONE of the following:

**3.1** Failure to a tricyclic antidepressant at the maximum tolerated dose for 6 to 8 weeks as confirmed by claims history of submission of medical records

**OR**

**3.2** History of intolerance of contraindication to a tricyclic antidepressant (please specify intolerance or contraindication)

**AND**

**4** - ONE of the following:

**4.1** Failure to generic pregabalin immediate-release capsules or generic pregabalin suspension as confirmed by claims history or submission of medical records

**OR**

**4.2** History of intolerance or contraindication to generic pregabalin immediate-release capsules or generic pregabalin suspension (please specify intolerance or contraindication)

Lysteda

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146359 |
| **Guideline Name** | Lysteda |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Brand Lysteda, generic tranexamic acid | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LYSTEDA | TRANEXAMIC ACID TAB 650 MG | 84100040000320 | Brand |
| TRANEXAMIC ACID | TRANEXAMIC ACID TAB 650 MG | 84100040000320 | Generic |

**Approval Criteria**

**1** - Diagnosis of cyclic heavy menstrual bleeding

Lytgobi

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146578 |
| **Guideline Name** | Lytgobi |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Lytgobi | |
|---|---|
| Diagnosis | Cholangiocarcinoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LYTGOBI | FUTIBATINIB TAB THERAPY PACK 4 MG (12 MG DAILY DOSE) | 2153222800B720 | Brand |
| LYTGOBI | FUTIBATINIB TAB THERAPY PACK 4 MG (16 MG DAILY DOSE) | 2153222800B725 | Brand |
| LYTGOBI | FUTIBATINIB TAB THERAPY PACK 4 MG (20 MG DAILY DOSE) | 2153222800B730 | Brand |

**Approval Criteria**

**1** - Diagnosis of cholangiocarcinoma (intrahepatic or extrahepatic)

**AND**

**2** - Disease is ONE of the following:

- Unresectable locally advanced
- 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: Lytgobi | |
|---|---|
| Diagnosis | Cholangiocarcinoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LYTGOBI | FUTIBATINIB TAB THERAPY PACK 4 MG (12 MG DAILY DOSE) | 2153222800B720 | Brand |
| LYTGOBI | FUTIBATINIB TAB THERAPY PACK 4 MG (16 MG DAILY DOSE) | 2153222800B725 | Brand |
| LYTGOBI | FUTIBATINIB TAB THERAPY PACK 4 MG (20 MG DAILY DOSE) | 2153222800B730 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LYTGOBI | FUTIBATINIB TAB THERAPY PACK 4 MG (12 MG DAILY DOSE) | 2153222800B720 | Brand |
| LYTGOBI | FUTIBATINIB TAB THERAPY PACK 4 MG (16 MG DAILY DOSE) | 2153222800B725 | Brand |
| LYTGOBI | FUTIBATINIB TAB THERAPY PACK 4 MG (20 MG DAILY DOSE) | 2153222800B730 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LYTGOBI | FUTIBATINIB TAB THERAPY PACK 4 MG (12 MG DAILY DOSE) | 2153222800B720 | Brand |
| LYTGOBI | FUTIBATINIB TAB THERAPY PACK 4 MG (16 MG DAILY DOSE) | 2153222800B725 | Brand |

| | | | |
|---|---|---|---|
| LYTGOBI | FUTIBATINIB TAB THERAPY PACK 4 MG (20 MG DAILY DOSE) | 2153222800B730 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Lytgobi therapy

Marinol, Syndros

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-161401 |
| **Guideline Name** | Marinol, Syndros |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 1 . Criteria

| Product Name: Syndros | |
|---|---|
| Diagnosis | Chemotherapy-induced nausea and vomiting |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SYNDROS | DRONABINOL SOLN 5 MG/ML | 50300030002020 | Brand |

**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** Patient is unable to swallow capsules

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MARINOL | DRONABINOL CAP 2.5 MG | 50300030000110 | Brand |
| DRONABINOL | DRONABINOL CAP 2.5 MG | 50300030000110 | Generic |
| DRONABINOL | DRONABINOL CAP 5 MG | 50300030000115 | Generic |
| DRONABINOL | DRONABINOL CAP 10 MG | 50300030000120 | Generic |
| MARINOL | DRONABINOL CAP 5 MG | 50300030000115 | Brand |
| MARINOL | DRONABINOL CAP 10 MG | 50300030000120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SYNDROS | DRONABINOL SOLN 5 MG/ML | 50300030002020 | Brand |

**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** Patient is unable to swallow capsules

| Product Name: Brand Marinol, generic dronabinol | |
|---|---|
| Diagnosis | Anorexia in a patient with AIDS |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| MARINOL | DRONABINOL CAP 2.5 MG | 50300030000110 | Brand |
| DRONABINOL | DRONABINOL CAP 2.5 MG | 50300030000110 | Generic |
| DRONABINOL | DRONABINOL CAP 5 MG | 50300030000115 | Generic |
| DRONABINOL | DRONABINOL CAP 10 MG | 50300030000120 | Generic |
| MARINOL | DRONABINOL CAP 5 MG | 50300030000115 | Brand |
| MARINOL | DRONABINOL CAP 10 MG | 50300030000120 | Brand |

**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**<br><br>**3.2.2.2** History of intolerance or contraindication to megestrol (generic Megace) (please specify intolerance or contraindication) |

## 2 . Revision History

| Date | Notes |
|---|---|
| 11/27/2024 | Added GPIs for Brand Marinol capsules 5mg and 10mg strengths. Minor update to 5HT-3 definition, with no changes to clinical intent. |

Mavenclad

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146579 |
| **Guideline Name** | Mavenclad |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Mavenclad | |
|---|---|
| Diagnosis | Relapsing Forms of Multiple Sclerosis (MS) |
| Approval Length | 2 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MAVENCLAD | CLADRIBINE TAB THERAPY PACK 10 MG (4 TABS) | 6240101500B718 | Brand |
| MAVENCLAD | CLADRIBINE TAB THERAPY PACK 10 MG (5 TABS) | 6240101500B722 | Brand |
| MAVENCLAD | CLADRIBINE TAB THERAPY PACK 10 MG (6 TABS) | 6240101500B726 | Brand |
| MAVENCLAD | CLADRIBINE TAB THERAPY PACK 10 MG (7 TABS) | 6240101500B732 | Brand |

| | | | |
|---|---|---|---|
| MAVENCLAD | CLADRIBINE TAB THERAPY PACK 10 MG (8 TABS) | 6240101500B736 | Brand |
| MAVENCLAD | CLADRIBINE TAB THERAPY PACK 10 MG (9 TABS) | 6240101500B740 | Brand |
| MAVENCLAD | CLADRIBINE TAB THERAPY PACK 10 MG (10 TABS) | 6240101500B744 | Brand |

**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)
- Aubagio (teriflunomide)
- Gilenya (fingolimod)
- Mayzent (siponimod)
- Tysabri (natalizumab)**
- Ocrevus (ocrelizumab)**
- Lemtrada (alemtuzumab)**
- Zeposia (ozanimod)*
- Kesimpta (ofatumumab)*
- Bafiertam (monomethyl fumarate)*

**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)
- Aubagio (teriflunomide)
- Gilenya (fingolimod)
- Mayzent (siponimod)
- Tysabri (natalizumab)**
- Ocrevus (ocrelizumab)**
- Lemtrada (alemtuzumab)**
- Zeposia (ozanimod)*
- Kesimpta (ofatumumab)*
- Bafiertam (monomethyl fumarate)*

**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)]

| Notes | *Avonex, Rebif, Betaseron, Bafiertam, Kesimpta, Zeposia, and Extavi a are non-preferred and should not be included in denial to provider. **Tysabri, Ocrevus, and Lemtrada are medical benefit and should not be included in denial to provider. |
|---|---|

| Product Name: Mavenclad | |
|---|---|
| Diagnosis | Relapsing Forms of Multiple Sclerosis (MS) |
| Approval Length | 2 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MAVENCLAD | CLADRIBINE TAB THERAPY PACK 10 MG (4 TABS) | 6240101500B718 | Brand |
| MAVENCLAD | CLADRIBINE TAB THERAPY PACK 10 MG (5 TABS) | 6240101500B722 | Brand |

| | | | |
|---|---|---|---|
| MAVENCLAD | CLADRIBINE TAB THERAPY PACK 10 MG (6 TABS) | 6240101500B726 | Brand |
| MAVENCLAD | CLADRIBINE TAB THERAPY PACK 10 MG (7 TABS) | 6240101500B732 | Brand |
| MAVENCLAD | CLADRIBINE TAB THERAPY PACK 10 MG (8 TABS) | 6240101500B736 | Brand |
| MAVENCLAD | CLADRIBINE TAB THERAPY PACK 10 MG (9 TABS) | 6240101500B740 | Brand |
| MAVENCLAD | CLADRIBINE TAB THERAPY PACK 10 MG (10 TABS) | 6240101500B744 | Brand |

**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 exceeded the FDA (Food and Drug Administration)-recommended limit of 2 treatment courses (4 treatment cycles) of Mavenclad

| | |
|---|---|
| Notes | Duration of coverage will be limited to 1 reauthorization to allow 2 cum ulative treatment courses (4 treatment cycles) of Mavenclad therapy. |

Mekinist

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-151095 |
| **Guideline Name** | Mekinist |
| **Formulary** | • Medicaid - Community & State New Mexico |

## 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MEKINIST | TRAMETINIB DIMETHYL SULFOXIDE TAB 0.5 MG (BASE EQUIVALENT) | 21533570100310 | Brand |
| MEKINIST | TRAMETINIB DIMETHYL SULFOXIDE TAB 2 MG (BASE EQUIVALENT) | 21533570100330 | Brand |
| MEKINIST | TRAMETINIB DIMETHYL SULFOXIDE FOR SOLN 0.05 MG/ML (BASE EQ) | 21533570102120 | Brand |

**Approval Criteria**

**1** - ONE of the following:

**1.1** BOTH of the following:

**1.1.1** ONE of the following:

**1.1.1.1** Unresectable melanoma

**OR**

**1.1.1.2** Metastatic melanoma

**OR**

**1.1.1.3** BOTH of the following:

**1.1.1.3.1** Prescribed as adjuvant therapy for melanoma involving the lymph node(s)

**AND**

**1.1.1.3.2** Used in combination with Tafinlar (dabrafenib)

**AND**

**1.1.2** Cancer is positive for BRAF V600 (gene) mutation

**OR**

**1.2** Distant metastatic uveal melanoma

**AND**

**2** - If the request is for Mekinist solution, there is a reason or special circumstance why the patient is unable to use Mekinist tablets (document reason or special circumstance)

| Product Name: Mekinist | |
|---|---|
| Diagnosis | Non-Small Cell Lung Cancer (NSCLC) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MEKINIST | TRAMETINIB DIMETHYL SULFOXIDE TAB 0.5 MG (BASE EQUIVALENT) | 21533570100310 | Brand |
| MEKINIST | TRAMETINIB DIMETHYL SULFOXIDE TAB 2 MG (BASE EQUIVALENT) | 21533570100330 | Brand |
| MEKINIST | TRAMETINIB DIMETHYL SULFOXIDE FOR SOLN 0.05 MG/ML (BASE EQ) | 21533570102120 | Brand |

**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 Tafinlar (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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MEKINIST | TRAMETINIB DIMETHYL SULFOXIDE TAB 0.5 MG (BASE EQUIVALENT) | 21533570100310 | Brand |
| MEKINIST | TRAMETINIB DIMETHYL SULFOXIDE TAB 2 MG (BASE EQUIVALENT) | 21533570100330 | Brand |
| MEKINIST | TRAMETINIB DIMETHYL SULFOXIDE FOR SOLN 0.05 MG/ML (BASE EQ) | 21533570102120 | Brand |

**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 Tafinlar (dabrafenib)

**AND**

**2** - If the request is for Mekinist solution, there is a reason or special circumstance why the patient is unable to use Mekinist tablets (document reason or special circumstance)

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MEKINIST | TRAMETINIB DIMETHYL SULFOXIDE TAB 0.5 MG (BASE EQUIVALENT) | 21533570100310 | Brand |
| MEKINIST | TRAMETINIB DIMETHYL SULFOXIDE TAB 2 MG (BASE EQUIVALENT) | 21533570100330 | Brand |
| MEKINIST | TRAMETINIB DIMETHYL SULFOXIDE FOR SOLN 0.05 MG/ML (BASE EQ) | 21533570102120 | Brand |

**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 Tafinlar (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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MEKINIST | TRAMETINIB DIMETHYL SULFOXIDE TAB 0.5 MG (BASE EQUIVALENT) | 21533570100310 | Brand |
| MEKINIST | TRAMETINIB DIMETHYL SULFOXIDE TAB 2 MG (BASE EQUIVALENT) | 21533570100330 | Brand |
| MEKINIST | TRAMETINIB DIMETHYL SULFOXIDE FOR SOLN 0.05 MG/ML (BASE EQ) | 21533570102120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MEKINIST | TRAMETINIB DIMETHYL SULFOXIDE TAB 0.5 MG (BASE EQUIVALENT) | 21533570100310 | Brand |
| MEKINIST | TRAMETINIB DIMETHYL SULFOXIDE TAB 2 MG (BASE EQUIVALENT) | 21533570100330 | Brand |
| MEKINIST | TRAMETINIB DIMETHYL SULFOXIDE FOR SOLN 0.05 MG/ML (BASE EQ) | 21533570102120 | Brand |

**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 Tafinlar (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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MEKINIST | TRAMETINIB DIMETHYL SULFOXIDE TAB 0.5 MG (BASE EQUIVALENT) | 21533570100310 | Brand |
| MEKINIST | TRAMETINIB DIMETHYL SULFOXIDE TAB 2 MG (BASE EQUIVALENT) | 21533570100330 | Brand |
| MEKINIST | TRAMETINIB DIMETHYL SULFOXIDE FOR SOLN 0.05 MG/ML (BASE EQ) | 21533570102120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MEKINIST | TRAMETINIB DIMETHYL SULFOXIDE TAB 0.5 MG (BASE EQUIVALENT) | 21533570100310 | Brand |
| MEKINIST | TRAMETINIB DIMETHYL SULFOXIDE TAB 2 MG (BASE EQUIVALENT) | 21533570100330 | Brand |
| MEKINIST | TRAMETINIB DIMETHYL SULFOXIDE FOR SOLN 0.05 MG/ML (BASE EQ) | 21533570102120 | Brand |

**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 Tafinlar (dabrafenib)

**AND**

**6** - If the request is for Mekinist solution, there is a reason or special circumstance why the patient is unable to use Mekinist tablets (document reason or special circumstance)

| Product Name: Mekinist | |
|---|---|
| Diagnosis | Pancreatic Cancer, Ambullary Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MEKINIST | TRAMETINIB DIMETHYL SULFOXIDE TAB 0.5 MG (BASE EQUIVALENT) | 21533570100310 | Brand |
| MEKINIST | TRAMETINIB DIMETHYL SULFOXIDE TAB 2 MG (BASE EQUIVALENT) | 21533570100330 | Brand |
| MEKINIST | TRAMETINIB DIMETHYL SULFOXIDE FOR SOLN 0.05 MG/ML (BASE EQ) | 21533570102120 | Brand |

**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 Tafinlar (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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MEKINIST | TRAMETINIB DIMETHYL SULFOXIDE TAB 0.5 MG (BASE EQUIVALENT) | 21533570100310 | Brand |
| MEKINIST | TRAMETINIB DIMETHYL SULFOXIDE TAB 2 MG (BASE EQUIVALENT) | 21533570100330 | Brand |
| MEKINIST | TRAMETINIB DIMETHYL SULFOXIDE FOR SOLN 0.05 MG/ML (BASE EQ) | 21533570102120 | Brand |

**Approval Criteria**

**1** - Diagnosis of hairy cell leukemia

**AND**

**2** - Used in combination with Tafinlar (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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MEKINIST | TRAMETINIB DIMETHYL SULFOXIDE TAB 0.5 MG (BASE EQUIVALENT) | 21533570100310 | Brand |
| MEKINIST | TRAMETINIB DIMETHYL SULFOXIDE TAB 2 MG (BASE EQUIVALENT) | 21533570100330 | Brand |
| MEKINIST | TRAMETINIB DIMETHYL SULFOXIDE FOR SOLN 0.05 MG/ML (BASE EQ) | 21533570102120 | Brand |

**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 Tafinlar (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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MEKINIST | TRAMETINIB DIMETHYL SULFOXIDE TAB 0.5 MG (BASE EQUIVALENT) | 21533570100310 | Brand |
| MEKINIST | TRAMETINIB DIMETHYL SULFOXIDE TAB 2 MG (BASE EQUIVALENT) | 21533570100330 | Brand |
| MEKINIST | TRAMETINIB DIMETHYL SULFOXIDE FOR SOLN 0.05 MG/ML (BASE EQ) | 21533570102120 | Brand |

**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 Tafinlar (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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MEKINIST | TRAMETINIB DIMETHYL SULFOXIDE TAB 0.5 MG (BASE EQUIVALENT) | 21533570100310 | Brand |
| MEKINIST | TRAMETINIB DIMETHYL SULFOXIDE TAB 2 MG (BASE EQUIVALENT) | 21533570100330 | Brand |
| MEKINIST | TRAMETINIB DIMETHYL SULFOXIDE FOR SOLN 0.05 MG/ML (BASE EQ) | 21533570102120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MEKINIST | TRAMETINIB DIMETHYL SULFOXIDE TAB 0.5 MG (BASE EQUIVALENT) | 21533570100310 | Brand |
| MEKINIST | TRAMETINIB DIMETHYL SULFOXIDE TAB 2 MG (BASE EQUIVALENT) | 21533570100330 | Brand |
| MEKINIST | TRAMETINIB DIMETHYL SULFOXIDE FOR SOLN 0.05 MG/ML (BASE EQ) | 21533570102120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MEKINIST | TRAMETINIB DIMETHYL SULFOXIDE TAB 0.5 MG (BASE EQUIVALENT) | 21533570100310 | Brand |
| MEKINIST | TRAMETINIB DIMETHYL SULFOXIDE TAB 2 MG (BASE EQUIVALENT) | 21533570100330 | Brand |
| MEKINIST | TRAMETINIB DIMETHYL SULFOXIDE FOR SOLN 0.05 MG/ML (BASE EQ) | 21533570102120 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Mekinist therapy

## 2 . Revision History

| Date | Notes |
|---|---|
| 8/6/2024 | Copy core |

Mektovi

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-156463 |
| **Guideline Name** | Mektovi |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 11/1/2024 |

## 1 . Criteria

| Product Name: Mektovi | |
|---|---|
| Diagnosis | Melanoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MEKTOVI | BINIMETINIB TAB 15 MG | 21533520000320 | Brand |

**Approval Criteria**

**1** - ALL of the following:

**1.1** ONE of the following diagnoses:

- Unresectable melanoma
- Metastatic melanoma

**AND**

**1.2** Patient is positive for BRAFV600 mutation

**AND**

**1.3** Used in combination with Braftovi (encorafenib)

**AND**

**1.4** ONE of the following:

**1.4.1** 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**

**1.4.2** 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**

**1.4.3** For continuation of prior Mektovi therapy

**OR**

**2** - BOTH of the following:

**2.1** Diagnosis of melanoma NRAS-mutated tumor

**AND**

**2.2** Progression after prior immune checkpoint inhibitor therapy

| Product Name: Mektovi | |
|---|---|
| Diagnosis | Melanoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MEKTOVI | BINIMETINIB TAB 15 MG | 21533520000320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MEKTOVI | BINIMETINIB TAB 15 MG | 21533520000320 | Brand |

**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 detectable mutation
- Testing is not available

| Product Name: Mektovi | |
|---|---|
| Diagnosis | Serous Carcinoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |

| Guideline Type | Prior Authorization |
|---|---|

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MEKTOVI | BINIMETINIB TAB 15 MG | 21533520000320 | Brand |

**Approval Criteria**

**1** - Diagnosis of low-grade serous carcinoma

**AND**

**2** - Disease is recurrent

| Product Name: Mektovi | |
|---|---|
| Diagnosis | Gastrointestinal Stromal Tumor (GIST) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MEKTOVI | BINIMETINIB TAB 15 MG | 21533520000320 | Brand |

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MEKTOVI | BINIMETINIB TAB 15 MG | 21533520000320 | Brand |

**Approval Criteria**

**1** - Diagnosis of non-small cell lung cancer (NSCLC)

**AND**

**2** - Disease is 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 | Histiocytic Neoplasms, Serous Carcinoma, Gastrointestinal Stromal Tumor (GIST), Non-Small Cell Lung Cancer (NSCLC) |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MEKTOVI | BINIMETINIB TAB 15 MG | 21533520000320 | Brand |

**Approval Criteria**

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

| Product Name: Mektovi | |
|---|---|
| Diagnosis | NCCN Recommended Regimen |

| | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MEKTOVI | BINIMETINIB TAB 15 MG | 21533520000320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MEKTOVI | BINIMETINIB TAB 15 MG | 21533520000320 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Mektovi therapy

## 2 . Revision History

| Date | Notes |
|---|---|
| 9/30/2024 | Added trial of alternative regimen to the non-small cell lung cancer se ction |

Mepron

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146361 |
| **Guideline Name** | Mepron |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Brand Mepron, generic atovaquone | |
|---|---|
| Diagnosis | Pneumocystis Jirovecii Pneumonia (PCP) Prophylaxis |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MEPRON | ATOVAQUONE SUSP 750 MG/5ML | 16400020001820 | Brand |
| ATOVAQUONE | ATOVAQUONE SUSP 750 MG/5ML | 16400020001820 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MEPRON | ATOVAQUONE SUSP 750 MG/5ML | 16400020001820 | Brand |
| ATOVAQUONE | ATOVAQUONE SUSP 750 MG/5ML | 16400020001820 | Generic |

**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)

Migranal, Trudhesa

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146363 |
| **Guideline Name** | Migranal, Trudhesa |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Brand Migranal, generic dihydroergotamine mesylate nasal spray, Trudhesa | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DIHYDROERGOTAMINE MESYLATE | DIHYDROERGOTAMINE MESYLATE NASAL SPRAY 4 MG/ML | 67000030102060 | Generic |
| MIGRANAL | DIHYDROERGOTAMINE MESYLATE NASAL SPRAY 4 MG/ML | 67000030102060 | Brand |
| TRUDHESA | DIHYDROERGOTAMINE MESYLATE HFA NASAL AEROSOL 0.725 MG/ACT | 67000030113420 | Brand |

**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 with step therapy), 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 with step therapy), 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DIHYDROERGOTAMINE MESYLATE | DIHYDROERGOTAMINE MESYLATE NASAL SPRAY 4 MG/ML | 67000030102060 | Generic |
| MIGRANAL | DIHYDROERGOTAMINE MESYLATE NASAL SPRAY 4 MG/ML | 67000030102060 | Brand |
| TRUDHESA | DIHYDROERGOTAMINE MESYLATE HFA NASAL AEROSOL 0.725 MG/ACT | 67000030113420 | Brand |

**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:

- Amitriptyline (Elavil)
- A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol*)
- Candesartan (generic Atacand)*
- Divalproex sodium (Depakote/Depakote ER)
- OnabotulinumtoxinA (Botox)**
- Topiramate (Topamax)
- Venlafaxine (Effexor/Effexor XR)
- Calcitonin gene-related peptide (CGRP) receptor antagonists [e.g., Aimovig (erenumab), Emgality (galcanezumab)]

**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**<br><br>**4.2** Physician acknowledges that the potential benefit outweighs the risk associated with the higher dose or quantity | |
|---|---|
| Notes | *Timolol and candesartan are non-preferred and should not be include d in denial to provider.<br>**This is a medical benefit, should not be included in denial to provider . |

Mozobil

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146582 |
| **Guideline Name** | Mozobil |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Brand Mozobil, generic plerixafor | |
|---|---|
| Diagnosis | Hematopoietic Stem Cell Mobilization |
| Approval Length | 30 Day(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MOZOBIL | PLERIXAFOR SUBCUTANEOUS INJ 24 MG/1.2ML (20 MG/ML) | 82502060002020 | Brand |
| PLERIXAFOR | PLERIXAFOR SUBCUTANEOUS INJ 24 MG/1.2ML (20 MG/ML) | 82502060002020 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MOZOBIL | PLERIXAFOR SUBCUTANEOUS INJ 24 MG/1.2ML (20 MG/ML) | 82502060002020 | Brand |
| PLERIXAFOR | PLERIXAFOR SUBCUTANEOUS INJ 24 MG/1.2ML (20 MG/ML) | 82502060002020 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MOZOBIL | PLERIXAFOR SUBCUTANEOUS INJ 24 MG/1.2ML (20 MG/ML) | 82502060002020 | Brand |
| PLERIXAFOR | PLERIXAFOR SUBCUTANEOUS INJ 24 MG/1.2ML (20 MG/ML) | 82502060002020 | Generic |

**Approval Criteria**

**1** - Documentation of positive clinical response to the requested therapy

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-161407 |
| **Guideline Name** | MS Agents |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 1 . Criteria

| Product Name: generic glatiramer, Glatopa, Mayzent, Plegridy | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| GLATOPA | GLATIRAMER ACETATE SOLN PREFILLED SYRINGE 20 MG/ML | 6240003010E520 | Generic |
| GLATIRAMER ACETATE | GLATIRAMER ACETATE SOLN PREFILLED SYRINGE 20 MG/ML | 6240003010E520 | Generic |
| GLATOPA | GLATIRAMER ACETATE SOLN PREFILLED SYRINGE 40 MG/ML | 6240003010E540 | Generic |
| GLATIRAMER ACETATE | GLATIRAMER ACETATE SOLN PREFILLED SYRINGE 40 MG/ML | 6240003010E540 | Generic |

| | | | |
|---|---|---|---|
| PLEGRIDY | PEGINTERFERON BETA-1A SOLN PREFILLED SYRINGE 125 MCG/0.5ML | 6240307530E520 | Brand |
| PLEGRIDY | PEGINTERFERON BETA-1A IM SOLN PREFILLED SYR 125 MCG/0.5ML | 6240307530E521 | Brand |
| PLEGRIDY STARTER PACK | PEGINTERFERON BETA-1A SOLN PREF SYR 63 & 94 MCG/0.5ML PACK | 6240307530E550 | Brand |
| MAYZENT STARTER PACK | SIPONIMOD FUMARATE TAB 0.25 MG (7) STARTER PACK | 6240707020B710 | Brand |
| MAYZENT STARTER PACK | SIPONIMOD FUMARATE TAB 0.25 MG (12) STARTER PACK | 6240707020B720 | Brand |
| MAYZENT | SIPONIMOD FUMARATE TAB 0.25 MG (BASE EQUIV) | 62407070200320 | Brand |
| MAYZENT | SIPONIMOD FUMARATE TAB 1 MG (BASE EQUIV) | 62407070200330 | Brand |
| MAYZENT | SIPONIMOD FUMARATE TAB 2 MG (BASE EQUIV) | 62407070200340 | Brand |
| PLEGRIDY | PEGINTERFERON BETA-1A SOLN AUTO-INJECTOR 125 MCG/0.5ML | 6240307530D520 | Brand |
| PLEGRIDY STARTER PACK | PEGINTERFERON BETA-1A SOLN AUTO-INJ 63 & 94 MCG/0.5ML PACK | 6240307530D550 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AVONEX | INTERFERON BETA-1A IM PREFILLED SYRINGE KIT 30 MCG/0.5ML | 6240306045F830 | Brand |
| AVONEX PEN | INTERFERON BETA-1A IM AUTO-INJECTOR KIT 30 MCG/0.5ML | 6240306045F530 | Brand |
| BETASERON | INTERFERON BETA-1B FOR INJ KIT 0.3 MG | 62403060506420 | Brand |
| EXTAVIA | INTERFERON BETA-1B FOR INJ KIT 0.3 MG | 62403060506420 | Brand |

| | | | |
|---|---|---|---|
| VUMERITY | DIROXIMEL FUMARATE CAPSULE DELAYED RELEASE 231 MG | 62405530006540 | Brand |
| BAFIERTAM | MONOMETHYL FUMARATE CAPSULE DELAYED RELEASE 95 MG | 62405550006520 | Brand |
| KESIMPTA | OFATUMUMAB SOLN AUTO-INJECTOR 20 MG/0.4ML | 6240506500D520 | Brand |
| PONVORY 14-DAY STARTER PACK | PONESIMOD TAB STARTER PACK 2,3,4,5,6,7,8,9 &10 MG | 6240706000B720 | Brand |
| PONVORY | PONESIMOD TAB 20 MG | 62407060000320 | Brand |
| REBIF REBIDOSE | INTERFERON BETA-1A SOLN AUTO-INJ 22 MCG/0.5ML | 6240306045D520 | Brand |
| REBIF REBIDOSE | INTERFERON BETA-1A SOLN AUTO-INJ 44 MCG/0.5ML | 6240306045D540 | Brand |
| REBIF REBIDOSE TITRATION PACK | INTERFERON BETA-1A AUTO-INJ 6X8.8 MCG/0.2ML & 6X22 MCG/0.5ML | 6240306045D560 | Brand |
| REBIF | INTERFERON BETA-1A SOLN PREF SYR 22 MCG/0.5ML | 6240306045E520 | Brand |
| REBIF | INTERFERON BETA-1A SOLN PREF SYR 44 MCG/0.5ML | 6240306045E540 | Brand |
| REBIF TITRATION PACK | INTERFERON BETA-1A PREF SYR 6X8.8 MCG/0.2ML & 6X22 MCG/0.5ML | 6240306045E560 | Brand |

**Approval Criteria**

**1** - Diagnosis of multiple sclerosis (MS)

**AND**

**2** - ONE of the following:

**2.1** 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

**OR**

**2.2** History of intolerance or contraindication to all of the preferred* alternatives (please specify intolerance or contraindication)

**OR**

**2.3** Patient is currently on the requested drug therapy as confirmed by claims history or submission of medical records

| Notes | *PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |
|---|---|

| Product Name: Tascenso ODT | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TASCENSO ODT | FINGOLIMOD LAURYL SULFATE TABLET DISINTEGRATING 0.25 MG | 62407025207220 | Brand |
| TASCENSO ODT | FINGOLIMOD LAURYL SULFATE TABLET DISINTEGRATING 0.5 MG | 62407025207230 | Brand |

**Approval Criteria**

**1** - Diagnosis of multiple sclerosis (MS)

**AND**

**2** - Patient is 10 years of age or older

**AND**

**3** - ONE of the following:

**3.1** Failure of fingolimod 0.5mg (generic Gilenya 0.5 mg) confirmed by claims history or submitted medical records

**OR**

**3.2** History of intolerance or contraindication to fingolimod 0.5mg (generic Gilenya 0.5 mg) (please specify intolerance or contraindication)

**OR**

**3.3** Patient is currently on Tascenso ODT therapy as documented by claims history or submission of medical records

| | |
|---|---|
| Notes | *PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |

| 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AUBAGIO | TERIFLUNOMIDE TAB 7 MG | 62404070000320 | Brand |
| AUBAGIO | TERIFLUNOMIDE TAB 14 MG | 62404070000330 | Brand |
| GILENYA | FINGOLIMOD HCL CAP 0.5 MG (BASE EQUIV) | 62407025100120 | Brand |
| COPAXONE | GLATIRAMER ACETATE SOLN PREFILLED SYRINGE 20 MG/ML | 6240003010E520 | Brand |
| COPAXONE | GLATIRAMER ACETATE SOLN PREFILLED SYRINGE 40 MG/ML | 6240003010E540 | Brand |
| TECFIDERA | DIMETHYL FUMARATE CAPSULE DELAYED RELEASE 120 MG | 62405525006520 | Brand |
| TECFIDERA STARTER PACK | DIMETHYL FUMARATE CAPSULE DR STARTER PACK 120 MG & 240 MG | 6240552500B320 | Brand |
| TECFIDERA | DIMETHYL FUMARATE CAPSULE DELAYED RELEASE 240 MG | 62405525006540 | Brand |

**Approval Criteria**

**1** - Diagnosis of multiple sclerosis (MS)

**AND**

**2** - ONE of the following:

**2.1** 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

**OR**

**2.2** History of intolerance or contraindication to all of the preferred* alternatives (please specify intolerance or contraindication)

**OR**

**2.3** Patient is currently on the requested drug therapy as confirmed by claims history or submission of medical records

**AND**

**3** - ONE of the following:

**3.1** 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**

**3.2** The brand is being requested due to an incomplete response with a generic/authorized generic equivalent, as documented by submission of medical records

**OR**

**3.3** The brand is being requested because transition to a generic/authorized generic equivalent could result in destabilization of the patient.

**OR**

**3.4** 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 | *PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |
|---|---|

| Product Name: Avonex, Bafiertam, Betaseron, Extavia, Kesimpta, Ponvory, Rebif, Brand 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AUBAGIO | TERIFLUNOMIDE TAB 7 MG | 62404070000320 | Brand |
| AUBAGIO | TERIFLUNOMIDE TAB 14 MG | 62404070000330 | Brand |
| GILENYA | FINGOLIMOD HCL CAP 0.5 MG (BASE EQUIV) | 62407025100120 | Brand |
| AVONEX | INTERFERON BETA-1A IM PREFILLED SYRINGE KIT 30 MCG/0.5ML | 6240306045F830 | Brand |
| AVONEX PEN | INTERFERON BETA-1A IM AUTO-INJECTOR KIT 30 MCG/0.5ML | 6240306045F530 | Brand |
| BETASERON | INTERFERON BETA-1B FOR INJ KIT 0.3 MG | 62403060506420 | Brand |
| EXTAVIA | INTERFERON BETA-1B FOR INJ KIT 0.3 MG | 62403060506420 | Brand |
| VUMERITY | DIROXIMEL FUMARATE CAPSULE DELAYED RELEASE 231 MG | 62405530006540 | Brand |
| BAFIERTAM | MONOMETHYL FUMARATE CAPSULE DELAYED RELEASE 95 MG | 62405550006520 | Brand |
| KESIMPTA | OFATUMUMAB SOLN AUTO-INJECTOR 20 MG/0.4ML | 6240506500D520 | Brand |
| PONVORY 14-DAY STARTER PACK | PONESIMOD TAB STARTER PACK 2,3,4,5,6,7,8,9 &10 MG | 6240706000B720 | Brand |
| PONVORY | PONESIMOD TAB 20 MG | 62407060000320 | Brand |
| COPAXONE | GLATIRAMER ACETATE SOLN PREFILLED SYRINGE 20 MG/ML | 6240003010E520 | Brand |

| | | | |
|---|---|---|---|
| COPAXONE | GLATIRAMER ACETATE SOLN PREFILLED SYRINGE 40 MG/ML | 6240003010E540 | Brand |
| TECFIDERA | DIMETHYL FUMARATE CAPSULE DELAYED RELEASE 120 MG | 62405525006520 | Brand |
| TECFIDERA | DIMETHYL FUMARATE CAPSULE DELAYED RELEASE 240 MG | 62405525006540 | Brand |
| REBIF REBIDOSE | INTERFERON BETA-1A SOLN AUTO-INJ 22 MCG/0.5ML | 6240306045D520 | Brand |
| REBIF REBIDOSE | INTERFERON BETA-1A SOLN AUTO-INJ 44 MCG/0.5ML | 6240306045D540 | Brand |
| REBIF REBIDOSE TITRATION PACK | INTERFERON BETA-1A AUTO-INJ 6X8.8 MCG/0.2ML & 6X22 MCG/0.5ML | 6240306045D560 | Brand |
| REBIF | INTERFERON BETA-1A SOLN PREF SYR 22 MCG/0.5ML | 6240306045E520 | Brand |
| REBIF | INTERFERON BETA-1A SOLN PREF SYR 44 MCG/0.5ML | 6240306045E540 | Brand |
| REBIF TITRATION PACK | INTERFERON BETA-1A PREF SYR 6X8.8 MCG/0.2ML & 6X22 MCG/0.5ML | 6240306045E560 | Brand |
| TASCENSO ODT | FINGOLIMOD LAURYL SULFATE TABLET DISINTEGRATING 0.25 MG | 62407025207220 | Brand |
| TASCENSO ODT | FINGOLIMOD LAURYL SULFATE TABLET DISINTEGRATING 0.5 MG | 62407025207230 | Brand |
| TECFIDERA STARTER PACK | DIMETHYL FUMARATE CAPSULE DR STARTER PACK 120 MG & 240 MG | 6240552500B320 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to therapy

## 2 . Revision History

| Date | Notes |
|---|---|
| 11/27/2024 | Updated GPIs. Removed dimethyl fumarate, teriflunomide and fingoli mod |

Mulpleta

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146584 |
| **Guideline Name** | Mulpleta |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Mulpleta | |
|---|---|
| Diagnosis | Thrombocytopenia |
| Approval Length | 1 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MULPLETA | LUSUTROMBOPAG TAB 3 MG | 82405045000320 | Brand |

**Approval Criteria**

**1** - Diagnosis of thrombocytopenia

**AND**

**2** - Patient has chronic liver disease

**AND**

**3** - Patient is scheduled to undergo a procedure

Multaq

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146364 |
| **Guideline Name** | Multaq |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Multaq | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MULTAQ | DRONEDARONE HCL TAB 400 MG (BASE EQUIVALENT) | 35400028100320 | Brand |

**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

Myalept

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146585 |
| **Guideline Name** | Myalept |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MYALEPT | METRELEPTIN FOR SUBCUTANEOUS INJ 11.3 MG | 30906050002120 | Brand |

**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 250 milligrams per deciliter) despite BOTH of the following:

- Dietary intervention
- Optimized therapy with at least two triglyceride-lowering agents from different classes (e.g., fibrates, statins) at maximum tolerated doses

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MYALEPT | METRELEPTIN FOR SUBCUTANEOUS INJ 11.3 MG | 30906050002120 | Brand |

**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

Mycapssa

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-147670 |
| **Guideline Name** | Mycapssa |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Mycapssa | |
|---|---|
| Diagnosis | Acromegaly |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MYCAPSSA | OCTREOTIDE ACETATE CAP DELAYED RELEASE 20 MG | 30170070106520 | Brand |

**Approval Criteria**

**1** - ALL of the following:

**1.1** Diagnosis of acromegaly by ONE of the following:

- Serum GH (growth hormone) level > 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 physician's lab) at time of diagnosis

**AND**

**1.2** ONE of the following:

**1.2.1** Inadequate response to ONE of the following:

- Surgery
- Radiation therapy
- Dopamine agonist (e.g., bromocriptine, cabergoline) therapy

**OR**

**1.2.2** Not a candidate for ALL of the following:

- Surgery
- Radiation therapy
- Dopamine agonist (e.g., bromocriptine, cabergoline) therapy

**AND**

**1.3** Patient has responded to and tolerated treatment with ONE of the following somatostatin analogs:

- Sandostatin (octreotide) or Sandostatin LAR
- Somatuline Depot (lanreotide) [Note: Somatuline Depot (lanreotide) might not be covered on your pharmacy prescription drug benefit. Coverage might be available on your medical benefit.]

**AND**

**1.4** The provider has submitted clinical justification why the patient is unable to be maintained on current octreotide or lanreotide therapy*

**OR**

**2** - Patient is currently on Mycapssa therapy for acromegaly

| Notes | *UHC generally does not consider frequency of dosing and/or lack of compliance to dosing regimens, an indication of medical necessity. |
|---|---|

| Product Name: Mycapssa | |
|---|---|
| Diagnosis | Acromegaly |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MYCAPSSA | OCTREOTIDE ACETATE CAP DELAYED RELEASE 20 MG | 30170070106520 | Brand |

**Approval Criteria**

**1** - Documentation of a positive clinical response to Mycapssa therapy

## 2 . Revision History

| Date | Notes |
|---|---|
| 5/22/2024 | Updated note to state: "[Note: Somatuline Depot (lanreotide) might n ot be covered on your pharmacy prescription drug benefit. Coverage might be available on your medical benefit.]" and placed note next to the alternative "Somatuline Depot (lanreotide)" within the criteria (inst ead of Notes section) per PA team request. |

Mytesi

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146365 |
| **Guideline Name** | Mytesi |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Mytesi | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MYTESI | CROFELEMER TAB DELAYED RELEASE 125 MG | 47250025000620 | Brand |

**Approval Criteria**

**1** - Diagnosis of human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS) associated diarrhea

Namzaric

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146367 |
| **Guideline Name** | Namzaric |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Namzaric | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NAMZARIC | MEMANTINE HCL-DONEPEZIL HCL CAP ER 24HR 14-10 MG | 62059902507030 | Brand |
| NAMZARIC | MEMANTINE HCL-DONEPEZIL HCL CAP ER 24HR 28-10 MG | 62059902507050 | Brand |
| NAMZARIC | MEMANTINE HCL-DONEPEZIL HCL CAP ER 24HR 7-10 MG | 62059902507020 | Brand |
| NAMZARIC | MEMANTINE HCL-DONEPEZIL HCL CAP ER 24HR 21-10 MG | 62059902507040 | Brand |

| | | | |
|---|---|---|---|
| NAMZARIC | MEMANTINE-DONEPEZIL CAP ER 24HR 7 & 14 & 21 & 28-10 MG PACK | 6205990250B630 | Brand |

**Approval Criteria**

**1** - BOTH of the following:

**1.1** History of BOTH of the following as confirmed by claims history or submission of medical records:

**1.1.1** Memantine (generic Namenda)

**AND**

**1.1.2** Donepezil (generic Aricept)

**AND**

**1.2** Patient is stabilized on 10mg of donepezil once daily as confirmed by claims history or submission of medical records

Nasonex, Xhance

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-155837 |
| **Guideline Name** | Nasonex, Xhance |
| **Formulary** | • Medicaid - Community & State New Mexico |

## 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MOMETASONE FUROATE | MOMETASONE FUROATE NASAL SUSP 50 MCG/ACT | 42200045101820 | Generic |
| NASONEX 24HR | MOMETASONE FUROATE NASAL SUSP 50 MCG/ACT | 42200045101820 | Brand |
| ALLERGY NASAL SPRAY | MOMETASONE FUROATE NASAL SUSP 50 MCG/ACT | 42200045101820 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XHANCE | FLUTICASONE PROPIONATE NASAL EXHALER SUSP 93 MCG/ACT | 4220003230G720 | Brand |

**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 | Copy Core |

Natpara

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-158412 |
| **Guideline Name** | Natpara |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 12/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NATPARA | PARATHYROID HORMONE (RECOMBINANT) FOR INJ CARTRIDGE 25 MCG | 3004405510E110 | Brand |
| NATPARA | PARATHYROID HORMONE (RECOMBINANT) FOR INJ CARTRIDGE 50 MCG | 3004405510E120 | Brand |
| NATPARA | PARATHYROID HORMONE (RECOMBINANT) FOR INJ CARTRIDGE 75 MCG | 3004405510E130 | Brand |

| | | | |
|---|---|---|---|
| NATPARA | PARATHYROID HORMONE (RECOMBINANT) FOR INJ CARTRIDGE 100 MCG | 3004405510E140 | Brand |

**Approval Criteria**

**1** - Diagnosis of hypocalcemia resulting from chronic hypoparathyroidism

**AND**

**2** - Patient is currently on adequate supplemental calcium and active vitamin D (e.g., calcitriol) therapy as evidenced by serum calcium (albumin corrected) greater than 7.5 mg/dL

**AND**

**3** - Prescribed by ONE of the following:

- Endocrinologist
- Nephrologist

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NATPARA | PARATHYROID HORMONE (RECOMBINANT) FOR INJ CARTRIDGE 25 MCG | 3004405510E110 | Brand |
| NATPARA | PARATHYROID HORMONE (RECOMBINANT) FOR INJ CARTRIDGE 50 MCG | 3004405510E120 | Brand |
| NATPARA | PARATHYROID HORMONE (RECOMBINANT) FOR INJ CARTRIDGE 75 MCG | 3004405510E130 | Brand |
| NATPARA | PARATHYROID HORMONE (RECOMBINANT) FOR INJ CARTRIDGE 100 MCG | 3004405510E140 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response [e.g., total serum calcium level (albumin corrected) within the lower half of the normal range (approximately 8 to 8.5 mg/dL)]

**AND**

**2** - Patient continues to take concomitant calcium supplementation that is sufficient to meet daily requirements

**AND**

**3** - Prescribed by ONE of the following:

- Endocrinologist
- Nephrologist

## 2 . Revision History

| Date | Notes |
|---|---|
| 11/1/2024 | Copy core |

Nayzilam and Valtoco

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-148227 |
| **Guideline Name** | Nayzilam and Valtoco |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NAYZILAM | MIDAZOLAM NASAL SPRAY SOLN 5 MG/0.1 ML | 72100060002010 | Brand |

**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** - The prescriber provides a reason or special circumstance that precludes the use of diazepam rectal gel

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NAYZILAM | MIDAZOLAM NASAL SPRAY SOLN 5 MG/0.1 ML | 72100060002010 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VALTOCO 15 MG DOSE | DIAZEPAM NASAL SPRAY THER PACK 2 X 7.5 MG/0.1ML (15 MG DOSE) | 7210003000C440 | Brand |

| | | | |
|---|---|---|---|
| VALTOCO 20 MG DOSE | DIAZEPAM NASAL SPRAY THER PACK 2 X 10 MG/0.1ML (20 MG DOSE) | 7210003000C450 | Brand |
| VALTOCO 5 MG DOSE | DIAZEPAM NASAL SPRAY 5 MG/0.1 ML | 72100030000920 | Brand |
| VALTOCO 10 MG DOSE | DIAZEPAM NASAL SPRAY 10 MG/0.1 ML | 72100030000930 | Brand |

**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** - The prescriber provides a reason or special circumstance that precludes the use of diazepam rectal gel

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VALTOCO 15 MG DOSE | DIAZEPAM NASAL SPRAY THER PACK 2 X 7.5 MG/0.1ML (15 MG DOSE) | 7210003000C440 | Brand |
| VALTOCO 20 MG DOSE | DIAZEPAM NASAL SPRAY THER PACK 2 X 10 MG/0.1ML (20 MG DOSE) | 7210003000C450 | Brand |
| VALTOCO 5 MG DOSE | DIAZEPAM NASAL SPRAY 5 MG/0.1 ML | 72100030000920 | Brand |
| VALTOCO 10 MG DOSE | DIAZEPAM NASAL SPRAY 10 MG/0.1 ML | 72100030000930 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to therapy

## 2 . Revision History

| Date | Notes |
|---|---|
| 6/10/2024 | Revised drug table for Valtoco name change. |

Nerlynx

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-155031 |
| **Guideline Name** | Nerlynx |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 10/1/2024 |

## 1 . Criteria

| Product Name: Nerlynx | |
|---|---|
| Diagnosis | Early-Stage or Node-Positive Breast Cancer |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NERLYNX | NERATINIB MALEATE TAB 40 MG (BASE EQUIVALENT) | 21533035100320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NERLYNX | NERATINIB MALEATE TAB 40 MG (BASE EQUIVALENT) | 21533035100320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NERLYNX | NERATINIB MALEATE TAB 40 MG (BASE EQUIVALENT) | 21533035100320 | Brand |

**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 | Advanced or Metastatic Breast Cancer, Breast Cancer with Brain Metastases |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NERLYNX | NERATINIB MALEATE TAB 40 MG (BASE EQUIVALENT) | 21533035100320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NERLYNX | NERATINIB MALEATE TAB 40 MG (BASE EQUIVALENT) | 21533035100320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NERLYNX | NERATINIB MALEATE TAB 40 MG (BASE EQUIVALENT) | 21533035100320 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Nerlynx therapy

## 2 . Revision History

| Date | Notes |
|---|---|
| 9/16/2024 | Updated formatting, no changes to criteria |

Nexavar

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-158294 |
| **Guideline Name** | Nexavar |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 12/1/2024 |

## 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NEXAVAR | SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT) | 21533060400320 | Brand |
| SORAFENIB | SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT) | 21533060400320 | Generic |
| SORAFENIB TOSYLATE | SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT) | 21533060400320 | Generic |

**Approval Criteria**

**1** - Diagnosis of renal cell carcinoma (RCC)

**AND**

**2** - ONE of the following:

**2.1** Disease has relapsed

**OR**

**2.2** BOTH of the following:

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

| Product Name: Brand Nexavar, generic sorafenib | |
|---|---|
| Diagnosis | Hepatocellular Carcinoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NEXAVAR | SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT) | 21533060400320 | Brand |
| SORAFENIB | SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT) | 21533060400320 | Generic |
| SORAFENIB TOSYLATE | SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT) | 21533060400320 | Generic |

**Approval Criteria**

**1** - Diagnosis of hepatocellular carcinoma

**AND**

**2** - ONE of the following:

**2.1** Patient has metastatic disease

**OR**

**2.2** Patient has extensive liver tumor burden

**OR**

**2.3** Patient is inoperable by performance status or comorbidity (local disease or local disease with minimal extrahepatic disease only)

**OR**

**2.4** BOTH of the following:

- Patient is not a transplant candidate
- Disease is unresectable

| Product Name: Brand Nexavar, generic sorafenib | |
|---|---|
| Diagnosis | Thyroid Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NEXAVAR | SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT) | 21533060400320 | Brand |

| | | | |
|---|---|---|---|
| SORAFENIB | SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT) | 21533060400320 | Generic |
| SORAFENIB TOSYLATE | SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT) | 21533060400320 | Generic |

**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 recurrent disease
- Persistent locoregional 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:

- Disease is progressive
- Disease is symptomatic with distant metastases

**AND**

**2.3** ONE of the following:

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

- Caprelsa (vandetanib)
- Cometriq (cabozantinib)

**OR**

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

- Caprelsa (vandetanib)
- Cometriq (cabozantinib)

| Product Name: Brand Nexavar, generic sorafenib | |
|---|---|
| Diagnosis | Soft Tissue Sarcoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NEXAVAR | SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT) | 21533060400320 | Brand |

| | | | |
|---|---|---|---|
| SORAFENIB | SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT) | 21533060400320 | Generic |
| SORAFENIB TOSYLATE | SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT) | 21533060400320 | Generic |

**Approval Criteria**

**1** - Diagnosis of angiosarcoma

**OR**

**2** - Diagnosis of desmoid tumors/aggressive fibromatosis

**OR**

**3** - BOTH of the following:

**3.1** Diagnosis of progressive gastrointestinal stromal tumors (GIST)

**AND**

**3.2** ONE of the following:

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

- imatinib (generic for Gleevec)
- sunitinib (generic for Sutent)
- Stivarga (regorafenib)
- Qinlock (ripretinib)

**OR**

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

- imatinib (generic for Gleevec)
- sunitinib (generic for Sutent)

- Stivarga (regorafenib)
- Qinlock (ripretinib)

**OR**

**4** - Diagnosis of 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NEXAVAR | SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT) | 21533060400320 | Brand |
| SORAFENIB | SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT) | 21533060400320 | Generic |
| SORAFENIB TOSYLATE | SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT) | 21533060400320 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NEXAVAR | SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT) | 21533060400320 | Brand |
| SORAFENIB | SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT) | 21533060400320 | Generic |
| SORAFENIB TOSYLATE | SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT) | 21533060400320 | Generic |

**Approval Criteria**

**1** - Diagnosis of acute myeloid leukemia (AML)

**AND**

**2** - Patient has FLT3-ITD mutation-positive disease

**AND**

**3** - ONE of the following:

- Patient has relapsed disease
- Patient has refractory disease

**AND**

**4** - Used in combination with ONE of the following:

- azacytidine (generic for Vidaza)
- decitabine (generic for Dacogen)

**AND**

**5** - Patient is unable to tolerate more aggressive treatment regimens

| Product Name: Brand Nexavar, generic sorafenib | |
|---|---|
| Diagnosis | Ovarian Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NEXAVAR | SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT) | 21533060400320 | Brand |
| SORAFENIB | SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT) | 21533060400320 | Generic |
| SORAFENIB TOSYLATE | SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT) | 21533060400320 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NEXAVAR | SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT) | 21533060400320 | Brand |
| SORAFENIB | SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT) | 21533060400320 | Generic |
| SORAFENIB TOSYLATE | SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT) | 21533060400320 | Generic |

**Approval Criteria**

**1** - Diagnosis of salivary gland tumor

**AND**

**2** - Disease is ONE of the following:

- Recurrent and 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NEXAVAR | SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT) | 21533060400320 | Brand |
| SORAFENIB | SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT) | 21533060400320 | Generic |
| SORAFENIB TOSYLATE | SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT) | 21533060400320 | Generic |

**Approval Criteria**

**1** - Diagnosis of myeloid/lymphoid neoplasm with eosinophilia and FLT3 rearrangement

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NEXAVAR | SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT) | 21533060400320 | Brand |
| SORAFENIB | SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT) | 21533060400320 | Generic |
| SORAFENIB TOSYLATE | SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT) | 21533060400320 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NEXAVAR | SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT) | 21533060400320 | Brand |
| SORAFENIB | SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT) | 21533060400320 | Generic |
| SORAFENIB TOSYLATE | SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT) | 21533060400320 | Generic |

**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 |
|---|---|

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NEXAVAR | SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT) | 21533060400320 | Brand |
| SORAFENIB | SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT) | 21533060400320 | Generic |
| SORAFENIB TOSYLATE | SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT) | 21533060400320 | Generic |

**Approval Criteria**

**1** - Documentation of positive clinical response to the requested therapy

## 2 . Revision History

| Date | Notes |
|---|---|
| 10/30/2024 | Updated product name lists throughout guideline. Minor update to re auth criteria sections, with no changes to clinical intent. Minor cosmet ic update to diagnosis header for NCCN sections, with no changes to clinical intent. |

Nexletol, Nexlizet

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-152706 |
| **Guideline Name** | Nexletol, Nexlizet |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 9/1/2024 |

## 1 . Criteria

| Product Name: Nexletol, Nexlizet | |
|---|---|
| Diagnosis | Hyperlipidemia |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NEXLETOL | BEMPEDOIC ACID TAB 180 MG | 39380020000320 | Brand |
| NEXLIZET | BEMPEDOIC ACID-EZETIMIBE TAB 180-10 MG | 39991002200320 | Brand |

**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 (creatine 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 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 | |
|---|---|
| Diagnosis | Hyperlipidemia |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NEXLETOL | BEMPEDOIC ACID TAB 180 MG | 39380020000320 | Brand |

| NEXLIZET | BEMPEDOIC ACID-EZETIMIBE TAB 180-10 MG | 39991002200320 | Brand |
|---|---|---|---|

**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 |
|---|---|
| 8/27/2024 | Updated indications to include established and high risk for CVD based on updated labeling. Lowered LDL-C threshold for initiation of therapy. Updated background. |

Ninlaro

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-151702 |
| **Guideline Name** | Ninlaro |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 9/1/2024 |

## 1 . Criteria

| Product Name: Ninlaro | |
|---|---|
| Diagnosis | Multiple Myeloma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NINLARO | IXAZOMIB CITRATE CAP 2.3 MG (BASE EQUIVALENT) | 21536045100120 | Brand |
| NINLARO | IXAZOMIB CITRATE CAP 3 MG (BASE EQUIVALENT) | 21536045100130 | Brand |
| NINLARO | IXAZOMIB CITRATE CAP 4 MG (BASE EQUIVALENT) | 21536045100140 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NINLARO | IXAZOMIB CITRATE CAP 2.3 MG (BASE EQUIVALENT) | 21536045100120 | Brand |
| NINLARO | IXAZOMIB CITRATE CAP 3 MG (BASE EQUIVALENT) | 21536045100130 | Brand |
| NINLARO | IXAZOMIB CITRATE CAP 4 MG (BASE EQUIVALENT) | 21536045100140 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NINLARO | IXAZOMIB CITRATE CAP 2.3 MG (BASE EQUIVALENT) | 21536045100120 | Brand |
| NINLARO | IXAZOMIB CITRATE CAP 3 MG (BASE EQUIVALENT) | 21536045100130 | Brand |
| NINLARO | IXAZOMIB CITRATE CAP 4 MG (BASE EQUIVALENT) | 21536045100140 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NINLARO | IXAZOMIB CITRATE CAP 2.3 MG (BASE EQUIVALENT) | 21536045100120 | Brand |
| NINLARO | IXAZOMIB CITRATE CAP 3 MG (BASE EQUIVALENT) | 21536045100130 | Brand |
| NINLARO | IXAZOMIB CITRATE CAP 4 MG (BASE EQUIVALENT) | 21536045100140 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| NINLARO | IXAZOMIB CITRATE CAP 2.3 MG (BASE EQUIVALENT) | 21536045100120 | Brand |
| NINLARO | IXAZOMIB CITRATE CAP 3 MG (BASE EQUIVALENT) | 21536045100130 | Brand |
| NINLARO | IXAZOMIB CITRATE CAP 4 MG (BASE EQUIVALENT) | 21536045100140 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NINLARO | IXAZOMIB CITRATE CAP 2.3 MG (BASE EQUIVALENT) | 21536045100120 | Brand |
| NINLARO | IXAZOMIB CITRATE CAP 3 MG (BASE EQUIVALENT) | 21536045100130 | Brand |
| NINLARO | IXAZOMIB CITRATE CAP 4 MG (BASE EQUIVALENT) | 21536045100140 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Ninlaro therapy

## 2 . Revision History

| Date | Notes |
|---|---|
| 8/13/2024 | Simplified criteria for multiple myeloma to only require diagnosis chec k. |

Nityr

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146591 |
| **Guideline Name** | Nityr |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Nityr | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NITYR | NITISINONE TAB 2 MG | 30904045000310 | Brand |
| NITYR | NITISINONE TAB 5 MG | 30904045000320 | Brand |
| NITYR | NITISINONE TAB 10 MG | 30904045000330 | Brand |

**Approval Criteria**

**1** - Diagnosis of hereditary tyrosinemia type 1

Nocdurna

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146371 |
| **Guideline Name** | Nocdurna |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NOCDURNA | DESMOPRESSIN ACETATE SUBLINGUAL TAB 27.7 MCG | 30201010100710 | Brand |
| NOCDURNA | DESMOPRESSIN ACETATE SUBLINGUAL TAB 55.3 MCG | 30201010100715 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NOCDURNA | DESMOPRESSIN ACETATE SUBLINGUAL TAB 27.7 MCG | 30201010100710 | Brand |
| NOCDURNA | DESMOPRESSIN ACETATE SUBLINGUAL TAB 55.3 MCG | 30201010100715 | Brand |

**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

Non-Preferred Drugs

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146833 |
| **Guideline Name** | Non-Preferred Drugs |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Non-Preferred Drugs | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Administrative |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| multi-source brand medication | | | |
| multi-source brand | | | |
| non-preferred | | | |
| non preferred | | | |

**Approval Criteria**

**1** - If the requested medication is a behavioral health medication, ONE of the following:

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

**OR**

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

**OR**

**2** - ALL of the following:

**2.1** One of the following:

**2.1.1** Both of the following:

**2.1.1.1** One of the following:

- History of failure to at least THREE preferred alternatives as confirmed by claims history or submission of medical records.* NOTE: In instances where there are fewer than three preferred alternatives, the patient must have a history of failure to all of the preferred products.
- History of contraindication or intolerance to THREE preferred alternatives (please specify contraindication or intolerance).* NOTE: In instances where there are fewer than three preferred alternatives, the patient must have a history of contraindication or intolerance to all of the preferred products.

**AND**

**2.1.1.2** One of the following:

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

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

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

**OR**

**2.1.1.2.2** If the request is for a generic when there is a brand available and 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).

**OR**

**2.1.2** There are no preferred formulary alternatives for the requested drug.

**AND**

**2.2** One of the following:

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

**OR**

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

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

| | |
|---|---|
| • Clinical pharmacology<br>• United States Pharmacopeia-National Formulary (USP-NF )<br><br>**AND**<br><br>**2.3** The drug is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plan's program. | |
| Notes | *PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html<br>Prior trials of formulary/PDL alternatives must sufficiently demonstrate that the formulary/PDL alternatives are either ineffective or inappropriate at the time of the request. |

## 2 . Revision History

| Date | Notes |
|---|---|
| 4/30/2024 | Removed PDL links for CORE markets in background section and added PDL link for NM in notes section. |

Northera

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-148221 |
| **Guideline Name** | Northera |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Brand Northera, generic droxidopa | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NORTHERA | DROXIDOPA CAP 100 MG | 38700030000130 | Brand |
| DROXIDOPA | DROXIDOPA CAP 100 MG | 38700030000130 | Generic |
| NORTHERA | DROXIDOPA CAP 200 MG | 38700030000140 | Brand |
| DROXIDOPA | DROXIDOPA CAP 200 MG | 38700030000140 | Generic |
| NORTHERA | DROXIDOPA CAP 300 MG | 38700030000150 | Brand |

| | | | |
|---|---|---|---|
| DROXIDOPA | DROXIDOPA CAP 300 MG | 38700030000150 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| NORTHERA | DROXIDOPA CAP 100 MG | 38700030000130 | Brand |
| DROXIDOPA | DROXIDOPA CAP 100 MG | 38700030000130 | Generic |
| NORTHERA | DROXIDOPA CAP 200 MG | 38700030000140 | Brand |
| DROXIDOPA | DROXIDOPA CAP 200 MG | 38700030000140 | Generic |
| NORTHERA | DROXIDOPA CAP 300 MG | 38700030000150 | Brand |
| DROXIDOPA | DROXIDOPA CAP 300 MG | 38700030000150 | Generic |

**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 |
|---|---|
| 6/6/2024 | Updated initial authorization duration to 12 months. |

Nourianz

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146374 |
| **Guideline Name** | Nourianz |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Nourianz | |
|---|---|
| Approval Length | 6 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NOURIANZ | ISTRADEFYLLINE TAB 20 MG | 73401025000320 | Brand |
| NOURIANZ | ISTRADEFYLLINE TAB 40 MG | 73401025000340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NOURIANZ | ISTRADEFYLLINE TAB 20 MG | 73401025000320 | Brand |

| NOURIANZ | ISTRADEFYLLINE TAB 40 MG | 73401025000340 | Brand |
|---|---|---|---|

**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

Nubeqa

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146593 |
| **Guideline Name** | Nubeqa |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Nubeqa | |
|---|---|
| Diagnosis | Prostate Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NUBEQA | DAROLUTAMIDE TAB 300 MG | 21402425000320 | Brand |

**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 recurrent

**OR**

**2.2** ALL of the following:

**2.2.1** Disease is metastatic

**AND**

**2.2.2** Disease is hormone-sensitive

**AND**

**2.2.3** Nubeqa will be used in combination with docetaxel

**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: Nubeqa | |
|---|---|
| Diagnosis | Prostate Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NUBEQA | DAROLUTAMIDE TAB 300 MG | 21402425000320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NUBEQA | DAROLUTAMIDE TAB 300 MG | 21402425000320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NUBEQA | DAROLUTAMIDE TAB 300 MG | 21402425000320 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Nubeqa therapy

Nucala

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-155049 |
| **Guideline Name** | Nucala |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 10/1/2024 |

## 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NUCALA | MEPOLIZUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML | 4460405500D530 | Brand |
| NUCALA | MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 100 MG/ML | 4460405500E530 | Brand |
| NUCALA | MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 40 MG/0.4ML | 4460405500E520 | Brand |

**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

- Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NUCALA | MEPOLIZUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML | 4460405500D530 | Brand |
| NUCALA | MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 100 MG/ML | 4460405500E530 | Brand |
| NUCALA | MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 40 MG/0.4ML | 4460405500E520 | Brand |

**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

- Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NUCALA | MEPOLIZUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML | 4460405500D530 | Brand |
| NUCALA | MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 100 MG/ML | 4460405500E530 | Brand |
| NUCALA | MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 40 MG/0.4ML | 4460405500E520 | Brand |

**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

- Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NUCALA | MEPOLIZUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML | 4460405500D530 | Brand |
| NUCALA | MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 100 MG/ML | 4460405500E530 | Brand |
| NUCALA | MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 40 MG/0.4ML | 4460405500E520 | Brand |

**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

- Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NUCALA | MEPOLIZUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML | 4460405500D530 | Brand |
| NUCALA | MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 100 MG/ML | 4460405500E530 | Brand |
| NUCALA | MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 40 MG/0.4ML | 4460405500E520 | Brand |

**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

- Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NUCALA | MEPOLIZUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML | 4460405500D530 | Brand |
| NUCALA | MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 100 MG/ML | 4460405500E530 | Brand |
| NUCALA | MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 40 MG/0.4ML | 4460405500E520 | Brand |

**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

- Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NUCALA | MEPOLIZUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML | 4460405500D530 | Brand |
| NUCALA | MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 100 MG/ML | 4460405500E530 | Brand |
| NUCALA | MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 40 MG/0.4ML | 4460405500E520 | Brand |

**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

- Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NUCALA | MEPOLIZUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML | 4460405500D530 | Brand |
| NUCALA | MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 100 MG/ML | 4460405500E530 | Brand |
| NUCALA | MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 40 MG/0.4ML | 4460405500E520 | Brand |

**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/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

- Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NUCALA | MEPOLIZUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML | 4460405500D530 | Brand |
| NUCALA | MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 100 MG/ML | 4460405500E530 | Brand |
| NUCALA | MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 40 MG/0.4ML | 4460405500E520 | Brand |

**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

- Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| NUCALA | MEPOLIZUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML | 4460405500D530 | Brand |
| NUCALA | MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 100 MG/ML | 4460405500E530 | Brand |
| NUCALA | MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 40 MG/0.4ML | 4460405500E520 | Brand |

**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

- Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NUCALA | MEPOLIZUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML | 4460405500D530 | Brand |
| NUCALA | MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 100 MG/ML | 4460405500E530 | Brand |
| NUCALA | MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 40 MG/0.4ML | 4460405500E520 | Brand |

**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

- Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NUCALA | MEPOLIZUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML | 4460405500D530 | Brand |
| NUCALA | MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 100 MG/ML | 4460405500E530 | Brand |
| NUCALA | MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 40 MG/0.4ML | 4460405500E520 | Brand |

**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

- Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), 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)]

## 2 . Revision History

| Date | Notes |
|---|---|
| 9/17/2024 | Specified existing prior authorization for under the medical benefit. |

Nuedexta

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146375 |
| **Guideline Name** | Nuedexta |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Nuedexta | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NUEDEXTA | DEXTROMETHORPHAN HBR-QUINIDINE SULFATE CAP 20-10 MG | 62609902300120 | Brand |

**Approval Criteria**

**1** - Diagnosis of pseudobulbar affect (PBA)

Nuplazid

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146376 |
| **Guideline Name** | Nuplazid |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NUPLAZID | PIMAVANSERIN TARTRATE CAP 34 MG (BASE EQUIVALENT) | 59400028200120 | Brand |
| NUPLAZID | PIMAVANSERIN TARTRATE TAB 10 MG (BASE EQUIVALENT) | 59400028200310 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NUPLAZID | PIMAVANSERIN TARTRATE CAP 34 MG (BASE EQUIVALENT) | 59400028200120 | Brand |
| NUPLAZID | PIMAVANSERIN TARTRATE TAB 10 MG (BASE EQUIVALENT) | 59400028200310 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Nuplazid therapy

Nurtec, Qulipta, Ubrelvy, Zavzpret

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-156787 |
| **Guideline Name** | Nurtec, Qulipta, Ubrelvy, Zavzpret |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 11/1/2024 |

## 1 . Criteria

| Product Name: Nurtec ODT | |
|---|---|
| Diagnosis | Acute Treatment of Migraine |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NURTEC | RIMEGEPANT SULFATE TAB DISINT 75 MG | 67701060707220 | Brand |

**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:

- naratriptan (generic Amerge)
- rizatriptan (generic Maxalt/Maxalt MLT)
- sumatriptan (generic Imitrex)

**OR**

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

- naratriptan (generic Amerge)
- rizatriptan (generic Maxalt/Maxalt MLT)
- sumatriptan (generic Imitrex)

**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)
- 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)]

**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 ALL 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)
- 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**

**4** - Medication will not be used in combination with another acute calcitonin gene-related peptide receptor (CGRP) antagonists (e.g., Ubrelvy, Zavzpret)

| Notes | * Timolol, candesartan, Ajovy and Qulipta are non-preferred and shoul d not be included in denial to provider<br>**Vyepti, OnabotulinumtoxinA are medical benefits and should not be i ncluded in denial to provider.<br>***CGRP antagonists for preventive treatment of migraines require a p rior authorization. |
|---|---|

| Product Name: Nurtec ODT | |
|---|---|
| Diagnosis | Preventive Treatment of Episodic Migraine |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NURTEC | RIMEGEPANT SULFATE TAB DISINT 75 MG | 67701060707220 | Brand |

**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:

- One of the following beta-blockers: 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 ALL of the following prophylactic therapies (please specify contraindication or intolerance):

- One of the following beta-blockers: 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** - 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, Ajovy, Emgality, Vyepti)

| Notes | * Timolol and candesartan are non-preferred and should not be includ ed in denial to provider |
|---|---|

| Product Name: Nurtec ODT | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NURTEC | RIMEGEPANT SULFATE TAB DISINT 75 MG | 67701060707220 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to therapy

**AND**

**2** - ONE of the following:

**2.1** Medication will not be used in combination with another acute calcitonin gene-related peptide receptor (CGRP) antagonist (e.g., Ubrelvy, Zavzpret)

**OR**

**2.2** Medication will not be used in combination with another CGRP antagonist or inhibitor used for the preventive treatment of migraines (e.g. Aimovig, Ajovy, Emgality, Vyepti)

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZAVZPRET | ZAVEGEPANT HCL NASAL SPRAY 10 MG/ACT | 67701090202020 | Brand |

**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 with step therapy), 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):

**2.2.1** TWO preferred 5-HT1 receptor agonist (triptan) alternatives (e.g., sumatriptan, rizatriptan, or naratriptan with step therapy), one of which must be sumatriptan nasal spray

**AND**

**2.2.2** Nurtec ODT

**AND**

**2.2.3** 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)
- 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)]

**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 ALL 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)

- 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**

**4** - Medication will not be used in combination with another acute calcitonin gene-related peptide receptor (CGRP) antagonists (e.g., Nurtec ODT, Ubrelvy)

| | |
|---|---|
| Notes | * Timolol, candesartan, Ajovy and Qulipta are non-preferred and shoul d not be included in denial to provider<br>**Vyepti, OnabotulinumtoxinA are medical benefits and should not be i ncluded in denial to provider.<br>***CGRP antagonists for preventive treatment of migraines require a p rior authorization. |

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| UBRELVY | UBROGEPANT TAB 50 MG | 67701080000320 | Brand |
| UBRELVY | UBROGEPANT TAB 100 MG | 67701080000340 | Brand |

**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:

- naratriptan (generic Amerge)
- rizatriptan (generic Maxalt/Maxalt MLT)
- sumatriptan (generic Imitrex)

**OR**

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

- naratriptan (generic Amerge)
- rizatriptan (generic Maxalt/Maxalt MLT)
- sumatriptan (generic Imitrex)

**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)
- 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)]

**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 ALL 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)
- 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**

**4** - Medication will not be used in combination with another acute calcitonin gene-related peptide receptor (CGRP) antagonists (e.g., Nurtec ODT, Zavzpret)

| | |
|---|---|
| Notes | * Timolol, Ajovy, Qulipta and candesartan are non-preferred and shoul d not be included in denial to provider<br>**Vyepti, OnabotulinumtoxinA are medical benefit and should not be i ncluded in denial to provider.<br>***CGRP antagonists for preventive treatment of migraines require a p rior authorization. |

| Product Name: Ubrelvy, Zavzpret | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZAVZPRET | ZAVEGEPANT HCL NASAL SPRAY 10 MG/ACT | 67701090202020 | Brand |
| UBRELVY | UBROGEPANT TAB 50 MG | 67701080000320 | Brand |
| UBRELVY | UBROGEPANT TAB 100 MG | 67701080000340 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to therapy

**AND**

**2** - Medication will not be used in combination with another acute calcitonin gene-related peptide receptor (CGRP) antagonist (e.g., Nurtec ODT)

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| QULIPTA | ATOGEPANT TAB 10 MG | 67701010000310 | Brand |
| QULIPTA | ATOGEPANT TAB 30 MG | 67701010000320 | Brand |
| QULIPTA | ATOGEPANT TAB 60 MG | 67701010000330 | Brand |

**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 member'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:

- One of the following beta-blockers: 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 ALL of the following prophylactic therapies (please specify contraindication or intolerance):

- One of the following beta-blockers: 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** - Medication will not be used in combination with another CGRP antagonist or inhibitor used for the preventive treatment of migraines (e.g. Aimovig, Ajovy, Emgality, Nurtec ODT, Vyepti)

| Notes | * Timolol, candesartan are non-preferred and should not be included i n denial to provider<br>**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| QULIPTA | ATOGEPANT TAB 10 MG | 67701010000310 | Brand |
| QULIPTA | ATOGEPANT TAB 30 MG | 67701010000320 | Brand |
| QULIPTA | ATOGEPANT TAB 60 MG | 67701010000330 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to therapy

**AND**

| |
|---|
| **2** - Medication will not be used in combination with another CGRP antagonist or inhibitor used for the preventive treatment of migraines (e.g., Aimovig, Ajovy, Emgality, Nurtec ODT, Vyepti) |

## 2 . Background

| **Benefit/Coverage/Program Information** |
|---|
| **PDL Link:**<br>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 |
|---|---|
| 10/1/2024 | Updated list of potential prophylactic therapies |

Nuzyra

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146378 |
| **Guideline Name** | Nuzyra |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Nuzyra tablets | |
|---|---|
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NUZYRA | OMADACYCLINE TOSYLATE TAB 150 MG (BASE EQUIVALENT) | 04200050200320 | Brand |

**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 submitted 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:

**4.1.1.1** Acute bacterial skin and skin structure infections

**AND**

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

**OR**

**4.1.2** BOTH of the following:

**4.1.2.1** Empirical treatment of a patient with acute bacterial skin and skin structure infections

**AND**

**4.1.2.2** 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 submitted 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 submitted 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 submitted 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 stru cture infections will be issued for up to 14 days. For all IDSA recogniz ed indications, authorization duration is based on provider and IDSA r ecommended treatment durations, up to 6 months. |

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-149508 |
| **Guideline Name** | OAB Agents |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/3/2024 |

## 1 . Criteria

| Product Name: generic tolterodine IR | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Step Therapy |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TOLTERODINE TARTRATE | TOLTERODINE TARTRATE TAB 1 MG | 54100060200320 | Generic |
| TOLTERODINE TARTRATE | TOLTERODINE TARTRATE TAB 2 MG | 54100060200330 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TOLTERODINE TARTRATE ER | TOLTERODINE TARTRATE CAP ER 24HR 2 MG | 54100060207020 | Generic |
| TOLTERODINE TARTRATE ER | TOLTERODINE TARTRATE CAP ER 24HR 4 MG | 54100060207030 | Generic |

**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, Brand Ditropan XL, darifenacin ER, Gelnique, Gemtesa, trospium ER, Brand Vesicare | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DETROL LA | TOLTERODINE TARTRATE CAP ER 24HR 2 MG | 54100060207020 | Brand |

| | | | |
|---|---|---|---|
| DETROL LA | TOLTERODINE TARTRATE CAP ER 24HR 4 MG | 54100060207030 | Brand |
| DITROPAN XL | OXYBUTYNIN CHLORIDE TAB ER 24HR 5 MG | 54100045207520 | Brand |
| DITROPAN XL | OXYBUTYNIN CHLORIDE TAB ER 24HR 10 MG | 54100045207530 | Brand |
| DARIFENACIN HYDROBROMIDE ER | DARIFENACIN HYDROBROMIDE TAB ER 24HR 7.5 MG (BASE EQUIV) | 54100010207520 | Generic |
| DARIFENACIN HYDROBROMIDE ER | DARIFENACIN HYDROBROMIDE TAB ER 24HR 15 MG (BASE EQUIV) | 54100010207530 | Generic |
| GELNIQUE | OXYBUTYNIN CHLORIDE TD GEL 10% | 54100045204030 | Brand |
| TROSPIUM CHLORIDE ER | TROSPIUM CHLORIDE CAP ER 24HR 60 MG | 54100065207020 | Generic |
| VESICARE | SOLIFENACIN SUCCINATE TAB 5 MG | 54100055200320 | Brand |
| VESICARE | SOLIFENACIN SUCCINATE TAB 10 MG | 54100055200330 | Brand |
| GEMTESA | VIBEGRON TAB 75 MG | 54200080000320 | Brand |

**Approval Criteria**

**1** - Failure to a trial of THREE of the following confirmed by claims history or submission of medical records:

- 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):

- 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 |
|---|---|

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OXYTROL | OXYBUTYNIN TD PATCH TWICE WEEKLY 3.9 MG/24HR | 54100045008720 | Brand |

**Approval Criteria**

**1** - Failure to a trial of THREE of the following, confirmed by claims history or submission of medical records:

- 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):

- 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, oxybutynin oral solution, Brand Detrol | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DETROL | TOLTERODINE TARTRATE TAB 1 MG | 54100060200320 | Brand |
| DETROL | TOLTERODINE TARTRATE TAB 2 MG | 54100060200330 | Brand |
| FLAVOXATE HCL | FLAVOXATE HCL TAB 100 MG | 54400025100310 | Generic |

| | | | |
|---|---|---|---|
| OXYBUTYNIN CHLORIDE | OXYBUTYNIN CHLORIDE SOLUTION 5 MG/5ML | 54100045202010 | Generic |

**Approval Criteria**

**1** - Failure to a trial of ALL of the following, confirmed by claims history or submission of medical records:

- oxybutynin syrup 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 syrup or tablet
- tolterodine tablet (generic Detrol)
- trospium tablet

| Product Name: Vesicare LS | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VESICARE LS | SOLIFENACIN SUCCINATE SUSP 5 MG/5ML (1 MG/ML) | 54100055201820 | Brand |

**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 syrup
- 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 syrup
- oxybutynin tablet
- oxybutynin extended release tablet (generic Ditropan XL)

| Product Name: Brand Myrbetriq tabs, generic mirabegron tabs, generic fesoterodine ER, Brand Toviaz | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MYRBETRIQ | MIRABEGRON TAB ER 24 HR 25 MG | 54200050007520 | Brand |
| MYRBETRIQ | MIRABEGRON TAB ER 24 HR 50 MG | 54200050007530 | Brand |
| FESOTERODINE FUMARATE ER | FESOTERODINE FUMARATE TAB ER 24HR 4 MG | 54100020207520 | Generic |
| TOVIAZ | FESOTERODINE FUMARATE TAB ER 24HR 4 MG | 54100020207520 | Brand |
| FESOTERODINE FUMARATE ER | FESOTERODINE FUMARATE TAB ER 24HR 8 MG | 54100020207530 | Generic |
| TOVIAZ | FESOTERODINE FUMARATE TAB ER 24HR 8 MG | 54100020207530 | Brand |
| MIRABEGRON ER | MIRABEGRON TAB ER 24 HR 25 MG | 54200050007520 | Generic |
| MIRABEGRON ER | MIRABEGRON TAB ER 24 HR 50 MG | 54200050007530 | Generic |

**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:

- 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):

- 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 syrup
- 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 syrup
- oxybutynin tablet
- oxybutynin extended release tablet (generic Ditropan XL)

| Product Name: Myrbetriq granules | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MYRBETRIQ | MIRABEGRON GRANULES FOR ORAL EXTENDED RELEASE SUSP 8 MG/ML | 5420005000G220 | Brand |

**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 syrup
- 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 syrup
- 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 |
|---|---|
| 7/3/2024 | Copy core |

Ocaliva

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146595 |
| **Guideline Name** | Ocaliva |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OCALIVA | OBETICHOLIC ACID TAB 5 MG | 52750060000320 | Brand |
| OCALIVA | OBETICHOLIC ACID TAB 10 MG | 52750060000330 | Brand |

**Approval Criteria**

**1** - Diagnosis of primary biliary cholangitis

**AND**

**2** - ONE of the following:

**2.1** Patient does not have cirrhosis

**OR**

**2.2** Patient has compensated cirrhosis without evidence of portal hypertension

**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** - Prescribed by ONE of the following:

- Hepatologist

- Gastroenterologist

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OCALIVA | OBETICHOLIC ACID TAB 5 MG | 52750060000320 | Brand |
| OCALIVA | OBETICHOLIC ACID TAB 10 MG | 52750060000330 | Brand |

**Approval Criteria**

**1** - Submission of medical records (e.g., laboratory values) documenting a reduction in alkaline phosphatase (ALP) level from pre-treatment baseline (i.e., prior to Ocaliva therapy) while on Ocaliva therapy

**AND**

**2** - ONE of the following:

**2.1** Patient does not have cirrhosis

**OR**

**2.2** Patient has compensated cirrhosis without evidence of portal hypertension

**AND**

**3** - Prescribed by ONE of the following:

- Hepatologist
- Gastroenterologist

Odomzo

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-160623 |
| **Guideline Name** | Odomzo |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 1 . Criteria

| Product Name: Odomzo | |
|---|---|
| Diagnosis | Basal Cell Carcinoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ODOMZO | SONIDEGIB PHOSPHATE CAP 200 MG (BASE EQUIVALENT) | 21370060200120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ODOMZO | SONIDEGIB PHOSPHATE CAP 200 MG (BASE EQUIVALENT) | 21370060200120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ODOMZO | SONIDEGIB PHOSPHATE CAP 200 MG (BASE EQUIVALENT) | 21370060200120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ODOMZO | SONIDEGIB PHOSPHATE CAP 200 MG (BASE EQUIVALENT) | 21370060200120 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Odomzo therapy

## 2 . Revision History

| Date | Notes |
| --- | --- |
| 11/13/2024 | Updated criteria per NCCN recommendations to reflect that Odomzo is recommended for basal cell carcinoma with nodal metastases but not with distant metastases |

Ogsiveo

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146597 |
| **Guideline Name** | Ogsiveo |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Ogsiveo | |
|---|---|
| Diagnosis | Desmoid Tumors |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OGSIVEO | NIROGACESTAT HYDROBROMIDE TAB 50 MG | 21532350200320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OGSIVEO | NIROGACESTAT HYDROBROMIDE TAB 50 MG | 21532350200320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OGSIVEO | NIROGACESTAT HYDROBROMIDE TAB 50 MG | 21532350200320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OGSIVEO | NIROGACESTAT HYDROBROMIDE TAB 50 MG | 21532350200320 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Ogsiveo therapy

Ohtuvayre

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-158298 |
| **Guideline Name** | Ohtuvayre |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 12/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OHTUVAYRE | ENSIFENTRINE INHALATION SUSP 3 MG/2.5ML | 44430020001820 | Brand |

**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 ISC/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 ISC/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 ISC/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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OHTUVAYRE | ENSIFENTRINE INHALATION SUSP 3 MG/2.5ML | 44430020001820 | Brand |

**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)<br><br>**AND**<br><br>**1.2** Improved FEV1 (forced expiratory volume) |

## 2 . Revision History

| Date | Notes |
|---|---|
| 10/30/2024 | New guideline. |

Ojemda

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-151313 |
| **Guideline Name** | Ojemda |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 9/1/2024 |

## 1 . Criteria

| Product Name: Ojemda | |
|---|---|
| Diagnosis | Pediatric Low-Grade Glioma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OJEMDA | TOVORAFENIB TAB 100 MG | 21532075000320 | Brand |
| OJEMDA | TOVORAFENIB FOR ORAL SUSP 25 MG/ML | 21532075001920 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OJEMDA | TOVORAFENIB TAB 100 MG | 21532075000320 | Brand |
| OJEMDA | TOVORAFENIB FOR ORAL SUSP 25 MG/ML | 21532075001920 | Brand |

**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 |
|---|---|

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OJEMDA | TOVORAFENIB TAB 100 MG | 21532075000320 | Brand |
| OJEMDA | TOVORAFENIB FOR ORAL SUSP 25 MG/ML | 21532075001920 | Brand |

**Approval Criteria**

**1** - Ojemda will be approved for uses not outlined above if 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OJEMDA | TOVORAFENIB TAB 100 MG | 21532075000320 | Brand |
| OJEMDA | TOVORAFENIB FOR ORAL SUSP 25 MG/ML | 21532075001920 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Ojemda therapy

## 2 . Revision History

| Date | Notes |
|---|---|
| 8/12/2024 | New guideline |

Ojjaara

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146598 |
| **Guideline Name** | Ojjaara |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Ojjaara | |
|---|---|
| Approval Length | 6 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OJJAARA | MOMELOTINIB DIHYDROCHLORIDE TAB 100 MG | 21537540300320 | Brand |
| OJJAARA | MOMELOTINIB DIHYDROCHLORIDE TAB 150 MG | 21537540300330 | Brand |
| OJJAARA | MOMELOTINIB DIHYDROCHLORIDE TAB 200 MG | 21537540300340 | Brand |

**Approval Criteria**

**1** - Disease is considered intermediate or high-risk based on one of the following diagnoses:

- Primary myelofibrosis
- Post-polycythemia vera myelofibrosis
- Post-essential thrombocythemia myelofibrosis

**AND**

**2** - Patient has anemia

| Product Name: Ojjaara | |
|---|---|
| Approval Length | 6 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OJJAARA | MOMELOTINIB DIHYDROCHLORIDE TAB 100 MG | 21537540300320 | Brand |
| OJJAARA | MOMELOTINIB DIHYDROCHLORIDE TAB 150 MG | 21537540300330 | Brand |
| OJJAARA | MOMELOTINIB DIHYDROCHLORIDE TAB 200 MG | 21537540300340 | Brand |

**Approval Criteria**

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

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OJJAARA | MOMELOTINIB DIHYDROCHLORIDE TAB 100 MG | 21537540300320 | Brand |

| | | | |
|---|---|---|---|
| OJJAARA | MOMELOTINIB DIHYDROCHLORIDE TAB 150 MG | 21537540300330 | Brand |
| OJJAARA | MOMELOTINIB DIHYDROCHLORIDE TAB 200 MG | 21537540300340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OJJAARA | MOMELOTINIB DIHYDROCHLORIDE TAB 100 MG | 21537540300320 | Brand |
| OJJAARA | MOMELOTINIB DIHYDROCHLORIDE TAB 150 MG | 21537540300330 | Brand |
| OJJAARA | MOMELOTINIB DIHYDROCHLORIDE TAB 200 MG | 21537540300340 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Ojjaara therapy

Olumiant

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146847 |
| **Guideline Name** | Olumiant |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Olumiant 1mg, Olumiant 2mg | |
|---|---|
| Diagnosis | Rheumatoid Arthritis |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OLUMIANT | BARICITINIB TAB 2 MG | 66603010000320 | Brand |
| OLUMIANT | BARICITINIB TAB 1 MG | 66603010000310 | Brand |

**Approval Criteria**

**1** - Diagnosis of moderately to severely active rheumatoid arthritis (RA)

**AND**

**2** - Patient is not receiving Olumiant in combination with one of the following:

- Biologic DMARD [e.g., Enbrel (etanercept), adalimumab, Cimzia (certolizumab), Simponi (golimumab)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]
- Janus kinase inhibitor [e.g., Xeljanz/Xeljanz XR (tofacitinib), Rinvoq (upadacitinib)]

**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:

**4.2.1.1** 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 submission of medical records

**OR**

**4.2.1.2** History of contraindication or intolerance to one non-biologic disease modifying anti-

| |
|---|
| rheumatic drug (DMARD) [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] (please specify contraindication or intolerance)<br><br>**OR**<br><br>**4.2.1.3** Patient has been previously treated with a biologic or targeted synthetic DMARD 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)]<br><br>**AND**<br><br>**4.2.2** One of the following:<br><br>**4.2.2.1** Failure to at least one TNF antagonist therapy as confirmed by claims history or submission of medical records<br><br>**OR**<br><br>**4.2.2.2** History of intolerance or contraindication to at least one TNF antagonist therapy (please specify intolerance or contraindication)<br><br>**OR**<br><br>**4.2.2.3** 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 criteria3) |

| | |
|---|---|
| Notes | Olumiant used for the treatment of alopecia areata is considered cos metic, is excluded, and is to be denied as a benefit exclusion. |

| Product Name: Olumiant 1mg, Olumiant 2mg | |
|---|---|
| Diagnosis | Rheumatoid Arthritis |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OLUMIANT | BARICITINIB TAB 2 MG | 66603010000320 | Brand |
| OLUMIANT | BARICITINIB TAB 1 MG | 66603010000310 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Olumiant therapy

**AND**

**2** - Patient is not receiving Olumiant in combination with one of the following:

- Biologic DMARD [e.g., Enbrel (etanercept), adalimumab, Cimzia (certolizumab), Simponi (golimumab)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]
- Janus kinase inhibitor [e.g., Xeljanz/Xeljanz XR (tofacitinib), Rinvoq (upadacitinib)]

| Notes | Olumiant used for the treatment of alopecia areata is considered cos metic, is excluded, and is to be denied as a benefit exclusion. |
|---|---|

## 2 . Revision History

| Date | Notes |
|---|---|
| 4/30/2024 | Removed references to other states in GL name. |

Omega

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146380 |
| **Guideline Name** | Omega |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LOVAZA | OMEGA-3-ACID ETHYL ESTERS CAP 1 GM | 39500045200130 | Brand |
| OMEGA-3-ACID ETHYL ESTERS | OMEGA-3-ACID ETHYL ESTERS CAP 1 GM | 39500045200130 | Generic |

| | | | |
|---|---|---|---|
| VASCEPA | ICOSAPENT ETHYL CAP 0.5 GM | 39500035100110 | Brand |
| ICOSAPENT ETHYL | ICOSAPENT ETHYL CAP 0.5 GM | 39500035100110 | Generic |
| VASCEPA | ICOSAPENT ETHYL CAP 1 GM | 39500035100120 | Brand |
| ICOSAPENT ETHYL | ICOSAPENT ETHYL CAP 1 GM | 39500035100120 | Generic |

**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 a cid 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LOVAZA | OMEGA-3-ACID ETHYL ESTERS CAP 1 GM | 39500045200130 | Brand |
| OMEGA-3-ACID ETHYL ESTERS | OMEGA-3-ACID ETHYL ESTERS CAP 1 GM | 39500045200130 | Generic |
| VASCEPA | ICOSAPENT ETHYL CAP 0.5 GM | 39500035100110 | Brand |
| ICOSAPENT ETHYL | ICOSAPENT ETHYL CAP 0.5 GM | 39500035100110 | Generic |
| VASCEPA | ICOSAPENT ETHYL CAP 1 GM | 39500035100120 | Brand |
| ICOSAPENT ETHYL | ICOSAPENT ETHYL CAP 1 GM | 39500035100120 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VASCEPA | ICOSAPENT ETHYL CAP 0.5 GM | 39500035100110 | Brand |
| ICOSAPENT ETHYL | ICOSAPENT ETHYL CAP 0.5 GM | 39500035100110 | Generic |
| VASCEPA | ICOSAPENT ETHYL CAP 1 GM | 39500035100120 | Brand |
| ICOSAPENT ETHYL | ICOSAPENT ETHYL CAP 1 GM | 39500035100120 | Generic |

**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:

- Men at least 55 years and women at least 65 years
- Cigarette smoker or stopped smoking within the past 3 months
- Hypertension [pretreatment blood pressure greater than or equal to 140 millimeters of mercury (mmHg) systolic or greater than or equal to 90 mmHg diastolic]
- HDL-C (high-density lipoprotein cholesterol) less than or equal to 40 mg/dL for men or less than or equal to 50 mg/dL for women
- High-sensitivity C-reactive protein greater than 3.0 mg/L (liter)
- Creatinine clearance greater than 30 and less than 60 milliliters/minute (mL/min)
- Retinopathy
- Micro- or macro-albuminuria
- Ankle-brachial index (ABI) less than 0.9 without symptoms of intermittent claudication

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VASCEPA | ICOSAPENT ETHYL CAP 0.5 GM | 39500035100110 | Brand |
| ICOSAPENT ETHYL | ICOSAPENT ETHYL CAP 0.5 GM | 39500035100110 | Generic |
| VASCEPA | ICOSAPENT ETHYL CAP 1 GM | 39500035100120 | Brand |
| ICOSAPENT ETHYL | ICOSAPENT ETHYL CAP 1 GM | 39500035100120 | Generic |

**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

Omnipod 5

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-147315 |
| **Guideline Name** | Omnipod 5 |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Omnipod 5 | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OMNIPOD 5 G6 PODS (GEN 5) | *INSULIN INFUSION DISPOSABLE PUMP RESERVOIR*** | 97201030506300 | Brand |
| OMNIPOD 5 G6 INTRO KIT (GEN 5) | *INSULIN INFUSION DISPOSABLE PUMP KIT*** | 97201030506400 | Brand |

| | | | |
|---|---|---|---|
| OMNIPOD 5 G7 PODS (GEN 5) | *INSULIN INFUSION DISPOSABLE PUMP RESERVOIR*** | 97201030506300 | Brand |
| OMNIPOD 5 G7 INTRO KIT (GEN 5) | *INSULIN INFUSION DISPOSABLE PUMP KIT*** | 97201030506400 | Brand |

**Approval Criteria**

**1** - Diagnosis of 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** - ONE of the following:

- Unexplained, nocturnal, or severe hypoglycemia
- Hypoglycemia unawareness
- Dawn phenomenon blood glucose greater than 200 mg/dL (milligrams/deciliter)
- Wide and unpredictable (erratic) swings in blood glucose levels
- Glycemic targets within individualized range but lifestyle requires increased flexibility of insulin pump use

- HbA1C greater than 7% or outside individualized targets

**AND**

**4** - BOTH of the following:

**4.1** Patient or caregiver is motivated to assume responsibility for self-care and insulin management

**AND**

**4.2** Patient or caregiver demonstrates knowledge of importance of nutrition including carbohydrate counting and meal planning

**AND**

**5** - 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 | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OMNIPOD 5 G6 PODS (GEN 5) | *INSULIN INFUSION DISPOSABLE PUMP RESERVOIR*** | 97201030506300 | Brand |
| OMNIPOD 5 G6 INTRO KIT (GEN 5) | *INSULIN INFUSION DISPOSABLE PUMP KIT*** | 97201030506400 | Brand |
| OMNIPOD 5 G7 PODS (GEN 5) | *INSULIN INFUSION DISPOSABLE PUMP RESERVOIR*** | 97201030506300 | Brand |
| OMNIPOD 5 G7 | *INSULIN INFUSION DISPOSABLE PUMP KIT*** | 97201030506400 | Brand |

| | | | |
|---|---|---|---|
| INTRO KIT (GEN 5) | | | |

**Approval Criteria**

**1** - Documentation of positive clinical response

| | |
|---|---|
| Notes | If patient meets criteria, approve using NDC List OMNIPOD5 |

| Product Name: Omnipod 5 G6 or G7 pods | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Quantity Limit |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OMNIPOD 5 G6 PODS (GEN 5) | *INSULIN INFUSION DISPOSABLE PUMP RESERVOIR*** | 97201030506300 | Brand |
| OMNIPOD 5 G7 PODS (GEN 5) | *INSULIN INFUSION DISPOSABLE PUMP RESERVOIR*** | 97201030506300 | Brand |

**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 G6 or G7 pods, for the requested quantity. |

## 2 . Revision History

| Date | Notes |
|---|---|
| 5/13/2024 | Added Omnipod 5 G7 products. |

Omvoh

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146601 |
| **Guideline Name** | Omvoh |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Omvoh SC | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OMVOH | MIRIKIZUMAB-MRKZ SUBCUTANEOUS SOLN AUTO-INJECTOR 100 MG/ML | 5250405040D520 | Brand |

**Approval Criteria**

**1** - Diagnosis of moderately to severely active ulcerative colitis

**AND**

**2** - ONE of the following:

**2.1** Patient has been established on therapy with Omvoh for moderately to severely active ulcerative colitis under an active UnitedHealthcare prior authorization

**OR**

**2.2** Patient is currently on Omvoh therapy for moderately to severely active ulcerative colitis as documented by claims history or submission of medical records (Document date and duration of therapy)

**AND**

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

- Biologic DMARD (disease modifying anti-rheumatic drug) [e.g., Enbrel (etanercept), adalimumab, Cimzia (certolizumab), Simponi (golimumab)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)
- Janus kinase inhibitor [e.g., Cibinqo (abrocitinib), Olumiant (baricitinib), Xeljanz/XR (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

**AND**

**4** - Prescribed by or in consultation with a gastroenterologist

| Product Name: Omvoh SC | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| OMVOH | MIRIKIZUMAB-MRKZ SUBCUTANEOUS SOLN AUTO-INJECTOR 100 MG/ML | 5250405040D520 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Omvoh therapy

**AND**

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

- Biologic DMARD (disease modifying anti-rheumatic drug) [e.g., Enbrel (etanercept), adalimumab, Cimzia (certolizumab), Simponi (golimumab)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)
- Janus kinase inhibitor [e.g., Cibinqo (abrocitinib), Olumiant (baricitinib), Xeljanz/XR (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

Onureg

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146602 |
| **Guideline Name** | Onureg |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Onureg | |
|---|---|
| Diagnosis | Acute Myeloid Leukemia |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ONUREG | AZACITIDINE TAB 200 MG | 21300003000320 | Brand |
| ONUREG | AZACITIDINE TAB 300 MG | 21300003000330 | Brand |

**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 | Acute Myeloid Leukemia |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ONUREG | AZACITIDINE TAB 200 MG | 21300003000320 | Brand |
| ONUREG | AZACITIDINE TAB 300 MG | 21300003000330 | Brand |

**Approval Criteria**

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

| Product Name: Onureg | |
|---|---|
| Diagnosis | NCCN Regimens |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ONUREG | AZACITIDINE TAB 200 MG | 21300003000320 | Brand |
| ONUREG | AZACITIDINE TAB 300 MG | 21300003000330 | Brand |

**Approval Criteria**

**1** - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

| Product Name: Onureg | |
|---|---|
| Diagnosis | NCCN Regimens |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ONUREG | AZACITIDINE TAB 200 MG | 21300003000320 | Brand |
| ONUREG | AZACITIDINE TAB 300 MG | 21300003000330 | Brand |

**Approval Criteria**

**1** - There is documentation of positive clinical response to Onureg therapy

Opfolda

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146603 |
| **Guideline Name** | Opfolda |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OPFOLDA | MIGLUSTAT (GAA DEFICIENCY) CAP 65 MG | 30907760000120 | Brand |

**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** - 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OPFOLDA | MIGLUSTAT (GAA DEFICIENCY) CAP 65 MG | 30907760000120 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Opfolda plus Pombiliti

**AND**

**2** - Opfolda continues to be prescribed in combination with Pombiliti

Ophthalmic Antihistamine

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146382 |
| **Guideline Name** | Ophthalmic Antihistamine |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: azelastine ophth soln | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Step Therapy |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| AZELASTINE HCL | AZELASTINE HCL OPHTH SOLN 0.05% | 86802006102020 | Generic |
| AZELASTINE HYDROCHLORIDE | AZELASTINE HCL OPHTH SOLN 0.05% | 86802006102020 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OLOPATADINE HYDROCHLORIDE | OLOPATADINE HCL OPHTH SOLN 0.1% (BASE EQUIVALENT) | 86802065102020 | Generic |
| OLOPATADINE HCL | OLOPATADINE HCL OPHTH SOLN 0.1% (BASE EQUIVALENT) | 86802065102020 | Generic |
| OLOPATADINE HYDROCHLORIDE | OLOPATADINE HCL OPHTH SOLN 0.2% (BASE EQUIVALENT) | 86802065102030 | Generic |

**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

Opzelura

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146383 |
| **Guideline Name** | Opzelura |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Opzelura | |
|---|---|
| Diagnosis | Atopic Dermatitis |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OPZELURA | RUXOLITINIB PHOSPHATE CREAM 1.5% | 90272060503720 | Brand |

**Approval Criteria**

**1** - Diagnosis of mild to moderate atopic dermatitis*

**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:

**2.1.1** ONE of the following:

**2.1.1.1** For mild atopic dermatitis: a topical corticosteroid [e.g., DesOwen (desonide), hydrocortisone] (any potency)

**OR**

**2.1.1.2** For moderate atopic dermatitis: a topical corticosteroid of at least a medium- to high-potency [e.g., Elocon (mometasone furoate), Synalar (fluocinolone acetonide), Lidex (fluocinonide)]

**OR**

**2.1.2** One topical calcineurin inhibitor [e.g., Elidel (pimecrolimus), Protopic (tacrolimus)]

**OR**

**2.1.3** Eucrisa (crisaborole)

**OR**

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

**2.2.1** ONE of the following:

**2.2.1.1** For mild atopic dermatitis: a topical corticosteroid [e.g., DesOwen (desonide), hydrocortisone] (any potency)

**OR**

**2.2.1.2** For moderate atopic dermatitis: a topical corticosteroid of at least a medium- to high-potency topical corticosteroid [e.g., Elocon (mometasone furoate), Synalar (fluocinolone acetonide), Lidex (fluocinonide)]

**AND**

**2.2.2** One topical calcineurin inhibitor [e.g., Elidel (pimecrolimus), Protopic (tacrolimus)]

**AND**

**2.2.3** Eucrisa (crisaborole)

**OR**

**2.3** Patient is currently on Opzelura therapy as confirmed by claims history or submission of medical records

**AND**

**3** - Patient is NOT receiving Opzelura in combination with another biologic medication [e.g., Dupixent (dupilumab), Xolair (omalizumab), Rituxan (rituximab), Enbrel (etanercept), Avsola/Inflectra (infliximab)] nor JAK inhibitor [e.g., Jakafi (ruxolitinib), Xeljanz (tofacitinib), Rinvoq (upadacitinib)]

**AND**

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

| Notes | *Medications for the treatment of Nonsegmental Vitiligo are considered cosmetic, are excluded, and are 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OPZELURA | RUXOLITINIB PHOSPHATE CREAM 1.5% | 90272060503720 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to therapy

**AND**

**2** - Patient is NOT receiving Opzelura in combination with another biologic medication [e.g., Dupixent (dupilumab), Xolair (omalizumab), Rituxan (rituximab), Enbrel (etanercept), Avsola/Inflectra (infliximab)] nor JAK inhibitor [e.g., Jakafi (ruxolitinib, Xeljanz (tofacitinib), Rinvoq (upadacitinib)]

**AND**

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

Orencia

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-160633 |
| **Guideline Name** | Orencia |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 1 . Criteria

| Product Name: Orencia | |
|---|---|
| Diagnosis | Rheumatoid Arthritis (RA) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ORENCIA | ABATACEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 50 MG/0.4ML | 6640001000E510 | Brand |
| ORENCIA | ABATACEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 87.5 MG/0.7ML | 6640001000E515 | Brand |
| ORENCIA | ABATACEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 125 MG/ML | 6640001000E520 | Brand |

| | | | |
|---|---|---|---|
| ORENCIA CLICKJECT | ABATACEPT SUBCUTANEOUS SOLN AUTO-INJECTOR 125 MG/ML | 6640001000D520 | Brand |

**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 Orencia 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 | *PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |
|---|---|

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ORENCIA | ABATACEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 50 MG/0.4ML | 6640001000E510 | Brand |
| ORENCIA | ABATACEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 87.5 MG/0.7ML | 6640001000E515 | Brand |
| ORENCIA | ABATACEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 125 MG/ML | 6640001000E520 | Brand |
| ORENCIA CLICKJECT | ABATACEPT SUBCUTANEOUS SOLN AUTO-INJECTOR 125 MG/ML | 6640001000D520 | Brand |

**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), Stelara (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, Stelara (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 BOTH of the following as confirmed by claims history or submission of medical records:

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

**OR**

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

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

**AND**

**1.4.2** 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, Stelara (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 | *PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |
|---|---|

| Product Name: Orencia | |
|---|---|
| Diagnosis | Polyarticular Juvenile Idiopathic Arthritis (PJIA) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ORENCIA | ABATACEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 50 MG/0.4ML | 6640001000E510 | Brand |
| ORENCIA | ABATACEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 87.5 MG/0.7ML | 6640001000E515 | Brand |

| | | | |
|---|---|---|---|
| ORENCIA | ABATACEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 125 MG/ML | 6640001000E520 | Brand |
| ORENCIA CLICKJECT | ABATACEPT SUBCUTANEOUS SOLN AUTO-INJECTOR 125 MG/ML | 6640001000D520 | Brand |

**Approval Criteria**

**1** - Diagnosis of moderate to severe polyarticular juvenile idiopathic arthritis

**AND**

**2** - 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**

**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 Orencia therapy as confirmed by claims history or submitted medical records

**AND**

**4** - Prescribed by, or in consultation with, a rheumatologist

| Notes | *PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |
|---|---|

| Product Name: Orencia | |
|---|---|
| Diagnosis | Rheumatoid Arthritis (RA), Psoriatic Arthritis, Polyarticular Juvenile Idiopathic Arthritis (PJIA) |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ORENCIA | ABATACEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 50 MG/0.4ML | 6640001000E510 | Brand |
| ORENCIA | ABATACEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 87.5 MG/0.7ML | 6640001000E515 | Brand |
| ORENCIA | ABATACEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 125 MG/ML | 6640001000E520 | Brand |
| ORENCIA CLICKJECT | ABATACEPT SUBCUTANEOUS SOLN AUTO-INJECTOR 125 MG/ML | 6640001000D520 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Orencia therapy

**AND**

**2** - Patient is NOT receiving Orencia in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), adalimumab, Stelara (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 i ndication. |

## 2 . Revision History

| Date | Notes |
|---|---|
| 11/14/2024 | Combined reauth sections. Removed Cimzia as step thru agent |

Orfadin

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146605 |
| **Guideline Name** | Orfadin |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Brand Orfadin, generic nitisinone | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NITISINONE | NITISINONE CAP 2 MG | 30904045000110 | Generic |
| ORFADIN | NITISINONE CAP 2 MG | 30904045000110 | Brand |
| NITISINONE | NITISINONE CAP 5 MG | 30904045000120 | Generic |
| ORFADIN | NITISINONE CAP 5 MG | 30904045000120 | Brand |
| NITISINONE | NITISINONE CAP 10 MG | 30904045000130 | Generic |

| | | | |
|---|---|---|---|
| ORFADIN | NITISINONE CAP 10 MG | 30904045000130 | Brand |
| ORFADIN | NITISINONE CAP 20 MG | 30904045000140 | Brand |
| NITISINONE | NITISINONE CAP 20 MG | 30904045000140 | Generic |
| ORFADIN | NITISINONE SUSP 4 MG/ML | 30904045001820 | Brand |

**Approval Criteria**

**1** - Diagnosis of hereditary tyrosinemia type 1

**AND**

**2** - Special clinical circumstances exist that precludes the use of Nityr (nitisinone) tablets for the patient (document special clinical circumstance)

| Product Name: Brand Orfadin, generic nitisinone | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NITISINONE | NITISINONE CAP 2 MG | 30904045000110 | Generic |
| ORFADIN | NITISINONE CAP 2 MG | 30904045000110 | Brand |
| NITISINONE | NITISINONE CAP 5 MG | 30904045000120 | Generic |
| ORFADIN | NITISINONE CAP 5 MG | 30904045000120 | Brand |
| NITISINONE | NITISINONE CAP 10 MG | 30904045000130 | Generic |
| ORFADIN | NITISINONE CAP 10 MG | 30904045000130 | Brand |
| ORFADIN | NITISINONE CAP 20 MG | 30904045000140 | Brand |
| NITISINONE | NITISINONE CAP 20 MG | 30904045000140 | Generic |
| ORFADIN | NITISINONE SUSP 4 MG/ML | 30904045001820 | Brand |

**Approval Criteria**

**1** - Patient shows evidence of positive clinical response (e.g., decrease in urinary/plasma succinylacetone and alpha-1-microglobulin levels) while on Orfadin therapy

Orgovyx

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146606 |
| **Guideline Name** | Orgovyx |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Orgovyx | |
|---|---|
| Diagnosis | Prostate Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ORGOVYX | RELUGOLIX TAB 120 MG | 21405570000320 | Brand |

**Approval Criteria**

**1** - Diagnosis of advanced prostate cancer

**AND**

**2** - Patient is a candidate for at least one year of continuous androgen-deprivation therapy

**AND**

**3** - ONE of the following:

- Evidence of biochemical [PSA (prostate-specific antigen)] or clinical relapse after local primary intervention with curative intent
- Newly diagnosed hormone-sensitive metastatic disease
- Advanced localized disease unlikely to be cured by local primary intervention with curative intent

**AND**

**4** - Patient has been without any major adverse cardiovascular events within 6 months before initiation (e.g., myocardial infarction, stroke)

| Product Name: Orgovyx | |
|---|---|
| Diagnosis | Prostate Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ORGOVYX | RELUGOLIX TAB 120 MG | 21405570000320 | Brand |

**Approval Criteria**

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

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ORGOVYX | RELUGOLIX TAB 120 MG | 21405570000320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ORGOVYX | RELUGOLIX TAB 120 MG | 21405570000320 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Orgovyx therapy

Oriahnn_MyFembree

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146385 |
| **Guideline Name** | Oriahnn_MyFembree |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Oriahnn, MyFembree | |
|---|---|
| Diagnosis | Uterine Fibroids |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ORIAHNN | ELAGOLIX-ESTRAD-NORETH 300-1-0.5MG & ELAGOLIX 300MG CAP PACK | 2499350340B220 | Brand |
| MYFEMBREE | RELUGOLIX-ESTRADIOL-NORETHINDRONE ACETATE TAB 40-1-0.5 MG | 24993503800320 | Brand |

**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:

**4.1** Failure after a three-month trial of tranexamic acid (e.g., Lysteda) as confirmed by claims history or submission of medical records

**OR**

**4.2** 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ORIAHNN | ELAGOLIX-ESTRAD-NORETH 300-1-0.5MG & ELAGOLIX 300MG CAP PACK | 2499350340B220 | Brand |
| MYFEMBREE | RELUGOLIX-ESTRADIOL-NORETHINDRONE ACETATE TAB 40-1-0.5 MG | 24993503800320 | Brand |

**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 treatmen t 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MYFEMBREE | RELUGOLIX-ESTRADIOL-NORETHINDRONE ACETATE TAB 40-1-0.5 MG | 24993503800320 | Brand |

**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 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

| Notes | *This is a medical benefit, should not be included in denial to provider. |
|---|---|

| Product Name: MyFembree | |
|---|---|
| Diagnosis | Pain Associated with Endometriosis |
| Approval Length | 12 months* |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MYFEMBREE | RELUGOLIX-ESTRADIOL-NORETHINDRONE ACETATE TAB 40-1-0.5 MG | 24993503800320 | Brand |

**Approval Criteria**

| | |
|---|---|
| **1** - Documentation of positive clinical response to therapy<br><br>**AND**<br><br>**2** - Impact to bone mineral density has been considered<br><br>**AND**<br><br>**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. |

Orilissa

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146387 |
| **Guideline Name** | Orilissa |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Orilissa 150 mg | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ORILISSA | ELAGOLIX SODIUM TAB 150 MG (BASE EQUIV) | 30090030100320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ORILISSA | ELAGOLIX SODIUM TAB 150 MG (BASE EQUIV) | 30090030100320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ORILISSA | ELAGOLIX SODIUM TAB 200 MG (BASE EQUIV) | 30090030100330 | Brand |

**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

Orkambi

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-151772 |
| **Guideline Name** | Orkambi |
| **Formulary** | • Medicaid - Community & State New Mexico |

## 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ORKAMBI | LUMACAFTOR-IVACAFTOR GRANULES PACKET 100-125 MG | 45309902303010 | Brand |
| ORKAMBI | LUMACAFTOR-IVACAFTOR GRANULES PACKET 150-188 MG | 45309902303020 | Brand |
| ORKAMBI | LUMACAFTOR-IVACAFTOR TAB 100-125 MG | 45309902300310 | Brand |
| ORKAMBI | LUMACAFTOR-IVACAFTOR TAB 200-125 MG | 45309902300320 | Brand |

| | | | |
|---|---|---|---|
| ORKAMBI | LUMACAFTOR-IVACAFTOR GRANULES PACKET 75-94 MG | 45309902303005 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ORKAMBI | LUMACAFTOR-IVACAFTOR GRANULES PACKET 100-125 MG | 45309902303010 | Brand |
| ORKAMBI | LUMACAFTOR-IVACAFTOR GRANULES PACKET 150-188 MG | 45309902303020 | Brand |
| ORKAMBI | LUMACAFTOR-IVACAFTOR TAB 100-125 MG | 45309902300310 | Brand |
| ORKAMBI | LUMACAFTOR-IVACAFTOR TAB 200-125 MG | 45309902300320 | Brand |
| ORKAMBI | LUMACAFTOR-IVACAFTOR GRANULES PACKET 75-94 MG | 45309902303005 | Brand |

**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-147208 |
| **Guideline Name** | Orladeyo |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ORLADEYO | BEROTRALSTAT HCL CAP 110 MG | 85840010200120 | Brand |
| ORLADEYO | BEROTRALSTAT HCL CAP 150 MG | 85840010200130 | Brand |

**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** Failure to Haegarda as confirmed by history or submission of medical records

**OR**

**4.2** History of contraindication, or intolerance to Haegarda (please specify a contraindication or intolerance)

**OR**

**4.3** 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**

**4.4** 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ORLADEYO | BEROTRALSTAT HCL CAP 110 MG | 85840010200120 | Brand |
| ORLADEYO | BEROTRALSTAT HCL CAP 150 MG | 85840010200130 | Brand |

**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 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 |
| --- | --- |
| 5/9/2024 | Update to diagnostic criteria for HAE with normal C1 inhibitor levels. Updated and simplified reauthorization criteria. |

Orserdu

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-147251 |
| **Guideline Name** | Orserdu |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Orserdu | |
|---|---|
| Diagnosis | Breast Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ORSERDU | ELACESTRANT HYDROCHLORIDE TAB 86 MG | 21403720100320 | Brand |
| ORSERDU | ELACESTRANT HYDROCHLORIDE TAB 345 MG | 21403720100340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ORSERDU | ELACESTRANT HYDROCHLORIDE TAB 86 MG | 21403720100320 | Brand |
| ORSERDU | ELACESTRANT HYDROCHLORIDE TAB 345 MG | 21403720100340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ORSERDU | ELACESTRANT HYDROCHLORIDE TAB 86 MG | 21403720100320 | Brand |
| ORSERDU | ELACESTRANT HYDROCHLORIDE TAB 345 MG | 21403720100340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ORSERDU | ELACESTRANT HYDROCHLORIDE TAB 86 MG | 21403720100320 | Brand |
| ORSERDU | ELACESTRANT HYDROCHLORIDE TAB 345 MG | 21403720100340 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Orserdu therapy

## 2 . Revision History

| Date | Notes |
|---|---|
| 5/10/2024 | Specified postmenopausal “woman” and added premenopausal wom an treated with ovarian ablation/suppression to coverage criteria per NCCN. |

Osphena

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146849 |
| **Guideline Name** | Osphena |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OSPHENA | OSPEMIFENE TAB 60 MG | 30053050000330 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OSPHENA | OSPEMIFENE TAB 60 MG | 30053050000330 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to therapy

## 2 . Revision History

| Date | Notes |
|---|---|
| 4/30/2024 | Removed reference to other states in GL name |

Otezla

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-151733 |
| **Guideline Name** | Otezla |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 9/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OTEZLA | APREMILAST TAB 30 MG | 66700015000330 | Brand |
| OTEZLA | APREMILAST TAB STARTER THERAPY PACK 10 MG & 20 MG & 30 MG | 6670001500B720 | Brand |
| OTEZLA | APREMILAST TAB STARTER THERAPY PACK 4 X 10 MG & 51 X 20 MG | 6670001500B710 | Brand |

| OTEZLA | APREMILAST TAB 20 MG | 66700015000320 | Brand |
|---|---|---|---|

**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 biologic or targeted synthetic disease-modifying antirheumatic drug (DMARD) FDA-approved for the treatment of psoriatic arthritis as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), Simponi (golimumab), Stelara (ustekinumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), Skyrizi (risankizumab-rzaa)]

**AND**

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

**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 Otezla 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 Otezla in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

**AND**

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

- Rheumatologist
- Dermatologist

| Product Name: Otezla | |
|---|---|
| Diagnosis | Plaque Psoriasis |

| | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OTEZLA | APREMILAST TAB 30 MG | 66700015000330 | Brand |
| OTEZLA | APREMILAST TAB STARTER THERAPY PACK 10 MG & 20 MG & 30 MG | 6670001500B720 | Brand |
| OTEZLA | APREMILAST TAB STARTER THERAPY PACK 4 X 10 MG & 51 X 20 MG | 6670001500B710 | Brand |
| OTEZLA | APREMILAST TAB 20 MG | 66700015000320 | Brand |

**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 biologic or targeted synthetic disease-modifying antirheumatic drug (DMARD) 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), Stelara (ustekinumab), Tremfya (guselkumab)]

**AND**

**1.3** Patient is not receiving Otezla in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx

(secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

**AND**

**1.4** Prescribed by or in consultation with a dermatologist

**OR**

**2** - All of the following:

**2.1** Patient is currently on Otezla 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 Otezla in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

**AND**

**2.4** Prescribed by or in consultation with a dermatologist

| Product Name: Otezla | |
|---|---|
| Diagnosis | Behcet's Disease |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |

| Guideline Type | Prior Authorization |
|---|---|

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OTEZLA | APREMILAST TAB 30 MG | 66700015000330 | Brand |
| OTEZLA | APREMILAST TAB STARTER THERAPY PACK 10 MG & 20 MG & 30 MG | 6670001500B720 | Brand |
| OTEZLA | APREMILAST TAB STARTER THERAPY PACK 4 X 10 MG & 51 X 20 MG | 6670001500B710 | Brand |
| OTEZLA | APREMILAST TAB 20 MG | 66700015000320 | Brand |

