Table of Contents

ACE Inhibitors

Optum Rx®

Prior Authorization Guideline

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

Guideline Note:

Effective Date:	4/1/2024

1 . Criteria

Product Name: Brand Epaned, generic enalapril oral solution	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

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 under 12 years of age

OR

2 - Patient is unable to swallow tablets

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

Product Name	Generic Name	GPI	Brand/Generic
QBRELIS	LISINOPRIL ORAL SOLN 1 MG/ML	36100030002020	Brand

Approval Criteria

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

OR

2 - Patient is unable to swallow tablets

2 . Revision History

Date	Notes
3/14/2024	Separated criteria for Qbrelis

Acne Agents

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-161864
Guideline Name	Acne Agents
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2025

1 . Criteria

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

Product Name	Generic Name	GPI	Brand/Generic
ABSORICA	ISOTRETINOIN CAP 10 MG	90050013000110	Brand
AMNESTEEM	ISOTRETINOIN CAP 10 MG	90050013000110	Generic
CLARAVIS	ISOTRETINOIN CAP 10 MG	90050013000110	Generic
ISOTRETINOIN	ISOTRETINOIN CAP 10 MG	90050013000110	Generic
MYORISAN	ISOTRETINOIN CAP 10 MG	90050013000110	Generic
ZENATANE	ISOTRETINOIN CAP 10 MG	90050013000110	Generic
ABSORICA	ISOTRETINOIN CAP 20 MG	90050013000120	Brand
AMNESTEEM	ISOTRETINOIN CAP 20 MG	90050013000120	Generic
CLARAVIS	ISOTRETINOIN CAP 20 MG	90050013000120	Generic
ISOTRETINOIN	ISOTRETINOIN CAP 20 MG	90050013000120	Generic
MYORISAN	ISOTRETINOIN CAP 20 MG	90050013000120	Generic
ZENATANE	ISOTRETINOIN CAP 20 MG	90050013000120	Generic
ABSORICA	ISOTRETINOIN CAP 25 MG	90050013000125	Brand
ISOTRETINOIN	ISOTRETINOIN CAP 25 MG	90050013000125	Generic
ABSORICA	ISOTRETINOIN CAP 30 MG	90050013000130	Brand
CLARAVIS	ISOTRETINOIN CAP 30 MG	90050013000130	Generic
ISOTRETINOIN	ISOTRETINOIN CAP 30 MG	90050013000130	Generic
MYORISAN	ISOTRETINOIN CAP 30 MG	90050013000130	Generic
ZENATANE	ISOTRETINOIN CAP 30 MG	90050013000130	Generic
ABSORICA	ISOTRETINOIN CAP 35 MG	90050013000135	Brand
ISOTRETINOIN	ISOTRETINOIN CAP 35 MG	90050013000135	Generic
ABSORICA	ISOTRETINOIN CAP 40 MG	90050013000140	Brand
AMNESTEEM	ISOTRETINOIN CAP 40 MG	90050013000140	Generic
CLARAVIS	ISOTRETINOIN CAP 40 MG	90050013000140	Generic
ISOTRETINOIN	ISOTRETINOIN CAP 40 MG	90050013000140	Generic
MYORISAN	ISOTRETINOIN CAP 40 MG	90050013000140	Generic
ZENATANE	ISOTRETINOIN CAP 40 MG	90050013000140	Generic
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

ADAPALENE/BENZOYL PEROXIDE TOPICAL GEL	ADAPALENE-BENZOYL PEROXIDE GEL 0.3-2.5%	90059902034030	Generic
EPIDUO FORTE	ADAPALENE-BENZOYL PEROXIDE GEL 0.3-2.5%	90059902034030	Brand
BP WASH	BENZOYL PEROXIDE LIQ 2.5%	90050010000903	Generic
PANOXYL	BENZOYL PEROXIDE LIQ 2.5%	90050010000903	Brand
CERAVE ACNE FOAMING CREAMCLEANSER	BENZOYL PEROXIDE LIQ 4%	90050010000904	Brand
CVS CREAMY ACNE FACE WASH	BENZOYL PEROXIDE LIQ 4%	90050010000904	Generic
PANOXYL CREAMY WASH	BENZOYL PEROXIDE LIQ 4%	90050010000904	Brand
BENZAC AC WASH	BENZOYL PEROXIDE LIQ 5%	90050010000905	Brand
BENZOYL PEROXIDE WASH	BENZOYL PEROXIDE LIQ 5%	90050010000905	Generic
BP WASH	BENZOYL PEROXIDE LIQ 5%	90050010000905	Generic
CVS ADVANCED 3-IN-1 EXFOLIATING CLEANSER	BENZOYL PEROXIDE LIQ 5%	90050010000905	Generic
DIFFERIN DAILY DEEP CLEANSER	BENZOYL PEROXIDE LIQ 5%	90050010000905	Brand
MEDPURA BENZOYL PEROXIDE	BENZOYL PEROXIDE LIQ 5%	90050010000905	Brand
BENZEPRO CREAMY WASH	BENZOYL PEROXIDE LIQ 7%	90050010000907	Brand
PR BENZOYL PEROXIDE WASH	BENZOYL PEROXIDE LIQ 7%	90050010000907	Brand
ACNE FOAMING WASH	BENZOYL PEROXIDE LIQ 10%	90050010000910	Generic
BENZOYL PEROXIDE TOPICAL WASH	BENZOYL PEROXIDE LIQ 10%	90050010000910	Generic
BENZOYL PEROXIDE WASH	BENZOYL PEROXIDE LIQ 10%	90050010000910	Generic
BP WASH	BENZOYL PEROXIDE LIQ 10%	90050010000910	Generic
CVS ACNE FOAMING FACE WASH	BENZOYL PEROXIDE LIQ 10%	90050010000910	Generic
CVS FOAMING ACNE FACE WASH	BENZOYL PEROXIDE LIQ 10%	90050010000910	Generic
MEDPURA BENZOYL PEROXIDE	BENZOYL PEROXIDE LIQ 10%	90050010000910	Brand
PANOXYL FOAMING WASH	BENZOYL PEROXIDE LIQ 10%	90050010000910	Brand
BENZEPRO	BENZOYL PEROXIDE LIQ 6.8%	90050010000911	Brand
PR BENZOYL PEROXIDE	BENZOYL PEROXIDE LIQ 6.9%	90050010000912	Brand

NEUTROGENA CLEAR PORE CLEANSER/MASK	BENZOYL PEROXIDE CLEANSER 3.5%	90050010000960	Brand
ADVANCED ACNE WASH	BENZOYL PEROXIDE ER LIQD CLEANSER 4.4%	90050010001130	Brand
EFFACLAR DUO	BENZOYL PEROXIDE SOLUTION 5.5%	90050010002025	Generic
ACNE TREATMENT CLEANSING BAR MAXIMUM STRENGTH	BENZOYL PEROXIDE BAR 10%	90050010003510	Generic
CVS ACNE CLEANSING BAR	BENZOYL PEROXIDE BAR 10%	90050010003510	Generic
CVS TARGETED ACNE SPOT TREATMENT	BENZOYL PEROXIDE CREAM 2.5%	90050010003705	Generic
NEUTROGENA ON-THE-SPOT ACNE TREATMENT	BENZOYL PEROXIDE CREAM 2.5%	90050010003705	Brand
SPOT ACNE TREATMENT	BENZOYL PEROXIDE CREAM 2.5%	90050010003705	Generic
EPSOLAY	BENZOYL PEROXIDE CREAM 5%	90050010003710	Brand
ACNE MAXIMUM STRENGTH	BENZOYL PEROXIDE CREAM 10%	90050010003720	Generic
CLEARASIL DAILY CLEAR VANISHING ACNE TREATMENT	BENZOYL PEROXIDE CREAM 10%	90050010003720	Brand
CLEARASIL RAPID RESCUE SPOT TREATMENT MAXIMUM STRENGTH	BENZOYL PEROXIDE CREAM 10%	90050010003720	Brand
CLEARSKIN	BENZOYL PEROXIDE CREAM 10%	90050010003720	Generic
CVS ACNE CONTROL CLEANSER	BENZOYL PEROXIDE CREAM 10%	90050010003720	Generic
CVS ACNE TREATMENT	BENZOYL PEROXIDE CREAM 10%	90050010003720	Generic
BENZEPRO	BENZOYL PEROXIDE FOAM 5.2%	90050010003928	Brand
BENZEFOAM	BENZOYL PEROXIDE FOAM 5.3%	90050010003930	Brand
BENZEPRO	BENZOYL PEROXIDE FOAM 5.3%	90050010003930	Generic
BENZEPRO	BENZOYL PEROXIDE FOAM 9.7%	90050010003945	Brand
BENZOYL PEROXIDE	BENZOYL PEROXIDE FOAM 9.8%	90050010003948	Generic
RA DAYLOGIC ACNE FOAMING WASH MAXIMUM STRENGTH	BENZOYL PEROXIDE FOAM 10%	90050010003950	Generic
ACNE MEDICATION 2.5	BENZOYL PEROXIDE GEL 2.5%	90050010004005	Generic
BENZOYL PEROXIDE	BENZOYL PEROXIDE GEL 2.5%	90050010004005	Generic
ACNE MEDICATION 5	BENZOYL PEROXIDE GEL 5%	90050010004010	Generic

BENZOYL PEROXIDE	BENZOYL PEROXIDE GEL 5%	90050010004010	Generic
MEDPURA BENZOYL PEROXIDE	BENZOYL PEROXIDE GEL 5%	90050010004010	Brand
BPO	BENZOYL PEROXIDE GEL 4%	90050010004012	Generic
BENZOYL PEROXIDE 8%	BENZOYL PEROXIDE GEL 8%	90050010004014	Brand
BPO	BENZOYL PEROXIDE GEL 8%	90050010004014	Generic
ACNE MEDICATION 10	BENZOYL PEROXIDE GEL 10%	90050010004015	Generic
ACNE TREATMENT GEL	BENZOYL PEROXIDE GEL 10%	90050010004015	Generic
ACNE-CLEAR	BENZOYL PEROXIDE GEL 10%	90050010004015	Generic
BENZOYL PEROXIDE	BENZOYL PEROXIDE GEL 10%	90050010004015	Generic
CLEAN & CLEAR PERSA-GEL MAXIMUM STRENGTH	BENZOYL PEROXIDE GEL 10%	90050010004015	Brand
CVS ACNE TREATMENT/MAXIMUM STRENGTH	BENZOYL PEROXIDE GEL 10%	90050010004015	Generic
MEDPURA BENZOYL PEROXIDE	BENZOYL PEROXIDE GEL 10%	90050010004015	Brand
BENZOYL PEROXIDE	BENZOYL PEROXIDE GEL 6.5%	90050010004058	Brand
ACNE MEDICATION 5	BENZOYL PEROXIDE LOTION 5%	90050010004110	Generic
ZACLIR CLEANSING	BENZOYL PEROXIDE LOTION 8%	90050010004118	Brand
ACNE MEDICATION 10	BENZOYL PEROXIDE LOTION 10%	90050010004120	Generic
BENZEPRO	BENZOYL PEROXIDE CLOTH 5.8%	90050010006373	Brand
BENZEPRO FOAMING CLOTHS	BENZOYL PEROXIDE CLOTH 6%	90050010006375	Brand
BPO FOAMING CLOTHS	BENZOYL PEROXIDE CLOTH 6%	90050010006375	Generic
RETIN-A	TRETINOIN CREAM 0.025%	90050030003703	Brand
TRETINOIN	TRETINOIN CREAM 0.025%	90050030003703	Generic
RETIN-A	TRETINOIN CREAM 0.05%	90050030003705	Brand
TRETINOIN	TRETINOIN CREAM 0.05%	90050030003705	Generic
RETIN-A	TRETINOIN CREAM 0.1%	90050030003710	Brand
TRETINOIN	TRETINOIN CREAM 0.1%	90050030003710	Generic
RETIN-A	TRETINOIN GEL 0.01%	90050030004005	Brand
TRETINOIN	TRETINOIN GEL 0.01%	90050030004005	Generic
RETIN-A	TRETINOIN GEL 0.025%	90050030004010	Brand
TRETINOIN	TRETINOIN GEL 0.025%	90050030004010	Generic

ATRALIN	TRETINOIN GEL 0.05%	90050030004015	Brand
TRETINOIN	TRETINOIN GEL 0.05%	90050030004015	Generic
ALTRENO	TRETINOIN LOTION 0.05%	90050030004130	Brand
RETIN-A MICRO	TRETINOIN MICROSPHERE GEL 0.04%	90050030204015	Brand
RETIN-A MICRO PUMP	TRETINOIN MICROSPHERE GEL 0.04%	90050030204015	Brand
TRETINOIN MICROSPHERE	TRETINOIN MICROSPHERE GEL 0.04%	90050030204015	Generic
TRETINOIN MICROSPHERE PUMP	TRETINOIN MICROSPHERE GEL 0.04%	90050030204015	Generic
RETIN-A MICRO	TRETINOIN MICROSPHERE GEL 0.06%	90050030204017	Brand
RETIN-A MICRO PUMP	TRETINOIN MICROSPHERE GEL 0.08%	90050030204020	Brand
RETIN-A MICRO	TRETINOIN MICROSPHERE GEL 0.1%	90050030204030	Brand
RETIN-A MICRO PUMP	TRETINOIN MICROSPHERE GEL 0.1%	90050030204030	Brand
TRETINOIN MICROSPHERE	TRETINOIN MICROSPHERE GEL 0.1%	90050030204030	Generic
TRETINOIN MICROSPHERE PUMP	TRETINOIN MICROSPHERE GEL 0.1%	90050030204030	Generic
CLINDAMYCIN PHOSPHATE/TRETINOIN	CLINDAMYCIN PHOSPHATE-TRETINOIN GEL 1.2-0.025%	90059902654020	Generic
VELTIN	CLINDAMYCIN PHOSPHATE-TRETINOIN GEL 1.2-0.025%	90059902654020	Brand
ZIANA	CLINDAMYCIN PHOSPHATE-TRETINOIN GEL 1.2-0.025%	90059902654020	Brand
ADAPALENE/BENZOYL PEROXIDE	ADAPALENE-BENZOYL PEROXIDE PAD 0.1-2.5%	90059902034320	Brand
CLINDAMYCIN PHOSPHATE	CLINDAMYCIN PHOSPHATE SOLN 1%	90051010102005	Generic
CLINDACIN	CLINDAMYCIN PHOSPHATE FOAM 1%	90051010103905	Generic
CLINDAMYCIN PHOSPHATE	CLINDAMYCIN PHOSPHATE FOAM 1%	90051010103905	Generic
CLINDAGEL	CLINDAMYCIN PHOSPHATE GEL 1%	90051010104005	Brand
CLINDAMYCIN PHOSPHATE	CLINDAMYCIN PHOSPHATE GEL 1%	90051010104005	Generic
CLEOCIN-T	CLINDAMYCIN PHOSPHATE LOTION 1%	90051010104105	Brand
CLINDAMYCIN PHOSPHATE	CLINDAMYCIN PHOSPHATE LOTION 1%	90051010104105	Generic

CLINDACIN ETZ PLEDGETS	CLINDAMYCIN PHOSPHATE SWAB 1%	90051010109420	Generic
CLINDACIN-P	CLINDAMYCIN PHOSPHATE SWAB 1%	90051010109420	Generic
CLINDAMYCIN PHOSPHATE	CLINDAMYCIN PHOSPHATE SWAB 1%	90051010109420	Generic
CLINDAMYCIN PHOSPHATE/BENZOYL PEROXIDE	CLINDAMYCIN PHOSPHATE-BENZOYL PEROXIDE GEL 1-5%	90059902194020	Generic
CLINDAMYCIN/BENZOYL PEROXIDE	CLINDAMYCIN PHOSPHATE-BENZOYL PEROXIDE GEL 1-5%	90059902194020	Generic
ACANYA	CLINDAMYCIN PHOSPHATE-BENZOYL PEROXIDE GEL 1.2-2.5%	90059902194030	Brand
CLINDAMYCIN PHOSPHATE/BENZOYL PEROXIDE	CLINDAMYCIN PHOSPHATE-BENZOYL PEROXIDE GEL 1.2-2.5%	90059902194030	Generic
ONEXTON	CLINDAMYCIN PHOSPHATE-BENZOYL PEROXIDE GEL 1.2-3.75%	90059902194040	Brand
BENZAMYCIN	BENZOYL PEROXIDE-ERYTHROMYCIN GEL 5-3%	90059902104010	Brand
ERYTHROMYCIN/BENZOYL PEROXIDE	BENZOYL PEROXIDE-ERYTHROMYCIN GEL 5-3%	90059902104010	Generic
ACZONE	DAPSONE GEL 5%	90051015004020	Brand
DAPSONE	DAPSONE GEL 5%	90051015004020	Generic
ACZONE	DAPSONE GEL 7.5%	90051015004030	Brand
DAPSONE	DAPSONE GEL 7.5%	90051015004030	Generic
ERYTHROMYCIN	ERYTHROMYCIN SOLN 2%	90051020002010	Generic
ERYGEL	ERYTHROMYCIN GEL 2%	90051020004010	Brand
ERYTHROMYCIN	ERYTHROMYCIN GEL 2%	90051020004010	Generic
ERY	ERYTHROMYCIN PADS 2%	90051020004320	Generic
OVACE PLUS WASH	SULFACETAMIDE SODIUM LIQUID 10%	90300060000920	Brand
OVACE WASH	SULFACETAMIDE SODIUM LIQUID 10%	90300060000920	Brand
SODIUM SULFACETAMIDE WASH	SULFACETAMIDE SODIUM LIQUID 10%	90300060000920	Generic
OVACE PLUS	SULFACETAMIDE SODIUM CREAM 10%	90300060003720	Brand
OVACE PLUS	SULFACETAMIDE SODIUM FOAM 9.8%	90300060003917	Brand
OVACE PLUS WASH	SULFACETAMIDE SODIUM CLEANSING GEL 10%	90300060004060	Brand

SODIUM SULFACETAMIDE	SULFACETAMIDE SODIUM CLEANSING GEL 10%	90300060004060	Generic
OVACE PLUS	SULFACETAMIDE SODIUM LOTION 9.8%	90300060004109	Brand
PLEXION NS	SULFACETAMIDE SODIUM SHAMPOO 9.8%	90300060004538	Brand
SODIUM SULFACETAMIDE	SULFACETAMIDE SODIUM SHAMPOO 9.8%	90300060004538	Generic
OVACE PLUS	SULFACETAMIDE SODIUM SHAMPOO 10%	90300060004540	Brand
SODIUM SULFACETAMIDE	SULFACETAMIDE SODIUM SHAMPOO 10%	90300060004540	Generic
SODIUM SULFACETAMIDE/SULFUR	SULFACETAMIDE SODIUM W/ SULFUR CLEANSER 9-4%	90059903200914	Generic
SODIUM SULFACETAMIDE/SULFUR WASH	SULFACETAMIDE SODIUM W/ SULFUR CLEANSER 9-4%	90059903200914	Generic
SODIUM SULFACETAMIDE/SULFUR	SULFACETAMIDE SODIUM W/ SULFUR CLEANSER 9-4.5%	90059903200915	Generic
SODIUM SULFACETAMIDE/SULFUR WASH	SULFACETAMIDE SODIUM W/ SULFUR CLEANSER 9-4.5%	90059903200915	Generic
SUMADAN WASH	SULFACETAMIDE SODIUM W/ SULFUR CLEANSER 9-4.5%	90059903200915	Brand
PLEXION CLEANSER	SULFACETAMIDE SODIUM W/ SULFUR CLEANSER 9.8-4.8%	90059903200917	Brand
SODIUM SULFACETAMIDE/SULFUR	SULFACETAMIDE SODIUM W/ SULFUR CLEANSER 9.8-4.8%	90059903200917	Generic
SODIUM SULFACETAMIDE/SULFUR CLEANSER	SULFACETAMIDE SODIUM W/ SULFUR CLEANSER 9.8-4.8%	90059903200917	Generic
AVAR LS CLEANSER	SULFACETAMIDE SODIUM W/ SULFUR CLEANSER 10-2%	90059903200918	Brand
SODIUM SULFACETAMIDE/SULFUR	SULFACETAMIDE SODIUM W/ SULFUR CLEANSER 10-2%	90059903200918	Generic
AVAR CLEANSER	SULFACETAMIDE SODIUM W/ SULFUR CLEANSER 10-5%	90059903200927	Brand
SODIUM SULFACETAMIDE/SULFUR	SULFACETAMIDE SODIUM W/ SULFUR CLEANSER 10-5%	90059903200927	Generic
SODIUM SULFACETAMIDE/SULFUR CLEANSER	SULFACETAMIDE SODIUM W/ SULFUR CLEANSER 10-5%	90059903200927	Generic
BP 10-1	SULFACETAMIDE SODIUM W/ SULFUR EMULSION 10-1%	90059903201615	Generic
SULFAMEZ WASH	SULFACETAMIDE SODIUM W/ SULFUR EMULSION 10-1%	90059903201615	Generic

SODIUM SULFACETAMIDE/SULFUR	SULFACETAMIDE SODIUM W/ SULFUR SUSP 8-4%	90059903201810	Generic
SULFACLEANSE 8/4	SULFACETAMIDE SODIUM W/ SULFUR SUSP 8-4%	90059903201810	Brand
CLENIA PLUS	SULFACETAMIDE SODIUM W/ SULFUR SUSP 9-4.25%	90059903201815	Brand
SODIUM SULFACETAMIDE/SULFUR	SULFACETAMIDE SODIUM W/ SULFUR SUSP 9-4.25%	90059903201815	Generic
ZMA CLEAR	SULFACETAMIDE SODIUM W/ SULFUR SUSP 9-4.5%	90059903201816	Brand
SODIUM SULFACETAMIDE/SULFUR	SULFACETAMIDE SODIUM W/ SULFUR SUSP 10-5%	90059903201820	Generic
PLEXION	SULFACETAMIDE SODIUM W/ SULFUR CREAM 9.8-4.8%	90059903203716	Brand
SODIUM SULFACETAMIDE/SULFUR	SULFACETAMIDE SODIUM W/ SULFUR CREAM 9.8-4.8%	90059903203716	Generic
AVAR-E LS	SULFACETAMIDE SODIUM W/ SULFUR CREAM 10-2%	90059903203718	Brand
SODIUM SULFACETAMIDE/SULFUR	SULFACETAMIDE SODIUM W/ SULFUR CREAM 10-2%	90059903203718	Generic
AVAR-E EMOLLIENT	SULFACETAMIDE SODIUM W/ SULFUR CREAM 10-5%	90059903203720	Brand
AVAR-E GREEN	SULFACETAMIDE SODIUM W/ SULFUR CREAM 10-5%	90059903203720	Brand
SODIUM SULFACETAMIDE/SULFUR	SULFACETAMIDE SODIUM W/ SULFUR CREAM 10-5%	90059903203720	Generic
SODIUM SULFACETAMIDE/SULFUR GREEN	SULFACETAMIDE SODIUM W/ SULFUR CREAM 10-5%	90059903203720	Generic
SSS 10%-5%	SULFACETAMIDE SODIUM W/ SULFUR CREAM 10-5%	90059903203720	Generic
SSS 10-5	SULFACETAMIDE SODIUM W/ SULFUR FOAM 10-5%	90059903203920	Brand
PLEXION	SULFACETAMIDE SODIUM W/ SULFUR LOTION 9.8-4.8%	90059903204109	Brand
SODIUM SULFACETAMIDE/SULFUR	SULFACETAMIDE SODIUM W/ SULFUR LOTION 9.8-4.8%	90059903204109	Generic
SODIUM SULFACETAMIDE/SULFUR	SULFACETAMIDE SODIUM W/ SULFUR LOTION 10-5%	90059903204110	Generic
PLEXION CLEANSING CLOTHS	SULFACETAMIDE SODIUM W/ SULFUR CLEANSING CLOTH 9.8-4.8%	90059903204310	Brand
SODIUM SULFACETAMIDE/SUL FUR	SULFACETAMIDE SODIUM W/ SULFUR CLEANSING CLOTH 9.8-4.8%	90059903204310	Generic

SODIUM SULFACETAMIDE/SULFUR	SULFACETAMIDE SODIUM W/ SULFUR CLEANSING PAD 10-4%	90059903204316	Generic
SUMAXIN	SULFACETAMIDE SODIUM W/ SULFUR CLEANSING PAD 10-4%	90059903204316	Brand
KLARON	SULFACETAMIDE SODIUM LOTION 10% (ACNE)	90051036104120	Brand
SODIUM SULFACETAMIDE	SULFACETAMIDE SODIUM LOTION 10% (ACNE)	90051036104120	Generic
SULFACETAMIDE SODIUM	SULFACETAMIDE SODIUM LOTION 10% (ACNE)	90051036104120	Generic
CLINDAMYCIN PHOSPHATE/BENZOYL PEROXIDE	CLINDAMYCIN PHOSPHATE-BENZOYL PEROXIDE GEL 1.2-3.75%	90059902194040	Generic
LINTERA WASH	BENZOYL PEROXIDE FOAM 10%	90050010003950	Brand
TRETINOIN MICROSPHERE	TRETINOIN MICROSPHERE GEL 0.08%	90050030204020	Generic
CABTREO	ADAPALENE-BENZOYL PEROXIDE-CLINDAMYCIN GEL 0.15-3.1-1.2%	90059903024018	Brand

Approval Criteria

1 - ONE of the following:

1.1 Patient is 25 years of age or under

OR

1.2 BOTH of the following:

1.2.1 Patient is 26 years of age or older

AND

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

AND

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

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

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

Product Name	Generic Name	GPI	Brand/Generic
ADAPALENE	ADAPALENE SOLN 0.1%	90050003002010	Brand
ADAPALENE	ADAPALENE CREAM 0.1%	90050003003710	Generic
DIFFERIN	ADAPALENE CREAM 0.1%	90050003003710	Brand
ADAPALENE	ADAPALENE GEL 0.1%	90050003004010	Generic
ADAPALENE TREATMENT	ADAPALENE GEL 0.1%	90050003004010	Generic
CVS ADAPALENE	ADAPALENE GEL 0.1%	90050003004010	Generic
DIFFERIN	ADAPALENE GEL 0.1%	90050003004010	Brand
ADAPALENE	ADAPALENE GEL 0.3%	90050003004030	Generic
ADAPALENE PUMP	ADAPALENE GEL 0.3%	90050003004030	Generic
DIFFERIN	ADAPALENE GEL 0.3%	90050003004030	Brand
DIFFERIN	ADAPALENE LOTION 0.1%	90050003004110	Brand
ADAPALENE	ADAPALENE PADS 0.1%	90050003004310	Brand

Approval Criteria

1 - ONE of the following:

1.1 Patient is 25 years of age or under and has tried a preferred topical tretinoin product*

OR

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

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

AND **1.2.2** Patient has tried a preferred topical tretinoin product* **AND** **2** - If the request is non-preferred*, the patient must have had a 14-day trial each of at least 2 preferred* medications	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

2 . Revision History

Date	Notes
12/10/2024	Removed Avita and Finacea foam.

Actimmune

Optum Rx®

Prior Authorization Guideline

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

Guideline Note:

Effective Date:	9/1/2023

1 . Criteria

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

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

Aemcolo

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-106361
Guideline Name	Aemcolo
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	7/1/2022

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

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-155817
Guideline Name	Afinitor
Formulary	• Medicaid - Community & State Indiana

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

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

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

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

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

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

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

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

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

Agents for the Treatment of Opioid Use Disorder

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-148949
Guideline Name	Agents for the Treatment of Opioid Use Disorder
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Buprenorphine sublingual tablet, Zubsolv, buprenorphine/naloxone sublingual tablet, Brand Suboxone, generic buprenorphine/naloxone sublingual film	
Diagnosis	Age Limit Exception*
Approval Length	12 month(s)
Guideline Type	Prior Authorization

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

Approval Criteria

1 - Both of the following:

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

AND

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

OR

2 - Both of the following:

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

AND

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

OR

3 - All of the following:

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

AND

3.2 One of the following:

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

AND

3.3 One of the following:

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

OR

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

AND

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

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

Product Name: Buprenorphine sublingual tablet, Zubsolv, buprenorphine/naloxone sublingual tablet, Brand Suboxone, generic buprenorphine/naloxone sublingual film	
Diagnosis	Non-Preferred*
Approval Length	12 month(s)

Guideline Type	Prior Authorization

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

Approval Criteria

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

1.1 History of failure to at least THREE preferred alternatives as confirmed by claims history or submission of medical records. NOTE: In instances where there are fewer than three preferred alternatives, the patient must have a history of failure to all of the preferred products

OR

1.2 History of contraindication or intolerance to THREE preferred alternatives (please specify contraindication or intolerance). NOTE: In instances where there are fewer than three preferred alternatives, the patient must have a history of contraindication or intolerance to all of the preferred products

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

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

Product Name	Generic Name	GPI	Brand/Generic
BRIXADI	BUPRENORPHINE EXTENDED RELEASE SOLN PREF SYR 64 MG/0.18ML	6520001000E515	Brand
BRIXADI	BUPRENORPHINE EXTENDED RELEASE SOLN PREF SYR 96 MG/0.27ML	6520001000E518	Brand
BRIXADI	BUPRENORPHINE EXTENDED RELEASE SOLN PREF SYR 128 MG/0.36ML	6520001000E523	Brand
BRIXADI	BUPRENORPHINE EXT REL SOLN PREF SYR (WEEKLY) 8 MG/0.16ML	6520001000E560	Brand
BRIXADI	BUPRENORPHINE EXT REL SOLN PREF SYR (WEEKLY) 16 MG/0.32ML	6520001000E565	Brand
BRIXADI	BUPRENORPHINE EXT REL SOLN PREF SYR (WEEKLY) 24 MG/0.48ML	6520001000E570	Brand
BRIXADI	BUPRENORPHINE EXT REL SOLN PREF SYR (WEEKLY) 32 MG/0.64ML	6520001000E575	Brand

Approval Criteria

1 - The patient is 18 years of age or older

AND

2 - One of the following:

2.1 Both of the following:

- Previous trial and failure of ONE preferred* oral formulation agent for opioid use disorder for a minimum of 7 days
- Previous trial and failure of Sublocade (buprenorphine)

OR

2.2 Prescriber has provided medical rationale for use of Brixadi (buprenorphine) over all oral formulation agents for opioid use disorder AND Sublocade (buprenorphine)

AND

3 - One of the following:

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

OR

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

AND

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

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

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

Product Name	Generic Name	GPI	Brand/Generic
BRIXADI	BUPRENORPHINE EXTENDED RELEASE SOLN PREF SYR 64 MG/0.18ML	6520001000E515	Brand
BRIXADI	BUPRENORPHINE EXTENDED RELEASE SOLN PREF SYR 96 MG/0.27ML	6520001000E518	Brand
BRIXADI	BUPRENORPHINE EXTENDED RELEASE SOLN PREF SYR 128 MG/0.36ML	6520001000E523	Brand
BRIXADI	BUPRENORPHINE EXT REL SOLN PREF SYR (WEEKLY) 8 MG/0.16ML	6520001000E560	Brand
BRIXADI	BUPRENORPHINE EXT REL SOLN PREF SYR (WEEKLY) 16 MG/0.32ML	6520001000E565	Brand
BRIXADI	BUPRENORPHINE EXT REL SOLN PREF SYR (WEEKLY) 24 MG/0.48ML	6520001000E570	Brand
BRIXADI	BUPRENORPHINE EXT REL SOLN PREF SYR (WEEKLY) 32 MG/0.64ML	6520001000E575	Brand

Approval Criteria

1 - One of the following:

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

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

AND

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

OR

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

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

AND

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

AND

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

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

Product Name	Generic Name	GPI	Brand/Generic
SUBLOCADE	BUPRENORPHINE EXTENDED RELEASE SOLN PREF SYR 100 MG/0.5ML	6520001000E520	Brand

SUBLOCADE	BUPRENORPHINE EXTENDED RELEASE SOLN PREF SYR 300 MG/1.5ML	6520001000E530	Brand

Approval Criteria

1 - The patient is 18 years of age or older

AND

2 - One of the following:

- Previous trial of ONE preferred* oral formulation agent for opioid use disorder for a minimum of 7 days
- Prescriber has provided medical rationale for use of Sublocade (buprenorphine) over all oral formulation agents for opioid use disorder

AND

3 - Dose requested does not exceed the following:

- 300 mg/month during initiation phase x 2 months
- 100 mg/month during maintenance phase

AND

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

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

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

Product Name	Generic Name	GPI	Brand/Generic

SUBLOCADE	BUPRENORPHINE EXTENDED RELEASE SOLN PREF SYR 100 MG/0.5ML	6520001000E520	Brand
SUBLOCADE	BUPRENORPHINE EXTENDED RELEASE SOLN PREF SYR 300 MG/1.5ML	6520001000E530	Brand

Approval Criteria

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

AND

2 - Dose requested does not exceed the following:

- 300 mg/month during initiation phase x 2 months
- 100 mg/month during maintenance phase

AND

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

2 . Revision History

Date	Notes
6/28/2024	Updated Brixadi dosing limits.

Akeega

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-138128
Guideline Name	Akeega
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	2/1/2024

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-151764
Guideline Name	Alecensa
Formulary	• Medicaid - Community & State Indiana

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.

Alfa Interferons

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-136313
Guideline Name	Alfa Interferons
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Intron A	
Diagnosis	Chronic Hepatitis B
Approval Length	48 Week(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
INTRON A	INTERFERON ALFA-2B FOR INJ 10000000 UNIT	21700060202130	Brand
INTRON A	INTERFERON ALFA-2B FOR INJ 18000000 UNIT	21700060202135	Brand
INTRON A	INTERFERON ALFA-2B FOR INJ 50000000 UNIT	21700060202160	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: Intron A	
Diagnosis	Chronic Hepatitis C
Approval Length	48 Week(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
INTRON A	INTERFERON ALFA-2B FOR INJ 10000000 UNIT	21700060202130	Brand
INTRON A	INTERFERON ALFA-2B FOR INJ 18000000 UNIT	21700060202135	Brand
INTRON A	INTERFERON ALFA-2B FOR INJ 50000000 UNIT	21700060202160	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: Intron A	
Diagnosis	Diagnoses Other Than Hepatitis

Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
INTRON A	INTERFERON ALFA-2B FOR INJ 10000000 UNIT	21700060202130	Brand
INTRON A	INTERFERON ALFA-2B FOR INJ 18000000 UNIT	21700060202135	Brand
INTRON A	INTERFERON ALFA-2B FOR INJ 50000000 UNIT	21700060202160	Brand

Approval Criteria

1 - Patient has ONE of the following diagnoses:

- Hairy cell leukemia
- Malignant melanoma
- Follicular lymphoma
- Condylomata acuminata (genital or perianal)
- AIDS (acquired immunodeficiency syndrome)-related Kaposi's sarcoma
- Giant cell tumors of the bone
- Mycosis fungoides/Sezary syndrome
- Primary cutaneous CD30+ T-cell lymphoproliferative disorders
- Adult T-cell leukemia/lymphoma

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

Product Name	Generic Name	GPI	Brand/Generic
INTRON A	INTERFERON ALFA-2B FOR INJ 10000000 UNIT	21700060202130	Brand
INTRON A	INTERFERON ALFA-2B FOR INJ 18000000 UNIT	21700060202135	Brand
INTRON A	INTERFERON ALFA-2B FOR INJ 50000000 UNIT	21700060202160	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Intron A	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
INTRON A	INTERFERON ALFA-2B FOR INJ 10000000 UNIT	21700060202130	Brand
INTRON A	INTERFERON ALFA-2B FOR INJ 18000000 UNIT	21700060202135	Brand
INTRON A	INTERFERON ALFA-2B FOR INJ 50000000 UNIT	21700060202160	Brand

Approval Criteria

1 - Documentation of positive clinical response to Intron A therapy

2 . Revision History

Date	Notes
11/14/2023	Removed Pegasys.

Allergy-Specific Immunotherapy

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-154716
Guideline Name	Allergy-Specific Immunotherapy
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	10/1/2024

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 grass-pollen induced allergic rhinitis

AND

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

AND

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

AND

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

AND

5 - ONE of the following:

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

- Intranasal corticosteroid
- Leukotriene inhibitor
- Antihistamine agent

OR

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

AND

6 - ONE of the following:

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

OR

6.2 Prescriber has provided documentation of contraindication to injectable immunotherapy

AND

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

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

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-induced allergic rhinitis

AND

2 - Documentation of a positive skin test or in vitro test for IgE (immunoglobulin E) antibodies to house dust mites (dermatophagoides farinae or dermatophagoides pteronyssinus)

AND

3 - Patient must be at least 12 years of age and no more than 65 years of age

AND

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

AND

5 - ONE of the following:

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

- Intranasal corticosteroid
- Leukotriene inhibitor
- Antihistamine agent

OR

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

AND

6 - ONE of the following:

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

OR

6.2 Prescriber has provided documentation of contraindication to injectable immunotherapy

AND

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

- Severe, unstable, or uncontrolled asthma

- Current oral inflammation or wound from previous pollen-specific sublingual immunotherapy

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 grass pollen-induced allergic rhinitis

AND

2 - Documentation of a positive skin test or in vitro test for any of the five grass species: Sweet Vernal, Orchard, Perennial Rye, Timothy or Kentucky Blue Grass

AND

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

AND

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

AND

5 - ONE of the following:

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

- Intranasal corticosteroid
- Leukotriene inhibitor
- Antihistamine agent

OR

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

AND

6 - ONE of the following:

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

OR

6.2 Prescriber has provided documentation of contraindication to injectable immunotherapy

AND

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

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

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 of peanut allergy

AND

2 - Patient is at least 1 years of age and no more than 17 years of age

AND

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

AND

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

- Severe, unstable, or uncontrolled asthma
- Severe or life-threatening anaphylaxis reaction in the past 60 days
- History of eosinophilic esophagitis or other eosinophilic GI (gastrointestinal) disease

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 short ragweed pollen-induced allergic rhinitis

AND

2 - Documentation of a positive skin test or in vitro test for short ragweed pollen

AND

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

AND

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

AND

5 - ONE of the following:

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

- Intranasal corticosteroid
- Leukotriene inhibitor
- Antihistamine agent

OR

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

AND

6 - ONE of the following:

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

OR

6.2 Prescriber has provided documentation of contraindication to injectable immunotherapy

AND

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

- Severe, unstable, or uncontrolled asthma

- Current oral inflammation or wound from previous pollen-specific sublingual immunotherapy

Product Name: Grastek, Odactra, Oralair, Palforzia, Ragwitek	
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
ODACTRA	*DUST MITE MIXED EXT SL TAB 12 SQ-HDM***	20109902220740	Brand
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
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
RAGWITEK	SHORT RAGWEED POLLEN ALLERGEN EXTRACT SL TAB 12 AMB A 1-U	20100060200720	Brand

Approval Criteria

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

2 . Revision History

Date	Notes
9/10/2024	Changed min. age of Palforzia.

Alunbrig

Prior Authorization Guideline

Guideline ID	GL-161363
Guideline Name	Alunbrig
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2025

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
11/27/2024	Added Anaplastic Large Cell Lymphoma.

Angiotensin Receptor Blocker Combinations

Optum Rx®

Prior Authorization Guideline

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

Guideline Note:

Effective Date:	7/1/2023

1 . Criteria

Product Name: telmisartan/amlodipine, Brand Exforge, generic amlodipine/valsartan, Brand Exforge HCT, generic amlodipine/valsartan/hydrochlorothiazide, Brand Tribenzor, generic olmesartan/amlodipine/hydrochlorothiazide, Brand Azor, generic amlodipine/olmesartan	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TELMISARTAN/AMLODIPINE	TELMISARTAN-AMLODIPINE TAB 40-5 MG	36993002700320	Generic
TELMISARTAN/AMLODIPINE	TELMISARTAN-AMLODIPINE TAB 40-10 MG	36993002700330	Generic

TELMISARTAN/AMLODIPINE	TELMISARTAN-AMLODIPINE TAB 80-5 MG	36993002700340	Generic
TELMISARTAN/AMLODIPINE	TELMISARTAN-AMLODIPINE TAB 80-10 MG	36993002700350	Generic
AMLODIPINE BESYLATE/VALSARTAN	AMLODIPINE BESYLATE-VALSARTAN TAB 5-160 MG	36993002100310	Generic
EXFORGE	AMLODIPINE BESYLATE-VALSARTAN TAB 5-160 MG	36993002100310	Brand
AMLODIPINE BESYLATE/VALSARTAN	AMLODIPINE BESYLATE-VALSARTAN TAB 5-320 MG	36993002100320	Generic
EXFORGE	AMLODIPINE BESYLATE-VALSARTAN TAB 5-320 MG	36993002100320	Brand
AMLODIPINE BESYLATE/VALSARTAN	AMLODIPINE BESYLATE-VALSARTAN TAB 10-160 MG	36993002100330	Generic
EXFORGE	AMLODIPINE BESYLATE-VALSARTAN TAB 10-160 MG	36993002100330	Brand
AMLODIPINE BESYLATE/VALSARTAN	AMLODIPINE BESYLATE-VALSARTAN TAB 10-320 MG	36993002100340	Generic
EXFORGE	AMLODIPINE BESYLATE-VALSARTAN TAB 10-320 MG	36993002100340	Brand
EXFORGE HCT	AMLODIPINE-VALSARTAN-HYDROCHLOROTHIAZIDE TAB 5-160-12.5 MG	36994503200320	Brand
AMLODIPINE/VALSARTAN/HYDROCHLOROTHIAZIDE	AMLODIPINE-VALSARTAN-HYDROCHLOROTHIAZIDE TAB 5-160-12.5 MG	36994503200320	Generic
EXFORGE HCT	AMLODIPINE-VALSARTAN-HYDROCHLOROTHIAZIDE TAB 5-160-25 MG	36994503200325	Brand
AMLODIPINE/VALSARTAN/HYDROCHLOROTHIAZIDE	AMLODIPINE-VALSARTAN-	36994503200325	Generic

	HYDROCHLOROTHIAZIDE TAB 5-160-25 MG		
EXFORGE HCT	AMLODIPINE-VALSARTAN-HYDROCHLOROTHIAZIDE TAB 10-160-12.5 MG	36994503200330	Brand
AMLODIPINE/VALSARTAN/HYDROCHLOROTHIAZIDE	AMLODIPINE-VALSARTAN-HYDROCHLOROTHIAZIDE TAB 10-160-12.5 MG	36994503200330	Generic
EXFORGE HCT	AMLODIPINE-VALSARTAN-HYDROCHLOROTHIAZIDE TAB 10-160-25 MG	36994503200335	Brand
AMLODIPINE/VALSARTAN/HYDROCHLOROTHIAZIDE	AMLODIPINE-VALSARTAN-HYDROCHLOROTHIAZIDE TAB 10-160-25 MG	36994503200335	Generic
EXFORGE HCT	AMLODIPINE-VALSARTAN-HYDROCHLOROTHIAZIDE TAB 10-320-25 MG	36994503200340	Brand
AMLODIPINE/VALSARTAN/HYDROCHLOROTHIAZIDE	AMLODIPINE-VALSARTAN-HYDROCHLOROTHIAZIDE TAB 10-320-25 MG	36994503200340	Generic
TRIBENZOR	OLMESARTAN-AMLODIPINE-HYDROCHLOROTHIAZIDE TAB 20-5-12.5 MG	36994503450310	Brand
OLMESARTAN MEDOXOMIL/AMLODIPINE/HYDROCHLOROTHIAZIDE	OLMESARTAN-AMLODIPINE-HYDROCHLOROTHIAZIDE TAB 20-5-12.5 MG	36994503450310	Generic
TRIBENZOR	OLMESARTAN-AMLODIPINE-HYDROCHLOROTHIAZIDE TAB 40-5-12.5 MG	36994503450320	Brand
OLMESARTAN MEDOXOMIL/AMLODIPINE/HYDROCHLOROTHIAZIDE	OLMESARTAN-AMLODIPINE-HYDROCHLOROTHIAZIDE TAB 40-5-12.5 MG	36994503450320	Generic
TRIBENZOR	OLMESARTAN-AMLODIPINE-HYDROCHLOROTHIAZIDE TAB 40-5-25 MG	36994503450330	Brand
OLMESARTAN MEDOXOMIL/AMLODIPINE/HYDROCHLOROTHIAZIDE	OLMESARTAN-AMLODIPINE-HYDROCHLOROTHIAZIDE TAB 40-5-25 MG	36994503450330	Generic

TRIBENZOR	OLMESARTAN-AMLODIPINE-HYDROCHLOROTHIAZIDE TAB 40-10-12.5 MG	36994503450340	Brand
OLMESARTAN MEDOXOMIL/AMLODIPINE/HYDROCHLOROTHIAZIDE	OLMESARTAN-AMLODIPINE-HYDROCHLOROTHIAZIDE TAB 40-10-12.5 MG	36994503450340	Generic
TRIBENZOR	OLMESARTAN-AMLODIPINE-HYDROCHLOROTHIAZIDE TAB 40-10-25 MG	36994503450350	Brand
OLMESARTAN MEDOXOMIL/AMLODIPINE/HYDROCHLOROTHIAZIDE	OLMESARTAN-AMLODIPINE-HYDROCHLOROTHIAZIDE TAB 40-10-25 MG	36994503450350	Generic
AZOR	AMLODIPINE BESYLATE-OLMESARTAN MEDOXOMIL TAB 5-20 MG	36993002050310	Brand
AMLODIPINE/OLMESARTAN MEDOXOMIL	AMLODIPINE BESYLATE-OLMESARTAN MEDOXOMIL TAB 5-20 MG	36993002050310	Generic
AZOR	AMLODIPINE BESYLATE-OLMESARTAN MEDOXOMIL TAB 5-40 MG	36993002050320	Brand
AMLODIPINE/OLMESARTAN MEDOXOMIL	AMLODIPINE BESYLATE-OLMESARTAN MEDOXOMIL TAB 5-40 MG	36993002050320	Generic
AZOR	AMLODIPINE BESYLATE-OLMESARTAN MEDOXOMIL TAB 10-20 MG	36993002050330	Brand
AMLODIPINE/OLMESARTAN MEDOXOMIL	AMLODIPINE BESYLATE-OLMESARTAN MEDOXOMIL TAB 10-20 MG	36993002050330	Generic
AZOR	AMLODIPINE BESYLATE-OLMESARTAN MEDOXOMIL TAB 10-40 MG	36993002050340	Brand
AMLODIPINE/OLMESARTAN MEDOXOMIL	AMLODIPINE BESYLATE-	36993002050340	Generic

	OLMESARTAN MEDOXOMIL TAB 10-40 MG		

Approval Criteria

1 - Trial and failure of the individual components

2 . Revision History

Date	Notes
4/25/2023	New

Angiotensin Receptor Blockers (ARBs)

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-150102
Guideline Name	Angiotensin Receptor Blockers (ARBs)
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	8/1/2024

1 . Criteria

Product Name: Valsartan oral solution	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VALSARTAN	VALSARTAN ORAL SOLN 4 MG/ML	36150080002025	Generic

Approval Criteria

1 - Patient is unable to swallow tablets

2 . Revision History

Date	Notes
7/22/2024	Removed age limits

Antiemetic, Antivertigo Agents

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-124875
Guideline Name	Antiemetic, Antivertigo Agents
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	7/1/2023

1 . Criteria

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

Product Name	Generic Name	GPI	Brand/Generic
SANCUSO	GRANISETRON TD PATCH 3.1 MG/24HR (CONTAINS 34.3 MG)	50250035005920	Brand

Approval Criteria

1 - Documentation indicating oral medications are unsuitable for patient use

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

Product Name	Generic Name	GPI	Brand/Generic
EMEND	APREPITANT FOR ORAL SUSP 125 MG (125 MG/5ML)	50280020001930	Brand

Approval Criteria

1 - Patient has tried Emend oral capsules

OR

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

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

Product Name	Generic Name	GPI	Brand/Generic
AKYNZEO	NETUPITANT-PALONOSETRON CAP 300-0.5 MG	50309902290120	Brand

Approval Criteria

1 - Patient has tried and failed combination therapy with preferred* agents of the same classes

OR

2 - Medical justification for use

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

2 . Revision History

Date	Notes
4/20/2023	New

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-125088
Guideline Name	Antihistamine-Decongestant Combinations - 2nd Generation Antihistamines
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	7/1/2023

1 . Criteria

Product Name: levocetirizine soln, Xyzal soln	
Approval Length	12 month(s)
Guideline Type	Step Therapy

Product Name	Generic Name	GPI	Brand/Generic
LEVOCETIRIZINE DIHYDROCHLORIDE	LEVOCETIRIZINE DIHYDROCHLORIDE SOLN 2.5 MG/5ML (0.5 MG/ML)	41550027102020	Generic
XYZAL ALLERGY 24HR CHILDRENS	LEVOCETIRIZINE DIHYDROCHLORIDE SOLN 2.5 MG/5ML (0.5 MG/ML)	41550027102020	Brand

Approval Criteria

1 - Patient had a trial of ONE of the following:

- loratadine solution
- cetirizine syrup

2 . Revision History

Date	Notes
4/27/2023	New guideline

Antimicrobials for Treatment of Vaginal Infections

Optum Rx®

Prior Authorization Guideline

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

Guideline Note:

Effective Date:	10/1/2023

1 . Criteria

Product Name: Brexafemme	
Approval Length	30 days for acute infection. 6 months for recurrent infection
Guideline Type	Prior Authorization

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

Approval Criteria

1 - One of the following:

1.1 Diagnosis of acute vulvovaginal candidiasis and the request does not exceed 4 tablets per treatment course

OR

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

AND

2 - ONE of the following:

2.1 Patient is 18 years of age or older

OR

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

AND

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

AND

4 - ONE of the following:

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

OR

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

Product Name: Vivjoa	
Approval Length	12 Week(s)
Guideline Type	Prior Authorization

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 (defined as 3 or more episodes of vulvovaginal candidiasis within a year)

AND

2 - Patient is 18 years of age or older

AND

3 - Provider attests patient is not considered to be of reproductive potential

AND

4 - ONE of the following:

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

OR

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

AND

5 - Request does not exceed 18 tablets per treatment course

2 . Revision History

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

Antimigraine Agents

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-155047
Guideline Name	Antimigraine Agents
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name: Aimovig	
Approval Length	1 year(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 with or without aura requiring prophylaxis

AND

2 - Patient is 18 years of age or older

AND

3 - One of the following:

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

- antiseizure agents (topiramate)
- beta-blockers (metoprolol, propranolol, or timolol)
- tricyclic antidepressants (amitriptyline or nortriptyline)
- valproic acid and derivatives (divalproex or valproic acid)

OR

3.2 Documented intolerance or contraindication to ALL of the following:

- amitriptyline
- nortriptyline
- divalproex
- valproate
- topiramate
- metoprolol
- propranolol
- timolol

Product Name: Aimovig	
Approval Length	1 year(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

Approval Criteria

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

Product Name: Ajovy	
Approval Length	1 year(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

Approval Criteria

1 - Diagnosis of migraine with or without aura requiring prophylaxis

AND

2 - Patient is 18 years of age or older

AND

3 - One of the following:

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

- antiseizure agents (topiramate)

- beta-blockers (metoprolol, propranolol, or timolol)
- tricyclic antidepressants (amitriptyline or nortriptyline)
- valproic acid and derivatives (divalproex or valproic acid)

OR

3.2 Documented intolerance or contraindication to ALL of the following:

- amitriptyline
- nortriptyline
- divalproex
- valproate
- topiramate
- metoprolol
- propranolol
- timolol

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

Approval Criteria

1 - History of Ajovy for at least 90 days within the past 120 days, confirmed by claims history or chart documentation

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

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
EMGALITY	GALCANEZUMAB-GNLM SUBCUTANEOUS SOLN AUTO-INJECTOR 120 MG/ML	6770203530D520	Brand
EMGALITY	GALCANEZUMAB-GNLM SUBCUTANEOUS SOLN PREFILLED SYR 100 MG/ML	6770203530E515	Brand
EMGALITY	GALCANEZUMAB-GNLM SUBCUTANEOUS SOLN PREFILLED SYR 120 MG/ML	6770203530E520	Brand

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of migraine with or without aura requiring prophylaxis

AND

1.2 Patient is 18 years of age or older

AND

1.3 One of the following:

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

- antiseizure agents (topiramate)
- beta-blockers (metoprolol, propranolol, or timolol)
- tricyclic antidepressants (amitriptyline or nortriptyline)
- valproic acid and derivatives (divalproex or valproic acid)

OR

1.3.2 Documented intolerance or contraindication to ALL of the following:

- amitriptyline
- nortriptyline
- divalproex
- valproate

- topiramate
- metoprolol
- propranolol
- timolol

AND

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

OR

2 - ALL of the following

2.1 Diagnosis of episodic cluster headache

AND

2.2 Patient is 18 years of age or older

AND

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

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

Product Name	Generic Name	GPI	Brand/Generic
EMGALITY	GALCANEZUMAB-GNLM SUBCUTANEOUS SOLN AUTO-INJECTOR 120 MG/ML	6770203530D520	Brand
EMGALITY	GALCANEZUMAB-GNLM SUBCUTANEOUS SOLN PREFILLED SYR 100 MG/ML	6770203530E515	Brand
EMGALITY	GALCANEZUMAB-GNLM SUBCUTANEOUS SOLN PREFILLED SYR 120 MG/ML	6770203530E520	Brand

Approval Criteria

1 - History of Emgality for at least 90 days within the past 120 days, confirmed by claims history or chart documentation

AND

2 - ONE of the following:

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

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

Product Name	Generic Name	GPI	Brand/Generic
NURTEC	RIMEGEPANT SULFATE TAB DISINT 75 MG	67701060707220	Brand

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of migraine with or without aura requiring acute treatment

AND

1.2 Patient is 18 years of age or older

AND

1.3 ONE of the following:

- Previous trial and failure of one triptan agent
- Medical justification for use over triptan agents

OR

2 - ALL of the following:

2.1 Diagnosis of episodic migraine requiring prophylaxis

AND

2.2 Patient is 18 years of age or older

AND

2.3 ONE of the following:

2.3.1 Greater than or equal to 60 days of therapy with TWO of the following preferred injectable prophylaxis agents:

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

OR

2.3.2 Medical justification for use over ALL of the following preferred injectable prophylaxis agents:

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

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

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

Product Name	Generic Name	GPI	Brand/Generic
NURTEC	RIMEGEPANT SULFATE TAB DISINT 75 MG	67701060707220	Brand

Approval Criteria

1 - All of the following:

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

AND

1.2 History of Nurtec ODT within the past 90 days, confirmed by claims history or chart documentation

AND

1.3 ONE of the following:

- Prior history of at least one triptan agent
- Medical justification for use over triptan agents

OR

2 - All of the following:

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

AND

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

AND

2.3 ONE of the following:

- Prior history of at least one preferred* injectable prophylaxis agent
- Medical justification for use over preferred* injectable prophylaxis agents

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

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

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 - All of the following:

1.1 Diagnosis of episodic migraine requiring prophylaxis

AND

1.2 Patient is 18 years of age or older

AND

1.3 ONE of the following:

1.3.1 Greater than or equal to 60 days of therapy with TWO of the following preferred injectable prophylaxis agents:

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

OR

1.3.2 Medical justification for use over ALL of the following preferred injectable prophylaxis agents:

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

OR

2 - All of the following:

2.1 Diagnosis of migraine with or without aura requiring prophylaxis

AND

2.2 Patient is 18 years of age or older

AND

2.3 ONE of the following:

2.3.1 Greater than or equal to 60 days of therapy with TWO of the following preferred injectable prophylaxis agents:

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

OR

2.3.2 Medical justification for use over ALL of the following preferred injectable prophylaxis agents:

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

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

Product Name: Qulipta	
Approval Length	1 year(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 - History of Qulipta for at least 90 days within the past 120 days, confirmed by claims history or chart documentation

AND

2 - ONE of the following:

- Prior history of at least one preferred* injectable prophylaxis agent
- Medical justification for use over preferred* injectable prophylaxis agents

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

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

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 - Diagnosis of migraine with or without aura requiring acute treatment

AND

2 - Patient is 18 years of age or older

AND

3 - ONE of the following:

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

AND

4 - One of the following:

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

OR

4.2 BOTH of the following:

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

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

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

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 - History of Reyvow within the past 90 days, confirmed by claims history or chart documentation

AND

2 - ONE of the following:

- Prior history of ALL preferred* acute migraine treatments
- Medical justification for use over ALL preferred* acute migraine treatments

AND

3 - One of the following:

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

OR

3.2 BOTH of the following:

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

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

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

Product Name	Generic Name	GPI	Brand/Generic
UBRELVY	UBROGEPANT TAB 50 MG	67701080000320	Brand
UBRELVY	UBROGEPANT TAB 100 MG	67701080000340	Brand

Approval Criteria

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

AND

2 - Patient is 18 years of age or older

AND

3 - ONE of the following:

- Previous trial and failure of one triptan agent
- Medical justification for use over triptan agents

Product Name: Ubrelvy	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
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 - History of Ubrelvy within the past 90 days, confirmed by claims history or chart documentation

AND

2 - ONE of the following:

- Prior history of at least one triptan agent
- Medical justification for use over triptan agents

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

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

Product Name	Generic Name	GPI	Brand/Generic
ELYXYB	CELECOXIB ORAL SOLN 120 MG/4.8ML (25 MG/ML)	67604030002020	Brand

Approval Criteria

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

AND

2 - Patient is 18 years of age or older

AND

3 - ONE of the following:

- Previous trial and failure of one triptan agent
- Medical justification for use over triptan agents

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

Product Name	Generic Name	GPI	Brand/Generic

ELYXYB	CELECOXIB ORAL SOLN 120 MG/4.8ML (25 MG/ML)	67604030002020	Brand

Approval Criteria

1 - History of Elyxyb within the past 90 days, confirmed by claims history or chart documentation

Product Name: Zavzpret	
Approval Length	1 year(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 - Diagnosis of migraine with or without aura requiring acute treatment

AND

2 - Patient is 18 years of age or older

AND

3 - ONE of the following:

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

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

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

Product Name	Generic Name	GPI	Brand/Generic
ZAVZPRET	ZAVEGEPANT HCL NASAL SPRAY 10 MG/ACT	67701090202020	Brand

Approval Criteria

1 - History of Zavzpret within the past 90 days, confirmed by claims history or chart documentation

AND

2 - One of the following:

- Prior history of ALL preferred* acute migraine treatments
- Medical justification for use over ALL preferred* acute migraine treatments

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

2 . Revision History

Date	Notes
9/17/2024	Updated T/F language on Aimovig, Ajovy, Emgality, Nurtec and Qulipta

Antiseizure Agents

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-161925
Guideline Name	Antiseizure Agents
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2025

1 . Criteria

Product Name: Briviact tab/soln, Brand Valium tab, Brand Diazepam inj, Brand Onfi tab/susp, generic carbamazepine susp, generic carbamazepine ER cap/tab, Brand Depakote DR/ER tablet, Aptiom, Brand Zarontin caps/soln, generic felbamate tab/soln, Brand Neurontin soln, Brand Gabapentin Tinytabs, generic lacosamide soln, Brand Vimpat tab/soln, Brand Lamictal tab/ODT/starter packs, Brand Lamictal XR, Libervant, Brand Keppra tab/soln, Brand Keppra XR tab, Brand Trileptal tab, Brand Fycompa, Brand Phenytek caps, Brand Mysoline, generic rufinamide tab/susp, Brand Banzel tab/susp, generic tiagabine, Brand Topamax tab, Brand Topamax sprinkle, generic topiramate ER cap (sprinkle), Brand Trokendi XR, Brand Sabril tablets, generic vigabatrin, Vigadrone tablets, Xcopri, Brand Zonegran, Brand Spritam, generic pregabalin	
Diagnosis	Non-Preferred*
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
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
VALIUM	DIAZEPAM TAB 2 MG	57100040000305	Brand
VALIUM	DIAZEPAM TAB 5 MG	57100040000310	Brand
VALIUM	DIAZEPAM TAB 10 MG	57100040000315	Brand
DIAZEPAM	DIAZEPAM INJ 5 MG/ML	57100040002010	Brand
ONFI	CLOBAZAM TAB 10 MG	72100007000310	Brand
ONFI	CLOBAZAM TAB 20 MG	72100007000320	Brand
ONFI	CLOBAZAM SUSPENSION 2.5 MG/ML	72100007001830	Brand
CARBAMAZEPINE	CARBAMAZEPINE SUSP 100 MG/5ML	72600020001810	Generic
CARBATROL	CARBAMAZEPINE CAP ER 12HR 100 MG	72600020006910	Brand
CARBAMAZEPINE ER	CARBAMAZEPINE CAP ER 12HR 100 MG	72600020006910	Generic
CARBATROL	CARBAMAZEPINE CAP ER 12HR 200 MG	72600020006920	Brand
CARBAMAZEPINE ER	CARBAMAZEPINE CAP ER 12HR 200 MG	72600020006920	Generic
CARBATROL	CARBAMAZEPINE CAP ER 12HR 300 MG	72600020006930	Brand
CARBAMAZEPINE ER	CARBAMAZEPINE CAP ER 12HR 300 MG	72600020006930	Generic
CARBAMAZEPINE ER	CARBAMAZEPINE TAB ER 12HR 100 MG	72600020007410	Generic
CARBAMAZEPINE ER	CARBAMAZEPINE TAB ER 12HR 200 MG	72600020007420	Generic
CARBAMAZEPINE ER	CARBAMAZEPINE TAB ER 12HR 400 MG	72600020007440	Generic
DEPAKOTE	DIVALPROEX SODIUM TAB DELAYED RELEASE 125 MG	72500010100605	Brand
DEPAKOTE	DIVALPROEX SODIUM TAB DELAYED RELEASE 250 MG	72500010100610	Brand
DEPAKOTE	DIVALPROEX SODIUM TAB DELAYED RELEASE 500 MG	72500010100615	Brand
DEPAKOTE ER	DIVALPROEX SODIUM TAB ER 24 HR 250 MG	72500010107520	Brand
DEPAKOTE ER	DIVALPROEX SODIUM TAB ER 24 HR 500 MG	72500010107530	Brand
ZARONTIN	ETHOSUXIMIDE CAP 250 MG	72400010000105	Brand

ZARONTIN	ETHOSUXIMIDE SOLN 250 MG/5ML	72400010002005	Brand
FELBAMATE	FELBAMATE TAB 400 MG	72120020000310	Generic
FELBAMATE	FELBAMATE TAB 600 MG	72120020000320	Generic
FELBAMATE	FELBAMATE SUSP 600 MG/5ML	72120020001810	Generic
GABAPENTIN TINYTABS	GABAPENTIN TAB 25 MG	72600030000303	Brand
GABAPENTIN TINYTABS	GABAPENTIN TAB 50 MG	72600030000305	Brand
NEURONTIN	GABAPENTIN ORAL SOLN 250 MG/5ML	72600030002020	Brand
VIMPAT	LACOSAMIDE TAB 50 MG	72600036000320	Brand
VIMPAT	LACOSAMIDE TAB 100 MG	72600036000330	Brand
VIMPAT	LACOSAMIDE TAB 150 MG	72600036000340	Brand
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
LAMICTAL	LAMOTRIGINE TAB 25 MG	72600040000310	Brand
LAMICTAL	LAMOTRIGINE TAB 100 MG	72600040000330	Brand
LAMICTAL	LAMOTRIGINE TAB 150 MG	72600040000335	Brand
LAMICTAL	LAMOTRIGINE TAB 200 MG	72600040000340	Brand
LAMICTAL STARTER/TAKING VALPROATE	LAMOTRIGINE TAB 35 X 25 MG STARTER KIT	72600040006420	Brand
LAMICTAL	LAMOTRIGINE TAB 25 MG	72600040000310	Brand
LAMICTAL	LAMOTRIGINE TAB 100 MG	72600040000330	Brand
LAMICTAL	LAMOTRIGINE TAB 150 MG	72600040000335	Brand
LAMICTAL	LAMOTRIGINE TAB 200 MG	72600040000340	Brand
LAMICTAL STARTER/TAKING VALPROATE	LAMOTRIGINE TAB 35 X 25 MG STARTER KIT	72600040006420	Brand
LAMICTAL STARTER/NOT TAKING CARBAMAZEPINE	LAMOTRIGINE TAB 25 MG (42) & 100 MG (7) STARTER KIT	72600040006430	Brand
LAMICTAL STARTER/TAKING CARBAMAZEPINE/NOT TAKING VALPROATE	LAMOTRIGINE TAB 84 X 25 MG & 14 X 100 MG STARTER KIT	72600040006435	Brand

LAMICTAL ODT	LAMOTRIGINE TAB DISINT 21 X 25 MG & 7 X 50 MG TITRATION KIT	72600040006450	Brand
LAMICTAL ODT	LAMOTRIGINE TAB DISINT 42 X 50MG & 14 X 100MG TITRATION KIT	72600040006455	Brand
LAMICTAL ODT	LAMOTRIGINE TAB DISINT 25 (14) & 50 MG (14) & 100 MG (7) KIT	72600040006460	Brand
LAMICTAL ODT	LAMOTRIGINE ORALLY DISINTEGRATING TAB 25 MG	72600040007225	Brand
LAMICTAL ODT	LAMOTRIGINE ORALLY DISINTEGRATING TAB 50 MG	72600040007230	Brand
LAMICTAL ODT	LAMOTRIGINE ORALLY DISINTEGRATING TAB 100 MG	72600040007240	Brand
LAMICTAL ODT	LAMOTRIGINE ORALLY DISINTEGRATING TAB 200 MG	72600040007250	Brand
LAMICTAL XR	LAMOTRIGINE TAB ER 24HR 25 MG	72600040007510	Brand
LAMICTAL XR	LAMOTRIGINE TAB ER 24HR 50 MG	72600040007520	Brand
LAMICTAL XR	LAMOTRIGINE TAB ER 24HR 100 MG	72600040007530	Brand
LAMICTAL XR	LAMOTRIGINE TAB ER 24HR 200 MG	72600040007540	Brand
LAMICTAL XR	LAMOTRIGINE TAB ER 24HR 250 MG	72600040007545	Brand
LAMICTAL XR	LAMOTRIGINE TAB ER 24HR 300 MG	72600040007550	Brand
KEPPRA	LEVETIRACETAM TAB 250 MG	72600043000320	Brand
KEPPRA	LEVETIRACETAM TAB 500 MG	72600043000330	Brand
KEPPRA	LEVETIRACETAM TAB 750 MG	72600043000340	Brand
KEPPRA	LEVETIRACETAM TAB 1000 MG	72600043000350	Brand
KEPPRA	LEVETIRACETAM ORAL SOLN 100 MG/ML	72600043002020	Brand
KEPPRA XR	LEVETIRACETAM TAB ER 24HR 500 MG	72600043007520	Brand
KEPPRA XR	LEVETIRACETAM TAB ER 24HR 750 MG	72600043007530	Brand
TRILEPTAL	OXCARBAZEPINE TAB 150 MG	72600046000310	Brand
TRILEPTAL	OXCARBAZEPINE TAB 300 MG	72600046000320	Brand
TRILEPTAL	OXCARBAZEPINE TAB 600 MG	72600046000340	Brand
TRILEPTAL	OXCARBAZEPINE TAB 150 MG	72600046000310	Brand
TRILEPTAL	OXCARBAZEPINE TAB 300 MG	72600046000320	Brand
TRILEPTAL	OXCARBAZEPINE TAB 600 MG	72600046000340	Brand
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
PHENYTEK	PHENYTOIN SODIUM EXTENDED CAP 200 MG	72200030200120	Brand
PHENYTEK	PHENYTOIN SODIUM EXTENDED CAP 300 MG	72200030200130	Brand
MYSOLINE	PRIMIDONE TAB 50 MG	72600060000305	Brand
MYSOLINE	PRIMIDONE TAB 250 MG	72600060000310	Brand
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
TIAGABINE HYDROCHLORIDE	TIAGABINE HCL TAB 2 MG	72170070100302	Generic
TIAGABINE HYDROCHLORIDE	TIAGABINE HCL TAB 4 MG	72170070100305	Generic
TIAGABINE HYDROCHLORIDE	TIAGABINE HCL TAB 12 MG	72170070100315	Generic
TIAGABINE HYDROCHLORIDE	TIAGABINE HCL TAB 16 MG	72170070100320	Generic
TOPIRAMATE ER	TOPIRAMATE CAP ER 24HR SPRINKLE 25 MG	7260007500F310	Generic
TOPIRAMATE ER	TOPIRAMATE CAP ER 24HR SPRINKLE 50 MG	7260007500F320	Generic
TOPIRAMATE ER	TOPIRAMATE CAP ER 24HR SPRINKLE 100 MG	7260007500F330	Generic
TOPIRAMATE ER	TOPIRAMATE CAP ER 24HR SPRINKLE 150 MG	7260007500F340	Generic
TOPIRAMATE ER	TOPIRAMATE CAP ER 24HR SPRINKLE 200 MG	7260007500F350	Generic
TOPAMAX	TOPIRAMATE TAB 25 MG	72600075000310	Brand
TOPAMAX	TOPIRAMATE TAB 50 MG	72600075000320	Brand
TOPAMAX	TOPIRAMATE TAB 100 MG	72600075000330	Brand
TOPAMAX	TOPIRAMATE TAB 200 MG	72600075000340	Brand
TOPAMAX SPRINKLE	TOPIRAMATE SPRINKLE CAP 15 MG	72600075006820	Brand

TOPAMAX SPRINKLE	TOPIRAMATE SPRINKLE CAP 25 MG	72600075006830	Brand
TROKENDI XR	TOPIRAMATE CAP ER 24HR 25 MG	72600075007020	Brand
TROKENDI XR	TOPIRAMATE CAP ER 24HR 50 MG	72600075007030	Brand
TROKENDI XR	TOPIRAMATE CAP ER 24HR 100 MG	72600075007040	Brand
TROKENDI XR	TOPIRAMATE CAP ER 24HR 200 MG	72600075007050	Brand
SABRIL	VIGABATRIN TAB 500 MG	72170085000320	Brand
VIGABATRIN	VIGABATRIN TAB 500 MG	72170085000320	Generic
VIGABATRIN	VIGABATRIN POWD PACK 500 MG	72170085003020	Generic
ZONEGRAN	ZONISAMIDE CAP 25 MG	72600090000105	Brand
ZONEGRAN	ZONISAMIDE CAP 100 MG	72600090000120	Brand
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
SPRITAM	LEVETIRACETAM TAB DISINTEGRATING SOLUBLE 250 MG	7260004300G820	Brand
SPRITAM	LEVETIRACETAM TAB DISINTEGRATING SOLUBLE 500 MG	7260004300G830	Brand
SPRITAM	LEVETIRACETAM TAB DISINTEGRATING SOLUBLE 750 MG	7260004300G840	Brand
SPRITAM	LEVETIRACETAM TAB DISINTEGRATING SOLUBLE 1000 MG	7260004300G850	Brand
PREGABALIN	PREGABALIN CAP 25 MG	72600057000110	Generic
PREGABALIN	PREGABALIN CAP 50 MG	72600057000115	Generic
PREGABALIN	PREGABALIN CAP 75 MG	72600057000120	Generic
PREGABALIN	PREGABALIN CAP 100 MG	72600057000125	Generic
PREGABALIN	PREGABALIN CAP 150 MG	72600057000135	Generic
PREGABALIN	PREGABALIN CAP 200 MG	72600057000145	Generic
PREGABALIN	PREGABALIN CAP 225 MG	72600057000150	Generic
PREGABALIN	PREGABALIN CAP 300 MG	72600057000160	Generic
PREGABALIN	PREGABALIN SOLN 20 MG/ML	72600057002020	Generic
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	72120010000B725	Brand
XCOPRI	CENOBAMATE TAB TITRATION PACK 14 X 150 MG & 14 X 200 MG	72120010000B730	Brand
XCOPRI	CENOBAMATE TAB PACK 100 MG & 150 MG TABS (250 MG DAILY DOSE)	72120010000B738	Brand
XCOPRI	CENOBAMATE TAB PACK 150 MG & 200 MG TABS (350 MG DAILY DOSE)	72120010000B740	Brand
XCOPRI	CENOBAMATE TAB 25 MG	72120010000310	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
LIBERVANT	DIAZEPAM BUCCAL FILM 5 MG	72100030008210	Brand
LIBERVANT	DIAZEPAM BUCCAL FILM 7.5 MG	72100030008215	Brand
LIBERVANT	DIAZEPAM BUCCAL FILM 10 MG	72100030008220	Brand
LIBERVANT	DIAZEPAM BUCCAL FILM 12.5 MG	72100030008225	Brand
LIBERVANT	DIAZEPAM BUCCAL FILM 15 MG	72100030008230	Brand
VIGADRONE	VIGABATRIN TAB 500 MG	72170085000320	Generic

Approval Criteria

1 - BOTH of the following:

1.1 Diagnosis of seizure disorder

AND

1.2 History of a preferred* antiseizure medication for at least 14 days in the past 90 days

OR

2 - For a non-seizure diagnosis ONE of the following:

2.1 History of one preferred* antiseizure medication

OR

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

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

Product Name: Briviact tab/soln, Brand Valium tab, Brand Diazepam inj, Brand Onfi tab/susp, generic carbamazepine susp, generic carbamazepine ER cap/tab, Brand Depakote DR/ER tablet, Aptiom, Brand Zarontin caps/soln, generic felbamate tab/soln, Brand Neurontin soln, Brand Gabapentin Tinytabs, generic lacosamide soln, Brand Vimpat tab/soln, Brand Lamictal tab/ODT/starter packs, Brand Lamictal XR, Libervant, Brand Keppra tab/soln, Brand Keppra XR tab, Brand Trileptal tab, Brand Fycompa, Brand Phenytek caps, Brand Mysoline, generic rufinamide tab/susp, Brand Banzel tab/susp, generic tiagabine, Brand Topamax tab, Brand Topamax sprinkle, generic topiramate ER cap (sprinkle), Brand Trokendi XR, Brand Sabril tablets, generic vigabatrin, Vigadrone tablets, Xcopri, Brand Zonegran, Brand Spritam, generic pregabalin

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

Product Name	Generic Name	GPI	Brand/Generic
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
VALIUM	DIAZEPAM TAB 2 MG	57100040000305	Brand
VALIUM	DIAZEPAM TAB 5 MG	57100040000310	Brand
VALIUM	DIAZEPAM TAB 10 MG	57100040000315	Brand
DIAZEPAM	DIAZEPAM INJ 5 MG/ML	57100040002010	Brand
ONFI	CLOBAZAM TAB 10 MG	72100007000310	Brand

ONFI	CLOBAZAM TAB 20 MG	72100007000320	Brand
ONFI	CLOBAZAM SUSPENSION 2.5 MG/ML	72100007001830	Brand
CARBAMAZEPINE	CARBAMAZEPINE SUSP 100 MG/5ML	72600020001810	Generic
CARBATROL	CARBAMAZEPINE CAP ER 12HR 100 MG	72600020006910	Brand
CARBAMAZEPINE ER	CARBAMAZEPINE CAP ER 12HR 100 MG	72600020006910	Generic
CARBATROL	CARBAMAZEPINE CAP ER 12HR 200 MG	72600020006920	Brand
CARBAMAZEPINE ER	CARBAMAZEPINE CAP ER 12HR 200 MG	72600020006920	Generic
CARBATROL	CARBAMAZEPINE CAP ER 12HR 300 MG	72600020006930	Brand
CARBAMAZEPINE ER	CARBAMAZEPINE CAP ER 12HR 300 MG	72600020006930	Generic
CARBAMAZEPINE ER	CARBAMAZEPINE TAB ER 12HR 100 MG	72600020007410	Generic
CARBAMAZEPINE ER	CARBAMAZEPINE TAB ER 12HR 200 MG	72600020007420	Generic
CARBAMAZEPINE ER	CARBAMAZEPINE TAB ER 12HR 400 MG	72600020007440	Generic
DEPAKOTE	DIVALPROEX SODIUM TAB DELAYED RELEASE 125 MG	72500010100605	Brand
DEPAKOTE	DIVALPROEX SODIUM TAB DELAYED RELEASE 250 MG	72500010100610	Brand
DEPAKOTE	DIVALPROEX SODIUM TAB DELAYED RELEASE 500 MG	72500010100615	Brand
DEPAKOTE ER	DIVALPROEX SODIUM TAB ER 24 HR 250 MG	72500010107520	Brand
DEPAKOTE ER	DIVALPROEX SODIUM TAB ER 24 HR 500 MG	72500010107530	Brand
ZARONTIN	ETHOSUXIMIDE CAP 250 MG	72400010000105	Brand
ZARONTIN	ETHOSUXIMIDE SOLN 250 MG/5ML	72400010002005	Brand
FELBAMATE	FELBAMATE TAB 400 MG	72120020000310	Generic
FELBAMATE	FELBAMATE TAB 600 MG	72120020000320	Generic
FELBAMATE	FELBAMATE SUSP 600 MG/5ML	72120020001810	Generic
GABAPENTIN TINYTABS	GABAPENTIN TAB 25 MG	72600030000303	Brand
GABAPENTIN TINYTABS	GABAPENTIN TAB 50 MG	72600030000305	Brand
NEURONTIN	GABAPENTIN ORAL SOLN 250 MG/5ML	72600030002020	Brand
VIMPAT	LACOSAMIDE TAB 50 MG	72600036000320	Brand
VIMPAT	LACOSAMIDE TAB 100 MG	72600036000330	Brand
VIMPAT	LACOSAMIDE TAB 150 MG	72600036000340	Brand
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
LAMICTAL	LAMOTRIGINE TAB 25 MG	72600040000310	Brand
LAMICTAL	LAMOTRIGINE TAB 100 MG	72600040000330	Brand
LAMICTAL	LAMOTRIGINE TAB 150 MG	72600040000335	Brand
LAMICTAL	LAMOTRIGINE TAB 200 MG	72600040000340	Brand
LAMICTAL STARTER/TAKING VALPROATE	LAMOTRIGINE TAB 35 X 25 MG STARTER KIT	72600040006420	Brand
LAMICTAL	LAMOTRIGINE TAB 25 MG	72600040000310	Brand
LAMICTAL	LAMOTRIGINE TAB 100 MG	72600040000330	Brand
LAMICTAL	LAMOTRIGINE TAB 150 MG	72600040000335	Brand
LAMICTAL	LAMOTRIGINE TAB 200 MG	72600040000340	Brand
LAMICTAL STARTER/TAKING VALPROATE	LAMOTRIGINE TAB 35 X 25 MG STARTER KIT	72600040006420	Brand
LAMICTAL STARTER/NOT TAKING CARBAMAZEPINE	LAMOTRIGINE TAB 25 MG (42) & 100 MG (7) STARTER KIT	72600040006430	Brand
LAMICTAL STARTER/TAKING CARBAMAZEPINE/NOT TAKING VALPROATE	LAMOTRIGINE TAB 84 X 25 MG & 14 X 100 MG STARTER KIT	72600040006435	Brand
LAMICTAL ODT	LAMOTRIGINE TAB DISINT 21 X 25 MG & 7 X 50 MG TITRATION KIT	72600040006450	Brand
LAMICTAL ODT	LAMOTRIGINE TAB DISINT 42 X 50MG & 14 X 100MG TITRATION KIT	72600040006455	Brand
LAMICTAL ODT	LAMOTRIGINE TAB DISINT 25 (14) & 50 MG (14) & 100 MG (7) KIT	72600040006460	Brand
LAMICTAL ODT	LAMOTRIGINE ORALLY DISINTEGRATING TAB 25 MG	72600040007225	Brand
LAMICTAL ODT	LAMOTRIGINE ORALLY DISINTEGRATING TAB 50 MG	72600040007230	Brand
LAMICTAL ODT	LAMOTRIGINE ORALLY DISINTEGRATING TAB 100 MG	72600040007240	Brand
LAMICTAL ODT	LAMOTRIGINE ORALLY DISINTEGRATING TAB 200 MG	72600040007250	Brand
LAMICTAL XR	LAMOTRIGINE TAB ER 24HR 25 MG	72600040007510	Brand
LAMICTAL XR	LAMOTRIGINE TAB ER 24HR 50 MG	72600040007520	Brand
LAMICTAL XR	LAMOTRIGINE TAB ER 24HR 100 MG	72600040007530	Brand

LAMICTAL XR	LAMOTRIGINE TAB ER 24HR 200 MG	72600040007540	Brand
LAMICTAL XR	LAMOTRIGINE TAB ER 24HR 250 MG	72600040007545	Brand
LAMICTAL XR	LAMOTRIGINE TAB ER 24HR 300 MG	72600040007550	Brand
KEPPRA	LEVETIRACETAM TAB 250 MG	72600043000320	Brand
KEPPRA	LEVETIRACETAM TAB 500 MG	72600043000330	Brand
KEPPRA	LEVETIRACETAM TAB 750 MG	72600043000340	Brand
KEPPRA	LEVETIRACETAM TAB 1000 MG	72600043000350	Brand
KEPPRA	LEVETIRACETAM ORAL SOLN 100 MG/ML	72600043002020	Brand
KEPPRA XR	LEVETIRACETAM TAB ER 24HR 500 MG	72600043007520	Brand
KEPPRA XR	LEVETIRACETAM TAB ER 24HR 750 MG	72600043007530	Brand
TRILEPTAL	OXCARBAZEPINE TAB 150 MG	72600046000310	Brand
TRILEPTAL	OXCARBAZEPINE TAB 300 MG	72600046000320	Brand
TRILEPTAL	OXCARBAZEPINE TAB 600 MG	72600046000340	Brand
TRILEPTAL	OXCARBAZEPINE TAB 150 MG	72600046000310	Brand
TRILEPTAL	OXCARBAZEPINE TAB 300 MG	72600046000320	Brand
TRILEPTAL	OXCARBAZEPINE TAB 600 MG	72600046000340	Brand
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
PHENYTEK	PHENYTOIN SODIUM EXTENDED CAP 200 MG	72200030200120	Brand
PHENYTEK	PHENYTOIN SODIUM EXTENDED CAP 300 MG	72200030200130	Brand
MYSOLINE	PRIMIDONE TAB 50 MG	72600060000305	Brand
MYSOLINE	PRIMIDONE TAB 250 MG	72600060000310	Brand
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
TIAGABINE HYDROCHLORIDE	TIAGABINE HCL TAB 2 MG	72170070100302	Generic
TIAGABINE HYDROCHLORIDE	TIAGABINE HCL TAB 4 MG	72170070100305	Generic
TIAGABINE HYDROCHLORIDE	TIAGABINE HCL TAB 12 MG	72170070100315	Generic
TIAGABINE HYDROCHLORIDE	TIAGABINE HCL TAB 16 MG	72170070100320	Generic
TOPIRAMATE ER	TOPIRAMATE CAP ER 24HR SPRINKLE 25 MG	7260007500F310	Generic
TOPIRAMATE ER	TOPIRAMATE CAP ER 24HR SPRINKLE 50 MG	7260007500F320	Generic
TOPIRAMATE ER	TOPIRAMATE CAP ER 24HR SPRINKLE 100 MG	7260007500F330	Generic
TOPIRAMATE ER	TOPIRAMATE CAP ER 24HR SPRINKLE 150 MG	7260007500F340	Generic
TOPIRAMATE ER	TOPIRAMATE CAP ER 24HR SPRINKLE 200 MG	7260007500F350	Generic
TOPAMAX	TOPIRAMATE TAB 25 MG	72600075000310	Brand
TOPAMAX	TOPIRAMATE TAB 50 MG	72600075000320	Brand
TOPAMAX	TOPIRAMATE TAB 100 MG	72600075000330	Brand
TOPAMAX	TOPIRAMATE TAB 200 MG	72600075000340	Brand
TOPAMAX SPRINKLE	TOPIRAMATE SPRINKLE CAP 15 MG	72600075006820	Brand
TOPAMAX SPRINKLE	TOPIRAMATE SPRINKLE CAP 25 MG	72600075006830	Brand
TROKENDI XR	TOPIRAMATE CAP ER 24HR 25 MG	72600075007020	Brand
TROKENDI XR	TOPIRAMATE CAP ER 24HR 50 MG	72600075007030	Brand
TROKENDI XR	TOPIRAMATE CAP ER 24HR 100 MG	72600075007040	Brand
TROKENDI XR	TOPIRAMATE CAP ER 24HR 200 MG	72600075007050	Brand
SABRIL	VIGABATRIN TAB 500 MG	72170085000320	Brand
VIGABATRIN	VIGABATRIN TAB 500 MG	72170085000320	Generic
VIGABATRIN	VIGABATRIN POWD PACK 500 MG	72170085003020	Generic
ZONEGRAN	ZONISAMIDE CAP 25 MG	72600090000105	Brand
ZONEGRAN	ZONISAMIDE CAP 100 MG	72600090000120	Brand
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
SPRITAM	LEVETIRACETAM TAB DISINTEGRATING SOLUBLE 250 MG	7260004300G820	Brand
SPRITAM	LEVETIRACETAM TAB DISINTEGRATING SOLUBLE 500 MG	7260004300G830	Brand
SPRITAM	LEVETIRACETAM TAB DISINTEGRATING SOLUBLE 750 MG	7260004300G840	Brand
SPRITAM	LEVETIRACETAM TAB DISINTEGRATING SOLUBLE 1000 MG	7260004300G850	Brand
PREGABALIN	PREGABALIN CAP 25 MG	72600057000110	Generic
PREGABALIN	PREGABALIN CAP 50 MG	72600057000115	Generic
PREGABALIN	PREGABALIN CAP 75 MG	72600057000120	Generic
PREGABALIN	PREGABALIN CAP 100 MG	72600057000125	Generic
PREGABALIN	PREGABALIN CAP 150 MG	72600057000135	Generic
PREGABALIN	PREGABALIN CAP 200 MG	72600057000145	Generic
PREGABALIN	PREGABALIN CAP 225 MG	72600057000150	Generic
PREGABALIN	PREGABALIN CAP 300 MG	72600057000160	Generic
PREGABALIN	PREGABALIN SOLN 20 MG/ML	72600057002020	Generic
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 25 MG	72120010000310	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
LIBERVANT	DIAZEPAM BUCCAL FILM 5 MG	72100030008210	Brand
LIBERVANT	DIAZEPAM BUCCAL FILM 7.5 MG	72100030008215	Brand
LIBERVANT	DIAZEPAM BUCCAL FILM 10 MG	72100030008220	Brand

LIBERVANT	DIAZEPAM BUCCAL FILM 12.5 MG	72100030008225	Brand
LIBERVANT	DIAZEPAM BUCCAL FILM 15 MG	72100030008230	Brand
VIGADRONE	VIGABATRIN TAB 500 MG	72170085000320	Generic

Approval Criteria

1 - BOTH of the following:

1.1 Diagnosis of seizure disorder

AND

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

OR

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

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

AND

2.2 ONE of the following:

2.2.1 History of one preferred* antiseizure medication

OR

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

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

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

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

Approval Criteria

1 - Diagnosis of seizure disorder

AND

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

AND

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

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

Product Name	Generic Name	GPI	Brand/Generic
VIGAFYDE	VIGABATRIN ORAL SOLN 100 MG/ML	72170085002020	Brand

Approval Criteria

1 - Diagnosis of seizure disorder

AND

2 - ONE of the following:

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

OR

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

Product Name: Brand Sabril powder packs, Vigadrone powder packs, Vigpoder. Vigafyde	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
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
VIGPODER	VIGABATRIN POWD PACK 500 MG	72170085003020	Generic
VIGAFYDE	VIGABATRIN ORAL SOLN 100 MG/ML	72170085002020	Brand

Approval Criteria

1 - Diagnosis of seizure disorder

AND

2 - Patient has history of the requested medication for 30 of the past 60 days, confirmed by claims history or chart documentation

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

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 - Diagnosis of seizures associated with ONE of the following:

- Dravet Syndrome
- SCN1A (gene) mutation

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

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

Approval Criteria

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

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

OR

2 - BOTH of the following:

2.1 Diagnosis of refractory epilepsy

AND

2.2 ONE of the following:

- Trial and failure of 2 other antiseizure medications
- Medical justification for use of Epidiolex

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

Product Name	Generic Name	GPI	Brand/Generic
EPRONTIA	TOPIRAMATE ORAL SOLN 25 MG/ML	72600075002020	Brand

Approval Criteria

1 - ONE of the following:

1.1 Patient is less than 18 years of age

OR

1.2 BOTH of the following:

1.2.1 Patient is 18 years of age or older

AND

1.2.2 Rationale justifying use over other oral formulations (e.g., capsule, sprinkle capsules, tablets, etc.)

Product Name: Fintepla	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
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 - BOTH of the following:

1.1 Diagnosis of seizures associated with of Dravet syndrome

AND

1.2 ONE of the following:

1.2.1 Trial and failure of Epidiolex and Diacomit

OR

1.2.2 Medical justification for use of Fintepla

OR

2 - BOTH of the following:

2.1 Diagnosis of seizures associated with Lennox-Gastaut syndrome

AND

2.2 ONE of the following:

2.2.1 Trial and failure of Epidiolex

OR

2.2.2 Medical justification for use of Fintepla

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

Product Name	Generic Name	GPI	Brand/Generic
ZONISADE	ZONISAMIDE ORAL SUSP 100 MG/5ML (20 MG/ML)	72600090001820	Brand

Approval Criteria

1 - Patient is less than 18 years of age

OR

2 - BOTH of the following:

2.1 Patient is 18 years of age or older

AND

2.2 Rationale justifying use over other oral formulations (e.g., capsule)

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

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

Approval Criteria

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

AND

2 - ONE of the following:

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

OR

2.2 Medical justification for use of Ztalmy

Product Name: Diacomit, Epidiolex, Fintepla, Ztalmy	
Approval Length	1 year(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
EPIDIOLEX	CANNABIDIOL SOLN 100 MG/ML	72600017002020	Brand
FINTEPLA	FENFLURAMINE HCL ORAL SOLN 2.2 MG/ML	72600028102020	Brand
ZTALMY	GANAXOLONE SUSP 50 MG/ML	72600033001820	Brand
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 - History of the requested medication for 30 of the past 60 days confirmed by claims history or chart documentation

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

Product Name	Generic Name	GPI	Brand/Generic
EPRONTIA	TOPIRAMATE ORAL SOLN 25 MG/ML	72600075002020	Brand
ZONISADE	ZONISAMIDE ORAL SUSP 100 MG/5ML (20 MG/ML)	72600090001820	Brand

Approval Criteria

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

AND

2 - ONE of the following:

2.1 Patient is less than 18 years of age

OR

2.2 BOTH of the following:

2.2.1 Patient is 18 years of age or older

AND

2.2.2 Rationale justifying use over other oral formulations (e.g., capsule, sprinkle capsules, tablets, etc.)

2 . Revision History

Date	Notes
12/12/2024	Added Libervant, Vigadrone tabs, Vigpoder and Vigafyde, Xcopri. Clarified heading of second criteria box and added PDL link. Added specific criteria for brand Sabril powder packets, Vigadrone, Vigpoder and Vigafyde. Corrected spelling of Gastaut in Fintepla initial auth section.

Antiulcer Agents

Optum Rx®

Prior Authorization Guideline

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

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Brand Carafate suspension	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CARAFATE	SUCRALFATE SUSP 1 GM/10ML	49300010001820	Brand

Approval Criteria

1 - BOTH of the following:

1.1 Patient is 1 year of age or older

AND **1.2** Patient is less than 12 years of age **OR** **2** - Patient is unable to swallow tablets

2 . Revision History

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

Antiviral Monoclonal Antibodies

Optum Rx®

Prior Authorization Guideline

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

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name: Synagis*	
Diagnosis	Patients less than 12 months of age at start of RSV season
Guideline Type	Prior Authorization

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 Patient was born before 29 weeks, 0 days' gestation

OR

1.2 BOTH of the following:

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

OR

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

OR

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

OR

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

OR

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

OR

1.7 BOTH of the following:

- Patient was born before 32 weeks, 0 days' gestation
- Patient required at least 28 days of supplemental oxygen after birth and continued to require supplemental oxygen, chronic systemic corticosteroid therapy, diuretic, or bronchodilator therapy within 6 months of the start of the second RSV season

OR

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

AND

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

AND

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

AND

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

AND

5 - Administered during RSV season

AND

6 - The patient is not hospitalized for RSV disease

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

Product Name: Synagis*	
Diagnosis	Patients less than 24 months of age at start of RSV season
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 The patient is or will be considered to be profoundly immunocompromised (Submission of chart notes or medical records that explicitly state how the member is or will be considered to be profoundly immunocompromised during the RSV season is required), including members undergoing cardiac transplantation during current RSV season

OR

1.2 BOTH of the following:

- Patient was born before 32 weeks, 0 days' gestation
- Patient required at least 28 days of supplemental oxygen after birth and continued to require supplemental oxygen, chronic systemic corticosteroid therapy, diuretic, or bronchodilator therapy within 6 months of the start of the second RSV season

OR

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

AND

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

AND **3** - Patient has not received Beyfortus (nirsevimas) within the same RSV season **AND** **4** - The number of doses requested do not exceed a maximum quantity of 5 per season **AND** **5** - Administered during RSV season **AND** **6** - The patient is not hospitalized for RSV disease	
Notes	*Approval duration will be up to a maximum of 5 doses or through the end of the defined RSV season, whichever comes first.

2 . Revision History

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

Antivirals - Anti-herpetic

Optum Rx®

Prior Authorization Guideline

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

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

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

Product Name	Generic Name	GPI	Brand/Generic
VALACYCLOVIR HYDROCHLORIDE	VALACYCLOVIR HCL TAB 500 MG	12405085100310	Generic
VALACYCLOVIR HYDROCHLORIDE	VALACYCLOVIR HCL TAB 1 GM	12405085100320	Generic
VALACYCLOVIR HCL	VALACYCLOVIR HCL TAB 1 GM	12405085100320	Generic

Approval Criteria

1 - Patient has a diagnosis of HIV **OR** **2** - Patient has tried and failed acyclovir **OR** **3** - Medical justification for use over acyclovir

2 . Revision History

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

Antivirals, Influenza

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-125099
Guideline Name	Antivirals, Influenza
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	7/1/2023

1 . Criteria

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

Product Name	Generic Name	GPI	Brand/Generic
RIMANTADINE HYDROCHLORIDE	RIMANTADINE HYDROCHLORIDE TAB 100 MG	12500070100320	Generic

Approval Criteria

1 - One of the following:

1.1 Patient is under 60 years of age and one of the following*:

1.1.1 History of failure to at least THREE preferred alternatives as confirmed by claims history or submission of medical records.** NOTE: In instances where there are fewer than three preferred alternatives, the patient must have a history of failure to all of the preferred products **OR** **1.1.2** History of contraindication or intolerance to THREE preferred alternatives (please specify contraindication or intolerance).** NOTE: In instances where there are fewer than three preferred alternatives, the patient must have a history of contraindication or intolerance to all of the preferred products **OR** **1.2** Patient is 60 years of age and older	
Notes	*This criteria comes from the Non-Preferred Drugs Policy. **PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

2 . Revision History

Date	Notes
4/27/2023	New guideline

Apokyn

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-127856
Guideline Name	Apokyn
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	9/1/2023

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

Arikayce

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-123310
Guideline Name	Arikayce
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	5/1/2023

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

2 . Revision History

Date	Notes
3/16/2023	Copy NY

Augtyro

Prior Authorization Guideline

Guideline ID	GL-155870
Guideline Name	Augtyro
Formulary	• Medicaid - Community & State Indiana

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.

Ayvakit

Prior Authorization Guideline

Guideline ID	GL-156204
Guideline Name	Ayvakit
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	11/1/2024

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
9/25/2024	Updated wording of systemic mastocytosis criteria per NCCN without change to clinical intent.

Balversa

Prior Authorization Guideline

Guideline ID	GL-151777
Guideline Name	Balversa
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	9/1/2024

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
8/14/2024	emoved coverage for FGFR2 genetic alterations. Added that first line of prior systemic therapy should contain an immune checkpoint inhibitor, if eligible.

Benefit Determination Mifeprex

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-123261
Guideline Name	Benefit Determination Mifeprex
Formulary	• Medicaid - Community & State Florida MMA • Medicaid - Community & State Indiana • Medicaid - Community & State Kansas • Medicaid - Community & State Louisiana • Medicaid - Community & State Michigan • Medicaid - Community & State Mississippi • Medicaid - Community & State Pennsylvania • Medicaid - Community & State Pennsylvania CHIP • Medicaid - Community & State Rhode Island • Medicaid - Community & State Texas • Medicaid - Community & State Virginia • Medicaid - Community & State Arizona • Medicaid - Community & State Nebraska

Guideline Note:

Effective Date:	3/19/2023

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

AND

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

2 . Revision History

Date	Notes
3/15/2023	Added KS and changed GL type to " benefit determination

Benlysta

Prior Authorization Guideline

Guideline ID	GL-128544
Guideline Name	Benlysta
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	10/1/2023

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)

2 . Revision History

Date	Notes
7/24/2023	Updated coverage criteria for SLE removing documentation of the pr esence of antibodies. Updated not used in combination from biologic DMARD to targeted immunomodulator without change in clinical inte nt.