**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 biologic disease-modifying antirheumatic

drug (DMARD) 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 Otezla in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

**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 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 Otezla in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept),

adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

**AND**

**2.5** Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Dermatologist

| Product Name: Otezla | |
|---|---|
| Diagnosis | Psoriatic Arthritis, Behcet's Disease, Plaque Psoriasis |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OTEZLA | APREMILAST TAB 30 MG | 66700015000330 | Brand |
| OTEZLA | APREMILAST TAB STARTER THERAPY PACK 10 MG & 20 MG & 30 MG | 6670001500B720 | Brand |
| OTEZLA | APREMILAST TAB STARTER THERAPY PACK 4 X 10 MG & 51 X 20 MG | 6670001500B710 | Brand |
| OTEZLA | APREMILAST TAB 20 MG | 66700015000320 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Otezla therapy

**AND**

**2** - Patient is not receiving Otezla in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

Oxbryta

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146611 |
| **Guideline Name** | Oxbryta |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OXBRYTA | VOXELOTOR TAB 300 MG | 82805080000310 | Brand |
| OXBRYTA | VOXELOTOR TAB 500 MG | 82805080000320 | Brand |
| OXBRYTA | VOXELOTOR TAB FOR ORAL SUSP 300 MG | 82805080007320 | Brand |

**Approval Criteria**

**1** - Diagnosis of sickle cell disease

**AND**

**2** - Patient is at least 4 years of age

**AND**

**3** - ONE of the following:

**3.1** Patient is currently receiving hydroxyurea therapy

**OR**

**3.2** Failure to hydroxyurea therapy as confirmed by claims history or submission of medical records

**OR**

**3.3** History of contraindication or intolerance to hydroxyurea therapy (please specify contraindication or intolerance)

**AND**

**4** - Patient has previously experienced 1 or more sickle cell-related vaso-occlusive crises within the previous 12 months

**AND**

**5** - Baseline hemoglobin (Hb) is less than or equal to 10.5 g/dL (grams/deciliter)

**AND**

**6** - Patient is not receiving concomitant chronic, prophylactic blood transfusion therapy

**AND**

**7** - Patient is not to receive Oxbryta in combination with Adakveo (crizanlizumab-tmca)

**AND**

**8** - Prescribed by, or in consultation with, a hematologist or other specialist with expertise in the diagnosis and management of sickle cell disease

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OXBRYTA | VOXELOTOR TAB 300 MG | 82805080000310 | Brand |
| OXBRYTA | VOXELOTOR TAB 500 MG | 82805080000320 | Brand |
| OXBRYTA | VOXELOTOR TAB FOR ORAL SUSP 300 MG | 82805080007320 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Oxbryta therapy as demonstrated by at least ONE of the following:

**1.1** Increase in hemoglobin (Hb) by greater than or equal to 1 g/dL (gram/deciliter) from baseline

**OR**

**1.2** Decrease in indirect bilirubin from baseline

**OR**

**1.3** Decrease in percent reticulocyte count from baseline

**OR**

**1.4** Patient has experienced a reduction in sickle cell-related vaso-occlusive crises

**AND**

**2** - Patient is not receiving Oxbryta in combination with Adakveo (crizanlizumab-tmca)

**AND**

**3** - Patient is not receiving concomitant chronic, prophylactic blood transfusion therapy

**AND**

**4** - Prescribed by, or in consultation with a hematologist, or other specialist with expertise in the diagnosis and management of sickle cell disease

Oxervate

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146612 |
| **Guideline Name** | Oxervate |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Oxervate | |
|---|---|
| Diagnosis | Neurotrophic keratitis |
| Approval Length | 8 Week(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OXERVATE | CENEGERMIN-BKBJ OPHTH SOLN 0.002% (20 MCG/ML) | 86770020202020 | Brand |

**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

PAH

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-151105 |
| **Guideline Name** | PAH |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 8/7/2024 |

## 1 . Criteria

| Product Name: Adempas, Brand Letairis, generic ambrisentan, Opsumit, generic sildenafil 20 mg, Brand Revatio tabs/susp, generic sildenafil susp, Tracleer, generic bosentan | |
|---|---|
| Diagnosis | Pulmonary Arterial Hypertension (PAH) |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ADEMPAS | RIOCIGUAT TAB 0.5 MG | 40134050000310 | Brand |
| ADEMPAS | RIOCIGUAT TAB 1 MG | 40134050000320 | Brand |
| ADEMPAS | RIOCIGUAT TAB 1.5 MG | 40134050000330 | Brand |
| ADEMPAS | RIOCIGUAT TAB 2 MG | 40134050000340 | Brand |

| | | | |
|---|---|---|---|
| ADEMPAS | RIOCIGUAT TAB 2.5 MG | 40134050000350 | Brand |
| LETAIRIS | AMBRISENTAN TAB 5 MG | 40160007000310 | Brand |
| AMBRISENTAN | AMBRISENTAN TAB 5 MG | 40160007000310 | Generic |
| LETAIRIS | AMBRISENTAN TAB 10 MG | 40160007000320 | Brand |
| AMBRISENTAN | AMBRISENTAN TAB 10 MG | 40160007000320 | Generic |
| OPSUMIT | MACITENTAN TAB 10 MG | 40160050000320 | Brand |
| SILDENAFIL CITRATE | SILDENAFIL CITRATE TAB 20 MG | 40143060100320 | Generic |
| REVATIO | SILDENAFIL CITRATE TAB 20 MG | 40143060100320 | Brand |
| SILDENAFIL CITRATE | SILDENAFIL CITRATE FOR SUSPENSION 10 MG/ML | 40143060101920 | Generic |
| REVATIO | SILDENAFIL CITRATE FOR SUSPENSION 10 MG/ML | 40143060101920 | Brand |
| TRACLEER | BOSENTAN TAB 62.5 MG | 40160015000320 | Brand |
| BOSENTAN | BOSENTAN TAB 62.5 MG | 40160015000320 | Generic |
| TRACLEER | BOSENTAN TAB 125 MG | 40160015000330 | Brand |
| BOSENTAN | BOSENTAN TAB 125 MG | 40160015000330 | Generic |
| TRACLEER | BOSENTAN TAB FOR ORAL SUSP 32 MG | 40160015007320 | Brand |
| SILDENAFIL | SILDENAFIL CITRATE FOR SUSPENSION 10 MG/ML | 40143060101920 | Generic |

**Approval Criteria**

**1** - Diagnosis of pulmonary arterial hypertension (PAH)

| Product Name: Brand Adcirca, Alyq, generic tadalafil (PAH, generic of Adcirca) | |
|---|---|
| Diagnosis | Pulmonary Arterial Hypertension (PAH) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ADCIRCA | TADALAFIL TAB 20 MG (PAH) | 40143080000320 | Brand |
| ALYQ | TADALAFIL TAB 20 MG (PAH) | 40143080000320 | Generic |

| TADALAFIL | TADALAFIL TAB 20 MG (PAH) | 40143080000320 | Generic |
|---|---|---|---|

**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:

- A PDE-5 inhibitor (phosphodiesterase-5) [e.g., sildenafil citrate (Revatio)]
- Adempas

**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:

- A PDE-5 inhibitor [e.g., sildenafil citrate (Revatio)]
- Adempas

**AND**

**2.2.2** An ERA [e.g., ambrisentan (generic Letairis), Opsumit, or bosentan (generic Tracleer)]

| Product Name: Liqrev, Tadliq | |
|---|---|
| Diagnosis | Pulmonary Arterial Hypertension (PAH) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LIQREV | SILDENAFIL CITRATE ORAL SUSP 10 MG/ML | 40143060101825 | Brand |
| TADLIQ | TADALAFIL ORAL SUSP 20 MG/5ML (PAH) | 40143080001820 | Brand |

**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:

- sildenafil citrate oral suspension (generic Revatio)
- Adempas

**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:

- A PDE-5 inhibitor (e.g., sildenafil citrate (Revatio))
- Adempas

**AND**

**2.2.2** An ERA [e.g., ambrisentan (generic Letairis), Opsumit, or bosentan (generic Tracleer)]

| Product Name: Opsynvi | |
|---|---|
| Diagnosis | Pulmonary Arterial Hypertension (PAH) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OPSYNVI | MACITENTAN-TADALAFIL TAB 10-20 MG | 40995502500310 | Brand |

| | | | |
|---|---|---|---|
| OPSYNVI | MACITENTAN-TADALAFIL TAB 10-40 MG | 40995502500320 | Brand |

**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:

- Sildenafil citrate (generic Revatio)
- A preferred ERA [e.g., ambrisentan (generic Letairis), Opsumit, or bosentan (generic Tracleer)]

| Product Name: Orenitram, Tyvaso DPI, Uptravi titration pack, Uptravi tabs | |
|---|---|
| Diagnosis | Pulmonary Arterial Hypertension (PAH) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ORENITRAM | TREPROSTINIL DIOLAMINE TAB ER 0.125 MG (BASE EQUIV) | 40170080050410 | Brand |
| ORENITRAM | TREPROSTINIL DIOLAMINE TAB ER 0.25 MG (BASE EQUIV) | 40170080050415 | Brand |

| | | | |
|---|---|---|---|
| ORENITRAM | TREPROSTINIL DIOLAMINE TAB ER 1 MG (BASE EQUIV) | 40170080050420 | Brand |
| ORENITRAM | TREPROSTINIL DIOLAMINE TAB ER 2.5 MG (BASE EQUIV) | 40170080050425 | Brand |
| ORENITRAM | TREPROSTINIL DIOLAMINE TAB ER 5 MG (BASE EQUIV) | 40170080050435 | Brand |
| TYVASO DPI MAINTENANCE KIT | TREPROSTINIL INH POWDER 16 MCG/CARTRIDGE | 40170080002920 | Brand |
| TYVASO DPI MAINTENANCE KIT | TREPROSTINIL INH POWDER 32 MCG/CARTRIDGE | 40170080002930 | Brand |
| TYVASO DPI MAINTENANCE KIT | TREPROSTINIL INH POWDER 48 MCG/CARTRIDGE | 40170080002940 | Brand |
| TYVASO DPI MAINTENANCE KIT | TREPROSTINIL INH POWDER 64 MCG/CARTRIDGE | 40170080002950 | Brand |
| TYVASO DPI TITRATION KIT | TREPROSTINIL INH POWDER 112 X 16MCG & 84 X 32MCG | 40170080002970 | Brand |
| TYVASO DPI TITRATION KIT | TREPROSTINIL INH POWD 112 X 16MCG & 112 X 32MCG & 28 X 48MCG | 40170080002980 | Brand |
| UPTRAVI TITRATION PACK | SELEXIPAG TAB THERAPY PACK 200 MCG (140) & 800 MCG (60) | 4012007000B720 | Brand |
| UPTRAVI | SELEXIPAG TAB 200 MCG | 40120070000310 | Brand |
| UPTRAVI | SELEXIPAG TAB 400 MCG | 40120070000315 | Brand |
| UPTRAVI | SELEXIPAG TAB 600 MCG | 40120070000320 | Brand |
| UPTRAVI | SELEXIPAG TAB 800 MCG | 40120070000325 | Brand |
| UPTRAVI | SELEXIPAG TAB 1000 MCG | 40120070000330 | Brand |
| UPTRAVI | SELEXIPAG TAB 1200 MCG | 40120070000335 | Brand |
| UPTRAVI | SELEXIPAG TAB 1400 MCG | 40120070000340 | Brand |
| UPTRAVI | SELEXIPAG TAB 1600 MCG | 40120070000345 | Brand |
| ORENITRAM TITRATION KIT MONTH 1 | TREPROSTINIL TAB ER TITR PK (MO1) 126 X0.125MG & 42 X0.25MG | 4017008005C110 | Brand |
| ORENITRAM TITRATION KIT MONTH 2 | TREPROSTINIL TAB ER TITR PK (MO2) 126 X0.125MG & 210 X0.25MG | 4017008005C120 | Brand |
| ORENITRAM TITRATION KIT MONTH 3 | TREPROSTINIL TAB ER TITR PK(MO3)126X0.125MG&42X0.25MG&84X1MG | 4017008005C130 | Brand |
| TYVASO DPI INSTITUTIONAL KIT | TREPROSTINIL INH POWDER 16 MCG/CARTRIDGE | 40170080002920 | Brand |

| | | | |
|---|---|---|---|
| TYVASO DPI INSTITUTIONAL KIT | TREPROSTINIL INH POWDER 32 MCG/CARTRIDGE | 40170080002930 | Brand |
| TYVASO DPI INSTITUTIONAL KIT | TREPROSTINIL INH POWDER 48 MCG/CARTRIDGE | 40170080002940 | Brand |
| TYVASO DPI INSTITUTIONAL KIT | TREPROSTINIL INH POWDER 64 MCG/CARTRIDGE | 40170080002950 | Brand |

**Approval Criteria**

**1** - ALL 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)

**AND**

**1.3** Prescribed by or in consultation with a cardiologist, pulmonologist, or rheumatologist

**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:

- A PDE-5 inhibitor (phosphodiesterase-5) [e.g. sildenafil citrate (generic Revatio)]
- Adempas

**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:

- A PDE-5 inhibitor [e.g., sildenafil citrate (generic Revatio)]
- Adempas

**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) as long-term concomitant therapy* | |
|---|---|
| Notes | *Concomitant use will be allowable for patients to transition from one of these agents to the other. |

| Product Name: Brand Adcirca, Alyq, generic tadalafil (PAH, generic of Adcirca), Tadliq, Liqrev, Opsynvi | |
|---|---|
| Diagnosis | Pulmonary Arterial Hypertension (PAH) |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ADCIRCA | TADALAFIL TAB 20 MG (PAH) | 40143080000320 | Brand |
| ALYQ | TADALAFIL TAB 20 MG (PAH) | 40143080000320 | Generic |
| TADALAFIL | TADALAFIL TAB 20 MG (PAH) | 40143080000320 | Generic |
| TADLIQ | TADALAFIL ORAL SUSP 20 MG/5ML (PAH) | 40143080001820 | Brand |
| LIQREV | SILDENAFIL CITRATE ORAL SUSP 10 MG/ML | 40143060101825 | Brand |
| OPSYNVI | MACITENTAN-TADALAFIL TAB 10-20 MG | 40995502500310 | Brand |
| OPSYNVI | MACITENTAN-TADALAFIL TAB 10-40 MG | 40995502500320 | Brand |

**Approval Criteria**

**1** - Documentation the patient is receiving clinical benefit to therapy

| Product Name: Orenitram, Tyvaso DPI, Uptravi titration pack, Uptravi tabs | |
|---|---|
| Diagnosis | Pulmonary Arterial Hypertension (PAH) |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| ORENITRAM | TREPROSTINIL DIOLAMINE TAB ER 0.125 MG (BASE EQUIV) | 40170080050410 | Brand |
| ORENITRAM | TREPROSTINIL DIOLAMINE TAB ER 0.25 MG (BASE EQUIV) | 40170080050415 | Brand |
| ORENITRAM | TREPROSTINIL DIOLAMINE TAB ER 1 MG (BASE EQUIV) | 40170080050420 | Brand |
| ORENITRAM | TREPROSTINIL DIOLAMINE TAB ER 2.5 MG (BASE EQUIV) | 40170080050425 | Brand |
| ORENITRAM | TREPROSTINIL DIOLAMINE TAB ER 5 MG (BASE EQUIV) | 40170080050435 | Brand |
| TYVASO DPI MAINTENANCE KIT | TREPROSTINIL INH POWDER 16 MCG/CARTRIDGE | 40170080002920 | Brand |
| TYVASO DPI MAINTENANCE KIT | TREPROSTINIL INH POWDER 32 MCG/CARTRIDGE | 40170080002930 | Brand |
| TYVASO DPI MAINTENANCE KIT | TREPROSTINIL INH POWDER 48 MCG/CARTRIDGE | 40170080002940 | Brand |
| TYVASO DPI MAINTENANCE KIT | TREPROSTINIL INH POWDER 64 MCG/CARTRIDGE | 40170080002950 | Brand |
| TYVASO DPI TITRATION KIT | TREPROSTINIL INH POWDER 112 X 16MCG & 84 X 32MCG | 40170080002970 | Brand |
| TYVASO DPI TITRATION KIT | TREPROSTINIL INH POWD 112 X 16MCG & 112 X 32MCG & 28 X 48MCG | 40170080002980 | Brand |
| UPTRAVI TITRATION PACK | SELEXIPAG TAB THERAPY PACK 200 MCG (140) & 800 MCG (60) | 4012007000B720 | Brand |
| UPTRAVI | SELEXIPAG TAB 200 MCG | 40120070000310 | Brand |
| UPTRAVI | SELEXIPAG TAB 400 MCG | 40120070000315 | Brand |
| UPTRAVI | SELEXIPAG TAB 600 MCG | 40120070000320 | Brand |
| UPTRAVI | SELEXIPAG TAB 800 MCG | 40120070000325 | Brand |
| UPTRAVI | SELEXIPAG TAB 1000 MCG | 40120070000330 | Brand |
| UPTRAVI | SELEXIPAG TAB 1200 MCG | 40120070000335 | Brand |
| UPTRAVI | SELEXIPAG TAB 1400 MCG | 40120070000340 | Brand |
| UPTRAVI | SELEXIPAG TAB 1600 MCG | 40120070000345 | Brand |
| ORENITRAM TITRATION KIT MONTH 1 | TREPROSTINIL TAB ER TITR PK (MO1) 126 X0.125MG & 42 X0.25MG | 4017008005C110 | Brand |
| ORENITRAM TITRATION KIT MONTH 2 | TREPROSTINIL TAB ER TITR PK (MO2) 126 X0.125MG & 210 X0.25MG | 4017008005C120 | Brand |

| | | | |
|---|---|---|---|
| ORENITRAM TITRATION KIT MONTH 3 | TREPROSTINIL TAB ER TITR PK(MO3)126X0.125MG&42X0.25MG&84X1MG | 4017008005C130 | Brand |
| TYVASO DPI INSTITUTIONAL KIT | TREPROSTINIL INH POWDER 16 MCG/CARTRIDGE | 40170080002920 | Brand |
| TYVASO DPI INSTITUTIONAL KIT | TREPROSTINIL INH POWDER 32 MCG/CARTRIDGE | 40170080002930 | Brand |
| TYVASO DPI INSTITUTIONAL KIT | TREPROSTINIL INH POWDER 48 MCG/CARTRIDGE | 40170080002940 | Brand |
| TYVASO DPI INSTITUTIONAL KIT | TREPROSTINIL INH POWDER 64 MCG/CARTRIDGE | 40170080002950 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ADEMPAS | RIOCIGUAT TAB 0.5 MG | 40134050000310 | Brand |
| ADEMPAS | RIOCIGUAT TAB 1 MG | 40134050000320 | Brand |
| ADEMPAS | RIOCIGUAT TAB 1.5 MG | 40134050000330 | Brand |
| ADEMPAS | RIOCIGUAT TAB 2 MG | 40134050000340 | Brand |
| ADEMPAS | RIOCIGUAT TAB 2.5 MG | 40134050000350 | Brand |

**Approval Criteria**

**1** - Diagnosis of inoperable or persistent/recurrent chronic thromboembolic pulmonary hypertension (CTEPH)

| Product Name: Tyvaso DPI | |
|---|---|
| Diagnosis | Pulmonary Hypertension Associated with Interstitial Lung Disease |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TYVASO DPI MAINTENANCE KIT | TREPROSTINIL INH POWDER 16 MCG/CARTRIDGE | 40170080002920 | Brand |
| TYVASO DPI MAINTENANCE KIT | TREPROSTINIL INH POWDER 32 MCG/CARTRIDGE | 40170080002930 | Brand |
| TYVASO DPI MAINTENANCE KIT | TREPROSTINIL INH POWDER 48 MCG/CARTRIDGE | 40170080002940 | Brand |
| TYVASO DPI MAINTENANCE KIT | TREPROSTINIL INH POWDER 64 MCG/CARTRIDGE | 40170080002950 | Brand |
| TYVASO DPI TITRATION KIT | TREPROSTINIL INH POWDER 112 X 16MCG & 84 X 32MCG | 40170080002970 | Brand |
| TYVASO DPI TITRATION KIT | TREPROSTINIL INH POWD 112 X 16MCG & 112 X 32MCG & 28 X 48MCG | 40170080002980 | Brand |
| TYVASO DPI INSTITUTIONAL KIT | TREPROSTINIL INH POWDER 16 MCG/CARTRIDGE | 40170080002920 | Brand |
| TYVASO DPI INSTITUTIONAL KIT | TREPROSTINIL INH POWDER 32 MCG/CARTRIDGE | 40170080002930 | Brand |
| TYVASO DPI INSTITUTIONAL KIT | TREPROSTINIL INH POWDER 48 MCG/CARTRIDGE | 40170080002940 | Brand |
| TYVASO DPI INSTITUTIONAL KIT | TREPROSTINIL INH POWDER 64 MCG/CARTRIDGE | 40170080002950 | Brand |

**Approval Criteria**

**1** - ALL of the following:

**1.1** Diagnosis of pulmonary hypertension associated with interstitial lung disease [WHO (World Health Organization) group 3] confirmed by right heart catheterization

**AND**

**1.2** Interstitial lung disease is diagnosed based on evidence of diffuse parenchymal lung disease on computed tomography of the chest

**AND**

**1.3** Pulmonary hypertension is symptomatic

**AND**

**2** - Prescribed by or in consultation with a cardiologist, pulmonologist, or rheumatologist

| Product Name: Tyvaso DPI | |
|---|---|
| Diagnosis | Pulmonary Hypertension Associated with Interstitial Lung Disease |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TYVASO DPI MAINTENANCE KIT | TREPROSTINIL INH POWDER 16 MCG/CARTRIDGE | 40170080002920 | Brand |
| TYVASO DPI MAINTENANCE KIT | TREPROSTINIL INH POWDER 32 MCG/CARTRIDGE | 40170080002930 | Brand |

| | | | |
|---|---|---|---|
| TYVASO DPI MAINTENANCE KIT | TREPROSTINIL INH POWDER 48 MCG/CARTRIDGE | 40170080002940 | Brand |
| TYVASO DPI MAINTENANCE KIT | TREPROSTINIL INH POWDER 64 MCG/CARTRIDGE | 40170080002950 | Brand |
| TYVASO DPI TITRATION KIT | TREPROSTINIL INH POWDER 112 X 16MCG & 84 X 32MCG | 40170080002970 | Brand |
| TYVASO DPI TITRATION KIT | TREPROSTINIL INH POWD 112 X 16MCG & 112 X 32MCG & 28 X 48MCG | 40170080002980 | Brand |
| TYVASO DPI INSTITUTIONAL KIT | TREPROSTINIL INH POWDER 16 MCG/CARTRIDGE | 40170080002920 | Brand |
| TYVASO DPI INSTITUTIONAL KIT | TREPROSTINIL INH POWDER 32 MCG/CARTRIDGE | 40170080002930 | Brand |
| TYVASO DPI INSTITUTIONAL KIT | TREPROSTINIL INH POWDER 48 MCG/CARTRIDGE | 40170080002940 | Brand |
| TYVASO DPI INSTITUTIONAL KIT | TREPROSTINIL INH POWDER 64 MCG/CARTRIDGE | 40170080002950 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to the requested therapy (e.g., improved exercise ability)

## 2 . Revision History

| Date | Notes |
|---|---|
| 8/6/2024 | Copy core |

Palforzia

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146614 |
| **Guideline Name** | Palforzia |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| PALFORZIA INITIAL DOSE ESCALATION | PEANUT POWDER-DNFP STARTER PACK 0.5 & 1 & 1.5 & 3 & 6 MG | 2010004020H510 | Brand |
| PALFORZIA LEVEL 1 | PEANUT POWDER-DNFP CAP SPRINKLE PACK 3 X 1 MG (3 MG DOSE) | 2010004020H525 | Brand |
| PALFORZIA LEVEL 2 | PEANUT POWDER-DNFP CAP SPRINKLE PACK 6 X 1 MG (6 MG DOSE) | 2010004020H530 | Brand |

| | | | |
|---|---|---|---|
| PALFORZIA LEVEL 3 | PEANUT POWDER-DNFP PACK 2 X 1 MG & 10 MG (12 MG DOSE) | 2010004020H535 | Brand |
| PALFORZIA LEVEL 4 | PEANUT POWDER-DNFP CAP SPRINKLE PACK 20 MG (20 MG DOSE) | 2010004020H540 | Brand |
| PALFORZIA LEVEL 5 | PEANUT POWDER-DNFP CAP SPRINKLE PACK 2 X 20 MG (40 MG DOSE) | 2010004020H545 | Brand |
| PALFORZIA LEVEL 6 | PEANUT POWDER-DNFP CAP SPRINKLE PACK 4 X 20 MG (80 MG DOSE) | 2010004020H550 | Brand |
| PALFORZIA LEVEL 7 | PEANUT POWDER-DNFP PACK 20 MG & 100 MG (120 MG DOSE) | 2010004020H555 | Brand |
| PALFORZIA LEVEL 8 | PEANUT POWDER-DNFP PACK 3 X 20 MG & 100 MG (160 MG DOSE) | 2010004020H560 | Brand |
| PALFORZIA LEVEL 9 | PEANUT POWDER-DNFP PACK 2 X 100 MG (200 MG DOSE) | 2010004020H565 | Brand |
| PALFORZIA LEVEL 10 | PEANUT POWDER-DNFP PACK 2 X 20 MG & 2 X 100 MG (240 MG DOSE) | 2010004020H570 | Brand |
| PALFORZIA LEVEL 11 (TITRATION) | PEANUT ALLERGEN POWDER-DNFP TITRATION PACKET 300 MG | 20100040203030 | Brand |
| PALFORZIA LEVEL 11 (MAINTENANCE) | PEANUT ALLERGEN POWDER-DNFP MAINTENANCE PACKET 300 MG | 20100040203050 | Brand |

**Approval Criteria**

**1** - Diagnosis and clinical history of peanut allergy as documented by BOTH of the following:

**1.1** A serum peanut-specific IgE (immunoglobulin E) level of greater than or equal to 0.35 kUA/L (kilounits of allergen/liter)

**AND**

**1.2** 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 4 to 17 years of age

- Patient is in the initial dose escalation phase of therapy

**OR**

**2.2** BOTH of the following:

- Patient is 4 years 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| PALFORZIA INITIAL DOSE ESCALATION | PEANUT POWDER-DNFP STARTER PACK 0.5 & 1 & 1.5 & 3 & 6 MG | 2010004020H510 | Brand |
| PALFORZIA LEVEL 1 | PEANUT POWDER-DNFP CAP SPRINKLE PACK 3 X 1 MG (3 MG DOSE) | 2010004020H525 | Brand |
| PALFORZIA LEVEL 2 | PEANUT POWDER-DNFP CAP SPRINKLE PACK 6 X 1 MG (6 MG DOSE) | 2010004020H530 | Brand |
| PALFORZIA LEVEL 3 | PEANUT POWDER-DNFP PACK 2 X 1 MG & 10 MG (12 MG DOSE) | 2010004020H535 | Brand |
| PALFORZIA LEVEL 4 | PEANUT POWDER-DNFP CAP SPRINKLE PACK 20 MG (20 MG DOSE) | 2010004020H540 | Brand |
| PALFORZIA LEVEL 5 | PEANUT POWDER-DNFP CAP SPRINKLE PACK 2 X 20 MG (40 MG DOSE) | 2010004020H545 | Brand |
| PALFORZIA LEVEL 6 | PEANUT POWDER-DNFP CAP SPRINKLE PACK 4 X 20 MG (80 MG DOSE) | 2010004020H550 | Brand |
| PALFORZIA LEVEL 7 | PEANUT POWDER-DNFP PACK 20 MG & 100 MG (120 MG DOSE) | 2010004020H555 | Brand |
| PALFORZIA LEVEL 8 | PEANUT POWDER-DNFP PACK 3 X 20 MG & 100 MG (160 MG DOSE) | 2010004020H560 | Brand |
| PALFORZIA LEVEL 9 | PEANUT POWDER-DNFP PACK 2 X 100 MG (200 MG DOSE) | 2010004020H565 | Brand |
| PALFORZIA LEVEL 10 | PEANUT POWDER-DNFP PACK 2 X 20 MG & 2 X 100 MG (240 MG DOSE) | 2010004020H570 | Brand |
| PALFORZIA LEVEL 11 (TITRATION) | PEANUT ALLERGEN POWDER-DNFP TITRATION PACKET 300 MG | 20100040203030 | Brand |
| PALFORZIA LEVEL 11 (MAINTENANCE) | PEANUT ALLERGEN POWDER-DNFP MAINTENANCE PACKET 300 MG | 20100040203050 | Brand |

**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

Palynziq

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-155065 |
| **Guideline Name** | Palynziq |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 10/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| PALYNZIQ | PEGVALIASE-PQPZ SUBCUTANEOUS SOLN PREF SYRINGE 2.5 MG/0.5ML | 3090855040E510 | Brand |
| PALYNZIQ | PEGVALIASE-PQPZ SUBCUTANEOUS SOLN PREF SYRINGE 10 MG/0.5ML | 3090855040E520 | Brand |
| PALYNZIQ | PEGVALIASE-PQPZ SUBCUTANEOUS SOLN PREF SYRINGE 20 MG/ML | 3090855040E530 | Brand |

**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 a one- to four-week trial of 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)

**AND**

**4** - Physician attestation that the patient will not be receiving Palynziq in combination with sapropterin dihydrochloride

**AND**

**5** - Submission of medical records (e.g., chart notes, laboratory values) documenting that the patient has a blood phenylalanine concentration greater than 600 micromoles/liter

| Product Name: Palynziq | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |

| Guideline Type | Prior Authorization |
|---|---|

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| PALYNZIQ | PEGVALIASE-PQPZ SUBCUTANEOUS SOLN PREF SYRINGE 2.5 MG/0.5ML | 3090855040E510 | Brand |
| PALYNZIQ | PEGVALIASE-PQPZ SUBCUTANEOUS SOLN PREF SYRINGE 10 MG/0.5ML | 3090855040E520 | Brand |
| PALYNZIQ | PEGVALIASE-PQPZ SUBCUTANEOUS SOLN PREF SYRINGE 20 MG/ML | 3090855040E530 | Brand |

**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 (Prescription

| |
|---|
| claim history that does not show any concomitant sapropterin dihydrochloride claim within 60 days of reauthorization request may be used as documentation) |

## 2 . Revision History

| Date | Notes |
|---|---|
| 9/17/2024 | Updated authorization durations to 12 months |

Panretin

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146389 |
| **Guideline Name** | Panretin |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Panretin | |
|---|---|
| Diagnosis | Kaposi's Sarcoma |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| PANRETIN | ALITRETINOIN GEL 0.1% | 90376015004020 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| PANRETIN | ALITRETINOIN GEL 0.1% | 90376015004020 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| PANRETIN | ALITRETINOIN GEL 0.1% | 90376015004020 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Panretin therapy

Pemazyre

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-160650 |
| **Guideline Name** | Pemazyre |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 1 . Criteria

| Product Name: Pemazyre | |
|---|---|
| Diagnosis | Cholangiocarcinoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| PEMAZYRE | PEMIGATINIB TAB 4.5 MG | 21532260000320 | Brand |
| PEMAZYRE | PEMIGATINIB TAB 9 MG | 21532260000330 | Brand |
| PEMAZYRE | PEMIGATINIB TAB 13.5 MG | 21532260000340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| PEMAZYRE | PEMIGATINIB TAB 4.5 MG | 21532260000320 | Brand |
| PEMAZYRE | PEMIGATINIB TAB 9 MG | 21532260000330 | Brand |
| PEMAZYRE | PEMIGATINIB TAB 13.5 MG | 21532260000340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| PEMAZYRE | PEMIGATINIB TAB 4.5 MG | 21532260000320 | Brand |
| PEMAZYRE | PEMIGATINIB TAB 9 MG | 21532260000330 | Brand |
| PEMAZYRE | PEMIGATINIB TAB 13.5 MG | 21532260000340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| PEMAZYRE | PEMIGATINIB TAB 4.5 MG | 21532260000320 | Brand |
| PEMAZYRE | PEMIGATINIB TAB 9 MG | 21532260000330 | Brand |
| PEMAZYRE | PEMIGATINIB TAB 13.5 MG | 21532260000340 | Brand |

**Approval Criteria**

**1** - Pemazyre will be approved for uses 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| PEMAZYRE | PEMIGATINIB TAB 4.5 MG | 21532260000320 | Brand |
| PEMAZYRE | PEMIGATINIB TAB 9 MG | 21532260000330 | Brand |
| PEMAZYRE | PEMIGATINIB TAB 13.5 MG | 21532260000340 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Pemazyre therapy

## 2 . Revision History

| Date | Notes |
|---|---|
| 11/14/2024 | Updated criteria for cholangiocarcinoma |

Piqray

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-147150 |
| **Guideline Name** | Piqray |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Piqray | |
|---|---|
| Diagnosis | Breast Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| PIQRAY 200MG DAILY DOSE | ALPELISIB TAB THERAPY PACK 200 MG DAILY DOSE | 2153801000B720 | Brand |
| PIQRAY 250MG | ALPELISIB TAB PACK 250 MG DAILY DOSE (200 MG & 50 MG TABS) | 2153801000B725 | Brand |

| | | | |
|---|---|---|---|
| DAILY DOSE | | | |
| PIQRAY 300MG DAILY DOSE | ALPELISIB TAB PACK 300 MG DAILY DOSE (2X150 MG TAB) | 2153801000B730 | Brand |

**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: Piqray | |
|---|---|
| Diagnosis | Breast Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| PIQRAY 200MG DAILY DOSE | ALPELISIB TAB THERAPY PACK 200 MG DAILY DOSE | 2153801000B720 | Brand |
| PIQRAY 250MG DAILY DOSE | ALPELISIB TAB PACK 250 MG DAILY DOSE (200 MG & 50 MG TABS) | 2153801000B725 | Brand |
| PIQRAY 300MG DAILY DOSE | ALPELISIB TAB PACK 300 MG DAILY DOSE (2X150 MG TAB) | 2153801000B730 | Brand |

**Approval Criteria**

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

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| PIQRAY 200MG DAILY DOSE | ALPELISIB TAB THERAPY PACK 200 MG DAILY DOSE | 2153801000B720 | Brand |
| PIQRAY 250MG DAILY DOSE | ALPELISIB TAB PACK 250 MG DAILY DOSE (200 MG & 50 MG TABS) | 2153801000B725 | Brand |
| PIQRAY 300MG DAILY DOSE | ALPELISIB TAB PACK 300 MG DAILY DOSE (2X150 MG TAB) | 2153801000B730 | Brand |

**Approval Criteria**

**1** - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

| Product Name: Piqray | |
|---|---|
| Diagnosis | NCCN Recommended Regimens |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| PIQRAY 200MG DAILY DOSE | ALPELISIB TAB THERAPY PACK 200 MG DAILY DOSE | 2153801000B720 | Brand |
| PIQRAY 250MG DAILY DOSE | ALPELISIB TAB PACK 250 MG DAILY DOSE (200 MG & 50 MG TABS) | 2153801000B725 | Brand |
| PIQRAY 300MG DAILY DOSE | ALPELISIB TAB PACK 300 MG DAILY DOSE (2X150 MG TAB) | 2153801000B730 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Piqray therapy

## 2 . Revision History

| Date | Notes |
|---|---|
| 5/7/2024 | Removed requirement for postmenopausal, premenopausal with ovarian ablation/suppression, or male under BC initial auth section; Minor verbiage update to NCCN Recommended Regimens initial auth section (with no changes to clinical intent). |

Pomalyst

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-150857 |
| **Guideline Name** | Pomalyst |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 8/2/2024 |

## 1 . Criteria

| Product Name: Pomalyst | |
|---|---|
| Diagnosis | Multiple Myeloma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| POMALYST | POMALIDOMIDE CAP 1 MG | 21450080000110 | Brand |
| POMALYST | POMALIDOMIDE CAP 2 MG | 21450080000115 | Brand |
| POMALYST | POMALIDOMIDE CAP 3 MG | 21450080000120 | Brand |
| POMALYST | POMALIDOMIDE CAP 4 MG | 21450080000125 | Brand |

**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)]

**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)]

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| POMALYST | POMALIDOMIDE CAP 1 MG | 21450080000110 | Brand |
| POMALYST | POMALIDOMIDE CAP 2 MG | 21450080000115 | Brand |
| POMALYST | POMALIDOMIDE CAP 3 MG | 21450080000120 | Brand |
| POMALYST | POMALIDOMIDE CAP 4 MG | 21450080000125 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| POMALYST | POMALIDOMIDE CAP 1 MG | 21450080000110 | Brand |
| POMALYST | POMALIDOMIDE CAP 2 MG | 21450080000115 | Brand |
| POMALYST | POMALIDOMIDE CAP 3 MG | 21450080000120 | Brand |
| POMALYST | POMALIDOMIDE CAP 4 MG | 21450080000125 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| POMALYST | POMALIDOMIDE CAP 1 MG | 21450080000110 | Brand |
| POMALYST | POMALIDOMIDE CAP 2 MG | 21450080000115 | Brand |
| POMALYST | POMALIDOMIDE CAP 3 MG | 21450080000120 | Brand |
| POMALYST | POMALIDOMIDE CAP 4 MG | 21450080000125 | Brand |

**Approval Criteria**

**1** - Diagnosis of primary central nervous system (CNS) lymphoma

**AND**

**2** - Used as second-line or subsequent therapy

| 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 |
|---|---|

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| POMALYST | POMALIDOMIDE CAP 1 MG | 21450080000110 | Brand |
| POMALYST | POMALIDOMIDE CAP 2 MG | 21450080000115 | Brand |
| POMALYST | POMALIDOMIDE CAP 3 MG | 21450080000120 | Brand |
| POMALYST | POMALIDOMIDE CAP 4 MG | 21450080000125 | Brand |

**Approval Criteria**

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

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| POMALYST | POMALIDOMIDE CAP 1 MG | 21450080000110 | Brand |
| POMALYST | POMALIDOMIDE CAP 2 MG | 21450080000115 | Brand |
| POMALYST | POMALIDOMIDE CAP 3 MG | 21450080000120 | Brand |
| POMALYST | POMALIDOMIDE CAP 4 MG | 21450080000125 | Brand |

**Approval Criteria**

**1** - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

| Product Name: Pomalyst | |
|---|---|
| Diagnosis | NCCN Recommended Regimen |
| Approval Length | 12 month(s) |

| Therapy Stage | Reauthorization |
|---|---|
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| POMALYST | POMALIDOMIDE CAP 1 MG | 21450080000110 | Brand |
| POMALYST | POMALIDOMIDE CAP 2 MG | 21450080000115 | Brand |
| POMALYST | POMALIDOMIDE CAP 3 MG | 21450080000120 | Brand |
| POMALYST | POMALIDOMIDE CAP 4 MG | 21450080000125 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Pomalyst therapy

## 2 . Revision History

| Date | Notes |
|---|---|
| 8/2/2024 | Annual review. Updated criteria for multiple myeloma and Kaposi sar coma. Updated background and references. |

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-161219 |
| **Guideline Name** | PPI (Proton Pump Inhibitors) |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 1 . Criteria

| Product Name: generic lansoprazole ODT, generic esomeprazole magnesium susp packets | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LANSOPRAZOLE | LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 15 MG | 4927004000H315 | Generic |
| LANSOPRAZOLE ODT | LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 15 MG | 4927004000H315 | Generic |
| LANSOPRAZOLE | LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 30 MG | 4927004000H330 | Generic |
| LANSOPRAZOLE ODT | LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 30 MG | 4927004000H330 | Generic |

| | | | |
|---|---|---|---|
| ESOMEPRAZOLE MAGNESIUM | ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 10 MG | 49270025103010 | Generic |
| ESOMEPRAZOLE MAGNESIUM | ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 20 MG | 49270025103020 | Generic |
| ESOMEPRAZOLE MAGNESIUM | ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 40 MG | 49270025103040 | Generic |

**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 tabs, Brand Dexilant, generic dexlansoprazole, Brand Nexium caps, Brand Nexium 24HR | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| PRILOSEC OTC | OMEPRAZOLE MAGNESIUM DELAYED RELEASE TAB 20 MG (BASE EQUIV) | 49270060100620 | Brand |
| CVS OMEPRAZOLE | OMEPRAZOLE DELAYED RELEASE TAB 20 MG | 49270060000620 | Generic |
| EQ OMEPRAZOLE | OMEPRAZOLE DELAYED RELEASE TAB 20 MG | 49270060000620 | Generic |
| EQL OMEPRAZOLE | OMEPRAZOLE DELAYED RELEASE TAB 20 MG | 49270060000620 | Generic |
| GNP OMEPRAZOLE | OMEPRAZOLE DELAYED RELEASE TAB 20 MG | 49270060000620 | Generic |
| HM OMEPRAZOLE | OMEPRAZOLE DELAYED RELEASE TAB 20 MG | 49270060000620 | Generic |
| KLS OMEPRAZOLE | OMEPRAZOLE DELAYED RELEASE TAB 20 MG | 49270060000620 | Generic |
| OMEPRAZOLE | OMEPRAZOLE DELAYED RELEASE TAB 20 MG | 49270060000620 | Generic |
| PX OMEPRAZOLE | OMEPRAZOLE DELAYED RELEASE TAB 20 MG | 49270060000620 | Generic |
| RA OMEPRAZOLE | OMEPRAZOLE DELAYED RELEASE TAB 20 MG | 49270060000620 | Generic |
| SB OMEPRAZOLE | OMEPRAZOLE DELAYED RELEASE TAB 20 MG | 49270060000620 | Generic |
| SM OMEPRAZOLE | OMEPRAZOLE DELAYED RELEASE TAB 20 MG | 49270060000620 | Generic |
| PROTONIX | PANTOPRAZOLE SODIUM EC TAB 20 MG (BASE EQUIV) | 49270070100610 | Brand |
| PROTONIX | PANTOPRAZOLE SODIUM EC TAB 40 MG (BASE EQUIV) | 49270070100620 | Brand |
| PREVACID | LANSOPRAZOLE CAP DELAYED RELEASE 15 MG | 49270040006510 | Brand |
| PREVACID 24HR | LANSOPRAZOLE CAP DELAYED RELEASE 15 MG | 49270040006510 | Brand |
| PREVACID | LANSOPRAZOLE CAP DELAYED RELEASE 30 MG | 49270040006520 | Brand |
| NEXIUM | ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 40 MG (BASE EQ) | 49270025106540 | Brand |
| ACIPHEX | RABEPRAZOLE SODIUM EC TAB 20 MG | 49270076100620 | Brand |
| RABEPRAZOLE SODIUM | RABEPRAZOLE SODIUM EC TAB 20 MG | 49270076100620 | Generic |
| DEXILANT | DEXLANSOPRAZOLE CAP DELAYED RELEASE 30 MG | 49270020006520 | Brand |
| DEXILANT | DEXLANSOPRAZOLE CAP DELAYED RELEASE 60 MG | 49270020006530 | Brand |
| OMEPRAZOLE | OMEPRAZOLE MAGNESIUM DELAYED RELEASE TAB 20 MG (BASE EQUIV) | 49270060100620 | Generic |

| | | | |
|---|---|---|---|
| ACID REDUCER | OMEPRAZOLE MAGNESIUM DELAYED RELEASE TAB 20 MG (BASE EQUIV) | 49270060100620 | Generic |
| OMEPRAZOLE DR | OMEPRAZOLE MAGNESIUM DELAYED RELEASE TAB 20 MG (BASE EQUIV) | 49270060100620 | Generic |
| DEXLANSOPRAZOLE | DEXLANSOPRAZOLE CAP DELAYED RELEASE 30 MG | 49270020006520 | Generic |
| DEXLANSOPRAZOLE | DEXLANSOPRAZOLE CAP DELAYED RELEASE 60 MG | 49270020006530 | Generic |
| QC OMEPRAZOLE | OMEPRAZOLE DELAYED RELEASE TAB 20 MG | 49270060000620 | Generic |
| NEXIUM | ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ) | 49270025106520 | Brand |
| NEXIUM 24HR | ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ) | 49270025106520 | Brand |
| NEXIUM 24HR CLEAR MINIS | ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ) | 49270025106520 | Brand |
| NEXIUM 24HR | ESOMEPRAZOLE MAGNESIUM TAB DELAYED RELEASE 20 MG | 49270025100620 | Brand |

**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 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 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, Brand Prevacid Solutab, Brand Nexium susp packets, generic pantoprazole susp packets, Rabeprazole Sprinkle | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| PRILOSEC | OMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 2.5 MG | 49270060103020 | Brand |
| PRILOSEC | OMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 10 MG | 49270060103030 | Brand |
| PROTONIX | PANTOPRAZOLE SODIUM FOR DELAYED RELEASE SUSP PACKET 40 MG | 49270070103020 | Brand |
| PREVACID SOLUTAB | LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 15 MG | 4927004000H315 | Brand |
| PREVACID SOLUTAB | LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 30 MG | 4927004000H330 | Brand |
| NEXIUM | ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACK 2.5 MG | 49270025103004 | Brand |
| NEXIUM | ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 5 MG | 49270025103007 | Brand |
| NEXIUM | ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 10 MG | 49270025103010 | Brand |
| NEXIUM | ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 20 MG | 49270025103020 | Brand |
| NEXIUM | ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 40 MG | 49270025103040 | Brand |
| PANTOPRAZOLE SODIUM | PANTOPRAZOLE SODIUM FOR DELAYED RELEASE SUSP PACKET 40 MG | 49270070103020 | Generic |
| RABEPRAZOLE SODIUM DR SPRINKLE | RABEPRAZOLE SODIUM CAPSULE SPRINKLE DR 10 MG | 49270076106810 | Brand |

**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, 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 esomeprazole magnesium caps, Nexium, Brand Aciphex, generic rabeprazole, Brand Dexilant, generic esomeprazole magnesium susp packets, generic dexlansoprazole, Brand Nexium, Brand Nexium 24HR, Rabeprazole Sprinkle, generic esomeprazole magnesium tabs (OTC)

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|---|---|
| Therapy Stage | Initial Authorization |
| Guideline Type | Quantity Limit |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OMEPRAZOLE | OMEPRAZOLE CAP DELAYED RELEASE 10 MG | 49270060006510 | Generic |
| OMEPRAZOLE DR | OMEPRAZOLE CAP DELAYED RELEASE 10 MG | 49270060006510 | Generic |
| OMEPRAZOLE | OMEPRAZOLE CAP DELAYED RELEASE 20 MG | 49270060006520 | Generic |
| OMEPRAZOLE | OMEPRAZOLE CAP DELAYED RELEASE 40 MG | 49270060006530 | Generic |
| OMEPRAZOLE DR | OMEPRAZOLE CAP DELAYED RELEASE 40 MG | 49270060006530 | Generic |
| PRILOSEC | OMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 2.5 MG | 49270060103020 | Brand |
| PRILOSEC | OMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 10 MG | 49270060103030 | Brand |
| PRILOSEC OTC | OMEPRAZOLE MAGNESIUM DELAYED RELEASE TAB 20 MG (BASE EQUIV) | 49270060100620 | Brand |

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|---|---|---|---|
| CVS OMEPRAZOLE | OMEPRAZOLE DELAYED RELEASE TAB 20 MG | 49270060000620 | Generic |
| EQ OMEPRAZOLE | OMEPRAZOLE DELAYED RELEASE TAB 20 MG | 49270060000620 | Generic |
| EQL OMEPRAZOLE | OMEPRAZOLE DELAYED RELEASE TAB 20 MG | 49270060000620 | Generic |
| GNP OMEPRAZOLE | OMEPRAZOLE DELAYED RELEASE TAB 20 MG | 49270060000620 | Generic |
| HM OMEPRAZOLE | OMEPRAZOLE DELAYED RELEASE TAB 20 MG | 49270060000620 | Generic |
| KLS OMEPRAZOLE | OMEPRAZOLE DELAYED RELEASE TAB 20 MG | 49270060000620 | Generic |
| OMEPRAZOLE | OMEPRAZOLE DELAYED RELEASE TAB 20 MG | 49270060000620 | Generic |
| PX OMEPRAZOLE | OMEPRAZOLE DELAYED RELEASE TAB 20 MG | 49270060000620 | Generic |
| RA OMEPRAZOLE | OMEPRAZOLE DELAYED RELEASE TAB 20 MG | 49270060000620 | Generic |
| SB OMEPRAZOLE | OMEPRAZOLE DELAYED RELEASE TAB 20 MG | 49270060000620 | Generic |
| SM OMEPRAZOLE | OMEPRAZOLE DELAYED RELEASE TAB 20 MG | 49270060000620 | Generic |
| PANTOPRAZOLE SODIUM | PANTOPRAZOLE SODIUM EC TAB 20 MG (BASE EQUIV) | 49270070100610 | Generic |
| PANTOPRAZOLE SODIUM DR | PANTOPRAZOLE SODIUM EC TAB 20 MG (BASE EQUIV) | 49270070100610 | Generic |
| PROTONIX | PANTOPRAZOLE SODIUM EC TAB 20 MG (BASE EQUIV) | 49270070100610 | Brand |
| PANTOPRAZOLE SODIUM | PANTOPRAZOLE SODIUM EC TAB 40 MG (BASE EQUIV) | 49270070100620 | Generic |
| PROTONIX | PANTOPRAZOLE SODIUM EC TAB 40 MG (BASE EQUIV) | 49270070100620 | Brand |
| PROTONIX | PANTOPRAZOLE SODIUM FOR DELAYED RELEASE SUSP PACKET 40 MG | 49270070103020 | Brand |
| CVS LANSOPRAZOLE | LANSOPRAZOLE CAP DELAYED RELEASE 15 MG | 49270040006510 | Generic |
| EQ LANSOPRAZOLE | LANSOPRAZOLE CAP DELAYED RELEASE 15 MG | 49270040006510 | Generic |
| GNP LANSOPRAZOLE | LANSOPRAZOLE CAP DELAYED RELEASE 15 MG | 49270040006510 | Generic |
| GOODSENSE LANSOPRAZOLE | LANSOPRAZOLE CAP DELAYED RELEASE 15 MG | 49270040006510 | Generic |
| HM LANSOPRAZOLE | LANSOPRAZOLE CAP DELAYED RELEASE 15 MG | 49270040006510 | Generic |
| LANSOPRAZOLE | LANSOPRAZOLE CAP DELAYED RELEASE 15 MG | 49270040006510 | Generic |

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|---|---|---|---|
| PREVACID | LANSOPRAZOLE CAP DELAYED RELEASE 15 MG | 49270040006510 | Brand |
| PREVACID 24HR | LANSOPRAZOLE CAP DELAYED RELEASE 15 MG | 49270040006510 | Brand |
| SM LANSOPRAZOLE | LANSOPRAZOLE CAP DELAYED RELEASE 15 MG | 49270040006510 | Generic |
| LANSOPRAZOLE | LANSOPRAZOLE CAP DELAYED RELEASE 30 MG | 49270040006520 | Generic |
| PREVACID | LANSOPRAZOLE CAP DELAYED RELEASE 30 MG | 49270040006520 | Brand |
| LANSOPRAZOLE | LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 15 MG | 4927004000H315 | Generic |
| LANSOPRAZOLE ODT | LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 15 MG | 4927004000H315 | Generic |
| PREVACID SOLUTAB | LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 15 MG | 4927004000H315 | Brand |
| LANSOPRAZOLE | LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 30 MG | 4927004000H330 | Generic |
| LANSOPRAZOLE ODT | LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 30 MG | 4927004000H330 | Generic |
| PREVACID SOLUTAB | LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 30 MG | 4927004000H330 | Brand |
| ESOMEPRAZOLE MAGNESIUM | ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 40 MG (BASE EQ) | 49270025106540 | Generic |
| NEXIUM | ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 40 MG (BASE EQ) | 49270025106540 | Brand |
| NEXIUM | ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACK 2.5 MG | 49270025103004 | Brand |
| NEXIUM | ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 5 MG | 49270025103007 | Brand |
| NEXIUM | ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 10 MG | 49270025103010 | Brand |
| NEXIUM | ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 20 MG | 49270025103020 | Brand |
| NEXIUM | ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 40 MG | 49270025103040 | Brand |
| ACIPHEX | RABEPRAZOLE SODIUM EC TAB 20 MG | 49270076100620 | Brand |
| RABEPRAZOLE SODIUM | RABEPRAZOLE SODIUM EC TAB 20 MG | 49270076100620 | Generic |
| DEXILANT | DEXLANSOPRAZOLE CAP DELAYED RELEASE 30 MG | 49270020006520 | Brand |
| DEXILANT | DEXLANSOPRAZOLE CAP DELAYED RELEASE 60 MG | 49270020006530 | Brand |
| ESOMEPRAZOLE MAGNESIUM | ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 10 MG | 49270025103010 | Generic |

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|---|---|---|---|
| ESOMEPRAZOLE MAGNESIUM | ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 20 MG | 49270025103020 | Generic |
| ESOMEPRAZOLE MAGNESIUM | ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 40 MG | 49270025103040 | Generic |
| OMEPRAZOLE | OMEPRAZOLE MAGNESIUM DELAYED RELEASE TAB 20 MG (BASE EQUIV) | 49270060100620 | Generic |
| PANTOPRAZOLE SODIUM | PANTOPRAZOLE SODIUM FOR DELAYED RELEASE SUSP PACKET 40 MG | 49270070103020 | Generic |
| QC LANSOPRAZOLE | LANSOPRAZOLE CAP DELAYED RELEASE 15 MG | 49270040006510 | Generic |
| CVS LANSOPRAZOLE | LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 15 MG | 4927004000H315 | Generic |
| ACID REDUCER | OMEPRAZOLE MAGNESIUM DELAYED RELEASE TAB 20 MG (BASE EQUIV) | 49270060100620 | Generic |
| OMEPRAZOLE DR | OMEPRAZOLE MAGNESIUM DELAYED RELEASE TAB 20 MG (BASE EQUIV) | 49270060100620 | Generic |
| PANTOPRAZOLE SODIUM DR | PANTOPRAZOLE SODIUM EC TAB 40 MG (BASE EQUIV) | 49270070100620 | Generic |
| DEXLANSOPRAZOLE | DEXLANSOPRAZOLE CAP DELAYED RELEASE 30 MG | 49270020006520 | Generic |
| DEXLANSOPRAZOLE | DEXLANSOPRAZOLE CAP DELAYED RELEASE 60 MG | 49270020006530 | Generic |
| QC OMEPRAZOLE | OMEPRAZOLE DELAYED RELEASE TAB 20 MG | 49270060000620 | Generic |
| ACID REDUCER | OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV) | 49270060106520 | Generic |
| CVS OMEPRAZOLE | OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV) | 49270060106520 | Generic |
| EQ OMEPRAZOLE MAGNESIUM | OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV) | 49270060106520 | Generic |
| GNP OMEPRAZOLE | OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV) | 49270060106520 | Generic |
| KP OMEPRAZOLE MAGNESIUM | OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV) | 49270060106520 | Generic |
| OMEPRAZOLE | OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV) | 49270060106520 | Generic |
| OMEPRAZOLE MAGNESIUM | OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV) | 49270060106520 | Generic |
| QC OMEPRAZOLE MAGNESIUM | OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV) | 49270060106520 | Generic |
| CVS ESOMEPRAZOLE MAGNESIUM | ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ) | 49270025106520 | Generic |
| EQ ESOMEPRAZOLE MAGNESIUM | ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ) | 49270025106520 | Generic |

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|---|---|---|---|
| ESOMEPRAZOLE MAGNESIUM | ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ) | 49270025106520 | Generic |
| ESOMEPRAZOLE MAGNESIUM DR | ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ) | 49270025106520 | Generic |
| GNP ESOMEPRAZOLE MAGNESIUM | ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ) | 49270025106520 | Generic |
| GOODSENSE ESOMEPRAZOLE MAGNESIUM | ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ) | 49270025106520 | Generic |
| HM ESOMEPRAZOLE MAGNESIUM DELAYED RELEASE | ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ) | 49270025106520 | Generic |
| KLS ESOMEPRAZOLE MAGNESIUM | ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ) | 49270025106520 | Generic |
| NEXIUM | ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ) | 49270025106520 | Brand |
| NEXIUM 24HR | ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ) | 49270025106520 | Brand |
| NEXIUM 24HR CLEAR MINIS | ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ) | 49270025106520 | Brand |
| QC ESOMEPRAZOLE MAGNESIUM | ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ) | 49270025106520 | Generic |
| RA ESOMEPRAZOLE MAGNESIUM | ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ) | 49270025106520 | Generic |
| SM ESOMEPRAZOLE MAGNESIUM | ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ) | 49270025106520 | Generic |
| RABEPRAZOLE SODIUM DR SPRINKLE | RABEPRAZOLE SODIUM CAPSULE SPRINKLE DR 10 MG | 49270076106810 | Brand |
| ESOMEPRAZOLE MAGNESIUM DR24HR | ESOMEPRAZOLE MAGNESIUM TAB DELAYED RELEASE 20 MG | 49270025100620 | Generic |
| NEXIUM 24HR | ESOMEPRAZOLE MAGNESIUM TAB DELAYED RELEASE 20 MG | 49270025100620 | Brand |

**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**

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|---|---|
| Notes | Authorization will be issued based on circumstance.<br>*Authorization will be issued for 8 weeks.<br>**Authorization of therapy will be issued for 12 months. |

Product Name: omeprazole caps, Prilosec, 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 esomeprazole magnesium caps, Nexium, Brand Aciphex, generic rabeprazole, Brand Dexilant, generic esomeprazole magnesium susp packets, generic dexlansoprazole, Brand Nexium, Brand Nexium 24HR, Rabeprazole Sprinkle, generic esomeprazole magnesium tabs (OTC)

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|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Quantity Limit |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OMEPRAZOLE | OMEPRAZOLE CAP DELAYED RELEASE 10 MG | 49270060006510 | Generic |
| OMEPRAZOLE DR | OMEPRAZOLE CAP DELAYED RELEASE 10 MG | 49270060006510 | Generic |
| OMEPRAZOLE | OMEPRAZOLE CAP DELAYED RELEASE 20 MG | 49270060006520 | Generic |
| OMEPRAZOLE | OMEPRAZOLE CAP DELAYED RELEASE 40 MG | 49270060006530 | Generic |
| OMEPRAZOLE DR | OMEPRAZOLE CAP DELAYED RELEASE 40 MG | 49270060006530 | Generic |
| PRILOSEC | OMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 2.5 MG | 49270060103020 | Brand |
| PRILOSEC | OMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 10 MG | 49270060103030 | Brand |

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|---|---|---|---|
| PRILOSEC OTC | OMEPRAZOLE MAGNESIUM DELAYED RELEASE TAB 20 MG (BASE EQUIV) | 49270060100620 | Brand |
| CVS OMEPRAZOLE | OMEPRAZOLE DELAYED RELEASE TAB 20 MG | 49270060000620 | Generic |
| EQ OMEPRAZOLE | OMEPRAZOLE DELAYED RELEASE TAB 20 MG | 49270060000620 | Generic |
| EQL OMEPRAZOLE | OMEPRAZOLE DELAYED RELEASE TAB 20 MG | 49270060000620 | Generic |
| GNP OMEPRAZOLE | OMEPRAZOLE DELAYED RELEASE TAB 20 MG | 49270060000620 | Generic |
| HM OMEPRAZOLE | OMEPRAZOLE DELAYED RELEASE TAB 20 MG | 49270060000620 | Generic |
| KLS OMEPRAZOLE | OMEPRAZOLE DELAYED RELEASE TAB 20 MG | 49270060000620 | Generic |
| OMEPRAZOLE | OMEPRAZOLE DELAYED RELEASE TAB 20 MG | 49270060000620 | Generic |
| PX OMEPRAZOLE | OMEPRAZOLE DELAYED RELEASE TAB 20 MG | 49270060000620 | Generic |
| RA OMEPRAZOLE | OMEPRAZOLE DELAYED RELEASE TAB 20 MG | 49270060000620 | Generic |
| SB OMEPRAZOLE | OMEPRAZOLE DELAYED RELEASE TAB 20 MG | 49270060000620 | Generic |
| SM OMEPRAZOLE | OMEPRAZOLE DELAYED RELEASE TAB 20 MG | 49270060000620 | Generic |
| PANTOPRAZOLE SODIUM | PANTOPRAZOLE SODIUM EC TAB 20 MG (BASE EQUIV) | 49270070100610 | Generic |
| PANTOPRAZOLE SODIUM DR | PANTOPRAZOLE SODIUM EC TAB 20 MG (BASE EQUIV) | 49270070100610 | Generic |
| PROTONIX | PANTOPRAZOLE SODIUM EC TAB 20 MG (BASE EQUIV) | 49270070100610 | Brand |
| PANTOPRAZOLE SODIUM | PANTOPRAZOLE SODIUM EC TAB 40 MG (BASE EQUIV) | 49270070100620 | Generic |
| PROTONIX | PANTOPRAZOLE SODIUM EC TAB 40 MG (BASE EQUIV) | 49270070100620 | Brand |
| PROTONIX | PANTOPRAZOLE SODIUM FOR DELAYED RELEASE SUSP PACKET 40 MG | 49270070103020 | Brand |
| CVS LANSOPRAZOLE | LANSOPRAZOLE CAP DELAYED RELEASE 15 MG | 49270040006510 | Generic |
| EQ LANSOPRAZOLE | LANSOPRAZOLE CAP DELAYED RELEASE 15 MG | 49270040006510 | Generic |
| GNP LANSOPRAZOLE | LANSOPRAZOLE CAP DELAYED RELEASE 15 MG | 49270040006510 | Generic |
| GOODSENSE LANSOPRAZOLE | LANSOPRAZOLE CAP DELAYED RELEASE 15 MG | 49270040006510 | Generic |
| HM LANSOPRAZOLE | LANSOPRAZOLE CAP DELAYED RELEASE 15 MG | 49270040006510 | Generic |

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|---|---|---|---|
| LANSOPRAZOLE | LANSOPRAZOLE CAP DELAYED RELEASE 15 MG | 49270040006510 | Generic |
| PREVACID | LANSOPRAZOLE CAP DELAYED RELEASE 15 MG | 49270040006510 | Brand |
| PREVACID 24HR | LANSOPRAZOLE CAP DELAYED RELEASE 15 MG | 49270040006510 | Brand |
| SM LANSOPRAZOLE | LANSOPRAZOLE CAP DELAYED RELEASE 15 MG | 49270040006510 | Generic |
| LANSOPRAZOLE | LANSOPRAZOLE CAP DELAYED RELEASE 30 MG | 49270040006520 | Generic |
| PREVACID | LANSOPRAZOLE CAP DELAYED RELEASE 30 MG | 49270040006520 | Brand |
| LANSOPRAZOLE | LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 15 MG | 4927004000H315 | Generic |
| LANSOPRAZOLE ODT | LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 15 MG | 4927004000H315 | Generic |
| PREVACID SOLUTAB | LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 15 MG | 4927004000H315 | Brand |
| LANSOPRAZOLE | LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 30 MG | 4927004000H330 | Generic |
| LANSOPRAZOLE ODT | LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 30 MG | 4927004000H330 | Generic |
| PREVACID SOLUTAB | LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 30 MG | 4927004000H330 | Brand |
| ESOMEPRAZOLE MAGNESIUM | ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 40 MG (BASE EQ) | 49270025106540 | Generic |
| NEXIUM | ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 40 MG (BASE EQ) | 49270025106540 | Brand |
| NEXIUM | ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACK 2.5 MG | 49270025103004 | Brand |
| NEXIUM | ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 5 MG | 49270025103007 | Brand |
| NEXIUM | ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 10 MG | 49270025103010 | Brand |
| NEXIUM | ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 20 MG | 49270025103020 | Brand |
| NEXIUM | ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 40 MG | 49270025103040 | Brand |
| ACIPHEX | RABEPRAZOLE SODIUM EC TAB 20 MG | 49270076100620 | Brand |
| RABEPRAZOLE SODIUM | RABEPRAZOLE SODIUM EC TAB 20 MG | 49270076100620 | Generic |
| DEXILANT | DEXLANSOPRAZOLE CAP DELAYED RELEASE 30 MG | 49270020006520 | Brand |
| DEXILANT | DEXLANSOPRAZOLE CAP DELAYED RELEASE 60 MG | 49270020006530 | Brand |

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|---|---|---|---|
| ESOMEPRAZOLE MAGNESIUM | ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 10 MG | 49270025103010 | Generic |
| ESOMEPRAZOLE MAGNESIUM | ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 20 MG | 49270025103020 | Generic |
| ESOMEPRAZOLE MAGNESIUM | ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 40 MG | 49270025103040 | Generic |
| OMEPRAZOLE | OMEPRAZOLE MAGNESIUM DELAYED RELEASE TAB 20 MG (BASE EQUIV) | 49270060100620 | Generic |
| PANTOPRAZOLE SODIUM | PANTOPRAZOLE SODIUM FOR DELAYED RELEASE SUSP PACKET 40 MG | 49270070103020 | Generic |
| QC LANSOPRAZOLE | LANSOPRAZOLE CAP DELAYED RELEASE 15 MG | 49270040006510 | Generic |
| CVS LANSOPRAZOLE | LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 15 MG | 4927004000H315 | Generic |
| ACID REDUCER | OMEPRAZOLE MAGNESIUM DELAYED RELEASE TAB 20 MG (BASE EQUIV) | 49270060100620 | Generic |
| OMEPRAZOLE DR | OMEPRAZOLE MAGNESIUM DELAYED RELEASE TAB 20 MG (BASE EQUIV) | 49270060100620 | Generic |
| PANTOPRAZOLE SODIUM DR | PANTOPRAZOLE SODIUM EC TAB 40 MG (BASE EQUIV) | 49270070100620 | Generic |
| DEXLANSOPRAZOLE | DEXLANSOPRAZOLE CAP DELAYED RELEASE 30 MG | 49270020006520 | Generic |
| DEXLANSOPRAZOLE | DEXLANSOPRAZOLE CAP DELAYED RELEASE 60 MG | 49270020006530 | Generic |
| QC OMEPRAZOLE | OMEPRAZOLE DELAYED RELEASE TAB 20 MG | 49270060000620 | Generic |
| ACID REDUCER | OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV) | 49270060106520 | Generic |
| CVS OMEPRAZOLE | OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV) | 49270060106520 | Generic |
| EQ OMEPRAZOLE MAGNESIUM | OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV) | 49270060106520 | Generic |
| GNP OMEPRAZOLE | OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV) | 49270060106520 | Generic |
| KP OMEPRAZOLE MAGNESIUM | OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV) | 49270060106520 | Generic |
| OMEPRAZOLE | OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV) | 49270060106520 | Generic |
| OMEPRAZOLE MAGNESIUM | OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV) | 49270060106520 | Generic |
| QC OMEPRAZOLE MAGNESIUM | OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV) | 49270060106520 | Generic |
| CVS ESOMEPRAZOLE MAGNESIUM | ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ) | 49270025106520 | Generic |

| | | | |
|---|---|---|---|
| EQ ESOMEPRAZOLE MAGNESIUM | ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ) | 49270025106520 | Generic |
| ESOMEPRAZOLE MAGNESIUM | ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ) | 49270025106520 | Generic |
| ESOMEPRAZOLE MAGNESIUM DR | ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ) | 49270025106520 | Generic |
| GNP ESOMEPRAZOLE MAGNESIUM | ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ) | 49270025106520 | Generic |
| GOODSENSE ESOMEPRAZOLE MAGNESIUM | ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ) | 49270025106520 | Generic |
| HM ESOMEPRAZOLE MAGNESIUM DELAYED RELEASE | ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ) | 49270025106520 | Generic |
| KLS ESOMEPRAZOLE MAGNESIUM | ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ) | 49270025106520 | Generic |
| NEXIUM | ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ) | 49270025106520 | Brand |
| NEXIUM 24HR | ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ) | 49270025106520 | Brand |
| NEXIUM 24HR CLEAR MINIS | ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ) | 49270025106520 | Brand |
| QC ESOMEPRAZOLE MAGNESIUM | ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ) | 49270025106520 | Generic |
| RA ESOMEPRAZOLE MAGNESIUM | ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ) | 49270025106520 | Generic |
| SM ESOMEPRAZOLE MAGNESIUM | ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ) | 49270025106520 | Generic |
| RABEPRAZOLE SODIUM DR SPRINKLE | RABEPRAZOLE SODIUM CAPSULE SPRINKLE DR 10 MG | 49270076106810 | Brand |
| ESOMEPRAZOLE MAGNESIUM DR24HR | ESOMEPRAZOLE MAGNESIUM TAB DELAYED RELEASE 20 MG | 49270025100620 | Generic |
| NEXIUM 24HR | ESOMEPRAZOLE MAGNESIUM TAB DELAYED RELEASE 20 MG | 49270025100620 | Brand |

**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 |
|---|---|
| 11/25/2024 | Copy core |

Pradaxa

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-160660 |
| **Guideline Name** | Pradaxa |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 1 . Criteria

| Product Name: dabigatran etexilate, Pradaxa | |
|---|---|
| Diagnosis | Continuation of Therapy Upon Hospital Discharge |
| Approval Length | 35 Day(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DABIGATRAN ETEXILATE | DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ) | 83337030200120 | Generic |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ) | 83337030200120 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE CAP 110 MG (ETEXILATE BASE EQ) | 83337030200130 | Brand |

| | | | |
|---|---|---|---|
| DABIGATRAN ETEXILATE | DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ) | 83337030200140 | Generic |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ) | 83337030200140 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE PELLET PACK 20 MG | 83337030203020 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE PELLET PACK 30 MG | 83337030203025 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE PELLET PACK 40 MG | 83337030203030 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE PELLET PACK 50 MG | 83337030203035 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE PELLET PACK 110 MG | 83337030203040 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE PELLET PACK 150 MG | 83337030203045 | Brand |
| DABIGATRAN ETEXILATE | DABIGATRAN ETEXILATE MESYLATE CAP 110 MG (ETEXILATE BASE EQ) | 83337030200130 | Generic |

**Approval Criteria**

**1** - For continuation of therapy upon hospital discharge

| Product Name: dabigatran etexilate, Pradaxa | |
|---|---|
| Diagnosis | Stroke and Systemic Embolism Prevention in an Adult Patient with Non-Valvular Atrial Fibrillation (AF) |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DABIGATRAN ETEXILATE | DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ) | 83337030200120 | Generic |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ) | 83337030200120 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE CAP 110 MG (ETEXILATE BASE EQ) | 83337030200130 | Brand |
| DABIGATRAN ETEXILATE | DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ) | 83337030200140 | Generic |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ) | 83337030200140 | Brand |

| | | | |
|---|---|---|---|
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE PELLET PACK 20 MG | 83337030203020 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE PELLET PACK 30 MG | 83337030203025 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE PELLET PACK 40 MG | 83337030203030 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE PELLET PACK 50 MG | 83337030203035 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE PELLET PACK 110 MG | 83337030203040 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE PELLET PACK 150 MG | 83337030203045 | Brand |
| DABIGATRAN ETEXILATE | DABIGATRAN ETEXILATE MESYLATE CAP 110 MG (ETEXILATE BASE EQ) | 83337030200130 | Generic |

**Approval Criteria**

**1** - Diagnosis of atrial fibrillation (AF)

**AND**

**2** - Patient does not have an artificial heart valve

| Product Name: dabigatran etexilate, Pradaxa | |
|---|---|
| Diagnosis | Prophylaxis of Venous Thromboembolism (VTE) and Pulmonary Embolism (PE) after Orthopedic Surgery in an Adult Patient (Hip Replacement: Labeled; Knee Replacement: Off-Label) |
| Approval Length | 35 Day(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DABIGATRAN ETEXILATE | DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ) | 83337030200120 | Generic |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ) | 83337030200120 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE CAP 110 MG (ETEXILATE BASE EQ) | 83337030200130 | Brand |
| DABIGATRAN ETEXILATE | DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ) | 83337030200140 | Generic |

| | | | |
|---|---|---|---|
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ) | 83337030200140 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE PELLET PACK 20 MG | 83337030203020 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE PELLET PACK 30 MG | 83337030203025 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE PELLET PACK 40 MG | 83337030203030 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE PELLET PACK 50 MG | 83337030203035 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE PELLET PACK 110 MG | 83337030203040 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE PELLET PACK 150 MG | 83337030203045 | Brand |
| DABIGATRAN ETEXILATE | DABIGATRAN ETEXILATE MESYLATE CAP 110 MG (ETEXILATE BASE EQ) | 83337030200130 | Generic |

**Approval Criteria**

**1** - ONE of the following:

- Patient has or is scheduled to have total knee replacement surgery
- Patient has or is scheduled to have total hip replacement surgery

**AND**

**2** - Patient does not have an artificial heart valve

| Product Name: dabigatran etexilate, Pradaxa | |
|---|---|
| Diagnosis | Treatment of Deep Vein Thrombosis (DVT) or Pulmonary Embolism (PE) in an Adult Patient |
| Approval Length | 6 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DABIGATRAN ETEXILATE | DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ) | 83337030200120 | Generic |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ) | 83337030200120 | Brand |

| | | | |
|---|---|---|---|
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE CAP 110 MG (ETEXILATE BASE EQ) | 83337030200130 | Brand |
| DABIGATRAN ETEXILATE | DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ) | 83337030200140 | Generic |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ) | 83337030200140 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE PELLET PACK 20 MG | 83337030203020 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE PELLET PACK 30 MG | 83337030203025 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE PELLET PACK 40 MG | 83337030203030 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE PELLET PACK 50 MG | 83337030203035 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE PELLET PACK 110 MG | 83337030203040 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE PELLET PACK 150 MG | 83337030203045 | Brand |
| DABIGATRAN ETEXILATE | DABIGATRAN ETEXILATE MESYLATE CAP 110 MG (ETEXILATE BASE EQ) | 83337030200130 | Generic |

**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

| Product Name: dabigatran etexilate, Pradaxa | |
|---|---|
| Diagnosis | Reduction in the Risk of Recurrence of Deep Vein Thrombosis (DVT) and Pulmonary Embolism (PE) in an Adult Patient |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| DABIGATRAN ETEXILATE | DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ) | 83337030200120 | Generic |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ) | 83337030200120 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE CAP 110 MG (ETEXILATE BASE EQ) | 83337030200130 | Brand |
| DABIGATRAN ETEXILATE | DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ) | 83337030200140 | Generic |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ) | 83337030200140 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE PELLET PACK 20 MG | 83337030203020 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE PELLET PACK 30 MG | 83337030203025 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE PELLET PACK 40 MG | 83337030203030 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE PELLET PACK 50 MG | 83337030203035 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE PELLET PACK 110 MG | 83337030203040 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE PELLET PACK 150 MG | 83337030203045 | Brand |
| DABIGATRAN ETEXILATE | DABIGATRAN ETEXILATE MESYLATE CAP 110 MG (ETEXILATE BASE EQ) | 83337030200130 | Generic |

**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 3 months prior to request

| Product Name: dabigatran etexilate, Pradaxa | |
|---|---|
| Diagnosis | Treatment of Venous Thromboembolic Events (VTE) in a Pediatric Patient |
| Approval Length | 6 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DABIGATRAN ETEXILATE | DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ) | 83337030200120 | Generic |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ) | 83337030200120 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE CAP 110 MG (ETEXILATE BASE EQ) | 83337030200130 | Brand |
| DABIGATRAN ETEXILATE | DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ) | 83337030200140 | Generic |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ) | 83337030200140 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE PELLET PACK 20 MG | 83337030203020 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE PELLET PACK 30 MG | 83337030203025 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE PELLET PACK 40 MG | 83337030203030 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE PELLET PACK 50 MG | 83337030203035 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE PELLET PACK 110 MG | 83337030203040 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE PELLET PACK 150 MG | 83337030203045 | Brand |
| DABIGATRAN ETEXILATE | DABIGATRAN ETEXILATE MESYLATE CAP 110 MG (ETEXILATE BASE EQ) | 83337030200130 | Generic |

**Approval Criteria**

**1** - Diagnosis of venous thromboembolic events (VTE)

**AND**

**2** - Patient does not have an artificial heart valve

| Product Name: dabigatran etexilate, Pradaxa | |
|---|---|
| Diagnosis | Reduction in the Risk of Recurrence of VTE in a Pediatric Patient |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DABIGATRAN ETEXILATE | DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ) | 83337030200120 | Generic |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ) | 83337030200120 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE CAP 110 MG (ETEXILATE BASE EQ) | 83337030200130 | Brand |
| DABIGATRAN ETEXILATE | DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ) | 83337030200140 | Generic |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ) | 83337030200140 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE PELLET PACK 20 MG | 83337030203020 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE PELLET PACK 30 MG | 83337030203025 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE PELLET PACK 40 MG | 83337030203030 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE PELLET PACK 50 MG | 83337030203035 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE PELLET PACK 110 MG | 83337030203040 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE PELLET PACK 150 MG | 83337030203045 | Brand |
| DABIGATRAN ETEXILATE | DABIGATRAN ETEXILATE MESYLATE CAP 110 MG (ETEXILATE BASE EQ) | 83337030200130 | Generic |

**Approval Criteria**

**1** - Diagnosis of venous thromboembolic events (VTE)

**AND**

**2** - Patient does not have an artificial heart valve

| |
|---|
| **AND**<br><br>**3** - Patient must have been treated with an anticoagulant (e.g., warfarin) for at least 3 months prior to request |

## 2 . Revision History

| Date | Notes |
|---|---|
| 11/14/2024 | Removed step therapy requirements |

Praluent

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146834 |
| **Guideline Name** | Praluent |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Praluent (all labelers) | |
|---|---|
| Diagnosis | Primary Hyperlipidemia (Including Heterozygous Familial Hypercholesterolemia (HeFH) and Atherosclerotic Cardiovascular Disease (ASCVD) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| PRALUENT | ALIROCUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 75 MG/ML | 3935001000D520 | Brand |
| PRALUENT | ALIROCUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML | 3935001000D530 | Brand |

**Approval Criteria**

**1** - Diagnosis of ONE of the following:

**1.1** Heterozygous familial hypercholesterolemia (HeFH) as confirmed by ONE of the following:

**1.1.1** BOTH of the following:

**1.1.1.1** Pre-treatment low density lipoprotein cholesterol (LDL-C) of ONE of the following:

- Greater than or equal to 190 milligrams/deciliter (mg/dL)
- Greater than or equal to 155 mg/dL if less than 16 years of age

**AND**

**1.1.1.2** ONE of the following:

- Family history of myocardial infarction in first-degree relative less than 60 years of age
- Family history of myocardial infarction in second-degree relative less than 50 years of age
- Family history of LDL-C greater than 190 mg/dL in first- or second-degree relative
- Family history of heterozygous or homozygous familial hypercholesterolemia in first- or second-degree relative
- Family history of tendinous xanthomata and/or arcus cornealis in first- or second degree relative

**OR**

**1.1.2** BOTH of the following:

**1.1.2.1** Pre-treatment LDL-C of ONE of the following:

- Greater than or equal to 190 mg/dL
- Greater than or equal to 155 mg/dL if less than 16 years of age

**AND**

**1.1.2.2** Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following:

- Functional mutation in LDL (low density lipoprotein), apoB (apolipoprotein B), or PCSK9 (proprotein convertase subtilisin/kexin type 9) gene
- Tendinous xanthomata
- Arcus cornealis before age 45

**OR**

**1.2** Atherosclerotic cardiovascular disease (ASCVD) as confirmed by ONE of the following:

- Acute coronary syndromes
- History of myocardial infarction
- Stable or unstable angina
- Coronary or other arterial revascularization
- Stroke
- Transient ischemic attack
- Peripheral arterial disease presumed to be of atherosclerotic origin

**OR**

**1.3** Primary hyperlipidemia with pre-treatment LDL-C greater than or equal to 190 mg/dL

**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 labeled contraindication to all statins as documented in medical records

**OR**

**2.3.3** Patient has experienced rhabdomyolysis or muscle symptoms with statin treatment with CK elevations greater than 10 times ULN

**AND**

**3** - ONE of the following:

**3.1** Submission of medical records (e.g., laboratory values) documenting ONE of the following LDL-C values while on maximally tolerated lipid lowering therapy for a minimum of at least 12 weeks within the last 120 days or 120 days prior to starting PCSK9 inhibitor therapy:

- LDL-C greater than or equal to 100 mg/dL with ASCVD
- LDL-C greater than or equal to 130 mg/dL without ASCVD

**OR**

**3.2** BOTH of the following:

**3.2.1** Submission of medical records (e.g., laboratory values) documenting ONE of the following LDL-C values while on maximally tolerated lipid lowering therapy for a minimum of at least 12 weeks within the last 120 days or 120 days prior to starting PCSK9 inhibitor therapy:

- LDL-C between 55 mg/dL and 99 mg/dL with ASCVD
- LDL-C between 100 mg/dL and 129 mg/dL without ASCVD

**AND**

**3.2.2** Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following (prescription claims history may be used in conjunction as documentation of medication use, dose, and duration):

**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 (please specify intolerance or contraindication)

**AND**

**4** - Patient has received comprehensive counseling regarding appropriate diet

**AND**

**5** - Prescribed by ONE of the following:

- Cardiologist
- Endocrinologist

- Lipid specialist

**AND**

**6** - Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor [e.g., Repatha (evolocumab)]

**AND**

**7** - Not used in combination with Leqvio (inclisiran)

| Product Name: Praluent (all labelers) | |
|---|---|
| Diagnosis | Primary Hyperlipidemia (Including Heterozygous Familial Hypercholesterolemia (HeFH) and Atherosclerotic Cardiovascular Disease (ASCVD) |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| PRALUENT | ALIROCUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 75 MG/ML | 3935001000D520 | Brand |
| PRALUENT | ALIROCUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML | 3935001000D530 | Brand |

**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 Leqvio (inclisiran)

| Product Name: Praluent (all labelers) | |
|---|---|
| Diagnosis | Homozygous Familial Hypercholesterolemia (HoFH) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| PRALUENT | ALIROCUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 75 MG/ML | 3935001000D520 | Brand |
| PRALUENT | ALIROCUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML | 3935001000D530 | Brand |

**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 two mutant alleles at the LDLR, APOB, PCSK9, or LDLRAP1 gene locus

**OR**

**1.2** BOTH of the following:

**1.2.1** Pre-treatment low density lipoprotein cholesterol (LDL-C) greater than 400 milligrams/deciliter (mg/dL)

**AND**

**1.2.2** ONE of the following:

**1.2.2.1** Xanthoma before 10 years of age

**OR**

**1.2.2.2** Evidence of heterozygous familial hypercholesterolemia (HeFH) in both parents

**AND**

**2** - Patient has received comprehensive counseling regarding appropriate diets

**AND**

**3** - Patient is receiving other lipid-lowering therapy confirmed by claims history or submitted medical records (e.g., statin, ezetimibe, LDL apheresis)

**AND**

**4** - Prescribed by one of the following:

- Cardiologist
- Endocrinologist
- Lipid specialist

**AND**

**5** - Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor [e.g., Repatha (evolocumab)]

**AND**

**6** - Not used in combination with Juxtapid (lomitapide)

| Product Name: Praluent (all labelers) | |
|---|---|
| Diagnosis | Homozygous Familial Hypercholesterolemia (HoFH) |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| PRALUENT | ALIROCUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 75 MG/ML | 3935001000D520 | Brand |
| PRALUENT | ALIROCUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML | 3935001000D530 | Brand |

**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)

| Product Name: Praluent (Non-72733 labelers) | |
|---|---|
| Diagnosis | Non-Preferred* |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| PRALUENT | ALIROCUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 75 MG/ML | 3935001000D520 | Brand |
| PRALUENT | ALIROCUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML | 3935001000D530 | Brand |

**Approval Criteria**

**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**

**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 | *Reference Non-Preferred Drugs policy. Prior trials of formulary/PDL a lternatives must sufficiently demonstrate that the formulary/PDL altern atives are either ineffective or inappropriate at the time of the request. PDL link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |
|---|---|

## 2 . Revision History

| Date | Notes |
| --- | --- |
| 4/30/2024 | Updated PDL link |

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146840 |
| **Guideline Name** | Preferred Non-Solid Dosage Forms |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| | |
|---|---|
| Diagnosis | Requests for Non-Solid Dosage Forms |
| Approval Length | 12 month(s) |
| Guideline Type | Administrative |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| Non-solid dosage forms | | | |
| Non solid dosage forms | | | |
| Solid oral dosage forms | | | |

**Approval Criteria**

**1** - ONE of the following:

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

**OR**

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

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex
- Clinical pharmacology
- United States Pharmacopeia-National Formulary (USP-NF)

**AND**

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

**AND**

**3** - ONE of the following:

**3.1** BOTH of the following:

**3.1.1** The patient is able to swallow a solid dosage form

**AND**

**3.1.2** ONE of the following:

**3.1.2.1** History of failure, contraindication, or intolerance to at least THREE preferred* solid oral dosage forms (Prior trials of formulary/PDL (preferred drug list) alternatives must sufficiently demonstrate that the formulary/PDL alternatives are either ineffective or inappropriate at the time of the request. NOTE: In instances where there are fewer than three preferred alternatives, the patient must have a history of failure, contraindication, or intolerance to ALL of the preferred products.)

| |
|---|
| **OR**<br><br>**3.1.2.2** There are no preferred formulary alternatives for the requested drug<br><br>**OR**<br><br>**3.2** Patient is unable to swallow a solid dosage form<br><br>**OR**<br><br>**3.3** Patient utilizes a feeding tube for medication administration<br><br>**OR**<br><br>**3.4** Request is for a nebulized formulation of an inhaled medication for a patient who has an inability to effectively utilize an agent in an inhaler formulation due to neuromuscular or cognitive disability, or other evidence of lack of response to the inhaled formulation supported by clinical documentation |
| Notes: *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |

## 2 . Revision History

| Date | Notes |
|---|---|
| 4/30/2024 | Updated PDL link |

Pretomanid

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146395 |
| **Guideline Name** | Pretomanid |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Pretomanid | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| PRETOMANID | PRETOMANID TAB 200 MG | 09000063000320 | Brand |

**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

Prevymis

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146619 |
| **Guideline Name** | Prevymis |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Prevymis tabs | |
|---|---|
| Diagnosis | Cytomegalovirus Prophylaxis |
| Approval Length | 9 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| PREVYMIS | LETERMOVIR TAB 240 MG | 12200045000320 | Brand |
| PREVYMIS | LETERMOVIR TAB 480 MG | 12200045000340 | Brand |

**Approval Criteria**

**1** - ALL of the following:

**1.1** Patient is a recipient of an allogeneic hematopoietic stem cell transplant

**AND**

**1.2** Patient is cytomegalovirus (CMV)-seropositive

**AND**

**1.3** Provider attests that Prevymis will be initiated between Day 0 and Day 28 post-transplantation (before or after engraftment) and is being prescribed as prophylaxis and not treatment of CMV infection

**OR**

**2** - ALL of the following:

**2.1** Patient is a recipient of a kidney transplant

**AND**

**2.2** Patient is CMV-seronegative

**AND**

**2.3** Donor is CMV-seropositive

**AND**

**2.4** Provider attests that Prevymis will be initiated between Day 0 and Day 7 post-transplantation (before or after engraftment) and is being prescribed as prophylaxis and not treatment of CMV infection

Procysbi

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146620 |
| **Guideline Name** | Procysbi |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| PROCYSBI | CYSTEAMINE BITARTRATE DELAYED RELEASE GRANULES PACKET 75 MG | 56400030103020 | Brand |
| PROCYSBI | CYSTEAMINE BITARTRATE DELAYED RELEASE GRANULES PACKET 300 MG | 56400030103040 | Brand |
| PROCYSBI | CYSTEAMINE BITARTRATE CAP DELAYED RELEASE 25 MG (BASE EQUIV) | 56400030106520 | Brand |

| | | | |
|---|---|---|---|
| PROCYSBI | CYSTEAMINE BITARTRATE CAP DELAYED RELEASE 75 MG (BASE EQUIV) | 56400030106530 | Brand |

**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 immediate-release cysteamine bitartrate (generic Cystagon), as confirmed by claims history or submission of medical records

**OR**

**3.2** History of intolerance or contraindication to immediate-release cysteamine bitartrate (generic 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| PROCYSBI | CYSTEAMINE BITARTRATE DELAYED RELEASE GRANULES PACKET 75 MG | 56400030103020 | Brand |
| PROCYSBI | CYSTEAMINE BITARTRATE DELAYED RELEASE GRANULES PACKET 300 MG | 56400030103040 | Brand |

| | | | |
|---|---|---|---|
| PROCYSBI | CYSTEAMINE BITARTRATE CAP DELAYED RELEASE 25 MG (BASE EQUIV) | 56400030106520 | Brand |
| PROCYSBI | CYSTEAMINE BITARTRATE CAP DELAYED RELEASE 75 MG (BASE EQUIV) | 56400030106530 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Procysbi therapy

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146396 |
| **Guideline Name** | Progesterone - Non-Oral |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Crinone, Endometrin | |
|---|---|
| Approval Length | 6 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CRINONE | PROGESTERONE VAGINAL GEL 4% | 55370060004010 | Brand |
| CRINONE | PROGESTERONE VAGINAL GEL 8% | 55370060004020 | Brand |
| ENDOMETRIN | PROGESTERONE VAGINAL INSERT 100 MG | 55370060009910 | Brand |

**Approval Criteria**

**1** - Treatment is for non-infertility use (e.g., secondary amenorrhea, reduce the risk of recurrent spontaneous preterm birth)

Progesterone - Oral

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146397 |
| **Guideline Name** | Progesterone - Oral |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Brand Prometrium, generic progesterone caps | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| PROGESTERONE | PROGESTERONE CAP 100 MG | 26000040000120 | Generic |
| PROMETRIUM | PROGESTERONE CAP 100 MG | 26000040000120 | Brand |
| PROGESTERONE | PROGESTERONE CAP 200 MG | 26000040000140 | Generic |
| PROMETRIUM | PROGESTERONE CAP 200 MG | 26000040000140 | Brand |

**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

Promacta, Alvaiz

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-160751 |
| **Guideline Name** | Promacta, Alvaiz |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 1 . Criteria

| Product Name: Promacta, Alvaiz | |
|---|---|
| Diagnosis | Chronic Immune Thrombocytopenia (ITP) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| PROMACTA | ELTROMBOPAG OLAMINE TAB 12.5 MG (BASE EQUIV) | 82405030100310 | Brand |
| PROMACTA | ELTROMBOPAG OLAMINE TAB 25 MG (BASE EQUIV) | 82405030100320 | Brand |
| PROMACTA | ELTROMBOPAG OLAMINE TAB 50 MG (BASE EQUIV) | 82405030100330 | Brand |

| | | | |
|---|---|---|---|
| PROMACTA | ELTROMBOPAG OLAMINE TAB 75 MG (BASE EQUIV) | 82405030100340 | Brand |
| PROMACTA | ELTROMBOPAG OLAMINE POWDER PACK FOR SUSP 25 MG (BASE EQUIV) | 82405030103020 | Brand |
| PROMACTA | ELTROMBOPAG OLAMINE POWDER PACK FOR SUSP 12.5 MG (BASE EQ) | 82405030103030 | Brand |
| ALVAIZ | ELTROMBOPAG CHOLINE TAB 9 MG (BASE EQUIV) | 82405030050310 | Brand |
| ALVAIZ | ELTROMBOPAG CHOLINE TAB 18 MG (BASE EQUIV) | 82405030050320 | Brand |
| ALVAIZ | ELTROMBOPAG CHOLINE TAB 36 MG (BASE EQUIV) | 82405030050330 | Brand |
| ALVAIZ | ELTROMBOPAG CHOLINE TAB 54 MG (BASE EQUIV) | 82405030050340 | Brand |

**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 Promacta as confirmed by claims history or submission of medical records

**OR**

**3.2** History of contraindication or intolerance to 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: Promacta, Alvaiz | |
|---|---|
| Diagnosis | Chronic Immune Thrombocytopenia (ITP) |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| PROMACTA | ELTROMBOPAG OLAMINE TAB 12.5 MG (BASE EQUIV) | 82405030100310 | Brand |
| PROMACTA | ELTROMBOPAG OLAMINE TAB 25 MG (BASE EQUIV) | 82405030100320 | Brand |
| PROMACTA | ELTROMBOPAG OLAMINE TAB 50 MG (BASE EQUIV) | 82405030100330 | Brand |
| PROMACTA | ELTROMBOPAG OLAMINE TAB 75 MG (BASE EQUIV) | 82405030100340 | Brand |

| | | | |
|---|---|---|---|
| PROMACTA | ELTROMBOPAG OLAMINE POWDER PACK FOR SUSP 25 MG (BASE EQUIV) | 82405030103020 | Brand |
| PROMACTA | ELTROMBOPAG OLAMINE POWDER PACK FOR SUSP 12.5 MG (BASE EQ) | 82405030103030 | Brand |
| ALVAIZ | ELTROMBOPAG CHOLINE TAB 9 MG (BASE EQUIV) | 82405030050310 | Brand |
| ALVAIZ | ELTROMBOPAG CHOLINE TAB 18 MG (BASE EQUIV) | 82405030050320 | Brand |
| ALVAIZ | ELTROMBOPAG CHOLINE TAB 36 MG (BASE EQUIV) | 82405030050330 | Brand |
| ALVAIZ | ELTROMBOPAG CHOLINE TAB 54 MG (BASE EQUIV) | 82405030050340 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Promacta or Alvaiz therapy

| Product Name: Promacta, Alvaiz | |
|---|---|
| Diagnosis | Chronic Hepatitis C-Associated Thrombocytopenia |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| PROMACTA | ELTROMBOPAG OLAMINE TAB 12.5 MG (BASE EQUIV) | 82405030100310 | Brand |
| PROMACTA | ELTROMBOPAG OLAMINE TAB 25 MG (BASE EQUIV) | 82405030100320 | Brand |
| PROMACTA | ELTROMBOPAG OLAMINE TAB 50 MG (BASE EQUIV) | 82405030100330 | Brand |
| PROMACTA | ELTROMBOPAG OLAMINE TAB 75 MG (BASE EQUIV) | 82405030100340 | Brand |
| PROMACTA | ELTROMBOPAG OLAMINE POWDER PACK FOR SUSP 25 MG (BASE EQUIV) | 82405030103020 | Brand |
| PROMACTA | ELTROMBOPAG OLAMINE POWDER PACK FOR SUSP 12.5 MG (BASE EQ) | 82405030103030 | Brand |
| ALVAIZ | ELTROMBOPAG CHOLINE TAB 9 MG (BASE EQUIV) | 82405030050310 | Brand |
| ALVAIZ | ELTROMBOPAG CHOLINE TAB 18 MG (BASE EQUIV) | 82405030050320 | Brand |
| ALVAIZ | ELTROMBOPAG CHOLINE TAB 36 MG (BASE EQUIV) | 82405030050330 | Brand |
| ALVAIZ | ELTROMBOPAG CHOLINE TAB 54 MG (BASE EQUIV) | 82405030050340 | Brand |

**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 Promacta as confirmed by claims history or submission of medical records

**OR**

**3.2** History of contraindication or intolerance to 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: Promacta, Alvaiz | |
|---|---|
| Diagnosis | Chronic Hepatitis C-Associated Thrombocytopenia |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| PROMACTA | ELTROMBOPAG OLAMINE TAB 12.5 MG (BASE EQUIV) | 82405030100310 | Brand |
| PROMACTA | ELTROMBOPAG OLAMINE TAB 25 MG (BASE EQUIV) | 82405030100320 | Brand |
| PROMACTA | ELTROMBOPAG OLAMINE TAB 50 MG (BASE EQUIV) | 82405030100330 | Brand |
| PROMACTA | ELTROMBOPAG OLAMINE TAB 75 MG (BASE EQUIV) | 82405030100340 | Brand |
| PROMACTA | ELTROMBOPAG OLAMINE POWDER PACK FOR SUSP 25 MG (BASE EQUIV) | 82405030103020 | Brand |
| PROMACTA | ELTROMBOPAG OLAMINE POWDER PACK FOR SUSP 12.5 MG (BASE EQ) | 82405030103030 | Brand |
| ALVAIZ | ELTROMBOPAG CHOLINE TAB 9 MG (BASE EQUIV) | 82405030050310 | Brand |
| ALVAIZ | ELTROMBOPAG CHOLINE TAB 18 MG (BASE EQUIV) | 82405030050320 | Brand |
| ALVAIZ | ELTROMBOPAG CHOLINE TAB 36 MG (BASE EQUIV) | 82405030050330 | Brand |
| ALVAIZ | ELTROMBOPAG CHOLINE TAB 54 MG (BASE EQUIV) | 82405030050340 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Promacta or Alvaiz therapy

**AND**

**2** - Patient is currently on antiviral interferon therapy for treatment of chronic hepatitis C

| Product Name: Promacta, Alvaiz | |
|---|---|
| Diagnosis | Aplastic Anemia |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |

| Guideline Type | Prior Authorization |
|---|---|

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| PROMACTA | ELTROMBOPAG OLAMINE TAB 12.5 MG (BASE EQUIV) | 82405030100310 | Brand |
| PROMACTA | ELTROMBOPAG OLAMINE TAB 25 MG (BASE EQUIV) | 82405030100320 | Brand |
| PROMACTA | ELTROMBOPAG OLAMINE TAB 50 MG (BASE EQUIV) | 82405030100330 | Brand |
| PROMACTA | ELTROMBOPAG OLAMINE TAB 75 MG (BASE EQUIV) | 82405030100340 | Brand |
| PROMACTA | ELTROMBOPAG OLAMINE POWDER PACK FOR SUSP 25 MG (BASE EQUIV) | 82405030103020 | Brand |
| PROMACTA | ELTROMBOPAG OLAMINE POWDER PACK FOR SUSP 12.5 MG (BASE EQ) | 82405030103030 | Brand |
| ALVAIZ | ELTROMBOPAG CHOLINE TAB 9 MG (BASE EQUIV) | 82405030050310 | Brand |
| ALVAIZ | ELTROMBOPAG CHOLINE TAB 18 MG (BASE EQUIV) | 82405030050320 | Brand |
| ALVAIZ | ELTROMBOPAG CHOLINE TAB 36 MG (BASE EQUIV) | 82405030050330 | Brand |
| ALVAIZ | ELTROMBOPAG CHOLINE TAB 54 MG (BASE EQUIV) | 82405030050340 | Brand |

**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 Promacta as confirmed by claims history or submission of medical records

**OR**

**3.2** History of contraindication or intolerance to 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: Promacta, Alvaiz | |
|---|---|
| Diagnosis | Aplastic Anemia |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| PROMACTA | ELTROMBOPAG OLAMINE TAB 12.5 MG (BASE EQUIV) | 82405030100310 | Brand |
| PROMACTA | ELTROMBOPAG OLAMINE TAB 25 MG (BASE EQUIV) | 82405030100320 | Brand |
| PROMACTA | ELTROMBOPAG OLAMINE TAB 50 MG (BASE EQUIV) | 82405030100330 | Brand |
| PROMACTA | ELTROMBOPAG OLAMINE TAB 75 MG (BASE EQUIV) | 82405030100340 | Brand |

| | | | |
|---|---|---|---|
| PROMACTA | ELTROMBOPAG OLAMINE POWDER PACK FOR SUSP 25 MG (BASE EQUIV) | 82405030103020 | Brand |
| PROMACTA | ELTROMBOPAG OLAMINE POWDER PACK FOR SUSP 12.5 MG (BASE EQ) | 82405030103030 | Brand |
| ALVAIZ | ELTROMBOPAG CHOLINE TAB 9 MG (BASE EQUIV) | 82405030050310 | Brand |
| ALVAIZ | ELTROMBOPAG CHOLINE TAB 18 MG (BASE EQUIV) | 82405030050320 | Brand |
| ALVAIZ | ELTROMBOPAG CHOLINE TAB 36 MG (BASE EQUIV) | 82405030050330 | Brand |
| ALVAIZ | ELTROMBOPAG CHOLINE TAB 54 MG (BASE EQUIV) | 82405030050340 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Promacta or Alvaiz therapy

## 2 . Revision History

| Date | Notes |
|---|---|
| 11/18/2024 | Added non-solid dosage form questions for Promacta packets |

Provigil, Nuvigil

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146398 |
| **Guideline Name** | Provigil, Nuvigil |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Brand Provigil, generic modafinil, Brand Nuvigil, generic armodafinil | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| MODAFINIL | MODAFINIL TAB 100 MG | 61400024000310 | Generic |
| PROVIGIL | MODAFINIL TAB 100 MG | 61400024000310 | Brand |
| MODAFINIL | MODAFINIL TAB 200 MG | 61400024000320 | Generic |
| PROVIGIL | MODAFINIL TAB 200 MG | 61400024000320 | Brand |
| ARMODAFINIL | ARMODAFINIL TAB 50 MG | 61400010000310 | Generic |
| NUVIGIL | ARMODAFINIL TAB 50 MG | 61400010000310 | Brand |

| | | | |
|---|---|---|---|
| ARMODAFINIL | ARMODAFINIL TAB 150 MG | 61400010000330 | Generic |
| NUVIGIL | ARMODAFINIL TAB 150 MG | 61400010000330 | Brand |
| ARMODAFINIL | ARMODAFINIL TAB 200 MG | 61400010000335 | Generic |
| NUVIGIL | ARMODAFINIL TAB 200 MG | 61400010000335 | Brand |
| ARMODAFINIL | ARMODAFINIL TAB 250 MG | 61400010000340 | Generic |
| NUVIGIL | ARMODAFINIL TAB 250 MG | 61400010000340 | Brand |

**Approval Criteria**

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

- Narcolepsy
- Excessive sleepiness due to obstructive sleep apnea
- Excessive sleepiness due to shift work disorder (circadian rhythm sleep disorder, shift work type)
- Idiopathic hypersomnia
- Diagnosis of multiple sclerosis (MS)
- Diagnosis of major depressive disorder or bipolar depression

Pulmozyme

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146622 |
| **Guideline Name** | Pulmozyme |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Pulmozyme | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| PULMOZYME | DORNASE ALFA INHAL SOLN 2.5 MG/2.5ML | 45304020002010 | Brand |

**Approval Criteria**

**1** - Diagnosis of cystic fibrosis

Pyrukynd

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-150405 |
| **Guideline Name** | Pyrukynd |
| **Formulary** | • Medicaid - Community & State New Mexico |

## 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| PYRUKYND TAPER PACK | MITAPIVAT SULFATE TAB THERAPY PACK 5 MG | 8587005070B710 | Brand |
| PYRUKYND TAPER PACK | MITAPIVAT SULFATE TAB THERAPY PACK 7 X 20 MG & 7 X 5 MG | 8587005070B720 | Brand |

| | | | |
|---|---|---|---|
| PYRUKYND TAPER PACK | MITAPIVAT SULFATE TAB THERAPY PACK 7 X 50 MG & 7 X 20 MG | 8587005070B735 | Brand |
| PYRUKYND | MITAPIVAT SULFATE TAB 5 MG | 85870050700310 | Brand |
| PYRUKYND | MITAPIVAT SULFATE TAB 20 MG | 85870050700325 | Brand |
| PYRUKYND | MITAPIVAT SULFATE TAB 50 MG | 85870050700340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| PYRUKYND TAPER PACK | MITAPIVAT SULFATE TAB THERAPY PACK 5 MG | 8587005070B710 | Brand |
| PYRUKYND TAPER PACK | MITAPIVAT SULFATE TAB THERAPY PACK 7 X 20 MG & 7 X 5 MG | 8587005070B720 | Brand |
| PYRUKYND TAPER PACK | MITAPIVAT SULFATE TAB THERAPY PACK 7 X 50 MG & 7 X 20 MG | 8587005070B735 | Brand |
| PYRUKYND | MITAPIVAT SULFATE TAB 5 MG | 85870050700310 | Brand |
| PYRUKYND | MITAPIVAT SULFATE TAB 20 MG | 85870050700325 | Brand |
| PYRUKYND | MITAPIVAT SULFATE TAB 50 MG | 85870050700340 | Brand |

**Approval Criteria**

**1** - BOTH of the following*:

| | |
|---|---|
| **1.1** Documentation of positive clinical response to Pyrukynd therapy<br><br>**AND**<br><br>**1.2** Prescribed by, or in consultation with, a nephrologist or hematologist<br><br>**OR**<br><br>**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.<br>**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

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146399 |
| **Guideline Name** | Qbrexza |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Qbrexza | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| QBREXZA | GLYCOPYRRONIUM TOSYLATE PAD 2.4% (BASE EQUIVALENT) | 90970030204320 | Brand |

**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)

Qinlock

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-154753 |
| **Guideline Name** | Qinlock |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 10/1/2024 |

## 1 . Criteria

| Product Name: Qinlock | |
|---|---|
| Diagnosis | Gastrointestinal Stromal Tumor (GIST) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| QINLOCK | RIPRETINIB TAB 50 MG | 21533053000320 | Brand |

**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 failure to 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** ALL of the following:

**3.2.1** Performance status 0-2

**AND**

**3.2.2** History of progression on imatinib (Gleevec) as confirmed by claims history or submission of medical records

**AND**

**3.2.3** 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:

**3.3.1** PDGFRA exon 18 mutations that are insensitive to imatinib (Gleevec) (including PDGFRA D842V)

**AND**

**3.3.2** History of progression on avapritinib (Ayvakit) as confirmed by claims history or submission of medical records

**AND**

**3.3.3** 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| QINLOCK | RIPRETINIB TAB 50 MG | 21533053000320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| QINLOCK | RIPRETINIB TAB 50 MG | 21533053000320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| QINLOCK | RIPRETINIB TAB 50 MG | 21533053000320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| QINLOCK | RIPRETINIB TAB 50 MG | 21533053000320 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Qinlock therapy

Qlosi, Vuity

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146400 |
| **Guideline Name** | Qlosi, Vuity |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VUITY | PILOCARPINE HCL OPHTH SOLN 1.25% | 86501030102017 | Brand |

**Approval Criteria**

**1** - Diagnosis of presbyopia

**AND**

**2** - Patient is between the ages of 40 to 55

**AND**

**3** - Patient is unable to use corrective lenses (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: Vuity | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VUITY | PILOCARPINE HCL OPHTH SOLN 1.25% | 86501030102017 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to therapy

**AND**

**2** - Age less than 55

**AND**

**3** - Prescribed by ONE of the following:

- Optometrist
- Ophthalmologist

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| Qlosi | | | |

**Approval Criteria**

**1** - Diagnosis of presbyopia

**AND**

**2** - Patient is between the ages of 45 to 64

**AND**

**3** - Patient is unable to use corrective lenses (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 | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| Qlosi | | | |

**Approval Criteria**

**1** - Documentation of positive clinical response to therapy

**AND**

**2** - Age less than 64

**AND**

**3** - Prescribed by ONE of the following:

- Optometrist
- Ophthalmologist

Quantity Limits

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146401 |
| **Guideline Name** | Quantity Limits |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Quantity Limit, Prescription Limit | |
|---|---|
| Diagnosis | Quantity limit review (General) |
| Approval Length | 12 month(s) |
| Guideline Type | Administrative |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| Quantity Limit | | | |
| Prescription Limit | | | |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| Quantity Limit | | | |
| Prescription Limit | | | |

**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 a ppropriate 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| Quantity Limit | | | |
| Prescription Limit | | | |

**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 perm itted |

| 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| Quantity Limit | | | |
| Prescription Limit | | | |

**Approval Criteria**

**1** - The physician attests that a larger quantity is needed for treatment of a larger surface area.

Radicava ORS

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-155393 |
| **Guideline Name** | Radicava ORS |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 10/1/2024 |

## 1 . Criteria

| Product Name: Radicava ORS | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RADICAVA ORS STARTER KIT | EDARAVONE ORAL SUSP 105 MG/5ML | 74509030001820 | Brand |
| RADICAVA ORS | EDARAVONE ORAL SUSP 105 MG/5ML | 74509030001820 | Brand |

**Approval Criteria**

**1** - BOTH of the following:

**1.1** Patient has been established on therapy with Radicava 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 “definite” or “probable” ALS per the El Escorial/revised Airlie House diagnostic criteria

**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 Radicava therapy

**AND**

**1.2.4** Patient is not dependent on invasive ventilation or tracheostomy

**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 “definite” or “probable” ALS per the El Escorial/revised Airlie House diagnostic criteria

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RADICAVA ORS STARTER KIT | EDARAVONE ORAL SUSP 105 MG/5ML | 74509030001820 | Brand |
| RADICAVA ORS | EDARAVONE ORAL SUSP 105 MG/5ML | 74509030001820 | Brand |

**Approval Criteria**

**1** - Diagnosis of “definite” or “probable” amyotrophic lateral sclerosis (ALS) per the El Escorial/revised Airlie House diagnostic criteria

**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 or tracheostomy

## 2 . Revision History

| Date | Notes |
|---|---|
| 9/20/2024 | Clarified criteria for existing prior authorization to be under the medic al benefit. Updated initial and reauth durations to 12 months. |

Ravicti

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146626 |
| **Guideline Name** | Ravicti |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RAVICTI | GLYCEROL PHENYLBUTYRATE LIQUID 1.1 GM/ML | 30908030000920 | Brand |

**Approval Criteria**

**1** - Diagnosis of urea cycle disorders (UCDs)

**AND**

**2** - Inadequate response to ONE of the following:

- Dietary protein restriction
- Amino acid supplementation

**AND**

**3** - 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**

**4** - ONE of the following:

**4.1** Failure to sodium phenylbutyrate (Buphenyl) as confirmed by claims history or submission of medical records*

**OR**

**4.2** History of intolerance or contraindication to sodium phenylbutyrate (Buphenyl) (please specify contraindication or intolerance)*

| 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RAVICTI | GLYCEROL PHENYLBUTYRATE LIQUID 1.1 GM/ML | 30908030000920 | Brand |

**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)

Rayos

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146402 |
| **Guideline Name** | Rayos |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Rayos | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RAYOS | PREDNISONE TAB DELAYED RELEASE 1 MG | 22100045000610 | Brand |
| RAYOS | PREDNISONE TAB DELAYED RELEASE 2 MG | 22100045000620 | Brand |
| RAYOS | PREDNISONE TAB DELAYED RELEASE 5 MG | 22100045000630 | Brand |

**Approval Criteria**

**1** - ONE of the following:

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

**OR**

**1.2** The intended use of Rayos 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** - Rayos is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plan's program

**AND**

**3** - Submission of medical records (e.g., chart notes, laboratory values) documenting an intolerance to generic prednisone tablets which is unable to be resolved with attempts to minimize the adverse effects where appropriate

**AND**

**4** - ONE of the following:

**4.1** Failure to TWO of the following as confirmed by claims history or submission of medical records:

- Dexamethasone tablet/oral solution
- Hydrocortisone tablet
- Methylprednisolone tablet
- Prednisolone tablet/oral solution

**OR**

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

- Dexamethasone tablet/oral solution
- Hydrocortisone tablet
- Methylprednisolone tablet
- Prednisolone tablet/oral solution

Rectiv

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-161192 |
| **Guideline Name** | Rectiv |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RECTIV | NITROGLYCERIN OINT 0.4% | 89254060004220 | Brand |
| NITROGLYCERIN | NITROGLYCERIN OINT 0.4% | 89254060004220 | Generic |

**Approval Criteria**

| |
|---|
| **1** - Diagnosis of moderate to severe pain associated with chronic anal fissures |

## 2 . Revision History

| Date | Notes |
|---|---|
| 11/22/2024 | Added generic Nitroglycerin ointment. |

Regranex

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146404 |
| **Guideline Name** | Regranex |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Regranex | |
|---|---|
| Approval Length | 6 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| REGRANEX | BECAPLERMIN GEL 0.01% | 90945020004020 | Brand |

**Approval Criteria**

**1** - Patient has a lower extremity diabetic neuropathic ulcer

Relistor

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146405 |
| **Guideline Name** | Relistor |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Relistor Injection | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RELISTOR | METHYLNALTREXONE BROMIDE INJ 8 MG/0.4ML (20 MG/ML) | 52580050102015 | Brand |
| RELISTOR | METHYLNALTREXONE BROMIDE INJ 12 MG/0.6ML (20 MG/ML) | 52580050102020 | Brand |

**Approval Criteria**

**1** - Documentation (e.g. chart notes) demonstrating a diagnosis of opioid induced constipation in a patient with advanced illness receiving palliative care

**OR**

**2** - Documentation (e.g. chart notes) demonstrating BOTH of the following:

**2.1** ONE of the following:

**2.1.1** Diagnosis of opioid induced constipation with chronic, non-cancer pain

**OR**

**2.1.2** Diagnosis of opioid induced constipation in patients with chronic pain related to prior cancer diagnosis or cancer treatment who do 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** ALL of the following:

**2.2.2.1** ONE of the following:

**2.2.2.1.1** Failure to ONE of the following as confirmed by claims history or submitted medical records

- Lactulose
- Polyethylene glycol (Miralex)

**OR**

**2.2.2.1.2** History of contraindication or intolerance to BOTH of the following (please specify intolerance or contraindication)

- Lactulose
- Polyethylene glycol (Miralex)

**AND**

**2.2.2.2** ONE of the following:

**2.2.2.2.1** Failure to lubiprostone (generic of Amitiza) as confirmed by claims history or submission of medical records

**OR**

**2.2.2.2.2** History of intolerance or contraindication to lubiprostone (generic of Amitiza) (please specify intolerance or contraindication)

**AND**

**2.2.2.3** ONE of the following:

**2.2.2.3.1** Failure to Movantik as confirmed by claims history or submitted medical records

**OR**

**2.2.2.3.2** History of contraindication or intolerance to Movantik (please specify intolerance or contraindication)

| Product Name: Relistor Injection | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| RELISTOR | METHYLNALTREXONE BROMIDE INJ 8 MG/0.4ML (20 MG/ML) | 52580050102015 | Brand |
| RELISTOR | METHYLNALTREXONE BROMIDE INJ 12 MG/0.6ML (20 MG/ML) | 52580050102020 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Relistor Injection therapy

| Product Name: Relistor tablet | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RELISTOR | METHYLNALTREXONE BROMIDE TAB 150 MG | 52580050100320 | Brand |

**Approval Criteria**

**1** - ONE of the following:

**1.1** Diagnosis of opioid induced constipation with chronic, non-cancer pain

**OR**

**1.2** Diagnosis of opioid induced constipation in patients with chronic pain related to prior cancer diagnosis or cancer treatment who do not require frequent (e.g., weekly) opioid dosage escalation

**AND**

**2** - ALL of the following:

**2.1** ONE of the following:

**2.1.1** Failure to ONE of the following as confirmed by claims history or submitted medical records

- Lactulose
- Polyethylene glycol (Miralex)

**OR**

**2.1.2** History of contraindication or intolerance to BOTH of the following (please specify intolerance or contraindication)

- Lactulose
- Polyethylene glycol (Miralex)

**AND**

**2.2** ONE of the following:

**2.2.1** Failure to lubiprostone (generic of Amitiza) as confirmed by claims history or submission of medical records

**OR**

**2.2.2** History of intolerance or contraindication to lubiprostone (generic of Amitiza) (please specify intolerance or contraindication)

**AND**

**2.3** ONE of the following:

**2.3.1** Failure to Movantik as confirmed by claims history or submitted medical records

**OR**

**2.3.2** History of contraindication or intolerance to Movantik (please specify intolerance or contraindication)

| Product Name: Relistor tablet | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RELISTOR | METHYLNALTREXONE BROMIDE TAB 150 MG | 52580050100320 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Relistor Tablet therapy

Relyvrio

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146627 |
| **Guideline Name** | Relyvrio |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Relyvrio | |
|---|---|
| Approval Length | 6 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RELYVRIO | SODIUM PHENYLBUTYRATE-TAURURSODIOL POWD PACK 3-1 GM | 74509902703020 | Brand |

**Approval Criteria**

**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 amyotrophic lateral sclerosis (ALS)

**AND**

**2** - Prescribed by, or in consultation with, a neurologist with expertise in the diagnosis of ALS

**AND**

**3** - Provider attestation that the patient's baseline functional ability has been documented prior to initiating treatment (e.g., speech, walking, climbing stairs, etc.)

**AND**

**4** - Patient is not dependent on invasive ventilation or tracheostomy

| Product Name: Relyvrio | |
|---|---|
| Approval Length | 6 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RELYVRIO | SODIUM PHENYLBUTYRATE-TAURURSODIOL POWD PACK 3-1 GM | 74509902703020 | Brand |

**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 Relyvrio therapy

**AND**

**4** - Provider attestation that the patient has slowed disease progression from baseline

**AND**

**5** - Patient is not dependent on invasive ventilation or tracheostomy

Repatha

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146407 |
| **Guideline Name** | Repatha |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Repatha | |
|---|---|
| Diagnosis | Primary Hyperlipidemia (including heterozygous familial hypercholesterolemia) and ASCVD |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| REPATHA | EVOLOCUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 140 MG/ML | 3935002000E520 | Brand |
| REPATHA PUSHTRONEX SYSTEM | EVOLOCUMAB SUBCUTANEOUS SOLN CARTRIDGE/INFUSOR 420 MG/3.5ML | 3935002000E230 | Brand |

| REPATHA SURECLICK | EVOLOCUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 140 MG/ML | 3935002000D520 | Brand |
|---|---|---|---|

**Approval Criteria**

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

**1.1** Heterozygous familial hypercholesterolemia (HeFH) as confirmed by ONE of the following:

**1.1.1** BOTH of the following:

**1.1.1.1** Pre-treatment LDL-C (low-density lipoprotein cholesterol) is ONE of the following:

- Greater than or equal to 190 milligrams/deciliter (mg/dL)
- Greater than or equal to 155 mg/dL if less than 16 years of age

**AND**

**1.1.1.2** ONE of the following:

- Family history of myocardial infarction in first-degree relative less than 60 years of age
- Family history of myocardial infarction in second-degree relative less than 50 years of age
- Family history of LDL-C greater than 190 mg/dL in first- or second-degree relative
- Family history of heterozygous or homozygous familial hypercholesterolemia in first- or second-degree relative
- Family history of tendinous xanthomata and/or arcus cornealis in first- or second-degree relative

**OR**

**1.1.2** BOTH of the following:

**1.1.2.1** Pre-treatment LDL-C is ONE of the following:

- Greater than or equal to 190 mg/dL
- Greater than or equal to 155 mg/dL if less than 16 years of age

**AND**

**1.1.2.2** Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following:

- Functional mutation in LDL (low-density lipoprotein), apoB (Apolipoprotein B), or PCSK9 (Proprotein convertase subtilisin/kexin type 9) gene
- Tendinous xanthomata
- Arcus cornealis before age 45

**OR**

**1.2** Atherosclerotic cardiovascular disease (ASCVD) as confirmed by ONE of the following:

- Acute coronary syndromes
- History of myocardial infarction
- Stable or unstable angina
- Coronary or other arterial revascularization
- Stroke
- Transient ischemic attack
- Peripheral arterial disease presumed to be of atherosclerotic origin

**OR**

**1.3** Primary hyperlipidemia with pre-treatment LDL-C greater than or equal to 190 mg/dL

**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 labeled 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** - ONE of the following:

**3.1** Submission of medical records (e.g., laboratory values) documenting ONE of the following LDL-C values while on maximally tolerated lipid lowering therapy for a minimum of at least 12 weeks within the last 120 days or 120 days prior to starting PCSK9 inhibitor therapy:

- LDL-C greater than or equal to 100 mg/dL with ASCVD
- LDL-C greater than or equal to 130 mg/dL without ASCVD

**OR**

**3.2** BOTH of the following:

**3.2.1** Submission of medical records (e.g., laboratory values) documenting ONE of the following LDL-C values while on maximally tolerated lipid lowering therapy for a minimum of at least 12 weeks within the last 120 days or 120 days prior to starting PCSK9 inhibitor therapy:

- LDL-C between 55 mg/dL and 99 mg/dL with ASCVD
- LDL-C between 100 mg/dL and 129 mg/dL without ASCVD

**AND**

**3.2.2** Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following (prescription claims history may be used in conjunction as documentation of medication use, dose, and duration):

**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 (please specify intolerance or contraindication)

**AND**

**4** - Patient has received comprehensive counseling regarding appropriate diet

**AND**

**5** - Prescribed by ONE of the following:

- Cardiologist
- Endocrinologist
- Lipid specialist

**AND**

**6** - Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor [e.g., Praluent (alirocumab)]

**AND**

**7** - Not used in combination with Leqvio (inclisiran)

| Product Name: Repatha | |
|---|---|
| Diagnosis | Primary Hyperlipidemia (including heterozygous familial hypercholesterolemia) and ASCVD |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| REPATHA | EVOLOCUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 140 MG/ML | 3935002000E520 | Brand |
| REPATHA PUSHTRONEX SYSTEM | EVOLOCUMAB SUBCUTANEOUS SOLN CARTRIDGE/INFUSOR 420 MG/3.5ML | 3935002000E230 | Brand |
| REPATHA SURECLICK | EVOLOCUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 140 MG/ML | 3935002000D520 | Brand |

**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., 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| REPATHA | EVOLOCUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 140 MG/ML | 3935002000E520 | Brand |
| REPATHA PUSHTRONEX SYSTEM | EVOLOCUMAB SUBCUTANEOUS SOLN CARTRIDGE/INFUSOR 420 MG/3.5ML | 3935002000E230 | Brand |
| REPATHA SURECLICK | EVOLOCUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 140 MG/ML | 3935002000D520 | Brand |

**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 two mutant alleles at the LDLR, APOB, PCSK9, or LDLRAP1 gene locus

**OR**

**1.2** BOTH of the following:

**1.2.1** Pre-treatment LDL-C (low-density lipoprotein cholesterol) greater than 400 mg/dL (milligrams/deciliter)

**AND**

**1.2.2** ONE of the following:

- Xanthoma before 10 years of age
- Evidence of heterozygous familial hypercholesterolemia (HeFH) in both parents

**AND**

**2** - Patient has received comprehensive counseling regarding appropriate diet

**AND**

**3** - Patient is receiving other lipid-lowering therapy confirmed by claims history or submitted medical records (e.g., statin, ezetimibe, LDL apheresis)

**AND**

**4** - Prescribed by ONE of the following:

- Cardiologist
- Endocrinologist
- Lipid specialist

**AND**

**5** - Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor [e.g., Praluent (alirocumab)]

**AND**

**6** - 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| REPATHA | EVOLOCUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 140 MG/ML | 3935002000E520 | Brand |
| REPATHA PUSHTRONEX SYSTEM | EVOLOCUMAB SUBCUTANEOUS SOLN CARTRIDGE/INFUSOR 420 MG/3.5ML | 3935002000E230 | Brand |
| REPATHA SURECLICK | EVOLOCUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 140 MG/ML | 3935002000D520 | Brand |

**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)

Repository Corticotropins

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146628 |
| **Guideline Name** | Repository Corticotropins |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Acthar, Cortrophin | |
|---|---|
| Diagnosis | Infantile spasm (i.e., West Syndrome)* |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ACTHAR | CORTICOTROPIN INJ GEL 80 UNIT/ML | 30300010004010 | Brand |
| CORTROPHIN | CORTICOTROPIN INJ GEL 80 UNIT/ML | 30300010004010 | Brand |

**Approval Criteria**

**1** - Diagnosis of infantile spasms (i.e., West Syndrome)*

**AND**

**2** - Patient is less than 2 years old

**AND**

**3** - Both of following:

**3.1** Initial dose: 75 U/m^2 (units/square meters) intramuscular (IM) twice daily for 2 weeks

**AND**

**3.2** After 2 weeks, dose should be tapered according to the following schedule: 30 U/m^2 IM in the morning for 3 days; 15 U/m^2 IM in the morning for 3 days; 10 U/m^2 IM in the morning for 3 days; 10 U/m^2 IM every other morning for 6 days (3 doses)

| | |
|---|---|
| Notes | *Acthar gel and Cortrophin gel are not medically necessary for treatm ent of acute exacerbations of multiple sclerosis. See Background for more information. |

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ACTHAR | CORTICOTROPIN INJ GEL 80 UNIT/ML | 30300010004010 | Brand |
| CORTROPHIN | CORTICOTROPIN INJ GEL 80 UNIT/ML | 30300010004010 | Brand |

**Approval Criteria**

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

| **AND**<br><br>**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 treatm ent of acute exacerbations of multiple sclerosis. See Background for more information. |

## 2 . Background

| **Benefit/Coverage/Program Information** |
|---|
| **More Information:**<br><br>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. |

Retevmo

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146629 |
| **Guideline Name** | Retevmo |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RETEVMO | SELPERCATINIB CAP 40 MG | 21535779000120 | Brand |
| RETEVMO | SELPERCATINIB CAP 80 MG | 21535779000140 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RETEVMO | SELPERCATINIB CAP 40 MG | 21535779000120 | Brand |
| RETEVMO | SELPERCATINIB CAP 80 MG | 21535779000140 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RETEVMO | SELPERCATINIB CAP 40 MG | 21535779000120 | Brand |
| RETEVMO | SELPERCATINIB CAP 80 MG | 21535779000140 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RETEVMO | SELPERCATINIB CAP 40 MG | 21535779000120 | Brand |
| RETEVMO | SELPERCATINIB CAP 80 MG | 21535779000140 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RETEVMO | SELPERCATINIB CAP 40 MG | 21535779000120 | Brand |
| RETEVMO | SELPERCATINIB CAP 80 MG | 21535779000140 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RETEVMO | SELPERCATINIB CAP 40 MG | 21535779000120 | Brand |
| RETEVMO | SELPERCATINIB CAP 80 MG | 21535779000140 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RETEVMO | SELPERCATINIB CAP 40 MG | 21535779000120 | Brand |
| RETEVMO | SELPERCATINIB CAP 80 MG | 21535779000140 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Retevmo therapy

Revlimid

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-151139 |
| **Guideline Name** | Revlimid |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 8/7/2024 |

## 1 . Criteria

| Product Name: Brand Revlimid, generic lenalidomide | |
|---|---|
| Diagnosis | Multiple Myeloma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| REVLIMID | LENALIDOMIDE CAPS 2.5 MG | 99394050000110 | Brand |
| REVLIMID | LENALIDOMIDE CAP 5 MG | 99394050000120 | Brand |
| REVLIMID | LENALIDOMIDE CAP 10 MG | 99394050000130 | Brand |
| REVLIMID | LENALIDOMIDE CAP 15 MG | 99394050000140 | Brand |

| | | | |
|---|---|---|---|
| REVLIMID | LENALIDOMIDE CAP 20 MG | 99394050000145 | Brand |
| REVLIMID | LENALIDOMIDE CAP 25 MG | 99394050000150 | Brand |
| LENALIDOMIDE | LENALIDOMIDE CAP 5 MG | 99394050000120 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 10 MG | 99394050000130 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 15 MG | 99394050000140 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 25 MG | 99394050000150 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAPS 2.5 MG | 99394050000110 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 20 MG | 99394050000145 | Generic |

**Approval Criteria**

**1** - Patient has a 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| REVLIMID | LENALIDOMIDE CAPS 2.5 MG | 99394050000110 | Brand |
| REVLIMID | LENALIDOMIDE CAP 5 MG | 99394050000120 | Brand |
| REVLIMID | LENALIDOMIDE CAP 10 MG | 99394050000130 | Brand |
| REVLIMID | LENALIDOMIDE CAP 15 MG | 99394050000140 | Brand |
| REVLIMID | LENALIDOMIDE CAP 20 MG | 99394050000145 | Brand |
| REVLIMID | LENALIDOMIDE CAP 25 MG | 99394050000150 | Brand |
| LENALIDOMIDE | LENALIDOMIDE CAP 5 MG | 99394050000120 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 10 MG | 99394050000130 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 15 MG | 99394050000140 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 25 MG | 99394050000150 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAPS 2.5 MG | 99394050000110 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 20 MG | 99394050000145 | Generic |

**Approval Criteria**

**1** - Patient has a diagnosis of symptomatic anemia due to myelodysplastic syndrome (MDS) associated with a deletion 5q

**OR**

**2** - BOTH of the following:

**2.1** Patient has a diagnosis of symptomatic anemia due to myelodysplastic syndrome (MDS) WITHOUT deletion 5q

**AND**

**2.2** ONE of the following:

**2.2.1** ALL of the following:

**2.2.1.1** Serum erythropoietin levels less than or equal to 500 mU/mL

**AND**

**2.2.1.2** One of the following:

- Ring sideroblasts < 15%
- Ring sideroblasts < 5% with an SF3B1 mutation

**AND**

**2.2.1.3** History of failure, contraindication or intolerance to one of the following:

- Erythropoietin stimulating agent (ESA) [e.g., Epogen, Procrit, Retacrit (epoetin alfa)] or darbepoetin alfa
- Reblozyl (luspatercept-aamt)

**AND**

**2.2.1.4** Used in combination with an erythropoietin stimulating agent (ESA) [e.g., Epogen, Procrit, Retacrit (epoetin alfa)] or darbepoetin alfa

**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** One of the following:

- Ring sideroblasts ≥ 15%
- Ring sideroblasts ≥ 5% with an SF3B1 mutation

**AND**

**2.2.2.3** History of failure, contraindication or intolerance to both of the following:

- Erythropoietin stimulating agent (ESA) [e.g., Epogen, Procrit, Retacrit (epoetin alfa)] or darbepoetin alfa
- Reblozyl (luspatercept-aamt)

**OR**

**2.2.3** All of the following:

**2.2.3.1** Serum erythropoetin levels > 500 mU/mL

**AND**

**2.2.3.2** One of the following:

- Ring sideroblasts < 15%
- Ring sideroblasts < 5% with an SF3B1 mutation

**AND**

**2.2.3.3** One of the following:

- Poor probability to respond to immunosuppressive therapy (e.g., azacitidine, decitabine)
- History of failure, contraindication, or intolerance to immunosuppressive therapy (e.g., azacitidine, decitabine)

**OR**

**2.2.4** All of the following:

**2.2.4.1** Serum erythropoetin levels > 500 mU/mL

**AND**

**2.2.4.2** One of the following:

- Ring sideroblasts ≥ 15%
- Ring sideroblasts ≥ 5% with an SF3B1 mutation

**AND**

**2.2.4.3** History of failure, contraindication or intolerance to Reblozyl (luspatercept-aamt)

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| REVLIMID | LENALIDOMIDE CAPS 2.5 MG | 99394050000110 | Brand |
| REVLIMID | LENALIDOMIDE CAP 5 MG | 99394050000120 | Brand |
| REVLIMID | LENALIDOMIDE CAP 10 MG | 99394050000130 | Brand |
| REVLIMID | LENALIDOMIDE CAP 15 MG | 99394050000140 | Brand |
| REVLIMID | LENALIDOMIDE CAP 20 MG | 99394050000145 | Brand |
| REVLIMID | LENALIDOMIDE CAP 25 MG | 99394050000150 | Brand |
| LENALIDOMIDE | LENALIDOMIDE CAP 5 MG | 99394050000120 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 10 MG | 99394050000130 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 15 MG | 99394050000140 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 25 MG | 99394050000150 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAPS 2.5 MG | 99394050000110 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 20 MG | 99394050000145 | Generic |

**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 or subsequent therapy

| Product Name: Brand Revlimid, generic lenalidomide | |
|---|---|
| Diagnosis | Hodgkin Lymphoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| REVLIMID | LENALIDOMIDE CAPS 2.5 MG | 99394050000110 | Brand |
| REVLIMID | LENALIDOMIDE CAP 5 MG | 99394050000120 | Brand |
| REVLIMID | LENALIDOMIDE CAP 10 MG | 99394050000130 | Brand |
| REVLIMID | LENALIDOMIDE CAP 15 MG | 99394050000140 | Brand |
| REVLIMID | LENALIDOMIDE CAP 20 MG | 99394050000145 | Brand |
| REVLIMID | LENALIDOMIDE CAP 25 MG | 99394050000150 | Brand |
| LENALIDOMIDE | LENALIDOMIDE CAP 5 MG | 99394050000120 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 10 MG | 99394050000130 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 15 MG | 99394050000140 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 25 MG | 99394050000150 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAPS 2.5 MG | 99394050000110 | Generic |

| | | | |
|---|---|---|---|
| LENALIDOMIDE | LENALIDOMIDE CAP 20 MG | 99394050000145 | Generic |

**Approval Criteria**

**1** - Patient has a diagnosis of Hodgkin lymphoma

**AND**

**2** - Disease is refractory to at least 3 prior lines of therapy

| Product Name: Brand Revlimid, generic lenalidomide | |
|---|---|
| Diagnosis | Systemic Light Chain Amyloidosis |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| REVLIMID | LENALIDOMIDE CAPS 2.5 MG | 99394050000110 | Brand |
| REVLIMID | LENALIDOMIDE CAP 5 MG | 99394050000120 | Brand |
| REVLIMID | LENALIDOMIDE CAP 10 MG | 99394050000130 | Brand |
| REVLIMID | LENALIDOMIDE CAP 15 MG | 99394050000140 | Brand |
| REVLIMID | LENALIDOMIDE CAP 20 MG | 99394050000145 | Brand |
| REVLIMID | LENALIDOMIDE CAP 25 MG | 99394050000150 | Brand |
| LENALIDOMIDE | LENALIDOMIDE CAP 5 MG | 99394050000120 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 10 MG | 99394050000130 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 15 MG | 99394050000140 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 25 MG | 99394050000150 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAPS 2.5 MG | 99394050000110 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 20 MG | 99394050000145 | Generic |

**Approval Criteria**

**1** - Patient has a diagnosis of systemic light chain amyloidosis

**AND**

**2** - Used in combination with ONE of the following:

- Dexamethasone
- Dexamethasone and cyclophosphamide
- Dexamethasone and Ninlaro® (ixazomib)

| 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| REVLIMID | LENALIDOMIDE CAPS 2.5 MG | 99394050000110 | Brand |
| REVLIMID | LENALIDOMIDE CAP 5 MG | 99394050000120 | Brand |
| REVLIMID | LENALIDOMIDE CAP 10 MG | 99394050000130 | Brand |
| REVLIMID | LENALIDOMIDE CAP 15 MG | 99394050000140 | Brand |
| REVLIMID | LENALIDOMIDE CAP 20 MG | 99394050000145 | Brand |
| REVLIMID | LENALIDOMIDE CAP 25 MG | 99394050000150 | Brand |
| LENALIDOMIDE | LENALIDOMIDE CAP 5 MG | 99394050000120 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 10 MG | 99394050000130 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 15 MG | 99394050000140 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 25 MG | 99394050000150 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAPS 2.5 MG | 99394050000110 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 20 MG | 99394050000145 | Generic |

**Approval Criteria**

**1** - Patient has a 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| REVLIMID | LENALIDOMIDE CAPS 2.5 MG | 99394050000110 | Brand |
| REVLIMID | LENALIDOMIDE CAP 5 MG | 99394050000120 | Brand |
| REVLIMID | LENALIDOMIDE CAP 10 MG | 99394050000130 | Brand |
| REVLIMID | LENALIDOMIDE CAP 15 MG | 99394050000140 | Brand |
| REVLIMID | LENALIDOMIDE CAP 20 MG | 99394050000145 | Brand |
| REVLIMID | LENALIDOMIDE CAP 25 MG | 99394050000150 | Brand |
| LENALIDOMIDE | LENALIDOMIDE CAP 5 MG | 99394050000120 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 10 MG | 99394050000130 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 15 MG | 99394050000140 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 25 MG | 99394050000150 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAPS 2.5 MG | 99394050000110 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 20 MG | 99394050000145 | Generic |

**Approval Criteria**

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

- Peripheral T-cell lymphoma
- T-cell leukemia/lymphoma
- Hepatosplenic gamma-delta T-cell lymphoma

**AND**

**2** - Used as second-line or subsequent therapy

| Product Name: Brand Revlimid, generic lenalidomide | |
|---|---|
| Diagnosis | Primary CNS Lymphoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| REVLIMID | LENALIDOMIDE CAPS 2.5 MG | 99394050000110 | Brand |
| REVLIMID | LENALIDOMIDE CAP 5 MG | 99394050000120 | Brand |
| REVLIMID | LENALIDOMIDE CAP 10 MG | 99394050000130 | Brand |
| REVLIMID | LENALIDOMIDE CAP 15 MG | 99394050000140 | Brand |
| REVLIMID | LENALIDOMIDE CAP 20 MG | 99394050000145 | Brand |
| REVLIMID | LENALIDOMIDE CAP 25 MG | 99394050000150 | Brand |
| LENALIDOMIDE | LENALIDOMIDE CAP 5 MG | 99394050000120 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 10 MG | 99394050000130 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 15 MG | 99394050000140 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 25 MG | 99394050000150 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAPS 2.5 MG | 99394050000110 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 20 MG | 99394050000145 | Generic |

**Approval Criteria**

**1** - Patient has a 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| REVLIMID | LENALIDOMIDE CAPS 2.5 MG | 99394050000110 | Brand |
| REVLIMID | LENALIDOMIDE CAP 5 MG | 99394050000120 | Brand |
| REVLIMID | LENALIDOMIDE CAP 10 MG | 99394050000130 | Brand |
| REVLIMID | LENALIDOMIDE CAP 15 MG | 99394050000140 | Brand |
| REVLIMID | LENALIDOMIDE CAP 20 MG | 99394050000145 | Brand |
| REVLIMID | LENALIDOMIDE CAP 25 MG | 99394050000150 | Brand |
| LENALIDOMIDE | LENALIDOMIDE CAP 5 MG | 99394050000120 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 10 MG | 99394050000130 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 15 MG | 99394050000140 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 25 MG | 99394050000150 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAPS 2.5 MG | 99394050000110 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 20 MG | 99394050000145 | Generic |

**Approval Criteria**

**1** - BOTH of the following:

**1.1** ONE of the following:

**1.1.1** Patient has a diagnosis of human immunodeficiency virus (HIV)-negative Kaposi Sarcoma

**OR**

**1.1.2** BOTH of the following:

**1.1.2.1** Diagnosis of HIV-related Kaposi Sarcoma

**AND**

**1.1.2.2** Patient is currently being treated with antiretroviral therapy (ART) confirmed by claims history or submission of medical records

**AND**

**1.2** Disease has progressed or not responded to two different systemic first-line systemic 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| REVLIMID | LENALIDOMIDE CAPS 2.5 MG | 99394050000110 | Brand |
| REVLIMID | LENALIDOMIDE CAP 5 MG | 99394050000120 | Brand |
| REVLIMID | LENALIDOMIDE CAP 10 MG | 99394050000130 | Brand |
| REVLIMID | LENALIDOMIDE CAP 15 MG | 99394050000140 | Brand |
| REVLIMID | LENALIDOMIDE CAP 20 MG | 99394050000145 | Brand |
| REVLIMID | LENALIDOMIDE CAP 25 MG | 99394050000150 | Brand |
| LENALIDOMIDE | LENALIDOMIDE CAP 5 MG | 99394050000120 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 10 MG | 99394050000130 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 15 MG | 99394050000140 | Generic |

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|---|---|---|---|
| LENALIDOMIDE | LENALIDOMIDE CAP 25 MG | 99394050000150 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAPS 2.5 MG | 99394050000110 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 20 MG | 99394050000145 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| REVLIMID | LENALIDOMIDE CAPS 2.5 MG | 99394050000110 | Brand |
| REVLIMID | LENALIDOMIDE CAP 5 MG | 99394050000120 | Brand |
| REVLIMID | LENALIDOMIDE CAP 10 MG | 99394050000130 | Brand |
| REVLIMID | LENALIDOMIDE CAP 15 MG | 99394050000140 | Brand |
| REVLIMID | LENALIDOMIDE CAP 20 MG | 99394050000145 | Brand |
| REVLIMID | LENALIDOMIDE CAP 25 MG | 99394050000150 | Brand |
| LENALIDOMIDE | LENALIDOMIDE CAP 5 MG | 99394050000120 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 10 MG | 99394050000130 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 15 MG | 99394050000140 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 25 MG | 99394050000150 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAPS 2.5 MG | 99394050000110 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 20 MG | 99394050000145 | Generic |

**Approval Criteria**

**1** - Patient has a 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 | * |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| REVLIMID | LENALIDOMIDE CAPS 2.5 MG | 99394050000110 | Brand |
| REVLIMID | LENALIDOMIDE CAP 5 MG | 99394050000120 | Brand |
| REVLIMID | LENALIDOMIDE CAP 10 MG | 99394050000130 | Brand |
| REVLIMID | LENALIDOMIDE CAP 15 MG | 99394050000140 | Brand |
| REVLIMID | LENALIDOMIDE CAP 20 MG | 99394050000145 | Brand |
| REVLIMID | LENALIDOMIDE CAP 25 MG | 99394050000150 | Brand |
| LENALIDOMIDE | LENALIDOMIDE CAP 5 MG | 99394050000120 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 10 MG | 99394050000130 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 15 MG | 99394050000140 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 25 MG | 99394050000150 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAPS 2.5 MG | 99394050000110 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 20 MG | 99394050000145 | Generic |

**Approval Criteria**

| **1** - Patient does not show evidence of progressive disease while on Revlimid therapy | |
|---|---|
| Notes | *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 |

| Product Name: Brand Revlimid, generic lenalidomide | |
|---|---|
| Diagnosis | Myelofibrosis-Associated Anemia |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| REVLIMID | LENALIDOMIDE CAPS 2.5 MG | 99394050000110 | Brand |
| REVLIMID | LENALIDOMIDE CAP 5 MG | 99394050000120 | Brand |
| REVLIMID | LENALIDOMIDE CAP 10 MG | 99394050000130 | Brand |
| REVLIMID | LENALIDOMIDE CAP 15 MG | 99394050000140 | Brand |
| REVLIMID | LENALIDOMIDE CAP 20 MG | 99394050000145 | Brand |
| REVLIMID | LENALIDOMIDE CAP 25 MG | 99394050000150 | Brand |
| LENALIDOMIDE | LENALIDOMIDE CAP 5 MG | 99394050000120 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 10 MG | 99394050000130 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 15 MG | 99394050000140 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 25 MG | 99394050000150 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAPS 2.5 MG | 99394050000110 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 20 MG | 99394050000145 | Generic |

**Approval Criteria**

**1** - Patient has a 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| REVLIMID | LENALIDOMIDE CAPS 2.5 MG | 99394050000110 | Brand |
| REVLIMID | LENALIDOMIDE CAP 5 MG | 99394050000120 | Brand |
| REVLIMID | LENALIDOMIDE CAP 10 MG | 99394050000130 | Brand |
| REVLIMID | LENALIDOMIDE CAP 15 MG | 99394050000140 | Brand |
| REVLIMID | LENALIDOMIDE CAP 20 MG | 99394050000145 | Brand |
| REVLIMID | LENALIDOMIDE CAP 25 MG | 99394050000150 | Brand |
| LENALIDOMIDE | LENALIDOMIDE CAP 5 MG | 99394050000120 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 10 MG | 99394050000130 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 15 MG | 99394050000140 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 25 MG | 99394050000150 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAPS 2.5 MG | 99394050000110 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 20 MG | 99394050000145 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| REVLIMID | LENALIDOMIDE CAPS 2.5 MG | 99394050000110 | Brand |
| REVLIMID | LENALIDOMIDE CAP 5 MG | 99394050000120 | Brand |
| REVLIMID | LENALIDOMIDE CAP 10 MG | 99394050000130 | Brand |
| REVLIMID | LENALIDOMIDE CAP 15 MG | 99394050000140 | Brand |
| REVLIMID | LENALIDOMIDE CAP 20 MG | 99394050000145 | Brand |
| REVLIMID | LENALIDOMIDE CAP 25 MG | 99394050000150 | Brand |
| LENALIDOMIDE | LENALIDOMIDE CAP 5 MG | 99394050000120 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 10 MG | 99394050000130 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 15 MG | 99394050000140 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 25 MG | 99394050000150 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAPS 2.5 MG | 99394050000110 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 20 MG | 99394050000145 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| REVLIMID | LENALIDOMIDE CAPS 2.5 MG | 99394050000110 | Brand |
| REVLIMID | LENALIDOMIDE CAP 5 MG | 99394050000120 | Brand |
| REVLIMID | LENALIDOMIDE CAP 10 MG | 99394050000130 | Brand |
| REVLIMID | LENALIDOMIDE CAP 15 MG | 99394050000140 | Brand |
| REVLIMID | LENALIDOMIDE CAP 20 MG | 99394050000145 | Brand |
| REVLIMID | LENALIDOMIDE CAP 25 MG | 99394050000150 | Brand |
| LENALIDOMIDE | LENALIDOMIDE CAP 5 MG | 99394050000120 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 10 MG | 99394050000130 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 15 MG | 99394050000140 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 25 MG | 99394050000150 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAPS 2.5 MG | 99394050000110 | Generic |
| LENALIDOMIDE | LENALIDOMIDE CAP 20 MG | 99394050000145 | Generic |

**Approval Criteria**

**1** - Documentation of positive clinical response to Revlimid therapy

Reyvow

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146408 |
| **Guideline Name** | Reyvow |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| REYVOW | LASMIDITAN SUCCINATE TAB 50 MG | 67406540600310 | Brand |
| REYVOW | LASMIDITAN SUCCINATE TAB 100 MG | 67406540600320 | Brand |

**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** History of a therapeutic 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:

- naratriptan (generic Amerge)
- rizatriptan (generic Maxalt/Maxalt MLT)
- sumatriptan (generic Imitrex)

**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):

- naratriptan (generic Amerge)
- rizatriptan (generic Maxalt/Maxalt MLT)
- sumatriptan (generic Imitrex)
- Nurtec ODT
- Ubrelvy

**AND**

**4** - Prescribed by or in consultation with ONE of the following specialists with expertise in the acute treatment of migraine:

- Neurologist
- Pain Specialist
- Headache Specialist [Headache specialists are physicians certified by the United Council for Neurologic Subspecialties (UCNS)]

**AND**

**5** - Prescriber attests to BOTH of the following:

**5.1** 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**

**5.2** 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**

**6** - ONE of the following:

**6.1** Patient is currently treated with ONE of the following prophylactic therapies:

- Amitriptyline (generic Elavil)
- 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)**
- Topiramate (generic Topamax)
- Venlafaxine (generic Effexor/Effexor XR)

**OR**

**6.2** Patient has less than 4 migraine days per month

**OR**

**6.3** Patient has greater than or equal to 4 migraine days per month and has contraindication or intolerance to ONE of the following prophylactic therapies:

- Amitriptyline (generic Elavil)
- 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)**
- Topiramate (generic Topamax)
- Venlafaxine (generic Effexor/Effexor XR)

| | |
|---|---|
| Notes | *Timolol, candesartan, Ajovy, and Qulipta are non-preferred and shoul d not be included in denial to provider.<br>**Vyepti and OnabotulinumtoxinA (generic Botox) are medical benefit, should not be included in denial to provider.<br>***CGRP antagonists for preventive treatment of migraines require a p rior authorization. |

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| REYVOW | LASMIDITAN SUCCINATE TAB 50 MG | 67406540600310 | Brand |
| REYVOW | LASMIDITAN SUCCINATE TAB 100 MG | 67406540600320 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to therapy

Rezdiffra

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-147405 |
| **Guideline Name** | Rezdiffra |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| REZDIFFRA | RESMETIROM 60 MG TAB | 52601060000320 | Brand |
| REZDIFFRA | RESMETIROM 80 MG TAB | 52601060000330 | Brand |
| REZDIFFRA | RESMETIROM 100 MG TAB | 52601060000340 | Brand |

**Approval Criteria**

**1** - Diagnosis of metabolic dysfunction-associated steatohepatitis (MASH) [formerly known as nonalcoholic steatohepatitis (NASH)]

**AND**

**2** - Disease is fibrosis stage F2 or F3 as confirmed by one of the following:

**2.1** FAST [FibroScan-aspartate aminotransferase (AST)]

**OR**

**2.2** MAST [derived from magnetic resonance imaging–proton density fat fraction, magnetic resonance elastography (MRE), and AST]

**OR**

**2.3** MEFIB [MRE combined with fibrosis-4 index (FIB-4)]

**OR**

**2.4** Liver biopsy

**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 a gastroenterologist or hepatologist

| Product Name: Rezdiffra | |
|---|---|
| Approval Length | 12 month(s) |

| Therapy Stage | Reauthorization |
|---|---|
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| REZDIFFRA | RESMETIROM 60 MG TAB | 52601060000320 | Brand |
| REZDIFFRA | RESMETIROM 80 MG TAB | 52601060000330 | Brand |
| REZDIFFRA | RESMETIROM 100 MG TAB | 52601060000340 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Rezdiffra therapy (e.g., improvement in or stabilization of fibrosis)

**AND**

**2** - Prescribed by or in consultation with a gastroenterologist or hepatologist

## 2 . Revision History

| Date | Notes |
|---|---|
| 5/14/2024 | New guideline |

Rezlidhia

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146631 |
| **Guideline Name** | Rezlidhia |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Rezlidhia | |
|---|---|
| Diagnosis | Acute Myeloid Leukemia (AML) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| REZLIDHIA | OLUTASIDENIB CAP 150 MG | 21534960000120 | Brand |

**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** - Disease is relapsed or refractory

| Product Name: Rezlidhia | |
|---|---|
| Diagnosis | Acute Myeloid Leukemia (AML) |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| REZLIDHIA | OLUTASIDENIB CAP 150 MG | 21534960000120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| REZLIDHIA | OLUTASIDENIB CAP 150 MG | 21534960000120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| REZLIDHIA | OLUTASIDENIB CAP 150 MG | 21534960000120 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Rezlidhia therapy

Rezurock

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-157766 |
| **Guideline Name** | Rezurock |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 12/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| REZUROCK | BELUMOSUDIL MESYLATE TAB 200 MG | 99398510500320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| REZUROCK | BELUMOSUDIL MESYLATE TAB 200 MG | 99398510500320 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Rezurock therapy

## 2 . Revision History

| Date | Notes |
|---|---|
| 10/21/2024 | Removed age requirement in initial auth section. |

Rinvoq

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-160770 |
| **Guideline Name** | Rinvoq |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 1 . Criteria

| Product Name: Rinvoq | |
|---|---|
| Diagnosis | Rheumatoid Arthritis (RA) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RINVOQ | UPADACITINIB TAB ER 24HR 15 MG | 66603072007520 | Brand |
| RINVOQ | UPADACITINIB TAB ER 24HR 30 MG | 66603072007530 | Brand |
| RINVOQ | UPADACITINIB TAB ER 24HR 45 MG | 66603072007540 | Brand |

**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:

**2.1.1.1** 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 submission of medical records

**OR**

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

**OR**

**2.1.1.3** 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., Enbrel (etanercept), Cimzia (certolizumab), adalimumab, Simponi (golimumab), Orencia (abatacept), Olumiant (baricitinib), 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:

**2.1.3.1** Failure to Olumiant as confirmed by claims history or submission of medical records

**OR**

**2.1.3.2** 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:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)

**AND**

**4** - Prescribed by or in consultation with a rheumatologist

| Notes | *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |
|---|---|

| Product Name: Rinvoq, Rinvoq LQ | |
|---|---|
| Diagnosis | Psoriatic Arthritis (PsA) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RINVOQ | UPADACITINIB TAB ER 24HR 15 MG | 66603072007520 | Brand |
| RINVOQ | UPADACITINIB TAB ER 24HR 30 MG | 66603072007530 | Brand |
| RINVOQ | UPADACITINIB TAB ER 24HR 45 MG | 66603072007540 | Brand |
| RINVOQ LQ | UPADACITINIB ORAL SOLN 1 MG/ML | 66603072002020 | Brand |

**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:

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

**OR**

**2.1.1.2** History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

**OR**

**2.1.1.3** 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., Enbrel (etanercept), Cimzia (certolizumab), adalimumab, Simponi (golimumab), Orencia (abatacept), Stelara (ustekinumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), Cosentyx (secukinumab), Taltz (ixekizumab), Olumiant (baricitinib), Otezla (apremilast), Skyrizi (risankizumab-rzaa)]

**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 BOTH of the following as confirmed by claims history or submission of medical records:

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

**OR**

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

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

**AND**

**2.1.2.1.2** ONE of the following:

**2.1.2.1.2.1** Failure to Cosentyx (secukinumab) as confirmed by claims history or submission of medical records

**OR**

**2.1.2.1.2.2** 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:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Otezla (apremilast)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)

**AND**

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

- Rheumatologist
- Dermatologist

| Notes | *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |
|---|---|

| Product Name: Rinvoq | |
|---|---|
| Diagnosis | Atopic Dermatitis |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RINVOQ | UPADACITINIB TAB ER 24HR 15 MG | 66603072007520 | Brand |
| RINVOQ | UPADACITINIB TAB ER 24HR 30 MG | 66603072007530 | Brand |
| RINVOQ | UPADACITINIB TAB ER 24HR 45 MG | 66603072007540 | Brand |

**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:

**2.1.2.1.1** 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), cyclosporine, azathioprine, methotrexate, mycophenolate mofetil, etc.]

**AND**

**2.1.2.1.2** 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 BOTH of the following FDA (Food and Drug Administration)-approved atopic dermatitis therapy is inadvisable (document drug and contraindication rationale):

- Adbry (tralokinumab-ldrm)
- Dupixent (dupilumab)

**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:

- Targeted immunomodulator [e.g., Adbry (tralokinumab-ldrm), Dupixent (dupilumab), Cibinqo (abrocitinib), Xeljanz/XR (tofacitinib), Olumiant (baricitinib), Opzelura (topical ruxolitinib)]
- 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 |
|---|---|

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RINVOQ | UPADACITINIB TAB ER 24HR 15 MG | 66603072007520 | Brand |
| RINVOQ | UPADACITINIB TAB ER 24HR 30 MG | 66603072007530 | Brand |
| RINVOQ | UPADACITINIB TAB ER 24HR 45 MG | 66603072007540 | Brand |

**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:

**2.1.1.1** Patient has had prior or concurrent inadequate response to a therapeutic course of oral corticosteroids and/or immunosuppressants (e.g., azathioprine, 6-mercaptopurine)

**OR**

**2.1.1.2** 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), Stelara (ustekinumab), Xeljanz/XR (tofacitinib)]

**AND**

**2.1.2** ONE of the following:

**2.1.2.1** Failure to one of the preferred adalimumab products* as confirmed by claims history or submission of medical records

**OR**

**2.1.2.2** History of intolerance or contraindication to one of the preferred adalimumab products* (please specify intolerance or contraindication)

**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:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Stelara (ustekinumab), Skyrizi (risankizumab)]
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

**AND**

**4** - Prescribed by or in consultation with a gastroenterologist

| | |
|---|---|
| Notes | *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |

| Product Name: Rinvoq | |
|---|---|
| Diagnosis | Ankylosing Spondylitis |
| Approval Length | 12 month(s) |

| Therapy Stage | Initial Authorization |
|---|---|
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RINVOQ | UPADACITINIB TAB ER 24HR 15 MG | 66603072007520 | Brand |
| RINVOQ | UPADACITINIB TAB ER 24HR 30 MG | 66603072007530 | Brand |
| RINVOQ | UPADACITINIB TAB ER 24HR 45 MG | 66603072007540 | Brand |

**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 targeted immunomodulator FDA-approved for the treatment of ankylosing spondylitis as confirmed by claims history or submission of medical records [e.g., Enbrel (etanercept), Cimzia (certolizumab), adalimumab, Simponi (golimumab), Xeljanz/Xeljanz XR (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:

**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 Rinvoq in combination with either of the following:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib)]
- 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:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib)]
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

**AND**

**2.4** Prescribed by or in consultation with a rheumatologist

| Notes | *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |
|---|---|

| Product Name: Rinvoq | |
|---|---|
| Diagnosis | Non-Radiographic Axial Spondyloarthritis (nr-axSpA) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RINVOQ | UPADACITINIB TAB ER 24HR 15 MG | 66603072007520 | Brand |
| RINVOQ | UPADACITINIB TAB ER 24HR 30 MG | 66603072007530 | Brand |
| RINVOQ | UPADACITINIB TAB ER 24HR 45 MG | 66603072007540 | Brand |

**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:

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

**OR**

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

**OR**

**2.1.1.3** 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)]

**AND**

**2.1.2** ONE of the following:

**2.1.2.1** ONE of the following:

**2.1.2.1.1** Failure to Cosentyx (secukinumab), as confirmed by claims history or submission of medical records

**OR**

**2.1.2.1.2** 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:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib)]
- 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RINVOQ | UPADACITINIB TAB ER 24HR 15 MG | 66603072007520 | Brand |
| RINVOQ | UPADACITINIB TAB ER 24HR 30 MG | 66603072007530 | Brand |
| RINVOQ | UPADACITINIB TAB ER 24HR 45 MG | 66603072007540 | Brand |

**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:

**2.1.2.1** Failure to ONE of the preferred adalimumab products* as confirmed by claims history or submission of medical records

**OR**

**2.1.2.2** History of intolerance or contraindication to ONE of the preferred adalimumab products* (please specify intolerance or contraindication)

**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:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Stelara (ustekinumab), Skyrizi (risankizumab)]
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

**AND**

**4** - Prescribed by or in consultation with a gastroenterologist

| | |
|---|---|
| Notes | *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |

| Product Name: Rinvoq, Rinvoq LQ | |
|---|---|
| Diagnosis | Polyarticular Juvenile Idiopathic Arthritis (pJIA) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RINVOQ | UPADACITINIB TAB ER 24HR 15 MG | 66603072007520 | Brand |
| RINVOQ | UPADACITINIB TAB ER 24HR 30 MG | 66603072007530 | Brand |
| RINVOQ | UPADACITINIB TAB ER 24HR 45 MG | 66603072007540 | Brand |
| RINVOQ LQ | UPADACITINIB ORAL SOLN 1 MG/ML | 66603072002020 | Brand |

**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 criteria5)

**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:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Olumiant (baricitinib), Xeljanz (tofacitinib)]
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

**AND**

**4** - Prescribed by or in consultation with a rheumatologist

| Notes | *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |
|---|---|

| 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RINVOQ | UPADACITINIB TAB ER 24HR 15 MG | 66603072007520 | Brand |
| RINVOQ | UPADACITINIB TAB ER 24HR 30 MG | 66603072007530 | Brand |
| RINVOQ | UPADACITINIB TAB ER 24HR 45 MG | 66603072007540 | Brand |

**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:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Otezla (apremilast)]*
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)*

| Notes | * Examples of drug(s) may not be applicable based on the requested i ndication. |
|---|---|

| 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RINVOQ | UPADACITINIB TAB ER 24HR 15 MG | 66603072007520 | Brand |
| RINVOQ | UPADACITINIB TAB ER 24HR 30 MG | 66603072007530 | Brand |
| RINVOQ | UPADACITINIB TAB ER 24HR 45 MG | 66603072007540 | Brand |
| RINVOQ LQ | UPADACITINIB ORAL SOLN 1 MG/ML | 66603072002020 | Brand |

**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:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Otezla (apremilast)]*
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)*

| Notes | * Examples of drug(s) may not be applicable based on the requested i ndication. |
|---|---|

| Product Name: Rinvoq | |
|---|---|
| Diagnosis | Atopic Dermatitis |
| Approval Length | 12 month(s) |

| Therapy Stage | Reauthorization |
|---|---|
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RINVOQ | UPADACITINIB TAB ER 24HR 15 MG | 66603072007520 | Brand |
| RINVOQ | UPADACITINIB TAB ER 24HR 30 MG | 66603072007530 | Brand |
| RINVOQ | UPADACITINIB TAB ER 24HR 45 MG | 66603072007540 | Brand |

**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:

- Targeted immunomodulator [e.g., Adbry (tralokinumab-ldrm), Dupixent (dupilumab), Cibinqo (abrocitinib), Xeljanz/XR (tofacitinib), Olumiant (baricitinib), Opzelura (topical ruxolitinib)]
- 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 |
| Medium potency | Betamethasone valerate | Cream, foam, lotion, ointment | 0.1 |
| | Clocortolone pivalate | Cream | 0.1 |
| | Desoximetasone | Cream | 0.05 |
| | Fluocinolone acetonide | Cream, ointment | 0.025 |
| | Flurandrenolide | Cream, ointment, lotion | 0.05 |
| | Fluticasone propionate | Cream | 0.05 |
| | Fluticasone propionate | Ointment | 0.005 |
| | Mometasone furoate | Cream, lotion | 0.1 |

| | | | |
|---|---|---|---|
| | Triamcinolone acetonide | Cream, ointment, lotion | 0.1 |
| Lower-medium potency | Hydrocortisone butyrate | Cream, ointment, solution | 0.1 |
| | Hydrocortisone probutate | Cream | 0.1 |
| | Hydrocortisone valerate | Cream, ointment | 0.2 |
| | Prednicarbate | Cream | 0.1 |
| Low potency | Alclometasone dipropionate | Cream, ointment | 0.05 |
| | Desonide | Cream, gel, foam, ointment | 0.05 |
| | Fluocinolone acetonide | Cream, solution | 0.01 |
| Lowest potency | Dexamethasone | Cream | 0.1 |
| | Hydrocortisone | Cream, lotion, ointment, solution | 0.25, 0.5, 1 |
| | Hydrocortisone acetate | Cream, ointment | 0.5-1 |

## 3 . Revision History

| Date | Notes |
|---|---|
| 11/18/2024 | Removed Cimzia as step thru agent. Updated safety language and st ep therapy bypass language |

Rivfloza

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-149311 |
| **Guideline Name** | Rivfloza |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/2/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RIVFLOZA | NEDOSIRAN SODIUM SUBCUTANEOUS SOLN PREF SYR 128 MG/0.8ML | 5662605060E520 | Brand |
| RIVFLOZA | NEDOSIRAN SODIUM SUBCUTANEOUS SOLN PREF SYR 160 MG/ML | 5662605060E530 | Brand |
| RIVFLOZA | NEDOSIRAN SODIUM SUBCUTANEOUS SOLN 80 MG/0.5ML | 56626050602020 | Brand |

**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 m^2)

**AND**

**1.5** Patient is NOT receiving Rivfloza in combination with Oxlumo (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 m^2 per day [90 mg/1.73 m^2 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 9 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 m^2)

**AND**

**2.6** Patient is NOT receiving Rivfloza in combination with Oxlumo (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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RIVFLOZA | NEDOSIRAN SODIUM SUBCUTANEOUS SOLN PREF SYR 128 MG/0.8ML | 5662605060E520 | Brand |
| RIVFLOZA | NEDOSIRAN SODIUM SUBCUTANEOUS SOLN PREF SYR 160 MG/ML | 5662605060E530 | Brand |
| RIVFLOZA | NEDOSIRAN SODIUM SUBCUTANEOUS SOLN 80 MG/0.5ML | 56626050602020 | Brand |

**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 m^2)

**AND**

**4** - Patient is NOT receiving Rivfloza in combination with Oxlumo (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 |
|---|---|
| 7/2/2024 | New program. |

Rozerem

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146409 |
| **Guideline Name** | Rozerem |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Brand Rozerem, generic ramelteon | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RAMELTEON | RAMELTEON TAB 8 MG | 60250060000320 | Generic |
| ROZEREM | RAMELTEON TAB 8 MG | 60250060000320 | Brand |

**Approval Criteria**

**1** - Failure of at least 2 weeks to ALL of the following sedative-hypnotic alternatives confirmed by claims history or submitted medical records:

- Zolpidem or zolpidem ER (generic Ambien, generic Ambien CR)
- Zaleplon (generic Sonata)
- Eszopiclone (generic Lunesta)

**OR**

**2** - History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- Zolpidem or zolpidem ER (generic Ambien, generic Ambien CR)
- Zaleplon (generic Sonata)
- Eszopiclone (generic Lunesta)

**OR**

**3** - History of or potential for a substance abuse disorder

Rozlytrek

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146634 |
| **Guideline Name** | Rozlytrek |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Rozlytrek | |
|---|---|
| Diagnosis | Non-Small Cell Lung Cancer (NSCLC) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ROZLYTREK | ENTRECTINIB CAP 100 MG | 21533820000120 | Brand |
| ROZLYTREK | ENTRECTINIB CAP 200 MG | 21533820000130 | Brand |
| ROZLYTREK | ENTRECTINIB PELLET PACK 50 MG | 21533820003020 | Brand |

**Approval Criteria**

**1** - Patient has diagnosis of metastatic non-small cell lung cancer (NSCLC)

**AND**

**2** - Disease is ROS1 (gene)-positive

| Product Name: Rozlytrek | |
|---|---|
| Diagnosis | Solid Tumors |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ROZLYTREK | ENTRECTINIB CAP 100 MG | 21533820000120 | Brand |
| ROZLYTREK | ENTRECTINIB CAP 200 MG | 21533820000130 | Brand |
| ROZLYTREK | ENTRECTINIB PELLET PACK 50 MG | 21533820003020 | Brand |

**Approval Criteria**

**1** - Presence of solid tumors [e.g., sarcoma, non-small cell lung cancer (NSCLC), salivary, breast, thyroid, colorectal, neuroendocrine, pancreatic, gynecological, cholangiocarcinoma, etc.]

**AND**

**2** - Disease is positive for neurotrophic receptor tyrosine 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
- Unresectable

| Product Name: Rozlytrek | |
|---|---|
| Diagnosis | Non-Small Cell Lung Cancer (NSCLC), Solid Tumors |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ROZLYTREK | ENTRECTINIB CAP 100 MG | 21533820000120 | Brand |
| ROZLYTREK | ENTRECTINIB CAP 200 MG | 21533820000130 | Brand |
| ROZLYTREK | ENTRECTINIB PELLET PACK 50 MG | 21533820003020 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ROZLYTREK | ENTRECTINIB CAP 100 MG | 21533820000120 | Brand |
| ROZLYTREK | ENTRECTINIB CAP 200 MG | 21533820000130 | Brand |
| ROZLYTREK | ENTRECTINIB PELLET PACK 50 MG | 21533820003020 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ROZLYTREK | ENTRECTINIB CAP 100 MG | 21533820000120 | Brand |
| ROZLYTREK | ENTRECTINIB CAP 200 MG | 21533820000130 | Brand |
| ROZLYTREK | ENTRECTINIB PELLET PACK 50 MG | 21533820003020 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Rozlytrek therapy

Rubraca

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146635 |
| **Guideline Name** | Rubraca |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RUBRACA | RUCAPARIB CAMSYLATE TAB 250 MG (BASE EQUIVALENT) | 21535570200325 | Brand |
| RUBRACA | RUCAPARIB CAMSYLATE TAB 300 MG (BASE EQUIVALENT) | 21535570200330 | Brand |

| | | | |
|---|---|---|---|
| RUBRACA | RUCAPARIB CAMSYLATE TAB 200 MG (BASE EQUIVALENT) | 21535570200320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RUBRACA | RUCAPARIB CAMSYLATE TAB 250 MG (BASE EQUIVALENT) | 21535570200325 | Brand |
| RUBRACA | RUCAPARIB CAMSYLATE TAB 300 MG (BASE EQUIVALENT) | 21535570200330 | Brand |
| RUBRACA | RUCAPARIB CAMSYLATE TAB 200 MG (BASE EQUIVALENT) | 21535570200320 | Brand |

**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** - History of failure, contraindication, or intolerance to taxane-based chemotherapy (e.g., docetaxel, Jevtana (cabazitaxel))

**AND**

**5** - ONE of the following:

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

**OR**

**5.2** Patient has had bilateral orchiectomy

| Product Name: Rubraca | |
|---|---|
| Diagnosis | Uterine cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RUBRACA | RUCAPARIB CAMSYLATE TAB 250 MG (BASE EQUIVALENT) | 21535570200325 | Brand |
| RUBRACA | RUCAPARIB CAMSYLATE TAB 300 MG (BASE EQUIVALENT) | 21535570200330 | Brand |
| RUBRACA | RUCAPARIB CAMSYLATE TAB 200 MG (BASE EQUIVALENT) | 21535570200320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RUBRACA | RUCAPARIB CAMSYLATE TAB 250 MG (BASE EQUIVALENT) | 21535570200325 | Brand |
| RUBRACA | RUCAPARIB CAMSYLATE TAB 300 MG (BASE EQUIVALENT) | 21535570200330 | Brand |
| RUBRACA | RUCAPARIB CAMSYLATE TAB 200 MG (BASE EQUIVALENT) | 21535570200320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RUBRACA | RUCAPARIB CAMSYLATE TAB 250 MG (BASE EQUIVALENT) | 21535570200325 | Brand |
| RUBRACA | RUCAPARIB CAMSYLATE TAB 300 MG (BASE EQUIVALENT) | 21535570200330 | Brand |
| RUBRACA | RUCAPARIB CAMSYLATE TAB 200 MG (BASE EQUIVALENT) | 21535570200320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RUBRACA | RUCAPARIB CAMSYLATE TAB 250 MG (BASE EQUIVALENT) | 21535570200325 | Brand |
| RUBRACA | RUCAPARIB CAMSYLATE TAB 300 MG (BASE EQUIVALENT) | 21535570200330 | Brand |
| RUBRACA | RUCAPARIB CAMSYLATE TAB 200 MG (BASE EQUIVALENT) | 21535570200320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RUBRACA | RUCAPARIB CAMSYLATE TAB 250 MG (BASE EQUIVALENT) | 21535570200325 | Brand |
| RUBRACA | RUCAPARIB CAMSYLATE TAB 300 MG (BASE EQUIVALENT) | 21535570200330 | Brand |
| RUBRACA | RUCAPARIB CAMSYLATE TAB 200 MG (BASE EQUIVALENT) | 21535570200320 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Rubraca therapy

Ruconest

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-148152 |
| **Guideline Name** | Ruconest |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Ruconest | |
|---|---|
| Diagnosis | Hereditary Angioedema (HAE) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RUCONEST | C1 ESTERASE INHIBITOR (RECOMBINANT) FOR IV INJ 2100 UNIT | 85802022102130 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RUCONEST | C1 ESTERASE INHIBITOR (RECOMBINANT) FOR IV INJ 2100 UNIT | 85802022102130 | Brand |

**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

| Date | Notes |
|---|---|

| | |
|---|---|
| 6/5/2024 | Update to types of genetic variant(s) and diagnostic criteria with normal C1 inhibitor levels in initial auth section and minor language update in reauth section; Minor cosmetic updates. |

Rukobia

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146410 |
| **Guideline Name** | Rukobia |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Rukobia | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RUKOBIA | FOSTEMSAVIR TROMETHAMINE TAB ER 12HR 600 MG | 12102330407420 | Brand |

**Approval Criteria**

**1** - Patient has been diagnosed with multidrug-resistant HIV-1 (human immunodeficiency virus) infection

**AND**

**2** - Patient is currently taking or will be prescribed an optimized background antiretroviral regimen

Rydapt

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146637 |
| **Guideline Name** | Rydapt |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Rydapt | |
|---|---|
| Diagnosis | Acute Myeloid Leukemia (AML) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RYDAPT | MIDOSTAURIN CAP 25 MG | 21533030000130 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RYDAPT | MIDOSTAURIN CAP 25 MG | 21533030000130 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RYDAPT | MIDOSTAURIN CAP 25 MG | 21533030000130 | Brand |

**Approval Criteria**

**1** - Diagnosis of lymphoid, myeloid, or mixed lineage neoplasms with eosinophilia

**AND**

**2** - ONE of the following:

- Patient has a FGFR1 rearrangement
- Patient has a 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RYDAPT | MIDOSTAURIN CAP 25 MG | 21533030000130 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RYDAPT | MIDOSTAURIN CAP 25 MG | 21533030000130 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RYDAPT | MIDOSTAURIN CAP 25 MG | 21533030000130 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Rydapt therapy

Samsca

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146638 |
| **Guideline Name** | Samsca |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Brand Samsca, generic tolvaptan | |
|---|---|
| Approval Length | 30 Day(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TOLVAPTAN | TOLVAPTAN TAB 15 MG | 30454060000320 | Generic |
| SAMSCA | TOLVAPTAN TAB 15 MG | 30454060000320 | Brand |
| TOLVAPTAN | TOLVAPTAN TAB 30 MG | 30454060000330 | Generic |
| SAMSCA | TOLVAPTAN TAB 30 MG | 30454060000330 | Brand |

**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

Sandostatin

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146639 |
| **Guideline Name** | Sandostatin |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Brand Sandostatin, generic octreotide | |
|---|---|
| Diagnosis | Acromegaly |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 50 MCG/ML | 3017007010E505 | Generic |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 100 MCG/ML | 3017007010E510 | Generic |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 500 MCG/ML | 3017007010E520 | Generic |

| | | | |
|---|---|---|---|
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML) | 30170070102005 | Generic |
| SANDOSTATIN | OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML) | 30170070102005 | Brand |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML) | 30170070102010 | Generic |
| SANDOSTATIN | OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML) | 30170070102010 | Brand |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 200 MCG/ML (0.2 MG/ML) | 30170070102015 | Generic |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML) | 30170070102020 | Generic |
| SANDOSTATIN | OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML) | 30170070102020 | Brand |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 1000 MCG/ML (1 MG/ML) | 30170070102030 | Generic |

**Approval Criteria**

**1** - Diagnosis of acromegaly

**AND**

**2** - ONE of the following:

**2.1** Inadequate response to ONE of the following:

- Surgery
- Radiotherapy
- Dopamine agonist (e.g., bromocriptine, cabergoline) therapy

**OR**

**2.2** NOT a candidate for any of the following:

- Surgery
- Radiotherapy
- 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 50 MCG/ML | 3017007010E505 | Generic |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 100 MCG/ML | 3017007010E510 | Generic |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 500 MCG/ML | 3017007010E520 | Generic |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML) | 30170070102005 | Generic |
| SANDOSTATIN | OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML) | 30170070102005 | Brand |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML) | 30170070102010 | Generic |
| SANDOSTATIN | OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML) | 30170070102010 | Brand |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 200 MCG/ML (0.2 MG/ML) | 30170070102015 | Generic |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML) | 30170070102020 | Generic |
| SANDOSTATIN | OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML) | 30170070102020 | Brand |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 1000 MCG/ML (1 MG/ML) | 30170070102030 | Generic |

**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** - Additional 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 50 MCG/ML | 3017007010E505 | Generic |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 100 MCG/ML | 3017007010E510 | Generic |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 500 MCG/ML | 3017007010E520 | Generic |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML) | 30170070102005 | Generic |
| SANDOSTATIN | OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML) | 30170070102005 | Brand |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML) | 30170070102010 | Generic |
| SANDOSTATIN | OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML) | 30170070102010 | Brand |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 200 MCG/ML (0.2 MG/ML) | 30170070102015 | Generic |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML) | 30170070102020 | Generic |
| SANDOSTATIN | OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML) | 30170070102020 | Brand |

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|---|---|---|---|
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 1000 MCG/ML (1 MG/ML) | 30170070102030 | Generic |

**Approval Criteria**

**1** - Patient has neuroendocrine tumors [e.g., 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** - ALL of the following:

- Diagnosis of Pheochromocytoma or Paraganglioma
- Disease is locally unresectable or distant metastases
- Disease is somatostatin receptor positive
- Presence of symptomatic disease

| Product Name: Brand Sandostatin, generic octreotide | |
|---|---|
| Diagnosis | Neuroendocrine and Adrenal Tumors |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 50 MCG/ML | 3017007010E505 | Generic |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 100 MCG/ML | 3017007010E510 | Generic |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 500 MCG/ML | 3017007010E520 | Generic |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML) | 30170070102005 | Generic |
| SANDOSTATIN | OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML) | 30170070102005 | Brand |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML) | 30170070102010 | Generic |

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|---|---|---|---|
| SANDOSTATIN | OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML) | 30170070102010 | Brand |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 200 MCG/ML (0.2 MG/ML) | 30170070102015 | Generic |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML) | 30170070102020 | Generic |
| SANDOSTATIN | OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML) | 30170070102020 | Brand |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 1000 MCG/ML (1 MG/ML) | 30170070102030 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 50 MCG/ML | 3017007010E505 | Generic |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 100 MCG/ML | 3017007010E510 | Generic |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 500 MCG/ML | 3017007010E520 | Generic |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML) | 30170070102005 | Generic |
| SANDOSTATIN | OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML) | 30170070102005 | Brand |

| | | | |
|---|---|---|---|
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML) | 30170070102010 | Generic |
| SANDOSTATIN | OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML) | 30170070102010 | Brand |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 200 MCG/ML (0.2 MG/ML) | 30170070102015 | Generic |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML) | 30170070102020 | Generic |
| SANDOSTATIN | OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML) | 30170070102020 | Brand |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 1000 MCG/ML (1 MG/ML) | 30170070102030 | Generic |

**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:

**2.1.1** Unresectable disease following first-line chemotherapy for potentially resectable locally advanced disease, solitary metastasis, or ipsilateral pleural metastasis

**OR**

**2.1.2** Extrathoracic metastatic disease

**OR**

**2.2** BOTH of the following:

**2.2.1** Used as first line therapy for ONE of the following:

- Unresectable locally advanced disease in combination with radiation therapy
- 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

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 50 MCG/ML | 3017007010E505 | Generic |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 100 MCG/ML | 3017007010E510 | Generic |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 500 MCG/ML | 3017007010E520 | Generic |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML) | 30170070102005 | Generic |
| SANDOSTATIN | OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML) | 30170070102005 | Brand |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML) | 30170070102010 | Generic |
| SANDOSTATIN | OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML) | 30170070102010 | Brand |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 200 MCG/ML (0.2 MG/ML) | 30170070102015 | Generic |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML) | 30170070102020 | Generic |
| SANDOSTATIN | OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML) | 30170070102020 | Brand |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 1000 MCG/ML (1 MG/ML) | 30170070102030 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 50 MCG/ML | 3017007010E505 | Generic |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 100 MCG/ML | 3017007010E510 | Generic |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 500 MCG/ML | 3017007010E520 | Generic |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML) | 30170070102005 | Generic |
| SANDOSTATIN | OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML) | 30170070102005 | Brand |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML) | 30170070102010 | Generic |
| SANDOSTATIN | OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML) | 30170070102010 | Brand |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 200 MCG/ML (0.2 MG/ML) | 30170070102015 | Generic |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML) | 30170070102020 | Generic |
| SANDOSTATIN | OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML) | 30170070102020 | Brand |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 1000 MCG/ML (1 MG/ML) | 30170070102030 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 50 MCG/ML | 3017007010E505 | Generic |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 100 MCG/ML | 3017007010E510 | Generic |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 500 MCG/ML | 3017007010E520 | Generic |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML) | 30170070102005 | Generic |
| SANDOSTATIN | OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML) | 30170070102005 | Brand |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML) | 30170070102010 | Generic |
| SANDOSTATIN | OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML) | 30170070102010 | Brand |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 200 MCG/ML (0.2 MG/ML) | 30170070102015 | Generic |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML) | 30170070102020 | Generic |
| SANDOSTATIN | OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML) | 30170070102020 | Brand |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 1000 MCG/ML (1 MG/ML) | 30170070102030 | Generic |

**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 | HIV/AIDS-Related Diarrhea |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 50 MCG/ML | 3017007010E505 | Generic |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 100 MCG/ML | 3017007010E510 | Generic |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 500 MCG/ML | 3017007010E520 | Generic |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML) | 30170070102005 | Generic |
| SANDOSTATIN | OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML) | 30170070102005 | Brand |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML) | 30170070102010 | Generic |
| SANDOSTATIN | OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML) | 30170070102010 | Brand |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 200 MCG/ML (0.2 MG/ML) | 30170070102015 | Generic |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML) | 30170070102020 | Generic |
| SANDOSTATIN | OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML) | 30170070102020 | Brand |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 1000 MCG/ML (1 MG/ML) | 30170070102030 | Generic |

**Approval Criteria**

**1** - Diagnosis of HIV (human immunodeficiency virus)/AIDS (acquired immunodeficiency syndrome)-related diarrhea

| Product Name: Brand Sandostatin, generic octreotide | |
|---|---|
| Diagnosis | Bleeding Gastroesophageal Varices |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 50 MCG/ML | 3017007010E505 | Generic |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 100 MCG/ML | 3017007010E510 | Generic |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 500 MCG/ML | 3017007010E520 | Generic |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML) | 30170070102005 | Generic |
| SANDOSTATIN | OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML) | 30170070102005 | Brand |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML) | 30170070102010 | Generic |
| SANDOSTATIN | OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML) | 30170070102010 | Brand |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 200 MCG/ML (0.2 MG/ML) | 30170070102015 | Generic |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML) | 30170070102020 | Generic |
| SANDOSTATIN | OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML) | 30170070102020 | Brand |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 1000 MCG/ML (1 MG/ML) | 30170070102030 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 50 MCG/ML | 3017007010E505 | Generic |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 100 MCG/ML | 3017007010E510 | Generic |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 500 MCG/ML | 3017007010E520 | Generic |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML) | 30170070102005 | Generic |
| SANDOSTATIN | OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML) | 30170070102005 | Brand |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML) | 30170070102010 | Generic |
| SANDOSTATIN | OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML) | 30170070102010 | Brand |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 200 MCG/ML (0.2 MG/ML) | 30170070102015 | Generic |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML) | 30170070102020 | Generic |
| SANDOSTATIN | OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML) | 30170070102020 | Brand |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 1000 MCG/ML (1 MG/ML) | 30170070102030 | Generic |

**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, HIV/AIDS-Related Diarrhea, Bleeding Gastroesophageal Varices, NCCN Recommended Regimens |
| Approval Length | 12 month(s) |

| Therapy Stage | Reauthorization |
|---|---|
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 50 MCG/ML | 3017007010E505 | Generic |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 100 MCG/ML | 3017007010E510 | Generic |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 500 MCG/ML | 3017007010E520 | Generic |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML) | 30170070102005 | Generic |
| SANDOSTATIN | OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML) | 30170070102005 | Brand |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML) | 30170070102010 | Generic |
| SANDOSTATIN | OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML) | 30170070102010 | Brand |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 200 MCG/ML (0.2 MG/ML) | 30170070102015 | Generic |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML) | 30170070102020 | Generic |
| SANDOSTATIN | OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML) | 30170070102020 | Brand |
| OCTREOTIDE ACETATE | OCTREOTIDE ACETATE INJ 1000 MCG/ML (1 MG/ML) | 30170070102030 | Generic |

**Approval Criteria**

**1** - Documentation of positive clinical response to the requested therapy

Scemblix

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146640 |
| **Guideline Name** | Scemblix |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Scemblix | |
|---|---|
| Diagnosis | Philadelphia Chromosome-Positive Chronic Myeloid Leukemia (Ph+CML) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SCEMBLIX | ASCIMINIB HCL TAB 20 MG | 21531806100320 | Brand |
| SCEMBLIX | ASCIMINIB HCL TAB 40 MG | 21531806100340 | Brand |

**Approval Criteria**

**1** - Diagnosis of chronic myeloid leukemia (CML)

**AND**

**2** - Disease is Philadelphia chromosome-positive (Ph+)

**AND**

**3** - Disease is in chronic phase

**AND**

**4** - ONE of the following:

**4.1** Patient has been previously treated with two or more tyrosine kinase inhibitors [e.g., Bosulif (bosutinib), imatinib (Gleevec), Sprycel (dasatinib), Tasigna (nilotinib)]

**OR**

**4.2** Disease is T315I mutation positive

| 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SCEMBLIX | ASCIMINIB HCL TAB 20 MG | 21531806100320 | Brand |

| | | | |
|---|---|---|---|
| SCEMBLIX | ASCIMINIB HCL TAB 40 MG | 21531806100340 | Brand |

**Approval Criteria**

**1** - BOTH of the following:

**1.1** Diagnosis of myeloid/lymphoid neoplasm with eosinophilia and ABL1 rearrangement

**AND**

**1.2** Disease is in chronic phase

**OR**

**2** - BOTH of the following:

**2.1** Diagnosis of lymphoid, myeloid, or mixed lineage neoplasm with eosinophilia and ABL1 rearrangement

**AND**

**2.2** Disease is in blast phase

| Product Name: Scemblix | |
|---|---|
| Diagnosis | Philadelphia Chromosome-Positive Chronic Myeloid Leukemia (Ph+CML), Myeloid/Lymphoid Neoplasms with Eosinophilia and ABL1 Gene Rearrangement |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SCEMBLIX | ASCIMINIB HCL TAB 20 MG | 21531806100320 | Brand |
| SCEMBLIX | ASCIMINIB HCL TAB 40 MG | 21531806100340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SCEMBLIX | ASCIMINIB HCL TAB 20 MG | 21531806100320 | Brand |
| SCEMBLIX | ASCIMINIB HCL TAB 40 MG | 21531806100340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SCEMBLIX | ASCIMINIB HCL TAB 20 MG | 21531806100320 | Brand |
| SCEMBLIX | ASCIMINIB HCL TAB 40 MG | 21531806100340 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Scemblix therapy

Sensipar

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146411 |
| **Guideline Name** | Sensipar |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Brand Sensipar, generic cinacalcet | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CINACALCET HYDROCHLORIDE | CINACALCET HCL TAB 30 MG (BASE EQUIV) | 30905225100320 | Generic |
| SENSIPAR | CINACALCET HCL TAB 30 MG (BASE EQUIV) | 30905225100320 | Brand |
| CINACALCET HYDROCHLORIDE | CINACALCET HCL TAB 60 MG (BASE EQUIV) | 30905225100330 | Generic |
| SENSIPAR | CINACALCET HCL TAB 60 MG (BASE EQUIV) | 30905225100330 | Brand |

| | | | |
|---|---|---|---|
| CINACALCET HYDROCHLORIDE | CINACALCET HCL TAB 90 MG (BASE EQUIV) | 30905225100340 | Generic |
| SENSIPAR | CINACALCET HCL TAB 90 MG (BASE EQUIV) | 30905225100340 | Brand |

**Approval Criteria**

**1** - Prescribed by or in consultation with an oncologist, endocrinologist, or nephrologist

**AND**

**2** - ONE of the following:

**2.1** Diagnosis of hypercalcemia with parathyroid carcinoma

**OR**

**2.2** ALL of the following:

**2.2.1** Diagnosis of primary hyperparathyroidism (HPT)

**AND**

**2.2.2** Severe hypercalcemia [serum calcium level greater than 12.5 mg/dL (milligrams/deciliter)] due to primary HPT

**AND**

**2.2.3** Patient is unable to undergo parathyroidectomy

**OR**

**2.3** ALL of the following:

**2.3.1** Diagnosis of secondary hyperparathyroidism with chronic kidney disease

**AND**

**2.3.2** Patient is on dialysis

**AND**

**2.3.3** BOTH of the following:

**2.3.3.1** ONE of the following:

- Patient has therapeutic failure to ONE phosphate binder (e.g., PhosLo, Fosrenol, Renvela, Renagel, etc.) confirmed by claims history or submitted medical records
- Patient has intolerance or contraindication to ONE phosphate binders (e.g., PhosLo, Fosrenol, Renvela, Renagel, etc.) (please specify intolerance or contraindication)

**AND**

**2.3.3.2** ONE of the following:

- Patient has therapeutic failure to ONE vitamin D analog (e.g., calcitriol, Hectorol, Zemplar, etc.) confirmed by claims history or submitted medical records
- Patient has intolerance or contraindication to ONE vitamin D analogs (e.g., calcitriol, Hectorol, Zemplar, etc.) (please specify intolerance or contraindication)

| Product Name: Brand Sensipar, generic cinacalcet | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| CINACALCET HYDROCHLORIDE | CINACALCET HCL TAB 30 MG (BASE EQUIV) | 30905225100320 | Generic |
| SENSIPAR | CINACALCET HCL TAB 30 MG (BASE EQUIV) | 30905225100320 | Brand |
| CINACALCET HYDROCHLORIDE | CINACALCET HCL TAB 60 MG (BASE EQUIV) | 30905225100330 | Generic |
| SENSIPAR | CINACALCET HCL TAB 60 MG (BASE EQUIV) | 30905225100330 | Brand |

| | | | |
|---|---|---|---|
| CINACALCET HYDROCHLORIDE | CINACALCET HCL TAB 90 MG (BASE EQUIV) | 30905225100340 | Generic |
| SENSIPAR | CINACALCET HCL TAB 90 MG (BASE EQUIV) | 30905225100340 | Brand |

**Approval Criteria**

**1** - Patient has experienced a reduction in serum calcium from baseline

Sevelamer carbonate

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146412 |
| **Guideline Name** | Sevelamer carbonate |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Generic sevelamer carbonate tablets | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Step Therapy |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SEVELAMER CARBONATE | SEVELAMER CARBONATE TAB 800 MG | 52800070050340 | Generic |

**Approval Criteria**

**1** - The patient did not exhibit an adequate response to treatment with at least an 8-week trial of calcium acetate as supported by claims history or submitted medical records

**OR**

**2** - The patient experienced an intolerance/adverse reaction to previous therapy with calcium acetate (please indicate intolerance/adverse reaction)

**OR**

**3** - The patient has a documented contraindication to treatment with calcium acetate (please indicate contraindication)

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-155750 |
| **Guideline Name** | SGLT2 Inhibitors |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 10/1/2024 |

## 1 . Criteria

| Product Name: Steglatro, Segluromet | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| STEGLATRO | ERTUGLIFLOZIN L-PYROGLUTAMIC ACID TAB 5 MG (BASE EQUIV) | 27700055200320 | Brand |
| STEGLATRO | ERTUGLIFLOZIN L-PYROGLUTAMIC ACID TAB 15 MG (BASE EQUIV) | 27700055200340 | Brand |
| SEGLUROMET | ERTUGLIFLOZIN-METFORMIN HCL TAB 2.5-500 MG | 27996002450310 | Brand |
| SEGLUROMET | ERTUGLIFLOZIN-METFORMIN HCL TAB 2.5-1000 MG | 27996002450320 | Brand |

| | | | |
|---|---|---|---|
| SEGLUROMET | ERTUGLIFLOZIN-METFORMIN HCL TAB 7.5-500 MG | 27996002450330 | Brand |
| SEGLUROMET | ERTUGLIFLOZIN-METFORMIN HCL TAB 7.5-1000 MG | 27996002450340 | Brand |

**Approval Criteria**

**1** - The patient has a diagnosis of type 2 diabetes mellitus

**AND**

**2** - ONE of the following:

**2.1** Suboptimal response to metformin at a minimum dose of 1500 milligrams 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: Jardiance | |
|---|---|
| Diagnosis | Type 2 Diabetes Mellitus* |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| JARDIANCE | EMPAGLIFLOZIN TAB 10 MG | 27700050000310 | Brand |
| JARDIANCE | EMPAGLIFLOZIN TAB 25 MG | 27700050000320 | Brand |

**Approval Criteria**

**1** - The patient has a diagnosis of type 2 diabetes mellitus

**AND**

**2** - ONE of the following:

**2.1** Suboptimal response to metformin at a minimum dose of 1500 milligrams 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** ONE of the following:

**3.1.1** Failure to Steglatro (ertugliflozin) OR Segluromet (ertugliflozin/metformin) for 90 days confirmed by claims history or submission of medical records

**OR**

**3.1.2** History of intolerance or contraindication to Steglatro (ertugliflozin) OR Segluromet (ertugliflozin/metformin) (please specify intolerance or contraindication)

**OR**

**3.2** BOTH of the following:

**3.2.1** ONE of the following:

**3.2.1.1** Documented history of heart failure

**OR**

**3.2.1.2** Documented history of chronic kidney disease

**OR**

**3.2.1.3** Documented history of atherosclerotic cardiovascular disease defined as having ONE or more of the following:

- History of an acute coronary syndrome or myocardial infarction
- Stable or unstable angina
- Coronary heart disease with or without revascularization
- Other arterial revascularization
- Stroke
- Peripheral artery disease assumed to be atherosclerotic in origin

**AND**

**3.2.2** ONE of the following:

**3.2.2.1** Failure to dapagliflozin (Farxiga authorized generic) for 90 days confirmed by claims history or submission of medical records

**OR**

**3.2.2.2** History of intolerance or contraindication to dapagliflozin (Farxiga authorized generic) (please specify intolerance or contraindication)

| | |
|---|---|
| Notes | *Patients with heart failure, CKD (chronic kidney disease), or ASCVD (atherosclerotic cardiovascular disease) WITH type 2 diabetes should use these criteria. |

| Product Name: Jardiance | |
|---|---|
| Diagnosis | Heart Failure WITHOUT Diabetes Type 2* |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| JARDIANCE | EMPAGLIFLOZIN TAB 10 MG | 27700050000310 | Brand |

| | | | |
|---|---|---|---|
| JARDIANCE | EMPAGLIFLOZIN TAB 25 MG | 27700050000320 | Brand |

**Approval Criteria**

**1** - The patient has a diagnosis of heart failure WITHOUT diabetes type 2 [NYHA (New York Heart Association) class II-IV*]

**AND**

**2** - ONE of the following:

**2.1** Failure to dapagliflozin (Farxiga authorized generic) as confirmed by claims history or submission of medical records.

**OR**

**2.2** History of intolerance or contraindication to dapagliflozin (Farxiga authorized generic) (please specify intolerance or contraindication)

| | |
|---|---|
| Notes | *Patients with heart failure, CKD (chronic kidney disease), or ASCVD (atherosclerotic cardiovascular disease) WITH type 2 diabetes should use Type 2 Diabetes Mellitus criteria. |

| Product Name: Jardiance | |
|---|---|
| Diagnosis | Chronic Kidney Disease (CKD), at risk of progression WITHOUT Diabetes Type 2* |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| JARDIANCE | EMPAGLIFLOZIN TAB 10 MG | 27700050000310 | Brand |
| JARDIANCE | EMPAGLIFLOZIN TAB 25 MG | 27700050000320 | Brand |

**Approval Criteria**

**1** - The patient has a diagnosis of chronic kidney disease (CKD) at risk of progression WITHOUT diabetes type 2

**AND**

**2** - ONE of the following:

**2.1** Patient is currently taking an angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB), as confirmed by claims history or submission of medical records.

**OR**

**2.2** Patient has documentation of intolerance or contraindication to ACE inhibitor or ARB (please specify intolerance or contraindication)

**AND**

**3** - ONE of the following:

**3.1** Failure to dapagliflozin (Farxiga authorized generic) as confirmed by claims history or submission of medical records.

**OR**

**3.2** History of intolerance or contraindication to dapagliflozin (Farxiga authorized generic) (please specify intolerance or contraindication)

| Notes | *Patients with heart failure, CKD (chronic kidney disease), or ASCVD (atherosclerotic cardiovascular disease) WITH type 2 diabetes should use Type 2 Diabetes Mellitus criteria. |
|---|---|

| Product Name: Invokana | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| INVOKANA | CANAGLIFLOZIN TAB 100 MG | 27700020000320 | Brand |
| INVOKANA | CANAGLIFLOZIN TAB 300 MG | 27700020000330 | Brand |

**Approval Criteria**

**1** - The patient has a diagnosis of type 2 diabetes mellitus

**AND**

**2** - ONE of the following:

**2.1** Suboptimal response to metformin at a minimum dose of 1500 milligrams 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** ONE of the following:

**3.1.1** Failure to Steglatro (ertugliflozin) OR Segluromet (ertugliflozin/metformin) for 90 days, confirmed by claims history or submission of medical records

**OR**

**3.1.2** History of contraindication or intolerance to Steglatro (ertugliflozin) OR Segluromet (ertugliflozin/metformin) (please specify contraindication or intolerance)

**OR**

**3.2** Documented history of diabetic nephropathy with albuminuria

**OR**

**3.3** BOTH of the following:

**3.3.1** ONE of the following:

**3.3.1.1** Documented history of heart failure

**OR**

**3.3.1.2** Documented history of chronic kidney disease

**OR**

**3.3.1.3** Documented history of atherosclerotic cardiovascular disease defined as having ONE or more of the following:

- History of an acute coronary syndrome or myocardial infarction
- Stable or unstable angina
- Coronary heart disease with or without revascularization
- Other arterial revascularization
- Stroke
- Peripheral artery disease assumed to be atherosclerotic in origin

**AND**

**3.3.2** ONE of the following:

**3.3.2.1** Failure to dapagliflozin (Farxiga authorized generic) for 90 days confirmed by claims history or submission of medical records

**OR**

**3.3.2.2** History of contraindication or intolerance to dapagliflozin (Farxiga authorized generic) (please specify contraindication or intolerance)

| Product Name: Farxiga, Dapagliflozin | |
|---|---|
| Diagnosis | Type 2 Diabetes Mellitus* |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DAPAGLIFLOZIN PROPANEDIOL | DAPAGLIFLOZIN PROPANEDIOL TAB 5 MG (BASE EQUIVALENT) | 27700040200310 | Generic |
| DAPAGLIFLOZIN PROPANEDIOL | DAPAGLIFLOZIN PROPANEDIOL TAB 10 MG (BASE EQUIVALENT) | 27700040200320 | Generic |
| FARXIGA | DAPAGLIFLOZIN PROPANEDIOL TAB 5 MG (BASE EQUIVALENT) | 27700040200310 | Generic |
| FARXIGA | DAPAGLIFLOZIN PROPANEDIOL TAB 10 MG (BASE EQUIVALENT) | 27700040200320 | Generic |

**Approval Criteria**

**1** - The patient has a diagnosis of type 2 diabetes mellitus

**AND**

**2** - ONE of the following:

**2.1** Suboptimal response to metformin at a minimum dose of 1500 milligrams 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** Documented history of heart failure

**OR**

**3.2** Documented history of chronic kidney disease

**OR**

**3.3** Documented history of atherosclerotic cardiovascular disease defined as having ONE or more of the following:

- History of an acute coronary syndrome or myocardial infarction
- Stable or unstable angina
- Coronary heart disease with or without revascularization
- Other arterial revascularization
- Stroke
- Peripheral artery disease assumed to be atherosclerotic in origin

**OR**

**3.4** TWO of the following risk factors for developing cardiovascular disease:

- Men greater than or equal to 55 years or women greater than or equal to 65 years
- Cigarette smoker or stopped smoking within the past 3 months
- Hypertension [pretreatment blood pressure greater than or equal to 140 millimeters of mercury (mmHg) systolic or greater than or equal to 90 mmHg diastolic]
- HDL-C less than or equal to 40 milligrams/deciliter (mg/dL) for men or less than or equal to 50 mg/dL for women
- High-sensitivity C-reactive protein greater than 3.0 milligrams/liter (mg/L)
- Creatinine clearance greater than 30 and less than 60 milliliters/minute (mL/min)
- Retinopathy
- Micro- or macro-albuminuria
- Ankle-brachial index (ABI) less than 0.9 without symptoms of intermittent claudication

**OR**

**3.5** ONE of the following:

**3.5.1** Failure to Steglatro (ertugliflozin) OR Segluromet (ertugliflozin/metformin) for 90 days confirmed by claims history or submission of medical records

**OR**

**3.5.2** History of contraindication or intolerance to Steglatro (ertugliflozin) OR Segluromet (ertugliflozin/metformin) (please specify contraindication or intolerance)

**AND**

**4** - If the request is for brand Farxiga, ONE of the following:

**4.1** Failure to dapagliflozin (Farxiga authorized generic) confirmed by claims history or submission of medical records

**OR**

**4.2** History of contraindication or intolerance to dapagliflozin (Farxiga authorized generic) (please specify contraindication or intolerance)

| | |
|---|---|
| Notes | *Patients with heart failure, CKD (chronic kidney disease), ASCVD (at herosclerotic cardiovascular disease), or ASCVD risk factors WITH ty pe 2 diabetes should use these criteria. |

| Product Name: Farxiga, Dapagliflozin | |
|---|---|
| Diagnosis | Heart Failure WITHOUT Diabetes Type 2* |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DAPAGLIFLOZIN PROPANEDIOL | DAPAGLIFLOZIN PROPANEDIOL TAB 5 MG (BASE EQUIVALENT) | 27700040200310 | Generic |
| DAPAGLIFLOZIN PROPANEDIOL | DAPAGLIFLOZIN PROPANEDIOL TAB 10 MG (BASE EQUIVALENT) | 27700040200320 | Generic |
| FARXIGA | DAPAGLIFLOZIN PROPANEDIOL TAB 5 MG (BASE EQUIVALENT) | 27700040200310 | Generic |
| FARXIGA | DAPAGLIFLOZIN PROPANEDIOL TAB 10 MG (BASE EQUIVALENT) | 27700040200320 | Generic |

**Approval Criteria**

**1** - The patient has a diagnosis of heart failure WITHOUT diabetes type 2 [NYHA (New York Heart Association) class II-IV*]

**AND**

**2** - If the request is for brand Farxiga, ONE of the following:

**2.1** Failure to dapagliflozin (Farxiga authorized generic) confirmed by claims history or submission of medical records

**OR**

**2.2** History of intolerance or contraindication to dapagliflozin (Farxiga authorized generic) (please specify intolerance or contraindication)

| Notes | *Patients with heart failure, CKD (chronic kidney disease), ASCVD (at herosclerotic cardiovascular disease), or ASCVD risk factors WITH ty pe 2 diabetes should use Type 2 Diabetes Mellitus criteria. |
|---|---|

| Product Name: Farxiga, Dapagliflozin | |
|---|---|
| Diagnosis | Chronic Kidney Disease WITHOUT Diabetes Type 2* |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DAPAGLIFLOZIN PROPANEDIOL | DAPAGLIFLOZIN PROPANEDIOL TAB 5 MG (BASE EQUIVALENT) | 27700040200310 | Generic |
| DAPAGLIFLOZIN PROPANEDIOL | DAPAGLIFLOZIN PROPANEDIOL TAB 10 MG (BASE EQUIVALENT) | 27700040200320 | Generic |
| FARXIGA | DAPAGLIFLOZIN PROPANEDIOL TAB 5 MG (BASE EQUIVALENT) | 27700040200310 | Generic |
| FARXIGA | DAPAGLIFLOZIN PROPANEDIOL TAB 10 MG (BASE EQUIVALENT) | 27700040200320 | Generic |

**Approval Criteria**

**1** - Patient has a diagnosis of chronic kidney disease WITHOUT diabetes type 2*

**AND**

**2** - ONE of the following:

**2.1** Patient currently taking an angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) confirmed by claims history or submission of medical records

**OR**

**2.2** Patient has documentation of intolerance or contraindication to ACE inhibitor or ARB (please specify intolerance or contraindication)

**AND**

**3** - If the request is for brand Farxiga, ONE of the following:

**3.1** Failure to dapagliflozin (Farxiga authorized generic) confirmed by claims history or submission of medical records

**OR**

**3.2** History of contraindication or intolerance to dapagliflozin (Farxiga authorized generic) (please specify contraindication or intolerance)

| | |
|---|---|
| Notes | *Patients with heart failure, CKD (chronic kidney disease), ASCVD (at herosclerotic cardiovascular disease), or ASCVD risk factors WITH ty pe 2 diabetes should use Type 2 Diabetes Mellitus criteria. |

| Product Name: Brenzavvy, Bexagliflozin, Synjardy, Synjardy XR, Invokamet, Invokamet XR, Xigduo XR, Dapagliflozin/Metformin ER | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| INVOKAMET | CANAGLIFLOZIN-METFORMIN HCL TAB 50-500 MG | 27996002200320 | Brand |

| | | | |
|---|---|---|---|
| INVOKAMET | CANAGLIFLOZIN-METFORMIN HCL TAB 50-1000 MG | 27996002200330 | Brand |
| INVOKAMET | CANAGLIFLOZIN-METFORMIN HCL TAB 150-500 MG | 27996002200340 | Brand |
| INVOKAMET | CANAGLIFLOZIN-METFORMIN HCL TAB 150-1000 MG | 27996002200350 | Brand |
| SYNJARDY | EMPAGLIFLOZIN-METFORMIN HCL TAB 5-500 MG | 27996002400310 | Brand |
| SYNJARDY | EMPAGLIFLOZIN-METFORMIN HCL TAB 5-1000 MG | 27996002400315 | Brand |
| SYNJARDY | EMPAGLIFLOZIN-METFORMIN HCL TAB 12.5-500 MG | 27996002400320 | Brand |
| SYNJARDY | EMPAGLIFLOZIN-METFORMIN HCL TAB 12.5-1000 MG | 27996002400325 | Brand |
| INVOKAMET XR | CANAGLIFLOZIN-METFORMIN HCL TAB ER 24HR 50-500 MG | 27996002207520 | Brand |
| INVOKAMET XR | CANAGLIFLOZIN-METFORMIN HCL TAB ER 24HR 50-1000 MG | 27996002207530 | Brand |
| INVOKAMET XR | CANAGLIFLOZIN-METFORMIN HCL TAB ER 24HR 150-500 MG | 27996002207540 | Brand |
| INVOKAMET XR | CANAGLIFLOZIN-METFORMIN HCL TAB ER 24HR 150-1000 MG | 27996002207550 | Brand |
| SYNJARDY XR | EMPAGLIFLOZIN-METFORMIN HCL TAB ER 24HR 5-1000 MG | 27996002407530 | Brand |
| SYNJARDY XR | EMPAGLIFLOZIN-METFORMIN HCL TAB ER 24HR 10-1000 MG | 27996002407540 | Brand |
| SYNJARDY XR | EMPAGLIFLOZIN-METFORMIN HCL TAB ER 24HR 12.5-1000 MG | 27996002407550 | Brand |
| SYNJARDY XR | EMPAGLIFLOZIN-METFORMIN HCL TAB ER 24HR 25-1000 MG | 27996002407560 | Brand |
| XIGDUO XR | DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 2.5-1000 MG | 27996002307507 | Brand |
| XIGDUO XR | DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 5-500 MG | 27996002307510 | Brand |
| XIGDUO XR | DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 5-1000 MG | 27996002307515 | Generic |
| DAPAGLIFLOZIN PROPANEDIOL/METFORMIN HYDROCHLORIDE | DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 5-1000 MG | 27996002307515 | Generic |
| XIGDUO XR | DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 10-500 MG | 27996002307520 | Brand |

| | | | |
|---|---|---|---|
| XIGDUO XR | DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 10-1000 MG | 27996002307525 | Generic |
| DAPAGLIFLOZIN PROPANEDIOL/METFORMIN HYDROCHLORIDE | DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 10-1000 MG | 27996002307525 | Generic |
| BEXAGLIFLOZIN | BEXAGLIFLOZIN TAB 20 MG | 27700010000320 | Generic |
| BRENZAVVY | BEXAGLIFLOZIN TAB 20 MG | 27700010000320 | Generic |

**Approval Criteria**

**1** - The patient has a diagnosis of type 2 diabetes mellitus

**AND**

**2** - ONE of the following:

**2.1** Suboptimal response to metformin at a minimum dose of 1500 milligrams 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 Steglatro (ertugliflozin) OR Segluromet (ertugliflozin/metformin) for 90 days confirmed by claims history or submission of medical records

**OR**

**3.2** History of intolerance or contraindication to Steglatro (ertugliflozin) OR Segluromet (ertugliflozin/metformin) (please specify intolerance or contraindication)

| Product Name: Inpefa | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| INPEFA | SOTAGLIFLOZIN TAB 200 MG | 40750010000320 | Brand |
| INPEFA | SOTAGLIFLOZIN TAB 400 MG | 40750010000340 | Brand |

**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:

**2.1** Failure to dapagliflozin (Farxiga authorized generic) confirmed by claims history or submission of medical records

**OR**

**2.2** History of contraindication or intolerance to dapagliflozin (Farxiga authorized generic) (please specify contraindication or intolerance)

## 2 . Revision History

| Date | Notes |
|---|---|
| 9/23/2024 | Updated step through language for generic Farxiga |

Short-Acting Opioid Products

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-161924 |
| **Guideline Name** | Short-Acting Opioid Products |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 1 . Criteria

| | |
|---|---|
| Product Name: butorphanol nasal sol, codeine, acetaminophen w/codeine soln and tabs, Brand Fioricet/codeine, generic butalbital/acetaminophen/caffeine w/codeine, Ascomp/codeine, generic butalbital/aspirin/caffeine w/codeine, morphine supp, tabs and soln, Brand Lortab, hydrocodone/acetaminophen soln, Brand Xodol, generic hydrocodone/acetaminophen tabs, hydrocodone/ibuprofen, Brand Dilaudid, generic hydromorphone, oxycodone caps, soln and conc, Brand Roxicodone, Oxaydo, generic oxycodone tabs, Brand Percocet, Prolate tabs and soln, Nalocet, Endocet, Oxycodone-acetaminophen soln and tabs, generic oxycodone/acetaminophen soln and tabs, oxymorphone, pentazocine w/naloxone, Brand Ultram, Synapryn, generic tramadol, Qdolo, Tramadol soln, Brand Ultracet, generic tramadol/acetaminophen, Nucynta, meperidine, levorphanol, Brand Trezix, generic acetaminophen/caffeine/dihydrocodeine, generic belladonna alkaloids/opium, opium, Apadaz, Benzhydrocodone/acetaminophen, Seglentis, Brand Roxybond, Brand Oxycodone | |
| Diagnosis | DUR: Non-cough and cold Opioid Naïve (Not having filled an opioid in the past 60 days) exceeding the 7 day supply limit and/or 50-90MME limit* |

| Guideline Type | Prior Authorization |
|---|---|

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BUTORPHANOL TARTRATE | BUTORPHANOL TARTRATE NASAL SOLN 10 MG/ML | 65200020102050 | Generic |
| ACETAMINOPHEN/CODEINE | ACETAMINOPHEN W/ CODEINE SOLN 120-12 MG/5ML | 65991002052020 | Generic |
| ACETAMINOPHEN/CODEINE | ACETAMINOPHEN W/ CODEINE TAB 300-15 MG | 65991002050310 | Generic |
| ACETAMINOPHEN/CODEINE PHOSPHATE | ACETAMINOPHEN W/ CODEINE TAB 300-15 MG | 65991002050310 | Generic |
| ACETAMINOPHEN/CODEINE | ACETAMINOPHEN W/ CODEINE TAB 300-30 MG | 65991002050315 | Generic |
| ACETAMINOPHEN/CODEINE #3 | ACETAMINOPHEN W/ CODEINE TAB 300-30 MG | 65991002050315 | Generic |
| ACETAMINOPHEN/CODEINE PHOSPHATE | ACETAMINOPHEN W/ CODEINE TAB 300-30 MG | 65991002050315 | Generic |
| ACETAMINOPHEN/CODEINE | ACETAMINOPHEN W/ CODEINE TAB 300-60 MG | 65991002050320 | Generic |
| ACETAMINOPHEN/CODEINE PHOSPHATE | ACETAMINOPHEN W/ CODEINE TAB 300-60 MG | 65991002050320 | Generic |
| CODEINE/ACETAMINOPHEN | ACETAMINOPHEN W/ CODEINE TAB 300-60 MG | 65991002050320 | Generic |
| BUTALBITAL/ACETAMINOPHEN/CAFFEINE/CODEINE | BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-325-40-30 MG | 65991004100115 | Generic |
| BUTALBITAL/ACETAMINOPHEN/CAFFEINE/CODEINE | BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-300-40-30 MG | 65991004100113 | Generic |
| FIORICET/CODEINE | BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-300-40-30 MG | 65991004100113 | Brand |
| ASCOMP/CODEINE | BUTALBITAL-ASPIRIN-CAFF W/ CODEINE CAP 50-325-40-30 MG | 65991004300115 | Generic |

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| BUTALBITAL/ASPIRIN/CAFFEINE/CODEINE | BUTALBITAL-ASPIRIN-CAFF W/ CODEINE CAP 50-325-40-30 MG | 65991004300115 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE ORAL SOLN 10 MG/5ML | 65100055102065 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE ORAL SOLN 100 MG/5ML (20 MG/ML) | 65100055102090 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE ORAL SOLN 20 MG/5ML | 65100055102070 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE SUPPOS 10 MG | 65100055105210 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE SUPPOS 20 MG | 65100055105215 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE SUPPOS 30 MG | 65100055105220 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE TAB 15 MG | 65100055100310 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE TAB 30 MG | 65100055100315 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE SUPPOS 5 MG | 65100055105205 | Generic |
| LORTAB | HYDROCODONE-ACETAMINOPHEN SOLN 10-300 MG/15ML | 65991702102024 | Brand |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN TAB 10-300 MG | 65991702100375 | Generic |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN TAB 10-325 MG | 65991702100305 | Generic |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN TAB 7.5-300 MG | 65991702100322 | Generic |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN TAB 7.5-325 MG | 65991702100358 | Generic |

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| HYDROCODONE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN TAB 7.5-325 MG | 65991702100358 | Generic |
| HYDROCODONE/IBUPROFEN | HYDROCODONE-IBUPROFEN TAB 10-200 MG | 65991702500330 | Generic |
| HYDROCODONE/IBUPROFEN | HYDROCODONE-IBUPROFEN TAB 7.5-200 MG | 65991702500320 | Generic |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN TAB 5-300 MG | 65991702100309 | Generic |
| XODOL | HYDROCODONE-ACETAMINOPHEN TAB 5-300 MG | 65991702100309 | Brand |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN TAB 5-325 MG | 65991702100356 | Generic |
| HYDROCODONE/IBUPROFEN | HYDROCODONE-IBUPROFEN TAB 5-200 MG | 65991702500315 | Generic |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN SOLN 7.5-325 MG/15ML | 65991702102015 | Generic |
| HYDROMORPHONE HCL | HYDROMORPHONE HCL SUPPOS 3 MG | 65100035105205 | Generic |
| DILAUDID | HYDROMORPHONE HCL TAB 4 MG | 65100035100320 | Brand |
| HYDROMORPHONE HCL | HYDROMORPHONE HCL TAB 4 MG | 65100035100320 | Generic |
| DILAUDID | HYDROMORPHONE HCL TAB 8 MG | 65100035100330 | Brand |
| HYDROMORPHONE HCL | HYDROMORPHONE HCL TAB 8 MG | 65100035100330 | Generic |
| DILAUDID | HYDROMORPHONE HCL TAB 2 MG | 65100035100310 | Brand |
| HYDROMORPHONE HCL | HYDROMORPHONE HCL TAB 2 MG | 65100035100310 | Generic |
| OXYCODONE HCL | OXYCODONE HCL CAP 5 MG | 65100075100110 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL CAP 5 MG | 65100075100110 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL CONC 100 MG/5ML (20 MG/ML) | 65100075101320 | Generic |

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| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL SOLN 5 MG/5ML | 65100075102005 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL TAB 10 MG | 65100075100320 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL TAB 15 MG | 65100075100325 | Generic |
| ROXICODONE | OXYCODONE HCL TAB 15 MG | 65100075100325 | Brand |
| ENDOCET | OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG | 65990002200335 | Generic |
| OXYCODONE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG | 65990002200335 | Generic |
| PERCOCET | OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG | 65990002200335 | Brand |
| ENDOCET | OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG | 65990002200327 | Generic |
| OXYCODONE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG | 65990002200327 | Generic |
| PERCOCET | OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG | 65990002200327 | Brand |
| ENDOCET | OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG | 65990002200305 | Generic |
| OXYCODONE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG | 65990002200305 | Generic |
| PERCOCET | OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG | 65990002200305 | Brand |
| ENDOCET | OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG | 65990002200310 | Generic |
| OXYCODONE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG | 65990002200310 | Generic |
| PERCOCET | OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG | 65990002200310 | Brand |
| OXYMORPHONE HYDROCHLORIDE | OXYMORPHONE HCL TAB 10 MG | 65100080100310 | Generic |
| OXYMORPHONE HYDROCHLORIDE | OXYMORPHONE HCL TAB 5 MG | 65100080100305 | Generic |

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| TRAMADOL HCL | TRAMADOL HCL TAB 50 MG | 6510009510032 0 | Generic |
| TRAMADOL HYDROCHLORIDE | TRAMADOL HCL TAB 50 MG | 6510009510032 0 | Generic |
| ULTRAM | TRAMADOL HCL TAB 50 MG | 6510009510032 0 | Brand |
| SYNAPRYN FUSEPAQ | *TRAMADOL HCL FOR ORAL SUSP 10 MG/ML (COMPOUND KIT)*** | 6510009510192 0 | Brand |
| TRAMADOL HYDROCHLORIDE/ACETAMINOPHEN | TRAMADOL-ACETAMINOPHEN TAB 37.5-325 MG | 6599500220032 0 | Generic |
| ULTRACET | TRAMADOL-ACETAMINOPHEN TAB 37.5-325 MG | 6599500220032 0 | Brand |
| NUCYNTA | TAPENTADOL HCL TAB 100 MG | 6510009110034 0 | Brand |
| NUCYNTA | TAPENTADOL HCL TAB 50 MG | 6510009110032 0 | Brand |
| NUCYNTA | TAPENTADOL HCL TAB 75 MG | 6510009110033 0 | Brand |
| MEPERIDINE HCL | MEPERIDINE HCL TAB 50 MG | 6510004510030 5 | Generic |
| MEPERIDINE HCL | MEPERIDINE HCL ORAL SOLN 50 MG/5ML | 6510004510206 0 | Generic |
| LEVORPHANOL TARTRATE | LEVORPHANOL TARTRATE TAB 2 MG | 6510004010030 5 | Generic |
| LEVORPHANOL TARTRATE | LEVORPHANOL TARTRATE TAB 3 MG | 6510004010031 0 | Generic |
| ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE | ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE CAP 320.5-30-16 MG | 6599130305011 5 | Generic |
| BELLADONNA/OPIUM | BELLADONNA ALKALOIDS & OPIUM SUPPOS 16.2-30 MG | 4910990215521 0 | Generic |
| BELLADONNA/OPIUM | BELLADONNA ALKALOIDS & OPIUM SUPPOS 16.2-60 MG | 4910990215522 0 | Generic |
| OPIUM | OPIUM TINCTURE 1% (10 MG/ML) (MORPHINE EQUIV) | 4710003020150 5 | Generic |

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| OPIUM TINCTURE | OPIUM TINCTURE 1% (10 MG/ML) (MORPHINE EQUIV) | 47100030201505 | Generic |
| APADAZ | BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 8.16-325 MG | 65990002020330 | Brand |
| BENZHYDROCODONE/ACETAMINOPHEN | BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 8.16-325 MG | 65990002020330 | Brand |
| APADAZ | BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 6.12-325 MG | 65990002020320 | Brand |
| BENZHYDROCODONE/ACETAMINOPHEN | BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 6.12-325 MG | 65990002020320 | Brand |
| APADAZ | BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 4.08-325 MG | 65990002020310 | Brand |
| BENZHYDROCODONE/ACETAMINOPHEN | BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 4.08-325 MG | 65990002020310 | Brand |
| OXYCODONE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN TAB 5-300 MG | 65990002200308 | Generic |
| PROLATE | OXYCODONE W/ ACETAMINOPHEN TAB 5-300 MG | 65990002200308 | Generic |
| OXYCODONE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN TAB 10-300 MG | 65990002200333 | Generic |
| PROLATE | OXYCODONE W/ ACETAMINOPHEN TAB 10-300 MG | 65990002200333 | Generic |
| OXYCODONE HYDROCHLORIDE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN SOLN 10-300 MG/5ML | 65990002202020 | Generic |
| PROLATE | OXYCODONE W/ ACETAMINOPHEN SOLN 10-300 MG/5ML | 65990002202020 | Generic |
| OXAYDO | OXYCODONE HCL TAB 7.5 MG | 65100075100315 | Brand |
| HYDROMORPHONE HYDROCHLORIDE | HYDROMORPHONE HCL TAB 4 MG | 65100035100320 | Generic |

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| HYDROMORPHONE HYDROCHLORIDE | HYDROMORPHONE HCL TAB 2 MG | 6510003510031 0 | Generic |
| CODEINE SULFATE | CODEINE SULFATE TAB 15 MG | 6510002020030 5 | Generic |
| CODEINE SULFATE | CODEINE SULFATE TAB 30 MG | 6510002020031 0 | Generic |
| CODEINE SULFATE | CODEINE SULFATE TAB 60 MG | 6510002020031 5 | Generic |
| DILAUDID | HYDROMORPHONE HCL LIQD 1 MG/ML | 6510003510092 0 | Brand |
| HYDROMORPHONE HCL | HYDROMORPHONE HCL LIQD 1 MG/ML | 6510003510092 0 | Generic |
| HYDROMORPHONE HYDROCHLORIDE | HYDROMORPHONE HCL LIQD 1 MG/ML | 6510003510092 0 | Generic |
| OXAYDO | OXYCODONE HCL TAB 5 MG | 6510007510031 0 | Brand |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL TAB 5 MG | 6510007510031 0 | Generic |
| ROXICODONE | OXYCODONE HCL TAB 5 MG | 6510007510031 0 | Brand |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL TAB 20 MG | 6510007510033 0 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL TAB 30 MG | 6510007510034 0 | Generic |
| ROXICODONE | OXYCODONE HCL TAB 30 MG | 6510007510034 0 | Brand |
| NALOCET | OXYCODONE W/ ACETAMINOPHEN TAB 2.5-300 MG | 6599000220030 3 | Generic |
| OXYCODONE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN TAB 2.5-300 MG | 6599000220030 3 | Generic |
| OXYCODONE AND ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN TAB 7.5-300 MG | 6599000220032 5 | Generic |
| PROLATE | OXYCODONE W/ ACETAMINOPHEN TAB 7.5-300 MG | 6599000220032 5 | Generic |
| PENTAZOCINE/NALOXONE HCL | PENTAZOCINE W/ NALOXONE HCL TAB 50-0.5 MG | 6520004030031 0 | Generic |
| QDOLO | TRAMADOL HCL ORAL SOLN 5 MG/ML | 6510009510200 5 | Generic |

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| TRAMADOL HYDROCHLORIDE | TRAMADOL HCL ORAL SOLN 5 MG/ML | 65100095102005 | Generic |
| SEGLENTIS | CELECOXIB-TRAMADOL HCL TAB 56-44 MG | 65995002100320 | Brand |
| ROXYBOND | OXYCODONE HCL TAB ABUSE DETER 5 MG | 6510007510A530 | Brand |
| ROXYBOND | OXYCODONE HCL TAB ABUSE DETER 15 MG | 6510007510A540 | Brand |
| ROXYBOND | OXYCODONE HCL TAB ABUSE DETER 30 MG | 6510007510A560 | Brand |
| OXYCODONE HYDROCHLORIDE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN SOLN 5-325 MG/5ML | 65990002202005 | Brand |
| TRAMADOL HYDROCHLORIDE | TRAMADOL HCL TAB 100 MG | 65100095100340 | Generic |
| TREZIX | ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE CAP 320.5-30-16 MG | 65991303050115 | Brand |
| MEPERIDINE HYDROCHLORIDE | MEPERIDINE HCL TAB 50 MG | 65100045100305 | Generic |
| TRAMADOL HYDROCHLORIDE | TRAMADOL HCL TAB 25 MG | 65100095100310 | Generic |
| ROXYBOND | OXYCODONE HCL TAB ABUSE DETER 5 MG | 6510007510A530 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL TAB ABUSE DETER 5 MG | 6510007510A530 | Generic |
| ROXYBOND | OXYCODONE HCL TAB ABUSE DETER 10 MG | 6510007510A535 | Brand |
| ROXYBOND | OXYCODONE HCL TAB ABUSE DETER 15 MG | 6510007510A540 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL TAB ABUSE DETER 15 MG | 6510007510A540 | Generic |
| ROXYBOND | OXYCODONE HCL TAB ABUSE DETER 30 MG | 6510007510A560 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL TAB ABUSE DETER 30 MG | 6510007510A560 | Generic |

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| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN SOLN 10-325 MG/15ML | 65991702102025 | Generic |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN TAB 2.5-325 MG | 65991702100302 | Generic |
| TRAMADOL HYDROCHLORIDE | TRAMADOL HCL TAB 75 MG | 65100095100330 | Generic |

**Approval Criteria**

**1** - Opioid naïve patients (defined as not having filled an opioid in the past 60 days) may receive greater than the 7 day supply limit and/or greater than 50 morphine milligram equivalents (MME) based on ALL of the following:

**1.1** If the request is for greater than the 7 day supply limit, ONE of the following:

**1.1.1** 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**

**1.1.2** End of life care, including hospice care

**OR**

**1.1.3** Palliative care

**OR**

**1.1.4** Sickle cell anemia

**OR**

**1.1.5** BOTH of the following:

**1.1.5.1** ONE of the following:

- Traumatic injury
- Post-surgical procedures, excluding dental procedures
- Prescriber attests that the patient has received an opioid within the past 60 days

**AND**

**1.1.5.2** Prescriber attests if requested for traumatic injury or post-surgical procedure, that based on injury or surgical procedure performed the patient requires greater than a 7 day supply of short-acting opioid to adequately control pain

**AND**

**1.2** If the request is for 50 MME to 90 MME, ONE of the following (NOTE: If the request exceeds 90 MME please skip this section and proceed to the MME Reviews section):

**1.2.1** Diagnosis of 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)
- End of life pain (including hospice care)
- Palliative care
- Sickle cell anemia

**OR**

**1.2.2** Patient is currently exceeding 50 MME and prescriber attests patient has been on opioids in the past 60 days

**OR**

**1.2.3** Document ALL of the following:

- The diagnosis is associated with the need for pain management with opioids
- If used in patients with medical comorbidities or if used concurrently with a benzodiazepine or other drugs that could potentially cause drug-drug interactions, the prescriber has acknowledged that they have completed an assessment of increased risk for respiratory depression
- The prescriber has acknowledged that they have completed an addiction risk and risk of overdose assessment

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| • Prescriber attests the patient requires more than 50 MME per day to adequately control pain | |
| Notes | *This section does NOT apply to cough and cold products.<br>**Approval length for cancer-related pain, end of life, palliative care, or sickle cell pain will be issued for 12 months. All other approvals will b e issued for the requested duration, not to exceed one month. |

| Product Name: butorphanol nasal sol, codeine, acetaminophen w/codeine soln and tabs, Brand Fioricet/codeine, generic butalbital/acetaminophen/caffeine w/codeine, Ascomp/codeine, generic butalbital/aspirin/caffeine w/codeine, morphine supp, tabs and soln, Brand Lortab, hydrocodone/acetaminophen soln, Brand Xodol, generic hydrocodone/acetaminophen tabs, hydrocodone/ibuprofen, Brand Dilaudid, generic hydromorphone, oxycodone caps, soln and conc, Brand Roxicodone, Oxaydo, generic oxycodone tabs, Brand Percocet, Prolate tabs and soln, Nalocet, Endocet, Oxycodone-acetaminophen soln and tabs, generic oxycodone/acetaminophen soln and tabs, oxymorphone, pentazocine w/naloxone, Brand Ultram, Synapryn, generic tramadol, Qdolo, Tramadol soln, Brand Ultracet, generic tramadol/acetaminophen, Nucynta, meperidine, levorphanol, Brand Trezix, generic acetaminophen/caffeine/dihydrocodeine, generic belladonna alkaloids/opium, opium, Apadaz, Benzhydrocodone/acetaminophen, Seglentis, Brand Roxybond, Brand Oxycodone | |
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| Diagnosis | Non-Preferred Reviews* |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BUTORPHANOL TARTRATE | BUTORPHANOL TARTRATE NASAL SOLN 10 MG/ML | 65200020102050 | Generic |
| ACETAMINOPHEN/CODEINE | ACETAMINOPHEN W/ CODEINE SOLN 120-12 MG/5ML | 65991002052020 | Generic |
| ACETAMINOPHEN/CODEINE | ACETAMINOPHEN W/ CODEINE TAB 300-15 MG | 65991002050310 | Generic |
| ACETAMINOPHEN/CODEINE PHOSPHATE | ACETAMINOPHEN W/ CODEINE TAB 300-15 MG | 65991002050310 | Generic |
| ACETAMINOPHEN/CODEINE | ACETAMINOPHEN W/ CODEINE TAB 300-30 MG | 65991002050315 | Generic |
| ACETAMINOPHEN/CODEINE #3 | ACETAMINOPHEN W/ CODEINE TAB 300-30 MG | 65991002050315 | Generic |

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| ACETAMINOPHEN/CODEINE PHOSPHATE | ACETAMINOPHEN W/ CODEINE TAB 300-30 MG | 65991002050315 | Generic |
| ACETAMINOPHEN/CODEINE | ACETAMINOPHEN W/ CODEINE TAB 300-60 MG | 65991002050320 | Generic |
| ACETAMINOPHEN/CODEINE PHOSPHATE | ACETAMINOPHEN W/ CODEINE TAB 300-60 MG | 65991002050320 | Generic |
| CODEINE/ACETAMINOPHEN | ACETAMINOPHEN W/ CODEINE TAB 300-60 MG | 65991002050320 | Generic |
| BUTALBITAL/ACETAMINOPHEN/CAFFEINE/CODEINE | BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-325-40-30 MG | 65991004100115 | Generic |
| BUTALBITAL/ACETAMINOPHEN/CAFFEINE/CODEINE | BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-300-40-30 MG | 65991004100113 | Generic |
| FIORICET/CODEINE | BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-300-40-30 MG | 65991004100113 | Brand |
| ASCOMP/CODEINE | BUTALBITAL-ASPIRIN-CAFF W/ CODEINE CAP 50-325-40-30 MG | 65991004300115 | Generic |
| BUTALBITAL/ASPIRIN/CAFFEINE/CODEINE | BUTALBITAL-ASPIRIN-CAFF W/ CODEINE CAP 50-325-40-30 MG | 65991004300115 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE ORAL SOLN 10 MG/5ML | 65100055102065 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE ORAL SOLN 100 MG/5ML (20 MG/ML) | 65100055102090 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE ORAL SOLN 20 MG/5ML | 65100055102070 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE SUPPOS 10 MG | 65100055105210 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE SUPPOS 20 MG | 65100055105215 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE SUPPOS 30 MG | 65100055105220 | Generic |

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| MORPHINE SULFATE | MORPHINE SULFATE TAB 15 MG | 6510005510031 0 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE TAB 30 MG | 6510005510031 5 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE SUPPOS 5 MG | 6510005510520 5 | Generic |
| LORTAB | HYDROCODONE-ACETAMINOPHEN SOLN 10-300 MG/15ML | 6599170210202 4 | Brand |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN TAB 10-300 MG | 6599170210037 5 | Generic |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN TAB 10-325 MG | 6599170210030 5 | Generic |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN TAB 7.5-300 MG | 6599170210032 2 | Generic |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN TAB 7.5-325 MG | 6599170210035 8 | Generic |
| HYDROCODONE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN TAB 7.5-325 MG | 6599170210035 8 | Generic |
| HYDROCODONE/IBUPROFEN | HYDROCODONE-IBUPROFEN TAB 10-200 MG | 6599170250033 0 | Generic |
| HYDROCODONE/IBUPROFEN | HYDROCODONE-IBUPROFEN TAB 7.5-200 MG | 6599170250032 0 | Generic |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN TAB 5-300 MG | 6599170210030 9 | Generic |
| XODOL | HYDROCODONE-ACETAMINOPHEN TAB 5-300 MG | 6599170210030 9 | Brand |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN TAB 5-325 MG | 6599170210035 6 | Generic |
| HYDROCODONE/IBUPROFEN | HYDROCODONE-IBUPROFEN TAB 5-200 MG | 6599170250031 5 | Generic |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN SOLN 7.5-325 MG/15ML | 6599170210201 5 | Generic |

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|---|---|---|---|
| HYDROMORPHONE HCL | HYDROMORPHONE HCL SUPPOS 3 MG | 65100035105205 | Generic |
| DILAUDID | HYDROMORPHONE HCL TAB 4 MG | 65100035100320 | Brand |
| HYDROMORPHONE HCL | HYDROMORPHONE HCL TAB 4 MG | 65100035100320 | Generic |
| DILAUDID | HYDROMORPHONE HCL TAB 8 MG | 65100035100330 | Brand |
| HYDROMORPHONE HCL | HYDROMORPHONE HCL TAB 8 MG | 65100035100330 | Generic |
| DILAUDID | HYDROMORPHONE HCL TAB 2 MG | 65100035100310 | Brand |
| HYDROMORPHONE HCL | HYDROMORPHONE HCL TAB 2 MG | 65100035100310 | Generic |
| OXYCODONE HCL | OXYCODONE HCL CAP 5 MG | 65100075100110 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL CAP 5 MG | 65100075100110 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL CONC 100 MG/5ML (20 MG/ML) | 65100075101320 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL SOLN 5 MG/5ML | 65100075102005 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL TAB 10 MG | 65100075100320 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL TAB 15 MG | 65100075100325 | Generic |
| ROXICODONE | OXYCODONE HCL TAB 15 MG | 65100075100325 | Brand |
| ENDOCET | OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG | 65990002200335 | Generic |
| OXYCODONE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG | 65990002200335 | Generic |
| PERCOCET | OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG | 65990002200335 | Brand |
| ENDOCET | OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG | 65990002200327 | Generic |
| OXYCODONE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG | 65990002200327 | Generic |

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|---|---|---|---|
| PERCOCET | OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG | 6599000220032 7 | Brand |
| ENDOCET | OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG | 6599000220030 5 | Generic |
| OXYCODONE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG | 6599000220030 5 | Generic |
| PERCOCET | OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG | 6599000220030 5 | Brand |
| ENDOCET | OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG | 6599000220031 0 | Generic |
| OXYCODONE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG | 6599000220031 0 | Generic |
| PERCOCET | OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG | 6599000220031 0 | Brand |
| OXYMORPHONE HYDROCHLORIDE | OXYMORPHONE HCL TAB 10 MG | 6510008010031 0 | Generic |
| OXYMORPHONE HYDROCHLORIDE | OXYMORPHONE HCL TAB 5 MG | 6510008010030 5 | Generic |
| TRAMADOL HCL | TRAMADOL HCL TAB 50 MG | 6510009510032 0 | Generic |
| TRAMADOL HYDROCHLORIDE | TRAMADOL HCL TAB 50 MG | 6510009510032 0 | Generic |
| ULTRAM | TRAMADOL HCL TAB 50 MG | 6510009510032 0 | Brand |
| SYNAPRYN FUSEPAQ | *TRAMADOL HCL FOR ORAL SUSP 10 MG/ML (COMPOUND KIT)*** | 6510009510192 0 | Brand |
| TRAMADOL HYDROCHLORIDE/ACETAMINOPHEN | TRAMADOL-ACETAMINOPHEN TAB 37.5-325 MG | 6599500220032 0 | Generic |
| ULTRACET | TRAMADOL-ACETAMINOPHEN TAB 37.5-325 MG | 6599500220032 0 | Brand |
| NUCYNTA | TAPENTADOL HCL TAB 100 MG | 6510009110034 0 | Brand |
| NUCYNTA | TAPENTADOL HCL TAB 50 MG | 6510009110032 0 | Brand |
| NUCYNTA | TAPENTADOL HCL TAB 75 MG | 6510009110033 0 | Brand |