Berinert

Prior Authorization Guideline

Guideline ID	GL-150091
Guideline Name	Berinert
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	8/1/2024

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
7/22/2024	Update to types of genetic variant(s) and diagnostic criteria with nor mal C1 inhibitor levels in initial auth section and minor update in reau th section.

Beta Adrenergic and Anticholinergic Combinations

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-132758
Guideline Name	Beta Adrenergic and Anticholinergic Combinations
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	10/1/2023

1 . Criteria

Product Name: Spiriva Respimat 1.25 mcg	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SPIRIVA RESPIMAT	TIOTROPIUM BROMIDE MONOHYDRATE INHAL AEROSOL 1.25 MCG/ACT	44100080103410	Brand

Approval Criteria

1 - Diagnosis of asthma

Product Name: Spiriva Respimat 2.5 mcg	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SPIRIVA RESPIMAT	TIOTROPIUM BROMIDE MONOHYDRATE INHAL AEROSOL 2.5 MCG/ACT	44100080103420	Brand

Approval Criteria

1 - Trial and failure of Spiriva Handihaler for at least 14 days

2 . Revision History

Date	Notes
9/11/2023	New GL

Beta Adrenergic Blockers

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-144411
Guideline Name	Beta Adrenergic Blockers
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2024

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 - Patient is 5 weeks of age or older AND less than or equal to 1 year of age

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

Product Name	Generic Name	GPI	Brand/Generic
SOTYLIZE	SOTALOL HCL ORAL SOLUTION 5 MG/ML	33100045102070	Brand

Approval Criteria

1 - One of the following:

1.1 Patient is under 12 years of age

OR

1.2 Patient is unable to swallow tablets/capsules

2 . Revision History

Date	Notes
3/14/2024	Updated guideline name. Separated Hemangeol criteria.

Beta Adrenergics and Corticosteroids

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-144247
Guideline Name	Beta Adrenergics and Corticosteroids
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2024

1 . Criteria

Product Name: Trelegy Ellipta	
Approval Length	12 month(s)
Guideline Type	Step Therapy

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

Approval Criteria

1 - All of the following:

1.1 Diagnosis of Asthma

AND

1.2 Patient has tried and failed Advair or Symbicort therapy for at least 90 of the past 120 days

OR

2 - All of the following:

2.1 Diagnosis of COPD

AND

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

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

Product Name	Generic Name	GPI	Brand/Generic
BREZTRI AEROSPHERE	BUDESONIDE-GLYCOPYRROLATE-FORMOTEROL AERS 160-9-4.8 MCG/ACT	44209903303220	Brand

Approval Criteria

1 - Patient has tried and failed Trelegy Ellipta

OR

2 - Patient has contraindication or intolerance to use of Trelegy Ellipta

Product Name: fluticasone/salmeterol (generic Airduo Respiclick)	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
FLUTICASONE PROPIONATE/SALMETEROL	FLUTICASONE-SALMETEROL AER POWDER BA 55-14 MCG/ACT	44209902708010	Generic
FLUTICASONE PROPIONATE/SALMETEROL	FLUTICASONE-SALMETEROL AER POWDER BA 113-14 MCG/ACT	44209902708015	Generic
FLUTICASONE PROPIONATE/SALMETEROL	FLUTICASONE-SALMETEROL AER POWDER BA 232-14 MCG/ACT	44209902708025	Generic

Approval Criteria

1 - Trial of at least 90 days of therapy with Airduo Respiclick

2 . Revision History

Date	Notes
3/13/2024	Removed Advair HFA 230/21 (fluticasone/salmeterol) and Advair Dis kus 500/50 (fluticasone/salmeterol)

Beta-Agonists - Short Acting

Optum Rx®

Prior Authorization Guideline

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

Guideline Note:

Effective Date:	7/1/2023

1 . Criteria

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

Product Name	Generic Name	GPI	Brand/Generic
XOPENEX HFA	LEVALBUTEROL TARTRATE INHAL AEROSOL 45 MCG/ACT (BASE EQUIV)	44201045503220	Generic

Approval Criteria

1 - Patient has tried albuterol HFA in the past 90 days

2 . Revision History

Date	Notes
4/27/2023	New

Biktarvy

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-120162
Guideline Name	Biktarvy
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/15/2023

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
1/13/2023	No clinical changes. Moved from SP to standard formulary.

Biltricide

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-82070
Guideline Name	Biltricide
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2021

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)

2 . Revision History

Date	Notes
3/5/2021	Bulk Load

Bone Formation Stimulating Agents

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-149099
Guideline Name	Bone Formation Stimulating Agents
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

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

Product Name	Generic Name	GPI	Brand/Generic
EVENITY	ROMOSOZUMAB-AQQG INJ SOLN PREFILLED SYRINGE 105 MG/1.17ML	3004486010E520	Brand

Approval Criteria

1 - Patient is 18 years of age or older

AND

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

AND

3 - Diagnosis of osteoporosis

AND

4 - ONE of the following:

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

AND

5 - ONE of the following:

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

AND

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

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

Notes	*Up to 1 year approval duration; approval duration should not exceed t he maximum allowable lifetime duration of 1 year (12 monthly doses) of total therapy with Evenity. **PDL Link: https://www.uhcprovider.com

	/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name: Evenity	
Approval Length	1 Year*
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
EVENITY	ROMOSOZUMAB-AQQG INJ SOLN PREFILLED SYRINGE 105 MG/1.17ML	3004486010E520	Brand

Approval Criteria

1 - History of Evenity (romosozumab) for at least 90 days within the past 120 days, confirmed by claims history or chart documentation

AND

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

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

AND

3 - ONE of the following*:

3.1 Total length of therapy has not exceeded 1 year

OR

3.2 Documentation of a medical rationale for continued use beyond 1 year

Notes	*Up to 1 year approval duration; approval duration should not exceed t he maximum allowable lifetime duration of 1 year (12 monthly doses) of total therapy with Evenity unless medical rationale for continued us e beyond 1 year has been provided.

Product Name: Tymlos	
Approval Length	1 Year*
Therapy Stage	Initial Authorization
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 - Patient is 18 years of age or older

AND

2 - Diagnosis of osteoporosis

AND

3 - ONE of the following:

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

AND

4 - ONE of the following:

- Previous trial and failure of Forteo (teriparatide)

- Documentation of a medical rationale for use over Forteo (teriparatide)

AND

5 - Prescriber attests to BOTH of the following:

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

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

AND

5.2 The patient has NOT undergone prior radiation therapy

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

Product Name: Brand Forteo, generic teriparatide, Brand Teriparatide	
Approval Length	1 Year*
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
FORTEO	TERIPARATIDE (RECOMBINANT) SOLN PEN-INJ 600 MCG/2.4ML	3004407000D220	Brand
TERIPARATIDE	TERIPARATIDE (RECOMBINANT) SOLN PEN-INJ 620 MCG/2.48ML	3004407000D221	Brand
TERIPARATIDE	TERIPARATIDE (RECOMBINANT) SOLN PEN-INJ 600 MCG/2.4ML	3004407000D220	Generic

Approval Criteria

1 - Patient is 18 years of age or older

AND

2 - Diagnosis of osteoporosis

AND

3 - ONE of the following:

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

AND

4 - Prescriber attests to BOTH of the following:

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

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

AND

4.2 The patient has NOT undergone prior radiation therapy

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

Product Name: Brand Forteo, generic teriparatide, Brand Teriparatide, Tymlos

Approval Length	1 Year*
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TYMLOS	ABALOPARATIDE SUBCUTANEOUS SOLN PEN-INJECTOR 3120 MCG/1.56ML	3004400500D230	Brand
FORTEO	TERIPARATIDE (RECOMBINANT) SOLN PEN-INJ 600 MCG/2.4ML	3004407000D220	Brand
TERIPARATIDE	TERIPARATIDE (RECOMBINANT) SOLN PEN-INJ 620 MCG/2.48ML	3004407000D221	Brand
TERIPARATIDE	TERIPARATIDE (RECOMBINANT) SOLN PEN-INJ 600 MCG/2.4ML	3004407000D220	Generic

Approval Criteria

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

AND

2 - Prescriber attests that the patient remains a candidate for treatment, by indicating BOTH of the following:

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

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

AND

2.2 The patient has NOT undergone prior radiation therapy

AND

3 - ONE of the following*: **3.1** Total length of therapy has not exceeded 2 years **OR** **3.2** Documentation of a medical rationale for continued use beyond 2 years	
Notes	*Up to 1 year approval duration; approval duration should not exceed the maximum allowable lifetime duration of 2 years of total combined therapy with Forteo, teriparatide, and/or Tymlos unless medical rationale for continued use beyond 2 years has been provided. **PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

2 . Revision History

Date	Notes
7/1/2024	Updated notes sections, where applicable. Added generic teriparatide as a target. Updated product name list and GPI table, where applicable. Minor cosmetic updates.

Bone Resorption Inhibitors

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-137547
Guideline Name	Bone Resorption Inhibitors
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

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

Product Name	Generic Name	GPI	Brand/Generic
RISEDRONATE SODIUM	RISEDRONATE SODIUM TAB 5 MG	30042065100305	Generic
RISEDRONATE SODIUM	RISEDRONATE SODIUM TAB 30 MG	30042065100320	Generic
RISEDRONATE SODIUM	RISEDRONATE SODIUM TAB 35 MG	30042065100330	Generic
RISEDRONATE SODIUM	RISEDRONATE SODIUM TAB 150 MG	30042065100380	Generic

Approval Criteria

1 - Patient has tried alendronate within the past 90 days

Product Name: alendronate oral solution	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALENDRONATE SODIUM	ALENDRONATE SODIUM ORAL SOLN 70 MG/75ML	30042010102020	Generic

Approval Criteria

1 - BOTH of the following:

1.1 Patient is 5 years of age or older

AND

1.2 Patient is less than 12 years of age

OR

2 - Patient is unable to swallow tablets

Product Name: Brand Miacalcin, generic calcitonin salmon inj	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

CALCITONIN SALMON	CALCITONIN (SALMON) INJ 200 UNIT/ML	30043020002020	Generic
MIACALCIN	CALCITONIN (SALMON) INJ 200 UNIT/ML	30043020002020	Brand

Approval Criteria

1 - Trial and failure of calcitonin-salmon nasal

OR

2 - Medical justification for use

2 . Revision History

Date	Notes
12/11/2023	Updated alendronate soln criteria, updated product name list.

Bosulif

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-147641
Guideline Name	Bosulif
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2024

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

2 . Revision History

Date	Notes
5/22/2024	Added Bosulif capsules.

BPH Agents

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-125064
Guideline Name	BPH Agents
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	7/1/2023

1 . Criteria

Product Name: Brand Jalyn, generic dutasteride/tamsulosin	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
JALYN	DUTASTERIDE-TAMSULOSIN HCL CAP 0.5-0.4 MG	56859902250120	Brand
DUTASTERIDE/TAMSULOSIN HYDROCHLORIDE	DUTASTERIDE-TAMSULOSIN HCL CAP 0.5-0.4 MG	56859902250120	Generic

Approval Criteria

1 - Documentation that the separate components are not suitable for use

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

Product Name	Generic Name	GPI	Brand/Generic
RAPAFLO	SILODOSIN CAP 4 MG	56852060000120	Brand
SILODOSIN	SILODOSIN CAP 4 MG	56852060000120	Generic
RAPAFLO	SILODOSIN CAP 8 MG	56852060000140	Brand
SILODOSIN	SILODOSIN CAP 8 MG	56852060000140	Generic

Approval Criteria

1 - Patient has had a trial of BOTH of the following:

- Alfuzosin ER
- Tamsulosin

OR

2 - Medical justification for use of silodosin

Product Name: Brand Cialis 2.5mg and 5mg, generic tadalafil 2.5mg and 5mg*	
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CIALIS	TADALAFIL TAB 2.5 MG	40304080000302	Brand
TADALAFIL	TADALAFIL TAB 2.5 MG	40304080000302	Generic
CIALIS	TADALAFIL TAB 5 MG	40304080000305	Brand
TADALAFIL	TADALAFIL TAB 5 MG	40304080000305	Generic

Approval Criteria

1 - One of the following:

1.1 Documentation of a trial and failure of ALL of the following:

- A nonselective alpha-blocker
- A selective alpha-blocker
- A 5-alpha reductase inhibitor
- A combination product for the treatment of BPH

OR

1.2 A medically justifiable reason why ALL of the following are not suitable for use:

- A nonselective alpha-blocker
- A selective alpha-blocker
- A 5-alpha reductase inhibitor
- A combination product for the treatment of BPH

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

Product Name: Entadfi	
Approval Length	26 Week(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ENTADFI	FINASTERIDE-TADALAFIL CAP 5-5 MG	56859902300120	Brand

Approval Criteria

1 - One of the following:

1.1 Documentation of a trial and failure of ALL of the following:

- A nonselective alpha-blocker
- A selective alpha-blocker
- A 5-alpha reductase inhibitor (must include finasteride)
- A combination product for the treatment of BPH

OR

1.2 A medically justifiable reason why ALL of the following are not suitable for use

- A nonselective alpha-blocker
- A selective alpha-blocker
- A 5-alpha reductase inhibitor (must include finasteride)
- A combination product for the treatment of BPH

2 . Revision History

Date	Notes
4/26/2023	New

Braftovi

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-156253
Guideline Name	Braftovi
Formulary	• Medicaid - Community & State Indiana

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

Bronchitol

Prior Authorization Guideline

Guideline ID	GL-124644
Guideline Name	Bronchitol
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2023

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-156257
Guideline Name	Brukinsa
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	11/1/2024

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
9/25/2024	Clinical coverage criteria added for follicular lymphoma and hairy cell leukemia. Updated B-cell lymphoma formatting

Bylvay

Prior Authorization Guideline

Guideline ID	GL-156301
Guideline Name	Bylvay
Formulary	• Medicaid - Community & State Indiana

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

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

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-136011
Guideline Name	C&S Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Clinical Review
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/14/2024

1 . Criteria

Diagnosis	Exception to Policy Limitations for Medicaid Patients Less Than 21 Years of Age
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
Early and Periodic Screening			
Exception to policy limitations			
EPSDT			
Less than 21 years			

Less than twenty-one years			
Less than twenty one years			
Under 21 years			
Under twenty-one years			
Under twenty one years			

Approval Criteria

1 - ONE of the following:

1.1 BOTH of the following:

1.1.1 The use of the requested medication is for an indicated diagnosis that is supported by the Food and Drug Administration (FDA)

AND

1.1.2 The use of the requested medication is NOT for experimental or investigational purposes

OR

1.2 The use of the requested medication is supported by information from ONE of the following appropriate compendia of current literature:

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

AND

2 - The requested medication is medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition (health problem)

AND

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

AND

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

AND

5 - Prescriber attests the requested medication is safe and effective

AND

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

6.1 The manufacturer

OR

6.2 ONE of the following compendia:

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

AND

7 - If for a non-preferred medication*, ONE of the following:

7.1 The requested medication is a behavioral health medication, and ONE of the following:

- The patient is receiving treatment with the requested non-preferred behavioral health medication and is new to the plan (enrollment effective date within the past 90 days)
- The patient is receiving treatment with the requested non-preferred behavioral health medication in the hospital/in-patient setting and must continue upon discharge

OR

7.2 For any other non-preferred medication, submission of documentation of failure to, contraindication to, or intolerance to 3 preferred alternatives, confirmed by claims history or submission of medical records. Submission of documentation showing preferred alternatives used to treat the condition were ineffective or inappropriate (must include regimen, duration, treatment goals, and response to treatment)

AND

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

8.1 Submission of the adverse reaction, allergy, or sensitivity to a generic or an authorized generic

OR

8.2 The requested medication is a behavioral health medication, and ONE of the following:

- The patient is receiving treatment with the requested behavioral health medication and is new to the plan (enrollment effective date within the past 90 days)
- The patient is receiving treatment with the requested behavioral health medication in the hospital/in-patient setting and must continue upon discharge

AND

9 - If the request is for a brand medication with an authorized generic, ONE of the following:

9.1 Submission of documentation of the adverse reaction, allergy, or sensitivity to a generic or an authorized generic

OR

9.2 Submission of documentation of an incomplete response with a generic/authorized generic equivalent

OR

9.3 Submission of documentation due to transition to a generic/authorized generic equivalent could result in destabilization of the beneficiary

OR

9.4 Submission of documentation due to special clinical circumstances precluding the use of a generic/authorized generic equivalent of the brand medication

OR

9.5 The requested medication is a behavioral health medication, and ONE of the following:

- The patient is receiving treatment with the requested behavioral health medication and is new to the plan (enrollment effective date within the past 90 days)
- The patient is receiving treatment with the requested behavioral health medication in the hospital/in-patient setting and must continue upon discharge

AND

10 - If the request is for a generic when brand medication is preferred formulation, ONE of the following:

10.1 Submission of documentation of the adverse reaction, allergy, or sensitivity to brand medication

OR

10.2 Submission of documentation of an incomplete response with brand medication

OR

10.3 Submission of documentation due to transition to a brand medication could result in destabilization of the beneficiary **OR** **10.4** Submission of documentation due to special clinical circumstances precluding the use of a brand medication **OR** **10.5** The requested medication is a behavioral health medication, and ONE of the following: • The patient is receiving treatment with the requested behavioral health medication and is new to the plan (enrollment effective date within the past 90 days) • The patient is receiving treatment with the requested behavioral health medication in the hospital/in-patient setting and must continue upon discharge	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

2 . Revision History

Date	Notes
11/6/2023	New guideline

Cablivi

Prior Authorization Guideline

Guideline ID	GL-86368
Guideline Name	Cablivi
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	7/1/2021
P&T Approval Date:	
P&T Revision Date:	

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)

2 . Revision History

Date	Notes
5/3/2021	Copy of NY

Cabometyx

Prior Authorization Guideline

Guideline ID	GL-138441
Guideline Name	Cabometyx
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	2/1/2024

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

Calcium Channel Blockers

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-150095
Guideline Name	Calcium Channel Blockers
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	8/1/2024

1 . Criteria

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

Product Name	Generic Name	GPI	Brand/Generic
NORLIQVA	AMLODIPINE BESYLATE ORAL SOLN 1 MG/ML (BASE EQUIVALENT)	34000003102020	Brand

Approval Criteria

1 - Patient is unable to swallow tablets

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

Product Name	Generic Name	GPI	Brand/Generic
NYMALIZE	NIMODIPINE ORAL SOLN 6 MG/ML	34000022002054	Brand

Approval Criteria

1 - Patient is 18 years of age or older

AND

2 - Patient is unable to swallow capsules

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

Product Name	Generic Name	GPI	Brand/Generic
KATERZIA	AMLODIPINE BENZOATE ORAL SUSP 1 MG/ML (BASE EQUIVALENT)	34000003081820	Brand

Approval Criteria

1 - One of the following:

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

OR

1.2 Patient is unable to swallow tablets

AND

2 - One of the following:

2.1 Previous trial and failure of Norliqva

OR

2.2 Medical rational for use of Katerzia

Product Name: Brand Caduet, generic amlodipine/atorvastatin	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AMLODIPINE BESYLATE/ATORVASTATIN CALCIUM	AMLODIPINE BESYLATE-ATORVASTATIN CALCIUM TAB 2.5-10 MG	40992502150305	Generic
AMLODIPINE BESYLATE/ATORVASTATIN CALCIUM	AMLODIPINE BESYLATE-ATORVASTATIN CALCIUM TAB 2.5-20 MG	40992502150310	Generic
AMLODIPINE BESYLATE/ATORVASTATIN CALCIUM	AMLODIPINE BESYLATE-ATORVASTATIN CALCIUM TAB 2.5-40 MG	40992502150315	Generic
AMLODIPINE BESYLATE/ATORVASTATIN CALCIUM	AMLODIPINE BESYLATE-ATORVASTATIN CALCIUM TAB 5-10 MG	40992502150320	Generic
CADUET	AMLODIPINE BESYLATE-ATORVASTATIN CALCIUM TAB 5-10 MG	40992502150320	Brand
AMLODIPINE BESYLATE/ATORVASTATIN CALCIUM	AMLODIPINE BESYLATE-ATORVASTATIN CALCIUM TAB 5-20 MG	40992502150325	Generic
CADUET	AMLODIPINE BESYLATE-ATORVASTATIN CALCIUM TAB 5-20 MG	40992502150325	Brand
AMLODIPINE BESYLATE/ATORVASTATIN CALCIUM	AMLODIPINE BESYLATE-ATORVASTATIN CALCIUM TAB 5-40 MG	40992502150330	Generic
CADUET	AMLODIPINE BESYLATE-ATORVASTATIN CALCIUM TAB 5-40 MG	40992502150330	Brand

AMLODIPINE BESYLATE/ATORVASTATIN CALCIUM	AMLODIPINE BESYLATE-ATORVASTATIN CALCIUM TAB 5-80 MG	40992502150335	Generic
CADUET	AMLODIPINE BESYLATE-ATORVASTATIN CALCIUM TAB 5-80 MG	40992502150335	Brand
AMLODIPINE BESYLATE/ATORVASTATIN CALCIUM	AMLODIPINE BESYLATE-ATORVASTATIN CALCIUM TAB 10-10 MG	40992502150350	Generic
CADUET	AMLODIPINE BESYLATE-ATORVASTATIN CALCIUM TAB 10-10 MG	40992502150350	Brand
AMLODIPINE BESYLATE/ATORVASTATIN CALCIUM	AMLODIPINE BESYLATE-ATORVASTATIN CALCIUM TAB 10-20 MG	40992502150355	Generic
CADUET	AMLODIPINE BESYLATE-ATORVASTATIN CALCIUM TAB 10-20 MG	40992502150355	Brand
AMLODIPINE BESYLATE/ATORVASTATIN CALCIUM	AMLODIPINE BESYLATE-ATORVASTATIN CALCIUM TAB 10-40 MG	40992502150360	Generic
CADUET	AMLODIPINE BESYLATE-ATORVASTATIN CALCIUM TAB 10-40 MG	40992502150360	Brand
AMLODIPINE BESYLATE/ATORVASTATIN CALCIUM	AMLODIPINE BESYLATE-ATORVASTATIN CALCIUM TAB 10-80 MG	40992502150365	Generic
CADUET	AMLODIPINE BESYLATE-ATORVASTATIN CALCIUM TAB 10-80 MG	40992502150365	Brand

Approval Criteria

1 - Documentation that separate components are not suitable for use

2 . Revision History

Date	Notes
7/22/2024	Removed age limit for Norliqva

Calquence

Prior Authorization Guideline

Guideline ID	GL-127149
Guideline Name	Calquence
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	8/1/2023

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

2 . Revision History

Date	Notes
6/27/2023	Copy NY

Caprelsa

Prior Authorization Guideline

Guideline ID	GL-136674
Guideline Name	Caprelsa
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2024

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 locally advanced disease
- Metastatic disease

AND

1.3 ONE of the following:

- Patient has symptomatic disease
- Patient has progressive disease

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

Cardiac Agents

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-154931
Guideline Name	Cardiac Agents
Formulary	• Medicaid - Community & State Indiana • Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name: Brand Corlanor tablets, generic ivabradine tablet	
Diagnosis	Heart failure due to dilated cardiomyopathy
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

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
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 - Diagnosis of stable, symptomatic heart failure due to dilated cardiomyopathy

AND

2 - Documentation of all of the following:

- Left ventricular ejection fraction is less than or equal to 45%
- Patient is in sinus rhythm
- Resting heart rate is elevated

AND

3 - Both of the following:

3.1 Patient is 6 months through 17 years of age

AND

3.2 Patient weighs greater than or equal to 40 kilograms (kg)

AND

4 - Both of the following:

4.1 Requested dose does not exceed 15mg/day (milligrams/day)

AND

4.2 Requested dose does not exceed 2 tablets/day

Product Name: Brand Corlanor tablets, generic ivabradine tablet	
Diagnosis	Heart failure due to dilated cardiomyopathy
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

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
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 - History of the requested agent for a least 90 days of the past 120 days, confirmed by claims history or chart documentation

AND

2 - Both of the following:

2.1 Patient is 6 months through 17 years of age

AND

2.2 Patient weighs greater than 40 kilograms (kg)

AND

3 - Both of the following:

3.1 Requested dose does not exceed 15mg/day (milligrams per day)

AND

3.2 Requested dose does not exceed 2 tablets/day

Product Name: Brand Corlanor tablets, generic ivabradine tablet	
Diagnosis	Heart failure NOT due to dilated cardiomyopathy
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

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
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 - Diagnosis of heart failure

AND

2 - Patient is 18 years of age or older

AND

3 - Documentation of both of the following:

- Left ventricular ejection fraction is less than or equal to 35%
- Resting heart rate is greater than or equal to 70 beats per minute

AND

4 - One of the following:

- Patient is currently maximized on beta-blocker therapy
- Patient has contraindication to beta-blocker use

AND

5 - Both of the following:

5.1 Requested dose does not exceed 15mg/day (milligrams per day)

AND

5.2 Requested dose does not exceed 2 tablets/day

Product Name: Brand Corlanor tablets, generic ivabradine tablet	
Diagnosis	Heart failure NOT due to dilated cardiomyopathy
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

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
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 - History of the requested agent for a least 90 days of the past 120 days, confirmed by claims history or chart documentation

AND

2 - Patient is 18 years of age or older

AND

3 - One of the following:

- Patient continues to be maximized on concurrent beta-blocker therapy
- Patient has contraindication to beta-blocker use

AND

4 - Both of the following:

4.1 Requested dose does not exceed 15mg/day (milligrams/day)

AND

4.2 Requested dose does not exceed 2 tablets/day

Product Name: Brand Corlanor tablets, generic ivabradine tablet	
Diagnosis	Inappropriate sinus tachycardia
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

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
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 - Diagnosis of inappropriate sinus tachycardia

AND

2 - Patient is 18 years of age or older

AND

3 - One of the following:

- Patient is currently maximized on beta-blocker therapy
- Patient has contraindication to beta-blocker use

AND

4 - Both of the following:

4.1 Requested dose does not exceed 15mg/day (milligrams per day)

AND

4.2 Requested dose does not exceed 2 tablets/day

Product Name: Brand Corlanor tablets, generic ivabradine tablet	
Diagnosis	Inappropriate sinus tachycardia
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

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
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 - History of the requested agent for a least 90 days of the past 120 days, confirmed by claims history or chart documentation

AND

2 - Patient is 18 years of age or older

AND

3 - One of the following:

- Patient continues to be maximized on concurrent beta-blocker therapy
- Patient has contraindication to beta-blocker use

AND

4 - Both of the following:

4.1 Requested dose does not exceed 15mg/day (milligrams per day)

AND

4.2 Requested dose does not exceed 2 tablets/day

Product Name: Corlanor oral solution	
Diagnosis	Heart failure due to dilated cardiomyopathy
Approval Length	1 year(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CORLANOR	IVABRADINE HCL ORAL SOLN 5 MG/5ML (BASE EQUIV)	40700035102020	Brand

Approval Criteria

1 - Diagnosis of stable, symptomatic heart failure due to dilated cardiomyopathy

AND

2 - Documentation of all of the following:

- Left ventricular ejection fraction is less than or equal to 45%
- Patient is in sinus rhythm
- Resting heart rate is elevated

AND

3 - Patient is 6 months through 17 years of age

AND

4 - One of the following:

4.1 Patient weighs less than 40 kilograms and one of the following:

4.1.1 If patient is 6 months through less than 1 year of age, the requested dose does not exceed 0.2 mg/kg/dose (milligrams per kilograms per dose) twice daily

OR

4.1.2 If patient is 1 year of age through 17 years of age, the requested dose does not exceed 0.3 mg/kg/dose twice daily, maximum of 15 milliliters per day (15 milligrams per day)

OR

4.2 Patient weighs greater than or equal to 40 kilograms and one of the following:

4.2.1 If patient is 6 months through 11 years of age, the requested dose does not exceed 15 milliliters per day (15 milligrams per day)

OR

4.2.2 If patient is 12 years of age through 17 years of age, both of the following:

- The requested dose does not exceed 15 milliliters per day (15 milligrams per day)
- Submission of medical records (e.g., chart notes) confirming patient cannot swallow tablets

Product Name: Corlanor oral solution	
Diagnosis	Heart failure due to dilated cardiomyopathy
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CORLANOR	IVABRADINE HCL ORAL SOLN 5 MG/5ML (BASE EQUIV)	40700035102020	Brand

Approval Criteria

1 - History of the requested agent for a least 90 days of the past 120 days, confirmed by claims history or chart documentation

AND

2 - Patient is 6 months through 17 years of age

AND

3 - One of the following:

3.1 Patient weighs less than 40 kilograms and one of the following:

3.1.1 If patient is 6 months through less than 1 year of age, the requested dose does not exceed 0.2 mg/kg/dose (milligrams per kilograms per dose) twice daily

OR

3.1.2 If patient is 1 year of age through 17 years of age, the requested dose does not exceed 0.3 mg/kg/dose twice daily, maximum of 15 milliliters per day (15 milligrams per day)

OR

3.2 Patient weighs greater than or equal to 40 kilograms and one of the following:

3.2.1 If patient is 6 months through 11 years of age, the requested dose does not exceed 15 milliliters per day (15 milligrams per day)

OR

3.2.2 If patient is 12 years of age through 17 years of age, both of the following:

- The requested dose does not exceed 15 milliliters per day (15 milligrams per day)
- Submission of medical records (e.g., chart notes) confirming patient cannot swallow tablets

Product Name: Corlanor oral solution	
Diagnosis	Heart failure NOT due to dilated cardiomyopathy
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CORLANOR	IVABRADINE HCL ORAL SOLN 5 MG/5ML (BASE EQUIV)	40700035102020	Brand

Approval Criteria

1 - Diagnosis of heart failure

AND

2 - Patient is 18 years of age or older

AND

3 - Documentation of both of the following:

- Left ventricular ejection fraction is less than or equal to 35%
- Resting heart rate is greater than or equal to 70 beats per minute

AND

4 - One of the following:

- Patient is currently maximized on beta-blocker therapy
- Patient has contraindication to beta-blocker use

AND

5 - Requested dose does not exceed 15 milliliters per day (15 milligrams per day)

AND

6 - Submission of medical records (e.g., chart notes) confirming patient cannot swallow tablets

Product Name: Corlanor oral solution	
Diagnosis	Heart failure NOT due to dilated cardiomyopathy
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CORLANOR	IVABRADINE HCL ORAL SOLN 5 MG/5ML (BASE EQUIV)	40700035102020	Brand

Approval Criteria

1 - History of the requested agent for a least 90 days of the past 120 days, confirmed by claims history or chart documentation

AND

2 - Patient is 18 years of age or older

AND

3 - One of the following:

- Patient continues to be maximized on concurrent beta-blocker therapy
- Patient has contraindication to beta-blocker use

AND

4 - Requested dose does not exceed 15 milliliters per day (15 milligrams per day)

AND

5 - Submission of medical records (e.g., chart notes) confirming patient cannot swallow tablets

Product Name: Corlanor oral solution	
Diagnosis	Inappropriate sinus tachycardia
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CORLANOR	IVABRADINE HCL ORAL SOLN 5 MG/5ML (BASE EQUIV)	40700035102020	Brand

Approval Criteria

1 - Diagnosis of inappropriate sinus tachycardia

AND

2 - Patient is 18 years of age or older

AND

3 - One of the following:

- Patient is currently maximized on beta-blocker therapy
- Patient has contraindication to beta-blocker use

AND

4 - Requested dose does not exceed 15 milliliters per day (15 milligrams per day)

AND

5 - Submission of medical records (e.g., chart notes) confirming patient cannot swallow tablets

Product Name: Corlanor oral solution	
Diagnosis	Inappropriate sinus tachycardia
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CORLANOR	IVABRADINE HCL ORAL SOLN 5 MG/5ML (BASE EQUIV)	40700035102020	Brand

Approval Criteria

1 - History of the requested agent for a least 90 days of the past 120 days, confirmed by claims history or chart documentation

AND

2 - Patient is 18 years of age or older

AND

3 - One of the following:

- Patient continues to be maximized on concurrent beta-blocker therapy
- Patient has contraindication to beta-blocker use

AND

4 - Requested dose does not exceed 15 milliliters per day (15 milligrams per day)

AND

5 - Submission of medical records (e.g., chart notes) confirming patient cannot swallow tablets

Product Name: Entresto tablet	
Approval Length	1 year(s)
Guideline Type	Prior Authorization

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

Approval Criteria

1 - One of the following:

1.1 Patient is not using an angiotensin converting enzyme (ACE) inhibitors or angiotensin II receptor blockers (ARBs) concurrently with Entresto

OR

1.2 The provider has submitted valid medical justification for the use of an angiotensin converting enzyme (ACE) inhibitors or angiotensin II receptor blockers (ARBs) concurrently with Entresto

Product Name: Entresto sprinkle	
Approval Length	1 year(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ENTRESTO	SACUBITRIL-VALSARTAN SPRINKLE CAP 6-6 MG	40992002606820	Brand
ENTRESTO	SACUBITRIL-VALSARTAN SPRINKLE CAP 15-16 MG	40992002606830	Brand

Approval Criteria

1 - One of the following:

1.1 Patient is not using angiotensin converting enzyme (ACE) inhibitors or angiotensin II receptor blockers (ARBs) concurrently with Entresto

OR

1.2 The provider has submitted valid medical justification for the use of an angiotensin converting enzyme (ACE) inhibitors or angiotensin II receptor blockers (ARBs) concurrently with Entresto

AND

2 - One of the following:

2.1 One of the following:

- Patient is less than 12 years of age
- Patient weighs less than 50kg

OR

2.2 ALL of the following:

- Patient is 12 years of age or older
- Patient weighs at least 50kg
- Submission of medical records (e.g., chart notes) confirming patient cannot swallow tablets

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

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 - All of the following:

1.1 Patient is 18 years of age or older

AND

1.2 Diagnosis of stable, symptomatic heart failure

AND

1.3 Documentation of left ventricular ejection fraction less than or equal to 45%

AND

1.4 One of the following:

- Patient has been hospitalized within the past 180 days for symptomatic heart failure
- Patient has received outpatient treatment with IV diuretics within the past 90 days

AND

1.5 Both of the following:

1.5.1 Requested dose does not exceed 10 mg/day (milligrams per day)

AND

1.5.2 Requested dose does not exceed 1 tablet/day

AND

1.6 For women of childbearing age, documentation of a negative pregnancy test within the past 60 days

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

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 - History of the requested agent for a least 90 days of the past 120 days, confirmed by claims history or chart documentation

AND

2 - Both of the following:

2.1 Requested dose does not exceed 10 mg/day (milligrams per day)

AND

2.2 Requested dose does not exceed 1 tablet/day

AND

3 - For women of childbearing age, documentation of a negative pregnancy test within the past 60 days

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

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 - All of the following:

1.1 Patient is 18 years of age or older

AND

1.2 Diagnosis of symptomatic obstructive hypertrophic cardiomyopathy (HCM)

AND

1.3 Documentation of both of the following:

- Left ventricular ejection fraction that is greater than or equal to 55%
- Left ventricular outflow tract (LVOT) gradient of 50 mmHg or greater

AND

1.4 One of the following:

- At least 90 days of drug therapy with a beta-adrenergic blocker or non-dihydropyridine calcium channel blocker

- Prescriber has provided valid medical rationale for the use of Camzyos over beta-adrenergic blocker and non-dihydropyridine calcium channel blocker therapy

AND

1.5 Patient is enrolled in the Camzyos/mavacamten REMS (Risk Evaluation and Mitigation Strategy) program

AND

1.6 Both of the following:

1.6.1 Requested dose does not exceed 15 mg/day (milligrams per day)

AND

1.6.2 Requested dose does not exceed 1 capsule/day

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

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 - History of the requested agent for a least 90 days of the past 120 days, confirmed by claims history or chart documentation

AND

2 - Both of the following:

2.1 Requested dose does not exceed 15 mg/day (milligrams per day)

AND

2.2 Requested dose does not exceed 1 capsule/day

2 . Revision History

Date	Notes
9/17/2024	Added generic ivabradine. Added criteria for Entresto sprinkle.

Carisoprodol Agents

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-126509
Guideline Name	Carisoprodol Agents
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	7/1/2023

1 . Criteria

Product Name: generic carisoprodol, Brand Soma, Brand Vanadom	
Approval Length	90 Day(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CARISOPRODOL	CARISOPRODOL TAB 250 MG	75100020000304	Generic
SOMA	CARISOPRODOL TAB 250 MG	75100020000304	Brand
VANADOM	CARISOPRODOL TAB 350 MG	75100020000305	Brand
CARISOPRODOL	CARISOPRODOL TAB 350 MG	75100020000305	Generic
SOMA	CARISOPRODOL TAB 350 MG	75100020000305	Brand

Approval Criteria

1 - Patient must have diagnosis of an acute musculoskeletal condition in the past 60 days

AND

2 - Patient is between 16 and 65 years of age

AND

3 - No history of meprobamate use in the past 90 days

AND

4 - ONE of the following*:

4.1 Trial and failure of ALL of the preferred non-liquid oral agents

OR

4.2 Documented history of intolerance to ALL of the preferred non-liquid oral agents

OR

4.3 Valid medical justification for the use of carisoprodol over the preferred non-liquid oral agents

AND

5 - Patient will not use concurrently with opiates or benzodiazepines

AND **6** - The request must be no more than a 21 days' supply, to be used within a 90-day period, every 180 days	
Notes	Approvals will be granted for up to 21 days' supply, to be used within a 90-day period, every 180 days. *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

2 . Revision History

Date	Notes
6/9/2023	Updated guideline name, updated GPI and product name lists, removed carisoprodol/asa/codeine, updated criteria and note.

Cayston

Prior Authorization Guideline

Guideline ID	GL-123638
Guideline Name	Cayston
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	5/1/2023

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)

2 . Revision History

Date	Notes
3/22/2023	Updated trial/failure language.

Cerdelga and Zavesca

Prior Authorization Guideline

Guideline ID	GL-136327
Guideline Name	Cerdelga and Zavesca
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2024

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

2 . Revision History

Date	Notes
11/14/2023	Annual review. Added Yargesa product.

Cholbam

Prior Authorization Guideline

Guideline ID	GL-127506
Guideline Name	Cholbam
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	8/1/2023

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

2 . Revision History

Date	Notes
7/3/2023	Revised initial and reauth criteria based upon policy updates.

Cinryze

Prior Authorization Guideline

Guideline ID	GL-147159
Guideline Name	Cinryze
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2024

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.

Cipro Suspension and Levaquin Solution

Prior Authorization Guideline

Guideline ID	GL-123771
Guideline Name	Cipro Suspension and Levaquin Solution
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	7/1/2023

1 . Criteria

Product Name: Brand Cipro suspension, generic ciprofloxacin suspension	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CIPROFLOXACIN	CIPROFLOXACIN FOR ORAL SUSP 250 MG/5ML (5%) (5 GM/100ML)	05000020001920	Generic
CIPRO	CIPROFLOXACIN FOR ORAL SUSP 250 MG/5ML (5%) (5 GM/100ML)	05000020001920	Brand
CIPROFLOXACIN	CIPROFLOXACIN FOR ORAL SUSP 500 MG/5ML (10%) (10 GM/100ML)	05000020001930	Generic
CIPRO	CIPROFLOXACIN FOR ORAL SUSP 500 MG/5ML (10%) (10 GM/100ML)	05000020001930	Brand

Approval Criteria

1 - Both of the following:

1.1 Patient is 12 years of age or older

AND

1.2 Patient is unable to swallow tablet formulation

OR

2 - Both of the following:

2.1 Patient is less than 12 years of age

AND

2.2 Patient has one of the following diagnoses:

- Anthrax
- Cystic fibrosis
- Community acquired pneumonia
- Shigella dysentery type 1
- Urinary tract infection (complicated) or pyelonephritis
- Tularemia

Product Name: Brand Cipro suspension, generic ciprofloxacin suspension	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CIPROFLOXACIN	CIPROFLOXACIN FOR ORAL SUSP 250 MG/5ML (5%) (5 GM/100ML)	05000020001920	Generic

CIPRO	CIPROFLOXACIN FOR ORAL SUSP 250 MG/5ML (5%) (5 GM/100ML)	05000020001920	Brand
CIPROFLOXACIN	CIPROFLOXACIN FOR ORAL SUSP 500 MG/5ML (10%) (10 GM/100ML)	05000020001930	Generic
CIPRO	CIPROFLOXACIN FOR ORAL SUSP 500 MG/5ML (10%) (10 GM/100ML)	05000020001930	Brand

Approval Criteria

1 - Both of the following:

1.1 Patient is 12 years of age or older

AND

1.2 Patient has history of use of ciprofloxacin suspension

OR

2 - Both of the following:

2.1 Patient is less than 12 years of age

AND

2.2 Medical rationale for continued use of the requested medication

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

Product Name	Generic Name	GPI	Brand/Generic
LEVOFLOXACIN	LEVOFLOXACIN ORAL SOLN 25 MG/ML	05000034002050	Generic

Approval Criteria

1 - Both of the following:

1.1 Patient is 12 years of age or older

AND

1.2 Patient is unable to swallow tablet formulation

OR

2 - Both of the following:

2.1 Patient is less than 12 years of age

AND

2.2 Patient has one of the following diagnoses:

- Anthrax
- Community acquired pneumonia
- Acute bacterial rhinosinusitis
- Tularemia
- Pneumonic plague

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

Product Name	Generic Name	GPI	Brand/Generic
LEVOFLOXACIN	LEVOFLOXACIN ORAL SOLN 25 MG/ML	05000034002050	Generic

Approval Criteria

1 - Both of the following:

1.1 Patient is 12 years of age or older

AND

1.2 Patient has history of use of levofloxacin solution

OR

2 - Both of the following:

2.1 Patient is less than 12 years of age

AND

2.2 Medical rationale for continued use of the requested medication

2 . Revision History

Date	Notes
4/7/2023	SPDL eff 7.1.23

Cometriq

Prior Authorization Guideline

Guideline ID	GL-127888
Guideline Name	Cometriq
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	9/1/2023

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-115710
Guideline Name	Complera
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2023

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

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-105739
Guideline Name	Compounds and Bulk Powders
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2022

1 . Criteria

Product Name: Compounds or Bulk Powders	
Approval Length	12 month(s)
Guideline Type	Administrative

Product Name	Generic Name	GPI	Brand/Generic
Bulk Powder			
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:

(1) Ketamine

(2) Gabapentin

(3) Flurbiprofen (topical ophthalmic use not included)

(4) Ketoprofen

(5) Morphine

(6) Nabumetone

(7) Oxycodone

(8) Cyclobenzaprine

(9) Baclofen

(10) Tramadol

(11) Hydrocodone

(12) Meloxicam

(13) Amitriptyline

(14) Pentoxifylline

(15) Orphenadrine

(16) Piroxicam

(17) Levocetirizine

(18) Amantadine

(19) Oxytocin

(20) Sumatriptan

(21) Chorionic gonadotropin (human)

(22) Clomipramine

(23) Dexamethasone

(24) Hydromorphone

(25) Methadone

(26) Papaverine

(27) Mefenamic acid

(28) Promethazine

(29) Succimer DMSA

(30) Tizanidine

(31) Apomorphine

(32) Carbamazepine

(33) Ketorolac

(34) Dimercaptopropane-sulfonate

(35) Dimercaptosuccinic acid

(36) Duloxetine

(37) Fluoxetine

(38) Bromfenac (topical ophthalmic use not included)

(39) Nepafenac (topical ophthalmic use not included)

Table 2: Example compounds that contain ingredients for cosmetic purposes:

(1) Hydroquinone

(2) Acetyl hexapeptide-8

(3) Tocopheryl Acid Succinate

(4) PracaSil TM-Plus

(5) Chrysaderm Day Cream

(6) Chrysaderm Night Cream

(7) PCCA Spira-Wash

(8) Lipopen Ultra

(9) Versapro

(10) Fluticasone

(11) Mometasone

(12) Halobetasol

(13) Betamethasone

(14) Clobetasol

(15) Triamcinolone

(16) Minoxidil

(17) Tretinoin

(18) Dexamethasone

(19) Spironolactone

(20) Cycloserine

(21) Tamoxifen

(22) Sermorelin

(23) Mederma Cream

(24) PCCA Cosmetic HRT Base

(25) Sanare Scar Therapy Cream

(26) Scarcin Cream

(27) Apothederm

(28) Stera Cream

(29) Copasil

(30) Collagenase

(31) Arbutin Alpha

(32) Nourisil

(33) Freedom Cepapro

(34) Freedom Silomac Andydrous

(35) Retinaldehyde

(36) Apothederm

Table 3: Example ingredients on the FDA's Do Not Compound List:

(1) 3,3′,4′,5-tetrachlorosalicylanilide

(2) Adenosine phosphate

(3) Adrenal cortex

(4) Alatrofloxacin mesylate

(5) Aminopyrine

(6) Astemizole

(7) Azaribine

(8) Benoxaprofen

(9) Bithionol

(10) Camphorated oil

(11) Carbetapentane citrate

(12) Casein, iodinated

(13) Cerivastatin sodium

(14) Chlormadinone acetate

(15) Chloroform

(16) Cisapride

(17) Defenfluramine hydrochloride

(18) Diamthazole dihydrochloride

(19) Dibromsalan

(20) Dihydrostreptomycin sulfate

(21) Dipyrone

(22) Encainide hydrochloride

(23) Etretinate

(24) Fenfluramine hydrochloride

(25) Flosequinan

(26) Glycerol, iodinated

(27) Grepafloxacin

(28) Mepazine

(29) Metabromsalan

(30) Methapyrilene

(31) Methopholine

(32) Methoxyflurane

(33) Mibefradil dihydrochloride

(34) Nomifensine maleate

(35) Novobiocin sodium

(36) Oxyphenisatin acetate

(37) Oxyphenisatin

(38) Pemoline

(39) Pergolide mesylate

(40) Phenacetin

(41) Phenformin hydrochloride

(42) Phenylpropanolamine

(43) Pipamazine

(44) Potassium arsenite

(45) Propoxyphene

(46) Rapacuronium bromide

(47) Rofecoxib

(48) Sibutramine hydrochloride

(49) Sparteine sulfate

(50) Sulfadimethoxine

(51) Sweet spirits of nitre

(52) Tegaserod maleate

(53) Temafloxacin hydrochloride

(54) Terfenadine

(55) Ticrynafen

(56) Tribromsalan

(57) Trichloroethane

(58) Troglitazone

(59) Trovafloxacin mesylate:

(60) Urethane

(61) Valdecoxib

(62) Zomepirac sodium

3 . Revision History

Date	Notes
4/6/2022	Updated criteria requirement for unique vehicle needed. Defined AS HP.

Continuous Glucose Monitors

Prior Authorization Guideline

Guideline ID	GL-157611
Guideline Name	Continuous Glucose Monitors
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	11/1/2024

1 . Criteria

Product Name: Non-preferred Continuous Glucose Monitors, sensors, and transmitters (includes all brands except Dexcom G6 and Dexcom G7)	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
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
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
EVERSENSE 365 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 PLUS/SENOSR/FLASH GLUCOSE MONITOR 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
EVERSENSE E3 SMART TRANSMITTER	*CONTINUOUS GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
EVERSENSE SMART TRANSMITTER	*CONTINUOUS GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
EVERSENSE 365 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 - If the request is non-preferred, the non-preferred continuous glucose monitor (CGM) system integrates with the member's pre-existing or plan authorized insulin infusion device *

OR

2 - A documented, medically justifiable reason that the non-preferred product should be used instead of the preferred product is provided

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

Product Name: Non-preferred Continuous Glucose Monitors, sensors, and transmitters (includes all brands except Dexcom G6 and Dexcom G7)	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
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
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
EVERSENSE 365 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 PLUS/SENOSR/FLASH GLUCOSE MONITOR 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
EVERSENSE E3 SMART TRANSMITTER	*CONTINUOUS GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
EVERSENSE SMART TRANSMITTER	*CONTINUOUS GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
EVERSENSE 365 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
10/17/2024	Updated GPIs and product name list

Copiktra

Prior Authorization Guideline

Guideline ID	GL-127439
Guideline Name	Copiktra
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	8/1/2023

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

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-151321
Guideline Name	Copper Chelating Agents
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	9/1/2024

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
8/12/2024	Updated trial/failure requirements for Cuprimine, Syprine, and trientin e 500 mg capsules.

Cotellic

Prior Authorization Guideline

Guideline ID	GL-138210
Guideline Name	Cotellic
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	2/1/2024

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 positive for ONE of the following mutations:

- BRAF V600E
- BRAF V600K

AND

3 - Used in combination with Zelboraf (vemurafenib)

Product Name: Cotellic	
Diagnosis	Melanoma, Central Nervous System (CNS) Cancers
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

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 - Cotellic will be approved for uses 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

2 . Revision History

Date	Notes
12/27/2023	Updates to histiocytic neoplasms criteria based on labeled indication and CNS cancer based on NCCN recommendations.

Cuvrior

Prior Authorization Guideline

Guideline ID	GL-151263
Guideline Name	Cuvrior
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	9/1/2024

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
8/9/2024	Updated language on why pt must switch from preferred penicillamine agent, added step through trientine 250 mg capsules, added prescriber requirement, and updated initial/reauth durations to 12 months.

Cystaran, Cystadrops

Prior Authorization Guideline

Guideline ID	GL-81932
Guideline Name	Cystaran, Cystadrops
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2021

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

2 . Revision History

Date	Notes
3/5/2021	Bulk Load

Daurismo

Prior Authorization Guideline

Guideline ID	GL-82053
Guideline Name	Daurismo
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2021

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

2 . Revision History

Date	Notes
3/5/2021	Bulk Load

Daybue

Prior Authorization Guideline

Guideline ID	GL-151781
Guideline Name	Daybue
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	9/1/2024

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
8/14/2024	Updated initial approval duration from 6 months to 12 months.

Descovy

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-151236
Guideline Name	Descovy
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	9/1/2024

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
8/8/2024	Minor update to specify type 1 infection for HIV diagnosis without cha nge to clinical intent.

Dificid

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-123772
Guideline Name	Dificid
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	7/1/2023

1 . Criteria

Product Name: Dificid	
Approval Length	1 year(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 clostridium difficile infection (CDI)

AND

2 - Patient is 6 months of age or older

AND

3 - One of the following:

3.1 Patient has an initial episode of CDI and one of the following:

- Patient is at increased risk of CDI recurrence
- Documentation supporting diagnosis of vancomycin-resistant pseudomembraneous colitis

OR

3.2 Patient has a recurrent episode of CDI

2 . Revision History

Date	Notes
4/7/2023	SPDL eff 7.1.23

Direct Oral Anticoagulants

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-137624
Guideline Name	Direct Oral Anticoagulants
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

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

Product Name	Generic Name	GPI	Brand/Generic
XARELTO	RIVAROXABAN FOR SUSP 1 MG/ML	83370060001920	Brand

Approval Criteria

1 - Patient is under 12 years of age

OR

2 - Patient is unable to swallow tablets

Product Name: Dabigatran	
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
DABIGATRAN ETEXILATE	DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ)	83337030200140	Generic

Approval Criteria

1 - Patient has tried and failed Brand Pradaxa

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

Product Name	Generic Name	GPI	Brand/Generic
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

Approval Criteria

1 - Patient has tried Eliquis and Xarelto

OR

2 - Documentation of medical justification for use of Savaysa

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

Product Name	Generic Name	GPI	Brand/Generic
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

Approval Criteria

1 - Patient is under 8 years of age

OR

2 - Patient is unable to swallow capsules

OR

3 - Documentation of medical rational for use of pellet formulation

2 . Revision History

Date	Notes
12/11/2023	Updaed Xarelto susp ST age to 12.

Disposable Insulin Delivery Devices

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-158063
Guideline Name	Disposable Insulin Delivery Devices
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	12/1/2024

1 . Criteria

Product Name: Omnipod Classic (Gen 3) pods and kits, Omnipod Dash (Gen 4) pods and kits, Omnipod Go, V-Go 20, V-Go 30, V-Go 40, CeQur Simplicity 2U patch and inserter*	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OMNIPOD DASH PDM KIT (GEN 4)	*INSULIN INFUSION DISPOSABLE PUMP KIT***	97201030506400	Brand
OMNIPOD DASH INTRO KIT (GEN 4)	*INSULIN INFUSION DISPOSABLE PUMP KIT***	97201030506400	Brand

CEQUR SIMPLICITY 2U	INJECTION DEVICE FOR INSULIN	97051050126220	Brand
CEQUR SIMPLICITY INSERTER	*INJECTION DEVICE FOR INSULIN - ACCESSORIES***	97051050126300	Brand
OMNIPOD CLASSIC PODS (GEN 3)	*INSULIN INFUSION DISPOSABLE PUMP RESERVOIR***	97201030506300	Brand
OMNIPOD DASH PODS (GEN 4)	*INSULIN INFUSION DISPOSABLE PUMP RESERVOIR***	97201030506300	Brand
OMNIPOD GO 10 UNITS/DAY	*INSULIN INFUSION DISPOSABLE PUMP KIT 10 UNIT/24HR***	97201030506410	Brand
OMNIPOD GO 15 UNITS/DAY	*INSULIN INFUSION DISPOSABLE PUMP KIT 15 UNIT/24HR***	97201030506415	Brand
OMNIPOD GO 20 UNITS/DAY	*INSULIN INFUSION DISPOSABLE PUMP KIT 20 UNIT/24HR***	97201030506420	Brand
V-GO 20	*INSULIN INFUSION DISPOSABLE PUMP KIT 20 UNIT/24HR***	97201030506420	Brand
OMNIPOD GO 25 UNITS/DAY	*INSULIN INFUSION DISPOSABLE PUMP KIT 25 UNIT/24HR***	97201030506425	Brand
OMNIPOD GO 30 UNITS/DAY	*INSULIN INFUSION DISPOSABLE PUMP KIT 30 UNIT/24HR***	97201030506430	Brand
V-GO 30	*INSULIN INFUSION DISPOSABLE PUMP KIT 30 UNIT/24HR***	97201030506430	Brand
OMNIPOD GO 35 UNITS/DAY	*INSULIN INFUSION DISPOSABLE PUMP KIT 35 UNIT/24HR***	97201030506435	Brand
OMNIPOD GO 40 UNITS/DAY	*INSULIN INFUSION DISPOSABLE PUMP KIT 40 UNIT/24HR***	97201030506440	Brand
V-GO 40	*INSULIN INFUSION DISPOSABLE PUMP KIT 40 UNIT/24HR***	97201030506440	Brand

Approval Criteria

1 - Diagnosis of Type I or Type II diabetes mellitus requiring insulin treatment

AND

2 - Daily dosing requirements are less than the disposable insulin delivery device's capacity

AND

3 - One of the following:

3.1 Patient has difficulty maintaining stable blood glucose levels (hyperglycemia or hypoglycemia) despite intensive insulin therapy and blood glucose monitoring (3 or more injections and blood glucose readings per day)

OR

3.2 Patient is less than 18 years of age and requires intensive insulin therapy and blood glucose monitoring (3 or more injections and blood glucose readings per day)

OR

3.3 Patient has physical impairments resulting in difficulty with self-injection of insulin

OR

3.4 Patient is pregnant

OR

3.5 Prescriber has provided other valid medical justification for use of a disposable insulin delivery device

AND

4 - For all requests other than CeQur Simplicity, other long-acting insulins/insulin analogs will be discontinued

Notes	*For Omnipod 5 see Omnipod 5 guideline

2 . Revision History

Date	Notes
10/28/2024	Updated Omnipod classic pod, Omnipod Dash pod and V-Go GPIs. Added Omnipod Go GPIs. Clarified hyper and hypo in step 3.1. Updated language to physical impairments in step 3.3. Updated step 4 to be excluded for CeQur Simplicity.

Dojolvi

Prior Authorization Guideline

Guideline ID	GL-151783
Guideline Name	Dojolvi
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	9/1/2024

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

8/14/2024	New guideline

Doptelet

Prior Authorization Guideline

Guideline ID	GL-120802
Guideline Name	Doptelet
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2023

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

2 . Revision History

Date	Notes
2/1/2023	Updated T/F language.

DPP4 Inhibitors and Combination Agents

Prior Authorization Guideline

Guideline ID	GL-161804
Guideline Name	DPP4 Inhibitors and Combination Agents
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2025

1 . Criteria

Product Name: Januvia, Tradjenta, Janumet, Janumet XR, Jentadueto, Jentadueto XR	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
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
TRADJENTA	LINAGLIPTIN TAB 5 MG	27550050000320	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
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

Approval Criteria

1 - Patient has tried metformin for 90 days of the past 120 days

OR

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

Product Name: Brand Alogliptin, Brand Onglyza, generic saxagliptin, Sitagliptin, Zituvio	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/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
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
ONGLYZA	SAXAGLIPTIN HCL TAB 2.5 MG (BASE EQUIV)	27550065100320	Brand
ONGLYZA	SAXAGLIPTIN HCL TAB 5 MG (BASE EQUIV)	27550065100330	Brand
SITAGLIPTIN	SITAGLIPTIN TAB 25 MG	27550070000320	Brand
SITAGLIPTIN	SITAGLIPTIN TAB 50 MG	27550070000330	Brand
SITAGLIPTIN	SITAGLIPTIN TAB 100 MG	27550070000340	Brand

Approval Criteria

1 - Patient has tried a preferred* medication for 90 days of the past 120 days

OR

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

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

Product Name: Brand Alogliptin/Metformin, Brand Kombiglyze XR, generic saxagliptin/metformin ER, Sitagliptin/Metformin, Zituvimet, Zituvimet XR	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
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
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
KOMBIGLYZE XR	SAXAGLIPTIN-METFORMIN HCL TAB ER 24HR 2.5-1000 MG	27992502607520	Brand
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
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
ZITUVIMET	SITAGLIPTIN FREE BASE-METFORMIN HCL TAB 50-500 MG	27992502690320	Brand
ZITUVIMET	SITAGLIPTIN FREE BASE-METFORMIN HCL TAB 50-1000 MG	27992502690330	Brand
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
ZITUVIMET XR	SITAGLIPTIN FREE BASE-METFORMIN HCL TAB ER 24HR 100-1000 MG	27992502697540	Brand

Approval Criteria

1 - Patient has tried a preferred* combination medication for 90 days of the past 120 days

OR

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

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

Product Name: Brand Alogliptin/Pioglitazone

Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
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 - Patient has tried and failed combination therapy with preferred* medications of the same classes for 90 days of the past 120 days

OR

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

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

2 . Revision History

Date	Notes
12/10/2024	Updated lookback period to 90days within 120 days or medical rationale. Added Zituvimet XR.

Dronabinol

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-126573
Guideline Name	Dronabinol
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	7/1/2023

1 . Criteria

Product Name: Brand Marinol, Generic dronabinol	
Diagnosis	Malignant cancer
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DRONABINOL	DRONABINOL CAP 2.5 MG	50300030000110	Generic
MARINOL	DRONABINOL CAP 2.5 MG	50300030000110	Brand
DRONABINOL	DRONABINOL CAP 5 MG	50300030000115	Generic
MARINOL	DRONABINOL CAP 5 MG	50300030000115	Brand

DRONABINOL	DRONABINOL CAP 10 MG	50300030000120	Generic
MARINOL	DRONABINOL CAP 10 MG	50300030000120	Brand

Approval Criteria

1 - Diagnosis of malignant cancer

AND

2 - History of an antineoplastic or radiation therapy in the past 45 days

AND

3 - One of the following:

3.1 Patient has tried and failed ONE of the following in the past 6 months:

- An oral selective 5HT3 receptor antagonist
- A substance P/NK-1 receptor antagonist

OR

3.2 Medical justification for use of dronabinol over BOTH of the following:

- Selective 5-HT3 receptor antagonists
- Substance P/NK-1 receptor antagonists

AND

4 - Patient is NOT currently receiving megestrol acetate suspension

Product Name: Brand Marinol, Generic dronabinol	
Diagnosis	Malignant cancer
Approval Length	1 year(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DRONABINOL	DRONABINOL CAP 2.5 MG	50300030000110	Generic
MARINOL	DRONABINOL CAP 2.5 MG	50300030000110	Brand
DRONABINOL	DRONABINOL CAP 5 MG	50300030000115	Generic
MARINOL	DRONABINOL CAP 5 MG	50300030000115	Brand
DRONABINOL	DRONABINOL CAP 10 MG	50300030000120	Generic
MARINOL	DRONABINOL CAP 10 MG	50300030000120	Brand

Approval Criteria

1 - Patient has a history of the requested agent

AND

2 - Diagnosis of malignant cancer

AND

3 - History of an antineoplastic or radiation therapy in the past 45 days

AND

4 - Patient is NOT currently receiving megestrol acetate suspension

Product Name: Brand Marinol, Generic dronabinol	
Diagnosis	HIV/AIDS
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DRONABINOL	DRONABINOL CAP 2.5 MG	50300030000110	Generic
MARINOL	DRONABINOL CAP 2.5 MG	50300030000110	Brand
DRONABINOL	DRONABINOL CAP 5 MG	50300030000115	Generic
MARINOL	DRONABINOL CAP 5 MG	50300030000115	Brand
DRONABINOL	DRONABINOL CAP 10 MG	50300030000120	Generic
MARINOL	DRONABINOL CAP 10 MG	50300030000120	Brand

Approval Criteria

1 - Diagnosis of HIV/AIDS with ONE of the following concurrent diagnoses in the past 2 years:

- Cachexia
- Anorexia
- Failure to thrive

AND

2 - Patient is 18 years of age or older

AND

3 - Patient is NOT currently receiving megestrol acetate suspension

AND

4 - ONE of the following:

- Member has tried and failed megestrol acetate suspension in the past six months
- Medical justification for use of dronabinol over megestrol acetate suspension

Product Name: Brand Marinol, Generic dronabinol	
Diagnosis	HIV/AIDS

Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DRONABINOL	DRONABINOL CAP 2.5 MG	50300030000110	Generic
MARINOL	DRONABINOL CAP 2.5 MG	50300030000110	Brand
DRONABINOL	DRONABINOL CAP 5 MG	50300030000115	Generic
MARINOL	DRONABINOL CAP 5 MG	50300030000115	Brand
DRONABINOL	DRONABINOL CAP 10 MG	50300030000120	Generic
MARINOL	DRONABINOL CAP 10 MG	50300030000120	Brand

Approval Criteria

1 - Patient has a history of the requested agent

AND

2 - Diagnosis of HIV/AIDS with ONE of the following concurrent diagnoses in the past 2 years:

- Cachexia
- Anorexia
- Failure to thrive

AND

3 - Patient is NOT currently receiving megestrol acetate suspension

Product Name: Brand Marinol, Generic dronabinol	
Diagnosis	Failure to thrive
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DRONABINOL	DRONABINOL CAP 2.5 MG	50300030000110	Generic
MARINOL	DRONABINOL CAP 2.5 MG	50300030000110	Brand
DRONABINOL	DRONABINOL CAP 5 MG	50300030000115	Generic
MARINOL	DRONABINOL CAP 5 MG	50300030000115	Brand
DRONABINOL	DRONABINOL CAP 10 MG	50300030000120	Generic
MARINOL	DRONABINOL CAP 10 MG	50300030000120	Brand

Approval Criteria

1 - Diagnosis of failure to thrive

AND

2 - Patient is 18 years of age or older

AND

3 - One of the following:

- Patient has tried and failed megestrol acetate suspension in the past six months
- Medical justification for use of dronabinol over megestrol acetate suspension

AND

4 - Patient is NOT currently receiving megestrol acetate suspension

Product Name: Brand Marinol, Generic dronabinol	
Diagnosis	Failure to thrive
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DRONABINOL	DRONABINOL CAP 2.5 MG	50300030000110	Generic
MARINOL	DRONABINOL CAP 2.5 MG	50300030000110	Brand
DRONABINOL	DRONABINOL CAP 5 MG	50300030000115	Generic
MARINOL	DRONABINOL CAP 5 MG	50300030000115	Brand
DRONABINOL	DRONABINOL CAP 10 MG	50300030000120	Generic
MARINOL	DRONABINOL CAP 10 MG	50300030000120	Brand

Approval Criteria

1 - Patient has a history of the requested medication

AND

2 - Diagnosis of failure to thrive

AND

3 - Patient is NOT currently receiving megestrol acetate suspension

2 . Revision History

Date	Notes
6/12/2023	Removed Syndros from the criteria

Dry Eye Disease or Keratoconjunctivitis Agents

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-148906
Guideline Name	Dry Eye Disease or Keratoconjunctivitis Agents
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

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

Product Name	Generic Name	GPI	Brand/Generic
CEQUA	CYCLOSPORINE (OPHTH) SOLN 0.09% (PF)	86720020002040	Brand

Approval Criteria

1 - Diagnosis of keratoconjunctivitis sicca (dry eye disease)

AND

2 - One of the following:

2.1 Previous trial and failure of BOTH Restasis single-dose vials and Xiidra

OR

2.2 Prescriber has provided valid medical justification for the use of Cequa over Restasis single-dose vials and Xiidra

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

Product Name	Generic Name	GPI	Brand/Generic
MIEBO	PERFLUOROHEXYLOCTANE OPHTH SOLN 1.338 GM/ML	86807018002020	Brand

Approval Criteria

1 - Diagnosis of dry eye disease

AND

2 - One of the following:

2.1 Previous trial and failure of both Restasis single-dose vials and Xiidra

OR

2.2 Prescriber has provided valid medical justification for the use of Miebo (perfluorohexyloctane) over Restasis single-dose vials and Xiidra

Product Name: Restasis MultiDose	
Approval Length	1 year(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

Approval Criteria

1 - Must meet all of the following:

1.1 Diagnosis of keratoconjunctivitis sicca (dry eye disease)

AND

1.2 One of the following:

1.2.1 Previous trial and failure of both Restasis single-dose vials and Xiidra

OR

1.2.2 Prescriber has provided valid medical justification for the use of Restasis MultiDose over Restasis single-dose vials and Xiidra

Product Name: Brand Restasis Single-Dose Vials, generic cyclosporine single-dose vials	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RESTASIS	CYCLOSPORINE (OPHTH) EMULSION 0.05%	86720020001620	Brand
CYCLOSPORINE	CYCLOSPORINE (OPHTH) EMULSION 0.05%	86720020001620	Generic

Approval Criteria

1 - Must meet both of the following:

1.1 Diagnosis of keratoconjunctivitis sicca (dry eye disease)

AND

1.2 Trial of artificial tears within the past 90 days

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

Product Name	Generic Name	GPI	Brand/Generic
TYRVAYA	VARENICLINE TARTRATE NASAL SOLN 0.03 MG/ACT	86280080202020	Brand

Approval Criteria

1 - Diagnosis of dry eye disease

AND

2 - One of the following:

2.1 Previous trial and failure of both Restasis single-dose vials and Xiidra

OR

2.2 Prescriber has provided valid medical justification for the use of Tyrvaya over Restasis single-dose vials and Xiidra

Product Name: Verkazia, Cyclosporine in Klarity	
Approval Length	1 year(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 - Must meet all of the following:

1.1 Diagnosis of vernal keratoconjunctivitis

AND

1.2 One of the following:

1.2.1 Trial and failure of two of the following for at least 15 days (per agent):

- Artificial tears
- Ophthalmic antihistamines (e.g., olopatadine, azelastine, ketotifen)
- Ophthalmic corticosteroids (e.g., dexamethasone, fluorometholone, loteprednol, prednisolone)
- Ophthalmic mast cell stabilizers (e.g., cromolyn sodium)

OR

1.2.2 Prescriber has provided valid medical justification for the use of Verkazia/Cyclosporine

in Klarity over artificial tears, ophthalmic antihistamines, corticosteroids, and mast cell stabilizers

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

Product Name	Generic Name	GPI	Brand/Generic
VEVYE	CYCLOSPORINE (OPHTH) SOLN 0.1%	86720020002043	Brand

Approval Criteria

1 - Diagnosis of keratoconjunctivitis sicca (dry eye disease)

AND

2 - One of the following:

2.1 Previous trial and failure of BOTH Restasis single-dose vials and Xiidra

OR

2.2 Prescriber has provided valid medical justification for the use of Vevye over Restasis single-dose vials and Xiidra

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

Product Name	Generic Name	GPI	Brand/Generic
XIIDRA	LIFITEGRAST OPHTH SOLN 5%	86734050002020	Brand

Approval Criteria

1 - Must meet both of the following:

1.1 Diagnosis of dry eye disease

AND

1.2 Trial of artificial tears within the past 90 days

Product Name: Eysuvis	
Approval Length	14 Day(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
EYSUVIS	LOTEPREDNOL ETABONATE OPHTH SUSP 0.25%	86300035101825	Brand

Approval Criteria

1 - Must meet all of the following:

1.1 Diagnosis of dry eye disease

AND

1.2 Requested duration of therapy does not exceed 14 days

AND

1.3 One of the following:

1.3.1 Previous trial and failure of both Restasis single-dose vials and Xiidra

OR

1.3.2 Prescriber has provided valid medical justification for the use of Eysuvis over Restasis single-dose vials and Xiidra

Product Name: Cequa, Miebo, Restasis Multidose, Tyrvaya, Vevye	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RESTASIS MULTIDOSE	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	86807018002020	Brand
VEVYE	CYCLOSPORINE (OPHTH) SOLN 0.1%	86720020002043	Brand

Approval Criteria

1 - History of the requested agent in the past 180 days

AND

2 - One of the following:

2.1 Previous trial and failure of both Restasis single-dose vials and Xiidra

OR

2.2 Prescriber has provided valid medical justification for the use of the requested drug over Restasis single-dose vials and Xiidra

Product Name: Brand Restasis Single-Dose Vials, generic cyclosporine single-dose vials, Verkazia, Cyclosporine in Klarity, Xiidra	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RESTASIS	CYCLOSPORINE (OPHTH) EMULSION 0.05%	86720020001620	Brand
XIIDRA	LIFITEGRAST OPHTH SOLN 5%	86734050002020	Brand
CYCLOSPORINE	CYCLOSPORINE (OPHTH) EMULSION 0.05%	86720020001620	Generic
VERKAZIA	CYCLOSPORINE (OPHTH) EMULSION 0.1%	86720020001630	Brand
CYCLOSPORINE IN KLARITY	CYCLOSPORINE (OPHTH) EMULSION 0.1%	86720020001630	Brand

Approval Criteria

1 - History of the requested agent in the past 180 days

Product Name: Eysuvis	
Approval Length	14 Day(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
EYSUVIS	LOTEPREDNOL ETABONATE OPHTH SUSP 0.25%	86300035101825	Brand
KLARITY-C DROPS	CYCLOSPORINE (OPHTH) EMULSION 0.1%	86720020001630	Brand

Approval Criteria

1 - History of the requested agent

AND

2 - Requested duration of therapy does not exceed 14 days

AND

3 - One of the following:

3.1 Previous trial and failure of both Restasis single-dose vials and Xiidra

OR

3.2 Prescriber has provided valid medical justification for the use of Eysuvis over Restasis single-dose vials and Xiidra

AND

4 - Prescriber has performed an ophthalmic evaluation under magnification AND an examination of intraocular pressure and has determined that Eysuvis is an appropriate treatment

2 . Revision History

Date	Notes
6/26/2024	Addition of Vevye. Updated reauth criteria. Aligned criteria to policy.

Duopa

Prior Authorization Guideline

Guideline ID	GL-115342
Guideline Name	Duopa
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	12/1/2022

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

2 . Revision History

Date	Notes
10/13/2022	Updated trial, failure language for step

Egrifta

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-86261
Guideline Name	Egrifta
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	5/11/2021
P&T Approval Date:	
P&T Revision Date:	

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

2 . Revision History

Date	Notes
4/30/2021	Update GPI's and product name list

Electrolyte Depleters

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-144364
Guideline Name	Electrolyte Depleters
Formulary	• Medicaid - Community & State Indiana • Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2024

1 . Criteria

Product Name: Fosrenol Powder Packets	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
FOSRENOL	LANTHANUM CARBONATE ORAL POWDER PACK 750 MG (ELEMENTAL)	52800045203030	Brand
FOSRENOL	LANTHANUM CARBONATE ORAL POWDER PACK 1000 MG (ELEMENTAL)	52800045203040	Brand

Approval Criteria

1 - Patient is under 18 years of age

OR

2 - Patient is unable to swallow tablets

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

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 - Patient has tried and failed preferred phosphate binders

OR

2 - Medical rationale for use of requested medication over all preferred phosphate binders

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

2 . Revision History

Date	Notes
3/14/2024	Added SP formulary and Xphozah criteria.

Elmiron

Prior Authorization Guideline

Guideline ID	GL-97793
Guideline Name	Elmiron
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2022

1 . Criteria

Product Name: Elmiron	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ELMIRON	PENTOSAN POLYSULFATE SODIUM CAPS 100 MG	56500060100110	Brand

Approval Criteria

1 - Submission of medical records showing diagnosis of bladder pain or discomfort associated with interstitial cystitis

OR

2 - Submission of medical records showing diagnosis of hemorrhagic cystitis in a patient who previously received pelvic irradiation or chemotherapy with cyclophosphamide

Product Name: Elmiron	
Approval Length	3 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ELMIRON	PENTOSAN POLYSULFATE SODIUM CAPS 100 MG	56500060100110	Brand

Approval Criteria

1 - Patient has history of the requested medication within the past 90 days

AND

2 - Documentation of symptom improvement (i.e., pain relief)

2 . Revision History

Date	Notes
11/3/2021	Updated all criteria to match state policy.

Empaveli

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-149996
Guideline Name	Empaveli
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	8/1/2024

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
7/18/2024	In initial auth section, simplified criteria language for converting to ne w complement inhibitor therapy.

Emverm

Prior Authorization Guideline

Guideline ID	GL-108749
Guideline Name	Emverm
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	8/1/2022

1 . Criteria

Product Name: Emverm	
Diagnosis	Enterobius vermicularis (pinworm)
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 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: Emverm	
Diagnosis	Echinococcosis (Tapeworm)
Approval Length	6 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 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: Emverm	
Diagnosis	Ascariasis (Roundworm)
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 Ascariasis (Roundworm)

Product Name: Emverm	
Diagnosis	Toxocariasis (Roundworm)
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 Toxocariasis (Roundworm)

Product Name: Emverm	
Diagnosis	Trichinellosis

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 Trichinellosis

Product Name: Emverm	
Diagnosis	Trichuriasis (Whipworm)
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 Trichuriasis (Whipworm)

Product Name: Emverm	
Diagnosis	Capillariasis
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 Capillariasis

Product Name: Emverm	
Diagnosis	Baylisascaris
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 Baylisascaris

2 . Revision History

Date	Notes
6/28/2022	Updated trial/failure language

Endari

Prior Authorization Guideline

Guideline ID	GL-123757
Guideline Name	Endari
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	5/1/2023

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

2 . Revision History

Date	Notes

3/24/2023	Copy NY

Enspryng

Prior Authorization Guideline

Guideline ID	GL-138859
Guideline Name	Enspryng
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	2/1/2024

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 - One of the following:

- History of one or more relapses that required rescue therapy during the previous 12 months
- History of two or more relapses that required rescue therapy during the previous 24 months

AND

4 - Prescribed by, or in consultation with, a neurologist

AND

5 - Patient is NOT receiving Enspryng in combination with any of the following:

- 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)]
- 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)]
- Anti-IL6 (anti-interleukin-6) therapy [e.g., Actemra (tocilizumab)]
- B-cell depletion therapy [e.g., rituximab, Uplizna (inebilizumab)]

2 . Revision History

Date	Notes
1/10/2024	Copy Core with the exception of t/f of rituximab

Enspryng

Prior Authorization Guideline

Guideline ID	GL-117570
Guideline Name	Enspryng
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2023

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 - 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)]
- 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 - 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)]
- Anti-IL6 (anti-interleukin-6) therapy [e.g., Actemra (tocilizumab)]
- B-cell depletion therapy [e.g., rituximab, Uplizna (inebilizumab)]

Erivedge

Prior Authorization Guideline

Guideline ID	GL-117571
Guideline Name	Erivedge
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2023

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-138263
Guideline Name	Erleada
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	2/1/2024

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

2 . Revision History

Date	Notes
12/28/2023	Updated GPI list.

Esbriet, Ofev

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-147181
Guideline Name	Esbriet, Ofev
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2024

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 - 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 - 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 - 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 - 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 - The prescriber is a pulmonologist

2 . Revision History

Date	Notes
5/8/2024	Removed criteria that Esbriet and ofev should not be used in combin ation

Exkivity

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-99462
Guideline Name	Exkivity
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	2/1/2022

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 - Exkivity will be approved for uses 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

2 . Revision History

Date	Notes
12/8/2021	New guideline

Fabhalta

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-150120
Guideline Name	Fabhalta
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	8/1/2024

1 . Criteria

Product Name: Fabhalta	
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, Soliris, Ultomiris)

OR

2.2 Patient is currently receiving another complement inhibitor (e.g., Empaveli, 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	
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, Soliris, Ultomiris)

AND

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

- Hematologist
- Oncologist

2 . Revision History

Date	Notes
7/23/2024	Simplified criteria language for converting to new complement inhibit or therapy.

Febuxostat

Prior Authorization Guideline

Guideline ID	GL-128909
Guideline Name	Febuxostat
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	10/1/2023

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-126579
Guideline Name	Fentanyl IR
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	7/1/2023

1 . Criteria

Product Name: Brand Actiq, generic fentanyl citrate lozenge, Fentora, fentanyl citrate buccal tabs	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
FENTANYL CITRATE ORAL TRANSMUCOSAL	FENTANYL CITRATE LOZENGE ON A HANDLE 200 MCG	65100025108450	Generic
ACTIQ	FENTANYL CITRATE LOZENGE ON A HANDLE 200 MCG	65100025108450	Brand
FENTANYL CITRATE ORAL TRANSMUCOSAL	FENTANYL CITRATE LOZENGE ON A HANDLE 400 MCG	65100025108455	Generic

ACTIQ	FENTANYL CITRATE LOZENGE ON A HANDLE 400 MCG	65100025108455	Brand
FENTANYL CITRATE ORAL TRANSMUCOSAL	FENTANYL CITRATE LOZENGE ON A HANDLE 600 MCG	65100025108460	Generic
ACTIQ	FENTANYL CITRATE LOZENGE ON A HANDLE 600 MCG	65100025108460	Brand
FENTANYL CITRATE ORAL TRANSMUCOSAL	FENTANYL CITRATE LOZENGE ON A HANDLE 800 MCG	65100025108465	Generic
ACTIQ	FENTANYL CITRATE LOZENGE ON A HANDLE 800 MCG	65100025108465	Brand
FENTANYL CITRATE ORAL TRANSMUCOSAL	FENTANYL CITRATE LOZENGE ON A HANDLE 1200 MCG	65100025108475	Generic
ACTIQ	FENTANYL CITRATE LOZENGE ON A HANDLE 1200 MCG	65100025108475	Brand
FENTANYL CITRATE ORAL TRANSMUCOSAL	FENTANYL CITRATE LOZENGE ON A HANDLE 1600 MCG	65100025108485	Generic
ACTIQ	FENTANYL CITRATE LOZENGE ON A HANDLE 1600 MCG	65100025108485	Brand
FENTORA	FENTANYL CITRATE BUCCAL TAB 100 MCG (BASE EQUIV)	65100025100310	Generic
FENTANYL CITRATE	FENTANYL CITRATE BUCCAL TAB 100 MCG (BASE EQUIV)	65100025100310	Generic
FENTORA	FENTANYL CITRATE BUCCAL TAB 200 MCG (BASE EQUIV)	65100025100320	Generic
FENTANYL CITRATE	FENTANYL CITRATE BUCCAL TAB 200 MCG (BASE EQUIV)	65100025100320	Generic
FENTORA	FENTANYL CITRATE BUCCAL TAB 400 MCG (BASE EQUIV)	65100025100330	Generic
FENTANYL CITRATE	FENTANYL CITRATE BUCCAL TAB 400 MCG (BASE EQUIV)	65100025100330	Generic
FENTORA	FENTANYL CITRATE BUCCAL TAB 600 MCG (BASE EQUIV)	65100025100340	Generic
FENTANYL CITRATE	FENTANYL CITRATE BUCCAL TAB 600 MCG (BASE EQUIV)	65100025100340	Generic
FENTORA	FENTANYL CITRATE BUCCAL TAB 800 MCG (BASE EQUIV)	65100025100350	Generic
FENTANYL CITRATE	FENTANYL CITRATE BUCCAL TAB 800 MCG (BASE EQUIV)	65100025100350	Generic

Approval Criteria

1 - Diagnosis of cancer or diagnosis within approved compendia

AND

2 - Member is enrolled in the TIRF REMS (Transmucosal Immediate Release Fentanyl Risk Evaluation and Mitigation Strategy) Access program and prescriber is monitoring in accordance with REMS requirements

AND

3 - Patient is currently utilizing a long-acting opioid medication around the clock

AND

4 - Patient must be tolerant to opioids, as defined by at least one week without adequate pain relief using ONE of the following:

- Greater than or equal to 60 milligrams (mg) oral morphine per day
- Greater than or equal to 25 micrograms per hour (mcg/hr) transdermal fentanyl
- Greater than or equal to 30 mg oral oxycodone per day
- Greater than or equal to 8 mg oral hydromorphone per day
- Greater than or equal to 25 mg oral oxymorphone per day
- Equianalgesic dose of another opioid

AND

5 - ONE of the following:

- If the request is for Actiq (fentanyl citrate lozenge) the patient is 16 years of age or older
- If the request is for Fentora (fentanyl citrate buccal tab) or Subsys the patient is 18 years of age or older

AND

6 - No concurrent claims for buprenorphine/naloxone or buprenorphine therapy, excluding buprenorphine patches (Butrans) and sublingual buprenorphine indicated for the treatment of pain (Belbuca), within the past 45 days*

AND

7 - Patient is not using concurrently with a carisoprodol-containing product

AND

8 - No concurrent claims for Lybalvi (olanzapine/samidorphan) within the past 45 days

AND

9 - Fewer than 5 different prescribers of opiates in the past 60 days

AND

10 - One of the following:

10.1 Member is not using the recommended medication concurrently with a benzodiazepine (claim within the past 30 days)

OR

10.2 Both of the following:

- Days' supply for the requested opioid is 7 days or less
- Including the days' supply for the requested agent, the patient will not exceed 7 days of concurrent opiate/benzodiazepine therapy in the past 180 days

OR

10.3 Patient has utilized concurrent benzodiazepine/opiate therapy, including any cross-tapered or discontinued agents, for at least 90 of the past 120 days

OR

10.4 ALL of the following for concurrent opiate/benzodiazepine therapy exceeding 7 days in the past 180 days:

10.4.1 Indications provided for both the benzodiazepine agent(s) and the opioid agent(s)

AND

10.4.2 Documentation of previous therapies attempted for the given indications

AND

10.4.3 Prescriber attests to ALL of the following:

- The patient's INSPECT report has been evaluated and continues to be evaluated on a regular basis
- The patient has been educated in regard to the risks of concurrent utilization of opioid and benzodiazepine therapy, and the patient accepts these risks
- The prescriber has consulted any other prescribers involved in concurrent therapy and all prescribers agree to pursue concurrent opioid and benzodiazepine therapy for the patient, if applicable
- The prescriber acknowledges the risk of adverse event(s), including respiratory depression, coma, and death, associated with concurrent utilization

Notes	*Unless faxed documentation has been received from the opioid prescriber with approval for opioid therapy from the buprenorphine or buprenorphine/naloxone prescriber.

Product Name: Brand Actiq, generic fentanyl citrate lozenge, Fentora, fentanyl citrate buccal tabs	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
FENTANYL CITRATE ORAL TRANSMUCOSAL	FENTANYL CITRATE LOZENGE ON A HANDLE 200 MCG	65100025108450	Generic
ACTIQ	FENTANYL CITRATE LOZENGE ON A HANDLE 200 MCG	65100025108450	Brand

FENTANYL CITRATE ORAL TRANSMUCOSAL	FENTANYL CITRATE LOZENGE ON A HANDLE 400 MCG	65100025108455	Generic
ACTIQ	FENTANYL CITRATE LOZENGE ON A HANDLE 400 MCG	65100025108455	Brand
FENTANYL CITRATE ORAL TRANSMUCOSAL	FENTANYL CITRATE LOZENGE ON A HANDLE 600 MCG	65100025108460	Generic
ACTIQ	FENTANYL CITRATE LOZENGE ON A HANDLE 600 MCG	65100025108460	Brand
FENTANYL CITRATE ORAL TRANSMUCOSAL	FENTANYL CITRATE LOZENGE ON A HANDLE 800 MCG	65100025108465	Generic
ACTIQ	FENTANYL CITRATE LOZENGE ON A HANDLE 800 MCG	65100025108465	Brand
FENTANYL CITRATE ORAL TRANSMUCOSAL	FENTANYL CITRATE LOZENGE ON A HANDLE 1200 MCG	65100025108475	Generic
ACTIQ	FENTANYL CITRATE LOZENGE ON A HANDLE 1200 MCG	65100025108475	Brand
FENTANYL CITRATE ORAL TRANSMUCOSAL	FENTANYL CITRATE LOZENGE ON A HANDLE 1600 MCG	65100025108485	Generic
ACTIQ	FENTANYL CITRATE LOZENGE ON A HANDLE 1600 MCG	65100025108485	Brand
FENTORA	FENTANYL CITRATE BUCCAL TAB 100 MCG (BASE EQUIV)	65100025100310	Generic
FENTANYL CITRATE	FENTANYL CITRATE BUCCAL TAB 100 MCG (BASE EQUIV)	65100025100310	Generic
FENTORA	FENTANYL CITRATE BUCCAL TAB 200 MCG (BASE EQUIV)	65100025100320	Generic
FENTANYL CITRATE	FENTANYL CITRATE BUCCAL TAB 200 MCG (BASE EQUIV)	65100025100320	Generic
FENTORA	FENTANYL CITRATE BUCCAL TAB 400 MCG (BASE EQUIV)	65100025100330	Generic
FENTANYL CITRATE	FENTANYL CITRATE BUCCAL TAB 400 MCG (BASE EQUIV)	65100025100330	Generic
FENTORA	FENTANYL CITRATE BUCCAL TAB 600 MCG (BASE EQUIV)	65100025100340	Generic
FENTANYL CITRATE	FENTANYL CITRATE BUCCAL TAB 600 MCG (BASE EQUIV)	65100025100340	Generic
FENTORA	FENTANYL CITRATE BUCCAL TAB 800 MCG (BASE EQUIV)	65100025100350	Generic
FENTANYL CITRATE	FENTANYL CITRATE BUCCAL TAB 800 MCG (BASE EQUIV)	65100025100350	Generic

Approval Criteria

1 - History of the requested agent within the past 45 days

AND

2 - If the request is for Actiq (fentanyl citrate lozenge), one of the following:

- Patient is maintaining the same strength and not exceeding 4 units of a single strength per day
- Patient is increasing strength and does not exceed 6 units of a single strength per day

AND

3 - No concurrent claims for buprenorphine/naloxone or buprenorphine therapy, excluding buprenorphine patches (Butrans) and sublingual buprenorphine indicated for the treatment of pain (Belbuca), within the past 45 days*

AND

4 - Patient is not using concurrently with a carisoprodol-containing product

AND

5 - No concurrent claims for Lybalvi (olanzapine/samidorphan) within the past 45 days

AND

6 - Fewer than 5 different prescribers of opiates in the past 60 days

AND

7 - One of the following:

7.1 Member is not using the recommended medication concurrently with a benzodiazepine (claim within the past 30 days)

OR

7.2 Both of the following:

- Days' supply for the requested opioid is 7 days or less
- Including the days' supply for the requested agent, the patient will not exceed 7 days of concurrent opiate/benzodiazepine therapy in the past 180 days

OR

7.3 Patient has utilized concurrent benzodiazepine/opiate therapy, including any cross-tapered or discontinued agents, for at least 90 of the past 120 days

OR

7.4 ALL of the following for concurrent opiate/benzodiazepine therapy exceeding 7 days in the past 180 days:

7.4.1 Indications provided for both the benzodiazepine agent(s) and the opioid agent(s)

AND

7.4.2 Documentation of previous therapies attempted for the given indications

AND

7.4.3 Prescriber attests to ALL of the following:

- The patient's INSPECT report has been evaluated and continues to be evaluated on a regular basis
- The patient has been educated in regard to the risks of concurrent utilization of opioid and benzodiazepine therapy, and the patient accepts these risks
- The prescriber has consulted any other prescribers involved in concurrent therapy and all prescribers agree to pursue concurrent opioid and benzodiazepine therapy for the patient, if applicable

• The prescriber acknowledges the risk of adverse event(s), including respiratory depression, coma, and death, associated with concurrent utilization	
Notes	*Unless faxed documentation has been received from the opioid prescriber with approval for opioid therapy from the buprenorphine or buprenorphine/naloxone prescriber.

2 . Revision History

Date	Notes
6/14/2023	Removed Subsys, updated initial criteria and DUR criteria. Added Re-auth box.

Fexofenadine

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-96662
Guideline Name	Fexofenadine
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	10/15/2021

1 . Criteria

Product Name: Brand Allegra tablets, generic fexofenadine tablets	
Approval Length	12 month(s)
Guideline Type	Step Therapy

Product Name	Generic Name	GPI	Brand/Generic
FEXOFENADINE HYDROCHLORIDE	FEXOFENADINE HCL TAB 60 MG	41550024100320	Generic
ALLER-EASE	FEXOFENADINE HCL TAB 60 MG	41550024100320	Generic
WAL-FEX ALLERGY 12 HOUR	FEXOFENADINE HCL TAB 60 MG	41550024100320	Generic
KP FEXOFENADINE HCL	FEXOFENADINE HCL TAB 60 MG	41550024100320	Generic
SM FEXOFENADINE HYDROCHLORIDE	FEXOFENADINE HCL TAB 60 MG	41550024100320	Generic

ALLEGRA ALLERGY	FEXOFENADINE HCL TAB 60 MG	41550024100320	Brand
HM FEXOFENADINE HYDROCHLORIDE	FEXOFENADINE HCL TAB 60 MG	41550024100320	Generic
CVS ALLERGY RELIEF	FEXOFENADINE HCL TAB 60 MG	41550024100320	Generic
FEXOFENADINE HYDROCHLORIDE	FEXOFENADINE HCL TAB 180 MG	41550024100350	Generic
ALLERGY RELIEF 24HR/INDOOR/OUTDOOR	FEXOFENADINE HCL TAB 180 MG	41550024100350	Generic
GOODSENSE ALLER-EASE	FEXOFENADINE HCL TAB 180 MG	41550024100350	Generic
HM ALLERGY RELIEF	FEXOFENADINE HCL TAB 180 MG	41550024100350	Generic
WAL-FEX 24 HOUR ALLERGY	FEXOFENADINE HCL TAB 180 MG	41550024100350	Generic
WAL-FEX ALLERGY	FEXOFENADINE HCL TAB 180 MG	41550024100350	Generic
ALLERGY RELIEF	FEXOFENADINE HCL TAB 180 MG	41550024100350	Generic
QC FEXOFENADINE HYDROCHLORIDE	FEXOFENADINE HCL TAB 180 MG	41550024100350	Generic
ALLERGY 24-HR	FEXOFENADINE HCL TAB 180 MG	41550024100350	Generic
MM FEXOFENADINE HYDROCHLORIDE	FEXOFENADINE HCL TAB 180 MG	41550024100350	Generic
EQL ALLER-EASE	FEXOFENADINE HCL TAB 180 MG	41550024100350	Generic
SM FEXOFENADINE HYDROCHLORIDE	FEXOFENADINE HCL TAB 180 MG	41550024100350	Generic
ALLEGRA ALLERGY	FEXOFENADINE HCL TAB 180 MG	41550024100350	Brand
24HR ALLERGY RELIEF	FEXOFENADINE HCL TAB 180 MG	41550024100350	Generic
QC ALLERGY RELIEF	FEXOFENADINE HCL TAB 180 MG	41550024100350	Generic
PX ALLERGY RELIEF	FEXOFENADINE HCL TAB 180 MG	41550024100350	Generic
HM FEXOFENADINE HYDROCHLORIDE	FEXOFENADINE HCL TAB 180 MG	41550024100350	Generic
EQ ALLERGY RELIEF	FEXOFENADINE HCL TAB 180 MG	41550024100350	Generic
ALLERGY RELIEF 24HR	FEXOFENADINE HCL TAB 180 MG	41550024100350	Generic
CVS ALLERGY RELIEF	FEXOFENADINE HCL TAB 180 MG	41550024100350	Generic
GNP ALLERGY RELIEF	FEXOFENADINE HCL TAB 180 MG	41550024100350	Generic
RA ALLERGY RELIEF	FEXOFENADINE HCL TAB 180 MG	41550024100350	Generic
RA ALLERGY RELIEF 24 HOUR	FEXOFENADINE HCL TAB 180 MG	41550024100350	Generic
WAL-FEX	FEXOFENADINE HCL TAB 180 MG	41550024100350	Generic
KLS ALLER-FEX	FEXOFENADINE HCL TAB 180 MG	41550024100350	Generic

Approval Criteria

1 - Patient has had a trial of cetirizine and loratadine within the past 90 days

2 . Revision History

Date	Notes
10/14/2021	New guideline

Filsuvez

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-150827
Guideline Name	Filsuvez
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	8/2/2024

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)

Firazyr, Sajazir

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-150097
Guideline Name	Firazyr, Sajazir
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	8/1/2024

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
7/22/2024	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-138521
Guideline Name	Firdapse
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	2/1/2024

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)]

Fruzaqla

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-147173
Guideline Name	Fruzaqla
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2024

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

2 . Revision History

Date	Notes
5/8/2024	New guideline

Galafold

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-136357
Guideline Name	Galafold
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Galafold	
Diagnosis	Fabry Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

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)

2 . Revision History

Date	Notes
11/15/2023	Added Elfabrio as a drug to not be used in combination

Gattex

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-134512
Guideline Name	Gattex
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	12/1/2023

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

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-138218
Guideline Name	Gavreto
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	2/1/2024

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

2 . Revision History

Date	Notes
12/27/2023	Updated NSCLC, hepatobiliary cancer, and thyroid carcinoma criteria .

Genvoya and Stribild

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-115880
Guideline Name	Genvoya and Stribild
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2023

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

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-127916
Guideline Name	Gilotrif
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	9/1/2023

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

2 . Revision History

Date	Notes
7/12/2023	Updated GPI and Brain Metastases criteria to match the most update d policy

Gleevec

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-135837
Guideline Name	Gleevec
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2024

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

GLP-1 Receptor Agonists and Combinations

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-161610
Guideline Name	GLP-1 Receptor Agonists and Combinations
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2025

1 . Criteria

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

Product Name	Generic Name	GPI	Brand/Generic
BYETTA	EXENATIDE SOLN PEN-INJECTOR 5 MCG/0.02ML	2717002000D220	Brand
BYETTA	EXENATIDE SOLN PEN-INJECTOR 10 MCG/0.04ML	2717002000D240	Brand

Approval Criteria

1 - Diagnosis of type 2 diabetes mellitus, as confirmed by chart documentation or claims history

AND

2 - Patient is 18 years of age or older

AND

3 - One of the following:

3.1 Previous trial of metformin for at least 90 days within a 120-day period, as confirmed by claims history, chart documentation, or provider attestation including dates of trial

OR

3.2 Documented intolerance or contraindication to metformin therapy

AND

4 - Dose requested does not exceed 20 mcg/day

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

Product Name	Generic Name	GPI	Brand/Generic
BYETTA	EXENATIDE SOLN PEN-INJECTOR 5 MCG/0.02ML	2717002000D220	Brand
BYETTA	EXENATIDE SOLN PEN-INJECTOR 10 MCG/0.04ML	2717002000D240	Brand

Approval Criteria

1 - Diagnosis of type 2 diabetes mellitus, as confirmed by chart documentation or claims history

AND

2 - Patient has a history of Byetta for at least 90 days within the past 120 days, confirmed by claims history, chart documentation, or provider attestation including dates of trial

AND

3 - Dose requested does not exceed 20 mcg/day

Product Name: Ozempic	
Diagnosis	Type 2 diabetes
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
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

Approval Criteria

1 - Patient is 18 years of age or older

AND

2 - Diagnosis of type 2 diabetes mellitus with or without cardiovascular disease, as confirmed by chart documentation or claims history

AND

3 - One of the following:

3.1 Previous trial of metformin for at least 90 days within a 120-day period, as confirmed by claims history, chart documentation, or provider attestation including dates of trial

OR

3.2 Documented intolerance or contraindication to metformin therapy

AND

4 - Dose requested does not exceed 2 mg/week

Product Name: Ozempic	
Diagnosis	Metabolic dysfunction-associated steatohepatitis (MASH), Metabolic dysfunction-associated steatotic liver disease (MASLD)
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
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

Approval Criteria

1 - Patient is 18 years of age or older

AND

2 - One of the following diagnosis

- Metabolic dysfunction-associated steatohepatitis (MASH)
- Metabolic dysfunction-associated steatotic liver disease (MASLD)

AND

3 - One of the following confirming the diagnosis (submission of medical records required)

3.1 FibroScan assessed liver stiffness (FAST) score greater than or equal to 0.67

OR

3.2 Patient is 35 years of age or older, with a Fibrosis-4 index (FIB-4) score between 2.67 and 3.47

OR

3.3 Liver biopsy

OR

3.4 MEFIB (magnetic resonance elastography [MRE] plus FIB-4) score with both of the following:

- FIB-4 score greater than or equal to 1.6
- MRE greater than or equal to 3.3 kPA

OR

3.5 MRE between 3.63 and 5 kPA

OR

3.6 MRI-PDFF*, MRE, and serum AST (MAST) score greater than or equal to 0.242

AND

4 - Prescribed by, or in consultation with, an endocrinologist, gastroenterologist, or hepatologist

AND

5 - Prescriber attests that patient does not have any of the following:

- Celiac disease
- Daily alcohol consumption exceeding 30 grams (2 standard drinks) per day
- Familial hypobetalipoproteinemia (FHBL)
- Hepatitis A, B, or C
- Lysosomal acid lipase (LAL) deficiency
- Wilson disease

AND

6 - Patient does not have history of any of the following in the past 90 days OR prescriber attests that alternate therapies are not appropriate for the patient and prescriber has a monitoring plan in place

- Amiodarone
- Glucocorticoids
- Methotrexate
- Synthetic estrogens
- Tamoxifen

AND

7 - Dose requested does not exceed 2 mg/week	
Notes	*MRI-PDFF= Magnetic Resonance Imaging Proton Density Fat Fraction

Product Name: Ozempic	
Diagnosis	Type 2 diabetes, Metabolic dysfunction-associated steatohepatitis (MASH), Metabolic dysfunction-associated steatotic liver disease (MASLD)
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
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

Approval Criteria

1 - One of the following:

1.1 Diagnosis of type 2 diabetes mellitus with or without cardiovascular disease, as confirmed by chart documentation or claims history

OR

1.2 Diagnosis of metabolic dysfunction-associated steatohepatitis (MASH) OR metabolic dysfunction-associated steatotic liver disease (MASLD), as confirmed by chart documentation or claims history

AND

2 - History of Ozempic for at least 84 days within the past 112 days, confirmed by claims history, chart documentation, or provider attestation including dates of trial

AND

3 - Dose requested does not exceed 2 mg/week

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

Product Name	Generic Name	GPI	Brand/Generic
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

Approval Criteria

1 - Diagnosis of type 2 diabetes mellitus with or without cardiovascular disease or cardiovascular disease risk factors, as confirmed by chart documentation or claims history

AND

2 - Patient is 10 years of age or older

AND

3 - One of the following:

3.1 Previous trial of metformin for at least 90 days within a 120-day period, as confirmed by claims history, chart documentation, or provider attestation including dates of trial

OR

3.2 Documented intolerance or contraindication to metformin therapy

AND

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

- 0.75 mg injection: 2 injections/week
- 1.5 mg, 3 mg, or 4.5 mg injection: 1 injection/week

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

Product Name	Generic Name	GPI	Brand/Generic
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

Approval Criteria

1 - Diagnosis of type 2 diabetes mellitus with or without cardiovascular disease or cardiovascular disease risk factors, as confirmed by chart documentation or claims history

AND

2 - History of Trulicity for at least 84 days within the past 112 days, confirmed by claims history, chart documentation, or provider attestation including dates of trial

AND

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

- 0.75 mg injection: 2 injections/week
- 1.5 mg, 3 mg, or 4.5 mg injection: 1 injection/week

Product Name: Victoza, Liraglutide	
Diagnosis	Type 2 diabetes, polycystic ovary syndrome
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
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

Approval Criteria

1 - Patient is 10 years of age or older

AND

2 - One of the following diagnoses, as confirmed by chart documentation or claims history:

- Type 2 diabetes mellitus with or without cardiovascular disease
- Polycystic ovary syndrome

AND

3 - One of the following:

3.1 Previous trial of metformin for at least 90 days within a 120-day, as confirmed by claims history, chart documentation, or provider attestation including dates of trial

OR

3.2 Documented intolerance or contraindication to metformin therapy

AND

4 - Dose requested does not exceed 1.8 mg/day

AND

5 - If the request is for liraglutide, prescriber has submitted medical justification for use of liraglutide (Victoza authorized generic) over brand name Victoza

Product Name: Victoza, Liraglutide	
Diagnosis	Metabolic-dysfunction associated steatotic liver disease (MASLD), Metabolic dysfunction associated steatohepatitis (MASH)
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
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

Approval Criteria

1 - Patient is 10 years of age or older

AND

2 - One of the following diagnosis:

- Metabolic dysfunction associated steatohepatitis (MASH)
- Metabolic dysfunction-associated steatotic liver disease (MASLD)

AND

3 - One of the following confirming the diagnosis (submission of medical records required)

3.1 FibroScan assessed liver stiffness (FAST) score greater than or equal to 0.67

OR

3.2 Patient is 35 years of age or older, with a Fibrosis-4 index (FIB-4) score between 2.67 and 3.47

OR

3.3 Liver biopsy

OR

3.4 MEFIB (magnetic resonance elastography [MRE] plus FIB-4) score with both of the following:

- FIB-4 score greater than or equal to 1.6
- MRE greater than or equal to 3.3 kPA

OR

3.5 MRE between 3.63 and 5 kPA

OR

3.6 MRI-PDFF*, MRE, and serum AST (MAST) score greater than or equal to 0.242

AND

4 - Prescribed by, or in consultation with, an endocrinologist, gastroenterologist, or hepatologist

AND

5 - Prescriber attests that patient does not have any of the following:

- Celiac disease
- Daily alcohol consumption exceeding 30 grams (2 standard drinks) per day
- Familial hypobetalipoproteinemia (FHBL)
- Hepatitis A, B, or C
- Lysosomal acid lipase (LAL) deficiency
- Wilson disease

AND

6 - Patient does not have history of any of the following in the past 90 days OR prescriber attests that alternate therapies are not appropriate for the patient and prescriber has a monitoring plan in place

- Amiodarone
- Glucocorticoids
- Methotrexate
- Synthetic estrogens
- Tamoxifen

AND

7 - Dose requested does not exceed 1.8 mg/day

AND

8 - If the request is for liraglutide, prescriber has submitted medical justification for use of liraglutide (Victoza authorized generic) over brand name Victoza

Notes	*MRI-PDFF= Magnetic Resonance Imaging Proton Density Fat Fraction

Product Name: Victoza, Liraglutide	
Diagnosis	Type 2 diabetes, polycystic ovary syndrome, Metabolic-dysfunction associated steatotic liver disease (MASLD), Metabolic dysfunction associated steatohepatitis (MASH)
Approval Length	1 year(s)
Therapy Stage	Reauthorization
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

Approval Criteria

1 - One of the following:

1.1 Diagnosis of type 2 diabetes mellitus with or without cardiovascular disease, as confirmed by chart documentation or claims history

OR

1.2 Diagnosis of metabolic dysfunction associated steatohepatitis (MASH) OR metabolic dysfunction-associated steatotic liver disease (MASLD), as confirmed by chart documentation or claims history

OR

1.3 Diagnosis of polycystic ovary syndrome, as confirmed by chart documentation or claims history

AND

2 - History of the requested agent for at least 90 days within the past 120 days, confirmed by claims history, chart documentation, or provider attestation including dates of trial

AND

3 - Dose requested does not exceed 1.8 mg/day

AND

4 - If the request is for liraglutide, both of the following:

- Previous trial of brand name Victoza
- Prescriber has submitted medical justification for use of liraglutide (Victoza authorized generic) over brand name Victoza

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

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 - Diagnosis of type 2 diabetes mellitus, as confirmed by chart documentation or claims history

AND

2 - Patient is 18 years of age or older

AND

3 - Previous trial with ONE of the following for at least 90 days in the past 120 days:

- A preferred* non-insulin injectable hypoglycemic
- A preferred* long-acting insulin

AND

4 - Dose requested does not exceed 60 units insulin glargine/20 mcg lixisenatide per day

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

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

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 - Diagnosis of type 2 diabetes mellitus, as confirmed by chart documentation or claims history

AND

2 - History of Soliqua for at least 90 days within the past 120 days, confirmed by claims history, chart documentation, or provider attestation including dates of trial

AND

3 - Dose requested does not exceed 60 units insulin glargine/20 mcg lixisenatide per day

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

Approval Criteria

1 - Diagnosis of type 2 diabetes mellitus, as confirmed by chart documentation or claims history

AND

2 - Patient is 10 years of age or older

AND

3 - One of the following:

3.1 Both of the following:

3.1.1 History of at least 90 days at an optimized dose*, supported by claims history, chart documentation, or provider attestation including dates of trial to both of the following:

- Ozempic (semaglutide) or Trulicity (dulaglutide)
- One additional preferred** GLP-1 receptor agonist

AND

3.1.2 Prescriber has submitted laboratory reports (e.g., HbA1c) with respective collection dates and times illustrating insufficient response to both of the following

- Ozempic (semaglutide) or Trulicity (dulaglutide)
- One additional preferred** GLP-1 receptor agonist

OR

3.2 Medical justification for use of Bydureon BCise (exenatide) over Byetta (exenatide), Ozempic (semaglutide), Trulicity (dulaglutide), AND Victoza (liraglutide) (any medical justification regarding intolerance or adverse effects must be supported by documentation within submitted chart notes. Gastrointestinal adverse effects are not considered an intolerance as they are expected class effects)

AND

4 - Dose requested does not exceed 2 mg/week

Notes	*See Table 1 in Background section **PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

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

Approval Criteria

1 - Diagnosis of type 2 diabetes mellitus, as confirmed by chart documentation or claims history

AND

2 - One of the following:

2.1 Both of the following:

2.1.1 History of at least 90 days at an optimized dose*, supported by claims history, chart documentation, or provider attestation including dates of trial to both of the following:

- Ozempic (semaglutide) or Trulicity (dulaglutide)
- One additional preferred** GLP-1 Receptor Agonist

AND

2.1.2 Prescriber has submitted laboratory reports (e.g., HbA1c) with respective collection dates and times illustrating insufficient response to both of the following

- Ozempic (semaglutide) or Trulicity (dulaglutide)
- One additional preferred** GLP-1 Receptor Agonist

OR

2.2 Medical justification for use of Bydureon BCise (exenatide) over Byetta (exenatide), Ozempic (semaglutide), Trulicity (dulaglutide), AND Victoza (liraglutide) (any medical justification regarding intolerance or adverse effects must be supported by documentation within submitted chart notes. Gastrointestinal adverse effects are not considered an intolerance as they are expected class effects)

AND

3 - History of Bydureon BCise for at least 84 days within the past 112 days, confirmed by claims history, chart documentation, or provider attestation including dates of trial

AND

4 - Dose requested does not exceed 2 mg/week

Notes	*See Table 1 in Background section **PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

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

Product Name	Generic Name	GPI	Brand/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

Approval Criteria

1 - Diagnosis of type 2 diabetes mellitus, as confirmed by chart documentation or claims history

AND

2 - Patient is 18 years of age or older

AND

3 - One of the following:

3.1 Both of the following:

3.1.1 History of at least 90 days at an optimized dose*, supported by claims history, chart documentation, or provider attestation including dates of trial to both of the following:

- Ozempic (semaglutide) or Trulicity (dulaglutide)
- One additional preferred** GLP-1 receptor agonist

AND

3.1.2 Prescriber has submitted laboratory reports (e.g., HbA1c) with respective collection dates and times illustrating insufficient response to both of the following

- Ozempic (semaglutide) or Trulicity (dulaglutide)
- One additional preferred** GLP-1 receptor agonist

OR

3.2 Medical justification for use of Mounjaro (tirzepatide) over Byetta (exenatide), Ozempic (semaglutide), Trulicity (dulaglutide), AND Victoza (liraglutide) (any medical justification regarding intolerance or adverse effects must be supported by documentation within submitted chart notes. Gastrointestinal adverse effects are not considered an intolerance as they are expected class effects)

AND

4 - Dose requested does not exceed 15 mg/week

Notes	*See Table 1 in Background section **PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

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

Product Name	Generic Name	GPI	Brand/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

Approval Criteria

1 - Diagnosis of type 2 diabetes mellitus, as confirmed by chart documentation or claims history

AND

2 - One of the following:

2.1 Both of the following:

2.1.1 History of at least 90 days at an optimized dose*, supported by claims history, chart documentation, or provider attestation including dates of trial to both of the following:

- Ozempic (semaglutide) or Trulicity (dulaglutide)
- One additional preferred** GLP-1 receptor agonist

AND

2.1.2 Prescriber has submitted laboratory reports (e.g., HbA1c) with respective collection dates and times illustrating insufficient response to both of the following

- Ozempic (semaglutide) or Trulicity (dulaglutide)
- One additional preferred** GLP-1 receptor agonist

OR

2.2 Medical justification for use of Mounjaro (tirzepatide) over Byetta (exenatide), Ozempic (semaglutide), Trulicity (dulaglutide), AND Victoza (liraglutide) (any medical justification regarding intolerance or adverse effects must be supported by documentation within

submitted chart notes. Gastrointestinal adverse effects are not considered an intolerance as they are expected class effects)

AND

3 - History of Mounjaro for at least 84 days within the past 112 days, confirmed by claims history, chart documentation, or provider attestation including dates of trial

AND

4 - Dose requested does not exceed 15 mg/week

Notes	*See Table 1 in Background section **PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

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

Product Name	Generic Name	GPI	Brand/Generic
RYBELSUS	SEMAGLUTIDE TAB 3 MG	27170070000310	Brand
RYBELSUS	SEMAGLUTIDE TAB 7 MG	27170070000320	Brand
RYBELSUS	SEMAGLUTIDE TAB 14 MG	27170070000330	Brand

Approval Criteria

1 - Diagnosis of type 2 diabetes mellitus, as confirmed by chart documentation or claims history

AND

2 - Patient is 18 years of age or older

AND

3 - One of the following:

3.1 Both of the following:

3.1.1 History of at least 90 days at an optimized dose*, supported by claims history, chart documentation, or provider attestation including dates of trial to both of the following:

- Ozempic (semaglutide) or Trulicity (dulaglutide)
- One additional preferred** GLP-1 receptor agonist

AND

3.1.2 Prescriber has submitted laboratory reports (e.g., HbA1c) with respective collection dates and times illustrating insufficient response to both of the following

- Ozempic (semaglutide) or Trulicity (dulaglutide)
- One additional preferred** GLP-1 receptor agonist

OR

3.2 Medical justification for use of Rybelsus (semaglutide) over Byetta (exenatide), Ozempic (semaglutide), Trulicity (dulaglutide), AND Victoza (liraglutide) (any medical justification regarding intolerance or adverse effects must be supported by documentation within submitted chart notes. Gastrointestinal adverse effects are not considered an intolerance as they are expected class effects)

AND

4 - Dose requested does not exceed 1 tablet/day

Notes	*See Table 1 in Background section **PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name: Rybelsus	
Approval Length	1 year(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RYBELSUS	SEMAGLUTIDE TAB 3 MG	27170070000310	Brand
RYBELSUS	SEMAGLUTIDE TAB 7 MG	27170070000320	Brand
RYBELSUS	SEMAGLUTIDE TAB 14 MG	27170070000330	Brand

Approval Criteria

1 - Diagnosis of type 2 diabetes mellitus, as confirmed by chart documentation or claims history

AND

2 - One of the following:

2.1 Both of the following:

2.1.1 History of at least 90 days at an optimized dose*, supported by claims history, chart documentation, or provider attestation including dates of trial to both of the following:

- Ozempic (semaglutide) or Trulicity (dulaglutide)
- One additional preferred** GLP-1 receptor agonist

AND

2.1.2 Prescriber has submitted laboratory reports (e.g., HbA1c) with respective collection dates and times illustrating insufficient response to both of the following

- Ozempic (semaglutide) or Trulicity (dulaglutide)
- One additional preferred** GLP-1 receptor agonist

OR

2.2 Medical justification for use of Rybelsus (semaglutide) over Byetta (exenatide), Ozempic (semaglutide), Trulicity (dulaglutide), AND Victoza (liraglutide) (any medical justification regarding intolerance or adverse effects must be supported by documentation within

submitted chart notes. Gastrointestinal adverse effects are not considered an intolerance as they are expected class effects)

AND

3 - History of Rybelsus for at least 90 days within the past 120 days, confirmed by claims history, chart documentation, or provider attestation including dates of trial

AND

4 - Dose requested does not exceed 1 tablet/day

Notes	*See Table 1 in Background section **PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name: Xultophy	
Approval Length	1 year(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, as confirmed by chart documentation or claims history

AND

2 - Patient is 18 years of age or older

AND

3 - One of the following:

3.1 Trial and failure of Soliqua as confirmed by claims history, chart documentation, or provider attestation including dates of trial

OR

3.2 Both of the following:

3.2.1 Medical justification for use of Xultophy over Soliqua

AND

3.2.2 Patient has had a previous trial of ONE of the following for at least 90 days in the past 120 days, as confirmed by claims history, chart documentation, or provider attestation including dates of trial:

- A preferred* non-insulin injectable hypoglycemic
- A preferred* long-acting insulin

AND

4 - Dose requested does not exceed 50 units insulin degludec/1.8 mg liraglutide per day

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

Product Name: Xultophy	
Approval Length	1 year(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 - Diagnosis of type 2 diabetes mellitus, as confirmed by chart documentation or claims history

AND

2 - One of the following:

2.1 Patient has a prior history of Soliqua, as confirmed by claims history, chart documentation, or provider attestation including dates of trial

OR

2.2 Medical justification for the use of Xultophy over Soliqua

AND

3 - History of Xultophy for at least 90 days within the past 120 days, confirmed by claims history, chart documentation, or provider attestation including dates of trial

AND

4 - Dose requested does not exceed 50 units insulin degludec/1.8 mg liraglutide per day

2 . Background

Benefit/Coverage/Program Information

Table 1: Optimized Dose

AGENT	OPTIMIZED DOSE
Byetta (exenatide)	10 mcg twice daily
Ozempic (semaglutide)	2 mg weekly

Trulicity (dulaglutide)	4.5 mg weekly
Victoza (liraglutide)	1.8 mg daily

3 . Revision History

Date	Notes
12/6/2024	Multiple criteria updates- Dx must be confirmed with documentation. Addition of MASLD, changes to look back period for reauths, brand V ictoza is preferred.

Gonadotropin-Releasing Hormone Agonists

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-161375
Guideline Name	Gonadotropin-Releasing Hormone Agonists
Formulary	• Medicaid - Community & State Indiana

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

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
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 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 - Diagnosis of advanced or metastatic prostate cancer

Product Name: Lupron Depot 7.5 mg, 22.5 mg, 30 mg, and 45 mg, leuprolide acetate inj kit 5 mg/mL, leuprolide acetate (3 month) 22.5 mg inj	
Diagnosis	Prostate Cancer
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 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 - Patient does not show evidence of progressive disease while on therapy

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
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
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 - Diagnosis of salivary gland tumor

AND

2 - Disease is one of the following:

- Recurrent
- Unresectable

- Metastatic

AND

3 - Disease is androgen receptor positive (AR+)

Product Name: leuprolide acetate inj kit 5 mg/mL	
Diagnosis	Salivary Gland Tumors
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

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

Product Name: leuprolide acetate inj kit 5 mg/mL	
Diagnosis	Uterine Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

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 - Diagnosis of one of the following:

- Low-grade endometrial stromal sarcoma (ESS)
- Adenosarcoma without sarcomatous overgrowth
- Estrogen receptor/progesterone receptor positive (ER/PR+) uterine sarcoma

Product Name: leuprolide acetate inj kit 5 mg/mL	
Diagnosis	Uterine Sarcoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

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

Product Name: Lupron Depot, Lupron Depot-Ped, leuprolide acetate inj kit 5 mg/mL	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

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 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Lupron Depot, Lupron Depot-Ped, leuprolide acetate inj kit 5 mg/mL	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

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 - Documentation of positive clinical response to therapy

2 . Revision History

Date	Notes
11/27/2024	Updated GPIs. Updated step therapy in CPP section as Fensolvi was moved to preferred and Lupron Depot Ped was moved to NP

Gralise, Horizant, and Lyrica CR

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-132243
Guideline Name	Gralise, Horizant, and Lyrica CR
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	10/1/2023

1 . Criteria

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

Product Name	Generic Name	GPI	Brand/Generic
GRALISE	GABAPENTIN (ONCE-DAILY) TAB 300 MG	62540030000320	Brand
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

Approval Criteria

1 - Patient is 18 years of age or older

AND

2 - Diagnosis of postherpetic neuralgia (PHN)

AND

3 - One of the following:

3.1 Previous trial and failure of immediate-release gabapentin for 90 days in the past 180 days

OR

3.2 Medical rationale for use of Gralise (gabapentin ER) over immediate-release gabapentin (Document medical rationale)

AND

4 - Both of the following:

4.1 The dose requested does not exceed 1800 mg/day

AND

4.2 The dose requested does not exceed one of the following:

- 300 mg strength - max of 1 tablet/day
- 450 mg strength - max of 1 tablet/day
- 600 mg strength -max of 2 tablets/day

- 750 mg strength - max of 2 tablets/day
- 900 mg strength - max of 2 tablets/day
- Titration pack - 1 pack/90 days

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

Product Name	Generic Name	GPI	Brand/Generic
GRALISE	GABAPENTIN (ONCE-DAILY) TAB 300 MG	62540030000320	Brand
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

Approval Criteria

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

AND

2 - Both of the following:

2.1 The dose requested does not exceed 1800 mg/day

AND

2.2 The dose requested does not exceed one of the following:

- 300 mg strength - max of 1 tablet/day
- 450 mg strength - max of 1 tablet/day

- 600 mg strength -max of 2 tablets/day
- 750 mg strength - max of 2 tablets/day
- 900 mg strength - max of 2 tablets/day
- Titration pack - 1 pack/90 days

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

Product Name	Generic Name	GPI	Brand/Generic
HORIZANT	GABAPENTIN ENACARBIL TAB ER 300 MG	62560030200420	Brand
HORIZANT	GABAPENTIN ENACARBIL TAB ER 600 MG	62560030200430	Brand

Approval Criteria

1 - Patient is 18 years of age or older

AND

2 - One of the following:

2.1 All of the following:

2.1.1 Diagnosis of postherpetic neuralgia (PHN)

AND

2.1.2 One of the following:

- Previous trial and failure of immediate-release gabapentin for 90 days in the past 180 days
- Medical rationale for use of Horizant (gabapentin ER) over immediate-release gabapentin (Document medical rationale)

OR

2.2 All of the following:

2.2.1 Diagnosis of moderate-to-severe primary restless legs syndrome (RLS)

AND

2.2.2 One of the following:

- Previous trial and failure of gabapentin IR, pramipexole, ropinirole or rotigotine patches for 90 days in the past 180 days
- Medical rationale for use of Horizant (gabapentin ER) over gabapentin IR, pramipexole, ropinirole and rotigotine patches (Document medical rationale)

AND

3 - Both of the following:

3.1 Dose requested does not exceed 1200 mg/day

AND

3.2 Dose requested does not exceed one of the following:

- 300 mg strength - max of 2 tablets/day
- 600 mg strength - max of 2 tablets/day

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

Product Name	Generic Name	GPI	Brand/Generic
HORIZANT	GABAPENTIN ENACARBIL TAB ER 300 MG	62560030200420	Brand

HORIZANT	GABAPENTIN ENACARBIL TAB ER 600 MG	62560030200430	Brand

Approval Criteria

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

AND

2 - Both of the following:

2.1 Dose requested does not exceed 1200 mg/day

AND

2.2 Dose requested does not exceed one of the following:

- 300 mg strength - max of 2 tablets/day
- 600 mg strength - max of 2 tablets/day

Product Name: Brand Lyrica CR, generic pregabalin ER	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

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 - Patient is 18 years of age or older

AND

2 - One of the following:

2.1 All of the following:

2.1.1 Diagnosis of diabetic peripheral neuropathy (DPN)

AND

2.1.2 Both of the following:

2.1.2.1 Dose requested does not exceed 330 mg/day

AND

2.1.2.2 Dose requested does not exceed one of the following:

- 82.5 mg strength - max of 3 tablets/day
- 165 mg strength - max of 1 tablet/day
- 330 mg strength - max of 1 tablet/day

OR

2.2 All of the following:

2.2.1 Diagnosis of postherpetic neuralgia (PHN)

AND

2.2.2 Both of the following:

2.2.2.1 Dose requested does not exceed 660 mg/day

AND

2.2.2.2 Dose requested does not exceed one of the following:

- 82.5 mg strength - max of 3 tablets/day
- 165 mg strength - max of 3 tablets/day
- 330 mg strength - max of 2 tablets/day

AND

3 - One of the following:

3.1 Previous trial and failure of immediate-release pregabalin for 90 days in the past 180 days

OR

3.2 Medical rationale for use of Lyrica CR (pregabalin ER) over immediate-release pregabalin (Document medical rationale)

Product Name: Brand Lyrica CR, generic pregabalin ER	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

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

AND

2 - One of the following:

2.1 All of the following:

2.1.1 Diagnosis of diabetic peripheral neuropathy (DPN)

AND

2.1.2 Both of the following:

2.1.2.1 Dose requested does not exceed 330 mg/day

AND

2.1.2.2 Dose requested does not exceed one of the following:

- 82.5 mg strength - max of 3 tablets/day
- 165 mg strength - max of 1 tablet/day
- 330 mg strength - max of 1 tablet/day

OR

2.2 All of the following:

2.2.1 Diagnosis of postherpetic neuralgia (PHN)

AND

2.2.2 Both of the following:

2.2.2.1 Dose requested does not exceed 660 mg/day

AND

2.2.2.2 Dose requested does not exceed one of the following:

- 82.5 mg strength - max of 3 tablets/day
- 165 mg strength - max of 3 tablets/day
- 330 mg strength - max of 2 tablets/day

2 . Revision History

Date	Notes
9/1/2023	Updated T/F for Horizant RLS to include gabapentin IR and look bac k of 90 in the last 180 days

Growth Hormones

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-161934
Guideline Name	Growth Hormones
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2025

1 . Criteria

Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ Nuspin, Omnitrope, Serostim, Zomacton	
Diagnosis	Pediatric Patients (Less than 18 Years of Age)
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
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
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
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 30 MG/3ML	3010002000D260	Brand
NUTROPIN AQ NUSPIN 5	SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/2ML	3010002000D207	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
OMNITROPE	SOMATROPIN SOLUTION CARTRIDGE 5 MG/1.5ML	3010002000E210	Brand
OMNITROPE	SOMATROPIN SOLUTION CARTRIDGE 10 MG/1.5ML	3010002000E213	Brand
OMNITROPE	SOMATROPIN FOR INJ 5.8 MG	30100020002123	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
ZOMACTON	SOMATROPIN FOR SUBCUTANEOUS INJ 5 MG	30100020002121	Brand
ZOMACTON	SOMATROPIN FOR INJ 10 MG	30100020002140	Brand

Approval Criteria

1 - ONE of the following:

1.1 ONE of the following diagnoses (submission of biochemical evidence or other applicable testing supporting the diagnosis is required):

1.1.1 Growth-hormone deficiency

OR

1.1.2 BOTH of the following:

- Noonan syndrome
- The request is for Norditropin

OR

1.1.3 Prader-Willi syndrome

OR

1.1.4 BOTH of the following:

- Renal function impairment associated with growth failure
- The request is for Nutropin AQ Nuspin

OR

1.1.5 BOTH of the following:

- Short stature homeobox-containing gene (SHOX) deficiency
- The request is for Humatrope or Zomacton

OR

1.1.6 Small for gestational age (SGA)

OR

1.1.7 Turner syndrome

OR

1.2 ALL of the following:

1.2.1 Diagnosis of idiopathic short stature

AND

1.2.2 Submission of growth chart confirming BOTH of the following:

- Height measurement of more than 2.0 standard deviations below population mean for given age
- Growth rate of 5 cm (centimeters)/year or less prior to starting growth hormone therapy

AND

2 - Submission of a radiology report showing BOTH of the following:

- Bone age of 14-15 or less in patients assigned female at birth, 16-17 or less in patients assigned male at birth
- If patient is nearing or at puberty (estimated age range 10-17 years of age), open epiphyses

AND

3 - Prescriber attestation that they have performed all necessary testing to ensure there are no expanding intracranial lesions or tumors prior to initiating growth hormone therapy

AND

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

4.1 Medication is requested for a product-specific indication**

OR

4.2 Prescriber has provided valid medical justification for the use of the non-preferred medication over a preferred medication

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html **Humatrope and Zomactan are non-preferred unless the patient has a diagnosis of SHOX deficiency, Nutropin AQ is non-preferred unless patient has a diagnosis of growth failure associated with chronic renal insufficiency.

Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ Nuspin, Omnitrope, Serostim, Zomacton	
Diagnosis	Pediatric Patients (Less than 18 Years of Age)
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
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
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
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 30 MG/3ML	3010002000D260	Brand
NUTROPIN AQ NUSPIN 5	SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/2ML	3010002000D207	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
OMNITROPE	SOMATROPIN SOLUTION CARTRIDGE 5 MG/1.5ML	3010002000E210	Brand
OMNITROPE	SOMATROPIN SOLUTION CARTRIDGE 10 MG/1.5ML	3010002000E213	Brand
OMNITROPE	SOMATROPIN FOR INJ 5.8 MG	30100020002123	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
ZOMACTON	SOMATROPIN FOR SUBCUTANEOUS INJ 5 MG	30100020002121	Brand
ZOMACTON	SOMATROPIN FOR INJ 10 MG	30100020002140	Brand

Approval Criteria

1 - Patient has ONE of the following diagnoses:

- Growth-hormone deficiency
- Noonan syndrome (Norditropin only)
- Prader-Willi syndrome
- Renal function impairment associated with growth failure (Nutropin AQ only)
- Short stature homeobox-containing gene (SHOX) deficiency (Humatrope or Zomacton only)
- Small for gestational age (SGA)
- Turner syndrome

AND

2 - Patient has a history of the requested medication for at least 90 days within the past 120 days, confirmed by claims history or chart documentation

AND

3 - Submission of a radiology report showing BOTH of the following:

- Bone age of 14-15 or less in patients assigned female at birth, 16-17 or less in patients assigned male at birth
- If patient is nearing or at puberty (estimated age range 10-17 years of age) open epiphyses

AND

4 - Prescriber attestation that they are continuing to monitor the patient for intracranial tumor recurrence, progression of underlying disease, or malignant transformation of skin lesions, if appropriate

AND

5 - ONE of the following:

5.1 Growth rate of 2 to 2.5 cm/year or more with growth hormone therapy

OR

5.2 BOTH of the following:

- The patient's diagnosis is idiopathic short stature
- The provider has documented valid medical justification for continued use

AND

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

6.1 Medication is requested for a product-specific indication**

OR

6.2 Prescriber has provided valid justification for the use of the non-preferred medication over a preferred medication

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html **Humatrope and Zomactan are non-preferred unless the patient has a diagnosis of SHOX deficiency, Nutropin AQ is non-preferred unless patient has a diagnosis of growth failure associated with chronic renal insufficiency.

Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ Nuspin, Omnitrope, Serostim, Zomacton	
Diagnosis	Adult Patients (18 Years of Age or Older) or Patients with Closed Epiphyses
Approval Length	1 year(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
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
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
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 30 MG/3ML	3010002000D260	Brand
NUTROPIN AQ NUSPIN 5	SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/2ML	3010002000D207	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
OMNITROPE	SOMATROPIN SOLUTION CARTRIDGE 5 MG/1.5ML	3010002000E210	Brand
OMNITROPE	SOMATROPIN SOLUTION CARTRIDGE 10 MG/1.5ML	3010002000E213	Brand
OMNITROPE	SOMATROPIN FOR INJ 5.8 MG	30100020002123	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
ZOMACTON	SOMATROPIN FOR SUBCUTANEOUS INJ 5 MG	30100020002121	Brand
ZOMACTON	SOMATROPIN FOR INJ 10 MG	30100020002140	Brand

Approval Criteria

1 - ONE of the following:

1.1 Patient is transitioning from pediatric growth hormone therapy, and ALL of the following:

1.1.1 Patient has reached adult height

AND

1.1.2 Patient stopped growth hormone therapy for at least 1 month before re-evaluation of the need for continued therapy

AND

1.1.3 Prescriber has determined that the patient will experience growth hormone deficiency into adulthood and would receive clinical benefit from continued growth hormone therapy

OR

1.2 BOTH of the following:

1.2.1 Patient has a diagnosis of adult growth-hormone deficiency

AND

1.2.2 Biochemical evidence or other applicable testing supporting the diagnosis

AND

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

2.1 Medication is requested for a product-specific indication**

OR

2.2 Prescriber has provided valid justification for the use of the non-preferred medication over a preferred medication

AND

3 - Prescriber attestation that they have performed all necessary testing to ensure there are no expanding intracranial lesions or tumors prior to initiating growth hormone therapy

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html **Humatrope and Zomactan are non-preferred unless the patient has a diagnosis of SHOX deficiency, Nutropin AQ is non-preferred unless patient has a diagnosis of growth failure associated with chronic renal insufficiency.

Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ Nuspin, Omnitrope, Serostim, Zomacton	
Diagnosis	Adult Patients (18 Years of Age or Older) or Patients with Closed Epiphyses
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
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
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
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 30 MG/3ML	3010002000D260	Brand
NUTROPIN AQ NUSPIN 5	SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/2ML	3010002000D207	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

OMNITROPE	SOMATROPIN SOLUTION CARTRIDGE 5 MG/1.5ML	3010002000E210	Brand
OMNITROPE	SOMATROPIN SOLUTION CARTRIDGE 10 MG/1.5ML	3010002000E213	Brand
OMNITROPE	SOMATROPIN FOR INJ 5.8 MG	30100020002123	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
ZOMACTON	SOMATROPIN FOR SUBCUTANEOUS INJ 5 MG	30100020002121	Brand
ZOMACTON	SOMATROPIN FOR INJ 10 MG	30100020002140	Brand

Approval Criteria

1 - ONE of the following:

1.1 Patient has previously been transitioned from pediatric growth hormone therapy

OR

1.2 Patient has a diagnosis of adult growth hormone deficiency

AND

2 - Patient has a history of growth hormone therapy for at least 90 days within the past 120 days, confirmed by claims history or chart documentation

AND

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

3.1 Medication is requested for a product-specific indication**

OR

3.2 Prescriber has provided valid justification for the use of the non-preferred medication over a preferred medication

AND

4 - Prescriber attestation that they are continuing to monitor the patient for intracranial tumor recurrence, progression of underlying disease, or malignant transformation of skin lesions, if appropriate

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html **Humatrope and Zomactan are non-preferred unless the patient has a diagnosis of SHOX deficiency, Nutropin AQ is non-preferred unless patient has a diagnosis of growth failure associated with chronic renal insufficiency.

Product Name: Serostim	
Diagnosis	HIV-Associated Wasting or Cachexia
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

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 HIV (human immunodeficiency virus)-associated wasting or cachexia

AND

2 - Patient has failed one other therapy for HIV-associated wasting or cachexia (e.g., anabolic steroids, or for adults 18 years or older: dronabinol, megestrol)

AND

3 - Patient must be on AIDS (acquired immunodeficiency syndrome)/HIV anti-retroviral therapy

AND

4 - Patient must have ONE of the following:

- Involuntary weight loss of greater than 10% of baseline total body weight
- Body cell mass of less than 30%

AND

5 - Patient must have a quantitative measurement of lean body mass using dual energy X-ray absorptiometry (DEXA) or bioelectric impedance analysis (BIA) prior to initiation of therapy

AND

6 - Prescriber attestation that they have performed all necessary testing to ensure there are no expanding intracranial lesions or tumors prior to initiating growth hormone therapy

Product Name: Serostim	
Diagnosis	HIV-Associated Wasting or Cachexia
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

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 HIV (human immunodeficiency virus)-associated wasting or cachexia

AND

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

AND

3 - Documentation stating patient is continuing to utilize AIDS (acquired immunodeficiency syndrome)/HIV antiretroviral therapy

AND

4 - Documentation of the patient's current total body weight or lean body mass, showing total body weight or lean body mass has increased from treatment baseline during treatment period

AND

5 - Prescriber attestation that they are continuing to monitor the patient for intracranial tumor recurrence, progression of underlying disease, or malignant transformation of skin lesions, if appropriate

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

Product Name	Generic Name	GPI	Brand/Generic
INCRELEX	MECASERMIN INJ 40 MG/4ML (10 MG/ML)	30160045002020	Brand

Approval Criteria

1 - Documented diagnosis of growth failure due to ONE of the following:

- Severe primary insulin-like growth factor-1 deficiency (primary IGFD)
- Growth hormone (GH) gene deletion with acquired neutralizing antibodies to GH

AND

2 - Submission of radiology report confirming open epiphyses

AND

3 - Patient is greater than or equal to 2 years of age and less than 18 years of age

AND

4 - Documentation of baseline height and weight

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

Product Name	Generic Name	GPI	Brand/Generic
INCRELEX	MECASERMIN INJ 40 MG/4ML (10 MG/ML)	30160045002020	Brand

Approval Criteria

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

AND

2 - Patient is less than 18 years of age

AND

3 - Submission of radiology report confirming open epiphyses

AND

4 - ONE of the following:

- Documentation of improvement in annualized growth velocity (AGV)
- Provider has documented valid medical justification for continued use

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

Product Name	Generic Name	GPI	Brand/Generic
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 - Diagnosis of growth failure due to growth hormone deficiency (documentation of biochemical evidence or other applicable testing supporting the diagnosis is required)

AND

2 - BOTH of the following:

- Patient is at least 3 years of age
- Patient is less than 18 years of age

AND

3 - Submission of a radiology report showing BOTH of the following:

- Bone age of 14-15 or less in females, 16-17 or less in males
- If patient is nearing or at puberty (estimated age range 10-17 years of age), open epiphyses

AND

4 - Prescriber attestation that they have performed all necessary testing to ensure there are no expanding intracranial lesions or tumors prior to initiating growth hormone therapy

AND

5 - ONE of the following:

5.1 Trial and failure of Skytrofa (lonapegsomatropin) or Sogroya (somapacitan), confirmed by claims history or chart documentation

OR

5.2 Prescriber has documented valid medical justification as to why Skytrofa (lonapegsomatropin) or Sogroya (somapacitan), are unsuitable for use

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

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
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 - History of the requested medication for at least 90 days within the past 120 days, confirmed by claims history or chart documentation

AND

2 - Patient is less than 18 years of age

AND

3 - Submission of a radiology report showing BOTH of the following:

- Bone age of 14-15 or less in females, 16-17 or less in males
- If patient is nearing or at puberty (estimated age range 10-17 years of age), open epiphyses

AND

4 - Prescriber attestation that they are continuing to monitor the patient for intracranial tumor recurrence, progression of underlying disease, or malignant transformation of skin lesions, if appropriate

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

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 - Diagnosis of growth failure due to growth hormone deficiency (submission of biochemical evidence or other applicable testing supporting the diagnosis is required)

AND

2 - Patient is less than 18 years of age

AND

3 - Patient weighs 11.5 kg (kilograms) or greater

AND

4 - Submission of radiology report showing BOTH of the following:

- Bone age of 14-15 or less in females, 16-17 or less in males

- If patient is nearing or at puberty (estimated age range 10-17 years of age), open epiphyses

AND

5 - Prescriber attestation that they have performed all necessary testing to ensure there are no expanding intracranial lesions or tumors prior to initiating growth hormone therapy

AND

6 - ONE of the following:

- Trial and failure of ONE preferred* somatropin product, confirmed by claims history or chart documentation
- Prescriber has documented valid medical justification as to why the available preferred* somatropin agent(s) are unsuitable for use

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

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

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

AND

2 - Patient is less than 18 years of age

AND

3 - Submission of radiology report showing BOTH of the following:

- Bone age of 14-15 or less in females, 16-17 or less in males
- If patient is nearing or at puberty (estimated age range 10-17 years of age), open epiphyses

AND

4 - Prescriber attestation that they are continuing to monitor the patient for intracranial tumor recurrence, progression of underlying disease, or malignant transformation of skin lesions, if appropriate

Product Name: Sogroya	
Approval Length	1 year(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 - ALL of the following:

1.1 Diagnosis of growth failure due to growth hormone deficiency (submission of biochemical evidence or other applicable testing supporting the diagnosis is required)

AND

1.2 BOTH of the following:

- Patient is at least 2.5 years of age
- Patient is less than 18 years of age

AND

1.3 Submission of a radiology report showing BOTH of the following:

- Bone age of 14-15 or less in females, 16-17 or less in males
- If patient is nearing or at puberty (estimated age range 10-17 years of age), open epiphyses

AND

1.4 Prescriber attestation that they have performed all necessary testing to ensure there are no expanding intracranial lesions or tumors prior to initiating growth hormone therapy

AND

1.5 ONE of the following:

- Trial and failure of ONE preferred* somatropin product, confirmed by claims history or chart documentation
- Prescriber has documented valid medical justification as to why all of the available preferred* somatropin agent(s) are unsuitable for use

OR

2 - ALL of the following:

2.1 Diagnosis of adult growth hormone deficiency (documentation of biochemical evidence or other applicable testing supporting the diagnosis is required)

AND

2.2 Patient is 18 years of age or older

AND

2.3 Prescriber attestation that they have performed all necessary testing to ensure there are no expanding intracranial lesions or tumors prior to initiating growth hormone therapy

AND

2.4 ONE of the following:

- Trial and failure of ONE preferred* somatropin product, confirmed by claims history or chart documentation
- Prescriber has documented valid medical justification as to why all of the available preferred* somatropin agent(s) are unsuitable for use

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

Product Name: Sogroya	
Approval Length	1 year(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 - History of the requested medication for at least 90 days within the past 120 days, confirmed by claims history or chart documentation

AND

2 - ONE of the following:

2.1 Patient is less than 18 years of age and BOTH of the following:

2.1.1 Submission of a radiology report showing a bone age of 14-15 or less in females, 16-17 or less in males

AND

2.1.2 If patient is nearing or at puberty (estimated age range 10-17 years of age), submission of a radiology report showing open epiphyses

OR

2.2 Patient is 18 years of age or older

AND

3 - Prescriber attestation that they are continuing to monitor the patient for intracranial tumor

recurrence, progression of underlying disease, or malignant transformation of skin lesions, if appropriate

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

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 - Documented diagnosis of achondroplasia

AND

2 - Submission of radiology report confirming open epiphyses

AND

3 - Patient is less than 18 years of age

AND

4 - Documentation of baseline height and weight

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

Guideline Type	Prior Authorization

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

AND

2 - Patient is less than 18 years of age

AND

3 - Submission of radiology report confirming open epiphyses

AND

4 - ONE of the following:

- Documentation of improvement in annualized growth velocity (AGV) of 1.5 cm/year
- Provider has documented valid medical justification for continued use

2 . Revision History

Date	Notes
12/11/2024	Removed Saizen/Saizenprep. Updated criteria to reflect Sogroya is p referred.

H2 Receptor Antagonists

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-137625
Guideline Name	H2 Receptor Antagonists
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

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

Product Name	Generic Name	GPI	Brand/Generic
FAMOTIDINE	FAMOTIDINE FOR SUSP 40 MG/5ML	49200030001920	Generic

Approval Criteria

1 - Patient is under 12 years of age

OR **2** - Patient is unable to swallow tablets

2 . Revision History

Date	Notes
12/11/2023	Updated age requirement in criteria.

Haegarda

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-147297
Guideline Name	Haegarda
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2024

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

HCG

Prior Authorization Guideline

Guideline ID	GL-138448
Guideline Name	HCG
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	2/1/2024

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

Hematinic Agents

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-124339
Guideline Name	Hematinic Agents
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	7/1/2023

1 . Criteria

Product Name: Aranesp			
Approval Length	6 month(s)		
Guideline Type	Prior Authorization		
Product Name	**Generic Name**	**GPI**	**Brand/Generic**
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

Approval Criteria

1 - Patient has anemia with ONE of the following:

- Chronic kidney disease (CKD)
- Myelodysplastic syndrome (MDS)

OR

2 - BOTH of the following:

2.1 Patient has chemotherapy-induced anemia with non-myeloid malignancies/neoplastic disease

AND

2.2 Patient has at least 2 additional months of chemotherapy planned

Product Name: Epogen	
Approval Length	6 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
EPOGEN	EPOETIN ALFA INJ 2000 UNIT/ML	82401020002010	Generic
EPOGEN	EPOETIN ALFA INJ 3000 UNIT/ML	82401020002015	Generic
EPOGEN	EPOETIN ALFA INJ 4000 UNIT/ML	82401020002020	Generic
EPOGEN	EPOETIN ALFA INJ 10000 UNIT/ML	82401020002040	Generic
EPOGEN	EPOETIN ALFA INJ 20000 UNIT/ML	82401020002050	Generic

Approval Criteria

1 - ONE of the following:

1.1 Patient has anemia with ONE of the following:

- Chronic kidney disease
- Congestive heart failure
- Hepatitis C for a patient receiving ribavirin with interferon alfa or ribavirin with peginterferon alfa
- HIV (human immunodeficiency virus)-infected patient receiving zidovudine
- Multiple myeloma
- Myelodysplastic syndrome (MDS)
- Myelofibrosis
- Neoplastic disease not associated with chemotherapy
- Rheumatoid arthritis
- Transfusion-dependent beta thalassemia

OR

1.2 Patient has anemia associated with radiation therapy

OR

1.3 Patient has anemia due to trauma or postsurgical event, transfusion refusal (e.g., Jehovah's Witness)

OR

1.4 Patient has anemia of prematurity

OR

1.5 Request is for blood unit collection in preparation for autotransfusion

OR

1.6 BOTH of the following:

1.6.1 Patient has chemotherapy-induced anemia with non-myeloid malignancies/neoplastic disease

AND

1.6.2 Patient has at least 2 additional months of chemotherapy planned

OR

1.7 Patient has chronic anemia in neoplastic disease not associated with chemotherapy

OR

1.8 Request is for iron overload transfusion

OR

1.9 Patient has post-partum anemia (during the puerperium)

OR

1.10 Request is for reduction in allogenic blood transfusions in an anemic surgical patient (e.g., elective noncardiac, nonvascular surgeries) at high risk for perioperative blood loss

Product Name: Mircera	
Approval Length	6 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MIRCERA	METHOXY PEG-EPOETIN BETA SOLN PREFILLED SYR 30 MCG/0.3ML	8240104010E510	Brand
MIRCERA	METHOXY PEG-EPOETIN BETA SOLN PREFILLED SYR 50 MCG/0.3ML	8240104010E515	Brand
MIRCERA	METHOXY PEG-EPOETIN BETA SOLN PREFILLED SYR 75 MCG/0.3ML	8240104010E520	Brand
MIRCERA	METHOXY PEG-EPOETIN BETA SOLN PREFILLED SYR 100 MCG/0.3ML	8240104010E525	Brand
MIRCERA	METHOXY PEG-EPOETIN BETA SOLN PREFILLED SYR 150 MCG/0.3ML	8240104010E535	Brand
MIRCERA	METHOXY PEG-EPOETIN BETA SOLN PREFILLED SYR 200 MCG/0.3ML	8240104010E545	Brand

Approval Criteria

1 - Patient has anemia with chronic kidney disease

AND

2 - ONE of the following:

2.1 Trial and failure of all preferred* agents

OR

2.2 Prescriber has submitted valid medical rationale for the use of Mircera over all preferred* agents

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

Product Name: Procrit	
Approval Length	6 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PROCRIT	EPOETIN ALFA INJ 2000 UNIT/ML	82401020002010	Generic
PROCRIT	EPOETIN ALFA INJ 3000 UNIT/ML	82401020002015	Generic
PROCRIT	EPOETIN ALFA INJ 4000 UNIT/ML	82401020002020	Generic
PROCRIT	EPOETIN ALFA INJ 10000 UNIT/ML	82401020002040	Generic
PROCRIT	EPOETIN ALFA INJ 20000 UNIT/ML	82401020002050	Generic
PROCRIT	EPOETIN ALFA INJ 40000 UNIT/ML	82401020002060	Brand

Approval Criteria

1 - ONE of the following:

1.1 Patient has anemia with ONE of the following:

- Chronic kidney disease
- Congestive heart failure
- Hepatitis C for a patient receiving ribavirin with interferon alfa or ribavirin with peginterferon alfa

- HIV (human immunodeficiency virus)-infected patient receiving zidovudine
- Multiple myeloma
- Myelodysplastic syndrome (MDS)
- Myelofibrosis
- Neoplastic disease not associated with chemotherapy
- Rheumatoid arthritis
- Transfusion-dependent beta thalassemia

OR

1.2 Patient has anemia associated with radiation therapy

OR

1.3 Patient has anemia due to trauma or postsurgical event, transfusion refusal (e.g., Jehovah's Witness)

OR

1.4 Patient has anemia of prematurity

OR

1.5 Request is for blood unit collection in preparation for autotransfusion

OR

1.6 BOTH of the following:

1.6.1 Patient has chemotherapy-induced anemia with non-myeloid malignancies/neoplastic disease

AND

1.6.2 Patient has at least 2 additional months of chemotherapy planned

OR

1.7 Patient has chronic anemia in neoplastic disease not associated with chemotherapy

OR

1.8 Request is for iron overload transfusion

OR

1.9 Patient has post-partum anemia (during the puerperium)

OR

1.10 Request is for reduction in allogenic blood transfusions in an anemic surgical patient (e.g., elective noncardiac, nonvascular surgeries) at high risk for perioperative blood loss

AND

2 - ONE of the following:

2.1 Trial and failure of all preferred* agents

OR

2.2 Prescriber has submitted valid medical rationale for the use of Procrit over all preferred* agents

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

Product Name: Retacrit	
Approval Length	6 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RETACRIT	EPOETIN ALFA-EPBX INJ 2000 UNIT/ML	82401020042010	Generic
RETACRIT	EPOETIN ALFA-EPBX INJ 3000 UNIT/ML	82401020042015	Generic
RETACRIT	EPOETIN ALFA-EPBX INJ 4000 UNIT/ML	82401020042020	Generic
RETACRIT	EPOETIN ALFA-EPBX INJ 10000 UNIT/ML	82401020042040	Generic
RETACRIT	EPOETIN ALFA-EPBX INJ 20000 UNIT/ML	82401020042050	Generic
RETACRIT	EPOETIN ALFA-EPBX INJ 40000 UNIT/ML	82401020042060	Brand

Approval Criteria

1 - Patient has anemia with ONE of the following:

- Chronic kidney disease
- Congestive heart failure
- Hepatitis C for a patient receiving ribavirin with interferon alfa or ribavirin with peginterferon alfa
- HIV (human immunodeficiency virus)-infected patient receiving zidovudine
- Multiple myeloma
- Myelodysplastic syndrome (MDS)
- Myelofibrosis
- Neoplastic disease not associated with chemotherapy
- Rheumatoid arthritis
- Transfusion-dependent beta thalassemia

OR

2 - Patient has anemia associated with radiation therapy

OR

3 - Patient has anemia due to trauma or postsurgical event, transfusion refusal (e.g., Jehovah's Witness)

OR

4 - Patient has anemia of prematurity

OR

5 - Request is for blood unit collection in preparation for autotransfusion

OR

6 - BOTH of the following:

6.1 Patient has chemotherapy-induced anemia with non-myeloid malignancies/neoplastic disease

AND

6.2 Patient has at least 2 additional months of chemotherapy planned

OR

7 - Patient has chronic anemia in neoplastic disease not associated with chemotherapy

OR

8 - Request is for iron overload transfusion

OR

9 - Patient has post-partum anemia (during the puerperium)

OR

10 - Request is for reduction in allogenic blood transfusions in an anemic surgical patient (e.g., elective noncardiac, nonvascular surgeries) at high risk for perioperative blood loss

2 . Revision History

Date	Notes
4/17/2023	Removed NP language from Epogen to match policy.

Hepatitis B Agents

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146287
Guideline Name	Hepatitis B Agents
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2024

1 . Criteria

Product Name: Vemlidy	
Approval Length	Lifetime approval
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VEMLIDY	TENOFOVIR ALAFENAMIDE FUMARATE TAB 25 MG	12352083200320	Brand

Approval Criteria

1 - The patient has a diagnosis of chronic viral hepatitis type B with documentation of ALL of the following:

- Compensated liver disease
- Negative HIV status
- Creatinine clearance greater than 15 mL/minute (milliliters per minute)

AND

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

- Gastroenterologist
- Hepatologist
- Infectious disease specialist

AND

3 - Patient is 6 years of age or older

AND

4 - Patient weighs at least 25 kilograms (kg)

AND

5 - ONE of the following:

- Previous trial and failure of entecavir at a maximum indication-based dose
- Prescriber has submitted valid medical rationale for the use of Vemlidy (tenofovir alafenamide) over entecavir

2 . Revision History

Date	Notes
4/29/2024	Updated minimum age requirement and added weight requirement; F ormatting updates.

Hetlioz

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-124146
Guideline Name	Hetlioz
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	7/1/2023

1 . Criteria

Product Name: Brand Hetlioz capsules, generic tasimelteon	
Approval Length	1 year(s)
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

Approval Criteria

1 - One of the following:

1.1 Diagnosis of non-24-hour sleep-wake disorder and all of the following:

1.1.1 Patient is 18 years of age or older

AND

1.1.2 Dose does not exceed 20mg daily

OR

1.2 Diagnosis of nighttime sleep disturbances in patients with Smith-Magenis syndrome and all of the following:

1.2.1 Patient is 3 years of age or older

AND

1.2.2 One of the following:

- Dose does not exceed 20mg daily for those ages 3 years and older weighing more than 28kg
- Dose does not exceed 0.7mg/kg/dose daily for those ages 3 to 15 years weighing less than 28kg

Product Name: Hetlioz suspension	
Approval Length	1 year(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
HETLIOZ LQ	TASIMELTEON ORAL SUSP 4 MG/ML	60250070001820	Brand

Approval Criteria

1 - One of the following:

1.1 Diagnosis of non-24-hour sleep-wake disorder and all of the following:

1.1.1 Patient is 18 years of age or older

AND

1.1.2 Dose does not exceed 20mg daily

AND

1.1.3 Patient is unable to swallow capsule formulation

OR

1.2 Diagnosis of nighttime sleep disturbances in patients with Smith-Magenis syndrome and all of the following:

1.2.1 Patient is 3 years of age or older

AND

1.2.2 One of the following:

- Dose does not exceed 20mg daily for those ages 3 years and older weighing more than 28kg
- Dose does not exceed 0.7mg/kg/dose daily for those ages 3 to 15 years weighing less than 28kg

AND

1.2.3 Patient is between 3 and 17 years of age OR unable to swallow capsule formulation

2 . Revision History

Date	Notes

4/3/2023	Added generic caps

HIV

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-152661
Guideline Name	HIV
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	9/1/2024

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

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

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

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

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) **AND** **2** - If the request is non-preferred*, ONE of the following: **2.1** History of contraindication or intolerance to THREE preferred* products **OR** **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. Approval Duration: 12 months for HIV; 4 weeks for PEP. *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

2 . Revision History

Date	Notes
8/26/2024	Updated GPI list. Removed note copied from CORE referencing MD.

HMG CoA Reductase Inhibitors

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-132806
Guideline Name	HMG CoA Reductase Inhibitors
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	10/1/2023

1 . Criteria

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

Product Name	Generic Name	GPI	Brand/Generic
ATORVALIQ	ATORVASTATIN CALCIUM SUSP 20 MG/5ML (4MG/ML) (BASE EQUIV)	39400010101810	Brand

Approval Criteria

1 - Patient is 10 years of age or older AND less than 12 years of age

OR **2** - Patient is unable to swallow tablets

2 . Revision History

Date	Notes
9/8/2023	New

Hycamtin

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-138238
Guideline Name	Hycamtin
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	2/1/2024

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

Ibrance

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-147459
Guideline Name	Ibrance
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2024

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

2 . Revision History

Date	Notes
5/16/2024	Specified type of unresectable WD-DDLS to be “retroperitoneal”.

Iclusig

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-138750
Guideline Name	Iclusig
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	2/1/2024

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

2 . Revision History

Date	Notes
1/8/2024	Updated Ph+ ALL criteria based on NCCN recommendations. Added criteria for GIST based on NCCN recommendations.

Idhifa

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-161232
Guideline Name	Idhifa
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2025

1 . Criteria

Product Name: Idhifa	
Diagnosis	Acute Myeloid Leukemia (AML)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

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
11/25/2024	Updated initial auth criteria for AML based on NCCN recommendations; Minor cosmetic updates.

Igalmi

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-148844
Guideline Name	Igalmi
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Igalmi	
Approval Length	5 Day(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
IGALMI	DEXMEDETOMIDINE HCL FILM 120 MCG	60206030108220	Brand
IGALMI	DEXMEDETOMIDINE HCL FILM 180 MCG	60206030108230	Brand

Approval Criteria

1 - Diagnosis of one of the following:

- Bipolar I or II disorder
- Schizophrenia

AND

2 - Member is 18 years of age and older

AND

3 - Prescriber attests to both of the following:

3.1 Patient is currently or will be maintained on maintenance psychotropic therapy

AND

3.2 Medication will be administered under the supervision of a healthcare provider

AND

4 - Dose requested does not exceed 2 sublingual films per 30-day period

2 . Revision History

Date	Notes
6/26/2024	New guideline

Imbruvica

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-136395
Guideline Name	Imbruvica
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2024

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 (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 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
11/15/2023	Updated B-Cell lymphomas with terminology changes.

Immunoglobulin A Nephropathy (IgAN) Agents

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-141428
Guideline Name	Immunoglobulin A Nephropathy (IgAN) Agents
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	3/1/2024

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 - The patient is 18 years of age or older

AND

2 - Diagnosis of proteinuria associated with immunoglobulin A nephropathy (IgAN) confirmed by renal biopsy (must submit evidence of biopsy)

AND

3 - Documentation supporting ONE of the following must be submitted:

3.1 Proteinuria greater than or equal to 1 g/day (gram per day)

OR

3.2 Urine protein-to-creatinine ratio (UPCR) greater than or equal to 1.5 g/g (grams per gram)

AND

4 - ONE of the following:

4.1 The patient has had a trial and failure of at least 90 days of drug therapy with an ACE inhibitor or ARB agent

OR

4.2 Prescriber has submitted valid medical justification for the use of Filspari (sparsentan) over ACE inhibitors and/or ARB agents

AND

5 - The patient is enrolled in the Filspari (sparsentan) REMS program and prescriber is monitoring in accordance with REMS requirements

AND

6 - The patient will not be using concomitantly with any of the following: ACE inhibitors, ARB agents, endothelin receptor antagonists (ERAs), aliskiren

AND

7 - Requested quantity does not exceed 1 tablet/day (200 mg or 400 mg strength tablets)

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

Product Name	Generic Name	GPI	Brand/Generic
FILSPARI	SPARSENTAN TAB 200 MG	56483065000320	Brand
FILSPARI	SPARSENTAN TAB 400 MG	56483065000340	Brand

Approval Criteria

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

AND

2 - The patient will not be using concomitantly with any of the following: ACE inhibitors, ARB agents, endothelin receptor antagonists (ERAs), aliskiren

AND

3 - Requested quantity does not exceed 1 tablet/day (200 mg or 400 mg strength tablets)

Product Name: Tarpeyo	
Approval Length	Up to a maximum of 9 months
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TARPEYO	BUDESONIDE DELAYED RELEASE CAP 4 MG	22100012006520	Brand

Approval Criteria

1 - The patient is 18 years of age or older

AND

2 - Diagnosis of proteinuria associated with immunoglobulin A nephropathy (IgAN) confirmed by renal biopsy (must submit evidence of biopsy)

AND

3 - Documentation supporting ONE of the following must be submitted:

3.1 Proteinuria greater than or equal to 1 g/day (gram per day)

OR

3.2 Urine protein-to-creatinine ratio (UPCR) greater than or equal to 0.8 g/g (grams per gram)

AND

4 - ONE of the following:

4.1 The patient has had a trial and failure of at least 90 days of drug therapy with an ACE inhibitor or ARB agent

OR

4.2 Prescriber has submitted valid medical justification for the use of Tarpeyo (budesonide) over ACE inhibitors and/or ARB agents

AND

5 - Requested quantity does not exceed 4 capsules/day

AND

6 - Requested length of therapy does not exceed 9 months total

2 . Revision History

Date	Notes
2/12/2024	New guideline

Inbrija

Prior Authorization Guideline

Guideline ID	GL-147441
Guideline Name	Inbrija
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2024

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

2 . Revision History

Date	Notes
5/15/2024	Revised initial authorization to 12 months.

Injectable and Transdermal Antipsychotics

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-161614
Guideline Name	Injectable and Transdermal Antipsychotics
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2025

1 . Criteria

Product Name: (All Antipsychotics) Abilify Asimtufii, Abilify Maintena, Aristada, Aristada Initio, Brand Zyprexa inj, generic olanzapine inj, Zyprexa Relprevv, Erzofri, Invega Sustenna, prochlorperazine inj, Brand Risperdal Consta, generic risperidone ER inj, Rykindo, Perseris, Uzedy, Secuado, chlorpromazine inj, fluphenazine inj, fluphenazine decanoate, Brand Haldol decanoate, Generic haloperidol decanoate, haloperidol lactate inj, Generic ziprasidone mesylate injection, Brand Geodon injection, Invega Trinza, Invega Hafyera	
Diagnosis	Duplicate Therapy with Another Antipsychotic
Therapy Stage	Initial Authorization
Guideline Type	Drug Utilization Review

Product Name	Generic Name	GPI	Brand/Generic
OLANZAPINE	OLANZAPINE FOR IM INJ 10 MG	59157060002120	Generic
ZYPREXA	OLANZAPINE FOR IM INJ 10 MG	59157060002120	Brand

GEODON	ZIPRASIDONE MESYLATE FOR INJ 20 MG (BASE EQUIVALENT)	59400085202120	Brand
ZIPRASIDONE MESYLATE	ZIPRASIDONE MESYLATE FOR INJ 20 MG (BASE EQUIVALENT)	59400085202120	Generic
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
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
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 INITIO	ARIPIPRAZOLE LAUROXIL IM ER SUSP PREFILLED SYR 675 MG/2.4ML	5925001520E435	Brand
ARISTADA	ARIPIPRAZOLE LAUROXIL IM ER SUSP PREFILLED SYR 882 MG/3.2ML	5925001520E440	Brand
ARISTADA	ARIPIPRAZOLE LAUROXIL IM ER SUSP PREFILLED SYR 1064 MG/3.9ML	5925001520E450	Brand
ZYPREXA RELPREVV	OLANZAPINE PAMOATE FOR EXTENDED REL IM SUSP 210 MG (BASE EQ)	59157060101950	Brand
ZYPREXA RELPREVV	OLANZAPINE PAMOATE FOR EXTENDED REL IM SUSP 300 MG (BASE EQ)	59157060101960	Brand
ZYPREXA RELPREVV	OLANZAPINE PAMOATE FOR EXTENDED REL IM SUSP 405 MG (BASE EQ)	59157060101970	Brand
RISPERDAL CONSTA	RISPERIDONE MICROSPHERES FOR IM EXTENDED REL SUSP 12.5 MG	5907007010G210	Brand
RISPERDAL CONSTA	RISPERIDONE MICROSPHERES FOR IM EXTENDED REL SUSP 25 MG	5907007010G220	Brand
RISPERDAL CONSTA	RISPERIDONE MICROSPHERES FOR IM EXTENDED REL SUSP 37.5 MG	5907007010G230	Brand
RISPERDAL CONSTA	RISPERIDONE MICROSPHERES FOR IM EXTENDED REL SUSP 50 MG	5907007010G240	Brand

CHLORPROMAZINE HCL	CHLORPROMAZINE HCL INJ 25 MG/ML	59200015102005	Generic
CHLORPROMAZINE HCL	CHLORPROMAZINE HCL INJ 50 MG/2ML	59200015102015	Generic
FLUPHENAZINE HCL	FLUPHENAZINE HCL INJ 2.5 MG/ML	59200025102005	Generic
FLUPHENAZINE DECANOATE	FLUPHENAZINE DECANOATE INJ 25 MG/ML	59200025302005	Generic
HALOPERIDOL DECANOATE	HALOPERIDOL DECANOATE IM SOLN 50 MG/ML	59100010302010	Generic
HALDOL DECANOATE 50	HALOPERIDOL DECANOATE IM SOLN 50 MG/ML	59100010302010	Brand
HALDOL DECANOATE 100	HALOPERIDOL DECANOATE IM SOLN 100 MG/ML	59100010302020	Brand
HALOPERIDOL DECANOATE	HALOPERIDOL DECANOATE IM SOLN 100 MG/ML	59100010302020	Generic
HALOPERIDOL LACTATE	HALOPERIDOL LACTATE INJ 5 MG/ML	59100010202005	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
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
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
CHLORPROMAZINE HYDROCHLORIDE	CHLORPROMAZINE HCL INJ 25 MG/ML	59200015102005	Generic
CHLORPROMAZINE HYDROCHLORIDE	CHLORPROMAZINE HCL INJ 50 MG/2ML	59200015102015	Generic
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
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
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
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
PROCHLORPERAZINE EDISYLATE	PROCHLORPERAZINE EDISYLATE INJ 10 MG/2ML	59200055202010	Generic
RYKINDO	RISPERIDONE FOR IM EXTENDED RELEASE SUSPENSION 25 MG	5907007000G220	Brand
RYKINDO	RISPERIDONE FOR IM EXTENDED RELEASE SUSPENSION 37.5 MG	5907007000G230	Brand
RYKINDO	RISPERIDONE FOR IM EXTENDED RELEASE SUSPENSION 50 MG	5907007000G240	Brand
RISPERIDONE ER	RISPERIDONE MICROSPHERES FOR IM EXTENDED REL SUSP 12.5 MG	5907007010G210	Generic
RISPERIDONE ER	RISPERIDONE MICROSPHERES FOR IM EXTENDED REL SUSP 25 MG	5907007010G220	Generic
RISPERIDONE ER	RISPERIDONE MICROSPHERES FOR IM EXTENDED REL SUSP 37.5 MG	5907007010G230	Generic
RISPERIDONE ER	RISPERIDONE MICROSPHERES FOR IM EXTENDED REL SUSP 50 MG	5907007010G240	Generic
ERZOFRI	PALIPERIDONE PALMITATE ER SUSP PREF SYR 39 MG/0.25ML	5907005010E626	Brand
ERZOFRI	PALIPERIDONE PALMITATE ER SUSP PREF SYR 78 MG/0.5ML	5907005010E629	Brand
ERZOFRI	PALIPERIDONE PALMITATE ER SUSP PREF SYR 117 MG/0.75ML	5907005010E632	Brand
ERZOFRI	PALIPERIDONE PALMITATE ER SUSP PREF SYR 156 MG/ML	5907005010E635	Brand
ERZOFRI	PALIPERIDONE PALMITATE ER SUSP PREF SYR 234 MG/1.5ML	5907005010E638	Brand
ERZOFRI	PALIPERIDONE PALMITATE ER SUSP PREF SYR 351 MG/2.25ML	5907005010E639	Brand

Approval Criteria

1 - ONE of the following:

1.1 The patient has had metabolic monitoring labs obtained within the past 12 months (with a 6-months grace period), confirmed by claims/medical history or chart documentation

OR

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

AND

2 - One of the following:

2.1 The patient will be utilizing the requested antipsychotic as monotherapy

OR

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

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

OR

2.2.2 All of the following:

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

OR

2.3 All of the following:

2.3.1 Diagnosis of depressed mood disorder

AND

2.3.2 BOTH of the following:

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

AND

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

AND

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

OR

2.4 ALL of the following:

2.4.1 Diagnosis of ONE of the following:

- Bipolar affective disorder
- Unspecified episodic mood disorder

AND

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

AND

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

OR

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

AND

3 - Patient is not utilizing more than 2 antipsychotics concurrently

Notes	*Approval Length – 90 days for cross taper, 4 months for patients new to antipsychotic therapy, 6 months for initial approval and not new to antipsychotic therapy

Product Name: (All Antipsychotics) Abilify Asimtufii, Abilify Maintena, Aristada, Aristada Initio, Brand Zyprexa inj, generic olanzapine inj, Zyprexa Relprevv, Erzofri, Invega Sustenna, prochlorperazine inj, Brand Risperdal Consta, generic risperidone ER inj, Rykindo, Perseris, Uzedy, Secuado, chlorpromazine inj, fluphenazine inj, fluphenazine decanoate, Brand Haldol decanoate, Generic haloperidol decanoate, haloperidol lactate inj, Generic ziprasidone mesylate injection, Brand Geodon injection, Invega Trinza, Invega Hafyera

Diagnosis	Duplicate Therapy with Another Antipsychotic
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Drug Utilization Review

Product Name	Generic Name	GPI	Brand/Generic
OLANZAPINE	OLANZAPINE FOR IM INJ 10 MG	59157060002120	Generic
ZYPREXA	OLANZAPINE FOR IM INJ 10 MG	59157060002120	Brand
GEODON	ZIPRASIDONE MESYLATE FOR INJ 20 MG (BASE EQUIVALENT)	59400085202120	Brand

ZIPRASIDONE MESYLATE	ZIPRASIDONE MESYLATE FOR INJ 20 MG (BASE EQUIVALENT)	59400085202120	Generic
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
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
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 INITIO	ARIPIPRAZOLE LAUROXIL IM ER SUSP PREFILLED SYR 675 MG/2.4ML	5925001520E435	Brand
ARISTADA	ARIPIPRAZOLE LAUROXIL IM ER SUSP PREFILLED SYR 882 MG/3.2ML	5925001520E440	Brand
ARISTADA	ARIPIPRAZOLE LAUROXIL IM ER SUSP PREFILLED SYR 1064 MG/3.9ML	5925001520E450	Brand
ZYPREXA RELPREVV	OLANZAPINE PAMOATE FOR EXTENDED REL IM SUSP 210 MG (BASE EQ)	59157060101950	Brand
ZYPREXA RELPREVV	OLANZAPINE PAMOATE FOR EXTENDED REL IM SUSP 300 MG (BASE EQ)	59157060101960	Brand
ZYPREXA RELPREVV	OLANZAPINE PAMOATE FOR EXTENDED REL IM SUSP 405 MG (BASE EQ)	59157060101970	Brand
RISPERDAL CONSTA	RISPERIDONE MICROSPHERES FOR IM EXTENDED REL SUSP 12.5 MG	5907007010G210	Brand
RISPERDAL CONSTA	RISPERIDONE MICROSPHERES FOR IM EXTENDED REL SUSP 25 MG	5907007010G220	Brand
RISPERDAL CONSTA	RISPERIDONE MICROSPHERES FOR IM EXTENDED REL SUSP 37.5 MG	5907007010G230	Brand
RISPERDAL CONSTA	RISPERIDONE MICROSPHERES FOR IM EXTENDED REL SUSP 50 MG	5907007010G240	Brand
CHLORPROMAZINE HCL	CHLORPROMAZINE HCL INJ 25 MG/ML	59200015102005	Generic

CHLORPROMAZINE HCL	CHLORPROMAZINE HCL INJ 50 MG/2ML	59200015102015	Generic
FLUPHENAZINE HCL	FLUPHENAZINE HCL INJ 2.5 MG/ML	59200025102005	Generic
FLUPHENAZINE DECANOATE	FLUPHENAZINE DECANOATE INJ 25 MG/ML	59200025302005	Generic
HALOPERIDOL DECANOATE	HALOPERIDOL DECANOATE IM SOLN 50 MG/ML	59100010302010	Generic
HALDOL DECANOATE 50	HALOPERIDOL DECANOATE IM SOLN 50 MG/ML	59100010302010	Brand
HALDOL DECANOATE 100	HALOPERIDOL DECANOATE IM SOLN 100 MG/ML	59100010302020	Brand
HALOPERIDOL DECANOATE	HALOPERIDOL DECANOATE IM SOLN 100 MG/ML	59100010302020	Generic
HALOPERIDOL LACTATE	HALOPERIDOL LACTATE INJ 5 MG/ML	59100010202005	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
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
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
CHLORPROMAZINE HYDROCHLORIDE	CHLORPROMAZINE HCL INJ 25 MG/ML	59200015102005	Generic
CHLORPROMAZINE HYDROCHLORIDE	CHLORPROMAZINE HCL INJ 50 MG/2ML	59200015102015	Generic
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
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

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
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
PROCHLORPERAZINE EDISYLATE	PROCHLORPERAZINE EDISYLATE INJ 10 MG/2ML	59200055202010	Generic
RYKINDO	RISPERIDONE FOR IM EXTENDED RELEASE SUSPENSION 25 MG	5907007000G220	Brand
RYKINDO	RISPERIDONE FOR IM EXTENDED RELEASE SUSPENSION 37.5 MG	5907007000G230	Brand
RYKINDO	RISPERIDONE FOR IM EXTENDED RELEASE SUSPENSION 50 MG	5907007000G240	Brand
RISPERIDONE ER	RISPERIDONE MICROSPHERES FOR IM EXTENDED REL SUSP 12.5 MG	5907007010G210	Generic
RISPERIDONE ER	RISPERIDONE MICROSPHERES FOR IM EXTENDED REL SUSP 25 MG	5907007010G220	Generic
RISPERIDONE ER	RISPERIDONE MICROSPHERES FOR IM EXTENDED REL SUSP 37.5 MG	5907007010G230	Generic
RISPERIDONE ER	RISPERIDONE MICROSPHERES FOR IM EXTENDED REL SUSP 50 MG	5907007010G240	Generic
ERZOFRI	PALIPERIDONE PALMITATE ER SUSP PREF SYR 39 MG/0.25ML	5907005010E626	Brand
ERZOFRI	PALIPERIDONE PALMITATE ER SUSP PREF SYR 78 MG/0.5ML	5907005010E629	Brand
ERZOFRI	PALIPERIDONE PALMITATE ER SUSP PREF SYR 117 MG/0.75ML	5907005010E632	Brand
ERZOFRI	PALIPERIDONE PALMITATE ER SUSP PREF SYR 156 MG/ML	5907005010E635	Brand
ERZOFRI	PALIPERIDONE PALMITATE ER SUSP PREF SYR 234 MG/1.5ML	5907005010E638	Brand
ERZOFRI	PALIPERIDONE PALMITATE ER SUSP PREF SYR 351 MG/2.25ML	5907005010E639	Brand

Approval Criteria

1 - History of the requested agent(s) for 90 of the past 120 days

AND

2 - The patient has had metabolic monitoring labs obtained within the past 12 months (with a 6-months grace period), confirmed by claims/medical history or chart documentation

AND

3 - One of the following:

3.1 The patient will be utilizing the requested antipsychotic as monotherapy

OR

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

AND

4 - Patient is not utilizing more than 2 antipsychotics concurrently

Product Name: (All Antipsychotics) Abilify Asimtufii, Abilify Maintena, Aristada, Aristada Initio, Brand Zyprexa inj, generic olanzapine inj, Zyprexa Relprevv, Erzofri, Invega Sustenna, prochlorperazine inj, Brand Risperdal Consta, generic risperidone ER inj, Rykindo, Perseris, Uzedy, Secuado, chlorpromazine inj, fluphenazine inj, fluphenazine decanoate, Brand Haldol decanoate, Generic haloperidol decanoate, haloperidol lactate inj, Generic ziprasidone mesylate injection, Brand Geodon injection, Invega Trinza, Invega Hafyera

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

Product Name	Generic Name	GPI	Brand/Generic
OLANZAPINE	OLANZAPINE FOR IM INJ 10 MG	59157060002120	Generic

ZYPREXA	OLANZAPINE FOR IM INJ 10 MG	59157060002120	Brand
GEODON	ZIPRASIDONE MESYLATE FOR INJ 20 MG (BASE EQUIVALENT)	59400085202120	Brand
ZIPRASIDONE MESYLATE	ZIPRASIDONE MESYLATE FOR INJ 20 MG (BASE EQUIVALENT)	59400085202120	Generic
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
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
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 INITIO	ARIPIPRAZOLE LAUROXIL IM ER SUSP PREFILLED SYR 675 MG/2.4ML	5925001520E435	Brand
ARISTADA	ARIPIPRAZOLE LAUROXIL IM ER SUSP PREFILLED SYR 882 MG/3.2ML	5925001520E440	Brand
ARISTADA	ARIPIPRAZOLE LAUROXIL IM ER SUSP PREFILLED SYR 1064 MG/3.9ML	5925001520E450	Brand
ZYPREXA RELPREVV	OLANZAPINE PAMOATE FOR EXTENDED REL IM SUSP 210 MG (BASE EQ)	59157060101950	Brand
ZYPREXA RELPREVV	OLANZAPINE PAMOATE FOR EXTENDED REL IM SUSP 300 MG (BASE EQ)	59157060101960	Brand
ZYPREXA RELPREVV	OLANZAPINE PAMOATE FOR EXTENDED REL IM SUSP 405 MG (BASE EQ)	59157060101970	Brand
RISPERDAL CONSTA	RISPERIDONE MICROSPHERES FOR IM EXTENDED REL SUSP 12.5 MG	5907007010G210	Brand
RISPERDAL CONSTA	RISPERIDONE MICROSPHERES FOR IM EXTENDED REL SUSP 25 MG	5907007010G220	Brand
RISPERDAL CONSTA	RISPERIDONE MICROSPHERES FOR IM EXTENDED REL SUSP 37.5 MG	5907007010G230	Brand

RISPERDAL CONSTA	RISPERIDONE MICROSPHERES FOR IM EXTENDED REL SUSP 50 MG	5907007010G240	Brand
CHLORPROMAZINE HCL	CHLORPROMAZINE HCL INJ 25 MG/ML	59200015102005	Generic
CHLORPROMAZINE HCL	CHLORPROMAZINE HCL INJ 50 MG/2ML	59200015102015	Generic
FLUPHENAZINE HCL	FLUPHENAZINE HCL INJ 2.5 MG/ML	59200025102005	Generic
FLUPHENAZINE DECANOATE	FLUPHENAZINE DECANOATE INJ 25 MG/ML	59200025302005	Generic
HALOPERIDOL DECANOATE	HALOPERIDOL DECANOATE IM SOLN 50 MG/ML	59100010302010	Generic
HALDOL DECANOATE 50	HALOPERIDOL DECANOATE IM SOLN 50 MG/ML	59100010302010	Brand
HALDOL DECANOATE 100	HALOPERIDOL DECANOATE IM SOLN 100 MG/ML	59100010302020	Brand
HALOPERIDOL DECANOATE	HALOPERIDOL DECANOATE IM SOLN 100 MG/ML	59100010302020	Generic
HALOPERIDOL LACTATE	HALOPERIDOL LACTATE INJ 5 MG/ML	59100010202005	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
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
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
CHLORPROMAZINE HYDROCHLORIDE	CHLORPROMAZINE HCL INJ 25 MG/ML	59200015102005	Generic
CHLORPROMAZINE HYDROCHLORIDE	CHLORPROMAZINE HCL INJ 50 MG/2ML	59200015102015	Generic
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

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
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
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
PROCHLORPERAZINE EDISYLATE	PROCHLORPERAZINE EDISYLATE INJ 10 MG/2ML	59200055202010	Generic
RYKINDO	RISPERIDONE FOR IM EXTENDED RELEASE SUSPENSION 25 MG	5907007000G220	Brand
RYKINDO	RISPERIDONE FOR IM EXTENDED RELEASE SUSPENSION 37.5 MG	5907007000G230	Brand
RYKINDO	RISPERIDONE FOR IM EXTENDED RELEASE SUSPENSION 50 MG	5907007000G240	Brand
RISPERIDONE ER	RISPERIDONE MICROSPHERES FOR IM EXTENDED REL SUSP 12.5 MG	5907007010G210	Generic
RISPERIDONE ER	RISPERIDONE MICROSPHERES FOR IM EXTENDED REL SUSP 25 MG	5907007010G220	Generic
RISPERIDONE ER	RISPERIDONE MICROSPHERES FOR IM EXTENDED REL SUSP 37.5 MG	5907007010G230	Generic
RISPERIDONE ER	RISPERIDONE MICROSPHERES FOR IM EXTENDED REL SUSP 50 MG	5907007010G240	Generic
ERZOFRI	PALIPERIDONE PALMITATE ER SUSP PREF SYR 39 MG/0.25ML	5907005010E626	Brand
ERZOFRI	PALIPERIDONE PALMITATE ER SUSP PREF SYR 78 MG/0.5ML	5907005010E629	Brand
ERZOFRI	PALIPERIDONE PALMITATE ER SUSP PREF SYR 117 MG/0.75ML	5907005010E632	Brand
ERZOFRI	PALIPERIDONE PALMITATE ER SUSP PREF SYR 156 MG/ML	5907005010E635	Brand
ERZOFRI	PALIPERIDONE PALMITATE ER SUSP PREF SYR 234 MG/1.5ML	5907005010E638	Brand
ERZOFRI	PALIPERIDONE PALMITATE ER SUSP PREF SYR 351 MG/2.25ML	5907005010E639	Brand

Approval Criteria

1 - All of the following:

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

AND

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

OR

2 - All of the following:

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

AND

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

OR

3 - All of the following:

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

AND

3.2 ONE of the following:

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

AND

3.3 One of the following:

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

OR

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

AND

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

Notes	*These criteria come from the Non- Drug Specific PA policy

2 . Background

Benefit/Coverage/Program Information
Table 1 - Adequate Dose

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

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

3 . Revision History

Date	Notes
12/3/2024	Added Erzofri. Updated note language in Age Limit Exception section .

Inlyta

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-161159
Guideline Name	Inlyta
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2025

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

11/21/2024	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

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-123560
Guideline Name	Inqovi
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	5/1/2023

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

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-117342
Guideline Name	Inrebic
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2023

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

2 . Revision History

Date	Notes
11/28/2022	Copy NY

Insulin Pen Needles and Syringes

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-161982
Guideline Name	Insulin Pen Needles and Syringes
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2025

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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/0.5ML/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/indiana-health-plans/in-comm-plan-home/in-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

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

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

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

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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
12/12/2024	Updated GPIs

Iqirvo

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-161349
Guideline Name	Iqirvo
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2025

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

11/26/2024	New program.

Iressa

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-136328
Guideline Name	Iressa
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2024

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

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-109711
Guideline Name	Iron Chelators
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	9/1/2022

1 . Criteria

Product Name: Brand Exjade, Brand Jadenu, generic deferasirox	
Diagnosis	Chronic Iron Overload due to Blood Transfusion
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

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

2 . Revision History

Date	Notes
7/22/2022	Updated coverage criteria for Ferriprox per changes to the FDA appr oved label. Added generic deferiprone 1000 mg tablet. Clarified listin g of generics throughout guideline.

Irritable Bowel Syndrome - Diarrhea

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-121858
Guideline Name	Irritable Bowel Syndrome - Diarrhea
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2023

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

Isturisa

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-109317
Guideline Name	Isturisa
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	9/1/2022

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

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-147140
Guideline Name	Iwilfin
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2024

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

2 . Revision History

Date	Notes
5/7/2024	New guideline

Jakafi

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-138575
Guideline Name	Jakafi
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	2/1/2024

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 improvement or reduction in spleen volume while on Jakafi, authorization will be issued for 2 months to allow for dose titration with discontinuation of therapy.

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

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-147445
Guideline Name	Jaypirca
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2024

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

2 . Revision History

Date	Notes
5/16/2024	Added criteria for CLL/SLL.

Jesduvroq (daprodustat)

Prior Authorization Guideline

Guideline ID	GL-137548
Guideline Name	Jesduvroq (daprodustat)
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Jesduvroq	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

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

AND

2 - Patient has been receiving dialysis for at least four months

AND

3 - Patient is 18 years of age or older

AND

4 - ONE of the following

- Patient has tried and failed one erythropoiesis-stimulating agent (ESA) (e.g., Aranesp, Epogen, Retacrit, Mircera, Procrit), confirmed by claims history or chart documentation
- Prescriber has submitted valid medical justification for the use of Jesduvroq (daprodustat) over all ESA agents listed above

AND

5 - Documentation patient has a pretreatment hemoglobin of less than 11 grams per deciliter (g/dL)

AND

6 - Prescribed by, or in consultation with, a nephrologist

AND

7 - Prescriber attests that patient will not be utilizing Jesduvroq (daprodustat) concomitantly with an ESA agent (e.g., Aranesp, Epogen, Retacrit, Mircera, Procrit)

Product Name: Jesduvroq	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

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 - History of the requested agent within the past 90 days, confirmed by claims history or chart documentation

AND

2 - ONE of the following:

- Patient has tried and failed an erythropoiesis-stimulating agent (ESA) (e.g., Aranesp, Epogen, Retacrit, Mircera, Procrit), confirmed by claims history or chart documentation
- Prescriber has submitted valid medical justification for the use of Jesduvroq (daprodustat) over all ESA agents listed above

AND

3 - Prescriber attests that patient is not/will not be utilizing Jesduvroq (daprodustat) concomitantly with an ESA agent (e.g., Aranesp, Epogen, Retacrit, Mircera, Procrit)

2 . Revision History

Date	Notes
12/11/2023	Updated patient to prescriber in second bullet of step 4 initial authorization.

Joenja

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-151234
Guideline Name	Joenja
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	9/1/2024

1 . Criteria

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

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
8/8/2024	Updated initial authorization duration to 12 months.

Jynarque

Prior Authorization Guideline

Guideline ID	GL-81962
Guideline Name	Jynarque
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2021

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 15 MG	30454060000320	Brand
JYNARQUE	TOLVAPTAN TAB 30 MG	30454060000330	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 THERAPY PACK 15 MG	3045406000B710	Brand
JYNARQUE	TOLVAPTAN TAB THERAPY PACK 30 & 15 MG	3045406000B720	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 15 MG	30454060000320	Brand
JYNARQUE	TOLVAPTAN TAB 30 MG	30454060000330	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 THERAPY PACK 15 MG	3045406000B710	Brand
JYNARQUE	TOLVAPTAN TAB THERAPY PACK 30 & 15 MG	3045406000B720	Brand

Approval Criteria

1 - Documentation of positive clinical response to Jynarque therapy

2 . Revision History

Date	Notes
3/5/2021	Bulk Load

Keveyis

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-123510
Guideline Name	Keveyis
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	5/1/2023

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

Kisqali

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146897
Guideline Name	Kisqali
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2024

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

2 . Revision History

Date	Notes
4/30/2024	Added clinical criteria for endometrial carcinoma. Minor verbiage/cosmetic updates to NCCN Recommended Regimens sections (with no changes to clinical intent).

Kisqali Femara Co-Pack

Prior Authorization Guideline

Guideline ID	GL-146899
Guideline Name	Kisqali Femara Co-Pack
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2024

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

2 . Revision History

Date	Notes
4/30/2024	Added clinical criteria for endometrial carcinoma. Minor verbiage/cosmetic updates to NCCN Recommended Regimens sections (with no changes to clinical intent).

Korlym

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-147299
Guideline Name	Korlym
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2024

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-161161
Guideline Name	Koselugo
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2025

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
11/21/2024	Updated diagnosis header in reauth section to remove reference to p ilocytic astrocytoma and added glioma.

Krazati

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-156451
Guideline Name	Krazati
Formulary	• Medicaid - Community & State Indiana

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

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-93265
Guideline Name	Kuvan
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	11/1/2021

1 . Criteria

Product Name: Brand Kuvan, generic sapropterin	
Diagnosis	Phenylketonuria (PKU)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KUVAN	SAPROPTERIN DIHYDROCHLORIDE POWDER PACKET 100 MG	30908565103020	Brand
KUVAN	SAPROPTERIN DIHYDROCHLORIDE POWDER PACKET 500 MG	30908565103040	Brand
SAPROPTERIN DIHYDROCHLORIDE	SAPROPTERIN DIHYDROCHLORIDE TAB 100 MG	30908565100320	Generic
SAPROPTERIN DIHYDROCHLORIDE	SAPROPTERIN DIHYDROCHLORIDE POWDER PACKET 100 MG	30908565103020	Generic

SAPROPTERIN DIHYDROCHLORIDE	SAPROPTERIN DIHYDROCHLORIDE POWDER PACKET 500 MG	30908565103040	Generic
KUVAN	SAPROPTERIN DIHYDROCHLORIDE TAB 100 MG	30908565100320	Brand

Approval Criteria

1 - Diagnosis of phenylketonuria (PKU)

2 . Revision History

Date	Notes
9/8/2021	Updated GPI's and product name list

Lampit

Prior Authorization Guideline

Guideline ID	GL-82103
Guideline Name	Lampit
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2021

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

2 . Revision History

Date	Notes
3/5/2021	Bulk Load

Laxatives and Cathartics

Prior Authorization Guideline

Guideline ID	GL-158344
Guideline Name	Laxatives and Cathartics
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	11/15/2024

1 . Criteria

Product Name: generic lubiprostone, Linzess	
Approval Length	12 month(s)
Guideline Type	Step Therapy

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
LUBIPROSTONE	LUBIPROSTONE CAP 8 MCG	52450045000110	Generic
LUBIPROSTONE	LUBIPROSTONE CAP 24 MCG	52450045000120	Generic

Approval Criteria

1 - Patient had a trial of ONE of the following:

- Lactulose
- Sorbitol
- Polyethylene glycol

Product Name: Ibsrela, Motegrity, Trulance	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
IBSRELA	TENAPANOR HCL TAB 50 MG	52558580100320	Brand
MOTEGRITY	PRUCALOPRIDE SUCCINATE TAB 1 MG (BASE EQUIVALENT)	52560060200320	Brand
MOTEGRITY	PRUCALOPRIDE SUCCINATE TAB 2 MG (BASE EQUIVALENT)	52560060200330	Brand
TRULANCE	PLECANATIDE TAB 3 MG	52543060000320	Brand

Approval Criteria

1 - Patient had a trial of Brand Amitiza and Linzess

OR

2 - BOTH of the following:

2.1 Patient had a trial of ONE of the following:

- Lactulose
- Sorbitol
- Polyethylene glycol

AND

2.2 There is medical justification for use over the preferred* medications

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

Product Name: Movantik, Relistor tabs, Symproic	
Approval Length	12 month(s)
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
RELISTOR	METHYLNALTREXONE BROMIDE TAB 150 MG	52580050100320	Brand
SYMPROIC	NALDEMEDINE TOSYLATE TAB 0.2 MG (BASE EQUIVALENT)	52580057200320	Brand

Approval Criteria

1 - Patient had a trial of ONE of the following:

- Lactulose
- Sorbitol
- Polyethylene glycol

AND

2 - Diagnosis of opioid-induced constipation

AND

3 - There is medical justification for use over the preferred* medications

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

Product Name: Brand Amitiza	
Approval Length	12 month(s)
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 - Patient had a trial of ONE of the following:

- Lactulose
- Sorbitol
- Polyethylene glycol

AND

2 - The brand is medically necessary due to ONE of the following:

2.1 The brand is being requested because of an adverse reaction, allergy, or sensitivity to the generic (specify the adverse reaction, allergy, or sensitivity)

OR

2.2 The brand is being requested due to an incomplete response with the generic, as documented by submission of medical records

OR

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

OR

2.4 Special clinical circumstances exist that preclude the use of the generic equivalent of the brand medication for the patient (document special clinical circumstances)

Product Name: Relistor inj	
Approval Length	12 month(s)
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 - Patient had a trial of ONE of the following:

- Lactulose
- Sorbitol
- Polyethylene glycol

AND

2 - Diagnosis of opioid-induced constipation

2 . Revision History

Date	Notes
10/31/2024	Criteria updated for lubiprostone/Amitiza to reflect PDL change.

Lenvima

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-147448
Guideline Name	Lenvima
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2024

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

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

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

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

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

2 . Revision History

Date	Notes
5/16/2024	Updated thyroid cancer criteria based on label and NCCN. Updated hepatobiliary and thymic cancer based on NCCN recommendations.

Leukotriene Receptor Antagonists

Prior Authorization Guideline

Guideline ID	GL-125086
Guideline Name	Leukotriene Receptor Antagonists
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	7/1/2023

1 . Criteria

Product Name: Brand Singulair granules, generic montelukast granules	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MONTELUKAST SODIUM	MONTELUKAST SODIUM ORAL GRANULES PACKET 4 MG (BASE EQUIV)	44505050103020	Generic
SINGULAIR	MONTELUKAST SODIUM ORAL GRANULES PACKET 4 MG (BASE EQUIV)	44505050103020	Brand

Approval Criteria

1 - Documentation indicating tablet formulations are unsuitable for use

2 . Revision History

Date	Notes
4/27/2023	New

Lipotropics

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-157631
Guideline Name	Lipotropics
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	11/1/2024

1 . Criteria

Product Name: Brand Vytorin, generic ezetimibe/simvastatin	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
EZETIMIBE/SIMVASTATIN	EZETIMIBE-SIMVASTATIN TAB 10-10 MG	39994002300320	Generic
VYTORIN	EZETIMIBE-SIMVASTATIN TAB 10-10 MG	39994002300320	Brand
EZETIMIBE/SIMVASTATIN	EZETIMIBE-SIMVASTATIN TAB 10-20 MG	39994002300330	Generic
VYTORIN	EZETIMIBE-SIMVASTATIN TAB 10-20 MG	39994002300330	Brand

EZETIMIBE/SIMVASTATIN	EZETIMIBE-SIMVASTATIN TAB 10-40 MG	39994002300340	Generic
VYTORIN	EZETIMIBE-SIMVASTATIN TAB 10-40 MG	39994002300340	Brand
EZETIMIBE/SIMVASTATIN	EZETIMIBE-SIMVASTATIN TAB 10-80 MG	39994002300350	Generic
VYTORIN	EZETIMIBE-SIMVASTATIN TAB 10-80 MG	39994002300350	Brand

Approval Criteria

1 - Trial history of a single-agent HMG-CoA (3-Hydroxy-3-Methylglutaryl Coenzyme A) reductase inhibitor for 90 days of the past 120 days

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

Product Name	Generic Name	GPI	Brand/Generic
NEXLETOL	BEMPEDOIC ACID TAB 180 MG	39380020000320	Brand

Approval Criteria

1 - One of the following:

1.1 Patient has tried and failed two statin agents

OR

1.2 Patient has tried and failed a statin in combination with ezetimibe

OR

1.3 Medical justification for use

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

Product Name	Generic Name	GPI	Brand/Generic
NEXLIZET	BEMPEDOIC ACID-EZETIMIBE TAB 180-10 MG	39991002200320	Brand

Approval Criteria

1 - One of the following:

1.1 Patient has tried and failed a statin in combination with ezetimibe

OR

1.2 Medical justification for use

2 . Revision History

Date	Notes
10/17/2024	Removed Brand Vascepa and generic icosapent ethyl

Livmarli

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-161268
Guideline Name	Livmarli
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2025

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
11/25/2024	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-123296
Guideline Name	Livtencity
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	5/1/2023

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

Lonsurf

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-150901
Guideline Name	Lonsurf
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	8/2/2024

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

8/2/2024	Updated background for FDA indications and NCCN recommendations. Updated diagnostic criteria for colorectal cancer. Updated gastric/ gastroesophageal junction adenocarcinoma diagnostic criteria.

Lorbrena

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-147457
Guideline Name	Lorbrena
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2024

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

2 . Revision History

Date	Notes
5/16/2024	Added criteria for NCCN recommended use of Lorbrena in uterine sa rcoma, peripheral T-Cell lymphoma and large B-cell lymphoma.

Lovenox

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-120242
Guideline Name	Lovenox
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	3/1/2023

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

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

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

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

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

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.