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|---|---|---|---|
| MEPERIDINE HCL | MEPERIDINE HCL TAB 50 MG | 65100045100305 | Generic |
| MEPERIDINE HCL | MEPERIDINE HCL ORAL SOLN 50 MG/5ML | 65100045102060 | Generic |
| LEVORPHANOL TARTRATE | LEVORPHANOL TARTRATE TAB 2 MG | 65100040100305 | Generic |
| LEVORPHANOL TARTRATE | LEVORPHANOL TARTRATE TAB 3 MG | 65100040100310 | Generic |
| ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE | ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE CAP 320.5-30-16 MG | 65991303050115 | Generic |
| BELLADONNA/OPIUM | BELLADONNA ALKALOIDS & OPIUM SUPPOS 16.2-30 MG | 49109902155210 | Generic |
| BELLADONNA/OPIUM | BELLADONNA ALKALOIDS & OPIUM SUPPOS 16.2-60 MG | 49109902155220 | Generic |
| OPIUM | OPIUM TINCTURE 1% (10 MG/ML) (MORPHINE EQUIV) | 47100030201505 | Generic |
| OPIUM TINCTURE | OPIUM TINCTURE 1% (10 MG/ML) (MORPHINE EQUIV) | 47100030201505 | Generic |
| APADAZ | BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 8.16-325 MG | 65990002020330 | Brand |
| BENZHYDROCODONE/ACETAMINOPHEN | BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 8.16-325 MG | 65990002020330 | Brand |
| APADAZ | BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 6.12-325 MG | 65990002020320 | Brand |
| BENZHYDROCODONE/ACETAMINOPHEN | BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 6.12-325 MG | 65990002020320 | Brand |
| APADAZ | BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 4.08-325 MG | 65990002020310 | Brand |
| BENZHYDROCODONE/ACETAMINOPHEN | BENZHYDROCODONE HCL- | 65990002020310 | Brand |

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|---|---|---|---|
| | ACETAMINOPHEN TAB 4.08-325 MG | | |
| OXYCODONE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN TAB 5-300 MG | 65990002200308 | Generic |
| PROLATE | OXYCODONE W/ ACETAMINOPHEN TAB 5-300 MG | 65990002200308 | Generic |
| OXYCODONE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN TAB 10-300 MG | 65990002200333 | Generic |
| PROLATE | OXYCODONE W/ ACETAMINOPHEN TAB 10-300 MG | 65990002200333 | Generic |
| OXYCODONE HYDROCHLORIDE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN SOLN 10-300 MG/5ML | 65990002202020 | Generic |
| PROLATE | OXYCODONE W/ ACETAMINOPHEN SOLN 10-300 MG/5ML | 65990002202020 | Generic |
| OXAYDO | OXYCODONE HCL TAB 7.5 MG | 65100075100315 | Brand |
| HYDROMORPHONE HYDROCHLORIDE | HYDROMORPHONE HCL TAB 4 MG | 65100035100320 | Generic |
| HYDROMORPHONE HYDROCHLORIDE | HYDROMORPHONE HCL TAB 2 MG | 65100035100310 | Generic |
| CODEINE SULFATE | CODEINE SULFATE TAB 15 MG | 65100020200305 | Generic |
| CODEINE SULFATE | CODEINE SULFATE TAB 30 MG | 65100020200310 | Generic |
| CODEINE SULFATE | CODEINE SULFATE TAB 60 MG | 65100020200315 | Generic |
| DILAUDID | HYDROMORPHONE HCL LIQD 1 MG/ML | 65100035100920 | Brand |
| HYDROMORPHONE HCL | HYDROMORPHONE HCL LIQD 1 MG/ML | 65100035100920 | Generic |
| HYDROMORPHONE HYDROCHLORIDE | HYDROMORPHONE HCL LIQD 1 MG/ML | 65100035100920 | Generic |
| OXAYDO | OXYCODONE HCL TAB 5 MG | 65100075100310 | Brand |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL TAB 5 MG | 65100075100310 | Generic |
| ROXICODONE | OXYCODONE HCL TAB 5 MG | 65100075100310 | Brand |

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|---|---|---|---|
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL TAB 20 MG | 65100075100330 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL TAB 30 MG | 65100075100340 | Generic |
| ROXICODONE | OXYCODONE HCL TAB 30 MG | 65100075100340 | Brand |
| NALOCET | OXYCODONE W/ ACETAMINOPHEN TAB 2.5-300 MG | 65990002200303 | Generic |
| OXYCODONE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN TAB 2.5-300 MG | 65990002200303 | Generic |
| OXYCODONE AND ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN TAB 7.5-300 MG | 65990002200325 | Generic |
| PROLATE | OXYCODONE W/ ACETAMINOPHEN TAB 7.5-300 MG | 65990002200325 | Generic |
| PENTAZOCINE/NALOXONE HCL | PENTAZOCINE W/ NALOXONE HCL TAB 50-0.5 MG | 65200040300310 | Generic |
| QDOLO | TRAMADOL HCL ORAL SOLN 5 MG/ML | 65100095102005 | Generic |
| TRAMADOL HYDROCHLORIDE | TRAMADOL HCL ORAL SOLN 5 MG/ML | 65100095102005 | Generic |
| SEGLENTIS | CELECOXIB-TRAMADOL HCL TAB 56-44 MG | 65995002100320 | Brand |
| ROXYBOND | OXYCODONE HCL TAB ABUSE DETER 5 MG | 6510007510A530 | Brand |
| ROXYBOND | OXYCODONE HCL TAB ABUSE DETER 15 MG | 6510007510A540 | Brand |
| ROXYBOND | OXYCODONE HCL TAB ABUSE DETER 30 MG | 6510007510A560 | Brand |
| OXYCODONE HYDROCHLORIDE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN SOLN 5-325 MG/5ML | 65990002202005 | Brand |
| TRAMADOL HYDROCHLORIDE | TRAMADOL HCL TAB 100 MG | 65100095100340 | Generic |
| TREZIX | ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE CAP 320.5-30-16 MG | 65991303050115 | Brand |

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|---|---|---|---|
| MEPERIDINE HYDROCHLORIDE | MEPERIDINE HCL TAB 50 MG | 65100045100305 | Generic |
| TRAMADOL HYDROCHLORIDE | TRAMADOL HCL TAB 25 MG | 65100095100310 | Generic |
| ROXYBOND | OXYCODONE HCL TAB ABUSE DETER 5 MG | 6510007510A530 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL TAB ABUSE DETER 5 MG | 6510007510A530 | Generic |
| ROXYBOND | OXYCODONE HCL TAB ABUSE DETER 10 MG | 6510007510A535 | Brand |
| ROXYBOND | OXYCODONE HCL TAB ABUSE DETER 15 MG | 6510007510A540 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL TAB ABUSE DETER 15 MG | 6510007510A540 | Generic |
| ROXYBOND | OXYCODONE HCL TAB ABUSE DETER 30 MG | 6510007510A560 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL TAB ABUSE DETER 30 MG | 6510007510A560 | Generic |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN SOLN 10-325 MG/15ML | 65991702102025 | Generic |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN TAB 2.5-325 MG | 65991702100302 | Generic |
| TRAMADOL HYDROCHLORIDE | TRAMADOL HCL TAB 75 MG | 65100095100330 | Generic |

**Approval Criteria**

**1** - ONE of the following:

**1.1** If the request is for tramadol 100 mg (milligram) tablets, the physician has provided rationale for needing to use the 100 mg tramadol tablet instead of two 50 mg tramadol tablets

**OR**

**1.2** 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**

**1.3** If the request is for Qdolo (tramadol soln), ONE of the following:

**1.3.1** Failure of tramadol 50mg tablets as confirmed by claims history or submission of medical records

**OR**

**1.3.2** History of intolerance or contraindication to tramadol 50mg tablets (please specify intolerance or contraindication)

**OR**

**1.3.3** Patient is unable to swallow a solid dosage form

**OR**

**1.3.4** Patient utilizes a feeding tube for medication administration

**OR**

**1.4** If the request is for another non-preferred medication**, then ONE of the following:

**1.4.1** 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**

**1.4.2** 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.<br>**PDL link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |
|---|---|

| Product Name: butorphanol nasal sol, codeine, acetaminophen w/codeine soln and tabs, Brand Fioricet/codeine, generic butalbital/acetaminophen/caffeine w/codeine, Ascomp/codeine, generic butalbital/aspirin/caffeine w/codeine, morphine supp, tabs and soln, Brand Lortab, hydrocodone/acetaminophen soln, Brand Xodol, generic hydrocodone/acetaminophen tabs, hydrocodone/ibuprofen, Brand Dilaudid, generic hydromorphone, oxycodone caps, soln and conc, Brand Roxicodone, Oxaydo, generic oxycodone tabs, Brand Percocet, Prolate tabs and soln, Nalocet, Endocet, Oxycodone-acetaminophen soln and tabs, generic oxycodone/acetaminophen soln and tabs, oxymorphone, pentazocine w/naloxone, Brand Ultram, Synapryn, generic tramadol, Qdolo, Tramadol soln, Brand Ultracet, generic tramadol/acetaminophen, Nucynta, meperidine, levorphanol, Brand Trezix, generic acetaminophen/caffeine/dihydrocodeine, generic belladonna alkaloids/opium, opium, Apadaz, Benzhydrocodone/acetaminophen, Seglentis, Brand Roxybond, Brand Oxycodone | |
|---|---|
| Diagnosis | Cancer-related pain/Hospice/End of Life/Sickle Cell Anemia Related Pain Exceeding the 90 MME Cumulative Threshold* |
| Guideline Type | Morphine Milligram Equivalents (MME) Reviews** |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BUTORPHANOL TARTRATE | BUTORPHANOL TARTRATE NASAL SOLN 10 MG/ML | 65200020102050 | Generic |
| ACETAMINOPHEN/CODEINE | ACETAMINOPHEN W/ CODEINE SOLN 120-12 MG/5ML | 65991002052020 | Generic |
| ACETAMINOPHEN/CODEINE | ACETAMINOPHEN W/ CODEINE TAB 300-15 MG | 65991002050310 | Generic |
| ACETAMINOPHEN/CODEINE PHOSPHATE | ACETAMINOPHEN W/ CODEINE TAB 300-15 MG | 65991002050310 | Generic |
| ACETAMINOPHEN/CODEINE | ACETAMINOPHEN W/ CODEINE TAB 300-30 MG | 65991002050315 | Generic |
| ACETAMINOPHEN/CODEINE #3 | ACETAMINOPHEN W/ CODEINE TAB 300-30 MG | 65991002050315 | Generic |
| ACETAMINOPHEN/CODEINE PHOSPHATE | ACETAMINOPHEN W/ CODEINE TAB 300-30 MG | 65991002050315 | Generic |
| ACETAMINOPHEN/CODEINE | ACETAMINOPHEN W/ CODEINE TAB 300-60 MG | 65991002050320 | Generic |

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|---|---|---|---|
| ACETAMINOPHEN/CODEINE PHOSPHATE | ACETAMINOPHEN W/ CODEINE TAB 300-60 MG | 65991002050320 | Generic |
| CODEINE/ACETAMINOPHEN | ACETAMINOPHEN W/ CODEINE TAB 300-60 MG | 65991002050320 | Generic |
| BUTALBITAL/ACETAMINOPHEN/CAFFEINE/CODEINE | BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-325-40-30 MG | 65991004100115 | Generic |
| BUTALBITAL/ACETAMINOPHEN/CAFFEINE/CODEINE | BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-300-40-30 MG | 65991004100113 | Generic |
| FIORICET/CODEINE | BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-300-40-30 MG | 65991004100113 | Brand |
| ASCOMP/CODEINE | BUTALBITAL-ASPIRIN-CAFF W/ CODEINE CAP 50-325-40-30 MG | 65991004300115 | Generic |
| BUTALBITAL/ASPIRIN/CAFFEINE/CODEINE | BUTALBITAL-ASPIRIN-CAFF W/ CODEINE CAP 50-325-40-30 MG | 65991004300115 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE ORAL SOLN 10 MG/5ML | 65100055102065 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE ORAL SOLN 100 MG/5ML (20 MG/ML) | 65100055102090 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE ORAL SOLN 20 MG/5ML | 65100055102070 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE SUPPOS 10 MG | 65100055105210 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE SUPPOS 20 MG | 65100055105215 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE SUPPOS 30 MG | 65100055105220 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE TAB 15 MG | 65100055100310 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE TAB 30 MG | 65100055100315 | Generic |

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| MORPHINE SULFATE | MORPHINE SULFATE SUPPOS 5 MG | 65100055105205 | Generic |
| LORTAB | HYDROCODONE-ACETAMINOPHEN SOLN 10-300 MG/15ML | 65991702102024 | Brand |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN TAB 10-300 MG | 65991702100375 | Generic |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN TAB 10-325 MG | 65991702100305 | Generic |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN TAB 7.5-300 MG | 65991702100322 | Generic |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN TAB 7.5-325 MG | 65991702100358 | Generic |
| HYDROCODONE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN TAB 7.5-325 MG | 65991702100358 | Generic |
| HYDROCODONE/IBUPROFEN | HYDROCODONE-IBUPROFEN TAB 10-200 MG | 65991702500330 | Generic |
| HYDROCODONE/IBUPROFEN | HYDROCODONE-IBUPROFEN TAB 7.5-200 MG | 65991702500320 | Generic |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN TAB 5-300 MG | 65991702100309 | Generic |
| XODOL | HYDROCODONE-ACETAMINOPHEN TAB 5-300 MG | 65991702100309 | Brand |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN TAB 5-325 MG | 65991702100356 | Generic |
| HYDROCODONE/IBUPROFEN | HYDROCODONE-IBUPROFEN TAB 5-200 MG | 65991702500315 | Generic |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN SOLN 7.5-325 MG/15ML | 65991702102015 | Generic |
| HYDROMORPHONE HCL | HYDROMORPHONE HCL SUPPOS 3 MG | 65100035105205 | Generic |
| DILAUDID | HYDROMORPHONE HCL TAB 4 MG | 65100035100320 | Brand |

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| HYDROMORPHONE HCL | HYDROMORPHONE HCL TAB 4 MG | 65100035100320 | Generic |
| DILAUDID | HYDROMORPHONE HCL TAB 8 MG | 65100035100330 | Brand |
| HYDROMORPHONE HCL | HYDROMORPHONE HCL TAB 8 MG | 65100035100330 | Generic |
| DILAUDID | HYDROMORPHONE HCL TAB 2 MG | 65100035100310 | Brand |
| HYDROMORPHONE HCL | HYDROMORPHONE HCL TAB 2 MG | 65100035100310 | Generic |
| OXYCODONE HCL | OXYCODONE HCL CAP 5 MG | 65100075100110 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL CAP 5 MG | 65100075100110 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL CONC 100 MG/5ML (20 MG/ML) | 65100075101320 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL SOLN 5 MG/5ML | 65100075102005 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL TAB 10 MG | 65100075100320 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL TAB 15 MG | 65100075100325 | Generic |
| ROXICODONE | OXYCODONE HCL TAB 15 MG | 65100075100325 | Brand |
| ENDOCET | OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG | 65990002200335 | Generic |
| OXYCODONE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG | 65990002200335 | Generic |
| PERCOCET | OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG | 65990002200335 | Brand |
| ENDOCET | OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG | 65990002200327 | Generic |
| OXYCODONE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG | 65990002200327 | Generic |
| PERCOCET | OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG | 65990002200327 | Brand |
| ENDOCET | OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG | 65990002200305 | Generic |

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| OXYCODONE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG | 65990002200305 | Generic |
| PERCOCET | OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG | 65990002200305 | Brand |
| ENDOCET | OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG | 65990002200310 | Generic |
| OXYCODONE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG | 65990002200310 | Generic |
| PERCOCET | OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG | 65990002200310 | Brand |
| OXYMORPHONE HYDROCHLORIDE | OXYMORPHONE HCL TAB 10 MG | 65100080100310 | Generic |
| OXYMORPHONE HYDROCHLORIDE | OXYMORPHONE HCL TAB 5 MG | 65100080100305 | Generic |
| TRAMADOL HCL | TRAMADOL HCL TAB 50 MG | 65100095100320 | Generic |
| TRAMADOL HYDROCHLORIDE | TRAMADOL HCL TAB 50 MG | 65100095100320 | Generic |
| ULTRAM | TRAMADOL HCL TAB 50 MG | 65100095100320 | Brand |
| SYNAPRYN FUSEPAQ | *TRAMADOL HCL FOR ORAL SUSP 10 MG/ML (COMPOUND KIT)*** | 65100095101920 | Brand |
| TRAMADOL HYDROCHLORIDE/ACETAMINOPHEN | TRAMADOL-ACETAMINOPHEN TAB 37.5-325 MG | 65995002200320 | Generic |
| ULTRACET | TRAMADOL-ACETAMINOPHEN TAB 37.5-325 MG | 65995002200320 | Brand |
| NUCYNTA | TAPENTADOL HCL TAB 100 MG | 65100091100340 | Brand |
| NUCYNTA | TAPENTADOL HCL TAB 50 MG | 65100091100320 | Brand |
| NUCYNTA | TAPENTADOL HCL TAB 75 MG | 65100091100330 | Brand |
| MEPERIDINE HCL | MEPERIDINE HCL TAB 50 MG | 65100045100305 | Generic |
| MEPERIDINE HCL | MEPERIDINE HCL ORAL SOLN 50 MG/5ML | 65100045102060 | Generic |

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| LEVORPHANOL TARTRATE | LEVORPHANOL TARTRATE TAB 2 MG | 6510004010030 5 | Generic |
| LEVORPHANOL TARTRATE | LEVORPHANOL TARTRATE TAB 3 MG | 6510004010031 0 | Generic |
| ACETAMINOPHEN/CAFFEINE/DIHYDROCODEIN E | ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE CAP 320.5-30-16 MG | 6599130305011 5 | Generic |
| BELLADONNA/OPIUM | BELLADONNA ALKALOIDS & OPIUM SUPPOS 16.2-30 MG | 4910990215521 0 | Generic |
| BELLADONNA/OPIUM | BELLADONNA ALKALOIDS & OPIUM SUPPOS 16.2-60 MG | 4910990215522 0 | Generic |
| OPIUM | OPIUM TINCTURE 1% (10 MG/ML) (MORPHINE EQUIV) | 4710003020150 5 | Generic |
| OPIUM TINCTURE | OPIUM TINCTURE 1% (10 MG/ML) (MORPHINE EQUIV) | 4710003020150 5 | Generic |
| APADAZ | BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 8.16-325 MG | 6599000202033 0 | Brand |
| BENZHYDROCODONE/ACETAMINOPHEN | BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 8.16-325 MG | 6599000202033 0 | Brand |
| APADAZ | BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 6.12-325 MG | 6599000202032 0 | Brand |
| BENZHYDROCODONE/ACETAMINOPHEN | BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 6.12-325 MG | 6599000202032 0 | Brand |
| APADAZ | BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 4.08-325 MG | 6599000202031 0 | Brand |
| BENZHYDROCODONE/ACETAMINOPHEN | BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 4.08-325 MG | 6599000202031 0 | Brand |
| OXYCODONE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN TAB 5-300 MG | 6599000220030 8 | Generic |

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| PROLATE | OXYCODONE W/ ACETAMINOPHEN TAB 5-300 MG | 65990002200308 | Generic |
| OXYCODONE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN TAB 10-300 MG | 65990002200333 | Generic |
| PROLATE | OXYCODONE W/ ACETAMINOPHEN TAB 10-300 MG | 65990002200333 | Generic |
| OXYCODONE HYDROCHLORIDE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN SOLN 10-300 MG/5ML | 65990002202020 | Generic |
| PROLATE | OXYCODONE W/ ACETAMINOPHEN SOLN 10-300 MG/5ML | 65990002202020 | Generic |
| OXAYDO | OXYCODONE HCL TAB 7.5 MG | 65100075100315 | Brand |
| HYDROMORPHONE HYDROCHLORIDE | HYDROMORPHONE HCL TAB 4 MG | 65100035100320 | Generic |
| HYDROMORPHONE HYDROCHLORIDE | HYDROMORPHONE HCL TAB 2 MG | 65100035100310 | Generic |
| CODEINE SULFATE | CODEINE SULFATE TAB 15 MG | 65100020200305 | Generic |
| CODEINE SULFATE | CODEINE SULFATE TAB 30 MG | 65100020200310 | Generic |
| CODEINE SULFATE | CODEINE SULFATE TAB 60 MG | 65100020200315 | Generic |
| DILAUDID | HYDROMORPHONE HCL LIQD 1 MG/ML | 65100035100920 | Brand |
| HYDROMORPHONE HCL | HYDROMORPHONE HCL LIQD 1 MG/ML | 65100035100920 | Generic |
| HYDROMORPHONE HYDROCHLORIDE | HYDROMORPHONE HCL LIQD 1 MG/ML | 65100035100920 | Generic |
| OXAYDO | OXYCODONE HCL TAB 5 MG | 65100075100310 | Brand |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL TAB 5 MG | 65100075100310 | Generic |
| ROXICODONE | OXYCODONE HCL TAB 5 MG | 65100075100310 | Brand |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL TAB 20 MG | 65100075100330 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL TAB 30 MG | 65100075100340 | Generic |

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| ROXICODONE | OXYCODONE HCL TAB 30 MG | 6510007510034 0 | Brand |
| NALOCET | OXYCODONE W/ ACETAMINOPHEN TAB 2.5-300 MG | 6599000220030 3 | Generic |
| OXYCODONE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN TAB 2.5-300 MG | 6599000220030 3 | Generic |
| OXYCODONE AND ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN TAB 7.5-300 MG | 6599000220032 5 | Generic |
| PROLATE | OXYCODONE W/ ACETAMINOPHEN TAB 7.5-300 MG | 6599000220032 5 | Generic |
| PENTAZOCINE/NALOXONE HCL | PENTAZOCINE W/ NALOXONE HCL TAB 50-0.5 MG | 6520004030031 0 | Generic |
| QDOLO | TRAMADOL HCL ORAL SOLN 5 MG/ML | 6510009510200 5 | Generic |
| TRAMADOL HYDROCHLORIDE | TRAMADOL HCL ORAL SOLN 5 MG/ML | 6510009510200 5 | Generic |
| SEGLENTIS | CELECOXIB-TRAMADOL HCL TAB 56-44 MG | 6599500210032 0 | Brand |
| ROXYBOND | OXYCODONE HCL TAB ABUSE DETER 5 MG | 6510007510A53 0 | Brand |
| ROXYBOND | OXYCODONE HCL TAB ABUSE DETER 15 MG | 6510007510A54 0 | Brand |
| ROXYBOND | OXYCODONE HCL TAB ABUSE DETER 30 MG | 6510007510A56 0 | Brand |
| OXYCODONE HYDROCHLORIDE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN SOLN 5-325 MG/5ML | 6599000220200 5 | Brand |
| TRAMADOL HYDROCHLORIDE | TRAMADOL HCL TAB 100 MG | 6510009510034 0 | Generic |
| TREZIX | ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE CAP 320.5-30-16 MG | 6599130305011 5 | Brand |
| MEPERIDINE HYDROCHLORIDE | MEPERIDINE HCL TAB 50 MG | 6510004510030 5 | Generic |
| TRAMADOL HYDROCHLORIDE | TRAMADOL HCL TAB 25 MG | 6510009510031 0 | Generic |

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| ROXYBOND | OXYCODONE HCL TAB ABUSE DETER 5 MG | 6510007510A530 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL TAB ABUSE DETER 5 MG | 6510007510A530 | Generic |
| ROXYBOND | OXYCODONE HCL TAB ABUSE DETER 10 MG | 6510007510A535 | Brand |
| ROXYBOND | OXYCODONE HCL TAB ABUSE DETER 15 MG | 6510007510A540 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL TAB ABUSE DETER 15 MG | 6510007510A540 | Generic |
| ROXYBOND | OXYCODONE HCL TAB ABUSE DETER 30 MG | 6510007510A560 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL TAB ABUSE DETER 30 MG | 6510007510A560 | Generic |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN SOLN 10-325 MG/15ML | 65991702102025 | Generic |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN TAB 2.5-325 MG | 65991702100302 | Generic |
| TRAMADOL HYDROCHLORIDE | TRAMADOL HCL TAB 75 MG | 65100095100330 | Generic |

**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)
- End of life diagnosis (hospice care)
- Sickle cell anemia related pain

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| Notes | *This section does NOT apply to cough and cold products.<br>**Approval length will be issued for up to the requested amount for 12 months for cancer-related pain/hospice/end of life/sickle cell anemia r elated pain. The authorization should be entered for an MME of 9999 so as to prevent future disruptions in therapy if the patient's dose is in creased. |

| Product Name: butorphanol nasal sol, codeine, acetaminophen w/codeine soln and tabs, Brand Fioricet/codeine, generic butalbital/acetaminophen/caffeine w/codeine, Ascomp/codeine, generic butalbital/aspirin/caffeine w/codeine, morphine supp, tabs and soln, Brand Lortab, hydrocodone/acetaminophen soln, Brand Xodol, generic hydrocodone/acetaminophen tabs, hydrocodone/ibuprofen, Brand Dilaudid, generic hydromorphone, oxycodone caps, soln and conc, Brand Roxicodone, Oxaydo, generic oxycodone tabs, Brand Percocet, Prolate tabs and soln, Nalocet, Endocet, Oxycodone-acetaminophen soln and tabs, generic oxycodone/acetaminophen soln and tabs, oxymorphone, pentazocine w/naloxone, Brand Ultram, Synapryn, generic tramadol, Qdolo, Tramadol soln, Brand Ultracet, generic tramadol/acetaminophen, Nucynta, meperidine, levorphanol, Brand Trezix, generic acetaminophen/caffeine/dihydrocodeine, generic belladonna alkaloids/opium, opium, Apadaz, Benzhydrocodone/acetaminophen, Seglentis, Brand Roxybond, Brand Oxycodone | |
|---|---|
| Diagnosis | Non-cancer-related pain/non-hospice/non-end of life/non-sickle cell anemia related pain Exceeding the 90 MME Cumulative Threshold * |
| Therapy Stage | Initial Authorization |
| Guideline Type | Morphine Milligram Equivalents (MME)** |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BUTORPHANOL TARTRATE | BUTORPHANOL TARTRATE NASAL SOLN 10 MG/ML | 65200020102050 | Generic |
| ACETAMINOPHEN/CODEINE | ACETAMINOPHEN W/ CODEINE SOLN 120-12 MG/5ML | 65991002052020 | Generic |
| ACETAMINOPHEN/CODEINE | ACETAMINOPHEN W/ CODEINE TAB 300-15 MG | 65991002050310 | Generic |
| ACETAMINOPHEN/CODEINE PHOSPHATE | ACETAMINOPHEN W/ CODEINE TAB 300-15 MG | 65991002050310 | Generic |
| ACETAMINOPHEN/CODEINE | ACETAMINOPHEN W/ CODEINE TAB 300-30 MG | 65991002050315 | Generic |
| ACETAMINOPHEN/CODEINE #3 | ACETAMINOPHEN W/ CODEINE TAB 300-30 MG | 65991002050315 | Generic |
| ACETAMINOPHEN/CODEINE PHOSPHATE | ACETAMINOPHEN W/ CODEINE TAB 300-30 MG | 65991002050315 | Generic |
| ACETAMINOPHEN/CODEINE | ACETAMINOPHEN W/ CODEINE TAB 300-60 MG | 65991002050320 | Generic |

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| ACETAMINOPHEN/CODEINE PHOSPHATE | ACETAMINOPHEN W/ CODEINE TAB 300-60 MG | 65991002050320 | Generic |
| CODEINE/ACETAMINOPHEN | ACETAMINOPHEN W/ CODEINE TAB 300-60 MG | 65991002050320 | Generic |
| BUTALBITAL/ACETAMINOPHEN/CAFFEINE/CODEINE | BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-325-40-30 MG | 65991004100115 | Generic |
| BUTALBITAL/ACETAMINOPHEN/CAFFEINE/CODEINE | BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-300-40-30 MG | 65991004100113 | Generic |
| FIORICET/CODEINE | BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-300-40-30 MG | 65991004100113 | Brand |
| ASCOMP/CODEINE | BUTALBITAL-ASPIRIN-CAFF W/ CODEINE CAP 50-325-40-30 MG | 65991004300115 | Generic |
| BUTALBITAL/ASPIRIN/CAFFEINE/CODEINE | BUTALBITAL-ASPIRIN-CAFF W/ CODEINE CAP 50-325-40-30 MG | 65991004300115 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE ORAL SOLN 10 MG/5ML | 65100055102065 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE ORAL SOLN 100 MG/5ML (20 MG/ML) | 65100055102090 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE ORAL SOLN 20 MG/5ML | 65100055102070 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE SUPPOS 10 MG | 65100055105210 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE SUPPOS 20 MG | 65100055105215 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE SUPPOS 30 MG | 65100055105220 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE TAB 15 MG | 65100055100310 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE TAB 30 MG | 65100055100315 | Generic |

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| MORPHINE SULFATE | MORPHINE SULFATE SUPPOS 5 MG | 65100055105205 | Generic |
| LORTAB | HYDROCODONE-ACETAMINOPHEN SOLN 10-300 MG/15ML | 65991702102024 | Brand |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN TAB 10-300 MG | 65991702100375 | Generic |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN TAB 10-325 MG | 65991702100305 | Generic |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN TAB 7.5-300 MG | 65991702100322 | Generic |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN TAB 7.5-325 MG | 65991702100358 | Generic |
| HYDROCODONE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN TAB 7.5-325 MG | 65991702100358 | Generic |
| HYDROCODONE/IBUPROFEN | HYDROCODONE-IBUPROFEN TAB 10-200 MG | 65991702500330 | Generic |
| HYDROCODONE/IBUPROFEN | HYDROCODONE-IBUPROFEN TAB 7.5-200 MG | 65991702500320 | Generic |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN TAB 5-300 MG | 65991702100309 | Generic |
| XODOL | HYDROCODONE-ACETAMINOPHEN TAB 5-300 MG | 65991702100309 | Brand |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN TAB 5-325 MG | 65991702100356 | Generic |
| HYDROCODONE/IBUPROFEN | HYDROCODONE-IBUPROFEN TAB 5-200 MG | 65991702500315 | Generic |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN SOLN 7.5-325 MG/15ML | 65991702102015 | Generic |
| HYDROMORPHONE HCL | HYDROMORPHONE HCL SUPPOS 3 MG | 65100035105205 | Generic |
| DILAUDID | HYDROMORPHONE HCL TAB 4 MG | 65100035100320 | Brand |

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| HYDROMORPHONE HCL | HYDROMORPHONE HCL TAB 4 MG | 65100035100320 | Generic |
| DILAUDID | HYDROMORPHONE HCL TAB 8 MG | 65100035100330 | Brand |
| HYDROMORPHONE HCL | HYDROMORPHONE HCL TAB 8 MG | 65100035100330 | Generic |
| DILAUDID | HYDROMORPHONE HCL TAB 2 MG | 65100035100310 | Brand |
| HYDROMORPHONE HCL | HYDROMORPHONE HCL TAB 2 MG | 65100035100310 | Generic |
| OXYCODONE HCL | OXYCODONE HCL CAP 5 MG | 65100075100110 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL CAP 5 MG | 65100075100110 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL CONC 100 MG/5ML (20 MG/ML) | 65100075101320 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL SOLN 5 MG/5ML | 65100075102005 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL TAB 10 MG | 65100075100320 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL TAB 15 MG | 65100075100325 | Generic |
| ROXICODONE | OXYCODONE HCL TAB 15 MG | 65100075100325 | Brand |
| ENDOCET | OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG | 65990002200335 | Generic |
| OXYCODONE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG | 65990002200335 | Generic |
| PERCOCET | OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG | 65990002200335 | Brand |
| ENDOCET | OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG | 65990002200327 | Generic |
| OXYCODONE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG | 65990002200327 | Generic |
| PERCOCET | OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG | 65990002200327 | Brand |
| ENDOCET | OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG | 65990002200305 | Generic |

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| OXYCODONE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG | 65990002200305 | Generic |
| PERCOCET | OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG | 65990002200305 | Brand |
| ENDOCET | OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG | 65990002200310 | Generic |
| OXYCODONE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG | 65990002200310 | Generic |
| PERCOCET | OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG | 65990002200310 | Brand |
| OXYMORPHONE HYDROCHLORIDE | OXYMORPHONE HCL TAB 10 MG | 65100080100310 | Generic |
| OXYMORPHONE HYDROCHLORIDE | OXYMORPHONE HCL TAB 5 MG | 65100080100305 | Generic |
| TRAMADOL HCL | TRAMADOL HCL TAB 50 MG | 65100095100320 | Generic |
| TRAMADOL HYDROCHLORIDE | TRAMADOL HCL TAB 50 MG | 65100095100320 | Generic |
| ULTRAM | TRAMADOL HCL TAB 50 MG | 65100095100320 | Brand |
| SYNAPRYN FUSEPAQ | *TRAMADOL HCL FOR ORAL SUSP 10 MG/ML (COMPOUND KIT)*** | 65100095101920 | Brand |
| TRAMADOL HYDROCHLORIDE/ACETAMINOPHEN | TRAMADOL-ACETAMINOPHEN TAB 37.5-325 MG | 65995002200320 | Generic |
| ULTRACET | TRAMADOL-ACETAMINOPHEN TAB 37.5-325 MG | 65995002200320 | Brand |
| NUCYNTA | TAPENTADOL HCL TAB 100 MG | 65100091100340 | Brand |
| NUCYNTA | TAPENTADOL HCL TAB 50 MG | 65100091100320 | Brand |
| NUCYNTA | TAPENTADOL HCL TAB 75 MG | 65100091100330 | Brand |
| MEPERIDINE HCL | MEPERIDINE HCL TAB 50 MG | 65100045100305 | Generic |
| MEPERIDINE HCL | MEPERIDINE HCL ORAL SOLN 50 MG/5ML | 65100045102060 | Generic |

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| LEVORPHANOL TARTRATE | LEVORPHANOL TARTRATE TAB 2 MG | 65100040100305 | Generic |
| LEVORPHANOL TARTRATE | LEVORPHANOL TARTRATE TAB 3 MG | 65100040100310 | Generic |
| ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE | ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE CAP 320.5-30-16 MG | 65991303050115 | Generic |
| BELLADONNA/OPIUM | BELLADONNA ALKALOIDS & OPIUM SUPPOS 16.2-30 MG | 49109902155210 | Generic |
| BELLADONNA/OPIUM | BELLADONNA ALKALOIDS & OPIUM SUPPOS 16.2-60 MG | 49109902155220 | Generic |
| OPIUM | OPIUM TINCTURE 1% (10 MG/ML) (MORPHINE EQUIV) | 47100030201505 | Generic |
| OPIUM TINCTURE | OPIUM TINCTURE 1% (10 MG/ML) (MORPHINE EQUIV) | 47100030201505 | Generic |
| APADAZ | BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 8.16-325 MG | 65990002020330 | Brand |
| BENZHYDROCODONE/ACETAMINOPHEN | BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 8.16-325 MG | 65990002020330 | Brand |
| APADAZ | BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 6.12-325 MG | 65990002020320 | Brand |
| BENZHYDROCODONE/ACETAMINOPHEN | BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 6.12-325 MG | 65990002020320 | Brand |
| APADAZ | BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 4.08-325 MG | 65990002020310 | Brand |
| BENZHYDROCODONE/ACETAMINOPHEN | BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 4.08-325 MG | 65990002020310 | Brand |
| OXYCODONE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN TAB 5-300 MG | 65990002200308 | Generic |

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| PROLATE | OXYCODONE W/ ACETAMINOPHEN TAB 5-300 MG | 65990002200308 | Generic |
| OXYCODONE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN TAB 10-300 MG | 65990002200333 | Generic |
| PROLATE | OXYCODONE W/ ACETAMINOPHEN TAB 10-300 MG | 65990002200333 | Generic |
| OXYCODONE HYDROCHLORIDE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN SOLN 10-300 MG/5ML | 65990002202020 | Generic |
| PROLATE | OXYCODONE W/ ACETAMINOPHEN SOLN 10-300 MG/5ML | 65990002202020 | Generic |
| OXAYDO | OXYCODONE HCL TAB 7.5 MG | 65100075100315 | Brand |
| HYDROMORPHONE HYDROCHLORIDE | HYDROMORPHONE HCL TAB 4 MG | 65100035100320 | Generic |
| HYDROMORPHONE HYDROCHLORIDE | HYDROMORPHONE HCL TAB 2 MG | 65100035100310 | Generic |
| CODEINE SULFATE | CODEINE SULFATE TAB 15 MG | 65100020200305 | Generic |
| CODEINE SULFATE | CODEINE SULFATE TAB 30 MG | 65100020200310 | Generic |
| CODEINE SULFATE | CODEINE SULFATE TAB 60 MG | 65100020200315 | Generic |
| DILAUDID | HYDROMORPHONE HCL LIQD 1 MG/ML | 65100035100920 | Brand |
| HYDROMORPHONE HCL | HYDROMORPHONE HCL LIQD 1 MG/ML | 65100035100920 | Generic |
| HYDROMORPHONE HYDROCHLORIDE | HYDROMORPHONE HCL LIQD 1 MG/ML | 65100035100920 | Generic |
| OXAYDO | OXYCODONE HCL TAB 5 MG | 65100075100310 | Brand |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL TAB 5 MG | 65100075100310 | Generic |
| ROXICODONE | OXYCODONE HCL TAB 5 MG | 65100075100310 | Brand |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL TAB 20 MG | 65100075100330 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL TAB 30 MG | 65100075100340 | Generic |

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| ROXICODONE | OXYCODONE HCL TAB 30 MG | 6510007510034 0 | Brand |
| NALOCET | OXYCODONE W/ ACETAMINOPHEN TAB 2.5-300 MG | 6599000220030 3 | Generic |
| OXYCODONE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN TAB 2.5-300 MG | 6599000220030 3 | Generic |
| OXYCODONE AND ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN TAB 7.5-300 MG | 6599000220032 5 | Generic |
| PROLATE | OXYCODONE W/ ACETAMINOPHEN TAB 7.5-300 MG | 6599000220032 5 | Generic |
| PENTAZOCINE/NALOXONE HCL | PENTAZOCINE W/ NALOXONE HCL TAB 50-0.5 MG | 6520004030031 0 | Generic |
| QDOLO | TRAMADOL HCL ORAL SOLN 5 MG/ML | 6510009510200 5 | Generic |
| TRAMADOL HYDROCHLORIDE | TRAMADOL HCL ORAL SOLN 5 MG/ML | 6510009510200 5 | Generic |
| SEGLENTIS | CELECOXIB-TRAMADOL HCL TAB 56-44 MG | 6599500210032 0 | Brand |
| ROXYBOND | OXYCODONE HCL TAB ABUSE DETER 5 MG | 6510007510A53 0 | Brand |
| ROXYBOND | OXYCODONE HCL TAB ABUSE DETER 15 MG | 6510007510A54 0 | Brand |
| ROXYBOND | OXYCODONE HCL TAB ABUSE DETER 30 MG | 6510007510A56 0 | Brand |
| OXYCODONE HYDROCHLORIDE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN SOLN 5-325 MG/5ML | 6599000220200 5 | Brand |
| TRAMADOL HYDROCHLORIDE | TRAMADOL HCL TAB 100 MG | 6510009510034 0 | Generic |
| TREZIX | ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE CAP 320.5-30-16 MG | 6599130305011 5 | Brand |
| MEPERIDINE HYDROCHLORIDE | MEPERIDINE HCL TAB 50 MG | 6510004510030 5 | Generic |
| TRAMADOL HYDROCHLORIDE | TRAMADOL HCL TAB 25 MG | 6510009510031 0 | Generic |

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| ROXYBOND | OXYCODONE HCL TAB ABUSE DETER 5 MG | 6510007510A530 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL TAB ABUSE DETER 5 MG | 6510007510A530 | Generic |
| ROXYBOND | OXYCODONE HCL TAB ABUSE DETER 10 MG | 6510007510A535 | Brand |
| ROXYBOND | OXYCODONE HCL TAB ABUSE DETER 15 MG | 6510007510A540 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL TAB ABUSE DETER 15 MG | 6510007510A540 | Generic |
| ROXYBOND | OXYCODONE HCL TAB ABUSE DETER 30 MG | 6510007510A560 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL TAB ABUSE DETER 30 MG | 6510007510A560 | Generic |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN SOLN 10-325 MG/15ML | 65991702102025 | Generic |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN TAB 2.5-325 MG | 65991702100302 | Generic |
| TRAMADOL HYDROCHLORIDE | TRAMADOL HCL TAB 75 MG | 6510009510033 0 | Generic |

**Approval Criteria**

**1** - Prescriber attests 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** - BOTH of the following:

- Patient has tried and failed non-opioid pain medication (document drug name and date of trial)
- Opioid medication doses of less than 90 morphine milligram 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.<br>**Approval length will be issued for 6 months for non-cancer-related pain/non-hospice/non-end of life/non-sickle cell anemia related pain up to the current requested MME plus 90 MME<br>***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 sol, codeine, acetaminophen w/codeine soln and tabs, Brand Fioricet/codeine, generic butalbital/acetaminophen/caffeine w/codeine, Ascomp/codeine, generic butalbital/aspirin/caffeine w/codeine, morphine supp, tabs and soln, Brand Lortab, hydrocodone/acetaminophen soln, Brand Xodol, generic hydrocodone/acetaminophen tabs, hydrocodone/ibuprofen, Brand Dilaudid, generic hydromorphone, oxycodone caps, soln and conc, Brand Roxicodone, Oxaydo, generic oxycodone tabs, Brand Percocet, Prolate tabs and soln, Nalocet, Endocet, Oxycodone-acetaminophen soln and tabs, generic oxycodone/acetaminophen soln and tabs, oxymorphone, pentazocine w/naloxone, Brand Ultram, Synapryn, generic tramadol, Qdolo, Tramadol soln, Brand Ultracet, generic tramadol/acetaminophen, Nucynta, meperidine, levorphanol, Brand Trezix, generic acetaminophen/caffeine/dihydrocodeine, generic belladonna alkaloids/opium, opium, Apadaz, Benzhydrocodone/acetaminophen, Seglentis, Brand Roxybond, Brand Oxycodone | |
|---|---|
| Diagnosis | Non-cancer-related pain/non-hospice/non-end of life/non-sickle cell anemia related pain Exceeding the 90 MME Cumulative Threshold* |

| Therapy Stage | Reauthorization |
|---|---|
| Guideline Type | Morphine Milligram Equivalents (MME)** |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BUTORPHANOL TARTRATE | BUTORPHANOL TARTRATE NASAL SOLN 10 MG/ML | 65200020102050 | Generic |
| ACETAMINOPHEN/CODEINE | ACETAMINOPHEN W/ CODEINE SOLN 120-12 MG/5ML | 65991002052020 | Generic |
| ACETAMINOPHEN/CODEINE | ACETAMINOPHEN W/ CODEINE TAB 300-15 MG | 65991002050310 | Generic |
| ACETAMINOPHEN/CODEINE PHOSPHATE | ACETAMINOPHEN W/ CODEINE TAB 300-15 MG | 65991002050310 | Generic |
| ACETAMINOPHEN/CODEINE | ACETAMINOPHEN W/ CODEINE TAB 300-30 MG | 65991002050315 | Generic |
| ACETAMINOPHEN/CODEINE #3 | ACETAMINOPHEN W/ CODEINE TAB 300-30 MG | 65991002050315 | Generic |
| ACETAMINOPHEN/CODEINE PHOSPHATE | ACETAMINOPHEN W/ CODEINE TAB 300-30 MG | 65991002050315 | Generic |
| ACETAMINOPHEN/CODEINE | ACETAMINOPHEN W/ CODEINE TAB 300-60 MG | 65991002050320 | Generic |
| ACETAMINOPHEN/CODEINE PHOSPHATE | ACETAMINOPHEN W/ CODEINE TAB 300-60 MG | 65991002050320 | Generic |
| CODEINE/ACETAMINOPHEN | ACETAMINOPHEN W/ CODEINE TAB 300-60 MG | 65991002050320 | Generic |
| BUTALBITAL/ACETAMINOPHEN/CAFFEINE/CODEINE | BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-325-40-30 MG | 65991004100115 | Generic |
| BUTALBITAL/ACETAMINOPHEN/CAFFEINE/CODEINE | BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-300-40-30 MG | 65991004100113 | Generic |
| FIORICET/CODEINE | BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-300-40-30 MG | 65991004100113 | Brand |
| ASCOMP/CODEINE | BUTALBITAL-ASPIRIN-CAFF W/ | 65991004300115 | Generic |

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|---|---|---|---|
| | CODEINE CAP 50-325-40-30 MG | | |
| BUTALBITAL/ASPIRIN/CAFFEINE/CODEINE | BUTALBITAL-ASPIRIN-CAFF W/ CODEINE CAP 50-325-40-30 MG | 65991004300115 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE ORAL SOLN 10 MG/5ML | 65100055102065 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE ORAL SOLN 100 MG/5ML (20 MG/ML) | 65100055102090 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE ORAL SOLN 20 MG/5ML | 65100055102070 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE SUPPOS 10 MG | 65100055105210 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE SUPPOS 20 MG | 65100055105215 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE SUPPOS 30 MG | 65100055105220 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE TAB 15 MG | 65100055100310 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE TAB 30 MG | 65100055100315 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE SUPPOS 5 MG | 65100055105205 | Generic |
| LORTAB | HYDROCODONE-ACETAMINOPHEN SOLN 10-300 MG/15ML | 65991702102024 | Brand |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN TAB 10-300 MG | 65991702100375 | Generic |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN TAB 10-325 MG | 65991702100305 | Generic |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN TAB 7.5-300 MG | 65991702100322 | Generic |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN TAB 7.5-325 MG | 65991702100358 | Generic |

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|---|---|---|---|
| HYDROCODONE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN TAB 7.5-325 MG | 65991702100358 | Generic |
| HYDROCODONE/IBUPROFEN | HYDROCODONE-IBUPROFEN TAB 10-200 MG | 65991702500330 | Generic |
| HYDROCODONE/IBUPROFEN | HYDROCODONE-IBUPROFEN TAB 7.5-200 MG | 65991702500320 | Generic |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN TAB 5-300 MG | 65991702100309 | Generic |
| XODOL | HYDROCODONE-ACETAMINOPHEN TAB 5-300 MG | 65991702100309 | Brand |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN TAB 5-325 MG | 65991702100356 | Generic |
| HYDROCODONE/IBUPROFEN | HYDROCODONE-IBUPROFEN TAB 5-200 MG | 65991702500315 | Generic |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN SOLN 7.5-325 MG/15ML | 65991702102015 | Generic |
| HYDROMORPHONE HCL | HYDROMORPHONE HCL SUPPOS 3 MG | 65100035105205 | Generic |
| DILAUDID | HYDROMORPHONE HCL TAB 4 MG | 65100035100320 | Brand |
| HYDROMORPHONE HCL | HYDROMORPHONE HCL TAB 4 MG | 65100035100320 | Generic |
| DILAUDID | HYDROMORPHONE HCL TAB 8 MG | 65100035100330 | Brand |
| HYDROMORPHONE HCL | HYDROMORPHONE HCL TAB 8 MG | 65100035100330 | Generic |
| DILAUDID | HYDROMORPHONE HCL TAB 2 MG | 65100035100310 | Brand |
| HYDROMORPHONE HCL | HYDROMORPHONE HCL TAB 2 MG | 65100035100310 | Generic |
| OXYCODONE HCL | OXYCODONE HCL CAP 5 MG | 65100075100110 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL CAP 5 MG | 65100075100110 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL CONC 100 MG/5ML (20 MG/ML) | 65100075101320 | Generic |

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|---|---|---|---|
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL SOLN 5 MG/5ML | 65100075102005 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL TAB 10 MG | 65100075100320 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL TAB 15 MG | 65100075100325 | Generic |
| ROXICODONE | OXYCODONE HCL TAB 15 MG | 65100075100325 | Brand |
| ENDOCET | OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG | 65990002200335 | Generic |
| OXYCODONE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG | 65990002200335 | Generic |
| PERCOCET | OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG | 65990002200335 | Brand |
| ENDOCET | OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG | 65990002200327 | Generic |
| OXYCODONE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG | 65990002200327 | Generic |
| PERCOCET | OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG | 65990002200327 | Brand |
| ENDOCET | OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG | 65990002200305 | Generic |
| OXYCODONE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG | 65990002200305 | Generic |
| PERCOCET | OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG | 65990002200305 | Brand |
| ENDOCET | OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG | 65990002200310 | Generic |
| OXYCODONE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG | 65990002200310 | Generic |
| PERCOCET | OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG | 65990002200310 | Brand |
| OXYMORPHONE HYDROCHLORIDE | OXYMORPHONE HCL TAB 10 MG | 65100080100310 | Generic |
| OXYMORPHONE HYDROCHLORIDE | OXYMORPHONE HCL TAB 5 MG | 65100080100305 | Generic |

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|---|---|---|---|
| TRAMADOL HCL | TRAMADOL HCL TAB 50 MG | 6510009510032 0 | Generic |
| TRAMADOL HYDROCHLORIDE | TRAMADOL HCL TAB 50 MG | 6510009510032 0 | Generic |
| ULTRAM | TRAMADOL HCL TAB 50 MG | 6510009510032 0 | Brand |
| SYNAPRYN FUSEPAQ | *TRAMADOL HCL FOR ORAL SUSP 10 MG/ML (COMPOUND KIT)*** | 6510009510192 0 | Brand |
| TRAMADOL HYDROCHLORIDE/ACETAMINOPHEN | TRAMADOL-ACETAMINOPHEN TAB 37.5-325 MG | 6599500220032 0 | Generic |
| ULTRACET | TRAMADOL-ACETAMINOPHEN TAB 37.5-325 MG | 6599500220032 0 | Brand |
| NUCYNTA | TAPENTADOL HCL TAB 100 MG | 6510009110034 0 | Brand |
| NUCYNTA | TAPENTADOL HCL TAB 50 MG | 6510009110032 0 | Brand |
| NUCYNTA | TAPENTADOL HCL TAB 75 MG | 6510009110033 0 | Brand |
| MEPERIDINE HCL | MEPERIDINE HCL TAB 50 MG | 6510004510030 5 | Generic |
| MEPERIDINE HCL | MEPERIDINE HCL ORAL SOLN 50 MG/5ML | 6510004510206 0 | Generic |
| LEVORPHANOL TARTRATE | LEVORPHANOL TARTRATE TAB 2 MG | 6510004010030 5 | Generic |
| LEVORPHANOL TARTRATE | LEVORPHANOL TARTRATE TAB 3 MG | 6510004010031 0 | Generic |
| ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE | ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE CAP 320.5-30-16 MG | 6599130305011 5 | Generic |
| BELLADONNA/OPIUM | BELLADONNA ALKALOIDS & OPIUM SUPPOS 16.2-30 MG | 4910990215521 0 | Generic |
| BELLADONNA/OPIUM | BELLADONNA ALKALOIDS & OPIUM SUPPOS 16.2-60 MG | 4910990215522 0 | Generic |
| OPIUM | OPIUM TINCTURE 1% (10 MG/ML) (MORPHINE EQUIV) | 4710003020150 5 | Generic |

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|---|---|---|---|
| OPIUM TINCTURE | OPIUM TINCTURE 1% (10 MG/ML) (MORPHINE EQUIV) | 47100030201505 | Generic |
| APADAZ | BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 8.16-325 MG | 65990002020330 | Brand |
| BENZHYDROCODONE/ACETAMINOPHEN | BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 8.16-325 MG | 65990002020330 | Brand |
| APADAZ | BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 6.12-325 MG | 65990002020320 | Brand |
| BENZHYDROCODONE/ACETAMINOPHEN | BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 6.12-325 MG | 65990002020320 | Brand |
| APADAZ | BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 4.08-325 MG | 65990002020310 | Brand |
| BENZHYDROCODONE/ACETAMINOPHEN | BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 4.08-325 MG | 65990002020310 | Brand |
| OXYCODONE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN TAB 5-300 MG | 65990002200308 | Generic |
| PROLATE | OXYCODONE W/ ACETAMINOPHEN TAB 5-300 MG | 65990002200308 | Generic |
| OXYCODONE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN TAB 10-300 MG | 65990002200333 | Generic |
| PROLATE | OXYCODONE W/ ACETAMINOPHEN TAB 10-300 MG | 65990002200333 | Generic |
| OXYCODONE HYDROCHLORIDE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN SOLN 10-300 MG/5ML | 65990002202020 | Generic |
| PROLATE | OXYCODONE W/ ACETAMINOPHEN SOLN 10-300 MG/5ML | 65990002202020 | Generic |
| OXAYDO | OXYCODONE HCL TAB 7.5 MG | 65100075100315 | Brand |
| HYDROMORPHONE HYDROCHLORIDE | HYDROMORPHONE HCL TAB 4 MG | 65100035100320 | Generic |

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| HYDROMORPHONE HYDROCHLORIDE | HYDROMORPHONE HCL TAB 2 MG | 6510003510031 0 | Generic |
| CODEINE SULFATE | CODEINE SULFATE TAB 15 MG | 6510002020030 5 | Generic |
| CODEINE SULFATE | CODEINE SULFATE TAB 30 MG | 6510002020031 0 | Generic |
| CODEINE SULFATE | CODEINE SULFATE TAB 60 MG | 6510002020031 5 | Generic |
| DILAUDID | HYDROMORPHONE HCL LIQD 1 MG/ML | 6510003510092 0 | Brand |
| HYDROMORPHONE HCL | HYDROMORPHONE HCL LIQD 1 MG/ML | 6510003510092 0 | Generic |
| HYDROMORPHONE HYDROCHLORIDE | HYDROMORPHONE HCL LIQD 1 MG/ML | 6510003510092 0 | Generic |
| OXAYDO | OXYCODONE HCL TAB 5 MG | 6510007510031 0 | Brand |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL TAB 5 MG | 6510007510031 0 | Generic |
| ROXICODONE | OXYCODONE HCL TAB 5 MG | 6510007510031 0 | Brand |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL TAB 20 MG | 6510007510033 0 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL TAB 30 MG | 6510007510034 0 | Generic |
| ROXICODONE | OXYCODONE HCL TAB 30 MG | 6510007510034 0 | Brand |
| NALOCET | OXYCODONE W/ ACETAMINOPHEN TAB 2.5-300 MG | 6599000220030 3 | Generic |
| OXYCODONE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN TAB 2.5-300 MG | 6599000220030 3 | Generic |
| OXYCODONE AND ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN TAB 7.5-300 MG | 6599000220032 5 | Generic |
| PROLATE | OXYCODONE W/ ACETAMINOPHEN TAB 7.5-300 MG | 6599000220032 5 | Generic |
| PENTAZOCINE/NALOXONE HCL | PENTAZOCINE W/ NALOXONE HCL TAB 50-0.5 MG | 6520004030031 0 | Generic |
| QDOLO | TRAMADOL HCL ORAL SOLN 5 MG/ML | 6510009510200 5 | Generic |

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|---|---|---|---|
| TRAMADOL HYDROCHLORIDE | TRAMADOL HCL ORAL SOLN 5 MG/ML | 65100095102005 | Generic |
| SEGLENTIS | CELECOXIB-TRAMADOL HCL TAB 56-44 MG | 65995002100320 | Brand |
| ROXYBOND | OXYCODONE HCL TAB ABUSE DETER 5 MG | 6510007510A530 | Brand |
| ROXYBOND | OXYCODONE HCL TAB ABUSE DETER 15 MG | 6510007510A540 | Brand |
| ROXYBOND | OXYCODONE HCL TAB ABUSE DETER 30 MG | 6510007510A560 | Brand |
| OXYCODONE HYDROCHLORIDE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN SOLN 5-325 MG/5ML | 65990002202005 | Brand |
| TRAMADOL HYDROCHLORIDE | TRAMADOL HCL TAB 100 MG | 65100095100340 | Generic |
| TREZIX | ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE CAP 320.5-30-16 MG | 65991303050115 | Brand |
| MEPERIDINE HYDROCHLORIDE | MEPERIDINE HCL TAB 50 MG | 65100045100305 | Generic |
| TRAMADOL HYDROCHLORIDE | TRAMADOL HCL TAB 25 MG | 65100095100310 | Generic |
| ROXYBOND | OXYCODONE HCL TAB ABUSE DETER 5 MG | 6510007510A530 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL TAB ABUSE DETER 5 MG | 6510007510A530 | Generic |
| ROXYBOND | OXYCODONE HCL TAB ABUSE DETER 10 MG | 6510007510A535 | Brand |
| ROXYBOND | OXYCODONE HCL TAB ABUSE DETER 15 MG | 6510007510A540 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL TAB ABUSE DETER 15 MG | 6510007510A540 | Generic |
| ROXYBOND | OXYCODONE HCL TAB ABUSE DETER 30 MG | 6510007510A560 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL TAB ABUSE DETER 30 MG | 6510007510A560 | Generic |

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| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN SOLN 10-325 MG/15ML | 65991702102025 | Generic |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN TAB 2.5-325 MG | 65991702100302 | Generic |
| TRAMADOL HYDROCHLORIDE | TRAMADOL HCL TAB 75 MG | 65100095100330 | Generic |

**Approval Criteria**

**1** - Prescriber attests 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)***

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|---|---|
| Notes | *This section does NOT apply to cough and cold products.<br>**Approval length will be issued for 6 months for non-cancer-related pain/non-hospice/non-end of life/non-sickle cell anemia related pain up to the current requested MME plus 90 MME<br>***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 sol, codeine, acetaminophen w/codeine soln and tabs, Brand Fioricet/codeine, generic butalbital/acetaminophen/caffeine w/codeine, Ascomp/codeine, generic butalbital/aspirin/caffeine w/codeine, morphine supp, tabs and soln, Brand Lortab, hydrocodone/acetaminophen soln, Brand Xodol, generic hydrocodone/acetaminophen tabs, hydrocodone/ibuprofen, Brand Dilaudid, generic hydromorphone, oxycodone caps, soln and conc, Brand Roxicodone, Oxaydo, generic oxycodone tabs, Brand Percocet, Prolate tabs and soln, Nalocet, Endocet, Oxycodone-acetaminophen soln and tabs, generic oxycodone/acetaminophen soln and tabs, oxymorphone, pentazocine w/naloxone, Brand Ultram, Synapryn, generic tramadol, Qdolo,

| Tramadol soln, Brand Ultracet, generic tramadol/acetaminophen, Nucynta, meperidine, levorphanol, Brand Trezix, generic acetaminophen/caffeine/dihydrocodeine, generic belladonna alkaloids/opium, opium, Apadaz, Benzhydrocodone/acetaminophen, Seglentis, Brand Roxybond, Brand Oxycodone | |
|---|---|
| Diagnosis | Criteria for Quantity Limit Reviews* |
| Guideline Type | Quantity Limit |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BUTORPHANOL TARTRATE | BUTORPHANOL TARTRATE NASAL SOLN 10 MG/ML | 65200020102050 | Generic |
| ACETAMINOPHEN/CODEINE | ACETAMINOPHEN W/ CODEINE SOLN 120-12 MG/5ML | 65991002052020 | Generic |
| ACETAMINOPHEN/CODEINE | ACETAMINOPHEN W/ CODEINE TAB 300-15 MG | 65991002050310 | Generic |
| ACETAMINOPHEN/CODEINE PHOSPHATE | ACETAMINOPHEN W/ CODEINE TAB 300-15 MG | 65991002050310 | Generic |
| ACETAMINOPHEN/CODEINE | ACETAMINOPHEN W/ CODEINE TAB 300-30 MG | 65991002050315 | Generic |
| ACETAMINOPHEN/CODEINE #3 | ACETAMINOPHEN W/ CODEINE TAB 300-30 MG | 65991002050315 | Generic |
| ACETAMINOPHEN/CODEINE PHOSPHATE | ACETAMINOPHEN W/ CODEINE TAB 300-30 MG | 65991002050315 | Generic |
| ACETAMINOPHEN/CODEINE | ACETAMINOPHEN W/ CODEINE TAB 300-60 MG | 65991002050320 | Generic |
| ACETAMINOPHEN/CODEINE PHOSPHATE | ACETAMINOPHEN W/ CODEINE TAB 300-60 MG | 65991002050320 | Generic |
| CODEINE/ACETAMINOPHEN | ACETAMINOPHEN W/ CODEINE TAB 300-60 MG | 65991002050320 | Generic |
| BUTALBITAL/ACETAMINOPHEN/CAFFEINE/CODEINE | BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-325-40-30 MG | 65991004100115 | Generic |
| BUTALBITAL/ACETAMINOPHEN/CAFFEINE/CODEINE | BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-300-40-30 MG | 65991004100113 | Generic |
| FIORICET/CODEINE | BUTALBITAL-ACETAMINOPHEN- | 65991004100113 | Brand |

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|---|---|---|---|
| | CAFF W/ COD CAP 50-300-40-30 MG | | |
| ASCOMP/CODEINE | BUTALBITAL-ASPIRIN-CAFF W/ CODEINE CAP 50-325-40-30 MG | 65991004300115 | Generic |
| BUTALBITAL/ASPIRIN/CAFFEINE/CODEINE | BUTALBITAL-ASPIRIN-CAFF W/ CODEINE CAP 50-325-40-30 MG | 65991004300115 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE ORAL SOLN 10 MG/5ML | 65100055102065 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE ORAL SOLN 100 MG/5ML (20 MG/ML) | 65100055102090 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE ORAL SOLN 20 MG/5ML | 65100055102070 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE SUPPOS 10 MG | 65100055105210 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE SUPPOS 20 MG | 65100055105215 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE SUPPOS 30 MG | 65100055105220 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE TAB 15 MG | 65100055100310 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE TAB 30 MG | 65100055100315 | Generic |
| MORPHINE SULFATE | MORPHINE SULFATE SUPPOS 5 MG | 65100055105205 | Generic |
| LORTAB | HYDROCODONE-ACETAMINOPHEN SOLN 10-300 MG/15ML | 65991702102024 | Brand |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN TAB 10-300 MG | 65991702100375 | Generic |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN TAB 10-325 MG | 65991702100305 | Generic |

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| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN TAB 7.5-300 MG | 65991702100322 | Generic |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN TAB 7.5-325 MG | 65991702100358 | Generic |
| HYDROCODONE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN TAB 7.5-325 MG | 65991702100358 | Generic |
| HYDROCODONE/IBUPROFEN | HYDROCODONE-IBUPROFEN TAB 10-200 MG | 65991702500330 | Generic |
| HYDROCODONE/IBUPROFEN | HYDROCODONE-IBUPROFEN TAB 7.5-200 MG | 65991702500320 | Generic |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN TAB 5-300 MG | 65991702100309 | Generic |
| XODOL | HYDROCODONE-ACETAMINOPHEN TAB 5-300 MG | 65991702100309 | Brand |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN TAB 5-325 MG | 65991702100356 | Generic |
| HYDROCODONE/IBUPROFEN | HYDROCODONE-IBUPROFEN TAB 5-200 MG | 65991702500315 | Generic |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN SOLN 7.5-325 MG/15ML | 65991702102015 | Generic |
| HYDROMORPHONE HCL | HYDROMORPHONE HCL SUPPOS 3 MG | 65100035105205 | Generic |
| DILAUDID | HYDROMORPHONE HCL TAB 4 MG | 65100035100320 | Brand |
| HYDROMORPHONE HCL | HYDROMORPHONE HCL TAB 4 MG | 65100035100320 | Generic |
| DILAUDID | HYDROMORPHONE HCL TAB 8 MG | 65100035100330 | Brand |
| HYDROMORPHONE HCL | HYDROMORPHONE HCL TAB 8 MG | 65100035100330 | Generic |
| DILAUDID | HYDROMORPHONE HCL TAB 2 MG | 65100035100310 | Brand |
| HYDROMORPHONE HCL | HYDROMORPHONE HCL TAB 2 MG | 65100035100310 | Generic |
| OXYCODONE HCL | OXYCODONE HCL CAP 5 MG | 65100075100110 | Generic |

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| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL CAP 5 MG | 65100075100110 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL CONC 100 MG/5ML (20 MG/ML) | 65100075101320 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL SOLN 5 MG/5ML | 65100075102005 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL TAB 10 MG | 65100075100320 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL TAB 15 MG | 65100075100325 | Generic |
| ROXICODONE | OXYCODONE HCL TAB 15 MG | 65100075100325 | Brand |
| ENDOCET | OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG | 65990002200335 | Generic |
| OXYCODONE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG | 65990002200335 | Generic |
| PERCOCET | OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG | 65990002200335 | Brand |
| ENDOCET | OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG | 65990002200327 | Generic |
| OXYCODONE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG | 65990002200327 | Generic |
| PERCOCET | OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG | 65990002200327 | Brand |
| ENDOCET | OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG | 65990002200305 | Generic |
| OXYCODONE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG | 65990002200305 | Generic |
| PERCOCET | OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG | 65990002200305 | Brand |
| ENDOCET | OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG | 65990002200310 | Generic |
| OXYCODONE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG | 65990002200310 | Generic |

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| PERCOCET | OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG | 65990002200310 | Brand |
| OXYMORPHONE HYDROCHLORIDE | OXYMORPHONE HCL TAB 10 MG | 65100080100310 | Generic |
| OXYMORPHONE HYDROCHLORIDE | OXYMORPHONE HCL TAB 5 MG | 65100080100305 | Generic |
| TRAMADOL HCL | TRAMADOL HCL TAB 50 MG | 65100095100320 | Generic |
| TRAMADOL HYDROCHLORIDE | TRAMADOL HCL TAB 50 MG | 65100095100320 | Generic |
| ULTRAM | TRAMADOL HCL TAB 50 MG | 65100095100320 | Brand |
| SYNAPRYN FUSEPAQ | *TRAMADOL HCL FOR ORAL SUSP 10 MG/ML (COMPOUND KIT)*** | 65100095101920 | Brand |
| TRAMADOL HYDROCHLORIDE/ACETAMINOPHEN | TRAMADOL-ACETAMINOPHEN TAB 37.5-325 MG | 65995002200320 | Generic |
| ULTRACET | TRAMADOL-ACETAMINOPHEN TAB 37.5-325 MG | 65995002200320 | Brand |
| NUCYNTA | TAPENTADOL HCL TAB 100 MG | 65100091100340 | Brand |
| NUCYNTA | TAPENTADOL HCL TAB 50 MG | 65100091100320 | Brand |
| NUCYNTA | TAPENTADOL HCL TAB 75 MG | 65100091100330 | Brand |
| MEPERIDINE HCL | MEPERIDINE HCL TAB 50 MG | 65100045100305 | Generic |
| MEPERIDINE HCL | MEPERIDINE HCL ORAL SOLN 50 MG/5ML | 65100045102060 | Generic |
| LEVORPHANOL TARTRATE | LEVORPHANOL TARTRATE TAB 2 MG | 65100040100305 | Generic |
| LEVORPHANOL TARTRATE | LEVORPHANOL TARTRATE TAB 3 MG | 65100040100310 | Generic |
| ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE | ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE CAP 320.5-30-16 MG | 65991303050115 | Generic |
| BELLADONNA/OPIUM | BELLADONNA ALKALOIDS & | 49109902155210 | Generic |

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| | OPIUM SUPPOS 16.2-30 MG | | |
| BELLADONNA/OPIUM | BELLADONNA ALKALOIDS & OPIUM SUPPOS 16.2-60 MG | 49109902155220 | Generic |
| OPIUM | OPIUM TINCTURE 1% (10 MG/ML) (MORPHINE EQUIV) | 47100030201505 | Generic |
| OPIUM TINCTURE | OPIUM TINCTURE 1% (10 MG/ML) (MORPHINE EQUIV) | 47100030201505 | Generic |
| APADAZ | BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 8.16-325 MG | 65990002020330 | Brand |
| BENZHYDROCODONE/ACETAMINOPHEN | BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 8.16-325 MG | 65990002020330 | Brand |
| APADAZ | BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 6.12-325 MG | 65990002020320 | Brand |
| BENZHYDROCODONE/ACETAMINOPHEN | BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 6.12-325 MG | 65990002020320 | Brand |
| APADAZ | BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 4.08-325 MG | 65990002020310 | Brand |
| BENZHYDROCODONE/ACETAMINOPHEN | BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 4.08-325 MG | 65990002020310 | Brand |
| OXYCODONE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN TAB 5-300 MG | 65990002200308 | Generic |
| PROLATE | OXYCODONE W/ ACETAMINOPHEN TAB 5-300 MG | 65990002200308 | Generic |
| OXYCODONE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN TAB 10-300 MG | 65990002200333 | Generic |
| PROLATE | OXYCODONE W/ ACETAMINOPHEN TAB 10-300 MG | 65990002200333 | Generic |
| OXYCODONE HYDROCHLORIDE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN | 65990002202020 | Generic |

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| | SOLN 10-300 MG/5ML | | |
| PROLATE | OXYCODONE W/ ACETAMINOPHEN SOLN 10-300 MG/5ML | 65990002202020 | Generic |
| OXAYDO | OXYCODONE HCL TAB 7.5 MG | 65100075100315 | Brand |
| HYDROMORPHONE HYDROCHLORIDE | HYDROMORPHONE HCL TAB 4 MG | 65100035100320 | Generic |
| HYDROMORPHONE HYDROCHLORIDE | HYDROMORPHONE HCL TAB 2 MG | 65100035100310 | Generic |
| CODEINE SULFATE | CODEINE SULFATE TAB 15 MG | 65100020200305 | Generic |
| CODEINE SULFATE | CODEINE SULFATE TAB 30 MG | 65100020200310 | Generic |
| CODEINE SULFATE | CODEINE SULFATE TAB 60 MG | 65100020200315 | Generic |
| DILAUDID | HYDROMORPHONE HCL LIQD 1 MG/ML | 65100035100920 | Brand |
| HYDROMORPHONE HCL | HYDROMORPHONE HCL LIQD 1 MG/ML | 65100035100920 | Generic |
| HYDROMORPHONE HYDROCHLORIDE | HYDROMORPHONE HCL LIQD 1 MG/ML | 65100035100920 | Generic |
| OXAYDO | OXYCODONE HCL TAB 5 MG | 65100075100310 | Brand |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL TAB 5 MG | 65100075100310 | Generic |
| ROXICODONE | OXYCODONE HCL TAB 5 MG | 65100075100310 | Brand |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL TAB 20 MG | 65100075100330 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL TAB 30 MG | 65100075100340 | Generic |
| ROXICODONE | OXYCODONE HCL TAB 30 MG | 65100075100340 | Brand |
| NALOCET | OXYCODONE W/ ACETAMINOPHEN TAB 2.5-300 MG | 65990002200303 | Generic |
| OXYCODONE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN TAB 2.5-300 MG | 65990002200303 | Generic |

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| OXYCODONE AND ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN TAB 7.5-300 MG | 65990002200325 | Generic |
| PROLATE | OXYCODONE W/ ACETAMINOPHEN TAB 7.5-300 MG | 65990002200325 | Generic |
| PENTAZOCINE/NALOXONE HCL | PENTAZOCINE W/ NALOXONE HCL TAB 50-0.5 MG | 65200040300310 | Generic |
| QDOLO | TRAMADOL HCL ORAL SOLN 5 MG/ML | 65100095102005 | Generic |
| TRAMADOL HYDROCHLORIDE | TRAMADOL HCL ORAL SOLN 5 MG/ML | 65100095102005 | Generic |
| SEGLENTIS | CELECOXIB-TRAMADOL HCL TAB 56-44 MG | 65995002100320 | Brand |
| ROXYBOND | OXYCODONE HCL TAB ABUSE DETER 5 MG | 6510007510A530 | Brand |
| ROXYBOND | OXYCODONE HCL TAB ABUSE DETER 15 MG | 6510007510A540 | Brand |
| ROXYBOND | OXYCODONE HCL TAB ABUSE DETER 30 MG | 6510007510A560 | Brand |
| OXYCODONE HYDROCHLORIDE/ACETAMINOPHEN | OXYCODONE W/ ACETAMINOPHEN SOLN 5-325 MG/5ML | 65990002202005 | Brand |
| TRAMADOL HYDROCHLORIDE | TRAMADOL HCL TAB 100 MG | 65100095100340 | Generic |
| TREZIX | ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE CAP 320.5-30-16 MG | 65991303050115 | Brand |
| MEPERIDINE HYDROCHLORIDE | MEPERIDINE HCL TAB 50 MG | 65100045100305 | Generic |
| TRAMADOL HYDROCHLORIDE | TRAMADOL HCL TAB 25 MG | 65100095100310 | Generic |
| ROXYBOND | OXYCODONE HCL TAB ABUSE DETER 5 MG | 6510007510A530 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL TAB ABUSE DETER 5 MG | 6510007510A530 | Generic |
| ROXYBOND | OXYCODONE HCL TAB ABUSE DETER 10 MG | 6510007510A535 | Brand |

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| ROXYBOND | OXYCODONE HCL TAB ABUSE DETER 15 MG | 6510007510A540 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL TAB ABUSE DETER 15 MG | 6510007510A540 | Generic |
| ROXYBOND | OXYCODONE HCL TAB ABUSE DETER 30 MG | 6510007510A560 | Generic |
| OXYCODONE HYDROCHLORIDE | OXYCODONE HCL TAB ABUSE DETER 30 MG | 6510007510A560 | Generic |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN SOLN 10-325 MG/15ML | 65991702102025 | Generic |
| HYDROCODONE BITARTRATE/ACETAMINOPHEN | HYDROCODONE-ACETAMINOPHEN TAB 2.5-325 MG | 65991702100302 | Generic |
| TRAMADOL HYDROCHLORIDE | TRAMADOL HCL TAB 75 MG | 65100095100330 | Generic |

**Approval Criteria**

**1** - The requested dose cannot be achieved by a higher strength formulary product

**AND**

**2** - The requested dose is within FDA (Food and Drug Administration) maximum dose per day, where an FDA maximum dose per day exists**

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| Notes | *This section does NOT apply to cough and cold products.<br>**Authorization will be issued for:<br>• 12 months for cancer-related pain/hospice/sickle cell anemia related pain/end of life related pain<br>• 6 months for non-cancer-related pain/non-hospice/non-sickle cell an emia related pain/non-end of life related pain |

Product Name: Brand Hycodan tab and syrup, generic hydrocodone/homatropine tabs and syrup, Hydromet syrup, Tuzistra XR, hydrocodone polst-chlorphen polst ER, M-END PE, Poly-Tussin AC, Capcof, Pro-Red AC, Histex-AC, Maxi-Tuss CD, promethazine-codeine syrup, promethazine-phenylephrine-codeine syrup (promethazine VC-codeine syrup), Rydex, Mar-Cof BP, Mar-Cof CG, Ninjacof-XG, Coditussin AC, M-Clear WC, codeine/guaifenesin soln

| (Virtussin AC/ALC, Virtussin A/C, Maxi-Tuss AC, Guaiatussin AC, G Tussin AC, Guaifenesin AC), Tusnel C, Virtussin DAC, Tuxarin ER, Coditussin DAC | |
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| Diagnosis | DUR: Cough and Cold Opioid Naïve (Not having filled an opioid in the past 60 days) exceeding the 7 day supply limit* |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TUZISTRA XR | CODEINE POLIST-CHLORPHEN POLISTER SUSP 14.7-2.8 MG/5ML | 4399520231G120 | Brand |
| HYDROCODONE POLISTIREX/CHLORPHENIRAMINE POLISTIREX | HYDROCOD POLST-CHLORPHEN POLSTER SUSP 10-8 MG/5ML | 4399520236G110 | Generic |
| M-END PE | PHENYLEPHRINE-BROMPHEN W/ CODEINE LIQD 3.33-1.33-6.33 MG/5ML | 43995303110916 | Brand |
| PRO-RED AC | PHENYLEPHRINE-DEXCHLORPHENIR-CODEINE SYRUP 5-1-9 MG/5ML | 43995303171220 | Brand |
| HISTEX-AC | PHENYLEPHRINE-TRIPROLIDINE-CODEINE SYRUP 10-2.5-10 MG/5ML | 43995303361220 | Brand |
| PROMETHAZINE/CODEINE | PROMETHAZINE W/ CODEINE SYRUP 6.25-10 MG/5ML | 43995202341210 | Generic |
| PROMETHAZINE VC/CODEINE | PROMETHAZINE-PHENYLEPHRINE-CODEINE SYRUP 6.25-5-10 MG/5ML | 43995303101210 | Generic |
| PROMETHAZINE/PHENYLEPHRINE/CODEINE | PROMETHAZINE-PHENYLEPHRINE-CODEINE SYRUP 6.25-5-10 MG/5ML | 43995303101210 | Generic |
| MAR-COF BP | PSEUDOEPHEDRINE-BROMPHEN-CODEINE LIQD 30-2-7.5 MG/5ML | 43995303190940 | Brand |
| NINJACOF-XG | GUAIFENESIN-CODEINE LIQUID 200-8 MG/5ML | 43997002280942 | Brand |
| MAR-COF CG EXPECTORANT | GUAIFENESIN-CODEINE LIQUID 225-7.5 MG/5ML | 43997002280947 | Brand |

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| TUXARIN ER | CODEINE PHOS-CHLORPHENIRAMINE MALEATE TAB ER 12HR 54.3-8 MG | 43995202327430 | Brand |
| CODEINE/GUAIFENESIN | GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML | 43997002282020 | Generic |
| G TUSSIN AC | GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML | 43997002282020 | Generic |
| GUAIATUSSIN AC | GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML | 43997002282020 | Generic |
| GUAIFENESIN AC | GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML | 43997002282020 | Generic |
| GUAIFENESIN/CODEINE | GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML | 43997002282020 | Generic |
| MAXI-TUSS AC | GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML | 43997002282020 | Generic |
| VIRTUSSIN A/C | GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML | 43997002282020 | Generic |
| HYCODAN | HYDROCODONE BITART-HOMATROPINE METHYLBROMIDE TAB 5-1.5 MG | 43101010100310 | Brand |
| HYDROCODONE BITARTRATE/HOMATROPINE METHYLBROMIDE | HYDROCODONE BITART-HOMATROPINE METHYLBROMIDE TAB 5-1.5 MG | 43101010100310 | Generic |
| HYCODAN | HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML | 43101010102010 | Brand |
| HYDROCODONE BITARTRATE/HOMATROPINE METHYLBROMIDE | HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML | 43101010102010 | Generic |
| HYDROCODONE/HOMATROPINE | HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML | 43101010102010 | Generic |
| HYDROMET | HYDROCODONE BITART- | 43101010102010 | Generic |

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| | HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML | | |
| M-CLEAR WC | GUAIFENESIN-CODEINE SOLN 100-6.33 MG/5ML | 43997002282018 | Brand |
| CAPCOF | PHENYLEPHRINE-CHLORPHEN W/ CODEINE SYRUP 5-2-10 MG/5ML | 43995303141220 | Brand |
| CODITUSSIN AC | GUAIFENESIN-CODEINE LIQUID 200-10 MG/5ML | 43997002280945 | Generic |
| GUAIFENESIN/CODEINE PHOSPHATE | GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML | 43997002282020 | Generic |
| POLY-TUSSIN AC | PHENYLEPHRINE-BROMPHEN W/ CODEINE LIQUID 10-4-10 MG/5ML | 43995303110935 | Generic |
| MAXI-TUSS CD | PHENYLEPHRINE-CHLORPHEN W/ CODEINE LIQUID 10-4-10 MG/5ML | 43995303140913 | Generic |
| RYDEX | PSEUDOEPHEDRINE -BROMPHEN-CODEINE LIQ 10-1.33-6.33 MG/5ML | 43995303190922 | Brand |
| CODITUSSIN DAC | PSEUDOEPHEDRINE W/ COD-GG LIQUID 30-10-200 MG/5ML | 43997303300938 | Generic |
| TUSNEL C | PSEUDOEPHEDRINE W/ COD-GG SYRUP 30-10-100 MG/5ML | 43997303301225 | Brand |

**Approval Criteria**

**1** - ONE of the following:

**1.1** 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** End of life care, including hospice care

**OR**

**1.3** Palliative care

**OR**

**1.4** Sickle cell anemia

**OR**

**1.5** BOTH of the following:

**1.5.1** ONE of the following:

- Traumatic injury
- Post-surgical procedures, excluding dental procedures
- Prescriber attests that the patient has received an opioid within the past 60 days

**AND**

**1.5.2** Prescriber attests if requested for traumatic injury or post-surgical procedure, that based on injury or surgical procedure performed the patient requires greater than a 7 day supply of short-acting opioid to adequately control pain

| Notes | *Approval length for cancer-related pain, end of life, palliative care, or sickle cell pain will be issued for 12 months. All other approvals will be issued for the requested duration, not to exceed one month. |
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| Product Name: Brand Hycodan tab and syrup, generic hydrocodone/homatropine tabs and syrup, Hydromet syrup, Tuzistra XR, hydrocodone polst-chlorphen polst ER, M-END PE, Poly-Tussin AC, Capcof, Pro-Red AC, Histex-AC, Maxi-Tuss CD, promethazine-codeine syrup, promethazine-phenylephrine-codeine syrup (promethazine VC-codeine syrup), Rydex, Mar-Cof BP, Mar-Cof CG, Ninjacof-XG, Coditussin AC, M-Clear WC, codeine/guaifenesin soln (Virtussin AC/ALC, Virtussin A/C, Maxi-Tuss AC, Guaiatussin AC, G Tussin AC, Guaifenesin AC), Tusnel C, Virtussin DAC, Tuxarin ER, Coditussin DAC | |
|---|---|
| Diagnosis | Cough and Cold Products Exceeding the 90 MME Cumulative Threshold |
| Guideline Type | Morphine Milligram Equivalents (MME)* |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TUZISTRA XR | CODEINE POLIST-CHLORPHEN POLISTER SUSP 14.7-2.8 MG/5ML | 4399520231G120 | Brand |
| HYDROCODONE POLISTIREX/CHLORPHENIRAMINE POLISTIREX | HYDROCOD POLST-CHLORPHEN POLSTER SUSP 10-8 MG/5ML | 4399520236G110 | Generic |
| M-END PE | PHENYLEPHRINE-BROMPHEN W/ CODEINE LIQD 3.33-1.33-6.33 MG/5ML | 43995303110916 | Brand |
| PRO-RED AC | PHENYLEPHRINE-DEXCHLORPHENIR-CODEINE SYRUP 5-1-9 MG/5ML | 43995303171220 | Brand |
| HISTEX-AC | PHENYLEPHRINE-TRIPROLIDINE-CODEINE SYRUP 10-2.5-10 MG/5ML | 43995303361220 | Brand |
| PROMETHAZINE/CODEINE | PROMETHAZINE W/ CODEINE SYRUP 6.25-10 MG/5ML | 43995202341210 | Generic |
| PROMETHAZINE VC/CODEINE | PROMETHAZINE-PHENYLEPHRINE-CODEINE SYRUP 6.25-5-10 MG/5ML | 43995303101210 | Generic |
| PROMETHAZINE/PHENYLEPHRINE/CODEINE | PROMETHAZINE-PHENYLEPHRINE-CODEINE SYRUP 6.25-5-10 MG/5ML | 43995303101210 | Generic |
| MAR-COF BP | PSEUDOEPHEDRINE-BROMPHEN-CODEINE LIQD 30-2-7.5 MG/5ML | 43995303190940 | Brand |
| NINJACOF-XG | GUAIFENESIN-CODEINE LIQUID 200-8 MG/5ML | 43997002280942 | Brand |
| MAR-COF CG EXPECTORANT | GUAIFENESIN-CODEINE LIQUID 225-7.5 MG/5ML | 43997002280947 | Brand |
| TUXARIN ER | CODEINE PHOS-CHLORPHENIRAMINE MALEATE TAB ER 12HR 54.3-8 MG | 43995202327430 | Brand |
| CODEINE/GUAIFENESIN | GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML | 43997002282020 | Generic |

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|---|---|---|---|
| G TUSSIN AC | GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML | 43997002282020 | Generic |
| GUAIATUSSIN AC | GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML | 43997002282020 | Generic |
| GUAIFENESIN AC | GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML | 43997002282020 | Generic |
| GUAIFENESIN/CODEINE | GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML | 43997002282020 | Generic |
| MAXI-TUSS AC | GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML | 43997002282020 | Generic |
| VIRTUSSIN A/C | GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML | 43997002282020 | Generic |
| HYDROCODONE BITARTRATE/HOMATROPINE METHYLBROMIDE | HYDROCODONE BITART-HOMATROPINE METHYLBROMIDE TAB 5-1.5 MG | 43101010100310 | Generic |
| HYCODAN | HYDROCODONE BITART-HOMATROPINE METHYLBROMIDE TAB 5-1.5 MG | 43101010100310 | Brand |
| HYDROCODONE BITARTRATE/HOMATROPINE METHYLBROMIDE | HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML | 43101010102010 | Generic |
| HYDROMET | HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML | 43101010102010 | Generic |
| HYCODAN | HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML | 43101010102010 | Brand |
| HYDROCODONE/HOMATROPINE | HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML | 43101010102010 | Generic |
| M-CLEAR WC | GUAIFENESIN-CODEINE SOLN 100-6.33 MG/5ML | 43997002282018 | Brand |

| | | | |
|---|---|---|---|
| CAPCOF | PHENYLEPHRINE-CHLORPHEN W/ CODEINE SYRUP 5-2-10 MG/5ML | 43995303141220 | Brand |
| CODITUSSIN AC | GUAIFENESIN-CODEINE LIQUID 200-10 MG/5ML | 43997002280945 | Generic |
| GUAIFENESIN/CODEINE PHOSPHATE | GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML | 43997002282020 | Generic |
| POLY-TUSSIN AC | PHENYLEPHRINE-BROMPHEN W/ CODEINE LIQUID 10-4-10 MG/5ML | 43995303110935 | Generic |
| MAXI-TUSS CD | PHENYLEPHRINE-CHLORPHEN W/ CODEINE LIQUID 10-4-10 MG/5ML | 43995303140913 | Generic |
| RYDEX | PSEUDOEPHEDRINE -BROMPHEN-CODEINE LIQ 10-1.33-6.33 MG/5ML | 43995303190922 | Brand |
| CODITUSSIN DAC | PSEUDOEPHEDRINE W/ COD-GG LIQUID 30-10-200 MG/5ML | 43997303300938 | Generic |
| TUSNEL C | PSEUDOEPHEDRINE W/ COD-GG SYRUP 30-10-100 MG/5ML | 43997303301225 | Brand |

**Approval Criteria**

**1** - The prescriber attests they are aware of patient's current opioid therapy and morphine milligram equivalents (MME) dose and feels the treatment with the requested product is medically necessary

| | |
|---|---|
| Notes | *Approval length will be issued for up to 30 days for cough and cold rel ated treatment. The authorization should be entered for the MME requ ested. |

| | |
|---|---|
| Product Name: Brand Hycodan tab and syrup, generic hydrocodone/homatropine tabs and syrup, Hydromet syrup, Tuzistra XR, hydrocodone polst-chlorphen polst ER, M-END PE, Poly-Tussin AC, Capcof, Pro-Red AC, Histex-AC, Maxi-Tuss CD, promethazine-codeine syrup, promethazine-phenylephrine-codeine syrup (promethazine VC-codeine syrup), Rydex, Mar-Cof BP, Mar-Cof CG, Ninjacof-XG, Coditussin AC, M-Clear WC, codeine/guaifenesin soln (Virtussin AC/ALC, Virtussin A/C, Maxi-Tuss AC, Guaiatussin AC, G Tussin AC, Guaifenesin AC), Tusnel C, Virtussin DAC, Tuxarin ER, Coditussin DAC | |
| Diagnosis | Under the Age of 18 Years for Cough and Cold Products |

| Approval Length | 30 Day(s) |
|---|---|
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TUZISTRA XR | CODEINE POLIST-CHLORPHEN POLISTER SUSP 14.7-2.8 MG/5ML | 4399520231G120 | Brand |
| HYDROCODONE POLISTIREX/CHLORPHENIRAMINE POLISTIREX | HYDROCOD POLST-CHLORPHEN POLSTER SUSP 10-8 MG/5ML | 4399520236G110 | Generic |
| M-END PE | PHENYLEPHRINE-BROMPHEN W/ CODEINE LIQD 3.33-1.33-6.33 MG/5ML | 43995303110916 | Brand |
| PRO-RED AC | PHENYLEPHRINE-DEXCHLORPHENIR-CODEINE SYRUP 5-1-9 MG/5ML | 43995303171220 | Brand |
| HISTEX-AC | PHENYLEPHRINE-TRIPROLIDINE-CODEINE SYRUP 10-2.5-10 MG/5ML | 43995303361220 | Brand |
| PROMETHAZINE/CODEINE | PROMETHAZINE W/ CODEINE SYRUP 6.25-10 MG/5ML | 43995202341210 | Generic |
| PROMETHAZINE VC/CODEINE | PROMETHAZINE-PHENYLEPHRINE-CODEINE SYRUP 6.25-5-10 MG/5ML | 43995303101210 | Generic |
| PROMETHAZINE/PHENYLEPHRINE/CODEINE | PROMETHAZINE-PHENYLEPHRINE-CODEINE SYRUP 6.25-5-10 MG/5ML | 43995303101210 | Generic |
| MAR-COF BP | PSEUDOEPHEDRINE-BROMPHEN-CODEINE LIQD 30-2-7.5 MG/5ML | 43995303190940 | Brand |
| NINJACOF-XG | GUAIFENESIN-CODEINE LIQUID 200-8 MG/5ML | 43997002280942 | Brand |
| MAR-COF CG EXPECTORANT | GUAIFENESIN-CODEINE LIQUID 225-7.5 MG/5ML | 43997002280947 | Brand |
| TUXARIN ER | CODEINE PHOS-CHLORPHENIRAMINE MALEATE TAB ER 12HR 54.3-8 MG | 43995202327430 | Brand |

| | | | |
|---|---|---|---|
| CODEINE/GUAIFENESIN | GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML | 43997002282020 | Generic |
| G TUSSIN AC | GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML | 43997002282020 | Generic |
| GUAIATUSSIN AC | GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML | 43997002282020 | Generic |
| GUAIFENESIN AC | GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML | 43997002282020 | Generic |
| GUAIFENESIN/CODEINE | GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML | 43997002282020 | Generic |
| MAXI-TUSS AC | GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML | 43997002282020 | Generic |
| VIRTUSSIN A/C | GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML | 43997002282020 | Generic |
| HYCODAN | HYDROCODONE BITART-HOMATROPINE METHYLBROMIDE TAB 5-1.5 MG | 43101010100310 | Brand |
| HYDROCODONE BITARTRATE/HOMATROPINE METHYLBROMIDE | HYDROCODONE BITART-HOMATROPINE METHYLBROMIDE TAB 5-1.5 MG | 43101010100310 | Generic |
| HYCODAN | HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML | 43101010102010 | Brand |
| HYDROCODONE BITARTRATE/HOMATROPINE METHYLBROMIDE | HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML | 43101010102010 | Generic |
| HYDROCODONE/HOMATROPINE | HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML | 43101010102010 | Generic |
| HYDROMET | HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML | 43101010102010 | Generic |

| | | | |
|---|---|---|---|
| M-CLEAR WC | GUAIFENESIN-CODEINE SOLN 100-6.33 MG/5ML | 43997002282018 | Brand |
| CAPCOF | PHENYLEPHRINE-CHLORPHEN W/ CODEINE SYRUP 5-2-10 MG/5ML | 43995303141220 | Brand |
| CODITUSSIN AC | GUAIFENESIN-CODEINE LIQUID 200-10 MG/5ML | 43997002280945 | Generic |
| GUAIFENESIN/CODEINE PHOSPHATE | GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML | 43997002282020 | Generic |
| POLY-TUSSIN AC | PHENYLEPHRINE-BROMPHEN W/ CODEINE LIQUID 10-4-10 MG/5ML | 43995303110935 | Generic |
| MAXI-TUSS CD | PHENYLEPHRINE-CHLORPHEN W/ CODEINE LIQUID 10-4-10 MG/5ML | 43995303140913 | Generic |
| RYDEX | PSEUDOEPHEDRINE -BROMPHEN-CODEINE LIQ 10-1.33-6.33 MG/5ML | 43995303190922 | Brand |
| CODITUSSIN DAC | PSEUDOEPHEDRINE W/ COD-GG LIQUID 30-10-200 MG/5ML | 43997303300938 | Generic |
| TUSNEL C | PSEUDOEPHEDRINE W/ COD-GG SYRUP 30-10-100 MG/5ML | 43997303301225 | Brand |

**Approval Criteria**

**1** - Prescriber attests they are aware of Food and Drug Administration (FDA) labeled contraindications regarding use of opioid containing cough and cold products in patients less than 18 years of age and feels the treatment with the requested product is medically necessary (Document rationale for use)

**AND**

**2** - Patient does not have a comorbid condition that may impact respiratory depression (e.g., asthma or other chronic lung disease, sleep apnea, body mass index > 30)

**AND**

**3** - Patient has tried and failed at least one non-opioid containing cough and cold remedy

| Product Name: Brand Hycodan tab and syrup, generic hydrocodone/homatropine tabs and syrup, Hydromet syrup, Tuzistra XR, hydrocodone polst-chlorphen polst ER, M-END PE, Poly-Tussin AC, Capcof, Pro-Red AC, Histex-AC, Maxi-Tuss CD, promethazine-codeine syrup, promethazine-phenylephrine-codeine syrup (promethazine VC-codeine syrup), Rydex, Mar-Cof BP, Mar-Cof CG, Ninjacof-XG, Coditussin AC, M-Clear WC, codeine/guaifenesin soln (Virtussin AC/ALC, Virtussin A/C, Maxi-Tuss AC, Guaiatussin AC, G Tussin AC, Guaifenesin AC), Tusnel C, Virtussin DAC, Tuxarin ER, Coditussin DAC | |
|---|---|
| Diagnosis | Cough and Cold Products Exceeding 120mL per fill and/or 360mL per 30 days* |
| Approval Length | 30 days** |
| Guideline Type | Quantity Limit |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TUZISTRA XR | CODEINE POLIST-CHLORPHEN POLIST ER SUSP 14.7-2.8 MG/5ML | 4399520231G120 | Brand |
| HYDROCODONE POLISTIREX/CHLORPHENIRAMINE POLISTIREX | HYDROCOD POLST-CHLORPHEN POLST ER SUSP 10-8 MG/5ML | 4399520236G110 | Generic |
| M-END PE | PHENYLEPHRINE-BROMPHEN W/ CODEINE LIQD 3.33-1.33-6.33 MG/5ML | 43995303110916 | Brand |
| PRO-RED AC | PHENYLEPHRINE-DEXCHLORPHENIR-CODEINE SYRUP 5-1-9 MG/5ML | 43995303171220 | Brand |
| HISTEX-AC | PHENYLEPHRINE-TRIPROLIDINE-CODEINE SYRUP 10-2.5-10 MG/5ML | 43995303361220 | Brand |
| PROMETHAZINE/CODEINE | PROMETHAZINE W/ CODEINE SYRUP 6.25-10 MG/5ML | 43995202341210 | Generic |
| PROMETHAZINE VC/CODEINE | PROMETHAZINE-PHENYLEPHRINE-CODEINE SYRUP 6.25-5-10 MG/5ML | 43995303101210 | Generic |

| | | | |
|---|---|---|---|
| PROMETHAZINE/PHENYLEPHRINE/CODEINE | PROMETHAZINE-PHENYLEPHRINE-CODEINE SYRUP 6.25-5-10 MG/5ML | 43995303101210 | Generic |
| MAR-COF BP | PSEUDOEPHEDRINE-BROMPHEN-CODEINE LIQD 30-2-7.5 MG/5ML | 43995303190940 | Brand |
| NINJACOF-XG | GUAIFENESIN-CODEINE LIQUID 200-8 MG/5ML | 43997002280942 | Brand |
| MAR-COF CG EXPECTORANT | GUAIFENESIN-CODEINE LIQUID 225-7.5 MG/5ML | 43997002280947 | Brand |
| TUXARIN ER | CODEINE PHOS-CHLORPHENIRAMINE MALEATE TAB ER 12HR 54.3-8 MG | 43995202327430 | Brand |
| CODEINE/GUAIFENESIN | GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML | 43997002282020 | Generic |
| G TUSSIN AC | GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML | 43997002282020 | Generic |
| GUAIATUSSIN AC | GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML | 43997002282020 | Generic |
| GUAIFENESIN AC | GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML | 43997002282020 | Generic |
| GUAIFENESIN/CODEINE | GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML | 43997002282020 | Generic |
| MAXI-TUSS AC | GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML | 43997002282020 | Generic |
| VIRTUSSIN A/C | GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML | 43997002282020 | Generic |
| HYCODAN | HYDROCODONE BITART-HOMATROPINE METHYLBROMIDE TAB 5-1.5 MG | 43101010100310 | Brand |
| HYDROCODONE BITARTRATE/HOMATROPINE METHYLBROMIDE | HYDROCODONE BITART-HOMATROPINE METHYLBROMIDE TAB 5-1.5 MG | 43101010100310 | Generic |
| HYCODAN | HYDROCODONE BITART- | 43101010102010 | Brand |

| | | | |
|---|---|---|---|
| | HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML | | |
| HYDROCODONE BITARTRATE/HOMATROPINE METHYLBROMIDE | HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML | 43101010102010 | Generic |
| HYDROCODONE/HOMATROPINE | HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML | 43101010102010 | Generic |
| HYDROMET | HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML | 43101010102010 | Generic |
| M-CLEAR WC | GUAIFENESIN-CODEINE SOLN 100-6.33 MG/5ML | 43997002282018 | Brand |
| CAPCOF | PHENYLEPHRINE-CHLORPHEN W/ CODEINE SYRUP 5-2-10 MG/5ML | 43995303141220 | Brand |
| CODITUSSIN AC | GUAIFENESIN-CODEINE LIQUID 200-10 MG/5ML | 43997002280945 | Generic |
| GUAIFENESIN/CODEINE PHOSPHATE | GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML | 43997002282020 | Generic |
| POLY-TUSSIN AC | PHENYLEPHRINE-BROMPHEN W/ CODEINE LIQUID 10-4-10 MG/5ML | 43995303110935 | Generic |
| MAXI-TUSS CD | PHENYLEPHRINE-CHLORPHEN W/ CODEINE LIQUID 10-4-10 MG/5ML | 43995303140913 | Generic |
| RYDEX | PSEUDOEPHEDRINE -BROMPHEN-CODEINE LIQ 10-1.33-6.33 MG/5ML | 43995303190922 | Brand |
| CODITUSSIN DAC | PSEUDOEPHEDRINE W/ COD-GG LIQUID 30-10-200 MG/5ML | 43997303300938 | Generic |
| TUSNEL C | PSEUDOEPHEDRINE W/ COD-GG SYRUP 30-10-100 MG/5ML | 43997303301225 | Brand |

**Approval Criteria**

**1** - Prescriber attests that a larger quantity is medically necessary

**AND**

**2** - The requested dose is within the Food and Drug Administration (FDA) maximum dose per day, where an FDA maximum dose per day exists

| | |
|---|---|
| Notes | *Quantity Limit Rules in place:<br>• 120mL/fill<br>• 360mL/30 days<br>**Authorization will be issued for up to 30 days. The authorization sho uld be entered for the quantity requested. |

Product Name: Brand Hycodan tab and syrup, generic hydrocodone/homatropine tabs and syrup, Hydromet syrup, Tuzistra XR, hydrocodone polst-chlorphen polst ER, M-END PE, Poly-Tussin AC, Capcof, Pro-Red AC, Histex-AC, Maxi-Tuss CD, promethazine-codeine syrup, promethazine-phenylephrine-codeine syrup (promethazine VC-codeine syrup), Rydex, Mar-Cof BP, Mar-Cof CG, Ninjacof-XG, Coditussin AC, M-Clear WC, codeine/guaifenesin soln (Virtussin AC/ALC, Virtussin A/C, Maxi-Tuss AC, Guaiatussin AC, G Tussin AC, Guaifenesin AC), Tusnel C, Virtussin DAC, Tuxarin ER, Coditussin DAC

| | |
|---|---|
| Diagnosis | Non-Preferred Cough and Cold Products |
| Approval Length | 30 Day(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TUZISTRA XR | CODEINE POLIST-CHLORPHEN POLIST ER SUSP 14.7-2.8 MG/5ML | 4399520231G120 | Brand |
| HYDROCODONE POLISTIREX/CHLORPHENIRAMINE POLISTIREX | HYDROCOD POLST-CHLORPHEN POLST ER SUSP 10-8 MG/5ML | 4399520236G110 | Generic |
| M-END PE | PHENYLEPHRINE-BROMPHEN W/ CODEINE LIQD 3.33-1.33-6.33 MG/5ML | 43995303110916 | Brand |
| PRO-RED AC | PHENYLEPHRINE-DEXCHLORPHENIR- | 43995303171220 | Brand |

| | | | |
|---|---|---|---|
| | CODEINE SYRUP 5-1-9 MG/5ML | | |
| HISTEX-AC | PHENYLEPHRINE-TRIPROLIDINE-CODEINE SYRUP 10-2.5-10 MG/5ML | 43995303361220 | Brand |
| PROMETHAZINE/CODEINE | PROMETHAZINE W/ CODEINE SYRUP 6.25-10 MG/5ML | 43995202341210 | Generic |
| PROMETHAZINE VC/CODEINE | PROMETHAZINE-PHENYLEPHRINE-CODEINE SYRUP 6.25-5-10 MG/5ML | 43995303101210 | Generic |
| PROMETHAZINE/PHENYLEPHRINE/CODEINE | PROMETHAZINE-PHENYLEPHRINE-CODEINE SYRUP 6.25-5-10 MG/5ML | 43995303101210 | Generic |
| MAR-COF BP | PSEUDOEPHEDRINE-BROMPHEN-CODEINE LIQD 30-2-7.5 MG/5ML | 43995303190940 | Brand |
| NINJACOF-XG | GUAIFENESIN-CODEINE LIQUID 200-8 MG/5ML | 43997002280942 | Brand |
| MAR-COF CG EXPECTORANT | GUAIFENESIN-CODEINE LIQUID 225-7.5 MG/5ML | 43997002280947 | Brand |
| TUXARIN ER | CODEINE PHOS-CHLORPHENIRAMINE MALEATE TAB ER 12HR 54.3-8 MG | 43995202327430 | Brand |
| CODEINE/GUAIFENESIN | GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML | 43997002282020 | Generic |
| G TUSSIN AC | GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML | 43997002282020 | Generic |
| GUAIATUSSIN AC | GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML | 43997002282020 | Generic |
| GUAIFENESIN AC | GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML | 43997002282020 | Generic |
| GUAIFENESIN/CODEINE | GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML | 43997002282020 | Generic |
| MAXI-TUSS AC | GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML | 43997002282020 | Generic |

| | | | |
|---|---|---|---|
| VIRTUSSIN A/C | GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML | 43997002282020 | Generic |
| HYDROCODONE BITARTRATE/HOMATROPINE METHYLBROMIDE | HYDROCODONE BITART-HOMATROPINE METHYLBROMIDE TAB 5-1.5 MG | 43101010100310 | Generic |
| HYCODAN | HYDROCODONE BITART-HOMATROPINE METHYLBROMIDE TAB 5-1.5 MG | 43101010100310 | Brand |
| HYDROCODONE BITARTRATE/HOMATROPINE METHYLBROMIDE | HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML | 43101010102010 | Generic |
| HYDROMET | HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML | 43101010102010 | Generic |
| HYCODAN | HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML | 43101010102010 | Brand |
| HYDROCODONE/HOMATROPINE | HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML | 43101010102010 | Generic |
| M-CLEAR WC | GUAIFENESIN-CODEINE SOLN 100-6.33 MG/5ML | 43997002282018 | Brand |
| CAPCOF | PHENYLEPHRINE-CHLORPHEN W/ CODEINE SYRUP 5-2-10 MG/5ML | 43995303141220 | Brand |
| CODITUSSIN AC | GUAIFENESIN-CODEINE LIQUID 200-10 MG/5ML | 43997002280945 | Generic |
| GUAIFENESIN/CODEINE PHOSPHATE | GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML | 43997002282020 | Generic |
| POLY-TUSSIN AC | PHENYLEPHRINE-BROMPHEN W/ CODEINE LIQUID 10-4-10 MG/5ML | 43995303110935 | Generic |
| MAXI-TUSS CD | PHENYLEPHRINE-CHLORPHEN W/ | 43995303140913 | Generic |

| | | | |
|---|---|---|---|
| | CODEINE LIQUID 10-4-10 MG/5ML | | |
| RYDEX | PSEUDOEPHEDRINE -BROMPHEN-CODEINE LIQ 10-1.33-6.33 MG/5ML | 43995303190922 | Brand |
| CODITUSSIN DAC | PSEUDOEPHEDRINE W/ COD-GG LIQUID 30-10-200 MG/5ML | 43997303300938 | Generic |
| TUSNEL C | PSEUDOEPHEDRINE W/ COD-GG SYRUP 30-10-100 MG/5ML | 43997303301225 | Brand |

**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/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |

## 2 . Revision History

| Date | Notes |
|---|---|
| 12/11/2024 | Added hydrocodone/apap 10/325 soln, tramadol 75mg and hydrocodone/apap 2.5/325. removed apap/caffeine/dihydrocodeine 325-30-16 mg. Updated Roxybond GPIs and added Brand oxycodone abuse deter GPIs. Updated cancer language. |

Signifor

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146641 |
| **Guideline Name** | Signifor |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SIGNIFOR | PASIREOTIDE DIASPARTATE INJ 0.3 MG/ML (BASE EQUIV) | 30170075202020 | Brand |
| SIGNIFOR | PASIREOTIDE DIASPARTATE INJ 0.6 MG/ML (BASE EQUIV) | 30170075202030 | Brand |
| SIGNIFOR | PASIREOTIDE DIASPARTATE INJ 0.9 MG/ML (BASE EQUIV) | 30170075202040 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SIGNIFOR | PASIREOTIDE DIASPARTATE INJ 0.3 MG/ML (BASE EQUIV) | 30170075202020 | Brand |
| SIGNIFOR | PASIREOTIDE DIASPARTATE INJ 0.6 MG/ML (BASE EQUIV) | 30170075202030 | Brand |
| SIGNIFOR | PASIREOTIDE DIASPARTATE INJ 0.9 MG/ML (BASE EQUIV) | 30170075202040 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Signifor therapy

Siliq

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-159277 |
| **Guideline Name** | Siliq |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SILIQ | BRODALUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 210 MG/1.5ML | 9025052000E520 | Brand |

**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, Stelara (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), Stelara (ustekinumab), Tremfya (guselkumab)]

**AND**

**4.2.2** One of the following:

**4.2.2.1** Failure to BOTH of the following preferred products, confirmed by claims history or submitted medical records:

- One of the preferred adalimumab products*
- One of the following: Enbrel (etanercept) or Ilumya (tildrakizumab)

**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)

- Ilumya (tildrakizumab)

**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 | *For a list of preferred adalimumab products please reference drug co verage tools. |
|---|---|

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SILIQ | BRODALUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 210 MG/1.5ML | 9025052000E520 | Brand |

**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, Stelara (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 Link**<br><br>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 |
| --- | --- |
| 11/5/2024 | Removed Cimzia as a step through agent. Updated safety check lan guage. Updated step therapy language to ensure step through prefer red adalimumab and updated step for Cosentyx to align with standar d step therapy language used for targeted immunomodulators. |

Simponi

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-160794 |
| **Guideline Name** | Simponi |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 1 . Criteria

| Product Name: Simponi | |
|---|---|
| Diagnosis | Rheumatoid Arthritis (RA) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SIMPONI | GOLIMUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 50 MG/0.5ML | 6627004000D520 | Brand |
| SIMPONI | GOLIMUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 100 MG/ML | 6627004000D540 | Brand |
| SIMPONI | GOLIMUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 50 MG/0.5ML | 6627004000E520 | Brand |

| SIMPONI | GOLIMUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/ML | 6627004000E540 | Brand |
|---|---|---|---|

**Approval Criteria**

**1** - Diagnosis of moderately to severely active rheumatoid arthritis (RA)

**AND**

**2** - Patient is NOT receiving Simponi in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

**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 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, Olumiant (baricitinib), 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 | *PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |
|---|---|

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SIMPONI | GOLIMUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 50 MG/0.5ML | 6627004000D520 | Brand |
| SIMPONI | GOLIMUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 100 MG/ML | 6627004000D540 | Brand |
| SIMPONI | GOLIMUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 50 MG/0.5ML | 6627004000E520 | Brand |

| SIMPONI | GOLIMUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/ML | 6627004000E540 | Brand |
|---|---|---|---|

**Approval Criteria**

**1** - Diagnosis of active psoriatic arthritis

**AND**

**2** - Patient is NOT receiving Simponi in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

**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 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, Stelara (ustekinumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), Otezla (apremilast), Rinvoq (upadacitinib)]

**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 | *PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |
|---|---|

Product Name: Simponi

| | |
|---|---|
| Diagnosis | Ankylosing Spondylitis |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SIMPONI | GOLIMUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 50 MG/0.5ML | 6627004000D520 | Brand |
| SIMPONI | GOLIMUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 100 MG/ML | 6627004000D540 | Brand |
| SIMPONI | GOLIMUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 50 MG/0.5ML | 6627004000E520 | Brand |
| SIMPONI | GOLIMUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/ML | 6627004000E540 | Brand |

**Approval Criteria**

**1** - Diagnosis of active ankylosing spondylitis

**AND**

**2** - Patient is NOT receiving Simponi in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

**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 targeted immunomodulator FDA-approved for the treatment of ankylosing spondylitis as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), adalimumab, Xeljanz/Xeljanz XR (tofacitinib), Rinvoq (upadacitinib)]

**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 | *PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |

| Product Name: Simponi | |
|---|---|
| Diagnosis | Ulcerative Colitis |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SIMPONI | GOLIMUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 50 MG/0.5ML | 6627004000D520 | Brand |
| SIMPONI | GOLIMUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 100 MG/ML | 6627004000D540 | Brand |
| SIMPONI | GOLIMUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 50 MG/0.5ML | 6627004000E520 | Brand |
| SIMPONI | GOLIMUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/ML | 6627004000E540 | Brand |

**Approval Criteria**

**1** - Diagnosis of moderately to severely active ulcerative colitis

**AND**

**2** - Patient is NOT receiving Simponi in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Stelara (ustekinumab), Skyrizi (risankizumab)]

**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 targeted immunomodulator FDA-approved for the treatment of ulcerative colitis as confirmed by claims history or submission of medical records [e.g., adalimumab, Stelara (ustekinumab), Xeljanz (tofacitinib), Rinvoq (upadacitinib)]

**AND**

**4.2.2** 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)

| Notes | *PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |
|---|---|

| 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SIMPONI | GOLIMUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 50 MG/0.5ML | 6627004000D520 | Brand |
| SIMPONI | GOLIMUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 100 MG/ML | 6627004000D540 | Brand |
| SIMPONI | GOLIMUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 50 MG/0.5ML | 6627004000E520 | Brand |
| SIMPONI | GOLIMUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/ML | 6627004000E540 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Simponi therapy

**AND**

**2** - Patient is NOT receiving Simponi in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Orencia (abatacept), adalimumab, Stelara (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 i ndication. |
|---|---|

## 2 . Revision History

| Date | Notes |
|---|---|
| 11/19/2024 | Removed Cimzia as step thru agent. Updated step therapy bypass la nguage |

Sivextro

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-155233 |
| **Guideline Name** | Sivextro |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 10/1/2024 |

## 1 . Criteria

| Product Name: Sivextro tablets | |
|---|---|
| Diagnosis | Skin and Skin Structure Infections |
| Approval Length | 6 Day(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SIVEXTRO | TEDIZOLID PHOSPHATE TAB 200 MG | 16230070200320 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SIVEXTRO | TEDIZOLID PHOSPHATE TAB 200 MG | 16230070200320 | Generic |

**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 |
| --- | --- |
| 9/18/2024 | Added “tablets” to product name to clarify that the policy is specific to oral tablets not IV form |

Skyclarys

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146644 |
| **Guideline Name** | Skyclarys |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SKYCLARYS | OMAVELOXOLONE CAP 50 MG | 74135060000120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SKYCLARYS | OMAVELOXOLONE CAP 50 MG | 74135060000120 | Brand |

**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)

Skyrizi

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-161042 |
| **Guideline Name** | Skyrizi |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SKYRIZI PEN | RISANKIZUMAB-RZAA SOLN AUTO-INJECTOR 150 MG/ML | 9025057070D520 | Brand |
| SKYRIZI | RISANKIZUMAB-RZAA SOLN PREFILLED SYRINGE 150 MG/ML | 9025057070E540 | Brand |
| SKYRIZI | RISANKIZUMAB-RZAA SUBCUTANEOUS SOLN CARTRIDGE 360 MG/2.4ML | 5250406070E220 | Brand |

| SKYRIZI | RISANKIZUMAB-RZAA SUBCUTANEOUS SOLN CARTRIDGE 180 MG/1.2ML | 5250406070E210 | Brand |
|---|---|---|---|

**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., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), 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 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., Cimzia (certolizumab), adalimumab, Stelara (ustekinumab), Tremfya (guselkumab)]

**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 BOTH of the following preferred products, confirmed by claims history or submitted medical records

- One of the preferred adalimumab products*
- One of the following: Enbrel (etanercept) or Ilumya (tildrakizumab)

**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)
- Ilumya (tildrakizumab)

**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 | *PDL links: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |
|---|---|

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SKYRIZI PEN | RISANKIZUMAB-RZAA SOLN AUTO-INJECTOR 150 MG/ML | 9025057070D520 | Brand |
| SKYRIZI | RISANKIZUMAB-RZAA SOLN PREFILLED SYRINGE 150 MG/ML | 9025057070E540 | Brand |
| SKYRIZI | RISANKIZUMAB-RZAA SUBCUTANEOUS SOLN CARTRIDGE 360 MG/2.4ML | 5250406070E220 | Brand |
| SKYRIZI | RISANKIZUMAB-RZAA SUBCUTANEOUS SOLN CARTRIDGE 180 MG/1.2ML | 5250406070E210 | Brand |

**Approval Criteria**

**1** - Diagnosis of active psoriatic arthritis

**AND**

**2** - Patient is NOT receiving Skyrizi in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

**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), Simponi (golimumab),

Stelara (ustekinumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), Otezla (apremilast), Rinvoq (upadacitinib)]

**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 submission of 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 submission of medical records
- History of intolerance or contraindication to Cosentyx (secukinumab) (please specify intolerance or contraindication)

| | |
|---|---|
| Notes | *PDL links: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SKYRIZI PEN | RISANKIZUMAB-RZAA SOLN AUTO-INJECTOR 150 MG/ML | 9025057070D520 | Brand |
| SKYRIZI | RISANKIZUMAB-RZAA SOLN PREFILLED SYRINGE 150 MG/ML | 9025057070E540 | Brand |

| | | | |
|---|---|---|---|
| SKYRIZI | RISANKIZUMAB-RZAA SUBCUTANEOUS SOLN CARTRIDGE 360 MG/2.4ML | 5250406070E220 | Brand |
| SKYRIZI | RISANKIZUMAB-RZAA SUBCUTANEOUS SOLN CARTRIDGE 180 MG/1.2ML | 5250406070E210 | Brand |

**Approval Criteria**

**1** - Diagnosis of moderately to severely active Crohn's disease

**AND**

**2** - One of the following:

**2.1** Patient has been established on therapy with Skyrizi under an active UnitedHealthcare 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., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Stelara (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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SKYRIZI PEN | RISANKIZUMAB-RZAA SOLN AUTO-INJECTOR 150 MG/ML | 9025057070D520 | Brand |
| SKYRIZI | RISANKIZUMAB-RZAA SOLN PREFILLED SYRINGE 150 MG/ML | 9025057070E540 | Brand |
| SKYRIZI | RISANKIZUMAB-RZAA SUBCUTANEOUS SOLN CARTRIDGE 360 MG/2.4ML | 5250406070E220 | Brand |
| SKYRIZI | RISANKIZUMAB-RZAA SUBCUTANEOUS SOLN CARTRIDGE 180 MG/1.2ML | 5250406070E210 | Brand |

**Approval Criteria**

**1** - Diagnosis of moderately to severely active ulcerative colitis

**AND**

**2** - One of the following:

**2.1** Patient has been established on therapy with 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., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Stelara (ustekinumab), adalimumab]

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SKYRIZI PEN | RISANKIZUMAB-RZAA SOLN AUTO-INJECTOR 150 MG/ML | 9025057070D520 | Brand |
| SKYRIZI | RISANKIZUMAB-RZAA SOLN PREFILLED SYRINGE 150 MG/ML | 9025057070E540 | Brand |
| SKYRIZI | RISANKIZUMAB-RZAA SUBCUTANEOUS SOLN CARTRIDGE 360 MG/2.4ML | 5250406070E220 | Brand |
| SKYRIZI | RISANKIZUMAB-RZAA SUBCUTANEOUS SOLN CARTRIDGE 180 MG/1.2ML | 5250406070E210 | Brand |

**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., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]*

| Notes | * Examples of drug(s) may not be applicable based on the requested i ndication. |
|---|---|

## 2 . Revision History

| Date | Notes |
|---|---|
| 11/20/2024 | Removed Cimzia as step thru agent. Updated step therapy bypass la nguage. Added PDL link |