Lucemyra

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-126584
Guideline Name	Lucemyra
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	7/1/2023

1 . Criteria

Product Name: Lucemyra	
Diagnosis	First Course of Therapy (Less than or equal to 14 days of therapy within 180 days)
Approval Length	14 Day(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LUCEMYRA	LOFEXIDINE HCL TAB 0.18 MG (BASE EQUIVALENT)	62805045100315	Brand

Approval Criteria

1 - One of the following:

1.1 Patient has a history of trial and failure of a guideline-accepted alpha-2 adrenergic agonist agent, confirmed by claims history or chart documentation

OR

1.2 Prescriber has provided valid medical rational for use of Lucemyra over other guideline-accepted alpha-2 adrenergic agonist agents

AND

2 - The request does not exceed the plan limitation maximum of 14 days supply (two separate 7 day fills) within 180 days

Product Name: Lucemyra	
Diagnosis	Subsequent Course of therapy (Greater than 14 days of therapy within 180 days)
Approval Length	14 Day(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LUCEMYRA	LOFEXIDINE HCL TAB 0.18 MG (BASE EQUIVALENT)	62805045100315	Brand

Approval Criteria

1 - Prescriber has provided valid medical rationale for continued use of Lucemyra

AND

2 - The request does not exceed the plan limitation maximum of 14 days supply (two separate 7 day fills)

2 . Revision History

Date	Notes
6/14/2023	Added T/F language and plan limitations (Two 7-day supplies in 180 days)

Lumakras

Prior Authorization Guideline

Guideline ID	GL-156452
Guideline Name	Lumakras
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	11/1/2024

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
9/30/2024	Added criteria for ampullary adenocarcinoma, colon cancer, and rect al cancer

Lynparza

Prior Authorization Guideline

Guideline ID	GL-156454
Guideline Name	Lynparza
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	11/1/2024

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

2 . Revision History

Date	Notes
9/30/2024	Updated formatting for ovarian cancer without change in clinical inten t.

Lytgobi

Prior Authorization Guideline

Guideline ID	GL-138740
Guideline Name	Lytgobi
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	2/1/2024

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

Macrolides

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-144304
Guideline Name	Macrolides
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2024

1 . Criteria

Product Name: generic erythromycin ethylsuccinate susp	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ERYTHROMYCIN ETHYLSUCCINATE	ERYTHROMYCIN ETHYLSUCCINATE FOR SUSP 200 MG/5ML	03100030301910	Generic
ERYTHROMYCIN ETHYLSUCCINATE	ERYTHROMYCIN ETHYLSUCCINATE FOR SUSP 400 MG/5ML	03100030301915	Generic

Approval Criteria

1 - Patient must be under 12 years of age

OR

2 - Patient must be unable to swallow tablets/capsules

Product Name: Brand Eryped susp, Brand E.E.S. Granules	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ERYPED 200	ERYTHROMYCIN ETHYLSUCCINATE FOR SUSP 200 MG/5ML	03100030301910	Brand
E.E.S. GRANULES	ERYTHROMYCIN ETHYLSUCCINATE FOR SUSP 200 MG/5ML	03100030301910	Brand
ERYPED 400	ERYTHROMYCIN ETHYLSUCCINATE FOR SUSP 400 MG/5ML	03100030301915	Brand

Approval Criteria

1 - Patient must have tried and failed generic erythromycin ethylsuccinate suspension in the past 90 days

OR

2 - BOTH of the following:

2.1 ONE of the following:

2.1.1 Patient must be under 12 years of age

OR

2.1.2 Patient must be unable to swallow tablets/capsules

AND

2.2 There is medical justification for use over the preferred* medications	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

2 . Revision History

Date	Notes
3/13/2024	Updated the NP criteria.

MASH-MASLD

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-154944
Guideline Name	MASH-MASLD
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	10/1/2024

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) with moderate (F2) to advanced (F3) liver fibrosis, confirmed by submission of both of the following:

1.1 One of the following tests indicating member has a diagnosis of steatohepatitis:

- FibroScan-aspartate aminotransferase (FAST)
- FibroScan controlled attenuation parameter (CAP)
- Liver biopsy
- MRI - protein density fat fraction (MRI-P DFF)
- MRI - aspartate aminotransferase (MAST)

AND

1.2 One of the following tests indicating member has moderate (F2) or advanced (F3) liver fibrosis:

- Enhance Liver Fibrosis (ELF)
- FibroScan
- Fibrosis-4 index (FIB-4) - for those 35 years of age or older
- Magnetic Resonance Elastography (MRE)
- Vibration-Controlled Transity Elastography (VCTE)

AND

2 - Patient is 18 years of age or older

AND

3 - Prescriber attests the patient does not have decompensated MASH cirrhosis

AND

4 - Prescribed by, or in consultation with, an endocrinologist, gastroenterologist, or hepatologist

AND

5 - The dose requested does not exceed 100 mg/day (milligrams per day)

AND

6 - The dose requested does not exceed one of the following:

- 60 mg strength - max of 1 tablet/day
- 80 mg strength - max of 1 tablet/day
- 100 mg strength - max of 1 tablet/day

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 - Submission of both of the following:

1.1 One of the following tests indicating improvement or stabilization of steatohepatitis:

- FibroScan-aspartate aminotransferase (FAST)
- FibroScan controlled attenuation parameter (CAP)
- Liver biopsy
- MRI - protein density fat fraction (MRI-P DFF)
- MRI - aspartate aminotransferase (MAST)

AND

1.2 One of the following tests indicating improvement or stabilization of fibrosis:

- Enhance Liver Fibrosis (ELF)
- FibroScan
- Fibrosis-4 index (FIB-4) - for those 35 years of age or older
- Magnetic Resonance Elastography (MRE)
- Vibration-Controlled Transity Elastography (VCTE)

AND

2 - Prescriber attests both of the following:

- Patient does not have decompensated metabolic dysfunction-associated steatohepatitis (MASH) cirrhosis
- Member continues to have signs of MASH and/or contributing metabolic dysfunction factors (e.g., hyperlipidemia, hypertension, insulin resistance, obesity)

AND

3 - The dose requested does not exceed 100 mg/day (milligrams per day)

AND

4 - The dose requested does not exceed one of the following:

- 60 mg strength - max of 1 tablet/day
- 80 mg strength - max of 1 tablet/day
- 100 mg strength - max of 1 tablet/day

2 . Revision History

Date	Notes
9/13/2024	Added FibroScan controlled attenuation parameter (CAP) as an optio n for testing

Mekinist

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-151758
Guideline Name	Mekinist
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	9/1/2024

1 . Criteria

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

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
8/14/2024	Added criteria for hairy cell leukemia, salivary gland tumor, and GIST.

Mektovi

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-156464
Guideline Name	Mektovi
Formulary	• Medicaid - Community & State Indiana

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 section

Mepron

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-98050
Guideline Name	Mepron
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2022

1 . Criteria

Product Name: Brand Mepron, generic atovaquone	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ATOVAQUONE	ATOVAQUONE SUSP 750 MG/5ML	16400020001820	Generic
MEPRON	ATOVAQUONE SUSP 750 MG/5ML	16400020001820	Brand

Approval Criteria

1 - ALL of the following:

1.1 Prophylaxis or treatment of Pneumocystis jirovecii pneumonia (PCP, PJP)

AND

1.2 ONE of the following:

1.2.1 Previous trial and failure of sulfamethoxazole/trimethoprim

OR

1.2.2 Prescriber has provided valid medical justification for the use of atovaquone over sulfamethoxazole/trimethoprim

OR

2 - BOTH of the following:

2.1 Diagnosis of babesiosis

AND

2.2 Patient will be using atovaquone concurrently with azithromycin

OR

3 - Prophylaxis or treatment of toxoplasma encephalitis in an HIV (human immunodeficiency virus)-infected patient

OR

4 - Treatment for ocular toxoplasmosis in an immunocompetent patient

Product Name: Brand Mepron, generic atovaquone	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ATOVAQUONE	ATOVAQUONE SUSP 750 MG/5ML	16400020001820	Generic
MEPRON	ATOVAQUONE SUSP 750 MG/5ML	16400020001820	Brand

Approval Criteria

1 - Patient has history of the requested medication within the past 90 days

AND

2 - Documentation from prescriber indicating improvement (including stabilization) in current clinical status

2 . Revision History

Date	Notes
11/5/2021	Updated all criteria to match state policy.

Migranal, Trudhesa

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-138766
Guideline Name	Migranal, Trudhesa
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	2/1/2024

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) (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 **4.2** Physician acknowledges that the potential benefit outweighs the risk associated with the higher dose or quantity	
Notes	*Nadolol and timolol are non-preferred and should not be included in denial to provider. **Candesartan is non-preferred and should not be included in denial to provider. ***This is a medical benefit, should not be included in denial to provider.

2 . Revision History

Date	Notes
1/9/2024	Updated QL criteria section because nadolol is non-preferred.

Miotics-Intraocular Pressure Reducers

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-137663
Guideline Name	Miotics-Intraocular Pressure Reducers
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

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

Product Name	Generic Name	GPI	Brand/Generic
SIMBRINZA	BRINZOLAMIDE-BRIMONIDINE TARTRATE OPHTH SUSP 1-0.2%	86609902201820	Brand

Approval Criteria

1 - Documentation that separate components are not suitable for use

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

Product Name	Generic Name	GPI	Brand/Generic
IYUZEH	LATANOPROST (PF) OPHTH SOLN 0.005%	86330050002025	Brand

Approval Criteria

1 - Trial and failure of latanoprost

OR

2 - Prescriber has provided medical justification for use of Iyuzeh over latanoprost

2 . Revision History

Date	Notes
12/12/2023	Added Iyuzeh and criteria.

Miscellaneous Oral Antidiabetic Agents

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-137614
Guideline Name	Miscellaneous Oral Antidiabetic Agents
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: glipizide/metformin, glyburide/metformin, generic pioglitazone			
Approval Length	12 month(s)		
Guideline Type	Prior Authorization		
Product Name	**Generic Name**	**GPI**	**Brand/Generic**
GLIPIZIDE/METFORMIN HYDROCHLORIDE	GLIPIZIDE-METFORMIN HCL TAB 2.5-250 MG	27997002350320	Generic
GLIPIZIDE/METFORMIN HYDROCHLORIDE	GLIPIZIDE-METFORMIN HCL TAB 2.5-500 MG	27997002350325	Generic
GLIPIZIDE/METFORMIN HYDROCHLORIDE	GLIPIZIDE-METFORMIN HCL TAB 5-500 MG	27997002350340	Generic
GLYBURIDE/METFORMIN HYDROCHLORIDE	GLYBURIDE-METFORMIN TAB 1.25-250 MG	27997002400310	Generic

GLYBURIDE/METFORMIN HYDROCHLORIDE	GLYBURIDE-METFORMIN TAB 2.5-500 MG	27997002400320	Generic
GLYBURIDE/METFORMIN HYDROCHLORIDE	GLYBURIDE-METFORMIN TAB 5-500 MG	27997002400330	Generic
PIOGLITAZONE HYDROCHLORIDE	PIOGLITAZONE HCL TAB 15 MG (BASE EQUIV)	27607050100320	Generic
PIOGLITAZONE HYDROCHLORIDE	PIOGLITAZONE HCL TAB 30 MG (BASE EQUIV)	27607050100330	Generic
PIOGLITAZONE HCL	PIOGLITAZONE HCL TAB 45 MG (BASE EQUIV)	27607050100340	Generic
PIOGLITAZONE HYDROCHLORIDE	PIOGLITAZONE HCL TAB 45 MG (BASE EQUIV)	27607050100340	Generic

Approval Criteria

1 - Patient has tried metformin

Product Name: Brand Riomet, generic metformin solution	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RIOMET	METFORMIN HCL ORAL SOLN 500 MG/5ML	27250050002020	Brand
METFORMIN HYDROCHLORIDE	METFORMIN HCL ORAL SOLN 500 MG/5ML	27250050002020	Generic

Approval Criteria

1 - BOTH of the following:

1.1 Patient is 10 years of age or older

AND

1.2 Patient is less than 12 years of age

OR

2 - Patient is unable to swallow tablets

Product Name: Brand Duetact, generic pioglitazone/glimepiride, Brand Actoplus Met, generic pioglitazone/metformin	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PIOGLITAZONE HCL-GLIMEPIRIDE	PIOGLITAZONE HCL-GLIMEPIRIDE TAB 30-2 MG	27997802400320	Generic
DUETACT	PIOGLITAZONE HCL-GLIMEPIRIDE TAB 30-2 MG	27997802400320	Brand
PIOGLITAZONE HCL-GLIMEPIRIDE	PIOGLITAZONE HCL-GLIMEPIRIDE TAB 30-4 MG	27997802400340	Generic
DUETACT	PIOGLITAZONE HCL-GLIMEPIRIDE TAB 30-4 MG	27997802400340	Brand
PIOGLITAZONE HCL/METFORMIN HCL	PIOGLITAZONE HCL-METFORMIN HCL TAB 15-500 MG	27998002400320	Generic
PIOGLITAZONE HCL/METFORMIN HCL	PIOGLITAZONE HCL-METFORMIN HCL TAB 15-850 MG	27998002400340	Generic
ACTOPLUS MET	PIOGLITAZONE HCL-METFORMIN HCL TAB 15-850 MG	27998002400340	Brand
ACTOPLUS MET	PIOGLITAZONE HCL-METFORMIN HCL TAB 15-500 MG	27998002400320	Brand

Approval Criteria

1 - Documentation that the separate components are unsuitable for use

2 . Revision History

Date	Notes

12/11/2023	Updated GPI and product name lists, updated metformin soln criteria .

Movement Disorder Agents

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-161816
Guideline Name	Movement Disorder Agents
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2025

1 . Criteria

Product Name: Austedo, Austedo Patient Titration Kit, Austedo XR, Austedo XR Patient Titration Kit	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

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

TITRATION KIT			
AUSTEDO XR PATIENT TITRATION KIT	DEUTETRABENAZINE TAB ER TITRATION PACK 12 & 18 & 24 & 30 MG	6238003000C140	Brand
AUSTEDO XR	DEUTETRABENAZINE TAB ER 24HR 6 MG	62380030007510	Brand
AUSTEDO XR	DEUTETRABENAZINE TAB ER 24HR 12 MG	62380030007520	Brand
AUSTEDO XR	DEUTETRABENAZINE TAB ER 24HR 18 MG	62380030007525	Brand
AUSTEDO XR	DEUTETRABENAZINE TAB ER 24HR 24 MG	62380030007530	Brand
AUSTEDO XR	DEUTETRABENAZINE TAB ER 24HR 30 MG	62380030007535	Brand
AUSTEDO XR	DEUTETRABENAZINE TAB ER 24HR 36 MG	62380030007540	Brand
AUSTEDO XR	DEUTETRABENAZINE TAB ER 24HR 42 MG	62380030007545	Brand
AUSTEDO XR	DEUTETRABENAZINE TAB ER 24HR 48 MG	62380030007550	Brand

Approval Criteria

1 - One of the following:

1.1 Diagnosis of chorea associated with Huntington's disease and both of the following:

1.1.1 Patient is 18 years of age or older

AND

1.1.2 Dose does not exceed 48 mg/day

OR

1.2 Diagnosis of tardive dyskinesia and all of the following:

1.2.1 Patient is 18 years of age or older

AND

1.2.2 One of the following:

1.2.2.1 Causative agent (e.g., antipsychotic, dopamine receptor blocking drug, etc.) has been removed from the patient's medication profile

OR

1.2.2.2 Medical rationale was provided as to why the causative agent (e.g., antipsychotic, dopamine receptor blocking drug, etc.) cannot be removed from the patient's medication profile

AND

1.2.3 Dose does not exceed 48 mg/day

Product Name: Austedo, Austedo Patient Titration Kit, Austedo XR, Austedo XR Patient Titration Kit	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AUSTEDO	DEUTETRABENAZINE TAB 6 MG	62380030000310	Brand
AUSTEDO	DEUTETRABENAZINE TAB 9 MG	62380030000320	Brand
AUSTEDO	DEUTETRABENAZINE TAB 12 MG	62380030000330	Brand
AUSTEDO PATIENT TITRATION KIT	DEUTETRABENAZINE TAB TITRATION PACK 6 MG & 9 MG & 12 MG	6238003000B720	Brand
AUSTEDO XR PATIENT TITRATION KIT	DEUTETRABENAZINE TAB ER TITRATION PACK 12 & 18 & 24 & 30 MG	6238003000C140	Brand

AUSTEDO XR	DEUTETRABENAZINE TAB ER 24HR 6 MG	62380030007510	Brand
AUSTEDO XR	DEUTETRABENAZINE TAB ER 24HR 12 MG	62380030007520	Brand
AUSTEDO XR	DEUTETRABENAZINE TAB ER 24HR 18 MG	62380030007525	Brand
AUSTEDO XR	DEUTETRABENAZINE TAB ER 24HR 24 MG	62380030007530	Brand
AUSTEDO XR	DEUTETRABENAZINE TAB ER 24HR 30 MG	62380030007535	Brand
AUSTEDO XR	DEUTETRABENAZINE TAB ER 24HR 36 MG	62380030007540	Brand
AUSTEDO XR	DEUTETRABENAZINE TAB ER 24HR 42 MG	62380030007545	Brand
AUSTEDO XR	DEUTETRABENAZINE TAB ER 24HR 48 MG	62380030007550	Brand

Approval Criteria

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

AND

2 - Dose does not exceed 48 mg/day

Product Name: Ingrezza	
Approval Length	1 year(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 80 MG (BASE EQUIV)	62380080200140	Brand
INGREZZA	VALBENAZINE TOSYLATE CAP 60 MG (BASE EQUIV)	62380080200130	Brand

INGREZZA	VALBENAZINE TOSYLATE CAPSULE SPRINKLE 40 MG (BASE EQUIV)	62380080206830	Brand
INGREZZA	VALBENAZINE TOSYLATE CAPSULE SPRINKLE 60 MG (BASE EQUIV)	62380080206850	Brand
INGREZZA	VALBENAZINE TOSYLATE CAPSULE SPRINKLE 80 MG (BASE EQUIV)	62380080206870	Brand

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of chorea associated with Huntington disease

AND

1.2 Patient is 18 years of age or older

AND

1.3 Dose does not exceed 80 mg/day

OR

2 - ALL of the following:

2.1 Diagnosis of tardive dyskinesia

AND

2.2 Patient is 18 years of age or older

AND

2.3 One of the following:

2.3.1 Causative agent (e.g., antipsychotic, dopamine receptor blocking drug, etc.) has been removed from the patient's medication profile

OR

2.3.2 Medical rationale was provided as to why the causative agent (e.g., antipsychotic, dopamine receptor blocking drug, etc.) cannot be removed from the patient's medication profile

AND

2.4 Dose does not exceed 80 mg/day

Product Name: Ingrezza	
Approval Length	1 year(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 80 MG (BASE EQUIV)	62380080200140	Brand
INGREZZA	VALBENAZINE TOSYLATE CAP 60 MG (BASE EQUIV)	62380080200130	Brand
INGREZZA	VALBENAZINE TOSYLATE CAPSULE SPRINKLE 40 MG (BASE EQUIV)	62380080206830	Brand
INGREZZA	VALBENAZINE TOSYLATE CAPSULE SPRINKLE 60 MG (BASE EQUIV)	62380080206850	Brand
INGREZZA	VALBENAZINE TOSYLATE CAPSULE SPRINKLE 80 MG (BASE EQUIV)	62380080206870	Brand

Approval Criteria

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

AND

2 - One of the following:

2.1 Diagnosis of chorea associated with Huntington disease

OR

2.2 Diagnosis of tardive dyskinesia

AND

3 - Dose does not exceed 80 mg/day

Product Name: generic tetrabenazine, Brand Xenazine	
Approval Length	1 year(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 - One of the following:

1.1 Diagnosis of chorea associated with Huntington's disease and both of the following:

1.1.1 Patient is 18 years of age or older

AND

1.1.2 Dose does not exceed 100 mg/day

OR

1.2 Diagnosis of tardive dyskinesia and all of the following:

1.2.1 Patient is 18 years of age or older

AND

1.2.2 One of the following:

1.2.2.1 Causative agent (e.g., antipsychotic, dopamine receptor blocking drug, etc.) has been removed from the patient's medication profile

OR

1.2.2.2 Medical rationale was provided as to why the causative agent (e.g., antipsychotic, dopamine receptor blocking drug, etc.) cannot be removed from the patient's medication profile

AND

1.2.3 Dose does not exceed 200 mg/day

OR

1.3 Both of the following:

1.3.1 Diagnosis of Tourette's syndrome

AND

1.3.2 Dose does not exceed 150 mg/day

OR

1.4 Diagnosis of other hyperkinetic movement disorder (e.g., hemiballismus, senile chorea, tic disorder) and both of the following:

1.4.1 Patient is 18 years of age or older

AND

1.4.2 Dose does not exceed 200 mg/day

Product Name: generic tetrabenazine, Brand Xenazine	
Approval Length	1 year(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 - History of the requested medication for at least 90 days within the past 120 days, confirmed by claims history or chart documentation

AND

2 - ONE of the following:

2.1 Both of the following:

2.1.1 Diagnosis of chorea associated with Huntington's disease

AND

2.1.2 Dose does not exceed 100 mg/day

OR

2.2 BOTH of the following:

2.2.1 Diagnosis of one of the following:

- Tardive dyskinesia
- Hyperkinetic movement disorder (e.g., hemiballismus, senile chorea, tic disorder)

AND

2.2.2 Dose does not exceed 200 mg/day

OR

2.3 Both of the following:

2.3.1 Diagnosis of Tourette’s syndrome

AND

2.3.2 Dose does not exceed 150 mg/day

2 . Revision History

Date	Notes
12/10/2024	Updated GPIs. Removed Tourette's syndrome indication from Austedo criteria. Combined Austedo and Austedo XR criteria

Mozobil

Prior Authorization Guideline

Guideline ID	GL-147564
Guideline Name	Mozobil
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2024

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

2 . Revision History

Date	Notes
5/21/2024	Added new generic plerixafor as a target to the guideline (updated GPI tables and product name lists accordingly); For NCCN Recommended Regimen (reauth section), updated criterion to remove reference to "Mozobil therapy" and replaced with "the requested therapy". No changes to clinical intent.

Mulpleta

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-116812
Guideline Name	Mulpleta
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2023

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

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-82110
Guideline Name	Multaq
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2021

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 - ONE of the following:

1.1 All of the following:

1.1.1 Diagnosis of ONE of the following:

- Paroxysmal Atrial Fibrillation (AF)
- Persistent AF defined as AF less than 6 months duration

AND

1.1.2 ONE of the following:

- Patient is in sinus rhythm
- Patient is planned to undergo cardioversion to sinus rhythm

AND

1.1.3 Patient does not have New York Heart Association (NYHA) Class IV heart failure

AND

1.1.4 Patient does not have symptomatic heart failure with recent decompensation requiring hospitalization

OR

1.2 For continuation of current therapy

2 . Revision History

Date	Notes
3/5/2021	Bulk Load

Multiple Sclerosis

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-154797
Guideline Name	Multiple Sclerosis
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name: generic teriflunomide, Brand Aubagio, generic fingolimod, Brand Gilenya, generic dimethyl fumarate, Brand Tecfidera, Avonex, Betaseron, generic glatiramer, Glatopa, Brand Copaxone, Rebif, Rebif Rebidose	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
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

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
GLATOPA	GLATIRAMER ACETATE SOLN PREFILLED SYRINGE 20 MG/ML	6240003010E520	Generic
GLATIRAMER ACETATE	GLATIRAMER ACETATE SOLN PREFILLED SYRINGE 20 MG/ML	6240003010E520	Generic
COPAXONE	GLATIRAMER ACETATE SOLN PREFILLED SYRINGE 20 MG/ML	6240003010E520	Brand
GLATOPA	GLATIRAMER ACETATE SOLN PREFILLED SYRINGE 40 MG/ML	6240003010E540	Generic
GLATIRAMER ACETATE	GLATIRAMER ACETATE SOLN PREFILLED SYRINGE 40 MG/ML	6240003010E540	Generic
COPAXONE	GLATIRAMER ACETATE SOLN PREFILLED SYRINGE 40 MG/ML	6240003010E540	Brand
GILENYA	FINGOLIMOD HCL CAP 0.25 MG (BASE EQUIV)	62407025100110	Brand
GILENYA	FINGOLIMOD HCL CAP 0.5 MG (BASE EQUIV)	62407025100120	Brand
FINGOLIMOD	FINGOLIMOD HCL CAP 0.5 MG (BASE EQUIV)	62407025100120	Generic
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
TECFIDERA	DIMETHYL FUMARATE CAPSULE DELAYED RELEASE 120 MG	62405525006520	Brand
DIMETHYL FUMARATE	DIMETHYL FUMARATE CAPSULE DELAYED RELEASE 120 MG	62405525006520	Generic
TECFIDERA	DIMETHYL FUMARATE CAPSULE DELAYED RELEASE 240 MG	62405525006540	Brand
DIMETHYL FUMARATE	DIMETHYL FUMARATE CAPSULE DELAYED RELEASE 240 MG	62405525006540	Generic

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

Approval Criteria

1 - Diagnosis of multiple sclerosis

Product Name: generic dalfampridine ER, Brand Ampyra	
Approval Length	100 Day(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

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

Approval Criteria

1 - Diagnosis of multiple sclerosis

AND

2 - Prescribed by or in consultation with a neurologist

Product Name: generic dalfampridine ER, Brand Ampyra	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

DALFAMPRIDINE ER	DALFAMPRIDINE TAB ER 12HR 10 MG	62406030007420	Generic
AMPYRA	DALFAMPRIDINE TAB ER 12HR 10 MG	62406030007420	Brand

Approval Criteria

1 - Documentation from a neurologist indicating improvement (including stabilization) in gait

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

Product Name	Generic Name	GPI	Brand/Generic
BAFIERTAM	MONOMETHYL FUMARATE CAPSULE DELAYED RELEASE 95 MG	62405550006520	Brand

Approval Criteria

1 - Diagnosis of multiple sclerosis

AND

2 - ONE of the following:

2.1 Previous trial and failure of at least 28 days of therapy with dimethyl fumarate

OR

2.2 Medical justification for use of the requested medication over dimethyl fumarate

AND

3 - Prescribed by or in consultation with a neurologist

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

Product Name	Generic Name	GPI	Brand/Generic
KESIMPTA	OFATUMUMAB SOLN AUTO-INJECTOR 20 MG/0.4ML	6240506500D520	Brand

Approval Criteria

1 - Diagnosis of multiple sclerosis

AND

2 - ONE of the following:

2.1 Patient's multiple sclerosis is secondary progressive

OR

2.2 Patient has had a trial of at least 28 days of therapy with ONE preferred* agent (excluding Ampyra)

OR

2.3 Medical justification for use of Kesimpta over ALL preferred* agents

AND

3 - Prescribed by or in consultation with a neurologist

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

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

Product Name	Generic Name	GPI	Brand/Generic
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

Approval Criteria

1 - Diagnosis of multiple sclerosis

AND

2 - ONE of the following:

2.1 BOTH of the following:

- Trial and failure of Avonex within the past 180 days
- Patient has had a trial of at least 28 days of therapy with ONE different preferred* agent (excluding Ampyra)

OR

2.2 Medical justification for use of Plegridy over ALL preferred* agents

AND

3 - Prescribed by or in consultation with a neurologist

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

Product Name: Tascenso ODT	
Approval Length	1 year(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

AND

2 - Prescribed by or in consultation with a neurologist

AND

3 - ONE of the following:

3.1 Patient is 10 years of age or older, and less than 18 years of age

OR

3.2 Patient is 18 years of age or older and cannot swallow oral capsules [e.g., Gilenya (fingolimod) capsules]

Product Name: Tascenso ODT	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
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 - History of the requested medication in the past 90 days

AND

2 - ONE of the following:

- Patient is less than 18 years of age
- Patient is 18 years of age or older and cannot swallow oral capsules [e.g., Gilenya (fingolimod) capsules]

Product Name: Zeposia	
Diagnosis	Multiple Sclerosis
Approval Length	1 year(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

AND

2 - ONE of the following:

2.1 Patient has had a trial of at least 28 days of therapy with ONE preferred* agent (excluding Ampyra)

OR

2.2 Medical justification for use of Zeposia over ALL preferred* agents

AND

3 - Prescribed by or in consultation with a neurologist

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

Product Name: Zeposia	
Diagnosis	Ulcerative Colitis

Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

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 moderate to severe ulcerative colitis

AND

2 - ONE of the following:

2.1 Trial and failure of at least one targeted immunomodulator agent with an ulcerative colitis indication (adalimumab, infliximab, golimumab, tofacitinib, upadacitinib, ustekinumab, vedolizumab)

OR

2.2 Medical rationale supporting the use of the requested medication over all targeted immunomodulator agents

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

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
EXTAVIA	INTERFERON BETA-1B FOR INJ KIT 0.3 MG	62403060506420	Brand

Approval Criteria

1 - Diagnosis of multiple sclerosis

AND

2 - ONE of the following:

2.1 If the patient has secondary progressive multiple sclerosis (SPMS), trial of Betaseron

OR

2.2 BOTH of the following:

2.2.1 Patient has had a trial of at least 28 days of therapy with Betaseron (interferon beta-1b) within the past 180 days

AND

2.2.2 Patient has had a trial of at least 28 days of therapy with ONE other preferred* agent (excluding Ampyra)

OR

2.3 Medical justification for use of Extavia over Betaseron (interferon beta-1b) and ALL preferred* agents

AND

3 - Prescribed by or in consultation with a neurologist

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

Product Name: Mavenclad	
Approval Length	4 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 multiple sclerosis or secondary progressive multiple sclerosis

AND

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

AND

3 - One of the following:

3.1 Patient has had trials of at least 28 days of therapy with TWO different preferred* agents (excluding Ampyra)

OR

3.2 Medical justification for use of Mavenclad over ALL preferred* agents	
Notes	*PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name: Mavenclad	
Approval Length	4 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 - History of the requested medication

AND

2 - Both of the following: *

- Patient has only received one initial treatment course
- 43 weeks have elapsed following completion of the first treatment course

Notes	*Mavenclad will be granted one reauthorization no earlier than 43 weeks following completion of first treatment course

Product Name: Mayzent

Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
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

Approval Criteria

1 - Diagnosis of multiple sclerosis

AND

2 - ONE of the following:

2.1 Patient's multiple sclerosis is secondary progressive

OR

2.2 Patient has had trials of at least 28 days of therapy with TWO different preferred* agents (excluding Ampyra)

OR

2.3 Medical justification for use of Mayzent over ALL preferred* agents

AND

3 - Prescribed by or in consultation with a neurologist

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

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

Product Name	Generic Name	GPI	Brand/Generic
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

Approval Criteria

1 - Diagnosis of multiple sclerosis

AND

2 - ONE of the following:

2.1 Patient's multiple sclerosis is secondary progressive

OR

2.2 Patient has had trials of at least 28 days of therapy with TWO different preferred* agents (excluding Ampyra)

OR

2.3 Medical justification for use of Ponvory over ALL preferred* agents

AND

3 - Prescribed by or in consultation with a neurologist

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

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

Product Name	Generic Name	GPI	Brand/Generic
VUMERITY	DIROXIMEL FUMARATE CAPSULE DELAYED RELEASE 231 MG	62405530006540	Brand

Approval Criteria

1 - Diagnosis of multiple sclerosis

AND

2 - ONE of the following:

2.1 BOTH of the following:

2.1.1 Trial and failure of at least 28 days of therapy with dimethyl fumarate (generic of Tecfidera)

AND

2.1.2 Trial and failure of at least 28 days of therapy with ONE other preferred* agent (excluding Ampyra)

OR

2.2 Medical justification for use of Vumerity over dimethyl fumarate (generic of Tecfidera) and ALL preferred* agents

AND

3 - Prescribed by or in consultation with a neurologist

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

Product Name: generic teriflunomide, Brand Aubagio, generic fingolimod, Brand Gilenya, Gilenya, generic dimethyl fumarate, Brand Tecfidera, Avonex, Betaseron, generic glatiramer, Glatopa, Brand Copaxone, Rebif, Rebif Rebidose, Kesimpta, Plegridy, Vumerity, Zeposia, Bafiertam, Extavia, Mayzent, Ponvory

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

Product Name	Generic Name	GPI	Brand/Generic
DALFAMPRIDINE ER	DALFAMPRIDINE TAB ER 12HR 10 MG	62406030007420	Generic
AMPYRA	DALFAMPRIDINE TAB ER 12HR 10 MG	62406030007420	Brand
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
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
EXTAVIA	INTERFERON BETA-1B FOR INJ KIT 0.3 MG	62403060506420	Brand
BETASERON	INTERFERON BETA-1B FOR INJ KIT 0.3 MG	62403060506420	Brand
GLATOPA	GLATIRAMER ACETATE SOLN PREFILLED SYRINGE 20 MG/ML	6240003010E520	Generic

GLATIRAMER ACETATE	GLATIRAMER ACETATE SOLN PREFILLED SYRINGE 20 MG/ML	6240003010E520	Generic
COPAXONE	GLATIRAMER ACETATE SOLN PREFILLED SYRINGE 20 MG/ML	6240003010E520	Brand
GLATOPA	GLATIRAMER ACETATE SOLN PREFILLED SYRINGE 40 MG/ML	6240003010E540	Generic
GLATIRAMER ACETATE	GLATIRAMER ACETATE SOLN PREFILLED SYRINGE 40 MG/ML	6240003010E540	Generic
COPAXONE	GLATIRAMER ACETATE SOLN PREFILLED SYRINGE 40 MG/ML	6240003010E540	Brand
GILENYA	FINGOLIMOD HCL CAP 0.25 MG (BASE EQUIV)	62407025100110	Brand
GILENYA	FINGOLIMOD HCL CAP 0.5 MG (BASE EQUIV)	62407025100120	Brand
FINGOLIMOD	FINGOLIMOD HCL CAP 0.5 MG (BASE EQUIV)	62407025100120	Generic
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
TECFIDERA	DIMETHYL FUMARATE CAPSULE DELAYED RELEASE 120 MG	62405525006520	Brand
DIMETHYL FUMARATE	DIMETHYL FUMARATE CAPSULE DELAYED RELEASE 120 MG	62405525006520	Generic
TECFIDERA	DIMETHYL FUMARATE CAPSULE DELAYED RELEASE 240 MG	62405525006540	Brand
DIMETHYL FUMARATE	DIMETHYL FUMARATE CAPSULE DELAYED RELEASE 240 MG	62405525006540	Generic
KESIMPTA	OFATUMUMAB SOLN AUTO-INJECTOR 20 MG/0.4ML	6240506500D520	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
TASCENSO ODT	FINGOLIMOD LAURYL SULFATE TABLET DISINTEGRATING 0.25 MG	62407025207220	Brand
TASCENSO ODT	FINGOLIMOD LAURYL SULFATE TABLET DISINTEGRATING 0.5 MG	62407025207230	Brand
VUMERITY	DIROXIMEL FUMARATE CAPSULE DELAYED RELEASE 231 MG	62405530006540	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 & 30 X 0.92 MG	6240705020B220	Brand
ZEPOSIA	OZANIMOD HCL CAP 0.92 MG	62407050200120	Brand
BAFIERTAM	MONOMETHYL FUMARATE CAPSULE DELAYED RELEASE 95 MG	62405550006520	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
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
ZEPOSIA STARTER KIT	OZANIMOD CAP PACK 4 X 0.23 MG & 3 X 0.46 MG & 21 X 0.92 MG	6240705020B215	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

Approval Criteria

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

2 . Revision History

Date	Notes
9/12/2024	Updated criteria for Plegridy (moved to NP). Removed list of alts thro ughout the guideline, and updated criteria to reference PDL.

Muscular Dystrophy Agents

Prior Authorization Guideline

Guideline ID	GL-124412
Guideline Name	Muscular Dystrophy Agents
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	7/1/2023

1 . Criteria

Product Name: Emflaza	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
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

Approval Criteria

1 - Diagnosis of Duchenne muscular dystrophy (DMD) confirmed by genetic testing

AND

2 - Patient is 2 years of age or older

AND

3 - Requested dose does not exceed 0.9mg/kg/day, rounded up to the nearest possible tablet dose or nearest tenth of a milliliter of oral suspension once daily (document weight)

AND

4 - Prescriber must provide documentation of current clinical status to compare upon re-evaluations of therapy (e.g. Brooke Score, 6 minute walk test, etc.)

Product Name: Emflaza	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
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

Approval Criteria

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

AND

2 - Documentation from prescriber indicating improvement (including stabilization) in current clinical status (e.g. Brooke Score, 6 minute walk test, etc.)

AND

3 - Requested dose does not exceed 0.9mg/kg/day, rounded up to the nearest possible tablet dose or nearest tenth of a milliliter of oral suspension once daily (document weight)

2 . Revision History

Date	Notes
4/10/2023	Updated daily dose requirement to be per day to match policy. Updated examples to match policy

Myalept

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-108459
Guideline Name	Myalept
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	8/1/2022

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

Mytesi

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-82111
Guideline Name	Mytesi
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2021

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

2 . Revision History

Date	Notes
3/5/2021	Bulk Load

Narcolepsy Agents

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-154894
Guideline Name	Narcolepsy Agents
Formulary	• Medicaid - Community & State Indiana • Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name: Brand Nuvigil, generic armodafinil	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NUVIGIL	ARMODAFINIL TAB 50 MG	61400010000310	Brand
ARMODAFINIL	ARMODAFINIL TAB 50 MG	61400010000310	Generic
NUVIGIL	ARMODAFINIL TAB 150 MG	61400010000330	Brand
ARMODAFINIL	ARMODAFINIL TAB 150 MG	61400010000330	Generic

NUVIGIL	ARMODAFINIL TAB 200 MG	61400010000335	Brand
ARMODAFINIL	ARMODAFINIL TAB 200 MG	61400010000335	Generic
NUVIGIL	ARMODAFINIL TAB 250 MG	61400010000340	Brand
ARMODAFINIL	ARMODAFINIL TAB 250 MG	61400010000340	Generic

Approval Criteria

1 - Patient is 18 years of age or older

AND

2 - Patient has ONE of the following diagnoses:

- Bipolar depression in conjunction with appropriate medical intervention(s)
- Narcolepsy with excessive daytime sleepiness
- Obstructive sleep apnea/hypopnea syndrome with residual excessive daytime sleepiness in conjunction with appropriate medical intervention(s)
- Shift work sleep disorder

Product Name: Brand Provigil, generic modafinil	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PROVIGIL	MODAFINIL TAB 100 MG	61400024000310	Brand
MODAFINIL	MODAFINIL TAB 100 MG	61400024000310	Generic
PROVIGIL	MODAFINIL TAB 200 MG	61400024000320	Brand
MODAFINIL	MODAFINIL TAB 200 MG	61400024000320	Generic

Approval Criteria

1 - ONE of the following:

1.1 Patient is 6 years of age or older and ONE of the following diagnoses:

- Attention Deficit Hyperactivity Disorder (ADHD)
- Narcolepsy with excessive daytime sleepiness

OR

1.2 Patient is 18 years of age or older and ONE of the following diagnoses:

- Depression-related fatigue in conjunction with appropriate medical intervention(s)
- Idiopathic hypersomnia
- Obstructive sleep apnea/hypopnea syndrome with residual excessive daytime sleepiness in conjunction with appropriate medical intervention(s)
- Shift work sleep disorder
- Sleep deprivation
- Steinert Myotonic Dystrophy Syndrome
- Unipolar depression or bipolar depression in conjunction with appropriate medical intervention(s)

Product Name: Sunosi	
Approval Length	1 year(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 - Patient is 18 years of age or older

AND

2 - ONE of the following:

2.1 Patient has a diagnosis of narcolepsy with excessive daytime sleepiness

OR

2.2 BOTH of the following:

2.2.1 Patient has a diagnosis of obstructive sleep apnea/hypopnea syndrome with residual excessive daytime sleepiness in conjunction with appropriate medical intervention(s)

AND

2.2.2 ONE of the following:

- Previous trial and failure of modafinil or armodafinil
- Prescriber has provided valid medical justification for the use of Sunosi (solriamfetol) over modafinil and armodafinil

Product Name: Wakix	
Approval Length	1 year(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 - The patient meets the appropriate age requirement:

- Narcolepsy with cataplexy or excessive daytime sleepiness: 6 years of age or older
- Obstructive sleep apnea/hypopnea syndrome with residual excessive daytime sleepiness: 18 years of age or older

AND

2 - ONE of the following:

2.1 Patient has a diagnosis of narcolepsy with cataplexy or excessive daytime sleepiness

OR

2.2 BOTH of the following:

2.2.1 Patient has a diagnosis of obstructive sleep apnea/hypopnea syndrome with residual excessive daytime sleepiness in conjunction with appropriate medical intervention(s)

AND

2.2.2 ONE of the following:

- Previous trial and failure of modafinil or armodafinil
- Prescriber has provided valid medical justification for the use of Wakix (pitolisant) over modafinil and armodafinil

Product Name: Brand Nuvigil, generic armodafinil, Brand Provigil, generic modafinil, Sunosi, Wakix	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NUVIGIL	ARMODAFINIL TAB 50 MG	61400010000310	Brand
ARMODAFINIL	ARMODAFINIL TAB 50 MG	61400010000310	Generic
NUVIGIL	ARMODAFINIL TAB 150 MG	61400010000330	Brand
ARMODAFINIL	ARMODAFINIL TAB 150 MG	61400010000330	Generic
NUVIGIL	ARMODAFINIL TAB 200 MG	61400010000335	Brand
ARMODAFINIL	ARMODAFINIL TAB 200 MG	61400010000335	Generic

NUVIGIL	ARMODAFINIL TAB 250 MG	61400010000340	Brand
ARMODAFINIL	ARMODAFINIL TAB 250 MG	61400010000340	Generic
PROVIGIL	MODAFINIL TAB 100 MG	61400024000310	Brand
MODAFINIL	MODAFINIL TAB 100 MG	61400024000310	Generic
PROVIGIL	MODAFINIL TAB 200 MG	61400024000320	Brand
MODAFINIL	MODAFINIL TAB 200 MG	61400024000320	Generic
SUNOSI	SOLRIAMFETOL HCL TAB 75 MG (BASE EQUIV)	61370070200320	Brand
SUNOSI	SOLRIAMFETOL HCL TAB 150 MG (BASE EQUIV)	61370070200340	Brand
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 - History of the requested medication within the past 90 days

Product Name: Brand Xyrem, generic sodium oxybate	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XYREM	SODIUM OXYBATE ORAL SOLUTION 500 MG/ML	62450060202020	Brand
SODIUM OXYBATE	SODIUM OXYBATE ORAL SOLUTION 500 MG/ML	62450060202020	Generic

Approval Criteria

1 - ONE of the following:

1.1 Patient is 7 years of age or older and BOTH of the following:

1.1.1 Patient has a diagnosis of narcolepsy with cataplexy or excessive daytime sleepiness

AND

1.1.2 The requested dose does NOT exceed ONE of the following:

- 12 milliliters per day for patients weighing 20 kilograms (kg) to less than 30 kg
- 15 milliliters per day for patients weighing 30 kg to less than 45 kg
- 18 milliliters per day for patients weighing at least 45 kg

OR

1.2 Patient is 18 years of age or older and ALL of the following:

1.2.1 Diagnosis of fibromyalgia

AND

1.2.2 ONE of the following:

1.2.2.1 Greater than or equal to 90 days of medication therapy with ONE of the following*:

- Amitriptyline
- SNRI (Serotonin–norepinephrine reuptake inhibitor)
- SSRI (Selective serotonin reuptake inhibitor)
- Anticonvulsant (e.g., gabapentin, pregabalin)
- NSAID (non-steroidal anti-inflammatory drug)
- Acetaminophen

OR

1.2.2.2 Prescriber has provided valid medical justification for the use of sodium oxybate over therapy with amitriptyline, SNRI, SSRI, anticonvulsant (gabapentin/pregabalin), NSAID, AND acetaminophen

AND

1.2.3 Requested dose does NOT exceed 12 milliliters per day

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

Product Name: Xywav	
Approval Length	3 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 - ONE of the following:

1.1 Patient is 7 years of age or older and BOTH of the following:

1.1.1 Diagnosis of narcolepsy with cataplexy or excessive daytime sleepiness

AND

1.1.2 Requested dose does NOT exceed ONE of the following:

- 12 milliliters per day for patients weighing 20 kilograms (kg) to less than 30 kg
- 15 milliliters per day for patients weighing 30 kg to less than 45 kg
- 18 milliliters per day for patients weighing at least 45 kg

OR

1.2 Patient is 18 years of age or older and BOTH of the following:

1.2.1 Diagnosis of idiopathic hypersomnia

AND

1.2.2 Requested dose does not exceed 18 milliliters per day

Product Name: Brand Xyrem, generic sodium oxybate, Xywav	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XYREM	SODIUM OXYBATE ORAL SOLUTION 500 MG/ML	62450060202020	Brand
XYWAV	CALCIUM, MAG, POTASSIUM, & SOD OXYBATES ORAL SOLN 500 MG/ML	62459904202020	Brand
SODIUM OXYBATE	SODIUM OXYBATE ORAL SOLUTION 500 MG/ML	62450060202020	Generic

Approval Criteria

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

AND

2 - Documented attempt to decrease dose or trial and failure of an alternative therapy within the past year

AND

3 - Documentation from prescriber indicating continued benefit from the medication (reduction in frequency of cataplexy, reduction in symptoms of excessive daytime sleepiness, etc.) without significant adverse events

2 . Revision History

Date	Notes
9/13/2024	Updated Wakix age requirements.

Natpara

Prior Authorization Guideline

Guideline ID	GL-161410
Guideline Name	Natpara
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2025

1 . Criteria

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

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
12/9/2024	Updated initial authorization criteria.

Nerlynx

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-156471
Guideline Name	Nerlynx
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	11/1/2024

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
9/30/2024	Updated formatting, no changes to criteria

Nexavar

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-161361
Guideline Name	Nexavar
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2025

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
11/26/2024	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.

Ninlaro

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-151701
Guideline Name	Ninlaro
Formulary	• Medicaid - Community & State Indiana

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

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-81981
Guideline Name	Nityr
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2021

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

2 . Revision History

Date	Notes
3/5/2021	Bulk Load

Nocdurna

Prior Authorization Guideline

Guideline ID	GL-147461
Guideline Name	Nocdurna
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2024

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

2 . Revision History

Date	Notes
5/17/2024	Increased initial authorization to 12 months.

Non-Preferred Drugs

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-108436
Guideline Name	Non-Preferred Drugs
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	8/1/2022

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			

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 • United States Pharmacopeia-National Formulary (USP-NF) **AND** **2.3** The drug is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plan's program.

Notes	*PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html. Prior trials of formulary/PDL alternatives must sufficiently demonstrate that the formulary/PDL alternatives are either ineffective or inappropriate at the time of the request.

2 . Revision History

Date	Notes
6/20/2022	Copy NY

Northera

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-150035
Guideline Name	Northera
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	8/1/2024

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
7/19/2024	Updated initial authorization duration to 12 months.

Nourianz

Prior Authorization Guideline

Guideline ID	GL-120138
Guideline Name	Nourianz
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	3/1/2023

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

2 . Revision History

Date	Notes
1/13/2023	Updated trial/failure language.

Nubeqa

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-115268
Guideline Name	Nubeqa
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	12/1/2022

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

Nuedexta

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-81266
Guideline Name	Nuedexta
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2021

1 . Criteria

Product Name: Nuedexta (dextromethorphan/quinidine)	
Approval Length	1 year(s)
Guideline Type	Prior Authorization

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)

AND

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

AND

3 - Patient does not have ONE of the following:

- Lupus-like syndrome
- Thrombocytopenia or bone marrow suppression
- Heart failure, QT prolongation, AV block or history of AV block, or on other medications that can lead to QT prolongation
- Currently utilizing MAOI therapy (or within past 14 days)
- Hepatitis induced by dextromethorphan/quinidine, quinine, mefloquine, or quinidine

2 . Revision History

Date	Notes
2/18/2021	IN 4/1 implementation

Nuzyra

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-147577
Guideline Name	Nuzyra
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2024

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 structure infections will be issued for up to 14 days. For all IDSA recognized indications, authorization duration is based on provider and IDSA recommended treatment durations, up to 6 months.

2 . Revision History

Date	Notes

5/21/2024	Updated product name section to specify Nuzyra "tablets". No chang es to clinical criteria.

Ocaliva

Prior Authorization Guideline

Guideline ID	GL-109292
Guideline Name	Ocaliva
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	9/1/2022

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

2 . Revision History

Date	Notes
7/12/2022	Changed clinical criteria based on changes to prescribing information . Revised order of listing of two criteria to better align with prescribing information.

Odomzo

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-96978
Guideline Name	Odomzo
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2022

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 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 - Odomzo will be approved for uses 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
10/19/2021	Updated

Ogsiveo

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-147518
Guideline Name	Ogsiveo
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2024

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
OGSIVEO	NIROGACESTAT HYDROBROMIDE TAB 100 MG	21532350200330	Brand
OGSIVEO	NIROGACESTAT HYDROBROMIDE TAB 150 MG	21532350200340	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
OGSIVEO	NIROGACESTAT HYDROBROMIDE TAB 100 MG	21532350200330	Brand
OGSIVEO	NIROGACESTAT HYDROBROMIDE TAB 150 MG	21532350200340	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
OGSIVEO	NIROGACESTAT HYDROBROMIDE TAB 100 MG	21532350200330	Brand
OGSIVEO	NIROGACESTAT HYDROBROMIDE TAB 150 MG	21532350200340	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
OGSIVEO	NIROGACESTAT HYDROBROMIDE TAB 100 MG	21532350200330	Brand
OGSIVEO	NIROGACESTAT HYDROBROMIDE TAB 150 MG	21532350200340	Brand

Approval Criteria

1 - Documentation of positive clinical response to Ogsiveo therapy

2 . Revision History

Date	Notes

5/20/2024	New guideline.

Ojemda

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-151312
Guideline Name	Ojemda
Formulary	• Medicaid - Community & State Indiana

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

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-138627
Guideline Name	Ojjaara
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	2/1/2024

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

Omnipod 5

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-147314
Guideline Name	Omnipod 5
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2024

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.

Ophthalmic Antibiotics

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-144311
Guideline Name	Ophthalmic Antibiotics
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2024

1 . Criteria

Product Name: Brand Vigamox, generic moxifloxacin ophth soln	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VIGAMOX	MOXIFLOXACIN HCL OPHTH SOLN 0.5% (BASE EQUIV)	86101038102020	Brand
MOXIFLOXACIN HYDROCHLORIDE	MOXIFLOXACIN HCL OPHTH SOLN 0.5% (BASE EQUIV)	86101038102020	Generic
MOXIFLOXACIN HYDROCHLORIDE	MOXIFLOXACIN HCL OPHTH SOLN 0.5% (BASE EQ) (2 TIMES DAILY)	86101038102025	Generic

Approval Criteria

1 - Patient is 30 years of age or older **OR** **2** - Patient has tried at least ONE preferred* medication within the past 30 days
Notes | *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

2 . Revision History

Date	Notes
3/13/2024	Removed Moxeza.

Opiates

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-161788
Guideline Name	Opiates
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2025

1 . Criteria

Product Name: Belbuca	
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

Approval Criteria

1 - Diagnosis of pain

AND

2 - No concurrent claims for buprenorphine/naloxone or buprenorphine therapy, excluding buprenorphine patches (Butrans) and sublingual buprenorphine indicated for the treatment of pain (Belbuca), exceeding a 7-day supply every 180 days*

AND

3 - The patient is not using concurrently with a carisoprodol-containing product

AND

4 - No concurrent claims for Lybalvi (olanzapine/samidorphan) within the past 45 days

AND

5 - One of the following:

5.1 Patient is not using the requested medication concurrently with a benzodiazepine (claim within the past 30 days)

OR

5.2 BOTH of the following:

- Days' supply for the requested opioid is 7 days or less
- Including the days' supply for the requested agent, the patient will not exceed 7 days of concurrent opiate/benzodiazepine therapy in the past 180 days

OR

5.3 Patient has utilized concurrent benzodiazepine/opiate therapy, including any cross-tapered or discontinued agents, for at least 90 of the past 120 days

OR

5.4 All of the following for concurrent opiate/benzodiazepine therapy exceeding 7 days in the past 180 days:

5.4.1 Indications provided for both the benzodiazepine agent(s) and the opioid agent(s)

AND

5.4.2 Documentation of previous therapies attempted for the given indications

AND

5.4.3 Prescriber attests to ALL of the following:

- The patient's INSPECT report has been evaluated and continues to be evaluated on a regular basis
- The patient has been educated in regard to the risks of concurrent utilization of opioid and benzodiazepine therapy, and the patient accepts these risks
- The prescriber has consulted any other prescribers involved in concurrent therapy and all prescribers agree to pursue concurrent opioid and benzodiazepine therapy for the patient, if applicable
- The prescriber acknowledges the risk of adverse event(s), including respiratory depression, coma, and death, associated with concurrent utilization

AND

6 - Fewer than 5 different prescribers of opiates in the past 60 days

AND

7 - ONE of the following:

7.1 BOTH of the following:

7.1.1 Patient is a current utilizer of opioid therapy (at least 90 days of therapy in the past 120 days)

AND

7.1.2 Patient is not utilizing more than one long-acting opioid agent

OR

7.2 The patient has one of the following indications for long-term opioid use:

- Cancer
- Sickle cell disease
- Palliative care
- Other terminal diagnosis associated with significant pain

AND

8 - ONE of the following:

- History of the requested agent for 90 of the past 105 days (stable therapy)
- History of a 14-day trial of Butrans (buprenorphine) patches within the past 90 days
- Prescriber has provided valid medical rationale as to why Butrans (buprenorphine patches) are unsuitable for use

Notes	*Unless faxed documentation has been received from the opioid prescriber with approval for opioid therapy from the buprenorphine or buprenorphine/naloxone prescriber.

Product Name: fentanyl patch	
Approval Length	12 month(s)

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/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
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

Approval Criteria

1 - ONE of the following:

1.1 BOTH of the following:

1.1.1 Patient is a current utilizer of opioid therapy (at least 90 days of therapy in the past 120 days)

AND

1.1.2 Patient is not utilizing more than one long-acting agent

OR

1.2 The patient has one of the following indications for long-term opioid use:

- Cancer
- Sickle cell disease
- Palliative care
- Other terminal diagnosis associated with significant pain

AND

2 - One of the following:

- History of the requested agent for 90 of the past 105 days (stable therapy)
- History of dysphagia
- Submission of medical records showing patient has a history of NPO (nothing-by-mouth) within the past 6 months
- Active cancer diagnosis
- History of 1 preferred long-acting opioid agent in the past 120 days

AND

3 - The patient is not using concurrently with a carisoprodol-containing product

AND

4 - No concurrent claims for Lybalvi (olanzapine/samidorphan) within the past 45 days

AND

5 - No concurrent claims for buprenorphine/naloxone or buprenorphine therapy, excluding buprenorphine patches (Butrans) and sublingual buprenorphine indicated for the treatment of pain (Belbuca), exceeding a 7-day supply every 180 days*

AND

6 - One of the following:

6.1 Patient is not using the requested medication concurrently with a benzodiazepine (claim within the past 30 days)

OR

6.2 BOTH of the following:

- Days' supply for the requested opioid is 7 days or less
- Including the days' supply for the requested agent, the patient will not exceed 7 days of concurrent opiate/benzodiazepine therapy in the past 180 days

OR

6.3 Patient has utilized concurrent benzodiazepine/opiate therapy, including any cross-tapered or discontinued agents, for at least 90 of the past 120 days

OR

6.4 All of the following for concurrent opiate/benzodiazepine therapy exceeding 7 days in the past 180 days:

6.4.1 Indications provided for both the benzodiazepine agent(s) and the opioid agent(s)

AND

6.4.2 Documentation of previous therapies attempted for the given indications

AND

6.4.3 Prescriber attests to ALL of the following:

- The patient's INSPECT report has been evaluated and continues to be evaluated on a regular basis
- The patient has been educated in regard to the risks of concurrent utilization of opioid and benzodiazepine therapy, and the patient accepts these risks
- The prescriber has consulted any other prescribers involved in concurrent therapy and all prescribers agree to pursue concurrent opioid and benzodiazepine therapy for the patient, if applicable
- The prescriber acknowledges the risk of adverse event(s), including respiratory depression, coma, and death, associated with concurrent utilization

AND

7 - Fewer than 5 different prescribers of opiates in the past 60 days

Notes	*Unless faxed documentation has been received from the opioid prescriber with approval for opioid therapy from the buprenorphine or buprenorphine/naloxone prescriber.

Product Name: brand Hysingla ER, generic hydrocodone ER tab, Oxymorphone ER	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG	6510003010A810	Brand
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG	6510003010A820	Brand
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG	6510003010A830	Brand
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG	6510003010A840	Brand
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG	6510003010A850	Brand
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG	6510003010A860	Brand
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG	6510003010A870	Brand
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 TAB ER 24HR DETER 20 MG	6510003010A810	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG	6510003010A820	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG	6510003010A830	Generic

HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG	6510003010A840	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG	6510003010A850	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG	6510003010A860	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG	6510003010A870	Generic

Approval Criteria

1 - No concurrent claims for buprenorphine/naloxone or buprenorphine therapy, excluding buprenorphine patches (Butrans) and sublingual buprenorphine indicated for the treatment of pain (Belbuca), exceeding a 7-day supply every 180 days*

AND

2 - The patient is not using concurrently with a carisoprodol-containing product

AND

3 - No concurrent claims for Lybalvi (olanzapine/samidorphan) within the past 45 days

AND

4 - One of the following:

4.1 Patient is not using the requested medication concurrently with a benzodiazepine (claim within the past 30 days)

OR

4.2 BOTH of the following:

- Days' supply for the requested opioid is 7 days or less
- Including the days' supply for the requested agent, the patient will not exceed 7 days of concurrent opiate/benzodiazepine therapy in the past 180 days

OR

4.3 Patient has utilized concurrent benzodiazepine/opiate therapy, including any cross-tapered or discontinued agents, for at least 90 of the past 120 days

OR

4.4 All of the following for concurrent opiate/benzodiazepine therapy exceeding 7 days in the past 180 days:

4.4.1 Indications provided for both the benzodiazepine agent(s) and the opioid agent(s)

AND

4.4.2 Documentation of previous therapies attempted for the given indications

AND

4.4.3 Prescriber attests to ALL of the following:

- The patient's INSPECT report has been evaluated and continues to be evaluated on a regular basis
- The patient has been educated in regard to the risks of concurrent utilization of opioid and benzodiazepine therapy, and the patient accepts these risks
- The prescriber has consulted any other prescribers involved in concurrent therapy and all prescribers agree to pursue concurrent opioid and benzodiazepine therapy for the patient, if applicable
- The prescriber acknowledges the risk of adverse event(s), including respiratory depression, coma, and death, associated with concurrent utilization

AND

5 - Fewer than 5 different prescribers of opiates in the past 60 days

AND

6 - ONE of the following:

6.1 BOTH of the following:

6.1.1 Patient is a current utilizer of opioid therapy (at least 90 days of therapy in the past 120 days)

AND

6.1.2 Patient is not utilizing more than one long-acting agent

OR

6.2 The patient has one of the following indications for long-term opioid use:

- Cancer
- Sickle cell disease
- Palliative care
- Other terminal diagnosis associated with significant pain

AND

7 - One of the following:

7.1 History of the requested agent for 90 of the past 105 days (stable therapy)

OR

7.2 BOTH of the following:

- History of trial with 2 different preferred long acting medications (2 different ingredients) in the past 90 days
- History of trial with 2 different non-preferred long acting medications (2 different ingredients) in the past 90 days

Notes	*Unless faxed documentation has been received from the opioid prescriber with approval for opioid therapy from the buprenorphine or buprenorphine/naloxone prescriber. IN PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name: Qdolo, tramadol oral soln, Seglentis	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL ORAL SOLN 5 MG/ML	65100095102005	Generic
SEGLENTIS	CELECOXIB-TRAMADOL HCL TAB 56-44 MG	65995002100320	Brand
QDOLO	TRAMADOL HCL ORAL SOLN 5 MG/ML	65100095102005	Generic

Approval Criteria

1 - No concurrent claims for buprenorphine/naloxone or buprenorphine therapy, excluding buprenorphine patches (Butrans) and sublingual buprenorphine indicated for the treatment of pain (Belbuca), exceeding a 7-day supply every 180 days*

AND

2 - The patient is not using concurrently with a carisoprodol-containing product

AND

3 - No concurrent claims for Lybalvi (olanzapine/samidorphan) within the past 45 days

AND

4 - One of the following:

4.1 Patient is not using the requested medication concurrently with a benzodiazepine (claim within the past 30 days)

OR

4.2 BOTH of the following:

- Days' supply for the requested opioid is 7 days or less
- Including the days' supply for the requested agent, the patient will not exceed 7 days of concurrent opiate/benzodiazepine therapy in the past 180 days

OR

4.3 Patient has utilized concurrent benzodiazepine/opiate therapy, including any cross-tapered or discontinued agents, for at least 90 of the past 120 days

OR

4.4 All of the following for concurrent opiate/benzodiazepine therapy exceeding 7 days in the past 180 days:

4.4.1 Indications provided for both the benzodiazepine agent(s) and the opioid agent(s)

AND

4.4.2 Documentation of previous therapies attempted for the given indications

AND

4.4.3 Prescriber attests to ALL of the following:

- The patient's INSPECT report has been evaluated and continues to be evaluated on a regular basis
- The patient has been educated in regard to the risks of concurrent utilization of opioid and benzodiazepine therapy, and the patient accepts these risks
- The prescriber has consulted any other prescribers involved in concurrent therapy and all prescribers agree to pursue concurrent opioid and benzodiazepine therapy for the patient, if applicable
- The prescriber acknowledges the risk of adverse event(s), including respiratory depression, coma, and death, associated with concurrent utilization

AND

5 - Fewer than 5 different prescribers of opiates in the past 60 days

AND

6 - ONE of the following:

6.1 BOTH of the following:

6.1.1 Patient is a current utilizer of opioid therapy (at least 90 days of therapy in the past 120 days)

AND

6.1.2 Patient is not utilizing more than one short-acting agent

OR

6.2 The patient has one of the following indications for long-term opioid use:

- Cancer
- Sickle cell disease
- Palliative care
- Other terminal diagnosis associated with significant pain

AND

7 - BOTH of the following:

- History of the requested agent for 90 of the past 105 days (stable therapy)
- For tramadol oral solution, the prescriber has provided rationale as to why the tablets are not suitable for use
- For Seglentis, the prescriber has provided valid rationale as to why separate components are unsuitable for use

AND

8 - The patient is 18 years of age or older (if less than 18 years of age, please see Age Limit criteria)

Notes	*Unless faxed documentation has been received from the opioid prescriber with approval for opioid therapy from the buprenorphine or buprenorphine/naloxone prescriber.

Product Name: Conzip, tramadol ER cap, tramadol ER tab, tramadol ER biphasic ER tab	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/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 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 HCL ER	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
TRAMADOL HCL ER	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 300 MG	65100095107090	Generic
CONZIP	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 100 MG	65100095107070	Generic
CONZIP	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 200 MG	65100095107080	Generic
CONZIP	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 300 MG	65100095107090	Generic

Approval Criteria

1 - No concurrent claims for buprenorphine/naloxone or buprenorphine therapy, excluding

buprenorphine patches (Butrans) and sublingual buprenorphine indicated for the treatment of pain (Belbuca), exceeding a 7-day supply every 180 days*

AND

2 - The patient is not using concurrently with a carisoprodol-containing product

AND

3 - No concurrent claims for Lybalvi (olanzapine/samidorphan) within the past 45 days

AND

4 - One of the following:

4.1 Patient is not using the requested medication concurrently with a benzodiazepine (claim within the past 30 days)

OR

4.2 BOTH of the following:

- Days' supply for the requested opioid is 7 days or less
- Including the days' supply for the requested agent, the patient will not exceed 7 days of concurrent opiate/benzodiazepine therapy in the past 180 days

OR

4.3 Patient has utilized concurrent benzodiazepine/opiate therapy, including any cross-tapered or discontinued agents, for at least 90 of the past 120 days

OR

4.4 All of the following for concurrent opiate/benzodiazepine therapy exceeding 7 days in the past 180 days:

4.4.1 Indications provided for both the benzodiazepine agent(s) and the opioid agent(s)

AND

4.4.2 Documentation of previous therapies attempted for the given indications

AND

4.4.3 Prescriber attests to ALL of the following:

- The patient's INSPECT report has been evaluated and continues to be evaluated on a regular basis
- The patient has been educated in regard to the risks of concurrent utilization of opioid and benzodiazepine therapy, and the patient accepts these risks
- The prescriber has consulted any other prescribers involved in concurrent therapy and all prescribers agree to pursue concurrent opioid and benzodiazepine therapy for the patient, if applicable
- The prescriber acknowledges the risk of adverse event(s), including respiratory depression, coma, and death, associated with concurrent utilization

AND

5 - Fewer than 5 different prescribers of opiates in the past 60 days

AND

6 - ONE of the following:

6.1 BOTH of the following:

6.1.1 Patient is a current utilizer of opioid therapy (at least 90 days of therapy in the past 120 days)

AND

6.1.2 Patient is not utilizing more than one Long-acting agent

OR

6.2 The patient has one of the following indications for long-term opioid use:

- Cancer
- Sickle cell disease
- Palliative care
- Other terminal diagnosis associated with significant pain

AND

7 - ONE of the following:

- History of the requested agent for 90 of the past 105 days (stable therapy)
- History of immediate release tramadol for 90 of the past 120 days

AND

8 - The patient is 18 years of age or older (if less than 18 years of age, please see Age Limit criteria)

Notes	*Unless faxed documentation has been received from the opioid prescriber with approval for opioid therapy from the buprenorphine or buprenorphine/naloxone prescriber.

Product Name: Long-Acting Opioids: brand Butrans, generic buprenorphine patch, brand MS Contin, generic morphine sulfate ER, generic morphine sulfate CR, Oxycontin, Oxycodone ER, hydromorphone ER, methadone (tab, conc, soln, intensol, tab for oral susp, inj), methadose (conc, SF conc and tab for oral susp), generic hydrocodone ER caps

Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR	65200010008820	Generic
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR	65200010008825	Generic
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR	65200010008830	Generic
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR	65200010008835	Generic
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR	65200010008840	Generic

BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR	65200010008820	Brand
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR	65200010008825	Brand
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR	65200010008830	Brand
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR	65200010008835	Brand
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR	65200010008840	Brand
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 15 MG	65100055100415	Generic
MS CONTIN	MORPHINE SULFATE TAB ER 15 MG	65100055100415	Brand
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 30 MG	65100055100432	Generic
MS CONTIN	MORPHINE SULFATE TAB ER 30 MG	65100055100432	Brand
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Generic
MS CONTIN	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Brand
MORPHINE SULFATE CR	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Generic
MS CONTIN	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Brand
MORPHINE SULFATE CR	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 200 MG	65100055100480	Generic
MS CONTIN	MORPHINE SULFATE TAB ER 200 MG	65100055100480	Brand
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

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
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 10 MG	6510007510A710	Brand
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 15 MG	6510007510A715	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 15 MG	6510007510A715	Generic
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 20 MG	6510007510A720	Brand
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 30 MG	6510007510A730	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 30 MG	6510007510A730	Generic
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

OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 60 MG	6510007510A760	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 60 MG	6510007510A760	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 60 MG	6510007510A760	Brand
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Brand
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
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 HCL	METHADONE HCL CONC 10 MG/ML	65100050101310	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL CONC 10 MG/ML	65100050101310	Generic
METHADONE HCL INTENSOL	METHADONE HCL CONC 10 MG/ML	65100050101310	Generic
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 HCL	METHADONE HCL TAB FOR ORAL SUSP 40 MG	65100050107320	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
METHADONE HCL	METHADONE HCL INJ 10 MG/ML	65100050102005	Generic
METHADOSE SUGAR-FREE	METHADONE HCL CONC 10 MG/ML	65100050101310	Brand
METHADOSE	METHADONE HCL CONC 10 MG/ML	65100050101310	Brand
METHADOSE	METHADONE HCL TAB FOR ORAL SUSP 40 MG	65100050107320	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 15 MG	6510007510A715	Brand
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 30 MG	6510007510A730	Brand
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Brand

Approval Criteria

1 - No concurrent claims for buprenorphine/naloxone or buprenorphine therapy, excluding buprenorphine patches (Butrans) and sublingual buprenorphine indicated for the treatment of pain (Belbuca), exceeding a 7-day supply every 180 days*

AND

2 - The patient is not using concurrently with a carisoprodol-containing product

AND

3 - No concurrent claims for Lybalvi (olanzapine/samidorphan) within the past 45 days

AND

4 - One of the following:

4.1 Patient is not using the requested medication concurrently with a benzodiazepine (claim within the past 30 days)

OR

4.2 BOTH of the following:

- Days' supply for the requested opioid is 7 days or less
- Including the days' supply for the requested agent, the patient will not exceed 7 days of concurrent opiate/benzodiazepine therapy in the past 180 days

OR

4.3 Patient has utilized concurrent benzodiazepine/opiate therapy, including any cross-tapered or discontinued agents, for at least 90 of the past 120 days

OR

4.4 All of the following for concurrent opiate/benzodiazepine therapy exceeding 7 days in the past 180 days:

4.4.1 Indications provided for both the benzodiazepine agent(s) and the opioid agent(s)

AND

4.4.2 Documentation of previous therapies attempted for the given indications

AND

4.4.3 Prescriber attests to ALL of the following:

- The patient's INSPECT report has been evaluated and continues to be evaluated on a regular basis
- The patient has been educated in regard to the risks of concurrent utilization of opioid and benzodiazepine therapy, and the patient accepts these risks
- The prescriber has consulted any other prescribers involved in concurrent therapy and all prescribers agree to pursue concurrent opioid and benzodiazepine therapy for the patient, if applicable
- The prescriber acknowledges the risk of adverse event(s), including respiratory depression, coma, and death, associated with concurrent utilization

AND

5 - Fewer than 5 different prescribers of opiates in the past 60 days

AND

6 - One of the following:

6.1 BOTH of the following:

6.1.1 Patient is a current utilizer (at least 90 days of therapy in the past 120 days)

AND

6.1.2 Patient is not utilizing more than one long-acting opioid agent

OR

6.2 The patient has one of the following indications for long-term opioid use:

- Cancer
- Sickle cell disease
- Palliative care
- Other terminal diagnosis associated with significant pain

AND

7 - If the request is for a non-preferred medication ONE of the following:

- History of at least 2 different preferred long-acting opioid products (2 different ingredients) in the past 90 days
- History of the requested agent for 90 of the past 105 days (stable therapy)

AND

8 - If the request is for a methadone product, the patient does not have a diagnosis of opioid use disorder (OUD) **

Notes	*Unless faxed documentation has been received from the opioid prescriber with approval for opioid therapy from the buprenorphine or buprenorphine/naloxone prescriber. **Methadone for the diagnosis of opioid use disorder (OUD) is not permissible for reimbursement through the pharmacy benefit. By law, only a SAMHSA-certified opioid treatment program (OTP) can dispense methadone for the treatment of OUD, as governed by 42 CFR 8. Patients taking methadone to treat OUD must receive the medication under the supervision of a practitioner at an OTP facility. The Indiana Health Coverage Programs (IHCP) requires providers to enroll under the Addiction Services/OTP provider type and to bill services as outlined in the Indiana Health Coverage Programs provider bulletin BT201755. IN PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name: belladonna/Opium suppositories	
Approval Length	For diagnosis of pain associated with ureteral spasm: 4 weeks; All other diagnoses:12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/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

Approval Criteria

1 - No concurrent claims for buprenorphine/naloxone or buprenorphine therapy, excluding buprenorphine patches (Butrans) and sublingual buprenorphine indicated for the treatment of pain (Belbuca), exceeding a 7-day supply every 180 days*

AND

2 - The patient is not using concurrently with a carisoprodol-containing product

AND

3 - No concurrent claims for Lybalvi (olanzapine/samidorphan) within the past 45 days

AND

4 - One of the following:

4.1 Patient is not using the requested medication concurrently with a benzodiazepine (claim within the past 30 days)

OR

4.2 BOTH of the following:

- Days' supply for the requested opioid is 7 days or less
- Including the days' supply for the requested agent, the patient will not exceed 7 days of concurrent opiate/benzodiazepine therapy in the past 180 days

OR

4.3 Patient has utilized concurrent benzodiazepine/opiate therapy, including any cross-tapered or discontinued agents, for at least 90 of the past 120 days

OR

4.4 All of the following for concurrent opiate/benzodiazepine therapy exceeding 7 days in the past 180 days:

4.4.1 Indications provided for both the benzodiazepine agent(s) and the opioid agent(s)

AND

4.4.2 Documentation of previous therapies attempted for the given indications

AND

4.4.3 Prescriber attests to ALL of the following:

- The patient's INSPECT report has been evaluated and continues to be evaluated on a regular basis
- The patient has been educated in regard to the risks of concurrent utilization of opioid and benzodiazepine therapy, and the patient accepts these risks
- The prescriber has consulted any other prescribers involved in concurrent therapy and all prescribers agree to pursue concurrent opioid and benzodiazepine therapy for the patient, if applicable
- The prescriber acknowledges the risk of adverse event(s), including respiratory depression, coma, and death, associated with concurrent utilization

AND

5 - Fewer than 5 different prescribers of opiates in the past 60 days

AND

6 - One of the following:

6.1 The patient has one of the following indications for long-term opioid use:

- Cancer
- Sickle cell disease
- Palliative care
- Other terminal diagnosis associated with significant pain

OR

6.2 Both of the following:

- The requested dose does not exceed 60 morphine milligram equivalents (MME) per day
- The patient has filled up to a 7-day supply of initial opioid therapy in the past 120 days

OR

6.3 The patient has a diagnosis of pain associated with ureteral spasm

AND

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

- History of at least 2 different preferred short-acting opioid products (2 different ingredients) in the past 6 months
- History of the requested medication for 90 of the past 105 days

Notes	*Unless faxed documentation has been received from the opioid prescriber with approval for opioid therapy from the buprenorphine or buprenorphine/naloxone prescriber. IN PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name: Opium tincture	
Approval Length	For patients with non-cancer treatment-related diarrhea: 4 weeks; For patients with cancer treatment-related diarrhea: 6 month(s); All other diagnoses: 12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OPIUM	OPIUM TINCTURE 1% (10 MG/ML) (MORPHINE EQUIV)	47100030201505	Generic
OPIUM TINCTURE	OPIUM TINCTURE 1% (10 MG/ML) (MORPHINE EQUIV)	47100030201505	Generic

Approval Criteria

1 - No concurrent claims for buprenorphine/naloxone or buprenorphine therapy, excluding buprenorphine patches (Butrans) and sublingual buprenorphine indicated for the treatment of pain (Belbuca), exceeding a 7-day supply every 180 days*

AND

2 - The patient is not using concurrently with a carisoprodol-containing product

AND

3 - No concurrent claims for Lybalvi (olanzapine/samidorphan) within the past 45 days

AND

4 - One of the following:

4.1 Patient is not using the requested medication concurrently with a benzodiazepine (claim within the past 30 days)

OR

4.2 BOTH of the following:

- Days' supply for the requested opioid is 7 days or less
- Including the days' supply for the requested agent, the patient will not exceed 7 days of concurrent opiate/benzodiazepine therapy in the past 180 days

OR

4.3 Patient has utilized concurrent benzodiazepine/opiate therapy, including any cross-tapered or discontinued agents, for at least 90 of the past 120 days

OR

4.4 All of the following for concurrent opiate/benzodiazepine therapy exceeding 7 days in the past 180 days:

4.4.1 Indications provided for both the benzodiazepine agent(s) and the opioid agent(s)

AND

4.4.2 Documentation of previous therapies attempted for the given indications

AND

4.4.3 Prescriber attests to ALL of the following:

- The patient's INSPECT report has been evaluated and continues to be evaluated on a regular basis
- The patient has been educated in regard to the risks of concurrent utilization of opioid and benzodiazepine therapy, and the patient accepts these risks
- The prescriber has consulted any other prescribers involved in concurrent therapy and all prescribers agree to pursue concurrent opioid and benzodiazepine therapy for the patient, if applicable
- The prescriber acknowledges the risk of adverse event(s), including respiratory depression, coma, and death, associated with concurrent utilization

AND

5 - Fewer than 5 different prescribers of opiates in the past 60 days

AND

6 - One of the following:

6.1 The patient has one of the following indications for long-term opioid use:

- Cancer
- Sickle cell disease
- Palliative care
- Other terminal diagnosis associated with significant pain

OR

6.2 Both of the following:

- The requested dose does not exceed 60 morphine milligram equivalents (MME) per day
- The patient has filled up to a 7-day supply of initial opioid therapy in the past 120 days

OR

6.3 The patient has a diagnosis of diarrhea and diarrhea is one of the following:

- Non-cancer treatment related
- Cancer treatment related

AND

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

- History of at least 2 different preferred short-acting opioid products (2 different ingredients) in the past 6 months
- History of the requested medication for 90 of the past 105 days

Notes	*Unless faxed documentation has been received from the opioid prescriber with approval for opioid therapy from the buprenorphine or buprenorphine/naloxone prescriber. IN PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name: Antitussives: Brand Hycodan, Hydromet, hydrocodone/homatropine syrup, hydrocodone/homatropine tabs, Tuzistra XR, hydrocodone polst/chlorpheniramine polst ER susp, M-END PE, Poly-Tussin AC, Capcof, Pro-Red AC, Histex-AC, Maxi-Tuss CD, promethazine w/codeine, Promethazine VC/codeine, promethazine-phenylephrine-codeine, Rydex, Mar-Cof BP, Ninjacof-XG, Coditussin AC, Mar-Cof GG, Trymine CG, M-Clear WC, Codeine/Guaifenesin, G Tussin AC, Guaiatussin AC, Guaifenesin AC, Guaifenesin/Codeine, Virtussin A/C, Virtussin AC/ALC, Maxi-Tuss AC, Coditussin DAC, Virtussin DAC, Tuxarin ER, Tusnel C

Approval Length	12 month(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
POLY-TUSSIN AC	PHENYLEPHRINE-BROMPHEN W/ CODEINE LIQUID 10-4-10 MG/5ML	43995303110935	Generic
CAPCOF	PHENYLEPHRINE-CHLORPHEN W/ CODEINE SYRUP 5-2-10 MG/5ML	43995303141220	Brand
PRO-RED AC	PHENYLEPHRINE-DEXCHLORPHENIR-CODEINE SYRUP 5-1-9 MG/5ML	43995303171220	Brand
MAXI-TUSS CD	PHENYLEPHRINE-CHLORPHEN W/ CODEINE LIQUID 10-4-10 MG/5ML	43995303140913	Generic
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
RYDEX	PSEUDOEPHEDRINE-BROMPHEN-CODEINE LIQ 10-1.33-6.33 MG/5ML	43995303190922	Brand
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
CODITUSSIN AC	GUAIFENESIN-CODEINE LIQUID 200-10 MG/5ML	43997002280945	Generic
MAR-COF CG EXPECTORANT	GUAIFENESIN-CODEINE LIQUID 225-7.5 MG/5ML	43997002280947	Brand
M-CLEAR WC	GUAIFENESIN-CODEINE SOLN 100-6.33 MG/5ML	43997002282018	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
GUAIFENESIN/CODEINE PHOSPHATE	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
CODITUSSIN DAC	PSEUDOEPHEDRINE W/ COD-GG LIQUID 30-10-200 MG/5ML	43997303300938	Generic
TUXARIN ER	CODEINE PHOS-CHLORPHENIRAMINE MALEATE TAB ER 12HR 54.3-8 MG	43995202327430	Brand
TUSNEL C	PSEUDOEPHEDRINE W/ COD-GG SYRUP 30-10-100 MG/5ML	43997303301225	Brand
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

Approval Criteria

1 - No concurrent claims for buprenorphine/naloxone or buprenorphine therapy, excluding buprenorphine patches (Butrans) and sublingual buprenorphine indicated for the treatment of pain (Belbuca), exceeding a 7-day supply every 180 days*

AND

2 - The patient is not using concurrently with a carisoprodol-containing product

AND

3 - No concurrent claims for Lybalvi (olanzapine/samidorphan) within the past 45 days

AND

4 - One of the following:

4.1 Patient is not using the requested medication concurrently with a benzodiazepine (claim within the past 30 days)

OR

4.2 BOTH of the following:

- Days' supply for the requested opioid is 7 days or less
- Including the days' supply for the requested agent, the patient will not exceed 7 days of concurrent opiate/benzodiazepine therapy in the past 180 days

OR

4.3 Patient has utilized concurrent benzodiazepine/opiate therapy, including any cross-tapered or discontinued agents, for at least 90 of the past 120 days

OR

4.4 All of the following for concurrent opiate/benzodiazepine therapy exceeding 7 days in the past 180 days:

4.4.1 Indications provided for both the benzodiazepine agent(s) and the opioid agent(s)

AND

4.4.2 Documentation of previous therapies attempted for the given indications

AND

4.4.3 Prescriber attests to ALL of the following:

- The patient's INSPECT report has been evaluated and continues to be evaluated on a regular basis
- The patient has been educated in regard to the risks of concurrent utilization of opioid and benzodiazepine therapy, and the patient accepts these risks
- The prescriber has consulted any other prescribers involved in concurrent therapy and all prescribers agree to pursue concurrent opioid and benzodiazepine therapy for the patient, if applicable
- The prescriber acknowledges the risk of adverse event(s), including respiratory depression, coma, and death, associated with concurrent utilization

AND

5 - Fewer than 5 different prescribers of opiates in the past 60 days

AND

6 - One of the following

6.1 One of the following diagnoses:

- Cancer
- Palliative care
- Other terminal diagnosis with concomitant irretractable cough

OR

6.2 Both of the following:

- The requested dose does not exceed 60 morphine milligram equivalents (MME) per day

- The patient has filled up to a 7-day supply of initial opioid therapy in the past 120 days

AND

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

- History of 2 different preferred antitussive products (2 different ingredients) in the past 6 months
- History of the requested medication for 90 of the past 105 days

AND

8 - The patient is 18 years of age or older (if less than 18 years of age, please see Age Limit criteria)

Notes	*Unless faxed documentation has been received from the opioid prescriber with approval for opioid therapy from the buprenorphine or buprenorphine/naloxone prescriber. IN PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name: Short-Acting Opioids: butorphanol, acetaminophen/codeine (soln and tabs), brand Fioricet/codeine, generic butalbital/acetaminophen/caffeine/codeine, ascomp/codeine, butalbital/aspirin/caffeine/codeine, Apadaz, Benzhydrocodone/acetaminophen, morphine sulfate (tab, soln and supp), codeine sulfate, brand Lortab, generic hydrocodone/acetaminophen soln, brand Xodol, generic hydrocodone/acetaminophen tab, hydrocodone/ibuprofen, brand Trezix, generic acetaminophen/caffeine/dihydrocodeine, brand dilaudid, generic hydromorphone, oxycodone cap, brand Roxicodone, brand Oxaydo, generic oxycodone tab, oxycodone conc, oxycodone soln, brand Percocet, Nalocet, Endocet, Prolate (tab and soln), Oxycodone/acetaminophen (tab and soln), generic oxycodone/acetaminophen tab, levorphanol, meperidine (tab and soln), oxymorphone, pentazocine/naloxone, brand Ultram, generic tramadol, brand Ultracet, generic tramadol/acetaminophen, Synapryn

Diagnosis	Prior Authorization/Opioid Naive (days supply limit)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

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
CODEINE/ACETAMINOPHEN	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

BENZHYDROCODONE/ACETAMINOPHEN	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 4.08-325 MG	65990002020310	Brand
APADAZ	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 4.08-325 MG	65990002020310	Brand
BENZHYDROCODONE/ACETAMINOPHEN	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 6.12-325 MG	65990002020320	Brand
APADAZ	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 6.12-325 MG	65990002020320	Brand
BENZHYDROCODONE/ACETAMINOPHEN	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 8.16-325 MG	65990002020330	Brand
APADAZ	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 8.16-325 MG	65990002020330	Brand
MORPHINE SULFATE	MORPHINE SULFATE TAB 15 MG	65100055100310	Generic
MORPHINE SULFATE	MORPHINE SULFATE TAB 30 MG	65100055100315	Generic
MORPHINE SULFATE	MORPHINE SULFATE ORAL SOLN 10 MG/5ML	65100055102065	Generic
MORPHINE SULFATE	MORPHINE SULFATE ORAL SOLN 20 MG/5ML	65100055102070	Generic
MORPHINE SULFATE	MORPHINE SULFATE ORAL SOLN 100 MG/5ML (20 MG/ML)	65100055102090	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 5 MG	65100055105205	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
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
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN SOLN 10-325 MG/15ML	65991702102025	Generic
LORTAB	HYDROCODONE-ACETAMINOPHEN SOLN 10-300 MG/15ML	65991702102024	Brand
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN SOLN 7.5-325 MG/15ML	65991702102015	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 10-325 MG	65991702100305	Generic
HYDROCODONE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 10-325 MG	65991702100305	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 7.5-300 MG	65991702100322	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 5-325 MG	65991702100356	Generic
HYDROCODONE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 5-325 MG	65991702100356	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 BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 10-300 MG	65991702100375	Generic
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
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE	ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE CAP 320.5-30-16 MG	65991303050115	Generic
TREZIX	ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE CAP 320.5-30-16 MG	65991303050115	Brand
HYDROMORPHONE HCL	HYDROMORPHONE HCL TAB 2 MG	65100035100310	Generic
HYDROMORPHONE HCL	HYDROMORPHONE HCL TAB 4 MG	65100035100320	Generic
HYDROMORPHONE HCL	HYDROMORPHONE HCL TAB 8 MG	65100035100330	Generic
HYDROMORPHONE HCL	HYDROMORPHONE HCL LIQD 1 MG/ML	65100035100920	Generic
HYDROMORPHONE HCL	HYDROMORPHONE HCL SUPPOS 3 MG	65100035105205	Generic
DILAUDID	HYDROMORPHONE HCL TAB 2 MG	65100035100310	Brand
DILAUDID	HYDROMORPHONE HCL TAB 4 MG	65100035100320	Brand
DILAUDID	HYDROMORPHONE HCL TAB 8 MG	65100035100330	Brand
DILAUDID	HYDROMORPHONE HCL LIQD 1 MG/ML	65100035100920	Brand
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL CAP 5 MG	65100075100110	Generic
OXYCODONE HCL	OXYCODONE HCL CAP 5 MG	65100075100110	Generic
ROXICODONE	OXYCODONE HCL TAB 15 MG	65100075100325	Brand
ROXICODONE	OXYCODONE HCL TAB 30 MG	65100075100340	Brand

OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 15 MG	65100075100325	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 20 MG	65100075100330	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 30 MG	65100075100340	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/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-300 MG	65990002200303	Generic
NALOCET	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-300 MG	65990002200303	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG	65990002200305	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG	65990002200305	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG	65990002200305	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 5-300 MG	65990002200308	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN TAB 5-300 MG	65990002200308	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG	65990002200310	Brand
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG	65990002200327	Brand
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 10-300 MG	65990002200333	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN TAB 10-300 MG	65990002200333	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG	65990002200335	Brand

OXYCODONE HYDROCHLORIDE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN SOLN 10-300 MG/5ML	65990002202020	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN SOLN 10-300 MG/5ML	65990002202020	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-300 MG	65990002200325	Generic
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG	65990002200310	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG	65990002200310	Generic
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG	65990002200327	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG	65990002200327	Generic
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG	65990002200335	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG	65990002200335	Generic
LEVORPHANOL TARTRATE	LEVORPHANOL TARTRATE TAB 2 MG	65100040100305	Generic
LEVORPHANOL TARTRATE	LEVORPHANOL TARTRATE TAB 3 MG	65100040100310	Generic
MEPERIDINE HCL	MEPERIDINE HCL TAB 50 MG	65100045100305	Generic
MEPERIDINE HCL	MEPERIDINE HCL ORAL SOLN 50 MG/5ML	65100045102060	Generic
OXYMORPHONE HYDROCHLORIDE	OXYMORPHONE HCL TAB 5 MG	65100080100305	Generic
OXYMORPHONE HYDROCHLORIDE	OXYMORPHONE HCL TAB 10 MG	65100080100310	Generic
PENTAZOCINE/NALOXONE HCL	PENTAZOCINE W/ NALOXONE TAB 50-0.5 MG	65200040300310	Generic
ULTRAM	TRAMADOL HCL TAB 50 MG	65100095100320	Brand

TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 100 MG	65100095100340	Generic
TRAMADOL HYDROCHLORIDE/ACETAMINOPHEN	TRAMADOL-ACETAMINOPHEN TAB 37.5-325 MG	65995002200320	Generic
ULTRACET	TRAMADOL-ACETAMINOPHEN TAB 37.5-325 MG	65995002200320	Brand
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 50 MG	65100095100320	Generic
TRAMADOL HCL	TRAMADOL HCL TAB 50 MG	65100095100320	Generic
SYNAPRYN FUSEPAQ	*TRAMADOL HCL FOR ORAL SUSP 10 MG/ML (COMPOUND KIT)***	65100095101920	Brand
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 10 MG	65100075100320	Generic
OXYCODONE HYDROCHLORIDE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN SOLN 5-325 MG/5ML	65990002202005	Brand
OXYCODONE AND ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-300 MG	65990002200325	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 5 MG	65100075100310	Generic
OXAYDO	OXYCODONE HCL TAB 5 MG	65100075100310	Brand
OXAYDO	OXYCODONE HCL TAB 7.5 MG	65100075100315	Brand
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 25 MG	65100095100310	Generic
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 75 MG	65100095100330	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 2.5-325 MG	65991702100302	Generic

Approval Criteria

1 - No concurrent claims for buprenorphine/naloxone or buprenorphine therapy, excluding buprenorphine patches (Butrans) and sublingual buprenorphine indicated for the treatment of pain (Belbuca), exceeding a 7-day supply every 180 days*

AND

2 - The patient is not using concurrently with a carisoprodol-containing product

AND

3 - No concurrent claims for Lybalvi (olanzapine/samidorphan) within the past 45 days

AND

4 - One of the following:

4.1 Patient is not using the requested medication concurrently with a benzodiazepine (claim within the past 30 days)

OR

4.2 BOTH of the following:

- Days' supply for the requested opioid is 7 days or less
- Including the days' supply for the requested agent, the patient will not exceed 7 days of concurrent opiate/benzodiazepine therapy in the past 180 days

OR

4.3 Patient has utilized concurrent benzodiazepine/opiate therapy, including any cross-tapered or discontinued agents, for at least 90 of the past 120 days

OR

4.4 All of the following for concurrent opiate/benzodiazepine therapy exceeding 7 days in the past 180 days:

4.4.1 Indications provided for both the benzodiazepine agent(s) and the opioid agent(s)

AND

4.4.2 Documentation of previous therapies attempted for the given indications

AND

4.4.3 Prescriber attests to ALL of the following:

- The patient's INSPECT report has been evaluated and continues to be evaluated on a regular basis
- The patient has been educated in regard to the risks of concurrent utilization of opioid and benzodiazepine therapy, and the patient accepts these risks
- The prescriber has consulted any other prescribers involved in concurrent therapy and all prescribers agree to pursue concurrent opioid and benzodiazepine therapy for the patient, if applicable
- The prescriber acknowledges the risk of adverse event(s), including respiratory depression, coma, and death, associated with concurrent utilization

AND

5 - Fewer than 5 different prescribers of opiates in the past 60 days

AND

6 - One of the following:

6.1 The patient has one of the following indications for long-term opioid use:

- Cancer
- Sickle cell disease
- Palliative care
- Other terminal diagnosis associated with significant pain

OR

6.2 Both of the following:

- The requested dose does not exceed 60 morphine milligram equivalents (MME) per day
- The patient has filled up to a 7-day supply of initial opioid therapy in the past 120 days

OR

6.3 Both of the following:

- Patient is a current utilizer (at least 90 days of therapy in the past 120 days)
- Patient is not using more than one short-acting opioid agent

AND

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

- History of at least 2 different preferred short-acting opioid products (2 different ingredients) in the past 6 months
- History of the requested medication for 90 of the past 105 days

AND

8 - If the request is for a codeine-containing or tramadol-containing product, the patient is 18 years of age or older (if less than 18 years of age, please see Age Limit criteria)

Notes	*Unless faxed documentation has been received from the opioid prescriber with approval for opioid therapy from the buprenorphine or buprenorphine/naloxone prescriber. IN PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name: fentanyl patch, brand Butrans, generic buprenorphine patch, brand MS Contin, generic morphine sulfate ER, generic morphine sulfate CR, Oxycontin, Oxycodone ER, hydromorphone ER, brand Hysingla ER, generic hydrocodone ER tab, Oxymorphone ER, brand Zohydro ER, generic hydrocodone ER cap, Conzip, tramadol ER cap, tramadol ER tab, tramadol ER biphasic ER tab, butorphanol, acetaminophen/codeine (soln and tabs), brand Fioricet/codeine, generic butalbital/acetaminophen/caffeine/codeine, ascomp/codeine, butalbital/aspirin/caffeine/codeine, Apadaz, Benzhydrocodone/acetaminophen, morphine sulfate (tab, soln and supp), codeine sulfate, brand Lortab, generic hydrocodone/acetaminophen soln, brand Xodol, generic hydrocodone/acetaminophen tab, hydrocodone/ibuprofen, brand Trezix, generic acetaminophen/caffeine/dihydrocodeine, brand

dilaudid, generic hydromorphone, oxycodone cap, brand Roxicodone, brand Oxaydo, generic oxycodone tab, oxycodone conc, oxycodone soln, brand Percocet, Nalocet, Endocet, Prolate (tab and soln), Oxycodone/acetaminophen (tab and soln), generic oxycodone/acetaminophen tab, levorphanol, meperidine (tab and soln), methadone (tab, conc, soln, intensol, tab for oral susp, inj), methadose (conc, SF conc and tab for oral susp), oxymorphone, pentazocine/naloxone, brand Ultram, generic tramadol, brand Ultracet, generic tramadol/acetaminophen, Synapryn, Qdolo, tramadol oral soln, belladonna/Opium, Opium, Seglentis, Roxybond, Oxycodone abuse deterrent tabs, Brand Hycodan, Hydromet, hydrocodone/homatropine syrup, hydrocodone/homatropine tabs, Tuzistra XR, hydrocodone polst/chlorpheniramine polst ER susp, M-END PE, Poly-Tussin AC, Capcof, Pro-Red AC, Histex-AC, Maxi-Tuss CD, promethazine w/codeine, Promethazine VC/codeine, promethazine-phenylephrine-codeine, Rydex, Mar-Cof BP, Ninjacof-XG, Coditussin AC, Mar-Cof GG, Trymine CG, M-Clear WC, Codeine/Guaifenesin, G Tussin AC, Guaiatussin AC, Guaifenesin AC, Guaifenesin/Codeine, Virtussin A/C, Virtussin AC/ALC, Maxi-Tuss AC, Coditussin DAC, Virtussin DAC, Tuxarin ER, Tusnel C *

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
CODEINE/ACETAMINOPHEN	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
BENZHYDROCODONE/ACETAMINOPHEN	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 4.08-325 MG	65990002020310	Brand
APADAZ	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 4.08-325 MG	65990002020310	Brand
BENZHYDROCODONE/ACETAMINOPHEN	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 6.12-325 MG	65990002020320	Brand
APADAZ	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 6.12-325 MG	65990002020320	Brand
BENZHYDROCODONE/ACETAMINOPHEN	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 8.16-325 MG	65990002020330	Brand
APADAZ	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 8.16-325 MG	65990002020330	Brand
MORPHINE SULFATE	MORPHINE SULFATE TAB 15 MG	65100055100310	Generic

MORPHINE SULFATE	MORPHINE SULFATE TAB 30 MG	65100055100315	Generic
MORPHINE SULFATE	MORPHINE SULFATE ORAL SOLN 10 MG/5ML	65100055102065	Generic
MORPHINE SULFATE	MORPHINE SULFATE ORAL SOLN 20 MG/5ML	65100055102070	Generic
MORPHINE SULFATE	MORPHINE SULFATE ORAL SOLN 100 MG/5ML (20 MG/ML)	65100055102090	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 5 MG	65100055105205	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
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	65200010108270	Brand

	900 MCG (BASE EQUIVALENT)		
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
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN SOLN 10-325 MG/15ML	65991702102025	Generic
LORTAB	HYDROCODONE-ACETAMINOPHEN SOLN 10-300 MG/15ML	65991702102024	Brand
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN SOLN 7.5-325 MG/15ML	65991702102015	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 10-325 MG	65991702100305	Generic
HYDROCODONE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 10-325 MG	65991702100305	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 7.5-300 MG	65991702100322	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 5-325 MG	65991702100356	Generic
HYDROCODONE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 5-325 MG	65991702100356	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 BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 10-300 MG	65991702100375	Generic
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
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE	ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE CAP 320.5-30-16 MG	65991303050115	Generic
TREZIX	ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE CAP 320.5-30-16 MG	65991303050115	Brand
HYDROMORPHONE HCL	HYDROMORPHONE HCL TAB 2 MG	65100035100310	Generic
HYDROMORPHONE HCL	HYDROMORPHONE HCL TAB 4 MG	65100035100320	Generic
HYDROMORPHONE HCL	HYDROMORPHONE HCL TAB 8 MG	65100035100330	Generic
HYDROMORPHONE HCL	HYDROMORPHONE HCL LIQD 1 MG/ML	65100035100920	Generic
HYDROMORPHONE HCL	HYDROMORPHONE HCL SUPPOS 3 MG	65100035105205	Generic
DILAUDID	HYDROMORPHONE HCL TAB 2 MG	65100035100310	Brand
DILAUDID	HYDROMORPHONE HCL TAB 4 MG	65100035100320	Brand
DILAUDID	HYDROMORPHONE HCL TAB 8 MG	65100035100330	Brand
DILAUDID	HYDROMORPHONE HCL LIQD 1 MG/ML	65100035100920	Brand
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL CAP 5 MG	65100075100110	Generic
OXYCODONE HCL	OXYCODONE HCL CAP 5 MG	65100075100110	Generic
ROXICODONE	OXYCODONE HCL TAB 15 MG	65100075100325	Brand
ROXICODONE	OXYCODONE HCL TAB 30 MG	65100075100340	Brand

OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 15 MG	65100075100325	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 20 MG	65100075100330	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 30 MG	65100075100340	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/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-300 MG	65990002200303	Generic
NALOCET	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-300 MG	65990002200303	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG	65990002200305	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG	65990002200305	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG	65990002200305	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 5-300 MG	65990002200308	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN TAB 5-300 MG	65990002200308	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG	65990002200310	Brand
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG	65990002200327	Brand
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 10-300 MG	65990002200333	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN TAB 10-300 MG	65990002200333	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG	65990002200335	Brand

OXYCODONE HYDROCHLORIDE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN SOLN 10-300 MG/5ML	65990002202020	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN SOLN 10-300 MG/5ML	65990002202020	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-300 MG	65990002200325	Generic
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG	65990002200310	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG	65990002200310	Generic
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG	65990002200327	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG	65990002200327	Generic
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG	65990002200335	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG	65990002200335	Generic
LEVORPHANOL TARTRATE	LEVORPHANOL TARTRATE TAB 2 MG	65100040100305	Generic
LEVORPHANOL TARTRATE	LEVORPHANOL TARTRATE TAB 3 MG	65100040100310	Generic
MEPERIDINE HCL	MEPERIDINE HCL TAB 50 MG	65100045100305	Generic
MEPERIDINE HCL	MEPERIDINE HCL ORAL SOLN 50 MG/5ML	65100045102060	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 HCL	METHADONE HCL CONC 10 MG/ML	65100050101310	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL CONC 10 MG/ML	65100050101310	Generic
METHADONE HCL INTENSOL	METHADONE HCL CONC 10 MG/ML	65100050101310	Generic
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 HCL	METHADONE HCL TAB FOR ORAL SUSP 40 MG	65100050107320	Generic
OXYMORPHONE HYDROCHLORIDE	OXYMORPHONE HCL TAB 5 MG	65100080100305	Generic
OXYMORPHONE HYDROCHLORIDE	OXYMORPHONE HCL TAB 10 MG	65100080100310	Generic
PENTAZOCINE/NALOXONE HCL	PENTAZOCINE W/ NALOXONE TAB 50-0.5 MG	65200040300310	Generic
ULTRAM	TRAMADOL HCL TAB 50 MG	65100095100320	Brand
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 100 MG	65100095100340	Generic
TRAMADOL HYDROCHLORIDE/ACETAMINOPHEN	TRAMADOL-ACETAMINOPHEN TAB 37.5-325 MG	65995002200320	Generic
ULTRACET	TRAMADOL-ACETAMINOPHEN TAB 37.5-325 MG	65995002200320	Brand
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 50 MG	65100095100320	Generic
TRAMADOL HCL	TRAMADOL HCL TAB 50 MG	65100095100320	Generic
SYNAPRYN FUSEPAQ	*TRAMADOL HCL FOR ORAL SUSP 10 MG/ML (COMPOUND KIT)***	65100095101920	Brand
BELLADONNA/OPIUM	BELLADONNA ALKALOIDS & OPIUM SUPPOS 16.2-30 MG	49109902155210	Generic
BELLADONNA/OPIUM	BELLADONNA ALKALOIDS &	49109902155220	Generic

	OPIUM SUPPOS 16.2-60 MG		
OPIUM	OPIUM TINCTURE 1% (10 MG/ML) (MORPHINE EQUIV)	47100030201505	Generic
OPIUM TINCTURE	OPIUM TINCTURE 1% (10 MG/ML) (MORPHINE EQUIV)	47100030201505	Generic
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR	65200010008820	Generic
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR	65200010008825	Generic
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR	65200010008830	Generic
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR	65200010008835	Generic
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR	65200010008840	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR	65200010008820	Brand
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR	65200010008825	Brand
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR	65200010008830	Brand
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR	65200010008835	Brand
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR	65200010008840	Brand
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 15 MG	65100055100415	Generic
MS CONTIN	MORPHINE SULFATE TAB ER 15 MG	65100055100415	Brand
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 30 MG	65100055100432	Generic
MS CONTIN	MORPHINE SULFATE TAB ER 30 MG	65100055100432	Brand

MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Generic
MS CONTIN	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Brand
MORPHINE SULFATE CR	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Generic
MS CONTIN	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Brand
MORPHINE SULFATE CR	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 200 MG	65100055100480	Generic
MS CONTIN	MORPHINE SULFATE TAB ER 200 MG	65100055100480	Brand
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
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
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
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
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG	6510003010A810	Brand
HYSINGLA ER	HYDROCODONE BITARTRATE TAB	6510003010A820	Brand

	ER 24HR DETER 30 MG		
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG	6510003010A830	Brand
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG	6510003010A840	Brand
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG	6510003010A850	Brand
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG	6510003010A860	Brand
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG	6510003010A870	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 10 MG	65100030106910	Generic
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 10 MG	65100030106910	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 15 MG	65100030106915	Generic
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 15 MG	65100030106915	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 20 MG	65100030106920	Generic
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 20 MG	65100030106920	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 30 MG	65100030106930	Generic
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 30 MG	65100030106930	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 40 MG	65100030106940	Generic

ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 40 MG	65100030106940	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 50 MG	65100030106950	Generic
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 50 MG	65100030106950	Brand
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
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 10 MG	6510007510A710	Brand
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 15 MG	6510007510A715	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 15 MG	6510007510A715	Generic

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 20 MG	6510007510A720	Brand
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 30 MG	6510007510A730	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 30 MG	6510007510A730	Generic
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
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 60 MG	6510007510A760	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 60 MG	6510007510A760	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 60 MG	6510007510A760	Brand
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Brand
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 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
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
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 10 MG	65100075100320	Generic
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL ORAL SOLN 5 MG/ML	65100095102005	Generic

SEGLENTIS	CELECOXIB-TRAMADOL HCL TAB 56-44 MG	65995002100320	Brand
OXYCODONE HYDROCHLORIDE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN SOLN 5-325 MG/5ML	65990002202005	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG	6510003010A810	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG	6510003010A820	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG	6510003010A830	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG	6510003010A840	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG	6510003010A850	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG	6510003010A860	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG	6510003010A870	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
POLY-TUSSIN AC	PHENYLEPHRINE-BROMPHEN W/ CODEINE LIQUID 10-4-10 MG/5ML	43995303110935	Generic
CAPCOF	PHENYLEPHRINE-CHLORPHEN W/	43995303141220	Brand

	CODEINE SYRUP 5-2-10 MG/5ML		
PRO-RED AC	PHENYLEPHRINE-DEXCHLORPHENIR-CODEINE SYRUP 5-1-9 MG/5ML	43995303171220	Brand
MAXI-TUSS CD	PHENYLEPHRINE-CHLORPHEN W/ CODEINE LIQUID 10-4-10 MG/5ML	43995303140913	Generic
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
RYDEX	PSEUDOEPHEDRINE-BROMPHEN-CODEINE LIQ 10-1.33-6.33 MG/5ML	43995303190922	Brand
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
CODITUSSIN AC	GUAIFENESIN-CODEINE LIQUID 200-10 MG/5ML	43997002280945	Generic
MAR-COF CG EXPECTORANT	GUAIFENESIN-CODEINE LIQUID 225-7.5 MG/5ML	43997002280947	Brand
M-CLEAR WC	GUAIFENESIN-CODEINE SOLN 100-6.33 MG/5ML	43997002282018	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
GUAIFENESIN/CODEINE PHOSPHATE	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
CODITUSSIN DAC	PSEUDOEPHEDRINE W/ COD-GG LIQUID 30-10-200 MG/5ML	43997303300938	Generic
TUXARIN ER	CODEINE PHOS-CHLORPHENIRAMINE MALEATE TAB ER 12HR 54.3-8 MG	43995202327430	Brand
TUSNEL C	PSEUDOEPHEDRINE W/ COD-GG SYRUP 30-10-100 MG/5ML	43997303301225	Brand
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	43101010102010	Generic

	METHYLBROM SOLN 5-1.5 MG/5ML		
TRAMADOL HCL ER	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
TRAMADOL HCL ER	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 300 MG	65100095107090	Generic
OXYCODONE AND ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-300 MG	65990002200325	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 5 MG	65100075100310	Generic
OXAYDO	OXYCODONE HCL TAB 5 MG	65100075100310	Brand
OXAYDO	OXYCODONE HCL TAB 7.5 MG	65100075100315	Brand
METHADONE HCL	METHADONE HCL INJ 10 MG/ML	65100050102005	Generic
CONZIP	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 100 MG	65100095107070	Generic
CONZIP	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 200 MG	65100095107080	Generic
CONZIP	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 300 MG	65100095107090	Generic
METHADOSE SUGAR-FREE	METHADONE HCL CONC 10 MG/ML	65100050101310	Brand
METHADOSE	METHADONE HCL CONC 10 MG/ML	65100050101310	Brand
METHADOSE	METHADONE HCL TAB FOR ORAL SUSP 40 MG	65100050107320	Generic
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 25 MG	65100095100310	Generic
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 75 MG	65100095100330	Generic

ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 10 MG	6510007510A535	Brand
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 2.5-325 MG	65991702100302	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB ABUSE DETER 5 MG	6510007510A530	Generic
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 5 MG	6510007510A530	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB ABUSE DETER 15 MG	6510007510A540	Generic
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 15 MG	6510007510A540	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB ABUSE DETER 30 MG	6510007510A560	Generic
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 30 MG	6510007510A560	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 15 MG	6510007510A715	Brand
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 30 MG	6510007510A730	Brand
QDOLO	TRAMADOL HCL ORAL SOLN 5 MG/ML	65100095102005	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Brand

Approval Criteria

1 - Diagnosis of cancer, sickle cell disease, palliative care, other terminal diagnosis associated with significant pain

OR

2 - Provider has submitted a taper plan with specific doses and durations

OR

3 - The patient has attempted a dose reduction of their opioid therapy within the past 12 months and all of the following:

- Attempt at MME reduction can be identified by chart notes or claims history
- Provider has submitted chart notes demonstrating adverse outcomes experienced with attempted taper

Notes	*Authorization will be issued for 12 months for Cancer, sickle cell disease, palliative care, and terminal diagnosis associated with significant pain. The authorization should be entered for an MME of 9999 so as to prevent future disruptions in therapy if the patient's dose is increased. Authorization for when member has attempted a dose reduction of their opioid therapy within the past 12 months will be granted for 12 months. Authorization for when a provider has submitted a taper plan with specific doses and durations will be granted for 6 months. These authorizations should be entered for the requested MME. **Reference Table 1 in background for MME Limits.