Sohonos

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146646 |
| **Guideline Name** | Sohonos |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SOHONOS | PALOVAROTENE CAP 1 MG | 75886060000120 | Brand |
| SOHONOS | PALOVAROTENE CAP 1.5 MG | 75886060000125 | Brand |
| SOHONOS | PALOVAROTENE CAP 2.5 MG | 75886060000130 | Brand |
| SOHONOS | PALOVAROTENE CAP 5 MG | 75886060000135 | Brand |
| SOHONOS | PALOVAROTENE CAP 10 MG | 75886060000140 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SOHONOS | PALOVAROTENE CAP 1 MG | 75886060000120 | Brand |
| SOHONOS | PALOVAROTENE CAP 1.5 MG | 75886060000125 | Brand |
| SOHONOS | PALOVAROTENE CAP 2.5 MG | 75886060000130 | Brand |
| SOHONOS | PALOVAROTENE CAP 5 MG | 75886060000135 | Brand |
| SOHONOS | PALOVAROTENE CAP 10 MG | 75886060000140 | Brand |

**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)

Somavert

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146647 |
| **Guideline Name** | Somavert |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SOMAVERT | PEGVISOMANT FOR INJ 10 MG (AS PROTEIN) | 30180060002120 | Brand |
| SOMAVERT | PEGVISOMANT FOR INJ 15 MG (AS PROTEIN) | 30180060002130 | Brand |
| SOMAVERT | PEGVISOMANT FOR INJ 20 MG (AS PROTEIN) | 30180060002140 | Brand |
| SOMAVERT | PEGVISOMANT FOR INJ 25 MG (AS PROTEIN) | 30180060002150 | Brand |
| SOMAVERT | PEGVISOMANT FOR INJ 30 MG (AS PROTEIN) | 30180060002160 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SOMAVERT | PEGVISOMANT FOR INJ 10 MG (AS PROTEIN) | 30180060002120 | Brand |
| SOMAVERT | PEGVISOMANT FOR INJ 15 MG (AS PROTEIN) | 30180060002130 | Brand |
| SOMAVERT | PEGVISOMANT FOR INJ 20 MG (AS PROTEIN) | 30180060002140 | Brand |
| SOMAVERT | PEGVISOMANT FOR INJ 25 MG (AS PROTEIN) | 30180060002150 | Brand |
| SOMAVERT | PEGVISOMANT FOR INJ 30 MG (AS PROTEIN) | 30180060002160 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Somavert therapy (e.g., age-normalized serum IGF-1 level)

Soriatane

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146417 |
| **Guideline Name** | Soriatane |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ACITRETIN | ACITRETIN CAP 10 MG | 90250510000110 | Generic |
| ACITRETIN | ACITRETIN CAP 17.5 MG | 90250510000115 | Generic |
| ACITRETIN | ACITRETIN CAP 25 MG | 90250510000125 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ACITRETIN | ACITRETIN CAP 10 MG | 90250510000110 | Generic |

| | | | |
|---|---|---|---|
| ACITRETIN | ACITRETIN CAP 17.5 MG | 90250510000115 | Generic |
| ACITRETIN | ACITRETIN CAP 25 MG | 90250510000125 | Generic |

**Approval Criteria**

**1** - Documentation of positive clinical response to the requested therapy

**AND**

**2** - Prescribed by or in consultation with a dermatologist

Sotyktu

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-161036 |
| **Guideline Name** | Sotyktu |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SOTYKTU | DEUCRAVACITINIB TAB 6 MG | 90250524000320 | Brand |

**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 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), Stelara (ustekinumab), Tremfya (guselkumab)]

**AND**

**3** - ONE of the following:

**3.1** 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)
- Ilumya (tildrakizumab)

**OR**

**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)
- Ilumya (tildrakizumab)

**AND**

**4** - ONE of the following:

**4.1** Failure to Cosentyx (secukinumab) confirmed by claims history or submission of medical records

**OR**

**4.2** History of intolerance or contraindication to Cosentyx (secukinumab) (please specify intolerance or contraindication)

**AND**

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

**AND**

**6** - Prescribed by or in consultation with a dermatologist

| Notes | *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |
|---|---|

| Product Name: Sotyktu | |
|---|---|
| Diagnosis | Plaque Psoriasis |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SOTYKTU | DEUCRAVACITINIB TAB 6 MG | 90250524000320 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Sotyktu therapy

| |
|---|
| **AND**<br><br>**2** - Patient is NOT receiving Sotyktu in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)] |

## 2 . Revision History

| Date | Notes |
|---|---|
| 11/19/2024 | Updated note for PDL link. Removed Cimzia as step thru agent. Updated step therapy bypass language |

Spevigo

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-151142 |
| **Guideline Name** | Spevigo |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 8/8/2024 |

## 1 . Criteria

| Product Name: Spevigo SC | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SPEVIGO | SPESOLIMAB-SBZO SUBCUTANEOUS SOLN PREF SYR 150 MG/ML | 9025057770E530 | Brand |

**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 non-acral skin

**AND**

**1.2** Pustulation is NOT restricted to 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 (Document date and duration of therapy)

**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), Stelara (ustekinumab), Skyrizi (risankizumab)]

**AND**

**5** - Prescribed by a dermatologist

| Product Name: Spevigo SC | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SPEVIGO | SPESOLIMAB-SBZO SUBCUTANEOUS SOLN PREF SYR 150 MG/ML | 9025057770E530 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to therapy (e.g., reduction in the rate and/or number of GPP 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), Stelara (ustekinumab), Skyrizi (risankizumab)]

**AND**

**4** - Prescribed by a dermatologist

## 2 . Revision History

| Date | Notes |
| --- | --- |
| 8/7/2024 | New program. |

Spravato

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-150655 |
| **Guideline Name** | Spravato |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 9/1/2024 |

## 1 . Criteria

| Product Name: Spravato | |
|---|---|
| Diagnosis | Major Depressive Disorder (Treatment-Resistant) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SPRAVATO 56MG DOSE | ESKETAMINE HCL NASAL SOLN 28 MG/DEVICE X 2 (56 MG DOSE PACK) | 5811002010C520 | Brand |
| SPRAVATO 84MG DOSE | ESKETAMINE HCL NASAL SOLN 28 MG/DEVICE X 3 (84 MG DOSE PACK) | 5811002010C530 | Brand |

**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** - Prescribed by or in consultation with a psychiatrist

**AND**

**3** - 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:

- Baseline score on the 17-item Hamilton Rating Scale for Depression (HAMD17)
- Baseline score on the 16-item Quick Inventory of Depressive Symptomatology (QIDS-C16)
- Baseline score on the 10-item Montgomery-Asberg Depression Rating Scale (MADRS)
- Baseline score on the 9-item Patient Health Questionnaire (PHQ-9)

**AND**

**4** - ONE of the following:

**4.1** Failure of THREE different antidepressant medications or treatment regimens at the maximally tolerated dose(s) for at least 8 weeks in the current depressive episode, 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 lithium, Cytomel (liothyronine), antipsychotics, or anticonvulsants

**OR**

**4.2** History of intolerance or contraindication to THREE of the following antidepressant medications or treatment regimens (please specify intolerance or contraindication). 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 lithium, Cytomel (liothyronine), antipsychotics, or anticonvulsants

**AND**

**5** - Spravato will be used in combination with an oral antidepressant (one that the patient has not previously failed)

**AND**

**6** - Provider and/or the provider's healthcare setting is certified in the Spravato REMS (Risk Evaluation and Mitigation Strategy) program

| Product Name: Spravato | |
|---|---|
| Diagnosis | Major Depressive Disorder (Treatment-Resistant) |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| SPRAVATO 56MG DOSE | ESKETAMINE HCL NASAL SOLN 28 MG/DEVICE X 2 (56 MG DOSE PACK) | 5811002010C520 | Brand |
| SPRAVATO 84MG DOSE | ESKETAMINE HCL NASAL SOLN 28 MG/DEVICE X 3 (84 MG DOSE PACK) | 5811002010C530 | Brand |

**Approval Criteria**

**1** - Documentation of remission or a positive clinical response to Spravato therapy

**AND**

**2** - Spravato will be used in combination with an oral antidepressant (confirmed by claims history or submitted medical records)

**AND**

**3** - 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) as defined by:

- Hamilton Rating Scale for Depression (HAMD17; remission defined as a score of less than or equal to 7)
- Quick Inventory of Depressive Symptomatology (QIDS-C16; remission defined as a score of less than or equal to 5)
- Montgomery-Asberg Depression Rating Scale (MADRS; remission defined as a score of less than or equal to 12)
- Baseline score on the 9-item Patient Health Questionnaire (PHQ-9)

**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 | 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SPRAVATO 56MG DOSE | ESKETAMINE HCL NASAL SOLN 28 MG/DEVICE X 2 (56 MG DOSE PACK) | 5811002010C520 | Brand |
| SPRAVATO 84MG DOSE | ESKETAMINE HCL NASAL SOLN 28 MG/DEVICE X 3 (84 MG DOSE PACK) | 5811002010C530 | Brand |

**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 s trength and 0.43 per day for the 84mg strength. If criteria are met, ent er 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SPRAVATO 56MG DOSE | ESKETAMINE HCL NASAL SOLN 28 MG/DEVICE X 2 (56 MG DOSE PACK) | 5811002010C520 | Brand |
| SPRAVATO 84MG DOSE | ESKETAMINE HCL NASAL SOLN 28 MG/DEVICE X 3 (84 MG DOSE PACK) | 5811002010C530 | Brand |

**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 s trength and 0.43 per day for the 84mg strength. If criteria are met, ent er one GPI-12 authorization with an MDD override of 1 and a PQE of 24 per 28 days. |
|---|---|

Sprycel

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-161083 |
| **Guideline Name** | Sprycel |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 1 . Criteria

| Product Name: Brand Sprycel, generic dasatinib | |
|---|---|
| Diagnosis | Philadelphia Chromosome-Positive or BCR-ABL1-Positive Chronic Myeloid Leukemia |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DASATINIB | DASATINIB TAB 20 MG | 21531820000320 | Generic |
| SPRYCEL | DASATINIB TAB 20 MG | 21531820000320 | Brand |
| DASATINIB | DASATINIB TAB 50 MG | 21531820000340 | Generic |

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|---|---|---|---|
| SPRYCEL | DASATINIB TAB 50 MG | 21531820000340 | Brand |
| DASATINIB | DASATINIB TAB 70 MG | 21531820000350 | Generic |
| SPRYCEL | DASATINIB TAB 70 MG | 21531820000350 | Brand |
| DASATINIB | DASATINIB TAB 80 MG | 21531820000354 | Generic |
| SPRYCEL | DASATINIB TAB 80 MG | 21531820000354 | Brand |
| DASATINIB | DASATINIB TAB 100 MG | 21531820000360 | Generic |
| SPRYCEL | DASATINIB TAB 100 MG | 21531820000360 | Brand |
| DASATINIB | DASATINIB TAB 140 MG | 21531820000380 | Generic |
| SPRYCEL | DASATINIB TAB 140 MG | 21531820000380 | Brand |

**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 Sprycel therapy

| Product Name: Brand Sprycel, generic dasatinib | |
|---|---|
| Diagnosis | Philadelphia Chromosome-Positive Acute Lymphoblastic Leukemia (Ph+ALL) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| DASATINIB | DASATINIB TAB 20 MG | 21531820000320 | Generic |
| SPRYCEL | DASATINIB TAB 20 MG | 21531820000320 | Brand |
| DASATINIB | DASATINIB TAB 50 MG | 21531820000340 | Generic |
| SPRYCEL | DASATINIB TAB 50 MG | 21531820000340 | Brand |
| DASATINIB | DASATINIB TAB 70 MG | 21531820000350 | Generic |
| SPRYCEL | DASATINIB TAB 70 MG | 21531820000350 | Brand |
| DASATINIB | DASATINIB TAB 80 MG | 21531820000354 | Generic |
| SPRYCEL | DASATINIB TAB 80 MG | 21531820000354 | Brand |
| DASATINIB | DASATINIB TAB 100 MG | 21531820000360 | Generic |
| SPRYCEL | DASATINIB TAB 100 MG | 21531820000360 | Brand |
| DASATINIB | DASATINIB TAB 140 MG | 21531820000380 | Generic |
| SPRYCEL | DASATINIB TAB 140 MG | 21531820000380 | Brand |

**Approval Criteria**

**1** - Diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ALL)

| Product Name: Brand Sprycel, generic dasatinib | |
|---|---|
| Diagnosis | Gastrointestinal Stromal Tumor (GIST) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DASATINIB | DASATINIB TAB 20 MG | 21531820000320 | Generic |
| SPRYCEL | DASATINIB TAB 20 MG | 21531820000320 | Brand |
| DASATINIB | DASATINIB TAB 50 MG | 21531820000340 | Generic |
| SPRYCEL | DASATINIB TAB 50 MG | 21531820000340 | Brand |
| DASATINIB | DASATINIB TAB 70 MG | 21531820000350 | Generic |
| SPRYCEL | DASATINIB TAB 70 MG | 21531820000350 | Brand |
| DASATINIB | DASATINIB TAB 80 MG | 21531820000354 | Generic |
| SPRYCEL | DASATINIB TAB 80 MG | 21531820000354 | Brand |

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|---|---|---|---|
| DASATINIB | DASATINIB TAB 100 MG | 21531820000360 | Generic |
| SPRYCEL | DASATINIB TAB 100 MG | 21531820000360 | Brand |
| DASATINIB | DASATINIB TAB 140 MG | 21531820000380 | Generic |
| SPRYCEL | DASATINIB TAB 140 MG | 21531820000380 | Brand |

**Approval Criteria**

**1** - Diagnosis of gastrointestinal stromal tumor (GIST) with PDGFRA exon 18 mutations

| Product Name: Brand Sprycel, generic dasatinib | |
|---|---|
| Diagnosis | Chondrosarcoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DASATINIB | DASATINIB TAB 20 MG | 21531820000320 | Generic |
| SPRYCEL | DASATINIB TAB 20 MG | 21531820000320 | Brand |
| DASATINIB | DASATINIB TAB 50 MG | 21531820000340 | Generic |
| SPRYCEL | DASATINIB TAB 50 MG | 21531820000340 | Brand |
| DASATINIB | DASATINIB TAB 70 MG | 21531820000350 | Generic |
| SPRYCEL | DASATINIB TAB 70 MG | 21531820000350 | Brand |
| DASATINIB | DASATINIB TAB 80 MG | 21531820000354 | Generic |
| SPRYCEL | DASATINIB TAB 80 MG | 21531820000354 | Brand |
| DASATINIB | DASATINIB TAB 100 MG | 21531820000360 | Generic |
| SPRYCEL | DASATINIB TAB 100 MG | 21531820000360 | Brand |
| DASATINIB | DASATINIB TAB 140 MG | 21531820000380 | Generic |
| SPRYCEL | DASATINIB TAB 140 MG | 21531820000380 | Brand |

**Approval Criteria**

**1** - Diagnosis of metastatic chondrosarcoma

| Product Name: Brand Sprycel, generic dasatinib | |
|---|---|
| Diagnosis | Chordoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DASATINIB | DASATINIB TAB 20 MG | 21531820000320 | Generic |
| SPRYCEL | DASATINIB TAB 20 MG | 21531820000320 | Brand |
| DASATINIB | DASATINIB TAB 50 MG | 21531820000340 | Generic |
| SPRYCEL | DASATINIB TAB 50 MG | 21531820000340 | Brand |
| DASATINIB | DASATINIB TAB 70 MG | 21531820000350 | Generic |
| SPRYCEL | DASATINIB TAB 70 MG | 21531820000350 | Brand |
| DASATINIB | DASATINIB TAB 80 MG | 21531820000354 | Generic |
| SPRYCEL | DASATINIB TAB 80 MG | 21531820000354 | Brand |
| DASATINIB | DASATINIB TAB 100 MG | 21531820000360 | Generic |
| SPRYCEL | DASATINIB TAB 100 MG | 21531820000360 | Brand |
| DASATINIB | DASATINIB TAB 140 MG | 21531820000380 | Generic |
| SPRYCEL | DASATINIB TAB 140 MG | 21531820000380 | Brand |

**Approval Criteria**

**1** - Diagnosis of recurrent chordoma

| Product Name: Brand Sprycel, generic dasatinib | |
|---|---|
| Diagnosis | Myeloid/Lymphoid Neoplasms with Eosinophilia |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

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|---|---|---|---|
| DASATINIB | DASATINIB TAB 20 MG | 21531820000320 | Generic |
| SPRYCEL | DASATINIB TAB 20 MG | 21531820000320 | Brand |
| DASATINIB | DASATINIB TAB 50 MG | 21531820000340 | Generic |
| SPRYCEL | DASATINIB TAB 50 MG | 21531820000340 | Brand |
| DASATINIB | DASATINIB TAB 70 MG | 21531820000350 | Generic |
| SPRYCEL | DASATINIB TAB 70 MG | 21531820000350 | Brand |
| DASATINIB | DASATINIB TAB 80 MG | 21531820000354 | Generic |
| SPRYCEL | DASATINIB TAB 80 MG | 21531820000354 | Brand |
| DASATINIB | DASATINIB TAB 100 MG | 21531820000360 | Generic |
| SPRYCEL | DASATINIB TAB 100 MG | 21531820000360 | Brand |
| DASATINIB | DASATINIB TAB 140 MG | 21531820000380 | Generic |
| SPRYCEL | DASATINIB TAB 140 MG | 21531820000380 | Brand |

**Approval Criteria**

**1** - Diagnosis of lymphoid, myeloid, or mixed lineage neoplasms with eosinophilia

**AND**

**2** - Patient has an ABL1 (gene) rearrangement

| Product Name: Brand Sprycel, generic dasatinib | |
|---|---|
| Diagnosis | Cutaneous Melanoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DASATINIB | DASATINIB TAB 20 MG | 21531820000320 | Generic |
| SPRYCEL | DASATINIB TAB 20 MG | 21531820000320 | Brand |
| DASATINIB | DASATINIB TAB 50 MG | 21531820000340 | Generic |
| SPRYCEL | DASATINIB TAB 50 MG | 21531820000340 | Brand |

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|---|---|---|---|
| DASATINIB | DASATINIB TAB 70 MG | 21531820000350 | Generic |
| SPRYCEL | DASATINIB TAB 70 MG | 21531820000350 | Brand |
| DASATINIB | DASATINIB TAB 80 MG | 21531820000354 | Generic |
| SPRYCEL | DASATINIB TAB 80 MG | 21531820000354 | Brand |
| DASATINIB | DASATINIB TAB 100 MG | 21531820000360 | Generic |
| SPRYCEL | DASATINIB TAB 100 MG | 21531820000360 | Brand |
| DASATINIB | DASATINIB TAB 140 MG | 21531820000380 | Generic |
| SPRYCEL | DASATINIB TAB 140 MG | 21531820000380 | Brand |

**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 | Philadelphia Chromosome-Positive or BCR-ABL1-Positive Chronic Myeloid Leukemia, Ph+ALL, GIST, Chondrosarcoma, Chordoma, Myeloid/Lymphoid Neoplasms with Eosinophilia, Cutaneous Melanoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |

| Guideline Type | Prior Authorization |
|---|---|

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DASATINIB | DASATINIB TAB 20 MG | 21531820000320 | Generic |
| SPRYCEL | DASATINIB TAB 20 MG | 21531820000320 | Brand |
| DASATINIB | DASATINIB TAB 50 MG | 21531820000340 | Generic |
| SPRYCEL | DASATINIB TAB 50 MG | 21531820000340 | Brand |
| DASATINIB | DASATINIB TAB 70 MG | 21531820000350 | Generic |
| SPRYCEL | DASATINIB TAB 70 MG | 21531820000350 | Brand |
| DASATINIB | DASATINIB TAB 80 MG | 21531820000354 | Generic |
| SPRYCEL | DASATINIB TAB 80 MG | 21531820000354 | Brand |
| DASATINIB | DASATINIB TAB 100 MG | 21531820000360 | Generic |
| SPRYCEL | DASATINIB TAB 100 MG | 21531820000360 | Brand |
| DASATINIB | DASATINIB TAB 140 MG | 21531820000380 | Generic |
| SPRYCEL | DASATINIB TAB 140 MG | 21531820000380 | Brand |

**Approval Criteria**

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

| Product Name: Brand Sprycel, generic dasatinib | |
|---|---|
| Diagnosis | NCCN Recommended Regimens |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DASATINIB | DASATINIB TAB 20 MG | 21531820000320 | Generic |
| SPRYCEL | DASATINIB TAB 20 MG | 21531820000320 | Brand |
| DASATINIB | DASATINIB TAB 50 MG | 21531820000340 | Generic |
| SPRYCEL | DASATINIB TAB 50 MG | 21531820000340 | Brand |
| DASATINIB | DASATINIB TAB 70 MG | 21531820000350 | Generic |

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|---|---|---|---|
| SPRYCEL | DASATINIB TAB 70 MG | 21531820000350 | Brand |
| DASATINIB | DASATINIB TAB 80 MG | 21531820000354 | Generic |
| SPRYCEL | DASATINIB TAB 80 MG | 21531820000354 | Brand |
| DASATINIB | DASATINIB TAB 100 MG | 21531820000360 | Generic |
| SPRYCEL | DASATINIB TAB 100 MG | 21531820000360 | Brand |
| DASATINIB | DASATINIB TAB 140 MG | 21531820000380 | Generic |
| SPRYCEL | DASATINIB TAB 140 MG | 21531820000380 | Brand |

**Approval Criteria**

**1** - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

| Product Name: Brand Sprycel, generic dasatinib | |
|---|---|
| Diagnosis | NCCN Recommended Regimens |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DASATINIB | DASATINIB TAB 20 MG | 21531820000320 | Generic |
| SPRYCEL | DASATINIB TAB 20 MG | 21531820000320 | Brand |
| DASATINIB | DASATINIB TAB 50 MG | 21531820000340 | Generic |
| SPRYCEL | DASATINIB TAB 50 MG | 21531820000340 | Brand |
| DASATINIB | DASATINIB TAB 70 MG | 21531820000350 | Generic |
| SPRYCEL | DASATINIB TAB 70 MG | 21531820000350 | Brand |
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| SPRYCEL | DASATINIB TAB 80 MG | 21531820000354 | Brand |
| DASATINIB | DASATINIB TAB 100 MG | 21531820000360 | Generic |
| SPRYCEL | DASATINIB TAB 100 MG | 21531820000360 | Brand |
| DASATINIB | DASATINIB TAB 140 MG | 21531820000380 | Generic |
| SPRYCEL | DASATINIB TAB 140 MG | 21531820000380 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Sprycel therapy

## 2 . Revision History

| Date | Notes |
|---|---|
| 11/20/2024 | Updated GPIs and product list to add generic. Updated criteria for GI ST |

Stelara

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-161096 |
| **Guideline Name** | Stelara |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| STELARA | USTEKINUMAB SOLN PREFILLED SYRINGE 45 MG/0.5ML | 9025058500E520 | Brand |
| STELARA | USTEKINUMAB SOLN PREFILLED SYRINGE 90 MG/ML | 9025058500E540 | Brand |
| STELARA | USTEKINUMAB INJ 45 MG/0.5ML | 90250585002020 | Brand |

**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:

**1.2.1.3.1** Failure to a 3 month trial of methotrexate at 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 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:

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

- One of the preferred adalimumab products*
- One of the following: Enbrel (etanercept) or Ilumya (tildrakizumab)

**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)

- Ilumya (tildrakizumab)

**AND**

**1.4** ONE of the following:

**1.4.1** Failure to Cosentyx (secukinumab) confirmed by claims history or submitted medical records

**OR**

**1.4.2** History of intolerance or contraindication to Cosentyx (secukinumab) (please specify intolerance or contraindication)

**AND**

**1.5** Patient is NOT receiving Stelara 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**

**1.6** ONE of the following:

**1.6.1** Requested medication is Stelara 45 mg (milligrams)/0.5 mL (milliliters)

**OR**

**1.6.2** BOTH of the following:

- Requested medication is Stelara 90 mg/1 mL
- Patient's weight is greater than 100 kilograms (220 pounds)

**AND**

**1.7** Prescribed by or in consultation with a dermatologist

**OR**

**2** - ALL of the following:

**2.1** Patient is currently on Stelara 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 Stelara 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

| Notes | *PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |
|---|---|

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| STELARA | USTEKINUMAB SOLN PREFILLED SYRINGE 45 MG/0.5ML | 9025058500E520 | Brand |
| STELARA | USTEKINUMAB SOLN PREFILLED SYRINGE 90 MG/ML | 9025058500E540 | Brand |
| STELARA | USTEKINUMAB INJ 45 MG/0.5ML | 90250585002020 | Brand |

**Approval Criteria**

**1** - ALL of the following:

**1.1** ONE of the following:

**1.1.1** BOTH of the following:

**1.1.1.1** Requested medication is Stelara 45 mg (milligrams)/0.5 mL (milliliters)

**AND**

**1.1.1.2** Diagnosis of active psoriatic arthritis

**OR**

**1.1.2** ALL of the following:

**1.1.2.1** Requested medication is Stelara 90 mg/1 mL

**AND**

**1.1.2.2** Patient's weight is greater than 100 kilograms (220 pounds)

**AND**

**1.1.2.3** Diagnosis of active psoriatic arthritis

**AND**

**1.1.2.4** Diagnosis of co-existent moderate to severe plaque psoriasis

**AND**

**1.2** Patient is NOT receiving Stelara 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:

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

**OR**

**1.3.2** History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

**OR**

**1.3.3** 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), Tremfya (guselkumab) Xeljanz (tofacitinib), Otezla (apremilast), Rinvoq (upadacitinib)]

**AND**

**1.4** BOTH of the following:

**1.4.1** ONE of the following:

**1.4.1.1** Failure to BOTH of the following, confirmed by claims history or submitted medical records:

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

**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)

**AND**

**1.4.2** ONE of the following:

**1.4.2.1** Failure to Cosentyx (secukinumab), confirmed by claims history or submitted 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 Stelara 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 Stelara 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

| Notes | *PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |
|---|---|

| Product Name: Stelara | |
|---|---|
| Diagnosis | Plaque Psoriasis, Psoriatic Arthritis |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| STELARA | USTEKINUMAB SOLN PREFILLED SYRINGE 45 MG/0.5ML | 9025058500E520 | Brand |
| STELARA | USTEKINUMAB SOLN PREFILLED SYRINGE 90 MG/ML | 9025058500E540 | Brand |
| STELARA | USTEKINUMAB INJ 45 MG/0.5ML | 90250585002020 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Stelara therapy

**AND**

**2** - Patient is NOT receiving Stelara 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)]*

| Notes | *Examples of drug(s) may not be applicable based on the requested i ndication. |
|---|---|

| Product Name: Stelara 90 mg/mL | |
|---|---|
| Diagnosis | Crohn's Disease (CD) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| STELARA | USTEKINUMAB SOLN PREFILLED SYRINGE 90 MG/ML | 9025058500E540 | Brand |

**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 Stelara 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 Stelara under an active UnitedHealthcare medical benefit prior authorization for treatment of moderately to severely active Crohn's disease

**AND**

**3** - Patient is NOT receiving Stelara 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

| Notes | *PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |
|---|---|

| Product Name: Stelara 90 mg/mL | |
|---|---|
| Diagnosis | Ulcerative Colitis |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| STELARA | USTEKINUMAB SOLN PREFILLED SYRINGE 90 MG/ML | 9025058500E540 | Brand |

**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:

**2.1.1.1** 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**

**2.1.1.2** 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:

**2.1.2.1** Failure to one of the preferred adalimumab products*, confirmed by claims history or submitted medical records

**OR**

**2.1.2.2** History of intolerance or contraindication to one of the preferred adalimumab products* (please specify intolerance or contraindication)

**OR**

**2.2** Patient is currently on Stelara 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 Stelara under an active UnitedHealthcare medical benefit prior authorization for treatment of moderately to severely active ulcerative colitis

**AND**

**3** - Patient is NOT receiving Stelara 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

| Notes | *PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |
|---|---|

| Product Name: Stelara 90 mg/mL | |
|---|---|
| Diagnosis | Crohn's Disease (CD), Ulcerative Colitis |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| STELARA | USTEKINUMAB SOLN PREFILLED SYRINGE 90 MG/ML | 9025058500E540 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Stelara therapy

**AND**

**2** - Patient is NOT receiving Stelara 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)] |

## 2 . Revision History

| Date | Notes |
|---|---|
| 11/20/2024 | Updated step therapy bypass language. Updated safety language. R emoved Cimzia as step thru agent. Added PDL link |

Stivarga

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-152509 |
| **Guideline Name** | Stivarga |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 9/1/2024 |

## 1 . Criteria

| Product Name: Stivarga | |
|---|---|
| Diagnosis | Colorectal Cancer (CRC) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| STIVARGA | REGORAFENIB TAB 40 MG | 21533050000320 | Brand |

**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
- Fluoropyrimidine-based chemotherapy
- Anti-VEGF therapy-based chemotherapy

**AND**

**3** - ONE of the following:

**3.1** Tumor is RAS mutant-type

**OR**

**3.2** BOTH of the following:

**3.2.1** Tumor is RAS wild-type

**AND**

**3.2.2** 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| STIVARGA | REGORAFENIB TAB 40 MG | 21533050000320 | Brand |
|---|---|---|---|

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| STIVARGA | REGORAFENIB TAB 40 MG | 21533050000320 | Brand |
|---|---|---|---|

**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** One of the following

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

- imatinib mesylate (generic Gleevec)
- sunitinib malate) (generic Sutent)

**OR**

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

- imatinib mesylate (generic Gleevec)

- sunitinib malate) (generic Sutent)

| Product Name: Stivarga | |
|---|---|
| Diagnosis | Hepatobiliary Cancers |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| STIVARGA | REGORAFENIB TAB 40 MG | 21533050000320 | Brand |

**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
- Resected 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| STIVARGA | REGORAFENIB TAB 40 MG | 21533050000320 | Brand |

**Approval Criteria**

**1** - Diagnosis of ONE of the following:

- Osteosarcoma
- Dedifferentiated chondrosarcoma
- High grade undifferentiated pleomorphic sarcoma (UPS)
- Ewing Sarcoma

**AND**

**2** - Disease is ONE of the following:

- Relapsed/refractory
- Metastatic

**AND**

**3** - Used as second-line therapy

| Product Name: Stivarga | |
|---|---|
| Diagnosis | Glioblastoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| STIVARGA | REGORAFENIB TAB 40 MG | 21533050000320 | Brand |

**Approval Criteria**

**1** - Diagnosis of recurrent or progressive glioblastoma

| Product Name: Stivarga | |
|---|---|
| Diagnosis | Colorectal Cancer (CRC), Soft Tissue Sarcoma (STS), Gastrointestinal Stromal Tumor (GIST), Hepatobiliary Cancer, Bone Cancer, Glioblastoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| STIVARGA | REGORAFENIB TAB 40 MG | 21533050000320 | Brand |

**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 |
|---|---|

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| STIVARGA | REGORAFENIB TAB 40 MG | 21533050000320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| STIVARGA | REGORAFENIB TAB 40 MG | 21533050000320 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Stivarga therapy

Strensiq

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146652 |
| **Guideline Name** | Strensiq |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Strensiq | |
|---|---|
| Approval Length | 6 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| STRENSIQ | ASFOTASE ALFA SUBCUTANEOUS INJ 18 MG/0.45ML | 30905610002020 | Brand |
| STRENSIQ | ASFOTASE ALFA SUBCUTANEOUS INJ 28 MG/0.7ML | 30905610002030 | Brand |
| STRENSIQ | ASFOTASE ALFA SUBCUTANEOUS INJ 40 MG/ML | 30905610002040 | Brand |
| STRENSIQ | ASFOTASE ALFA SUBCUTANEOUS INJ 80 MG/0.8ML | 30905610002050 | Brand |

**Approval Criteria**

**1** - Diagnosis of perinatal/infantile or juvenile-onset hypophosphatasia based on ALL of the following:

**1.1** ONE of the following:

**1.1.1** Onset of clinical signs and symptoms of hypophosphatasia prior to age 18 years (e.g., respiratory insufficiency, vitamin B6 responsive seizures, hypotonia, failure to thrive, delayed walking, waddling gait, dental abnormalities, low trauma fractures)

**OR**

**1.1.2** Radiographic evidence supporting the diagnosis of hypophosphatasia at the age of onset prior to age 18 years (e.g., craniosynostosis, infantile rickets, non-traumatic fractures)

**AND**

**1.2** ONE of the following:

**1.2.1** BOTH of the following:

**1.2.1.1** Patient has low level activity of serum alkaline phosphatase (ALP) evidenced by an ALP level below the age and gender-adjusted normal range

**AND**

**1.2.1.2** Patient has an elevated level of tissue non-specific alkaline phosphatase (TNSALP) substrate [e.g., serum pyridoxal 5'-phosphate (PLP) level, serum or urine phosphoethanolamine (PEA) level, urinary inorganic pyrophosphate (PPi level)]

**OR**

**1.2.2** Confirmation of tissue-nonspecific alkaline phosphatase (TNSALP) gene mutation by ALPL genomic DNA (deoxyribonucleic acid) testing*

**AND**

**2** - Prescribed by ONE of the following:

- Endocrinologist
- A specialist experienced in the treatment of metabolic bone disorders

**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 vial

**AND**

**4.2.2** Patient's weight is greater than or equal to 40 kg

| | |
|---|---|
| Notes | *Results of prior genetic testing can be submitted as confirmation of di agnosis 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| STRENSIQ | ASFOTASE ALFA SUBCUTANEOUS INJ 18 MG/0.45ML | 30905610002020 | Brand |
| STRENSIQ | ASFOTASE ALFA SUBCUTANEOUS INJ 28 MG/0.7ML | 30905610002030 | Brand |
| STRENSIQ | ASFOTASE ALFA SUBCUTANEOUS INJ 40 MG/ML | 30905610002040 | Brand |
| STRENSIQ | ASFOTASE ALFA SUBCUTANEOUS INJ 80 MG/0.8ML | 30905610002050 | Brand |

**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** - Clinically relevant decrease from baseline in tissue non-specific alkaline phosphatase

(TNSALP) substrate [e.g., serum pyridoxal 5'-phosphate (PLP) level, serum or urine phosphoethanolamine (PEA) level, urinary inorganic pyrophosphate (PPi level)]

**AND**

**3** - Prescribed by ONE of the following:

- Endocrinologist
- A specialist experienced in the treatment of metabolic bone diseases

**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 vials

**AND**

**5.2.2** Patient's weight is greater than or equal to 40 kg

Stromectol

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146418 |
| **Guideline Name** | Stromectol |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Brand Stromectol, generic ivermectin tabs | |
|---|---|
| Approval Length | 1 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| STROMECTOL | IVERMECTIN TAB 3 MG | 15000007000310 | Brand |
| IVERMECTIN | IVERMECTIN TAB 3 MG | 15000007000310 | Generic |

**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

Sublingual Immunotherapy (SLIT)

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146419 |
| **Guideline Name** | Sublingual Immunotherapy (SLIT) |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| GRASTEK | TIMOTHY GRASS POLLEN ALLERGEN EXT SL TAB 2800 BAU | 20100048000740 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| GRASTEK | TIMOTHY GRASS POLLEN ALLERGEN EXT SL TAB 2800 BAU | 20100048000740 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ORALAIR CHILDREN/ADOLESCENTS STARTER PACK | *GRASS MIXED POLLEN EXT SL TAB 100 IR (INDEX OF REACTIVITY)* | 20109905200720 | Brand |
| ORALAIR | *GRASS MIXED POLLEN EXT SL TAB 300 IR (INDEX OF REACTIVITY)* | 20109905200730 | Brand |
| ORALAIR ADULT STARTER PACK | *GRASS MIXED POLLEN EXT SL TAB 300 IR (INDEX OF REACTIVITY)* | 20109905200730 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ORALAIR CHILDREN/ADOLESCENTS STARTER PACK | *GRASS MIXED POLLEN EXT SL TAB 100 IR (INDEX OF REACTIVITY)* | 20109905200720 | Brand |
| ORALAIR | *GRASS MIXED POLLEN EXT SL TAB 300 IR (INDEX OF REACTIVITY)* | 20109905200730 | Brand |
| ORALAIR ADULT STARTER PACK | *GRASS MIXED POLLEN EXT SL TAB 300 IR (INDEX OF REACTIVITY)* | 20109905200730 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RAGWITEK | SHORT RAGWEED POLLEN ALLERGEN EXTRACT SL TAB 12 AMB A 1-U | 20100060200720 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| RAGWITEK | SHORT RAGWEED POLLEN ALLERGEN EXTRACT SL TAB 12 AMB A 1-U | 20100060200720 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ODACTRA | *DUST MITE MIXED EXT SL TAB 12 SQ-HDM*** | 20109902220740 | Brand |

**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 (Singulair)]

**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 (Singulair)]

**AND**

**4** - Patient does not have unstable and/or uncontrolled asthma

**AND**

**5** - Prescribed by or in consultation with a specialist in allergy and immunology

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| ODACTRA | *DUST MITE MIXED EXT SL TAB 12 SQ-HDM*** | 20109902220740 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Odactra therapy

Sucraid

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-148728 |
| **Guideline Name** | Sucraid |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Sucraid | |
|---|---|
| Approval Length | 3 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SUCRAID | SACROSIDASE SOLN 8500 UNIT/ML | 51200060002030 | Brand |

**Approval Criteria**

**1** - Diagnosis of congenital sucrase-isomaltase deficiency (CSID)

**AND**

**2** - 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SUCRAID | SACROSIDASE SOLN 8500 UNIT/ML | 51200060002030 | Brand |

**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 |
|---|---|
| 6/20/2024 | Added carbon-13 sucrose breath test as an acceptable confirmatory diagnostic test. |

Sunosi

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146421 |
| **Guideline Name** | Sunosi |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Sunosi | |
|---|---|
| Diagnosis | Narcolepsy |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SUNOSI | SOLRIAMFETOL HCL TAB 75 MG (BASE EQUIV) | 61370070200320 | Brand |
| SUNOSI | SOLRIAMFETOL HCL TAB 150 MG (BASE EQUIV) | 61370070200340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SUNOSI | SOLRIAMFETOL HCL TAB 75 MG (BASE EQUIV) | 61370070200320 | Brand |
| SUNOSI | SOLRIAMFETOL HCL TAB 150 MG (BASE EQUIV) | 61370070200340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SUNOSI | SOLRIAMFETOL HCL TAB 75 MG (BASE EQUIV) | 61370070200320 | Brand |
| SUNOSI | SOLRIAMFETOL HCL TAB 150 MG (BASE EQUIV) | 61370070200340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SUNOSI | SOLRIAMFETOL HCL TAB 75 MG (BASE EQUIV) | 61370070200320 | Brand |
| SUNOSI | SOLRIAMFETOL HCL TAB 150 MG (BASE EQUIV) | 61370070200340 | Brand |

**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)

Sutent

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-147812 |
| **Guideline Name** | Sutent |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SUTENT | SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT) | 21533070300120 | Brand |
| SUNITINIB MALATE | SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT) | 21533070300120 | Generic |
| SUTENT | SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT) | 21533070300130 | Brand |

| | | | |
|---|---|---|---|
| SUNITINIB MALATE | SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT) | 21533070300130 | Generic |
| SUTENT | SUNITINIB MALATE CAP 37.5 MG (BASE EQUIVALENT) | 21533070300135 | Brand |
| SUNITINIB MALATE | SUNITINIB MALATE CAP 37.5 MG (BASE EQUIVALENT) | 21533070300135 | Generic |
| SUTENT | SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT) | 21533070300140 | Brand |
| SUNITINIB MALATE | SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT) | 21533070300140 | Generic |

**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 and should not be included in denial to provi der. |

| Product Name: Brand Sutent, generic sunitinib | |
|---|---|
| Diagnosis | Renal Cell Carcinoma (RCC) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SUTENT | SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT) | 21533070300120 | Brand |
| SUNITINIB MALATE | SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT) | 21533070300120 | Generic |
| SUTENT | SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT) | 21533070300130 | Brand |
| SUNITINIB MALATE | SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT) | 21533070300130 | Generic |
| SUTENT | SUNITINIB MALATE CAP 37.5 MG (BASE EQUIVALENT) | 21533070300135 | Brand |
| SUNITINIB MALATE | SUNITINIB MALATE CAP 37.5 MG (BASE EQUIVALENT) | 21533070300135 | Generic |
| SUTENT | SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT) | 21533070300140 | Brand |
| SUNITINIB MALATE | SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT) | 21533070300140 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SUTENT | SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT) | 21533070300120 | Brand |
| SUNITINIB MALATE | SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT) | 21533070300120 | Generic |
| SUTENT | SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT) | 21533070300130 | Brand |
| SUNITINIB MALATE | SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT) | 21533070300130 | Generic |
| SUTENT | SUNITINIB MALATE CAP 37.5 MG (BASE EQUIVALENT) | 21533070300135 | Brand |
| SUNITINIB MALATE | SUNITINIB MALATE CAP 37.5 MG (BASE EQUIVALENT) | 21533070300135 | Generic |
| SUTENT | SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT) | 21533070300140 | Brand |
| SUNITINIB MALATE | SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT) | 21533070300140 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SUTENT | SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT) | 21533070300120 | Brand |
| SUNITINIB MALATE | SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT) | 21533070300120 | Generic |
| SUTENT | SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT) | 21533070300130 | Brand |
| SUNITINIB MALATE | SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT) | 21533070300130 | Generic |
| SUTENT | SUNITINIB MALATE CAP 37.5 MG (BASE EQUIVALENT) | 21533070300135 | Brand |
| SUNITINIB MALATE | SUNITINIB MALATE CAP 37.5 MG (BASE EQUIVALENT) | 21533070300135 | Generic |
| SUTENT | SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT) | 21533070300140 | Brand |
| SUNITINIB MALATE | SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT) | 21533070300140 | Generic |

**Approval Criteria**

**1** - Diagnosis of ONE of the following:

- Alveolar soft part sarcoma (ASPS)
- Angiosarcoma
- Solitary fibrous tumor/hemangiopericytoma

| Product Name: Brand Sutent, generic sunitinib | |
|---|---|
| Diagnosis | Thyroid Carcinoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SUTENT | SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT) | 21533070300120 | Brand |
| SUNITINIB MALATE | SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT) | 21533070300120 | Generic |
| SUTENT | SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT) | 21533070300130 | Brand |
| SUNITINIB MALATE | SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT) | 21533070300130 | Generic |
| SUTENT | SUNITINIB MALATE CAP 37.5 MG (BASE EQUIVALENT) | 21533070300135 | Brand |
| SUNITINIB MALATE | SUNITINIB MALATE CAP 37.5 MG (BASE EQUIVALENT) | 21533070300135 | Generic |
| SUTENT | SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT) | 21533070300140 | Brand |
| SUNITINIB MALATE | SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT) | 21533070300140 | Generic |

**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 |
|---|---|

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SUTENT | SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT) | 21533070300120 | Brand |
| SUNITINIB MALATE | SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT) | 21533070300120 | Generic |
| SUTENT | SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT) | 21533070300130 | Brand |
| SUNITINIB MALATE | SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT) | 21533070300130 | Generic |
| SUTENT | SUNITINIB MALATE CAP 37.5 MG (BASE EQUIVALENT) | 21533070300135 | Brand |
| SUNITINIB MALATE | SUNITINIB MALATE CAP 37.5 MG (BASE EQUIVALENT) | 21533070300135 | Generic |
| SUTENT | SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT) | 21533070300140 | Brand |
| SUNITINIB MALATE | SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT) | 21533070300140 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SUTENT | SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT) | 21533070300120 | Brand |
| SUNITINIB MALATE | SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT) | 21533070300120 | Generic |
| SUTENT | SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT) | 21533070300130 | Brand |
| SUNITINIB MALATE | SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT) | 21533070300130 | Generic |
| SUTENT | SUNITINIB MALATE CAP 37.5 MG (BASE EQUIVALENT) | 21533070300135 | Brand |

| | | | |
|---|---|---|---|
| SUNITINIB MALATE | SUNITINIB MALATE CAP 37.5 MG (BASE EQUIVALENT) | 21533070300135 | Generic |
| SUTENT | SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT) | 21533070300140 | Brand |
| SUNITINIB MALATE | SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT) | 21533070300140 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SUTENT | SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT) | 21533070300120 | Brand |
| SUNITINIB MALATE | SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT) | 21533070300120 | Generic |
| SUTENT | SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT) | 21533070300130 | Brand |
| SUNITINIB MALATE | SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT) | 21533070300130 | Generic |

| | | | |
|---|---|---|---|
| SUTENT | SUNITINIB MALATE CAP 37.5 MG (BASE EQUIVALENT) | 21533070300135 | Brand |
| SUNITINIB MALATE | SUNITINIB MALATE CAP 37.5 MG (BASE EQUIVALENT) | 21533070300135 | Generic |
| SUTENT | SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT) | 21533070300140 | Brand |
| SUNITINIB MALATE | SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT) | 21533070300140 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SUTENT | SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT) | 21533070300120 | Brand |
| SUNITINIB MALATE | SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT) | 21533070300120 | Generic |
| SUTENT | SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT) | 21533070300130 | Brand |
| SUNITINIB MALATE | SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT) | 21533070300130 | Generic |
| SUTENT | SUNITINIB MALATE CAP 37.5 MG (BASE EQUIVALENT) | 21533070300135 | Brand |
| SUNITINIB MALATE | SUNITINIB MALATE CAP 37.5 MG (BASE EQUIVALENT) | 21533070300135 | Generic |
| SUTENT | SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT) | 21533070300140 | Brand |
| SUNITINIB MALATE | SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT) | 21533070300140 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SUTENT | SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT) | 21533070300120 | Brand |
| SUNITINIB MALATE | SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT) | 21533070300120 | Generic |
| SUTENT | SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT) | 21533070300130 | Brand |
| SUNITINIB MALATE | SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT) | 21533070300130 | Generic |
| SUTENT | SUNITINIB MALATE CAP 37.5 MG (BASE EQUIVALENT) | 21533070300135 | Brand |
| SUNITINIB MALATE | SUNITINIB MALATE CAP 37.5 MG (BASE EQUIVALENT) | 21533070300135 | Generic |
| SUTENT | SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT) | 21533070300140 | Brand |
| SUNITINIB MALATE | SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT) | 21533070300140 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SUTENT | SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT) | 21533070300120 | Brand |
| SUNITINIB MALATE | SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT) | 21533070300120 | Generic |
| SUTENT | SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT) | 21533070300130 | Brand |
| SUNITINIB MALATE | SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT) | 21533070300130 | Generic |
| SUTENT | SUNITINIB MALATE CAP 37.5 MG (BASE EQUIVALENT) | 21533070300135 | Brand |
| SUNITINIB MALATE | SUNITINIB MALATE CAP 37.5 MG (BASE EQUIVALENT) | 21533070300135 | Generic |
| SUTENT | SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT) | 21533070300140 | Brand |
| SUNITINIB MALATE | SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT) | 21533070300140 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SUTENT | SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT) | 21533070300120 | Brand |
| SUNITINIB MALATE | SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT) | 21533070300120 | Generic |
| SUTENT | SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT) | 21533070300130 | Brand |
| SUNITINIB MALATE | SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT) | 21533070300130 | Generic |

| | | | |
|---|---|---|---|
| SUTENT | SUNITINIB MALATE CAP 37.5 MG (BASE EQUIVALENT) | 21533070300135 | Brand |
| SUNITINIB MALATE | SUNITINIB MALATE CAP 37.5 MG (BASE EQUIVALENT) | 21533070300135 | Generic |
| SUTENT | SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT) | 21533070300140 | Brand |
| SUNITINIB MALATE | SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT) | 21533070300140 | Generic |

**Approval Criteria**

**1** - Documentation of positive clinical response to therapy

## 2 . Revision History

| Date | Notes |
|---|---|
| 5/28/2024 | Updated criteria for GIST, neuroendocrine/adrenal tumors, and thyroid carcinoma per NCCN recommendations. |

Symdeko

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-151686 |
| **Guideline Name** | Symdeko |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 9/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SYMDEKO | TEZACAFTOR-IVACAFTOR 100-150 MG & IVACAFTOR 150 MG TAB TBPK | 4530990280B720 | Brand |
| SYMDEKO | TEZACAFTOR-IVACAFTOR 50-75 MG & IVACAFTOR 75 MG TAB TBPK | 4530990280B710 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SYMDEKO | TEZACAFTOR-IVACAFTOR 100-150 MG & IVACAFTOR 150 MG TAB TBPK | 4530990280B720 | Brand |
| SYMDEKO | TEZACAFTOR-IVACAFTOR 50-75 MG & IVACAFTOR 75 MG TAB TBPK | 4530990280B710 | Brand |

**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 CFTR Gene Mutations** | | | | | |
| 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.

^ A patient must have two copies of the F508del mutation or at least one copy of a responsive mutation presented in the table to be indicated.

† 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 |
|---|---|
| 8/13/2024 | Simplified reauthorization criteria |

Synagis

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-157006 |
| **Guideline Name** | Synagis |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 11/1/2024 |

## 1 . Criteria

| Product Name: Synagis* | |
|---|---|
| Diagnosis | Prematurity |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SYNAGIS | PALIVIZUMAB IM SOLN 50 MG/0.5ML | 19502060002015 | Brand |
| SYNAGIS | PALIVIZUMAB IM SOLN 100 MG/ML | 19502060002020 | Brand |

**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) 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.”<br>**Information regarding RSV season may be found at:<br>• Centers for Disease and Prevention (CDC) surveillance reports: https://www.cdc.gov/nrevss/php/dashboard/index.html<br>***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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SYNAGIS | PALIVIZUMAB IM SOLN 50 MG/0.5ML | 19502060002015 | Brand |
| SYNAGIS | PALIVIZUMAB IM SOLN 100 MG/ML | 19502060002020 | Brand |

**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) 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."<br>**Information regarding RSV season may be found at:<br>• Centers for Disease and Prevention (CDC) surveillance reports: https://www.cdc.gov/nrevss/php/dashboard/index.html<br>***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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SYNAGIS | PALIVIZUMAB IM SOLN 50 MG/0.5ML | 19502060002015 | Brand |
| SYNAGIS | PALIVIZUMAB IM SOLN 100 MG/ML | 19502060002020 | Brand |

**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) 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.”<br>**Information regarding RSV season may be found at:<br>• Centers for Disease and Prevention (CDC) surveillance reports: http s://www.cdc.gov/nrevss/php/dashboard/index.html<br>***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 hospit al, this dose will be considered the first dose of the maximum 5 dose s eries for the season. Any subsequent doses received in the hospital s etting, are also considered as part of the maximum 5 dose series. For infants born during the RSV “season,” fewer than 5 monthly doses ma y be needed. |
|---|---|

| Product Name: Synagis* | |
|---|---|
| Diagnosis | Congenital abnormalities of the airway or neuromuscular disease |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SYNAGIS | PALIVIZUMAB IM SOLN 50 MG/0.5ML | 19502060002015 | Brand |
| SYNAGIS | PALIVIZUMAB IM SOLN 100 MG/ML | 19502060002020 | Brand |

**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) 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."<br>**Information regarding RSV season may be found at:<br>• Centers for Disease and Prevention (CDC) surveillance reports: https://www.cdc.gov/nrevss/php/dashboard/index.html<br>***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 s |
|---|---|

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|---|---|
| | eries for the season. Any subsequent doses received in the hospital s etting, are also considered as part of the maximum 5 dose series. For infants born during the RSV “season,” fewer than 5 monthly doses ma y be needed. |

| Product Name: Synagis* | |
|---|---|
| Diagnosis | Immunocompromised children less than 24 months of age |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SYNAGIS | PALIVIZUMAB IM SOLN 50 MG/0.5ML | 19502060002015 | Brand |
| SYNAGIS | PALIVIZUMAB IM SOLN 100 MG/ML | 19502060002020 | Brand |

**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) 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."<br>**Information regarding RSV season may be found at:<br>• Centers for Disease and Prevention (CDC) surveillance reports: http s://www.cdc.gov/nrevss/php/dashboard/index.html<br>***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 hospit al, this dose will be considered the first dose of the maximum 5 dose s eries for the season. Any subsequent doses received in the hospital s etting, are also considered as part of the maximum 5 dose series. For infants born during the RSV "season," fewer than 5 monthly doses ma y be needed. |

| Product Name: Synagis* | |
|---|---|
| Diagnosis | Cystic fibrosis (CF) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SYNAGIS | PALIVIZUMAB IM SOLN 50 MG/0.5ML | 19502060002015 | Brand |
| SYNAGIS | PALIVIZUMAB IM SOLN 100 MG/ML | 19502060002020 | Brand |

**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) 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]<br>• Routine use of prophylaxis in children with cystic fibrosis (unless indications noted in proven indications above are present)<br>• Prophylaxis for primary asthma prevention or to reduce subsequent episodes of wheezing in infants and children<br>• Synagis prophylaxis for prevention of nosocomial disease<br><br>**AND**<br><br>**7** - The request is NOT for one of the following:<br><br>• 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<br>• Treatment of symptomatic RSV disease | |
| Notes | *Approval for up to 5 doses per single RSV "season."<br>**Information regarding RSV season may be found at:<br>• Centers for Disease and Prevention (CDC) surveillance reports: http s://www.cdc.gov/nrevss/php/dashboard/index.html<br>***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 hospit al, this dose will be considered the first dose of the maximum 5 dose s eries for the season. Any subsequent doses received in the hospital s etting, are also considered as part of the maximum 5 dose series. For infants born during the RSV "season," fewer than 5 monthly doses ma y be needed. |

## 2 . Background

| **Benefit/Coverage/Program Information** |
|---|
| **Additional Information**<br><br>In most of North America, peak RSV activity typically occurs between November and March, usually beginning in November or December, peaking in January or February, and ending by the end of March or sometime in April. Communities in the southern United States, particularly some communities in the state of Florida, tend to experience the earliest onset of |

RSV. Data from the Centers for Disease Control and Prevention (CDC) have identified variations in the onset and offset of the RSV "season" in the state of Florida that could affect the timing of Synagis administration.

- Despite varied onsets, the RSV "season" is of the same duration (5 months) in the different regions of Florida.
- On the basis of the epidemiology of RSV in Alaska, particularly in remote regions where the burden of RSV disease is significantly greater than the general US population, the selection of Alaska Native infants eligible for prophylaxis may differ from the remainder of the United States. Clinicians may wish to use RSV surveillance data generated by the state of Alaska to assist in determining onset and end of the RSV season for qualifying infants.
- Limited information is available concerning the burden of RSV disease among Native American populations. However, special consideration may be prudent for Navajo and White Mountain Apache infants in the first year of life.

For analysis of National Respiratory and Enteric Virus Surveillance System (NREVSS) reports in the CDC Morbidity and Mortality Weekly Report, season onset is defined as the first of 2 consecutive weeks during which the mean percentage of specimens testing positive for RSV antigen is ≥ 10% or the mean percentage of specimens testing positive for RSV by PCR is ≥ 3%, whichever occurs first. RSV "season" offset is defined as the last week during which the mean percentage of positive specimens is ≥ 10%, or the mean percentage of positive specimens by PCR is ≥ 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 |
|---|---|
| 10/3/2024 | Updated CDC website. Removed old sharepoint link. |

Synribo

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146657 |
| **Guideline Name** | Synribo |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Synribo | |
|---|---|
| Diagnosis | Chronic Myeloid Leukemia |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SYNRIBO | OMACETAXINE MEPESUCCINATE FOR INJ 3.5 MG | 21700040102120 | Brand |

**Approval Criteria**

**1** - ONE of the following:

**1.1** Diagnosis of chronic or accelerated phase chronic myelogenous leukemia

**OR**

**1.2** Diagnosis of advanced phase chronic myelogenous leukemia with progression to accelerated phase

**OR**

**1.3** Patient has relapsed disease after hematopoietic stem cell transplant for chronic myeloid leukemia

**AND**

**2** - Patient has a history of resistance and/or intolerance to TWO or more tyrosine kinase inhibitors [e.g., Gleevec (imatinib), Sprycel (dasatinib), Tasigna (nilotinib), Bosulif (bosutinib), Iclusig (ponatinib)]

| Product Name: Synribo | |
|---|---|
| Diagnosis | Chronic Myeloid Leukemia |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SYNRIBO | OMACETAXINE MEPESUCCINATE FOR INJ 3.5 MG | 21700040102120 | Brand |

**Approval Criteria**

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

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SYNRIBO | OMACETAXINE MEPESUCCINATE FOR INJ 3.5 MG | 21700040102120 | Brand |

**Approval Criteria**

**1** - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

| Product Name: Synribo | |
|---|---|
| Diagnosis | NCCN Recommended Regimens |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| SYNRIBO | OMACETAXINE MEPESUCCINATE FOR INJ 3.5 MG | 21700040102120 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Synribo therapy

Tabrecta

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146658 |
| **Guideline Name** | Tabrecta |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TABRECTA | CAPMATINIB HCL TAB 150 MG | 21533716200320 | Brand |
| TABRECTA | CAPMATINIB HCL TAB 200 MG | 21533716200330 | Brand |

**Approval Criteria**

**1** - Diagnosis of non-small cell lung cancer (NSCLC)

**AND**

**2** - ONE of the following:

**2.1** Presence of mesenchymal-epithelial transition (MET) exon 14 skipping positive tumors

**OR**

**2.2** High level MET amplification in lung cancer

| Product Name: Tabrecta | |
|---|---|
| Diagnosis | Non-Small Cell Lung Cancer (NSCLC) |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TABRECTA | CAPMATINIB HCL TAB 150 MG | 21533716200320 | Brand |
| TABRECTA | CAPMATINIB HCL TAB 200 MG | 21533716200330 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TABRECTA | CAPMATINIB HCL TAB 150 MG | 21533716200320 | Brand |
| TABRECTA | CAPMATINIB HCL TAB 200 MG | 21533716200330 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TABRECTA | CAPMATINIB HCL TAB 150 MG | 21533716200320 | Brand |
| TABRECTA | CAPMATINIB HCL TAB 200 MG | 21533716200330 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Tabrecta therapy

Tafinlar

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-151115 |
| **Guideline Name** | Tafinlar |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 8/7/2024 |

## 1 . Criteria

| Product Name: Tafinlar | |
|---|---|
| Diagnosis | Melanoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TAFINLAR | DABRAFENIB MESYLATE CAP 50 MG (BASE EQUIVALENT) | 21532025100120 | Brand |
| TAFINLAR | DABRAFENIB MESYLATE CAP 75 MG (BASE EQUIVALENT) | 21532025100130 | Brand |
| TAFINLAR | DABRAFENIB MESYLATE TAB FOR ORAL SUSP 10 MG (BASE EQUIV) | 21532025107320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TAFINLAR | DABRAFENIB MESYLATE CAP 50 MG (BASE EQUIVALENT) | 21532025100120 | Brand |
| TAFINLAR | DABRAFENIB MESYLATE CAP 75 MG (BASE EQUIVALENT) | 21532025100130 | Brand |
| TAFINLAR | DABRAFENIB MESYLATE TAB FOR ORAL SUSP 10 MG (BASE EQUIV) | 21532025107320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TAFINLAR | DABRAFENIB MESYLATE CAP 50 MG (BASE EQUIVALENT) | 21532025100120 | Brand |
| TAFINLAR | DABRAFENIB MESYLATE CAP 75 MG (BASE EQUIVALENT) | 21532025100130 | Brand |
| TAFINLAR | DABRAFENIB MESYLATE TAB FOR ORAL SUSP 10 MG (BASE EQUIV) | 21532025107320 | Brand |

**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 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 | Thyroid Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TAFINLAR | DABRAFENIB MESYLATE CAP 50 MG (BASE EQUIVALENT) | 21532025100120 | Brand |
| TAFINLAR | DABRAFENIB MESYLATE CAP 75 MG (BASE EQUIVALENT) | 21532025100130 | Brand |
| TAFINLAR | DABRAFENIB MESYLATE TAB FOR ORAL SUSP 10 MG (BASE EQUIV) | 21532025107320 | Brand |

**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 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)

**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 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 | Hepatobiliary Cancers |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TAFINLAR | DABRAFENIB MESYLATE CAP 50 MG (BASE EQUIVALENT) | 21532025100120 | Brand |
| TAFINLAR | DABRAFENIB MESYLATE CAP 75 MG (BASE EQUIVALENT) | 21532025100130 | Brand |
| TAFINLAR | DABRAFENIB MESYLATE TAB FOR ORAL SUSP 10 MG (BASE EQUIV) | 21532025107320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TAFINLAR | DABRAFENIB MESYLATE CAP 50 MG (BASE EQUIVALENT) | 21532025100120 | Brand |
| TAFINLAR | DABRAFENIB MESYLATE CAP 75 MG (BASE EQUIVALENT) | 21532025100130 | Brand |
| TAFINLAR | DABRAFENIB MESYLATE TAB FOR ORAL SUSP 10 MG (BASE EQUIV) | 21532025107320 | Brand |

**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 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 | Solid Tumors |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TAFINLAR | DABRAFENIB MESYLATE CAP 50 MG (BASE EQUIVALENT) | 21532025100120 | Brand |
| TAFINLAR | DABRAFENIB MESYLATE CAP 75 MG (BASE EQUIVALENT) | 21532025100130 | Brand |
| TAFINLAR | DABRAFENIB MESYLATE TAB FOR ORAL SUSP 10 MG (BASE EQUIV) | 21532025107320 | Brand |

**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 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 | Epithelial Ovarian Cancer/Fallopian Tube Cancer/Primary Peritoneal Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TAFINLAR | DABRAFENIB MESYLATE CAP 50 MG (BASE EQUIVALENT) | 21532025100120 | Brand |
| TAFINLAR | DABRAFENIB MESYLATE CAP 75 MG (BASE EQUIVALENT) | 21532025100130 | Brand |
| TAFINLAR | DABRAFENIB MESYLATE TAB FOR ORAL SUSP 10 MG (BASE EQUIV) | 21532025107320 | Brand |

**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 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 | Pancreatic Cancer / Ampullary Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TAFINLAR | DABRAFENIB MESYLATE CAP 50 MG (BASE EQUIVALENT) | 21532025100120 | Brand |
| TAFINLAR | DABRAFENIB MESYLATE CAP 75 MG (BASE EQUIVALENT) | 21532025100130 | Brand |
| TAFINLAR | DABRAFENIB MESYLATE TAB FOR ORAL SUSP 10 MG (BASE EQUIV) | 21532025107320 | Brand |

**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 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 | Hairy Cell Leukemia |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TAFINLAR | DABRAFENIB MESYLATE CAP 50 MG (BASE EQUIVALENT) | 21532025100120 | Brand |
| TAFINLAR | DABRAFENIB MESYLATE CAP 75 MG (BASE EQUIVALENT) | 21532025100130 | Brand |
| TAFINLAR | DABRAFENIB MESYLATE TAB FOR ORAL SUSP 10 MG (BASE EQUIV) | 21532025107320 | Brand |

**Approval Criteria**

**1** - Diagnosis of hairy cell leukemia

**AND**

**2** - Used in combination with Mekinist (trametinib)

**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 | Salivary Gland Tumor |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TAFINLAR | DABRAFENIB MESYLATE CAP 50 MG (BASE EQUIVALENT) | 21532025100120 | Brand |
| TAFINLAR | DABRAFENIB MESYLATE CAP 75 MG (BASE EQUIVALENT) | 21532025100130 | Brand |
| TAFINLAR | DABRAFENIB MESYLATE TAB FOR ORAL SUSP 10 MG (BASE EQUIV) | 21532025107320 | Brand |

**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 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 | Gastrointestinal Stromal Tumor (GIST) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TAFINLAR | DABRAFENIB MESYLATE CAP 50 MG (BASE EQUIVALENT) | 21532025100120 | Brand |
| TAFINLAR | DABRAFENIB MESYLATE CAP 75 MG (BASE EQUIVALENT) | 21532025100130 | Brand |
| TAFINLAR | DABRAFENIB MESYLATE TAB FOR ORAL SUSP 10 MG (BASE EQUIV) | 21532025107320 | Brand |

**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 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 | All Indications except NCCN Recommended Regimens |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TAFINLAR | DABRAFENIB MESYLATE CAP 50 MG (BASE EQUIVALENT) | 21532025100120 | Brand |
| TAFINLAR | DABRAFENIB MESYLATE CAP 75 MG (BASE EQUIVALENT) | 21532025100130 | Brand |
| TAFINLAR | DABRAFENIB MESYLATE TAB FOR ORAL SUSP 10 MG (BASE EQUIV) | 21532025107320 | Brand |

**Approval Criteria**

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

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TAFINLAR | DABRAFENIB MESYLATE CAP 50 MG (BASE EQUIVALENT) | 21532025100120 | Brand |
| TAFINLAR | DABRAFENIB MESYLATE CAP 75 MG (BASE EQUIVALENT) | 21532025100130 | Brand |
| TAFINLAR | DABRAFENIB MESYLATE TAB FOR ORAL SUSP 10 MG (BASE EQUIV) | 21532025107320 | Brand |

**Approval Criteria**

**1** - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

**AND**

**2** - 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 | NCCN Recommended Regimens |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TAFINLAR | DABRAFENIB MESYLATE CAP 50 MG (BASE EQUIVALENT) | 21532025100120 | Brand |
| TAFINLAR | DABRAFENIB MESYLATE CAP 75 MG (BASE EQUIVALENT) | 21532025100130 | Brand |
| TAFINLAR | DABRAFENIB MESYLATE TAB FOR ORAL SUSP 10 MG (BASE EQUIV) | 21532025107320 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Tafinlar therapy

## 2 . Revision History

| Date | Notes |
|---|---|
| 8/6/2024 | Added new criteria for hairy cell leukemia, salivary gland tumor, and GIST. |

Tagrisso

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146660 |
| **Guideline Name** | Tagrisso |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Tagrisso | |
|---|---|
| Diagnosis | Central Nervous System (CNS) Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TAGRISSO | OSIMERTINIB MESYLATE TAB 40 MG (BASE EQUIVALENT) | 21360068200320 | Brand |
| TAGRISSO | OSIMERTINIB MESYLATE TAB 80 MG (BASE EQUIVALENT) | 21360068200330 | Brand |

**Approval Criteria**

**1** - Diagnosis of ONE of the following central nervous system (CNS) cancers:

- Limited brain metastases from non-small cell lung cancer (NSCLC)
- Extensive brain metastases from NSCLC
- Leptomeningeal metastases from NSCLC

**AND**

**2** - Primary disease (tumor) is responsive to Tagrisso therapy [e.g., epidermal growth factor receptor (EGFR) T790M mutation, exon 19 deletions, or exon 21 L858R mutation-positive NSCLC]

| Product Name: Tagrisso | |
|---|---|
| Diagnosis | Central Nervous System (CNS) Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TAGRISSO | OSIMERTINIB MESYLATE TAB 40 MG (BASE EQUIVALENT) | 21360068200320 | Brand |
| TAGRISSO | OSIMERTINIB MESYLATE TAB 80 MG (BASE EQUIVALENT) | 21360068200330 | Brand |

**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 |
|---|---|

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TAGRISSO | OSIMERTINIB MESYLATE TAB 40 MG (BASE EQUIVALENT) | 21360068200320 | Brand |
| TAGRISSO | OSIMERTINIB MESYLATE TAB 80 MG (BASE EQUIVALENT) | 21360068200330 | Brand |

**Approval Criteria**

**1** - Diagnosis of non-small cell lung cancer (NSCLC)

**AND**

**2** - ONE of the following:

**2.1** ALL of the following:

**2.1.1** Disease is recurrent, advanced, or metastatic

**AND**

**2.1.2** Disease is sensitizing EGFR mutation positive (e.g., EGFR T790M mutation, exon 19 deletions, exon 21 L858R, S768I, L861Q, or G719X mutation-positive)

**AND**

**2.1.3** Used as a first-line therapy

**OR**

**2.2** ALL of the following:

**2.2.1** Disease is recurrent, advanced, or metastatic

**AND**

**2.2.2** Disease is sensitizing EGFR mutation positive (e.g., EGFR T790M mutation, positive exon 19 deletions, exon 21 L858R, S768I, L861Q, or G719X mutation-positive)

**AND**

**2.2.3** Subsequent therapy for disease that has progressed while on Tagrisso therapy

**OR**

**2.3** ALL of the following:

**2.3.1** Disease is recurrent, advanced, or metastatic

**AND**

**2.3.2** Disease is epidermal growth factor receptor (EGFR) T790M mutation-positive

**AND**

**2.3.3** ONE of the following:

- Failure to prior EGFR tyrosine kinase inhibitor (TKI) therapy [e.g., Tarceva (erlotinib), Gilotrif (afatinib), Iressa (gefitinib)]
- History of contraindication or intolerance to prior EGFR TKI therapy [e.g., Tarceva (erlotinib), Gilotrif (afatinib), Iressa (gefitinib)]

**OR**

**2.4** BOTH of the following:

**2.4.1** Disease is EGFR exon 19 deletion or exon 21 L858R mutation positive

**AND**

**2.4.2** Used as adjuvant therapy after tumor resection

| Product Name: Tagrisso | |
|---|---|
| Diagnosis | Non-Small Cell Lung Cancer (NSCLC) |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TAGRISSO | OSIMERTINIB MESYLATE TAB 40 MG (BASE EQUIVALENT) | 21360068200320 | Brand |
| TAGRISSO | OSIMERTINIB MESYLATE TAB 80 MG (BASE EQUIVALENT) | 21360068200330 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TAGRISSO | OSIMERTINIB MESYLATE TAB 40 MG (BASE EQUIVALENT) | 21360068200320 | Brand |
| TAGRISSO | OSIMERTINIB MESYLATE TAB 80 MG (BASE EQUIVALENT) | 21360068200330 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TAGRISSO | OSIMERTINIB MESYLATE TAB 40 MG (BASE EQUIVALENT) | 21360068200320 | Brand |
| TAGRISSO | OSIMERTINIB MESYLATE TAB 80 MG (BASE EQUIVALENT) | 21360068200330 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Tagrisso therapy

Takhzyro

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-147196 |
| **Guideline Name** | Takhzyro |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Takhzyro | |
|---|---|
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TAKHZYRO | LANADELUMAB-FLYO SOLN PREF SYRINGE 150 MG/ML | 8584204020E510 | Brand |
| TAKHZYRO | LANADELUMAB-FLYO SOLN PREF SYRINGE 300 MG/2ML (150 MG/ML) | 8584204020E520 | Brand |
| TAKHZYRO | LANADELUMAB-FLYO INJ 300 MG/2ML (150 MG/ML) | 85842040202020 | Brand |

**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:

**1.2.1** 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

**OR**

**1.2.2** Recurring angioedema attacks that are refractory to high-dose antihistamines with confirmed family history of angioedema

**OR**

**1.2.3** 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** - BOTH of the following:

**2.1** For prophylaxis against HAE attacks

**AND**

**2.2** Not used in combination with other products indicated for prophylaxis against HAE attacks (e.g., Cinryze, Haegarda, Orladeyo)

**AND**

**3** - BOTH of the following:

**3.1** 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**

**3.2** Documentation of baseline HAE attack rate is greater than or equal to one attack per 4 weeks

**AND**

**4** - Prescribed by ONE of the following:

- Immunologist
- Allergist

**AND**

**5** - ONE of the following:

**5.1** Failure to Haegarda confirmed by claims history or submitted medical records

**OR**

**5.2** History of contraindication or intolerance to Haegarda (please specify intolerance or contraindication)

**OR**

**5.3** Patient is currently on Takhzyro therapy confirmed by claims history or submitted medical records

**AND**

**6** - ONE of the following:

**6.1** For adult and pediatric patients 12 years and older, Takhzyro 300 mg (milligrams) is given every 2 weeks*

**OR**

**6.2** For pediatric patients 6 to less than 12 years of age, Takhzyro 150 mg is given every 2 weeks*

**OR**

**6.3** 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.<br>**Pediatric patients less than 6 years of age approval length: 12 mont hs. |

| Product Name: Takhzyro | |
|---|---|
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TAKHZYRO | LANADELUMAB-FLYO SOLN PREF SYRINGE 150 MG/ML | 8584204020E510 | Brand |
| TAKHZYRO | LANADELUMAB-FLYO SOLN PREF SYRINGE 300 MG/2ML (150 MG/ML) | 8584204020E520 | Brand |
| TAKHZYRO | LANADELUMAB-FLYO INJ 300 MG/2ML (150 MG/ML) | 85842040202020 | Brand |

**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, Ruconest, Firazyr, Kalbitor) as determined by claims information, while on Takhzyro therapy

**AND**

**3** - Prescribed by ONE of the following:

- Immunologist
- Allergist

**AND**

**4** - BOTH of the following:

**4.1** For prophylaxis against hereditary angioedema (HAE) attacks

**AND**

**4.2** Not used in combination with other products indicated for prophylaxis against HAE attacks (e.g., Cinryze, Haegarda, Orladeyo)

**AND**

**5** - ONE of the following:

**5.1** Patient is less than 6 years of age and Takhzyro 150 mg (milligrams) is given every 4 weeks*

**OR**

**5.2** Patient is at least 6 years of age, and BOTH of the following:

**5.2.1** Documentation of the number of acute HAE attacks in the previous 6 months, while on Takhzyro therapy

**AND**

**5.2.2** ONE of the following:

**5.2.2.1** 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**

**5.2.2.2** 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.<br>**Patients experiencing unexpected breakthrough HAE attacks once s witched to every 4 week dosing will require additional review to allow f or 2 weeks dosing.<br>***Patient experienced 1 or more HAE attacks in the previous 6 month s approval length: 6 months. |
|---|---|

## 2 . Revision History

| Date | Notes |
|---|---|
| 5/9/2024 | Update to diagnostic criteria for HAE with normal C1 inhibitor levels.<br>Updated and simplified reauthorization criteria. |

Taltz

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-161122 |
| **Guideline Name** | Taltz |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TALTZ | IXEKIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 80 MG/ML | 9025055400D520 | Brand |
| TALTZ | IXEKIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 80 MG/ML | 9025055400E520 | Brand |
| TALTZ | IXEKIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 20 MG/0.25ML | 9025055400E510 | Brand |

| TALTZ | IXEKIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 40 MG/0.5ML | 9025055400E515 | Brand |
|---|---|---|---|

**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 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 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 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), Stelara (ustekinumab), Tremfya (guselkumab)]

**AND**

**1.3** One of the following:

**1.3.1** Failure to BOTH of the following confirmed by claims history or submission of medical records:

- One of the preferred adalimumab products^
- One of the following: Enbrel (etanercept) or Ilumya (tildrakizumab)

**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)
- Ilumya (tildrakizumab)

**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 targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

**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 targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

**AND**

**2.4** Prescribed by or in consultation with a dermatologist

| Notes | ^PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |
|---|---|

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TALTZ | IXEKIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 80 MG/ML | 9025055400D520 | Brand |
| TALTZ | IXEKIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 80 MG/ML | 9025055400E520 | Brand |
| TALTZ | IXEKIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 20 MG/0.25ML | 9025055400E510 | Brand |
| TALTZ | IXEKIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 40 MG/0.5ML | 9025055400E515 | Brand |

**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), Stelara (ustekinumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), Otezla (apremilast), Skyrizi (risankizumab)]

**AND**

**1.3** One of the following:

**1.3.1** Failure to BOTH of the following preferred products 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 preferred products (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 targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

**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 targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

**AND**

**2.4** Prescribed by or in consultation with one of the following:

- Rheumatologist
- Dermatologist

| Notes | ^PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |
|---|---|

| Product Name: Taltz | |
|---|---|
| Diagnosis | Ankylosing Spondylitis |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TALTZ | IXEKIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 80 MG/ML | 9025055400D520 | Brand |
| TALTZ | IXEKIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 80 MG/ML | 9025055400E520 | Brand |
| TALTZ | IXEKIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 20 MG/0.25ML | 9025055400E510 | Brand |
| TALTZ | IXEKIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 40 MG/0.5ML | 9025055400E515 | Brand |

**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 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)].

**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 targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

**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 targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

**AND**

**2.4** Prescribed by or in consultation with a rheumatologist

| Notes | ^PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |
|---|---|

| Product Name: Taltz | |
|---|---|
| Diagnosis | Non-Radiographic Axial Spondyloarthritis |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TALTZ | IXEKIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 80 MG/ML | 9025055400D520 | Brand |
| TALTZ | IXEKIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 80 MG/ML | 9025055400E520 | Brand |
| TALTZ | IXEKIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 20 MG/0.25ML | 9025055400E510 | Brand |
| TALTZ | IXEKIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 40 MG/0.5ML | 9025055400E515 | Brand |

**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 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)]

**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 targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

**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 targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TALTZ | IXEKIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 80 MG/ML | 9025055400D520 | Brand |
| TALTZ | IXEKIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 80 MG/ML | 9025055400E520 | Brand |
| TALTZ | IXEKIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 20 MG/0.25ML | 9025055400E510 | Brand |
| TALTZ | IXEKIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 40 MG/0.5ML | 9025055400E515 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Taltz therapy

**AND**

**2** - Patient is NOT receiving Taltz in combination with another targeted immunomodulator

| | |
|---|---|
| [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]* | |
| Notes | *Examples of drug(s) may not be applicable based on the requested i ndication. |

## 2 . Revision History

| Date | Notes |
|---|---|
| 11/20/2024 | Updated step therapy bypass language. Updated safety language. R emoved Cimzia as step thru agent. Combined reauth buckets |

Talzenna

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146663 |
| **Guideline Name** | Talzenna |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Talzenna | |
|---|---|
| Diagnosis | Breast Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TALZENNA | TALAZOPARIB TOSYLATE CAP 0.25 MG (BASE EQUIVALENT) | 21535580400110 | Brand |
| TALZENNA | TALAZOPARIB TOSYLATE CAP 0.5 MG (BASE EQUIVALENT) | 21535580400114 | Brand |
| TALZENNA | TALAZOPARIB TOSYLATE CAP 0.75 MG (BASE EQUIVALENT) | 21535580400118 | Brand |

| | | | |
|---|---|---|---|
| TALZENNA | TALAZOPARIB TOSYLATE CAP 1 MG (BASE EQUIVALENT) | 21535580400120 | Brand |
| TALZENNA | TALAZOPARIB TOSYLATE CAP 0.1 MG (BASE EQUIVALENT) | 21535580400105 | Brand |
| TALZENNA | TALAZOPARIB TOSYLATE CAP 0.35 MG (BASE EQUIVALENT) | 21535580400112 | Brand |

**Approval Criteria**

**1** - Diagnosis of breast cancer

**AND**

**2** - Disease is ONE of the following:

- Locally advanced
- Metastatic

**AND**

**3** - Presence of a germline BRCA (breast cancer)-mutation

**AND**

**4** - ONE of the following:

**4.1** Patient is currently on Talzenna therapy as confirmed by claims history or submitted medical records

**OR**

**4.2** History of intolerance or contraindication to Lynparza (please specify intolerance or contraindication)

**OR**

**4.3** Provider attests that the patient is not an appropriate candidate for Lynparza

| Product Name: Talzenna | |
|---|---|
| Diagnosis | Prostate Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TALZENNA | TALAZOPARIB TOSYLATE CAP 0.25 MG (BASE EQUIVALENT) | 21535580400110 | Brand |
| TALZENNA | TALAZOPARIB TOSYLATE CAP 0.5 MG (BASE EQUIVALENT) | 21535580400114 | Brand |
| TALZENNA | TALAZOPARIB TOSYLATE CAP 0.75 MG (BASE EQUIVALENT) | 21535580400118 | Brand |
| TALZENNA | TALAZOPARIB TOSYLATE CAP 1 MG (BASE EQUIVALENT) | 21535580400120 | Brand |
| TALZENNA | TALAZOPARIB TOSYLATE CAP 0.1 MG (BASE EQUIVALENT) | 21535580400105 | Brand |
| TALZENNA | TALAZOPARIB TOSYLATE CAP 0.35 MG (BASE EQUIVALENT) | 21535580400112 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TALZENNA | TALAZOPARIB TOSYLATE CAP 0.25 MG (BASE EQUIVALENT) | 21535580400110 | Brand |
| TALZENNA | TALAZOPARIB TOSYLATE CAP 0.5 MG (BASE EQUIVALENT) | 21535580400114 | Brand |
| TALZENNA | TALAZOPARIB TOSYLATE CAP 0.75 MG (BASE EQUIVALENT) | 21535580400118 | Brand |
| TALZENNA | TALAZOPARIB TOSYLATE CAP 1 MG (BASE EQUIVALENT) | 21535580400120 | Brand |
| TALZENNA | TALAZOPARIB TOSYLATE CAP 0.1 MG (BASE EQUIVALENT) | 21535580400105 | Brand |
| TALZENNA | TALAZOPARIB TOSYLATE CAP 0.35 MG (BASE EQUIVALENT) | 21535580400112 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TALZENNA | TALAZOPARIB TOSYLATE CAP 0.25 MG (BASE EQUIVALENT) | 21535580400110 | Brand |
| TALZENNA | TALAZOPARIB TOSYLATE CAP 0.5 MG (BASE EQUIVALENT) | 21535580400114 | Brand |
| TALZENNA | TALAZOPARIB TOSYLATE CAP 0.75 MG (BASE EQUIVALENT) | 21535580400118 | Brand |
| TALZENNA | TALAZOPARIB TOSYLATE CAP 1 MG (BASE EQUIVALENT) | 21535580400120 | Brand |
| TALZENNA | TALAZOPARIB TOSYLATE CAP 0.1 MG (BASE EQUIVALENT) | 21535580400105 | Brand |
| TALZENNA | TALAZOPARIB TOSYLATE CAP 0.35 MG (BASE EQUIVALENT) | 21535580400112 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TALZENNA | TALAZOPARIB TOSYLATE CAP 0.25 MG (BASE EQUIVALENT) | 21535580400110 | Brand |
| TALZENNA | TALAZOPARIB TOSYLATE CAP 0.5 MG (BASE EQUIVALENT) | 21535580400114 | Brand |
| TALZENNA | TALAZOPARIB TOSYLATE CAP 0.75 MG (BASE EQUIVALENT) | 21535580400118 | Brand |

| | | | |
|---|---|---|---|
| TALZENNA | TALAZOPARIB TOSYLATE CAP 1 MG (BASE EQUIVALENT) | 21535580400120 | Brand |
| TALZENNA | TALAZOPARIB TOSYLATE CAP 0.1 MG (BASE EQUIVALENT) | 21535580400105 | Brand |
| TALZENNA | TALAZOPARIB TOSYLATE CAP 0.35 MG (BASE EQUIVALENT) | 21535580400112 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Talzenna therapy

Tarceva

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146664 |
| **Guideline Name** | Tarceva |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Brand Tarceva, generic erlotinib | |
|---|---|
| Diagnosis | Pancreatic Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TARCEVA | ERLOTINIB HCL TAB 25 MG (BASE EQUIVALENT) | 21360025100320 | Brand |
| ERLOTINIB HYDROCHLORIDE | ERLOTINIB HCL TAB 25 MG (BASE EQUIVALENT) | 21360025100320 | Generic |
| TARCEVA | ERLOTINIB HCL TAB 100 MG (BASE EQUIVALENT) | 21360025100330 | Brand |

| | | | |
|---|---|---|---|
| ERLOTINIB HYDROCHLORIDE | ERLOTINIB HCL TAB 100 MG (BASE EQUIVALENT) | 21360025100330 | Generic |
| TARCEVA | ERLOTINIB HCL TAB 150 MG (BASE EQUIVALENT) | 21360025100360 | Brand |
| ERLOTINIB HYDROCHLORIDE | ERLOTINIB HCL TAB 150 MG (BASE EQUIVALENT) | 21360025100360 | Generic |

**Approval Criteria**

**1** - Diagnosis of pancreatic cancer

**AND**

**2** - Disease is ONE of the following:

- Locally advanced
- Unresectable
- Metastatic

**AND**

**3** - Used in combination with gemcitabine

| Product Name: Brand Tarceva, generic erlotinib | |
|---|---|
| Diagnosis | Non-Small Cell Lung Cancer (NSCLC) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TARCEVA | ERLOTINIB HCL TAB 25 MG (BASE EQUIVALENT) | 21360025100320 | Brand |
| ERLOTINIB HYDROCHLORIDE | ERLOTINIB HCL TAB 25 MG (BASE EQUIVALENT) | 21360025100320 | Generic |
| TARCEVA | ERLOTINIB HCL TAB 100 MG (BASE EQUIVALENT) | 21360025100330 | Brand |
| ERLOTINIB HYDROCHLORIDE | ERLOTINIB HCL TAB 100 MG (BASE EQUIVALENT) | 21360025100330 | Generic |

| | | | |
|---|---|---|---|
| TARCEVA | ERLOTINIB HCL TAB 150 MG (BASE EQUIVALENT) | 21360025100360 | Brand |
| ERLOTINIB HYDROCHLORIDE | ERLOTINIB HCL TAB 150 MG (BASE EQUIVALENT) | 21360025100360 | Generic |

**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:

- Tumors are positive for epidermal growth factor receptor (EGFR)exon 19 deletions
- Tumors are positive for exon 21 (L858R) substitution mutations
- Tumors are positive for a known sensitizing EGFR mutation (e.g., S768I, L861Q, G719X)

| Product Name: Brand Tarceva, generic erlotinib | |
|---|---|
| Diagnosis | Chordoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TARCEVA | ERLOTINIB HCL TAB 25 MG (BASE EQUIVALENT) | 21360025100320 | Brand |
| ERLOTINIB HYDROCHLORIDE | ERLOTINIB HCL TAB 25 MG (BASE EQUIVALENT) | 21360025100320 | Generic |

| | | | |
|---|---|---|---|
| TARCEVA | ERLOTINIB HCL TAB 100 MG (BASE EQUIVALENT) | 21360025100330 | Brand |
| ERLOTINIB HYDROCHLORIDE | ERLOTINIB HCL TAB 100 MG (BASE EQUIVALENT) | 21360025100330 | Generic |
| TARCEVA | ERLOTINIB HCL TAB 150 MG (BASE EQUIVALENT) | 21360025100360 | Brand |
| ERLOTINIB HYDROCHLORIDE | ERLOTINIB HCL TAB 150 MG (BASE EQUIVALENT) | 21360025100360 | Generic |

**Approval Criteria**

**1** - Diagnosis of chordoma

| Product Name: Brand Tarceva, generic erlotinib | |
|---|---|
| Diagnosis | Kidney Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TARCEVA | ERLOTINIB HCL TAB 25 MG (BASE EQUIVALENT) | 21360025100320 | Brand |
| ERLOTINIB HYDROCHLORIDE | ERLOTINIB HCL TAB 25 MG (BASE EQUIVALENT) | 21360025100320 | Generic |
| TARCEVA | ERLOTINIB HCL TAB 100 MG (BASE EQUIVALENT) | 21360025100330 | Brand |
| ERLOTINIB HYDROCHLORIDE | ERLOTINIB HCL TAB 100 MG (BASE EQUIVALENT) | 21360025100330 | Generic |
| TARCEVA | ERLOTINIB HCL TAB 150 MG (BASE EQUIVALENT) | 21360025100360 | Brand |
| ERLOTINIB HYDROCHLORIDE | ERLOTINIB HCL TAB 150 MG (BASE EQUIVALENT) | 21360025100360 | Generic |

**Approval Criteria**

**1** - Diagnosis of kidney cancer

**AND**

**2** - Disease is stage IV or relapsed

**AND**

**3** - Disease is of non-clear cell histology

| Product Name: Brand Tarceva, generic erlotinib | |
|---|---|
| Diagnosis | Central Nervous System (CNS) Cancers |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TARCEVA | ERLOTINIB HCL TAB 25 MG (BASE EQUIVALENT) | 21360025100320 | Brand |
| ERLOTINIB HYDROCHLORIDE | ERLOTINIB HCL TAB 25 MG (BASE EQUIVALENT) | 21360025100320 | Generic |
| TARCEVA | ERLOTINIB HCL TAB 100 MG (BASE EQUIVALENT) | 21360025100330 | Brand |
| ERLOTINIB HYDROCHLORIDE | ERLOTINIB HCL TAB 100 MG (BASE EQUIVALENT) | 21360025100330 | Generic |
| TARCEVA | ERLOTINIB HCL TAB 150 MG (BASE EQUIVALENT) | 21360025100360 | Brand |
| ERLOTINIB HYDROCHLORIDE | ERLOTINIB HCL TAB 150 MG (BASE EQUIVALENT) | 21360025100360 | Generic |

**Approval Criteria**

**1** - Diagnosis of brain, leptomeningeal, or spine metastases from non-small cell lung cancer (NSCLC)

**AND**

**2** - ONE of the following:

- Tumors are positive for epidermal growth factor receptor (EGFR) exon 19 deletions
- Tumors are positive for exon 21 (L858R) substitution mutations
- Tumors are positive for a known sensitizing EGFR mutation (e.g., S768I, L861Q, G719X)

| Product Name: Brand Tarceva, generic erlotinib | |
|---|---|
| Diagnosis | Vulvar cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TARCEVA | ERLOTINIB HCL TAB 25 MG (BASE EQUIVALENT) | 21360025100320 | Brand |
| ERLOTINIB HYDROCHLORIDE | ERLOTINIB HCL TAB 25 MG (BASE EQUIVALENT) | 21360025100320 | Generic |
| TARCEVA | ERLOTINIB HCL TAB 100 MG (BASE EQUIVALENT) | 21360025100330 | Brand |
| ERLOTINIB HYDROCHLORIDE | ERLOTINIB HCL TAB 100 MG (BASE EQUIVALENT) | 21360025100330 | Generic |
| TARCEVA | ERLOTINIB HCL TAB 150 MG (BASE EQUIVALENT) | 21360025100360 | Brand |
| ERLOTINIB HYDROCHLORIDE | ERLOTINIB HCL TAB 150 MG (BASE EQUIVALENT) | 21360025100360 | Generic |

**Approval Criteria**

**1** - Diagnosis of vulvar cancer

| Product Name: Brand Tarceva, generic erlotinib | |
|---|---|
| Diagnosis | Pancreatic Cancer, Non-Small Cell Lung Cancer (NSCLC), Chordoma, Kidney Cancer, Central Nervous System (CNS) Cancers, Vulvar Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |

| Guideline Type | Prior Authorization |
|---|---|

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TARCEVA | ERLOTINIB HCL TAB 25 MG (BASE EQUIVALENT) | 21360025100320 | Brand |
| ERLOTINIB HYDROCHLORIDE | ERLOTINIB HCL TAB 25 MG (BASE EQUIVALENT) | 21360025100320 | Generic |
| TARCEVA | ERLOTINIB HCL TAB 100 MG (BASE EQUIVALENT) | 21360025100330 | Brand |
| ERLOTINIB HYDROCHLORIDE | ERLOTINIB HCL TAB 100 MG (BASE EQUIVALENT) | 21360025100330 | Generic |
| TARCEVA | ERLOTINIB HCL TAB 150 MG (BASE EQUIVALENT) | 21360025100360 | Brand |
| ERLOTINIB HYDROCHLORIDE | ERLOTINIB HCL TAB 150 MG (BASE EQUIVALENT) | 21360025100360 | Generic |

**Approval Criteria**

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

| Product Name: Brand Tarceva, generic erlotinib | |
|---|---|
| Diagnosis | NCCN Recommended Regimens |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TARCEVA | ERLOTINIB HCL TAB 25 MG (BASE EQUIVALENT) | 21360025100320 | Brand |
| ERLOTINIB HYDROCHLORIDE | ERLOTINIB HCL TAB 25 MG (BASE EQUIVALENT) | 21360025100320 | Generic |
| TARCEVA | ERLOTINIB HCL TAB 100 MG (BASE EQUIVALENT) | 21360025100330 | Brand |
| ERLOTINIB HYDROCHLORIDE | ERLOTINIB HCL TAB 100 MG (BASE EQUIVALENT) | 21360025100330 | Generic |
| TARCEVA | ERLOTINIB HCL TAB 150 MG (BASE EQUIVALENT) | 21360025100360 | Brand |
| ERLOTINIB HYDROCHLORIDE | ERLOTINIB HCL TAB 150 MG (BASE EQUIVALENT) | 21360025100360 | Generic |

**Approval Criteria**

**1** - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

| Product Name: Brand Tarceva, generic erlotinib | |
|---|---|
| Diagnosis | NCCN Recommended Regimens |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TARCEVA | ERLOTINIB HCL TAB 25 MG (BASE EQUIVALENT) | 21360025100320 | Brand |
| ERLOTINIB HYDROCHLORIDE | ERLOTINIB HCL TAB 25 MG (BASE EQUIVALENT) | 21360025100320 | Generic |
| TARCEVA | ERLOTINIB HCL TAB 100 MG (BASE EQUIVALENT) | 21360025100330 | Brand |
| ERLOTINIB HYDROCHLORIDE | ERLOTINIB HCL TAB 100 MG (BASE EQUIVALENT) | 21360025100330 | Generic |
| TARCEVA | ERLOTINIB HCL TAB 150 MG (BASE EQUIVALENT) | 21360025100360 | Brand |
| ERLOTINIB HYDROCHLORIDE | ERLOTINIB HCL TAB 150 MG (BASE EQUIVALENT) | 21360025100360 | Generic |

**Approval Criteria**

**1** - Documentation of positive clinical response to Tarceva therapy

Targretin (bexarotene)

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146665 |
| **Guideline Name** | Targretin (bexarotene) |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BEXAROTENE | BEXAROTENE CAP 75 MG | 21708220000120 | Generic |
| TARGRETIN | BEXAROTENE CAP 75 MG | 21708220000120 | Brand |
| TARGRETIN | BEXAROTENE GEL 1% | 90376220004020 | Brand |
| BEXAROTENE | BEXAROTENE GEL 1% | 90376220004020 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BEXAROTENE | BEXAROTENE CAP 75 MG | 21708220000120 | Generic |
| TARGRETIN | BEXAROTENE CAP 75 MG | 21708220000120 | Brand |
| TARGRETIN | BEXAROTENE GEL 1% | 90376220004020 | Brand |
| BEXAROTENE | BEXAROTENE GEL 1% | 90376220004020 | Generic |

**Approval Criteria**

**1** - Patient has not had disease progression while on therapy

| Product Name: Brand Targretin, generic bexarotene | |
|---|---|
| Diagnosis | NCCN Recommended Regimens |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BEXAROTENE | BEXAROTENE CAP 75 MG | 21708220000120 | Generic |
| TARGRETIN | BEXAROTENE CAP 75 MG | 21708220000120 | Brand |
| TARGRETIN | BEXAROTENE GEL 1% | 90376220004020 | Brand |
| BEXAROTENE | BEXAROTENE GEL 1% | 90376220004020 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| BEXAROTENE | BEXAROTENE CAP 75 MG | 21708220000120 | Generic |
| TARGRETIN | BEXAROTENE CAP 75 MG | 21708220000120 | Brand |
| TARGRETIN | BEXAROTENE GEL 1% | 90376220004020 | Brand |
| BEXAROTENE | BEXAROTENE GEL 1% | 90376220004020 | Generic |

**Approval Criteria**

**1** - Documentation of positive clinical response to therapy

Tarpeyo

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146666 |
| **Guideline Name** | Tarpeyo |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Tarpeyo | |
|---|---|
| Approval Length | 9 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TARPEYO | BUDESONIDE DELAYED RELEASE CAP 4 MG | 22100012006520 | Brand |

**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 m^2 (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** - ONE of the following:

**6.1** Failure of ONE 30-day trial of a glucocorticoid (e.g., methylprednisolone, prednisone) confirmed by claims history or submitted medical records

**OR**

**6.2** History of intolerance or contraindication to ONE glucocorticoid (please specify intolerance or contraindication)

**AND**

**7** - Prescribed by or in consultation with a nephrologist

Tasigna

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146667 |
| **Guideline Name** | Tasigna |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Tasigna | |
|---|---|
| Diagnosis | Chronic Myeloid Leukemia |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TASIGNA | NILOTINIB HCL CAP 50 MG (BASE EQUIVALENT) | 21531860200110 | Brand |
| TASIGNA | NILOTINIB HCL CAP 150 MG (BASE EQUIVALENT) | 21531860200115 | Brand |
| TASIGNA | NILOTINIB HCL CAP 200 MG (BASE EQUIVALENT) | 21531860200125 | Brand |

**Approval Criteria**

**1** - Diagnosis of chronic myeloid leukemia

**AND**

**2** - ONE of the following:

**2.1** Patient is not a candidate for imatinib (Gleevec) as attested by physician

**OR**

**2.2** Patient is currently on Tasigna therapy

| Product Name: Tasigna | |
|---|---|
| Diagnosis | Gastrointestinal Stromal Tumor (GIST) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TASIGNA | NILOTINIB HCL CAP 50 MG (BASE EQUIVALENT) | 21531860200110 | Brand |
| TASIGNA | NILOTINIB HCL CAP 150 MG (BASE EQUIVALENT) | 21531860200115 | Brand |
| TASIGNA | NILOTINIB HCL CAP 200 MG (BASE EQUIVALENT) | 21531860200125 | Brand |

**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)

| Product Name: Tasigna | |
|---|---|
| Diagnosis | Acute Lymphoblastic Leukemia (Ph+B-ALL) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TASIGNA | NILOTINIB HCL CAP 50 MG (BASE EQUIVALENT) | 21531860200110 | Brand |
| TASIGNA | NILOTINIB HCL CAP 150 MG (BASE EQUIVALENT) | 21531860200115 | Brand |
| TASIGNA | NILOTINIB HCL CAP 200 MG (BASE EQUIVALENT) | 21531860200125 | Brand |

**Approval Criteria**

**1** - Diagnosis of Philadelphia chromosome-positive B-cell acute lymphoblastic leukemia (Ph+B-ALL)

| Product Name: Tasigna | |
|---|---|
| Diagnosis | Myeloid/Lymphoid Neoplasms with Eosinophilia and Tyrosine Kinase Fusion Genes |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TASIGNA | NILOTINIB HCL CAP 50 MG (BASE EQUIVALENT) | 21531860200110 | Brand |
| TASIGNA | NILOTINIB HCL CAP 150 MG (BASE EQUIVALENT) | 21531860200115 | Brand |
| TASIGNA | NILOTINIB HCL CAP 200 MG (BASE EQUIVALENT) | 21531860200125 | Brand |

**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

| Product Name: Tasigna | |
|---|---|
| Diagnosis | Melanoma: Cutaneous |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TASIGNA | NILOTINIB HCL CAP 50 MG (BASE EQUIVALENT) | 21531860200110 | Brand |
| TASIGNA | NILOTINIB HCL CAP 150 MG (BASE EQUIVALENT) | 21531860200115 | Brand |
| TASIGNA | NILOTINIB HCL CAP 200 MG (BASE EQUIVALENT) | 21531860200125 | Brand |

**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

| Product Name: Tasigna | |
|---|---|
| Diagnosis | Soft Tissue Sarcoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TASIGNA | NILOTINIB HCL CAP 50 MG (BASE EQUIVALENT) | 21531860200110 | Brand |
| TASIGNA | NILOTINIB HCL CAP 150 MG (BASE EQUIVALENT) | 21531860200115 | Brand |
| TASIGNA | NILOTINIB HCL CAP 200 MG (BASE EQUIVALENT) | 21531860200125 | Brand |

**Approval Criteria**

**1** - Diagnosis of pigmented villonodular synovitis/tenosynovial giant cell tumor

| Product Name: Tasigna | |
|---|---|
| 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TASIGNA | NILOTINIB HCL CAP 50 MG (BASE EQUIVALENT) | 21531860200110 | Brand |
| TASIGNA | NILOTINIB HCL CAP 150 MG (BASE EQUIVALENT) | 21531860200115 | Brand |
| TASIGNA | NILOTINIB HCL CAP 200 MG (BASE EQUIVALENT) | 21531860200125 | Brand |

**Approval Criteria**

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

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TASIGNA | NILOTINIB HCL CAP 50 MG (BASE EQUIVALENT) | 21531860200110 | Brand |
| TASIGNA | NILOTINIB HCL CAP 150 MG (BASE EQUIVALENT) | 21531860200115 | Brand |
| TASIGNA | NILOTINIB HCL CAP 200 MG (BASE EQUIVALENT) | 21531860200125 | Brand |

**Approval Criteria**

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

| Product Name: Tasigna | |
|---|---|
| Diagnosis | NCCN Recommended Regimens |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TASIGNA | NILOTINIB HCL CAP 50 MG (BASE EQUIVALENT) | 21531860200110 | Brand |
| TASIGNA | NILOTINIB HCL CAP 150 MG (BASE EQUIVALENT) | 21531860200115 | Brand |
| TASIGNA | NILOTINIB HCL CAP 200 MG (BASE EQUIVALENT) | 21531860200125 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Tasigna therapy

Tasmar

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146422 |
| **Guideline Name** | Tasmar |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: generic tolcapone, Brand Tasmar | |
|---|---|
| Approval Length | 3 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TOLCAPONE | TOLCAPONE TAB 100 MG | 73152070000320 | Generic |
| TASMAR | TOLCAPONE TAB 100 MG | 73152070000320 | Brand |

**Approval Criteria**

**1** - Diagnosis of Parkinson's disease

**AND**

**2** - 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**

**3** - ONE of the following:

**3.1** Failure to TWO of the following anti-Parkinson's disease 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., selegiline)

**OR**

**3.2** History of intolerance or contraindication to ALL of the following anti-Parkinson's disease 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)

**AND**

**4** - Patient has received baseline liver function tests to rule out the presence of underlying liver disease

**AND**

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

**AND**

**6** - Prescriber attests they have had complete discussion with the patient about the risks and benefits of Tasmar (tolcapone) use, including the risk of liver failure

| Product Name: generic tolcapone, Brand Tasmar | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TOLCAPONE | TOLCAPONE TAB 100 MG | 73152070000320 | Generic |
| TASMAR | TOLCAPONE TAB 100 MG | 73152070000320 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Tasmar (tolcapone) therapy

**AND**

**2** - Patient will continue to receive treatment with a carbidopa/levodopa-containing medication

**AND**

**3** - Patient has received periodic evaluation of liver function tests to rule out liver failure associated with Tasmar (tolcapone) use

Tavalisse

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146668 |
| **Guideline Name** | Tavalisse |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Tavalisse | |
|---|---|
| Diagnosis | Chronic immune thrombocytopenia (ITP) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TAVALISSE | FOSTAMATINIB DISODIUM TAB 100 MG (BASE EQUIVALENT) | 85756040100310 | Brand |
| TAVALISSE | FOSTAMATINIB DISODIUM TAB 150 MG (BASE EQUIVALENT) | 85756040100320 | Brand |

**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 Promacta (eltrombopag) confirmed by claims history or submitted medical records

**OR**

**2.1.2.2** History of contraindication or intolerance to Promacta (eltrombopag) (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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TAVALISSE | FOSTAMATINIB DISODIUM TAB 100 MG (BASE EQUIVALENT) | 85756040100310 | Brand |
| TAVALISSE | FOSTAMATINIB DISODIUM TAB 150 MG (BASE EQUIVALENT) | 85756040100320 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Tavalisse therapy

Tavneos

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146669 |
| **Guideline Name** | Tavneos |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TAVNEOS | AVACOPAN CAP 10 MG | 85805510000120 | Brand |

**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 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TAVNEOS | AVACOPAN CAP 10 MG | 85805510000120 | Brand |

**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

Tazverik

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-147187 |
| **Guideline Name** | Tazverik |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Tazverik | |
|---|---|
| Diagnosis | Epithelioid Sarcoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TAZVERIK | TAZEMETOSTAT HBR TAB 200 MG | 21533675200320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TAZVERIK | TAZEMETOSTAT HBR TAB 200 MG | 21533675200320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TAZVERIK | TAZEMETOSTAT HBR TAB 200 MG | 21533675200320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TAZVERIK | TAZEMETOSTAT HBR TAB 200 MG | 21533675200320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TAZVERIK | TAZEMETOSTAT HBR TAB 200 MG | 21533675200320 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Tazverik therapy

## 2 . Revision History

| Date | Notes |
|---|---|
| 5/8/2024 | New guideline |

Tegsedi

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146671 |
| **Guideline Name** | Tegsedi |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Tegsedi | |
|---|---|
| Diagnosis | Hereditary transthyretin-mediated (hATTR) amyloidosis with polyneuropathy |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TEGSEDI | INOTERSEN SOD SUBCUTANEOUS PREF SYR 284 MG/1.5ML (BASE EQ) | 6270104010E520 | Brand |

**Approval Criteria**

**1** - BOTH of the following:

- Diagnosis of Hereditary transthyretin-mediated (hATTR) amyloidosis with polyneuropathy
- Documentation that the patient has a pathogenic transthyretin (TTR) mutation (e.g., V30M)

**AND**

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

**AND**

**3** - Documentation of ONE of the following:

- Patient has a baseline polyneuropathy disability (PND) score less than or equal to IIIb
- Patient has a baseline familial amyloidotic polyneuropathy (FAP) Stage 1 or 2
- Patient has a baseline neuropathy impairment (NIS) score greater than or equal to 10 and less than or equal to 130

**AND**

**4** - Patient has not had a liver transplant

**AND**

**5** - Presence of clinical signs and symptoms of the disease (e.g., peripheral sensorimotor polyneuropathy, autonomic neuropathy, motor disability, etc.)

**AND**

**6** - Patient is not receiving Tegsedi in combination with ONE of the following:

- Oligonucleotide agents [e.g., Onpattro (patisiran), Amvuttra (vutrisiran)]
- Tafamidis (e.g., Vyndaqel, Vyndamax)

| Product Name: Tegsedi | |
|---|---|
| Diagnosis | Hereditary transthyretin-mediated (hATTR) amyloidosis with polyneuropathy |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TEGSEDI | INOTERSEN SOD SUBCUTANEOUS PREF SYR 284 MG/1.5ML (BASE EQ) | 6270104010E520 | Brand |

**Approval Criteria**

**1** - Documentation that the patient has experienced a positive clinical response to Tegsedi therapy (e.g., improved neurologic impairment, motor function, quality of life, slowing of disease progression, etc.)