Product Name: acetaminophen/codeine (soln and tabs), brand Fioricet/codeine, generic butalbital/acetaminophen/caffeine/codeine, ascomp/codeine, butalbital/aspirin/caffeine/codeine, codeine sulfate, brand Trezix, generic acetaminophen/caffeine/dihydrocodeine, brand Ultram, generic tramadol, brand Ultracet, generic tramadol/acetaminophen, Qdolo, tramadol oral soln, Seglentis, Conzip, tramadol ER cap, tramadol ER tab, tramadol ER biphasic ER tab, Tuzistra XR, hydrocodone polst/chlorpheniramine polst ER susp, M-END PE, Poly-Tussin AC, Capcof, Pro-Red AC, Histex-AC, Maxi-Tuss CD, promethazine w/codeine, Promethazine VC/codeine, promethazine-phenylephrine-codeine, Rydex, Mar-Cof BP, Ninjacof-XG, Coditussin AC, Mar-Cof GG, Trymine CG, M-Clear WC, Codeine/Guaifenesin, G Tussin AC, Guaiatussin AC, Guaifenesin AC, Guaifenesin/Codeine, Virtussin A/C, Virtussin AC/ALC, Maxi-Tuss AC, Coditussin DAC, Virtussin DAC, Tuxarin ER, Tusnel C, butorphanol

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

Product Name	Generic Name	GPI	Brand/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
CODEINE/ACETAMINOPHEN	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
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
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE	ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE CAP 320.5-30-16 MG	65991303050115	Generic
TREZIX	ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE CAP 320.5-30-16 MG	65991303050115	Brand
ULTRAM	TRAMADOL HCL TAB 50 MG	65100095100320	Brand
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 100 MG	65100095100340	Generic
TRAMADOL HYDROCHLORIDE/ACETAMINOPHEN	TRAMADOL-ACETAMINOPHEN TAB 37.5-325 MG	65995002200320	Generic
ULTRACET	TRAMADOL-ACETAMINOPHEN TAB 37.5-325 MG	65995002200320	Brand
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 50 MG	65100095100320	Generic
TRAMADOL HCL	TRAMADOL HCL TAB 50 MG	65100095100320	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 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	TRAMADOL HCL ORAL SOLN 5 MG/ML	65100095102005	Generic
SEGLENTIS	CELECOXIB-TRAMADOL HCL TAB 56-44 MG	65995002100320	Brand
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
POLY-TUSSIN AC	PHENYLEPHRINE-BROMPHEN W/ CODEINE LIQUID 10-4-10 MG/5ML	43995303110935	Generic
CAPCOF	PHENYLEPHRINE-CHLORPHEN W/ CODEINE SYRUP 5-2-10 MG/5ML	43995303141220	Brand
PRO-RED AC	PHENYLEPHRINE-DEXCHLORPHENIR-CODEINE SYRUP 5-1-9 MG/5ML	43995303171220	Brand
MAXI-TUSS CD	PHENYLEPHRINE-CHLORPHEN W/ CODEINE LIQUID 10-4-10 MG/5ML	43995303140913	Generic
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

RYDEX	PSEUDOEPHEDRINE-BROMPHEN-CODEINE LIQ 10-1.33-6.33 MG/5ML	43995303190922	Brand
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
CODITUSSIN AC	GUAIFENESIN-CODEINE LIQUID 200-10 MG/5ML	43997002280945	Generic
MAR-COF CG EXPECTORANT	GUAIFENESIN-CODEINE LIQUID 225-7.5 MG/5ML	43997002280947	Brand
M-CLEAR WC	GUAIFENESIN-CODEINE SOLN 100-6.33 MG/5ML	43997002282018	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
GUAIFENESIN/CODEINE PHOSPHATE	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
CODITUSSIN DAC	PSEUDOEPHEDRINE W/ COD-GG LIQUID 30-10-200 MG/5ML	43997303300938	Generic
TUXARIN ER	CODEINE PHOS-CHLORPHENIRAMI	43995202327430	Brand

	NE MALEATE TAB ER 12HR 54.3-8 MG		
TUSNEL C	PSEUDOEPHEDRINE W/ COD-GG SYRUP 30-10-100 MG/5ML	43997303301225	Brand
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
TRAMADOL HCL ER	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
TRAMADOL HCL ER	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 300 MG	65100095107090	Generic
CONZIP	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 100 MG	65100095107070	Generic

CONZIP	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 200 MG	65100095107080	Generic
CONZIP	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 300 MG	65100095107090	Generic
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 25 MG	65100095100310	Generic
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 75 MG	65100095100330	Generic
QDOLO	TRAMADOL HCL ORAL SOLN 5 MG/ML	65100095102005	Generic

Approval Criteria

1 - All of the following:

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

AND

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

OR

2 - All of the following:

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

AND

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

OR

3 - All of the following:

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

AND

3.2 ONE of the following:

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

AND

3.3 One of the following:

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

OR

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

AND

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

Notes	These criteria are from the Non-Drug-Specific Prior Authorization Criteria policy

Product Name: All Opioid Products	
Diagnosis	DDI: Lybalvi + Opioid
Approval Length	12 month(s)
Guideline Type	Drug Utilization Review

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
CODEINE/ACETAMINOPHEN	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-	65991004100113	Generic

	CAFF W/ COD CAP 50-300-40-30 MG		
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
BENZHYDROCODONE/ACETAMINOPHEN	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 4.08-325 MG	65990002020310	Brand
APADAZ	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 4.08-325 MG	65990002020310	Brand
BENZHYDROCODONE/ACETAMINOPHEN	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 6.12-325 MG	65990002020320	Brand
APADAZ	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 6.12-325 MG	65990002020320	Brand
BENZHYDROCODONE/ACETAMINOPHEN	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 8.16-325 MG	65990002020330	Brand
APADAZ	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 8.16-325 MG	65990002020330	Brand
MORPHINE SULFATE	MORPHINE SULFATE TAB 15 MG	65100055100310	Generic
MORPHINE SULFATE	MORPHINE SULFATE TAB 30 MG	65100055100315	Generic
MORPHINE SULFATE	MORPHINE SULFATE ORAL SOLN 10 MG/5ML	65100055102065	Generic
MORPHINE SULFATE	MORPHINE SULFATE ORAL SOLN 20 MG/5ML	65100055102070	Generic

MORPHINE SULFATE	MORPHINE SULFATE ORAL SOLN 100 MG/5ML (20 MG/ML)	65100055102090	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 5 MG	65100055105205	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
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
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

HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN SOLN 10-325 MG/15ML	65991702102025	Generic
LORTAB	HYDROCODONE-ACETAMINOPHEN SOLN 10-300 MG/15ML	65991702102024	Brand
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN SOLN 7.5-325 MG/15ML	65991702102015	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 10-325 MG	65991702100305	Generic
HYDROCODONE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 10-325 MG	65991702100305	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 7.5-300 MG	65991702100322	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 5-325 MG	65991702100356	Generic
HYDROCODONE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 5-325 MG	65991702100356	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 BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 10-300 MG	65991702100375	Generic
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
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE	ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE CAP 320.5-30-16 MG	65991303050115	Generic
TREZIX	ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE CAP 320.5-30-16 MG	65991303050115	Brand
HYDROMORPHONE HCL	HYDROMORPHONE HCL TAB 2 MG	65100035100310	Generic
HYDROMORPHONE HCL	HYDROMORPHONE HCL TAB 4 MG	65100035100320	Generic
HYDROMORPHONE HCL	HYDROMORPHONE HCL TAB 8 MG	65100035100330	Generic
HYDROMORPHONE HCL	HYDROMORPHONE HCL LIQD 1 MG/ML	65100035100920	Generic
HYDROMORPHONE HCL	HYDROMORPHONE HCL SUPPOS 3 MG	65100035105205	Generic
DILAUDID	HYDROMORPHONE HCL TAB 2 MG	65100035100310	Brand
DILAUDID	HYDROMORPHONE HCL TAB 4 MG	65100035100320	Brand
DILAUDID	HYDROMORPHONE HCL TAB 8 MG	65100035100330	Brand
DILAUDID	HYDROMORPHONE HCL LIQD 1 MG/ML	65100035100920	Brand
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL CAP 5 MG	65100075100110	Generic
OXYCODONE HCL	OXYCODONE HCL CAP 5 MG	65100075100110	Generic
ROXICODONE	OXYCODONE HCL TAB 15 MG	65100075100325	Brand
ROXICODONE	OXYCODONE HCL TAB 30 MG	65100075100340	Brand
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 15 MG	65100075100325	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 20 MG	65100075100330	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 30 MG	65100075100340	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/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-300 MG	65990002200303	Generic
NALOCET	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-300 MG	65990002200303	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG	65990002200305	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG	65990002200305	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG	65990002200305	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 5-300 MG	65990002200308	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN TAB 5-300 MG	65990002200308	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG	65990002200310	Brand
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG	65990002200327	Brand
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 10-300 MG	65990002200333	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN TAB 10-300 MG	65990002200333	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG	65990002200335	Brand
OXYCODONE HYDROCHLORIDE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN SOLN 10-300 MG/5ML	65990002202020	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN SOLN 10-300 MG/5ML	65990002202020	Generic

PROLATE	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-300 MG	65990002200325	Generic
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG	65990002200310	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG	65990002200310	Generic
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG	65990002200327	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG	65990002200327	Generic
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG	65990002200335	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG	65990002200335	Generic
LEVORPHANOL TARTRATE	LEVORPHANOL TARTRATE TAB 2 MG	65100040100305	Generic
LEVORPHANOL TARTRATE	LEVORPHANOL TARTRATE TAB 3 MG	65100040100310	Generic
MEPERIDINE HCL	MEPERIDINE HCL TAB 50 MG	65100045100305	Generic
MEPERIDINE HCL	MEPERIDINE HCL ORAL SOLN 50 MG/5ML	65100045102060	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 HCL	METHADONE HCL CONC 10 MG/ML	65100050101310	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL CONC 10 MG/ML	65100050101310	Generic
METHADONE HCL INTENSOL	METHADONE HCL CONC 10 MG/ML	65100050101310	Generic

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 HCL	METHADONE HCL TAB FOR ORAL SUSP 40 MG	65100050107320	Generic
OXYMORPHONE HYDROCHLORIDE	OXYMORPHONE HCL TAB 5 MG	65100080100305	Generic
OXYMORPHONE HYDROCHLORIDE	OXYMORPHONE HCL TAB 10 MG	65100080100310	Generic
PENTAZOCINE/NALOXONE HCL	PENTAZOCINE W/ NALOXONE TAB 50-0.5 MG	65200040300310	Generic
ULTRAM	TRAMADOL HCL TAB 50 MG	65100095100320	Brand
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 100 MG	65100095100340	Generic
TRAMADOL HYDROCHLORIDE/ACETAMINOPHEN	TRAMADOL-ACETAMINOPHEN TAB 37.5-325 MG	65995002200320	Generic
ULTRACET	TRAMADOL-ACETAMINOPHEN TAB 37.5-325 MG	65995002200320	Brand
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 50 MG	65100095100320	Generic
TRAMADOL HCL	TRAMADOL HCL TAB 50 MG	65100095100320	Generic
SYNAPRYN FUSEPAQ	*TRAMADOL HCL FOR ORAL SUSP 10 MG/ML (COMPOUND KIT)***	65100095101920	Brand
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
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR	65200010008820	Generic
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR	65200010008825	Generic
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR	65200010008830	Generic
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR	65200010008835	Generic
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR	65200010008840	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR	65200010008820	Brand
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR	65200010008825	Brand
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR	65200010008830	Brand
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR	65200010008835	Brand
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR	65200010008840	Brand
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 15 MG	65100055100415	Generic
MS CONTIN	MORPHINE SULFATE TAB ER 15 MG	65100055100415	Brand
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 30 MG	65100055100432	Generic
MS CONTIN	MORPHINE SULFATE TAB ER 30 MG	65100055100432	Brand
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Generic

MS CONTIN	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Brand
MORPHINE SULFATE CR	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Generic
MS CONTIN	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Brand
MORPHINE SULFATE CR	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 200 MG	65100055100480	Generic
MS CONTIN	MORPHINE SULFATE TAB ER 200 MG	65100055100480	Brand
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
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
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
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
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG	6510003010A810	Brand
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG	6510003010A820	Brand
HYSINGLA ER	HYDROCODONE BITARTRATE TAB	6510003010A830	Brand

	ER 24HR DETER 40 MG		
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG	6510003010A840	Brand
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG	6510003010A850	Brand
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG	6510003010A860	Brand
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG	6510003010A870	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 10 MG	65100030106910	Generic
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 10 MG	65100030106910	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 15 MG	65100030106915	Generic
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 15 MG	65100030106915	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 20 MG	65100030106920	Generic
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 20 MG	65100030106920	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 30 MG	65100030106930	Generic
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 30 MG	65100030106930	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 40 MG	65100030106940	Generic
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 40 MG	65100030106940	Brand

HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 50 MG	65100030106950	Generic
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 50 MG	65100030106950	Brand
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
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 10 MG	6510007510A710	Brand
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 15 MG	6510007510A715	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 15 MG	6510007510A715	Generic
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 20 MG	6510007510A720	Brand
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 30 MG	6510007510A730	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 30 MG	6510007510A730	Generic
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
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 60 MG	6510007510A760	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 60 MG	6510007510A760	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 60 MG	6510007510A760	Brand
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Brand
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 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
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
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 10 MG	65100075100320	Generic
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL ORAL SOLN 5 MG/ML	65100095102005	Generic
SEGLENTIS	CELECOXIB-TRAMADOL HCL TAB 56-44 MG	65995002100320	Brand

HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG	65100030 10A810	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG	65100030 10A820	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG	65100030 10A830	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG	65100030 10A840	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG	65100030 10A850	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG	65100030 10A860	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG	65100030 10A870	Generic
OXYCODONE HYDROCHLORIDE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN SOLN 5-325 MG/5ML	65990002202005	Brand
TUZISTRA XR	CODEINE POLIST-CHLORPHEN POLIST ER SUSP 14.7-2.8 MG/5ML	43995202 31G120	Brand
HYDROCODONE POLISTIREX/CHLORPHENIRAMINE POLISTIREX	HYDROCOD POLST-CHLORPHEN POLST ER SUSP 10-8 MG/5ML	43995202 36G110	Generic
M-END PE	PHENYLEPHRINE-BROMPHEN W/ CODEINE LIQD 3.33-1.33-6.33 MG/5ML	43995303110916	Brand
POLY-TUSSIN AC	PHENYLEPHRINE-BROMPHEN W/ CODEINE LIQUID 10-4-10 MG/5ML	43995303110935	Generic
CAPCOF	PHENYLEPHRINE-CHLORPHEN W/ CODEINE SYRUP 5-2-10 MG/5ML	43995303141220	Brand

PRO-RED AC	PHENYLEPHRINE-DEXCHLORPHENIR-CODEINE SYRUP 5-1-9 MG/5ML	43995303171220	Brand
MAXI-TUSS CD	PHENYLEPHRINE-CHLORPHEN W/ CODEINE LIQUID 10-4-10 MG/5ML	43995303140913	Generic
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
RYDEX	PSEUDOEPHEDRINE-BROMPHEN-CODEINE LIQ 10-1.33-6.33 MG/5ML	43995303190922	Brand
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
CODITUSSIN AC	GUAIFENESIN-CODEINE LIQUID 200-10 MG/5ML	43997002280945	Generic
MAR-COF CG EXPECTORANT	GUAIFENESIN-CODEINE LIQUID 225-7.5 MG/5ML	43997002280947	Brand
M-CLEAR WC	GUAIFENESIN-CODEINE SOLN 100-6.33 MG/5ML	43997002282018	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

GUAIFENESIN/CODEINE PHOSPHATE	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
CODITUSSIN DAC	PSEUDOEPHEDRINE W/ COD-GG LIQUID 30-10-200 MG/5ML	43997303300938	Generic
TUXARIN ER	CODEINE PHOS-CHLORPHENIRAMINE MALEATE TAB ER 12HR 54.3-8 MG	43995202327430	Brand
TUSNEL C	PSEUDOEPHEDRINE W/ COD-GG SYRUP 30-10-100 MG/5ML	43997303301225	Brand
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

TRAMADOL HCL ER	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
TRAMADOL HCL ER	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 300 MG	65100095107090	Generic
OXYCODONE AND ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-300 MG	65990002200325	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 5 MG	65100075100310	Generic
OXAYDO	OXYCODONE HCL TAB 5 MG	65100075100310	Brand
OXAYDO	OXYCODONE HCL TAB 7.5 MG	65100075100315	Brand
METHADONE HCL	METHADONE HCL INJ 10 MG/ML	65100050102005	Generic
CONZIP	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 100 MG	65100095107070	Generic
CONZIP	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 200 MG	65100095107080	Generic
CONZIP	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 300 MG	65100095107090	Generic
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 25 MG	65100095100310	Generic
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 75 MG	65100095100330	Generic
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 10 MG	6510007510A535	Brand
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 2.5-325 MG	65991702100302	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB ABUSE DETER 5 MG	6510007510A530	Generic

ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 5 MG	6510007510A530	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB ABUSE DETER 15 MG	6510007510A540	Generic
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 15 MG	6510007510A540	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB ABUSE DETER 30 MG	6510007510A560	Generic
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 30 MG	6510007510A560	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 15 MG	6510007510A715	Brand
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 30 MG	6510007510A730	Brand
QDOLO	TRAMADOL HCL ORAL SOLN 5 MG/ML	65100095102005	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Brand

Approval Criteria

1 - The patient has not used Lybalvi (olanzapine/samidorphan) within the past 45 days

2 . Background

Benefit/Coverage/Program Information

Table 1: Planned Taper Schedule for MME Limit Reduction

Date of Reduction	MME Daily Limit
January 1, 2025	400
April 1, 2025	375

July 1, 2025	350
October 1, 2025	325
January 1, 2026	300
April 1, 2026	275
July 1, 2026	250
October 1, 2026	225

3 . Revision History

Date	Notes
12/9/2024	Removed Xtampza ER and Nucynta ER. Added Qdolo. Updated Oxy contin and Roxybond GPIs. Added tramadol 75 mg, hydrocodone/ap ap 2.5/325mg and Oxycodone abuse deterrent tabs. Updated MME t able in background.

Oral Antipsychotics

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-158410
Guideline Name	Oral Antipsychotics
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	12/1/2024

1 . Criteria

Product Name: Prochlorperazine*	
Diagnosis	Nausea and Vomiting
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PROCHLORPERAZINE MALEATE	PROCHLORPERAZINE MALEATE TAB 5 MG (BASE EQUIVALENT)	59200055100305	Generic
PROCHLORPERAZINE MALEATE	PROCHLORPERAZINE MALEATE TAB 10 MG (BASE EQUIVALENT)	59200055100310	Generic

Approval Criteria

1 - Diagnosis of Nausea and Vomiting

Notes	*For all psychiatry-based diagnoses utilize applicable criteria (e.g., Duplicate Therapy, Age Limit Exception)

Product Name: Lybalvi *	
Diagnosis	DDI: Lybalvi + Opioid
Approval Length	12 month(s)
Guideline Type	Drug Utilization Review

Product Name	Generic Name	GPI	Brand/Generic
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

Approval Criteria

1 - ALL of the following:

- Patient is not using opiate agonists (including buprenorphine) concurrently with Lybalvi
- Patient has not used short-acting opiates within the past 7 days prior to initiating Lybalvi therapy
- Patient has not used long-acting opiates within the past 14 days prior to initiating Lybalvi therapy

Notes	*Additional criteria may apply (e.g., Duplicate Therapy, Age Limit Exception)

Product Name: Brand Abilify, Generic aripiprazole (tabs, oral solution, ODT), Abilify Mycite, Generic asenapine, Brand Saphris, Vraylar, Generic clozapine (tab, ODT), Brand Clozaril, Brand Latuda, Generic lurasidone, Brand Zyprexa, Generic olanzapine, Brand Zyprexa Zydis, Generic olanzapine ODT, Generic paliperidone ER, Brand Invega, Brand Seroquel, Generic quetiapine, Brand Seroquel XR, Generic quetiapine ER, Brand Risperdal, Generic risperidone (tabs, ODT), Brand Geodon, Generic ziprasidone, Caplyta, chlorpromazine (tabs, oral conc), fluphenazine (tabs, oral conc, elixir), haloperidol (tabs, oral conc), loxapine, molindone,

perphenazine, perphenazine/amitriptyline, pimozide, thioridazine, thiothixene, trifluoperazine, Fanapt, Generic olanzapine/fluoxetine, Brand Symbyax, Rexulti, Lybalvi, prochlorperazine *	
Diagnosis	Duplicate Therapy with Another Antipsychotic
Therapy Stage	Initial Authorization
Guideline Type	Drug Utilization Review

Product Name	Generic Name	GPI	Brand/Generic
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
SAPHRIS	ASENAPINE MALEATE SL TAB 2.5 MG (BASE EQUIV)	59155015100710	Brand
SAPHRIS	ASENAPINE MALEATE SL TAB 5 MG (BASE EQUIV)	59155015100720	Brand
SAPHRIS	ASENAPINE MALEATE SL TAB 10 MG (BASE EQUIV)	59155015100730	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
VRAYLAR	CARIPRAZINE HCL CAP THERAPY PACK 1.5 MG (1) & 3 MG (6)	5940001810B220	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
CLOZAPINE	CLOZAPINE TAB 25 MG	59152020000320	Generic
CLOZARIL	CLOZAPINE TAB 25 MG	59152020000320	Brand
CLOZAPINE	CLOZAPINE TAB 100 MG	59152020000330	Generic
CLOZARIL	CLOZAPINE TAB 100 MG	59152020000330	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
LATUDA	LURASIDONE HCL TAB 20 MG	59400023100310	Brand
LATUDA	LURASIDONE HCL TAB 40 MG	59400023100320	Brand
LATUDA	LURASIDONE HCL TAB 60 MG	59400023100330	Brand
LATUDA	LURASIDONE HCL TAB 80 MG	59400023100340	Brand
LATUDA	LURASIDONE HCL TAB 120 MG	59400023100350	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
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
OLANZAPINE/FLUOXETINE	OLANZAPINE-FLUOXETINE HCL CAP 3-25 MG	62995002500110	Generic
SYMBYAX	OLANZAPINE-FLUOXETINE HCL CAP 3-25 MG	62995002500110	Brand
OLANZAPINE/FLUOXETINE	OLANZAPINE-FLUOXETINE HCL CAP 6-25 MG	62995002500120	Generic
SYMBYAX	OLANZAPINE-FLUOXETINE HCL CAP 6-25 MG	62995002500120	Brand
OLANZAPINE/FLUOXETINE	OLANZAPINE-FLUOXETINE HCL CAP 6-50 MG	62995002500125	Generic
OLANZAPINE/FLUOXETINE	OLANZAPINE-FLUOXETINE HCL CAP 12-25 MG	62995002500140	Generic
OLANZAPINE/FLUOXETINE	OLANZAPINE-FLUOXETINE HCL CAP 12-50 MG	62995002500145	Generic
PALIPERIDONE ER	PALIPERIDONE TAB ER 24HR 1.5 MG	59070050007505	Generic

INVEGA	PALIPERIDONE TAB ER 24HR 1.5 MG	59070050007505	Brand
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
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
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
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
RISPERIDONE	RISPERIDONE TAB 0.25 MG	59070070000303	Generic
RISPERIDONE	RISPERIDONE TAB 0.5 MG	59070070000306	Generic
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 0.5 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
GEODON	ZIPRASIDONE HCL CAP 20 MG	59400085100120	Brand
ZIPRASIDONE HCL	ZIPRASIDONE HCL CAP 20 MG	59400085100120	Generic
GEODON	ZIPRASIDONE HCL CAP 40 MG	59400085100130	Brand
ZIPRASIDONE HCL	ZIPRASIDONE HCL CAP 40 MG	59400085100130	Generic

GEODON	ZIPRASIDONE HCL CAP 60 MG	59400085100140	Brand
ZIPRASIDONE HCL	ZIPRASIDONE HCL CAP 60 MG	59400085100140	Generic
GEODON	ZIPRASIDONE HCL CAP 80 MG	59400085100150	Brand
ZIPRASIDONE HCL	ZIPRASIDONE HCL CAP 80 MG	59400085100150	Generic
CHLORPROMAZINE HCL	CHLORPROMAZINE HCL TAB 10 MG	59200015100305	Generic
CHLORPROMAZINE HCL	CHLORPROMAZINE HCL TAB 25 MG	59200015100310	Generic
CHLORPROMAZINE HCL	CHLORPROMAZINE HCL TAB 50 MG	59200015100315	Generic
CHLORPROMAZINE HCL	CHLORPROMAZINE HCL TAB 100 MG	59200015100320	Generic
CHLORPROMAZINE HCL	CHLORPROMAZINE HCL TAB 200 MG	59200015100325	Generic
FLUPHENAZINE HCL	FLUPHENAZINE HCL TAB 1 MG	59200025100305	Generic
FLUPHENAZINE HCL	FLUPHENAZINE HCL TAB 2.5 MG	59200025100310	Generic
FLUPHENAZINE HCL	FLUPHENAZINE HCL TAB 5 MG	59200025100315	Generic
FLUPHENAZINE HCL	FLUPHENAZINE HCL TAB 10 MG	59200025100320	Generic
FLUPHENAZINE HCL	FLUPHENAZINE HCL ORAL CONC 5 MG/ML	59200025101320	Generic
HALOPERIDOL	HALOPERIDOL TAB 0.5 MG	59100010100305	Generic
HALOPERIDOL	HALOPERIDOL TAB 1 MG	59100010100310	Generic
HALOPERIDOL	HALOPERIDOL TAB 2 MG	59100010100315	Generic
HALOPERIDOL	HALOPERIDOL TAB 5 MG	59100010100320	Generic
HALOPERIDOL	HALOPERIDOL TAB 10 MG	59100010100325	Generic
HALOPERIDOL	HALOPERIDOL TAB 20 MG	59100010100330	Generic
HALOPERIDOL	HALOPERIDOL LACTATE ORAL CONC 2 MG/ML	59100010201305	Generic
LOXAPINE	LOXAPINE SUCCINATE CAP 5 MG	59154020200105	Generic
LOXAPINE SUCCINATE	LOXAPINE SUCCINATE CAP 5 MG	59154020200105	Generic
LOXAPINE	LOXAPINE SUCCINATE CAP 10 MG	59154020200110	Generic
LOXAPINE SUCCINATE	LOXAPINE SUCCINATE CAP 10 MG	59154020200110	Generic
LOXAPINE	LOXAPINE SUCCINATE CAP 25 MG	59154020200115	Generic

LOXAPINE SUCCINATE	LOXAPINE SUCCINATE CAP 25 MG	59154020200115	Generic
LOXAPINE	LOXAPINE SUCCINATE CAP 50 MG	59154020200120	Generic
LOXAPINE SUCCINATE	LOXAPINE SUCCINATE CAP 50 MG	59154020200120	Generic
PERPHENAZINE	PERPHENAZINE TAB 2 MG	59200045000305	Generic
PERPHENAZINE	PERPHENAZINE TAB 4 MG	59200045000310	Generic
PERPHENAZINE	PERPHENAZINE TAB 8 MG	59200045000315	Generic
PERPHENAZINE	PERPHENAZINE TAB 16 MG	59200045000320	Generic
PERPHENAZINE/AMITRIPTYLINE	PERPHENAZINE-AMITRIPTYLINE TAB 2-10 MG	62994002600310	Generic
PERPHENAZINE/AMITRIPTYLINE	PERPHENAZINE-AMITRIPTYLINE TAB 2-25 MG	62994002600315	Generic
PERPHENAZINE/AMITRIPTYLINE	PERPHENAZINE-AMITRIPTYLINE TAB 4-10 MG	62994002600320	Generic
PERPHENAZINE/AMITRIPTYLINE	PERPHENAZINE-AMITRIPTYLINE TAB 4-25 MG	62994002600325	Generic
PERPHENAZINE/AMITRIPTYLINE	PERPHENAZINE-AMITRIPTYLINE TAB 4-50 MG	62994002600330	Generic
PIMOZIDE	PIMOZIDE TAB 1 MG	62000030000303	Generic
PIMOZIDE	PIMOZIDE TAB 2 MG	62000030000305	Generic
THIORIDAZINE HCL	THIORIDAZINE HCL TAB 10 MG	59200080100305	Generic
THIORIDAZINE HCL	THIORIDAZINE HCL TAB 25 MG	59200080100315	Generic
THIORIDAZINE HCL	THIORIDAZINE HCL TAB 50 MG	59200080100320	Generic
THIORIDAZINE HCL	THIORIDAZINE HCL TAB 100 MG	59200080100325	Generic
THIOTHIXENE	THIOTHIXENE CAP 1 MG	59300020100105	Generic
THIOTHIXENE	THIOTHIXENE CAP 2 MG	59300020100110	Generic
THIOTHIXENE	THIOTHIXENE CAP 5 MG	59300020100115	Generic
THIOTHIXENE	THIOTHIXENE CAP 10 MG	59300020100120	Generic
TRIFLUOPERAZINE HCL	TRIFLUOPERAZINE HCL TAB 1 MG (BASE EQUIVALENT)	59200085100305	Generic
TRIFLUOPERAZINE HCL	TRIFLUOPERAZINE HCL TAB 2 MG (BASE EQUIVALENT)	59200085100310	Generic
TRIFLUOPERAZINE HCL	TRIFLUOPERAZINE HCL TAB 5 MG (BASE EQUIVALENT)	59200085100315	Generic
TRIFLUOPERAZINE HCL	TRIFLUOPERAZINE HCL TAB 10 MG (BASE EQUIVALENT)	59200085100320	Generic
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
ARIPIPRAZOLE	ARIPIPRAZOLE ORAL SOLUTION 1 MG/ML	59250015002020	Generic
ARIPIPRAZOLE ODT	ARIPIPRAZOLE ORALLY DISINTEGRATING TAB 10 MG	59250015007220	Generic
ARIPIPRAZOLE ODT	ARIPIPRAZOLE ORALLY DISINTEGRATING TAB 15 MG	59250015007230	Generic
CAPLYTA	LUMATEPERONE TOSYLATE CAP 42 MG	59400022400120	Brand
CLOZAPINE	CLOZAPINE TAB 50 MG	59152020000325	Generic
CLOZARIL	CLOZAPINE TAB 50 MG	59152020000325	Brand
CLOZAPINE	CLOZAPINE TAB 200 MG	59152020000340	Generic
CLOZARIL	CLOZAPINE TAB 200 MG	59152020000340	Brand
RISPERIDONE ODT	RISPERIDONE ORALLY DISINTEGRATING TAB 0.25 MG	59070070007210	Generic
ASENAPINE MALEATE SL	ASENAPINE MALEATE SL TAB 2.5 MG (BASE EQUIV)	59155015100710	Generic
ASENAPINE MALEATE SL	ASENAPINE MALEATE SL TAB 5 MG (BASE EQUIV)	59155015100720	Generic
ASENAPINE MALEATE SL	ASENAPINE MALEATE SL TAB 10 MG (BASE EQUIV)	59155015100730	Generic
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
FLUPHENAZINE HYDROCHLORIDE	FLUPHENAZINE HCL ELIXIR 2.5 MG/5ML	59200025101005	Generic
CAPLYTA	LUMATEPERONE TOSYLATE CAP 10.5 MG	59400022400110	Brand
CAPLYTA	LUMATEPERONE TOSYLATE CAP 21 MG	59400022400115	Brand
CHLORPROMAZINE HYDROCHLORIDE	CHLORPROMAZINE HCL CONC 30 MG/ML	59200015101305	Generic
CHLORPROMAZINE HYDROCHLORIDE	CHLORPROMAZINE HCL CONC 100 MG/ML	59200015101310	Generic
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
PROCHLORPERAZINE MALEATE	PROCHLORPERAZINE MALEATE TAB 5 MG (BASE EQUIVALENT)	59200055100305	Generic
PROCHLORPERAZINE MALEATE	PROCHLORPERAZINE MALEATE TAB 10 MG (BASE EQUIVALENT)	59200055100310	Generic
LURASIDONE HYDROCHLORIDE	LURASIDONE HCL TAB 20 MG	59400023100310	Generic
LURASIDONE HYDROCHLORIDE	LURASIDONE HCL TAB 40 MG	59400023100320	Generic
LURASIDONE HYDROCHLORIDE	LURASIDONE HCL TAB 60 MG	59400023100330	Generic
LURASIDONE HYDROCHLORIDE	LURASIDONE HCL TAB 80 MG	59400023100340	Generic
LURASIDONE HYDROCHLORIDE	LURASIDONE HCL TAB 120 MG	59400023100350	Generic
QUETIAPINE FUMARATE	QUETIAPINE FUMARATE TAB 150 MG	59153070100325	Generic

CHLORPROMAZINE HYDROCHLORIDE	CHLORPROMAZINE HCL TAB 10 MG	59200015100305	Generic
CHLORPROMAZINE HYDROCHLORIDE	CHLORPROMAZINE HCL TAB 25 MG	59200015100310	Generic
CHLORPROMAZINE HYDROCHLORIDE	CHLORPROMAZINE HCL TAB 50 MG	59200015100315	Generic
CHLORPROMAZINE HYDROCHLORIDE	CHLORPROMAZINE HCL TAB 100 MG	59200015100320	Generic
CHLORPROMAZINE HYDROCHLORIDE	CHLORPROMAZINE HCL TAB 200 MG	59200015100325	Generic
FLUPHENAZINE HYDROCHLORIDE	FLUPHENAZINE HCL TAB 1 MG	59200025100305	Generic
FLUPHENAZINE HYDROCHLORIDE	FLUPHENAZINE HCL TAB 2.5 MG	59200025100310	Generic
FLUPHENAZINE HYDROCHLORIDE	FLUPHENAZINE HCL TAB 5 MG	59200025100315	Generic
FLUPHENAZINE HYDROCHLORIDE	FLUPHENAZINE HCL TAB 10 MG	59200025100320	Generic
TRIFLUOPERAZINE HYDROCHLORIDE	TRIFLUOPERAZINE HCL TAB 1 MG (BASE EQUIVALENT)	59200085100305	Generic
TRIFLUOPERAZINE HYDROCHLORIDE	TRIFLUOPERAZINE HCL TAB 2 MG (BASE EQUIVALENT)	59200085100310	Generic
TRIFLUOPERAZINE HYDROCHLORIDE	TRIFLUOPERAZINE HCL TAB 5 MG (BASE EQUIVALENT)	59200085100315	Generic
TRIFLUOPERAZINE HYDROCHLORIDE	TRIFLUOPERAZINE HCL TAB 10 MG (BASE EQUIVALENT)	59200085100320	Generic
ZIPRASIDONE HYDROCHLORIDE	ZIPRASIDONE HCL CAP 20 MG	59400085100120	Generic
ZIPRASIDONE HYDROCHLORIDE	ZIPRASIDONE HCL CAP 40 MG	59400085100130	Generic
ZIPRASIDONE HYDROCHLORIDE	ZIPRASIDONE HCL CAP 60 MG	59400085100140	Generic
ZIPRASIDONE HYDROCHLORIDE	ZIPRASIDONE HCL CAP 80 MG	59400085100150	Generic

Approval Criteria

1 - ONE of the following:

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

OR

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

AND

2 - One of the following:

2.1 The patient will be utilizing the requested antipsychotic as monotherapy

OR

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

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

OR

2.2.2 All of the following:

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

OR

2.3 All of the following:

2.3.1 Diagnosis of depressed mood disorder

AND

2.3.2 BOTH of the following:

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

AND

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

AND

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

OR

2.4 ALL of the following:

2.4.1 Diagnosis of ONE of the following:

- Bipolar affective disorder
- Unspecified episodic mood disorder

AND

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

AND

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

OR

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

AND

3 - Patient is not utilizing more than 2 antipsychotics concurrently

Notes	*Approval Length – 90 days for cross taper, 4 months for patients new to antipsychotic therapy, 6 months for initial approval and not new to antipsychotic therapy

Product Name: Brand Abilify, Generic aripiprazole (tabs, oral solution, ODT), Abilify Mycite, Generic asenapine, Brand Saphris, Vraylar, Generic clozapine (tab, ODT), Brand Clozaril, Brand Latuda, Generic lurasidone, Brand Zyprexa, Generic olanzapine, Brand Zyprexa Zydis, Generic olanzapine ODT, Generic paliperidone ER, Brand Invega, Brand Seroquel, Generic quetiapine, Brand Seroquel XR, Generic quetiapine ER, Brand Risperdal, Generic risperidone (tabs, ODT), Brand Geodon, Generic ziprasidone, Caplyta, chlorpromazine (tabs, oral conc), fluphenazine (tabs, oral conc, elixir), haloperidol (tabs, oral conc), loxapine, molindone, perphenazine, perphenazine/amitriptyline, pimozide, thioridazine, thiothixene, trifluoperazine, Fanapt, Generic olanzapine/fluoxetine, Brand Symbyax, Rexulti, Lybalvi, prochlorperazine

Diagnosis	Duplicate Therapy with Another Antipsychotic
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Drug Utilization Review

Product Name	Generic Name	GPI	Brand/Generic
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
SAPHRIS	ASENAPINE MALEATE SL TAB 2.5 MG (BASE EQUIV)	59155015100710	Brand
SAPHRIS	ASENAPINE MALEATE SL TAB 5 MG (BASE EQUIV)	59155015100720	Brand
SAPHRIS	ASENAPINE MALEATE SL TAB 10 MG (BASE EQUIV)	59155015100730	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
VRAYLAR	CARIPRAZINE HCL CAP THERAPY PACK 1.5 MG (1) & 3 MG (6)	5940001810B220	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
CLOZAPINE	CLOZAPINE TAB 25 MG	59152020000320	Generic
CLOZARIL	CLOZAPINE TAB 25 MG	59152020000320	Brand
CLOZAPINE	CLOZAPINE TAB 100 MG	59152020000330	Generic
CLOZARIL	CLOZAPINE TAB 100 MG	59152020000330	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
LATUDA	LURASIDONE HCL TAB 20 MG	59400023100310	Brand
LATUDA	LURASIDONE HCL TAB 40 MG	59400023100320	Brand
LATUDA	LURASIDONE HCL TAB 60 MG	59400023100330	Brand
LATUDA	LURASIDONE HCL TAB 80 MG	59400023100340	Brand
LATUDA	LURASIDONE HCL TAB 120 MG	59400023100350	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
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
OLANZAPINE/FLUOXETINE	OLANZAPINE-FLUOXETINE HCL CAP 3-25 MG	62995002500110	Generic
SYMBYAX	OLANZAPINE-FLUOXETINE HCL CAP 3-25 MG	62995002500110	Brand
OLANZAPINE/FLUOXETINE	OLANZAPINE-FLUOXETINE HCL CAP 6-25 MG	62995002500120	Generic
SYMBYAX	OLANZAPINE-FLUOXETINE HCL CAP 6-25 MG	62995002500120	Brand
OLANZAPINE/FLUOXETINE	OLANZAPINE-FLUOXETINE HCL CAP 6-50 MG	62995002500125	Generic
OLANZAPINE/FLUOXETINE	OLANZAPINE-FLUOXETINE HCL CAP 12-25 MG	62995002500140	Generic
OLANZAPINE/FLUOXETINE	OLANZAPINE-FLUOXETINE HCL CAP 12-50 MG	62995002500145	Generic
PALIPERIDONE ER	PALIPERIDONE TAB ER 24HR 1.5 MG	59070050007505	Generic
INVEGA	PALIPERIDONE TAB ER 24HR 1.5 MG	59070050007505	Brand
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
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
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
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
RISPERIDONE	RISPERIDONE TAB 0.25 MG	59070070000303	Generic
RISPERIDONE	RISPERIDONE TAB 0.5 MG	59070070000306	Generic
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 0.5 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
GEODON	ZIPRASIDONE HCL CAP 20 MG	59400085100120	Brand
ZIPRASIDONE HCL	ZIPRASIDONE HCL CAP 20 MG	59400085100120	Generic
GEODON	ZIPRASIDONE HCL CAP 40 MG	59400085100130	Brand
ZIPRASIDONE HCL	ZIPRASIDONE HCL CAP 40 MG	59400085100130	Generic
GEODON	ZIPRASIDONE HCL CAP 60 MG	59400085100140	Brand
ZIPRASIDONE HCL	ZIPRASIDONE HCL CAP 60 MG	59400085100140	Generic
GEODON	ZIPRASIDONE HCL CAP 80 MG	59400085100150	Brand
ZIPRASIDONE HCL	ZIPRASIDONE HCL CAP 80 MG	59400085100150	Generic
CHLORPROMAZINE HCL	CHLORPROMAZINE HCL TAB 10 MG	59200015100305	Generic
CHLORPROMAZINE HCL	CHLORPROMAZINE HCL TAB 25 MG	59200015100310	Generic
CHLORPROMAZINE HCL	CHLORPROMAZINE HCL TAB 50 MG	59200015100315	Generic
CHLORPROMAZINE HCL	CHLORPROMAZINE HCL TAB 100 MG	59200015100320	Generic
CHLORPROMAZINE HCL	CHLORPROMAZINE HCL TAB 200 MG	59200015100325	Generic
FLUPHENAZINE HCL	FLUPHENAZINE HCL TAB 1 MG	59200025100305	Generic
FLUPHENAZINE HCL	FLUPHENAZINE HCL TAB 2.5 MG	59200025100310	Generic

FLUPHENAZINE HCL	FLUPHENAZINE HCL TAB 5 MG	59200025100315	Generic
FLUPHENAZINE HCL	FLUPHENAZINE HCL TAB 10 MG	59200025100320	Generic
FLUPHENAZINE HCL	FLUPHENAZINE HCL ORAL CONC 5 MG/ML	59200025101320	Generic
HALOPERIDOL	HALOPERIDOL TAB 0.5 MG	59100010100305	Generic
HALOPERIDOL	HALOPERIDOL TAB 1 MG	59100010100310	Generic
HALOPERIDOL	HALOPERIDOL TAB 2 MG	59100010100315	Generic
HALOPERIDOL	HALOPERIDOL TAB 5 MG	59100010100320	Generic
HALOPERIDOL	HALOPERIDOL TAB 10 MG	59100010100325	Generic
HALOPERIDOL	HALOPERIDOL TAB 20 MG	59100010100330	Generic
HALOPERIDOL	HALOPERIDOL LACTATE ORAL CONC 2 MG/ML	59100010201305	Generic
LOXAPINE	LOXAPINE SUCCINATE CAP 5 MG	59154020200105	Generic
LOXAPINE SUCCINATE	LOXAPINE SUCCINATE CAP 5 MG	59154020200105	Generic
LOXAPINE	LOXAPINE SUCCINATE CAP 10 MG	59154020200110	Generic
LOXAPINE SUCCINATE	LOXAPINE SUCCINATE CAP 10 MG	59154020200110	Generic
LOXAPINE	LOXAPINE SUCCINATE CAP 25 MG	59154020200115	Generic
LOXAPINE SUCCINATE	LOXAPINE SUCCINATE CAP 25 MG	59154020200115	Generic
LOXAPINE	LOXAPINE SUCCINATE CAP 50 MG	59154020200120	Generic
LOXAPINE SUCCINATE	LOXAPINE SUCCINATE CAP 50 MG	59154020200120	Generic
PERPHENAZINE	PERPHENAZINE TAB 2 MG	59200045000305	Generic
PERPHENAZINE	PERPHENAZINE TAB 4 MG	59200045000310	Generic
PERPHENAZINE	PERPHENAZINE TAB 8 MG	59200045000315	Generic
PERPHENAZINE	PERPHENAZINE TAB 16 MG	59200045000320	Generic
PERPHENAZINE/AMITRIPTYLINE	PERPHENAZINE-AMITRIPTYLINE TAB 2-10 MG	62994002600310	Generic
PERPHENAZINE/AMITRIPTYLINE	PERPHENAZINE-AMITRIPTYLINE TAB 2-25 MG	62994002600315	Generic
PERPHENAZINE/AMITRIPTYLINE	PERPHENAZINE-AMITRIPTYLINE TAB 4-10 MG	62994002600320	Generic
PERPHENAZINE/AMITRIPTYLINE	PERPHENAZINE-AMITRIPTYLINE TAB 4-25 MG	62994002600325	Generic

PERPHENAZINE/AMITRIPTYLINE	PERPHENAZINE-AMITRIPTYLINE TAB 4-50 MG	62994002600330	Generic
PIMOZIDE	PIMOZIDE TAB 1 MG	62000030000303	Generic
PIMOZIDE	PIMOZIDE TAB 2 MG	62000030000305	Generic
THIORIDAZINE HCL	THIORIDAZINE HCL TAB 10 MG	59200080100305	Generic
THIORIDAZINE HCL	THIORIDAZINE HCL TAB 25 MG	59200080100315	Generic
THIORIDAZINE HCL	THIORIDAZINE HCL TAB 50 MG	59200080100320	Generic
THIORIDAZINE HCL	THIORIDAZINE HCL TAB 100 MG	59200080100325	Generic
THIOTHIXENE	THIOTHIXENE CAP 1 MG	59300020100105	Generic
THIOTHIXENE	THIOTHIXENE CAP 2 MG	59300020100110	Generic
THIOTHIXENE	THIOTHIXENE CAP 5 MG	59300020100115	Generic
THIOTHIXENE	THIOTHIXENE CAP 10 MG	59300020100120	Generic
TRIFLUOPERAZINE HCL	TRIFLUOPERAZINE HCL TAB 1 MG (BASE EQUIVALENT)	59200085100305	Generic
TRIFLUOPERAZINE HCL	TRIFLUOPERAZINE HCL TAB 2 MG (BASE EQUIVALENT)	59200085100310	Generic
TRIFLUOPERAZINE HCL	TRIFLUOPERAZINE HCL TAB 5 MG (BASE EQUIVALENT)	59200085100315	Generic
TRIFLUOPERAZINE HCL	TRIFLUOPERAZINE HCL TAB 10 MG (BASE EQUIVALENT)	59200085100320	Generic
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
ARIPIPRAZOLE	ARIPIPRAZOLE ORAL SOLUTION 1 MG/ML	59250015002020	Generic
ARIPIPRAZOLE ODT	ARIPIPRAZOLE ORALLY DISINTEGRATING TAB 10 MG	59250015007220	Generic
ARIPIPRAZOLE ODT	ARIPIPRAZOLE ORALLY DISINTEGRATING TAB 15 MG	59250015007230	Generic
CAPLYTA	LUMATEPERONE TOSYLATE CAP 42 MG	59400022400120	Brand
CLOZAPINE	CLOZAPINE TAB 50 MG	59152020000325	Generic
CLOZARIL	CLOZAPINE TAB 50 MG	59152020000325	Brand
CLOZAPINE	CLOZAPINE TAB 200 MG	59152020000340	Generic
CLOZARIL	CLOZAPINE TAB 200 MG	59152020000340	Brand
RISPERIDONE ODT	RISPERIDONE ORALLY DISINTEGRATING TAB 0.25 MG	59070070007210	Generic

ASENAPINE MALEATE SL	ASENAPINE MALEATE SL TAB 2.5 MG (BASE EQUIV)	59155015100710	Generic
ASENAPINE MALEATE SL	ASENAPINE MALEATE SL TAB 5 MG (BASE EQUIV)	59155015100720	Generic
ASENAPINE MALEATE SL	ASENAPINE MALEATE SL TAB 10 MG (BASE EQUIV)	59155015100730	Generic
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
FLUPHENAZINE HYDROCHLORIDE	FLUPHENAZINE HCL ELIXIR 2.5 MG/5ML	59200025101005	Generic
CAPLYTA	LUMATEPERONE TOSYLATE CAP 10.5 MG	59400022400110	Brand
CAPLYTA	LUMATEPERONE TOSYLATE CAP 21 MG	59400022400115	Brand
CHLORPROMAZINE HYDROCHLORIDE	CHLORPROMAZINE HCL CONC 30 MG/ML	59200015101305	Generic
CHLORPROMAZINE HYDROCHLORIDE	CHLORPROMAZINE HCL CONC 100 MG/ML	59200015101310	Generic
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
PROCHLORPERAZINE MALEATE	PROCHLORPERAZINE MALEATE TAB 5 MG (BASE EQUIVALENT)	59200055100305	Generic
PROCHLORPERAZINE MALEATE	PROCHLORPERAZINE MALEATE TAB 10 MG (BASE EQUIVALENT)	59200055100310	Generic
LURASIDONE HYDROCHLORIDE	LURASIDONE HCL TAB 20 MG	59400023100310	Generic
LURASIDONE HYDROCHLORIDE	LURASIDONE HCL TAB 40 MG	59400023100320	Generic
LURASIDONE HYDROCHLORIDE	LURASIDONE HCL TAB 60 MG	59400023100330	Generic
LURASIDONE HYDROCHLORIDE	LURASIDONE HCL TAB 80 MG	59400023100340	Generic
LURASIDONE HYDROCHLORIDE	LURASIDONE HCL TAB 120 MG	59400023100350	Generic
QUETIAPINE FUMARATE	QUETIAPINE FUMARATE TAB 150 MG	59153070100325	Generic
CHLORPROMAZINE HYDROCHLORIDE	CHLORPROMAZINE HCL TAB 10 MG	59200015100305	Generic
CHLORPROMAZINE HYDROCHLORIDE	CHLORPROMAZINE HCL TAB 25 MG	59200015100310	Generic
CHLORPROMAZINE HYDROCHLORIDE	CHLORPROMAZINE HCL TAB 50 MG	59200015100315	Generic
CHLORPROMAZINE HYDROCHLORIDE	CHLORPROMAZINE HCL TAB 100 MG	59200015100320	Generic
CHLORPROMAZINE HYDROCHLORIDE	CHLORPROMAZINE HCL TAB 200 MG	59200015100325	Generic
FLUPHENAZINE HYDROCHLORIDE	FLUPHENAZINE HCL TAB 1 MG	59200025100305	Generic
FLUPHENAZINE HYDROCHLORIDE	FLUPHENAZINE HCL TAB 2.5 MG	59200025100310	Generic
FLUPHENAZINE HYDROCHLORIDE	FLUPHENAZINE HCL TAB 5 MG	59200025100315	Generic
FLUPHENAZINE HYDROCHLORIDE	FLUPHENAZINE HCL TAB 10 MG	59200025100320	Generic
TRIFLUOPERAZINE HYDROCHLORIDE	TRIFLUOPERAZINE HCL TAB 1 MG (BASE EQUIVALENT)	59200085100305	Generic

TRIFLUOPERAZINE HYDROCHLORIDE	TRIFLUOPERAZINE HCL TAB 2 MG (BASE EQUIVALENT)	59200085100310	Generic
TRIFLUOPERAZINE HYDROCHLORIDE	TRIFLUOPERAZINE HCL TAB 5 MG (BASE EQUIVALENT)	59200085100315	Generic
TRIFLUOPERAZINE HYDROCHLORIDE	TRIFLUOPERAZINE HCL TAB 10 MG (BASE EQUIVALENT)	59200085100320	Generic
ZIPRASIDONE HYDROCHLORIDE	ZIPRASIDONE HCL CAP 20 MG	59400085100120	Generic
ZIPRASIDONE HYDROCHLORIDE	ZIPRASIDONE HCL CAP 40 MG	59400085100130	Generic
ZIPRASIDONE HYDROCHLORIDE	ZIPRASIDONE HCL CAP 60 MG	59400085100140	Generic
ZIPRASIDONE HYDROCHLORIDE	ZIPRASIDONE HCL CAP 80 MG	59400085100150	Generic

Approval Criteria

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

AND

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

AND

3 - One of the following:

3.1 The patient will be utilizing the requested antipsychotic as monotherapy

OR

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

AND

4 - Patient is not utilizing more than 2 antipsychotics concurrently

Product Name: (ALL Antipsychotics), Brand Abilify, Generic aripiprazole (tabs, oral solution, ODT), Abilify Mycite, Generic asenapine, Brand Saphris, Vraylar, Generic clozapine (tab, ODT), Brand Clozaril, Cobenfy, Brand Latuda, Generic lurasidone, Brand Zyprexa, Generic olanzapine, Brand Zyprexa Zydis, Generic olanzapine ODT, Generic paliperidone ER, Brand Invega, Brand Seroquel, Generic quetiapine, Brand Seroquel XR, Generic quetiapine ER, Brand Risperdal, Generic risperidone (tabs, ODT), Brand Geodon, Generic ziprasidone, Caplyta, chlorpromazine (tabs, oral conc), fluphenazine (tabs, oral conc, elixir), haloperidol (tabs, oral conc), loxapine, molindone, perphenazine, perphenazine/amitriptyline, pimozide, thioridazine, thiothixene, trifluoperazine, Fanapt, Generic olanzapine/fluoxetine, Brand Symbyax, Rexulti, Lybalvi, prochlorperazine

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

Product Name	Generic Name	GPI	Brand/Generic
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
SAPHRIS	ASENAPINE MALEATE SL TAB 2.5 MG (BASE EQUIV)	59155015100710	Brand
SAPHRIS	ASENAPINE MALEATE SL TAB 5 MG (BASE EQUIV)	59155015100720	Brand

SAPHRIS	ASENAPINE MALEATE SL TAB 10 MG (BASE EQUIV)	59155015100730	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
VRAYLAR	CARIPRAZINE HCL CAP THERAPY PACK 1.5 MG (1) & 3 MG (6)	5940001810B220	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
CLOZAPINE	CLOZAPINE TAB 25 MG	59152020000320	Generic
CLOZARIL	CLOZAPINE TAB 25 MG	59152020000320	Brand
CLOZAPINE	CLOZAPINE TAB 100 MG	59152020000330	Generic
CLOZARIL	CLOZAPINE TAB 100 MG	59152020000330	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
LATUDA	LURASIDONE HCL TAB 20 MG	59400023100310	Brand
LATUDA	LURASIDONE HCL TAB 40 MG	59400023100320	Brand
LATUDA	LURASIDONE HCL TAB 60 MG	59400023100330	Brand
LATUDA	LURASIDONE HCL TAB 80 MG	59400023100340	Brand
LATUDA	LURASIDONE HCL TAB 120 MG	59400023100350	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
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

OLANZAPINE/FLUOXETINE	OLANZAPINE-FLUOXETINE HCL CAP 3-25 MG	62995002500110	Generic
SYMBYAX	OLANZAPINE-FLUOXETINE HCL CAP 3-25 MG	62995002500110	Brand
OLANZAPINE/FLUOXETINE	OLANZAPINE-FLUOXETINE HCL CAP 6-25 MG	62995002500120	Generic
SYMBYAX	OLANZAPINE-FLUOXETINE HCL CAP 6-25 MG	62995002500120	Brand
OLANZAPINE/FLUOXETINE	OLANZAPINE-FLUOXETINE HCL CAP 6-50 MG	62995002500125	Generic
OLANZAPINE/FLUOXETINE	OLANZAPINE-FLUOXETINE HCL CAP 12-25 MG	62995002500140	Generic
OLANZAPINE/FLUOXETINE	OLANZAPINE-FLUOXETINE HCL CAP 12-50 MG	62995002500145	Generic
PALIPERIDONE ER	PALIPERIDONE TAB ER 24HR 1.5 MG	59070050007505	Generic
INVEGA	PALIPERIDONE TAB ER 24HR 1.5 MG	59070050007505	Brand
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
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
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
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
RISPERIDONE	RISPERIDONE TAB 0.25 MG	59070070000303	Generic
RISPERIDONE	RISPERIDONE TAB 0.5 MG	59070070000306	Generic
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 0.5 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
GEODON	ZIPRASIDONE HCL CAP 20 MG	59400085100120	Brand
ZIPRASIDONE HCL	ZIPRASIDONE HCL CAP 20 MG	59400085100120	Generic
GEODON	ZIPRASIDONE HCL CAP 40 MG	59400085100130	Brand
ZIPRASIDONE HCL	ZIPRASIDONE HCL CAP 40 MG	59400085100130	Generic
GEODON	ZIPRASIDONE HCL CAP 60 MG	59400085100140	Brand
ZIPRASIDONE HCL	ZIPRASIDONE HCL CAP 60 MG	59400085100140	Generic
GEODON	ZIPRASIDONE HCL CAP 80 MG	59400085100150	Brand
ZIPRASIDONE HCL	ZIPRASIDONE HCL CAP 80 MG	59400085100150	Generic
CHLORPROMAZINE HCL	CHLORPROMAZINE HCL TAB 10 MG	59200015100305	Generic
CHLORPROMAZINE HCL	CHLORPROMAZINE HCL TAB 25 MG	59200015100310	Generic
CHLORPROMAZINE HCL	CHLORPROMAZINE HCL TAB 50 MG	59200015100315	Generic
CHLORPROMAZINE HCL	CHLORPROMAZINE HCL TAB 100 MG	59200015100320	Generic
CHLORPROMAZINE HCL	CHLORPROMAZINE HCL TAB 200 MG	59200015100325	Generic
FLUPHENAZINE HCL	FLUPHENAZINE HCL TAB 1 MG	59200025100305	Generic
FLUPHENAZINE HCL	FLUPHENAZINE HCL TAB 2.5 MG	59200025100310	Generic
FLUPHENAZINE HCL	FLUPHENAZINE HCL TAB 5 MG	59200025100315	Generic
FLUPHENAZINE HCL	FLUPHENAZINE HCL TAB 10 MG	59200025100320	Generic
FLUPHENAZINE HCL	FLUPHENAZINE HCL ORAL CONC 5 MG/ML	59200025101320	Generic
HALOPERIDOL	HALOPERIDOL TAB 0.5 MG	59100010100305	Generic
HALOPERIDOL	HALOPERIDOL TAB 1 MG	59100010100310	Generic
HALOPERIDOL	HALOPERIDOL TAB 2 MG	59100010100315	Generic

HALOPERIDOL	HALOPERIDOL TAB 5 MG	59100010100320	Generic
HALOPERIDOL	HALOPERIDOL TAB 10 MG	59100010100325	Generic
HALOPERIDOL	HALOPERIDOL TAB 20 MG	59100010100330	Generic
HALOPERIDOL	HALOPERIDOL LACTATE ORAL CONC 2 MG/ML	59100010201305	Generic
LOXAPINE	LOXAPINE SUCCINATE CAP 5 MG	59154020200105	Generic
LOXAPINE SUCCINATE	LOXAPINE SUCCINATE CAP 5 MG	59154020200105	Generic
LOXAPINE	LOXAPINE SUCCINATE CAP 10 MG	59154020200110	Generic
LOXAPINE SUCCINATE	LOXAPINE SUCCINATE CAP 10 MG	59154020200110	Generic
LOXAPINE	LOXAPINE SUCCINATE CAP 25 MG	59154020200115	Generic
LOXAPINE SUCCINATE	LOXAPINE SUCCINATE CAP 25 MG	59154020200115	Generic
LOXAPINE	LOXAPINE SUCCINATE CAP 50 MG	59154020200120	Generic
LOXAPINE SUCCINATE	LOXAPINE SUCCINATE CAP 50 MG	59154020200120	Generic
PERPHENAZINE	PERPHENAZINE TAB 2 MG	59200045000305	Generic
PERPHENAZINE	PERPHENAZINE TAB 4 MG	59200045000310	Generic
PERPHENAZINE	PERPHENAZINE TAB 8 MG	59200045000315	Generic
PERPHENAZINE	PERPHENAZINE TAB 16 MG	59200045000320	Generic
PERPHENAZINE/AMITRIPTYLINE	PERPHENAZINE-AMITRIPTYLINE TAB 2-10 MG	62994002600310	Generic
PERPHENAZINE/AMITRIPTYLINE	PERPHENAZINE-AMITRIPTYLINE TAB 2-25 MG	62994002600315	Generic
PERPHENAZINE/AMITRIPTYLINE	PERPHENAZINE-AMITRIPTYLINE TAB 4-10 MG	62994002600320	Generic
PERPHENAZINE/AMITRIPTYLINE	PERPHENAZINE-AMITRIPTYLINE TAB 4-25 MG	62994002600325	Generic
PERPHENAZINE/AMITRIPTYLINE	PERPHENAZINE-AMITRIPTYLINE TAB 4-50 MG	62994002600330	Generic
PIMOZIDE	PIMOZIDE TAB 1 MG	62000030000303	Generic
PIMOZIDE	PIMOZIDE TAB 2 MG	62000030000305	Generic
THIORIDAZINE HCL	THIORIDAZINE HCL TAB 10 MG	59200080100305	Generic
THIORIDAZINE HCL	THIORIDAZINE HCL TAB 25 MG	59200080100315	Generic
THIORIDAZINE HCL	THIORIDAZINE HCL TAB 50 MG	59200080100320	Generic

THIORIDAZINE HCL	THIORIDAZINE HCL TAB 100 MG	59200080100325	Generic
THIOTHIXENE	THIOTHIXENE CAP 1 MG	59300020100105	Generic
THIOTHIXENE	THIOTHIXENE CAP 2 MG	59300020100110	Generic
THIOTHIXENE	THIOTHIXENE CAP 5 MG	59300020100115	Generic
THIOTHIXENE	THIOTHIXENE CAP 10 MG	59300020100120	Generic
TRIFLUOPERAZINE HCL	TRIFLUOPERAZINE HCL TAB 1 MG (BASE EQUIVALENT)	59200085100305	Generic
TRIFLUOPERAZINE HCL	TRIFLUOPERAZINE HCL TAB 2 MG (BASE EQUIVALENT)	59200085100310	Generic
TRIFLUOPERAZINE HCL	TRIFLUOPERAZINE HCL TAB 5 MG (BASE EQUIVALENT)	59200085100315	Generic
TRIFLUOPERAZINE HCL	TRIFLUOPERAZINE HCL TAB 10 MG (BASE EQUIVALENT)	59200085100320	Generic
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
ARIPIPRAZOLE	ARIPIPRAZOLE ORAL SOLUTION 1 MG/ML	59250015002020	Generic
ARIPIPRAZOLE ODT	ARIPIPRAZOLE ORALLY DISINTEGRATING TAB 10 MG	59250015007220	Generic
ARIPIPRAZOLE ODT	ARIPIPRAZOLE ORALLY DISINTEGRATING TAB 15 MG	59250015007230	Generic
CAPLYTA	LUMATEPERONE TOSYLATE CAP 42 MG	59400022400120	Brand
CLOZAPINE	CLOZAPINE TAB 50 MG	59152020000325	Generic
CLOZARIL	CLOZAPINE TAB 50 MG	59152020000325	Brand
CLOZAPINE	CLOZAPINE TAB 200 MG	59152020000340	Generic
CLOZARIL	CLOZAPINE TAB 200 MG	59152020000340	Brand
RISPERIDONE ODT	RISPERIDONE ORALLY DISINTEGRATING TAB 0.25 MG	59070070007210	Generic
ASENAPINE MALEATE SL	ASENAPINE MALEATE SL TAB 2.5 MG (BASE EQUIV)	59155015100710	Generic
ASENAPINE MALEATE SL	ASENAPINE MALEATE SL TAB 5 MG (BASE EQUIV)	59155015100720	Generic
ASENAPINE MALEATE SL	ASENAPINE MALEATE SL TAB 10 MG (BASE EQUIV)	59155015100730	Generic
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
FLUPHENAZINE HYDROCHLORIDE	FLUPHENAZINE HCL ELIXIR 2.5 MG/5ML	59200025101005	Generic
CAPLYTA	LUMATEPERONE TOSYLATE CAP 10.5 MG	59400022400110	Brand
CAPLYTA	LUMATEPERONE TOSYLATE CAP 21 MG	59400022400115	Brand
CHLORPROMAZINE HYDROCHLORIDE	CHLORPROMAZINE HCL CONC 30 MG/ML	59200015101305	Generic
CHLORPROMAZINE HYDROCHLORIDE	CHLORPROMAZINE HCL CONC 100 MG/ML	59200015101310	Generic
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
PROCHLORPERAZINE MALEATE	PROCHLORPERAZINE MALEATE TAB 5 MG (BASE EQUIVALENT)	59200055100305	Generic
PROCHLORPERAZINE MALEATE	PROCHLORPERAZINE MALEATE TAB 10 MG (BASE EQUIVALENT)	59200055100310	Generic
LURASIDONE HYDROCHLORIDE	LURASIDONE HCL TAB 20 MG	59400023100310	Generic
LURASIDONE HYDROCHLORIDE	LURASIDONE HCL TAB 40 MG	59400023100320	Generic
LURASIDONE HYDROCHLORIDE	LURASIDONE HCL TAB 60 MG	59400023100330	Generic
LURASIDONE HYDROCHLORIDE	LURASIDONE HCL TAB 80 MG	59400023100340	Generic
LURASIDONE HYDROCHLORIDE	LURASIDONE HCL TAB 120 MG	59400023100350	Generic
QUETIAPINE FUMARATE	QUETIAPINE FUMARATE TAB 150 MG	59153070100325	Generic
CHLORPROMAZINE HYDROCHLORIDE	CHLORPROMAZINE HCL TAB 10 MG	59200015100305	Generic
CHLORPROMAZINE HYDROCHLORIDE	CHLORPROMAZINE HCL TAB 25 MG	59200015100310	Generic
CHLORPROMAZINE HYDROCHLORIDE	CHLORPROMAZINE HCL TAB 50 MG	59200015100315	Generic
CHLORPROMAZINE HYDROCHLORIDE	CHLORPROMAZINE HCL TAB 100 MG	59200015100320	Generic
CHLORPROMAZINE HYDROCHLORIDE	CHLORPROMAZINE HCL TAB 200 MG	59200015100325	Generic
FLUPHENAZINE HYDROCHLORIDE	FLUPHENAZINE HCL TAB 1 MG	59200025100305	Generic
FLUPHENAZINE HYDROCHLORIDE	FLUPHENAZINE HCL TAB 2.5 MG	59200025100310	Generic
FLUPHENAZINE HYDROCHLORIDE	FLUPHENAZINE HCL TAB 5 MG	59200025100315	Generic
FLUPHENAZINE HYDROCHLORIDE	FLUPHENAZINE HCL TAB 10 MG	59200025100320	Generic
TRIFLUOPERAZINE HYDROCHLORIDE	TRIFLUOPERAZINE HCL TAB 1 MG (BASE EQUIVALENT)	59200085100305	Generic
TRIFLUOPERAZINE HYDROCHLORIDE	TRIFLUOPERAZINE HCL TAB 2 MG (BASE EQUIVALENT)	59200085100310	Generic
TRIFLUOPERAZINE HYDROCHLORIDE	TRIFLUOPERAZINE HCL TAB 5 MG (BASE EQUIVALENT)	59200085100315	Generic
TRIFLUOPERAZINE HYDROCHLORIDE	TRIFLUOPERAZINE HCL TAB 10 MG (BASE EQUIVALENT)	59200085100320	Generic
ZIPRASIDONE HYDROCHLORIDE	ZIPRASIDONE HCL CAP 20 MG	59400085100120	Generic

ZIPRASIDONE HYDROCHLORIDE	ZIPRASIDONE HCL CAP 40 MG	59400085100130	Generic
ZIPRASIDONE HYDROCHLORIDE	ZIPRASIDONE HCL CAP 60 MG	59400085100140	Generic
ZIPRASIDONE HYDROCHLORIDE	ZIPRASIDONE HCL CAP 80 MG	59400085100150	Generic
COBENFY STARTER PACK	XANOMELINE-TROSPIUM CHLORIDE CAP PACK 50-20 MG & 100-20 MG	5919990280B220	Brand
COBENFY	XANOMELINE TARTRATE-TROSPIUM CHLORIDE CAP 50-20 MG	59199902800120	Brand
COBENFY	XANOMELINE TARTRATE-TROSPIUM CHLORIDE CAP 100-20 MG	59199902800130	Brand
COBENFY	XANOMELINE TARTRATE-TROSPIUM CHLORIDE CAP 125-30 MG	59199902800135	Brand

Approval Criteria

1 - All of the following:

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

AND

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

OR

2 - All of the following:

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

AND

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

OR

3 - All of the following:

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

AND

3.2 ONE of the following:

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

AND

3.3 One of the following:

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

OR

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

AND

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

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

Product Name: Brand Symbyax, Generic olanzapine/fluoxetine	
Diagnosis	Duplicate Therapy with Another SSRI/SNRI*
Therapy Stage	Initial Authorization
Guideline Type	Drug Utilization Review

Product Name	Generic Name	GPI	Brand/Generic
OLANZAPINE/FLUOXETINE	OLANZAPINE-FLUOXETINE HCL CAP 3-25 MG	62995002500110	Generic
SYMBYAX	OLANZAPINE-FLUOXETINE HCL CAP 3-25 MG	62995002500110	Brand
OLANZAPINE/FLUOXETINE	OLANZAPINE-FLUOXETINE HCL CAP 6-25 MG	62995002500120	Generic
SYMBYAX	OLANZAPINE-FLUOXETINE HCL CAP 6-25 MG	62995002500120	Brand
OLANZAPINE/FLUOXETINE	OLANZAPINE-FLUOXETINE HCL CAP 6-50 MG	62995002500125	Generic
OLANZAPINE/FLUOXETINE	OLANZAPINE-FLUOXETINE HCL CAP 12-25 MG	62995002500140	Generic
OLANZAPINE/FLUOXETINE	OLANZAPINE-FLUOXETINE HCL CAP 12-50 MG	62995002500145	Generic

Approval Criteria

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

OR

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

OR

3 - Medical rationale supporting duplication of therapy**

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

Product Name: Brand Symbyax, Generic olanzapine/fluoxetine	
Diagnosis	Duplicate Therapy with Another SSRI/SNRI*
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Drug Utilization Review

Product Name	Generic Name	GPI	Brand/Generic
OLANZAPINE/FLUOXETINE	OLANZAPINE-FLUOXETINE HCL CAP 3-25 MG	62995002500110	Generic
SYMBYAX	OLANZAPINE-FLUOXETINE HCL CAP 3-25 MG	62995002500110	Brand
OLANZAPINE/FLUOXETINE	OLANZAPINE-FLUOXETINE HCL CAP 6-25 MG	62995002500120	Generic
SYMBYAX	OLANZAPINE-FLUOXETINE HCL CAP 6-25 MG	62995002500120	Brand
OLANZAPINE/FLUOXETINE	OLANZAPINE-FLUOXETINE HCL CAP 6-50 MG	62995002500125	Generic
OLANZAPINE/FLUOXETINE	OLANZAPINE-FLUOXETINE HCL CAP 12-25 MG	62995002500140	Generic
OLANZAPINE/FLUOXETINE	OLANZAPINE-FLUOXETINE HCL CAP 12-50 MG	62995002500145	Generic

Approval Criteria

1 - Evidence of duplication of therapy with the requested SSRI/SNRI agents for 90 of the past 120 days

Notes	*This criteria applies to the SSRI and SNRI Duplicate Therapy Policy

Product Name: Cobenfy	
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
COBENFY STARTER PACK	XANOMELINE-TROSPIUM CHLORIDE CAP PACK 50-20 MG & 100-20 MG	5919990280B220	Brand
COBENFY	XANOMELINE TARTRATE-TROSPIUM CHLORIDE CAP 50-20 MG	59199902800120	Brand
COBENFY	XANOMELINE TARTRATE-TROSPIUM CHLORIDE CAP 100-20 MG	59199902800130	Brand
COBENFY	XANOMELINE TARTRATE-TROSPIUM CHLORIDE CAP 125-30 MG	59199902800135	Brand

Approval Criteria

1 - Diagnosis of schizophrenia

AND

2 - One of the following:

2.1 Cobenfy (xanomeline and trospium chloride) will be used as single-agent antipsychotic therapy

OR

2.2 Patient will be cross-tapering from a different antipsychotic agent to Cobenfy (xanomeline and trospium chloride) as single-agent antipsychotic therapy*

AND

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

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

Notes	*Approval Length - 90 days for cross-taper from a different antipsychotic agent; otherwise, 6 months

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

Product Name	Generic Name	GPI	Brand/Generic
COBENFY STARTER PACK	XANOMELINE-TROSPIUM CHLORIDE CAP PACK 50-20 MG & 100-20 MG	5919990280B220	Brand
COBENFY	XANOMELINE TARTRATE-TROSPIUM CHLORIDE CAP 50-20 MG	59199902800120	Brand
COBENFY	XANOMELINE TARTRATE-TROSPIUM CHLORIDE CAP 100-20 MG	59199902800130	Brand
COBENFY	XANOMELINE TARTRATE-TROSPIUM CHLORIDE CAP 125-30 MG	59199902800135	Brand

Approval Criteria

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

AND

2 - Prescriber attests patient has been and will continue to use Cobenfy (xanomeline and trospium chloride) as single-agent antipsychotic therapy

AND

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

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

2 . Background

Benefit/Coverage/Program Information
Table 1 - Adequate Dose

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

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

3 . Revision History

Date	Notes
11/5/2024	Updated reauth for Duplicate Therapy with Another Antipsychotic. Added Cobenfy to age limit and added Cobenfy specific section (updated product name of Duplicate Therapy with Another Antipsychotic sections to remove all antipsychotics from heading). Updated Lumateperone adequate dose in Table 1 of background.

Orfadin

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-127398
Guideline Name	Orfadin
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	8/1/2023

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

Orladeyo

Prior Authorization Guideline

Guideline ID	GL-147206
Guideline Name	Orladeyo
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2024

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

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-147249
Guideline Name	Orserdu
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2024

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

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-124497
Guideline Name	Osphena
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2023

1 . Criteria

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

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

Oxervate

Prior Authorization Guideline

Guideline ID	GL-98032
Guideline Name	Oxervate
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2022

1 . Criteria

Product Name: Oxervate	
Diagnosis	Neurotrophic keratitis
Approval Length	8 Week(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OXERVATE	CENEGERMIN-BKBJ OPHTH SOLN 0.002% (20 MCG/ML)	86770020202020	Brand

Approval Criteria

1 - Patient is 2 years of age or older

AND

2 - Diagnosis of neurotrophic keratitis

AND

3 - Prescribed by, or in consultation with, an ophthalmologist

AND

4 - Patient has not received 8 weeks or more of prior cenegermin (Oxervate) treatment for the affected eye

2 . Revision History

Date	Notes
11/4/2021	Updated all criteria to match state policy.