**AND**

**2** - Patient is not receiving Tegsedi in combination with ONE of the following:

- Oligonucleotide agents [e.g., Onpattro (patisiran), Amvuttra (vutrisiran)]
- Tafamidis (e.g., Vyndaqel, Vyndamax)

Temodar

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146672 |
| **Guideline Name** | Temodar |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Brand Temodar, generic temozolomide | |
|---|---|
| Diagnosis | Central Nervous Systems (CNS) Tumor |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 100 MG | 21104070000140 | Generic |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 140 MG | 21104070000143 | Generic |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 180 MG | 21104070000147 | Generic |
| TEMODAR | TEMOZOLOMIDE CAP 250 MG | 21104070000150 | Brand |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 250 MG | 21104070000150 | Generic |

| | | | |
|---|---|---|---|
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 5 MG | 21104070000110 | Generic |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 20 MG | 21104070000120 | Generic |

**Approval Criteria**

**1** - Diagnosis of ONE of the following types of central nervous system tumors:

- Intracranial and Spinal Ependymoma (excluding Subependymoma)
- World Health Organization (WHO) Grade 2, 3, or 4 isocitrate dehydrogenase (IDH)-mutation Astrocytoma
- WHO Grade 2 or 3 IDH-mutant, 1p19q Codeleted Oligodendroglioma
- Medulloblastoma
- Circumscribed Gliomas
- Glioblastoma
- Limited or extensive brain metastases
- Primary CNS (central nervous system) lymphoma

| Product Name: Brand Temodar, generic temozolomide | |
|---|---|
| Diagnosis | Melanoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 100 MG | 21104070000140 | Generic |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 140 MG | 21104070000143 | Generic |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 180 MG | 21104070000147 | Generic |
| TEMODAR | TEMOZOLOMIDE CAP 250 MG | 21104070000150 | Brand |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 250 MG | 21104070000150 | Generic |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 5 MG | 21104070000110 | Generic |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 20 MG | 21104070000120 | Generic |

**Approval Criteria**

**1** - Diagnosis of ONE of the following types of melanoma:

- Metastatic or unresectable cutaneous melanoma
- Metastatic or unresectable uveal melanoma
- Mucosal melanoma

| Product Name: Brand Temodar, generic temozolomide | |
|---|---|
| Diagnosis | Neuroendocrine and Adrenal Tumors |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 100 MG | 21104070000140 | Generic |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 140 MG | 21104070000143 | Generic |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 180 MG | 21104070000147 | Generic |
| TEMODAR | TEMOZOLOMIDE CAP 250 MG | 21104070000150 | Brand |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 250 MG | 21104070000150 | Generic |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 5 MG | 21104070000110 | Generic |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 20 MG | 21104070000120 | Generic |

**Approval Criteria**

**1** - Diagnosis of ONE of the following types of neuroendocrine tumors:

- Bronchopulmonary/thymic disease
- Poorly controlled carcinoid syndrome in gastrointestinal tract, lung or thymus
- Pancreas
- Pheochromocytoma/paraganglioma
- Poorly differentiated (High Grade)/ large or small cell
- Well differentiated grade 3 neuroendocrine tumors

| Product Name: Brand Temodar, generic temozolomide | |
|---|---|
| Diagnosis | Primary Cutaneous Lymphomas |
| Approval Length | 12 month(s) |

| Therapy Stage | Initial Authorization |
|---|---|
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 100 MG | 21104070000140 | Generic |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 140 MG | 21104070000143 | Generic |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 180 MG | 21104070000147 | Generic |
| TEMODAR | TEMOZOLOMIDE CAP 250 MG | 21104070000150 | Brand |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 250 MG | 21104070000150 | Generic |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 5 MG | 21104070000110 | Generic |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 20 MG | 21104070000120 | Generic |

**Approval Criteria**

**1** - Diagnosis of ONE of the following types of primary cutaneous lymphomas:

- Mycosis fungoides (MF)
- Sézary syndrome (SS)

| Product Name: Brand Temodar, generic temozolomide | |
|---|---|
| Diagnosis | Soft Tissue Sarcoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 100 MG | 21104070000140 | Generic |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 140 MG | 21104070000143 | Generic |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 180 MG | 21104070000147 | Generic |
| TEMODAR | TEMOZOLOMIDE CAP 250 MG | 21104070000150 | Brand |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 250 MG | 21104070000150 | Generic |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 5 MG | 21104070000110 | Generic |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 20 MG | 21104070000120 | Generic |

**Approval Criteria**

**1** - ONE of the following:

- Diagnosis of recurrent unresectable or stage IV retroperitoneal/intra-abdominal soft tissue sarcoma
- Diagnosis of rhabdomyosarcoma
- Undifferentiated pleomorphic sarcoma
- Diagnosis of solitary fibrous tumor/hemangiopericytoma

**OR**

**2** - BOTH of the following:

**2.1** Diagnosis of soft tissue sarcoma of the extremity/body wall, head/neck

**AND**

**2.2** ONE of the following:

- Disease is stage IV
- Disease has disseminated metastases

| Product Name: Brand Temodar, generic temozolomide | |
|---|---|
| Diagnosis | Bone Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 100 MG | 21104070000140 | Generic |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 140 MG | 21104070000143 | Generic |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 180 MG | 21104070000147 | Generic |
| TEMODAR | TEMOZOLOMIDE CAP 250 MG | 21104070000150 | Brand |

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|---|---|---|---|
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 250 MG | 21104070000150 | Generic |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 5 MG | 21104070000110 | Generic |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 20 MG | 21104070000120 | Generic |

**Approval Criteria**

**1** - Diagnosis of ONE of the following:

- Ewing's sarcoma family of tumors
- Mesenchymal chondrosarcoma

**AND**

**2** - ONE of the following:

- Disease has relapsed
- Disease is progressive following primary treatment
- Used as second-line therapy for metastatic disease

**AND**

**3** - Used in combination with Campostar (irinotecan)

| Product Name: Brand Temodar, generic temozolomide | |
|---|---|
| Diagnosis | Uterine Sarcoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 100 MG | 21104070000140 | Generic |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 140 MG | 21104070000143 | Generic |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 180 MG | 21104070000147 | Generic |
| TEMODAR | TEMOZOLOMIDE CAP 250 MG | 21104070000150 | Brand |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 250 MG | 21104070000150 | Generic |

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|---|---|---|---|
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 5 MG | 21104070000110 | Generic |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 20 MG | 21104070000120 | Generic |

**Approval Criteria**

**1** - Diagnosis of recurrent or metastatic uterine sarcoma

| Product Name: Brand Temodar, generic temozolomide | |
|---|---|
| Diagnosis | Small Cell Lung Cancer (SCLC) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 100 MG | 21104070000140 | Generic |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 140 MG | 21104070000143 | Generic |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 180 MG | 21104070000147 | Generic |
| TEMODAR | TEMOZOLOMIDE CAP 250 MG | 21104070000150 | Brand |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 250 MG | 21104070000150 | Generic |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 5 MG | 21104070000110 | Generic |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 20 MG | 21104070000120 | Generic |

**Approval Criteria**

**1** - Diagnosis of small cell lung cancer (SCLC)

**AND**

**2** - ONE of the following:

**2.1** Relapse following complete or partial response or stable disease with primary treatment

**OR**

**2.2** Primary progressive disease

| Product Name: Brand Temodar, generic temozolomide | |
|---|---|
| Diagnosis | Central Nervous Systems (CNS) Tumor, Melanoma, Neuroendocrine and Adrenal Tumors, Primary Cutaneous Lymphomas, Soft Tissue Sarcoma, Bone Cancer, Uterine Sarcoma, Small Cell Lung Cancer (SCLC) |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 100 MG | 21104070000140 | Generic |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 140 MG | 21104070000143 | Generic |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 180 MG | 21104070000147 | Generic |
| TEMODAR | TEMOZOLOMIDE CAP 250 MG | 21104070000150 | Brand |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 250 MG | 21104070000150 | Generic |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 5 MG | 21104070000110 | Generic |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 20 MG | 21104070000120 | Generic |

**Approval Criteria**

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

| Product Name: Brand Temodar, generic temozolomide | |
|---|---|
| Diagnosis | NCCN Recommended Regimens |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 100 MG | 21104070000140 | Generic |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 140 MG | 21104070000143 | Generic |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 180 MG | 21104070000147 | Generic |
| TEMODAR | TEMOZOLOMIDE CAP 250 MG | 21104070000150 | Brand |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 250 MG | 21104070000150 | Generic |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 5 MG | 21104070000110 | Generic |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 20 MG | 21104070000120 | Generic |

**Approval Criteria**

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

| Product Name: Brand Temodar, generic temozolomide | |
|---|---|
| Diagnosis | NCCN Recommended Regimens |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 100 MG | 21104070000140 | Generic |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 140 MG | 21104070000143 | Generic |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 180 MG | 21104070000147 | Generic |
| TEMODAR | TEMOZOLOMIDE CAP 250 MG | 21104070000150 | Brand |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 250 MG | 21104070000150 | Generic |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 5 MG | 21104070000110 | Generic |
| TEMOZOLOMIDE | TEMOZOLOMIDE CAP 20 MG | 21104070000120 | Generic |

**Approval Criteria**

**1** - Documentation of positive clinical response to Temodar therapy

Tepmetko

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146673 |
| **Guideline Name** | Tepmetko |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TEPMETKO | TEPOTINIB HCL TAB 225 MG | 21533773100320 | Brand |

**Approval Criteria**

**1** - Diagnosis of non-small cell lung cancer

**AND**

**2** - Disease is recurrent, advanced, or metastatic

**AND**

**3** - Tumor is MET exon 14 skipping mutation positive

| Product Name: Tepmetko | |
|---|---|
| Diagnosis | Non-Small Cell Lung Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TEPMETKO | TEPOTINIB HCL TAB 225 MG | 21533773100320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TEPMETKO | TEPOTINIB HCL TAB 225 MG | 21533773100320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TEPMETKO | TEPOTINIB HCL TAB 225 MG | 21533773100320 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Tepmetko therapy

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146425 |
| **Guideline Name** | Test Strips |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Non-preferred Test Strips | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ACCU-CHEK AVIVA PLUS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| ACCU-CHEK GUIDE | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| ACCU-CHEK SMARTVIEW STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| ACCUTREND GLUCOSE | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |

| | | | |
|---|---|---|---|
| ADVANCE INTUITION TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| ADVANCE MICRO-DRAW TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| ADVOCATE REDI-CODE | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| ADVOCATE REDI-CODE+ TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| ADVOCATE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| AGAMATRIX AMP NO CODE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| AGAMATRIX JAZZ TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| AGAMATRIX KEYNOTE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| AGAMATRIX PRESTO TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| ASSURE II | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| ASSURE II CHECK STRIP | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| ASSURE II TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| ASSURE PLATINUM TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| ASSURE PRISM MULTI TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| ASSURE PRO TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| ASSURE 3 TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| ASSURE 4 TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| BIOSCANNER GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |

| | | | |
|---|---|---|---|
| BLOOD GLUCOSE TEST STRIPS PREMIUM | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| CAREONE BLOOD GLUCOSE TEST STRIPS/PREMIUM | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| CAREONE BLOOD GLUCOSE TEST STRIPS/VALUE | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| CARESENS N BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| CARETOUCH BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| CLEVER CHEK AUTO-CODE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| CLEVER CHEK AUTO-CODE VOICE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| CLEVER CHEK TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| CLEVER CHOICE AUTO-CODE PRO TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| CLEVER CHOICE MICRO TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| CLEVER CHOICE NO CODING TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| CLEVER CHOICE TALK NO CODING TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| CONTOUR BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| CONTOUR NEXT BLOOD GLUCOSE TEST | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| COOL BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| CVS ADVANCED GLUCOSE METER TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| D-CARE BLOOD GLUCOSE | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |

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|---|---|---|---|
| DIATHRIVE BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| DIATRUE PLUS BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| DUO-CARE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| EASY PLUS II BLOOD GLUCOSE TEST | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| EASY STEP TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| EASY TALK BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| EASY TOUCH GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| EASY TOUCH HEALTHPRO GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| EASY TRAK BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| EASYGLUCO | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| EASYMAX TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| EASYMAX 15 TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| EASYPRO BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| EASYPRO PLUS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| ELEMENT COMPACT TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| ELEMENT TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| EMBRACE BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| EMBRACE EVO BLOOD GLUCOSETEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |

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|---|---|---|---|
| EMBRACE PRO BLOOD GLUCOSETEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| EMBRACE TALK BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| EQ BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| EVOLUTION AUTOCODE | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FIFTY50 GLUCOSE TEST STRIP 2.0 | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FORA BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FORA D15G BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FORA D20 BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FORA D40/G31 BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FORA GD20 TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FORA GD50 BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FORA GTEL BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FORA G20 BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FORA G30/PREMIUM V10 BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FORA TN'G/TN'G VOICE BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FORA V10 BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |

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|---|---|---|---|
| FORA V12 BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FORA V20 BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FORA V30A BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FORACARE GD40 | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FORACARE PREMIUM V10 TESTSTRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FORACARE TEST N GO TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FORTISCARE BLOOD GLUCOSE TEST STRIP | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FREESTYLE INSULINX BLOOD GLUCOSE TEST | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FREESTYLE INSULINX BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FREESTYLE LITE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FREESTYLE PRECISION NEO BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FREESTYLE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| GENULTIMATE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| GE100 BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| GHT TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| GLUCO PERFECT 3 TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| GLUCOCARD EXPRESSION BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| GLUCOCARD SHINE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |

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|---|---|---|---|
| GLUCOCARD VITAL TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| GLUCOCARD X-SENSOR | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| GLUCOCARD 01 SENSOR PLUS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| GLUCOCARD 01 SENSOR PLUS TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| GLUCOCOM TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| GLUCONAVII BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| GLUCOSE METER TEST STRIPS ADVANCED | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| GNP EASY TOUCH GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| GOODSENSE PREMIUM BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| HW EMBRACE PRO BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| HW EMBRACE TALK BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| IGLUCOSE BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| IN TOUCH BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| INFINITY BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| INFINITY VOICE | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| KROGER BLOOD GLUCOSE TESTSTRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| KROGER PREMIUM BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |

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|---|---|---|---|
| LIBERTY NEXT GENERATION BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| LIBERTY TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| MEIJER BLOOD GLUCOSE TESTSTRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| MEIJER ESSENTIAL BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| MEIJER PREMIUM BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| MEIJER TRUETEST BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| MEIJER TRUETRACK BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| MICRODOT TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| MM EASY TOUCH GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| MYGLUCOHEALTH BLOOD GLUCOSE TEST | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| NEUTEK 2TEK TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| NOVA MAX GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| ONE DROP BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| OPTIUMEZ TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| PHARMACIST CHOICE AUTOCODE BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| PHARMACIST CHOICE NO CODING BLOOD | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |

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|---|---|---|---|
| GLUCOSE TEST STRIPS | | | |
| POCKETCHEM EZ BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| PRECISION XTRA BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| PREMIUM BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| PRO VOICE V8/V9 BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| PRODIGY NO CODING BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| PTS PANELS GLUCOSE TEST | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| QUICKTEK TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| QUINTET AC BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| QUINTET BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| REFUAH PLUS BLOOD GLUCOSETEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| RELION CONFIRM/MICRO TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| RELION PREMIER BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| RELION PRIME BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| RELION ULTIMA BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| REXALL BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| RIGHTEST GS100 BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |

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|---|---|---|---|
| RIGHTEST GS300 BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| RIGHTEST GS550 BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| SMART SENSE PREMIUM BLOODGLUCOSE STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| SMART SENSE VALUE BLOOD GLUCOSE STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| SMARTEST BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| SOLUS V2 AUDIBLE TEST | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| SUPREME TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| TGT BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| TGT BLOOD GLUCOSE TEST STRIPS PREMIUM | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| TRUE FOCUS SELF MONITORING BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| TRUE METRIX BLOOD GLUCOSETEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| TRUE METRIX SELF MONITORING BLOOD GLUCOSE STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| TRUETEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| TRUETRACK BLOOD GLUCOSE TEST | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| TRUETRACK TEST | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| UNISTRIP1 GENERIC | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |

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|---|---|---|---|
| BLULINK GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| CVS GLUCOSE METER TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| DIATHRIVE+ BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| EASY TRAK II BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FORA TN'G ADVANCE PRO BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FORA 6 CONNECT | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| GOJJI BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| GOJJI BLOOD GLUCOSE TEST STRIPS/GOJJI STERILE LANCETS 30G | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| KROGER HEALTHPRO GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| MICRODOT XTRA TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| RELION TRUE METRIX BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| TRUE METRIX PRO GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| VERASENS BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| VIVAGUARD INO BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| EASY TALK PLUS II BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |

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|---|---|---|---|
| FORTISCARE G1 BLOOD GLUCOSE TEST STRIP | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| GNP TRUE METRIX SELF MONITORING BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| GNP TRUETRACK BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| GNP TRUETRACK SMART SYSTEM | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| RIGHTEST GS333 BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| BLOOD GLUCOSE TEST STRIPS333 | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| ON CALL EXPRESS BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| ONETOUCH VERIO IN VITRO MEDI-CAL | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| PIP BLOOD GLUCOSE TEST STRIP | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |

**Approval Criteria**

**1** - ONE of the following:

**1.1** Failure of both of the following confirmed by claims history or submitted medical records:

- OneTouch Ultra Test Strips
- OneTouch Verio Test Strips

**OR**

**1.2** History of intolerance or contraindication to both of the following (please specify intolerance or contraindication):

- OneTouch Ultra Test Strips

- OneTouch Verio Test Strips

**OR**

**2** - Patient is on an insulin pump

| Product Name: All Test Strips | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Quantity Limit |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ACCU-CHEK AVIVA PLUS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| ACCU-CHEK GUIDE | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| ACCU-CHEK SMARTVIEW STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| ACCUTREND GLUCOSE | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| ADVANCE INTUITION TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| ADVANCE MICRO-DRAW TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| ADVOCATE REDI-CODE | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| ADVOCATE REDI-CODE+ TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| ADVOCATE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| AGAMATRIX AMP NO CODE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| AGAMATRIX JAZZ TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| AGAMATRIX KEYNOTE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| AGAMATRIX PRESTO TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |

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| ASSURE II | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| ASSURE II CHECK STRIP | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| ASSURE II TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| ASSURE PLATINUM TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| ASSURE PRISM MULTI TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| ASSURE PRO TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| ASSURE 3 TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| ASSURE 4 TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| BIOSCANNER GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| BLOOD GLUCOSE TEST STRIPS PREMIUM | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| CAREONE BLOOD GLUCOSE TEST STRIPS/PREMIUM | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| CAREONE BLOOD GLUCOSE TEST STRIPS/VALUE | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| CARESENS N BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| CARETOUCH BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| CLEVER CHEK AUTO-CODE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| CLEVER CHEK AUTO-CODE VOICE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| CLEVER CHEK TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |

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| CLEVER CHOICE AUTO-CODE PRO TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| CLEVER CHOICE MICRO TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| CLEVER CHOICE NO CODING TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| CLEVER CHOICE TALK NO CODING TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| CONTOUR BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| CONTOUR NEXT BLOOD GLUCOSE TEST | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| COOL BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| CVS ADVANCED GLUCOSE METER TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| D-CARE BLOOD GLUCOSE | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| DIATHRIVE BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| DIATRUE PLUS BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| DUO-CARE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| EASY PLUS II BLOOD GLUCOSE TEST | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| EASY STEP TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| EASY TALK BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| EASY TOUCH GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| EASY TOUCH HEALTHPRO GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |

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| EASY TRAK BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| EASYGLUCO | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| EASYMAX TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| EASYMAX 15 TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| EASYPRO BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| EASYPRO PLUS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| ELEMENT COMPACT TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| ELEMENT TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| EMBRACE BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| EMBRACE EVO BLOOD GLUCOSETEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| EMBRACE PRO BLOOD GLUCOSETEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| EMBRACE TALK BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| EQ BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| EVOLUTION AUTOCODE | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FIFTY50 GLUCOSE TEST STRIP 2.0 | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FORA BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FORA D15G BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FORA D20 BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |

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|---|---|---|---|
| FORA D40/G31 BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FORA GD20 TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FORA GD50 BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FORA GTEL BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FORA G20 BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FORA G30/PREMIUM V10 BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FORA TN'G/TN'G VOICE BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FORA V10 BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FORA V12 BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FORA V20 BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FORA V30A BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FORACARE GD40 | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FORACARE PREMIUM V10 TESTSTRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FORACARE TEST N GO TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FORTISCARE BLOOD GLUCOSE TEST STRIP | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FREESTYLE INSULINX BLOOD GLUCOSE TEST | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FREESTYLE INSULINX BLOOD | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |

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|---|---|---|---|
| GLUCOSE TEST STRIPS | | | |
| FREESTYLE LITE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FREESTYLE PRECISION NEO BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FREESTYLE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| GENULTIMATE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| GE100 BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| GHT TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| GLUCO PERFECT 3 TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| GLUCOCARD EXPRESSION BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| GLUCOCARD SHINE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| GLUCOCARD VITAL TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| GLUCOCARD X-SENSOR | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| GLUCOCARD 01 SENSOR PLUS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| GLUCOCARD 01 SENSOR PLUS TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| GLUCOCOM TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| GLUCONAVII BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| GLUCOSE METER TEST STRIPS ADVANCED | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| GNP EASY TOUCH GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| GOODSENSE PREMIUM BLOOD | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |

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| GLUCOSE TEST STRIPS | | | |
| HW EMBRACE PRO BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| HW EMBRACE TALK BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| IGLUCOSE BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| IN TOUCH BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| INFINITY BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| INFINITY VOICE | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| KROGER BLOOD GLUCOSE TESTSTRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| KROGER PREMIUM BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| LIBERTY NEXT GENERATION BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| LIBERTY TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| MEIJER BLOOD GLUCOSE TESTSTRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| MEIJER ESSENTIAL BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| MEIJER PREMIUM BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| MEIJER TRUETEST BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| MEIJER TRUETRACK | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |

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|---|---|---|---|
| BLOOD GLUCOSE TEST STRIPS | | | |
| MICRODOT TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| MM EASY TOUCH GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| MYGLUCOHEALTH BLOOD GLUCOSE TEST | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| NEUTEK 2TEK TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| NOVA MAX GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| ONE DROP BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| ONETOUCH VERIO TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| OPTIUMEZ TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| PHARMACIST CHOICE AUTOCODE BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| PHARMACIST CHOICE NO CODING BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| POCKETCHEM EZ BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| PRECISION XTRA BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| PREMIUM BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| PRO VOICE V8/V9 BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| PRODIGY NO CODING BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |

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|---|---|---|---|
| PTS PANELS GLUCOSE TEST | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| QUICKTEK TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| QUINTET AC BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| QUINTET BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| REFUAH PLUS BLOOD GLUCOSETEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| RELION CONFIRM/MICRO TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| RELION PREMIER BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| RELION PRIME BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| RELION ULTIMA BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| REXALL BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| RIGHTEST GS100 BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| RIGHTEST GS300 BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| RIGHTEST GS550 BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| SMART SENSE PREMIUM BLOODGLUCOSE STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| SMART SENSE VALUE BLOOD GLUCOSE STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| SMARTEST BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| SOLUS V2 AUDIBLE TEST | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |

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|---|---|---|---|
| SUPREME TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| TGT BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| TGT BLOOD GLUCOSE TEST STRIPS PREMIUM | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| TRUE FOCUS SELF MONITORING BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| TRUE METRIX BLOOD GLUCOSETEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| TRUE METRIX SELF MONITORING BLOOD GLUCOSE STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| TRUETEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| TRUETRACK BLOOD GLUCOSE TEST | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| TRUETRACK TEST | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| UNISTRIP1 GENERIC | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| BLULINK GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| CVS GLUCOSE METER TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| DIATHRIVE+ BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| EASY TRAK II BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FORA TN'G ADVANCE PRO BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FORA 6 CONNECT | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |

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|---|---|---|---|
| GOJJI BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| GOJJI BLOOD GLUCOSE TEST STRIPS/GOJJI STERILE LANCETS 30G | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| KROGER HEALTHPRO GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| MICRODOT XTRA TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| ONETOUCH ULTRA | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| RELION TRUE METRIX BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| TRUE METRIX PRO GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| VERASENS BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| VIVAGUARD INO BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| EASY TALK PLUS II BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| FORTISCARE G1 BLOOD GLUCOSE TEST STRIP | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| GNP TRUE METRIX SELF MONITORING BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| GNP TRUETRACK BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| GNP TRUETRACK SMART SYSTEM | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| RIGHTEST GS333 BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |

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|---|---|---|---|
| BLOOD GLUCOSE TEST STRIPS333 | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| ON CALL EXPRESS BLOOD GLUCOSE TEST STRIPS | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| ONETOUCH VERIO IN VITRO MEDI-CAL | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |
| PIP BLOOD GLUCOSE TEST STRIP | GLUCOSE BLOOD TEST STRIP | 94100030006100 | Brand |

**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:

**2.1** The patient is experiencing or is prone to hypoglycemia or hyperglycemia and requires additional testing to achieve glycemic control

**OR**

**2.2** The patient's physician is adjusting medications and the patient requires additional blood glucose testing during this time

**OR**

**2.3** The patient's physician is adjusting MNT (medical nutrition therapy) and the patient requires additional blood glucose testing during this time

**OR**

| | |
|---|---|
| **2.4** The patient requires additional testing due to fluctuations in blood glucose due to physical activity/exercise<br><br>**OR**<br><br>**2.5** Other circumstances where prescribing physician confirms that the patient requires a greater quantity because of more frequent blood glucose testing (clinical review required by 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. |

Testosterone

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-148271 |
| **Guideline Name** | Testosterone |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Androderm, generic testosterone gel, Brand Androgel, 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 | |
|---|---|
| Diagnosis | Hypogonadism |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization* |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ANDRODERM | TESTOSTERONE TD PATCH 24HR 2 MG/24HR | 23100030008503 | Brand |
| ANDRODERM | TESTOSTERONE TD PATCH 24HR 4 MG/24HR | 23100030008510 | Brand |

| | | | |
|---|---|---|---|
| TESTOSTERONE | TESTOSTERONE TD GEL 25 MG/2.5GM (1%) | 23100030004025 | Generic |
| ANDROGEL | TESTOSTERONE TD GEL 25 MG/2.5GM (1%) | 23100030004025 | Brand |
| TESTOSTERONE | TESTOSTERONE TD GEL 50 MG/5GM (1%) | 23100030004030 | Generic |
| ANDROGEL | TESTOSTERONE TD GEL 50 MG/5GM (1%) | 23100030004030 | Brand |
| TESTOSTERONE | TESTOSTERONE TD GEL 40.5 MG/2.5GM (1.62%) | 23100030004047 | Generic |
| ANDROGEL | TESTOSTERONE TD GEL 40.5 MG/2.5GM (1.62%) | 23100030004047 | Brand |
| TESTOSTERONE | TESTOSTERONE TD GEL 20.25 MG/ACT (1.62%) | 23100030004050 | Generic |
| TESTOSTERONE PUMP | TESTOSTERONE TD GEL 20.25 MG/ACT (1.62%) | 23100030004050 | Generic |
| ANDROGEL PUMP | TESTOSTERONE TD GEL 20.25 MG/ACT (1.62%) | 23100030004050 | Brand |
| TESTOSTERONE | TESTOSTERONE TD SOLN 30 MG/ACT | 23100030002020 | Generic |
| TESTOSTERONE TOPICAL SOLUTION | TESTOSTERONE TD SOLN 30 MG/ACT | 23100030002020 | Generic |
| FORTESTA | TESTOSTERONE TD GEL 10MG/ACT (2%) | 23100030004070 | Brand |
| TESTOSTERONE | TESTOSTERONE TD GEL 10MG/ACT (2%) | 23100030004070 | Generic |
| TESTIM | TESTOSTERONE TD GEL 50 MG/5GM (1%) | 23100030004030 | Brand |
| VOGELXO | TESTOSTERONE TD GEL 50 MG/5GM (1%) | 23100030004030 | Brand |
| TESTOSTERONE PUMP | TESTOSTERONE TD GEL 12.5 MG/ACT (1%) | 23100030004040 | Generic |
| VOGELXO PUMP | TESTOSTERONE TD GEL 12.5 MG/ACT (1%) | 23100030004040 | Brand |
| TESTOSTERONE | TESTOSTERONE TD GEL 20.25 MG/1.25GM (1.62%) | 23100030004044 | Generic |
| XYOSTED | TESTOSTERONE ENANTHATE SOLUTION AUTO-INJECTOR 50 MG/0.5ML | 2310003020D520 | Brand |
| XYOSTED | TESTOSTERONE ENANTHATE SOLUTION AUTO-INJECTOR 75 MG/0.5ML | 2310003020D530 | Brand |
| XYOSTED | TESTOSTERONE ENANTHATE SOLUTION AUTO-INJECTOR 100 MG/0.5ML | 2310003020D540 | Brand |
| JATENZO | TESTOSTERONE UNDECANOATE CAP 158 MG | 23100030800130 | Brand |
| JATENZO | TESTOSTERONE UNDECANOATE CAP 198 MG | 23100030800135 | Brand |
| JATENZO | TESTOSTERONE UNDECANOATE CAP 237 MG | 23100030800140 | Brand |
| KYZATREX | TESTOSTERONE UNDECANOATE CAP 100 MG | 23100030800124 | Brand |
| KYZATREX | TESTOSTERONE UNDECANOATE CAP 150 MG | 23100030800128 | Brand |
| KYZATREX | TESTOSTERONE UNDECANOATE CAP 200 MG | 23100030800136 | Brand |

| | | | |
|---|---|---|---|
| TLANDO | TESTOSTERONE UNDECANOATE CAP 112.5 MG | 23100030800125 | Brand |
| NATESTO | TESTOSTERONE NASAL GEL 5.5 MG/ACT | 23100030004080 | Brand |
| DEPO-TESTOSTERONE | TESTOSTERONE CYPIONATE IM INJ IN OIL 100 MG/ML | 23100030102010 | Brand |
| TESTOSTERONE CYPIONATE | TESTOSTERONE CYPIONATE IM INJ IN OIL 100 MG/ML | 23100030102010 | Generic |
| DEPO-TESTOSTERONE | TESTOSTERONE CYPIONATE IM INJ IN OIL 200 MG/ML | 23100030102015 | Brand |
| TESTOSTERONE CYPIONATE | TESTOSTERONE CYPIONATE IM INJ IN OIL 200 MG/ML | 23100030102015 | Generic |
| TESTOSTERONE ENANTHATE | TESTOSTERONE ENANTHATE IM INJ IN OIL 200 MG/ML | 23100030202010 | Generic |

**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 Xyosted, BOTH of the following:

**7.2.1** ONE of the following:

**7.2.1.1** Failure to testosterone cypionate injection (generic Depo-Testosterone), confirmed by claims history or submitted medical records

**OR**

**7.2.1.2** History of intolerance or contraindication to testosterone cypionate injection (generic Depo-Testosterone) (please specify intolerance or contraindication)

**AND**

**7.2.2** ONE of the following:

**7.2.2.1** Failure to intramuscular testosterone enanthate injection, confirmed by claims history or submitted medical records

**OR**

**7.2.2.2** History of intolerance or contraindication to intramuscular testosterone enanthate injection (please specify intolerance or contraindication)

**OR**

**7.3** If the request is for Jatenzo, Kyzatrex, or Tlando, ONE of the following:

**7.3.1** 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**

**7.3.2** 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 a ccess should be reviewed using reauthorization criteria<br>**PDL link: https://www.uhcprovider.com/en/health-plans-by-state/new -mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |
|---|---|

| Product Name: Androderm, generic testosterone gel, Brand Androgel, 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 | |
|---|---|
| Diagnosis | Gender Dysphoria |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization* |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ANDRODERM | TESTOSTERONE TD PATCH 24HR 2 MG/24HR | 23100030008503 | Brand |
| ANDRODERM | TESTOSTERONE TD PATCH 24HR 4 MG/24HR | 23100030008510 | Brand |
| TESTOSTERONE | TESTOSTERONE TD GEL 25 MG/2.5GM (1%) | 23100030004025 | Generic |
| ANDROGEL | TESTOSTERONE TD GEL 25 MG/2.5GM (1%) | 23100030004025 | Brand |
| TESTOSTERONE | TESTOSTERONE TD GEL 50 MG/5GM (1%) | 23100030004030 | Generic |
| ANDROGEL | TESTOSTERONE TD GEL 50 MG/5GM (1%) | 23100030004030 | Brand |
| TESTOSTERONE | TESTOSTERONE TD GEL 40.5 MG/2.5GM (1.62%) | 23100030004047 | Generic |
| ANDROGEL | TESTOSTERONE TD GEL 40.5 MG/2.5GM (1.62%) | 23100030004047 | Brand |
| TESTOSTERONE | TESTOSTERONE TD GEL 20.25 MG/ACT (1.62%) | 23100030004050 | Generic |
| TESTOSTERONE PUMP | TESTOSTERONE TD GEL 20.25 MG/ACT (1.62%) | 23100030004050 | Generic |
| ANDROGEL PUMP | TESTOSTERONE TD GEL 20.25 MG/ACT (1.62%) | 23100030004050 | Brand |
| TESTOSTERONE | TESTOSTERONE TD SOLN 30 MG/ACT | 23100030002020 | Generic |
| TESTOSTERONE TOPICAL SOLUTION | TESTOSTERONE TD SOLN 30 MG/ACT | 23100030002020 | Generic |
| FORTESTA | TESTOSTERONE TD GEL 10MG/ACT (2%) | 23100030004070 | Brand |
| TESTOSTERONE | TESTOSTERONE TD GEL 10MG/ACT (2%) | 23100030004070 | Generic |
| TESTIM | TESTOSTERONE TD GEL 50 MG/5GM (1%) | 23100030004030 | Brand |
| VOGELXO | TESTOSTERONE TD GEL 50 MG/5GM (1%) | 23100030004030 | Brand |
| TESTOSTERONE PUMP | TESTOSTERONE TD GEL 12.5 MG/ACT (1%) | 23100030004040 | Generic |
| VOGELXO PUMP | TESTOSTERONE TD GEL 12.5 MG/ACT (1%) | 23100030004040 | Brand |
| TESTOSTERONE | TESTOSTERONE TD GEL 20.25 MG/1.25GM (1.62%) | 23100030004044 | Generic |

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|---|---|---|---|
| XYOSTED | TESTOSTERONE ENANTHATE SOLUTION AUTO-INJECTOR 50 MG/0.5ML | 2310003020D520 | Brand |
| XYOSTED | TESTOSTERONE ENANTHATE SOLUTION AUTO-INJECTOR 75 MG/0.5ML | 2310003020D530 | Brand |
| XYOSTED | TESTOSTERONE ENANTHATE SOLUTION AUTO-INJECTOR 100 MG/0.5ML | 2310003020D540 | Brand |
| JATENZO | TESTOSTERONE UNDECANOATE CAP 158 MG | 23100030800130 | Brand |
| JATENZO | TESTOSTERONE UNDECANOATE CAP 198 MG | 23100030800135 | Brand |
| JATENZO | TESTOSTERONE UNDECANOATE CAP 237 MG | 23100030800140 | Brand |
| KYZATREX | TESTOSTERONE UNDECANOATE CAP 100 MG | 23100030800124 | Brand |
| KYZATREX | TESTOSTERONE UNDECANOATE CAP 150 MG | 23100030800128 | Brand |
| KYZATREX | TESTOSTERONE UNDECANOATE CAP 200 MG | 23100030800136 | Brand |
| TLANDO | TESTOSTERONE UNDECANOATE CAP 112.5 MG | 23100030800125 | Brand |
| NATESTO | TESTOSTERONE NASAL GEL 5.5 MG/ACT | 23100030004080 | Brand |
| DEPO-TESTOSTERONE | TESTOSTERONE CYPIONATE IM INJ IN OIL 100 MG/ML | 23100030102010 | Brand |
| TESTOSTERONE CYPIONATE | TESTOSTERONE CYPIONATE IM INJ IN OIL 100 MG/ML | 23100030102010 | Generic |
| DEPO-TESTOSTERONE | TESTOSTERONE CYPIONATE IM INJ IN OIL 200 MG/ML | 23100030102015 | Brand |
| TESTOSTERONE CYPIONATE | TESTOSTERONE CYPIONATE IM INJ IN OIL 200 MG/ML | 23100030102015 | Generic |
| TESTOSTERONE ENANTHATE | TESTOSTERONE ENANTHATE IM INJ IN OIL 200 MG/ML | 23100030202010 | Generic |

**Approval Criteria**

**1** - Patient is using hormones to change physical characteristics

**AND**

**2** - Patient must be diagnosed with gender dysphoria, as defined by the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM)

**AND**

**3** - Patient is NOT taking any of the following growth hormones, unless diagnosed with panhypopituitarism:

- Genotropin
- Humatrope
- Norditropin FlexPro
- Nutropin AQ
- Omnitrope
- Saizen

**AND**

**4** - Patient is NOT taking any aromatase inhibitors [e.g., Arimidex (anastrozole), Femara (letrozole), Aromasin (exemestane)]

**AND**

**5** - ONE of the following:

**5.1** If the request is for a non-preferred** topical testosterone (gel, solution) or testosterone transdermal systems (patches), ONE of the following:

**5.1.1** 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**

**5.1.2** 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**

**5.2** If the request is for Xyosted, BOTH of the following:

**5.2.1** ONE of the following:

**5.2.1.1** Failure to testosterone cypionate injection (generic Depo-Testosterone), confirmed by claims history or submitted medical records

**OR**

**5.2.1.2** History of intolerance or contraindication to testosterone cypionate injection (generic Depo-Testosterone) (please specify intolerance or contraindication)

**AND**

**5.2.2** ONE of the following:

**5.2.2.1** Failure to intramuscular testosterone enanthate injection, confirmed by claims history or submitted medical records

**OR**

**5.2.2.2** History of intolerance or contraindication to intramuscular testosterone enanthate injection (please specify intolerance or contraindication)

**OR**

**5.3** If the request is for Jatenzo, Kyzatrex, or Tlando, ONE of the following:

**5.3.1** 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**

**5.3.2** 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 a ccess should be reviewed using reauthorization criteria<br>**PDL link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |

| Product Name: Androderm, generic testosterone gel, Brand Androgel, 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 | |
|---|---|
| Diagnosis | Hypogonadism, Gender Dysphoria |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ANDRODERM | TESTOSTERONE TD PATCH 24HR 2 MG/24HR | 23100030008503 | Brand |
| ANDRODERM | TESTOSTERONE TD PATCH 24HR 4 MG/24HR | 23100030008510 | Brand |
| TESTOSTERONE | TESTOSTERONE TD GEL 25 MG/2.5GM (1%) | 23100030004025 | Generic |
| ANDROGEL | TESTOSTERONE TD GEL 25 MG/2.5GM (1%) | 23100030004025 | Brand |
| TESTOSTERONE | TESTOSTERONE TD GEL 50 MG/5GM (1%) | 23100030004030 | Generic |
| ANDROGEL | TESTOSTERONE TD GEL 50 MG/5GM (1%) | 23100030004030 | Brand |
| TESTOSTERONE | TESTOSTERONE TD GEL 40.5 MG/2.5GM (1.62%) | 23100030004047 | Generic |
| ANDROGEL | TESTOSTERONE TD GEL 40.5 MG/2.5GM (1.62%) | 23100030004047 | Brand |
| TESTOSTERONE | TESTOSTERONE TD GEL 20.25 MG/ACT (1.62%) | 23100030004050 | Generic |
| TESTOSTERONE PUMP | TESTOSTERONE TD GEL 20.25 MG/ACT (1.62%) | 23100030004050 | Generic |
| ANDROGEL PUMP | TESTOSTERONE TD GEL 20.25 MG/ACT (1.62%) | 23100030004050 | Brand |
| TESTOSTERONE | TESTOSTERONE TD SOLN 30 MG/ACT | 23100030002020 | Generic |

| | | | |
|---|---|---|---|
| TESTOSTERONE TOPICAL SOLUTION | TESTOSTERONE TD SOLN 30 MG/ACT | 23100030002020 | Generic |
| FORTESTA | TESTOSTERONE TD GEL 10MG/ACT (2%) | 23100030004070 | Brand |
| TESTOSTERONE | TESTOSTERONE TD GEL 10MG/ACT (2%) | 23100030004070 | Generic |
| TESTIM | TESTOSTERONE TD GEL 50 MG/5GM (1%) | 23100030004030 | Brand |
| VOGELXO | TESTOSTERONE TD GEL 50 MG/5GM (1%) | 23100030004030 | Brand |
| TESTOSTERONE PUMP | TESTOSTERONE TD GEL 12.5 MG/ACT (1%) | 23100030004040 | Generic |
| VOGELXO PUMP | TESTOSTERONE TD GEL 12.5 MG/ACT (1%) | 23100030004040 | Brand |
| TESTOSTERONE | TESTOSTERONE TD GEL 20.25 MG/1.25GM (1.62%) | 23100030004044 | Generic |
| XYOSTED | TESTOSTERONE ENANTHATE SOLUTION AUTO-INJECTOR 50 MG/0.5ML | 2310003020D520 | Brand |
| XYOSTED | TESTOSTERONE ENANTHATE SOLUTION AUTO-INJECTOR 75 MG/0.5ML | 2310003020D530 | Brand |
| XYOSTED | TESTOSTERONE ENANTHATE SOLUTION AUTO-INJECTOR 100 MG/0.5ML | 2310003020D540 | Brand |
| JATENZO | TESTOSTERONE UNDECANOATE CAP 158 MG | 23100030800130 | Brand |
| JATENZO | TESTOSTERONE UNDECANOATE CAP 198 MG | 23100030800135 | Brand |
| JATENZO | TESTOSTERONE UNDECANOATE CAP 237 MG | 23100030800140 | Brand |
| KYZATREX | TESTOSTERONE UNDECANOATE CAP 100 MG | 23100030800124 | Brand |
| KYZATREX | TESTOSTERONE UNDECANOATE CAP 150 MG | 23100030800128 | Brand |
| KYZATREX | TESTOSTERONE UNDECANOATE CAP 200 MG | 23100030800136 | Brand |
| TLANDO | TESTOSTERONE UNDECANOATE CAP 112.5 MG | 23100030800125 | Brand |
| NATESTO | TESTOSTERONE NASAL GEL 5.5 MG/ACT | 23100030004080 | Brand |
| DEPO-TESTOSTERONE | TESTOSTERONE CYPIONATE IM INJ IN OIL 100 MG/ML | 23100030102010 | Brand |
| TESTOSTERONE CYPIONATE | TESTOSTERONE CYPIONATE IM INJ IN OIL 100 MG/ML | 23100030102010 | Generic |
| DEPO-TESTOSTERONE | TESTOSTERONE CYPIONATE IM INJ IN OIL 200 MG/ML | 23100030102015 | Brand |
| TESTOSTERONE CYPIONATE | TESTOSTERONE CYPIONATE IM INJ IN OIL 200 MG/ML | 23100030102015 | Generic |
| TESTOSTERONE ENANTHATE | TESTOSTERONE ENANTHATE IM INJ IN OIL 200 MG/ML | 23100030202010 | Generic |

**Approval Criteria**

**1** - ONE of the following:

**1.1** 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)

**OR**

**1.2** BOTH of the following:

**1.2.1** Patient has a diagnosis of ONE of the following:

- Hypogonadism
- Gender dysphoria, as defined by the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM)

**AND**

**1.2.2** ONE of the following:

**1.2.2.1** 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**

**1.2.2.2** 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**

**1.2.2.3** BOTH of the following:

**1.2.2.3.1** 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**

**1.2.2.3.2** 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**

**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 inhibitors [e.g., Arimidex (anastrozole), Femara (letrozole), Aromasin (exemestane)]

## 2 . Revision History

| Date | Notes |
|---|---|
| 6/7/2024 | Updated Natesto GPI. Added injectable testosterone agents that were previously open access to clinical review. Updated Initial auth notes and T/F options. Updated reauth criteria. |

Tezspire

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-155266 |
| **Guideline Name** | Tezspire |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 10/1/2024 |

## 1 . Criteria

| Product Name: Tezspire auto-injector pen | |
|---|---|
| Diagnosis | Severe Asthma |
| Approval Length | 6 month(s) |
| Therapy Stage | Initial Authorization - Transitioning from UHC medical benefits |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TEZSPIRE | TEZEPELUMAB-EKKO SUBCUTANEOUS SOLN AUTO-INJ 210 MG/1.91ML | 4460807525D520 | Brand |

**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:

- Anti-interleukin-5 therapy [e.g., Cinqair (resilizumab), 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 | 6 month(s) |
| Therapy Stage | Initial Authorization - Not transitioning from UHC medical benefits |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TEZSPIRE | TEZEPELUMAB-EKKO SUBCUTANEOUS SOLN AUTO-INJ 210 MG/1.91ML | 4460807525D520 | Brand |

**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:

- Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TEZSPIRE | TEZEPELUMAB-EKKO SUBCUTANEOUS SOLN AUTO-INJ 210 MG/1.91ML | 4460807525D520 | Brand |

**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 Respiclick (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:

- Anti-interleukin-5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab), Nucala (mepolizumab)]
- Anti-IgE therapy [e.g., Xolair (omalizumab)]
- Anti-interleukin-4 therapy [e.g., Dupixent (dupilumab)]

## 2 . Revision History

| Date | Notes |
|---|---|
| 9/19/2024 | Modified wording for existing prior authorization for under the medical benefit. |

Thalomid

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-150980 |
| **Guideline Name** | Thalomid |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 8/5/2024 |

## 1 . Criteria

| Product Name: Thalomid | |
|---|---|
| Diagnosis | Multiple Myeloma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| THALOMID | THALIDOMIDE CAP 50 MG | 99392070000120 | Brand |
| THALOMID | THALIDOMIDE CAP 100 MG | 99392070000130 | Brand |
| THALOMID | THALIDOMIDE CAP 150 MG | 99392070000135 | Brand |
| THALOMID | THALIDOMIDE CAP 200 MG | 99392070000140 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| THALOMID | THALIDOMIDE CAP 50 MG | 99392070000120 | Brand |
| THALOMID | THALIDOMIDE CAP 100 MG | 99392070000130 | Brand |
| THALOMID | THALIDOMIDE CAP 150 MG | 99392070000135 | Brand |
| THALOMID | THALIDOMIDE CAP 200 MG | 99392070000140 | Brand |

**Approval Criteria**

**1** - Diagnosis of moderate to severe erythema nodosum leprosum (ENL)

**AND**

**2** - ONE of the following:

**2.1** Used for acute treatment

**OR**

**2.2** Used as maintenance therapy for prevention 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| THALOMID | THALIDOMIDE CAP 50 MG | 99392070000120 | Brand |
| THALOMID | THALIDOMIDE CAP 100 MG | 99392070000130 | Brand |
| THALOMID | THALIDOMIDE CAP 150 MG | 99392070000135 | Brand |
| THALOMID | THALIDOMIDE CAP 200 MG | 99392070000140 | Brand |

**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:

**2.2.1** Therapy is for active idiopathic multicentric CD with no evidence of organ failure

**AND**

**2.2.2** Used in combination with cyclophosphamide and prednisone

**AND**

**2.2.3** Patient is human immunodeficiency virus (HIV)-negative

**AND**

**2.2.4** 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| THALOMID | THALIDOMIDE CAP 50 MG | 99392070000120 | Brand |
| THALOMID | THALIDOMIDE CAP 100 MG | 99392070000130 | Brand |
| THALOMID | THALIDOMIDE CAP 150 MG | 99392070000135 | Brand |
| THALOMID | THALIDOMIDE CAP 200 MG | 99392070000140 | Brand |

**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:

**1.2.1** Diagnosis of AIDS-related Kaposi Sarcoma

**AND**

**1.2.2** 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| THALOMID | THALIDOMIDE CAP 50 MG | 99392070000120 | Brand |
| THALOMID | THALIDOMIDE CAP 100 MG | 99392070000130 | Brand |
| THALOMID | THALIDOMIDE CAP 150 MG | 99392070000135 | Brand |
| THALOMID | THALIDOMIDE CAP 200 MG | 99392070000140 | Brand |

**Approval Criteria**

**1** - Diagnosis of Langerhans cell histiocytosis

**OR**

**2** - Diagnosis of Rosai-Dorfman Disease

| Product Name: Thalomid | |
|---|---|
| Diagnosis | Multiple Myeloma, Castleman Disease (CD), Kaposi Sarcoma, Langerhans Cell Histiocytosis, Rosai-Dorfman Disease |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| THALOMID | THALIDOMIDE CAP 50 MG | 99392070000120 | Brand |
| THALOMID | THALIDOMIDE CAP 100 MG | 99392070000130 | Brand |
| THALOMID | THALIDOMIDE CAP 150 MG | 99392070000135 | Brand |
| THALOMID | THALIDOMIDE CAP 200 MG | 99392070000140 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| THALOMID | THALIDOMIDE CAP 50 MG | 99392070000120 | Brand |
| THALOMID | THALIDOMIDE CAP 100 MG | 99392070000130 | Brand |
| THALOMID | THALIDOMIDE CAP 150 MG | 99392070000135 | Brand |
| THALOMID | THALIDOMIDE CAP 200 MG | 99392070000140 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| THALOMID | THALIDOMIDE CAP 50 MG | 99392070000120 | Brand |
| THALOMID | THALIDOMIDE CAP 100 MG | 99392070000130 | Brand |
| THALOMID | THALIDOMIDE CAP 150 MG | 99392070000135 | Brand |
| THALOMID | THALIDOMIDE CAP 200 MG | 99392070000140 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Thalomid therapy

## 2 . Revision History

| Date | Notes |
|---|---|
| 8/5/2024 | Removed criteria for myelofibrosis-associated anemia. Renamed dia gnosis header from B-Cell Lymphomas to Castleman Disease (CD). Updated criteria for Kaposi sarcoma per NCCN guidance. |

Therapeutic Duplication (Subtype A)

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-162195 |
| **Guideline Name** | Therapeutic Duplication (Subtype A) |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 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, Airsupra, Alvesco, ArmonAir Digihaler, Asmanex Twisthaler, Asmanex HFA, Arnuity Ellipta, Qvar RediHaler, Lonhala Magnair, Trelegy Ellipta, Brand Advair Diskus, generic fluticasone propionate/salmeterol diskus (generic Advair Diskus), generic Wixela Inhub (generic Advair Diskus), AirDuo Respiclick,

fluticasone/salmeterol (authorized generic of AirDuo), Brand Advair HFA, Brand Fluticasone/salmeterol HFA, Brand Symbicort, generic budesonide/formoterol, Breyna, AirDuo Digihaler, Dulera, Breo Ellipta, Brand fluticasone/vilanterol Ellipta, Basaglar Tempo pen, Basaglar Kwikpen, Insulin Glargine Solostar, Lantus Solostar, Toujeo Solostar, Toujeo Max Solostar, Semglee Pen Injector, Insulin Glargine-YFGN pen, Lantus vial, Insulin Glargine vial, Semglee vial, Insulin Glargine-YFGN vial, Levemir vial, Levemir Flextouch, Levemir Flexpen, Tresiba vial, Insulin Degludec vial, Tresiba Flextouch, Insulin Degludec Flextouch, Rezvoglar, Baclofen tabs, generic baclofen suspension, Brand Fleqsuvy, Brand Ozobax DS, brand Ozobax, Brand Baclofen solution, brand Lioresal intrathecal, generic baclofen intrathecal, brand Gablofen intrathecal, baclofen intrathecal solution, Lyvispah, generic carisoprodol tab, brand Soma, brand Vanadom tab, generic chlorzoxazone, brand Lorzone, generic cyclobenzaprine, brand Fexmid, generic cyclobenzaprine ER, brand Amrix, metaxalone, methocarbamol, orphenadrine CR/ER, generic tizanidine caps/tabs, brand Zanaflex caps/tabs, brand Dantrium, generic dantrolene, brand Norgesic, generic orphenadrine/aspirin/caffeine, norgesic forte, orphengesic forte, Brand Neurontin caps/tabs/soln, generic gabapentin caps/tabs/soln, gabapentin tinytabs, brand Lyrica caps/soln, generic pregabalin caps/soln, brand Gralise, brand Lyrica CR, generic pregabalin ER, Horizant, Zorvolex, brand Zipsor, generic diclofenac caps, brand Lofena, generic diclofenac tabs, diclofenac DR/ER, brand Cambia, generic diclofenac packet (migraine), etodolac cap, brand Lodine, generic etodolac tab, etodolac ER, brand Nalfon caps/tabs, generic fenoprofen caps/tabs, flurbiprofen, ibuprofen caps/tabs/chewable (includes All Manufactures), Brand Advil, ibuprofen suspension (40 mg/ml & 100 mg/5ml), indomethacin caps, indomethacin ER/SR caps, indocin susp, indocin suppository, indomethacin suppository, ketoprofen cap, ketoprofen ER cap, ketorolac tabs, meclofenamate cap, mefenamic acid, meloxicam cap/tab, brand Relafen DS, generic nabumetone, generic naproxen tab/susp/caps (includes All Manufactures), brand naprosyn tab/susp, brand Aleve, brand Anaprox DS, brand EC-Naprosyn, generic naproxen DR, generic EC-naproxen, brand Naprelan, generic naproxen CR/ER, Brand Daypro, generic oxaprozin, brand Feldene, generic piroxicam, sulindac, tolmetin, brand Celebrex, generic celecoxib, Elyxyb, brand Arthrotec, generic diclofenac sodium/misoprostol, brand Duexis, generic ibuprofen/famotidine, brand Vimovo, generic naproxen/esomeprazole, brand Advil PM, generic ibuprofen/diphenhydramine, brand Aleve PM, generic naproxen/diphenhydramine, hydrocodone/ibuprofen, brand Treximet, generic sumatriptan/naproxen, Motrin Dual Action/Tylenol, Advil Dual Action/acetaminophen, acetaminophen/ibuprofen, Naproxen/capsaicin cream (Naprotin), Inpefa, Saxenda, Wegovy, 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

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| Diagnosis | DUR: Therapeutic Duplication |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
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| ARFORMOTEROL TARTRATE | ARFORMOTEROL TARTRATE SOLN NEBU 15 MCG/2ML (BASE EQUIV) | 44201012102520 | Generic |
| BROVANA | ARFORMOTEROL TARTRATE SOLN NEBU 15 MCG/2ML (BASE EQUIV) | 44201012102520 | Brand |
| FORMOTEROL FUMARATE | FORMOTEROL FUMARATE SOLN NEBU 20 MCG/2ML | 44201027102520 | Generic |
| PERFOROMIST | FORMOTEROL FUMARATE SOLN NEBU 20 MCG/2ML | 44201027102520 | Brand |
| STRIVERDI RESPIMAT | OLODATEROL HCL INHAL AEROSOL SOLN 2.5 MCG/ACT (BASE EQUIV) | 44201052203410 | Brand |
| SPIRIVA HANDIHALER | TIOTROPIUM BROMIDE MONOHYDRATE INHAL CAP 18 MCG (BASE EQUIV) | 44100080100120 | Brand |
| SPIRIVA RESPIMAT | TIOTROPIUM BROMIDE MONOHYDRATE INHAL AEROSOL 1.25 MCG/ACT | 44100080103410 | Brand |
| SPIRIVA RESPIMAT | TIOTROPIUM BROMIDE MONOHYDRATE INHAL AEROSOL 2.5 MCG/ACT | 44100080103420 | Brand |
| TUDORZA PRESSAIR | ACLIDINIUM BROMIDE AEROSOL POWD BREATH ACTIVATED 400 MCG/ACT | 44100007108020 | Brand |
| IPRATROPIUM BROMIDE | IPRATROPIUM BROMIDE INHAL SOLN 0.02% | 44100030102020 | Generic |
| ATROVENT HFA | IPRATROPIUM BROMIDE HFA INHAL AEROSOL 17 MCG/ACT | 44100030123420 | Brand |
| STIOLTO RESPIMAT | TIOTROPIUM BR-OLODATEROL INHAL AERO SOLN 2.5-2.5 MCG/ACT | 44209902923420 | Brand |
| BEVESPI AEROSPHERE | GLYCOPYRROLATE-FORMOTEROL FUMARATE AEROSOL 9-4.8 MCG/ACT | 44209902543220 | Brand |
| DUAKLIR PRESSAIR | ACLIDINIUM BR-FORMOTEROL FUM AERO POW BR ACT 400-12 MCG/ACT | 44209902268030 | Brand |
| GLYXAMBI | EMPAGLIFLOZIN-LINAGLIPTIN TAB 10-5 MG | 27996502300320 | Brand |
| GLYXAMBI | EMPAGLIFLOZIN-LINAGLIPTIN TAB 25-5 MG | 27996502300330 | Brand |
| STEGLUJAN | ERTUGLIFLOZIN-SITAGLIPTIN TAB 5-100 MG | 27996502350320 | Brand |
| STEGLUJAN | ERTUGLIFLOZIN-SITAGLIPTIN TAB 15-100 MG | 27996502350330 | Brand |

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| QTERN | DAPAGLIFLOZIN-SAXAGLIPTIN TAB 5-5 MG | 27996502200320 | Brand |
| QTERN | DAPAGLIFLOZIN-SAXAGLIPTIN TAB 10-5 MG | 27996502200330 | Brand |
| TRIJARDY XR | EMPAGLIFLOZIN-LINAGLIPTIN-METFORMIN TAB ER 24HR 5-2.5-1000MG | 27996703407510 | Brand |
| TRIJARDY XR | EMPAGLIFLOZIN-LINAGLIPTIN-METFORMIN TAB ER 24HR 10-5-1000 MG | 27996703407520 | Brand |
| TRIJARDY XR | EMPAGLIFLOZIN-LINAGLIP-METFORMIN TAB ER 24HR 12.5-2.5-1000MG | 27996703407530 | Brand |
| TRIJARDY XR | EMPAGLIFLOZIN-LINAGLIPTIN-METFORMIN TAB ER 24HR 25-5-1000 MG | 27996703407540 | Brand |
| BREZTRI AEROSPHERE | BUDESONIDE-GLYCOPYRROLATE-FORMOTEROL AERS 160-9-4.8 MCG/ACT | 44209903303220 | Brand |
| PULMICORT | BUDESONIDE INHALATION SUSP 0.25 MG/2ML | 44400015001830 | Brand |
| BUDESONIDE | BUDESONIDE INHALATION SUSP 0.25 MG/2ML | 44400015001830 | Generic |
| PULMICORT | BUDESONIDE INHALATION SUSP 0.5 MG/2ML | 44400015001840 | Brand |
| BUDESONIDE | BUDESONIDE INHALATION SUSP 0.5 MG/2ML | 44400015001840 | Generic |
| PULMICORT | BUDESONIDE INHALATION SUSP 1 MG/2ML | 44400015001850 | Brand |
| BUDESONIDE | BUDESONIDE INHALATION SUSP 1 MG/2ML | 44400015001850 | Generic |
| ADLYXIN | LIXISENATIDE SOLN PEN-INJECTOR 20 MCG/0.2ML (100 MCG/ML) | 2717005600D230 | Brand |
| VICTOZA | LIRAGLUTIDE SOLN PEN-INJECTOR 18 MG/3ML (6 MG/ML) | 2717005000D220 | Brand |
| TRULICITY | DULAGLUTIDE SOLN PEN-INJECTOR 0.75 MG/0.5ML | 2717001500D520 | Brand |
| TRULICITY | DULAGLUTIDE SOLN PEN-INJECTOR 1.5 MG/0.5ML | 2717001500D530 | Brand |
| TRULICITY | DULAGLUTIDE SOLN PEN-INJECTOR 3 MG/0.5ML | 2717001500D540 | Brand |
| TRULICITY | DULAGLUTIDE SOLN PEN-INJECTOR 4.5 MG/0.5ML | 2717001500D550 | Brand |

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| BYDUREON BCISE | EXENATIDE EXTENDED RELEASE SUSP AUTO-INJECTOR 2 MG/0.85ML | 2717002000D420 | Brand |
| BYETTA | EXENATIDE SOLN PEN-INJECTOR 5 MCG/0.02ML | 2717002000D220 | Brand |
| BYETTA | EXENATIDE SOLN PEN-INJECTOR 10 MCG/0.04ML | 2717002000D240 | Brand |
| OZEMPIC | SEMAGLUTIDE SOLN PEN-INJ 0.25 OR 0.5 MG/DOSE (2 MG/1.5ML) | 2717007000D210 | Brand |
| OZEMPIC | SEMAGLUTIDE SOLN PEN-INJ 0.25 OR 0.5 MG/DOSE (2 MG/3ML) | 2717007000D221 | Brand |
| OZEMPIC | SEMAGLUTIDE SOLN PEN-INJ 1 MG/DOSE (4 MG/3ML) | 2717007000D222 | Brand |
| OZEMPIC | SEMAGLUTIDE SOLN PEN-INJ 2 MG/DOSE (8 MG/3ML) | 2717007000D225 | Brand |
| RYBELSUS | SEMAGLUTIDE TAB 3 MG | 27170070000310 | Brand |
| RYBELSUS | SEMAGLUTIDE TAB 7 MG | 27170070000320 | Brand |
| RYBELSUS | SEMAGLUTIDE TAB 14 MG | 27170070000330 | Brand |
| JANUVIA | SITAGLIPTIN PHOSPHATE TAB 25 MG (BASE EQUIV) | 27550070100320 | Brand |
| JANUVIA | SITAGLIPTIN PHOSPHATE TAB 50 MG (BASE EQUIV) | 27550070100330 | Brand |
| JANUVIA | SITAGLIPTIN PHOSPHATE TAB 100 MG (BASE EQUIV) | 27550070100340 | Brand |
| JANUMET | SITAGLIPTIN-METFORMIN HCL TAB 50-500 MG | 27992502700320 | Brand |
| JANUMET | SITAGLIPTIN-METFORMIN HCL TAB 50-1000 MG | 27992502700340 | Brand |
| JANUMET XR | SITAGLIPTIN-METFORMIN HCL TAB ER 24HR 50-500 MG | 27992502707520 | Brand |
| JANUMET XR | SITAGLIPTIN-METFORMIN HCL TAB ER 24HR 50-1000 MG | 27992502707530 | Brand |
| JANUMET XR | SITAGLIPTIN-METFORMIN HCL TAB ER 24HR 100-1000 MG | 27992502707540 | Brand |
| ONGLYZA | SAXAGLIPTIN HCL TAB 2.5 MG (BASE EQUIV) | 27550065100320 | Brand |
| ONGLYZA | SAXAGLIPTIN HCL TAB 5 MG (BASE EQUIV) | 27550065100330 | Brand |
| KOMBIGLYZE XR | SAXAGLIPTIN-METFORMIN HCL TAB ER 24HR 2.5-1000 MG | 27992502607520 | Brand |

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| KOMBIGLYZE XR | SAXAGLIPTIN-METFORMIN HCL TAB ER 24HR 5-500 MG | 27992502607530 | Brand |
| KOMBIGLYZE XR | SAXAGLIPTIN-METFORMIN HCL TAB ER 24HR 5-1000 MG | 27992502607540 | Brand |
| TRADJENTA | LINAGLIPTIN TAB 5 MG | 27550050000320 | Brand |
| JENTADUETO | LINAGLIPTIN-METFORMIN HCL TAB 2.5-500 MG | 27992502400320 | Brand |
| JENTADUETO | LINAGLIPTIN-METFORMIN HCL TAB 2.5-850 MG | 27992502400330 | Brand |
| JENTADUETO | LINAGLIPTIN-METFORMIN HCL TAB 2.5-1000 MG | 27992502400340 | Brand |
| JENTADUETO XR | LINAGLIPTIN-METFORMIN HCL TAB ER 24HR 2.5-1000 MG | 27992502407520 | Brand |
| JENTADUETO XR | LINAGLIPTIN-METFORMIN HCL TAB ER 24HR 5-1000 MG | 27992502407530 | Brand |
| ALOGLIPTIN | ALOGLIPTIN BENZOATE TAB 6.25 MG (BASE EQUIV) | 27550010100310 | Generic |
| NESINA | ALOGLIPTIN BENZOATE TAB 6.25 MG (BASE EQUIV) | 27550010100310 | Generic |
| ALOGLIPTIN | ALOGLIPTIN BENZOATE TAB 12.5 MG (BASE EQUIV) | 27550010100320 | Generic |
| NESINA | ALOGLIPTIN BENZOATE TAB 12.5 MG (BASE EQUIV) | 27550010100320 | Generic |
| ALOGLIPTIN | ALOGLIPTIN BENZOATE TAB 25 MG (BASE EQUIV) | 27550010100330 | Generic |
| NESINA | ALOGLIPTIN BENZOATE TAB 25 MG (BASE EQUIV) | 27550010100330 | Generic |
| ALOGLIPTIN/METFORMIN HCL | ALOGLIPTIN-METFORMIN HCL TAB 12.5-500 MG | 27992502100320 | Generic |
| KAZANO | ALOGLIPTIN-METFORMIN HCL TAB 12.5-500 MG | 27992502100320 | Generic |
| ALOGLIPTIN/METFORMIN HYDROCHLORIDE | ALOGLIPTIN-METFORMIN HCL TAB 12.5-1000 MG | 27992502100330 | Generic |
| KAZANO | ALOGLIPTIN-METFORMIN HCL TAB 12.5-1000 MG | 27992502100330 | Generic |
| OSENI | ALOGLIPTIN-PIOGLITAZONE TAB 12.5-15 MG | 27994002100320 | Brand |
| ALOGLIPTIN/PIOGLITAZONE | ALOGLIPTIN-PIOGLITAZONE TAB 12.5-30 MG | 27994002100325 | Generic |

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| OSENI | ALOGLIPTIN-PIOGLITAZONE TAB 12.5-30 MG | 27994002100325 | Generic |
| ALOGLIPTIN/PIOGLITAZONE | ALOGLIPTIN-PIOGLITAZONE TAB 12.5-45 MG | 27994002100330 | Generic |
| OSENI | ALOGLIPTIN-PIOGLITAZONE TAB 12.5-45 MG | 27994002100330 | Generic |
| ALOGLIPTIN/PIOGLITAZONE | ALOGLIPTIN-PIOGLITAZONE TAB 25-15 MG | 27994002100340 | Generic |
| OSENI | ALOGLIPTIN-PIOGLITAZONE TAB 25-15 MG | 27994002100340 | Generic |
| ALOGLIPTIN/PIOGLITAZONE | ALOGLIPTIN-PIOGLITAZONE TAB 25-30 MG | 27994002100345 | Generic |
| OSENI | ALOGLIPTIN-PIOGLITAZONE TAB 25-30 MG | 27994002100345 | Generic |
| ALOGLIPTIN/PIOGLITAZONE | ALOGLIPTIN-PIOGLITAZONE TAB 25-45 MG | 27994002100350 | Generic |
| OSENI | ALOGLIPTIN-PIOGLITAZONE TAB 25-45 MG | 27994002100350 | Generic |
| MOUNJARO | TIRZEPATIDE SOLN PEN-INJECTOR 2.5 MG/0.5ML | 2717308000D510 | Brand |
| MOUNJARO | TIRZEPATIDE SOLN PEN-INJECTOR 5 MG/0.5ML | 2717308000D515 | Brand |
| MOUNJARO | TIRZEPATIDE SOLN PEN-INJECTOR 7.5 MG/0.5ML | 2717308000D520 | Brand |
| MOUNJARO | TIRZEPATIDE SOLN PEN-INJECTOR 10 MG/0.5ML | 2717308000D525 | Brand |
| MOUNJARO | TIRZEPATIDE SOLN PEN-INJECTOR 12.5 MG/0.5ML | 2717308000D530 | Brand |
| MOUNJARO | TIRZEPATIDE SOLN PEN-INJECTOR 15 MG/0.5ML | 2717308000D535 | Brand |
| XULTOPHY 100/3.6 | INSULIN DEGLUDEC-LIRAGLUTIDE SOL PEN-INJ 100-3.6 UNIT-MG/ML | 2799100225D220 | Brand |
| SOLIQUA 100/33 | INSULIN GLARGINE-LIXISENATIDE SOL PEN-INJ 100-33 UNIT-MCG/ML | 2799100235D220 | Brand |
| INVOKANA | CANAGLIFLOZIN TAB 100 MG | 27700020000320 | Brand |

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| INVOKANA | CANAGLIFLOZIN TAB 300 MG | 27700020000330 | Brand |
| FARXIGA | DAPAGLIFLOZIN PROPANEDIOL TAB 5 MG (BASE EQUIVALENT) | 27700040200310 | Brand |
| FARXIGA | DAPAGLIFLOZIN PROPANEDIOL TAB 10 MG (BASE EQUIVALENT) | 27700040200320 | Brand |
| JARDIANCE | EMPAGLIFLOZIN TAB 10 MG | 27700050000310 | Brand |
| JARDIANCE | EMPAGLIFLOZIN TAB 25 MG | 27700050000320 | Brand |
| INVOKAMET | CANAGLIFLOZIN-METFORMIN HCL TAB 50-500 MG | 27996002200320 | Brand |
| INVOKAMET | CANAGLIFLOZIN-METFORMIN HCL TAB 50-1000 MG | 27996002200330 | Brand |
| INVOKAMET | CANAGLIFLOZIN-METFORMIN HCL TAB 150-500 MG | 27996002200340 | Brand |
| INVOKAMET | CANAGLIFLOZIN-METFORMIN HCL TAB 150-1000 MG | 27996002200350 | Brand |
| INVOKAMET XR | CANAGLIFLOZIN-METFORMIN HCL TAB ER 24HR 50-500 MG | 27996002207520 | Brand |
| INVOKAMET XR | CANAGLIFLOZIN-METFORMIN HCL TAB ER 24HR 50-1000 MG | 27996002207530 | Brand |
| INVOKAMET XR | CANAGLIFLOZIN-METFORMIN HCL TAB ER 24HR 150-500 MG | 27996002207540 | Brand |
| INVOKAMET XR | CANAGLIFLOZIN-METFORMIN HCL TAB ER 24HR 150-1000 MG | 27996002207550 | Brand |
| SYNJARDY | EMPAGLIFLOZIN-METFORMIN HCL TAB 5-500 MG | 27996002400310 | Brand |
| SYNJARDY | EMPAGLIFLOZIN-METFORMIN HCL TAB 5-1000 MG | 27996002400315 | Brand |
| SYNJARDY | EMPAGLIFLOZIN-METFORMIN HCL TAB 12.5-500 MG | 27996002400320 | Brand |
| SYNJARDY | EMPAGLIFLOZIN-METFORMIN HCL TAB 12.5-1000 MG | 27996002400325 | Brand |

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| SYNJARDY XR | EMPAGLIFLOZIN-METFORMIN HCL TAB ER 24HR 5-1000 MG | 27996002407530 | Brand |
| SYNJARDY XR | EMPAGLIFLOZIN-METFORMIN HCL TAB ER 24HR 10-1000 MG | 27996002407540 | Brand |
| SYNJARDY XR | EMPAGLIFLOZIN-METFORMIN HCL TAB ER 24HR 12.5-1000 MG | 27996002407550 | Brand |
| SYNJARDY XR | EMPAGLIFLOZIN-METFORMIN HCL TAB ER 24HR 25-1000 MG | 27996002407560 | Brand |
| STEGLATRO | ERTUGLIFLOZIN L-PYROGLUTAMIC ACID TAB 5 MG (BASE EQUIV) | 27700055200320 | Brand |
| STEGLATRO | ERTUGLIFLOZIN L-PYROGLUTAMIC ACID TAB 15 MG (BASE EQUIV) | 27700055200340 | Brand |
| SEGLUROMET | ERTUGLIFLOZIN-METFORMIN HCL TAB 2.5-500 MG | 27996002450310 | Brand |
| SEGLUROMET | ERTUGLIFLOZIN-METFORMIN HCL TAB 2.5-1000 MG | 27996002450320 | Brand |
| SEGLUROMET | ERTUGLIFLOZIN-METFORMIN HCL TAB 7.5-500 MG | 27996002450330 | Brand |
| SEGLUROMET | ERTUGLIFLOZIN-METFORMIN HCL TAB 7.5-1000 MG | 27996002450340 | Brand |
| FLOVENT HFA | FLUTICASONE PROPIONATE HFA INHAL AERO 44 MCG/ACT (50/VALVE) | 44400033223220 | Generic |
| FLOVENT HFA | FLUTICASONE PROPIONATE HFA INHAL AER 110 MCG/ACT (125/VALVE) | 44400033223230 | Generic |
| FLOVENT HFA | FLUTICASONE PROPIONATE HFA INHAL AER 220 MCG/ACT (250/VALVE) | 44400033223240 | Generic |
| FLOVENT DISKUS | FLUTICASONE PROPIONATE AER POW BA 50 MCG/ACT | 44400033208010 | Brand |
| FLOVENT DISKUS | FLUTICASONE PROPIONATE AER POW BA 100 MCG/ACT | 44400033208020 | Brand |

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| FLOVENT DISKUS | FLUTICASONE PROPIONATE AER POW BA 250 MCG/ACT | 44400033208030 | Brand |
| ALVESCO | CICLESONIDE INHAL AEROSOL 80 MCG/ACT | 44400017003420 | Brand |
| ALVESCO | CICLESONIDE INHAL AEROSOL 160 MCG/ACT | 44400017003440 | Brand |
| ARMONAIR DIGIHALER | FLUTICASONE PROPIONATE AER POW BA 55 MCG/ACT WITH SENSOR | 44400033218020 | Brand |
| ARMONAIR DIGIHALER | FLUTICASONE PROPIONATE AER POW BA 113 MCG/ACT WITH SENSOR | 44400033218030 | Brand |
| ARMONAIR DIGIHALER | FLUTICASONE PROPIONATE AER POW BA 232 MCG/ACT WITH SENSOR | 44400033218040 | Brand |
| ASMANEX HFA | MOMETASONE FUROATE INHAL AEROSOL SUSPENSION 50 MCG/ACT | 44400036203210 | Brand |
| ASMANEX HFA | MOMETASONE FUROATE INHAL AEROSOL SUSPENSION 100 MCG/ACT | 44400036203220 | Brand |
| ASMANEX HFA | MOMETASONE FUROATE INHAL AEROSOL SUSPENSION 200 MCG/ACT | 44400036203230 | Brand |
| ASMANEX TWISTHALER 30 METERED DOSES | MOMETASONE FUROATE INHAL POWD 110 MCG/ACT (BREATH ACTIVATED) | 44400036208010 | Brand |
| ASMANEX TWISTHALER 120 METERED DOSES | MOMETASONE FUROATE INHAL POWD 220 MCG/ACT (BREATH ACTIVATED) | 44400036208020 | Brand |
| ASMANEX TWISTHALER 14 METERED DOSES | MOMETASONE FUROATE INHAL POWD 220 MCG/ACT (BREATH ACTIVATED) | 44400036208020 | Brand |
| ASMANEX TWISTHALER 30 METERED DOSES | MOMETASONE FUROATE INHAL POWD 220 MCG/ACT (BREATH ACTIVATED) | 44400036208020 | Brand |
| ASMANEX TWISTHALER 60 METERED DOSES | MOMETASONE FUROATE INHAL POWD 220 MCG/ACT (BREATH ACTIVATED) | 44400036208020 | Brand |
| ARNUITY ELLIPTA | FLUTICASONE FUROATE AEROSOL POWDER BREATH ACTIV 50 MCG/ACT | 44400033108010 | Brand |

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| ARNUITY ELLIPTA | FLUTICASONE FUROATE AEROSOL POWDER BREATH ACTIV 100 MCG/ACT | 44400033108020 | Brand |
| ARNUITY ELLIPTA | FLUTICASONE FUROATE AEROSOL POWDER BREATH ACTIV 200 MCG/ACT | 44400033108030 | Brand |
| QVAR REDIHALER | BECLOMETHASONE DIPROP HFA BREATH ACT INH AER 40 MCG/ACT | 44400010128120 | Brand |
| QVAR REDIHALER | BECLOMETHASONE DIPROP HFA BREATH ACT INH AER 80 MCG/ACT | 44400010128140 | Brand |
| LONHALA MAGNAIR REFILL KIT | GLYCOPYRROLATE INHAL SOLUTION 25 MCG/ML | 44100020102030 | Brand |
| LONHALA MAGNAIR STARTER KIT | GLYCOPYRROLATE INHAL SOLUTION 25 MCG/ML | 44100020102030 | Brand |
| TRELEGY ELLIPTA | FLUTICASONE-UMECLIDINIUM-VILANTEROL AEPB 100-62.5-25 MCG/ACT | 44209903408020 | Brand |
| TRELEGY ELLIPTA | FLUTICASONE-UMECLIDINIUM-VILANTEROL AEPB 200-62.5-25 MCG/ACT | 44209903408040 | Brand |
| AIRDUO RESPICLICK 55/14 | FLUTICASONE-SALMETEROL AER POWDER BA 55-14 MCG/ACT | 44209902708010 | Generic |
| FLUTICASONE PROPIONATE/SALMETEROL | FLUTICASONE-SALMETEROL AER POWDER BA 55-14 MCG/ACT | 44209902708010 | Generic |
| AIRDUO RESPICLICK 113/14 | FLUTICASONE-SALMETEROL AER POWDER BA 113-14 MCG/ACT | 44209902708015 | Generic |
| FLUTICASONE PROPIONATE/SALMETEROL | FLUTICASONE-SALMETEROL AER POWDER BA 113-14 MCG/ACT | 44209902708015 | Generic |
| ADVAIR DISKUS | FLUTICASONE-SALMETEROL AER POWDER BA 100-50 MCG/ACT | 44209902708020 | Brand |
| FLUTICASONE PROPIONATE/SALMETEROL | FLUTICASONE-SALMETEROL AER POWDER BA 100-50 MCG/ACT | 44209902708020 | Generic |

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| FLUTICASONE PROPIONATE/SALMETEROL DISKUS | FLUTICASONE-SALMETEROL AER POWDER BA 100-50 MCG/ACT | 44209902708020 | Generic |
| WIXELA INHUB | FLUTICASONE-SALMETEROL AER POWDER BA 100-50 MCG/ACT | 44209902708020 | Generic |
| AIRDUO RESPICLICK 232/14 | FLUTICASONE-SALMETEROL AER POWDER BA 232-14 MCG/ACT | 44209902708025 | Generic |
| FLUTICASONE PROPIONATE/SALMETEROL | FLUTICASONE-SALMETEROL AER POWDER BA 232-14 MCG/ACT | 44209902708025 | Generic |
| ADVAIR DISKUS | FLUTICASONE-SALMETEROL AER POWDER BA 250-50 MCG/ACT | 44209902708030 | Brand |
| FLUTICASONE PROPIONATE/SALMETEROL | FLUTICASONE-SALMETEROL AER POWDER BA 250-50 MCG/ACT | 44209902708030 | Generic |
| FLUTICASONE PROPIONATE/SALMETEROL DISKUS | FLUTICASONE-SALMETEROL AER POWDER BA 250-50 MCG/ACT | 44209902708030 | Generic |
| WIXELA INHUB | FLUTICASONE-SALMETEROL AER POWDER BA 250-50 MCG/ACT | 44209902708030 | Generic |
| ADVAIR DISKUS | FLUTICASONE-SALMETEROL AER POWDER BA 500-50 MCG/ACT | 44209902708040 | Brand |
| FLUTICASONE PROPIONATE/SALMETEROL | FLUTICASONE-SALMETEROL AER POWDER BA 500-50 MCG/ACT | 44209902708040 | Generic |
| FLUTICASONE PROPIONATE/SALMETEROL DISKUS | FLUTICASONE-SALMETEROL AER POWDER BA 500-50 MCG/ACT | 44209902708040 | Generic |
| WIXELA INHUB | FLUTICASONE-SALMETEROL AER POWDER BA 500-50 MCG/ACT | 44209902708040 | Generic |
| BUDESONIDE/FORMOTEROL FUMARATE DIHYDRATE | BUDESONIDE-FORMOTEROL FUMARATE DIHYD AEROSOL 80-4.5 MCG/ACT | 44209902413220 | Generic |

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| BUDESONIDE/FORMOTEROL FUMARATE DIHYDRATE | BUDESONIDE-FORMOTEROL FUMARATE DIHYD AEROSOL 160-4.5 MCG/ACT | 44209902413240 | Generic |
| AIRDUO DIGIHALER 55/14 | FLUTICASONE-SALMETEROL AER POWDER BA 55-14 MCG/ACT W/ SENSOR | 44209902718020 | Brand |
| AIRDUO DIGIHALER 113/14 | FLUTICASONE-SALMETEROL AER POWDER BA 113-14 MCG/ACT W/SENSOR | 44209902718030 | Brand |
| AIRDUO DIGIHALER 232/14 | FLUTICASONE-SALMETEROL AER POWDER BA 232-14 MCG/ACT W/SENSOR | 44209902718040 | Brand |
| DULERA | MOMETASONE FUROATE-FORMOTEROL FUMARATE AEROSOL 50-5 MCG/ACT | 44209902903210 | Brand |
| DULERA | MOMETASONE FUROATE-FORMOTEROL FUMARATE AEROSOL 100-5 MCG/ACT | 44209902903220 | Brand |
| DULERA | MOMETASONE FUROATE-FORMOTEROL FUMARATE AEROSOL 200-5 MCG/ACT | 44209902903240 | Brand |
| BREO ELLIPTA | FLUTICASONE FUROATE-VILANTEROL AERO POWD BA 100-25 MCG/ACT | 44209902758020 | Generic |
| FLUTICASONE FUROATE/VILANTEROL ELLIPTA | FLUTICASONE FUROATE-VILANTEROL AERO POWD BA 100-25 MCG/ACT | 44209902758020 | Generic |
| BREO ELLIPTA | FLUTICASONE FUROATE-VILANTEROL AERO POWD BA 200-25 MCG/ACT | 44209902758030 | Generic |
| FLUTICASONE FUROATE/VILANTEROL ELLIPTA | FLUTICASONE FUROATE-VILANTEROL AERO POWD BA 200-25 MCG/ACT | 44209902758030 | Generic |
| BASAGLAR TEMPO PEN | INSULIN GLARGINE PEN-INJ WITH TRANSMITTER PORT 100 UNIT/ML | 2710400300D222 | Brand |
| BASAGLAR KWIKPEN | INSULIN GLARGINE SOLN PEN-INJECTOR 100 UNIT/ML | 2710400300D220 | Brand |
| INSULIN GLARGINE SOLOSTAR | INSULIN GLARGINE SOLN PEN-INJECTOR 100 UNIT/ML | 2710400300D220 | Brand |
| LANTUS SOLOSTAR | INSULIN GLARGINE SOLN PEN-INJECTOR 100 UNIT/ML | 2710400300D220 | Brand |

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| TOUJEO SOLOSTAR | INSULIN GLARGINE SOLN PEN-INJECTOR 300 UNIT/ML (1 UNIT DIAL) | 2710400300D233 | Brand |
| TOUJEO MAX SOLOSTAR | INSULIN GLARGINE SOLN PEN-INJECTOR 300 UNIT/ML (2 UNIT DIAL) | 2710400300D236 | Brand |
| INSULIN GLARGINE | INSULIN GLARGINE-YFGN SOLN PEN-INJECTOR 100 UNIT/ML | 2710400390D220 | Brand |
| SEMGLEE | INSULIN GLARGINE-YFGN SOLN PEN-INJECTOR 100 UNIT/ML | 2710400390D220 | Brand |
| INSULIN GLARGINE | INSULIN GLARGINE INJ 100 UNIT/ML | 27104003002020 | Brand |
| LANTUS | INSULIN GLARGINE INJ 100 UNIT/ML | 27104003002020 | Brand |
| SEMGLEE | INSULIN GLARGINE INJ 100 UNIT/ML | 27104003002020 | Brand |
| SEMGLEE | INSULIN GLARGINE-YFGN INJ 100 UNIT/ML | 27104003902020 | Brand |
| LEVEMIR | INSULIN DETEMIR INJ 100 UNIT/ML | 27104006002020 | Brand |
| LEVEMIR FLEXPEN | INSULIN DETEMIR SOLN PEN-INJECTOR 100 UNIT/ML | 2710400600D220 | Brand |
| LEVEMIR FLEXTOUCH | INSULIN DETEMIR SOLN PEN-INJECTOR 100 UNIT/ML | 2710400600D220 | Brand |
| INSULIN DEGLUDEC | INSULIN DEGLUDEC INJ 100 UNIT/ML | 27104007002020 | Brand |
| TRESIBA | INSULIN DEGLUDEC INJ 100 UNIT/ML | 27104007002020 | Brand |
| INSULIN DEGLUDEC FLEXTOUCH | INSULIN DEGLUDEC SOLN PEN-INJECTOR 100 UNIT/ML | 2710400700D210 | Brand |
| TRESIBA FLEXTOUCH | INSULIN DEGLUDEC SOLN PEN-INJECTOR 100 UNIT/ML | 2710400700D210 | Brand |
| INSULIN DEGLUDEC FLEXTOUCH | INSULIN DEGLUDEC SOLN PEN-INJECTOR 200 UNIT/ML | 2710400700D220 | Brand |
| TRESIBA FLEXTOUCH | INSULIN DEGLUDEC SOLN PEN-INJECTOR 200 UNIT/ML | 2710400700D220 | Brand |
| REZVOGLAR KWIKPEN | INSULIN GLARGINE-AGLR SOLN PEN-INJECTOR 100 UNIT/ML | 2710400305D220 | Brand |
| BACLOFEN | BACLOFEN TAB 5 MG | 75100010000303 | Generic |

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| BACLOFEN | BACLOFEN TAB 10 MG | 75100010000305 | Generic |
| BACLOFEN | BACLOFEN TAB 20 MG | 75100010000310 | Generic |
| BACLOFEN | BACLOFEN SUSP 25 MG/5ML | 75100010001825 | Generic |
| LIORESAL INTRATHECAL | BACLOFEN INTRATHECAL INJ 0.05 MG/ML (50 MCG/ML) | 75100010002020 | Brand |
| BACLOFEN | BACLOFEN INTRATHECAL INJ 10 MG/20ML (500 MCG/ML) | 75100010002034 | Generic |
| GABLOFEN | BACLOFEN INTRATHECAL INJ 10 MG/20ML (500 MCG/ML) | 75100010002034 | Brand |
| LIORESAL INTRATHECAL | BACLOFEN INTRATHECAL INJ 10 MG/20ML (500 MCG/ML) | 75100010002034 | Brand |
| BACLOFEN | BACLOFEN INTRATHECAL INJ 20 MG/20ML (1000 MCG/ML) | 75100010002039 | Generic |
| GABLOFEN | BACLOFEN INTRATHECAL INJ 20 MG/20ML (1000 MCG/ML) | 75100010002039 | Brand |
| LIORESAL INTRATHECAL | BACLOFEN INTRATHECAL INJ 10 MG/5ML (2000 MCG/ML) | 75100010002046 | Brand |
| BACLOFEN | BACLOFEN INTRATHECAL INJ 40 MG/20ML (2000 MCG/ML) | 75100010002050 | Generic |
| GABLOFEN | BACLOFEN INTRATHECAL INJ 40 MG/20ML (2000 MCG/ML) | 75100010002050 | Brand |
| LIORESAL INTRATHECAL | BACLOFEN INTRATHECAL INJ 40 MG/20ML (2000 MCG/ML) | 75100010002050 | Brand |
| BACLOFEN | BACLOFEN ORAL SOLN 5 MG/5ML | 75100010002070 | Generic |
| OZOBAX | BACLOFEN ORAL SOLN 5 MG/5ML | 75100010002070 | Generic |
| LYVISPAH | BACLOFEN GRANULES PACKET 5 MG | 75100010003010 | Brand |
| LYVISPAH | BACLOFEN GRANULES PACKET 10 MG | 75100010003020 | Brand |
| LYVISPAH | BACLOFEN GRANULES PACKET 20 MG | 75100010003030 | Brand |
| CARISOPRODOL | CARISOPRODOL TAB 250 MG | 75100020000304 | Generic |

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| SOMA | CARISOPRODOL TAB 250 MG | 75100020000304 | Brand |
| CARISOPRODOL | CARISOPRODOL TAB 350 MG | 75100020000305 | Generic |
| SOMA | CARISOPRODOL TAB 350 MG | 75100020000305 | Brand |
| VANADOM | CARISOPRODOL TAB 350 MG | 75100020000305 | Brand |
| CHLORZOXAZONE | CHLORZOXAZONE TAB 250 MG | 75100040000305 | Generic |
| CHLORZOXAZONE | CHLORZOXAZONE TAB 375 MG | 75100040000307 | Generic |
| LORZONE | CHLORZOXAZONE TAB 375 MG | 75100040000307 | Brand |
| CHLORZOXAZONE | CHLORZOXAZONE TAB 500 MG | 75100040000310 | Generic |
| CHLORZOXAZONE | CHLORZOXAZONE TAB 750 MG | 75100040000320 | Generic |
| LORZONE | CHLORZOXAZONE TAB 750 MG | 75100040000320 | Brand |
| CYCLOBENZAPRINE HYDROCHLORIDE | CYCLOBENZAPRINE HCL TAB 5 MG | 75100050100303 | Generic |
| CYCLOBENZAPRINE HYDROCHLORIDE | CYCLOBENZAPRINE HCL TAB 7.5 MG | 75100050100304 | Generic |
| FEXMID | CYCLOBENZAPRINE HCL TAB 7.5 MG | 75100050100304 | Brand |
| CYCLOBENZAPRINE HYDROCHLORIDE | CYCLOBENZAPRINE HCL TAB 10 MG | 75100050100305 | Generic |
| AMRIX | CYCLOBENZAPRINE HCL CAP ER 24HR 15 MG | 75100050107015 | Brand |
| CYCLOBENZAPRINE HYDROCHLORIDE ER | CYCLOBENZAPRINE HCL CAP ER 24HR 15 MG | 75100050107015 | Generic |
| AMRIX | CYCLOBENZAPRINE HCL CAP ER 24HR 30 MG | 75100050107030 | Brand |
| CYCLOBENZAPRINE HYDROCHLORIDE ER | CYCLOBENZAPRINE HCL CAP ER 24HR 30 MG | 75100050107030 | Generic |
| METAXALONE | METAXALONE TAB 400 MG | 75100060000310 | Generic |
| METAXALONE | METAXALONE TAB 800 MG | 75100060000320 | Generic |
| METHOCARBAMOL | METHOCARBAMOL TAB 500 MG | 75100070000305 | Generic |
| METHOCARBAMOL | METHOCARBAMOL TAB 750 MG | 75100070000310 | Generic |
| METHOCARBAMOL | METHOCARBAMOL TAB 1000 MG | 75100070000320 | Generic |

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| ORPHENADRINE CITRATE CR | ORPHENADRINE CITRATE TAB ER 12HR 100 MG | 75100080107410 | Generic |
| ORPHENADRINE CITRATE ER | ORPHENADRINE CITRATE TAB ER 12HR 100 MG | 75100080107410 | Generic |
| TIZANIDINE HCL | TIZANIDINE HCL CAP 2 MG (BASE EQUIVALENT) | 75100090100110 | Generic |
| ZANAFLEX | TIZANIDINE HCL CAP 2 MG (BASE EQUIVALENT) | 75100090100110 | Brand |
| TIZANIDINE HCL | TIZANIDINE HCL CAP 4 MG (BASE EQUIVALENT) | 75100090100120 | Generic |
| ZANAFLEX | TIZANIDINE HCL CAP 4 MG (BASE EQUIVALENT) | 75100090100120 | Brand |
| TIZANIDINE HCL | TIZANIDINE HCL CAP 6 MG (BASE EQUIVALENT) | 75100090100130 | Generic |
| ZANAFLEX | TIZANIDINE HCL CAP 6 MG (BASE EQUIVALENT) | 75100090100130 | Brand |
| TIZANIDINE HCL | TIZANIDINE HCL TAB 2 MG (BASE EQUIVALENT) | 75100090100310 | Generic |
| TIZANIDINE HYDROCHLORIDE | TIZANIDINE HCL TAB 4 MG (BASE EQUIVALENT) | 75100090100320 | Generic |
| ZANAFLEX | TIZANIDINE HCL TAB 4 MG (BASE EQUIVALENT) | 75100090100320 | Brand |
| DANTRIUM | DANTROLENE SODIUM CAP 25 MG | 75200010100105 | Brand |
| DANTROLENE SODIUM | DANTROLENE SODIUM CAP 25 MG | 75200010100105 | Generic |
| DANTROLENE SODIUM | DANTROLENE SODIUM CAP 50 MG | 75200010100110 | Generic |
| DANTROLENE SODIUM | DANTROLENE SODIUM CAP 100 MG | 75200010100115 | Generic |
| NORGESIC | ORPHENADRINE W/ ASPIRIN & CAFFEINE TAB 25-385-30 MG | 75990003200310 | Brand |
| ORPHENADRINE/ASPIRIN/CAFFEINE | ORPHENADRINE W/ ASPIRIN & CAFFEINE TAB 25-385-30 MG | 75990003200310 | Generic |
| NORGESIC FORTE | ORPHENADRINE W/ ASPIRIN & CAFFEINE TAB 50-770-60 MG | 75990003200320 | Generic |
| ORPHENGESIC FORTE | ORPHENADRINE W/ ASPIRIN & CAFFEINE TAB 50-770-60 MG | 75990003200320 | Generic |
| GABAPENTIN | GABAPENTIN CAP 100 MG | 72600030000110 | Generic |
| NEURONTIN | GABAPENTIN CAP 100 MG | 72600030000110 | Brand |
| GABAPENTIN | GABAPENTIN CAP 300 MG | 72600030000130 | Generic |

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| NEURONTIN | GABAPENTIN CAP 300 MG | 72600030000130 | Brand |
| GABAPENTIN | GABAPENTIN CAP 400 MG | 72600030000140 | Generic |
| NEURONTIN | GABAPENTIN CAP 400 MG | 72600030000140 | Brand |
| GABAPENTIN TINYTABS | GABAPENTIN TAB 25 MG | 72600030000303 | Brand |
| GABAPENTIN TINYTABS | GABAPENTIN TAB 50 MG | 72600030000305 | Brand |
| GABAPENTIN | GABAPENTIN TAB 600 MG | 72600030000330 | Generic |
| NEURONTIN | GABAPENTIN TAB 600 MG | 72600030000330 | Brand |
| GABAPENTIN | GABAPENTIN TAB 800 MG | 72600030000340 | Generic |
| NEURONTIN | GABAPENTIN TAB 800 MG | 72600030000340 | Brand |
| GABAPENTIN | GABAPENTIN ORAL SOLN 250 MG/5ML | 72600030002020 | Generic |
| NEURONTIN | GABAPENTIN ORAL SOLN 250 MG/5ML | 72600030002020 | Brand |
| LYRICA | PREGABALIN CAP 25 MG | 72600057000110 | Brand |
| PREGABALIN | PREGABALIN CAP 25 MG | 72600057000110 | Generic |
| LYRICA | PREGABALIN CAP 50 MG | 72600057000115 | Brand |
| PREGABALIN | PREGABALIN CAP 50 MG | 72600057000115 | Generic |
| LYRICA | PREGABALIN CAP 75 MG | 72600057000120 | Brand |
| PREGABALIN | PREGABALIN CAP 75 MG | 72600057000120 | Generic |
| LYRICA | PREGABALIN CAP 100 MG | 72600057000125 | Brand |
| PREGABALIN | PREGABALIN CAP 100 MG | 72600057000125 | Generic |
| LYRICA | PREGABALIN CAP 150 MG | 72600057000135 | Brand |
| PREGABALIN | PREGABALIN CAP 150 MG | 72600057000135 | Generic |
| LYRICA | PREGABALIN CAP 200 MG | 72600057000145 | Brand |
| PREGABALIN | PREGABALIN CAP 200 MG | 72600057000145 | Generic |
| LYRICA | PREGABALIN CAP 225 MG | 72600057000150 | Brand |
| PREGABALIN | PREGABALIN CAP 225 MG | 72600057000150 | Generic |
| LYRICA | PREGABALIN CAP 300 MG | 72600057000160 | Brand |
| PREGABALIN | PREGABALIN CAP 300 MG | 72600057000160 | Generic |
| LYRICA | PREGABALIN SOLN 20 MG/ML | 72600057002020 | Brand |
| PREGABALIN | PREGABALIN SOLN 20 MG/ML | 72600057002020 | Generic |
| GRALISE | GABAPENTIN (ONCE-DAILY) TAB 300 MG | 62540030000320 | Brand |

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| GRALISE | GABAPENTIN (ONCE-DAILY) TAB 450 MG | 62540030000325 | Brand |
| GRALISE | GABAPENTIN (ONCE-DAILY) TAB 600 MG | 62540030000330 | Brand |
| GRALISE | GABAPENTIN (ONCE-DAILY) TAB 750 MG | 62540030000345 | Brand |
| GRALISE | GABAPENTIN (ONCE-DAILY) TAB 900 MG | 62540030000360 | Brand |
| GRALISE | GABAPENTIN (ONCE-DAILY) TAB PACK 300 MG (9) & 600 MG (24) | 62540030006330 | Brand |
| LYRICA CR | PREGABALIN TAB ER 24HR 82.5 MG | 62540060007520 | Brand |
| PREGABALIN ER | PREGABALIN TAB ER 24HR 82.5 MG | 62540060007520 | Generic |
| LYRICA CR | PREGABALIN TAB ER 24HR 165 MG | 62540060007530 | Brand |
| PREGABALIN ER | PREGABALIN TAB ER 24HR 165 MG | 62540060007530 | Generic |
| LYRICA CR | PREGABALIN TAB ER 24HR 330 MG | 62540060007540 | Brand |
| PREGABALIN ER | PREGABALIN TAB ER 24HR 330 MG | 62540060007540 | Generic |
| HORIZANT | GABAPENTIN ENACARBIL TAB ER 300 MG | 62560030200420 | Brand |
| HORIZANT | GABAPENTIN ENACARBIL TAB ER 600 MG | 62560030200430 | Brand |
| ZORVOLEX | DICLOFENAC CAP 18 MG | 66100007000120 | Brand |
| ZORVOLEX | DICLOFENAC CAP 35 MG | 66100007000130 | Brand |
| DICLOFENAC POTASSIUM | DICLOFENAC POTASSIUM TAB 25 MG | 66100007100320 | Generic |
| LOFENA | DICLOFENAC POTASSIUM TAB 25 MG | 66100007100320 | Brand |
| DICLOFENAC POTASSIUM | DICLOFENAC POTASSIUM TAB 50 MG | 66100007100330 | Generic |
| DICLOFENAC POTASSIUM | DICLOFENAC POTASSIUM CAP 25 MG | 66100007100120 | Generic |
| ZIPSOR | DICLOFENAC POTASSIUM CAP 25 MG | 66100007100120 | Brand |
| DICLOFENAC SODIUM DR | DICLOFENAC SODIUM TAB DELAYED RELEASE 25 MG | 66100007200610 | Generic |
| DICLOFENAC SODIUM DR | DICLOFENAC SODIUM TAB DELAYED RELEASE 50 MG | 66100007200620 | Generic |
| DICLOFENAC SODIUM DR | DICLOFENAC SODIUM TAB DELAYED RELEASE 75 MG | 66100007200630 | Generic |

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| DICLOFENAC SODIUM ER | DICLOFENAC SODIUM TAB ER 24HR 100 MG | 66100007207530 | Generic |
| CAMBIA | DICLOFENAC POTASSIUM (MIGRAINE) PACKET 50 MG | 67600040103020 | Brand |
| DICLOFENAC POTASSIUM | DICLOFENAC POTASSIUM (MIGRAINE) PACKET 50 MG | 67600040103020 | Generic |
| ETODOLAC | ETODOLAC CAP 200 MG | 66100008000120 | Generic |
| ETODOLAC | ETODOLAC CAP 300 MG | 66100008000130 | Generic |
| ETODOLAC | ETODOLAC TAB 400 MG | 66100008000310 | Generic |
| LODINE | ETODOLAC TAB 400 MG | 66100008000310 | Brand |
| ETODOLAC | ETODOLAC TAB 500 MG | 66100008000320 | Generic |
| ETODOLAC ER | ETODOLAC TAB ER 24HR 400 MG | 66100008007520 | Generic |
| ETODOLAC ER | ETODOLAC TAB ER 24HR 500 MG | 66100008007530 | Generic |
| ETODOLAC ER | ETODOLAC TAB ER 24HR 600 MG | 66100008007540 | Generic |
| FENOPROFEN CALCIUM | FENOPROFEN CALCIUM CAP 200 MG | 66100010100105 | Generic |
| FENOPROFEN CALCIUM | FENOPROFEN CALCIUM CAP 400 MG | 66100010100120 | Generic |
| NALFON | FENOPROFEN CALCIUM CAP 400 MG | 66100010100120 | Brand |
| FENOPROFEN CALCIUM | FENOPROFEN CALCIUM TAB 600 MG | 66100010100305 | Generic |
| NALFON | FENOPROFEN CALCIUM TAB 600 MG | 66100010100305 | Brand |
| FLURBIPROFEN | FLURBIPROFEN TAB 50 MG | 66100012000310 | Generic |
| FLURBIPROFEN | FLURBIPROFEN TAB 100 MG | 66100012000315 | Generic |
| IBUPROFEN | IBUPROFEN CAP 200 MG | 66100020000105 | Generic |
| IBUPROFEN | IBUPROFEN TAB 200 MG | 66100020000305 | Generic |
| IBUPROFEN | IBUPROFEN TAB 400 MG | 66100020000320 | Generic |
| IBUPROFEN | IBUPROFEN TAB 600 MG | 66100020000330 | Generic |
| IBUPROFEN | IBUPROFEN TAB 800 MG | 66100020000340 | Generic |
| IBUPROFEN | IBUPROFEN CHEW TAB 100 MG | 66100020000520 | Generic |
| IBUPROFEN INFANTS | IBUPROFEN SUSP 40 MG/ML | 66100020001810 | Generic |

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| CHILDRENS IBUPROFEN | IBUPROFEN SUSP 100 MG/5ML | 66100020001820 | Generic |
| INDOMETHACIN | INDOMETHACIN CAP 25 MG | 66100030000105 | Generic |
| INDOMETHACIN | INDOMETHACIN CAP 50 MG | 66100030000110 | Generic |
| INDOMETHACIN ER | INDOMETHACIN CAP ER 75 MG | 66100030000205 | Generic |
| INDOMETHACIN SR | INDOMETHACIN CAP ER 75 MG | 66100030000205 | Generic |
| INDOCIN | INDOMETHACIN SUSP 25 MG/5ML | 66100030001805 | Brand |
| INDOCIN | INDOMETHACIN SUPPOS 50 MG | 66100030005205 | Brand |
| INDOMETHACIN | INDOMETHACIN SUPPOS 100 MG | 66100030005210 | Brand |
| KETOPROFEN | KETOPROFEN CAP 25 MG | 66100035000103 | Generic |
| KETOPROFEN | KETOPROFEN CAP 50 MG | 66100035000105 | Generic |
| KETOPROFEN ER | KETOPROFEN CAP ER 24HR 200 MG | 66100035007030 | Generic |
| KETOROLAC TROMETHAMINE | KETOROLAC TROMETHAMINE TAB 10 MG | 66100037100320 | Generic |
| MECLOFENAMATE SODIUM | MECLOFENAMATE SODIUM CAP 50 MG | 66100040100105 | Generic |
| MECLOFENAMATE SODIUM | MECLOFENAMATE SODIUM CAP 100 MG | 66100040100110 | Generic |
| MEFENAMIC ACID | MEFENAMIC ACID CAP 250 MG | 66100050000105 | Generic |
| MELOXICAM | MELOXICAM CAP 5 MG | 66100052000115 | Generic |
| MELOXICAM | MELOXICAM CAP 10 MG | 66100052000125 | Generic |
| MELOXICAM | MELOXICAM TAB 7.5 MG | 66100052000320 | Generic |
| MELOXICAM | MELOXICAM TAB 15 MG | 66100052000330 | Generic |
| NABUMETONE | NABUMETONE TAB 500 MG | 66100055000320 | Generic |
| NABUMETONE | NABUMETONE TAB 750 MG | 66100055000330 | Generic |
| RELAFEN DS | NABUMETONE TAB 1000 MG | 66100055000340 | Brand |
| NAPROXEN | NAPROXEN TAB 250 MG | 66100060000305 | Generic |
| NAPROXEN | NAPROXEN TAB 375 MG | 66100060000310 | Generic |
| NAPROSYN | NAPROXEN TAB 500 MG | 66100060000315 | Brand |
| NAPROXEN | NAPROXEN TAB 500 MG | 66100060000315 | Generic |

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| EC-NAPROSYN | NAPROXEN TAB EC 375 MG | 66100060000610 | Brand |
| EC-NAPROXEN | NAPROXEN TAB EC 375 MG | 66100060000610 | Generic |
| NAPROXEN | NAPROXEN TAB EC 375 MG | 66100060000610 | Generic |
| EC-NAPROSYN | NAPROXEN TAB EC 500 MG | 66100060000615 | Brand |
| EC-NAPROXEN | NAPROXEN TAB EC 500 MG | 66100060000615 | Generic |
| NAPROXEN | NAPROXEN TAB EC 500 MG | 66100060000615 | Generic |
| NAPROSYN | NAPROXEN SUSP 125 MG/5ML | 66100060001805 | Brand |
| NAPROXEN | NAPROXEN SUSP 125 MG/5ML | 66100060001805 | Generic |
| NAPROXEN SODIUM | NAPROXEN SODIUM CAP 220 MG | 66100060100127 | Generic |
| NAPROXEN | NAPROXEN SODIUM TAB 220 MG | 66100060100303 | Generic |
| NAPROXEN SODIUM | NAPROXEN SODIUM TAB 275 MG | 66100060100305 | Generic |
| NAPROXEN SODIUM | NAPROXEN SODIUM TAB 550 MG | 66100060100310 | Generic |
| NAPRELAN | NAPROXEN SODIUM TAB ER 24HR 375 MG (BASE EQUIV) | 66100060107520 | Brand |
| NAPROXEN SODIUM CR | NAPROXEN SODIUM TAB ER 24HR 375 MG (BASE EQUIV) | 66100060107520 | Generic |
| NAPROXEN SODIUM ER | NAPROXEN SODIUM TAB ER 24HR 375 MG (BASE EQUIV) | 66100060107520 | Generic |
| NAPRELAN | NAPROXEN SODIUM TAB ER 24HR 500 MG (BASE EQUIV) | 66100060107540 | Brand |
| NAPROXEN SODIUM ER | NAPROXEN SODIUM TAB ER 24HR 500 MG (BASE EQUIV) | 66100060107540 | Generic |
| NAPRELAN | NAPROXEN SODIUM TAB ER 24HR 750 MG (BASE EQUIV) | 66100060107550 | Brand |
| NAPROXEN SODIUM | NAPROXEN SODIUM TAB ER 24HR 750 MG (BASE EQUIV) | 66100060107550 | Generic |
| DAYPRO | OXAPROZIN TAB 600 MG | 66100065000320 | Brand |
| OXAPROZIN | OXAPROZIN TAB 600 MG | 66100065000320 | Generic |

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| FELDENE | PIROXICAM CAP 10 MG | 66100070000105 | Brand |
| PIROXICAM | PIROXICAM CAP 10 MG | 66100070000105 | Generic |
| FELDENE | PIROXICAM CAP 20 MG | 66100070000110 | Brand |
| PIROXICAM | PIROXICAM CAP 20 MG | 66100070000110 | Generic |
| SULINDAC | SULINDAC TAB 150 MG | 66100080000305 | Generic |
| SULINDAC | SULINDAC TAB 200 MG | 66100080000310 | Generic |
| TOLMETIN SODIUM | TOLMETIN SODIUM TAB 600 MG | 66100090100320 | Generic |
| CELEBREX | CELECOXIB CAP 50 MG | 66100525000110 | Brand |
| CELECOXIB | CELECOXIB CAP 50 MG | 66100525000110 | Generic |
| CELEBREX | CELECOXIB CAP 100 MG | 66100525000120 | Brand |
| CELECOXIB | CELECOXIB CAP 100 MG | 66100525000120 | Generic |
| CELEBREX | CELECOXIB CAP 200 MG | 66100525000130 | Brand |
| CELECOXIB | CELECOXIB CAP 200 MG | 66100525000130 | Generic |
| CELEBREX | CELECOXIB CAP 400 MG | 66100525000140 | Brand |
| CELECOXIB | CELECOXIB CAP 400 MG | 66100525000140 | Generic |
| ELYXYB | CELECOXIB ORAL SOLN 120 MG/4.8ML (25 MG/ML) | 67604030002020 | Brand |
| ARTHROTEC 50 | DICLOFENAC W/ MISOPROSTOL TAB DELAYED RELEASE 50-0.2 MG | 66109902200620 | Brand |
| DICLOFENAC SODIUM/MISOPROSTOL | DICLOFENAC W/ MISOPROSTOL TAB DELAYED RELEASE 50-0.2 MG | 66109902200620 | Generic |
| ARTHROTEC 75 | DICLOFENAC W/ MISOPROSTOL TAB DELAYED RELEASE 75-0.2 MG | 66109902200630 | Brand |
| DICLOFENAC SODIUM/MISOPROSTOL | DICLOFENAC W/ MISOPROSTOL TAB DELAYED RELEASE 75-0.2 MG | 66109902200630 | Generic |
| DUEXIS | IBUPROFEN-FAMOTIDINE TAB 800-26.6 MG | 66109902320340 | Brand |
| IBUPROFEN/FAMOTIDINE | IBUPROFEN-FAMOTIDINE TAB 800-26.6 MG | 66109902320340 | Generic |
| NAPROXEN/ESOMEPRAZOLE MAGNESIUM | NAPROXEN-ESOMEPRAZOLE MAGNESIUM TAB DR 375-20 MG | 66109902440620 | Generic |

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| VIMOVO | NAPROXEN-ESOMEPRAZOLE MAGNESIUM TAB DR 375-20 MG | 66109902440620 | Brand |
| NAPROXEN/ESOMEPRAZOLE MAGNESIUM | NAPROXEN-ESOMEPRAZOLE MAGNESIUM TAB DR 500-20 MG | 66109902440640 | Generic |
| VIMOVO | NAPROXEN-ESOMEPRAZOLE MAGNESIUM TAB DR 500-20 MG | 66109902440640 | Brand |
| QC IBUPROFEN/DIPHENHYDRAMINE | IBUPROFEN-DIPHENHYDRAMINE HCL CAP 200-25 MG | 60309902420120 | Generic |
| ALEVE PM | NAPROXEN SODIUM-DIPHENHYDRAMINE HCL TAB 220-25 MG | 60309902600320 | Brand |
| RA NAPROXEN SODIUM PM | NAPROXEN SODIUM-DIPHENHYDRAMINE HCL TAB 220-25 MG | 60309902600320 | Generic |
| ADVIL PM | IBUPROFEN-DIPHENHYDRAMINE HCL CAP 200-25 MG | 60309902420120 | Brand |
| HYDROCODONE/IBUPROFEN | HYDROCODONE-IBUPROFEN TAB 5-200 MG | 65991702500315 | Generic |
| HYDROCODONE/IBUPROFEN | HYDROCODONE-IBUPROFEN TAB 7.5-200 MG | 65991702500320 | Generic |
| HYDROCODONE/IBUPROFEN | HYDROCODONE-IBUPROFEN TAB 10-200 MG | 65991702500330 | Generic |
| SUMATRIPTAN/NAPROXEN SODIUM | SUMATRIPTAN-NAPROXEN SODIUM TAB 85-500 MG | 67992002600320 | Generic |
| TREXIMET | SUMATRIPTAN-NAPROXEN SODIUM TAB 85-500 MG | 67992002600320 | Brand |
| ADVIL DUAL ACTION /ACETAMINOPHEN | IBUPROFEN-ACETAMINOPHEN TAB 125-250 MG | 66109902300305 | Brand |
| MOTRIN DUAL ACTION/TYLENOL | IBUPROFEN-ACETAMINOPHEN TAB 125-250 MG | 66109902300305 | Brand |
| NAPROTIN | NAPROXEN TAB 500 MG & CAPSAICIN CREAM 0.025% KIT | 66109902476420 | Brand |
| SM IBUPROFEN JR | IBUPROFEN TAB 100 MG | 66100020000303 | Generic |
| ALEVE | NAPROXEN SODIUM CAP 220 MG | 66100060100127 | Brand |

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| ALEVE | NAPROXEN SODIUM TAB 220 MG | 66100060100303 | Brand |
| ANAPROX DS | NAPROXEN SODIUM TAB 550 MG | 66100060100310 | Brand |
| INPEFA | SOTAGLIFLOZIN TAB 200 MG | 40750010000320 | Brand |
| SAXENDA | LIRAGLUTIDE (WEIGHT MNGMT) SOLN PEN-INJ 18 MG/3ML (6 MG/ML) | 6125205000D220 | Brand |
| WEGOVY | SEMAGLUTIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 0.25 MG/0.5ML | 6125207000D520 | Brand |
| WEGOVY | SEMAGLUTIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 0.5 MG/0.5ML | 6125207000D525 | Brand |
| WEGOVY | SEMAGLUTIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 1 MG/0.5ML | 6125207000D530 | Brand |
| WEGOVY | SEMAGLUTIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 1.7 MG/0.75ML | 6125207000D535 | Brand |
| WEGOVY | SEMAGLUTIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 2.4 MG/0.75ML | 6125207000D540 | Brand |
| TOLMETIN SODIUM | TOLMETIN SODIUM CAP 400 MG | 66100090100105 | Generic |
| BREO ELLIPTA | FLUTICASONE FUROATE-VILANTEROL AERO POWD BA 50-25 MCG/ACT | 44209902758010 | Brand |
| AIRSUPRA | ALBUTEROL-BUDESONIDE INHALATION AEROSOL 90-80 MCG/ACT | 44209902783220 | Brand |
| FLUTICASONE PROPIONATE/SALMETEROL HFA | FLUTICASONE-SALMETEROL INHAL AEROSOL 45-21 MCG/ACT | 44209902703250 | Generic |
| ADVAIR HFA | FLUTICASONE-SALMETEROL INHAL AEROSOL 45-21 MCG/ACT | 44209902703250 | Generic |
| FLUTICASONE PROPIONATE/SALMETEROL HFA | FLUTICASONE-SALMETEROL INHAL AEROSOL 115-21 MCG/ACT | 44209902703260 | Generic |
| ADVAIR HFA | FLUTICASONE-SALMETEROL INHAL AEROSOL 115-21 MCG/ACT | 44209902703260 | Generic |
| FLUTICASONE PROPIONATE/SALMETEROL HFA | FLUTICASONE-SALMETEROL INHAL AEROSOL 230-21 MCG/ACT | 44209902703270 | Generic |

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| ADVAIR HFA | FLUTICASONE-SALMETEROL INHAL AEROSOL 230-21 MCG/ACT | 44209902703270 | Generic |
| FLEQSUVY | BACLOFEN SUSP 25 MG/5ML | 75100010001825 | Brand |
| PULMICORT FLEXHALER | BUDESONIDE INHAL AERO POWD 90 MCG/ACT (BREATH ACTIVATED) | 44400015008009 | Generic |
| PULMICORT FLEXHALER | BUDESONIDE INHAL AERO POWD 180 MCG/ACT (BREATH ACTIVATED) | 44400015008018 | Generic |
| BREYNA | BUDESONIDE-FORMOTEROL FUMARATE DIHYD AEROSOL 80-4.5 MCG/ACT | 44209902413220 | Generic |
| SYMBICORT | BUDESONIDE-FORMOTEROL FUMARATE DIHYD AEROSOL 80-4.5 MCG/ACT | 44209902413220 | Brand |
| BREYNA | BUDESONIDE-FORMOTEROL FUMARATE DIHYD AEROSOL 160-4.5 MCG/ACT | 44209902413240 | Generic |
| SYMBICORT | BUDESONIDE-FORMOTEROL FUMARATE DIHYD AEROSOL 160-4.5 MCG/ACT | 44209902413240 | Brand |
| ANORO ELLIPTA | UMECLIDINIUM-VILANTEROL AERO POWD BA 62.5-25 MCG/ACT | 44209902958020 | Brand |
| INCRUSE ELLIPTA | UMECLIDINIUM BR AERO POWD BREATH ACT 62.5 MCG/ACT (BASE EQ) | 44100090208030 | Brand |
| SEREVENT DISKUS | SALMETEROL XINAFOATE AER POW BA 50 MCG/ACT (BASE EQUIV) | 44201058108020 | Brand |
| XIGDUO XR | DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 2.5-1000 MG | 27996002307507 | Brand |
| XIGDUO XR | DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 5-500 MG | 27996002307510 | Brand |
| XIGDUO XR | DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 5-1000 MG | 27996002307515 | Brand |
| XIGDUO XR | DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 10-500 MG | 27996002307520 | Brand |

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| XIGDUO XR | DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 10-1000 MG | 27996002307525 | Brand |
| INSULIN GLARGINE-YFGN | INSULIN GLARGINE-YFGN INJ 100 UNIT/ML | 27104003902020 | Brand |
| INDOMETHACIN | INDOMETHACIN SUPPOS 50 MG | 66100030005205 | Generic |
| SAXAGLIPTIN HYDROCHLORIDE/METFORMIN HYDROCHLORIDE ER | SAXAGLIPTIN-METFORMIN HCL TAB ER 24HR 2.5-1000 MG | 27992502607520 | Generic |
| SAXAGLIPTIN HYDROCHLORIDE/METFORMIN HYDROCHLORIDE ER | SAXAGLIPTIN-METFORMIN HCL TAB ER 24HR 5-500 MG | 27992502607530 | Generic |
| SAXAGLIPTIN HYDROCHLORIDE/METFORMIN HYDROCHLORIDE ER | SAXAGLIPTIN-METFORMIN HCL TAB ER 24HR 5-1000 MG | 27992502607540 | Generic |
| SAXAGLIPTIN HYDROCHLORIDE | SAXAGLIPTIN HCL TAB 2.5 MG (BASE EQUIV) | 27550065100320 | Generic |
| SAXAGLIPTIN HYDROCHLORIDE | SAXAGLIPTIN HCL TAB 5 MG (BASE EQUIV) | 27550065100330 | Generic |
| TIOTROPIUM BROMIDE | TIOTROPIUM BROMIDE MONOHYDRATE INHAL CAP 18 MCG (BASE EQUIV) | 44100080100120 | Generic |
| INPEFA | SOTAGLIFLOZIN TAB 400 MG | 40750010000340 | Brand |
| BACLOFEN | BACLOFEN ORAL SOLN 10 MG/5ML | 75100010002075 | Generic |
| OZOBAX DS | BACLOFEN ORAL SOLN 10 MG/5ML | 75100010002075 | Generic |
| BEXAGLIFLOZIN | BEXAGLIFLOZIN TAB 20 MG | 27700010000320 | Generic |
| FLUTICASONE PROPIONATE DISKUS | FLUTICASONE PROPIONATE AER POW BA 50 MCG/ACT | 44400033208010 | Brand |
| FLUTICASONE PROPIONATE DISKUS | FLUTICASONE PROPIONATE AER POW BA 100 MCG/ACT | 44400033208020 | Brand |
| FLUTICASONE PROPIONATE DISKUS | FLUTICASONE PROPIONATE AER POW BA 250 MCG/ACT | 44400033208030 | Brand |
| FLUTICASONE PROPIONATE HFA | FLUTICASONE PROPIONATE HFA INHAL AERO 44 MCG/ACT (50/VALVE) | 44400033223220 | Brand |
| FLUTICASONE PROPIONATE HFA | FLUTICASONE PROPIONATE HFA INHAL AER 110 MCG/ACT (125/VALVE) | 44400033223230 | Brand |

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| FLUTICASONE PROPIONATE HFA | FLUTICASONE PROPIONATE HFA INHAL AER 220 MCG/ACT (250/VALVE) | 44400033223240 | Brand |
| NAPROXEN DR | NAPROXEN TAB EC 500 MG | 66100060000615 | Generic |
| ACETAMINOPHEN/IBUPROFEN | IBUPROFEN-ACETAMINOPHEN TAB 125-250 MG | 66109902300305 | Generic |
| BRENZAVVY | BEXAGLIFLOZIN TAB 20 MG | 27700010000320 | Generic |
| ADVIL JUNIOR STRENGTH | IBUPROFEN TAB 100 MG | 66100020000303 | Brand |
| ZEPBOUND | TIRZEPATIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 2.5 MG/0.5ML | 6125258000D520 | Brand |
| ZEPBOUND | TIRZEPATIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 5 MG/0.5ML | 6125258000D525 | Brand |
| ZEPBOUND | TIRZEPATIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 7.5 MG/0.5ML | 6125258000D530 | Brand |
| ZEPBOUND | TIRZEPATIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 10 MG/0.5ML | 6125258000D535 | Brand |
| ZEPBOUND | TIRZEPATIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 12.5 MG/0.5ML | 6125258000D540 | Brand |
| ZEPBOUND | TIRZEPATIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 15 MG/0.5ML | 6125258000D545 | Brand |
| COXANTO | OXAPROZIN CAP 300 MG | 66100065000120 | Brand |
| JANTOVEN | WARFARIN SODIUM TAB 1 MG | 83200030200303 | Generic |
| WARFARIN SODIUM | WARFARIN SODIUM TAB 1 MG | 83200030200303 | Generic |
| JANTOVEN | WARFARIN SODIUM TAB 2 MG | 83200030200305 | Generic |
| WARFARIN SODIUM | WARFARIN SODIUM TAB 2 MG | 83200030200305 | Generic |
| JANTOVEN | WARFARIN SODIUM TAB 2.5 MG | 83200030200310 | Generic |
| WARFARIN SODIUM | WARFARIN SODIUM TAB 2.5 MG | 83200030200310 | Generic |
| JANTOVEN | WARFARIN SODIUM TAB 3 MG | 83200030200311 | Generic |
| WARFARIN SODIUM | WARFARIN SODIUM TAB 3 MG | 83200030200311 | Generic |

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| JANTOVEN | WARFARIN SODIUM TAB 4 MG | 83200030200313 | Generic |
| WARFARIN SODIUM | WARFARIN SODIUM TAB 4 MG | 83200030200313 | Generic |
| JANTOVEN | WARFARIN SODIUM TAB 5 MG | 83200030200315 | Generic |
| WARFARIN SODIUM | WARFARIN SODIUM TAB 5 MG | 83200030200315 | Generic |
| JANTOVEN | WARFARIN SODIUM TAB 6 MG | 83200030200317 | Generic |
| WARFARIN SODIUM | WARFARIN SODIUM TAB 6 MG | 83200030200317 | Generic |
| JANTOVEN | WARFARIN SODIUM TAB 7.5 MG | 83200030200320 | Generic |
| WARFARIN SODIUM | WARFARIN SODIUM TAB 7.5 MG | 83200030200320 | Generic |
| JANTOVEN | WARFARIN SODIUM TAB 10 MG | 83200030200325 | Generic |
| WARFARIN SODIUM | WARFARIN SODIUM TAB 10 MG | 83200030200325 | Generic |
| DABIGATRAN ETEXILATE | DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ) | 83337030200120 | Generic |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ) | 83337030200120 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE CAP 110 MG (ETEXILATE BASE EQ) | 83337030200130 | Brand |
| DABIGATRAN ETEXILATE | DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ) | 83337030200140 | Generic |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ) | 83337030200140 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE PELLET PACK 20 MG | 83337030203020 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE PELLET PACK 30 MG | 83337030203025 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE PELLET PACK 40 MG | 83337030203030 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE PELLET PACK 50 MG | 83337030203035 | Brand |

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| PRADAXA | DABIGATRAN ETEXILATE MESYLATE PELLET PACK 110 MG | 83337030203040 | Brand |
| PRADAXA | DABIGATRAN ETEXILATE MESYLATE PELLET PACK 150 MG | 83337030203045 | Brand |
| ELIQUIS | APIXABAN TAB 2.5 MG | 83370010000320 | Brand |
| ELIQUIS | APIXABAN TAB 5 MG | 83370010000330 | Brand |
| SAVAYSA | EDOXABAN TOSYLATE TAB 15 MG (BASE EQUIVALENT) | 83370030200315 | Brand |
| SAVAYSA | EDOXABAN TOSYLATE TAB 30 MG (BASE EQUIVALENT) | 83370030200330 | Brand |
| SAVAYSA | EDOXABAN TOSYLATE TAB 60 MG (BASE EQUIVALENT) | 83370030200350 | Brand |
| XARELTO STARTER PACK | RIVAROXABAN TAB STARTER THERAPY PACK 15 MG & 20 MG | 8337006000B720 | Brand |
| XARELTO | RIVAROXABAN TAB 2.5 MG | 83370060000310 | Brand |
| XARELTO | RIVAROXABAN TAB 10 MG | 83370060000320 | Brand |
| XARELTO | RIVAROXABAN TAB 15 MG | 83370060000330 | Brand |
| XARELTO | RIVAROXABAN TAB 20 MG | 83370060000340 | Brand |
| XARELTO | RIVAROXABAN FOR SUSP 1 MG/ML | 83370060001920 | Brand |
| ESZOPICLONE | ESZOPICLONE TAB 1 MG | 60204035000320 | Generic |
| LUNESTA | ESZOPICLONE TAB 1 MG | 60204035000320 | Brand |
| ESZOPICLONE | ESZOPICLONE TAB 2 MG | 60204035000330 | Generic |
| LUNESTA | ESZOPICLONE TAB 2 MG | 60204035000330 | Brand |
| ESZOPICLONE | ESZOPICLONE TAB 3 MG | 60204035000340 | Generic |
| LUNESTA | ESZOPICLONE TAB 3 MG | 60204035000340 | Brand |
| ZALEPLON | ZALEPLON CAP 5 MG | 60204070000120 | Generic |
| ZALEPLON | ZALEPLON CAP 10 MG | 60204070000130 | Generic |
| ZOLPIDEM TARTRATE | ZOLPIDEM TARTRATE CAP 7.5 MG | 60204080100120 | Brand |
| AMBIEN | ZOLPIDEM TARTRATE TAB 5 MG | 60204080100310 | Brand |
| ZOLPIDEM TARTRATE | ZOLPIDEM TARTRATE TAB 5 MG | 60204080100310 | Generic |

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| AMBIEN | ZOLPIDEM TARTRATE TAB 10 MG | 60204080100315 | Brand |
| ZOLPIDEM TARTRATE | ZOLPIDEM TARTRATE TAB 10 MG | 60204080100315 | Generic |
| AMBIEN CR | ZOLPIDEM TARTRATE TAB ER 6.25 MG | 60204080100410 | Brand |
| ZOLPIDEM TARTRATE ER | ZOLPIDEM TARTRATE TAB ER 6.25 MG | 60204080100410 | Generic |
| AMBIEN CR | ZOLPIDEM TARTRATE TAB ER 12.5 MG | 60204080100420 | Brand |
| ZOLPIDEM TARTRATE ER | ZOLPIDEM TARTRATE TAB ER 12.5 MG | 60204080100420 | Generic |
| ZOLPIDEM TARTRATE | ZOLPIDEM TARTRATE SL TAB 1.75 MG | 60204080100708 | Generic |
| ZOLPIDEM TARTRATE | ZOLPIDEM TARTRATE SL TAB 3.5 MG | 60204080100715 | Generic |
| EDLUAR | ZOLPIDEM TARTRATE SL TAB 5 MG | 60204080100720 | Brand |
| EDLUAR | ZOLPIDEM TARTRATE SL TAB 10 MG | 60204080100730 | Brand |
| RAMELTEON | RAMELTEON TAB 8 MG | 60250060000320 | Generic |
| ROZEREM | RAMELTEON TAB 8 MG | 60250060000320 | Brand |
| DOXEPIN HYDROCHLORIDE | DOXEPIN HCL (SLEEP) TAB 3 MG (BASE EQUIV) | 60400030100320 | Generic |
| SILENOR | DOXEPIN HCL (SLEEP) TAB 3 MG (BASE EQUIV) | 60400030100320 | Brand |
| DOXEPIN HYDROCHLORIDE | DOXEPIN HCL (SLEEP) TAB 6 MG (BASE EQUIV) | 60400030100330 | Generic |
| SILENOR | DOXEPIN HCL (SLEEP) TAB 6 MG (BASE EQUIV) | 60400030100330 | Brand |
| BELSOMRA | SUVOREXANT TAB 5 MG | 60500070000305 | Brand |
| BELSOMRA | SUVOREXANT TAB 10 MG | 60500070000310 | Brand |
| BELSOMRA | SUVOREXANT TAB 15 MG | 60500070000315 | Brand |
| BELSOMRA | SUVOREXANT TAB 20 MG | 60500070000320 | Brand |
| DAYVIGO | LEMBOREXANT TAB 5 MG | 60500040000320 | Brand |
| DAYVIGO | LEMBOREXANT TAB 10 MG | 60500040000340 | Brand |
| QUVIVIQ | DARIDOREXANT HCL TAB 25 MG | 60500020100320 | Brand |
| QUVIVIQ | DARIDOREXANT HCL TAB 50 MG | 60500020100340 | Brand |
| DEXMEDETOMIDINE HCL | DEXMEDETOMIDINE HCL IV SOLN 200 MCG/2ML | 60206030102020 | Generic |

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| DEXMEDETOMIDINE HYDROCHLORIDE | DEXMEDETOMIDINE HCL IV SOLN 200 MCG/2ML | 60206030102020 | Generic |
| PRECEDEX | DEXMEDETOMIDINE HCL IV SOLN 200 MCG/2ML | 60206030102020 | Brand |
| DEXMEDETOMIDINE HCL | DEXMEDETOMIDINE HCL IV SOLN 400 MCG/4ML | 60206030102030 | Brand |
| DEXMEDETOMIDINE HCL | DEXMEDETOMIDINE HCL IV SOLN 1000 MCG/10ML | 60206030102040 | Brand |
| IGALMI | DEXMEDETOMIDINE HCL FILM 120 MCG | 60206030108220 | Brand |
| IGALMI | DEXMEDETOMIDINE HCL FILM 180 MCG | 60206030108230 | Brand |
| HETLIOZ | TASIMELTEON CAPSULE 20 MG | 60250070000130 | Brand |
| TASIMELTEON | TASIMELTEON CAPSULE 20 MG | 60250070000130 | Generic |
| HETLIOZ LQ | TASIMELTEON ORAL SUSP 4 MG/ML | 60250070001820 | Brand |
| RESTORIL | TEMAZEPAM CAP 7.5 MG | 60201030000103 | Brand |
| TEMAZEPAM | TEMAZEPAM CAP 7.5 MG | 60201030000103 | Generic |
| RESTORIL | TEMAZEPAM CAP 15 MG | 60201030000105 | Brand |
| TEMAZEPAM | TEMAZEPAM CAP 15 MG | 60201030000105 | Generic |
| RESTORIL | TEMAZEPAM CAP 22.5 MG | 60201030000108 | Brand |
| TEMAZEPAM | TEMAZEPAM CAP 22.5 MG | 60201030000108 | Generic |
| RESTORIL | TEMAZEPAM CAP 30 MG | 60201030000110 | Brand |
| TEMAZEPAM | TEMAZEPAM CAP 30 MG | 60201030000110 | Generic |
| TRIAZOLAM | TRIAZOLAM TAB 0.125 MG | 60201040000305 | Generic |
| HALCION | TRIAZOLAM TAB 0.25 MG | 60201040000310 | Brand |
| TRIAZOLAM | TRIAZOLAM TAB 0.25 MG | 60201040000310 | Generic |
| DORAL | QUAZEPAM TAB 15 MG | 60201028000310 | Brand |
| QUAZEPAM | QUAZEPAM TAB 15 MG | 60201028000310 | Generic |
| FLURAZEPAM HYDROCHLORIDE | FLURAZEPAM HCL CAP 15 MG | 60201010100105 | Generic |
| FLURAZEPAM HYDROCHLORIDE | FLURAZEPAM HCL CAP 30 MG | 60201010100110 | Generic |
| ESTAZOLAM | ESTAZOLAM TAB 1 MG | 60201005000310 | Generic |
| ESTAZOLAM | ESTAZOLAM TAB 2 MG | 60201005000320 | Generic |
| ZITUVIO | SITAGLIPTIN TAB 25 MG | 27550070000320 | Brand |
| ZITUVIO | SITAGLIPTIN TAB 50 MG | 27550070000330 | Brand |

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| ZITUVIO | SITAGLIPTIN TAB 100 MG | 27550070000340 | Brand |
| DAPAGLIFLOZIN PROPANEDIOL | DAPAGLIFLOZIN PROPANEDIOL TAB 5 MG (BASE EQUIVALENT) | 27700040200310 | Generic |
| FARXIGA | DAPAGLIFLOZIN PROPANEDIOL TAB 5 MG (BASE EQUIVALENT) | 27700040200310 | Generic |
| DAPAGLIFLOZIN PROPANEDIOL | DAPAGLIFLOZIN PROPANEDIOL TAB 10 MG (BASE EQUIVALENT) | 27700040200320 | Generic |
| FARXIGA | DAPAGLIFLOZIN PROPANEDIOL TAB 10 MG (BASE EQUIVALENT) | 27700040200320 | Generic |
| XIGDUO XR | DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 5-1000 MG | 27996002307515 | Generic |
| DAPAGLIFLOZIN PROPANEDIOL/METFORMIN HYDROCHLORIDE | DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 5-1000 MG | 27996002307515 | Generic |
| XIGDUO XR | DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 10-1000 MG | 27996002307525 | Generic |
| DAPAGLIFLOZIN PROPANEDIOL/METFORMIN HYDROCHLORIDE | DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 10-1000 MG | 27996002307525 | Generic |
| COXANTO | OXAPROZIN CAP 300 MG | 66100065000120 | Generic |
| OXAPROZIN | OXAPROZIN CAP 300 MG | 66100065000120 | Generic |
| BACLOFEN | BACLOFEN TAB 15 MG | 75100010000308 | Generic |
| SITAGLIPTIN/METFORMIN HYDROCHLORIDE | SITAGLIPTIN FREE BASE-METFORMIN HCL TAB 50-500 MG | 27992502690320 | Brand |
| SITAGLIPTIN/METFORMIN HYDROCHLORIDE | SITAGLIPTIN FREE BASE-METFORMIN HCL TAB 50-1000 MG | 27992502690330 | Brand |
| TANLOR | METHOCARBAMOL TAB 1000 MG | 75100070000320 | Brand |
| DOLOBID | DIFLUNISAL TAB 250 MG | 64100050000305 | Brand |
| DIFLUNISAL | DIFLUNISAL TAB 500 MG | 64100050000310 | Generic |
| ZITUVIMET XR | SITAGLIPTIN FREE BASE-METFORMIN HCL TAB ER 24HR 50-500 MG | 27992502697520 | Brand |
| ZITUVIMET XR | SITAGLIPTIN FREE BASE-METFORMIN HCL TAB ER 24HR 50-1000 MG | 27992502697530 | Brand |

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| ZITUVIMET XR | SITAGLIPTIN FREE BASE-METFORMIN HCL TAB ER 24HR 100-1000 MG | 27992502697540 | Brand |
| ZITUVIMET | SITAGLIPTIN FREE BASE-METFORMIN HCL TAB 50-500 MG | 27992502690320 | Brand |
| ZITUVIMET | SITAGLIPTIN FREE BASE-METFORMIN HCL TAB 50-1000 MG | 27992502690330 | Brand |
| TRESNI | DICLOFENAC SODIUM SUPPOS 100 MG | 66100007205220 | Brand |

**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 |
|---|---|
| 12/17/2024 | Added Dolobid, generic diflunisal, Zituvimet, Zituvimet XR, Tresni. |

Therapeutic Duplication (Subtype B)

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-162165 |
| **Guideline Name** | Therapeutic Duplication (Subtype B) |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 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 (adalimumab-AATY, adalimumab-RYVK, adalimumab-ADBM, adalimumab-AACF, adalimumab-ADAZ, adalimumab-FKJP), 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, Ocrevus Zunovo, 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, Nemluvio, Ebglyss | |
| Diagnosis | DUR: Therapeutic Duplication |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| STELARA | USTEKINUMAB SOLN PREFILLED SYRINGE 45 MG/0.5ML | 9025058500E520 | Brand |
| STELARA | USTEKINUMAB SOLN PREFILLED SYRINGE 90 MG/ML | 9025058500E540 | Brand |
| STELARA | USTEKINUMAB INJ 45 MG/0.5ML | 90250585002020 | Brand |
| CIMZIA | CERTOLIZUMAB PEGOL FOR INJ KIT 2 X 200 MG | 52505020106420 | Brand |
| HUMIRA PEN | ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML | 6627001500F520 | Brand |
| HUMIRA PEN-CD/UC/HS STARTER | ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML | 6627001500F520 | Brand |
| HUMIRA PEN-PS/UV STARTER | ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML | 6627001500F520 | Brand |
| HUMIRA PEN | ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.4ML | 6627001500F530 | Brand |
| HUMIRA PEN | ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML | 6627001500F540 | Brand |
| HUMIRA PEN-CD/UC/HS STARTER | ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML | 6627001500F540 | Brand |
| HUMIRA PEN-PEDIATRIC UC STARTER PACK | ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML | 6627001500F540 | Brand |
| HUMIRA PEN-PS/UV STARTER | ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML & 40 MG/0.4ML | 6627001500F550 | Brand |
| HUMIRA | ADALIMUMAB PREFILLED SYRINGE KIT 10 MG/0.1ML | 6627001500F804 | Brand |
| HUMIRA | ADALIMUMAB PREFILLED SYRINGE KIT 20 MG/0.2ML | 6627001500F809 | Brand |
| HUMIRA | ADALIMUMAB PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001500F820 | Brand |
| HUMIRA | ADALIMUMAB PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001500F830 | Brand |
| HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK | ADALIMUMAB PREFILLED SYRINGE KIT 80 MG/0.8ML | 6627001500F840 | Brand |
| HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK | ADALIMUMAB PREFILLED SYRINGE KIT 80 MG/0.8ML & 40 MG/0.4ML | 6627001500F880 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 40 MG/0.8ML | 6627001510D520 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 10 MG/0.2ML | 6627001510E505 | Brand |

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|---|---|---|---|
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 20 MG/0.4ML | 6627001510E510 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 40 MG/0.8ML | 6627001510E520 | Brand |
| SIMPONI | GOLIMUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 50 MG/0.5ML | 6627004000D520 | Brand |
| SIMPONI | GOLIMUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 100 MG/ML | 6627004000D540 | Brand |
| SIMPONI | GOLIMUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 50 MG/0.5ML | 6627004000E520 | Brand |
| SIMPONI | GOLIMUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/ML | 6627004000E540 | Brand |
| ENBREL SURECLICK | ETANERCEPT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML | 6629003000D530 | Brand |
| ENBREL MINI | ETANERCEPT SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML | 6629003000E230 | Brand |
| ENBREL | ETANERCEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 25 MG/0.5ML | 6629003000E525 | Brand |
| ENBREL | ETANERCEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 50 MG/ML | 6629003000E530 | Brand |
| ENBREL | ETANERCEPT SUBCUTANEOUS INJ 25 MG/0.5ML | 66290030002015 | Brand |
| ACTEMRA ACTPEN | TOCILIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 162 MG/0.9ML | 6650007000D520 | Brand |
| ACTEMRA | TOCILIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 162 MG/0.9ML | 6650007000E520 | Brand |
| ACTEMRA | TOCILIZUMAB IV INJ 80 MG/4ML | 66500070002030 | Brand |
| ACTEMRA | TOCILIZUMAB IV INJ 200 MG/10ML | 66500070002035 | Brand |
| ACTEMRA | TOCILIZUMAB IV INJ 400 MG/20ML | 66500070002040 | Brand |
| COSENTYX SENSOREADY PEN | SECUKINUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 150 MG/ML | 9025057500D520 | Brand |
| COSENTYX SENSOREADY PEN | SECUKINUMAB SUBCUTANEOUS AUTO-INJ 150 MG/ML (300 MG DOSE) | 9025057500D530 | Brand |
| COSENTYX | SECUKINUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 75 MG/0.5ML | 9025057500E510 | Brand |
| COSENTYX | SECUKINUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/ML | 9025057500E520 | Brand |
| COSENTYX | SECUKINUMAB SUBCUTANEOUS PREF SYR 150 MG/ML (300 MG DOSE) | 9025057500E530 | Brand |
| ILARIS | CANAKINUMAB SUBCUTANEOUS INJ 150 MG/ML | 66460020002015 | Brand |
| KINERET | ANAKINRA SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/0.67ML | 6626001000E520 | Brand |

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|---|---|---|---|
| KEVZARA | SARILUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML | 6650006000D520 | Brand |
| KEVZARA | SARILUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.14ML | 6650006000D530 | Brand |
| KEVZARA | SARILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/1.14ML | 6650006000E520 | Brand |
| KEVZARA | SARILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 200 MG/1.14ML | 6650006000E530 | Brand |
| TALTZ | IXEKIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 80 MG/ML | 9025055400D520 | Brand |
| TALTZ | IXEKIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 80 MG/ML | 9025055400E520 | Brand |
| TREMFYA | GUSELKUMAB SOLN PEN-INJECTOR 100 MG/ML | 9025054200D520 | Brand |
| TREMFYA | GUSELKUMAB SOLN PREFILLED SYRINGE 100 MG/ML | 9025054200E520 | Brand |
| ORENCIA CLICKJECT | ABATACEPT SUBCUTANEOUS SOLN AUTO-INJECTOR 125 MG/ML | 6640001000D520 | Brand |
| ORENCIA | ABATACEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 50 MG/0.4ML | 6640001000E510 | Brand |
| ORENCIA | ABATACEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 87.5 MG/0.7ML | 6640001000E515 | Brand |
| ORENCIA | ABATACEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 125 MG/ML | 6640001000E520 | Brand |
| ORENCIA | ABATACEPT FOR IV SOLN 250 MG | 66400010002120 | Brand |
| XELJANZ | TOFACITINIB CITRATE TAB 5 MG (BASE EQUIVALENT) | 66603065100320 | Brand |
| XELJANZ | TOFACITINIB CITRATE TAB 10 MG (BASE EQUIVALENT) | 66603065100330 | Brand |
| XELJANZ | TOFACITINIB CITRATE ORAL SOLN 1 MG/ML (BASE EQUIVALENT) | 66603065102020 | Brand |
| XELJANZ XR | TOFACITINIB CITRATE TAB ER 24HR 11 MG (BASE EQUIVALENT) | 66603065107530 | Brand |
| XELJANZ XR | TOFACITINIB CITRATE TAB ER 24HR 22 MG (BASE EQUIVALENT) | 66603065107550 | Brand |
| SILIQ | BRODALUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 210 MG/1.5ML | 9025052000E520 | Brand |
| OTEZLA | APREMILAST TAB STARTER THERAPY PACK 10 MG & 20 MG & 30 MG | 6670001500B720 | Brand |
| OTEZLA | APREMILAST TAB 30 MG | 66700015000330 | Brand |
| OLUMIANT | BARICITINIB TAB 1 MG | 66603010000310 | Brand |
| OLUMIANT | BARICITINIB TAB 2 MG | 66603010000320 | Brand |
| OLUMIANT | BARICITINIB TAB 4 MG | 66603010000340 | Brand |

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| ILUMYA | TILDRAKIZUMAB-ASMN SUBCUTANEOUS SOLN PREF SYRINGE 100 MG/ML | 9025058010E520 | Brand |
| SKYRIZI | RISANKIZUMAB-RZAA SUBCUTANEOUS SOLN CARTRIDGE 180 MG/1.2ML | 5250406070E210 | Brand |
| SKYRIZI | RISANKIZUMAB-RZAA SUBCUTANEOUS SOLN CARTRIDGE 360 MG/2.4ML | 5250406070E220 | Brand |
| SKYRIZI | RISANKIZUMAB-RZAA IV SOLN 600 MG/10ML (60 MG/ML) | 52504060702020 | Brand |
| SKYRIZI PEN | RISANKIZUMAB-RZAA SOLN AUTO-INJECTOR 150 MG/ML | 9025057070D520 | Brand |
| SKYRIZI | RISANKIZUMAB-RZAA SOLN PREFILLED SYRINGE 150 MG/ML | 9025057070E540 | Brand |
| RINVOQ | UPADACITINIB TAB ER 24HR 15 MG | 66603072007520 | Brand |
| RINVOQ | UPADACITINIB TAB ER 24HR 30 MG | 66603072007530 | Brand |
| RINVOQ | UPADACITINIB TAB ER 24HR 45 MG | 66603072007540 | Brand |
| SOTYKTU | DEUCRAVACITINIB TAB 6 MG | 90250524000320 | Brand |
| CIBINQO | ABROCITINIB TAB 50 MG | 90272005000320 | Brand |
| CIBINQO | ABROCITINIB TAB 100 MG | 90272005000325 | Brand |
| CIBINQO | ABROCITINIB TAB 200 MG | 90272005000330 | Brand |
| ADBRY | TRALOKINUMAB-LDRM SUBCUTANEOUS SOLN PREFILLED SYR 150 MG/ML | 9027308045E520 | Brand |
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 200 MG/1.14ML | 9027302000D515 | Brand |
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 300 MG/2ML | 9027302000D520 | Brand |
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/0.67ML | 9027302000E510 | Brand |
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 200 MG/1.14ML | 9027302000E515 | Brand |
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML | 9027302000E520 | Brand |
| STELARA | USTEKINUMAB IV SOLN 130 MG/26ML (5 MG/ML) (FOR IV INFUSION) | 52504070002020 | Brand |
| COPAXONE | GLATIRAMER ACETATE SOLN PREFILLED SYRINGE 20 MG/ML | 6240003010E520 | Brand |
| GLATIRAMER ACETATE | GLATIRAMER ACETATE SOLN PREFILLED SYRINGE 20 MG/ML | 6240003010E520 | Generic |
| GLATOPA | GLATIRAMER ACETATE SOLN PREFILLED SYRINGE 20 MG/ML | 6240003010E520 | Generic |
| COPAXONE | GLATIRAMER ACETATE SOLN PREFILLED SYRINGE 40 MG/ML | 6240003010E540 | Brand |
| GLATIRAMER ACETATE | GLATIRAMER ACETATE SOLN PREFILLED SYRINGE 40 MG/ML | 6240003010E540 | Generic |

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| GLATOPA | GLATIRAMER ACETATE SOLN PREFILLED SYRINGE 40 MG/ML | 6240003010E540 | Generic |
| MAVENCLAD | CLADRIBINE TAB THERAPY PACK 10 MG (4 TABS) | 6240101500B718 | Brand |
| MAVENCLAD | CLADRIBINE TAB THERAPY PACK 10 MG (5 TABS) | 6240101500B722 | Brand |
| MAVENCLAD | CLADRIBINE TAB THERAPY PACK 10 MG (6 TABS) | 6240101500B726 | Brand |
| MAVENCLAD | CLADRIBINE TAB THERAPY PACK 10 MG (7 TABS) | 6240101500B732 | Brand |
| MAVENCLAD | CLADRIBINE TAB THERAPY PACK 10 MG (8 TABS) | 6240101500B736 | Brand |
| MAVENCLAD | CLADRIBINE TAB THERAPY PACK 10 MG (9 TABS) | 6240101500B740 | Brand |
| MAVENCLAD | CLADRIBINE TAB THERAPY PACK 10 MG (10 TABS) | 6240101500B744 | Brand |
| REBIF REBIDOSE | INTERFERON BETA-1A SOLN AUTO-INJ 22 MCG/0.5ML | 6240306045D520 | Brand |
| REBIF REBIDOSE | INTERFERON BETA-1A SOLN AUTO-INJ 44 MCG/0.5ML | 6240306045D540 | Brand |
| REBIF REBIDOSE TITRATION PACK | INTERFERON BETA-1A AUTO-INJ 6X8.8 MCG/0.2ML & 6X22 MCG/0.5ML | 6240306045D560 | Brand |
| REBIF | INTERFERON BETA-1A SOLN PREF SYR 22 MCG/0.5ML | 6240306045E520 | Brand |
| REBIF | INTERFERON BETA-1A SOLN PREF SYR 44 MCG/0.5ML | 6240306045E540 | Brand |
| REBIF TITRATION PACK | INTERFERON BETA-1A PREF SYR 6X8.8 MCG/0.2ML & 6X22 MCG/0.5ML | 6240306045E560 | Brand |
| AVONEX PEN | INTERFERON BETA-1A IM AUTO-INJECTOR KIT 30 MCG/0.5ML | 6240306045F530 | Brand |
| AVONEX | INTERFERON BETA-1A IM PREFILLED SYRINGE KIT 30 MCG/0.5ML | 6240306045F830 | Brand |
| BETASERON | INTERFERON BETA-1B FOR INJ KIT 0.3 MG | 62403060506420 | Brand |
| EXTAVIA | INTERFERON BETA-1B FOR INJ KIT 0.3 MG | 62403060506420 | Brand |
| PLEGRIDY | PEGINTERFERON BETA-1A SOLN PEN-INJECTOR 125 MCG/0.5ML | 6240307530D520 | Brand |
| PLEGRIDY STARTER PACK | PEGINTERFERON BETA-1A SOLN PEN-INJ 63 & 94 MCG/0.5ML PACK | 6240307530D550 | Brand |
| PLEGRIDY | PEGINTERFERON BETA-1A SOLN PREFILLED SYRINGE 125 MCG/0.5ML | 6240307530E520 | Brand |
| PLEGRIDY | PEGINTERFERON BETA-1A IM SOLN PREFILLED SYR 125 MCG/0.5ML | 6240307530E521 | Brand |
| PLEGRIDY STARTER PACK | PEGINTERFERON BETA-1A SOLN PREF SYR 63 & 94 MCG/0.5ML PACK | 6240307530E550 | Brand |

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| AUBAGIO | TERIFLUNOMIDE TAB 7 MG | 62404070000320 | Brand |
| TERIFLUNOMIDE | TERIFLUNOMIDE TAB 7 MG | 62404070000320 | Generic |
| AUBAGIO | TERIFLUNOMIDE TAB 14 MG | 62404070000330 | Brand |
| TERIFLUNOMIDE | TERIFLUNOMIDE TAB 14 MG | 62404070000330 | Generic |
| LEMTRADA | ALEMTUZUMAB IV INJ 12 MG/1.2ML (10 MG/ML) | 62405010002020 | Brand |
| TYSABRI | NATALIZUMAB FOR IV INJ CONC 300 MG/15ML | 62405050001320 | Brand |
| OCREVUS | OCRELIZUMAB SOLN FOR IV INFUSION 300 MG/10ML | 62405060002020 | Brand |
| VUMERITY | DIROXIMEL FUMARATE CAPSULE DELAYED RELEASE 231 MG | 62405530006540 | Brand |
| GILENYA | FINGOLIMOD HCL CAP 0.25 MG (BASE EQUIV) | 62407025100110 | Brand |
| FINGOLIMOD | FINGOLIMOD HCL CAP 0.5 MG (BASE EQUIV) | 62407025100120 | Generic |
| GILENYA | FINGOLIMOD HCL CAP 0.5 MG (BASE EQUIV) | 62407025100120 | Brand |
| TASCENSO ODT | FINGOLIMOD LAURYL SULFATE TABLET DISINTEGRATING 0.25 MG | 62407025207220 | Brand |
| TASCENSO ODT | FINGOLIMOD LAURYL SULFATE TABLET DISINTEGRATING 0.5 MG | 62407025207230 | Brand |
| ZEPOSIA | OZANIMOD HCL CAP 0.92 MG | 62407050200120 | Brand |
| MAYZENT | SIPONIMOD FUMARATE TAB 0.25 MG (BASE EQUIV) | 62407070200320 | Brand |
| MAYZENT | SIPONIMOD FUMARATE TAB 1 MG (BASE EQUIV) | 62407070200330 | Brand |
| MAYZENT | SIPONIMOD FUMARATE TAB 2 MG (BASE EQUIV) | 62407070200340 | Brand |
| MAYZENT STARTER PACK | SIPONIMOD FUMARATE TAB 0.25 MG (7) STARTER PACK | 6240707020B710 | Brand |
| MAYZENT STARTER PACK | SIPONIMOD FUMARATE TAB 0.25 MG (12) STARTER PACK | 6240707020B720 | Brand |
| BAFIERTAM | MONOMETHYL FUMARATE CAPSULE DELAYED RELEASE 95 MG | 62405550006520 | Brand |
| KESIMPTA | OFATUMUMAB SOLN AUTO-INJECTOR 20 MG/0.4ML | 6240506500D520 | Brand |
| DIMETHYL FUMARATE | DIMETHYL FUMARATE CAPSULE DELAYED RELEASE 120 MG | 62405525006520 | Generic |
| TECFIDERA | DIMETHYL FUMARATE CAPSULE DELAYED RELEASE 120 MG | 62405525006520 | Brand |
| DIMETHYL FUMARATE | DIMETHYL FUMARATE CAPSULE DELAYED RELEASE 240 MG | 62405525006540 | Generic |

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| TECFIDERA | DIMETHYL FUMARATE CAPSULE DELAYED RELEASE 240 MG | 62405525006540 | Brand |
| PONVORY | PONESIMOD TAB 20 MG | 62407060000320 | Brand |
| PONVORY 14-DAY STARTER PACK | PONESIMOD TAB STARTER PACK 2,3,4,5,6,7,8,9 &10 MG | 6240706000B720 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 75 MG/0.5ML | 4460306000E510 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/ML | 4460306000E520 | Brand |
| XOLAIR | OMALIZUMAB FOR INJ 150 MG | 44603060002120 | Brand |
| FASENRA PEN | BENRALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 30 MG/ML | 4460402000D520 | Brand |
| FASENRA | BENRALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 30 MG/ML | 4460402000E520 | Brand |
| NUCALA | MEPOLIZUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML | 4460405500D530 | Brand |
| NUCALA | MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 40 MG/0.4ML | 4460405500E520 | Brand |
| NUCALA | MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 100 MG/ML | 4460405500E530 | Brand |
| NUCALA | MEPOLIZUMAB FOR INJ 100 MG | 44604055002120 | Brand |
| CINQAIR | RESLIZUMAB IV INFUSION SOLN 100 MG/10ML (10 MG/ML) | 44604460002020 | Brand |
| TEZSPIRE | TEZEPELUMAB-EKKO SUBCUTANEOUS SOLN PREF SYR 210 MG/1.91ML | 4460807525E520 | Brand |
| TEZSPIRE | TEZEPELUMAB-EKKO SUBCUTANEOUS SOLN AUTO-INJ 210 MG/1.91ML | 4460807525D520 | Brand |
| ZEPOSIA 7-DAY STARTER PACK | OZANIMOD CAP PACK 4 X 0.23 MG & 3 X 0.46 MG | 6240705020B210 | Brand |
| ZEPOSIA STARTER KIT | OZANIMOD CAP PACK 4 X 0.23 MG & 3 X 0.46 MG & 21 X 0.92 MG | 6240705020B215 | Brand |
| ZEPOSIA STARTER KIT | OZANIMOD CAP PACK 4 X 0.23 MG & 3 X 0.46 MG & 30 X 0.92 MG | 6240705020B220 | Brand |
| IDACIO | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| IDACIO STARTER PACKAGE FOR CROHNS DISEASE | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| IDACIO STARTER PACKAGE FOR PLAQUE PSORIASIS | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| ADALIMUMAB-FKJP | ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001535F810 | Brand |

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|---|---|---|---|
| HULIO | ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001535F810 | Brand |
| ADALIMUMAB-FKJP | ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001535F520 | Brand |
| HULIO | ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001535F520 | Brand |
| ADALIMUMAB-FKJP | ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001535F820 | Brand |
| HULIO | ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001535F820 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001505F820 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001505F810 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 10 MG/0.2ML | 6627001505F805 | Brand |
| CYLTEZO STARTER PACKAGE FOR PSORIASIS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| YUSIMRY | ADALIMUMAB-AQVH SOLN PEN-INJECTOR 40 MG/0.8ML | 6627001509D520 | Brand |
| HADLIMA PUSHTOUCH | ADALIMUMAB-BWWD SOLN AUTO-INJECTOR 40 MG/0.4ML | 6627001520D510 | Brand |
| HADLIMA PUSHTOUCH | ADALIMUMAB-BWWD SOLN AUTO-INJECTOR 40 MG/0.8ML | 6627001520D520 | Brand |
| HADLIMA | ADALIMUMAB-BWWD SOLN PREFILLED SYRINGE 40 MG/0.4ML | 6627001520E510 | Brand |
| HADLIMA | ADALIMUMAB-BWWD SOLN PREFILLED SYRINGE 40 MG/0.8ML | 6627001520E520 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.4ML | 6627001504D515 | Brand |
| ADALIMUMAB-ADAZ | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.4ML | 6627001504D515 | Brand |
| HYRIMOZ CROHN'S DISEASE AND ULCERATIVE COLITIS STARTER PACK | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML | 6627001504D540 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML | 6627001504D540 | Brand |

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|---|---|---|---|
| HYRIMOZ PLAQUE PSORIASIS STARTER PACK | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML & 40 MG/0.4ML | 6627001504D560 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 10 MG/0.1ML | 6627001504E508 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 20 MG/0.2ML | 6627001504E513 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.4ML | 6627001504E515 | Brand |
| ADALIMUMAB-ADAZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.4ML | 6627001504E515 | Brand |
| HYRIMOZ PEDIATRIC CROHNS DISEASE STARTER PACK | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 80 MG/0.8ML | 6627001504E540 | Brand |
| HYRIMOZ PEDIATRIC CROHN'SDISEASE STARTER PACK | ADALIMUMAB-ADAZ SOLN PREFILLED SYR 80 MG/0.8ML & 40 MG/0.4ML | 6627001504E560 | Brand |
| YUFLYMA 2-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001503F530 | Brand |
| YUFLYMA 1-PEN KIT | ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001503F530 | Brand |
| YUFLYMA 2-SYRINGE KIT | ADALIMUMAB-AATY PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001503F830 | Brand |
| DIMETHYL FUMARATE STARTERPACK | DIMETHYL FUMARATE CAPSULE DR STARTER PACK 120 MG & 240 MG | 6240552500B320 | Generic |
| TECFIDERA STARTER PACK | DIMETHYL FUMARATE CAPSULE DR STARTER PACK 120 MG & 240 MG | 6240552500B320 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.8ML | 6627001504D520 | Brand |
| HYRIMOZ | ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.8ML | 6627001504E520 | Brand |
| ENTYVIO | VEDOLIZUMAB SOLN PEN-INJECTOR 108 MG/0.68ML | 5250308000D520 | Brand |
| ABRILADA | ADALIMUMAB-AFZB PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001507F810 | Brand |
| ABRILADA | ADALIMUMAB-AFZB PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001507F820 | Brand |
| VELSIPITY | ETRASIMOD ARGININE TAB 2 MG | 52504525100350 | Brand |
| BIMZELX | BIMEKIZUMAB-BKZX SUBCUTANEOUS SOLN AUTO-INJECTOR 160 MG/ML | 9025051800D520 | Brand |
| BIMZELX | BIMEKIZUMAB-BKZX SUBCUTANEOUS SOLN PREFILLED SYR 160 MG/ML | 9025051800E520 | Brand |
| OMVOH | MIRIKIZUMAB-MRKZ SUBCUTANEOUS SOLN AUTO-INJECTOR 100 MG/ML | 5250405040D520 | Brand |

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|---|---|---|---|
| OMVOH | MIRIKIZUMAB-MRKZ IV SOLN 300 MG/15ML (20 MG/ML) | 52504050402030 | Brand |
| COSENTYX UNOREADY | SECUKINUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML | 9025057500D550 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| ADALIMUMAB-ADBM CROHNS/UC/HS STARTER | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| ADALIMUMAB-ADBM PSORIASIS/UVEITIS STARTER | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001505F520 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 10 MG/0.2ML | 6627001505F805 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 20 MG/0.4ML | 6627001505F810 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001505F820 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 20 MG/0.2ML | 6627001510E508 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 40 MG/0.4ML | 6627001510E517 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 40 MG/0.4ML | 6627001510D517 | Brand |
| AMJEVITA | ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 80 MG/0.8ML | 6627001510D537 | Brand |
| YUFLYMA | ADALIMUMAB-AATY AUTO-INJECTOR KIT 80 MG/0.8ML | 6627001503F560 | Brand |
| YUFLYMA CD/UC/HS STARTER | ADALIMUMAB-AATY AUTO-INJECTOR KIT 80 MG/0.8ML | 6627001503F560 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 75 MG/0.5ML | 4460306000D510 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 150 MG/ML | 4460306000D520 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML | 4460306000D530 | Brand |
| ABRILADA 1-PEN KIT | ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001507F520 | Brand |
| ABRILADA 2-PEN KIT | ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001507F520 | Brand |
| HYRIMOZ SENSOREADY PENS | ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML | 6627001504D540 | Brand |

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|---|---|---|---|
| ADALIMUMAB-AACF (2 PEN) | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| IDACIO (2 PEN) | ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML | 6627001502F540 | Brand |
| IDACIO (2 SYRINGE) | ADALIMUMAB-AACF PREFILLED SYRINGE KIT 40 MG/0.8ML | 6627001502F840 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML | 4460306000E530 | Brand |
| ZYMFENTRA 2-SYRINGE | INFLIXIMAB-DYYB SOLN PREFILLED SYRINGE KIT 120 MG/ML | 5250504020F830 | Brand |
| ZYMFENTRA 1-PEN | INFLIXIMAB-DYYB SOLN AUTO-INJECTOR KIT 120 MG/ML | 5250504020F530 | Brand |
| ZYMFENTRA 2-PEN | INFLIXIMAB-DYYB SOLN AUTO-INJECTOR KIT 120 MG/ML | 5250504020F530 | Brand |
| ADALIMUMAB-AATY 2-SYRINGE KIT | ADALIMUMAB-AATY PREFILLED SYRINGE KIT 20 MG/0.2ML | 6627001503F820 | Brand |
| YUFLYMA 2-SYRINGE KIT | ADALIMUMAB-AATY PREFILLED SYRINGE KIT 20 MG/0.2ML | 6627001503F820 | Brand |
| ADALIMUMAB-RYVK (2 PEN) | ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001540F520 | Brand |
| SIMLANDI 1-PEN KIT | ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001540F520 | Brand |
| SIMLANDI 2-PEN KIT | ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001540F520 | Brand |
| SPEVIGO | SPESOLIMAB-SBZO SUBCUTANEOUS SOLN PREF SYR 150 MG/ML | 9025057770E530 | Brand |
| TYENNE | TOCILIZUMAB-AAZG IV INJ 80 MG/4ML | 66500070172030 | Brand |
| TYENNE | TOCILIZUMAB-AAZG IV INJ 200 MG/10ML | 66500070172035 | Brand |
| TYENNE | TOCILIZUMAB-AAZG IV INJ 400 MG/20ML | 66500070172040 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| ADALIMUMAB-ADBM STARTER PACKAGE FOR CROHNS DISEASE/UC/HS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| ADALIMUMAB-ADBM STARTER PACKAGE FOR PSORIASIS/UVEITIS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |

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|---|---|---|---|
| CYLTEZO STARTER PACKAGE FOR PSORIASIS/UVEITIS | ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML | 6627001505F515 | Brand |
| ADALIMUMAB-ADBM | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001505F815 | Brand |
| CYLTEZO | ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001505F815 | Brand |
| OMVOH | MIRIKIZUMAB-MRKZ SUBCUTANEOUS SOL PREFILL SYRINGE 100 MG/ML | 5250405040E520 | Brand |
| FASENRA | BENRALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 10 MG/0.5ML | 4460402000E515 | Brand |
| RINVOQ LQ | UPADACITINIB ORAL SOLN 1 MG/ML | 66603072002020 | Brand |
| TYENNE | TOCILIZUMAB-AAZG SUBCUTANEOUS SOLN AUTO-INJ 162 MG/0.9ML | 6650007017D520 | Brand |
| TYENNE | TOCILIZUMAB-AAZG SUBCUTANEOUS SOLN PREF SYR 162 MG/0.9ML | 6650007017E520 | Brand |
| ADBRY | TRALOKINUMAB-LDRM SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML | 9027308045D530 | Brand |
| ADALIMUMAB-RYVK | ADALIMUMAB-RYVK PREFILLED SYRINGE KIT 40 MG/0.4ML | 6627001540F820 | Brand |
| OTEZLA | APREMILAST TAB 20 MG | 66700015000320 | Brand |
| OTEZLA | APREMILAST TAB STARTER THERAPY PACK 4 X 10 MG & 51 X 20 MG | 6670001500B710 | Brand |
| TALTZ | IXEKIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 20 MG/0.25ML | 9025055400E510 | Brand |
| TALTZ | IXEKIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 40 MG/0.5ML | 9025055400E515 | Brand |
| NEMLUVIO | NEMOLIZUMAB-ILTO FOR SUBCUTANEOUS AUTO-INJECTOR 30 MG | 9079355510D420 | Brand |
| EBGLYSS | LEBRIKIZUMAB-LBKZ SUBCUTANEOUS SOLN AUTO-INJECT 250 MG/2ML | 9027304010D520 | Brand |
| EBGLYSS | LEBRIKIZUMAB-LBKZ SOLUTION PREFILLED SYRINGE 250 MG/2ML | 9027304010E520 | Brand |
| TREMFYA | GUSELKUMAB SOLN AUTO-INJECTOR 100 MG/ML | 9025054200D520 | Brand |
| TREMFYA | GUSELKUMAB SOLN AUTO-INJECTOR 200 MG/2ML | 9025054200D540 | Brand |
| TREMFYA | GUSELKUMAB SOLN PREFILLED SYRINGE 200 MG/2ML | 9025054200E540 | Brand |
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 200 MG/1.14ML | 9027302000D515 | Brand |
| DUPIXENT | DUPILUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML | 9027302000D520 | Brand |
| OCREVUS ZUNOVO | OCRELIZUMAB-HYALURONIDASE-OCSQ INJ 920-23000 MG-UNIT/23ML | 62409902602040 | Brand |

**Approval Criteria**

**1** - The requested medication will be used exclusively, and the previously prescribed medication will be discontinued

## 2 . Revision History

| Date | Notes |
|---|---|
| 12/17/2024 | Updated drug list/GPIs. |

Tibsovo

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146677 |
| **Guideline Name** | Tibsovo |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Tibsovo | |
|---|---|
| Diagnosis | Acute Myeloid Leukemia (AML) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TIBSOVO | IVOSIDENIB TAB 250 MG | 21534940000320 | Brand |

**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 60 years of age or older AND not a candidate for or declines intensive induction therapy
- Patient is 60 years of age or older AND 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TIBSOVO | IVOSIDENIB TAB 250 MG | 21534940000320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TIBSOVO | IVOSIDENIB TAB 250 MG | 21534940000320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TIBSOVO | IVOSIDENIB TAB 250 MG | 21534940000320 | Brand |

**Approval Criteria**

**1** - Diagnosis of oligodendroglioma

**AND**

**2** - Disease is recurrent or progressive

**AND**

**3** - Presence of BOTH of the following:

- IDH1 mutation
- 1p19q codeletion

**AND**

**4** - Karnofsky Performance Status (KPS) greater than or equal to 60

**AND**

**5** - Disease is WHO grade 2 or 3

| Product Name: Tibsovo | |
|---|---|
| Diagnosis | Astrocytoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TIBSOVO | IVOSIDENIB TAB 250 MG | 21534940000320 | Brand |

**Approval Criteria**

**1** - Diagnosis of astrocytoma

**AND**

**2** - Disease is recurrent or progressive

**AND**

**3** - Presence of IDH1 mutation

**AND**

**4** - Karnofsky Performance Status (KPS) greater than or equal to 60

**AND**

**5** - Disease is WHO grade 2

| Product Name: Tibsovo | |
|---|---|
| Diagnosis | Myelodysplastic Syndrome (MDS) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TIBSOVO | IVOSIDENIB TAB 250 MG | 21534940000320 | Brand |

**Approval Criteria**

**1** - Diagnosis of myelodysplastic syndrome (MDS)

**AND**

**2** - Disease is relapsed or refractory

**AND**

**3** - Presence of IDH1 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TIBSOVO | IVOSIDENIB TAB 250 MG | 21534940000320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TIBSOVO | IVOSIDENIB TAB 250 MG | 21534940000320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TIBSOVO | IVOSIDENIB TAB 250 MG | 21534940000320 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Tibsovo therapy

Tobramycin Inhalation

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146678 |
| **Guideline Name** | Tobramycin Inhalation |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: generic tobramycin 300 mg/4mL nebu soln (generic Bethkis) | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TOBRAMYCIN | TOBRAMYCIN NEBU SOLN 300 MG/4ML | 07000070002530 | Generic |

**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, generic tobramycin 300 mg/5mL nebu soln, Brand Tobramycin 300mg/5mL nebu soln, Tobi Podhaler, Brand Bethkis | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TOBRAMYCIN | TOBRAMYCIN NEBU SOLN 300 MG/5ML | 07000070002520 | Generic |
| TOBI | TOBRAMYCIN NEBU SOLN 300 MG/5ML | 07000070002520 | Brand |
| KITABIS PAK | TOBRAMYCIN NEBU SOLN 300 MG/5ML | 07000070002520 | Generic |
| TOBI PODHALER | TOBRAMYCIN INHAL CAP 28 MG | 07000070000120 | Brand |
| BETHKIS | TOBRAMYCIN NEBU SOLN 300 MG/4ML | 07000070002530 | Brand |

**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/4mL (milligrams/milliliter) solution for inhalation (generic Bethkis) as confirmed by claims history or submission of medical records

**OR**

**3.2** History of contraindication or intolerance to generic tobramycin 300 mg/4mL solution for inhalation (generic Bethkis) (please specify contraindication or intolerance)

| Product Name: Kitabis Pak, Brand Tobi nebu soln, generic tobramycin 300 mg/5mL nebu soln, Brand Tobramycin 300mg/5mL nebu soln, Tobi Podhaler, Brand Bethkis | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TOBRAMYCIN | TOBRAMYCIN NEBU SOLN 300 MG/5ML | 07000070002520 | Generic |
| TOBI | TOBRAMYCIN NEBU SOLN 300 MG/5ML | 07000070002520 | Brand |
| KITABIS PAK | TOBRAMYCIN NEBU SOLN 300 MG/5ML | 07000070002520 | Generic |
| TOBI PODHALER | TOBRAMYCIN INHAL CAP 28 MG | 07000070000120 | Brand |
| BETHKIS | TOBRAMYCIN NEBU SOLN 300 MG/4ML | 07000070002530 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to therapy

Tocilizumab

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-155299 |
| **Guideline Name** | Tocilizumab |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 10/1/2024 |

## 1 . Criteria

| Product Name: Actemra subcutaneous, Tyenne subcutaneous | |
|---|---|
| Diagnosis | Rheumatoid Arthritis (RA) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ACTEMRA ACTPEN | TOCILIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 162 MG/0.9ML | 6650007000D520 | Brand |
| ACTEMRA | TOCILIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 162 MG/0.9ML | 6650007000E520 | Brand |
| TYENNE | TOCILIZUMAB-AAZG SUBCUTANEOUS SOLN AUTO-INJ 162 MG/0.9ML | 6650007017D520 | Brand |

| TYENNE | TOCILIZUMAB-AAZG SUBCUTANEOUS SOLN PREF SYR 162 MG/0.9ML | 6650007017E520 | Brand |
|---|---|---|---|

**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 biologic or targeted synthetic DMARD FDA (Food and Drug Administration)-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)]

**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 targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

**AND**

**1.6** Prescribed by or in consultation with a rheumatologist

**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 targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

**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

| | |
|---|---|
| Notes | *For a list of preferred adalimumab products please reference drug co verage tools.<br>**For a list of preferred tocilizumab products please reference drug co verage tools. |

| Product Name: Actemra subcutaneous, Tyenne subcutaneous | |
|---|---|
| Diagnosis | Giant Cell Arteritis (GCA) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ACTEMRA ACTPEN | TOCILIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 162 MG/0.9ML | 6650007000D520 | Brand |
| ACTEMRA | TOCILIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 162 MG/0.9ML | 6650007000E520 | Brand |
| TYENNE | TOCILIZUMAB-AAZG SUBCUTANEOUS SOLN AUTO-INJ 162 MG/0.9ML | 6650007017D520 | Brand |
| TYENNE | TOCILIZUMAB-AAZG SUBCUTANEOUS SOLN PREF SYR 162 MG/0.9ML | 6650007017E520 | Brand |

**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 targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

**AND**

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

| Notes | **For a list of preferred tocilizumab products please reference drug co verage tools. |
|---|---|

| Product Name: Actemra subcutaneous, Tyenne subcutaneous | |
|---|---|
| Diagnosis | Polyarticular Juvenile Idiopathic Arthritis (PJIA) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ACTEMRA ACTPEN | TOCILIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 162 MG/0.9ML | 6650007000D520 | Brand |
| ACTEMRA | TOCILIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 162 MG/0.9ML | 6650007000E520 | Brand |
| TYENNE | TOCILIZUMAB-AAZG SUBCUTANEOUS SOLN AUTO-INJ 162 MG/0.9ML | 6650007017D520 | Brand |
| TYENNE | TOCILIZUMAB-AAZG SUBCUTANEOUS SOLN PREF SYR 162 MG/0.9ML | 6650007017E520 | Brand |

**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 targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

**AND**

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

| | |
|---|---|
| Notes | *For a list of preferred adalimumab products please reference drug co verage tools.<br>**For a list of preferred tocilizumab products please reference drug co verage tools. |

| Product Name: Actemra subcutaneous, Tyenne subcutaneous | |
|---|---|
| Diagnosis | Systemic Juvenile Idiopathic Arthritis (SJIA) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ACTEMRA ACTPEN | TOCILIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 162 MG/0.9ML | 6650007000D520 | Brand |

| | | | |
|---|---|---|---|
| ACTEMRA | TOCILIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 162 MG/0.9ML | 6650007000E520 | Brand |
| TYENNE | TOCILIZUMAB-AAZG SUBCUTANEOUS SOLN AUTO-INJ 162 MG/0.9ML | 6650007017D520 | Brand |
| TYENNE | TOCILIZUMAB-AAZG SUBCUTANEOUS SOLN PREF SYR 162 MG/0.9ML | 6650007017E520 | Brand |

**Approval Criteria**

**1** - Diagnosis of active systemic juvenile idiopathic arthritis (SJIA)

**AND**

**2** - Patient is NOT receiving tocilizumab in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

**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

| | |
|---|---|
| Notes | **For a list of preferred tocilizumab products please reference drug co verage tools. |

| Product Name: Actemra subcutaneous, Tyenne subcutaneous | |
|---|---|
| Diagnosis | Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ACTEMRA ACTPEN | TOCILIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 162 MG/0.9ML | 6650007000D520 | Brand |
| ACTEMRA | TOCILIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 162 MG/0.9ML | 6650007000E520 | Brand |
| TYENNE | TOCILIZUMAB-AAZG SUBCUTANEOUS SOLN AUTO-INJ 162 MG/0.9ML | 6650007017D520 | Brand |
| TYENNE | TOCILIZUMAB-AAZG SUBCUTANEOUS SOLN PREF SYR 162 MG/0.9ML | 6650007017E520 | Brand |

**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 targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

**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

| | |
|---|---|
| Notes | **For a list of preferred tocilizumab products please reference drug co verage tools. |

| Product Name: Actemra subcutaneous, Tyenne subcutaneous | |
|---|---|
| Diagnosis | RA, GCA, PJIA, SJIA, SSc-ILD |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ACTEMRA ACTPEN | TOCILIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 162 MG/0.9ML | 6650007000D520 | Brand |
| ACTEMRA | TOCILIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 162 MG/0.9ML | 6650007000E520 | Brand |
| TYENNE | TOCILIZUMAB-AAZG SUBCUTANEOUS SOLN AUTO-INJ 162 MG/0.9ML | 6650007017D520 | Brand |
| TYENNE | TOCILIZUMAB-AAZG SUBCUTANEOUS SOLN PREF SYR 162 MG/0.9ML | 6650007017E520 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to tocilizumab therapy

| | |
|---|---|
| **AND**<br><br>**2** - Patient is NOT receiving tocilizumab in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]*<br><br>**AND**<br><br>**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) | |
| Notes | * Examples of drug(s) may not be applicable based on the requested i ndication.<br>**For a list of preferred tocilizumab products please reference drug co verage tools. |

## 2 . Background

| **Benefit/Coverage/Program Information** |
|---|
| **PDL Link**<br><br>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 |
|---|---|
| 9/19/2024 | Updated safety language. Added Tyenne and renamed policy to Tocili zumab. Updated step through agents where appropriate. |

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146920 |
| **Guideline Name** | Topical NSAIDs |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Brand diclofenac epolamine patch, Brand Flector | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| DICLOFENAC EPOLAMINE | DICLOFENAC EPOLAMINE PATCH 1.3% | 90210030205920 | Generic |
| FLECTOR | DICLOFENAC EPOLAMINE PATCH 1.3% | 90210030205920 | Generic |

**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 Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |
|---|---|

| Product Name: Brand Pennsaid, generic diclofenac sodium soln 2%, diclofenac sodium soln 1.5% | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| PENNSAID | DICLOFENAC SODIUM SOLN 2% | 90210030302030 | Brand |
| DICLOFENAC SODIUM | DICLOFENAC SODIUM SOLN 1.5% | 90210030302025 | Generic |
| DICLOFENAC SODIUM | DICLOFENAC SODIUM SOLN 2% | 90210030302030 | Generic |

**Approval Criteria**

**1** - Patient has a 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 of BOTH of the following, as confirmed by claims history or submitted 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 of ONE of the following, as confirmed by claims history or submitted 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 Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |
|---|---|

| Product Name: Voltaren (Rx and OTC formulations) | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VOLTAREN | DICLOFENAC SODIUM GEL 1% (1.16% DIETHYLAMINE EQUIV) | 90210030304020 | Brand |

**Approval Criteria**

**1** - The patient has a diagnosis of pain due to osteoarthritis of joints amenable to topical treatment, including but not limited to the hands, knees, ankles, elbows, feet, and wrists

**AND**

**2** - ONE of the following:

**2.1** If the request is for the 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 the 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):<br><br>• diclofenac topical gel 1% (Rx formulation) (generic Voltaren)<br>• diclofenac topical gel 1% (OTC formulation) (generic Voltaren) | |
| Notes | *PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |

## 2 . Revision History

| Date | Notes |
|---|---|
| 5/1/2024 | Added NM PDL Link |

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-161609 |
| **Guideline Name** | Topical Retinoid Products |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 1 . Criteria

| | |
|---|---|
| Product Name: generic tretinoin microsphere, Retin-A Micro, Brand Differin cream, generic adapalene cream, Differin gel (Rx only)/lotion, adapalene gel/soln/pads, Fabior, tazarotene foam, Tazorac, generic tazarotene, adapalene/benzoyl peroxide, Brand Epiduo, Brand Epiduo Forte, Brand Atralin, generic tretinoin gel, Avita, Brand Retin-A, Altreno, Aklief, Arazlo | |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TRETINOIN MICROSPHERE | TRETINOIN MICROSPHERE GEL 0.04% | 90050030204015 | Generic |
| TRETINOIN MICROSPHERE PUMP | TRETINOIN MICROSPHERE GEL 0.04% | 90050030204015 | Generic |
| RETIN-A MICRO PUMP | TRETINOIN MICROSPHERE GEL 0.04% | 90050030204015 | Brand |
| RETIN-A MICRO | TRETINOIN MICROSPHERE GEL 0.04% | 90050030204015 | Brand |

| | | | |
|---|---|---|---|
| TRETINOIN MICROSPHERE | TRETINOIN MICROSPHERE GEL 0.1% | 90050030204030 | Generic |
| TRETINOIN MICROSPHERE PUMP | TRETINOIN MICROSPHERE GEL 0.1% | 90050030204030 | Generic |
| RETIN-A MICRO PUMP | TRETINOIN MICROSPHERE GEL 0.1% | 90050030204030 | Brand |
| RETIN-A MICRO | TRETINOIN MICROSPHERE GEL 0.1% | 90050030204030 | Brand |
| DIFFERIN | ADAPALENE CREAM 0.1% | 90050003003710 | Brand |
| ADAPALENE | ADAPALENE CREAM 0.1% | 90050003003710 | Generic |
| DIFFERIN | ADAPALENE GEL 0.1% | 90050003004010 | Brand |
| ADAPALENE | ADAPALENE GEL 0.1% | 90050003004010 | Generic |
| ADAPALENE TREATMENT | ADAPALENE GEL 0.1% | 90050003004010 | Generic |
| DIFFERIN | ADAPALENE GEL 0.3% | 90050003004030 | Brand |
| ADAPALENE | ADAPALENE GEL 0.3% | 90050003004030 | Generic |
| ADAPALENE PUMP | ADAPALENE GEL 0.3% | 90050003004030 | Generic |
| DIFFERIN | ADAPALENE LOTION 0.1% | 90050003004110 | Brand |
| ADAPALENE | ADAPALENE SOLN 0.1% | 90050003002010 | Brand |
| ADAPALENE | ADAPALENE PADS 0.1% | 90050003004310 | Brand |
| TAZAROTENE | TAZAROTENE (ACNE) FOAM 0.1% | 90050027003930 | Brand |
| FABIOR | TAZAROTENE (ACNE) FOAM 0.1% | 90050027003930 | Brand |
| TAZORAC | TAZAROTENE CREAM 0.1% | 90250070003730 | Brand |
| TAZAROTENE | TAZAROTENE CREAM 0.1% | 90250070003730 | Generic |
| TAZORAC | TAZAROTENE GEL 0.05% | 90250070004020 | Brand |
| TAZAROTENE | TAZAROTENE GEL 0.05% | 90250070004020 | Generic |
| TAZORAC | TAZAROTENE GEL 0.1% | 90250070004030 | Brand |
| TAZAROTENE | TAZAROTENE GEL 0.1% | 90250070004030 | Generic |
| TAZORAC | TAZAROTENE CREAM 0.05% | 90250070003720 | Brand |
| ADAPALENE/BENZOYL PEROXIDE | ADAPALENE-BENZOYL PEROXIDE GEL 0.1-2.5% | 90059902034020 | Generic |
| EPIDUO | ADAPALENE-BENZOYL PEROXIDE GEL 0.1-2.5% | 90059902034020 | Brand |
| ADAPALENE/BENZOYL PEROXIDE | ADAPALENE-BENZOYL PEROXIDE GEL 0.3-2.5% | 90059902034030 | Generic |
| EPIDUO FORTE | ADAPALENE-BENZOYL PEROXIDE GEL 0.3-2.5% | 90059902034030 | Brand |
| ADAPALENE/BENZOYL PEROXIDE | ADAPALENE-BENZOYL PEROXIDE PAD 0.1-2.5% | 90059902034320 | Brand |

| | | | |
|---|---|---|---|
| ATRALIN | TRETINOIN GEL 0.05% | 90050030004015 | Brand |
| TRETINOIN | TRETINOIN GEL 0.05% | 90050030004015 | Generic |
| AVITA | TRETINOIN CREAM 0.025% | 90050030003703 | Brand |
| RETIN-A | TRETINOIN CREAM 0.025% | 90050030003703 | Brand |
| AVITA | TRETINOIN GEL 0.025% | 90050030004010 | Brand |
| RETIN-A | TRETINOIN GEL 0.025% | 90050030004010 | Brand |
| TRETINOIN | TRETINOIN GEL 0.025% | 90050030004010 | Generic |
| RETIN-A | TRETINOIN CREAM 0.05% | 90050030003705 | Brand |
| RETIN-A | TRETINOIN CREAM 0.1% | 90050030003710 | Brand |
| RETIN-A | TRETINOIN GEL 0.01% | 90050030004005 | Brand |
| TRETINOIN | TRETINOIN GEL 0.01% | 90050030004005 | Generic |
| RETIN-A MICRO | TRETINOIN MICROSPHERE GEL 0.06% | 90050030204017 | Brand |
| RETIN-A MICRO PUMP | TRETINOIN MICROSPHERE GEL 0.08% | 90050030204020 | Brand |
| ALTRENO | TRETINOIN LOTION 0.05% | 90050030004130 | Brand |
| AKLIEF | TRIFAROTENE CREAM 0.005% | 90050035003720 | Brand |
| ARAZLO | TAZAROTENE (ACNE) LOTION 0.045% | 90050027004120 | Brand |
| TRETINOIN MICROSPHERE | TRETINOIN MICROSPHERE GEL 0.08% | 90050030204020 | Generic |
| TAZAROTENE | TAZAROTENE CREAM 0.05% | 90250070003720 | Generic |

**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 the re are fewer than three preferred alternatives, the patient must have a history of failure, contraindication, or intolerance to ALL of the preferre d products.<br>*PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new -mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |

| Product Name: generic tretinoin cream | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TRETINOIN | TRETINOIN CREAM 0.025% | 90050030003703 | Generic |
| TRETINOIN | TRETINOIN CREAM 0.05% | 90050030003705 | Generic |
| TRETINOIN | TRETINOIN CREAM 0.1% | 90050030003710 | Generic |

**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) |

## 3 . Revision History

| Date | Notes |
|---|---|
| 12/3/2024 | Updated GPIs |

Trelegy Ellipta, Breztri

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146429 |
| **Guideline Name** | Trelegy Ellipta, Breztri |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Trelegy Ellipta, Breztri Aerosphere | |
|---|---|
| Diagnosis | Chronic Obstructive Pulmonary Disease (COPD) |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TRELEGY ELLIPTA | FLUTICASONE-UMECLIDINIUM-VILANTEROL AEPB 100-62.5-25 MCG/ACT | 44209903408020 | Brand |
| TRELEGY ELLIPTA | FLUTICASONE-UMECLIDINIUM-VILANTEROL AEPB 200-62.5-25 MCG/ACT | 44209903408040 | Brand |
| BREZTRI AEROSPHERE | BUDESONIDE-GLYCOPYRROLATE-FORMOTEROL AERS 160-9-4.8 MCG/ACT | 44209903303220 | Brand |

**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/salmeterol (authorized generic of AirDuo)
- 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):

- Anoro Ellipta (umeclidinium/vilanterol)
- Stiolto Respimat (tiotropium/olodaterol)
- fluticasone/salmeterol (authorized generic of AirDuo)
- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

**OR**

**2.3** Eosinophil count greater than or equal to 300 cells/microliter as confirmed by submission of medical records

| Product Name: Trelegy Ellipta, Breztri Aerosphere | |
|---|---|
| Diagnosis | Asthma |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TRELEGY ELLIPTA | FLUTICASONE-UMECLIDINIUM-VILANTEROL AEPB 100-62.5-25 MCG/ACT | 44209903408020 | Brand |
| TRELEGY ELLIPTA | FLUTICASONE-UMECLIDINIUM-VILANTEROL AEPB 200-62.5-25 MCG/ACT | 44209903408040 | Brand |
| BREZTRI AEROSPHERE | BUDESONIDE-GLYCOPYRROLATE-FORMOTEROL AERS 160-9-4.8 MCG/ACT | 44209903303220 | Brand |

**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)
- 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)
- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

Tremfya

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-161131 |
| **Guideline Name** | Tremfya |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TREMFYA | GUSELKUMAB SOLN AUTO-INJECTOR 100 MG/ML | 9025054200D520 | Brand |
| TREMFYA | GUSELKUMAB SOLN AUTO-INJECTOR 200 MG/2ML | 9025054200D540 | Brand |
| TREMFYA | GUSELKUMAB SOLN PREFILLED SYRINGE 100 MG/ML | 9025054200E520 | Brand |

| | | | |
|---|---|---|---|
| TREMFYA | GUSELKUMAB SOLN PREFILLED SYRINGE 200 MG/2ML | 9025054200E540 | Brand |

**Approval Criteria**

**1** - Diagnosis of chronic moderate to severe plaque psoriasis

**AND**

**2** - Patient is NOT receiving Tremfya in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), 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 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 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), Stelara (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 BOTH of the following, as confirmed by claims history or submission of medical records:

- One of the preferred adalimumab products*
- One of the following: Enbrel (etanercept) or Ilumya (tildrakizumab)

**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)
- Ilumya (tildrakizumab)

**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 | *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |
|---|---|

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TREMFYA | GUSELKUMAB SOLN AUTO-INJECTOR 100 MG/ML | 9025054200D520 | Brand |
| TREMFYA | GUSELKUMAB SOLN AUTO-INJECTOR 200 MG/2ML | 9025054200D540 | Brand |
| TREMFYA | GUSELKUMAB SOLN PREFILLED SYRINGE 100 MG/ML | 9025054200E520 | Brand |
| TREMFYA | GUSELKUMAB SOLN PREFILLED SYRINGE 200 MG/2ML | 9025054200E540 | Brand |

**Approval Criteria**

**1** - Diagnosis of active psoriatic arthritis

**AND**

**2** - Patient is NOT receiving Tremfya in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

**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 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), Stelara (ustekinumab), Xeljanz/XR (tofacitinib), Otezla (apremilast), Rinvoq (upadacitinib)]

**AND**

**4.2.2** One of the following:

- Failure to BOTH of the following preferred biologic products 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**

**4.2.3** 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 | *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |
|---|---|

| Product Name: Tremfya | |
|---|---|
| Diagnosis | Plaque Psoriasis, Psoriatic Arthritis (PsA) |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TREMFYA | GUSELKUMAB SOLN AUTO-INJECTOR 100 MG/ML | 9025054200D520 | Brand |
| TREMFYA | GUSELKUMAB SOLN AUTO-INJECTOR 200 MG/2ML | 9025054200D540 | Brand |
| TREMFYA | GUSELKUMAB SOLN PREFILLED SYRINGE 100 MG/ML | 9025054200E520 | Brand |
| TREMFYA | GUSELKUMAB SOLN PREFILLED SYRINGE 200 MG/2ML | 9025054200E540 | Brand |

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

## 2 . Revision History

| Date | Notes |
|---|---|
| 11/21/2024 | Updated safety language and step therapy bypass language. Remov ed Cimzia as step thru agent. Added PDL link |

Trikafta

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-151756 |
| **Guideline Name** | Trikafta |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 9/1/2024 |

## 1 . Criteria

| Product Name: Trikafta | |
|---|---|
| Diagnosis | Cystic Fibrosis |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TRIKAFTA | ELEXACAF-TEZACAF-IVACAF 100-50-75 MG &IVACAFTOR 150 MG TBPK | 4530990340B740 | Brand |
| TRIKAFTA | ELEXACAF-TEZACAF-IVACAF 50-25-37.5 MG & IVACAFTOR 75 MG TBPK | 4530990340B720 | Brand |
| TRIKAFTA | ELEXACAF-TEZACAF-IVACAF 80-40-60 MG& IVACAF 59.5MG THPK GRAN | 4530990340B120 | Brand |

| | | | |
|---|---|---|---|
| TRIKAFTA | ELEXACAF-TEZACAF-IVACAF 100-50-75 MG& IVACAF 75MG THPK GRAN | 4530990340B140 | Brand |

**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 mutations in the CFTR gene:

- F508del mutation
- A mutation that is responsive based on in vitro data (see chart in Table 1 of background section)

**AND**

**3** - The patient is greater than or equal to 2 years of age

**AND**

**4** - Prescribed by, or in consultation with, a provider who specializes in the treatment of CF

| Product Name: Trikafta | |
|---|---|
| Diagnosis | Cystic Fibrosis |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TRIKAFTA | ELEXACAF-TEZACAF-IVACAF 100-50-75 MG &IVACAFTOR 150 MG TBPK | 4530990340B740 | Brand |
| TRIKAFTA | ELEXACAF-TEZACAF-IVACAF 50-25-37.5 MG & IVACAFTOR 75 MG TBPK | 4530990340B720 | Brand |

| | | | |
|---|---|---|---|
| TRIKAFTA | ELEXACAF-TEZACAF-IVACAF 80-40-60 MG& IVACAF 59.5MG THPK GRAN | 4530990340B120 | Brand |
| TRIKAFTA | ELEXACAF-TEZACAF-IVACAF 100-50-75 MG& IVACAF 75MG THPK GRAN | 4530990340B140 | Brand |

**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 that are responsive to Trikafta

| | | | | | |
|---|---|---|---|---|---|
| *3141del9* | *E822K* | *G1069R* | *L967S* | *R117L* | *S912L* |
| *546insCTA* | *F191V* | *G1244E* | *L997F* | *R117P* | *S945L* |
| *A46D* | *F311del* | *G1249R* | *L1077P* | *R170H* | *S977F* |
| *A120T* | *F311L* | *G1349D* | *L1324P* | *R258G* | *S1159F* |
| *A234D* | *F508C* | *H139R* | *L1335P* | *R334L* | *S1159P* |
| *A349V* | *F508C;S1251N* † | *H199Y* | *L1480P* | *R334Q* | *S1251N* |
| *A455E* | *F508del* * | *H939R* | *M152V* | *R347H* | *S1255P* |
| *A554E* | *F575Y* | *H1054D* | *M265R* | *R347L* | *T338I* |
| *A1006E* | *F1016S* | *H1085P* | *M952I* | *R347P* | *T1036N* |
| *A1067T* | *F1052V* | *H1085R* | *M952T* | *R352Q* | *T1053I* |
| *D110E* | *F1074L* | *H1375P* | *M1101K* | *R352W* | *V201M* |
| *D110H* | *F1099L* | *I148T* | *P5L* | *R553Q* | *V232D* |
| *D192G* | *G27R* | *I175V* | *P67L* | *R668C* | *V456A* |

| | | | | | |
|---|---|---|---|---|---|
| *D443Y* | *G85E* | *I336K* | *P205S* | *R751L* | *V456F* |
| *D443Y;G576A;R668C* † | *G126D* | *I502T* | *P574H* | *R792G* | *V562I* |
| *D579G* | *G178E* | *I601F* | *Q98R* | *R933G* | *V754M* |
| *D614G* | *G178R* | *I618T* | *Q237E* | *R1066H* | *V1153E* |
| *D836Y* | *G194R* | *I807M* | *Q237H* | *R1070Q* | *V1240G* |
| *D924N* | *G194V* | *I980K* | *Q359R* | *R1070W* | *V1293G* |
| *D979V* | *G314E* | *I1027T* | *Q1291R* | *R1162L* | *W361R* |
| *D1152H* | *G463V* | *I1139V* | *R31L* | *R1283M* | *W1098C* |
| *D1270N* | *G480C* | *I1269N* | *R74Q* | *R1283S* | *W1282R* |
| *E56K* | *G551D* | *I1366N* | *R74W* | *S13F* | *Y109N* |
| *E60K* | *G551S* | *K1060T* | *R74W;D1270N* † | *S341P* | *Y161D* |
| *E92K* | *G576A* | *L15P* | *R74W;V201M* † | *S364P* | *Y161S* |
| *E116K* | *G576A;R668C* † | *L165S* | *R74W;V201M; D1270N* † | *S492F* | *Y563N* |
| *E193K* | *G622D* | *L206W* | *R75Q* | *S549N* | *Y1014C* |
| *E403D* | *G628R* | *L320V* | *R117C* | *S549R* | *Y1032C* |
| *E474K* | *G970D* | *L346P* | *R117G* | *S589N* | |
| *E588V* | *G1061R* | *L453S* | *R117H* | *S737F* | |

* *F508del* is a responsive *CFTR* mutation based on both clinical and *in vitro* data.

† 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 |
|---|---|

| | |
|---|---|
| 8/14/2024 | Removed prescriber requirement from reauthorization criteria. Increa sed initial authorization approval duration to 12 months. |

Triptans

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-152691 |
| **Guideline Name** | Triptans |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 9/1/2024 |

## 1 . Criteria

| Product Name: generic naratriptan | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Step Therapy |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| NARATRIPTAN HCL | NARATRIPTAN HCL TAB 1 MG (BASE EQUIV) | 67406050100310 | Generic |
| NARATRIPTAN HCL | NARATRIPTAN HCL TAB 2.5 MG (BASE EQUIV) | 67406050100320 | Generic |

**Approval Criteria**

**1** - Diagnosis of migraine headaches with or without aura

**AND**

**2** - ONE of the following:

**2.1** Failure to sumatriptan (generic Imitrex) tablets at a minimum dose of 50 mg (milligrams) as confirmed by claims history or submission of medical records

**OR**

**2.2** History of contraindication or intolerance to sumatriptan (generic Imitrex) tablets (please specify intolerance or contraindication)

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

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ALMOTRIPTAN | ALMOTRIPTAN MALATE TAB 6.25 MG | 67406010100320 | Generic |
| ALMOTRIPTAN MALATE | ALMOTRIPTAN MALATE TAB 6.25 MG | 67406010100320 | Generic |
| ALMOTRIPTAN | ALMOTRIPTAN MALATE TAB 12.5 MG | 67406010100330 | Generic |
| ALMOTRIPTAN MALATE | ALMOTRIPTAN MALATE TAB 12.5 MG | 67406010100330 | Generic |
| ELETRIPTAN HYDROBROMIDE | ELETRIPTAN HYDROBROMIDE TAB 20 MG (BASE EQUIVALENT) | 67406025100320 | Generic |
| RELPAX | ELETRIPTAN HYDROBROMIDE TAB 20 MG (BASE EQUIVALENT) | 67406025100320 | Brand |
| ELETRIPTAN HYDROBROMIDE | ELETRIPTAN HYDROBROMIDE TAB 40 MG (BASE EQUIVALENT) | 67406025100340 | Generic |

| | | | |
|---|---|---|---|
| RELPAX | ELETRIPTAN HYDROBROMIDE TAB 40 MG (BASE EQUIVALENT) | 67406025100340 | Brand |
| FROVATRIPTAN SUCCINATE | FROVATRIPTAN SUCCINATE TAB 2.5 MG (BASE EQUIVALENT) | 67406030100320 | Generic |
| FROVA | FROVATRIPTAN SUCCINATE TAB 2.5 MG (BASE EQUIVALENT) | 67406030100320 | Brand |
| ONZETRA XSAIL | SUMATRIPTAN SUCCINATE EXHALER POWDER 11 MG/NOSEPIECE | 6740607010G420 | Brand |
| RIZATRIPTAN BENZOATE | RIZATRIPTAN BENZOATE TAB 5 MG (BASE EQUIVALENT) | 67406060100310 | Generic |
| MAXALT | RIZATRIPTAN BENZOATE TAB 10 MG (BASE EQUIVALENT) | 67406060100320 | Brand |
| RIZATRIPTAN BENZOATE | RIZATRIPTAN BENZOATE TAB 10 MG (BASE EQUIVALENT) | 67406060100320 | Generic |
| RIZATRIPTAN BENZOATE ODT | RIZATRIPTAN BENZOATE ORAL DISINTEGRATING TAB 5 MG (BASE EQ) | 67406060107220 | Generic |
| MAXALT-MLT | RIZATRIPTAN BENZOATE ORAL DISINTEGRATING TAB 10 MG (BASE EQ) | 67406060107230 | Brand |
| RIZATRIPTAN BENZOATE ODT | RIZATRIPTAN BENZOATE ORAL DISINTEGRATING TAB 10 MG (BASE EQ) | 67406060107230 | Generic |
| IMITREX STATDOSE SYSTEM | SUMATRIPTAN SUCCINATE SOLUTION AUTO-INJECTOR 4 MG/0.5ML | 6740607010D510 | Brand |
| SUMATRIPTAN SUCCINATE | SUMATRIPTAN SUCCINATE SOLUTION AUTO-INJECTOR 4 MG/0.5ML | 6740607010D510 | Generic |
| IMITREX STATDOSE SYSTEM | SUMATRIPTAN SUCCINATE SOLUTION AUTO-INJECTOR 6 MG/0.5ML | 6740607010D520 | Brand |
| SUMATRIPTAN SUCCINATE | SUMATRIPTAN SUCCINATE SOLUTION AUTO-INJECTOR 6 MG/0.5ML | 6740607010D520 | Generic |
| SUMATRIPTAN SUCCINATE | SUMATRIPTAN SUCCINATE INJ 6 MG/0.5ML | 67406070102010 | Generic |
| IMITREX | SUMATRIPTAN NASAL SPRAY 5 MG/ACT | 67406070002010 | Brand |
| SUMATRIPTAN | SUMATRIPTAN NASAL SPRAY 5 MG/ACT | 67406070002010 | Generic |
| IMITREX | SUMATRIPTAN NASAL SPRAY 20 MG/ACT | 67406070002040 | Brand |
| SUMATRIPTAN | SUMATRIPTAN NASAL SPRAY 20 MG/ACT | 67406070002040 | Generic |
| IMITREX | SUMATRIPTAN SUCCINATE TAB 25 MG | 67406070100305 | Brand |

| | | | |
|---|---|---|---|
| SUMATRIPTAN SUCCINATE | SUMATRIPTAN SUCCINATE TAB 25 MG | 67406070100305 | Generic |
| IMITREX | SUMATRIPTAN SUCCINATE TAB 50 MG | 67406070100310 | Brand |
| SUMATRIPTAN SUCCINATE | SUMATRIPTAN SUCCINATE TAB 50 MG | 67406070100310 | Generic |
| IMITREX | SUMATRIPTAN SUCCINATE TAB 100 MG | 67406070100320 | Brand |
| SUMATRIPTAN SUCCINATE | SUMATRIPTAN SUCCINATE TAB 100 MG | 67406070100320 | Generic |
| IMITREX STATDOSE REFILL | SUMATRIPTAN SUCCINATE SOLUTION CARTRIDGE 4 MG/0.5ML | 6740607010E210 | Brand |
| SUMATRIPTAN SUCCINATE REFILL | SUMATRIPTAN SUCCINATE SOLUTION CARTRIDGE 4 MG/0.5ML | 6740607010E210 | Generic |
| IMITREX STATDOSE REFILL | SUMATRIPTAN SUCCINATE SOLUTION CARTRIDGE 6 MG/0.5ML | 6740607010E220 | Brand |
| SUMATRIPTAN SUCCINATE REFILL | SUMATRIPTAN SUCCINATE SOLUTION CARTRIDGE 6 MG/0.5ML | 6740607010E220 | Generic |
| SUMATRIPTAN/NAPROXEN SODIUM | SUMATRIPTAN-NAPROXEN SODIUM TAB 85-500 MG | 67992002600320 | Generic |
| TREXIMET | SUMATRIPTAN-NAPROXEN SODIUM TAB 85-500 MG | 67992002600320 | Brand |
| ZEMBRACE SYMTOUCH | SUMATRIPTAN SUCCINATE SOLUTION AUTO-INJECTOR 3 MG/0.5ML | 6740607010D505 | Brand |
| ZOLMITRIPTAN | ZOLMITRIPTAN TAB 2.5 MG | 67406080000320 | Generic |
| ZOMIG | ZOLMITRIPTAN TAB 2.5 MG | 67406080000320 | Brand |
| ZOLMITRIPTAN | ZOLMITRIPTAN TAB 5 MG | 67406080000330 | Generic |
| ZOMIG | ZOLMITRIPTAN TAB 5 MG | 67406080000330 | Brand |
| ZOLMITRIPTAN ODT | ZOLMITRIPTAN ORALLY DISINTEGRATING TAB 2.5 MG | 67406080007220 | Generic |
| ZOLMITRIPTAN ODT | ZOLMITRIPTAN ORALLY DISINTEGRATING TAB 5 MG | 67406080007230 | Generic |
| ZOMIG | ZOLMITRIPTAN NASAL SPRAY 2.5 MG/SPRAY UNIT | 67406080002010 | Brand |
| ZOMIG | ZOLMITRIPTAN NASAL SPRAY 5 MG/SPRAY UNIT | 67406080002020 | Brand |
| ZOLMITRIPTAN | ZOLMITRIPTAN NASAL SPRAY 5 MG/SPRAY UNIT | 67406080002020 | Generic |
| TOSYMRA | SUMATRIPTAN NASAL SPRAY 10 MG/ACT | 67406070002020 | Brand |
| ZOLMITRIPTAN | ZOLMITRIPTAN NASAL SPRAY 2.5 MG/SPRAY UNIT | 67406080002010 | Generic |

**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 ALL of the following as confirmed by claims history or submission of medical records:

- Naratriptan
- Rizatriptan
- One of the following sumatriptan formulations: tablets, nasal spray, 4 mg injection, or 6 mg injection

**OR**

**1.2.2** Patient has a history of contraindication or intolerance to ALL of the following (please specify intolerance or contraindication):

- Naratriptan
- Rizatriptan
- One of the following sumatriptan formulations: tablets, nasal spray, 4 mg injection, or 6 mg injection

| 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| IMITREX STATDOSE SYSTEM | SUMATRIPTAN SUCCINATE SOLUTION AUTO-INJECTOR 4 MG/0.5ML | 6740607010D510 | Brand |
| SUMATRIPTAN SUCCINATE | SUMATRIPTAN SUCCINATE SOLUTION AUTO-INJECTOR 4 MG/0.5ML | 6740607010D510 | Generic |
| IMITREX STATDOSE SYSTEM | SUMATRIPTAN SUCCINATE SOLUTION AUTO-INJECTOR 6 MG/0.5ML | 6740607010D520 | Brand |
| SUMATRIPTAN SUCCINATE | SUMATRIPTAN SUCCINATE SOLUTION AUTO-INJECTOR 6 MG/0.5ML | 6740607010D520 | Generic |
| SUMATRIPTAN SUCCINATE | SUMATRIPTAN SUCCINATE INJ 6 MG/0.5ML | 67406070102010 | Generic |
| IMITREX STATDOSE REFILL | SUMATRIPTAN SUCCINATE SOLUTION CARTRIDGE 4 MG/0.5ML | 6740607010E210 | Brand |
| SUMATRIPTAN SUCCINATE REFILL | SUMATRIPTAN SUCCINATE SOLUTION CARTRIDGE 4 MG/0.5ML | 6740607010E210 | Generic |
| IMITREX STATDOSE REFILL | SUMATRIPTAN SUCCINATE SOLUTION CARTRIDGE 6 MG/0.5ML | 6740607010E220 | Brand |
| SUMATRIPTAN SUCCINATE REFILL | SUMATRIPTAN SUCCINATE SOLUTION CARTRIDGE 6 MG/0.5ML | 6740607010E220 | Generic |

**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:

- Amitriptyline (generic Elavil)
- One of the following beta-blockers: atenolol, metoprolol, nadolol, propranolol, or timolol*
- Candesartan* (generic Atacand)
- Divalproex sodium (generic Depakote/Depakote ER)
- OnabotulinumtoxinA (generic Botox)**
- Topiramate (generic Topamax)
- Venlafaxine (generic Effexor/Effexor XR)
- Calcitonin gene-related peptide (CGRP) receptor antagonists [e.g., Aimovig (erenumab), Emgality (galcanezumab)]

**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.<br>*Timolol, candesartan are non-preferred and should not be included in denial to provider.<br>**This is a medical benefit, should not be included in denial to provider. |

| 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| IMITREX STATDOSE SYSTEM | SUMATRIPTAN SUCCINATE SOLUTION AUTO-INJECTOR 4 MG/0.5ML | 6740607010D510 | Brand |
| SUMATRIPTAN SUCCINATE | SUMATRIPTAN SUCCINATE SOLUTION AUTO-INJECTOR 4 MG/0.5ML | 6740607010D510 | Generic |
| IMITREX STATDOSE SYSTEM | SUMATRIPTAN SUCCINATE SOLUTION AUTO-INJECTOR 6 MG/0.5ML | 6740607010D520 | Brand |
| SUMATRIPTAN SUCCINATE | SUMATRIPTAN SUCCINATE SOLUTION AUTO-INJECTOR 6 MG/0.5ML | 6740607010D520 | Generic |
| SUMATRIPTAN SUCCINATE | SUMATRIPTAN SUCCINATE INJ 6 MG/0.5ML | 67406070102010 | Generic |
| IMITREX STATDOSE REFILL | SUMATRIPTAN SUCCINATE SOLUTION CARTRIDGE 4 MG/0.5ML | 6740607010E210 | Brand |
| SUMATRIPTAN SUCCINATE REFILL | SUMATRIPTAN SUCCINATE SOLUTION CARTRIDGE 4 MG/0.5ML | 6740607010E210 | Generic |
| IMITREX STATDOSE REFILL | SUMATRIPTAN SUCCINATE SOLUTION CARTRIDGE 6 MG/0.5ML | 6740607010E220 | Brand |
| SUMATRIPTAN SUCCINATE REFILL | SUMATRIPTAN SUCCINATE SOLUTION CARTRIDGE 6 MG/0.5ML | 6740607010E220 | Generic |

**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

| | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Quantity Limit |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ALMOTRIPTAN | ALMOTRIPTAN MALATE TAB 6.25 MG | 67406010100320 | Generic |
| ALMOTRIPTAN MALATE | ALMOTRIPTAN MALATE TAB 6.25 MG | 67406010100320 | Generic |
| ALMOTRIPTAN | ALMOTRIPTAN MALATE TAB 12.5 MG | 67406010100330 | Generic |

| | | | |
|---|---|---|---|
| ALMOTRIPTAN MALATE | ALMOTRIPTAN MALATE TAB 12.5 MG | 67406010100330 | Generic |
| ELETRIPTAN HYDROBROMIDE | ELETRIPTAN HYDROBROMIDE TAB 20 MG (BASE EQUIVALENT) | 67406025100320 | Generic |
| RELPAX | ELETRIPTAN HYDROBROMIDE TAB 20 MG (BASE EQUIVALENT) | 67406025100320 | Brand |
| ELETRIPTAN HYDROBROMIDE | ELETRIPTAN HYDROBROMIDE TAB 40 MG (BASE EQUIVALENT) | 67406025100340 | Generic |
| RELPAX | ELETRIPTAN HYDROBROMIDE TAB 40 MG (BASE EQUIVALENT) | 67406025100340 | Brand |
| FROVATRIPTAN SUCCINATE | FROVATRIPTAN SUCCINATE TAB 2.5 MG (BASE EQUIVALENT) | 67406030100320 | Generic |
| FROVA | FROVATRIPTAN SUCCINATE TAB 2.5 MG (BASE EQUIVALENT) | 67406030100320 | Brand |
| NARATRIPTAN HCL | NARATRIPTAN HCL TAB 1 MG (BASE EQUIV) | 67406050100310 | Generic |
| NARATRIPTAN HCL | NARATRIPTAN HCL TAB 2.5 MG (BASE EQUIV) | 67406050100320 | Generic |
| ONZETRA XSAIL | SUMATRIPTAN SUCCINATE EXHALER POWDER 11 MG/NOSEPIECE | 6740607010G420 | Brand |
| RIZATRIPTAN BENZOATE | RIZATRIPTAN BENZOATE TAB 5 MG (BASE EQUIVALENT) | 67406060100310 | Generic |
| MAXALT | RIZATRIPTAN BENZOATE TAB 10 MG (BASE EQUIVALENT) | 67406060100320 | Brand |
| RIZATRIPTAN BENZOATE | RIZATRIPTAN BENZOATE TAB 10 MG (BASE EQUIVALENT) | 67406060100320 | Generic |
| RIZATRIPTAN BENZOATE ODT | RIZATRIPTAN BENZOATE ORAL DISINTEGRATING TAB 5 MG (BASE EQ) | 67406060107220 | Generic |
| MAXALT-MLT | RIZATRIPTAN BENZOATE ORAL DISINTEGRATING TAB 10 MG (BASE EQ) | 67406060107230 | Brand |
| RIZATRIPTAN BENZOATE ODT | RIZATRIPTAN BENZOATE ORAL DISINTEGRATING TAB 10 MG (BASE EQ) | 67406060107230 | Generic |
| IMITREX | SUMATRIPTAN NASAL SPRAY 5 MG/ACT | 67406070002010 | Brand |
| SUMATRIPTAN | SUMATRIPTAN NASAL SPRAY 5 MG/ACT | 67406070002010 | Generic |
| IMITREX | SUMATRIPTAN NASAL SPRAY 20 MG/ACT | 67406070002040 | Brand |
| SUMATRIPTAN | SUMATRIPTAN NASAL SPRAY 20 MG/ACT | 67406070002040 | Generic |
| IMITREX | SUMATRIPTAN SUCCINATE TAB 25 MG | 67406070100305 | Brand |

| | | | |
|---|---|---|---|
| SUMATRIPTAN SUCCINATE | SUMATRIPTAN SUCCINATE TAB 25 MG | 67406070100305 | Generic |
| IMITREX | SUMATRIPTAN SUCCINATE TAB 50 MG | 67406070100310 | Brand |
| SUMATRIPTAN SUCCINATE | SUMATRIPTAN SUCCINATE TAB 50 MG | 67406070100310 | Generic |
| IMITREX | SUMATRIPTAN SUCCINATE TAB 100 MG | 67406070100320 | Brand |
| SUMATRIPTAN SUCCINATE | SUMATRIPTAN SUCCINATE TAB 100 MG | 67406070100320 | Generic |
| SUMATRIPTAN/NAPROXEN SODIUM | SUMATRIPTAN-NAPROXEN SODIUM TAB 85-500 MG | 67992002600320 | Generic |
| TREXIMET | SUMATRIPTAN-NAPROXEN SODIUM TAB 85-500 MG | 67992002600320 | Brand |
| ZEMBRACE SYMTOUCH | SUMATRIPTAN SUCCINATE SOLUTION AUTO-INJECTOR 3 MG/0.5ML | 6740607010D505 | Brand |
| ZOLMITRIPTAN | ZOLMITRIPTAN TAB 2.5 MG | 67406080000320 | Generic |
| ZOMIG | ZOLMITRIPTAN TAB 2.5 MG | 67406080000320 | Brand |
| ZOLMITRIPTAN | ZOLMITRIPTAN TAB 5 MG | 67406080000330 | Generic |
| ZOMIG | ZOLMITRIPTAN TAB 5 MG | 67406080000330 | Brand |
| ZOLMITRIPTAN ODT | ZOLMITRIPTAN ORALLY DISINTEGRATING TAB 2.5 MG | 67406080007220 | Generic |
| ZOLMITRIPTAN ODT | ZOLMITRIPTAN ORALLY DISINTEGRATING TAB 5 MG | 67406080007230 | Generic |
| ZOMIG | ZOLMITRIPTAN NASAL SPRAY 2.5 MG/SPRAY UNIT | 67406080002010 | Brand |
| ZOMIG | ZOLMITRIPTAN NASAL SPRAY 5 MG/SPRAY UNIT | 67406080002020 | Brand |
| ZOLMITRIPTAN | ZOLMITRIPTAN NASAL SPRAY 5 MG/SPRAY UNIT | 67406080002020 | Generic |
| TOSYMRA | SUMATRIPTAN NASAL SPRAY 10 MG/ACT | 67406070002020 | Brand |
| ZOLMITRIPTAN | ZOLMITRIPTAN NASAL SPRAY 2.5 MG/SPRAY UNIT | 67406080002010 | Generic |

**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:

- Amitriptyline (generic Elavil)
- One of the following beta-blockers: atenolol, metoprolol, nadolol, propranolol, or timolol*
- Candesartan* (generic Atacand)
- Divalproex sodium (generic Depakote/Depakote ER)
- OnabotulinumtoxinA (generic Botox)**
- Topiramate (generic Topamax)
- Venlafaxine (generic Effexor/Effexor XR)
- Calcitonin gene-related peptide (CGRP) receptor antagonists [e.g., Aimovig (erenumab), Emgality (galcanezumab)]

**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.<br>*Timolol, candesartan are non-preferred and should not be included in denial to provider.<br>**This is a medical benefit, should not be included in denial to provider<br>. |
|---|---|

## 2 . Background

**Benefit/Coverage/Program Information**

**Table 1. Quantity Limits**

| Drug Name | Strength | Quantity Limit |
|---|---|---|
| Brand Amerge<br>generic naratriptan | 1mg, 2.5mg | 9 tabs/month |
| Brand Frova<br>Generic frovatriptan | 2.5mg | 9 tabs/month |
| Brand Imitrex tablets<br>Generic sumatriptan tablets | 25mg, 50mg, 100mg | 9 tabs/month |
| Brand Maxalt<br>Generic rizatriptan | 5mg, 10mg | 9 tabs/month |
| Brand Maxalt MLT<br>Generic rizatriptan ODT | 5mg, 10mg | 9 tabs/month |
| Generic almotriptan | 6.25mg, 12.5mg | 6 tabs/month |
| Relpax | 20mg, 40mg | 6 tabs/month |

| | | |
|---|---|---|
| Generic eletriptan | | |
| Brand Zomig<br>Generic zolmitriptan | 2.5mg, 5mg | 6 tabs/month |
| Brand Zomig ZMT<br>Generic zolmitriptan ODT | 2.5mg, 5mg | 6 tabs/month |
| Brand Imitrex nasal spray<br>Generic sumatriptan nasal spray | 5mg, 20mg | 6 spray devices/month |
| Zomig nasal spray | 2.5mg, 5mg | 6 spray devices/month |
| Treximet<br>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<br>Generic Sumatriptan Autoinjector/Cartridge Refills | 4mg/0.5mL<br>6mg/0.5mL | 8 autoinjectors or cartridge refills/month (4 boxes/month) |
| Brand Imitrex<br>Generic Sumatriptan<br>Vials | 6mg/0.5mL | 10 vials/month (2 boxes/month) |
| Generic Sumatriptan<br>Pre-filled Syringe | 6mg/0.5mL | 8 prefilled syringes (4 boxes/month) |
| Tosymra nasal spray | 10mg | 6 units per 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

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

## 3 . Revision History

| Date | Notes |
|---|---|
| 8/27/2024 | Copy core |

Truqap

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146681 |
| **Guideline Name** | Truqap |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Truqap | |
|---|---|
| Diagnosis | Breast Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TRUQAP | CAPIVASERTIB TAB 160 MG | 21530320000320 | Brand |
| TRUQAP | CAPIVASERTIB TAB 200 MG | 21530320000325 | Brand |

**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** - 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TRUQAP | CAPIVASERTIB TAB 160 MG | 21530320000320 | Brand |
| TRUQAP | CAPIVASERTIB TAB 200 MG | 21530320000325 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TRUQAP | CAPIVASERTIB TAB 160 MG | 21530320000320 | Brand |

| | | | |
|---|---|---|---|
| TRUQAP | CAPIVASERTIB TAB 200 MG | 21530320000325 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TRUQAP | CAPIVASERTIB TAB 160 MG | 21530320000320 | Brand |
| TRUQAP | CAPIVASERTIB TAB 200 MG | 21530320000325 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Truqap therapy

Tryvio

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-154415 |
| **Guideline Name** | Tryvio |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 9/5/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TRYVIO | APROCITENTAN TAB 12.5 MG | 36180010000320 | Brand |

**Approval Criteria**

**1** - Diagnosis of resistant hypertension

**AND**

**2** - One of the following:

**2.1** Systolic blood pressure greater than or equal to 130 mm Hg (millimeters of mercury) on two consecutive measurements

**OR**

**2.2** Diastolic blood pressure greater than or equal to 80 mm Hg on two consecutive measurements

**AND**

**3** - Patient is receiving concomitant therapy with all of the following confirmed by claims history or submitted medical records:

**3.1** Maximally tolerated blocker of the renin-angiotensin system [angiotensin-converting enzyme (ACE) inhibitor (e.g., enalapril, lisinopril) or angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan)]

**AND**

**3.2** Maximally tolerated calcium channel blocker (e.g., amlodipine, diltiazem, verapamil)

**AND**

**3.3** Maximally tolerated diuretics (e.g., hydrochlorothiazide)

**AND**

**4** - One of the following:

**4.1** Patient is receiving concomitant therapy with a mineralocorticoid receptor antagonist [MRA (e.g., spironolactone, eplerenone)] confirmed by claims history or submitted medical records

**OR**

**4.2** Patient has a contraindication, or intolerance to mineralocorticoid receptor antagonist [MRA (e.g., spironolactone, eplerenone)] (please specify intolerance or contraindication)

**AND**

**5** - One of the following:

**5.1** Patient is receiving concomitant therapy with a beta-blocker (e.g., labetalol, carvedilol) confirmed by claims history or submitted medical records

**OR**

**5.2** Patient has a contraindication, or intolerance to beta-blockers (e.g., labetalol, carvedilol) (please specify intolerance or contraindication)

**AND**

**6** - Prescribed by or in consultation with a cardiologist

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TRYVIO | APROCITENTAN TAB 12.5 MG | 36180010000320 | Brand |

**Approval Criteria**

**1** - Documentation the patient is receiving clinical benefit to Tryvio therapy

**AND**

**2** - Patient is receiving concomitant therapy with all of the following confirmed by claims history or submitted medical records:

**2.1** Maximally tolerated blocker of the renin-angiotensin system [angiotensin-converting enzyme (ACE) inhibitor (e.g., enalapril, lisinopril) or angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan)]

**AND**

**2.2** Maximally tolerated calcium channel blocker (e.g., amlodipine, diltiazem, verapamil)

**AND**

**2.3** Maximally tolerated diuretics (e.g., hydrochlorothiazide)

## 2 . Revision History

| Date | Notes |
|---|---|
| 9/5/2024 | New guideline. |

Tukysa

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146682 |
| **Guideline Name** | Tukysa |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Tukysa | |
|---|---|
| Diagnosis | Breast Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TUKYSA | TUCATINIB TAB 50 MG | 21170080000320 | Brand |
| TUKYSA | TUCATINIB TAB 150 MG | 21170080000340 | Brand |

**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 (Herceptin, Kanjinti), pertuzumab (Perjeta), ado-trastuzumab emtansine (T-DM1)]

**AND**

**5** - Used in combination with trastuzumab (e.g., Herceptin, Kanjinti, Ontruzant) and capecitabine (Xeloda)

| Product Name: Tukysa | |
|---|---|
| Diagnosis | CNS Cancers |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TUKYSA | TUCATINIB TAB 50 MG | 21170080000320 | Brand |
| TUKYSA | TUCATINIB TAB 150 MG | 21170080000340 | Brand |

**Approval Criteria**

**1** - Diagnosis of brain metastases with HER2 (human epidermal growth factor receptor 2) positive breast cancer

**AND**

**2** - Patient has been previously treated with an anti-HER2-based regimen [e.g., trastuzumab (Herceptin, Kanjinti), pertuzumab (Perjeta), ado-trastuzumab emtansine (T-DM1)]

**AND**

**3** - Used in combination with trastuzumab (e.g., Herceptin, Kanjinti, Ontruzant) and capecitabine (Xeloda)

| Product Name: Tukysa | |
|---|---|
| Diagnosis | Colorectal Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TUKYSA | TUCATINIB TAB 50 MG | 21170080000320 | Brand |
| TUKYSA | TUCATINIB TAB 150 MG | 21170080000340 | Brand |

**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., Herceptin, Kanjinti)

| Product Name: Tukysa | |
|---|---|
| Diagnosis | Breast Cancer, CNS Cancers, Colorectal Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TUKYSA | TUCATINIB TAB 50 MG | 21170080000320 | Brand |
| TUKYSA | TUCATINIB TAB 150 MG | 21170080000340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TUKYSA | TUCATINIB TAB 50 MG | 21170080000320 | Brand |
| TUKYSA | TUCATINIB TAB 150 MG | 21170080000340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TUKYSA | TUCATINIB TAB 50 MG | 21170080000320 | Brand |
| TUKYSA | TUCATINIB TAB 150 MG | 21170080000340 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Tukysa therapy

Turalio

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-161274 |
| **Guideline Name** | Turalio |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TURALIO | PEXIDARTINIB HCL CAP 125 MG (BASE EQUIVALENT) | 21533045010110 | Brand |

**Approval Criteria**

**1** - Patient has a 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TURALIO | PEXIDARTINIB HCL CAP 125 MG (BASE EQUIVALENT) | 21533045010110 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| TURALIO | PEXIDARTINIB HCL CAP 125 MG (BASE EQUIVALENT) | 21533045010110 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TURALIO | PEXIDARTINIB HCL CAP 125 MG (BASE EQUIVALENT) | 21533045010110 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TURALIO | PEXIDARTINIB HCL CAP 125 MG (BASE EQUIVALENT) | 21533045010110 | Brand |

**Approval Criteria**

| |
|---|
| **1** - Documentation of positive clinical response to Turalio therapy |

## 2 . Revision History

| Date | Notes |
|---|---|
| 11/26/2024 | Updated GPIs |

Tykerb

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-161480 |
| **Guideline Name** | Tykerb |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 1 . Criteria

| Product Name: Brand Tykerb, generic lapatinib | |
|---|---|
| Diagnosis | Breast Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LAPATINIB DITOSYLATE | LAPATINIB DITOSYLATE TAB 250 MG (BASE EQUIV) | 21533026100320 | Generic |
| TYKERB | LAPATINIB DITOSYLATE TAB 250 MG (BASE EQUIV) | 21533026100320 | Brand |

**Approval Criteria**

**1** - ALL of the following:

**1.1** Diagnosis of recurrent unresectable (local or regional) or stage IV breast cancer

**AND**

**1.2** Disease is hormone receptor positive and human epidermal growth factor receptor 2-positive (HER2+)

**AND**

**1.3** Used in combination with an aromatase inhibitor [e.g., Aromasin (exemestane), Femara (letrozole), Arimidex (anastrozole)]

**OR**

**2** - ALL of the following:

**2.1** ONE of the following:

- Diagnosis of recurrent unresectable (local or regional) or stage IV breast cancer
- Breast cancer that is unresponsive to preoperative systemic therapy

**AND**

**2.2** Disease is HER2+

**AND**

**2.3** 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LAPATINIB DITOSYLATE | LAPATINIB DITOSYLATE TAB 250 MG (BASE EQUIV) | 21533026100320 | Generic |
| TYKERB | LAPATINIB DITOSYLATE TAB 250 MG (BASE EQUIV) | 21533026100320 | Brand |

**Approval Criteria**

**1** - ALL of the following:

**1.1** Diagnosis of recurrent, central nervous system (CNS) cancer with metastatic lesions

**AND**

**1.2** Tykerb is active against primary (breast) tumor

**AND**

**1.3** 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LAPATINIB DITOSYLATE | LAPATINIB DITOSYLATE TAB 250 MG (BASE EQUIV) | 21533026100320 | Generic |
| TYKERB | LAPATINIB DITOSYLATE TAB 250 MG (BASE EQUIV) | 21533026100320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LAPATINIB DITOSYLATE | LAPATINIB DITOSYLATE TAB 250 MG (BASE EQUIV) | 21533026100320 | Generic |
| TYKERB | LAPATINIB DITOSYLATE TAB 250 MG (BASE EQUIV) | 21533026100320 | Brand |

**Approval Criteria**

**1** - Diagnosis of colon cancer

**AND**

**2** - Disease is human epidermal growth factor receptor 2 (HER2)-amplified and RAS and BRAF wild type

**AND**

**3** - ONE of the following:

**3.1** Disease is proficient mismatch repair/microsatellite-stable (pMMR/MSS)

**OR**

**3.2** BOTH of the following:

**3.2.1** Disease is positive for deficient mismatch repair/microsatellite instability-high (dMMR/MSI-H) or polymerase epsilon/delta (POLE/POLD1) mutation

**AND**

**3.2.2** ONE of the following:

- Patient is ineligible for or progressed on checkpoint inhibitor immunotherapy [e.g., Opdivo (nivolumab), Keytruda (pembrolizumab), Jemperli (dostarlimab-gxly)]
- Patient has a contraindication to checkpoint inhibitor immunotherapy

**AND**

**4** - ONE of the following:

**4.1** 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**

**4.2** Intensive chemotherapy with one of the following is not recommended:

- Oxaliplatin
- Irinotecan
- Capecitabine

**OR**

**4.3** Used as second-line and subsequent therapy for progression of advanced or metastatic disease

**AND**

**5** - Used in combination with trastuzumab

**AND**

**6** - 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LAPATINIB DITOSYLATE | LAPATINIB DITOSYLATE TAB 250 MG (BASE EQUIV) | 21533026100320 | Generic |
| TYKERB | LAPATINIB DITOSYLATE TAB 250 MG (BASE EQUIV) | 21533026100320 | Brand |

**Approval Criteria**

**1** - Diagnosis of rectal cancer

**AND**

**2** - Disease is human epidermal growth factor receptor 2 (HER2)-amplified and RAS and BRAF wild type

**AND**

**3** - ONE of the following:

**3.1** Disease is proficient mismatch repair/microsatellite-stable (pMMR/MSS)

**OR**

**3.2** BOTH of the following:

**3.2.1** Disease is positive for deficient mismatch repair/microsatellite instability-high (dMMR/MSI-H) or polymerase epsilon/delta (POLE/POLD1) mutation

**AND**

**3.2.2** ONE of the following:

- Patient is ineligible for or progressed on checkpoint inhibitor immunotherapy [e.g., Opdivo (nivolumab), Keytruda (pembrolizumab), Jemperli (dostarlimab-gxly)]
- Patient has a contraindication to checkpoint inhibitor immunotherapy

**AND**

**4** - ONE of the following:

**4.1** 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**

**4.2** Intensive chemotherapy with one of the following is not recommended:

- Oxaliplatin
- Irinotecan
- Capecitabine

**OR**

**4.3** Used as second-line and subsequent therapy for progression of advanced or metastatic disease

**AND**

**5** - Used in combination with trastuzumab

**AND**

**6** - 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LAPATINIB DITOSYLATE | LAPATINIB DITOSYLATE TAB 250 MG (BASE EQUIV) | 21533026100320 | Generic |
| TYKERB | LAPATINIB DITOSYLATE TAB 250 MG (BASE EQUIV) | 21533026100320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| LAPATINIB DITOSYLATE | LAPATINIB DITOSYLATE TAB 250 MG (BASE EQUIV) | 21533026100320 | Generic |
| TYKERB | LAPATINIB DITOSYLATE TAB 250 MG (BASE EQUIV) | 21533026100320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LAPATINIB DITOSYLATE | LAPATINIB DITOSYLATE TAB 250 MG (BASE EQUIV) | 21533026100320 | Generic |
| TYKERB | LAPATINIB DITOSYLATE TAB 250 MG (BASE EQUIV) | 21533026100320 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Tykerb therapy

## 2 . Revision History

| Date | Notes |
|---|---|
| 12/2/2024 | Updated coverage criteria for breast cancer, central nervous system cancers, chordoma, colon cancer, and rectal cancer |

Tymlos

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146685 |
| **Guideline Name** | Tymlos |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Tymlos | |
|---|---|
| Approval Length | 24 Months* |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TYMLOS | ABALOPARATIDE SUBCUTANEOUS SOLN PEN-INJECTOR 3120 MCG/1.56ML | 3004400500D230 | Brand |

**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 parat hyroid hormone analog therapy (e.g., Teriparatide Injection, Forteo, T ymlos) in the patient's lifetime. |
|---|---|

Upneeq

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146431 |
| **Guideline Name** | Upneeq |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Upneeq | |
|---|---|
| Diagnosis | Acquired Blepharoptosis |
| Approval Length | 6 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| UPNEEQ | OXYMETAZOLINE HCL OPHTH SOLN 0.1% | 86802236102020 | Brand |

**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:

**3.1** Marginal reflex distance-1 (MRD-1) is less than or equal to 2 millimeters (mm) in primary gaze

**OR**

**3.2** Marginal reflex distance-1 (MRD-1) is less than or equal to 2 mm in down gaze

**OR**

**3.3** 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 | |
|---|---|
| Diagnosis | Acquired Blepharoptosis |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| UPNEEQ | OXYMETAZOLINE HCL OPHTH SOLN 0.1% | 86802236102020 | Brand |

**Approval Criteria**

**1** - Documentation of a positive clinical response to therapy

Vafseo

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-158251 |
| **Guideline Name** | Vafseo |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 12/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VAFSEO | VADADUSTAT TAB 150 MG | 82402580000320 | Brand |
| VAFSEO | VADADUSTAT TAB 300 MG | 82402580000330 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VAFSEO | VADADUSTAT TAB 150 MG | 82402580000320 | Brand |
| VAFSEO | VADADUSTAT TAB 300 MG | 82402580000330 | Brand |

**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 12 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 |
|---|---|
| 10/30/2024 | New |

Valchlor

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146686 |
| **Guideline Name** | Valchlor |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Valchlor | |
|---|---|
| Diagnosis | Primary Cutaneous Lymphomas |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VALCHLOR | MECHLORETHAMINE HCL GEL 0.016% (BASE EQUIVALENT) | 90371050204030 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VALCHLOR | MECHLORETHAMINE HCL GEL 0.016% (BASE EQUIVALENT) | 90371050204030 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| VALCHLOR | MECHLORETHAMINE HCL GEL 0.016% (BASE EQUIVALENT) | 90371050204030 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VALCHLOR | MECHLORETHAMINE HCL GEL 0.016% (BASE EQUIVALENT) | 90371050204030 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VALCHLOR | MECHLORETHAMINE HCL GEL 0.016% (BASE EQUIVALENT) | 90371050204030 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Valchlor therapy

Vanflyta

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-158192 |
| **Guideline Name** | Vanflyta |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 12/1/2024 |

## 1 . Criteria

| Product Name: Vanflyta | |
|---|---|
| Diagnosis | Acute Myeloid Leukemia |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VANFLYTA | QUIZARTINIB DIHYDROCHLORIDE TAB 17.7 MG | 21533047100320 | Brand |
| VANFLYTA | QUIZARTINIB DIHYDROCHLORIDE TAB 26.5 MG | 21533047100325 | Brand |

**Approval Criteria**

**1** - Diagnosis of acute myeloid leukemia (AML)

**AND**

**2** - Disease is FLT3 internal tandem duplication (ITD) positive

**AND**

**3** - ONE of the following:

**3.1** Vanflyta will be used in combination with standard cytarabine and anthracycline induction and cytarabine consolidation, and as maintenance monotherapy following consolidation chemotherapy

**OR**

**3.2** Vanflyta will be used for patients with relapsed/refractory disease as a component of repeating the initial successful induction regimen or as a single agent

| Product Name: Vanflyta | |
|---|---|
| Diagnosis | Acute Myeloid Leukemia |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VANFLYTA | QUIZARTINIB DIHYDROCHLORIDE TAB 17.7 MG | 21533047100320 | Brand |
| VANFLYTA | QUIZARTINIB DIHYDROCHLORIDE TAB 26.5 MG | 21533047100325 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VANFLYTA | QUIZARTINIB DIHYDROCHLORIDE TAB 17.7 MG | 21533047100320 | Brand |
| VANFLYTA | QUIZARTINIB DIHYDROCHLORIDE TAB 26.5 MG | 21533047100325 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VANFLYTA | QUIZARTINIB DIHYDROCHLORIDE TAB 17.7 MG | 21533047100320 | Brand |
| VANFLYTA | QUIZARTINIB DIHYDROCHLORIDE TAB 26.5 MG | 21533047100325 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Vanflyta therapy

## 2 . Revision History

| Date | Notes |
|---|---|

| | |
|---|---|
| 10/29/2024 | For AML, added "Initial Authorization" therapy stage and added allow ance for relapsed/refractory disease per NCCN recommendations. |

Vecamyl

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146688 |
| **Guideline Name** | Vecamyl |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VECAMYL | MECAMYLAMINE HCL TAB 2.5 MG | 36600020100310 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VECAMYL | MECAMYLAMINE HCL TAB 2.5 MG | 36600020100310 | Brand |

**Approval Criteria**

**1** - Documentation of a positive clinical response to Vecamyl therapy

Velsipity

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-148559 |
| **Guideline Name** | Velsipity |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VELSIPITY | ETRASIMOD ARGININE TAB 2 MG | 52504525100350 | Brand |

**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 and/or immunosuppressants (e.g., azathioprine, 6-mercaptopurine)

**OR**

**2.2** Patient has been previously treated with a biologic or targeted synthetic disease-modifying antirheumatic drug (DMARD) 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), Stelara (ustekinumab), Xeljanz (tofacitinib), Rinvoq (upadacitinib)]

**AND**

**3** - ONE of the following:

**3.1** Failure to one of the preferred adalimumab products* as confirmed by claims history or submission of medical records

**OR**

**3.2** History of intolerance or contraindication to one of the preferred adalimumab products* (please specify intolerance or contraindication)

**AND**

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

- Biologic DMARD [e.g., Enbrel (etanercept), adalimumab, Cimzia (certolizumab), Simponi (golimumab)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

**AND**

**5** - Prescribed by or in consultation with a gastroenterologist

| Notes | *For a list of preferred adalimumab products please reference drug co verage tools. |
|---|---|

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VELSIPITY | ETRASIMOD ARGININE TAB 2 MG | 52504525100350 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Velsipity therapy

**AND**

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

- Biologic disease-modifying antirheumatic drug (DMARD) [e.g., Enbrel (etanercept), adalimumab, Cimzia (certolizumab), Simponi (golimumab)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

## 2 . Background

| Benefit/Coverage/Program Information |
|---|
| **PDL link** |

| |
|---|
| 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 |
|---|---|
| 6/17/2024 | New program. |

Vemlidy

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146689 |
| **Guideline Name** | Vemlidy |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Vemlidy | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VEMLIDY | TENOFOVIR ALAFENAMIDE FUMARATE TAB 25 MG | 12352083200320 | Brand |

**Approval Criteria**

**1** - ONE of the following:

**1.1** Failure to entecavir (generic Baraclude) as confirmed by claims history or submission of medical records

**OR**

**1.2** History of contraindication or intolerance to entecavir (generic Baraclude) (please specify contraindication or intolerance)

**OR**

**1.3** Patient is not a suitable candidate for entecavir (generic Baraclude)

**AND**

**2** - ONE of the following:

**2.1** Failure to tenofovir disoproxil fumarate (generic Viread) as confirmed by claims history or submission of medical records

**OR**

**2.2** History of contraindication or intolerance to tenofovir disoproxil fumarate (generic Viread) (please specify contraindication or intolerance)

**OR**

**2.3** Patient has an estimated glomerular filtration rate below 90 mL/min (milliliters/minute)

**OR**

**2.4** Patient has 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**

**2.5** Patient has 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**

**2.6** Patient has a prior low-trauma or non-traumatic fracture

**OR**

**2.7** Patient is less than 20 years of age

Venclexta

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-149599 |
| **Guideline Name** | Venclexta |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/5/2024 |

## 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VENCLEXTA STARTING PACK | VENETOCLAX TAB THERAPY STARTER PACK 10 & 50 & 100 MG | 2147008000B720 | Brand |
| VENCLEXTA | VENETOCLAX TAB 10 MG | 21470080000320 | Brand |

| | | | |
|---|---|---|---|
| VENCLEXTA | VENETOCLAX TAB 50 MG | 21470080000340 | Brand |
| VENCLEXTA | VENETOCLAX TAB 100 MG | 21470080000360 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VENCLEXTA STARTING PACK | VENETOCLAX TAB THERAPY STARTER PACK 10 & 50 & 100 MG | 2147008000B720 | Brand |
| VENCLEXTA | VENETOCLAX TAB 10 MG | 21470080000320 | Brand |
| VENCLEXTA | VENETOCLAX TAB 50 MG | 21470080000340 | Brand |
| VENCLEXTA | VENETOCLAX TAB 100 MG | 21470080000360 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VENCLEXTA STARTING PACK | VENETOCLAX TAB THERAPY STARTER PACK 10 & 50 & 100 MG | 2147008000B720 | Brand |
| VENCLEXTA | VENETOCLAX TAB 10 MG | 21470080000320 | Brand |
| VENCLEXTA | VENETOCLAX TAB 50 MG | 21470080000340 | Brand |
| VENCLEXTA | VENETOCLAX TAB 100 MG | 21470080000360 | Brand |

**Approval Criteria**

**1** - ALL of the following:

**1.1** Diagnosis of newly-diagnosed acute myeloid leukemia (AML)

**AND**

**1.2** ONE of the following:

**1.2.1** Used as treatment induction in candidates for intensive induction therapy

**OR**

**1.2.2** Used as treatment induction in candidates for lower-intensity induction therapy

**OR**

**1.2.3** Used as follow-up after induction therapy following response to previous lower intensity therapy with the same regimen

**OR**

**1.2.4** 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:

**2.1** Diagnosis of relapsed/refractory acute myeloid leukemia (AML)

**AND**

**2.2** Used as a component of repeating the initial successful induction regimen

**AND**

**2.3** Greater than or equal to 12 months since induction regimen if not administered continuously

**AND**

**2.4** Therapy was not stopped due to development of clinical resistance

**OR**

**3** - ALL of the following:

**3.1** Diagnosis of blastic plasmacytoid dendritic cell neoplasm (BPDCN) - acute myeloid leukemia (AML)

**AND**

**3.2** Considered systemic disease and therapy is given as palliative intent

**AND**

**3.3** 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)

**AND**

**3.4** 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VENCLEXTA STARTING PACK | VENETOCLAX TAB THERAPY STARTER PACK 10 & 50 & 100 MG | 2147008000B720 | Brand |
| VENCLEXTA | VENETOCLAX TAB 10 MG | 21470080000320 | Brand |
| VENCLEXTA | VENETOCLAX TAB 50 MG | 21470080000340 | Brand |
| VENCLEXTA | VENETOCLAX TAB 100 MG | 21470080000360 | Brand |

**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 dexamethasone

| Product Name: Venclexta | |
|---|---|
| Diagnosis | Acute Lymphoblastic Leukemia (ALL) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VENCLEXTA STARTING PACK | VENETOCLAX TAB THERAPY STARTER PACK 10 & 50 & 100 MG | 2147008000B720 | Brand |
| VENCLEXTA | VENETOCLAX TAB 10 MG | 21470080000320 | Brand |
| VENCLEXTA | VENETOCLAX TAB 50 MG | 21470080000340 | Brand |
| VENCLEXTA | VENETOCLAX TAB 100 MG | 21470080000360 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VENCLEXTA STARTING PACK | VENETOCLAX TAB THERAPY STARTER PACK 10 & 50 & 100 MG | 2147008000B720 | Brand |
| VENCLEXTA | VENETOCLAX TAB 10 MG | 21470080000320 | Brand |
| VENCLEXTA | VENETOCLAX TAB 50 MG | 21470080000340 | Brand |
| VENCLEXTA | VENETOCLAX TAB 100 MG | 21470080000360 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| VENCLEXTA STARTING PACK | VENETOCLAX TAB THERAPY STARTER PACK 10 & 50 & 100 MG | 2147008000B720 | Brand |
| VENCLEXTA | VENETOCLAX TAB 10 MG | 21470080000320 | Brand |
| VENCLEXTA | VENETOCLAX TAB 50 MG | 21470080000340 | Brand |
| VENCLEXTA | VENETOCLAX TAB 100 MG | 21470080000360 | Brand |

**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, Tafinlar)

| Product Name: Venclexta | |
|---|---|
| Diagnosis | Accelerated/Blast Phase Myeloproliferative Neoplasm |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VENCLEXTA STARTING PACK | VENETOCLAX TAB THERAPY STARTER PACK 10 & 50 & 100 MG | 2147008000B720 | Brand |
| VENCLEXTA | VENETOCLAX TAB 10 MG | 21470080000320 | Brand |
| VENCLEXTA | VENETOCLAX TAB 50 MG | 21470080000340 | Brand |
| VENCLEXTA | VENETOCLAX TAB 100 MG | 21470080000360 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VENCLEXTA STARTING PACK | VENETOCLAX TAB THERAPY STARTER PACK 10 & 50 & 100 MG | 2147008000B720 | Brand |
| VENCLEXTA | VENETOCLAX TAB 10 MG | 21470080000320 | Brand |
| VENCLEXTA | VENETOCLAX TAB 50 MG | 21470080000340 | Brand |
| VENCLEXTA | VENETOCLAX TAB 100 MG | 21470080000360 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VENCLEXTA STARTING PACK | VENETOCLAX TAB THERAPY STARTER PACK 10 & 50 & 100 MG | 2147008000B720 | Brand |
| VENCLEXTA | VENETOCLAX TAB 10 MG | 21470080000320 | Brand |
| VENCLEXTA | VENETOCLAX TAB 50 MG | 21470080000340 | Brand |
| VENCLEXTA | VENETOCLAX TAB 100 MG | 21470080000360 | Brand |

**Approval Criteria**

**1** - Diagnosis of Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma which has been previously treated

| Product Name: Venclexta | |
|---|---|
| Diagnosis | All Indications except NCCN Recommended Regimens |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VENCLEXTA STARTING PACK | VENETOCLAX TAB THERAPY STARTER PACK 10 & 50 & 100 MG | 2147008000B720 | Brand |
| VENCLEXTA | VENETOCLAX TAB 10 MG | 21470080000320 | Brand |
| VENCLEXTA | VENETOCLAX TAB 50 MG | 21470080000340 | Brand |
| VENCLEXTA | VENETOCLAX TAB 100 MG | 21470080000360 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VENCLEXTA STARTING PACK | VENETOCLAX TAB THERAPY STARTER PACK 10 & 50 & 100 MG | 2147008000B720 | Brand |
| VENCLEXTA | VENETOCLAX TAB 10 MG | 21470080000320 | Brand |
| VENCLEXTA | VENETOCLAX TAB 50 MG | 21470080000340 | Brand |
| VENCLEXTA | VENETOCLAX TAB 100 MG | 21470080000360 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VENCLEXTA STARTING PACK | VENETOCLAX TAB THERAPY STARTER PACK 10 & 50 & 100 MG | 2147008000B720 | Brand |
| VENCLEXTA | VENETOCLAX TAB 10 MG | 21470080000320 | Brand |
| VENCLEXTA | VENETOCLAX TAB 50 MG | 21470080000340 | Brand |
| VENCLEXTA | VENETOCLAX TAB 100 MG | 21470080000360 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Venclexta therapy

## 2 . Revision History

| Date | Notes |
|---|---|
| 7/5/2024 | Updated criteria for ALL and AML based on NCCN recommendations . Updated verbiage for MM and NCCN Recommended Regimens. Ad ded criteria for CMML, hairy cell leukemia, and accelerated/blast pha se myeloproliferative neoplasms based on NCCN recommendations. |

Veozah

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146433 |
| **Guideline Name** | Veozah |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VEOZAH | FEZOLINETANT TAB 45 MG | 30606030000320 | Brand |

**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)]

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VEOZAH | FEZOLINETANT TAB 45 MG | 30606030000320 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to therapy (e.g., decrease in frequency and severity of vasomotor symptoms from baseline)