Palynziq

Prior Authorization Guideline

Guideline ID	GL-156821
Guideline Name	Palynziq
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	11/1/2024

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
10/1/2024	Updated authorization durations to 12 months

Pancreatic Enzymes

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-125017
Guideline Name	Pancreatic Enzymes
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	7/1/2023

1 . Criteria

Product Name: Pertzye, Viokace	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PERTZYE	PANCRELIPASE (LIP-PROT-AMYL) DR CAP 4000-14375-15125 UNIT	51200024006709	Brand
PERTZYE	PANCRELIPASE (LIP-PROT-AMYL) DR CAP 8000-28750-30250 UNIT	51200024006725	Brand
PERTZYE	PANCRELIPASE (LIP-PROT-AMYL) DR CAP 16000-57500-60500 UNIT	51200024006749	Brand
PERTZYE	PANCRELIPASE (LIP-PROT-AMYL) DR CAP 24000-86250-90750 UNIT	51200024006762	Brand

VIOKACE	PANCRELIPASE (LIP-PROT-AMYL) TAB 10440-39150-39150 UNIT	51200024000330	Brand
VIOKACE	PANCRELIPASE (LIP-PROT-AMYL) TAB 20880-78300-78300 UNIT	51200024000360	Brand

Approval Criteria

1 - Patient has utilized 30 cumulative days of preferred* agent therapy in the past 180 days

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

2 . Revision History

Date	Notes
4/25/2023	New

Panretin

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-82119
Guideline Name	Panretin
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2021

1 . Criteria

Product Name: Panretin	
Diagnosis	AIDS-related Kaposi's Sarcoma (KS)
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 acquired immunodeficiency syndrome (AIDS)-related Kaposi's Sarcoma (KS)

AND

2 - Patient is not receiving systemic anti-KS treatment

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

Product Name	Generic Name	GPI	Brand/Generic
PANRETIN	ALITRETINOIN GEL 0.1%	90376015004020	Brand

Approval Criteria

1 - Panretin will be approved for uses 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

2 . Revision History

Date	Notes
3/5/2021	Bulk Load

PCSK9 Inhibitors and Select Lipotropics

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-154997
Guideline Name	PCSK9 Inhibitors and Select Lipotropics
Formulary	• Medicaid - Community & State Indiana • Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	10/1/2024

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 - Patient is enrolled in the Juxtapid REMS (Risk Evaluation and Mitigation Strategy) program and prescriber is monitoring in accordance with REMS requirements

AND

2 - The patient is 18 years of age or older

AND

3 - Prescribed by, or in consultation with, a cardiologist or endocrinologist

AND

4 - One of the following:

4.1 Trial and failure of Praluent or Repatha

OR

4.2 BOTH of the following:

- Medical rationale for use of Juxtapid over Praluent or Repatha
- Patient has had trial and failure of at least 90 days of high dose rosuvastatin (20 mg/40 mg) or atorvastatin (40 mg/80 mg, if rosuvastatin intolerant) therapy concurrently with ezetimibe (or documented intolerance/contraindication to statins/ezetimibe)

AND

5 - For those of childbearing potential, documentation of a negative pregnancy test in the past 30 days and prescriber has counseled member on risks associated with conceiving while utilizing Juxtapid and appropriate methods of contraception

AND

6 - One of the following:

6.1 The patient will be utilizing maximally tolerated statin therapy with or without ezetimibe concurrently with Juxtapid

OR

6.2 Documented intolerance to statin and/or ezetimibe therapy

OR

6.3 Medical rationale against use of statin or ezetimibe therapy

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 - History of Juxtapid for at least 90 days within the past 120 days, confirmed by claims history or chart documentation

AND

2 - One of the following:

2.1 Prior history of at least one preferred PCSK9 inhibitor*

OR

2.2 Valid medical rationale for the use of Juxtapid over preferred PCSK9 inhibitors*

AND

3 - One of the following:

3.1 Continued concurrent use of maximally tolerated statin therapy with or without ezetimibe

OR

3.2 Documented intolerance to statin and/or ezetimibe therapy

OR

3.3 Medical rationale against use of statin or ezetimibe therapy

AND

4 - One of the following:

4.1 Reduction in LDL-C (low-density lipoprotein-cholesterol) from baseline

OR

4.2 Maintenance of goal LDL-C

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

Product Name: Niacin ER (generic Niaspan)	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NIACIN ER	NIACIN TAB ER 500 MG (ANTIHYPERLIPIDEMIC)	39450050000450	Generic
NIACIN ER	NIACIN TAB ER 750 MG (ANTIHYPERLIPIDEMIC)	39450050000460	Generic
NIACIN ER	NIACIN TAB ER 1000 MG (ANTIHYPERLIPIDEMIC)	39450050000470	Generic

Approval Criteria

1 - Diagnosis of severe hypertriglyceridemia [baseline triglycerides greater than or equal to 500 mg/dL (milligrams per deciliter)] and one of the following:

1.1 Concurrent therapy with ALL of the following for at least 90 days:

- Omega-3 fatty acid (omega-3-acid ethyl esters or icosapent ethyl)
- Fibric acid derivative
- Statin therapy

OR

1.2 Documented intolerance of omega-3 fatty acid, fibric acid derivative, AND statin therapy

OR

1.3 Medical rationale against the use of omega-3 fatty acid, fibric acid derivatives, AND statin therapy

AND

2 - Patient is 17 years of age or older

Product Name: Niacin ER (generic Niaspan)	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NIACIN ER	NIACIN TAB ER 500 MG (ANTIHYPERLIPIDEMIC)	39450050000450	Generic
NIACIN ER	NIACIN TAB ER 750 MG (ANTIHYPERLIPIDEMIC)	39450050000460	Generic
NIACIN ER	NIACIN TAB ER 1000 MG (ANTIHYPERLIPIDEMIC)	39450050000470	Generic

Approval Criteria

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

Product Name: Praluent	
Diagnosis	ASCVD (Atherosclerotic Cardiovascular Disease)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

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 clinical ASCVD (atherosclerotic cardiovascular disease)

AND

2 - ONE of the following:

2.1 Patient at very high risk of future ASCVD events* requiring therapy for secondary prevention and one of the following:

2.1.1 Persistently elevated LDL-C (low-density lipoprotein cholesterol) (greater than or equal to 55 mg/dL) despite treatment with one of the following:

2.1.1.1 For patient requiring greater than 25% additional lowering, one of the following:

- At least 90 days of therapy with high intensity rosuvastatin (20 mg/40 mg) therapy
- For those intolerant to rosuvastatin, at least 90 days of therapy with high intensity atorvastatin (40 mg/80 mg) therapy

OR

2.1.1.2 For patient requiring less than or equal to 25% additional lowering, one of the following:

- At least 90 days of therapy with high intensity rosuvastatin (20 mg/40 mg) therapy with ezetimibe
- For those intolerant to rosuvastatin, at least 90 days of therapy with high intensity atorvastatin (40 mg/80 mg) therapy with ezetimibe

OR

2.1.2 Documented intolerance of both rosuvastatin and atorvastatin with or without ezetimibe OR medical rationale against the use of statin therapy with or without ezetimibe therapy

OR

2.2 Patient is NOT at very high risk of future ASCVD events* requiring therapy for secondary prevention and one of the following:

2.2.1 Persistently elevated LDL-C (greater than or equal to 70 mg/dL) despite treatment with one of the following:

- At least 90 days of therapy with high intensity rosuvastatin (20 mg/40 mg) therapy with ezetimibe
- For those intolerant to rosuvastatin, at least 90 days of therapy with high intensity atorvastatin (40 mg/80 mg) therapy with ezetimibe

OR

2.2.2 Documented intolerance of both rosuvastatin and atorvastatin and/or ezetimibe

OR

2.2.3 Medical rationale against the use of statin therapy and/or ezetimibe therapy

OR

2.3 Patient with a baseline LDL-C greater than or equal to 190 mg/dL not due to secondary causes (see Table 3), without clinical or genetic diagnosis of familial hypercholesterolemia, requiring therapy for secondary prevention and one of the following:

2.3.1 Persistently elevated LDL-C (greater than or equal to 70 mg/dL) despite treatment with one of the following:

2.3.1.1 For patient requiring greater than 25% additional lowering, one of the following:

- At least 90 days of therapy with high intensity rosuvastatin (20 mg/40 mg) therapy
- For those intolerant to rosuvastatin, at least 90 days of therapy with high intensity atorvastatin (40 mg/80 mg) therapy

OR

2.3.1.2 For patient requiring less than or equal to 25% additional lowering, one of the following:

- At least 90 days of therapy with high intensity rosuvastatin (20 mg/40 mg) therapy with ezetimibe
- For those intolerant to rosuvastatin, at least 90 days of therapy with high intensity atorvastatin (40 mg/80 mg) therapy with ezetimibe

OR

2.3.2 Documented intolerance of both rosuvastatin and atorvastatin with or without ezetimibe OR medical rationale against the use of statin therapy with or without ezetimibe therapy

OR

2.4 Patient at very high risk of future ASCVD events* with a baseline LDL-C greater than or equal to 190 mg/dL not due to secondary causes (see Table 3), a diagnosis of familial hypercholesterolemia, and requiring treatment for secondary prevention and one of the following:

2.4.1 Persistently elevated LDL-C (greater than or equal to 55 mg/dL) despite treatment with one of the following:

2.4.1.1 For patient requiring greater than 25% additional lowering, one of the following:

- At least 90 days of therapy with high intensity rosuvastatin (20 mg/40 mg) therapy
- For those intolerant to rosuvastatin, at least 90 days of therapy with high intensity atorvastatin (40 mg/80 mg) therapy

OR

2.4.1.2 For patient requiring less than or equal to 25% additional lowering, one of the following:

- At least 90 days of therapy with high intensity rosuvastatin (20 mg/40 mg) therapy with ezetimibe
- For those intolerant to rosuvastatin, at least 90 days of therapy with high intensity atorvastatin (40 mg/80 mg) therapy with ezetimibe

OR

2.4.2 Documented intolerance of both rosuvastatin and atorvastatin with or without ezetimibe OR medical rationale against the use of statin therapy with or without ezetimibe therapy

AND

3 - The patient is 18 years of age or older

AND

4 - One of the following:

4.1 The patient will be utilizing maximally tolerated statin therapy with or without ezetimibe concurrently with Praluent

OR

4.2 Documented intolerance to statin and/or ezetimibe therapy

OR

4.3 Medical rationale against use of statin or ezetimibe therapy

AND

5 - One of the following:

5.1 The dose requested is 75 mg every 2 weeks

OR

5.2 The dose requested is 300 mg every 4 weeks

OR

5.3 The dose requested is 150 mg every 2 weeks and one of the following:

- Patient has homozygous familial hypercholesterolemia
- Patient has heterozygous familial hypercholesterolemia and is undergoing LDL apheresis

• Patient has not achieved clinically meaningful response after at least 4 weeks of dosing at 75 mg every 2 weeks or 300 mg every 4 weeks	
Notes	*Very High Risk of future ASCVD events is defined as: multiple (2 or more) major ASCVD events from Table 1 OR 1 major ASCVD event fr om Table 1 and multiple (2 or more) high risk conditions from Table 2

Product Name: Praluent	
Diagnosis	Primary hyperlipidemia, without clinical ASCVD (Atherosclerotic Cardiovascular Disease)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

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 primary hyperlipidemia, without clinical ASCVD (atherosclerotic cardiovascular disease)

AND

2 - Baseline LDL-C (low-density lipoprotein cholesterol) greater than or equal to 190 mg/dL (milligrams per deciliter) not due to secondary causes (see Table 3), with or without concomitant ASCVD risk factors, requiring therapy for primary prevention

AND

3 - One of the following:

3.1 Persistently elevated LDL-C (greater than or equal to 100 mg/dL) despite treatment with one of the following:

3.1.1 For patient requiring greater than 25% additional lowering, one of the following:

- At least 90 days of therapy with high intensity rosuvastatin (20 mg/40 mg) therapy
- For those intolerant to rosuvastatin, at least 90 days of therapy with high intensity atorvastatin (40 mg/80 mg) therapy

OR

3.1.2 For patient requiring less than or equal to 25% additional lowering, one of the following:

- At least 90 days of therapy with high intensity rosuvastatin (20 mg/40 mg) therapy with ezetimibe
- For those intolerant to rosuvastatin, at least 90 days of therapy with high intensity atorvastatin (40 mg/80 mg) therapy with ezetimibe

OR

3.2 Documented intolerance of both rosuvastatin and atorvastatin with or without ezetimibe OR medical rationale against the use of statin therapy with or without ezetimibe therapy

AND

4 - The patient is 18 years of age or older

AND

5 - One of the following:

5.1 Patient will be utilizing maximally tolerated statin therapy with or without ezetimibe concurrently with Praluent

OR

5.2 Documented intolerance to statin and/or ezetimibe therapy

OR

5.3 Medical rationale against use of statin or ezetimibe therapy

AND

6 - One of the following:

6.1 The dose requested is 75 mg every 2 weeks

OR

6.2 The dose requested is 300 mg every 4 weeks

OR

6.3 The dose requested is 150 mg every 2 weeks and one of the following:

- Patient has homozygous familial hypercholesterolemia
- Patient has heterozygous familial hypercholesterolemia and is undergoing LDL apheresis
- Patient has not achieved clinically meaningful response after at least 4 weeks of dosing at 75 mg every 2 weeks or 300 mg every 4 weeks

Product Name: Praluent	
Diagnosis	HoFH (Homozygous Familial Hypercholesterolemia), HeFH (Heterozygous Familial Hypercholesterolemia)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

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) OR heterozygous familial hypercholesterolemia (HeFH)

AND

2 - One of the following:

2.1 Persistently elevated LDL-C (low-density lipoprotein cholesterol) (greater than or equal to 70 mg/dL) despite treatment with one of the following:

- At least 90 days of therapy with high intensity rosuvastatin (20 mg/40 mg) therapy concurrently with ezetimibe
- For those intolerant to rosuvastatin, at least 90 days of therapy with high intensity atorvastatin (40 mg/80 mg) therapy concurrently with ezetimibe

OR

2.2 Documented intolerance of both rosuvastatin and atorvastatin and/or ezetimibe

OR

2.3 Medical rationale against the use of statin and/or ezetimibe therapy

AND

3 - One of the following:

- If for a diagnosis of HeFH, patient is 8 years of age or older
- If for a diagnosis of HoFH, patient is 18 years of age or older

AND

4 - One of the following:

4.1 Patient will be utilizing maximally tolerated statin therapy with or without ezetimibe concurrently with Praluent

OR

4.2 Documented intolerance to statin and/or ezetimibe therapy

OR

4.3 Medical rationale against use of statin or ezetimibe therapy

AND

5 - One of the following:

5.1 The dose requested is 75 mg every 2 weeks

OR

5.2 The dose requested is 300 mg every 4 weeks

OR

5.3 The dose requested is 150 mg every 2 weeks and one of the following:

- Patient has homozygous familial hypercholesterolemia
- Patient has heterozygous familial hypercholesterolemia and is undergoing LDL apheresis
- Patient has not achieved clinically meaningful response after at least 4 weeks of dosing at 75 mg every 2 weeks or 300 mg every 4 weeks

OR

5.4 The dose requested is 150 mg every 4 weeks and both of the following:

- Patient has heterozygous familial hypercholesterolemia
- Patient is under 18 years of age and weighs less than 50 kg

Product Name: Praluent	
Diagnosis	ASCVD (Atherosclerotic Cardiovascular Disease), Primary hyperlipidemia, without clinical ASCVD, HoFH (Homozygous Familial Hypercholesterolemia), HeFH (Heterozygous Familial Hypercholesterolemia)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

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 Praluent for at least 90 days within the past 120 days, confirmed by claims history or chart documentation

AND

2 - ONE of the following:

- Continued concurrent use of maximally tolerated statin therapy with or without ezetimibe
- Documented intolerance to statin and/or ezetimibe therapy OR medical rationale against the use of statin and/or ezetimibe therapy

AND

3 - One of the following:

3.1 The dose requested is 75 mg every 2 weeks

OR

3.2 The dose requested is 300 mg every 4 weeks

OR

3.3 The dose requested is 150 mg every 2 weeks and one of the following:

- Patient has homozygous familial hypercholesterolemia
- Patient has heterozygous familial hypercholesterolemia and is undergoing LDL (low-density lipoprotein) apheresis
- Patient has not achieved clinically meaningful response after at least 4 weeks of dosing at 75 mg every 2 weeks or 300 mg every 4 weeks

OR

3.4 The dose requested is 150 mg every 4 weeks and both of the following:

- Patient has heterozygous familial hypercholesterolemia
- Patient is under 18 years of age and weighs less than 50 kg

AND

4 - One of the following:

4.1 Reduction in LDL-C from baseline

OR

4.2 Maintenance of goal LDL-C

Product Name: Repatha	
Diagnosis	ASCVD (Atherosclerotic Cardiovascular Disease)

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

Product Name	Generic Name	GPI	Brand/Generic
REPATHA SURECLICK	EVOLOCUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 140 MG/ML	3935002000D520	Brand
REPATHA PUSHTRONEX SYSTEM	EVOLOCUMAB SUBCUTANEOUS SOLN CARTRIDGE/INFUSOR 420 MG/3.5ML	3935002000E230	Brand
REPATHA	EVOLOCUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 140 MG/ML	3935002000E520	Brand

Approval Criteria

1 - Diagnosis of clinical ASCVD (atherosclerotic cardiovascular disease)

AND

2 - ONE of the following:

2.1 Patient is at very high risk of future ASCVD events* requiring therapy for secondary prevention and one of the following:

2.1.1 Persistently elevated LDL-C (low-density lipoprotein cholesterol) (greater than or equal to 55 mg/dL) despite treatment with one of the following:

2.1.1.1 For patient requiring greater than 25% additional lowering, one of the following:

- At least 90 days of therapy with high intensity rosuvastatin (20 mg/40 mg) therapy
- For those intolerant to rosuvastatin, at least 90 days of therapy with high intensity atorvastatin (40 mg/80 mg) therapy

OR

2.1.1.2 For patient requiring less than or equal to 25% additional lowering, one of the following:

- At least 90 days of therapy with high intensity rosuvastatin (20 mg/40 mg) therapy with ezetimibe

- For those intolerant to rosuvastatin, at least 90 days of therapy with high intensity atorvastatin (40 mg/80 mg) therapy with ezetimibe

OR

2.1.2 Documented intolerance of both rosuvastatin and atorvastatin with or without ezetimibe OR medical rationale against the use of statin therapy with or without ezetimibe therapy

OR

2.2 Patient is NOT at very high risk of future ASCVD events* requiring therapy for secondary prevention and one of the following:

2.2.1 Persistently elevated LDL-C (greater than or equal to 70 mg/dL) despite treatment with one of the following:

- At least 90 days of therapy with high intensity rosuvastatin (20 mg/40 mg) therapy with ezetimibe
- For those intolerant to rosuvastatin, at least 90 days of therapy with high intensity atorvastatin (40 mg/80 mg) therapy with ezetimibe

OR

2.2.2 Documented intolerance of both rosuvastatin and atorvastatin and/or ezetimibe

OR

2.2.3 Medical rationale against the use of statin therapy and/or ezetimibe therapy

OR

2.3 Patient with a baseline LDL-C greater than or equal to 190 mg/dL not due to secondary causes (see Table 3), without clinical or genetic diagnosis of familial hypercholesterolemia, requiring therapy for secondary prevention and one of the following:

2.3.1 Persistently elevated LDL-C (greater than or equal to 70 mg/dL) despite treatment with one of the following:

2.3.1.1 For patient requiring greater than 25% additional lowering, one of the following:

- At least 90 days of therapy with high intensity rosuvastatin (20 mg/40 mg) therapy
- For those intolerant to rosuvastatin, at least 90 days of therapy with high intensity atorvastatin (40 mg/80 mg) therapy

OR

2.3.1.2 For patient requiring less than or equal to 25% additional lowering, one of the following:

- At least 90 days of therapy with high intensity rosuvastatin (20 mg/40 mg) therapy with ezetimibe
- For those intolerant to rosuvastatin, at least 90 days of therapy with high intensity atorvastatin (40 mg/80 mg) therapy with ezetimibe

OR

2.3.2 Documented intolerance of both rosuvastatin and atorvastatin with or without ezetimibe OR medical rationale against the use of statin therapy with or without ezetimibe therapy

OR

2.4 Patient is at very high risk of future ASCVD events* with a baseline LDL-C greater than or equal to 190 mg/dL not due to secondary causes (see Table 3), a diagnosis of familial hypercholesterolemia, and requiring treatment for secondary prevention and one of the following:

2.4.1 Persistently elevated LDL-C (greater than or equal to 55 mg/dL) despite treatment with one of the following:

2.4.1.1 For patient requiring greater than 25% additional lowering, one of the following:

- At least 90 days of therapy with high intensity rosuvastatin (20 mg/40 mg) therapy
- For those intolerant to rosuvastatin, at least 90 days of therapy with high intensity atorvastatin (40 mg/80 mg) therapy

OR

2.4.1.2 For patient requiring less than or equal to 25% additional lowering, one of the following:

- At least 90 days of therapy with high intensity rosuvastatin (20 mg/40 mg) therapy with ezetimibe
- For those intolerant to rosuvastatin, at least 90 days of therapy with high intensity atorvastatin (40 mg/80 mg) therapy with ezetimibe

OR

2.4.2 Documented intolerance of both rosuvastatin and atorvastatin with or without ezetimibe OR medical rationale against the use of statin therapy with or without ezetimibe therapy

AND

3 - The patient is 18 years of age or older

AND

4 - One of the following:

4.1 Patient will be utilizing maximally tolerated statin therapy with or without ezetimibe concurrently with Repatha

OR

4.2 Documented intolerance to statin and/or ezetimibe therapy

OR

4.3 Medical rationale against use of statin or ezetimibe therapy

AND

5 - One of the following:

5.1 The dose requested is 140 mg every 2 weeks

OR

5.2 The dose requested is 420 mg once monthly

OR

5.3 Dose requested is 420 mg every 2 weeks and the patient is receiving lipid apheresis

Notes	*Very High Risk of future ASCVD events is defined as: multiple (2 or more) major ASCVD events from Table 1 OR 1 major ASCVD event fr om Table 1 and multiple (2 or more) high risk conditions from Table 2

Product Name: Repatha	
Diagnosis	Primary hyperlipidemia, without clinical ASCVD (Atherosclerotic Cardiovascular Disease)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
REPATHA SURECLICK	EVOLOCUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 140 MG/ML	3935002000D520	Brand
REPATHA PUSHTRONEX SYSTEM	EVOLOCUMAB SUBCUTANEOUS SOLN CARTRIDGE/INFUSOR 420 MG/3.5ML	3935002000E230	Brand
REPATHA	EVOLOCUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 140 MG/ML	3935002000E520	Brand

Approval Criteria

1 - Diagnosis of primary hyperlipidemia, without clinical ASCVD (atherosclerotic cardiovascular disease)

AND

2 - Patient with a baseline LDL-C (low-density lipoprotein cholesterol) greater than or equal to 190 mg/dL (milligrams per deciliter) not due to secondary causes (see Table 3), with or without concomitant ASCVD risk factors, requiring therapy for primary prevention

AND

3 - One of the following:

3.1 Persistently elevated LDL-C (greater than or equal to 100 mg/dL) despite treatment with one of the following:

3.1.1 For patient requiring greater than 25% additional lowering, one of the following:

- At least 90 days of therapy with high intensity rosuvastatin (20 mg/40 mg) therapy
- For those intolerant to rosuvastatin, at least 90 days of therapy with high intensity atorvastatin (40 mg/80 mg) therapy

OR

3.1.2 For patient requiring less than or equal to 25% additional lowering, one of the following:

- At least 90 days of therapy with high intensity rosuvastatin (20 mg/40 mg) therapy with ezetimibe
- For those intolerant to rosuvastatin, at least 90 days of therapy with high intensity atorvastatin (40 mg/80 mg) therapy with ezetimibe

OR

3.2 Documented intolerance of both rosuvastatin and atorvastatin with or without ezetimibe OR medical rationale against the use of statin therapy with or without ezetimibe therapy

AND

4 - The patient is 18 years of age or older

AND

5 - One of the following:

5.1 Patient will be utilizing maximally tolerated statin therapy with or without ezetimibe concurrently with Repatha

OR

5.2 Documented intolerance to statin and/or ezetimibe therapy

OR

5.3 Medical rationale against use of statin or ezetimibe therapy

AND

6 - One of the following:

6.1 The dose requested is 140 mg every 2 weeks

OR

6.2 The dose requested is 420 mg once monthly

OR

6.3 The dose requested is 420 mg every 2 weeks and patient is receiving lipid apheresis

Product Name: Repatha	
Diagnosis	HoFH (Homozygous Familial Hypercholesterolemia), HeFH (Heterozygous Familial Hypercholesterolemia)
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
REPATHA SURECLICK	EVOLOCUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 140 MG/ML	3935002000D520	Brand
REPATHA PUSHTRONEX SYSTEM	EVOLOCUMAB SUBCUTANEOUS SOLN CARTRIDGE/INFUSOR 420 MG/3.5ML	3935002000E230	Brand
REPATHA	EVOLOCUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 140 MG/ML	3935002000E520	Brand

Approval Criteria

1 - Diagnosis of homozygous familial hypercholesterolemia (HoFH) or heterozygous familial hypercholesterolemia (HeFH)

AND

2 - One of the following:

2.1 Persistently elevated LDL-C (low-density lipoprotein cholesterol) (greater than or equal to 70 mg/dL) despite treatment with one of the following:

- At least 90 days of therapy with high intensity rosuvastatin (20 mg/40 mg) therapy concurrently with ezetimibe
- For those intolerant to rosuvastatin, at least 90 days of therapy with high intensity atorvastatin (40 mg/80 mg) therapy concurrently with ezetimibe

OR

2.2 Documented intolerance of both rosuvastatin and atorvastatin and/or ezetimibe

OR

2.3 Medical rationale against the use of statin and/or ezetimibe therapy

AND

3 - The patient is 10 years of age or older

AND

4 - One of the following:

4.1 Patient will be utilizing maximally tolerated statin therapy with or without ezetimibe concurrently with Repatha

OR

4.2 Documented intolerance to statin and/or ezetimibe therapy

OR

4.3 Medical rationale against use of statin or ezetimibe therapy

AND

5 - One of the following:

5.1 If the patient has a diagnosis of HoFH, one of the following:

5.1.1 The dose requested is 420 mg once monthly

OR

5.1.2 The dose requested is 420 mg every 2 weeks and one of the following:

- Patient has not achieved clinically meaningful response after at least 12 weeks at 420 mg once monthly dosing
- Patient is receiving lipid apheresis

OR

5.2 If the patient has a diagnosis of HeFH, one of the following:

5.2.1 The dose requested is 140 mg every 2 weeks

OR

5.2.2 The dose requested is 420 mg once monthly

OR

5.2.3 The dose requested is 420 mg every 2 weeks and patient is receiving lipid apheresis

Product Name: Repatha	
Diagnosis	ASCVD (Atherosclerotic Cardiovascular Disease), Primary hyperlipidemia, without clinical ASCVD, HoFH (Homozygous Familial Hypercholesterolemia), HeFH (Heterozygous Familial Hypercholesterolemia)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
REPATHA SURECLICK	EVOLOCUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 140 MG/ML	3935002000D520	Brand
REPATHA PUSHTRONEX SYSTEM	EVOLOCUMAB SUBCUTANEOUS SOLN CARTRIDGE/INFUSOR 420 MG/3.5ML	3935002000E230	Brand
REPATHA	EVOLOCUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 140 MG/ML	3935002000E520	Brand

Approval Criteria

1 - History of Repatha for at least 90 days within the past 120 days, confirmed by claims history or chart documentation

AND

2 - One of the following:

- Continued concurrent use of maximally tolerated statin therapy with or without ezetimibe
- Documented intolerance to statin and/or ezetimibe therapy OR medical rationale against use of statin or ezetimibe therapy

AND

3 - One of the following:

3.1 If the patient has a diagnosis of HoFH (homozygous familial hypercholesterolemia), one of the following:

3.1.1 The dose requested is 420 mg once monthly

OR

3.1.2 The dose requested is 420 mg every 2 weeks and one of the following:

- Patient has not achieved clinically meaningful response after at least 12 weeks at 420 mg once monthly dosing
- Patient is receiving lipid apheresis

OR

3.2 For all other diagnoses, one of the following:

3.2.1 The dose requested is 140 mg every 2 weeks

OR

3.2.2 The dose requested is 420 mg once monthly

OR

3.2.3 The dose requested is 420 mg every 2 weeks and patient is receiving lipid apheresis

AND

4 - One of the following:

4.1 Reduction in LDL-C from baseline

OR

4.2 Maintenance of goal LDL-C

2 . Background

Benefit/Coverage/Program Information

Table 1. Major ASCVD Events

Acute Coronary Syndrome (ACS) within the past 12 months
History of myocardial infarction (other than recent ACS event listed above)
History of ischemic stroke
Peripheral artery disease (PAD) with history of claudication with ABI <0.85
PAD with history of previous revascularization or amputation

Table 2. High-Risk Conditions

Age >/= 65 years
Heterozygous familial hypercholesterolemia
History of prior coronary artery bypass surgery outside of major ASCVD event

History of prior percutaneous coronary intervention outside of major ASCVD event
Diabetes mellitus
Hypertension
Chronic kidney disease (eGFR 15-59 mL/min/1.73m^2)
Current smoker
Persistently elevated LDL-C (>/= 100 mg/dL) despite maximally tolerated statin therapy plus ezetimibe
Congestive heart failure

Table 3. Secondary Causes of Dyslipidemia

Cholestatic Liver Disease
Chronic Renal Disease
Cigarette Smoking
Diabetes Mellitus
Excessive Alcohol Consumption
Extreme Dietary Patterns (e.g., anorexia nervosa)
Hypothyroidism
Medications (e.g., thiazide diuretics, beta blockers, oral estrogens)
Nephrotic Syndrome
Obesity

3 . Revision History

Date	Notes
9/16/2024	Updated Juxtapid pregnancy test language and Praluent HeFH min a ge and quantity limits. Corrected typo in step 2.2.1 of Repatha ASCV D section.

Pemazyre

Prior Authorization Guideline

Guideline ID	GL-136384
Guideline Name	Pemazyre
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2024

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
- 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
11/15/2023	Updated criteria for Myeloid/Lymphoid Neoplasms.

Phosphodiesterase Inhibitors for COPD

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-159180
Guideline Name	Phosphodiesterase Inhibitors for COPD
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	12/1/2024

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
ROFLUMILAST	ROFLUMILAST TAB 250 MCG	44450065000310	Generic
DALIRESP	ROFLUMILAST TAB 250 MCG	44450065000310	Brand
ROFLUMILAST	ROFLUMILAST TAB 500 MCG	44450065000320	Generic
DALIRESP	ROFLUMILAST TAB 500 MCG	44450065000320	Brand

Approval Criteria

1 - Patient has severe chronic obstructive pulmonary disease (COPD) associated with chronic bronchitis

AND

2 - Chart documentation shows patient has a history of exacerbations

AND

3 - Chart documentation shows patient has an FEV-1 that is less than or equal to 50% predicted

AND

4 - One of the following:

4.1 Patient is utilizing a combination long-acting beta-agonist (LABA)/long-acting muscarinic antagonist (LAMA)/inhaled corticosteroid (ICS) therapy for at least 90 days in the past 120 days

OR

4.2 BOTH of the following:

4.2.1 Prescriber has provided medical rationale for the use of Daliresp (roflumilast) over combination LAMA/LABA/ICS therapy

AND

4.2.2 One of the following:

- Member is utilizing combination LABA/LAMA therapy for at least 90 days in the past 120 days

- Prescriber has provided medical rationale for the use of Daliresp (roflumilast) over combination LABA/LAMA therapy

AND

5 - One of the following:

5.1 Prescriber attests patient will continue to utilize appropriate adjunct therapy while on Daliresp (roflumilast)

OR

5.2 Prescriber has provided medical rationale for discontinuing use of adjunct therapy (please document)

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

Product Name	Generic Name	GPI	Brand/Generic
OHTUVAYRE	ENSIFENTRINE INHALATION SUSP 3 MG/2.5ML	44430020001820	Brand

Approval Criteria

1 - Patient has diagnosis of chronic obstructive pulmonary disease (COPD)

AND

2 - Chart documentation shows patient has an FEV-1/FVC ratio of less than 0.7 measured by spirometry

AND

3 - Chart documentation shows patient has a Modified Medical Research Council (mMRC) dyspnea score of greater than or equal to 2

AND

4 - One of the following:

4.1 Patient is utilizing a combination long-acting beta-agonist (LABA)/long-acting muscarinic antagonist (LAMA)/inhaled corticosteroid (ICS) therapy for at least 90 days in the past 120 days

OR

4.2 BOTH of the following:

4.2.1 Prescriber has provided medical rationale for the use of Ohtuvayre (ensifentrine) over combination LAMA/LABA/ICS therapy

AND

4.2.2 One of the following:

- Member is utilizing combination LABA/LAMA therapy for at least 90 days in the past 120 days
- Prescriber has provided medical rationale for the use of Ohtuvayre (ensifentrine) over combination LABA/LAMA therapy

AND

5 - One of the following:

5.1 Prescriber attests patient will continue to utilize appropriate adjunct therapy while on Ohtuvayre (ensifentrine)

OR

5.2 Prescriber has provided medical rationale for discontinuing use of adjunct therapy (please document)

Product Name: Brand Daliresp, generic roflumilast, Ohtuvayre	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ROFLUMILAST	ROFLUMILAST TAB 250 MCG	44450065000310	Generic
DALIRESP	ROFLUMILAST TAB 250 MCG	44450065000310	Brand
ROFLUMILAST	ROFLUMILAST TAB 500 MCG	44450065000320	Generic
DALIRESP	ROFLUMILAST TAB 500 MCG	44450065000320	Brand
OHTUVAYRE	ENSIFENTRINE INHALATION SUSP 3 MG/2.5ML	44430020001820	Brand

Approval Criteria

1 - History of the requested agent for at least 90 days within the past 120 days, as confirmed by claims history, chart documentation, or provider attestation including dates of trial

AND

2 - One of the following:

2.1 Patient is continuing to utilize adjunct therapy, as applicable

OR

2.2 Medical rationale has been provided for not continuing adjunct therapy (please document)

2 . Revision History

Date	Notes
11/4/2024	New

Piqray

Prior Authorization Guideline

Guideline ID	GL-147148
Guideline Name	Piqray
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2024

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 ova rian ablation/suppression, or male under BC initial auth section; Mino r verbiage update to NCCN Recommended Regimens initial auth sec tion (with no changes to clinical intent).

Pomalyst

Prior Authorization Guideline

Guideline ID	GL-151385
Guideline Name	Pomalyst
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	9/1/2024

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
8/13/2024	Updated criteria for multiple myeloma and Kaposi sarcoma.

Pompe Disease Agents

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-154706
Guideline Name	Pompe Disease Agents
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name: Opfolda	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

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 confirmed by ONE of the following (submission of documentation required):

1.1 Deficiency of acid alpha-glucosidase (GAA) enzyme

OR

1.2 GAA genotyping or gene sequencing

AND

2 - Patient is 18 years of age or older

AND

3 - Patient weighs greater than or equal to 40 kilograms

AND

4 - Prescriber attests that patient will be using Opfolda (miglustat) and Pombiliti (cipaglucosidase alfa) concurrently

AND

5 - Prescriber attests that patient will NOT be using Opfolda (miglustat) concurrently with Lumizyme (alglucosidase alfa) or Nexviazyme (avalglucosidase alfa)

AND

6 - Prescribed by, or in consultation with, a geneticist, metabolic disorder specialist or neurologist

AND

7 - For those of childbearing potential, documentation of a negative pregnancy test from within the past 30 days and prescriber has counseled patient on risks associated with conceiving while utilizing Pombiliti/Opfolda and medically appropriate methods of contraception

AND

8 - Dose requested does not exceed 260 milligrams every other week (8 capsules/28 days)

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

Product Name	Generic Name	GPI	Brand/Generic
OPFOLDA	MIGLUSTAT (GAA DEFICIENCY) CAP 65 MG	30907760000120	Brand

Approval Criteria

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

AND

2 - Prescriber attests to ALL of the following:

2.1 Opfolda (miglustat) will continue to be used in conjunction with Pombiliti (cipaglucosidase alfa)

AND

2.2 For those of childbearing potential, patient is not currently pregnant and prescriber has counseled patient regarding medically appropriate methods of contraception

AND

2.3 Patient will NOT be using Opfolda (miglustat) concurrently with Lumizyme (alglucosidase alfa) or Nexviazyme (avalglucosidase alfa)

AND

3 - Prescriber has submitted documentation supporting improvement or stabilization in disease state (e.g., forced vital capacity, six-minute walk test)

AND

4 - Dose requested does not exceed 260 milligrams every other week (8 capsules/28 days)

2 . Revision History

Date	Notes
9/10/2024	Criteria added to not use Opfolda with Lumizyme or Nexviazyme.

Preferred Non-Solid Dosage Forms

Prior Authorization Guideline

Guideline ID	GL-122060
Guideline Name	Preferred Non-Solid Dosage Forms
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/16/2023

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

3.1.2.2 There are no preferred formulary alternatives for the requested drug

OR

3.2 Patient is unable to swallow a solid dosage form

OR

3.3 Patient utilizes a feeding tube for medication administration

OR

3.4 Request is for a nebulized formulation of an inhaled medication for a patient who has an inability to effectively utilize an agent in an inhaler formulation due to neuromuscular or cognitive disability, or other evidence of lack of response to the inhaled formulation supported by clinical documentation

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

Presbyopia Agents

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-123777
Guideline Name	Presbyopia Agents
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	7/1/2023

1 . Criteria

Product Name: Vuity	
Approval Length	1 year(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 18 years of age or older

AND

3 - Prescribed by, or in consultation with, an optometrist or ophthalmologist

AND

4 - Previous trial/failure/intolerance of corrective lenses (e.g., eyeglasses, contact lenses)

Product Name: Vuity	
Approval Length	1 year(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 - History of the requested agent in the past 90 days

Notes	*If patient does not meet history requirement for reauthorization criteria, please refer to initial authorization criteria

2 . Revision History

Date	Notes
4/11/2023	SPDL eff 7.1.23

Prevymis

Prior Authorization Guideline

Guideline ID	GL-129062
Guideline Name	Prevymis
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	10/1/2023

1 . Criteria

Product Name: Prevymis tabs	
Diagnosis	Cytomegalovirus Prophylaxis
Approval Length	9 month(s)
Guideline Type	Prior Authorization

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-109261
Guideline Name	Procysbi
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	9/1/2022

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

Progesterone – Non-Oral

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-147395
Guideline Name	Progesterone – Non-Oral
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2024

1 . Criteria

Product Name: Endometrin	
Approval Length	6 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
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)

2 . Revision History

Date	Notes
5/14/2024	New

Promacta, Alvaiz

Prior Authorization Guideline

Guideline ID	GL-160752
Guideline Name	Promacta, Alvaiz
Formulary	• Medicaid - Community & State Indiana

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

Proton Pump Inhibitors

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-150081
Guideline Name	Proton Pump Inhibitors
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	8/1/2024

1 . Criteria

Product Name: (All Rx and OTC Products per label name included) generic omeprazole tabs, Brand Prilosec tabs, Brand Protonix tabs, Brand Prevacid caps, Nexium caps, generic rabeprazole tabs, Brand Aciphex tabs, generic dexlansoprazole caps, generic omeprazole/sodium bicarb caps, Brand Zegerid caps, omeprazole 20.6 mg caps, omeprazole ODT, generic esomeprazole 24HR, Brand Nexium 24HR	
Diagnosis	Non-Preferred Products - NOT exceeding 90 days PPI therapy within past 180 days
Approval Length	90 Days*
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

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
TGT 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 24HR	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	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	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 CLEAR MINIS	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	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
NEXIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
NEXIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
NEXIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
NEXIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
NEXIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
NEXIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
ACIPHEX	RABEPRAZOLE SODIUM EC TAB 20 MG	49270076100620	Brand
RABEPRAZOLE SODIUM	RABEPRAZOLE SODIUM EC TAB 20 MG	49270076100620	Generic
OMEPRAZOLE	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
CVS OMEPRAZOLE/SODIUM BICARBONATE	OMEPRAZOLE-SODIUM BICARBONATE CAP 20-1100 MG	49996002600120	Generic
ZEGERID	OMEPRAZOLE-SODIUM BICARBONATE CAP 20-1100 MG	49996002600120	Brand
OMEPRAZOLE/SODIUM BICARBONATE	OMEPRAZOLE-SODIUM BICARBONATE CAP 20-1100 MG	49996002600120	Generic
ZEGERID	OMEPRAZOLE-SODIUM BICARBONATE CAP 40-1100 MG	49996002600140	Brand
OMEPRAZOLE/SODIUM BICARBONATE	OMEPRAZOLE-SODIUM BICARBONATE CAP 40-1100 MG	49996002600140	Generic
OMEPRAZOLE	OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV)	49270060106520	Generic
OMEPRAZOLE ODT	OMEPRAZOLE TABLET DELAYED RELEASE DISINTEGRATING 20 MG	4927006000H320	Generic
ESOMEPRAZOLE MAGNESIUM DR24HR	ESOMEPRAZOLE MAGNESIUM TAB DELAYED RELEASE 20 MG	49270025100620	Generic

NEXIUM 24HR	ESOMEPRAZOLE MAGNESIUM TAB DELAYED RELEASE 20 MG	49270025100620	Brand
NEXIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 40 MG (BASE EQ)	49270025106540	Brand

Approval Criteria

1 - One of the following**:

1.1 Trial and failure history of two different (chemical entities) preferred agents within the same subclass for a total duration of 4 weeks (supported by chart documentation or claims history)

OR

1.2 Prescriber has submitted medical justification for use of the requested non-preferred agent over ALL preferred agents within the same subclass

Notes	*Approval duration should not allow member to exceed 90 days of PPI therapy within 180 days **PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name: (All Rx and OTC Products per label name included) generic omeprazole tabs, Brand Prilosec tabs, Brand Protonix tabs, Brand Prevacid caps, Nexium caps, generic rabeprazole tabs, Brand Aciphex tabs, generic dexlansoprazole caps, generic omeprazole/sodium bicarb caps, Brand Zegerid caps, omeprazole 20.6 mg caps, omeprazole ODT, generic esomeprazole 24HR, Brand Nexium 24HR

Diagnosis	Non-Preferred Products - NOT exceeding 90 days PPI therapy within past 180 days
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

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
TGT 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 24HR	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	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	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 CLEAR MINIS	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	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
NEXIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
NEXIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
NEXIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
NEXIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
NEXIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
NEXIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	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
OMEPRAZOLE	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
CVS OMEPRAZOLE/SODIUM BICARBONATE	OMEPRAZOLE-SODIUM BICARBONATE CAP 20-1100 MG	49996002600120	Generic
ZEGERID	OMEPRAZOLE-SODIUM BICARBONATE CAP 20-1100 MG	49996002600120	Brand
OMEPRAZOLE/SODIUM BICARBONATE	OMEPRAZOLE-SODIUM BICARBONATE CAP 20-1100 MG	49996002600120	Generic
ZEGERID	OMEPRAZOLE-SODIUM BICARBONATE CAP 40-1100 MG	49996002600140	Brand
OMEPRAZOLE/SODIUM BICARBONATE	OMEPRAZOLE-SODIUM BICARBONATE CAP 40-1100 MG	49996002600140	Generic
OMEPRAZOLE	OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV)	49270060106520	Generic
OMEPRAZOLE ODT	OMEPRAZOLE TABLET DELAYED RELEASE DISINTEGRATING 20 MG	4927006000H320	Generic
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 - History of the requested agent within the past 365 days

Product Name: (All Rx and OTC Products per label name included) generic omeprazole caps, Brand Prilosec tabs, generic omeprazole tabs, generic pantoprazole tabs, Brand Protonix tabs, generic lansoprazole caps, Brand Prevacid caps, generic esomeprazole magnesium caps, Brand Nexium caps, generic rabeprazole tabs, Brand Aciphex tabs, generic dexlansoprazole caps, Brand Dexilant caps, generic omeprazole/sodium bicarb caps, Brand Zegerid caps, omeprazole 20.6 mg caps, omeprazole ODT, generic esomeprazole 24HR, Brand Nexium 24HR

Diagnosis	Exceeding 90 days PPI therapy within past 180 days
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

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 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
TGT 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
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
HEARTBURN TREATMENT 24 HOUR	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Generic
HM LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Generic
KLS LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Generic
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
RA LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Generic
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
GOODSENSE 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
GOODSENSE 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	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
NEXIUM 24HR	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	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	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 CLEAR MINIS	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
SM 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
RA 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
RA 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	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	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	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
GNP ESOMEPRAZOLE MAGNESIUM	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
NEXIUM 24HR	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
NEXIUM 24HR	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
CVS ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
CVS ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
CVS 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
HM ESOMEPRAZOLE MAGNESIUM DELAYED RELEASE	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
HM ESOMEPRAZOLE MAGNESIUM DELAYED RELEASE	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
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
CVS ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic

CVS ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
CVS 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	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
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
SM ESOMEPRAZOLE MAGNESIUM	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
GNP 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
KLS 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	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	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
NEXIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
NEXIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
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
NEXIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
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	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	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	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	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	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	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	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
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	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
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
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	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	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	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	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	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	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	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 40 MG (BASE EQ)	49270025106540	Generic
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 CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
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
OMEPRAZOLE	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
CVS OMEPRAZOLE/SODIUM BICARBONATE	OMEPRAZOLE-SODIUM BICARBONATE CAP 20-1100 MG	49996002600120	Generic
ZEGERID	OMEPRAZOLE-SODIUM BICARBONATE CAP 20-1100 MG	49996002600120	Brand
OMEPRAZOLE/SODIUM BICARBONATE	OMEPRAZOLE-SODIUM BICARBONATE CAP 20-1100 MG	49996002600120	Generic

ZEGERID	OMEPRAZOLE-SODIUM BICARBONATE CAP 40-1100 MG	49996002600140	Brand
OMEPRAZOLE/SODIUM BICARBONATE	OMEPRAZOLE-SODIUM BICARBONATE CAP 40-1100 MG	49996002600140	Generic
OMEPRAZOLE	OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV)	49270060106520	Generic
OMEPRAZOLE ODT	OMEPRAZOLE TABLET DELAYED RELEASE DISINTEGRATING 20 MG	4927006000H320	Generic
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 - One of the following:

1.1 Patient has one of the following diagnoses:

- Barrett's esophagus
- Abnormality of secretion of gastrin
- Zollinger-Ellison syndrome
- Any disease leading to hypersecretion

OR

1.2 Diagnosis of duodenal/gastric/peptic ulcer that has not healed* (see notes)

OR

1.3 Patient is on continuous drug therapy requiring gastroprotection (e.g. anticoagulants, corticosteroids, antiplatelet agents, NSAIDS, etc.)

OR

1.4 Both of the following:

1.4.1 Diagnosis of one of the following:

- Erosive esophagitis

- Gastroesophageal reflux disease (GERD)

AND

1.4.2 One of the following:

- Previous trial and failure of intermittent PPI therapy (patient has experienced discontinuation of PPI therapy)
- Previous trial and failure of H2 antagonist therapy
- Previous trial and failure of antacid therapy

AND

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

2.1 Trial and failure history of two different (chemical entities) preferred agents within the same subclass for a total duration of 4 weeks (supported by chart documentation or claims history)

OR

2.2 Prescriber has submitted medical justification for use of the requested non-preferred agent over ALL preferred agents within the same subclass

Notes	*Diagnosis of duodenal/gastric/peptic ulcer that has not healed: Approve only 4 additional weeks beyond patient's previous 90 days of use (permit a total of 118 days of therapy per 180 days). **PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name: (All Rx and OTC Products per label name included) Brand Prilosec susp packet, generic lansoprazole ODT, Brand Prevacid Solutab, Rabeprazole sprinkle, generic esomeprazole susp packet, generic pantoprazole susp packet, generic omeprazole/sodium bicarb powd pack, Brand Zegerid powd pack, Konvomep	
Diagnosis	Non-Preferred Non-Solid Dosage Forms - NOT exceeding 90 days PPI therapy within past 180 days
Approval Length	90 Days*
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

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
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 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
PANTOPRAZOLE SODIUM	PANTOPRAZOLE SODIUM FOR DELAYED RELEASE SUSP PACKET 40 MG	49270070103020	Generic
ZEGERID	OMEPRAZOLE-SODIUM BICARBONATE POWD PACK FOR SUSP 20-1680 MG	49996002603020	Brand
OMEPRAZOLE/SODIUM BICARBONATE	OMEPRAZOLE-SODIUM BICARBONATE POWD PACK FOR SUSP 20-1680 MG	49996002603020	Generic
ZEGERID	OMEPRAZOLE-SODIUM BICARBONATE POWD PACK FOR SUSP 40-1680 MG	49996002603040	Brand
OMEPRAZOLE/SODIUM BICARBONATE	OMEPRAZOLE-SODIUM BICARBONATE POWD PACK FOR SUSP 40-1680 MG	49996002603040	Generic
KONVOMEP	OMEPRAZOLE-SODIUM BICARBONATE FOR ORAL SUSP 2-84 MG/ML	49996002601920	Brand

RABEPRAZOLE SODIUM DR SPRINKLE	RABEPRAZOLE SODIUM CAPSULE SPRINKLE DR 10 MG	49270076106810	Brand

Approval Criteria

1 - Patient is unable to swallow tablet/capsule formulation

AND

2 - One of the following:

2.1 Trial and failure of both Brand Nexium Packets and Brand Protonix Pak for a total duration of 4 weeks (supported by chart documentation or claims history)

OR

2.2 Prescriber has submitted medical justification for use of the requested non-preferred agent over both Brand Nexium Packets and Brand Protonix Pak

Notes	*Approval duration should not allow member to exceed 90 days of PPI therapy within 180 days

Product Name: (All Rx and OTC Products per label name included) Brand Prilosec susp packet, generic lansoprazole ODT, Brand Prevacid Solutab, Rabeprazole sprinkle, generic esomeprazole susp packet, generic pantoprazole susp packet, generic omeprazole/sodium bicarb powd pack, Brand Zegerid powd pack, Konvomep	
Diagnosis	Non-Preferred Non-Solid Dosage Forms - NOT exceeding 90 days PPI therapy within past 180 days
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

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

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 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
PANTOPRAZOLE SODIUM	PANTOPRAZOLE SODIUM FOR DELAYED RELEASE SUSP PACKET 40 MG	49270070103020	Generic
ZEGERID	OMEPRAZOLE-SODIUM BICARBONATE POWD PACK FOR SUSP 20-1680 MG	49996002603020	Brand
OMEPRAZOLE/SODIUM BICARBONATE	OMEPRAZOLE-SODIUM BICARBONATE POWD PACK FOR SUSP 20-1680 MG	49996002603020	Generic
ZEGERID	OMEPRAZOLE-SODIUM BICARBONATE POWD PACK FOR SUSP 40-1680 MG	49996002603040	Brand
OMEPRAZOLE/SODIUM BICARBONATE	OMEPRAZOLE-SODIUM BICARBONATE POWD PACK FOR SUSP 40-1680 MG	49996002603040	Generic
KONVOMEP	OMEPRAZOLE-SODIUM BICARBONATE FOR ORAL SUSP 2-84 MG/ML	49996002601920	Brand
RABEPRAZOLE SODIUM DR SPRINKLE	RABEPRAZOLE SODIUM CAPSULE SPRINKLE DR 10 MG	49270076106810	Brand

Approval Criteria

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

Product Name: (All Rx and OTC Products per label name included) Brand Prilosec susp packet, generic lansoprazole ODT, Brand Prevacid Solutab, Rabeprazole sprinkle, generic esomeprazole susp packet, Brand Nexium packet, generic pantoprazole susp packet, Brand Protonix packet, generic omeprazole/sodium bicarb powd pack, Brand Zegerid powd pack, Konvomep	
Diagnosis	Non-Solid Dosage Forms - Exceeding 90 days PPI therapy within past 180 days
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

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
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 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

PANTOPRAZOLE SODIUM	PANTOPRAZOLE SODIUM FOR DELAYED RELEASE SUSP PACKET 40 MG	49270070103020	Generic
ZEGERID	OMEPRAZOLE-SODIUM BICARBONATE POWD PACK FOR SUSP 20-1680 MG	49996002603020	Brand
OMEPRAZOLE/SODIUM BICARBONATE	OMEPRAZOLE-SODIUM BICARBONATE POWD PACK FOR SUSP 20-1680 MG	49996002603020	Generic
ZEGERID	OMEPRAZOLE-SODIUM BICARBONATE POWD PACK FOR SUSP 40-1680 MG	49996002603040	Brand
OMEPRAZOLE/SODIUM BICARBONATE	OMEPRAZOLE-SODIUM BICARBONATE POWD PACK FOR SUSP 40-1680 MG	49996002603040	Generic
PROTONIX	PANTOPRAZOLE SODIUM FOR DELAYED RELEASE SUSP PACKET 40 MG	49270070103020	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
KONVOMEP	OMEPRAZOLE-SODIUM BICARBONATE FOR ORAL SUSP 2-84 MG/ML	49996002601920	Brand
RABEPRAZOLE SODIUM DR SPRINKLE	RABEPRAZOLE SODIUM CAPSULE SPRINKLE DR 10 MG	49270076106810	Brand

Approval Criteria

1 - One of the following:

1.1 Patient has one of the following diagnoses:

- Barrett's esophagus
- Abnormality of secretion of gastrin
- Zollinger-Ellison syndrome
- Any disease leading to hypersecretion

OR

1.2 Diagnosis of duodenal/gastric/peptic ulcer that has not healed* (see notes)

OR

1.3 Patient is on continuous drug therapy requiring gastroprotection (e.g. anticoagulants, corticosteroids, antiplatelet agents, NSAIDS, etc.)

OR

1.4 Both of the following:

1.4.1 Diagnosis of one of the following:

- Erosive esophagitis
- Gastroesophageal reflux disease (GERD)

AND

1.4.2 One of the following:

- Previous trial and failure of intermittent PPI therapy (patient has experienced discontinuation of PPI therapy)
- Previous trial and failure of H2 antagonist therapy
- Previous trial and failure of antacid therapy

AND

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

2.1 Patient is unable to swallow tablet/capsule formulation

AND

2.2 One of the following:

2.2.1 Trial and failure of both Brand Nexium Packets and Brand Protonix Pak for a total duration of 4 weeks (supported by chart documentation or claims history)

OR

2.2.2 Prescriber has submitted medical justification for use of the requested non-preferred agent over both Brand Nexium Packets and Brand Protonix Pak

Notes	*Diagnosis of duodenal/gastric/peptic ulcer that has not healed: Approve only 4 additional weeks beyond patient's previous 90 days of use (permit a total of 118 days of therapy per 180 days).

Product Name: (All Rx and OTC Products per label name included) generic omeprazole caps, Brand Prilosec tabs, generic omeprazole tabs, generic pantoprazole tabs, Brand Protonix tabs and susp packet, generic lansoprazole caps, Brand Prevacid caps, generic esomeprazole magnesium caps, Brand Nexium caps and susp packet, generic rabeprazole tabs, Brand Aciphex tabs, generic dexlansoprazole caps, Brand Dexilant caps, generic omeprazole/sodium bicarb caps, Brand Zegerid caps, Brand Prilosec susp packet, generic lansoprazole ODT, Brand Prevacid Solutab, Rabeprazole sprinkle, generic esomeprazole susp packet, generic pantoprazole susp packet, generic omeprazole/sodium bicarb powd pack, Brand Zegerid powd pack, Konvomep, omeprazole 20.6 mg caps, omeprazole ODT, generic esomeprazole 24HR, Brand Nexium 24HR

Diagnosis	Quantity Limit
Approval Length	90 Days*
Guideline Type	Quantity Limit (Max Daily Dose)

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
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
TGT 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
HEARTBURN TREATMENT 24 HOUR	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Generic
HM LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Generic
KLS LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Generic
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
RA LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Generic
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
GOODSENSE 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

GOODSENSE 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	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
NEXIUM 24HR	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	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	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 CLEAR MINIS	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
SM 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
RA 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
RA 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	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	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	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

GNP ESOMEPRAZOLE MAGNESIUM	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
NEXIUM 24HR	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
NEXIUM 24HR	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
CVS ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
CVS ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
CVS 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
HM ESOMEPRAZOLE MAGNESIUM DELAYED RELEASE	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
HM ESOMEPRAZOLE MAGNESIUM DELAYED RELEASE	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
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
CVS ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
CVS ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
CVS 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	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
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
SM ESOMEPRAZOLE MAGNESIUM	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
GNP 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
KLS 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	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	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
NEXIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
NEXIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
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
NEXIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
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	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	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	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	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	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	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	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
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	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
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
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	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	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	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	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	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	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	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 CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
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	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
DEXLANSOPRAZOLE	DEXLANSOPRAZOLE CAP DELAYED RELEASE 30 MG	49270020006520	Generic
DEXLANSOPRAZOLE	DEXLANSOPRAZOLE CAP DELAYED RELEASE 60 MG	49270020006530	Generic
CVS OMEPRAZOLE/SODIUM BICARBONATE	OMEPRAZOLE-SODIUM BICARBONATE CAP 20-1100 MG	49996002600120	Generic
ZEGERID	OMEPRAZOLE-SODIUM BICARBONATE CAP 20-1100 MG	49996002600120	Brand
OMEPRAZOLE/SODIUM BICARBONATE	OMEPRAZOLE-SODIUM BICARBONATE CAP 20-1100 MG	49996002600120	Generic
ZEGERID	OMEPRAZOLE-SODIUM BICARBONATE CAP 40-1100 MG	49996002600140	Brand
OMEPRAZOLE/SODIUM BICARBONATE	OMEPRAZOLE-SODIUM BICARBONATE CAP 40-1100 MG	49996002600140	Generic
ZEGERID	OMEPRAZOLE-SODIUM BICARBONATE POWD PACK FOR SUSP 20-1680 MG	49996002603020	Brand
OMEPRAZOLE/SODIUM BICARBONATE	OMEPRAZOLE-SODIUM BICARBONATE POWD PACK FOR SUSP 20-1680 MG	49996002603020	Generic
ZEGERID	OMEPRAZOLE-SODIUM BICARBONATE POWD PACK FOR SUSP 40-1680 MG	49996002603040	Brand
OMEPRAZOLE/SODIUM BICARBONATE	OMEPRAZOLE-SODIUM BICARBONATE POWD PACK FOR SUSP 40-1680 MG	49996002603040	Generic
KONVOMEP	OMEPRAZOLE-SODIUM BICARBONATE FOR ORAL SUSP 2-84 MG/ML	49996002601920	Brand
OMEPRAZOLE	OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV)	49270060106520	Generic
OMEPRAZOLE ODT	OMEPRAZOLE TABLET DELAYED RELEASE DISINTEGRATING 20 MG	4927006000H320	Generic
ESOMEPRAZOLE MAGNESIUM DR24HR	ESOMEPRAZOLE MAGNESIUM TAB DELAYED RELEASE 20 MG	49270025100620	Generic
NEXIUM 24HR	ESOMEPRAZOLE MAGNESIUM TAB DELAYED RELEASE 20 MG	49270025100620	Brand
RABEPRAZOLE SODIUM DR SPRINKLE	RABEPRAZOLE SODIUM CAPSULE SPRINKLE DR 10 MG	49270076106810	Brand

Approval Criteria

1 - One of the following:

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

OR

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

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex
- Clinical pharmacology
- United States Pharmacopoeia-National Formulary (USP-NF)

AND

2 - The drug is being prescribed within the manufacturer's published dosing guidelines or falls within dosing guidelines found in ONE of the following compendia of current literature

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex
- Clinical pharmacology
- United States Pharmacopoeia-National Formulary (USP-NF)

AND

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

AND

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

Notes	These criteria are from the Quantity Limits policy. *May approve UP TO 1 year if member meets drug-specific criteria for PPI therapy in excess of 90 days per 180 days; otherwise, approval should not exceed 90 days of therapy within 180 days.

Product Name: (All Rx and OTC Products per label name included) generic omeprazole caps, Brand Prilosec tabs, generic omeprazole tabs, generic pantoprazole tabs, Brand Protonix tabs and susp packet, generic lansoprazole caps, Brand Prevacid caps, generic esomeprazole magnesium caps, Brand Nexium caps and susp packet, generic rabeprazole tabs, Brand Aciphex tabs, generic dexlansoprazole caps, Brand Dexilant caps, generic omeprazole/sodium bicarb caps, Brand Zegerid caps, Brand Prilosec susp packet, generic lansoprazole ODT, Brand Prevacid Solutab, Rabeprazole sprinkle, generic esomeprazole susp packet, generic pantoprazole susp packet, generic omeprazole/sodium bicarb powd pack, Brand Zegerid powd pack, Konvomep, omeprazole 20.6 mg caps, omeprazole ODT, generic esomeprazole 24HR, Brand Nexium 24HR

Diagnosis	Exceeding 90 days PPI therapy within past 180 days; Non-Solid Dosage Forms - Exceeding 90 days PPI therapy within past 180 days
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

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
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
TGT 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
HEARTBURN TREATMENT 24 HOUR	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Generic
HM LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Generic
KLS LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Generic
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
RA LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Generic
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
GOODSENSE 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
GOODSENSE 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	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
NEXIUM 24HR	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	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	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 CLEAR MINIS	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
SM 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
RA 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
RA 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	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	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	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
GNP ESOMEPRAZOLE MAGNESIUM	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
NEXIUM 24HR	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
NEXIUM 24HR	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
CVS ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
CVS ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
CVS 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
HM ESOMEPRAZOLE MAGNESIUM DELAYED RELEASE	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
HM ESOMEPRAZOLE MAGNESIUM DELAYED RELEASE	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
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
CVS ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
CVS ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
CVS 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	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
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
SM ESOMEPRAZOLE MAGNESIUM	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
GNP 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
KLS 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	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	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
NEXIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
NEXIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
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
NEXIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
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	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	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	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	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	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	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	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic

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	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
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
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	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	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	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	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	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	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	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 CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
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	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
DEXLANSOPRAZOLE	DEXLANSOPRAZOLE CAP DELAYED RELEASE 30 MG	49270020006520	Generic
DEXLANSOPRAZOLE	DEXLANSOPRAZOLE CAP DELAYED RELEASE 60 MG	49270020006530	Generic
CVS OMEPRAZOLE/SODIUM BICARBONATE	OMEPRAZOLE-SODIUM BICARBONATE CAP 20-1100 MG	49996002600120	Generic

ZEGERID	OMEPRAZOLE-SODIUM BICARBONATE CAP 20-1100 MG	49996002600120	Brand
OMEPRAZOLE/SODIUM BICARBONATE	OMEPRAZOLE-SODIUM BICARBONATE CAP 20-1100 MG	49996002600120	Generic
ZEGERID	OMEPRAZOLE-SODIUM BICARBONATE CAP 40-1100 MG	49996002600140	Brand
OMEPRAZOLE/SODIUM BICARBONATE	OMEPRAZOLE-SODIUM BICARBONATE CAP 40-1100 MG	49996002600140	Generic
ZEGERID	OMEPRAZOLE-SODIUM BICARBONATE POWD PACK FOR SUSP 20-1680 MG	49996002603020	Brand
OMEPRAZOLE/SODIUM BICARBONATE	OMEPRAZOLE-SODIUM BICARBONATE POWD PACK FOR SUSP 20-1680 MG	49996002603020	Generic
ZEGERID	OMEPRAZOLE-SODIUM BICARBONATE POWD PACK FOR SUSP 40-1680 MG	49996002603040	Brand
OMEPRAZOLE/SODIUM BICARBONATE	OMEPRAZOLE-SODIUM BICARBONATE POWD PACK FOR SUSP 40-1680 MG	49996002603040	Generic
KONVOMEP	OMEPRAZOLE-SODIUM BICARBONATE FOR ORAL SUSP 2-84 MG/ML	49996002601920	Brand
OMEPRAZOLE	OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV)	49270060106520	Generic
OMEPRAZOLE ODT	OMEPRAZOLE TABLET DELAYED RELEASE DISINTEGRATING 20 MG	4927006000H320	Generic
ESOMEPRAZOLE MAGNESIUM DR24HR	ESOMEPRAZOLE MAGNESIUM TAB DELAYED RELEASE 20 MG	49270025100620	Generic
NEXIUM 24HR	ESOMEPRAZOLE MAGNESIUM TAB DELAYED RELEASE 20 MG	49270025100620	Brand
RABEPRAZOLE SODIUM DR SPRINKLE	RABEPRAZOLE SODIUM CAPSULE SPRINKLE DR 10 MG	49270076106810	Brand

Approval Criteria

1 - Patient has one of the following diagnoses:

- Barrett's esophagus
- Abnormality of secretion of gastrin
- Zollinger-Ellison syndrome
- Any disease leading to hypersecretion

OR

2 - Diagnosis of duodenal/gastric/peptic ulcer that has not healed* (see notes)

OR **3** - Patient is on continuous drug therapy requiring gastroprotection (e.g. anticoagulants, corticosteroids, antiplatelet agents, NSAIDS, etc.) **OR** **4** - Both of the following: **4.1** Diagnosis of erosive esophagitis or Gastroesophageal reflux disease (GERD) **AND** **4.2** Previous trial and failure of intermittent PPI therapy (member has trialed discontinuation of PPI therapy within the previous approval timeframe)	
Notes	*Diagnosis of duodenal/gastric/peptic ulcer that has not healed: Approve only 4 additional weeks

2 . Revision History

Date	Notes
7/22/2024	Removed age limits for non-solid dosage forms. Updated T/F language for non-solid dosage forms. Updated required value from ALL to 1 in step 1.4.1 pf Non-Solid Dosage Forms - Exceeding 90 days PPI therapy within past 180 days section.

Pulmonary Antihypertensives

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-150849
Guideline Name	Pulmonary Antihypertensives
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	8/2/2024

1 . Criteria

Product Name: Winrevair	
Approval Length	1 year(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 - Diagnosis of pulmonary arterial hypertension (WHO Group 1)

AND

2 - Prescribed by, or in consultation with, a pulmonologist or cardiologist

AND

3 - Patient is 18 years of age or older

AND

4 - One of the following:

4.1 Patient has previous trial and failure of at least 60 days of therapy with any agent from two of the following subcategories:

- Endothelin receptor antagonists
- Phosphodiesterase 5-inhibitors
- Prostacyclin receptor modulators
- Soluble guanylate cyclase stimulator

OR

4.2 Prescriber has provided valid medical justification for the use of Winrevair (sotatercept-csrk) over all agents within all of the following subcategories:

- Endothelin receptor antagonists
- Phosphodiesterase 5-inhibitors
- Prostacyclin receptor modulators
- Soluble guanylate cyclase stimulator

AND

5 - Prescriber attests to all of the following:

- Prescriber has obtained baseline hemoglobin (Hgb) and platelet count prior to initiating therapy
- Baseline platelet count is 50,000/mm3 (50 x 109/L) or greater
- Prescriber will continue to monitor Hgb and platelet count and adjust dosing per the prescribing information

AND

6 - Requested dose does not exceed 0.7 milligrams per kilogram (actual body weight) every 3 weeks

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

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 - History of the requested medication for at least 60 days within the past 90 days, confirmed by claims history or submission of medical records

AND

2 - Prescriber has submitted documentation (e.g., current and previous chart notes) explicitly supporting improvement or stabilization in disease state (e.g., WHO Functional Class classification, 6-minute walk test, etc.)

AND

3 - Requested dose does not exceed 0.7 milligrams per kilogram (actual body weight) every 3 weeks

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

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 - Diagnosis of pulmonary arterial hypertension (WHO Group 1)

AND

2 - Prescribed by, or in consultation with, a pulmonologist or cardiologist

AND

3 - One of the following:

- Previous trial and failure of separate components
- Prescriber has provided valid medical rationale for the use of macitentan/tadalafil combination over separate components

AND

4 - Requested dose does not exceed 10 milligrams/40 milligrams per day

AND

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

AND

6 - For female patients, patient is enrolled in the Opsynvi (macitentan/tadalafil) REMS (Risk Evaluation and Mitigation Strategy) program

AND

7 - Patient does not have an active claim for any of the following:

- Nitrate therapy
- PDE-5 inhibitor (other than the one being requested)
- Adempas (riociguat)

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

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 - History of the requested medication for at least 60 days within the past 90 days, confirmed by claims history or submission of medical records

AND

2 - Requested dose does not exceed 10 milligrams/40 milligrams per day

AND

3 - Patient does not have an active claim for any of the following:

- Nitrate therapy
- PDE-5 inhibitor (other than the one being requested)
- Adempas (riociguat)

Product Name: Brand Letairis, generic ambrisentan	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
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

Approval Criteria

1 - Diagnosis of arterial pulmonary hypertension

AND

2 - Prescribed by, or in consultation with, a pulmonologist or cardiologist

AND

3 - ONE of the following:

- Previous trial and failure of bosentan
- Prescriber has provided valid medical rationale of ambrisentan over bosentan

AND

4 - Requested dose does not exceed one of the following:

- 10 mg (milligrams)/day
- 5 mg/day if on concomitant cyclosporine therapy

AND

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

AND

6 - Patient is enrolled in the Ambrisentan or PS-Ambrisentan REMS program (female patients only)

Product Name: Brand Letairis, generic ambrisentan	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
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

Approval Criteria

1 - History of the requested medication for at least 60 days within the past 90 days, confirmed by claims history or submission of medical records

AND

2 - Requested dose does not exceed one of the following:

- 10 mg/day
- 5 mg/day if on concomitant cyclosporine therapy

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

Product Name	Generic Name	GPI	Brand/Generic
OPSUMIT	MACITENTAN TAB 10 MG	40160050000320	Brand

Approval Criteria

1 - Diagnosis of arterial pulmonary hypertension

AND

2 - Prescribed by, or in consultation with, a pulmonologist or cardiologist

AND

3 - ONE of the following:

- Previous trial and failure of bosentan
- Prescriber has provided valid medical rationale for the use of macitentan over bosentan

AND

4 - Requested dose does not exceed 10 mg/day

AND

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

AND

6 - Patient is enrolled in the Opsumit/macitentan REMS program (female patients only)

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

Product Name	Generic Name	GPI	Brand/Generic
OPSUMIT	MACITENTAN TAB 10 MG	40160050000320	Brand

Approval Criteria

1 - History of the requested medication for at least 60 days within the past 90 days, confirmed by claims history or submission of medical records

AND

2 - Requested dose does not exceed 10 mg/day

Product Name: Brand Tracleer, generic bosentan, Tracleer	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
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

Approval Criteria

1 - Diagnosis of arterial pulmonary hypertension

AND

2 - Prescribed by, or in consultation with, a pulmonologist or cardiologist

AND

3 - ONE of the following:

3.1 For adult patients (tablet formulation), ONE of the following:

3.1.1 Requested dose does not exceed 250 mg/day for patients weighing greater than 40 kg (kilograms)

OR

3.1.2 Requested dose does not exceed 125 mg/day for patients weighing less than or equal to 40 kg

OR

3.2 For pediatric patients 12 years of age or older (tablet formulation), ONE of the following:

3.2.1 Requested dose does not exceed 250 mg/day for patients weighing greater than 40 kg

OR

3.2.2 Requested dose does not exceed 125 mg/day for patients weighing less than or equal to 40 kg

OR

3.3 For pediatric patients less than or equal to 12 years of age (dispersible tablet formulation), ONE of the following:

3.3.1 Requested dose does not exceed 32 mg/day (1 dispersible tablet/day) for patients weighing 4 kg to 8 kg

OR

3.3.2 Requested dose does not exceed 64 mg/day (2 dispersible tablets/day) for patients weighing greater than 8 kg to 16 kg

OR

3.3.3 Requested dose does not exceed 96 mg/day (3 dispersible tablets/day) for patients weighing greater than 16 kg to 24 kg

OR

3.3.4 Requested dose does not exceed 128 mg/day (4 dispersible tablets/day) for patients weighing greater than 24 kg to 40 kg

AND

4 - Patient does not have active claims for cyclosporine-A or glyburide

AND

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

AND

6 - Patient is enrolled in the Tracleer/bosentan REMS program

Product Name: Brand Tracleer, generic bosentan, Tracleer	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
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

Approval Criteria

1 - History of the requested medication for at least 60 days within the past 90 days, confirmed by claims history or submission of medical records

AND

2 - Patient does not have active claims for cyclosporine-A or glyburide

AND

3 - ONE of the following:

3.1 For adult patients (tablet formulation), ONE of the following:

3.1.1 Requested dose does not exceed 250 mg/day for patients weighing greater than 40 kg (kilograms)

OR

3.1.2 Requested dose does not exceed 125 mg/day for patients weighing less than or equal to 40 kg

OR

3.2 For pediatric patients 12 years of age or older (tablet formulation), ONE of the following:

3.2.1 Requested dose does not exceed 250 mg/day for patients weighing greater than 40 kg

OR

3.2.2 Requested dose does not exceed 125 mg/day for patients weighing less than or equal to 40 kg

OR

3.3 For pediatric patients less than or equal to 12 years of age (dispersible tablet formulation), ONE of the following:

3.3.1 Requested dose does not exceed 32 mg/day (1 dispersible tablet/day) for patients weighing 4 kg to 8 kg

OR

3.3.2 Requested dose does not exceed 64 mg/day (2 dispersible tablets/day) for patients weighing greater than 8 kg to 16 kg

OR

3.3.3 Requested dose does not exceed 96 mg/day (3 dispersible tablets/day) for patients weighing greater than 16 kg to 24 kg

OR

3.3.4 Requested dose does not exceed 128 mg/day (4 dispersible tablets/day) for patients weighing greater than 24 kg to 40 kg

Product Name: Liqrev	
Approval Length	1 year(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

Approval Criteria

1 - Diagnosis of arterial pulmonary hypertension

AND

2 - Prescribed by, or in consultation with, a pulmonologist or cardiologist

AND

3 - Requested dose does not exceed 60 mg/day

AND

4 - Patient is 18 years of age or older

AND

5 - Patient is unable to swallow tablet formulation of sildenafil

AND

6 - ONE of the following:

6.1 Patient has previous trial and failure of Revatio suspension

OR

6.2 Provider has submitted medical rationale for use of Liqrev suspension over Revatio suspension

AND

7 - Patient does not have an active claim for any of the following:

- Nitrate therapy
- Adempas (riociguat)
- Reyataz (atazanavir)
- Prezista (darunavir)
- Lexiva (fosamprenavir)
- Crixivan (indinavir)
- Kaletra (lopinavir/ritonavir)
- Viracept (nelfinavir)
- Norvir (ritonavir)

- Invirase (saquinavir)
- Aptivus (tipranavir)
- PDE-5 inhibitor (other than the one being requested)

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

Product Name	Generic Name	GPI	Brand/Generic
LIQREV	SILDENAFIL CITRATE ORAL SUSP 10 MG/ML	40143060101825	Brand

Approval Criteria

1 - History of the requested medication for at least 60 days within the past 90 days, confirmed by claims history or submission of medical records

AND

2 - Patient is unable to swallow tablet formulation of sildenafil

AND

3 - ONE of the following:

3.1 Patient has previous trial and failure of Revatio suspension

OR

3.2 Provider has submitted medical rationale for use of Liqrev suspension over Revatio suspension

AND

4 - Requested dose does not exceed 60 mg/day

AND

5 - Patient does not have an active claim for any of the following:

- Nitrate therapy
- Adempas (riociguat)
- Reyataz (atazanavir)
- Prezista (darunavir)
- Lexiva (fosamprenavir)
- Crixivan (indinavir)
- Kaletra (lopinavir/ritonavir)
- Viracept (nelfinavir)
- Norvir (ritonavir)
- Invirase (saquinavir)
- Aptivus (tipranavir)
- PDE-5 inhibitor (other than the one being requested)

Product Name: Brand Revatio, generic sildenafil	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
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

Approval Criteria

1 - Diagnosis of arterial pulmonary hypertension

AND

2 - Prescribed by, or in consultation with, a pulmonologist or cardiologist

AND

3 - Requested dose does not exceed 60 mg/day

AND

4 - Patient does not have an active claim for any of the following:

- Nitrate therapy
- Adempas (riociguat)
- Reyataz (atazanavir)
- Prezista (darunavir)
- Lexiva (fosamprenavir)
- Crixivan (indinavir)
- Kaletra (lopinavir/ritonavir)
- Viracept (nelfinavir)
- Norvir (ritonavir)
- Invirase (saquinavir)
- Aptivus (tipranavir)
- PDE-5 inhibitor (other than the one being requested)

AND

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

- Patient is under 12 years of age
- Patient is 12 years of age or older and unable to swallow tablet formulation of sildenafil

Product Name: Brand Revatio, generic sildenafil	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
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

Approval Criteria

1 - History of the requested medication for at least 60 days within the past 90 days, confirmed by claims history or submission of medical records

AND

2 - Requested dose does not exceed 60 mg/day

AND

3 - Patient does not have an active claim for any of the following:

- Nitrate therapy
- Adempas (riociguat)
- Reyataz (atazanavir)
- Prezista (darunavir)
- Lexiva (fosamprenavir)
- Crixivan (indinavir)
- Kaletra (lopinavir/ritonavir)
- Viracept (nelfinavir)
- Norvir (ritonavir)
- Invirase (saquinavir)
- Aptivus (tipranavir)
- PDE-5 inhibitor (other than the one being requested)

AND

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

- Patient is under 12 years of age
- Patient is 12 years of age or older and unable to swallow tablet formulation of sildenafil

Product Name: Brand Adcirca, generic tadalafil, Alyq	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

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 - Diagnosis of arterial pulmonary hypertension

AND

2 - Prescribed by, or in consultation with, a pulmonologist or cardiologist

AND

3 - Requested dose does not exceed 40 mg/day

AND

4 - Patient does not have an active claim for any of the following:

- Nitrate therapy
- PDE5 inhibitor (other than the one being requested)
- Adempas (riociguat)

AND

5 - If the request is for Alyq, the patient has a trial and failure of generic tadalafil or medical justification for use

Product Name: Brand Adcirca, generic tadalafil, Alyq	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

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 - History of the requested medication for at least 60 days within the past 90 days, confirmed by claims history or submission of medical records

AND

2 - Requested dose does not exceed 40 mg/day

AND

3 - Patient does not have an active claim for any of the following:

- Nitrate therapy
- PDE-5 inhibitor (other than the one being requested)
- Adempas (riociguat)

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

Product Name	Generic Name	GPI	Brand/Generic
TADLIQ	TADALAFIL ORAL SUSP 20 MG/5ML (PAH)	40143080001820	Brand

Approval Criteria

1 - Diagnosis of arterial pulmonary hypertension

AND

2 - Prescribed by, or in consultation with, a pulmonologist or cardiologist

AND

3 - ONE of the following:

- Previous trial and failure of Revatio suspension
- Prescriber has provided valid medical rationale for the use of Tadliq over Revatio suspension

AND

4 - Requested dose does not exceed 40 mg/day

AND

5 - ONE of the following:

- Patient is under 12 years of age
- Patient is 12 years of age or older and unable to swallow tablet formulation of tadalafil

AND

6 - Patient does not have an active claim for any of the following:

- Nitrate therapy
- PDE-5 inhibitor (other than the one being requested)
- Adempas (riociguat)

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

Product Name	Generic Name	GPI	Brand/Generic
TADLIQ	TADALAFIL ORAL SUSP 20 MG/5ML (PAH)	40143080001820	Brand

Approval Criteria

1 - History of the requested medication for at least 60 days within the past 90 days, confirmed by claims history or submission of medical records

AND

2 - Requested dose does not exceed 40 mg/day

AND

3 - Patient does not have an active claim for any of the following:

- Nitrate therapy
- PDE-5 inhibitor (other than the one being requested)
- Adempas (riociguat)

AND

4 - ONE of the following:

- Patient is under 12 years of age
- Patient is 12 years of age or older and unable to swallow tablet formulation of tadalafil

Product Name: Orenitram, Orenitram titration kit	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

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
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

Approval Criteria

1 - Diagnosis of arterial pulmonary hypertension

AND

2 - Prescribed by, or in consultation with, a pulmonologist or cardiologist

AND

3 - Patient does not have severe hepatic impairment (Child-Pugh class C)

Product Name: Orenitram, Orenitram titration kit	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

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
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

Approval Criteria

1 - History of the requested medication for at least 60 days within the past 90 days, confirmed by claims history or submission of medical records

AND

2 - Patient does not have severe hepatic impairment (Child-Pugh class C)

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

Product Name	Generic Name	GPI	Brand/Generic
TYVASO	TREPROSTINIL INHALATION SOLUTION 0.6 MG/ML	40170080002020	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 MAINTENANCE KIT	TREPROSTINIL INH POWDER 112 X 32MCG & 112 X 48MCG	40170080002960	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 REFILL KIT	TREPROSTINIL INHALATION SOLUTION 0.6 MG/ML	40170080002020	Brand
TYVASO STARTER KIT	TREPROSTINIL INHALATION SOLUTION 0.6 MG/ML	40170080002020	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 - Diagnosis of arterial pulmonary hypertension or pulmonary hypertension associated with interstitial lung disease

AND

2 - Prescribed by, or in consultation with, a pulmonologist or cardiologist

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

Product Name	Generic Name	GPI	Brand/Generic
TYVASO	TREPROSTINIL INHALATION SOLUTION 0.6 MG/ML	40170080002020	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 MAINTENANCE KIT	TREPROSTINIL INH POWDER 112 X 32MCG & 112 X 48MCG	40170080002960	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 REFILL KIT	TREPROSTINIL INHALATION SOLUTION 0.6 MG/ML	40170080002020	Brand
TYVASO STARTER KIT	TREPROSTINIL INHALATION SOLUTION 0.6 MG/ML	40170080002020	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 - History of the requested medication for at least 60 days within the past 90 days, confirmed by claims history or submission of medical records

Product Name: Uptravi, Uptravi Titration Pack	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
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
UPTRAVI	SELEXIPAG FOR IV SOLN 1800 MCG	40120070002120	Brand
UPTRAVI TITRATION PACK	SELEXIPAG TAB THERAPY PACK 200 MCG (140) & 800 MCG (60)	4012007000B720	Brand

Approval Criteria

1 - Diagnosis of arterial pulmonary hypertension

AND

2 - Prescribed by, or in consultation with, a pulmonologist or cardiologist

AND

3 - Patient does not have an active claim for CYP2C8 (enzyme) inhibitor (e.g., gemfibrozil)

AND

4 - ONE of the following:

- Previous trial and failure of Orenitram
- Prescriber has submitted valid medical rationale for the use of Uptravi over Orenitram

Product Name: Uptravi, Uptravi Titration Pack	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

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
UPTRAVI	SELEXIPAG FOR IV SOLN 1800 MCG	40120070002120	Brand
UPTRAVI TITRATION PACK	SELEXIPAG TAB THERAPY PACK 200 MCG (140) & 800 MCG (60)	4012007000B720	Brand

Approval Criteria

1 - History of the requested medication for at least 60 days within the past 90 days, confirmed by claims history or submission of medical records

AND

2 - Patient does not have an active claim for CYP2C8 inhibitor (e.g., gemfibrozil)

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

Product Name	Generic Name	GPI	Brand/Generic
VENTAVIS	ILOPROST INHALATION SOLUTION 10 MCG/ML	40170060002020	Brand
VENTAVIS	ILOPROST INHALATION SOLUTION 20 MCG/ML	40170060002040	Brand

Approval Criteria

1 - Diagnosis of arterial pulmonary hypertension

AND

2 - Prescribed by, or in consultation with, a pulmonologist or cardiologist

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

Product Name	Generic Name	GPI	Brand/Generic
VENTAVIS	ILOPROST INHALATION SOLUTION 10 MCG/ML	40170060002020	Brand
VENTAVIS	ILOPROST INHALATION SOLUTION 20 MCG/ML	40170060002040	Brand

Approval Criteria

1 - History of the requested medication for at least 60 days within the past 90 days, confirmed by claims history or submission of medical records

Product Name: Adempas	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
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 - ONE of the following:

- Diagnosis of arterial pulmonary hypertension
- Diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH)

AND

2 - Prescribed by, or in consultation with, a pulmonologist or cardiologist

AND

3 - Requested dose does not exceed 7.5 mg/day (patients who smoke may require further dosing evaluation)

AND

4 - Patient does not have an active claim for any of the following:

- Nitrate therapy
- PDE-5 inhibitor
- Non-specific PDE inhibitor (dipyridamole, theophylline, aminophylline)
- Verquvo (vericiguat)

AND

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

AND

6 - Patient is enrolled in the Adempas REMS program (female patients only)

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

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 - History of the requested medication for at least 60 days within the past 90 days, confirmed by claims history or submission of medical records

AND

2 - Requested dose does not exceed 7.5 mg/day (patients who smoke may require further dosing evaluation)

AND

3 - Patient does not have an active claim for any of the following:

- Nitrate therapy
- PDE-5 inhibitor
- Non-specific PDE inhibitor (dipyridamole, theophylline, aminophylline)
- Verquvo (vericiguat)

2 . Revision History

Date	Notes
8/2/2024	Updated Tyvaso DPI GPIs. Added Winrevair and Opsynvi. Updated d iagnosis to add arterial. Updated pregnancy test language.

Pulmozyme

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-147428
Guideline Name	Pulmozyme
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2024

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

2 . Revision History

Date	Notes
5/15/2024	Updated generic name in GPI table. Removed dx header and minor cosmetic updates. No changes to clinical intent.

Qbrexza

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-125831
Guideline Name	Qbrexza
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	7/1/2023

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)

2 . Revision History

Date	Notes
5/16/2023	New

Qinlock

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-156862
Guideline Name	Qinlock
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	11/1/2024

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

2 . Revision History

Date	Notes
10/1/2024	Updated disease type for GIST based on NCCN recommendations

Quantity Limits

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-128960
Guideline Name	Quantity Limits
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	10/1/2023

1 . Criteria

Product Name: Quantity Limit, Prescription Limit	
Diagnosis	Quantity limit review (General)
Approval Length	12 month(s)
Guideline Type	Administrative

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 appropriate trained professional (physician or pharmacist) based on the applicable regulatory requirement.

Product Name: Quantity Limit, Prescription Limit

Diagnosis	Monthly prescription limit review for migraine therapy, benzodiazepines, or muscle relaxants
Approval Length	1 month(s)
Guideline Type	Administrative

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.

2 . Revision History

Date	Notes

7/25/2023	Updated guideline name. Defined FDA and reformatted step 2 of Quantity limit review (General) section.

Radicava ORS

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-156416
Guideline Name	Radicava ORS
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	11/1/2024

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
9/27/2024	Clarified criteria for existing prior authorization to be under the medic al benefit. Updated initial and reauth durations to 12 months.

Rayos

Prior Authorization Guideline

Guideline ID	GL-161328
Guideline Name	Rayos
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2025

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

2 . Revision History

Date	Notes
11/26/2024	Minor updates to embedded step criterion (no changes to clinical inte nt).

Rectiv

Prior Authorization Guideline

Guideline ID	GL-82128
Guideline Name	Rectiv
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2021

1 . Criteria

Product Name: Rectiv	
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

Approval Criteria

1 - Diagnosis of moderate to severe pain associated with chronic anal fissures

2 . Revision History

Date	Notes
3/5/2021	Bulk Load

Regranex

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-82129
Guideline Name	Regranex
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2021

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

2 . Revision History

Date	Notes
3/5/2021	Bulk Load

Relyvrio

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-139117
Guideline Name	Relyvrio
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	3/1/2024

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

Repository Corticotropins

Prior Authorization Guideline

Guideline ID	GL-114249
Guideline Name	Repository Corticotropins
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	11/1/2022

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 treatment 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 **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: The Acthar Gel and Purified Cortrophin Gel package inserts have listed other conditions in which it may be used. UHCP has determined that use of Acthar Gel and Purified Cortrophin Gel is not medically necessary for treatment of the following disorders and diseases: multiple sclerosis; rheumatic; collagen; dermatologic; allergic states; ophthalmic; respiratory; and edematous state.

3 . Revision History

Date	Notes
9/22/2022	Updated background

Respiratory and Allergy Biologics

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-155000
Guideline Name	Respiratory and Allergy Biologics
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name: Dupixent	
Diagnosis	Asthma
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 300 MG/2ML	9027302000D520	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 200 MG/1.14ML	9027302000D515	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 asthma (eosinophilic phenotype or corticosteroid-dependent)

AND

2 - Patient is 6 years of age or older

AND

3 - Patient is utilizing ONE of the following inhaled asthma treatments for 90 of the past 120 days:

- High-dose inhaled corticosteroid (ICS) AND a long-acting beta 2 agonist (LABA) concurrently
- High-dose ICS/LABA combination product
- High-dose ICS/long acting antimuscarinic (LAMA)/LABA combination product

AND

4 - Dupixent will be used as adjunct therapy along with one of the above inhaled asthma treatments

AND

5 - Patient has inadequately controlled asthma as evidenced by ONE of the following:

- Greater than or equal to 3 canisters of a short-acting beta 2 agonist (SABA) in past 60 days
- Oral steroid use in the past 45 days
- ER (emergency room) visit with primary diagnosis of asthma in past 45 days

Product Name: Dupixent

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

Product Name	Generic Name	GPI	Brand/Generic
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 300 MG/2ML	9027302000D520	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 200 MG/1.14ML	9027302000D515	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 atopic dermatitis

AND

2 - Patient is 6 months of age or older

AND

3 - Patient has had greater than or equal to 45 days of topical drug therapy with ONE of the following:

- Pimecrolimus
- Tacrolimus
- Corticosteroids

Product Name: Dupixent	
Diagnosis	Eosinophilic Esophagitis
Approval Length	6 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 300 MG/2ML	9027302000D520	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 200 MG/1.14ML	9027302000D515	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 1 year of age or older

AND

3 - Patient weighs 15 kg (kilograms) or more

AND

4 - One of the following:

4.1 Patient is 10 years of age or younger

OR

4.2 Patient has had a trial and failure of a 12-week course of Eohilia (budesonide) suspension

OR

4.3 Provider has documented valid medical justification for the use Dupixent (dupilumab) over Eohilia (budesonide) (please document)

Product Name: Dupixent	
Diagnosis	Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 200 MG/1.14ML	9027302000E515	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML	9027302000E520	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 300 MG/2ML	9027302000D520	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 200 MG/1.14ML	9027302000D515	Brand

Approval Criteria

1 - Diagnosis of inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP)

AND

2 - Patient is 18 years of age or older

AND

3 - Patient has had greater than or equal to 90 days of therapy with an intranasal corticosteroid

AND

4 - Dupixent will be used as adjunct therapy along with an intranasal corticosteroid

Product Name: Dupixent	
Diagnosis	Prurigo Nodularis
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 300 MG/2ML	9027302000D520	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 200 MG/1.14ML	9027302000D515	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 is 18 years of age or older

AND

3 - Patient has had greater than or equal to 30 days of topical drug therapy with at least ONE of the following:

- Pimecrolimus

- Tacrolimus
- Corticosteroids

Product Name: Dupixent	
Diagnosis	Asthma, Atopic Dermatitis, Eosinophilic Esophagitis, Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP), Prurigo Nodularis
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 300 MG/2ML	9027302000D520	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 200 MG/1.14ML	9027302000D515	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 - Patient has a history of Dupixent within the past 90 days

AND

2 - ONE of the following:

- Patient is continuing to utilize adjunct therapy, if applicable
- Medical rationale has been provided for not continuing adjunct therapy

Product Name: Fasenra	
Diagnosis	Asthma
Approval Length	6 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
FASENRA PEN	BENRALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 30 MG/ML	4460402000D520	Brand
FASENRA	BENRALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 30 MG/ML	4460402000E520	Brand
FASENRA	BENRALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 10 MG/0.5ML	4460402000E515	Brand

Approval Criteria

1 - Diagnosis of asthma (eosinophilic phenotype)

AND

2 - Patient is 6 years of age or older

AND

3 - Patient is utilizing ONE of the following inhaled asthma treatments for 90 of the past 120 days:

- Concurrent high-dose inhaled corticosteroid (ICS) AND a long-acting beta 2 agonist (LABA)
- A high-dose ICS/LABA combination product
- A high-dose ICS/LAMA/LABA combination product

AND

4 - Fasenra will be used as adjunct therapy along with the above inhaled asthma treatment

AND

5 - Patient has inadequately controlled asthma as evidenced by ONE of the following:

- Greater than or equal to 3 canisters of a short-acting beta2 agonist (SABA) in past 60 days
- Oral steroid use in the past 45 days
- ER visit with primary diagnosis of asthma in past 45 days

Product Name: Fasenra	
Diagnosis	Asthma
Approval Length	6 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
FASENRA	BENRALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 30 MG/ML	4460402000E520	Brand
FASENRA	BENRALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 10 MG/0.5ML	4460402000E515	Brand

Approval Criteria

1 - Patient has a history of Fasenra within the past 90 days

AND

2 - ONE of the following:

- Patient is continuing to utilize adjunct therapy, if applicable
- Medical rationale has been provided for not continuing adjunct therapy

Product Name: Nucala	
Diagnosis	Asthma
Approval Length	6 month(s)

Therapy Stage	Initial Authorization
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
NUCALA	MEPOLIZUMAB FOR INJ 100 MG	44604055002120	Brand

Approval Criteria

1 - Diagnosis of asthma (eosinophilic phenotype)

AND

2 - Patient is 6 years of age or older

AND

3 - Patient is utilizing ONE of the following inhaled asthma treatments for 90 of the past 120 days:

- Concurrent high-dose inhaled corticosteroid (ICS) AND a long-acting beta 2 agonist (LABA)
- A high-dose ICS/LABA combination product
- A high-dose ICS/LAMA/LABA combination product

AND

4 - Nucala will be used as adjunct therapy along with the above inhaled asthma treatment

AND

5 - Patient has inadequately controlled asthma as evidenced by ONE of the following:

- Greater than or equal to 3 canisters of a short-acting beta 2 agonist (SABA) in past 60 days
- Oral steroid use in the past 45 days
- ER visit with primary diagnosis of asthma in past 45 days

Product Name: Nucala	
Diagnosis	Eosinophilic Granulomatosis with Polyangiitis (Churg-Strauss syndrome)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

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
NUCALA	MEPOLIZUMAB FOR INJ 100 MG	44604055002120	Brand

Approval Criteria

1 - Patient has diagnosis of eosinophilic granulomatosis with polyangiitis (Churg-Strauss Syndrome)

AND

2 - Patient is 18 years of age or older

AND

3 - Patient has had greater than or equal to 90 days of drug therapy with ONE of the following:

- Systemic glucocorticoid
- Azathioprine
- Methotrexate
- Cyclophosphamide
- Mycophenolate

Product Name: Nucala	
Diagnosis	Hypereosinophilic syndrome (HES)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

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
NUCALA	MEPOLIZUMAB FOR INJ 100 MG	44604055002120	Brand

Approval Criteria

1 - Patient has diagnosis of hypereosinophilic syndrome (HES)

AND

2 - Patient is 12 years of age or older

Product Name: Nucala	
Diagnosis	Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

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
NUCALA	MEPOLIZUMAB FOR INJ 100 MG	44604055002120	Brand

Approval Criteria

1 - Patient has diagnosis of inadequately controlled chronic rhinosinusitis with nasal polyps (CRSwNP)

AND

2 - Patient is 18 years of age or older

AND

3 - Patient has had greater than or equal to 90 days of therapy with an intranasal corticosteroid

AND

4 - Nucala will be used as adjunct therapy along with an intranasal corticosteroid

Product Name: Nucala	
Diagnosis	Asthma, Eosinophilic Granulomatosis with Polyangiitis (Churg-Strauss syndrome), Hypereosinophilic syndrome (HES), Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)
Approval Length	6 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
NUCALA	MEPOLIZUMAB FOR INJ 100 MG	44604055002120	Brand

Approval Criteria

1 - History of Nucala within the past 90 days

AND

2 - ONE of the following:

- Patient is continuing to utilize adjunct therapy, if applicable
- Medical rationale has been provided for not continuing adjunct therapy

Product Name: Tezspire auto injector	
Diagnosis	Asthma
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
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 asthma

AND

2 - Patient is 12 years of age or older

AND

3 - Patient is utilizing ONE of the following inhaled asthma treatments for 90 of the past 120 days:

- Concurrent high-dose inhaled corticosteroid (ICS) AND a long-acting beta 2 agonist (LABA)
- A high-dose ICS/LABA combination product
- A high-dose ICS/LAMA/LABA combination product

AND

4 - Tezspire will be used as adjunct therapy along with one of the above inhaled asthma treatments

AND

5 - Patient has inadequately controlled asthma as evidenced by ONE of the following:

- Greater than or equal to 3 canisters of a short-acting beta2 agonist (SABA) in past 60 days
- Oral steroid use in the past 45 days
- ER visit with primary diagnosis of asthma in past 45 days

Product Name: Tezspire auto injector	
Diagnosis	Asthma
Approval Length	6 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 - History of Tezspire within the past 90 days

AND

2 - ONE of the following:

- Patient is continuing to utilize adjunct therapy, if applicable
- Medical rationale has been provided for not continuing adjunct therapy

Product Name: Xolair	
Diagnosis	Asthma
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
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
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 asthma (severe allergic asthma or nonallergic eosinophilic asthma)

AND

2 - Documentation of ONE of the following:

- A positive percutaneous allergy skin test
- In vitro reactivity to a perennial aeroallergen within the past year

AND

3 - Patient is 6 years of age or older

AND

4 - Patient is utilizing ONE of the following inhaled asthma treatments for 90 of the past 120 days:

- Concurrent high-dose inhaled corticosteroid (ICS) AND a long-acting beta 2 agonist (LABA)
- A high-dose ICS/LABA combination product
- A high-dose ICS/LAMA/LABA combination product

AND

5 - Xolair will be used as adjunct therapy along with one of the above inhaled asthma treatments

AND

6 - Patient has inadequately controlled asthma as evidenced by ONE of the following:

- Greater than or equal to 3 canisters of a short-acting beta 2 agonist (SABA) in past 60 days
- Oral steroid use in the past 45 days
- ER visit with primary diagnosis of asthma in past 45 days

Product Name: Xolair	
Diagnosis	Chronic Idiopathic Urticaria
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
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
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 idiopathic urticaria

AND

2 - Documentation of at least 6 weeks of symptoms

AND

3 - Patient is 12 years of age or older

AND

4 - The patient has had at least 14 days of drug therapy with a histamine 1 (H1)-receptor antagonist

Product Name: Xolair	
Diagnosis	Nasal Polyps
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
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
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 inadequately controlled nasal polyps

AND

2 - Patient is 18 years of age or older

AND

3 - The patient has had at least 90 days of therapy with an intranasal corticosteroid

AND

4 - Xolair will be used as adjunct therapy along with an intranasal corticosteroid

Product Name: Xolair	
Diagnosis	IgE-Mediated Food Allergy
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
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
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 - History of an IgE-mediated (Type 1) allergic reaction to one or more food allergens (submission of chart notes explicitly stating suspected food allergen and respective reaction experienced required)

AND

2 - Submission of documentation (chart notes, laboratory tests/values, assessments, etc.) of one of the following:

- Positive skin prick test (SPT) (greater than or equal to 4 millimeter wheal) to identified foods
- Positive IgE screening (greater than or equal to 6 kUA/L) to identified foods

AND

3 - Patient is at least 1 year of age or older

AND

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

AND

5 - Prescriber attests that member has been counseled to continue food allergen avoidance while utilizing Xolair (omalizumab)

Product Name: Xolair	
Diagnosis	Asthma, Chronic Idiopathic Urticaria, Nasal Polyps, IgE-Mediated Food Allergy
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
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
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 - History of Xolair within the past 90 days

AND

2 - ONE of the following:

- Patient is continuing to utilize adjunct therapy, if applicable
- Medical rationale has been provided for not continuing adjunct therapy

2 . Revision History

Date	Notes
9/16/2024	Updated criteria for eosinophilic esophagitis. GPI updated.

Retevmo

Prior Authorization Guideline

Guideline ID	GL-118335
Guideline Name	Retevmo
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	2/1/2023

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

2 . Revision History

Date	Notes

12/13/2022	Copy NY

Revlimid

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-151757
Guideline Name	Revlimid
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	9/1/2024

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

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

2 . Revision History

Date	Notes
8/14/2024	Updated criteria per NCCN for myelodysplastic syndrome, b-cell lymphomas, myelofibrosis-associated anemia, Hodgkin lymphoma, systemic light chain amyloidosis, chronic lymphocytic leukemia/small lymphocytic lymphoma, t-cell lymphoma, and kaposi sarcoma. Renamed and updated criteria for histiocytic neoplasms. Moved castleman disease from b-cell lymphoma into its own criteria.

Rezlidhia

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-123358
Guideline Name	Rezlidhia
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	5/1/2023

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

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-161237
Guideline Name	Rezurock
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2025

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
11/25/2024	Removed age requirement in initial auth section.

Rivfloza

Prior Authorization Guideline

Guideline ID	GL-150940
Guideline Name	Rivfloza
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	8/5/2024

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 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
8/5/2024	New program.

Rozlytrek

Prior Authorization Guideline

Guideline ID	GL-147646
Guideline Name	Rozlytrek
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2024

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

2 . Revision History

Date	Notes
5/22/2024	Copy Core

Rubraca

Prior Authorization Guideline

Guideline ID	GL-125947
Guideline Name	Rubraca
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	7/1/2023

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

2 . Revision History

Date	Notes
5/22/2023	Copy NY

Ruconest

Prior Authorization Guideline

Guideline ID	GL-150096
Guideline Name	Ruconest
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	8/1/2024

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

7/22/2024	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

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-82134
Guideline Name	Rukobia
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2021

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

2 . Revision History

Date	Notes
3/5/2021	Bulk Load

Rydapt

Prior Authorization Guideline

Guideline ID	GL-109388
Guideline Name	Rydapt
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	9/1/2022

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 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

2 . Revision History

Date	Notes
7/14/2022	Added myeloid/lymphoid neoplasms criteria per NCCN guideline update.

Samsca

Prior Authorization Guideline

Guideline ID	GL-127874
Guideline Name	Samsca
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	9/1/2023

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

Scemblix

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-139239
Guideline Name	Scemblix
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	3/1/2024

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

Sedative-Hypnotics and Benzodiazepines

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-161871
Guideline Name	Sedative-Hypnotics and Benzodiazepines
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2025

1 . Criteria

Product Name: Brand Ambien CR; Generic zolpidem ER; Amytal; Edluar; Generic zolpidem; Brand Lunesta; Generic eszopiclone; meprobamate; zaleplon; Brand Ambien; Generic zolpidem; Zolpimist; Brand Nembutal; Generic Pentobarbital; alprazolam ODT; Generic alprazolam; Brand Xanax; Generic alprazolam ER; Brand Xanax XR; alprazolam intensol; chlordiazepoxide; chlordiazepoxide/amitriptyline; Generic clonazepam; Brand Klonopin; clonazepam ODT; Generic clorazepate dipotassium; Brand Tranxene T; Generic diazepam; Brand Valium; diazepam intensol; Brand Doral; Generic quazepam; estazolam; flurazepam; Brand Ativan; Generic lorazepam; lorazepam intensol; Loreev XR; midazolam; oxazepam; Brand Restoril; Generic temazepam; Brand Halcion; Generic triazolam; Belsomra; Quviviq; Dayvigo; zolpidem caps; Brand Librax; Generic chlordiazepoxide/clidinium; Brand Onfi; Generic clobazam; Sympazan	
Diagnosis	Duplicate Therapy
Approval Length	12 month(s)
Guideline Type	Drug Utilization Review

Product Name	Generic Name	GPI	Brand/Generic
ALPRAZOLAM ODT	ALPRAZOLAM ORALLY DISINTEGRATING TAB 0.25 MG	57100010007205	Generic
ALPRAZOLAM	ALPRAZOLAM TAB 0.25 MG	57100010000305	Generic
XANAX	ALPRAZOLAM TAB 0.25 MG	57100010000305	Brand
ALPRAZOLAM ER	ALPRAZOLAM TAB ER 24HR 0.5 MG	57100010007505	Generic
ALPRAZOLAM XR	ALPRAZOLAM TAB ER 24HR 0.5 MG	57100010007505	Generic
XANAX XR	ALPRAZOLAM TAB ER 24HR 0.5 MG	57100010007505	Brand
ALPRAZOLAM	ALPRAZOLAM TAB 0.5 MG	57100010000310	Generic
XANAX	ALPRAZOLAM TAB 0.5 MG	57100010000310	Brand
ALPRAZOLAM ODT	ALPRAZOLAM ORALLY DISINTEGRATING TAB 1 MG	57100010007215	Generic
ALPRAZOLAM ER	ALPRAZOLAM TAB ER 24HR 1 MG	57100010007510	Generic
ALPRAZOLAM XR	ALPRAZOLAM TAB ER 24HR 1 MG	57100010007510	Generic
XANAX XR	ALPRAZOLAM TAB ER 24HR 1 MG	57100010007510	Brand
ALPRAZOLAM	ALPRAZOLAM TAB 1 MG	57100010000315	Generic
XANAX	ALPRAZOLAM TAB 1 MG	57100010000315	Brand
ALPRAZOLAM INTENSOL	ALPRAZOLAM CONC 1 MG/ML	57100010001310	Generic
ALPRAZOLAM ODT	ALPRAZOLAM ORALLY DISINTEGRATING TAB 2 MG	57100010007220	Generic
ALPRAZOLAM ER	ALPRAZOLAM TAB ER 24HR 2 MG	57100010007520	Generic
ALPRAZOLAM XR	ALPRAZOLAM TAB ER 24HR 2 MG	57100010007520	Generic
XANAX XR	ALPRAZOLAM TAB ER 24HR 2 MG	57100010007520	Brand
ALPRAZOLAM	ALPRAZOLAM TAB 2 MG	57100010000320	Generic
XANAX	ALPRAZOLAM TAB 2 MG	57100010000320	Brand
ALPRAZOLAM ER	ALPRAZOLAM TAB ER 24HR 3 MG	57100010007530	Generic

ALPRAZOLAM XR	ALPRAZOLAM TAB ER 24HR 3 MG	57100010007530	Generic
XANAX XR	ALPRAZOLAM TAB ER 24HR 3 MG	57100010007530	Brand
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
AMYTAL SODIUM	AMOBARBITAL SODIUM FOR INJ 500 MG	60100010102110	Brand
CHLORDIAZEPOXIDE HCL	CHLORDIAZEPOXIDE HCL CAP 10 MG	57100020100110	Generic
CHLORDIAZEPOXIDE HCL	CHLORDIAZEPOXIDE HCL CAP 5 MG	57100020100105	Generic
CHLORDIAZEPOXIDE/AMITRIPTYLINE	CHLORDIAZEPOXIDE-AMITRIPTYLINE TAB 5-12.5 MG	62992002200310	Generic
CHLORDIAZEPOXIDE/AMITRIPTYLINE	CHLORDIAZEPOXIDE-AMITRIPTYLINE TAB 10-25 MG	62992002200320	Generic
CLONAZEPAM	CLONAZEPAM TAB 0.5 MG	72100010000305	Generic
CLONAZEPAM	CLONAZEPAM TAB 1 MG	72100010000310	Generic
CLONAZEPAM	CLONAZEPAM TAB 2 MG	72100010000315	Generic
CLONAZEPAM ODT	CLONAZEPAM ORALLY DISINTEGRATING TAB 0.125 MG	72100010007210	Generic
CLONAZEPAM ODT	CLONAZEPAM ORALLY DISINTEGRATING TAB 0.25 MG	72100010007215	Generic
CLONAZEPAM ODT	CLONAZEPAM ORALLY DISINTEGRATING TAB 0.5 MG	72100010007220	Generic
CLONAZEPAM ODT	CLONAZEPAM ORALLY DISINTEGRATING TAB 1 MG	72100010007230	Generic
CLONAZEPAM ODT	CLONAZEPAM ORALLY DISINTEGRATING TAB 2 MG	72100010007240	Generic
CLORAZEPATE DIPOTASSIUM	CLORAZEPATE DIPOTASSIUM TAB 15 MG	57100030100320	Generic

CLORAZEPATE DIPOTASSIUM	CLORAZEPATE DIPOTASSIUM TAB 3.75 MG	57100030100305	Generic
CLORAZEPATE DIPOTASSIUM	CLORAZEPATE DIPOTASSIUM TAB 7.5 MG	57100030100310	Generic
DIAZEPAM	DIAZEPAM TAB 10 MG	57100040000315	Generic
DIAZEPAM	DIAZEPAM TAB 2 MG	57100040000305	Generic
DIAZEPAM	DIAZEPAM TAB 5 MG	57100040000310	Generic
DIAZEPAM	DIAZEPAM IM SOLUTION AUTO-INJ 10 MG/2ML	5710004000D520	Generic
DIAZEPAM	DIAZEPAM CONC 5 MG/ML	57100040001310	Generic
DIAZEPAM INTENSOL	DIAZEPAM CONC 5 MG/ML	57100040001310	Generic
DIAZEPAM	DIAZEPAM INJ 5 MG/ML	57100040002010	Generic
EDLUAR	ZOLPIDEM TARTRATE SL TAB 5 MG	60204080100720	Brand
EDLUAR	ZOLPIDEM TARTRATE SL TAB 10 MG	60204080100730	Brand
ZOLPIDEM TARTRATE	ZOLPIDEM TARTRATE SL TAB 1.75 MG	60204080100708	Generic
ZOLPIDEM TARTRATE	ZOLPIDEM TARTRATE SL TAB 3.5 MG	60204080100715	Generic
ESTAZOLAM	ESTAZOLAM TAB 1 MG	60201005000310	Generic
ESTAZOLAM	ESTAZOLAM TAB 2 MG	60201005000320	Generic
ATIVAN	LORAZEPAM TAB 0.5 MG	57100060000305	Brand
LORAZEPAM	LORAZEPAM TAB 0.5 MG	57100060000305	Generic
ATIVAN	LORAZEPAM TAB 1 MG	57100060000310	Brand
LORAZEPAM	LORAZEPAM TAB 1 MG	57100060000310	Generic
ATIVAN	LORAZEPAM TAB 2 MG	57100060000315	Brand
LORAZEPAM	LORAZEPAM TAB 2 MG	57100060000315	Generic
LORAZEPAM	LORAZEPAM CONC 2 MG/ML	57100060001320	Generic
LORAZEPAM INTENSOL	LORAZEPAM CONC 2 MG/ML	57100060001320	Generic
ATIVAN	LORAZEPAM INJ 2 MG/ML	57100060002005	Brand
LORAZEPAM	LORAZEPAM INJ 2 MG/ML	57100060002005	Generic
ATIVAN	LORAZEPAM INJ 4 MG/ML	57100060002010	Brand
LORAZEPAM	LORAZEPAM INJ 4 MG/ML	57100060002010	Generic

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
MEPROBAMATE	MEPROBAMATE TAB 200 MG	57200050000305	Generic
MEPROBAMATE	MEPROBAMATE TAB 400 MG	57200050000310	Generic
MIDAZOLAM HCL	MIDAZOLAM HCL SYRUP 2 MG/ML (BASE EQUIVALENT)	60201025101220	Generic
OXAZEPAM	OXAZEPAM CAP 10 MG	57100070000105	Generic
OXAZEPAM	OXAZEPAM CAP 15 MG	57100070000110	Generic
OXAZEPAM	OXAZEPAM CAP 30 MG	57100070000115	Generic
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
ZALEPLON	ZALEPLON CAP 5 MG	60204070000120	Generic
ZALEPLON	ZALEPLON CAP 10 MG	60204070000130	Generic
AMBIEN	ZOLPIDEM TARTRATE TAB 10 MG	60204080100315	Brand
ZOLPIDEM TARTRATE	ZOLPIDEM TARTRATE TAB 10 MG	60204080100315	Generic
AMBIEN	ZOLPIDEM TARTRATE TAB 5 MG	60204080100310	Brand
ZOLPIDEM TARTRATE	ZOLPIDEM TARTRATE TAB 5 MG	60204080100310	Generic

ZOLPIMIST	ZOLPIDEM TARTRATE ORAL SPRAY 5 MG/ACT	60204080102020	Brand
PENTOBARBITAL SODIUM	PENTOBARBITAL SODIUM INJ 50 MG/ML	60100055102010	Generic
NEMBUTAL SODIUM	PENTOBARBITAL SODIUM INJ 50 MG/ML	60100055102010	Brand
LOREEV XR	LORAZEPAM CAP ER 24HR SPRINKLE 1 MG	5710006000F310	Brand
LOREEV XR	LORAZEPAM CAP ER 24HR SPRINKLE 2 MG	5710006000F320	Brand
LOREEV XR	LORAZEPAM CAP ER 24HR SPRINKLE 3 MG	5710006000F330	Brand
KLONOPIN	CLONAZEPAM TAB 0.5 MG	72100010000305	Brand
KLONOPIN	CLONAZEPAM TAB 1 MG	72100010000310	Brand
KLONOPIN	CLONAZEPAM TAB 2 MG	72100010000315	Brand
CHLORDIAZEPOXIDE HYDROCHLORIDE	CHLORDIAZEPOXIDE HCL CAP 5 MG	57100020100105	Generic
CHLORDIAZEPOXIDE HYDROCHLORIDE	CHLORDIAZEPOXIDE HCL CAP 10 MG	57100020100110	Generic
CHLORDIAZEPOXIDE HYDROCHLORIDE	CHLORDIAZEPOXIDE HCL CAP 25 MG	57100020100115	Generic
LOREEV XR	LORAZEPAM CAP ER 24HR SPRINKLE 1.5 MG	5710006000F315	Brand
TRANXENE T	CLORAZEPATE DIPOTASSIUM TAB 7.5 MG	57100030100310	Brand
VALIUM	DIAZEPAM TAB 2 MG	57100040000305	Brand
VALIUM	DIAZEPAM TAB 5 MG	57100040000310	Brand
VALIUM	DIAZEPAM TAB 10 MG	57100040000315	Brand
DIAZEPAM	DIAZEPAM INJ 5 MG/ML	57100040002010	Brand
MIDAZOLAM HYDROCHLORIDE	MIDAZOLAM HCL SYRUP 2 MG/ML (BASE EQUIVALENT)	60201025101220	Generic
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
QUVIVIQ	DARIDOREXANT HCL TAB 25 MG	60500020100320	Brand
QUVIVIQ	DARIDOREXANT HCL TAB 50 MG	60500020100340	Brand
DAYVIGO	LEMBOREXANT TAB 5 MG	60500040000320	Brand

DAYVIGO	LEMBOREXANT TAB 10 MG	60500040000340	Brand
QUAZEPAM	QUAZEPAM TAB 15 MG	60201028000310	Generic
DORAL	QUAZEPAM TAB 15 MG	60201028000310	Brand
ZOLPIDEM TARTRATE	ZOLPIDEM TARTRATE CAP 7.5 MG	60204080100120	Brand
ALPRAZOLAM ODT	ALPRAZOLAM ORALLY DISINTEGRATING TAB 0.5 MG	57100010007210	Generic
FLURAZEPAM HYDROCHLORIDE	FLURAZEPAM HCL CAP 15 MG	60201010100105	Generic
FLURAZEPAM HYDROCHLORIDE	FLURAZEPAM HCL CAP 30 MG	60201010100110	Generic
CHLORDIAZEPOXIDE HCL/CLIDINIUM BROMIDE	CHLORDIAZEPOXIDE HCL-CLIDINIUM BROMIDE CAP 5-2.5 MG	49109902450110	Generic
CHLORDIAZEPOXIDE HYDROCHLORIDE/CLIDINIUM BROMIDE	CHLORDIAZEPOXIDE HCL-CLIDINIUM BROMIDE CAP 5-2.5 MG	49109902450110	Generic
LIBRAX	CHLORDIAZEPOXIDE HCL-CLIDINIUM BROMIDE CAP 5-2.5 MG	49109902450110	Brand
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
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 - If the request is a clobazam product, the patient has a seizure diagnosis

OR

2 - One of the following:

2.1 The medications involved in the therapeutic duplication are being cross-tapered

OR

2.2 The sedative-hypnotic or benzodiazepine in patient's history is being discontinued or there are plans to discontinue

OR

2.3 There is medical rationale supporting duplication of therapy

Product Name: alprazolam ODT; Generic alprazolam; Brand Xanax; Generic alprazolam ER; Brand Xanax XR; alprazolam intensol; chlordiazepoxide; chlordiazepoxide/amitriptyline; Generic clonazepam; Brand Klonopin; clonazepam ODT; Generic clorazepate dipotassium; Brand Tranxene T; Generic diazepam; Brand Valium; diazepam intensol; Brand Doral; Generic quazepam; estazolam; flurazepam; Brand Ativan; Generic lorazepam; lorazepam intensol; midazolam; oxazepam; Brand Restoril; Generic temazepam; Brand Halcion; Generic triazolam

Diagnosis	(> 15 day supply and/or > 30 day supply within 90 days)
Approval Length	6 month(s) for catatonia, 12 month(s) for all other indications
Guideline Type	Quantity Limit

Product Name	Generic Name	GPI	Brand/Generic
ALPRAZOLAM ODT	ALPRAZOLAM ORALLY DISINTEGRATING TAB 0.25 MG	57100010007205	Generic
ALPRAZOLAM	ALPRAZOLAM TAB 0.25 MG	57100010000305	Generic
XANAX	ALPRAZOLAM TAB 0.25 MG	57100010000305	Brand
ALPRAZOLAM ER	ALPRAZOLAM TAB ER 24HR 0.5 MG	57100010007505	Generic
ALPRAZOLAM XR	ALPRAZOLAM TAB ER 24HR 0.5 MG	57100010007505	Generic

XANAX XR	ALPRAZOLAM TAB ER 24HR 0.5 MG	57100010007505	Brand
ALPRAZOLAM	ALPRAZOLAM TAB 0.5 MG	57100010000310	Generic
XANAX	ALPRAZOLAM TAB 0.5 MG	57100010000310	Brand
ALPRAZOLAM ODT	ALPRAZOLAM ORALLY DISINTEGRATING TAB 1 MG	57100010007215	Generic
ALPRAZOLAM ER	ALPRAZOLAM TAB ER 24HR 1 MG	57100010007510	Generic
ALPRAZOLAM XR	ALPRAZOLAM TAB ER 24HR 1 MG	57100010007510	Generic
XANAX XR	ALPRAZOLAM TAB ER 24HR 1 MG	57100010007510	Brand
ALPRAZOLAM	ALPRAZOLAM TAB 1 MG	57100010000315	Generic
XANAX	ALPRAZOLAM TAB 1 MG	57100010000315	Brand
ALPRAZOLAM INTENSOL	ALPRAZOLAM CONC 1 MG/ML	57100010001310	Generic
ALPRAZOLAM ODT	ALPRAZOLAM ORALLY DISINTEGRATING TAB 2 MG	57100010007220	Generic
ALPRAZOLAM ER	ALPRAZOLAM TAB ER 24HR 2 MG	57100010007520	Generic
ALPRAZOLAM XR	ALPRAZOLAM TAB ER 24HR 2 MG	57100010007520	Generic
XANAX XR	ALPRAZOLAM TAB ER 24HR 2 MG	57100010007520	Brand
ALPRAZOLAM	ALPRAZOLAM TAB 2 MG	57100010000320	Generic
XANAX	ALPRAZOLAM TAB 2 MG	57100010000320	Brand
ALPRAZOLAM ER	ALPRAZOLAM TAB ER 24HR 3 MG	57100010007530	Generic
ALPRAZOLAM XR	ALPRAZOLAM TAB ER 24HR 3 MG	57100010007530	Generic
XANAX XR	ALPRAZOLAM TAB ER 24HR 3 MG	57100010007530	Brand
CHLORDIAZEPOXIDE HCL	CHLORDIAZEPOXIDE HCL CAP 10 MG	57100020100110	Generic
CHLORDIAZEPOXIDE HCL	CHLORDIAZEPOXIDE HCL CAP 5 MG	57100020100105	Generic
CHLORDIAZEPOXIDE/AMITRIPTYLINE	CHLORDIAZEPOXIDE-AMITRIPTYLINE TAB 5-12.5 MG	62992002200310	Generic
CHLORDIAZEPOXIDE/AMITRIPTYLINE	CHLORDIAZEPOXIDE-AMITRIPTYLINE TAB 10-25 MG	62992002200320	Generic

CLONAZEPAM	CLONAZEPAM TAB 0.5 MG	72100010000305	Generic
CLONAZEPAM	CLONAZEPAM TAB 1 MG	72100010000310	Generic
CLONAZEPAM	CLONAZEPAM TAB 2 MG	72100010000315	Generic
CLONAZEPAM ODT	CLONAZEPAM ORALLY DISINTEGRATING TAB 0.125 MG	72100010007210	Generic
CLONAZEPAM ODT	CLONAZEPAM ORALLY DISINTEGRATING TAB 0.25 MG	72100010007215	Generic
CLONAZEPAM ODT	CLONAZEPAM ORALLY DISINTEGRATING TAB 0.5 MG	72100010007220	Generic
CLONAZEPAM ODT	CLONAZEPAM ORALLY DISINTEGRATING TAB 1 MG	72100010007230	Generic
CLONAZEPAM ODT	CLONAZEPAM ORALLY DISINTEGRATING TAB 2 MG	72100010007240	Generic
DIAZEPAM	DIAZEPAM TAB 10 MG	57100040000315	Generic
DIAZEPAM	DIAZEPAM TAB 2 MG	57100040000305	Generic
DIAZEPAM	DIAZEPAM TAB 5 MG	57100040000310	Generic
DIAZEPAM	DIAZEPAM IM SOLUTION AUTO-INJ 10 MG/2ML	5710004000D520	Generic
DIAZEPAM	DIAZEPAM CONC 5 MG/ML	57100040001310	Generic
DIAZEPAM INTENSOL	DIAZEPAM CONC 5 MG/ML	57100040001310	Generic
DIAZEPAM	DIAZEPAM INJ 5 MG/ML	57100040002010	Generic
ESTAZOLAM	ESTAZOLAM TAB 1 MG	60201005000310	Generic
ESTAZOLAM	ESTAZOLAM TAB 2 MG	60201005000320	Generic
ATIVAN	LORAZEPAM TAB 0.5 MG	57100060000305	Brand
LORAZEPAM	LORAZEPAM TAB 0.5 MG	57100060000305	Generic
ATIVAN	LORAZEPAM TAB 1 MG	57100060000310	Brand
LORAZEPAM	LORAZEPAM TAB 1 MG	57100060000310	Generic
ATIVAN	LORAZEPAM TAB 2 MG	57100060000315	Brand
LORAZEPAM	LORAZEPAM TAB 2 MG	57100060000315	Generic
LORAZEPAM	LORAZEPAM CONC 2 MG/ML	57100060001320	Generic
LORAZEPAM INTENSOL	LORAZEPAM CONC 2 MG/ML	57100060001320	Generic

ATIVAN	LORAZEPAM INJ 2 MG/ML	57100060002005	Brand
LORAZEPAM	LORAZEPAM INJ 2 MG/ML	57100060002005	Generic
ATIVAN	LORAZEPAM INJ 4 MG/ML	57100060002010	Brand
LORAZEPAM	LORAZEPAM INJ 4 MG/ML	57100060002010	Generic
MIDAZOLAM HCL	MIDAZOLAM HCL SYRUP 2 MG/ML (BASE EQUIVALENT)	60201025101220	Generic
OXAZEPAM	OXAZEPAM CAP 10 MG	57100070000105	Generic
OXAZEPAM	OXAZEPAM CAP 15 MG	57100070000110	Generic
OXAZEPAM	OXAZEPAM CAP 30 MG	57100070000115	Generic
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
KLONOPIN	CLONAZEPAM TAB 0.5 MG	72100010000305	Brand
KLONOPIN	CLONAZEPAM TAB 1 MG	72100010000310	Brand
KLONOPIN	CLONAZEPAM TAB 2 MG	72100010000315	Brand
CHLORDIAZEPOXIDE HYDROCHLORIDE	CHLORDIAZEPOXIDE HCL CAP 5 MG	57100020100105	Generic
CHLORDIAZEPOXIDE HYDROCHLORIDE	CHLORDIAZEPOXIDE HCL CAP 10 MG	57100020100110	Generic
CHLORDIAZEPOXIDE HYDROCHLORIDE	CHLORDIAZEPOXIDE HCL CAP 25 MG	57100020100115	Generic
TRANXENE T	CLORAZEPATE DIPOTASSIUM TAB 7.5 MG	57100030100310	Brand
VALIUM	DIAZEPAM TAB 2 MG	57100040000305	Brand
VALIUM	DIAZEPAM TAB 5 MG	57100040000310	Brand
VALIUM	DIAZEPAM TAB 10 MG	57100040000315	Brand

DIAZEPAM	DIAZEPAM INJ 5 MG/ML	57100040002010	Brand
MIDAZOLAM HYDROCHLORIDE	MIDAZOLAM HCL SYRUP 2 MG/ML (BASE EQUIVALENT)	60201025101220	Generic
QUAZEPAM	QUAZEPAM TAB 15 MG	60201028000310	Generic
DORAL	QUAZEPAM TAB 15 MG	60201028000310	Brand
CLORAZEPATE DIPOTASSIUM	CLORAZEPATE DIPOTASSIUM TAB 3.75 MG	57100030100305	Generic
CLORAZEPATE DIPOTASSIUM	CLORAZEPATE DIPOTASSIUM TAB 7.5 MG	57100030100310	Generic
CLORAZEPATE DIPOTASSIUM	CLORAZEPATE DIPOTASSIUM TAB 15 MG	57100030100320	Generic
ALPRAZOLAM ODT	ALPRAZOLAM ORALLY DISINTEGRATING TAB 0.5 MG	57100010007210	Generic
FLURAZEPAM HYDROCHLORIDE	FLURAZEPAM HCL CAP 15 MG	60201010100105	Generic
FLURAZEPAM HYDROCHLORIDE	FLURAZEPAM HCL CAP 30 MG	60201010100110	Generic

Approval Criteria

1 - One of the following:

1.1 Patient has at least 90 days of benzodiazepine therapy in the past 180 days

OR

1.2 ONE of the following:

1.2.1 Diagnosis of cancer, seizure disorder, catatonia, intractable Meniere's disease, or other terminal illness

OR

1.2.2 Diagnosis of spasticity associated with a central neurological disorder (e.g. cerebral palsy, dystonia, paraplegia, etc.) and BOTH of the following:

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

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex
- Clinical pharmacology
- United States Pharmacopeia-National Formulary (USP-NF)

AND

1.2.2.2 ONE of the following:

- Prescribed by, or in consultation with, a neurologist or physical medicine and rehabilitation specialist
- Previous trial and failure of at least two non-benzodiazepine muscle relaxants

OR

1.2.3 Diagnosis of akathisia and ONE of the following:

- Previous trial and failure of propranolol
- Prescriber has provided medical rationale for the use of a benzodiazepine over propranolol

OR

1.3 Documentation of valid medical justification to exceed plan limitation maximum for initiation of benzodiazepine therapy [15-day supply with a subsequent claim(s) not to exceed 15-day supply (for a total of 30 days of therapy) every 90 days]

Product Name: Loreev XR	
Diagnosis	(> 15 day supply and/or > 30 day supply within 90 days)
Approval Length	6 month(s) for catatonia, 12 month(s) for all other indications
Guideline Type	Quantity Limit

Product Name	Generic Name	GPI	Brand/Generic
LOREEV XR	LORAZEPAM CAP ER 24HR SPRINKLE 1 MG	5710006000F310	Brand

LOREEV XR	LORAZEPAM CAP ER 24HR SPRINKLE 2 MG	5710006000F320	Brand
LOREEV XR	LORAZEPAM CAP ER 24HR SPRINKLE 3 MG	5710006000F330	Brand
LOREEV XR	LORAZEPAM CAP ER 24HR SPRINKLE 1.5 MG	5710006000F315	Brand

Approval Criteria

1 - One of the following:

1.1 The patient has current approval for long-term benzodiazepine therapy (1 year or greater)

OR

1.2 ONE of the following:

1.2.1 Patient has at least 90 days of benzodiazepine therapy in the past 180 days

OR

1.2.2 ONE of the following:

1.2.2.1 Diagnosis of cancer, seizure disorder, catatonia, intractable Meniere's disease, or other terminal illness

OR

1.2.2.2 Diagnosis of spasticity associated with a central neurological disorder (e.g. cerebral palsy, dystonia, paraplegia, etc.) and BOTH of the following:

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

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

- United States Pharmacopeia-National Formulary (USP-NF)

AND

1.2.2.2.2 ONE of the following:

- Prescribed by, or in consultation with, a neurologist or physical medicine and rehabilitation specialist
- Previous trial and failure of at least two non-benzodiazepine muscle relaxants

OR

1.2.2.3 Diagnosis of akathisia and ONE of the following:

- Previous trial and failure of propranolol
- Prescriber has provided medical rationale for the use of a benzodiazepine over propranolol

OR

1.3 Documentation of valid medical justification to exceed plan limitation maximum for initiation of benzodiazepine therapy [15-day supply with a subsequent claim(s) not to exceed 15-day supply (for a total of 30 days of therapy) every 90 days]

AND

2 - BOTH of the following:

- History of lorazepam IR formulation for at least 90 of the past 180 days
- Documentation the patient has been utilizing lorazepam IR formulation at a consistent scheduled TID (three times per day) dose within the previous 30 days

2 . Revision History

Date	Notes
12/10/2024	Removed Diastat (diazepam) rectal gel

SGLT2 Inhibitors and Combinations

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-124980
Guideline Name	SGLT2 Inhibitors and Combinations
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	7/1/2023

1 . Criteria

Product Name: Glyxambi, Qtern, Steglujan, Trijardy XR	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
GLYXAMBI	EMPAGLIFLOZIN-LINAGLIPTIN TAB 10-5 MG	27996502300320	Brand
GLYXAMBI	EMPAGLIFLOZIN-LINAGLIPTIN TAB 25-5 MG	27996502300330	Brand
QTERN	DAPAGLIFLOZIN-SAXAGLIPTIN TAB 5-5 MG	27996502200320	Brand
QTERN	DAPAGLIFLOZIN-SAXAGLIPTIN TAB 10-5 MG	27996502200330	Brand
STEGLUJAN	ERTUGLIFLOZIN-SITAGLIPTIN TAB 5-100 MG	27996502350320	Brand
STEGLUJAN	ERTUGLIFLOZIN-SITAGLIPTIN TAB 15-100 MG	27996502350330	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

Approval Criteria

1 - Patient has tried and failed combination therapy with preferred* agents of the same classes

OR

2 - Medical justification for use

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

2 . Revision History

Date	Notes
4/24/2023	New

Signifor

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-82006
Guideline Name	Signifor
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2021

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 - Both of the following:

1.1 Diagnosis of endogenous Cushing's disease (i.e., hypercortisolism is not a result of chronic administration of high dose glucocorticoids)

AND

1.2 One of the following:

- Pituitary surgery has not been curative for the patient
- Patient is not a candidate for pituitary surgery

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

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

2 . Revision History

Date	Notes
3/5/2021	Bulk Load

Sivextro

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-156864
Guideline Name	Sivextro
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	11/1/2024

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
10/1/2024	Added “tablets” to product name to clarify that the policy is specific to oral tablets not IV form

Skeletal Muscle Relaxants

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-150092
Guideline Name	Skeletal Muscle Relaxants
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	8/1/2024

1 . Criteria

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

Product Name	Generic Name	GPI	Brand/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

Approval Criteria

1 - Patient is unable to swallow tablets

Product Name: Baclofen solution, Ozobax solution, Ozobax DS, Brand Fleqsuvy, generic baclofen suspension	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
FLEQSUVY	BACLOFEN SUSP 25 MG/5ML	75100010001825	Brand
OZOBAX	BACLOFEN ORAL SOLN 5 MG/5ML	75100010002070	Generic
BACLOFEN	BACLOFEN ORAL SOLN 5 MG/5ML	75100010002070	Brand
BACLOFEN	BACLOFEN SUSP 25 MG/5ML	75100010001825	Generic
BACLOFEN	BACLOFEN ORAL SOLN 10 MG/5ML	75100010002075	Generic
OZOBAX DS	BACLOFEN ORAL SOLN 10 MG/5ML	75100010002075	Generic

Approval Criteria

1 - Patient is unable to swallow tablets

AND

2 - ONE of the following:

- Trial and failure of Lyvispah
- Documentation of medical rationale for use

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

Product Name	Generic Name	GPI	Brand/Generic
AMRIX	CYCLOBENZAPRINE HCL CAP ER 24HR 15 MG	75100050107015	Brand

AMRIX	CYCLOBENZAPRINE HCL CAP ER 24HR 30 MG	75100050107030	Brand
CYCLOBENZAPRINE HYDROCHLORIDE ER	CYCLOBENZAPRINE HCL CAP ER 24HR 15 MG	75100050107015	Generic
CYCLOBENZAPRINE HYDROCHLORIDE ER	CYCLOBENZAPRINE HCL CAP ER 24HR 30 MG	75100050107030	Generic

Approval Criteria

1 - Trial of cyclobenzaprine (immediate release) within the past 30 days

AND

2 - One of the following:

2.1 History of failure to at least TWO additional preferred alternatives as confirmed by claims history or submission of medical records.*

OR

2.2 History of contraindication or intolerance to TWO additional preferred alternatives (please specify contraindication or intolerance).*

Notes	NOTE: In instances where there are fewer than three preferred alternatives, the patient must have a history of failure, contraindication or intolerance to all of the preferred products.

2 . Revision History

Date	Notes
7/22/2024	Removed age limits for baclofen products

Skyclarys

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-127234
Guideline Name	Skyclarys
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	8/1/2023

1 . Criteria

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

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)

2 . Revision History

Date	Notes
6/28/2023	New guideline.

Smoking Deterrent Agents

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-137508
Guideline Name	Smoking Deterrent Agents
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: nicotine transdermal patch, Nicoderm CQ, nicotine gum, Thrive, Nicorette, nicotine lozenge, Nicotrol NS, Nicotrol Inhaler	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NICOTINE TRANSDERMAL SYSTEM	NICOTINE TD PATCH 24 HR KIT 21-14-7 MG/24HR	62100005006430	Generic
NICODERM CQ	NICOTINE TD PATCH 24HR 7 MG/24HR	62100005008520	Brand
NICOTINE TRANSDERMAL SYSTEM	NICOTINE TD PATCH 24HR 7 MG/24HR	62100005008520	Generic

NICOTINE STEP 3	NICOTINE TD PATCH 24HR 7 MG/24HR	62100005008520	Generic
NICOTINE TRANSDERMAL SYSTEM STEP 3	NICOTINE TD PATCH 24HR 7 MG/24HR	62100005008520	Generic
CVS NICOTINE TRANSDERMAL SYSTEM/STEP 3	NICOTINE TD PATCH 24HR 7 MG/24HR	62100005008520	Generic
NICOTINE TRANSDERMAL SYSTSTEM STEP 3/CLEAR	NICOTINE TD PATCH 24HR 7 MG/24HR	62100005008520	Generic
EQ NICOTINE STEP 3	NICOTINE TD PATCH 24HR 7 MG/24HR	62100005008520	Generic
SM NICOTINE TRANSDERMAL SYSTEM/STEP 3/CLEAR	NICOTINE TD PATCH 24HR 7 MG/24HR	62100005008520	Generic
GNP NICOTINE TRANSDERMAL SYSTEM	NICOTINE TD PATCH 24HR 7 MG/24HR	62100005008520	Generic
HM NICOTINE TRANSDERMAL SYSTEM STEP 3	NICOTINE TD PATCH 24HR 7 MG/24HR	62100005008520	Generic
NICODERM CQ	NICOTINE TD PATCH 24HR 14 MG/24HR	62100005008530	Brand
NICOTINE TRANSDERMAL SYSTEM	NICOTINE TD PATCH 24HR 14 MG/24HR	62100005008530	Generic
NICOTINE	NICOTINE TD PATCH 24HR 14 MG/24HR	62100005008530	Generic
SM NICOTINE TRANSDERMAL SYSTEM/STEP 2/CLEAR	NICOTINE TD PATCH 24HR 14 MG/24HR	62100005008530	Generic
NICOTINE TRANSDERMAL SYSTEM STEP 2/CLEAR	NICOTINE TD PATCH 24HR 14 MG/24HR	62100005008530	Generic
EQ NICOTINE	NICOTINE TD PATCH 24HR 14 MG/24HR	62100005008530	Generic
RA NICOTINE	NICOTINE TD PATCH 24HR 14 MG/24HR	62100005008530	Generic
CVS NICOTINE TRANSDERMAL SYSTEM	NICOTINE TD PATCH 24HR 14 MG/24HR	62100005008530	Generic
QC NICOTINE TRANSDERMAL SYSTEM/STEP 2	NICOTINE TD PATCH 24HR 14 MG/24HR	62100005008530	Generic

GNP NICOTINE TRANSDERMAL SYSTEM STEP 2	NICOTINE TD PATCH 24HR 14 MG/24HR	62100005008530	Generic
CVS NICOTINE TRANSDERMAL SYSTEM STEP 2	NICOTINE TD PATCH 24HR 14 MG/24HR	62100005008530	Generic
NICOTINE TRANSDERMAL SYSTEM STEP 2	NICOTINE TD PATCH 24HR 14 MG/24HR	62100005008530	Generic
NICODERM CQ	NICOTINE TD PATCH 24HR 21 MG/24HR	62100005008540	Brand
NICOTINE TRANSDERMAL SYSTEM STEP 1	NICOTINE TD PATCH 24HR 21 MG/24HR	62100005008540	Generic
NICOTINE TRANSDERMAL SYSTEM	NICOTINE TD PATCH 24HR 21 MG/24HR	62100005008540	Generic
NICOTINE	NICOTINE TD PATCH 24HR 21 MG/24HR	62100005008540	Generic
RA NICOTINE TRANSDERMAL SYSTEM	NICOTINE TD PATCH 24HR 21 MG/24HR	62100005008540	Generic
HM NICOTINE TRANSDERMAL SYSTEM STEP 1	NICOTINE TD PATCH 24HR 21 MG/24HR	62100005008540	Generic
EQ NICOTINE	NICOTINE TD PATCH 24HR 21 MG/24HR	62100005008540	Generic
RA NICOTINE	NICOTINE TD PATCH 24HR 21 MG/24HR	62100005008540	Generic
HABITROL	NICOTINE TD PATCH 24HR 21 MG/24HR	62100005008540	Generic
CVS NICOTINE TRANSDERMAL SYSTEM STEP 1	NICOTINE TD PATCH 24HR 21 MG/24HR	62100005008540	Generic
NICOTINE TRANSDERMAL SYSTEM STEP 1/CLEAR	NICOTINE TD PATCH 24HR 21 MG/24HR	62100005008540	Generic
QC NICOTINE TRANSDERMAL SYSTEM/STEP 1	NICOTINE TD PATCH 24HR 21 MG/24HR	62100005008540	Generic
GNP NICOTINE TRANSDERMAL SYSTEM	NICOTINE TD PATCH 24HR 21 MG/24HR	62100005008540	Generic
NICOTINE STEP 1	NICOTINE TD PATCH 24HR 21 MG/24HR	62100005008540	Generic

SM NICOTINE TRANSDERMAL SYSTEM/STEP 1/CLEAR	NICOTINE TD PATCH 24HR 21 MG/24HR	62100005008540	Generic
NICOTINE GUM	NICOTINE POLACRILEX GUM 2 MG	62100010002810	Generic
NICOTINE	NICOTINE POLACRILEX GUM 2 MG	62100010002810	Generic
EQ NICOTINE POLACRILEX	NICOTINE POLACRILEX GUM 2 MG	62100010002810	Generic
CVS NICOTINE	NICOTINE POLACRILEX GUM 2 MG	62100010002810	Generic
HM NICOTINE POLACRILEX	NICOTINE POLACRILEX GUM 2 MG	62100010002810	Generic
NICOTINE POLACRILEX REFILL	NICOTINE POLACRILEX GUM 2 MG	62100010002810	Generic
GOODSENSE NICOTINE POLACRILEX GUM	NICOTINE POLACRILEX GUM 2 MG	62100010002810	Generic
PX STOP SMOKING AID	NICOTINE POLACRILEX GUM 2 MG	62100010002810	Generic
RA NICOTINE GUM	NICOTINE POLACRILEX GUM 2 MG	62100010002810	Generic
SM NICOTINE POLACRILEX	NICOTINE POLACRILEX GUM 2 MG	62100010002810	Generic
GNP NICOTINE POLACRILEX	NICOTINE POLACRILEX GUM 2 MG	62100010002810	Generic
CVS NICOTINE POLACRILEX	NICOTINE POLACRILEX GUM 2 MG	62100010002810	Generic
NICOTINE POLACRILEX STARTER KIT	NICOTINE POLACRILEX GUM 2 MG	62100010002810	Generic
RA NICOTINE	NICOTINE POLACRILEX GUM 2 MG	62100010002810	Generic
NICOTINE POLACRILEX	NICOTINE POLACRILEX GUM 2 MG	62100010002810	Generic
KLS QUIT2	NICOTINE POLACRILEX GUM 2 MG	62100010002810	Generic
THRIVE	NICOTINE POLACRILEX GUM 2 MG	62100010002810	Brand
NICORETTE	NICOTINE POLACRILEX GUM 2 MG	62100010002810	Brand
NICORETTE STARTER KIT	NICOTINE POLACRILEX GUM 2 MG	62100010002810	Brand
CVS NICOTINE POLACRILEX STARTER	NICOTINE POLACRILEX GUM 2 MG	62100010002810	Generic
NICOTINE GUM	NICOTINE POLACRILEX GUM 4 MG	62100010002820	Generic
NICOTINE	NICOTINE POLACRILEX GUM 4 MG	62100010002820	Generic

EQ NICOTINE POLACRILEX	NICOTINE POLACRILEX GUM 4 MG	62100010002820	Generic
CVS NICOTINE	NICOTINE POLACRILEX GUM 4 MG	62100010002820	Generic
HM NICOTINE POLACRILEX	NICOTINE POLACRILEX GUM 4 MG	62100010002820	Generic
GOODSENSE NICOTINE GUM	NICOTINE POLACRILEX GUM 4 MG	62100010002820	Generic
NICOTINE POLACRILEX REFILL	NICOTINE POLACRILEX GUM 4 MG	62100010002820	Generic
GOODSENSE NICOTINE POLACRILEX GUM	NICOTINE POLACRILEX GUM 4 MG	62100010002820	Generic
PX STOP SMOKING AID	NICOTINE POLACRILEX GUM 4 MG	62100010002820	Generic
RA NICOTINE GUM	NICOTINE POLACRILEX GUM 4 MG	62100010002820	Generic
SM NICOTINE POLACRILEX	NICOTINE POLACRILEX GUM 4 MG	62100010002820	Generic
GNP NICOTINE POLACRILEX	NICOTINE POLACRILEX GUM 4 MG	62100010002820	Generic
KLS QUIT4	NICOTINE POLACRILEX GUM 4 MG	62100010002820	Generic
CVS NICOTINE POLACRILEX	NICOTINE POLACRILEX GUM 4 MG	62100010002820	Generic
SM NICOTINE	NICOTINE POLACRILEX GUM 4 MG	62100010002820	Generic
NICOTINE POLACRILEX STARTER KIT	NICOTINE POLACRILEX GUM 4 MG	62100010002820	Generic
RA NICOTINE	NICOTINE POLACRILEX GUM 4 MG	62100010002820	Generic
NICOTINE POLACRILEX	NICOTINE POLACRILEX GUM 4 MG	62100010002820	Generic
CVS NICOTINE GUM	NICOTINE POLACRILEX GUM 4 MG	62100010002820	Generic
NICORETTE	NICOTINE POLACRILEX GUM 4 MG	62100010002820	Brand
NICORETTE STARTER KIT	NICOTINE POLACRILEX GUM 4 MG	62100010002820	Brand
GNP NICOTINE GUM	NICOTINE POLACRILEX GUM 4 MG	62100010002820	Generic
NICOTINE POLACRILEX MINI	NICOTINE POLACRILEX LOZENGE 2 MG	62100010004710	Generic
EQ NICOTINE POLACRILEX	NICOTINE POLACRILEX LOZENGE 2 MG	62100010004710	Generic

HM NICOTINE POLACRILEX	NICOTINE POLACRILEX LOZENGE 2 MG	62100010004710	Generic
NICORETTE MINI	NICOTINE POLACRILEX LOZENGE 2 MG	62100010004710	Brand
EQL NICOTINE POLACRILEX	NICOTINE POLACRILEX LOZENGE 2 MG	62100010004710	Generic
PX STOP SMOKING AID	NICOTINE POLACRILEX LOZENGE 2 MG	62100010004710	Generic
SM NICOTINE POLACRILEX	NICOTINE POLACRILEX LOZENGE 2 MG	62100010004710	Generic
GNP NICOTINE POLACRILEX	NICOTINE POLACRILEX LOZENGE 2 MG	62100010004710	Generic
CVS NICOTINE POLACRILEX	NICOTINE POLACRILEX LOZENGE 2 MG	62100010004710	Generic
SM NICOTINE	NICOTINE POLACRILEX LOZENGE 2 MG	62100010004710	Generic
GNP NICOTINE MINI LOZENGE	NICOTINE POLACRILEX LOZENGE 2 MG	62100010004710	Generic
NICOTINE POLACRILEX	NICOTINE POLACRILEX LOZENGE 2 MG	62100010004710	Generic
NICOTINE MINI LOZENGE	NICOTINE POLACRILEX LOZENGE 2 MG	62100010004710	Generic
RA MINI NICOTINE	NICOTINE POLACRILEX LOZENGE 2 MG	62100010004710	Generic
KLS QUIT2	NICOTINE POLACRILEX LOZENGE 2 MG	62100010004710	Generic
GOODSENSE NICOTINE	NICOTINE POLACRILEX LOZENGE 2 MG	62100010004710	Generic
CVS NICOTINE LOZENGE	NICOTINE POLACRILEX LOZENGE 2 MG	62100010004710	Generic
NICORETTE	NICOTINE POLACRILEX LOZENGE 2 MG	62100010004710	Brand
RA NICOTINE POLACRILEX	NICOTINE POLACRILEX LOZENGE 2 MG	62100010004710	Generic
NICOTINE	NICOTINE POLACRILEX LOZENGE 4 MG	62100010004720	Generic
EQ NICOTINE POLACRILEX	NICOTINE POLACRILEX LOZENGE 4 MG	62100010004720	Generic
EQ NICOTINE LOZENGES	NICOTINE POLACRILEX LOZENGE 4 MG	62100010004720	Generic
NICORETTE MINI	NICOTINE POLACRILEX LOZENGE 4 MG	62100010004720	Brand
EQL NICOTINE POLACRILEX	NICOTINE POLACRILEX LOZENGE 4 MG	62100010004720	Generic
PX STOP SMOKING AID	NICOTINE POLACRILEX LOZENGE 4 MG	62100010004720	Generic
SM NICOTINE POLACRILEX	NICOTINE POLACRILEX LOZENGE 4 MG	62100010004720	Generic

GNP NICOTINE POLACRILEX	NICOTINE POLACRILEX LOZENGE 4 MG	62100010004720	Generic
KLS QUIT4	NICOTINE POLACRILEX LOZENGE 4 MG	62100010004720	Generic
GOODSENSE NICOTINE POLACRILEX	NICOTINE POLACRILEX LOZENGE 4 MG	62100010004720	Generic
CVS NICOTINE POLACRILEX	NICOTINE POLACRILEX LOZENGE 4 MG	62100010004720	Generic
GNP NICOTINE MINI LOZENGE	NICOTINE POLACRILEX LOZENGE 4 MG	62100010004720	Generic
NICOTINE POLACRILEX	NICOTINE POLACRILEX LOZENGE 4 MG	62100010004720	Generic
NICOTINE MINI LOZENGE	NICOTINE POLACRILEX LOZENGE 4 MG	62100010004720	Generic
RA MINI NICOTINE	NICOTINE POLACRILEX LOZENGE 4 MG	62100010004720	Generic
GOODSENSE NICOTINE	NICOTINE POLACRILEX LOZENGE 4 MG	62100010004720	Generic
CVS NICOTINE LOZENGE	NICOTINE POLACRILEX LOZENGE 4 MG	62100010004720	Generic
NICORETTE	NICOTINE POLACRILEX LOZENGE 4 MG	62100010004720	Brand
RA NICOTINE POLACRILEX	NICOTINE POLACRILEX LOZENGE 4 MG	62100010004720	Generic
GNP NICOTINE POLACRILEX MINI	NICOTINE POLACRILEX LOZENGE 4 MG	62100010004720	Generic
NICOTROL NS	NICOTINE NASAL SPRAY 10 MG/ML (0.5 MG/SPRAY)	62100005002020	Brand
NICOTROL INHALER	NICOTINE INHALER SYSTEM 10 MG (4 MG DELIVERED)	62100005002410	Brand
HM NICOTINE TRANSDERMAL SYSTEM STEP 2	NICOTINE TD PATCH 24HR 14 MG/24HR	62100005008530	Generic
GNP NICOTINE GUM	NICOTINE POLACRILEX GUM 2 MG	62100010002810	Generic
HM NICOTINE POLACRILEX	NICOTINE POLACRILEX LOZENGE 4 MG	62100010004720	Generic

Approval Criteria

1 - Patient is 10 years of age or older

AND **2** - If the request is non-preferred*, the patient had a trial and failure of THREE preferred* medications within this drug class that are indicated for the patient's diagnosis (if applicable)

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

Product Name: varenicline, Apo-varenicline	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VARENICLINE STARTING MONTH BOX	VARENICLINE TARTRATE TAB 11 X 0.5 MG & 42 X 1 MG START PACK	6210008020B720	Generic
VARENICLINE TARTRATE	VARENICLINE TARTRATE TAB 0.5 MG (BASE EQUIV)	62100080200320	Generic
APO-VARENICLINE	VARENICLINE TARTRATE TAB 0.5 MG (BASE EQUIV)	62100080200320	Brand
VARENICLINE TARTRATE	VARENICLINE TARTRATE TAB 1 MG (BASE EQUIV)	62100080200330	Generic
APO-VARENICLINE	VARENICLINE TARTRATE TAB 1 MG (BASE EQUIV)	62100080200330	Brand
VARENICLINE STARTING MONTH	VARENICLINE TARTRATE TAB 11 X 0.5 MG & 42 X 1 MG START PACK	6210008020B720	Generic

Approval Criteria

1 - Patient is 18 years of age or older

2 . Revision History

Date	Notes

12/11/2023	Updated GPI and product name lists, added NP criteria and PDL link in note.

Sohonos

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-147561
Guideline Name	Sohonos
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2024

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)

2 . Revision History

Date	Notes
5/21/2024	New program.

Solaraze

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-124376
Guideline Name	Solaraze
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	7/1/2023

1 . Criteria

Product Name: Brand Solaraze, generic diclofenac 3% (actinic keratoses) gel	
Approval Length	1 year(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SOLARAZE	DICLOFENAC SODIUM (ACTINIC KERATOSES) GEL 3%	90374035304020	Brand
DICLOFENAC SODIUM	DICLOFENAC SODIUM (ACTINIC KERATOSES) GEL 3%	90374035304020	Generic

Approval Criteria

1 - Diagnosis of actinic keratosis

2 . Revision History

Date	Notes
4/7/2023	Updated GL type to PA

Somavert

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-129170
Guideline Name	Somavert
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	10/1/2023

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

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-98051
Guideline Name	Soriatane
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2022

1 . Criteria

Product Name: generic acitretin, Brand Soriatane	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ACITRETIN	ACITRETIN CAP 10 MG	90250510000110	Generic
SORIATANE	ACITRETIN CAP 10 MG	90250510000110	Brand
ACITRETIN	ACITRETIN CAP 17.5 MG	90250510000115	Generic
ACITRETIN	ACITRETIN CAP 25 MG	90250510000125	Generic
SORIATANE	ACITRETIN CAP 25 MG	90250510000125	Brand

Approval Criteria

1 - Patient must meet ONE of the following indications for treatment:

- Hyperkeratotic dermatitis of the palms
- Lichen planus
- Palmoplantar pustulosis
- Prophylaxis of skin cancer in a high-risk kidney transplant recipient
- Psoriasis classified as severe
- Squamous cell carcinoma
- Subcorneal pustular dermatosis (SPD; Sneddon-Wilkinson disease)

Product Name: generic acitretin, Brand Soriatane	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ACITRETIN	ACITRETIN CAP 10 MG	90250510000110	Generic
SORIATANE	ACITRETIN CAP 10 MG	90250510000110	Brand
ACITRETIN	ACITRETIN CAP 17.5 MG	90250510000115	Generic
ACITRETIN	ACITRETIN CAP 25 MG	90250510000125	Generic
SORIATANE	ACITRETIN CAP 25 MG	90250510000125	Brand

Approval Criteria

1 - Patient must have a history of the requested medication within the past 90 days

2 . Revision History

Date	Notes
11/5/2021	Updated all criteria to match state policy.

Spravato

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-157265
Guideline Name	Spravato
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	11/1/2024

1 . Criteria

Product Name: Spravato	
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 - Patient is 18 years of age or older **AND** **2** - Patient is taking an oral antidepressant

2 . Revision History

Date	Notes
10/9/2024	New guideline

Sprycel

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-136516
Guideline Name	Sprycel
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Sprycel	
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
SPRYCEL	DASATINIB TAB 20 MG	21531820000320	Brand
SPRYCEL	DASATINIB TAB 50 MG	21531820000340	Brand
SPRYCEL	DASATINIB TAB 70 MG	21531820000350	Brand

SPRYCEL	DASATINIB TAB 80 MG	21531820000354	Brand
SPRYCEL	DASATINIB TAB 100 MG	21531820000360	Brand
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: Sprycel	
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
SPRYCEL	DASATINIB TAB 20 MG	21531820000320	Brand
SPRYCEL	DASATINIB TAB 50 MG	21531820000340	Brand
SPRYCEL	DASATINIB TAB 70 MG	21531820000350	Brand
SPRYCEL	DASATINIB TAB 80 MG	21531820000354	Brand
SPRYCEL	DASATINIB TAB 100 MG	21531820000360	Brand
SPRYCEL	DASATINIB TAB 140 MG	21531820000380	Brand

Approval Criteria

1 - Diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ALL)

Product Name: Sprycel	
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
SPRYCEL	DASATINIB TAB 20 MG	21531820000320	Brand
SPRYCEL	DASATINIB TAB 50 MG	21531820000340	Brand
SPRYCEL	DASATINIB TAB 70 MG	21531820000350	Brand
SPRYCEL	DASATINIB TAB 80 MG	21531820000354	Brand
SPRYCEL	DASATINIB TAB 100 MG	21531820000360	Brand
SPRYCEL	DASATINIB TAB 140 MG	21531820000380	Brand

Approval Criteria

1 - Diagnosis of gastrointestinal stromal tumor (GIST) with PDGFRA D842V mutation

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

Product Name	Generic Name	GPI	Brand/Generic
SPRYCEL	DASATINIB TAB 20 MG	21531820000320	Brand

SPRYCEL	DASATINIB TAB 50 MG	21531820000340	Brand
SPRYCEL	DASATINIB TAB 70 MG	21531820000350	Brand
SPRYCEL	DASATINIB TAB 80 MG	21531820000354	Brand
SPRYCEL	DASATINIB TAB 100 MG	21531820000360	Brand
SPRYCEL	DASATINIB TAB 140 MG	21531820000380	Brand

Approval Criteria

1 - Diagnosis of metastatic chondrosarcoma

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

Product Name	Generic Name	GPI	Brand/Generic
SPRYCEL	DASATINIB TAB 20 MG	21531820000320	Brand
SPRYCEL	DASATINIB TAB 50 MG	21531820000340	Brand
SPRYCEL	DASATINIB TAB 70 MG	21531820000350	Brand
SPRYCEL	DASATINIB TAB 80 MG	21531820000354	Brand
SPRYCEL	DASATINIB TAB 100 MG	21531820000360	Brand
SPRYCEL	DASATINIB TAB 140 MG	21531820000380	Brand

Approval Criteria

1 - Diagnosis of recurrent chordoma

Product Name: Sprycel	
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
SPRYCEL	DASATINIB TAB 20 MG	21531820000320	Brand
SPRYCEL	DASATINIB TAB 50 MG	21531820000340	Brand
SPRYCEL	DASATINIB TAB 70 MG	21531820000350	Brand
SPRYCEL	DASATINIB TAB 80 MG	21531820000354	Brand
SPRYCEL	DASATINIB TAB 100 MG	21531820000360	Brand
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: Sprycel	
Diagnosis	Cutaneous Melanoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SPRYCEL	DASATINIB TAB 20 MG	21531820000320	Brand
SPRYCEL	DASATINIB TAB 50 MG	21531820000340	Brand
SPRYCEL	DASATINIB TAB 70 MG	21531820000350	Brand
SPRYCEL	DASATINIB TAB 80 MG	21531820000354	Brand
SPRYCEL	DASATINIB TAB 100 MG	21531820000360	Brand
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: Sprycel	
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
SPRYCEL	DASATINIB TAB 20 MG	21531820000320	Brand
SPRYCEL	DASATINIB TAB 50 MG	21531820000340	Brand
SPRYCEL	DASATINIB TAB 70 MG	21531820000350	Brand
SPRYCEL	DASATINIB TAB 80 MG	21531820000354	Brand
SPRYCEL	DASATINIB TAB 100 MG	21531820000360	Brand

SPRYCEL	DASATINIB TAB 140 MG	21531820000380	Brand

Approval Criteria

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

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

Product Name	Generic Name	GPI	Brand/Generic
SPRYCEL	DASATINIB TAB 20 MG	21531820000320	Brand
SPRYCEL	DASATINIB TAB 50 MG	21531820000340	Brand
SPRYCEL	DASATINIB TAB 70 MG	21531820000350	Brand
SPRYCEL	DASATINIB TAB 80 MG	21531820000354	Brand
SPRYCEL	DASATINIB TAB 100 MG	21531820000360	Brand
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: Sprycel	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

SPRYCEL	DASATINIB TAB 20 MG	21531820000320	Brand
SPRYCEL	DASATINIB TAB 50 MG	21531820000340	Brand
SPRYCEL	DASATINIB TAB 70 MG	21531820000350	Brand
SPRYCEL	DASATINIB TAB 80 MG	21531820000354	Brand
SPRYCEL	DASATINIB TAB 100 MG	21531820000360	Brand
SPRYCEL	DASATINIB TAB 140 MG	21531820000380	Brand

Approval Criteria

1 - Documentation of positive clinical response to Sprycel therapy

SSRI and SNRI

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-124721
Guideline Name	SSRI and SNRI
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	7/1/2023

1 . Criteria

Product Name: Brand Celexa, Generic citalopram, Drizalma, Brand Pristiq, Generic desvenlafaxine succinate ER, Desvenlafaxine ER, Brand Cymbalta, Generic duloxetine, Brand Lexapro, Generic escitalopram, Brand Prozac, Generic fluoxetine caps, Fluoxetine (tabs, soln, DR caps, PMDD tabs), fluvoxamine, Fetzima, Brand Zoloft, Generic sertraline tabs and oral conc, Sertraline caps, Savella, Venlafaxine Besylate 112.5mg ER tabs, Venlafaxine tabs, Brand Effexor XR, Generic venlafaxine ER caps, Venlafaxine ER tabs, Brand Viibryd, Generic vilazodone, Qelbree, Trintellix, Brand Strattera, Generic atomoxetine, Brand Paxil, Generic paroxetine tablets, Paroxetine oral susp, Brand Paxil CR, Generic paroxetine ER, Pexeva, paroxetine capsules	
Diagnosis	Duplicate Therapy with Another SSRI/SNRI
Therapy Stage	Initial Authorization
Guideline Type	Drug Utilization Review (DUR)

Product Name	Generic Name	GPI	Brand/Generic

CELEXA	CITALOPRAM HYDROBROMIDE TAB 10 MG (BASE EQUIV)	58160020100310	Brand
CITALOPRAM HYDROBROMIDE	CITALOPRAM HYDROBROMIDE TAB 10 MG (BASE EQUIV)	58160020100310	Generic
CELEXA	CITALOPRAM HYDROBROMIDE TAB 20 MG (BASE EQUIV)	58160020100320	Brand
CITALOPRAM HYDROBROMIDE	CITALOPRAM HYDROBROMIDE TAB 20 MG (BASE EQUIV)	58160020100320	Generic
CELEXA	CITALOPRAM HYDROBROMIDE TAB 40 MG (BASE EQUIV)	58160020100340	Brand
CITALOPRAM HYDROBROMIDE	CITALOPRAM HYDROBROMIDE TAB 40 MG (BASE EQUIV)	58160020100340	Generic
CITALOPRAM HYDROBROMIDE	CITALOPRAM HYDROBROMIDE ORAL SOLN 10 MG/5ML	58160020102020	Generic
DESVENLAFAXINE ER	DESVENLAFAXINE SUCCINATE TAB ER 24HR 25 MG (BASE EQUIV)	58180020207510	Generic
PRISTIQ	DESVENLAFAXINE SUCCINATE TAB ER 24HR 25 MG (BASE EQUIV)	58180020207510	Brand
DESVENLAFAXINE ER	DESVENLAFAXINE SUCCINATE TAB ER 24HR 50 MG (BASE EQUIV)	58180020207520	Generic
PRISTIQ	DESVENLAFAXINE SUCCINATE TAB ER 24HR 50 MG (BASE EQUIV)	58180020207520	Brand
DESVENLAFAXINE ER	DESVENLAFAXINE SUCCINATE TAB ER 24HR 100 MG (BASE EQUIV)	58180020207540	Generic
PRISTIQ	DESVENLAFAXINE SUCCINATE TAB ER 24HR 100 MG (BASE EQUIV)	58180020207540	Brand
ESCITALOPRAM OXALATE	ESCITALOPRAM OXALATE TAB 5 MG (BASE EQUIV)	58160034100310	Generic
LEXAPRO	ESCITALOPRAM OXALATE TAB 5 MG (BASE EQUIV)	58160034100310	Brand
ESCITALOPRAM OXALATE	ESCITALOPRAM OXALATE TAB 10 MG (BASE EQUIV)	58160034100320	Generic
LEXAPRO	ESCITALOPRAM OXALATE TAB 10 MG (BASE EQUIV)	58160034100320	Brand
ESCITALOPRAM OXALATE	ESCITALOPRAM OXALATE TAB 20 MG (BASE EQUIV)	58160034100330	Generic
LEXAPRO	ESCITALOPRAM OXALATE TAB 20 MG (BASE EQUIV)	58160034100330	Brand
ESCITALOPRAM OXALATE	ESCITALOPRAM OXALATE SOLN 5 MG/5ML (BASE EQUIV)	58160034102020	Generic
FLUVOXAMINE MALEATE	FLUVOXAMINE MALEATE TAB 25 MG	58160045100310	Generic
FLUVOXAMINE MALEATE	FLUVOXAMINE MALEATE TAB 50 MG	58160045100320	Generic
FLUVOXAMINE MALEATE	FLUVOXAMINE MALEATE TAB 100 MG	58160045100330	Generic

FLUVOXAMINE MALEATE ER	FLUVOXAMINE MALEATE CAP ER 24HR 100 MG	58160045107020	Generic
FLUVOXAMINE MALEATE ER	FLUVOXAMINE MALEATE CAP ER 24HR 150 MG	58160045107030	Generic
FETZIMA TITRATION PACK	LEVOMILNACIPRAN HCL CAP ER 24HR 20 & 40 MG THERAPY PACK	5818005010B620	Brand
FETZIMA	LEVOMILNACIPRAN HCL CAP ER 24HR 20 MG (BASE EQUIVALENT)	58180050107020	Brand
FETZIMA	LEVOMILNACIPRAN HCL CAP ER 24HR 40 MG (BASE EQUIVALENT)	58180050107040	Brand
FETZIMA	LEVOMILNACIPRAN HCL CAP ER 24HR 80 MG (BASE EQUIVALENT)	58180050107060	Brand
FETZIMA	LEVOMILNACIPRAN HCL CAP ER 24HR 120 MG (BASE EQUIVALENT)	58180050107080	Brand
PEXEVA	PAROXETINE MESYLATE TAB 10 MG (BASE EQUIV)	58160060300310	Brand
PEXEVA	PAROXETINE MESYLATE TAB 20 MG (BASE EQUIV)	58160060300320	Brand
PEXEVA	PAROXETINE MESYLATE TAB 30 MG (BASE EQUIV)	58160060300330	Brand
TRINTELLIX	VORTIOXETINE HBR TAB 5 MG (BASE EQUIV)	58120093100310	Brand
TRINTELLIX	VORTIOXETINE HBR TAB 10 MG (BASE EQUIV)	58120093100320	Brand
TRINTELLIX	VORTIOXETINE HBR TAB 20 MG (BASE EQUIV)	58120093100340	Brand
DRIZALMA SPRINKLE	DULOXETINE HCL CAP DELAYED RELEASE SPRINKLE 20 MG (BASE EQ)	5818002510H120	Brand
DRIZALMA SPRINKLE	DULOXETINE HCL CAP DELAYED RELEASE SPRINKLE 30 MG (BASE EQ)	5818002510H130	Brand
DRIZALMA SPRINKLE	DULOXETINE HCL CAP DELAYED RELEASE SPRINKLE 40 MG (BASE EQ)	5818002510H140	Brand
DRIZALMA SPRINKLE	DULOXETINE HCL CAP DELAYED RELEASE SPRINKLE 60 MG (BASE EQ)	5818002510H160	Brand
SAVELLA	MILNACIPRAN HCL TAB 12.5 MG	62504050100320	Brand
SAVELLA	MILNACIPRAN HCL TAB 25 MG	62504050100330	Brand
SAVELLA	MILNACIPRAN HCL TAB 50 MG	62504050100340	Brand
SAVELLA	MILNACIPRAN HCL TAB 100 MG	62504050100350	Brand
SAVELLA TITRATION PACK	MILNACIPRAN HCL TAB 12.5 MG (5) & 25 MG (8) & 50 MG (42) PAK	62504050106320	Brand
PAROXETINE	PAROXETINE MESYLATE CAP 7.5 MG (BASE EQUIV)	62226060300110	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
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
CITALOPRAM HYDROBROMIDE	CITALOPRAM HYDROBROMIDE CAP 30 MG	58160020100120	Brand
CYMBALTA	DULOXETINE HCL ENTERIC COATED PELLETS CAP 20 MG (BASE EQ)	58180025106720	Brand
DULOXETINE HYDROCHLORIDE	DULOXETINE HCL ENTERIC COATED PELLETS CAP 20 MG (BASE EQ)	58180025106720	Generic

CYMBALTA	DULOXETINE HCL ENTERIC COATED PELLETS CAP 30 MG (BASE EQ)	58180025106730	Brand
DULOXETINE HCL	DULOXETINE HCL ENTERIC COATED PELLETS CAP 30 MG (BASE EQ)	58180025106730	Generic
DULOXETINE HYDROCHLORIDE	DULOXETINE HCL ENTERIC COATED PELLETS CAP 30 MG (BASE EQ)	58180025106730	Generic
DULOXETINE HCL	DULOXETINE HCL ENTERIC COATED PELLETS CAP 40 MG (BASE EQ)	58180025106740	Generic
DULOXETINE HYDROCHLORIDE	DULOXETINE HCL ENTERIC COATED PELLETS CAP 40 MG (BASE EQ)	58180025106740	Generic
CYMBALTA	DULOXETINE HCL ENTERIC COATED PELLETS CAP 60 MG (BASE EQ)	58180025106750	Brand
DULOXETINE HYDROCHLORIDE	DULOXETINE HCL ENTERIC COATED PELLETS CAP 60 MG (BASE EQ)	58180025106750	Generic
FLUOXETINE HYDROCHLORIDE	FLUOXETINE HCL CAP 10 MG	58160040000110	Generic
PROZAC	FLUOXETINE HCL CAP 10 MG	58160040000110	Brand
FLUOXETINE HYDROCHLORIDE	FLUOXETINE HCL CAP 20 MG	58160040000120	Generic
FLUOXETINE HCL	FLUOXETINE HCL CAP 20 MG	58160040000120	Generic
PROZAC	FLUOXETINE HCL CAP 20 MG	58160040000120	Brand
FLUOXETINE HYDROCHLORIDE	FLUOXETINE HCL CAP 40 MG	58160040000140	Generic
PROZAC	FLUOXETINE HCL CAP 40 MG	58160040000140	Brand
FLUOXETINE HYDROCHLORIDE	FLUOXETINE HCL TAB 10 MG	58160040000310	Generic
FLUOXETINE HYDROCHLORIDE	FLUOXETINE HCL TAB 20 MG	58160040000320	Generic
FLUOXETINE HYDROCHLORIDE	FLUOXETINE HCL TAB 60 MG	58160040000360	Generic
FLUOXETINE HYDROCHLORIDE	FLUOXETINE HCL SOLUTION 20 MG/5ML	58160040002020	Generic
FLUOXETINE HCL	FLUOXETINE HCL SOLUTION 20 MG/5ML	58160040002020	Generic
FLUOXETINE DR	FLUOXETINE HCL CAP DELAYED RELEASE 90 MG	58160040006530	Generic
FLUOXETINE HYDROCHLORIDE	FLUOXETINE HCL (PMDD) TAB 10 MG	62206040000310	Generic
FLUOXETINE HYDROCHLORIDE	FLUOXETINE HCL (PMDD) TAB 20 MG	62206040000320	Generic
PAXIL	PAROXETINE HCL TAB 10 MG	58160060000310	Brand
PAROXETINE HYDROCHLORIDE	PAROXETINE HCL TAB 10 MG	58160060000310	Generic
PAXIL	PAROXETINE HCL TAB 20 MG	58160060000320	Brand

PAROXETINE HYDROCHLORIDE	PAROXETINE HCL TAB 20 MG	58160060000320	Generic
PAXIL	PAROXETINE HCL TAB 30 MG	58160060000330	Brand
PAROXETINE HCL	PAROXETINE HCL TAB 30 MG	58160060000330	Generic
PAROXETINE HYDROCHLORIDE	PAROXETINE HCL TAB 30 MG	58160060000330	Generic
PAXIL	PAROXETINE HCL TAB 40 MG	58160060000340	Brand
PAROXETINE HCL	PAROXETINE HCL TAB 40 MG	58160060000340	Generic
PAROXETINE HYDROCHLORIDE	PAROXETINE HCL TAB 40 MG	58160060000340	Generic
PAXIL	PAROXETINE HCL ORAL SUSP 10 MG/5ML (BASE EQUIV)	58160060001820	Brand
PAROXETINE HYDROCHLORIDE	PAROXETINE HCL ORAL SUSP 10 MG/5ML (BASE EQUIV)	58160060001820	Generic
PAROXETINE HYDROCHLORIDE ER	PAROXETINE HCL TAB ER 24HR 12.5 MG	58160060007520	Generic
PAXIL CR	PAROXETINE HCL TAB ER 24HR 12.5 MG	58160060007520	Brand
PAROXETINE HCL ER	PAROXETINE HCL TAB ER 24HR 12.5 MG	58160060007520	Generic
PAROXETINE HYDROCHLORIDE ER	PAROXETINE HCL TAB ER 24HR 25 MG	58160060007530	Generic
PAXIL CR	PAROXETINE HCL TAB ER 24HR 25 MG	58160060007530	Brand
PAROXETINE HCL ER	PAROXETINE HCL TAB ER 24HR 25 MG	58160060007530	Generic
PAROXETINE HYDROCHLORIDE ER	PAROXETINE HCL TAB ER 24HR 37.5 MG	58160060007540	Generic
PAXIL CR	PAROXETINE HCL TAB ER 24HR 37.5 MG	58160060007540	Brand
PAROXETINE HCL ER	PAROXETINE HCL TAB ER 24HR 37.5 MG	58160060007540	Generic
SERTRALINE HYDROCHLORIDE	SERTRALINE HCL CAP 150 MG	58160070100130	Brand
SERTRALINE HYDROCHLORIDE	SERTRALINE HCL CAP 200 MG	58160070100140	Brand
SERTRALINE HCL	SERTRALINE HCL TAB 25 MG	58160070100305	Generic
SERTRALINE HYDROCHLORIDE	SERTRALINE HCL TAB 25 MG	58160070100305	Generic
ZOLOFT	SERTRALINE HCL TAB 25 MG	58160070100305	Brand
SERTRALINE HCL	SERTRALINE HCL TAB 50 MG	58160070100310	Generic

SERTRALINE HYDROCHLORIDE	SERTRALINE HCL TAB 50 MG	58160070100310	Generic
ZOLOFT	SERTRALINE HCL TAB 50 MG	58160070100310	Brand
SERTRALINE HYDROCHLORIDE	SERTRALINE HCL TAB 100 MG	58160070100320	Generic
ZOLOFT	SERTRALINE HCL TAB 100 MG	58160070100320	Brand
SERTRALINE HCL	SERTRALINE HCL ORAL CONCENTRATE FOR SOLUTION 20 MG/ML	58160070101320	Generic
SERTRALINE HYDROCHLORIDE	SERTRALINE HCL ORAL CONCENTRATE FOR SOLUTION 20 MG/ML	58160070101320	Generic
ZOLOFT	SERTRALINE HCL ORAL CONCENTRATE FOR SOLUTION 20 MG/ML	58160070101320	Brand
VENLAFAXINE BESYLATE ER	VENLAFAXINE BESYLATE TAB ER 24HR 112.5 MG	58180090057520	Brand
VENLAFAXINE HYDROCHLORIDE	VENLAFAXINE HCL TAB 25 MG (BASE EQUIVALENT)	58180090100320	Generic
VENLAFAXINE HCL	VENLAFAXINE HCL TAB 25 MG (BASE EQUIVALENT)	58180090100320	Generic
VENLAFAXINE HYDROCHLORIDE	VENLAFAXINE HCL TAB 37.5 MG (BASE EQUIVALENT)	58180090100340	Generic
VENLAFAXINE HCL	VENLAFAXINE HCL TAB 37.5 MG (BASE EQUIVALENT)	58180090100340	Generic
VENLAFAXINE HYDROCHLORIDE	VENLAFAXINE HCL TAB 50 MG (BASE EQUIVALENT)	58180090100350	Generic
VENLAFAXINE HCL	VENLAFAXINE HCL TAB 50 MG (BASE EQUIVALENT)	58180090100350	Generic
VENLAFAXINE HYDROCHLORIDE	VENLAFAXINE HCL TAB 75 MG (BASE EQUIVALENT)	58180090100360	Generic
VENLAFAXINE HCL	VENLAFAXINE HCL TAB 75 MG (BASE EQUIVALENT)	58180090100360	Generic
VENLAFAXINE HYDROCHLORIDE	VENLAFAXINE HCL TAB 100 MG (BASE EQUIVALENT)	58180090100370	Generic
VENLAFAXINE HCL	VENLAFAXINE HCL TAB 100 MG (BASE EQUIVALENT)	58180090100370	Generic
VENLAFAXINE HCL ER	VENLAFAXINE HCL CAP ER 24HR 37.5 MG (BASE EQUIVALENT)	58180090107020	Generic
VENLAFAXINE HYDROCHLORIDE ER	VENLAFAXINE HCL CAP ER 24HR 37.5 MG (BASE EQUIVALENT)	58180090107020	Generic
EFFEXOR XR	VENLAFAXINE HCL CAP ER 24HR 37.5 MG (BASE EQUIVALENT)	58180090107020	Brand
VENLAFAXINE HYDROCHLORIDE ER	VENLAFAXINE HCL CAP ER 24HR 75 MG (BASE EQUIVALENT)	58180090107030	Generic

EFFEXOR XR	VENLAFAXINE HCL CAP ER 24HR 75 MG (BASE EQUIVALENT)	58180090107030	Brand
VENLAFAXINE HCL ER	VENLAFAXINE HCL CAP ER 24HR 150 MG (BASE EQUIVALENT)	58180090107050	Generic
VENLAFAXINE HYDROCHLORIDE ER	VENLAFAXINE HCL CAP ER 24HR 150 MG (BASE EQUIVALENT)	58180090107050	Generic
VENLAFAXINE HYDROCHLORIDEER	VENLAFAXINE HCL CAP ER 24HR 150 MG (BASE EQUIVALENT)	58180090107050	Generic
EFFEXOR XR	VENLAFAXINE HCL CAP ER 24HR 150 MG (BASE EQUIVALENT)	58180090107050	Brand
VENLAFAXINE HCL ER	VENLAFAXINE HCL TAB ER 24HR 37.5 MG (BASE EQUIVALENT)	58180090107510	Generic
VENLAFAXINE HYDROCHLORIDE ER	VENLAFAXINE HCL TAB ER 24HR 37.5 MG (BASE EQUIVALENT)	58180090107510	Generic
VENLAFAXINE HYDROCHLORIDE ER	VENLAFAXINE HCL TAB ER 24HR 75 MG (BASE EQUIVALENT)	58180090107520	Generic
VENLAFAXINE HYDROCHLORIDE ER	VENLAFAXINE HCL TAB ER 24HR 150 MG (BASE EQUIVALENT)	58180090107530	Generic
VENLAFAXINE HYDROCHLORIDE ER	VENLAFAXINE HCL TAB ER 24HR 225 MG (BASE EQUIVALENT)	58180090107540	Generic
VIIBRYD	VILAZODONE HCL TAB 10 MG	58120088100310	Brand
VILAZODONE HYDROCHLORIDE	VILAZODONE HCL TAB 10 MG	58120088100310	Generic
VIIBRYD	VILAZODONE HCL TAB 20 MG	58120088100320	Brand
VILAZODONE HYDROCHLORIDE	VILAZODONE HCL TAB 20 MG	58120088100320	Generic
VIIBRYD	VILAZODONE HCL TAB 40 MG	58120088100340	Brand
VILAZODONE HYDROCHLORIDE	VILAZODONE HCL TAB 40 MG	58120088100340	Generic
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
DESVENLAFAXINE ER	DESVENLAFAXINE TAB ER 24HR 50 MG	58180020007520	Brand
DESVENLAFAXINE ER	DESVENLAFAXINE TAB ER 24HR 100 MG	58180020007540	Brand

Approval Criteria

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

OR

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

OR

3 - Medical rationale supporting duplication of therapy*

Notes	*Approval Duration – Cross-taper or discontinuation: 90 days; Initial approval: 6 months

Product Name: Brand Celexa, Generic citalopram, Drizalma, Brand Pristiq, Generic desvenlafaxine succinate ER, Desvenlafaxine ER, Brand Cymbalta, Generic duloxetine, Brand Lexapro, Generic escitalopram, Brand Prozac, Generic fluoxetine caps, Fluoxetine (tabs, soln, DR caps, PMDD tabs), fluvoxamine, Fetzima, Brand Zoloft, Generic sertraline tabs and oral conc, Sertraline caps, Savella, Venlafaxine Besylate 112.5mg ER tabs, Venlafaxine tabs, Brand Effexor XR, Generic venlafaxine ER caps, Venlafaxine ER tabs, Brand Viibryd, Generic vilazodone, Qelbree, Trintellix, Brand Strattera, Generic atomoxetine, Brand Paxil, Generic paroxetine tablets, Paroxetine oral susp, Brand Paxil CR, Generic paroxetine ER, Pexeva, paroxetine capsules

Diagnosis	Duplicate Therapy with Another SSRI/SNRI
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Drug Utilization Review (DUR)

Product Name	Generic Name	GPI	Brand/Generic
CELEXA	CITALOPRAM HYDROBROMIDE TAB 10 MG (BASE EQUIV)	58160020100310	Brand
CITALOPRAM HYDROBROMIDE	CITALOPRAM HYDROBROMIDE TAB 10 MG (BASE EQUIV)	58160020100310	Generic
CELEXA	CITALOPRAM HYDROBROMIDE TAB 20 MG (BASE EQUIV)	58160020100320	Brand
CITALOPRAM HYDROBROMIDE	CITALOPRAM HYDROBROMIDE TAB 20 MG (BASE EQUIV)	58160020100320	Generic
CELEXA	CITALOPRAM HYDROBROMIDE TAB 40 MG (BASE EQUIV)	58160020100340	Brand

CITALOPRAM HYDROBROMIDE	CITALOPRAM HYDROBROMIDE TAB 40 MG (BASE EQUIV)	58160020100340	Generic
CITALOPRAM HYDROBROMIDE	CITALOPRAM HYDROBROMIDE ORAL SOLN 10 MG/5ML	58160020102020	Generic
DESVENLAFAXINE ER	DESVENLAFAXINE SUCCINATE TAB ER 24HR 25 MG (BASE EQUIV)	58180020207510	Generic
PRISTIQ	DESVENLAFAXINE SUCCINATE TAB ER 24HR 25 MG (BASE EQUIV)	58180020207510	Brand
DESVENLAFAXINE ER	DESVENLAFAXINE SUCCINATE TAB ER 24HR 50 MG (BASE EQUIV)	58180020207520	Generic
PRISTIQ	DESVENLAFAXINE SUCCINATE TAB ER 24HR 50 MG (BASE EQUIV)	58180020207520	Brand
DESVENLAFAXINE ER	DESVENLAFAXINE SUCCINATE TAB ER 24HR 100 MG (BASE EQUIV)	58180020207540	Generic
PRISTIQ	DESVENLAFAXINE SUCCINATE TAB ER 24HR 100 MG (BASE EQUIV)	58180020207540	Brand
ESCITALOPRAM OXALATE	ESCITALOPRAM OXALATE TAB 5 MG (BASE EQUIV)	58160034100310	Generic
LEXAPRO	ESCITALOPRAM OXALATE TAB 5 MG (BASE EQUIV)	58160034100310	Brand
ESCITALOPRAM OXALATE	ESCITALOPRAM OXALATE TAB 10 MG (BASE EQUIV)	58160034100320	Generic
LEXAPRO	ESCITALOPRAM OXALATE TAB 10 MG (BASE EQUIV)	58160034100320	Brand
ESCITALOPRAM OXALATE	ESCITALOPRAM OXALATE TAB 20 MG (BASE EQUIV)	58160034100330	Generic
LEXAPRO	ESCITALOPRAM OXALATE TAB 20 MG (BASE EQUIV)	58160034100330	Brand
ESCITALOPRAM OXALATE	ESCITALOPRAM OXALATE SOLN 5 MG/5ML (BASE EQUIV)	58160034102020	Generic
FLUVOXAMINE MALEATE	FLUVOXAMINE MALEATE TAB 25 MG	58160045100310	Generic
FLUVOXAMINE MALEATE	FLUVOXAMINE MALEATE TAB 50 MG	58160045100320	Generic
FLUVOXAMINE MALEATE	FLUVOXAMINE MALEATE TAB 100 MG	58160045100330	Generic
FLUVOXAMINE MALEATE ER	FLUVOXAMINE MALEATE CAP ER 24HR 100 MG	58160045107020	Generic
FLUVOXAMINE MALEATE ER	FLUVOXAMINE MALEATE CAP ER 24HR 150 MG	58160045107030	Generic
FETZIMA TITRATION PACK	LEVOMILNACIPRAN HCL CAP ER 24HR 20 & 40 MG THERAPY PACK	5818005010B620	Brand
FETZIMA	LEVOMILNACIPRAN HCL CAP ER 24HR 20 MG (BASE EQUIVALENT)	58180050107020	Brand
FETZIMA	LEVOMILNACIPRAN HCL CAP ER 24HR 40 MG (BASE EQUIVALENT)	58180050107040	Brand

FETZIMA	LEVOMILNACIPRAN HCL CAP ER 24HR 80 MG (BASE EQUIVALENT)	58180050107060	Brand
FETZIMA	LEVOMILNACIPRAN HCL CAP ER 24HR 120 MG (BASE EQUIVALENT)	58180050107080	Brand
PEXEVA	PAROXETINE MESYLATE TAB 10 MG (BASE EQUIV)	58160060300310	Brand
PEXEVA	PAROXETINE MESYLATE TAB 20 MG (BASE EQUIV)	58160060300320	Brand
PEXEVA	PAROXETINE MESYLATE TAB 30 MG (BASE EQUIV)	58160060300330	Brand
TRINTELLIX	VORTIOXETINE HBR TAB 5 MG (BASE EQUIV)	58120093100310	Brand
TRINTELLIX	VORTIOXETINE HBR TAB 10 MG (BASE EQUIV)	58120093100320	Brand
TRINTELLIX	VORTIOXETINE HBR TAB 20 MG (BASE EQUIV)	58120093100340	Brand
DRIZALMA SPRINKLE	DULOXETINE HCL CAP DELAYED RELEASE SPRINKLE 20 MG (BASE EQ)	5818002510H120	Brand
DRIZALMA SPRINKLE	DULOXETINE HCL CAP DELAYED RELEASE SPRINKLE 30 MG (BASE EQ)	5818002510H130	Brand
DRIZALMA SPRINKLE	DULOXETINE HCL CAP DELAYED RELEASE SPRINKLE 40 MG (BASE EQ)	5818002510H140	Brand
DRIZALMA SPRINKLE	DULOXETINE HCL CAP DELAYED RELEASE SPRINKLE 60 MG (BASE EQ)	5818002510H160	Brand
SAVELLA	MILNACIPRAN HCL TAB 12.5 MG	62504050100320	Brand
SAVELLA	MILNACIPRAN HCL TAB 25 MG	62504050100330	Brand
SAVELLA	MILNACIPRAN HCL TAB 50 MG	62504050100340	Brand
SAVELLA	MILNACIPRAN HCL TAB 100 MG	62504050100350	Brand
SAVELLA TITRATION PACK	MILNACIPRAN HCL TAB 12.5 MG (5) & 25 MG (8) & 50 MG (42) PAK	62504050106320	Brand
PAROXETINE	PAROXETINE MESYLATE CAP 7.5 MG (BASE EQUIV)	62226060300110	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
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
CITALOPRAM HYDROBROMIDE	CITALOPRAM HYDROBROMIDE CAP 30 MG	58160020100120	Brand
CYMBALTA	DULOXETINE HCL ENTERIC COATED PELLETS CAP 20 MG (BASE EQ)	58180025106720	Brand
DULOXETINE HYDROCHLORIDE	DULOXETINE HCL ENTERIC COATED PELLETS CAP 20 MG (BASE EQ)	58180025106720	Generic
CYMBALTA	DULOXETINE HCL ENTERIC COATED PELLETS CAP 30 MG (BASE EQ)	58180025106730	Brand
DULOXETINE HCL	DULOXETINE HCL ENTERIC COATED PELLETS CAP 30 MG (BASE EQ)	58180025106730	Generic
DULOXETINE HYDROCHLORIDE	DULOXETINE HCL ENTERIC COATED PELLETS CAP 30 MG (BASE EQ)	58180025106730	Generic
DULOXETINE HCL	DULOXETINE HCL ENTERIC COATED PELLETS CAP 40 MG (BASE EQ)	58180025106740	Generic
DULOXETINE HYDROCHLORIDE	DULOXETINE HCL ENTERIC COATED PELLETS CAP 40 MG (BASE EQ)	58180025106740	Generic

CYMBALTA	DULOXETINE HCL ENTERIC COATED PELLETS CAP 60 MG (BASE EQ)	58180025106750	Brand
DULOXETINE HYDROCHLORIDE	DULOXETINE HCL ENTERIC COATED PELLETS CAP 60 MG (BASE EQ)	58180025106750	Generic
FLUOXETINE HYDROCHLORIDE	FLUOXETINE HCL CAP 10 MG	58160040000110	Generic
PROZAC	FLUOXETINE HCL CAP 10 MG	58160040000110	Brand
FLUOXETINE HYDROCHLORIDE	FLUOXETINE HCL CAP 20 MG	58160040000120	Generic
FLUOXETINE HCL	FLUOXETINE HCL CAP 20 MG	58160040000120	Generic
PROZAC	FLUOXETINE HCL CAP 20 MG	58160040000120	Brand
FLUOXETINE HYDROCHLORIDE	FLUOXETINE HCL CAP 40 MG	58160040000140	Generic
PROZAC	FLUOXETINE HCL CAP 40 MG	58160040000140	Brand
FLUOXETINE HYDROCHLORIDE	FLUOXETINE HCL TAB 10 MG	58160040000310	Generic
FLUOXETINE HYDROCHLORIDE	FLUOXETINE HCL TAB 20 MG	58160040000320	Generic
FLUOXETINE HYDROCHLORIDE	FLUOXETINE HCL TAB 60 MG	58160040000360	Generic
FLUOXETINE HYDROCHLORIDE	FLUOXETINE HCL SOLUTION 20 MG/5ML	58160040002020	Generic
FLUOXETINE HCL	FLUOXETINE HCL SOLUTION 20 MG/5ML	58160040002020	Generic
FLUOXETINE DR	FLUOXETINE HCL CAP DELAYED RELEASE 90 MG	58160040006530	Generic
FLUOXETINE HYDROCHLORIDE	FLUOXETINE HCL (PMDD) TAB 10 MG	62206040000310	Generic
FLUOXETINE HYDROCHLORIDE	FLUOXETINE HCL (PMDD) TAB 20 MG	62206040000320	Generic
PAXIL	PAROXETINE HCL TAB 10 MG	58160060000310	Brand
PAROXETINE HYDROCHLORIDE	PAROXETINE HCL TAB 10 MG	58160060000310	Generic
PAXIL	PAROXETINE HCL TAB 20 MG	58160060000320	Brand
PAROXETINE HYDROCHLORIDE	PAROXETINE HCL TAB 20 MG	58160060000320	Generic
PAXIL	PAROXETINE HCL TAB 30 MG	58160060000330	Brand
PAROXETINE HCL	PAROXETINE HCL TAB 30 MG	58160060000330	Generic
PAROXETINE HYDROCHLORIDE	PAROXETINE HCL TAB 30 MG	58160060000330	Generic
PAXIL	PAROXETINE HCL TAB 40 MG	58160060000340	Brand
PAROXETINE HCL	PAROXETINE HCL TAB 40 MG	58160060000340	Generic

PAROXETINE HYDROCHLORIDE	PAROXETINE HCL TAB 40 MG	58160060000340	Generic
PAXIL	PAROXETINE HCL ORAL SUSP 10 MG/5ML (BASE EQUIV)	58160060001820	Brand
PAROXETINE HYDROCHLORIDE	PAROXETINE HCL ORAL SUSP 10 MG/5ML (BASE EQUIV)	58160060001820	Generic
PAROXETINE HYDROCHLORIDE ER	PAROXETINE HCL TAB ER 24HR 12.5 MG	58160060007520	Generic
PAXIL CR	PAROXETINE HCL TAB ER 24HR 12.5 MG	58160060007520	Brand
PAROXETINE HCL ER	PAROXETINE HCL TAB ER 24HR 12.5 MG	58160060007520	Generic
PAROXETINE HYDROCHLORIDE ER	PAROXETINE HCL TAB ER 24HR 25 MG	58160060007530	Generic
PAXIL CR	PAROXETINE HCL TAB ER 24HR 25 MG	58160060007530	Brand
PAROXETINE HCL ER	PAROXETINE HCL TAB ER 24HR 25 MG	58160060007530	Generic
PAROXETINE HYDROCHLORIDE ER	PAROXETINE HCL TAB ER 24HR 37.5 MG	58160060007540	Generic
PAXIL CR	PAROXETINE HCL TAB ER 24HR 37.5 MG	58160060007540	Brand
PAROXETINE HCL ER	PAROXETINE HCL TAB ER 24HR 37.5 MG	58160060007540	Generic
SERTRALINE HYDROCHLORIDE	SERTRALINE HCL CAP 150 MG	58160070100130	Brand
SERTRALINE HYDROCHLORIDE	SERTRALINE HCL CAP 200 MG	58160070100140	Brand
SERTRALINE HCL	SERTRALINE HCL TAB 25 MG	58160070100305	Generic
SERTRALINE HYDROCHLORIDE	SERTRALINE HCL TAB 25 MG	58160070100305	Generic
ZOLOFT	SERTRALINE HCL TAB 25 MG	58160070100305	Brand
SERTRALINE HCL	SERTRALINE HCL TAB 50 MG	58160070100310	Generic
SERTRALINE HYDROCHLORIDE	SERTRALINE HCL TAB 50 MG	58160070100310	Generic
ZOLOFT	SERTRALINE HCL TAB 50 MG	58160070100310	Brand
SERTRALINE HYDROCHLORIDE	SERTRALINE HCL TAB 100 MG	58160070100320	Generic
ZOLOFT	SERTRALINE HCL TAB 100 MG	58160070100320	Brand
SERTRALINE HCL	SERTRALINE HCL ORAL CONCENTRATE FOR SOLUTION 20 MG/ML	58160070101320	Generic
SERTRALINE HYDROCHLORIDE	SERTRALINE HCL ORAL CONCENTRATE FOR SOLUTION 20 MG/ML	58160070101320	Generic

ZOLOFT	SERTRALINE HCL ORAL CONCENTRATE FOR SOLUTION 20 MG/ML	58160070101320	Brand
VENLAFAXINE BESYLATE ER	VENLAFAXINE BESYLATE TAB ER 24HR 112.5 MG	58180090057520	Brand
VENLAFAXINE HYDROCHLORIDE	VENLAFAXINE HCL TAB 25 MG (BASE EQUIVALENT)	58180090100320	Generic
VENLAFAXINE HCL	VENLAFAXINE HCL TAB 25 MG (BASE EQUIVALENT)	58180090100320	Generic
VENLAFAXINE HYDROCHLORIDE	VENLAFAXINE HCL TAB 37.5 MG (BASE EQUIVALENT)	58180090100340	Generic
VENLAFAXINE HCL	VENLAFAXINE HCL TAB 37.5 MG (BASE EQUIVALENT)	58180090100340	Generic
VENLAFAXINE HYDROCHLORIDE	VENLAFAXINE HCL TAB 50 MG (BASE EQUIVALENT)	58180090100350	Generic
VENLAFAXINE HCL	VENLAFAXINE HCL TAB 50 MG (BASE EQUIVALENT)	58180090100350	Generic
VENLAFAXINE HYDROCHLORIDE	VENLAFAXINE HCL TAB 75 MG (BASE EQUIVALENT)	58180090100360	Generic
VENLAFAXINE HCL	VENLAFAXINE HCL TAB 75 MG (BASE EQUIVALENT)	58180090100360	Generic
VENLAFAXINE HYDROCHLORIDE	VENLAFAXINE HCL TAB 100 MG (BASE EQUIVALENT)	58180090100370	Generic
VENLAFAXINE HCL	VENLAFAXINE HCL TAB 100 MG (BASE EQUIVALENT)	58180090100370	Generic
VENLAFAXINE HCL ER	VENLAFAXINE HCL CAP ER 24HR 37.5 MG (BASE EQUIVALENT)	58180090107020	Generic
VENLAFAXINE HYDROCHLORIDE ER	VENLAFAXINE HCL CAP ER 24HR 37.5 MG (BASE EQUIVALENT)	58180090107020	Generic
EFFEXOR XR	VENLAFAXINE HCL CAP ER 24HR 37.5 MG (BASE EQUIVALENT)	58180090107020	Brand
VENLAFAXINE HYDROCHLORIDE ER	VENLAFAXINE HCL CAP ER 24HR 75 MG (BASE EQUIVALENT)	58180090107030	Generic
EFFEXOR XR	VENLAFAXINE HCL CAP ER 24HR 75 MG (BASE EQUIVALENT)	58180090107030	Brand
VENLAFAXINE HCL ER	VENLAFAXINE HCL CAP ER 24HR 150 MG (BASE EQUIVALENT)	58180090107050	Generic
VENLAFAXINE HYDROCHLORIDE ER	VENLAFAXINE HCL CAP ER 24HR 150 MG (BASE EQUIVALENT)	58180090107050	Generic
VENLAFAXINE HYDROCHLORIDEER	VENLAFAXINE HCL CAP ER 24HR 150 MG (BASE EQUIVALENT)	58180090107050	Generic
EFFEXOR XR	VENLAFAXINE HCL CAP ER 24HR 150 MG (BASE EQUIVALENT)	58180090107050	Brand

VENLAFAXINE HCL ER	VENLAFAXINE HCL TAB ER 24HR 37.5 MG (BASE EQUIVALENT)	58180090107510	Generic
VENLAFAXINE HYDROCHLORIDE ER	VENLAFAXINE HCL TAB ER 24HR 37.5 MG (BASE EQUIVALENT)	58180090107510	Generic
VENLAFAXINE HYDROCHLORIDE ER	VENLAFAXINE HCL TAB ER 24HR 75 MG (BASE EQUIVALENT)	58180090107520	Generic
VENLAFAXINE HYDROCHLORIDE ER	VENLAFAXINE HCL TAB ER 24HR 150 MG (BASE EQUIVALENT)	58180090107530	Generic
VENLAFAXINE HYDROCHLORIDE ER	VENLAFAXINE HCL TAB ER 24HR 225 MG (BASE EQUIVALENT)	58180090107540	Generic
VIIBRYD	VILAZODONE HCL TAB 10 MG	58120088100310	Brand
VILAZODONE HYDROCHLORIDE	VILAZODONE HCL TAB 10 MG	58120088100310	Generic
VIIBRYD	VILAZODONE HCL TAB 20 MG	58120088100320	Brand
VILAZODONE HYDROCHLORIDE	VILAZODONE HCL TAB 20 MG	58120088100320	Generic
VIIBRYD	VILAZODONE HCL TAB 40 MG	58120088100340	Brand
VILAZODONE HYDROCHLORIDE	VILAZODONE HCL TAB 40 MG	58120088100340	Generic
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
DESVENLAFAXINE ER	DESVENLAFAXINE TAB ER 24HR 50 MG	58180020007520	Brand
DESVENLAFAXINE ER	DESVENLAFAXINE TAB ER 24HR 100 MG	58180020007540	Brand

Approval Criteria

1 - Evidence of duplication of therapy with the requested SSRI/SNRI agents for 90 of the past 120 days

Product Name: Brand Celexa, Generic citalopram, Drizalma, Brand Pristiq, Generic desvenlafaxine succinate ER, Desvenlafaxine ER, Brand Cymbalta, Generic duloxetine, Brand Lexapro, Generic escitalopram, Brand Prozac, Generic fluoxetine caps, Fluoxetine (tabs, soln, DR caps, PMDD tabs), fluvoxamine, Fetzima, Brand Zoloft, Generic sertraline tabs and oral conc, Sertraline caps, Savella, Venlafaxine Besylate 112.5mg ER tabs, Venlafaxine tabs, Brand Effexor XR, Generic venlafaxine ER caps, Venlafaxine ER tabs,

Brand Viibryd, Generic vilazodone, Qelbree, Trintellix, Brand Strattera, Generic atomoxetine, Brand Paxil, Generic paroxetine tablets, Paroxetine oral susp, Brand Paxil CR, Generic paroxetine ER, Pexeva, paroxetine capsules	
Diagnosis	Age Limit Exception*
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CELEXA	CITALOPRAM HYDROBROMIDE TAB 10 MG (BASE EQUIV)	58160020100310	Brand
CITALOPRAM HYDROBROMIDE	CITALOPRAM HYDROBROMIDE TAB 10 MG (BASE EQUIV)	58160020100310	Generic
CELEXA	CITALOPRAM HYDROBROMIDE TAB 20 MG (BASE EQUIV)	58160020100320	Brand
CITALOPRAM HYDROBROMIDE	CITALOPRAM HYDROBROMIDE TAB 20 MG (BASE EQUIV)	58160020100320	Generic
CELEXA	CITALOPRAM HYDROBROMIDE TAB 40 MG (BASE EQUIV)	58160020100340	Brand
CITALOPRAM HYDROBROMIDE	CITALOPRAM HYDROBROMIDE TAB 40 MG (BASE EQUIV)	58160020100340	Generic
CITALOPRAM HYDROBROMIDE	CITALOPRAM HYDROBROMIDE ORAL SOLN 10 MG/5ML	58160020102020	Generic
DESVENLAFAXINE ER	DESVENLAFAXINE SUCCINATE TAB ER 24HR 25 MG (BASE EQUIV)	58180020207510	Generic
PRISTIQ	DESVENLAFAXINE SUCCINATE TAB ER 24HR 25 MG (BASE EQUIV)	58180020207510	Brand
DESVENLAFAXINE ER	DESVENLAFAXINE SUCCINATE TAB ER 24HR 50 MG (BASE EQUIV)	58180020207520	Generic
PRISTIQ	DESVENLAFAXINE SUCCINATE TAB ER 24HR 50 MG (BASE EQUIV)	58180020207520	Brand
DESVENLAFAXINE ER	DESVENLAFAXINE SUCCINATE TAB ER 24HR 100 MG (BASE EQUIV)	58180020207540	Generic
PRISTIQ	DESVENLAFAXINE SUCCINATE TAB ER 24HR 100 MG (BASE EQUIV)	58180020207540	Brand
ESCITALOPRAM OXALATE	ESCITALOPRAM OXALATE TAB 5 MG (BASE EQUIV)	58160034100310	Generic
LEXAPRO	ESCITALOPRAM OXALATE TAB 5 MG (BASE EQUIV)	58160034100310	Brand
ESCITALOPRAM OXALATE	ESCITALOPRAM OXALATE TAB 10 MG (BASE EQUIV)	58160034100320	Generic
LEXAPRO	ESCITALOPRAM OXALATE TAB 10 MG (BASE EQUIV)	58160034100320	Brand
ESCITALOPRAM OXALATE	ESCITALOPRAM OXALATE TAB 20 MG (BASE EQUIV)	58160034100330	Generic

LEXAPRO	ESCITALOPRAM OXALATE TAB 20 MG (BASE EQUIV)	58160034100330	Brand
ESCITALOPRAM OXALATE	ESCITALOPRAM OXALATE SOLN 5 MG/5ML (BASE EQUIV)	58160034102020	Generic
FLUVOXAMINE MALEATE	FLUVOXAMINE MALEATE TAB 25 MG	58160045100310	Generic
FLUVOXAMINE MALEATE	FLUVOXAMINE MALEATE TAB 50 MG	58160045100320	Generic
FLUVOXAMINE MALEATE	FLUVOXAMINE MALEATE TAB 100 MG	58160045100330	Generic
FLUVOXAMINE MALEATE ER	FLUVOXAMINE MALEATE CAP ER 24HR 100 MG	58160045107020	Generic
FLUVOXAMINE MALEATE ER	FLUVOXAMINE MALEATE CAP ER 24HR 150 MG	58160045107030	Generic
FETZIMA TITRATION PACK	LEVOMILNACIPRAN HCL CAP ER 24HR 20 & 40 MG THERAPY PACK	5818005010B620	Brand
FETZIMA	LEVOMILNACIPRAN HCL CAP ER 24HR 20 MG (BASE EQUIVALENT)	58180050107020	Brand
FETZIMA	LEVOMILNACIPRAN HCL CAP ER 24HR 40 MG (BASE EQUIVALENT)	58180050107040	Brand
FETZIMA	LEVOMILNACIPRAN HCL CAP ER 24HR 80 MG (BASE EQUIVALENT)	58180050107060	Brand
FETZIMA	LEVOMILNACIPRAN HCL CAP ER 24HR 120 MG (BASE EQUIVALENT)	58180050107080	Brand
PEXEVA	PAROXETINE MESYLATE TAB 10 MG (BASE EQUIV)	58160060300310	Brand
PEXEVA	PAROXETINE MESYLATE TAB 20 MG (BASE EQUIV)	58160060300320	Brand
PEXEVA	PAROXETINE MESYLATE TAB 30 MG (BASE EQUIV)	58160060300330	Brand
TRINTELLIX	VORTIOXETINE HBR TAB 5 MG (BASE EQUIV)	58120093100310	Brand
TRINTELLIX	VORTIOXETINE HBR TAB 10 MG (BASE EQUIV)	58120093100320	Brand
TRINTELLIX	VORTIOXETINE HBR TAB 20 MG (BASE EQUIV)	58120093100340	Brand
DRIZALMA SPRINKLE	DULOXETINE HCL CAP DELAYED RELEASE SPRINKLE 20 MG (BASE EQ)	5818002510H120	Brand
DRIZALMA SPRINKLE	DULOXETINE HCL CAP DELAYED RELEASE SPRINKLE 30 MG (BASE EQ)	5818002510H130	Brand
DRIZALMA SPRINKLE	DULOXETINE HCL CAP DELAYED RELEASE SPRINKLE 40 MG (BASE EQ)	5818002510H140	Brand
DRIZALMA SPRINKLE	DULOXETINE HCL CAP DELAYED RELEASE SPRINKLE 60 MG (BASE EQ)	5818002510H160	Brand
SAVELLA	MILNACIPRAN HCL TAB 12.5 MG	62504050100320	Brand