Verkazia

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146434 |
| **Guideline Name** | Verkazia |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Verkazia, Cyclosporine in Klarity | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VERKAZIA | CYCLOSPORINE (OPHTH) EMULSION 0.1% | 86720020001630 | Brand |
| CYCLOSPORINE IN KLARITY | CYCLOSPORINE (OPHTH) EMULSION 0.1% | 86720020001630 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VERKAZIA | CYCLOSPORINE (OPHTH) EMULSION 0.1% | 86720020001630 | Brand |
| CYCLOSPORINE IN KLARITY | CYCLOSPORINE (OPHTH) EMULSION 0.1% | 86720020001630 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response

Verquvo

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146436 |
| **Guideline Name** | Verquvo |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VERQUVO | VERICIGUAT TAB 2.5 MG | 40900085000321 | Brand |
| VERQUVO | VERICIGUAT TAB 5 MG | 40900085000330 | Brand |
| VERQUVO | VERICIGUAT TAB 10 MG | 40900085000340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VERQUVO | VERICIGUAT TAB 2.5 MG | 40900085000321 | Brand |
| VERQUVO | VERICIGUAT TAB 5 MG | 40900085000330 | Brand |
| VERQUVO | VERICIGUAT TAB 10 MG | 40900085000340 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to therapy

Verzenio

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-151148 |
| **Guideline Name** | Verzenio |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 8/8/2024 |

## 1 . Criteria

| Product Name: Verzenio | |
|---|---|
| Diagnosis | Breast Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VERZENIO | ABEMACICLIB TAB 50 MG | 21531010000305 | Brand |
| VERZENIO | ABEMACICLIB TAB 100 MG | 21531010000310 | Brand |
| VERZENIO | ABEMACICLIB TAB 150 MG | 21531010000315 | Brand |
| VERZENIO | ABEMACICLIB TAB 200 MG | 21531010000320 | Brand |

**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** BOTH of the following:

**4.2.1** Disease is early breast cancer at high risk of recurrence (i.e., greater than or equal to 4 positive lymph nodes, or 1-3 positive lymph nodes with one or both of the following: Grade 3 disease, tumor size greater than or equal to 5 centimeters)

**AND**

**4.2.2** Used in combination with an aromatase inhibitor (e.g., anastrozole, letrozole, exemestane) or tamoxifen

| Product Name: Verzenio | |
|---|---|
| Diagnosis | Breast Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VERZENIO | ABEMACICLIB TAB 50 MG | 21531010000305 | Brand |
| VERZENIO | ABEMACICLIB TAB 100 MG | 21531010000310 | Brand |
| VERZENIO | ABEMACICLIB TAB 150 MG | 21531010000315 | Brand |
| VERZENIO | ABEMACICLIB TAB 200 MG | 21531010000320 | Brand |

**Approval Criteria**

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

| Product Name: Verzenio | |
|---|---|
| Diagnosis | Endometrial Carcinoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |

| Guideline Type | Prior Authorization |
|---|---|

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VERZENIO | ABEMACICLIB TAB 50 MG | 21531010000305 | Brand |
| VERZENIO | ABEMACICLIB TAB 100 MG | 21531010000310 | Brand |
| VERZENIO | ABEMACICLIB TAB 150 MG | 21531010000315 | Brand |
| VERZENIO | ABEMACICLIB TAB 200 MG | 21531010000320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VERZENIO | ABEMACICLIB TAB 50 MG | 21531010000305 | Brand |
| VERZENIO | ABEMACICLIB TAB 100 MG | 21531010000310 | Brand |
| VERZENIO | ABEMACICLIB TAB 150 MG | 21531010000315 | Brand |
| VERZENIO | ABEMACICLIB TAB 200 MG | 21531010000320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VERZENIO | ABEMACICLIB TAB 50 MG | 21531010000305 | Brand |
| VERZENIO | ABEMACICLIB TAB 100 MG | 21531010000310 | Brand |
| VERZENIO | ABEMACICLIB TAB 150 MG | 21531010000315 | Brand |
| VERZENIO | ABEMACICLIB TAB 200 MG | 21531010000320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VERZENIO | ABEMACICLIB TAB 50 MG | 21531010000305 | Brand |
| VERZENIO | ABEMACICLIB TAB 100 MG | 21531010000310 | Brand |
| VERZENIO | ABEMACICLIB TAB 150 MG | 21531010000315 | Brand |

| VERZENIO | ABEMACICLIB TAB 200 MG | 21531010000320 | Brand |
|---|---|---|---|

**Approval Criteria**

**1** - Documentation of positive clinical response to Verzenio therapy

## 2 . Revision History

| Date | Notes |
|---|---|
| 8/7/2024 | Annual review. Updated background and added clinical criteria for en dometrial carcinoma per NCCN. Updated references. |

Verzenio

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146691 |
| **Guideline Name** | Verzenio |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Verzenio | |
|---|---|
| Diagnosis | Breast Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VERZENIO | ABEMACICLIB TAB 50 MG | 21531010000305 | Brand |
| VERZENIO | ABEMACICLIB TAB 100 MG | 21531010000310 | Brand |
| VERZENIO | ABEMACICLIB TAB 150 MG | 21531010000315 | Brand |
| VERZENIO | ABEMACICLIB TAB 200 MG | 21531010000320 | Brand |

**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** BOTH of the following:

**4.2.1** Disease is early breast cancer at high risk of recurrence (i.e., greater than or equal to 4 positive lymph nodes, or 1-3 positive lymph nodes with one or both of the following: Grade 3 disease, tumor size greater than or equal to 5 centimeters)

**AND**

**4.2.2** Used in combination with an aromatase inhibitor (e.g., anastrozole, letrozole, exemestane) or tamoxifen

| Product Name: Verzenio | |
|---|---|
| Diagnosis | Breast Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VERZENIO | ABEMACICLIB TAB 50 MG | 21531010000305 | Brand |
| VERZENIO | ABEMACICLIB TAB 100 MG | 21531010000310 | Brand |
| VERZENIO | ABEMACICLIB TAB 150 MG | 21531010000315 | Brand |
| VERZENIO | ABEMACICLIB TAB 200 MG | 21531010000320 | Brand |

**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 |
|---|---|

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VERZENIO | ABEMACICLIB TAB 50 MG | 21531010000305 | Brand |
| VERZENIO | ABEMACICLIB TAB 100 MG | 21531010000310 | Brand |
| VERZENIO | ABEMACICLIB TAB 150 MG | 21531010000315 | Brand |
| VERZENIO | ABEMACICLIB TAB 200 MG | 21531010000320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VERZENIO | ABEMACICLIB TAB 50 MG | 21531010000305 | Brand |
| VERZENIO | ABEMACICLIB TAB 100 MG | 21531010000310 | Brand |
| VERZENIO | ABEMACICLIB TAB 150 MG | 21531010000315 | Brand |
| VERZENIO | ABEMACICLIB TAB 200 MG | 21531010000320 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Verzenio therapy

Vijoice

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-152575 |
| **Guideline Name** | Vijoice |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 9/1/2024 |

## 1 . Criteria

| Product Name: Vijoice tablets, Vijoice granules | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VIJOICE | ALPELISIB (PROS) TAB THERAPY PACK 50 MG DAILY DOSE | 9948601000B720 | Brand |
| VIJOICE | ALPELISIB (PROS) TAB THERAPY PACK 125 MG DAILY DOSE | 9948601000B730 | Brand |
| VIJOICE | ALPELISIB (PROS) PAK 250 MG DAILY DOSE (200 MG & 50 MG TABS) | 9948601000B740 | Brand |
| VIJOICE | ALPELISIB (PROS) ORAL GRANULES PACKET 50 MG | 99486010003020 | Brand |

**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: Vijoice tablets, Vijoice granules | |
|---|---|
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VIJOICE | ALPELISIB (PROS) TAB THERAPY PACK 50 MG DAILY DOSE | 9948601000B720 | Brand |
| VIJOICE | ALPELISIB (PROS) TAB THERAPY PACK 125 MG DAILY DOSE | 9948601000B730 | Brand |
| VIJOICE | ALPELISIB (PROS) PAK 250 MG DAILY DOSE (200 MG & 50 MG TABS) | 9948601000B740 | Brand |
| VIJOICE | ALPELISIB (PROS) ORAL GRANULES PACKET 50 MG | 99486010003020 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Vijoice 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 |
|---|---|
| 8/23/2024 | Added new GPI for Vijoice granules formulation. Updated product name list and GPI table accordingly. Updated initial authorization criteria. Updated initial authorization duration to 12 months. |

Vitrakvi

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146693 |
| **Guideline Name** | Vitrakvi |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Vitrakvi | |
|---|---|
| Diagnosis | Solid Tumors |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VITRAKVI | LAROTRECTINIB SULFATE CAP 25 MG (BASE EQUIVALENT) | 21533835200120 | Brand |
| VITRAKVI | LAROTRECTINIB SULFATE CAP 100 MG (BASE EQUIVALENT) | 21533835200150 | Brand |
| VITRAKVI | LAROTRECTINIB SULFATE ORAL SOLN 20 MG/ML (BASE EQUIVALENT) | 21533835202020 | Brand |

**Approval Criteria**

**1** - Presence of a solid tumor

**AND**

**2** - Disease is positive for neurotrophic receptor tyrosine 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, G623R, G696A, F617L)

**AND**

**4** - Disease is ONE of the following:

- Metastatic
- Unresectable

| Product Name: Vitrakvi | |
|---|---|
| Diagnosis | Solid tumors |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VITRAKVI | LAROTRECTINIB SULFATE CAP 25 MG (BASE EQUIVALENT) | 21533835200120 | Brand |
| VITRAKVI | LAROTRECTINIB SULFATE CAP 100 MG (BASE EQUIVALENT) | 21533835200150 | Brand |

| | | | |
|---|---|---|---|
| VITRAKVI | LAROTRECTINIB SULFATE ORAL SOLN 20 MG/ML (BASE EQUIVALENT) | 21533835202020 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VITRAKVI | LAROTRECTINIB SULFATE CAP 25 MG (BASE EQUIVALENT) | 21533835200120 | Brand |
| VITRAKVI | LAROTRECTINIB SULFATE CAP 100 MG (BASE EQUIVALENT) | 21533835200150 | Brand |
| VITRAKVI | LAROTRECTINIB SULFATE ORAL SOLN 20 MG/ML (BASE EQUIVALENT) | 21533835202020 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VITRAKVI | LAROTRECTINIB SULFATE CAP 25 MG (BASE EQUIVALENT) | 21533835200120 | Brand |

| | | | |
|---|---|---|---|
| VITRAKVI | LAROTRECTINIB SULFATE CAP 100 MG (BASE EQUIVALENT) | 21533835200150 | Brand |
| VITRAKVI | LAROTRECTINIB SULFATE ORAL SOLN 20 MG/ML (BASE EQUIVALENT) | 21533835202020 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Vitrakvi therapy

Vivjoa

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146437 |
| **Guideline Name** | Vivjoa |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Vivjoa | |
|---|---|
| Approval Length | 4 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VIVJOA | OTESECONAZOLE CAP THERAPY PACK 150 MG (12 WEEKS) | 1140805000B220 | Brand |

**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

Vizimpro

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146694 |
| **Guideline Name** | Vizimpro |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VIZIMPRO | DACOMITINIB TAB 15 MG | 21360019000320 | Brand |
| VIZIMPRO | DACOMITINIB TAB 30 MG | 21360019000330 | Brand |
| VIZIMPRO | DACOMITINIB TAB 45 MG | 21360019000340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VIZIMPRO | DACOMITINIB TAB 15 MG | 21360019000320 | Brand |
| VIZIMPRO | DACOMITINIB TAB 30 MG | 21360019000330 | Brand |
| VIZIMPRO | DACOMITINIB TAB 45 MG | 21360019000340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VIZIMPRO | DACOMITINIB TAB 15 MG | 21360019000320 | Brand |
| VIZIMPRO | DACOMITINIB TAB 30 MG | 21360019000330 | Brand |
| VIZIMPRO | DACOMITINIB TAB 45 MG | 21360019000340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VIZIMPRO | DACOMITINIB TAB 15 MG | 21360019000320 | Brand |
| VIZIMPRO | DACOMITINIB TAB 30 MG | 21360019000330 | Brand |
| VIZIMPRO | DACOMITINIB TAB 45 MG | 21360019000340 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Vizimpro therapy

Vonjo

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-154898 |
| **Guideline Name** | Vonjo |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 10/1/2024 |

## 1 . Criteria

| Product Name: Vonjo | |
|---|---|
| Diagnosis | Myelofibrosis (MF) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VONJO | PACRITINIB CITRATE CAP 100 MG | 21537550100120 | Brand |

**Approval Criteria**

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

- Primary myelofibrosis
- Post-polycythemia vera myelofibrosis
- Post-essential thrombocythemia myelofibrosis
- Accelerated/blast phase myeloproliferative neoplasm

**AND**

**2** - One of the following:

**2.1** BOTH of the following:

**2.1.1** Patient has symptomatic lower-risk myelofibrosis

**AND**

**2.1.2** Patient has a platelet count less than 50 x 10^9/L

**OR**

**2.2** All of the following:

**2.2.1** Patient has higher-risk myelofibrosis

**AND**

**2.2.2** Patient is not a transplant candidate or transplant not currently feasible

**AND**

**2.2.3** One of the following:

**2.2.3.1** Patient has a platelet count less than 50 x 10^9/L

**OR**

**2.2.3.2** Both of the following:

**2.2.3.2.1** Patient has symptomatic splenomegaly and/or constitutional symptoms

**AND**

**2.2.3.2.2** Patient has a platelet count greater than or equal to 50 x 10^9/L

**OR**

**2.3** Used for treatment of myelofibrosis-associated anemia

**OR**

**2.4** Used for splenomegaly and other disease-related symptoms in one of the following:

**2.4.1** Continued near the start of conditioning therapy of transplant candidates

**OR**

**2.4.2** Palliation in combination with hypomethylating agents (azacitidine or decitabine) as bridging therapy prior to transplant, or if not a candidate for transplant

| Product Name: Vonjo | |
|---|---|
| Diagnosis | Myelofibrosis (MF) |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VONJO | PACRITINIB CITRATE CAP 100 MG | 21537550100120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VONJO | PACRITINIB CITRATE CAP 100 MG | 21537550100120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VONJO | PACRITINIB CITRATE CAP 100 MG | 21537550100120 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Vonjo therapy

Voranigo

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-161120 |
| **Guideline Name** | Voranigo |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 1 . Criteria

| Product Name: Voranigo | |
|---|---|
| Diagnosis | Astrocytoma/Oligodendroglioma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VORANIGO | VORASIDENIB TAB 10 MG | 21535180000320 | Brand |
| VORANIGO | VORASIDENIB TAB 40 MG | 21535180000340 | Brand |

**Approval Criteria**

**1** - One of the following diagnoses:

- Astrocytoma
- Oligodendroglioma

**AND**

**2** - Patient has grade 2 disease

**AND**

**3** - Presence of IDH1 or IDH2 mutation

**AND**

**4** - History of one of the following:

- Biopsy
- Sub-total resection
- Gross total resection

| Product Name: Voranigo | |
|---|---|
| Diagnosis | Astrocytoma/Oligodendroglioma |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VORANIGO | VORASIDENIB TAB 10 MG | 21535180000320 | Brand |
| VORANIGO | VORASIDENIB TAB 40 MG | 21535180000340 | Brand |

**Approval Criteria**

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

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VORANIGO | VORASIDENIB TAB 10 MG | 21535180000320 | Brand |
| VORANIGO | VORASIDENIB TAB 40 MG | 21535180000340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VORANIGO | VORASIDENIB TAB 10 MG | 21535180000320 | Brand |
| VORANIGO | VORASIDENIB TAB 40 MG | 21535180000340 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Voranigo therapy

## 2 . Revision History

| Date | Notes |
|---|---|
| 11/20/2024 | New; copy core |

Votrient

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146696 |
| **Guideline Name** | Votrient |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VOTRIENT | PAZOPANIB HCL TAB 200 MG (BASE EQUIV) | 21533042100320 | Brand |
| PAZOPANIB HYDROCHLORIDE | PAZOPANIB HCL TAB 200 MG (BASE EQUIV) | 21533042100320 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VOTRIENT | PAZOPANIB HCL TAB 200 MG (BASE EQUIV) | 21533042100320 | Brand |
| PAZOPANIB HYDROCHLORIDE | PAZOPANIB HCL TAB 200 MG (BASE EQUIV) | 21533042100320 | Generic |

**Approval Criteria**

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

- Angiosarcoma
- Alveolar soft part sarcoma
- Pleomorphic rhabdomyosarcoma
- Retroperitoneal/intra-abdominal disease that is unresectable, stage IV, or postoperative treatment for residual disease

- Soft tissue sarcoma of the extremity/superficial trunk or head/neck with disease that is stage IV or recurrent and has disseminated metastases
- Solitary fibrous tumor/hemangiopericytoma
- Desmoid tumors (aggressive fibromatosis)
- Dermatofibrosarcoma Protuberans (DFSP) with Fibrosarcomatous Transformation
- Dedifferentiated Chordoma

| Product Name: Brand Votrient, generic pazopanib | |
|---|---|
| Diagnosis | Thyroid Carcinoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VOTRIENT | PAZOPANIB HCL TAB 200 MG (BASE EQUIV) | 21533042100320 | Brand |
| PAZOPANIB HYDROCHLORIDE | PAZOPANIB HCL TAB 200 MG (BASE EQUIV) | 21533042100320 | Generic |

**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** 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 medullary carcinoma

**AND**

**2.2** One of the following:

- Disease is progressive
- Disease is symptomatic with distant metastases

**AND**

**2.3** One of the following:

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

- Caprelsa (vandetanib)
- Cometriq (cabozantinib)

**OR**

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

- Caprelsa (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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VOTRIENT | PAZOPANIB HCL TAB 200 MG (BASE EQUIV) | 21533042100320 | Brand |
| PAZOPANIB HYDROCHLORIDE | PAZOPANIB HCL TAB 200 MG (BASE EQUIV) | 21533042100320 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VOTRIENT | PAZOPANIB HCL TAB 200 MG (BASE EQUIV) | 21533042100320 | Brand |
| PAZOPANIB HYDROCHLORIDE | PAZOPANIB HCL TAB 200 MG (BASE EQUIV) | 21533042100320 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VOTRIENT | PAZOPANIB HCL TAB 200 MG (BASE EQUIV) | 21533042100320 | Brand |
| PAZOPANIB HYDROCHLORIDE | PAZOPANIB HCL TAB 200 MG (BASE EQUIV) | 21533042100320 | Generic |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VOTRIENT | PAZOPANIB HCL TAB 200 MG (BASE EQUIV) | 21533042100320 | Brand |
| PAZOPANIB HYDROCHLORIDE | PAZOPANIB HCL TAB 200 MG (BASE EQUIV) | 21533042100320 | Generic |

**Approval Criteria**

**1** - Diagnosis of Gastrointestinal Stromal Tumors (GIST)

**AND**

**2** - Disease is 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 Gleevac)
- 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VOTRIENT | PAZOPANIB HCL TAB 200 MG (BASE EQUIV) | 21533042100320 | Brand |
| PAZOPANIB HYDROCHLORIDE | PAZOPANIB HCL TAB 200 MG (BASE EQUIV) | 21533042100320 | Generic |

**Approval Criteria**

**1** - Diagnosis of Merkel Cell Carcinoma

**AND**

**2** - Disease is M1 disseminated

**AND**

**3** - One of the following:

**3.1** Anti-PD-L1 or anti-PD-1 therapy is contraindicated

**OR**

**3.2** 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VOTRIENT | PAZOPANIB HCL TAB 200 MG (BASE EQUIV) | 21533042100320 | Brand |
| PAZOPANIB HYDROCHLORIDE | PAZOPANIB HCL TAB 200 MG (BASE EQUIV) | 21533042100320 | Generic |

**Approval Criteria**

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

| Product Name: Brand Votrient, generic pazopanib | |
|---|---|
| Diagnosis | NCCN Recommended Regimens |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VOTRIENT | PAZOPANIB HCL TAB 200 MG (BASE EQUIV) | 21533042100320 | Brand |
| PAZOPANIB HYDROCHLORIDE | PAZOPANIB HCL TAB 200 MG (BASE EQUIV) | 21533042100320 | Generic |

**Approval Criteria**

**1** - Votrient will be approved for uses 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VOTRIENT | PAZOPANIB HCL TAB 200 MG (BASE EQUIV) | 21533042100320 | Brand |
| PAZOPANIB HYDROCHLORIDE | PAZOPANIB HCL TAB 200 MG (BASE EQUIV) | 21533042100320 | Generic |

**Approval Criteria**

**1** - Documentation of positive clinical response to Votrient therapy

Vowst

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146697 |
| **Guideline Name** | Vowst |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Vowst | |
|---|---|
| Approval Length | 1 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VOWST | FECAL MICROBIOTA SPORES, LIVE-BRPK CAPS | 52522020100120 | Brand |

**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

Voxzogo

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146698 |
| **Guideline Name** | Voxzogo |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VOXZOGO | VOSORITIDE FOR SUBCUTANEOUS INJ 0.4 MG | 30950080002120 | Brand |
| VOXZOGO | VOSORITIDE FOR SUBCUTANEOUS INJ 0.56 MG | 30950080002130 | Brand |
| VOXZOGO | VOSORITIDE FOR SUBCUTANEOUS INJ 1.2 MG | 30950080002140 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VOXZOGO | VOSORITIDE FOR SUBCUTANEOUS INJ 0.4 MG | 30950080002120 | Brand |
| VOXZOGO | VOSORITIDE FOR SUBCUTANEOUS INJ 0.56 MG | 30950080002130 | Brand |
| VOXZOGO | VOSORITIDE FOR SUBCUTANEOUS INJ 1.2 MG | 30950080002140 | Brand |

**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 continues to have 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

Voydeya

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-150928 |
| **Guideline Name** | Voydeya |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 8/5/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VOYDEYA | DANICOPAN TAB THERAPY PACK 50 MG & 100 MG | 8580852000B720 | Brand |
| VOYDEYA | DANICOPAN TAB 100 MG | 85808520000320 | Brand |

**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** - All of the following:

**2.1** Patient is currently receiving complement protein C5 inhibitor Soliris (eculizumab) or Ultomiris (ravulizumab)

**AND**

**2.2** Patient is experiencing extravascular hemolysis (EVH) while on complement protein C5 inhibitor Soliris (eculizumab) or Ultomiris (ravulizumab)

**AND**

**2.3** Patient will continue to receive complement protein C5 inhibitor Soliris (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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VOYDEYA | DANICOPAN TAB THERAPY PACK 50 MG & 100 MG | 8580852000B720 | Brand |
| VOYDEYA | DANICOPAN TAB 100 MG | 85808520000320 | Brand |

**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 Soliris (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

Vtama

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146438 |
| **Guideline Name** | Vtama |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Vtama | |
|---|---|
| Approval Length | 6 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VTAMA | TAPINAROF CREAM 1% | 90250075003720 | Brand |

**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

**AND**

**3** - Patient is NOT receiving Vtama in combination with any a Targeted Immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

**AND**

**4** - Prescribed by, or in consultation with, a dermatologist

Product Name: Vtama

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VTAMA | TAPINAROF CREAM 1% | 90250075003720 | Brand |

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

Vyndaqel and Vyndamax

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-160429 |
| **Guideline Name** | Vyndaqel and Vyndamax |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 12/1/2024 |

## 1 . Criteria

| Product Name: Vyndaqel, Vyndamax | |
|---|---|
| Diagnosis | Transthyretin (ATTR)-mediated amyloidosis with cardiomyopathy (ATTR-CM) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VYNDAQEL | TAFAMIDIS MEGLUMINE (CARDIAC) CAP 20 MG | 40550080200120 | Brand |
| VYNDAMAX | TAFAMIDIS CAP 61 MG | 40550080000120 | Brand |

**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 monoclonal protein identified in serum, urine immunofixation (IFE), serum free light chain (sFLC) assay

**AND**

**3** - Prescribed by, or in consultation, with a cardiologist

**AND**

**4** - Presence of clinical signs and symptoms of cardiomyopathy (e.g., heart failure, dyspnea, edema, hepatomegaly, ascites, angina, etc.)

**AND**

**5** - Documentation of BOTH of the following:

**5.1** ONE of the following:

**5.1.1** Patient has New York Heart Association (NYHA) Functional Class I or II heart failure

**OR**

**5.1.2** BOTH of the following:

**5.1.2.1** Patient has New York Heart Association (NYHA) Functional Class III heart failure

**AND**

**5.1.2.2** Patient's cardiopulmonary functional status allows patient to ambulate 100 meters or greater in six minutes or less

**AND**

**5.2** Patient has an N-terminal pro-B-type naturetic peptide (NT-proBNP) level greater than or equal to 600 picograms/milliliter

**AND**

**6** - One of the following:

**6.1** Patient is not receiving Vyndaqel/Vyndamax in combination with an RNA-targeted

therapy for ATTR amyloidosis [i.e., Amvuttra (vutrisiran), Onpattro (patisiran), Tegsedi (inotersen), or Wainua (eplontersen)]

**OR**

**6.2** If the patient is receiving Vyndaqel/Vyndamax in combination with an RNA-targeted therapy for ATTR amyloidosis [i.e., Amvuttra (vutrisiran), Onpattro (patisiran), Tegsedi (inotersen), or Wainua (eplontersen)], the physician attests that he/she will coordinate care with other specialist(s) involved in the patient's amyloidosis treatment plan to determine optimal long term monotherapy** treatment regimen

| | |
|---|---|
| Notes | NOTE: *May require prior authorization and notification<br>** Referring to monotherapy with Vyndaqel/Vyndamax, Amvuttra, Onpattro, Tegsedi, or Wainua. |

| Product Name: Vyndaqel, Vyndamax | |
|---|---|
| Diagnosis | Transthyretin (ATTR)-mediated amyloidosis with cardiomyopathy (ATTR-CM) |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| VYNDAQEL | TAFAMIDIS MEGLUMINE (CARDIAC) CAP 20 MG | 40550080200120 | Brand |
| VYNDAMAX | TAFAMIDIS CAP 61 MG | 40550080000120 | Brand |

**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** - Prescribed by or in consultation with a cardiologist

**AND**

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

**AND**

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

## 2 . Revision History

| Date | Notes |
|---|---|
| 11/11/2024 | Updated criteria wording for concomitant use |

Wainua

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146700 |
| **Guideline Name** | Wainua |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| WAINUA | EPLONTERSEN SODIUM SUBCUTANEOUS SOLN AUTO-INJ 45 MG/0.8ML | 6270102510D520 | Brand |

**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)]
- Tafamidis (e.g., Vyndaqel, Vyndamax)

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| WAINUA | EPLONTERSEN SODIUM SUBCUTANEOUS SOLN AUTO-INJ 45 MG/0.8ML | 6270102510D520 | Brand |

**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)]
- Tafamidis (e.g., Vyndaqel, Vyndamax)

Wakix

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146701 |
| **Guideline Name** | Wakix |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| WAKIX | PITOLISANT HCL TAB 4.45 MG (BASE EQUIVALENT) | 61450070100318 | Brand |
| WAKIX | PITOLISANT HCL TAB 17.8 MG (BASE EQUIVALENT) | 61450070100338 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| WAKIX | PITOLISANT HCL TAB 4.45 MG (BASE EQUIVALENT) | 61450070100318 | Brand |
| WAKIX | PITOLISANT HCL TAB 17.8 MG (BASE EQUIVALENT) | 61450070100338 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| WAKIX | PITOLISANT HCL TAB 4.45 MG (BASE EQUIVALENT) | 61450070100318 | Brand |
| WAKIX | PITOLISANT HCL TAB 17.8 MG (BASE EQUIVALENT) | 61450070100338 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| WAKIX | PITOLISANT HCL TAB 4.45 MG (BASE EQUIVALENT) | 61450070100318 | Brand |
| WAKIX | PITOLISANT HCL TAB 17.8 MG (BASE EQUIVALENT) | 61450070100338 | Brand |

**Approval Criteria**

**1** - Reduction in frequency of cataplexy attacks associated with therapy

**OR**

**2** - Reduction in symptoms of excessive daytime sleepiness associated with therapy

Wegovy

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-152718 |
| **Guideline Name** | Wegovy |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 10/1/2024 |

## 1 . Criteria

| Product Name: Wegovy | |
|---|---|
| Diagnosis | Reduction of risk of major adverse cardiovascular events |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| WEGOVY | SEMAGLUTIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 0.25 MG/0.5ML | 6125207000D520 | Brand |
| WEGOVY | SEMAGLUTIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 0.5 MG/0.5ML | 6125207000D525 | Brand |
| WEGOVY | SEMAGLUTIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 1 MG/0.5ML | 6125207000D530 | Brand |

| | | | |
|---|---|---|---|
| WEGOVY | SEMAGLUTIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 1.7 MG/0.75ML | 6125207000D535 | Brand |
| WEGOVY | SEMAGLUTIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 2.4 MG/0.75ML | 6125207000D540 | Brand |

**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 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 | |
|---|---|
| Diagnosis | Reduction of risk of major adverse cardiovascular events |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| WEGOVY | SEMAGLUTIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 0.25 MG/0.5ML | 6125207000D520 | Brand |
| WEGOVY | SEMAGLUTIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 0.5 MG/0.5ML | 6125207000D525 | Brand |
| WEGOVY | SEMAGLUTIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 1 MG/0.5ML | 6125207000D530 | Brand |
| WEGOVY | SEMAGLUTIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 1.7 MG/0.75ML | 6125207000D535 | Brand |

| | | | |
|---|---|---|---|
| WEGOVY | SEMAGLUTIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 2.4 MG/0.75ML | 6125207000D540 | Brand |

**Approval Criteria**

**1** - BMI (body mass index) greater than or equal to 27 kg/m2 (kilograms per square meter)

**AND**

**2** - Used in combination with a reduced calorie diet and increased physical activity

**AND**

**3** - Patient does NOT have diagnosis of diabetes or HgA1c greater than or equal to 6.5%

**AND**

**4** - Patient does NOT have New York Heart Association class IV heart failure

| Product Name: Wegovy | |
|---|---|
| Diagnosis | Weight Loss |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| WEGOVY | SEMAGLUTIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 0.25 MG/0.5ML | 6125207000D520 | Brand |
| WEGOVY | SEMAGLUTIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 0.5 MG/0.5ML | 6125207000D525 | Brand |
| WEGOVY | SEMAGLUTIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 1 MG/0.5ML | 6125207000D530 | Brand |
| WEGOVY | SEMAGLUTIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 1.7 MG/0.75ML | 6125207000D535 | Brand |
| WEGOVY | SEMAGLUTIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 2.4 MG/0.75ML | 6125207000D540 | Brand |

**Approval Criteria**

**1** - Wegovy when used solely for the treatment of weight loss is excluded and is to be denied as a benefit exclusion

## 2 . Revision History

| Date | Notes |
|---|---|
| 8/27/2024 | New guideline |

Welireg

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-155269 |
| **Guideline Name** | Welireg |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 10/1/2024 |

## 1 . Criteria

| Product Name: Welireg | |
|---|---|
| Diagnosis | Von Hippel-Lindau (VHL) Disease |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| WELIREG | BELZUTIFAN TAB 40 MG | 21421020000320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| WELIREG | BELZUTIFAN TAB 40 MG | 21421020000320 | Brand |

**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 | Von Hippel-Lindau (VHL) Disease, Advanced Renal Cell Carcinoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| WELIREG | BELZUTIFAN TAB 40 MG | 21421020000320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| WELIREG | BELZUTIFAN TAB 40 MG | 21421020000320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| WELIREG | BELZUTIFAN TAB 40 MG | 21421020000320 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Welireg therapy

## 2 . Revision History

| Date | Notes |
|---|---|
| 9/19/2024 | Updated examples of PD-L1 checkpoint inhibitors and VEGF-TKIs wi thin advanced RCC criteria. |

Winrevair

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-152475 |
| **Guideline Name** | Winrevair |
| **Formulary** | • Medicaid - Community & State New Mexico |

## 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| WINREVAIR | SOTATERCEPT-CSRK FOR SUBCUTANEOUS SOLN KIT 45 MG | 40110070206420 | Brand |
| WINREVAIR | SOTATERCEPT-CSRK FOR SUBCUTANEOUS SOLN KIT 60 MG | 40110070206425 | Brand |
| WINREVAIR | SOTATERCEPT-CSRK FOR SUBCUTANEOUS SOLN KIT 2 X 45 MG | 40110070206430 | Brand |

| | | | |
|---|---|---|---|
| WINREVAIR | SOTATERCEPT-CSRK FOR SUBCUTANEOUS SOLN KIT 2 X 60 MG | 40110070206435 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| WINREVAIR | SOTATERCEPT-CSRK FOR SUBCUTANEOUS SOLN KIT 45 MG | 40110070206420 | Brand |
| WINREVAIR | SOTATERCEPT-CSRK FOR SUBCUTANEOUS SOLN KIT 60 MG | 40110070206425 | Brand |
| WINREVAIR | SOTATERCEPT-CSRK FOR SUBCUTANEOUS SOLN KIT 2 X 45 MG | 40110070206430 | Brand |
| WINREVAIR | SOTATERCEPT-CSRK FOR SUBCUTANEOUS SOLN KIT 2 X 60 MG | 40110070206435 | Brand |

**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 | Copy core |

Xalkori

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146703 |
| **Guideline Name** | Xalkori |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Xalkori | |
|---|---|
| Diagnosis | Inflammatory Myofibroblastic Tumor (IMT) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XALKORI | CRIZOTINIB CAP 200 MG | 21530517000120 | Brand |
| XALKORI | CRIZOTINIB CAP 250 MG | 21530517000125 | Brand |
| XALKORI | CRIZOTINIB CAP SPRINKLE 20 MG | 21530517006820 | Brand |
| XALKORI | CRIZOTINIB CAP SPRINKLE 50 MG | 21530517006830 | Brand |

| | | | |
|---|---|---|---|
| XALKORI | CRIZOTINIB CAP SPRINKLE 150 MG | 21530517006850 | Brand |

**Approval Criteria**

**1** - Diagnosis of 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XALKORI | CRIZOTINIB CAP 200 MG | 21530517000120 | Brand |
| XALKORI | CRIZOTINIB CAP 250 MG | 21530517000125 | Brand |
| XALKORI | CRIZOTINIB CAP SPRINKLE 20 MG | 21530517006820 | Brand |
| XALKORI | CRIZOTINIB CAP SPRINKLE 50 MG | 21530517006830 | Brand |
| XALKORI | CRIZOTINIB CAP SPRINKLE 150 MG | 21530517006850 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XALKORI | CRIZOTINIB CAP 200 MG | 21530517000120 | Brand |
| XALKORI | CRIZOTINIB CAP 250 MG | 21530517000125 | Brand |
| XALKORI | CRIZOTINIB CAP SPRINKLE 20 MG | 21530517006820 | Brand |
| XALKORI | CRIZOTINIB CAP SPRINKLE 50 MG | 21530517006830 | Brand |
| XALKORI | CRIZOTINIB CAP SPRINKLE 150 MG | 21530517006850 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XALKORI | CRIZOTINIB CAP 200 MG | 21530517000120 | Brand |
| XALKORI | CRIZOTINIB CAP 250 MG | 21530517000125 | Brand |
| XALKORI | CRIZOTINIB CAP SPRINKLE 20 MG | 21530517006820 | Brand |
| XALKORI | CRIZOTINIB CAP SPRINKLE 50 MG | 21530517006830 | Brand |
| XALKORI | CRIZOTINIB CAP SPRINKLE 150 MG | 21530517006850 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XALKORI | CRIZOTINIB CAP 200 MG | 21530517000120 | Brand |

| | | | |
|---|---|---|---|
| XALKORI | CRIZOTINIB CAP 250 MG | 21530517000125 | Brand |
| XALKORI | CRIZOTINIB CAP SPRINKLE 20 MG | 21530517006820 | Brand |
| XALKORI | CRIZOTINIB CAP SPRINKLE 50 MG | 21530517006830 | Brand |
| XALKORI | CRIZOTINIB CAP SPRINKLE 150 MG | 21530517006850 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XALKORI | CRIZOTINIB CAP 200 MG | 21530517000120 | Brand |
| XALKORI | CRIZOTINIB CAP 250 MG | 21530517000125 | Brand |
| XALKORI | CRIZOTINIB CAP SPRINKLE 20 MG | 21530517006820 | Brand |
| XALKORI | CRIZOTINIB CAP SPRINKLE 50 MG | 21530517006830 | Brand |
| XALKORI | CRIZOTINIB CAP SPRINKLE 150 MG | 21530517006850 | Brand |

**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 | Inflammatory Myofibroblastic Tumor (IMT), Non-Small Cell Lung Cancer (NSCLC), Central Nervous System (CNS) Cancers, Anaplastic Large Cell Lymphoma, Histiocytic Neoplasms, Melanoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XALKORI | CRIZOTINIB CAP 200 MG | 21530517000120 | Brand |
| XALKORI | CRIZOTINIB CAP 250 MG | 21530517000125 | Brand |
| XALKORI | CRIZOTINIB CAP SPRINKLE 20 MG | 21530517006820 | Brand |
| XALKORI | CRIZOTINIB CAP SPRINKLE 50 MG | 21530517006830 | Brand |
| XALKORI | CRIZOTINIB CAP SPRINKLE 150 MG | 21530517006850 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XALKORI | CRIZOTINIB CAP 200 MG | 21530517000120 | Brand |
| XALKORI | CRIZOTINIB CAP 250 MG | 21530517000125 | Brand |
| XALKORI | CRIZOTINIB CAP SPRINKLE 20 MG | 21530517006820 | Brand |
| XALKORI | CRIZOTINIB CAP SPRINKLE 50 MG | 21530517006830 | Brand |
| XALKORI | CRIZOTINIB CAP SPRINKLE 150 MG | 21530517006850 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XALKORI | CRIZOTINIB CAP 200 MG | 21530517000120 | Brand |
| XALKORI | CRIZOTINIB CAP 250 MG | 21530517000125 | Brand |
| XALKORI | CRIZOTINIB CAP SPRINKLE 20 MG | 21530517006820 | Brand |
| XALKORI | CRIZOTINIB CAP SPRINKLE 50 MG | 21530517006830 | Brand |
| XALKORI | CRIZOTINIB CAP SPRINKLE 150 MG | 21530517006850 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Xalkori therapy

Xarelto

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146440 |
| **Guideline Name** | Xarelto |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Xarelto tablets, Xarelto oral suspension | |
|---|---|
| Diagnosis | Continuation of Therapy Upon Hospital Discharge |
| Approval Length | 35 Day(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XARELTO STARTER PACK | RIVAROXABAN TAB STARTER THERAPY PACK 15 MG & 20 MG | 8337006000B720 | Brand |
| XARELTO | RIVAROXABAN TAB 2.5 MG | 83370060000310 | Brand |
| XARELTO | RIVAROXABAN TAB 10 MG | 83370060000320 | Brand |
| XARELTO | RIVAROXABAN TAB 15 MG | 83370060000330 | Brand |

| | | | |
|---|---|---|---|
| XARELTO | RIVAROXABAN TAB 20 MG | 83370060000340 | Brand |
| XARELTO | RIVAROXABAN FOR SUSP 1 MG/ML | 83370060001920 | Brand |

**Approval Criteria**

**1** - Xarelto will be approved as continuation of therapy upon hospital discharge

| Product Name: Xarelto tablets, Xarelto oral 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XARELTO STARTER PACK | RIVAROXABAN TAB STARTER THERAPY PACK 15 MG & 20 MG | 8337006000B720 | Brand |
| XARELTO | RIVAROXABAN TAB 2.5 MG | 83370060000310 | Brand |
| XARELTO | RIVAROXABAN TAB 10 MG | 83370060000320 | Brand |
| XARELTO | RIVAROXABAN TAB 15 MG | 83370060000330 | Brand |
| XARELTO | RIVAROXABAN TAB 20 MG | 83370060000340 | Brand |
| XARELTO | RIVAROXABAN FOR SUSP 1 MG/ML | 83370060001920 | Brand |

**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 BOTH of the following as confirmed by claims history or submission of medical records:

- Eliquis
- Savaysa

**OR**

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

- Eliquis
- Savaysa

**OR**

**3.3** Continuation of prior Xarelto therapy

| Product Name: Xarelto tablets, Xarelto oral 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XARELTO STARTER PACK | RIVAROXABAN TAB STARTER THERAPY PACK 15 MG & 20 MG | 8337006000B720 | Brand |
| XARELTO | RIVAROXABAN TAB 2.5 MG | 83370060000310 | Brand |
| XARELTO | RIVAROXABAN TAB 10 MG | 83370060000320 | Brand |
| XARELTO | RIVAROXABAN TAB 15 MG | 83370060000330 | Brand |
| XARELTO | RIVAROXABAN TAB 20 MG | 83370060000340 | Brand |
| XARELTO | RIVAROXABAN FOR SUSP 1 MG/ML | 83370060001920 | Brand |

**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: Xarelto tablets, Xarelto oral suspension | |
|---|---|
| Diagnosis | Treatment of Deep Vein Thrombosis (DVT) or Pulmonary Embolism (PE) in Adult Patients |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| XARELTO STARTER PACK | RIVAROXABAN TAB STARTER THERAPY PACK 15 MG & 20 MG | 8337006000B720 | Brand |
| XARELTO | RIVAROXABAN TAB 2.5 MG | 83370060000310 | Brand |
| XARELTO | RIVAROXABAN TAB 10 MG | 83370060000320 | Brand |
| XARELTO | RIVAROXABAN TAB 15 MG | 83370060000330 | Brand |
| XARELTO | RIVAROXABAN TAB 20 MG | 83370060000340 | Brand |
| XARELTO | RIVAROXABAN FOR SUSP 1 MG/ML | 83370060001920 | Brand |

**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 BOTH of the following as confirmed by claims history or submission of medical records:

- Eliquis
- Savaysa

**OR**

**3.2** History on intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Eliquis
- Savaysa

**OR**

**3.3** Continuation of prior Xarelto therapy

| Product Name: Xarelto tablets, Xarelto oral 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XARELTO STARTER PACK | RIVAROXABAN TAB STARTER THERAPY PACK 15 MG & 20 MG | 8337006000B720 | Brand |
| XARELTO | RIVAROXABAN TAB 2.5 MG | 83370060000310 | Brand |
| XARELTO | RIVAROXABAN TAB 10 MG | 83370060000320 | Brand |
| XARELTO | RIVAROXABAN TAB 15 MG | 83370060000330 | Brand |
| XARELTO | RIVAROXABAN TAB 20 MG | 83370060000340 | Brand |
| XARELTO | RIVAROXABAN FOR SUSP 1 MG/ML | 83370060001920 | Brand |

**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**

**2** - 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: Xarelto tablets, Xarelto oral 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XARELTO STARTER PACK | RIVAROXABAN TAB STARTER THERAPY PACK 15 MG & 20 MG | 8337006000B720 | Brand |
| XARELTO | RIVAROXABAN TAB 2.5 MG | 83370060000310 | Brand |
| XARELTO | RIVAROXABAN TAB 10 MG | 83370060000320 | Brand |
| XARELTO | RIVAROXABAN TAB 15 MG | 83370060000330 | Brand |
| XARELTO | RIVAROXABAN TAB 20 MG | 83370060000340 | Brand |
| XARELTO | RIVAROXABAN FOR SUSP 1 MG/ML | 83370060001920 | Brand |

**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: Xarelto tablets, Xarelto oral 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XARELTO STARTER PACK | RIVAROXABAN TAB STARTER THERAPY PACK 15 MG & 20 MG | 8337006000B720 | Brand |
| XARELTO | RIVAROXABAN TAB 2.5 MG | 83370060000310 | Brand |
| XARELTO | RIVAROXABAN TAB 10 MG | 83370060000320 | Brand |
| XARELTO | RIVAROXABAN TAB 15 MG | 83370060000330 | Brand |
| XARELTO | RIVAROXABAN TAB 20 MG | 83370060000340 | Brand |
| XARELTO | RIVAROXABAN FOR SUSP 1 MG/ML | 83370060001920 | Brand |

**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**

**2** - 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: Xarelto tablets, Xarelto oral suspension | |
|---|---|
| Diagnosis | Thromboprophylaxis in Pediatric Patients with Congenital Heart Disease After the Fontan Procedure |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XARELTO STARTER PACK | RIVAROXABAN TAB STARTER THERAPY PACK 15 MG & 20 MG | 8337006000B720 | Brand |
| XARELTO | RIVAROXABAN TAB 2.5 MG | 83370060000310 | Brand |
| XARELTO | RIVAROXABAN TAB 10 MG | 83370060000320 | Brand |
| XARELTO | RIVAROXABAN TAB 15 MG | 83370060000330 | Brand |
| XARELTO | RIVAROXABAN TAB 20 MG | 83370060000340 | Brand |
| XARELTO | RIVAROXABAN FOR SUSP 1 MG/ML | 83370060001920 | Brand |

**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: Xarelto tablets, Xarelto oral 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XARELTO STARTER PACK | RIVAROXABAN TAB STARTER THERAPY PACK 15 MG & 20 MG | 8337006000B720 | Brand |
| XARELTO | RIVAROXABAN TAB 2.5 MG | 83370060000310 | Brand |
| XARELTO | RIVAROXABAN TAB 10 MG | 83370060000320 | Brand |
| XARELTO | RIVAROXABAN TAB 15 MG | 83370060000330 | Brand |
| XARELTO | RIVAROXABAN TAB 20 MG | 83370060000340 | Brand |
| XARELTO | RIVAROXABAN FOR SUSP 1 MG/ML | 83370060001920 | Brand |

**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**

**2** - Patient has received at least 5 days of initial parenteral anticoagulant treatment

**AND**

**4** - Patient is 0 years to 17 years of age

Xdemvy

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146441 |
| **Guideline Name** | Xdemvy |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Xdemvy | |
|---|---|
| Approval Length | 6 Week(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XDEMVY | LOTILANER OPHTH SOLN 0.25% | 86106050002020 | Brand |

**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

Xeljanz, Xeljanz XR, Xeljanz Oral Solution

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-161147 |
| **Guideline Name** | Xeljanz, Xeljanz XR, Xeljanz Oral Solution |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XELJANZ | TOFACITINIB CITRATE TAB 5 MG (BASE EQUIVALENT) | 66603065100320 | Brand |
| XELJANZ | TOFACITINIB CITRATE TAB 10 MG (BASE EQUIVALENT) | 66603065100330 | Brand |
| XELJANZ XR | TOFACITINIB CITRATE TAB ER 24HR 11 MG (BASE EQUIVALENT) | 66603065107530 | Brand |

| | | | |
|---|---|---|---|
| XELJANZ XR | TOFACITINIB CITRATE TAB ER 24HR 22 MG (BASE EQUIVALENT) | 66603065107550 | Brand |

**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 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), adalimumab, Simponi (golimumab), Orencia (abatacept), Olumiant (baricitinib), Rinvoq (upadacitinib)]

**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:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Rinvoq (upadacitinib), Olumiant (baricitinib)]

- 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:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Rinvoq (upadacitinib), Olumiant (baricitinib)]
- 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 | *PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |

| Product Name: Xeljanz tabs, Xeljanz XR | |
|---|---|
| Diagnosis | Psoriatic Arthritis (PsA) |
| Approval Length | 12 month(s) |

| Therapy Stage | Initial Authorization |
|---|---|
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XELJANZ | TOFACITINIB CITRATE TAB 5 MG (BASE EQUIVALENT) | 66603065100320 | Brand |
| XELJANZ | TOFACITINIB CITRATE TAB 10 MG (BASE EQUIVALENT) | 66603065100330 | Brand |
| XELJANZ XR | TOFACITINIB CITRATE TAB ER 24HR 11 MG (BASE EQUIVALENT) | 66603065107530 | Brand |
| XELJANZ XR | TOFACITINIB CITRATE TAB ER 24HR 22 MG (BASE EQUIVALENT) | 66603065107550 | Brand |

**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 targeted immunomodulator FDA-approved for the treatment of psoriatic arthritis as confirmed by claims history or submission of medical records [e.g., Enbrel (etanercept), Cimzia (certolizumab), adalimumab, Simponi (golimumab), Orencia (abatacept), Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

**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:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Rinvoq (upadacitinib), Olumiant (baricitinib), Otezla (apremilast)]
- 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 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 in combination with either of the following:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Rinvoq (upadacitinib), Olumiant (baricitinib), Otezla (apremilast)]

- Potent immunosuppressant (e.g., azathioprine or cyclosporine)

**AND**

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

- Rheumatologist
- Dermatologist

| Notes | *PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |
|---|---|

| Product Name: Xeljanz tabs, Xeljanz XR | |
|---|---|
| Diagnosis | Ulcerative Colitis (UC) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XELJANZ | TOFACITINIB CITRATE TAB 5 MG (BASE EQUIVALENT) | 66603065100320 | Brand |
| XELJANZ | TOFACITINIB CITRATE TAB 10 MG (BASE EQUIVALENT) | 66603065100330 | Brand |
| XELJANZ XR | TOFACITINIB CITRATE TAB ER 24HR 11 MG (BASE EQUIVALENT) | 66603065107530 | Brand |
| XELJANZ XR | TOFACITINIB CITRATE TAB ER 24HR 22 MG (BASE EQUIVALENT) | 66603065107550 | Brand |

**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 targeted immunomodulator FDA-approved for the treatment of ulcerative colitis as confirmed by claims history or submission of medical records [e.g., Simponi (golimumab), Stelara (ustekinumab), Rinvoq (upadacitinib)]

**AND**

**1.3** ONE of the following:

**1.3.1** Failure to one of the preferred adalimumab products* as confirmed by claims history or submission of medical records

**OR**

**1.3.2** History of intolerance or contraindication to one of the preferred adalimumab products* (please specify intolerance or contraindication)

**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:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Rinvoq (upadacitinib), Olumiant (baricitinib), Stelara (ustekinumab), Skyrizi (risankizumab)]
- 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:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Rinvoq (upadacitinib), Olumiant (baricitinib), Stelara (ustekinumab), Skyrizi (risankizumab)]
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

**AND**

**2.4** Prescribed by or in consultation with a gastroenterologist

| Notes | *PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |
|---|---|

| Product Name: Xeljanz tabs, Xeljanz XR | |
|---|---|
| Diagnosis | Ankylosing Spondylitis |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XELJANZ | TOFACITINIB CITRATE TAB 5 MG (BASE EQUIVALENT) | 66603065100320 | Brand |
| XELJANZ | TOFACITINIB CITRATE TAB 10 MG (BASE EQUIVALENT) | 66603065100330 | Brand |
| XELJANZ XR | TOFACITINIB CITRATE TAB ER 24HR 11 MG (BASE EQUIVALENT) | 66603065107530 | Brand |
| XELJANZ XR | TOFACITINIB CITRATE TAB ER 24HR 22 MG (BASE EQUIVALENT) | 66603065107550 | Brand |

**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 targeted immunomodulator FDA-approved for the treatment of ankylosing spondylitis as confirmed by claims history or submission of medical records [e.g., Enbrel (etanercept), Cimzia (certolizumab), adalimumab, Simponi (golimumab), Rinvoq (upadacitinib)]

**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:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Rinvoq (upadacitinib), Olumiant (baricitinib)]
- 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:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Rinvoq (upadacitinib), Olumiant (baricitinib)]
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

**AND**

**2.4** Prescribed by or in consultation with a rheumatologist

| Notes | *PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |
|---|---|

| Product Name: Xeljanz tabs, Xeljanz XR | |
|---|---|
| Diagnosis | Rheumatoid Arthritis (RA), Psoriatic Arthritis (PsA), Ulcerative Colitis (UC), Ankylosing Spondylitis |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XELJANZ | TOFACITINIB CITRATE TAB 5 MG (BASE EQUIVALENT) | 66603065100320 | Brand |
| XELJANZ | TOFACITINIB CITRATE TAB 10 MG (BASE EQUIVALENT) | 66603065100330 | Brand |
| XELJANZ XR | TOFACITINIB CITRATE TAB ER 24HR 11 MG (BASE EQUIVALENT) | 66603065107530 | Brand |
| XELJANZ XR | TOFACITINIB CITRATE TAB ER 24HR 22 MG (BASE EQUIVALENT) | 66603065107550 | Brand |

**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:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Rinvoq (upadacitinib), Olumiant (baricitinib), Otezla (apremilast)]*
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)*

| Notes | * Examples of drug(s) may not be applicable based on the requested i ndication. |
|---|---|

| 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XELJANZ | TOFACITINIB CITRATE TAB 5 MG (BASE EQUIVALENT) | 66603065100320 | Brand |
| XELJANZ | TOFACITINIB CITRATE TAB 10 MG (BASE EQUIVALENT) | 66603065100330 | Brand |
| XELJANZ | TOFACITINIB CITRATE ORAL SOLN 1 MG/ML (BASE EQUIVALENT) | 66603065102020 | Brand |

**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:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Olumiant (baricitinib), Rinvoq (upadacitinib)]
- 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:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Olumiant (baricitinib), Rinvoq (upadacitinib)]
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

**AND**

**2.4** Prescribed by or in consultation with a rheumatologist

| Notes | *PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |
|---|---|

| 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XELJANZ | TOFACITINIB CITRATE TAB 5 MG (BASE EQUIVALENT) | 66603065100320 | Brand |
| XELJANZ | TOFACITINIB CITRATE TAB 10 MG (BASE EQUIVALENT) | 66603065100330 | Brand |
| XELJANZ | TOFACITINIB CITRATE ORAL SOLN 1 MG/ML (BASE EQUIVALENT) | 66603065102020 | Brand |

**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:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Olumiant (baricitinib), Rinvoq (upadacitinib)]
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

## 2 . Revision History

| Date | Notes |
|---|---|
| 11/21/2024 | Updated step therapy bypass language. Removed Cimzia as step thr u agent |

Xenazine

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146705 |
| **Guideline Name** | Xenazine |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Brand Xenazine, generic tetrabenazine | |
|---|---|
| Diagnosis | Chorea associated with Huntington's Disease |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TETRABENAZINE | TETRABENAZINE TAB 12.5 MG | 62380070000310 | Generic |
| XENAZINE | TETRABENAZINE TAB 12.5 MG | 62380070000310 | Brand |
| TETRABENAZINE | TETRABENAZINE TAB 25 MG | 62380070000320 | Generic |
| XENAZINE | TETRABENAZINE TAB 25 MG | 62380070000320 | Brand |

**Approval Criteria**

**1** - Diagnosis of chorea in patients with Huntington's disease

| Product Name: Brand Xenazine, generic tetrabenazine | |
|---|---|
| Diagnosis | Tardive Dyskinesia (Off-Label) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TETRABENAZINE | TETRABENAZINE TAB 12.5 MG | 62380070000310 | Generic |
| XENAZINE | TETRABENAZINE TAB 12.5 MG | 62380070000310 | Brand |
| TETRABENAZINE | TETRABENAZINE TAB 25 MG | 62380070000320 | Generic |
| XENAZINE | TETRABENAZINE TAB 25 MG | 62380070000320 | Brand |

**Approval Criteria**

**1** - Diagnosis of tardive dyskinesia

**AND**

**2** - ONE of the following:

**2.1** Patient has persistent symptoms of tardive dyskinesia despite a trial of dose reduction, tapering, or discontinuation of the offending medication

**OR**

**2.2** Patient is not a candidate for a trial of dose reduction, tapering, or discontinuation of the offending medication

**AND**

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

- Neurologist
- Psychiatrist

| Product Name: Brand Xenazine, generic tetrabenazine | |
|---|---|
| Diagnosis | Tourette's Syndrome (Off-Label) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TETRABENAZINE | TETRABENAZINE TAB 12.5 MG | 62380070000310 | Generic |
| XENAZINE | TETRABENAZINE TAB 12.5 MG | 62380070000310 | Brand |
| TETRABENAZINE | TETRABENAZINE TAB 25 MG | 62380070000320 | Generic |
| XENAZINE | TETRABENAZINE TAB 25 MG | 62380070000320 | Brand |

**Approval Criteria**

**1** - Patient has tics associated with Tourette's syndrome

**AND**

**2** - ONE of the following:

**2.1** Failure of haloperidol confirmed by claims history or submitted medical records

**OR**

**2.2** History of intolerance or contraindication to haloperidol (please specify intolerance or contraindication)

**AND**

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

- Neurologist
- Psychiatrist

| Product Name: Brand Xenazine, generic tetrabenazine | |
|---|---|
| Diagnosis | Tardive Dyskinesia (Off-Label), Tourette's Syndrome (Off-Label) |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| TETRABENAZINE | TETRABENAZINE TAB 12.5 MG | 62380070000310 | Generic |
| XENAZINE | TETRABENAZINE TAB 12.5 MG | 62380070000310 | Brand |
| TETRABENAZINE | TETRABENAZINE TAB 25 MG | 62380070000320 | Generic |
| XENAZINE | TETRABENAZINE TAB 25 MG | 62380070000320 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to therapy

Xenleta

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146442 |
| **Guideline Name** | Xenleta |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Xenleta | |
|---|---|
| Diagnosis | Community-acquired bacterial pneumonia |
| Approval Length | 7 Day(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XENLETA | LEFAMULIN ACETATE TAB 600 MG | 16240040100320 | Brand |

**Approval Criteria**

**1** - One of the following:

**1.1** For continuation of therapy upon hospital discharge

**OR**

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

**OR**

**1.3** All of the following:

**1.3.1** Diagnosis of community-acquired bacterial pneumonia (CABP)

**AND**

**1.3.2** Infection caused by an organism that is confirmed to be or likely to be susceptible to treatment with Xenleta

**AND**

**1.3.3** One of the following:

**1.3.3.1** Failure to three of the following antibiotics or antibiotic regimens confirmed by claims history or submitted medical records:

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

**OR**

**1.3.3.2** History of contraindication or intolerance 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: Xenleta | |
|---|---|
| Diagnosis | Off-Label Uses |
| Approval Length | Based on provider and IDSA recommended treatment durations, not to exceed 6 months |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XENLETA | LEFAMULIN ACETATE TAB 600 MG | 16240040100320 | Brand |

**Approval Criteria**

**1** - One of the following:

**1.1** For continuation of therapy upon hospital discharge

**OR**

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

**OR**

**1.3** The drug has been recognized for treatment of the indication by the Infectious Diseases Society of America (IDSA)

Xermelo

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-151737 |
| **Guideline Name** | Xermelo |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 9/1/2024 |

## 1 . Criteria

| Product Name: Xermelo | |
|---|---|
| Diagnosis | Carcinoid Syndrome Diarrhea |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XERMELO | TELOTRISTAT ETHYL TAB 250 MG (AS TELOTRISTAT ETIPRATE) | 52570075100330 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XERMELO | TELOTRISTAT ETHYL TAB 250 MG (AS TELOTRISTAT ETIPRATE) | 52570075100330 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Xermelo

## 2 . Revision History

| Date | Notes |
|---|---|
| 8/14/2024 | Updated initial authorization duration to 12 months. |

Xifaxan

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-148288 |
| **Guideline Name** | Xifaxan |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Xifaxan 200mg | |
|---|---|
| Diagnosis | Travelers' Diarrhea |
| Approval Length | 1 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XIFAXAN | RIFAXIMIN TAB 200 MG | 16000049000320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XIFAXAN | RIFAXIMIN TAB 550 MG | 16000049000340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XIFAXAN | RIFAXIMIN TAB 550 MG | 16000049000340 | Brand |

**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 |
|---|---|

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XIFAXAN | RIFAXIMIN TAB 550 MG | 16000049000340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XIFAXAN | RIFAXIMIN TAB 550 MG | 16000049000340 | Brand |

**Approval Criteria**

**1** - Patient continues to need Xifaxan and has experienced positive results with prior use

| Product Name: Xifaxan 200mg | |
|---|---|
| Diagnosis | Inflammatory Bowel Disease (e.g. Crohn's Disease, Ulcerative Colitis, Diverticulitis) (Off-label) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XIFAXAN | RIFAXIMIN TAB 200 MG | 16000049000320 | Brand |

**Approval Criteria**

**1** - Diagnosis of inflammatory bowel disease

**AND**

**2** - ONE of the following:

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

- Ciprofloxacin (generic Cipro)
- Metronidazole (generic Flagyl)

**OR**

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

- Ciprofloxacin (generic Cipro)
- Metronidazole (generic Flagyl)

| Product Name: Xifaxan 200mg | |
|---|---|
| Diagnosis | Inflammatory Bowel Disease (e.g. Crohn's Disease, Ulcerative Colitis, Diverticulitis) (Off-label) |

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XIFAXAN | RIFAXIMIN TAB 200 MG | 16000049000320 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Xifaxan therapy

## 2 . Revision History

| Date | Notes |
|---|---|
| 6/7/2024 | Updated language from “Diagnosis of hepatic encephalopathy” to “U sed for prophylaxis of hepatic encephalopathy (HE) recurrence” to ali gn with PI; Minor cosmetic updates. |

Xolair

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-150979 |
| **Guideline Name** | Xolair |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 8/6/2024 |

## 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XOLAIR | OMALIZUMAB FOR INJ 150 MG | 44603060002120 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 75 MG/0.5ML | 4460306000E510 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/ML | 4460306000E520 | Brand |

| | | | |
|---|---|---|---|
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 75 MG/0.5ML | 4460306000D510 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 150 MG/ML | 4460306000D520 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML | 4460306000D530 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML | 4460306000E530 | Brand |

**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 (resilizumab), 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XOLAIR | OMALIZUMAB FOR INJ 150 MG | 44603060002120 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 75 MG/0.5ML | 4460306000E510 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/ML | 4460306000E520 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 75 MG/0.5ML | 4460306000D510 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 150 MG/ML | 4460306000D520 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML | 4460306000D530 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML | 4460306000E530 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XOLAIR | OMALIZUMAB FOR INJ 150 MG | 44603060002120 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 75 MG/0.5ML | 4460306000E510 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/ML | 4460306000E520 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 75 MG/0.5ML | 4460306000D510 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 150 MG/ML | 4460306000D520 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML | 4460306000D530 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML | 4460306000E530 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XOLAIR | OMALIZUMAB FOR INJ 150 MG | 44603060002120 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 75 MG/0.5ML | 4460306000E510 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/ML | 4460306000E520 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 75 MG/0.5ML | 4460306000D510 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 150 MG/ML | 4460306000D520 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML | 4460306000D530 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML | 4460306000E530 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XOLAIR | OMALIZUMAB FOR INJ 150 MG | 44603060002120 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 75 MG/0.5ML | 4460306000E510 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/ML | 4460306000E520 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 75 MG/0.5ML | 4460306000D510 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 150 MG/ML | 4460306000D520 | Brand |

| | | | |
|---|---|---|---|
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML | 4460306000D530 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML | 4460306000E530 | Brand |

**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-antihi stamines are considered high risk medications to be avoided (e.g., Be ers criteria, HEDIS) should be directed to try alternatives that are not c onsidered high risk. |

| Product Name: Xolair | |
|---|---|
| Diagnosis | Chronic Urticaria |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XOLAIR | OMALIZUMAB FOR INJ 150 MG | 44603060002120 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 75 MG/0.5ML | 4460306000E510 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/ML | 4460306000E520 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 75 MG/0.5ML | 4460306000D510 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 150 MG/ML | 4460306000D520 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML | 4460306000D530 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML | 4460306000E530 | Brand |

**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 (resilizumab), 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XOLAIR | OMALIZUMAB FOR INJ 150 MG | 44603060002120 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 75 MG/0.5ML | 4460306000E510 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/ML | 4460306000E520 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 75 MG/0.5ML | 4460306000D510 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 150 MG/ML | 4460306000D520 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML | 4460306000D530 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML | 4460306000E530 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XOLAIR | OMALIZUMAB FOR INJ 150 MG | 44603060002120 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 75 MG/0.5ML | 4460306000E510 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/ML | 4460306000E520 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 75 MG/0.5ML | 4460306000D510 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 150 MG/ML | 4460306000D520 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML | 4460306000D530 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML | 4460306000E530 | Brand |

**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 (resilizumab), 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XOLAIR | OMALIZUMAB FOR INJ 150 MG | 44603060002120 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 75 MG/0.5ML | 4460306000E510 | Brand |

| | | | |
|---|---|---|---|
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/ML | 4460306000E520 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 75 MG/0.5ML | 4460306000D510 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 150 MG/ML | 4460306000D520 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML | 4460306000D530 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML | 4460306000E530 | Brand |

**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 (resilizumab), 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| XOLAIR | OMALIZUMAB FOR INJ 150 MG | 44603060002120 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 75 MG/0.5ML | 4460306000E510 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/ML | 4460306000E520 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 75 MG/0.5ML | 4460306000D510 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 150 MG/ML | 4460306000D520 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML | 4460306000D530 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML | 4460306000E530 | Brand |

**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 (resilizumab), 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XOLAIR | OMALIZUMAB FOR INJ 150 MG | 44603060002120 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 75 MG/0.5ML | 4460306000E510 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/ML | 4460306000E520 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 75 MG/0.5ML | 4460306000D510 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 150 MG/ML | 4460306000D520 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML | 4460306000D530 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML | 4460306000E530 | Brand |

**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 (resilizumab), 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XOLAIR | OMALIZUMAB FOR INJ 150 MG | 44603060002120 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 75 MG/0.5ML | 4460306000E510 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/ML | 4460306000E520 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 75 MG/0.5ML | 4460306000D510 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 150 MG/ML | 4460306000D520 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML | 4460306000D530 | Brand |
| XOLAIR | OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML | 4460306000E530 | Brand |

**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 (resilizumab), Fasenra (benralizumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

**AND**

**5** - Prescribed by an allergist or immunologist

## 2 . Revision History

| Date | Notes |
|---|---|
| 8/5/2024 | Expanded coverage of Xolair for IgE-mediated food allergy to all food s. Updated references. |

Xolremdi

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-156895 |
| **Guideline Name** | Xolremdi |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 11/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XOLREMDI | MAVORIXAFOR CAP 100 MG | 82502046000120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XOLREMDI | MAVORIXAFOR CAP 100 MG | 82502046000120 | Brand |

**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 |
|---|---|
| 10/2/2024 | New program |

Xopenex Respules

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146444 |
| **Guideline Name** | Xopenex Respules |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Brand Xopenex inhalation soln, generic levalbuterol inhalation soln | |
|---|---|
| Approval Length | 12 month(s) |
| Guideline Type | Step Therapy |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| LEVALBUTEROL HCL | LEVALBUTEROL HCL SOLN NEBU 0.31 MG/3ML (BASE EQUIV) | 44201045102510 | Generic |
| LEVALBUTEROL HYDROCHLORIDE | LEVALBUTEROL HCL SOLN NEBU 0.31 MG/3ML (BASE EQUIV) | 44201045102510 | Generic |
| XOPENEX | LEVALBUTEROL HCL SOLN NEBU 0.31 MG/3ML (BASE EQUIV) | 44201045102510 | Brand |
| LEVALBUTEROL HCL | LEVALBUTEROL HCL SOLN NEBU 0.63 MG/3ML (BASE EQUIV) | 44201045102520 | Generic |

| | | | |
|---|---|---|---|
| LEVALBUTEROL HYDROCHLORIDE | LEVALBUTEROL HCL SOLN NEBU 0.63 MG/3ML (BASE EQUIV) | 44201045102520 | Generic |
| XOPENEX | LEVALBUTEROL HCL SOLN NEBU 0.63 MG/3ML (BASE EQUIV) | 44201045102520 | Brand |
| LEVALBUTEROL HCL | LEVALBUTEROL HCL SOLN NEBU 1.25 MG/3ML (BASE EQUIV) | 44201045102530 | Generic |
| LEVALBUTEROL HYDROCHLORIDE | LEVALBUTEROL HCL SOLN NEBU 1.25 MG/3ML (BASE EQUIV) | 44201045102530 | Generic |
| XOPENEX | LEVALBUTEROL HCL SOLN NEBU 1.25 MG/3ML (BASE EQUIV) | 44201045102530 | Brand |
| LEVALBUTEROL | LEVALBUTEROL HCL SOLN NEBU CONC 1.25 MG/0.5ML (BASE EQUIV) | 44201045102560 | Generic |
| XOPENEX CONCENTRATE | LEVALBUTEROL HCL SOLN NEBU CONC 1.25 MG/0.5ML (BASE EQUIV) | 44201045102560 | Brand |

**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)

Xospata

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146708 |
| **Guideline Name** | Xospata |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Xospata | |
|---|---|
| Diagnosis | Acute Myeloid Leukemia |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XOSPATA | GILTERITINIB FUMARATE TABLET 40 MG (BASE EQUIVALENT) | 21533020200320 | Brand |

**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 in combination with azacitidine 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

| Product Name: Xospata | |
|---|---|
| Diagnosis | Myeloid/Lymphoid Neoplasms |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XOSPATA | GILTERITINIB FUMARATE TABLET 40 MG (BASE EQUIVALENT) | 21533020200320 | Brand |

**Approval Criteria**

**1** - Diagnosis of lymphoid, myeloid, or mixed lineage neoplasms with eosinophilia

**AND**

**2** - ONE of the following:

**2.1** Patient has an FMS-like tyrosine kinase 3 (FLT3) rearrangement in chronic phase

**OR**

**2.2** Patient has an FMS-like tyrosine kinase 3 (FLT3) rearrangement in blast phase

| Product Name: Xospata | |
|---|---|
| Diagnosis | Acute Myeloid Leukemia, Myeloid/Lymphoid Neoplasms |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XOSPATA | GILTERITINIB FUMARATE TABLET 40 MG (BASE EQUIVALENT) | 21533020200320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XOSPATA | GILTERITINIB FUMARATE TABLET 40 MG (BASE EQUIVALENT) | 21533020200320 | Brand |

**Approval Criteria**

**1** - Xospata will be approved for uses 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XOSPATA | GILTERITINIB FUMARATE TABLET 40 MG (BASE EQUIVALENT) | 21533020200320 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Xospata therapy

Xphozah

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-147369 |
| **Guideline Name** | Xphozah |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XPHOZAH | TENAPANOR HCL TAB 20 MG | 30903260600325 | Brand |
| XPHOZAH | TENAPANOR HCL TAB 30 MG | 30903260600330 | Brand |

**Approval Criteria**

**1** - Diagnosis of chronic kidney disease (CKD)

**AND**

**2** - Patient is receiving dialysis

**AND**

**3** - Serum phosphorus is greater than 6.5 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 |
|---|---|

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XPHOZAH | TENAPANOR HCL TAB 20 MG | 30903260600325 | Brand |
| XPHOZAH | TENAPANOR HCL TAB 30 MG | 30903260600330 | Brand |

**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 |
|---|---|
| 5/14/2024 | New guideline. |

Xpovio

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146709 |
| **Guideline Name** | Xpovio |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Xpovio | |
|---|---|
| Diagnosis | Multiple Myeloma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XPOVIO 80 MG TWICE WEEKLY | SELINEXOR TAB THERAPY PACK 20 MG (80 MG TWICE WEEKLY) | 2156006000B720 | Brand |
| XPOVIO 60 MG TWICE WEEKLY | SELINEXOR TAB THERAPY PACK 20 MG (60 MG TWICE WEEKLY) | 2156006000B755 | Brand |

| | | | |
|---|---|---|---|
| XPOVIO | SELINEXOR TAB THERAPY PACK 40 MG (40 MG ONCE WEEKLY) | 2156006000B760 | Brand |
| XPOVIO | SELINEXOR TAB THERAPY PACK 40 MG (40 MG TWICE WEEKLY) | 2156006000B765 | Brand |
| XPOVIO | SELINEXOR TAB THERAPY PACK 40 MG (80 MG ONCE WEEKLY) | 2156006000B770 | Brand |
| XPOVIO | SELINEXOR TAB THERAPY PACK 50 MG (100 MG ONCE WEEKLY) | 2156006000B775 | Brand |
| XPOVIO | SELINEXOR TAB THERAPY PACK 60 MG (60 MG ONCE WEEKLY) | 2156006000B780 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XPOVIO 80 MG TWICE WEEKLY | SELINEXOR TAB THERAPY PACK 20 MG (80 MG TWICE WEEKLY) | 2156006000B720 | Brand |
| XPOVIO 60 MG TWICE WEEKLY | SELINEXOR TAB THERAPY PACK 20 MG (60 MG TWICE WEEKLY) | 2156006000B755 | Brand |
| XPOVIO | SELINEXOR TAB THERAPY PACK 40 MG (40 MG ONCE WEEKLY) | 2156006000B760 | Brand |
| XPOVIO | SELINEXOR TAB THERAPY PACK 40 MG (40 MG TWICE WEEKLY) | 2156006000B765 | Brand |
| XPOVIO | SELINEXOR TAB THERAPY PACK 40 MG (80 MG ONCE WEEKLY) | 2156006000B770 | Brand |
| XPOVIO | SELINEXOR TAB THERAPY PACK 50 MG (100 MG ONCE WEEKLY) | 2156006000B775 | Brand |
| XPOVIO | SELINEXOR TAB THERAPY PACK 60 MG (60 MG ONCE WEEKLY) | 2156006000B780 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XPOVIO 80 MG TWICE WEEKLY | SELINEXOR TAB THERAPY PACK 20 MG (80 MG TWICE WEEKLY) | 2156006000B720 | Brand |
| XPOVIO 60 MG TWICE WEEKLY | SELINEXOR TAB THERAPY PACK 20 MG (60 MG TWICE WEEKLY) | 2156006000B755 | Brand |
| XPOVIO | SELINEXOR TAB THERAPY PACK 40 MG (40 MG ONCE WEEKLY) | 2156006000B760 | Brand |
| XPOVIO | SELINEXOR TAB THERAPY PACK 40 MG (40 MG TWICE WEEKLY) | 2156006000B765 | Brand |
| XPOVIO | SELINEXOR TAB THERAPY PACK 40 MG (80 MG ONCE WEEKLY) | 2156006000B770 | Brand |
| XPOVIO | SELINEXOR TAB THERAPY PACK 50 MG (100 MG ONCE WEEKLY) | 2156006000B775 | Brand |
| XPOVIO | SELINEXOR TAB THERAPY PACK 60 MG (60 MG ONCE WEEKLY) | 2156006000B780 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XPOVIO 80 MG TWICE WEEKLY | SELINEXOR TAB THERAPY PACK 20 MG (80 MG TWICE WEEKLY) | 2156006000B720 | Brand |
| XPOVIO 60 MG TWICE WEEKLY | SELINEXOR TAB THERAPY PACK 20 MG (60 MG TWICE WEEKLY) | 2156006000B755 | Brand |
| XPOVIO | SELINEXOR TAB THERAPY PACK 40 MG (40 MG ONCE WEEKLY) | 2156006000B760 | Brand |
| XPOVIO | SELINEXOR TAB THERAPY PACK 40 MG (40 MG TWICE WEEKLY) | 2156006000B765 | Brand |
| XPOVIO | SELINEXOR TAB THERAPY PACK 40 MG (80 MG ONCE WEEKLY) | 2156006000B770 | Brand |
| XPOVIO | SELINEXOR TAB THERAPY PACK 50 MG (100 MG ONCE WEEKLY) | 2156006000B775 | Brand |
| XPOVIO | SELINEXOR TAB THERAPY PACK 60 MG (60 MG ONCE WEEKLY) | 2156006000B780 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XPOVIO 80 MG TWICE WEEKLY | SELINEXOR TAB THERAPY PACK 20 MG (80 MG TWICE WEEKLY) | 2156006000B720 | Brand |
| XPOVIO 60 MG TWICE WEEKLY | SELINEXOR TAB THERAPY PACK 20 MG (60 MG TWICE WEEKLY) | 2156006000B755 | Brand |

| | | | |
|---|---|---|---|
| XPOVIO | SELINEXOR TAB THERAPY PACK 40 MG (40 MG ONCE WEEKLY) | 2156006000B760 | Brand |
| XPOVIO | SELINEXOR TAB THERAPY PACK 40 MG (40 MG TWICE WEEKLY) | 2156006000B765 | Brand |
| XPOVIO | SELINEXOR TAB THERAPY PACK 40 MG (80 MG ONCE WEEKLY) | 2156006000B770 | Brand |
| XPOVIO | SELINEXOR TAB THERAPY PACK 50 MG (100 MG ONCE WEEKLY) | 2156006000B775 | Brand |
| XPOVIO | SELINEXOR TAB THERAPY PACK 60 MG (60 MG ONCE WEEKLY) | 2156006000B780 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Xpovio therapy

Xtandi

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-152523 |
| **Guideline Name** | Xtandi |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 9/1/2024 |

## 1 . Criteria

| Product Name: Xtandi | |
|---|---|
| Diagnosis | Prostate Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XTANDI | ENZALUTAMIDE CAP 40 MG | 21402430000120 | Brand |
| XTANDI | ENZALUTAMIDE TAB 40 MG | 21402430000320 | Brand |
| XTANDI | ENZALUTAMIDE TAB 80 MG | 21402430000340 | Brand |

**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** BOTH of the following:

**3.1.1** Disease is castration-resistant

**AND**

**3.1.2** ONE of the following:

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

- Erleada (apalutamide)
- Nubeqa (darolutamide)

**OR**

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

- Erleada (apalutamide)
- Nubeqa (darolutamide)

**OR**

**3.1.2.3** Continuation of ongoing Xtandi therapy

**OR**

**3.2** BOTH of the following:

**3.2.1** Disease is BOTH of the following:

- Metastatic
- Castration-sensitive

**AND**

**3.2.2** ONE of the following:

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

- abiraterone (generic Zytiga)
- Erleada (apalutamide)
- Nubeqa (darolutamide)

**OR**

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

- abiraterone (generic Zytiga)
- Erleada (apalutamide)
- Nubeqa (darolutamide)

**OR**

**3.2.2.3** Continuation of ongoing Xtandi therapy

**OR**

**3.3** BOTH of the following:

**3.3.1** Disease is ALL of the following:

- Non-metastatic
- Castration-sensitive
- Recurrent

- High risk for metastasis

**AND**

**3.3.2** ONE of the following:

**3.3.2.1** Failure to abiraterone (generic Zytiga) as confirmed by claims history or submission of medical records

**OR**

**3.3.2.2** History of contraindication or intolerance to abiraterone (generic Zytiga) (please specify contraindication or intolerance)

**OR**

**3.3.2.3** Continuation of ongoing Xtandi therapy

| Product Name: Xtandi | |
|---|---|
| Diagnosis | Prostate Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XTANDI | ENZALUTAMIDE CAP 40 MG | 21402430000120 | Brand |
| XTANDI | ENZALUTAMIDE TAB 40 MG | 21402430000320 | Brand |
| XTANDI | ENZALUTAMIDE TAB 80 MG | 21402430000340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XTANDI | ENZALUTAMIDE CAP 40 MG | 21402430000120 | Brand |
| XTANDI | ENZALUTAMIDE TAB 40 MG | 21402430000320 | Brand |
| XTANDI | ENZALUTAMIDE TAB 80 MG | 21402430000340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XTANDI | ENZALUTAMIDE CAP 40 MG | 21402430000120 | Brand |
| XTANDI | ENZALUTAMIDE TAB 40 MG | 21402430000320 | Brand |
| XTANDI | ENZALUTAMIDE TAB 80 MG | 21402430000340 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Xtandi therapy

## 2 . Revision History

| Date | Notes |
| --- | --- |
| 8/22/2024 | Copy core |

Xuriden

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146711 |
| **Guideline Name** | Xuriden |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XURIDEN | URIDINE TRIACETATE ORAL GRANULES PACKET 2 GM | 30903875203020 | Brand |

**Approval Criteria**

**1** - Diagnosis of a hereditary orotic aciduria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XURIDEN | URIDINE TRIACETATE ORAL GRANULES PACKET 2 GM | 30903875203020 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Xuriden therapy

Xyrem, Xywav, Lumryz

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-158013 |
| **Guideline Name** | Xyrem, Xywav, Lumryz |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 12/1/2024 |

## 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XYWAV | CALCIUM, MAG, POTASSIUM, & SOD OXYBATES ORAL SOLN 500 MG/ML | 62459904202020 | Brand |
| SODIUM OXYBATE | SODIUM OXYBATE ORAL SOLUTION 500 MG/ML | 62450060202020 | Generic |
| XYREM | SODIUM OXYBATE ORAL SOLUTION 500 MG/ML | 62450060202020 | Generic |

| | | | |
|---|---|---|---|
| LUMRYZ | SODIUM OXYBATE PACK FOR ORAL ER SUSP 4.5 GM | 62450060203020 | Brand |
| LUMRYZ | SODIUM OXYBATE PACK FOR ORAL ER SUSP 6 GM | 62450060203025 | Brand |
| LUMRYZ | SODIUM OXYBATE PACK FOR ORAL ER SUSP 7.5 GM | 62450060203030 | Brand |
| LUMRYZ | SODIUM OXYBATE PACK FOR ORAL ER SUSP 9 GM | 62450060203035 | Brand |
| LUMRYZ STARTER PACK | SODIUM OXYBATE PACK FOR ER SUSP 4.5 & 6 & 7.5 GM STARTER PAK | 6245006020B120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XYWAV | CALCIUM, MAG, POTASSIUM, & SOD OXYBATES ORAL SOLN 500 MG/ML | 62459904202020 | Brand |
| SODIUM OXYBATE | SODIUM OXYBATE ORAL SOLUTION 500 MG/ML | 62450060202020 | Generic |
| XYREM | SODIUM OXYBATE ORAL SOLUTION 500 MG/ML | 62450060202020 | Generic |
| LUMRYZ | SODIUM OXYBATE PACK FOR ORAL ER SUSP 4.5 GM | 62450060203020 | Brand |
| LUMRYZ | SODIUM OXYBATE PACK FOR ORAL ER SUSP 6 GM | 62450060203025 | Brand |

| | | | |
|---|---|---|---|
| LUMRYZ | SODIUM OXYBATE PACK FOR ORAL ER SUSP 7.5 GM | 62450060203030 | Brand |
| LUMRYZ | SODIUM OXYBATE PACK FOR ORAL ER SUSP 9 GM | 62450060203035 | Brand |
| LUMRYZ STARTER PACK | SODIUM OXYBATE PACK FOR ER SUSP 4.5 & 6 & 7.5 GM STARTER PAK | 6245006020B120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XYWAV | CALCIUM, MAG, POTASSIUM, & SOD OXYBATES ORAL SOLN 500 MG/ML | 62459904202020 | Brand |
| SODIUM OXYBATE | SODIUM OXYBATE ORAL SOLUTION 500 MG/ML | 62450060202020 | Generic |
| XYREM | SODIUM OXYBATE ORAL SOLUTION 500 MG/ML | 62450060202020 | Generic |
| LUMRYZ | SODIUM OXYBATE PACK FOR ORAL ER SUSP 4.5 GM | 62450060203020 | Brand |
| LUMRYZ | SODIUM OXYBATE PACK FOR ORAL ER SUSP 6 GM | 62450060203025 | Brand |
| LUMRYZ | SODIUM OXYBATE PACK FOR ORAL ER SUSP 7.5 GM | 62450060203030 | Brand |
| LUMRYZ | SODIUM OXYBATE PACK FOR ORAL ER SUSP 9 GM | 62450060203035 | Brand |

| | | | |
|---|---|---|---|
| LUMRYZ STARTER PACK | SODIUM OXYBATE PACK FOR ER SUSP 4.5 & 6 & 7.5 GM STARTER PAK | 6245006020B120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XYWAV | CALCIUM, MAG, POTASSIUM, & SOD OXYBATES ORAL SOLN 500 MG/ML | 62459904202020 | Brand |
| SODIUM OXYBATE | SODIUM OXYBATE ORAL SOLUTION 500 MG/ML | 62450060202020 | Generic |
| XYREM | SODIUM OXYBATE ORAL SOLUTION 500 MG/ML | 62450060202020 | Generic |
| LUMRYZ | SODIUM OXYBATE PACK FOR ORAL ER SUSP 4.5 GM | 62450060203020 | Brand |
| LUMRYZ | SODIUM OXYBATE PACK FOR ORAL ER SUSP 6 GM | 62450060203025 | Brand |
| LUMRYZ | SODIUM OXYBATE PACK FOR ORAL ER SUSP 7.5 GM | 62450060203030 | Brand |
| LUMRYZ | SODIUM OXYBATE PACK FOR ORAL ER SUSP 9 GM | 62450060203035 | Brand |
| LUMRYZ STARTER PACK | SODIUM OXYBATE PACK FOR ER SUSP 4.5 & 6 & 7.5 GM STARTER PAK | 6245006020B120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XYWAV | CALCIUM, MAG, POTASSIUM, & SOD OXYBATES ORAL SOLN 500 MG/ML | 62459904202020 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| XYWAV | CALCIUM, MAG, POTASSIUM, & SOD OXYBATES ORAL SOLN 500 MG/ML | 62459904202020 | Brand |

**Approval Criteria**

**1** - Documentation demonstrating reduction in symptoms of excessive daytime sleepiness associated with therapy

## 2 . Revision History

| Date | Notes |
|---|---|
| 10/25/2024 | Added new Lumryz GPI. Removed * from Narcolepsy Type 1 Reauth . Updated initial auth length for idiopathic Hypersomnia. |

Yonsa

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146714 |
| **Guideline Name** | Yonsa |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Yonsa | |
|---|---|
| Diagnosis | Prostate Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| YONSA | ABIRATERONE ACETATE MICRONIZED TAB 125 MG | 21406010250310 | Brand |

**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 (e.g., N1)

**OR**

**2.3** Patient is in a very-high-risk group receiving external beam radiation therapy (EBRT)

**AND**

**3** - Used in combination with methylprednisolone

**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), Firmagon (degarelix)]

**OR**

**4.2** Patient has had bilateral orchiectomy

**AND**

**5** - ONE of the following:

**5.1** Prescriber provides a reason or special circumstance the patient cannot take abiraterone (generic Zytiga)

**OR**

**5.2** Patient is currently on Yonsa therapy

| Product Name: Yonsa | |
|---|---|
| Diagnosis | Prostate Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| YONSA | ABIRATERONE ACETATE MICRONIZED TAB 125 MG | 21406010250310 | Brand |

**Approval Criteria**

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

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| YONSA | ABIRATERONE ACETATE MICRONIZED TAB 125 MG | 21406010250310 | Brand |

**Approval Criteria**

**1** - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

| Product Name: Yonsa | |
|---|---|
| Diagnosis | NCCN Recommended Regimens |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| YONSA | ABIRATERONE ACETATE MICRONIZED TAB 125 MG | 21406010250310 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Yonsa therapy

Zejula

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146715 |
| **Guideline Name** | Zejula |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Zejula | |
|---|---|
| Diagnosis | Ovarian Cancer (Maintenance Therapy) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZEJULA | NIRAPARIB TOSYLATE CAP 100 MG (BASE EQUIVALENT) | 21535550200120 | Brand |
| ZEJULA | NIRAPARIB TOSYLATE TAB 100 MG (BASE EQUIVALENT) | 21535550200320 | Brand |
| ZEJULA | NIRAPARIB TOSYLATE TAB 200 MG (BASE EQUIVALENT) | 21535550200330 | Brand |

| | | | |
|---|---|---|---|
| ZEJULA | NIRAPARIB TOSYLATE TAB 300 MG (BASE EQUIVALENT) | 21535550200340 | Brand |

**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:

- Recurrent, with deleterious or suspected deleterious germline BRCA (breast cancer) mutation
- Advanced

**AND**

**3** - Patient is in a complete or partial response to a platinum-based chemotherapy

**AND**

**4** - Request is for maintenance therapy

| Product Name: Zejula | |
|---|---|
| Diagnosis | Ovarian Cancer (Treatment) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZEJULA | NIRAPARIB TOSYLATE CAP 100 MG (BASE EQUIVALENT) | 21535550200120 | Brand |

| | | | |
|---|---|---|---|
| ZEJULA | NIRAPARIB TOSYLATE TAB 100 MG (BASE EQUIVALENT) | 21535550200320 | Brand |
| ZEJULA | NIRAPARIB TOSYLATE TAB 200 MG (BASE EQUIVALENT) | 21535550200330 | Brand |
| ZEJULA | NIRAPARIB TOSYLATE TAB 300 MG (BASE EQUIVALENT) | 21535550200340 | Brand |

**Approval Criteria**

**1** - Diagnosis of advanced, persistent, or recurrent ovarian, fallopian tube, or primary peritoneal cancer

**AND**

**2** - Disease is platinum-sensitive

**AND**

**3** - Used in combination with bevacizumab

| Product Name: Zejula | |
|---|---|
| Diagnosis | Uterine Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZEJULA | NIRAPARIB TOSYLATE CAP 100 MG (BASE EQUIVALENT) | 21535550200120 | Brand |
| ZEJULA | NIRAPARIB TOSYLATE TAB 100 MG (BASE EQUIVALENT) | 21535550200320 | Brand |
| ZEJULA | NIRAPARIB TOSYLATE TAB 200 MG (BASE EQUIVALENT) | 21535550200330 | Brand |
| ZEJULA | NIRAPARIB TOSYLATE TAB 300 MG (BASE EQUIVALENT) | 21535550200340 | Brand |

**Approval Criteria**

**1** - Diagnosis of BRCA (breast cancer) altered uterine leiomyosarcoma (uLMS)

**AND**

**2** - Disease has progressed following prior treatment with ONE of the following:

- gemcitabine plus docetaxel
- doxorubicin

| Product Name: Zejula | |
|---|---|
| Diagnosis | Ovarian Cancer (Maintenance Therapy, Treatment), Uterine Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZEJULA | NIRAPARIB TOSYLATE CAP 100 MG (BASE EQUIVALENT) | 21535550200120 | Brand |
| ZEJULA | NIRAPARIB TOSYLATE TAB 100 MG (BASE EQUIVALENT) | 21535550200320 | Brand |
| ZEJULA | NIRAPARIB TOSYLATE TAB 200 MG (BASE EQUIVALENT) | 21535550200330 | Brand |
| ZEJULA | NIRAPARIB TOSYLATE TAB 300 MG (BASE EQUIVALENT) | 21535550200340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZEJULA | NIRAPARIB TOSYLATE CAP 100 MG (BASE EQUIVALENT) | 21535550200120 | Brand |
| ZEJULA | NIRAPARIB TOSYLATE TAB 100 MG (BASE EQUIVALENT) | 21535550200320 | Brand |
| ZEJULA | NIRAPARIB TOSYLATE TAB 200 MG (BASE EQUIVALENT) | 21535550200330 | Brand |
| ZEJULA | NIRAPARIB TOSYLATE TAB 300 MG (BASE EQUIVALENT) | 21535550200340 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZEJULA | NIRAPARIB TOSYLATE CAP 100 MG (BASE EQUIVALENT) | 21535550200120 | Brand |
| ZEJULA | NIRAPARIB TOSYLATE TAB 100 MG (BASE EQUIVALENT) | 21535550200320 | Brand |
| ZEJULA | NIRAPARIB TOSYLATE TAB 200 MG (BASE EQUIVALENT) | 21535550200330 | Brand |
| ZEJULA | NIRAPARIB TOSYLATE TAB 300 MG (BASE EQUIVALENT) | 21535550200340 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Zejula therapy

Zelboraf

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-147406 |
| **Guideline Name** | Zelboraf |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Zelboraf | |
|---|---|
| Diagnosis | Melanoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZELBORAF | VEMURAFENIB TAB 240 MG | 21532080000320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZELBORAF | VEMURAFENIB TAB 240 MG | 21532080000320 | Brand |

**Approval Criteria**

**1** - ONE of the following:

**1.1** BOTH of the following:

- Patient has metastatic brain lesions
- 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZELBORAF | VEMURAFENIB TAB 240 MG | 21532080000320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZELBORAF | VEMURAFENIB TAB 240 MG | 21532080000320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZELBORAF | VEMURAFENIB TAB 240 MG | 21532080000320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZELBORAF | VEMURAFENIB TAB 240 MG | 21532080000320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZELBORAF | VEMURAFENIB TAB 240 MG | 21532080000320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| ZELBORAF | VEMURAFENIB TAB 240 MG | 21532080000320 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZELBORAF | VEMURAFENIB TAB 240 MG | 21532080000320 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Zelboraf therapy

## 2 . Revision History

| Date | Notes |
|---|---|
| 5/14/2024 | Under thyroid cancer initial criteria section, updated diagnosis option from Hurthle cell carcinoma to oncocytic carcinoma. |

Zeposia

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-148670 |
| **Guideline Name** | Zeposia |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Zeposia | |
|---|---|
| Diagnosis | Multiple Sclerosis |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZEPOSIA 7-DAY STARTER PACK | OZANIMOD CAP PACK 4 X 0.23 MG & 3 X 0.46 MG | 6240705020B210 | Brand |

| | | | |
|---|---|---|---|
| ZEPOSIA STARTER KIT | OZANIMOD CAP PACK 4 X 0.23 MG & 3 X 0.46 MG & 30 X 0.92 MG | 6240705020B220 | Brand |
| ZEPOSIA | OZANIMOD HCL CAP 0.92 MG | 62407050200120 | Brand |
| ZEPOSIA STARTER KIT | OZANIMOD CAP PACK 4 X 0.23 MG & 3 X 0.46 MG & 21 X 0.92 MG | 6240705020B215 | Brand |

**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 Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |

| Product Name: Zeposia | |
|---|---|
| Diagnosis | Multiple Sclerosis |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZEPOSIA 7-DAY STARTER PACK | OZANIMOD CAP PACK 4 X 0.23 MG & 3 X 0.46 MG | 6240705020B210 | Brand |
| ZEPOSIA STARTER KIT | OZANIMOD CAP PACK 4 X 0.23 MG & 3 X 0.46 MG & 30 X 0.92 MG | 6240705020B220 | Brand |
| ZEPOSIA | OZANIMOD HCL CAP 0.92 MG | 62407050200120 | Brand |
| ZEPOSIA STARTER KIT | OZANIMOD CAP PACK 4 X 0.23 MG & 3 X 0.46 MG & 21 X 0.92 MG | 6240705020B215 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZEPOSIA 7-DAY STARTER PACK | OZANIMOD CAP PACK 4 X 0.23 MG & 3 X 0.46 MG | 6240705020B210 | Brand |
| ZEPOSIA STARTER KIT | OZANIMOD CAP PACK 4 X 0.23 MG & 3 X 0.46 MG & 30 X 0.92 MG | 6240705020B220 | Brand |
| ZEPOSIA | OZANIMOD HCL CAP 0.92 MG | 62407050200120 | Brand |

| | | | |
|---|---|---|---|
| ZEPOSIA STARTER KIT | OZANIMOD CAP PACK 4 X 0.23 MG & 3 X 0.46 MG & 21 X 0.92 MG | 6240705020B215 | Brand |

**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)

**OR**

**1.2.2** Patient has been previously treated with a biologic or targeted synthetic disease modifying antirheumatic drug (DMARD) 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), Stelara (ustekinumab), Xeljanz (tofacitinib), Rinvoq (upadacitinib)]

**AND**

**1.3** Patient is NOT receiving Zeposia in combination with any of the following:

- Biologic DMARD [e.g., Enbrel (etanercept), adalimumab, Cimzia (certolizumab), Simponi (golimumab)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

**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 any of the following:

- Biologic DMARD [e.g., Enbrel (etanercept), adalimumab, Cimzia (certolizumab), Simponi (golimumab)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

**AND**

**2.4** Prescribed by or in consultation with a gastroenterologist

| Notes | *For a list of preferred adalimumab products please reference drug co verage tools.<br><br>PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html |
|---|---|

| Product Name: Zeposia | |
|---|---|
| Diagnosis | Ulcerative Colitis |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZEPOSIA 7-DAY STARTER PACK | OZANIMOD CAP PACK 4 X 0.23 MG & 3 X 0.46 MG | 6240705020B210 | Brand |
| ZEPOSIA STARTER KIT | OZANIMOD CAP PACK 4 X 0.23 MG & 3 X 0.46 MG & 30 X 0.92 MG | 6240705020B220 | Brand |
| ZEPOSIA | OZANIMOD HCL CAP 0.92 MG | 62407050200120 | Brand |
| ZEPOSIA STARTER KIT | OZANIMOD CAP PACK 4 X 0.23 MG & 3 X 0.46 MG & 21 X 0.92 MG | 6240705020B215 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Zeposia therapy

**AND**

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

- Biologic DMARD [e.g., Enbrel (etanercept), adalimumab, Simponi (golimumab), Stelara (ustekinumab)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

## 2 . Revision History

| Date | Notes |
|---|---|
| 6/19/2024 | Added new GPI for Zeposia to GPI tables. Updated notes section. Minor cosmetic update. |

Zilbrysq

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146718 |
| **Guideline Name** | Zilbrysq |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

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

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZILBRYSQ | ZILUCOPLAN SODIUM SUBCUTANEOUS SOLN PREF SYR 16.6 MG/0.416ML | 8580509520E520 | Brand |
| ZILBRYSQ | ZILUCOPLAN SODIUM SUBCUTANEOUS SOLN PREF SYR 23 MG/0.574ML | 8580509520E530 | Brand |
| ZILBRYSQ | ZILUCOPLAN SODIUM SUBCUTANEOUS SOLN PREF SYR 32.4 MG/0.81ML | 8580509520E540 | Brand |

**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., Soliris, Ultomiris) or a neonatal Fc receptor blocker (e.g., Rystiggo, Vyvgart,Vyvgart Hytrulo)

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZILBRYSQ | ZILUCOPLAN SODIUM SUBCUTANEOUS SOLN PREF SYR 16.6 MG/0.416ML | 8580509520E520 | Brand |
| ZILBRYSQ | ZILUCOPLAN SODIUM SUBCUTANEOUS SOLN PREF SYR 23 MG/0.574ML | 8580509520E530 | Brand |
| ZILBRYSQ | ZILUCOPLAN SODIUM SUBCUTANEOUS SOLN PREF SYR 32.4 MG/0.81ML | 8580509520E540 | Brand |

**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 MG-ADL score from pre-treatment baseline

| | |
|---|---|
| **AND**<br><br>**1.2** Reduction in signs and symptoms of myasthenia gravis<br><br>**AND**<br><br>**1.3** Maintenance, reduction, or discontinuation of dose(s) of baseline immunosuppressive therapy (IST) prior to starting Zilbrysq*<br><br>**AND**<br><br>**2** - Patient is not receiving Zilbrysq in combination with another complement inhibitor (e.g., Soliris, Ultomiris) or a neonatal Fc receptor blocker (e.g., Rystiggo, Vyvgart,Vyvgart Hytrulo)<br><br>**AND**<br><br>**3** - Prescribed by, or in consultation with, a neurologist | |
| Notes | *Add on, dose escalation of IST, or additional rescue therapy from bas eline to treat myasthenia gravis or exacerbation of symptoms while on Zilbrysq therapy will be considered as treatment failure |

Zokinvy

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146719 |
| **Guideline Name** | Zokinvy |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Zokinvy | |
|---|---|
| Diagnosis | Hutchinson-Gilford Progeria Syndrome |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZOKINVY | LONAFARNIB CAP 50 MG | 99463045000120 | Brand |
| ZOKINVY | LONAFARNIB CAP 75 MG | 99463045000130 | Brand |

**Approval Criteria**

**1** - Diagnosis of Hutchinson-Gilford Progeria Syndrome

| Product Name: Zokinvy | |
|---|---|
| Diagnosis | Progeroid Laminopathies |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZOKINVY | LONAFARNIB CAP 50 MG | 99463045000120 | Brand |
| ZOKINVY | LONAFARNIB CAP 75 MG | 99463045000130 | Brand |

**Approval Criteria**

**1** - Diagnosis of processing deficient Progeroid Laminopathies

**AND**

**2** - Documentation of ONE of the following:

- Heterozygous LMNA (gene) mutation with progerin-like protein accumulation
- Homozygous or compound heterozygous ZMPSTE24 (gene) mutations

Zolinza

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146720 |
| **Guideline Name** | Zolinza |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Zolinza | |
|---|---|
| Diagnosis | Cutaneous T-Cell Lymphoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZOLINZA | VORINOSTAT CAP 100 MG | 21531575000120 | Brand |

**Approval Criteria**

**1** - Diagnosis of cutaneous T-cell lymphoma (CTCL)

**AND**

**2** - Patient has progressive, persistent, or recurrent disease on or following two systemic therapies [e.g., Adcetris (brentuximab vedotin), bexarotene, interferon alfa-db, interferon gamma-1b, methotrexate, Poteligeo (mogamulizumab), romidepsin]

| Product Name: Zolinza | |
|---|---|
| Diagnosis | Cutaneous T-Cell Lymphoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZOLINZA | VORINOSTAT CAP 100 MG | 21531575000120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZOLINZA | VORINOSTAT CAP 100 MG | 21531575000120 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZOLINZA | VORINOSTAT CAP 100 MG | 21531575000120 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Zolinza therapy

Zoryve

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146446 |
| **Guideline Name** | Zoryve |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Zoryve cream | |
|---|---|
| Diagnosis | Plaque Psoriasis |
| Approval Length | 6 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZORYVE | ROFLUMILAST CREAM 0.3% | 90250045003720 | Brand |

**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 Zoryve cream in combination with ONE of the following:

- Biologic DMARD [e.g., Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab), Cosentyx (Secukinumab), Stelara (Ustekinumab), Orencia (abatacept)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

**AND**

**4** - Prescribed by, or in consultation with, a dermatologist

| Product Name: Zoryve cream | |
|---|---|
| Diagnosis | Plaque Psoriasis |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZORYVE | ROFLUMILAST CREAM 0.3% | 90250045003720 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to therapy

**AND**

**2** - Patient is not receiving Zoryve cream in combination with ONE of the following:

- Biologic DMARD [e.g., Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab), Cosentyx (Secukinumab), Stelara (Ustekinumab), Orencia (abatacept)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

| Product Name: Zoryve foam | |
|---|---|
| Diagnosis | Seborrheic dermatitis |
| Approval Length | 6 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| ZORYVE | ROFLUMILAST FOAM 0.3% | 90300045003920 | Brand |
|---|---|---|---|

**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 ONE of the following:

- Biologic immunomodulator [e.g., Dupixent (dupilumab), Adbry (tralokinumab-ldrm)]
- Janus kinase inhibitor [e.g., Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib), Opzelura (topical ruxolitinib), Cibinqo (abrocitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

**AND**

**4** - Prescribed by, or in consultation with, one of the following:

- Dermatologist
- Allergist
- Immunologist

| Product Name: Zoryve foam | |
|---|---|
| Diagnosis | Seborrheic Dermatitis |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZORYVE | ROFLUMILAST FOAM 0.3% | 90300045003920 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to therapy

**AND**

**2** - Patient is not receiving Zoryve foam in combination with ONE of the following:

- Biologic immunomodulator [e.g., Dupixent (dupilumab), Adbry (tralokinumab-ldrm)]
- Janus kinase inhibitor [e.g., Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib), Opzelura (topical ruxolitinib), Cibinqo (abrocitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

Zurzuvae

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146447 |
| **Guideline Name** | Zurzuvae |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Zurzuvae | |
|---|---|
| Approval Length | 1 month(s) |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZURZUVAE | ZURANOLONE CAP 20 MG | 58060090000120 | Brand |
| ZURZUVAE | ZURANOLONE CAP 25 MG | 58060090000125 | Brand |
| ZURZUVAE | ZURANOLONE CAP 30 MG | 58060090000130 | Brand |

**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

Zydelig

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146721 |
| **Guideline Name** | Zydelig |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZYDELIG | IDELALISIB TAB 100 MG | 21538040000320 | Brand |
| ZYDELIG | IDELALISIB TAB 150 MG | 21538040000330 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZYDELIG | IDELALISIB TAB 100 MG | 21538040000320 | Brand |
| ZYDELIG | IDELALISIB TAB 150 MG | 21538040000330 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZYDELIG | IDELALISIB TAB 100 MG | 21538040000320 | Brand |
| ZYDELIG | IDELALISIB TAB 150 MG | 21538040000330 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZYDELIG | IDELALISIB TAB 100 MG | 21538040000320 | Brand |
| ZYDELIG | IDELALISIB TAB 150 MG | 21538040000330 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Zydelig therapy

Zykadia

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146722 |
| **Guideline Name** | Zykadia |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZYKADIA | CERITINIB TAB 150 MG | 21530514000330 | Brand |

**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** - ONE of the following:

- Tumor is ALK (anaplastic lymphoma kinase)-positive
- Tumor is ROS-1 (gene) positive

| Product Name: Zykadia | |
|---|---|
| Diagnosis | Soft Tissue Sarcoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZYKADIA | CERITINIB TAB 150 MG | 21530514000330 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZYKADIA | CERITINIB TAB 150 MG | 21530514000330 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZYKADIA | CERITINIB TAB 150 MG | 21530514000330 | Brand |

**Approval Criteria**

**1** - Diagnosis of Erdheim-Chester Disease

**AND**

**2** - Disease is positive for anaplastic lymphoma kinase (ALK) rearrangement

| Product Name: Zykadia | |
|---|---|
| Diagnosis | Inflammatory Myofibroblastic Tumor (IMT) |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZYKADIA | CERITINIB TAB 150 MG | 21530514000330 | Brand |

**Approval Criteria**

**1** - Diagnosis of advanced, recurrent, metastatic, or inoperable inflammatory myofibroblastic tumor (IMT)

**AND**

**2** - Disease is positive for anaplastic lymphoma kinase (ALK) translocation

| Product Name: Zykadia | |
|---|---|
| Diagnosis | Anaplastic Large Cell Lymphoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZYKADIA | CERITINIB TAB 150 MG | 21530514000330 | Brand |

**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 | Non-Small Cell Lung Cancer (NSCLC), Soft Tissue Sarcoma, Central Nervous System (CNS) Cancers, Histiocytic Neoplasms, Inflammatory Myofibroblastic Tumor (IMT), Anaplastic Large Cell Lymphoma |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZYKADIA | CERITINIB TAB 150 MG | 21530514000330 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|

| | | | |
|---|---|---|---|
| ZYKADIA | CERITINIB TAB 150 MG | 21530514000330 | Brand |

**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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZYKADIA | CERITINIB TAB 150 MG | 21530514000330 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Zykadia therapy

Zymfentra

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-161136 |
| **Guideline Name** | Zymfentra |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 1/1/2025 |

## 1 . Criteria

| Product Name: Zymfentra | |
|---|---|
| Diagnosis | Ulcerative Colitis |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZYMFENTRA 2-PEN | INFLIXIMAB-DYYB SOLN AUTO-INJECTOR KIT 120 MG/ML | 5250504020F530 | Brand |
| ZYMFENTRA 1-PEN | INFLIXIMAB-DYYB SOLN AUTO-INJECTOR KIT 120 MG/ML | 5250504020F530 | Brand |
| ZYMFENTRA 2-SYRINGE | INFLIXIMAB-DYYB SOLN PREFILLED SYRINGE KIT 120 MG/ML | 5250504020F830 | Brand |

**Approval Criteria**

**1** - Diagnosis of moderately to severely active ulcerative colitis (UC)

**AND**

**2** - One of the following:

**2.1** 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**

**2.2** Patient is currently on Zymfentra therapy for moderately to severely active ulcerative colitis as confirmed by claims history or submission of medical records

**AND**

**3** - Patient is not receiving Zymfentra in combination with a targeted immunomodulator [e.g., adalimumab, Entyvio (vedolizumab), Olumiant (baricitinib), Omvoh (mirikizumab-mrkz), Rinvoq (upadacitinib), Simponi (golimumab), Skyrizi (risankizumab), Stelara (ustekinumab), Xeljanz (tofacitinib)]

**AND**

**4** - 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZYMFENTRA 2-PEN | INFLIXIMAB-DYYB SOLN AUTO-INJECTOR KIT 120 MG/ML | 5250504020F530 | Brand |
| ZYMFENTRA 1-PEN | INFLIXIMAB-DYYB SOLN AUTO-INJECTOR KIT 120 MG/ML | 5250504020F530 | Brand |
| ZYMFENTRA 2-SYRINGE | INFLIXIMAB-DYYB SOLN PREFILLED SYRINGE KIT 120 MG/ML | 5250504020F830 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Zymfentra therapy

**AND**

**2** - Patient is not receiving Zymfentra in combination with a targeted immunomodulator [e.g., adalimumab, Entyvio (vedolizumab), Olumiant (baricitinib), Omvoh (mirikizumab-mrkz), Rinvoq (upadacitinib), Simponi (golimumab), Skyrizi (risankizumab), Stelara (ustekinumab), Xeljanz (tofacitinib)]

| Product Name: Zymfentra | |
|---|---|
| Diagnosis | Crohn's disease |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZYMFENTRA 2-PEN | INFLIXIMAB-DYYB SOLN AUTO-INJECTOR KIT 120 MG/ML | 5250504020F530 | Brand |
| ZYMFENTRA 1-PEN | INFLIXIMAB-DYYB SOLN AUTO-INJECTOR KIT 120 MG/ML | 5250504020F530 | Brand |
| ZYMFENTRA 2-SYRINGE | INFLIXIMAB-DYYB SOLN PREFILLED SYRINGE KIT 120 MG/ML | 5250504020F830 | Brand |

**Approval Criteria**

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

**AND**

**2** - One of the following:

**2.1** 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**

**2.2** 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**

**3** - Patient is not receiving Zymfentra in combination with a targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Entyvio (vedolizumab), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Skyrizi (risankizumab), Stelara (ustekinumab), Xeljanz (tofacitinib)]

**AND**

**4** - 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 |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZYMFENTRA 2-PEN | INFLIXIMAB-DYYB SOLN AUTO-INJECTOR KIT 120 MG/ML | 5250504020F530 | Brand |
| ZYMFENTRA 1-PEN | INFLIXIMAB-DYYB SOLN AUTO-INJECTOR KIT 120 MG/ML | 5250504020F530 | Brand |

| | | | |
|---|---|---|---|
| ZYMFENTRA 2-SYRINGE | INFLIXIMAB-DYYB SOLN PREFILLED SYRINGE KIT 120 MG/ML | 5250504020F830 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Zymfentra therapy

**AND**

**2** - Patient is not receiving Zymfentra in combination with a targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Entyvio (vedolizumab), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Skyrizi (risankizumab), Stelara (ustekinumab), Xeljanz (tofacitinib)]

## 2 . Revision History

| Date | Notes |
|---|---|
| 11/21/2024 | New; copy core |

Zytiga

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-150964 |
| **Guideline Name** | Zytiga |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 8/5/2024 |

## 1 . Criteria

| Product Name: Brand Zytiga, generic abiraterone | |
|---|---|
| Diagnosis | Prostate Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ABIRATERONE ACETATE | ABIRATERONE ACETATE TAB 250 MG | 21406010200320 | Generic |
| ZYTIGA | ABIRATERONE ACETATE TAB 250 MG | 21406010200320 | Brand |
| ABIRATERONE ACETATE | ABIRATERONE ACETATE TAB 500 MG | 21406010200330 | Generic |

| ZYTIGA | ABIRATERONE ACETATE TAB 500 MG | 21406010200330 | Brand |
|---|---|---|---|

**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, generic abiraterone | |
|---|---|
| Diagnosis | Prostate Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ABIRATERONE ACETATE | ABIRATERONE ACETATE TAB 250 MG | 21406010200320 | Generic |
| ZYTIGA | ABIRATERONE ACETATE TAB 250 MG | 21406010200320 | Brand |
| ABIRATERONE ACETATE | ABIRATERONE ACETATE TAB 500 MG | 21406010200330 | Generic |
| ZYTIGA | ABIRATERONE ACETATE TAB 500 MG | 21406010200330 | Brand |

**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, generic abiraterone | |
|---|---|
| Diagnosis | Salivary Gland Tumor |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ABIRATERONE ACETATE | ABIRATERONE ACETATE TAB 250 MG | 21406010200320 | Generic |
| ZYTIGA | ABIRATERONE ACETATE TAB 250 MG | 21406010200320 | Brand |
| ABIRATERONE ACETATE | ABIRATERONE ACETATE TAB 500 MG | 21406010200330 | Generic |
| ZYTIGA | ABIRATERONE ACETATE TAB 500 MG | 21406010200330 | Brand |

**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, generic abiraterone | |
|---|---|
| Diagnosis | Salivary Gland Tumor |
| Approval Length | 12 month(s) |

| Therapy Stage | Reauthorization |
|---|---|
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ABIRATERONE ACETATE | ABIRATERONE ACETATE TAB 250 MG | 21406010200320 | Generic |
| ZYTIGA | ABIRATERONE ACETATE TAB 250 MG | 21406010200320 | Brand |
| ABIRATERONE ACETATE | ABIRATERONE ACETATE TAB 500 MG | 21406010200330 | Generic |
| ZYTIGA | ABIRATERONE ACETATE TAB 500 MG | 21406010200330 | Brand |

**Approval Criteria**

**1** - Patient does not show evidence of progressive disease while on Zytiga 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, generic abiraterone | |
|---|---|
| Diagnosis | NCCN Recommended Regimens |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ABIRATERONE ACETATE | ABIRATERONE ACETATE TAB 250 MG | 21406010200320 | Generic |
| ZYTIGA | ABIRATERONE ACETATE TAB 250 MG | 21406010200320 | Brand |
| ABIRATERONE ACETATE | ABIRATERONE ACETATE TAB 500 MG | 21406010200330 | Generic |
| ZYTIGA | ABIRATERONE ACETATE TAB 500 MG | 21406010200330 | Brand |

**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, generic abiraterone | |
|---|---|
| Diagnosis | NCCN Recommended Regimens |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ABIRATERONE ACETATE | ABIRATERONE ACETATE TAB 250 MG | 21406010200320 | Generic |
| ZYTIGA | ABIRATERONE ACETATE TAB 250 MG | 21406010200320 | Brand |
| ABIRATERONE ACETATE | ABIRATERONE ACETATE TAB 500 MG | 21406010200330 | Generic |
| ZYTIGA | ABIRATERONE ACETATE TAB 500 MG | 21406010200330 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Zytiga 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

Zytiga

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146723 |
| **Guideline Name** | Zytiga |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Brand Zytiga, generic abiraterone | |
|---|---|
| Diagnosis | Prostate Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ABIRATERONE ACETATE | ABIRATERONE ACETATE TAB 250 MG | 21406010200320 | Generic |
| ZYTIGA | ABIRATERONE ACETATE TAB 250 MG | 21406010200320 | Brand |
| ABIRATERONE ACETATE | ABIRATERONE ACETATE TAB 500 MG | 21406010200330 | Generic |

| ZYTIGA | ABIRATERONE ACETATE TAB 500 MG | 21406010200330 | Brand |
|---|---|---|---|

**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, generic abiraterone | |
|---|---|
| Diagnosis | Prostate Cancer |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ABIRATERONE ACETATE | ABIRATERONE ACETATE TAB 250 MG | 21406010200320 | Generic |
| ZYTIGA | ABIRATERONE ACETATE TAB 250 MG | 21406010200320 | Brand |
| ABIRATERONE ACETATE | ABIRATERONE ACETATE TAB 500 MG | 21406010200330 | Generic |
| ZYTIGA | ABIRATERONE ACETATE TAB 500 MG | 21406010200330 | Brand |

**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, generic abiraterone | |
|---|---|
| Diagnosis | NCCN Recommended Regimens |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ABIRATERONE ACETATE | ABIRATERONE ACETATE TAB 250 MG | 21406010200320 | Generic |
| ZYTIGA | ABIRATERONE ACETATE TAB 250 MG | 21406010200320 | Brand |
| ABIRATERONE ACETATE | ABIRATERONE ACETATE TAB 500 MG | 21406010200330 | Generic |
| ZYTIGA | ABIRATERONE ACETATE TAB 500 MG | 21406010200330 | Brand |

**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, generic abiraterone | |
|---|---|
| Diagnosis | NCCN Recommended Regimens |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ABIRATERONE ACETATE | ABIRATERONE ACETATE TAB 250 MG | 21406010200320 | Generic |
| ZYTIGA | ABIRATERONE ACETATE TAB 250 MG | 21406010200320 | Brand |

| | | | |
|---|---|---|---|
| ABIRATERONE ACETATE | ABIRATERONE ACETATE TAB 500 MG | 21406010200330 | Generic |
| ZYTIGA | ABIRATERONE ACETATE TAB 500 MG | 21406010200330 | Brand |

**Approval Criteria**

**1** - Documentation of positive clinical response to Zytiga 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

Zyvox

# Prior Authorization Guideline

| | |
|---|---|
| **Guideline ID** | GL-146448 |
| **Guideline Name** | Zyvox |
| **Formulary** | • Medicaid - Community & State New Mexico |

## Guideline Note:

| | |
|---|---|
| Effective Date: | 7/1/2024 |

## 1 . Criteria

| Product Name: Brand Zyvox, generic linezolid | |
|---|---|
| Guideline Type | Prior Authorization |

| Product Name | Generic Name | GPI | Brand/Generic |
|---|---|---|---|
| ZYVOX | LINEZOLID TAB 600 MG | 16230040000330 | Brand |
| LINEZOLID | LINEZOLID TAB 600 MG | 16230040000330 | Generic |
| ZYVOX | LINEZOLID FOR SUSP 100 MG/5ML | 16230040001920 | Brand |
| LINEZOLID | LINEZOLID FOR SUSP 100 MG/5ML | 16230040001920 | Generic |

**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 Enterococcus faecium, 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. |