SAVELLA	MILNACIPRAN HCL TAB 25 MG	62504050100330	Brand
SAVELLA	MILNACIPRAN HCL TAB 50 MG	62504050100340	Brand
SAVELLA	MILNACIPRAN HCL TAB 100 MG	62504050100350	Brand
SAVELLA TITRATION PACK	MILNACIPRAN HCL TAB 12.5 MG (5) & 25 MG (8) & 50 MG (42) PAK	62504050106320	Brand
PAROXETINE	PAROXETINE MESYLATE CAP 7.5 MG (BASE EQUIV)	62226060300110	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
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
CITALOPRAM HYDROBROMIDE	CITALOPRAM HYDROBROMIDE CAP 30 MG	58160020100120	Brand
CYMBALTA	DULOXETINE HCL ENTERIC COATED PELLETS CAP 20 MG (BASE EQ)	58180025106720	Brand
DULOXETINE HYDROCHLORIDE	DULOXETINE HCL ENTERIC COATED PELLETS CAP 20 MG (BASE EQ)	58180025106720	Generic
CYMBALTA	DULOXETINE HCL ENTERIC COATED PELLETS CAP 30 MG (BASE EQ)	58180025106730	Brand
DULOXETINE HCL	DULOXETINE HCL ENTERIC COATED PELLETS CAP 30 MG (BASE EQ)	58180025106730	Generic
DULOXETINE HYDROCHLORIDE	DULOXETINE HCL ENTERIC COATED PELLETS CAP 30 MG (BASE EQ)	58180025106730	Generic
DULOXETINE HCL	DULOXETINE HCL ENTERIC COATED PELLETS CAP 40 MG (BASE EQ)	58180025106740	Generic
DULOXETINE HYDROCHLORIDE	DULOXETINE HCL ENTERIC COATED PELLETS CAP 40 MG (BASE EQ)	58180025106740	Generic
CYMBALTA	DULOXETINE HCL ENTERIC COATED PELLETS CAP 60 MG (BASE EQ)	58180025106750	Brand
DULOXETINE HYDROCHLORIDE	DULOXETINE HCL ENTERIC COATED PELLETS CAP 60 MG (BASE EQ)	58180025106750	Generic
FLUOXETINE HYDROCHLORIDE	FLUOXETINE HCL CAP 10 MG	58160040000110	Generic
PROZAC	FLUOXETINE HCL CAP 10 MG	58160040000110	Brand
FLUOXETINE HYDROCHLORIDE	FLUOXETINE HCL CAP 20 MG	58160040000120	Generic
FLUOXETINE HCL	FLUOXETINE HCL CAP 20 MG	58160040000120	Generic
PROZAC	FLUOXETINE HCL CAP 20 MG	58160040000120	Brand
FLUOXETINE HYDROCHLORIDE	FLUOXETINE HCL CAP 40 MG	58160040000140	Generic
PROZAC	FLUOXETINE HCL CAP 40 MG	58160040000140	Brand
FLUOXETINE HYDROCHLORIDE	FLUOXETINE HCL TAB 10 MG	58160040000310	Generic
FLUOXETINE HYDROCHLORIDE	FLUOXETINE HCL TAB 20 MG	58160040000320	Generic
FLUOXETINE HYDROCHLORIDE	FLUOXETINE HCL TAB 60 MG	58160040000360	Generic
FLUOXETINE HYDROCHLORIDE	FLUOXETINE HCL SOLUTION 20 MG/5ML	58160040002020	Generic

FLUOXETINE HCL	FLUOXETINE HCL SOLUTION 20 MG/5ML	58160040002020	Generic
FLUOXETINE DR	FLUOXETINE HCL CAP DELAYED RELEASE 90 MG	58160040006530	Generic
FLUOXETINE HYDROCHLORIDE	FLUOXETINE HCL (PMDD) TAB 10 MG	62206040000310	Generic
FLUOXETINE HYDROCHLORIDE	FLUOXETINE HCL (PMDD) TAB 20 MG	62206040000320	Generic
PAXIL	PAROXETINE HCL TAB 10 MG	58160060000310	Brand
PAROXETINE HYDROCHLORIDE	PAROXETINE HCL TAB 10 MG	58160060000310	Generic
PAXIL	PAROXETINE HCL TAB 20 MG	58160060000320	Brand
PAROXETINE HYDROCHLORIDE	PAROXETINE HCL TAB 20 MG	58160060000320	Generic
PAXIL	PAROXETINE HCL TAB 30 MG	58160060000330	Brand
PAROXETINE HCL	PAROXETINE HCL TAB 30 MG	58160060000330	Generic
PAROXETINE HYDROCHLORIDE	PAROXETINE HCL TAB 30 MG	58160060000330	Generic
PAXIL	PAROXETINE HCL TAB 40 MG	58160060000340	Brand
PAROXETINE HCL	PAROXETINE HCL TAB 40 MG	58160060000340	Generic
PAROXETINE HYDROCHLORIDE	PAROXETINE HCL TAB 40 MG	58160060000340	Generic
PAXIL	PAROXETINE HCL ORAL SUSP 10 MG/5ML (BASE EQUIV)	58160060001820	Brand
PAROXETINE HYDROCHLORIDE	PAROXETINE HCL ORAL SUSP 10 MG/5ML (BASE EQUIV)	58160060001820	Generic
PAROXETINE HYDROCHLORIDE ER	PAROXETINE HCL TAB ER 24HR 12.5 MG	58160060007520	Generic
PAXIL CR	PAROXETINE HCL TAB ER 24HR 12.5 MG	58160060007520	Brand
PAROXETINE HCL ER	PAROXETINE HCL TAB ER 24HR 12.5 MG	58160060007520	Generic
PAROXETINE HYDROCHLORIDE ER	PAROXETINE HCL TAB ER 24HR 25 MG	58160060007530	Generic
PAXIL CR	PAROXETINE HCL TAB ER 24HR 25 MG	58160060007530	Brand
PAROXETINE HCL ER	PAROXETINE HCL TAB ER 24HR 25 MG	58160060007530	Generic
PAROXETINE HYDROCHLORIDE ER	PAROXETINE HCL TAB ER 24HR 37.5 MG	58160060007540	Generic
PAXIL CR	PAROXETINE HCL TAB ER 24HR 37.5 MG	58160060007540	Brand

PAROXETINE HCL ER	PAROXETINE HCL TAB ER 24HR 37.5 MG	58160060007540	Generic
SERTRALINE HYDROCHLORIDE	SERTRALINE HCL CAP 150 MG	58160070100130	Brand
SERTRALINE HYDROCHLORIDE	SERTRALINE HCL CAP 200 MG	58160070100140	Brand
SERTRALINE HCL	SERTRALINE HCL TAB 25 MG	58160070100305	Generic
SERTRALINE HYDROCHLORIDE	SERTRALINE HCL TAB 25 MG	58160070100305	Generic
ZOLOFT	SERTRALINE HCL TAB 25 MG	58160070100305	Brand
SERTRALINE HCL	SERTRALINE HCL TAB 50 MG	58160070100310	Generic
SERTRALINE HYDROCHLORIDE	SERTRALINE HCL TAB 50 MG	58160070100310	Generic
ZOLOFT	SERTRALINE HCL TAB 50 MG	58160070100310	Brand
SERTRALINE HYDROCHLORIDE	SERTRALINE HCL TAB 100 MG	58160070100320	Generic
ZOLOFT	SERTRALINE HCL TAB 100 MG	58160070100320	Brand
SERTRALINE HCL	SERTRALINE HCL ORAL CONCENTRATE FOR SOLUTION 20 MG/ML	58160070101320	Generic
SERTRALINE HYDROCHLORIDE	SERTRALINE HCL ORAL CONCENTRATE FOR SOLUTION 20 MG/ML	58160070101320	Generic
ZOLOFT	SERTRALINE HCL ORAL CONCENTRATE FOR SOLUTION 20 MG/ML	58160070101320	Brand
VENLAFAXINE BESYLATE ER	VENLAFAXINE BESYLATE TAB ER 24HR 112.5 MG	58180090057520	Brand
VENLAFAXINE HYDROCHLORIDE	VENLAFAXINE HCL TAB 25 MG (BASE EQUIVALENT)	58180090100320	Generic
VENLAFAXINE HCL	VENLAFAXINE HCL TAB 25 MG (BASE EQUIVALENT)	58180090100320	Generic
VENLAFAXINE HYDROCHLORIDE	VENLAFAXINE HCL TAB 37.5 MG (BASE EQUIVALENT)	58180090100340	Generic
VENLAFAXINE HCL	VENLAFAXINE HCL TAB 37.5 MG (BASE EQUIVALENT)	58180090100340	Generic
VENLAFAXINE HYDROCHLORIDE	VENLAFAXINE HCL TAB 50 MG (BASE EQUIVALENT)	58180090100350	Generic
VENLAFAXINE HCL	VENLAFAXINE HCL TAB 50 MG (BASE EQUIVALENT)	58180090100350	Generic
VENLAFAXINE HYDROCHLORIDE	VENLAFAXINE HCL TAB 75 MG (BASE EQUIVALENT)	58180090100360	Generic
VENLAFAXINE HCL	VENLAFAXINE HCL TAB 75 MG (BASE EQUIVALENT)	58180090100360	Generic
VENLAFAXINE HYDROCHLORIDE	VENLAFAXINE HCL TAB 100 MG (BASE EQUIVALENT)	58180090100370	Generic

VENLAFAXINE HCL	VENLAFAXINE HCL TAB 100 MG (BASE EQUIVALENT)	58180090100370	Generic
VENLAFAXINE HCL ER	VENLAFAXINE HCL CAP ER 24HR 37.5 MG (BASE EQUIVALENT)	58180090107020	Generic
VENLAFAXINE HYDROCHLORIDE ER	VENLAFAXINE HCL CAP ER 24HR 37.5 MG (BASE EQUIVALENT)	58180090107020	Generic
EFFEXOR XR	VENLAFAXINE HCL CAP ER 24HR 37.5 MG (BASE EQUIVALENT)	58180090107020	Brand
VENLAFAXINE HYDROCHLORIDE ER	VENLAFAXINE HCL CAP ER 24HR 75 MG (BASE EQUIVALENT)	58180090107030	Generic
EFFEXOR XR	VENLAFAXINE HCL CAP ER 24HR 75 MG (BASE EQUIVALENT)	58180090107030	Brand
VENLAFAXINE HCL ER	VENLAFAXINE HCL CAP ER 24HR 150 MG (BASE EQUIVALENT)	58180090107050	Generic
VENLAFAXINE HYDROCHLORIDE ER	VENLAFAXINE HCL CAP ER 24HR 150 MG (BASE EQUIVALENT)	58180090107050	Generic
VENLAFAXINE HYDROCHLORIDEER	VENLAFAXINE HCL CAP ER 24HR 150 MG (BASE EQUIVALENT)	58180090107050	Generic
EFFEXOR XR	VENLAFAXINE HCL CAP ER 24HR 150 MG (BASE EQUIVALENT)	58180090107050	Brand
VENLAFAXINE HCL ER	VENLAFAXINE HCL TAB ER 24HR 37.5 MG (BASE EQUIVALENT)	58180090107510	Generic
VENLAFAXINE HYDROCHLORIDE ER	VENLAFAXINE HCL TAB ER 24HR 37.5 MG (BASE EQUIVALENT)	58180090107510	Generic
VENLAFAXINE HYDROCHLORIDE ER	VENLAFAXINE HCL TAB ER 24HR 75 MG (BASE EQUIVALENT)	58180090107520	Generic
VENLAFAXINE HYDROCHLORIDE ER	VENLAFAXINE HCL TAB ER 24HR 150 MG (BASE EQUIVALENT)	58180090107530	Generic
VENLAFAXINE HYDROCHLORIDE ER	VENLAFAXINE HCL TAB ER 24HR 225 MG (BASE EQUIVALENT)	58180090107540	Generic
VIIBRYD	VILAZODONE HCL TAB 10 MG	58120088100310	Brand
VILAZODONE HYDROCHLORIDE	VILAZODONE HCL TAB 10 MG	58120088100310	Generic
VIIBRYD	VILAZODONE HCL TAB 20 MG	58120088100320	Brand
VILAZODONE HYDROCHLORIDE	VILAZODONE HCL TAB 20 MG	58120088100320	Generic
VIIBRYD	VILAZODONE HCL TAB 40 MG	58120088100340	Brand
VILAZODONE HYDROCHLORIDE	VILAZODONE HCL TAB 40 MG	58120088100340	Generic

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
DESVENLAFAXINE ER	DESVENLAFAXINE TAB ER 24HR 50 MG	58180020007520	Brand
DESVENLAFAXINE ER	DESVENLAFAXINE TAB ER 24HR 100 MG	58180020007540	Brand

Approval Criteria

1 - All of the following:

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

AND

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

OR

2 - All of the following:

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

AND

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

OR

3 - All of the following:

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

AND

3.2 ONE of the following:

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

AND

3.3 One of the following:

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

OR

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

AND

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

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

2 . Revision History

Date	Notes

4/17/2023	Aligned criteria with with the policy and added the age limit criteria fro m the non-drug specific PA policy

Stimulants

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-124893
Guideline Name	Stimulants
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	7/1/2023

1 . Criteria

Product Name: Adhansia XR, Adzenys ER, Adzenys XR-ODT, Generic amphetamine, Brand Evekeo, Generic amphetamine/dextroamphetamine, Brand Adderall, generic amphetamine/dextroamphetamine ER, Brand Adderall XR, Brand Aptensio XR, generic methylphenidate ER (XR) cap, Azstarys, Cotempla XR-ODT, Brand Daytrana, Generic methylphenidate patch, Generic dexmethylphenidate, Brand Focalin, Generic dexmethylphenidate ER, Brand Focalin XR, Dyanavel XR, Generic dextroamphetamine tabs, Brand Zenzedi, Generic dextroamphetamine ER, Brand Dexedrine ER, Generic dextroamphetamine soln, Brand Procentra, Evekeo ODT, Generic methamphetamine, Brand Desoxyn, Jornay PM, Generic methylphenidate tabs, Brand Ritalin, methylphenidate chew, methylphenidate ER tabs, Generic methylphenidate ER osmotic tabs, Brand Concerta, Brand Relexxii, Generic methylphenidate ER (LA) caps, Brand Ritalin LA, methylphenidate ER (CD) caps, methylphenidate ER (24 HR) tabs, Generic methylphenidate soln, Brand Methylin soln, Mydayis, Quillichew ER, Quillivant XR, Vyvanse, Vyvanse chew, Xelstrym*	
Diagnosis	Duplicate Therapy with Another Stimulant
Guideline Type	Drug Utilization Review (DUR)

Product Name	Generic Name	GPI	Brand/Generic
DYANAVEL XR	AMPHETAMINE EXTENDED RELEASE SUSP 2.5 MG/ML	6110001000G120	Brand
ADZENYS XR-ODT	AMPHETAMINE TAB EXTENDED RELEASE DISINTEGRATING 3.1 MG	6110001000H410	Brand
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
EVEKEO	AMPHETAMINE SULFATE TAB 5 MG	61100010100310	Brand
EVEKEO	AMPHETAMINE SULFATE TAB 10 MG	61100010100320	Brand
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
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	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	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	AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 30 MG	61109902107030	Generic
MYDAYIS	AMPHETAMINE-DEXTROAMPHETAMINE 3-BEAD CAP ER 24HR 12.5 MG	61109902107060	Brand
MYDAYIS	AMPHETAMINE-DEXTROAMPHETAMINE 3-BEAD CAP ER 24HR 25 MG	61109902107065	Brand
MYDAYIS	AMPHETAMINE-DEXTROAMPHETAMINE 3-BEAD CAP ER 24HR 37.5 MG	61109902107070	Brand
MYDAYIS	AMPHETAMINE-DEXTROAMPHETAMINE 3-BEAD CAP ER 24HR 50 MG	61109902107075	Brand
DEXMETHYLPHENIDATE HCL 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 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 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 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 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 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 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 40 MG	61400016107060	Generic
FOCALIN XR	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 40 MG	61400016107060	Brand
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
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
ZENZEDI	DEXTROAMPHETAMINE SULFATE TAB 15 MG	61100020100315	Brand
ZENZEDI	DEXTROAMPHETAMINE SULFATE TAB 20 MG	61100020100330	Brand
ZENZEDI	DEXTROAMPHETAMINE SULFATE TAB 30 MG	61100020100350	Brand
DEXTROAMPHETAMINE SULFATE	DEXTROAMPHETAMINE SULFATE ORAL SOLUTION 5 MG/5ML	61100020102020	Generic
PROCENTRA	DEXTROAMPHETAMINE SULFATE ORAL SOLUTION 5 MG/5ML	61100020102020	Brand
DEXTROAMPHETAMINE SULFATE ER	DEXTROAMPHETAMINE SULFATE CAP ER 24HR 5 MG	61100020107005	Generic
DEXEDRINE	DEXTROAMPHETAMINE SULFATE CAP ER 24HR 10 MG	61100020107010	Brand
DEXTROAMPHETAMINE SULFATE ER	DEXTROAMPHETAMINE SULFATE CAP ER 24HR 10 MG	61100020107010	Generic

DEXEDRINE	DEXTROAMPHETAMINE SULFATE CAP ER 24HR 15 MG	61100020107015	Brand
DEXTROAMPHETAMINE SULFATE ER	DEXTROAMPHETAMINE SULFATE CAP ER 24HR 15 MG	61100020107015	Generic
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CAP 10 MG	61100025100110	Brand
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CAP 20 MG	61100025100120	Brand
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CAP 30 MG	61100025100130	Brand
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CAP 40 MG	61100025100140	Brand
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CAP 50 MG	61100025100150	Brand
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CAP 60 MG	61100025100160	Brand
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CAP 70 MG	61100025100170	Brand
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CHEW TAB 10 MG	61100025100510	Brand
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CHEW TAB 20 MG	61100025100520	Brand
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CHEW TAB 30 MG	61100025100530	Brand
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CHEW TAB 40 MG	61100025100540	Brand
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CHEW TAB 50 MG	61100025100550	Brand
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CHEW TAB 60 MG	61100025100560	Brand
DESOXYN	METHAMPHETAMINE HCL TAB 5 MG	61100030100305	Brand
METHAMPHETAMINE HCL	METHAMPHETAMINE HCL TAB 5 MG	61100030100305	Generic
DAYTRANA	METHYLPHENIDATE TD PATCH 10 MG/9HR	61400020005910	Brand
DAYTRANA	METHYLPHENIDATE TD PATCH 15 MG/9HR	61400020005915	Brand

DAYTRANA	METHYLPHENIDATE TD PATCH 20 MG/9HR	61400020005920	Brand
DAYTRANA	METHYLPHENIDATE TD PATCH 30 MG/9HR	61400020005930	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
RITALIN	METHYLPHENIDATE HCL TAB 5 MG	61400020100305	Brand
RITALIN	METHYLPHENIDATE HCL TAB 10 MG	61400020100310	Brand
RITALIN	METHYLPHENIDATE HCL TAB 20 MG	61400020100315	Brand
CONCERTA	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 18 MG	61400020100460	Brand
CONCERTA	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 27 MG	61400020100465	Brand
CONCERTA	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 36 MG	61400020100470	Brand
CONCERTA	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 54 MG	61400020100480	Brand
METHYLIN	METHYLPHENIDATE HCL SOLN 5 MG/5ML	61400020102020	Brand
METHYLPHENIDATE HYDROCHLORIDE	METHYLPHENIDATE HCL SOLN 5 MG/5ML	61400020102020	Generic
METHYLIN	METHYLPHENIDATE HCL SOLN 10 MG/5ML	61400020102030	Brand
METHYLPHENIDATE HYDROCHLORIDE	METHYLPHENIDATE HCL SOLN 10 MG/5ML	61400020102030	Generic
RITALIN LA	METHYLPHENIDATE HCL CAP ER 24HR 10 MG (LA)	61400020107010	Brand
RITALIN LA	METHYLPHENIDATE HCL CAP ER 24HR 20 MG (LA)	61400020107020	Brand
RITALIN LA	METHYLPHENIDATE HCL CAP ER 24HR 30 MG (LA)	61400020107030	Brand

RITALIN LA	METHYLPHENIDATE HCL CAP ER 24HR 40 MG (LA)	61400020107040	Brand
APTENSIO XR	METHYLPHENIDATE HCL CAP ER 24HR 10 MG (XR)	61400020107055	Brand
APTENSIO XR	METHYLPHENIDATE HCL CAP ER 24HR 15 MG (XR)	61400020107060	Brand
APTENSIO XR	METHYLPHENIDATE HCL CAP ER 24HR 20 MG (XR)	61400020107065	Brand
APTENSIO XR	METHYLPHENIDATE HCL CAP ER 24HR 30 MG (XR)	61400020107070	Brand
APTENSIO XR	METHYLPHENIDATE HCL CAP ER 24HR 40 MG (XR)	61400020107075	Brand
APTENSIO XR	METHYLPHENIDATE HCL CAP ER 24HR 50 MG (XR)	61400020107080	Brand
APTENSIO XR	METHYLPHENIDATE HCL CAP ER 24HR 60 MG (XR)	61400020107085	Brand
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
ADZENYS ER	AMPHETAMINE EXTENDED RELEASE SUSP 1.25 MG/ML	6110001000G110	Brand
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 72 MG	61400020100490	Generic
AMPHETAMINE SULFATE	AMPHETAMINE SULFATE TAB 5 MG	61100010100310	Generic
AMPHETAMINE SULFATE	AMPHETAMINE SULFATE TAB 10 MG	61100010100320	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

JORNAY PM	METHYLPHENIDATE HCL CAP DELAYED ER 24HR 100 MG (PM)	61400020107094	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
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
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 10 MG (XR)	61400020107055	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 15 MG (XR)	61400020107060	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 20 MG (XR)	61400020107065	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 30 MG (XR)	61400020107070	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 40 MG (XR)	61400020107075	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 50 MG (XR)	61400020107080	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 60 MG (XR)	61400020107085	Generic
DEXMETHYLPHENIDATE HYDROCHLORIDE ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 5 MG	61400016107020	Generic

DEXMETHYLPHENIDATE HYDROCHLORIDE ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 10 MG	61400016107030	Generic
DEXMETHYLPHENIDATE HYDROCHLORIDE ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 15 MG	61400016107035	Generic
DEXMETHYLPHENIDATE HYDROCHLORIDE 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 ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 30 MG	61400016107050	Generic
DEXMETHYLPHENIDATE HYDROCHLORIDE ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 35 MG	61400016107055	Generic
DEXMETHYLPHENIDATE HYDROCHLORIDE ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 40 MG	61400016107060	Generic
DEXTROAMPHETAMINE SULFATE	DEXTROAMPHETAMINE SULFATE TAB 20 MG	61100020100330	Generic
DEXTROAMPHETAMINE SULFATE	DEXTROAMPHETAMINE SULFATE TAB 30 MG	61100020100350	Generic
QUILLIVANT XR	METHYLPHENIDATE HCL FOR ER SUSP 25 MG/5ML (5 MG/ML)	6140002010G220	Brand
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 10 MG (LA)	61400020107010	Generic
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
DEXTROAMPHETAMINE SULFATE	DEXTROAMPHETAMINE SULFATE TAB 15 MG	61100020100315	Generic
METHYLPHENIDATE	METHYLPHENIDATE TD PATCH 10 MG/9HR	61400020005910	Generic
METHYLPHENIDATE	METHYLPHENIDATE TD PATCH 15 MG/9HR	61400020005915	Generic
METHYLPHENIDATE	METHYLPHENIDATE TD PATCH 20 MG/9HR	61400020005920	Generic
METHYLPHENIDATE	METHYLPHENIDATE TD PATCH 30 MG/9HR	61400020005930	Generic

METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 45 MG	61400020100475	Generic
RELEXXII	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
RELEXXII	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 63 MG	61400020100485	Generic
RELEXXII	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 72 MG	61400020100490	Brand
DEXMETHYLPHENIDATE HYDROCHLORIDE	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 25 MG	61400016107045	Generic
DEXMETHYLPHENIDATE HYDROCHLORIDE	DEXMETHYLPHENIDATE HCL TAB 2.5 MG	61400016100320	Generic
FOCALIN	DEXMETHYLPHENIDATE HCL TAB 2.5 MG	61400016100320	Brand
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
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
XELSTRYM	DEXTROAMPHETAMINE TD PATCH 18 MG/9HR	61100020005940	Brand
METHYLPHENIDATE HYDROCHLORIDE CD	METHYLPHENIDATE HCL CAP ER 10 MG (CD)	61400020100210	Generic

METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 10 MG (CD)	61400020100210	Generic
METHYLPHENIDATE HYDROCHLORIDE CD	METHYLPHENIDATE HCL CAP ER 20 MG (CD)	61400020100220	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 20 MG (CD)	61400020100220	Generic
METHYLPHENIDATE HYDROCHLORIDE CD	METHYLPHENIDATE HCL CAP ER 30 MG (CD)	61400020100230	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 30 MG (CD)	61400020100230	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 40 MG (CD)	61400020100240	Generic
METHYLPHENIDATE HYDROCHLORIDE CD	METHYLPHENIDATE HCL CAP ER 50 MG (CD)	61400020100250	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 50 MG (CD)	61400020100250	Generic
METHYLPHENIDATE HYDROCHLORIDE CD	METHYLPHENIDATE HCL CAP ER 60 MG (CD)	61400020100260	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 60 MG (CD)	61400020100260	Generic
METHYLPHENIDATE HYDROCHLORIDE	METHYLPHENIDATE HCL TAB 5 MG	61400020100305	Generic
METHYLPHENIDATE HYDROCHLORIDE	METHYLPHENIDATE HCL TAB 10 MG	61400020100310	Generic
METHYLPHENIDATE HYDROCHLORIDE	METHYLPHENIDATE HCL TAB 20 MG	61400020100315	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	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 18 MG	61400020100460	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 27 MG	61400020100465	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 36 MG	61400020100470	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 54 MG	61400020100480	Generic
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 ER	METHYLPHENIDATE HCL CAP ER 24HR 20 MG (LA)	61400020107020	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 30 MG (LA)	61400020107030	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 40 MG (LA)	61400020107040	Generic
METHYLPHENIDATE HYDROCHLORIDE ER (LA)	METHYLPHENIDATE HCL CAP ER 24HR 60 MG (LA)	61400020107048	Generic
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
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

Approval Criteria

1 - One of the following:

1.1 Patient is 19 years of age or younger

OR

1.2 Patient has a Food and Drug Administration (FDA)-labeled or approved compendia indication (See Table 1 in Background)

AND

2 - One of the following:

2.1 Evidence of duplication of therapy with the requested stimulant agents for 90 of the past 120 days

OR

2.2 The request is for immediate-release dextroamphetamine tablets or immediate-release amphetamine salts in combination with Vyvanse

OR

2.3 The medications involved in the therapeutic duplication are being cross tapered or discontinued

Notes	*Approval Length: 45 days for any request involving cross-tapering or discontinuation, 6 months for all others

Product Name: Adhansia XR, Adzenys ER, Adzenys XR-ODT, Generic amphetamine, Brand Evekeo, Generic amphetamine/dextroamphetamine, Brand Adderall, generic amphetamine/dextroamphetamine ER, Brand Adderall XR, Brand Aptensio XR, generic methylphenidate ER (XR) cap, Azstarys, Cotempla XR-ODT, Brand Daytrana, Generic methylphenidate patch, Generic dexmethylphenidate, Brand Focalin, Generic dexmethylphenidate ER, Brand Focalin XR, Dyanavel XR, Generic dextroamphetamine tabs, Brand Zenzedi, Generic dextroamphetamine ER, Brand Dexedrine ER, Generic dextroamphetamine soln, Brand Procentra, Evekeo ODT, Generic methamphetamine, Brand Desoxyn, Jornay PM, Generic methylphenidate tabs, Brand Ritalin, methylphenidate chew, methylphenidate ER tabs, Generic methylphenidate ER osmotic tabs, Brand Concerta, Brand Relexxii, Generic methylphenidate ER (LA) caps, Brand Ritalin LA, methylphenidate ER (CD) caps, methylphenidate ER (24 HR) tabs, Generic methylphenidate soln, Brand Methylin soln, Mydayis, Quillichew ER, Quillivant XR, Vyvanse, Vyvanse chew, Xelstrym*	
Diagnosis	Single stimulant agent in adults (greater than 19 years of age)
Approval Length	6 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DYANAVEL XR	AMPHETAMINE EXTENDED RELEASE SUSP 2.5 MG/ML	6110001000G120	Brand
ADZENYS XR-ODT	AMPHETAMINE TAB EXTENDED RELEASE DISINTEGRATING 3.1 MG	6110001000H410	Brand
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
EVEKEO	AMPHETAMINE SULFATE TAB 5 MG	61100010100310	Brand
EVEKEO	AMPHETAMINE SULFATE TAB 10 MG	61100010100320	Brand
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
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	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	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	AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 30 MG	61109902107030	Generic
MYDAYIS	AMPHETAMINE-DEXTROAMPHETAMINE 3-BEAD CAP ER 24HR 12.5 MG	61109902107060	Brand
MYDAYIS	AMPHETAMINE-DEXTROAMPHETAMINE 3-BEAD CAP ER 24HR 25 MG	61109902107065	Brand
MYDAYIS	AMPHETAMINE-DEXTROAMPHETAMINE 3-BEAD CAP ER 24HR 37.5 MG	61109902107070	Brand
MYDAYIS	AMPHETAMINE-DEXTROAMPHETAMINE 3-BEAD CAP ER 24HR 50 MG	61109902107075	Brand
DEXMETHYLPHENIDATE HCL 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 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 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 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 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 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 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 40 MG	61400016107060	Generic
FOCALIN XR	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 40 MG	61400016107060	Brand
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
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
ZENZEDI	DEXTROAMPHETAMINE SULFATE TAB 15 MG	61100020100315	Brand
ZENZEDI	DEXTROAMPHETAMINE SULFATE TAB 20 MG	61100020100330	Brand
ZENZEDI	DEXTROAMPHETAMINE SULFATE TAB 30 MG	61100020100350	Brand
DEXTROAMPHETAMINE SULFATE	DEXTROAMPHETAMINE SULFATE ORAL SOLUTION 5 MG/5ML	61100020102020	Generic
PROCENTRA	DEXTROAMPHETAMINE SULFATE ORAL SOLUTION 5 MG/5ML	61100020102020	Brand
DEXTROAMPHETAMINE SULFATE ER	DEXTROAMPHETAMINE SULFATE CAP ER 24HR 5 MG	61100020107005	Generic
DEXEDRINE	DEXTROAMPHETAMINE SULFATE CAP ER 24HR 10 MG	61100020107010	Brand
DEXTROAMPHETAMINE SULFATE ER	DEXTROAMPHETAMINE SULFATE CAP ER 24HR 10 MG	61100020107010	Generic

DEXEDRINE	DEXTROAMPHETAMINE SULFATE CAP ER 24HR 15 MG	61100020107015	Brand
DEXTROAMPHETAMINE SULFATE ER	DEXTROAMPHETAMINE SULFATE CAP ER 24HR 15 MG	61100020107015	Generic
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CAP 10 MG	61100025100110	Brand
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CAP 20 MG	61100025100120	Brand
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CAP 30 MG	61100025100130	Brand
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CAP 40 MG	61100025100140	Brand
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CAP 50 MG	61100025100150	Brand
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CAP 60 MG	61100025100160	Brand
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CAP 70 MG	61100025100170	Brand
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CHEW TAB 10 MG	61100025100510	Brand
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CHEW TAB 20 MG	61100025100520	Brand
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CHEW TAB 30 MG	61100025100530	Brand
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CHEW TAB 40 MG	61100025100540	Brand
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CHEW TAB 50 MG	61100025100550	Brand
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CHEW TAB 60 MG	61100025100560	Brand
DESOXYN	METHAMPHETAMINE HCL TAB 5 MG	61100030100305	Brand
METHAMPHETAMINE HCL	METHAMPHETAMINE HCL TAB 5 MG	61100030100305	Generic
DAYTRANA	METHYLPHENIDATE TD PATCH 10 MG/9HR	61400020005910	Brand
DAYTRANA	METHYLPHENIDATE TD PATCH 15 MG/9HR	61400020005915	Brand

DAYTRANA	METHYLPHENIDATE TD PATCH 20 MG/9HR	61400020005920	Brand
DAYTRANA	METHYLPHENIDATE TD PATCH 30 MG/9HR	61400020005930	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
RITALIN	METHYLPHENIDATE HCL TAB 5 MG	61400020100305	Brand
RITALIN	METHYLPHENIDATE HCL TAB 10 MG	61400020100310	Brand
RITALIN	METHYLPHENIDATE HCL TAB 20 MG	61400020100315	Brand
CONCERTA	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 18 MG	61400020100460	Brand
CONCERTA	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 27 MG	61400020100465	Brand
CONCERTA	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 36 MG	61400020100470	Brand
CONCERTA	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 54 MG	61400020100480	Brand
METHYLIN	METHYLPHENIDATE HCL SOLN 5 MG/5ML	61400020102020	Brand
METHYLPHENIDATE HYDROCHLORIDE	METHYLPHENIDATE HCL SOLN 5 MG/5ML	61400020102020	Generic
METHYLIN	METHYLPHENIDATE HCL SOLN 10 MG/5ML	61400020102030	Brand
METHYLPHENIDATE HYDROCHLORIDE	METHYLPHENIDATE HCL SOLN 10 MG/5ML	61400020102030	Generic
RITALIN LA	METHYLPHENIDATE HCL CAP ER 24HR 10 MG (LA)	61400020107010	Brand
RITALIN LA	METHYLPHENIDATE HCL CAP ER 24HR 20 MG (LA)	61400020107020	Brand
RITALIN LA	METHYLPHENIDATE HCL CAP ER 24HR 30 MG (LA)	61400020107030	Brand

RITALIN LA	METHYLPHENIDATE HCL CAP ER 24HR 40 MG (LA)	61400020107040	Brand
APTENSIO XR	METHYLPHENIDATE HCL CAP ER 24HR 10 MG (XR)	61400020107055	Brand
APTENSIO XR	METHYLPHENIDATE HCL CAP ER 24HR 15 MG (XR)	61400020107060	Brand
APTENSIO XR	METHYLPHENIDATE HCL CAP ER 24HR 20 MG (XR)	61400020107065	Brand
APTENSIO XR	METHYLPHENIDATE HCL CAP ER 24HR 30 MG (XR)	61400020107070	Brand
APTENSIO XR	METHYLPHENIDATE HCL CAP ER 24HR 40 MG (XR)	61400020107075	Brand
APTENSIO XR	METHYLPHENIDATE HCL CAP ER 24HR 50 MG (XR)	61400020107080	Brand
APTENSIO XR	METHYLPHENIDATE HCL CAP ER 24HR 60 MG (XR)	61400020107085	Brand
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
ADZENYS ER	AMPHETAMINE EXTENDED RELEASE SUSP 1.25 MG/ML	6110001000G110	Brand
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 72 MG	61400020100490	Generic
AMPHETAMINE SULFATE	AMPHETAMINE SULFATE TAB 5 MG	61100010100310	Generic
AMPHETAMINE SULFATE	AMPHETAMINE SULFATE TAB 10 MG	61100010100320	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

JORNAY PM	METHYLPHENIDATE HCL CAP DELAYED ER 24HR 100 MG (PM)	61400020107094	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
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
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 10 MG (XR)	61400020107055	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 15 MG (XR)	61400020107060	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 20 MG (XR)	61400020107065	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 30 MG (XR)	61400020107070	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 40 MG (XR)	61400020107075	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 50 MG (XR)	61400020107080	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 60 MG (XR)	61400020107085	Generic
DEXMETHYLPHENIDATE HYDROCHLORIDE ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 5 MG	61400016107020	Generic

DEXMETHYLPHENIDATE HYDROCHLORIDE ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 10 MG	61400016107030	Generic
DEXMETHYLPHENIDATE HYDROCHLORIDE ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 15 MG	61400016107035	Generic
DEXMETHYLPHENIDATE HYDROCHLORIDE 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 ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 30 MG	61400016107050	Generic
DEXMETHYLPHENIDATE HYDROCHLORIDE ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 35 MG	61400016107055	Generic
DEXMETHYLPHENIDATE HYDROCHLORIDE ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 40 MG	61400016107060	Generic
DEXTROAMPHETAMINE SULFATE	DEXTROAMPHETAMINE SULFATE TAB 20 MG	61100020100330	Generic
DEXTROAMPHETAMINE SULFATE	DEXTROAMPHETAMINE SULFATE TAB 30 MG	61100020100350	Generic
QUILLIVANT XR	METHYLPHENIDATE HCL FOR ER SUSP 25 MG/5ML (5 MG/ML)	6140002010G220	Brand
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 10 MG (LA)	61400020107010	Generic
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
DEXTROAMPHETAMINE SULFATE	DEXTROAMPHETAMINE SULFATE TAB 15 MG	61100020100315	Generic
METHYLPHENIDATE	METHYLPHENIDATE TD PATCH 10 MG/9HR	61400020005910	Generic
METHYLPHENIDATE	METHYLPHENIDATE TD PATCH 15 MG/9HR	61400020005915	Generic
METHYLPHENIDATE	METHYLPHENIDATE TD PATCH 20 MG/9HR	61400020005920	Generic
METHYLPHENIDATE	METHYLPHENIDATE TD PATCH 30 MG/9HR	61400020005930	Generic

METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 45 MG	61400020100475	Generic
RELEXXII	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
RELEXXII	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 63 MG	61400020100485	Generic
RELEXXII	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 72 MG	61400020100490	Brand
DEXMETHYLPHENIDATE HYDROCHLORIDE	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 25 MG	61400016107045	Generic
DEXMETHYLPHENIDATE HYDROCHLORIDE	DEXMETHYLPHENIDATE HCL TAB 2.5 MG	61400016100320	Generic
FOCALIN	DEXMETHYLPHENIDATE HCL TAB 2.5 MG	61400016100320	Brand
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
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
XELSTRYM	DEXTROAMPHETAMINE TD PATCH 18 MG/9HR	61100020005940	Brand
METHYLPHENIDATE HYDROCHLORIDE CD	METHYLPHENIDATE HCL CAP ER 10 MG (CD)	61400020100210	Generic

METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 10 MG (CD)	61400020100210	Generic
METHYLPHENIDATE HYDROCHLORIDE CD	METHYLPHENIDATE HCL CAP ER 20 MG (CD)	61400020100220	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 20 MG (CD)	61400020100220	Generic
METHYLPHENIDATE HYDROCHLORIDE CD	METHYLPHENIDATE HCL CAP ER 30 MG (CD)	61400020100230	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 30 MG (CD)	61400020100230	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 40 MG (CD)	61400020100240	Generic
METHYLPHENIDATE HYDROCHLORIDE CD	METHYLPHENIDATE HCL CAP ER 50 MG (CD)	61400020100250	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 50 MG (CD)	61400020100250	Generic
METHYLPHENIDATE HYDROCHLORIDE CD	METHYLPHENIDATE HCL CAP ER 60 MG (CD)	61400020100260	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 60 MG (CD)	61400020100260	Generic
METHYLPHENIDATE HYDROCHLORIDE	METHYLPHENIDATE HCL TAB 5 MG	61400020100305	Generic
METHYLPHENIDATE HYDROCHLORIDE	METHYLPHENIDATE HCL TAB 10 MG	61400020100310	Generic
METHYLPHENIDATE HYDROCHLORIDE	METHYLPHENIDATE HCL TAB 20 MG	61400020100315	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	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 18 MG	61400020100460	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 27 MG	61400020100465	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 36 MG	61400020100470	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 54 MG	61400020100480	Generic
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 ER	METHYLPHENIDATE HCL CAP ER 24HR 20 MG (LA)	61400020107020	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 30 MG (LA)	61400020107030	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 40 MG (LA)	61400020107040	Generic
METHYLPHENIDATE HYDROCHLORIDE ER (LA)	METHYLPHENIDATE HCL CAP ER 24HR 60 MG (LA)	61400020107048	Generic
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
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

Approval Criteria

1 - Patient has a Food and Drug Administration (FDA)-labeled or approved compendia indication for the use of stimulant agents (See Table 1 in Background)

Product Name: Adhansia XR, Adzenys ER, Adzenys XR-ODT, Generic amphetamine, Brand Evekeo, Generic amphetamine/dextroamphetamine, Brand Adderall, generic amphetamine/dextroamphetamine ER, Brand Adderall XR, Brand Aptensio XR, generic methylphenidate ER (XR) cap, Azstarys, Cotempla XR-ODT, Brand Daytrana, Generic methylphenidate patch, Generic dexmethylphenidate, Brand Focalin, Generic

dexmethylphenidate ER, Brand Focalin XR, Dyanavel XR, Generic dextroamphetamine tabs, Brand Zenzedi, Generic dextroamphetamine ER, Brand Dexedrine ER, Generic dextroamphetamine soln, Brand Procentra, Evekeo ODT, Generic methamphetamine, Brand Desoxyn, Jornay PM, Generic methylphenidate tabs, Brand Ritalin, methylphenidate chew, methylphenidate ER tabs, Generic methylphenidate ER osmotic tabs, Brand Concerta, Brand Relexxii, Generic methylphenidate ER (LA) caps, Brand Ritalin LA, methylphenidate ER (CD) caps, methylphenidate ER (24 HR) tabs, Generic methylphenidate soln, Brand Methylin soln, Mydayis, Quillichew ER, Quillivant XR, Vyvanse, Vyvanse chew, Xelstrym*

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

Product Name	Generic Name	GPI	Brand/Generic
DYANAVEL XR	AMPHETAMINE EXTENDED RELEASE SUSP 2.5 MG/ML	6110001000G120	Brand
ADZENYS XR-ODT	AMPHETAMINE TAB EXTENDED RELEASE DISINTEGRATING 3.1 MG	6110001000H410	Brand
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
EVEKEO	AMPHETAMINE SULFATE TAB 5 MG	61100010100310	Brand
EVEKEO	AMPHETAMINE SULFATE TAB 10 MG	61100010100320	Brand
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
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	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	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	AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 30 MG	61109902107030	Generic
MYDAYIS	AMPHETAMINE-DEXTROAMPHETAMINE 3-BEAD CAP ER 24HR 12.5 MG	61109902107060	Brand
MYDAYIS	AMPHETAMINE-DEXTROAMPHETAMINE 3-BEAD CAP ER 24HR 25 MG	61109902107065	Brand
MYDAYIS	AMPHETAMINE-DEXTROAMPHETAMINE 3-BEAD CAP ER 24HR 37.5 MG	61109902107070	Brand
MYDAYIS	AMPHETAMINE-DEXTROAMPHETAMINE 3-BEAD CAP ER 24HR 50 MG	61109902107075	Brand
DEXMETHYLPHENIDATE HCL 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 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 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 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 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 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 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 40 MG	61400016107060	Generic
FOCALIN XR	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 40 MG	61400016107060	Brand
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
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
ZENZEDI	DEXTROAMPHETAMINE SULFATE TAB 15 MG	61100020100315	Brand
ZENZEDI	DEXTROAMPHETAMINE SULFATE TAB 20 MG	61100020100330	Brand
ZENZEDI	DEXTROAMPHETAMINE SULFATE TAB 30 MG	61100020100350	Brand
DEXTROAMPHETAMINE SULFATE	DEXTROAMPHETAMINE SULFATE ORAL SOLUTION 5 MG/5ML	61100020102020	Generic

PROCENTRA	DEXTROAMPHETAMINE SULFATE ORAL SOLUTION 5 MG/5ML	61100020102020	Brand
DEXTROAMPHETAMINE SULFATE ER	DEXTROAMPHETAMINE SULFATE CAP ER 24HR 5 MG	61100020107005	Generic
DEXEDRINE	DEXTROAMPHETAMINE SULFATE CAP ER 24HR 10 MG	61100020107010	Brand
DEXTROAMPHETAMINE SULFATE ER	DEXTROAMPHETAMINE SULFATE CAP ER 24HR 10 MG	61100020107010	Generic
DEXEDRINE	DEXTROAMPHETAMINE SULFATE CAP ER 24HR 15 MG	61100020107015	Brand
DEXTROAMPHETAMINE SULFATE ER	DEXTROAMPHETAMINE SULFATE CAP ER 24HR 15 MG	61100020107015	Generic
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CAP 10 MG	61100025100110	Brand
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CAP 20 MG	61100025100120	Brand
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CAP 30 MG	61100025100130	Brand
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CAP 40 MG	61100025100140	Brand
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CAP 50 MG	61100025100150	Brand
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CAP 60 MG	61100025100160	Brand
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CAP 70 MG	61100025100170	Brand
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CHEW TAB 10 MG	61100025100510	Brand
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CHEW TAB 20 MG	61100025100520	Brand
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CHEW TAB 30 MG	61100025100530	Brand
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CHEW TAB 40 MG	61100025100540	Brand
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CHEW TAB 50 MG	61100025100550	Brand

VYVANSE	LISDEXAMFETAMINE DIMESYLATE CHEW TAB 60 MG	61100025100560	Brand
DESOXYN	METHAMPHETAMINE HCL TAB 5 MG	61100030100305	Brand
METHAMPHETAMINE HCL	METHAMPHETAMINE HCL TAB 5 MG	61100030100305	Generic
DAYTRANA	METHYLPHENIDATE TD PATCH 10 MG/9HR	61400020005910	Brand
DAYTRANA	METHYLPHENIDATE TD PATCH 15 MG/9HR	61400020005915	Brand
DAYTRANA	METHYLPHENIDATE TD PATCH 20 MG/9HR	61400020005920	Brand
DAYTRANA	METHYLPHENIDATE TD PATCH 30 MG/9HR	61400020005930	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
RITALIN	METHYLPHENIDATE HCL TAB 5 MG	61400020100305	Brand
RITALIN	METHYLPHENIDATE HCL TAB 10 MG	61400020100310	Brand
RITALIN	METHYLPHENIDATE HCL TAB 20 MG	61400020100315	Brand
CONCERTA	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 18 MG	61400020100460	Brand
CONCERTA	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 27 MG	61400020100465	Brand
CONCERTA	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 36 MG	61400020100470	Brand
CONCERTA	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 54 MG	61400020100480	Brand
METHYLIN	METHYLPHENIDATE HCL SOLN 5 MG/5ML	61400020102020	Brand
METHYLPHENIDATE HYDROCHLORIDE	METHYLPHENIDATE HCL SOLN 5 MG/5ML	61400020102020	Generic

METHYLIN	METHYLPHENIDATE HCL SOLN 10 MG/5ML	61400020102030	Brand
METHYLPHENIDATE HYDROCHLORIDE	METHYLPHENIDATE HCL SOLN 10 MG/5ML	61400020102030	Generic
RITALIN LA	METHYLPHENIDATE HCL CAP ER 24HR 10 MG (LA)	61400020107010	Brand
RITALIN LA	METHYLPHENIDATE HCL CAP ER 24HR 20 MG (LA)	61400020107020	Brand
RITALIN LA	METHYLPHENIDATE HCL CAP ER 24HR 30 MG (LA)	61400020107030	Brand
RITALIN LA	METHYLPHENIDATE HCL CAP ER 24HR 40 MG (LA)	61400020107040	Brand
APTENSIO XR	METHYLPHENIDATE HCL CAP ER 24HR 10 MG (XR)	61400020107055	Brand
APTENSIO XR	METHYLPHENIDATE HCL CAP ER 24HR 15 MG (XR)	61400020107060	Brand
APTENSIO XR	METHYLPHENIDATE HCL CAP ER 24HR 20 MG (XR)	61400020107065	Brand
APTENSIO XR	METHYLPHENIDATE HCL CAP ER 24HR 30 MG (XR)	61400020107070	Brand
APTENSIO XR	METHYLPHENIDATE HCL CAP ER 24HR 40 MG (XR)	61400020107075	Brand
APTENSIO XR	METHYLPHENIDATE HCL CAP ER 24HR 50 MG (XR)	61400020107080	Brand
APTENSIO XR	METHYLPHENIDATE HCL CAP ER 24HR 60 MG (XR)	61400020107085	Brand
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
ADZENYS ER	AMPHETAMINE EXTENDED RELEASE SUSP 1.25 MG/ML	6110001000G110	Brand
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 72 MG	61400020100490	Generic
AMPHETAMINE SULFATE	AMPHETAMINE SULFATE TAB 5 MG	61100010100310	Generic
AMPHETAMINE SULFATE	AMPHETAMINE SULFATE TAB 10 MG	61100010100320	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
JORNAY PM	METHYLPHENIDATE HCL CAP DELAYED ER 24HR 100 MG (PM)	61400020107094	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
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
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 10 MG (XR)	61400020107055	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 15 MG (XR)	61400020107060	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 20 MG (XR)	61400020107065	Generic

METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 30 MG (XR)	61400020107070	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 40 MG (XR)	61400020107075	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 50 MG (XR)	61400020107080	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 60 MG (XR)	61400020107085	Generic
DEXMETHYLPHENIDATE HYDROCHLORIDE ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 5 MG	61400016107020	Generic
DEXMETHYLPHENIDATE HYDROCHLORIDE ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 10 MG	61400016107030	Generic
DEXMETHYLPHENIDATE HYDROCHLORIDE ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 15 MG	61400016107035	Generic
DEXMETHYLPHENIDATE HYDROCHLORIDE 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 ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 30 MG	61400016107050	Generic
DEXMETHYLPHENIDATE HYDROCHLORIDE ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 35 MG	61400016107055	Generic
DEXMETHYLPHENIDATE HYDROCHLORIDE ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 40 MG	61400016107060	Generic
DEXTROAMPHETAMINE SULFATE	DEXTROAMPHETAMINE SULFATE TAB 20 MG	61100020100330	Generic
DEXTROAMPHETAMINE SULFATE	DEXTROAMPHETAMINE SULFATE TAB 30 MG	61100020100350	Generic
QUILLIVANT XR	METHYLPHENIDATE HCL FOR ER SUSP 25 MG/5ML (5 MG/ML)	6140002010G220	Brand
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 10 MG (LA)	61400020107010	Generic
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
DEXTROAMPHETAMINE SULFATE	DEXTROAMPHETAMINE SULFATE TAB 15 MG	61100020100315	Generic

METHYLPHENIDATE	METHYLPHENIDATE TD PATCH 10 MG/9HR	61400020005910	Generic
METHYLPHENIDATE	METHYLPHENIDATE TD PATCH 15 MG/9HR	61400020005915	Generic
METHYLPHENIDATE	METHYLPHENIDATE TD PATCH 20 MG/9HR	61400020005920	Generic
METHYLPHENIDATE	METHYLPHENIDATE TD PATCH 30 MG/9HR	61400020005930	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 45 MG	61400020100475	Generic
RELEXXII	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
RELEXXII	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 63 MG	61400020100485	Generic
RELEXXII	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 72 MG	61400020100490	Brand
DEXMETHYLPHENIDATE HYDROCHLORIDE	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 25 MG	61400016107045	Generic
DEXMETHYLPHENIDATE HYDROCHLORIDE	DEXMETHYLPHENIDATE HCL TAB 2.5 MG	61400016100320	Generic
FOCALIN	DEXMETHYLPHENIDATE HCL TAB 2.5 MG	61400016100320	Brand
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
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
XELSTRYM	DEXTROAMPHETAMINE TD PATCH 18 MG/9HR	61100020005940	Brand
METHYLPHENIDATE HYDROCHLORIDE CD	METHYLPHENIDATE HCL CAP ER 10 MG (CD)	61400020100210	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 10 MG (CD)	61400020100210	Generic
METHYLPHENIDATE HYDROCHLORIDE CD	METHYLPHENIDATE HCL CAP ER 20 MG (CD)	61400020100220	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 20 MG (CD)	61400020100220	Generic
METHYLPHENIDATE HYDROCHLORIDE CD	METHYLPHENIDATE HCL CAP ER 30 MG (CD)	61400020100230	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 30 MG (CD)	61400020100230	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 40 MG (CD)	61400020100240	Generic
METHYLPHENIDATE HYDROCHLORIDE CD	METHYLPHENIDATE HCL CAP ER 50 MG (CD)	61400020100250	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 50 MG (CD)	61400020100250	Generic
METHYLPHENIDATE HYDROCHLORIDE CD	METHYLPHENIDATE HCL CAP ER 60 MG (CD)	61400020100260	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 60 MG (CD)	61400020100260	Generic
METHYLPHENIDATE HYDROCHLORIDE	METHYLPHENIDATE HCL TAB 5 MG	61400020100305	Generic
METHYLPHENIDATE HYDROCHLORIDE	METHYLPHENIDATE HCL TAB 10 MG	61400020100310	Generic
METHYLPHENIDATE HYDROCHLORIDE	METHYLPHENIDATE HCL TAB 20 MG	61400020100315	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	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 18 MG	61400020100460	Generic

METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 27 MG	61400020100465	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 36 MG	61400020100470	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 54 MG	61400020100480	Generic
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 ER	METHYLPHENIDATE HCL CAP ER 24HR 20 MG (LA)	61400020107020	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 30 MG (LA)	61400020107030	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 40 MG (LA)	61400020107040	Generic
METHYLPHENIDATE HYDROCHLORIDE ER (LA)	METHYLPHENIDATE HCL CAP ER 24HR 60 MG (LA)	61400020107048	Generic
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
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

Approval Criteria

1 - All of the following:

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

AND

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

OR

2 - All of the following:

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

AND

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

OR

3 - All of the following:

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

AND

3.2 ONE of the following:

- The requested agent has newly implemented age limits which did not previously apply to the patient

- The request is for continuation of therapy from another plan or following inpatient therapy

AND

3.3 One of the following:

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

OR

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

AND

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

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

2 . Background

Benefit/Coverage/Program Information

Table 1:

FDA-Labeled Diagnoses or Approved Compendia Diagnoses
ADHD
Narcolepsy
Binge Eating Disorder (lisdexamfetamine only)

Depression
Mania (dextroamphetamine only)
Cocaine Dependence (dextroamphetamine only)
Personality Disorder
Schizophrenia
Sleep Deprivation

3 . Revision History

Date	Notes
4/21/2023	Added Dyanavel XR Chews

Stivarga

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-152508
Guideline Name	Stivarga
Formulary	• Medicaid - Community & State Indiana

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-136413
Guideline Name	Strensiq
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2024

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

2 . Revision History

Date	Notes
11/16/2023	removal of routine audit language

Sucraid

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-150916
Guideline Name	Sucraid
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	8/2/2024

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
8/2/2024	Added carbon-13 sucrose breath test as an acceptable confirmatory diagnostic test.

Sutent

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-147811
Guideline Name	Sutent
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2024

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 provider.

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.

Synribo

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-118440
Guideline Name	Synribo
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	2/1/2023

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

Systemic Antifungals

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-154915
Guideline Name	Systemic Antifungals
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name: Brand Sporanox soln, generic itraconazole soln, Brand Vfend susp, generic voriconazole susp	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

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
VORICONAZOLE	VORICONAZOLE FOR SUSP 40 MG/ML	11407080001920	Generic
VFEND	VORICONAZOLE FOR SUSP 40 MG/ML	11407080001920	Brand

Approval Criteria

1 - One of the following:

1.1 Patient has tried and failed ALL preferred agents* (i.e., each preferred chemical entity)

OR

1.2 Provider has provided medical justification as to why each preferred agent* is not appropriate for use (e.g., infection being treated is not susceptible to preferred agents)

AND

2 - One of the following:

2.1 Patient is 12 years of age or under

OR

2.2 Patient is unable to swallow tablets

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

Product Name: Brand Noxafil, generic posaconazole DR tab, generic posaconazole susp	
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	POSACONAZOLE TAB DELAYED RELEASE 100 MG	11407060000620	Generic
POSACONAZOLE DR	POSACONAZOLE TAB DELAYED RELEASE 100 MG	11407060000620	Generic
NOXAFIL	POSACONAZOLE SUSP 40 MG/ML	11407060001820	Brand
POSACONAZOLE	POSACONAZOLE SUSP 40 MG/ML	11407060001820	Generic

Approval Criteria

1 - Both of the following:

- The requested agent is being used for the treatment of oropharyngeal candidiasis
- Patient has tried fluconazole

OR

2 - Both of the following:

2.1 Patient is severely immunocompromised

AND

2.2 The requested agent is being used as prophylaxis against ONE of the following:

- Invasive Aspergillus
- Candida Infections

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

Product Name	Generic Name	GPI	Brand/Generic
NOXAFIL	POSACONAZOLE FOR DELAYED RELEASE SUSP PACKET 300 MG	11407060003020	Brand

Approval Criteria

1 - Member is 2 years of age or older AND less than 13 years of age

2 . Revision History

Date	Notes
9/13/2024	Updated Sporanox/Vfend Soln. criteria.

Tabrecta

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-157150
Guideline Name	Tabrecta
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	11/1/2024

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

2 . Revision History

Date	Notes
10/7/2024	Minor update to NCCN Recommended Regimens initial auth section (no changes to clinical intent).

Tafinlar

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-151316
Guideline Name	Tafinlar
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	9/1/2024

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
8/12/2024	Added new criteria for hairy cell leukemia, salivary gland tumor, and GIST.

Tagrisso

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-138694
Guideline Name	Tagrisso
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	2/1/2024

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

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-147194
Guideline Name	Takhzyro
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2024

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. **Pediatric patients less than 6 years of age approval length: 12 months.

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. **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. ***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. Updated and simplified reauthorization criteria.

Talzenna

Prior Authorization Guideline

Guideline ID	GL-134182
Guideline Name	Talzenna
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	11/1/2023

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

2 . Revision History

Date	Notes
10/3/2023	Added new Talzenna 0.1 mg and 0.35 mg strengths. Added criteria fo r HRR gene-mutated mCRPC per label.

Tarceva

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-118486
Guideline Name	Tarceva
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	2/1/2023

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

2 . Revision History

Date	Notes
12/16/2022	Copy NY

Targeted Immunomodulators

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-158334
Guideline Name	Targeted Immunomodulators
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

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

Product Name	Generic Name	GPI	Brand/Generic
ACTEMRA	TOCILIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 162 MG/0.9ML	6650007000E520	Brand
ACTEMRA ACTPEN	TOCILIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 162 MG/0.9ML	6650007000D520	Brand

Approval Criteria

1 - ONE of the following:

1.1 ONE of the following diagnoses:

- Cytokine release syndrome
- Polyarticular juvenile idiopathic arthritis
- Systemic juvenile idiopathic arthritis
- Systemic sclerosis-associated interstitial lung disease (SSc-ILD)

OR

1.2 Diagnosis of giant cell arteritis, and BOTH of the following:

1.2.1 At least 90 days of drug therapy with ONE of the following:

- Systemic glucocorticoid
- Azathioprine
- Methotrexate

AND

1.2.2 Patient will be using a systemic glucocorticoid concurrently with the requested medication

OR

1.3 Diagnosis of rheumatoid arthritis, and ONE of the following:

1.3.1 At least 90 days of drug therapy with ONE of the following:

- Azathioprine
- Hydroxychloroquine
- Leflunomide
- Methotrexate
- Sulfasalazine

OR

1.3.2 Previous trial and failure of another targeted immunomodulator agent

AND

2 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Product Name: Adalimumab-FKJP, Hadlima, Humira, Simlandi	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ADALIMUMAB-FKJP	ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML	6627001535F520	Brand
ADALIMUMAB-FKJP	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001535F810	Brand
ADALIMUMAB-FKJP	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001535F820	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
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
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

Approval Criteria

1 - ONE of the following:

1.1 ONE of the following diagnoses:

- Ankylosing spondylitis
- Polyarticular juvenile idiopathic arthritis
- Psoriatic arthritis
- Ulcerative colitis

OR

1.2 Diagnosis of Crohn's disease, and ONE of the following:

1.2.1 Diagnosis of Crohn’s disease classified as moderate, severe, or fistulizing

OR

1.2.2 Previous trial and failure of another targeted immunomodulator agent

OR

1.2.3 At least 90 days of drug therapy with at least ONE of the following:

- Azathioprine
- Mercaptopurine
- Mesalamine
- Methotrexate
- Systemic glucocorticoid

OR

1.3 BOTH of the following:

1.3.1 Diagnosis of hidradenitis suppurativa

AND

1.3.2 At least 90 days of drug therapy with ONE of the following:

- Oral or topical antibiotic therapy
- Oral retinoid therapy
- Dapsone
- Acitretin

OR

1.4 BOTH of the following:

1.4.1 Diagnosis of non-infectious uveitis

AND

1.4.2 At least 90 days of drug therapy with ONE of the following:

- Oral or injectable steroid therapy
- Methotrexate
- Mycophenolate
- Azathioprine
- Cyclosporine
- Tacrolimus
- Cyclophosphamide

OR

1.5 Diagnosis of psoriasis, and ONE of the following:

1.5.1 Diagnosis of psoriasis classified as severe

OR

1.5.2 Diagnosis of psoriasis of the fingernail

OR

1.5.3 At least 90 days of topical drug therapy with ONE of the following:

- Calcipotriene
- Corticosteroids
- Tazarotene

OR

1.5.4 At least 90 days of systemic drug therapy with ONE of the following:

- Cyclosporine
- Methotrexate
- Acitretin

OR

1.5.5 Previous trial and failure of another targeted immunomodulator agent

OR

1.6 Diagnosis of rheumatoid arthritis, and ONE of the following:

1.6.1 Previous trial and failure of another targeted immunomodulator agent

OR

1.6.2 At least 90 days of drug therapy with ONE of the following:

- Azathioprine
- Hydroxychloroquine
- Leflunomide
- Methotrexate
- Sulfasalazine

AND

2 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

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

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 atopic dermatitis

AND

2 - Patient is 12 years of age or older

AND

3 - ONE of the following:

3.1 At least 45 days of topical drug therapy with ONE of the following:

- Corticosteroids
- Pimecrolimus
- Tacrolimus

OR

3.2 Prescriber has provided valid medical justification for the use of Adbry over topical drug therapies

AND

4 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

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

Product Name	Generic Name	GPI	Brand/Generic
ENBREL SURECLICK	ETANERCEPT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML	6629003000D530	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 MINI	ETANERCEPT SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML	6629003000E230	Brand
ENBREL	ETANERCEPT SUBCUTANEOUS INJ 25 MG/0.5ML	66290030002015	Brand

Approval Criteria

1 - ONE of the following:

1.1 ONE of the following diagnoses:

- Polyarticular juvenile idiopathic arthritis
- Psoriatic arthritis (adult or juvenile)
- Ankylosing spondylitis

OR

1.2 Diagnosis of psoriasis, and ONE of the following:

1.2.1 Diagnosis of psoriasis classified as severe

OR

1.2.2 At least 90 days of topical drug therapy with ONE of the following:

- Calcipotriene
- Corticosteroids
- Tazarotene

OR

1.2.3 At least 90 days of systemic drug therapy with ONE of the following:

- Cyclosporine
- Methotrexate
- Acitretin

OR

1.2.4 Previous trial and failure of another targeted immunomodulator agent

OR

1.3 Diagnosis of rheumatoid arthritis, and ONE of the following:

1.3.1 At least 90 days of drug therapy with ONE of the following:

- Azathioprine
- Hydroxychloroquine
- Leflunomide
- Methotrexate
- Sulfasalazine

OR

1.3.2 Previous trial and failure of another targeted immunomodulator agent

AND

2 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Product Name: Kineret	
Approval Length	1 year(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 - ONE of the following:

1.1 ONE of the following diagnoses:

- Neonatal onset multisystem inflammatory disease (NOMID)
- Deficiency of interleukin-1 receptor antagonist (DIRA)

OR

1.2 Diagnosis of rheumatoid arthritis, and ONE of the following:

1.2.1 At least 90 days of drug therapy with ONE of the following:

- Azathioprine
- Hydroxychloroquine
- Leflunomide
- Methotrexate
- Sulfasalazine

OR

1.2.2 Previous trial and failure of another targeted immunomodulator agent

AND

2 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Product Name: Olumiant	
Approval Length	Rheumatoid arthritis - 12 months; Severe Alopecia Areata - 6 months
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OLUMIANT	BARICITINIB TAB 2 MG	66603010000320	Brand
OLUMIANT	BARICITINIB TAB 1 MG	66603010000310	Brand

OLUMIANT	BARICITINIB TAB 4 MG	66603010000340	Brand

Approval Criteria

1 - ONE of the following:

1.1 Diagnosis of rheumatoid arthritis, and BOTH of the following:

1.1.1 Previous trial and failure of at least ONE tumor necrosis factor (TNF) blocker

AND

1.1.2 Previous trial and failure of at least ONE other targeted immunomodulator agent

OR

1.2 Submission of chart notes showing a diagnosis of severe alopecia areata defined as greater than or equal to 50% of hair loss, and BOTH of the following:

1.2.1 Patient is 18 years of age or older

AND

1.2.2 Prescribed by, or in consultation with, a dermatologist

AND

2 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

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

Product Name	Generic Name	GPI	Brand/Generic
OLUMIANT	BARICITINIB TAB 2 MG	66603010000320	Brand
OLUMIANT	BARICITINIB TAB 1 MG	66603010000310	Brand
OLUMIANT	BARICITINIB TAB 4 MG	66603010000340	Brand

Approval Criteria

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

AND

2 - If the request is for reauthorization for treatment of severe alopecia areata, documentation of patient status and response to therapy (Document status/response)

AND

3 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

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

Product Name	Generic Name	GPI	Brand/Generic
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

Approval Criteria

1 - ONE of the following:

1.1 ONE of the following diagnoses:

- Polyarticular juvenile idiopathic arthritis
- Psoriatic arthritis

OR

1.2 Diagnosis of rheumatoid arthritis, and ONE of the following:

1.2.1 At least 90 days of drug therapy with ONE of the following:

- Azathioprine
- Hydroxychloroquine
- Leflunomide
- Methotrexate
- Sulfasalazine

OR

1.2.2 Previous trial and failure of another targeted immunomodulator agent

OR

1.3 Diagnosis of acute graft-versus host disease prophylaxis, and BOTH of the following:

1.3.1 Patient will be using Orencia concurrently with both methotrexate AND a calcineurin inhibitor

AND

1.3.2 Patient will be concurrently undergoing hematopoietic stem cell transplantation from a matched or 1 allele-mismatched unrelated donor

AND

2 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

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

Product Name	Generic Name	GPI	Brand/Generic
OTEZLA	APREMILAST TAB STARTER THERAPY PACK 10 MG & 20 MG & 30 MG	6670001500B720	Brand
OTEZLA	APREMILAST TAB 30 MG	66700015000330	Brand
OTEZLA	APREMILAST TAB 20 MG	66700015000320	Brand
OTEZLA	APREMILAST TAB STARTER THERAPY PACK 4 X 10 MG & 51 X 20 MG	6670001500B710	Brand

Approval Criteria

1 - ONE of the following:

1.1 Diagnosis of psoriatic arthritis

OR

1.2 BOTH of the following:

1.2.1 Diagnosis of oral ulcers associated with Behcet's disease in an adult (18 years of age and older)

AND

1.2.2 At least 90 days of drug therapy with colchicine

OR

1.3 Diagnosis of psoriasis, and ONE of the following:

1.3.1 Diagnosis of psoriasis classified as severe

OR

1.3.2 At least 90 days of topical drug therapy with ONE of the following:

- Calcipotriene
- Corticosteroids
- Tazarotene

OR

1.3.3 At least 90 days of systemic drug therapy with ONE of the following:

- Cyclosporine
- Methotrexate
- Acitretin

OR

1.3.4 Previous trial and failure of another targeted immunomodulator agent

Product Name: Simponi	
Approval Length	1 year(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 - ONE of the following:

1.1 ONE of the following diagnoses:

- Ankylosing spondylitis
- Polyarticular juvenile idiopathic arthritis
- Psoriatic arthritis
- Ulcerative colitis

OR

1.2 Diagnosis of rheumatoid arthritis, and ONE of the following:

1.2.1 At least 90 days of drug therapy with ONE of the following:

- Azathioprine
- Hydroxychloroquine
- Leflunomide
- Methotrexate
- Sulfasalazine

OR

1.2.2 Previous trial and failure of another targeted immunomodulator agent

AND

2 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

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

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 - ONE of the following:

1.1 ONE of the following diagnoses:

- Ankylosing spondylitis
- Non-radiographic axial spondyloarthritis
- Psoriatic arthritis

OR

1.2 Diagnosis of psoriasis, and ONE of the following:

1.2.1 Diagnosis of psoriasis classified as severe

OR

1.2.2 At least 90 days of topical drug therapy with ONE of the following:

- Calcipotriene
- Corticosteroids
- Tazarotene

OR

1.2.3 At least 90 days of systemic drug therapy with ONE of the following:

- Cyclosporine
- Methotrexate
- Acitretin

OR

1.2.4 Previous trial and failure of another targeted immunomodulator agent

AND

2 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

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

Product Name	Generic Name	GPI	Brand/Generic
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 - ONE of the following:

1.1 ONE of the following diagnoses:

- Polyarticular juvenile idiopathic arthritis

- Systemic juvenile idiopathic arthritis

OR

1.2 Diagnosis of giant cell arteritis, and BOTH of the following:

1.2.1 At least 90 days of drug therapy with ONE of the following:

- Systemic glucocorticoid
- Azathioprine
- Methotrexate

AND

1.2.2 Patient will be using a systemic glucocorticoid concurrently with the requested medication

OR

1.3 Diagnosis of rheumatoid arthritis, and ONE of the following:

1.3.1 At least 90 days of drug therapy with ONE of the following:

- Azathioprine
- Hydroxychloroquine
- Leflunomide
- Methotrexate
- Sulfasalazine

OR

1.3.2 Previous trial and failure of another targeted immunomodulator agent

AND

2 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Product Name: Xeljanz tabs/oral soln	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

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 - ONE of the following:

1.1 ALL of the following:

1.1.1 ONE of the following diagnoses:

- Ankylosing spondylitis
- Psoriatic arthritis

AND

1.1.2 Previous trial and failure of at least ONE tumor necrosis factor (TNF) blocker

AND

1.1.3 Dose does not exceed 5 mg (milligrams) twice daily

OR

1.2 ALL of the following:

1.2.1 Diagnosis of polyarticular juvenile idiopathic arthritis

AND

1.2.2 Previous trial and failure of a TNF blocker with juvenile idiopathic arthritis indication [e.g., adalimumab agents, Enbrel (etanercept), or Simponi (golimumab)]

AND

1.2.3 Dose does not exceed 5 mg twice daily

OR

1.3 Diagnosis of rheumatoid arthritis, and BOTH of the following:

1.3.1 ONE of the following:

1.3.1.1 Previous trial and failure of at least ONE TNF blocker

OR

1.3.1.2 At least 90 days of drug therapy with ONE of the following:

- Azathioprine
- Hydroxychloroquine
- Leflunomide
- Methotrexate
- Sulfasalazine

AND

1.3.2 Dose does not exceed 5 mg twice daily

OR

1.4 ALL of the following:

1.4.1 Diagnosis of ulcerative colitis

AND

1.4.2 Previous trial and failure of a TNF blocker with an ulcerative colitis indication [e.g., adalimumab agents, Simponi (golimumab), or infliximab agents]

AND

1.4.3 ONE of the following:

1.4.3.1 Dose does not exceed 10 mg twice daily for the induction period up to 16 weeks

OR

1.4.3.2 Dose does not exceed 5 mg twice daily for the maintenance period

AND

2 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

AND

3 - If the request is for Xeljanz oral solution, ONE of the following:

3.1 Both of the following:

- Patient is 2 years of age or older AND less than 18 years of age
- Patient weighs 10 kg or more AND less than 40kg

OR

3.2 Provider has submitted documentation supporting inability to swallow tablet formulation

Product Name: Xeljanz XR

Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
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 - ONE of the following:

1.1 ALL of the following:

1.1.1 ONE of the following diagnoses:

- Ankylosing spondylitis
- Psoriatic arthritis
- Rheumatoid arthritis

AND

1.1.2 Previous trial and failure of a tumor necrosis factor (TNF) blocker or Xeljanz IR (immediate release)

AND

1.1.3 Dose does not exceed 11 mg once daily

OR

1.2 ALL of the following:

1.2.1 Diagnosis of ulcerative colitis

AND

1.2.2 Previous trial and failure of a TNF blocker with ulcerative colitis indication [e.g. adalimumab agents, Simponi (golimumab), or infliximab agents] or Xeljanz IR

AND

1.2.3 ONE of the following:

1.2.3.1 Dose does not exceed 22 mg once daily for the induction period up to 16 weeks

OR

1.2.3.2 Dose does not exceed 11 mg once daily for the maintenance period

AND

2 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

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

Product Name	Generic Name	GPI	Brand/Generic
XELJANZ	TOFACITINIB CITRATE TAB 5 MG (BASE EQUIVALENT)	66603065100320	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
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 - History of the requested medication for at least 90 of the past 120 days, as confirmed by claims history or chart documentation

AND

2 - Dose requested does not exceed any of the established quantity limits for the indication:

2.1 For Xeljanz, ONE of the following:

2.1.1 For ankylosing spondylitis, psoriatic arthritis, polyarticular juvenile idiopathic arthritis, or rheumatoid arthritis, dose does not exceed 5 mg twice daily

OR

2.1.2 For ulcerative colitis, dose does not exceed 10 mg twice daily for the induction period up to 16 weeks, and dose does not exceed 5 mg twice daily for the maintenance period

OR

2.2 For Xeljanz XR, ONE of the following:

2.2.1 For ankylosing spondylitis, psoriatic arthritis, or rheumatoid arthritis, dose does not exceed 11 mg once daily

OR

2.2.2 For ulcerative colitis, dose does not exceed 22 mg once daily for the induction period up to 16 weeks, and dose does not exceed 11 mg once daily for the maintenance period

AND

3 - If the request is for Xeljanz oral solution, ONE of the following:

3.1 Both of the following

- Patient is 2 years of age or older AND less than 18 years of age
- Patient weighs 10 kg or more AND less than 40kg

OR

3.2 Provider has submitted documentation supporting inability to swallow tablet formulation

AND

4 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

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

Product Name	Generic Name	GPI	Brand/Generic
CIMZIA STARTER KIT	CERTOLIZUMAB PEGOL PREFILLED SYRINGE KIT 6 X 200 MG/ML	5250502010F840	Brand
CIMZIA	CERTOLIZUMAB PEGOL FOR INJ KIT 2 X 200 MG	52505020106420	Brand
CIMZIA	CERTOLIZUMAB PEGOL PREFILLED SYRINGE KIT 200 MG/ML	5250502010F840	Brand

Approval Criteria

1 - ONE of the following diagnoses:

- Ankylosing spondylitis
- Crohn's disease
- Non-radiographic axial spondyloarthritis
- Psoriasis

- Psoriatic arthritis
- Rheumatoid arthritis

AND

2 - Previous trial and failure of another targeted immunomodulator agent

AND

3 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

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

Product Name	Generic Name	GPI	Brand/Generic
COSENTYX SENSOREADY PEN	SECUKINUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 150 MG/ML	9025057500D520	Brand
COSENTYX	SECUKINUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/ML	9025057500E520	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
COSENTYX	SECUKINUMAB IV SOLN 125 MG/5ML	90250575002050	Brand

Approval Criteria

1 - ONE of the following:

1.1 BOTH of the following:

1.1.1 ONE of the following diagnoses:

- Ankylosing spondylitis
- Non-radiographic axial spondyloarthritis
- Psoriasis
- Psoriatic arthritis
- Rheumatoid arthritis

AND

1.1.2 Previous trial and failure of another targeted immunomodulator agent

OR

1.2 BOTH of the following:

1.2.1 Diagnosis of hidradenitis suppurativa

AND

1.2.2 Previous trial and failure of a preferred adalimumab agent

OR

1.3 Diagnosis of enthesitis-related arthritis (ERA)

AND

2 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Product Name: Entyvio Pen	
Approval Length	1 year(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ENTYVIO	VEDOLIZUMAB SOLN PEN-INJECTOR 108 MG/0.68ML	5250308000D520	Brand

Approval Criteria

1 - ONE of the following diagnoses:

- Crohn's disease
- Ulcerative colitis

AND

2 - Previous trial and failure of another targeted immunomodulator agent

AND

3 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

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

Product Name	Generic Name	GPI	Brand/Generic
KEVZARA	SARILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/1.14ML	6650006000E520	Brand
KEVZARA	SARILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 200 MG/1.14ML	6650006000E530	Brand
KEVZARA	SARILUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML	6650006000D520	Brand
KEVZARA	SARILUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.14ML	6650006000D530	Brand

Approval Criteria

1 - ONE of the following:

1.1 ALL of the following:

1.1.1 Diagnosis of polyarticular juvenile idiopathic arthritis

AND

1.1.2 Previous trial and failure of another targeted immunomodulator agent

AND

1.1.3 Patient weighs at least 63 kilograms

OR

1.2 BOTH of the following:

1.2.1 Diagnosis of polymyalgia rheumatica

AND

1.2.2 At least 90 days of drug therapy with oral corticosteroids or methotrexate

OR

1.3 BOTH of the following:

1.3.1 Diagnosis of rheumatoid arthritis

AND

1.3.2 Previous trial and failure of another targeted immunomodulator agent

AND

2 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Product Name: Litfulo	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LITFULO	RITLECITINIB TOSYLATE CAP 50 MG (BASE EQUIV)	90731060100120	Brand

Approval Criteria

1 - Submission of chart notes showing a diagnosis of severe alopecia areata defined as greater than or equal to 50% of hair loss

AND

2 - Patient is 12 years of age or older

AND

3 - Previous trial and failure of Olumiant

AND

4 - Prescribed by, or in consultation with, a dermatologist

AND

5 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

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

Product Name	Generic Name	GPI	Brand/Generic
LITFULO	RITLECITINIB TOSYLATE CAP 50 MG (BASE EQUIV)	90731060100120	Brand

Approval Criteria

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

AND

2 - Documentation of patient status and response to therapy (document status/response)

AND

3 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Product Name: Rinvoq ER tablets	
Approval Length	1 year(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 - ONE of the following:

1.1 Diagnosis of atopic dermatitis, and ALL of the following:

1.1.1 Patient is at least 12 years of age AND weighs at least 40 kg (kilograms)

AND

1.1.2 ONE of the following:

1.1.2.1 Patient has tried and failed ONE systemic agent with an atopic dermatitis indication

OR

1.1.2.2 If patient was unable to utilize a systemic agent, patient has trialed at least 45 days of topical drug therapy with ONE of the following (documentation required):

- Pimecrolimus
- Tacrolimus
- Corticosteroids

OR

1.1.2.3 Prescriber has provided valid medical justification for the use of the requested medication over topical corticosteroids and/or topical immunomodulator agents

AND

1.1.3 For patients 65 years of age or older, requested dose does not exceed 15 mg (milligrams) daily

OR

1.2 ALL of the following:

1.2.1 Diagnosis of ONE of the following:

- Ankylosing spondylitis
- Non-radiographic axial spondyloarthritis
- Polyarticular juvenile idiopathic arthritis
- Psoriatic arthritis
- Rheumatoid arthritis

AND

1.2.2 Previous trial and failure of at least ONE tumor necrosis factor (TNF) blocker

OR

1.3 BOTH of the following:

1.3.1 Diagnosis of Crohn's disease

AND

1.3.2 Previous trial and failure of at least ONE TNF blocker with Crohn’s disease indication (adalimumab agents, Cimzia (certolizumab), infliximab agents)

OR

1.4 BOTH of the following:

1.4.1 Diagnosis of ulcerative colitis

AND

1.4.2 Previous trial and failure of at least ONE TNF blocker with ulcerative colitis indication (e.g. adalimumab agents, infliximab agents, Simponi (golimumab))

AND

2 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

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

Product Name	Generic Name	GPI	Brand/Generic
RINVOQ LQ	UPADACITINIB ORAL SOLN 1 MG/ML	66603072002020	Brand

Approval Criteria

1 - Diagnosis of ONE of the following:

- Psoriatic arthritis
- Polyarticular juvenile idiopathic arthritis

AND

2 - Previous trial and failure of at least ONE TNF blocker

AND

3 - Patient is at least 2 years of age AND weighs at least 10 kilograms

AND

4 - ONE of the following:

4.1 Patient is less than 18 years of age AND weighs less than 30 kilograms

OR

4.2 Provider has submitted documentation supporting inability to swallow tablet formulation

AND

5 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

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

Product Name	Generic Name	GPI	Brand/Generic
RINVOQ LQ	UPADACITINIB ORAL SOLN 1 MG/ML	66603072002020	Brand

Approval Criteria

1 - History of the requested medication for at least 90 of the past 120 days, as confirmed by claims history or chart documentation

AND

2 - One of the following:

2.1 Patient is less than 18 years of age AND weighs less than 30 kilograms

OR

2.2 Provider has submitted documentation supporting inability to swallow tablet formulation

AND

3 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Product Name: Siliq	
Approval Length	1 year(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 psoriasis

AND

2 - Previous trial and failure of another targeted immunomodulator agent

AND

3 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Product Name: Abrilada, Adalimumab-AACF, Idacio, Adalimumab-ADAZ, Hyrimoz, Adalimumab-ADBM, Cyltezo, Adalimumab-RYVK, Amjevita, Hulio, Adalimumab-AATY, Yuflyma, Yusimry	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
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	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 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 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
HYRIMOZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.8ML	6627001504D520	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.8ML	6627001504E520	Brand
ABRILADA 2-PEN KIT	ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML	6627001507F520	Brand
ABRILADA 1-PEN KIT	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
IDACIO STARTER PACKAGE FOR CROHNS DISEASE	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 STARTER PACKAGE FOR PLAQUE PSORIASIS	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
HYRIMOZ SENSOREADY PENS	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001504D540	Brand
CYLTEZO STARTER PACKAGE FOR PSORIASIS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
CYLTEZO	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
CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 10 MG/0.2ML	6627001505F805	Brand
CYLTEZO	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 10 MG/0.2ML	6627001505F805	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001505F810	Brand
CYLTEZO	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001505F810	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001505F820	Brand
CYLTEZO	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001505F820	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 40 MG/0.4ML	6627001510D517	Brand

AMJEVITA	ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 40 MG/0.8ML	6627001510D520	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001510D537	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 10 MG/0.2ML	6627001510E505	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 20 MG/0.2ML	6627001510E508	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 20 MG/0.4ML	6627001510E510	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001510E517	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 40 MG/0.8ML	6627001510E520	Brand
HULIO	ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML	6627001535F520	Brand
HULIO	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001535F810	Brand
HULIO	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001535F820	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 CD/UC/HS STARTER	ADALIMUMAB-AATY AUTO-INJECTOR KIT 80 MG/0.8ML	6627001503F560	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
YUFLYMA 2-SYRINGE KIT	ADALIMUMAB-AATY PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001503F830	Brand
YUSIMRY	ADALIMUMAB-AQVH SOLN PEN-INJECTOR 40 MG/0.8ML	6627001509D520	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

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 (2 PEN)	ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML	6627001540F520	Brand

Approval Criteria

1 - ONE of the following diagnoses:

- Ankylosing spondylitis
- Crohn's disease
- Hidradenitis suppurativa
- Non-infectious uveitis
- Polyarticular juvenile idiopathic arthritis
- Psoriasis
- Psoriatic arthritis
- Rheumatoid arthritis
- Ulcerative colitis

AND

2 - Previous trial and failure of at least ONE other targeted immunomodulator agent that is not adalimumab

AND

3 - Both of the following:

- Previous trial of ALL preferred adalimumab product(s)
- Prescriber has provided valid medical rationale for the use of the requested non-preferred adalimumab product over ALL of the preferred adalimumab product(s)

AND

4 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Product Name: Abrilada, Adalimumab-AACF, Idacio, Adalimumab-ADAZ, Hyrimoz, Adalimumab-ADBM, Cyltezo, Adalimumab-RYVK, Amjevita, Hulio, Adalimumab-AATY, Yuflyma, Yusimry	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AMJEVITA	ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 40 MG/0.8ML	6627001510D520	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 10 MG/0.2ML	6627001510E505	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
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	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001504E515	Brand
ADALIMUMAB-ADAZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001504E515	Brand

HULIO	ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML	6627001535F520	Brand
HULIO	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001535F810	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
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
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
YUSIMRY	ADALIMUMAB-AQVH SOLN PEN-INJECTOR 40 MG/0.8ML	6627001509D520	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 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
ADALIMUMAB-ADBM	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 CROHNS/UC/HS 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 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
HYRIMOZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.8ML	6627001504D520	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.8ML	6627001504E520	Brand
YUFLYMA CD/UC/HS STARTER	ADALIMUMAB-AATY AUTO-INJECTOR KIT 80 MG/0.8ML	6627001503F560	Brand
ABRILADA 2-PEN KIT	ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML	6627001507F520	Brand
ABRILADA 1-PEN KIT	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
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
HYRIMOZ SENSOREADY PENS	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001504D540	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-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
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 (2 PEN)	ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML	6627001540F520	Brand

Approval Criteria

1 - History of the requested medication for at least 90 of the past 120 days, as confirmed by claims history or chart documentation

AND

2 - Both of the following:

- Previous trial of ALL preferred adalimumab product(s)
- Prescriber has provided valid medical rationale for the use of the requested non-preferred adalimumab product over ALL of the preferred adalimumab product(s)

AND

3 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

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

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

Approval Criteria

1 - ONE of the following:

1.1 Diagnosis of Cryopyrin-Associated Periodic Syndrome (CAPS) [including familial cold autoinflammatory syndrome (FCAS) and Muckle-Wells syndrome (MWS)]

OR

1.2 BOTH of the following:

1.2.1 Diagnosis of recurrent pericarditis (RP)

AND

1.2.2 At least 90 days of drug therapy with ONE of the following:

- Colchicine
- Systemic glucocorticoids

OR

1.3 BOTH of the following:

1.3.1 Diagnosis of deficiency of interleukin-1 receptor antagonist (DIRA)

AND

1.3.2 Previous trial and failure of Kineret (anakinra)

AND

2 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Product Name: Bimzelx	
Approval Length	1 year(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 - Diagnosis of psoriasis

AND

2 - Previous trial and failure of at least TWO other targeted immunomodulator agents

AND

3 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Product Name: Cibinqo	
Approval Length	1 year(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 atopic dermatitis

AND

2 - Patient is at least 12 years of age

AND

3 - ONE of the following:

3.1 BOTH of the following:

- At least 60 days of therapy with Dupixent (dupilumab)
- At least 120 days of therapy with Adbry (tralokinumab-ldrm)

OR

3.2 At least 60 days of therapy with Rinvoq (upadacitinib)

OR

3.3 Prescriber has provided valid medical justification for the use of the requested medication over Dupixent (dupilumab), Adbry (tralokinumab-ldrm), and Rinvoq (upadacitinib)

AND

4 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

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

Product Name	Generic Name	GPI	Brand/Generic

ILARIS	CANAKINUMAB SUBCUTANEOUS INJ 150 MG/ML	66460020002015	Brand

Approval Criteria

1 - ONE of the following:

1.1 ONE of the following diagnoses:

- Cryopyrin-Associated Periodic Syndrome (CAPS) [including familial cold autoinflammatory syndrome (FCAS) and Muckle-Wells syndrome (MWS)]
- Systemic juvenile idiopathic arthritis
- Tumor necrosis factor receptor associated periodic syndrome (TRAPS)
- Hyperimmunoglobulin D (Hyper-IgD) syndrome (HIDS)/mevalonate kinase deficiency (MKD)

OR

1.2 BOTH of the following:

1.2.1 Diagnosis of adult-onset Still's disease

AND

1.2.2 At least 90 days of drug therapy with ONE of the following:

- Corticosteroids
- Methotrexate
- NSAIDs (non-steroidal anti-inflammatory drugs)

OR

1.3 BOTH of the following:

1.3.1 Diagnosis of familial Mediterranean fever (FMF)

AND

1.3.2 At least 90 days of drug therapy with colchicine

OR

1.4 BOTH of the following:

1.4.1 Diagnosis of gout flares

AND

1.4.2 ONE of the following:

1.4.2.1 Both of the following:

- Previous trial and failure of colchicine, corticosteroids, AND NSAIDs (non-steroidal anti-inflammatory drugs) in the past 30 days
- Prescriber has submitted chart documentation illustrating inadequate response

OR

1.4.2.2 Prescriber has submitted chart documentation supporting contraindication to colchicine, NSAIDs, AND prolonged corticosteroid use

AND

2 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

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

Product Name	Generic Name	GPI	Brand/Generic
ILUMYA	TILDRAKIZUMAB-ASMN SUBCUTANEOUS SOLN PREF SYRINGE 100 MG/ML	9025058010E520	Brand

Approval Criteria

1 - Diagnosis of psoriasis

AND

2 - Previous trial and failure of at least TWO other targeted immunomodulator agents

AND

3 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Product Name: Omvoh	
Approval Length	1 year(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
OMVOH	MIRIKIZUMAB-MRKZ SUBCUTANEOUS SOL PREFILL SYRINGE 100 MG/ML	5250405040E520	Brand

Approval Criteria

1 - Diagnosis of ulcerative colitis

AND

2 - Previous trial and failure of at least TWO other targeted immunomodulator agents

AND

3 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

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

Product Name	Generic Name	GPI	Brand/Generic
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

Approval Criteria

1 - ONE of the following diagnoses:

- Crohn's disease
- Psoriasis
- Psoriatic arthritis
- Ulcerative colitis

AND

2 - Previous trial and failure of at least TWO other targeted immunomodulator agents

AND

3 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

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

Product Name	Generic Name	GPI	Brand/Generic
SOTYKTU	DEUCRAVACITINIB TAB 6 MG	90250524000320	Brand

Approval Criteria

1 - Patient is 18 years of age and older

AND

2 - Diagnosis of psoriasis

AND

3 - Previous trial and failure of at least TWO other targeted immunomodulator agents

AND

4 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Product Name: Spevigo syringe

Approval Length	1 year(s)
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) flare

AND

2 - Patient is at least 12 years of age AND weighs at least 40 kilograms

AND

3 - Prescribed by, or in consultation with, a dermatologist or rheumatologist

AND

4 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Product Name: Stelara	
Approval Length	1 year(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 - ONE of the following diagnoses:

- Crohn's disease
- Psoriasis
- Psoriatic arthritis
- Ulcerative colitis

AND

2 - Previous trial and failure of at least TWO other targeted immunomodulator agents

AND

3 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

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

Product Name	Generic Name	GPI	Brand/Generic
TREMFYA	GUSELKUMAB SOLN PREFILLED SYRINGE 100 MG/ML	9025054200E520	Brand
TREMFYA	GUSELKUMAB SOLN PEN-INJECTOR 100 MG/ML	9025054200D520	Brand

Approval Criteria

1 - ONE of the following diagnoses:

- Psoriasis

- Psoriatic arthritis

AND

2 - Previous trial and failure of at least TWO other targeted immunomodulator agents

AND

3 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Product Name: Velsipity	
Approval Length	1 year(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 ulcerative colitis

AND

2 - Previous trial and failure of BOTH of the following:

- Zeposia (ozanimod)
- At least ONE other targeted immunomodulator agent

AND

3 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Product Name: Actemra, Adalimumab-FKJP, Adbry, Arcalyst, Cibinqo, Cimzia, Cosentyx, Enbrel, Entyvio Pen, Hadlima, Humira, Ilaris, Ilumya, Kevzara, Kineret, Orencia, Otezla, Rinvoq ER tablets, Siliq, Simlandi, Simponi, Skyrizi, Sotyktu, Stelara, Taltz, Tremfya, Tyenne, Bimzelx, Omvoh, Velsipity	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ACTEMRA	TOCILIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 162 MG/0.9ML	6650007000E520	Brand
COSENTYX SENSOREADY PEN	SECUKINUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 150 MG/ML	9025057500D520	Brand
COSENTYX	SECUKINUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/ML	9025057500E520	Brand
ENBREL SURECLICK	ETANERCEPT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML	6629003000D530	Brand
ENBREL	ETANERCEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 25 MG/0.5ML	6629003000E525	Brand
ENBREL	ETANERCEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 50 MG/ML	6629003000E530	Brand
ILARIS	CANAKINUMAB SUBCUTANEOUS INJ 150 MG/ML	66460020002015	Brand
KINERET	ANAKINRA SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/0.67ML	6626001000E520	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
OTEZLA	APREMILAST TAB STARTER THERAPY PACK 10 MG & 20 MG & 30 MG	6670001500B720	Brand
OTEZLA	APREMILAST TAB 30 MG	66700015000330	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
STELARA	USTEKINUMAB IV SOLN 130 MG/26ML (5 MG/ML) (FOR IV INFUSION)	52504070002020	Brand
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
TALTZ	IXEKIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 80 MG/ML	9025055400D520	Brand
TALTZ	IXEKIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 80 MG/ML	9025055400E520	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
SILIQ	BRODALUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 210 MG/1.5ML	9025052000E520	Brand
TREMFYA	GUSELKUMAB SOLN PREFILLED SYRINGE 100 MG/ML	9025054200E520	Brand
ILUMYA	TILDRAKIZUMAB-ASMN SUBCUTANEOUS SOLN PREF SYRINGE 100 MG/ML	9025058010E520	Brand
ACTEMRA ACTPEN	TOCILIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 162 MG/0.9ML	6650007000D520	Brand
TREMFYA	GUSELKUMAB SOLN PEN-INJECTOR 100 MG/ML	9025054200D520	Brand
RINVOQ	UPADACITINIB TAB ER 24HR 15 MG	66603072007520	Brand
ENBREL MINI	ETANERCEPT SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML	6629003000E230	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
ENBREL	ETANERCEPT SUBCUTANEOUS INJ 25 MG/0.5ML	66290030002015	Brand
KEVZARA	SARILUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML	6650006000D520	Brand
KEVZARA	SARILUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.14ML	6650006000D530	Brand
ARCALYST	RILONACEPT FOR INJ 220 MG	66450060002120	Brand
COSENTYX	SECUKINUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 75 MG/0.5ML	9025057500E510	Brand
RINVOQ	UPADACITINIB TAB ER 24HR 30 MG	66603072007530	Brand

RINVOQ	UPADACITINIB TAB ER 24HR 45 MG	66603072007540	Brand
ADBRY	TRALOKINUMAB-LDRM SUBCUTANEOUS SOLN PREFILLED SYR 150 MG/ML	9027308045E520	Brand
CIBINQO	ABROCITINIB TAB 50 MG	90272005000320	Brand
CIBINQO	ABROCITINIB TAB 100 MG	90272005000325	Brand
CIBINQO	ABROCITINIB TAB 200 MG	90272005000330	Brand
SOTYKTU	DEUCRAVACITINIB TAB 6 MG	90250524000320	Brand
HUMIRA PEN-PS/UV STARTER	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML	6627001500F520	Brand
HUMIRA PEN	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML	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

CIMZIA STARTER KIT	CERTOLIZUMAB PEGOL PREFILLED SYRINGE KIT 6 X 200 MG/ML	5250502010F840	Brand
CIMZIA	CERTOLIZUMAB PEGOL FOR INJ KIT 2 X 200 MG	52505020106420	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
COSENTYX UNOREADY	SECUKINUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML	9025057500D550	Brand
COSENTYX	SECUKINUMAB IV SOLN 125 MG/5ML	90250575002050	Brand
ADALIMUMAB-FKJP	ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML	6627001535F520	Brand
ADALIMUMAB-FKJP	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001535F810	Brand
ADALIMUMAB-FKJP	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001535F820	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
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
VELSIPITY	ETRASIMOD ARGININE TAB 2 MG	52504525100350	Brand
CIMZIA	CERTOLIZUMAB PEGOL PREFILLED SYRINGE KIT 200 MG/ML	5250502010F840	Brand
OMVOH	MIRIKIZUMAB-MRKZ SUBCUTANEOUS SOL PREFILL SYRINGE 100 MG/ML	5250405040E520	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
ADBRY	TRALOKINUMAB-LDRM SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML	9027308045D530	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
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
ENTYVIO	VEDOLIZUMAB SOLN PEN-INJECTOR 108 MG/0.68ML	5250308000D520	Brand

Approval Criteria

1 - History of the requested medication for at least 90 of the past 120 days, as confirmed by claims history or chart documentation

AND

2 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Product Name: Zymfentra	
Approval Length	1 year(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 moderate to severe Crohn's disease or ulcerative colitis

AND

2 - Previous trial and failure of at least ONE other targeted immunomodulator agent that is not infliximab

AND

3 - Both of the following:

- Previous trial of preferred infliximab product(s)
- Prescriber has provided valid medical rationale for the use of the requested non-preferred infliximab product over the preferred infliximab product(s)

AND

4 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Product Name: Zymfentra	
Approval Length	1 year(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 - History of the requested medication for at least 90 of the past 120 days, as confirmed by claims history or chart documentation

AND

2 - Both of the following:

- Previous trial of preferred infliximab product(s)
- Prescriber has provided valid medical rationale for the use of the requested non-preferred infliximab product over the preferred infliximab product(s)

AND

3 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

Targretin (bexarotene)

Prior Authorization Guideline

Guideline ID	GL-138786
Guideline Name	Targretin (bexarotene)
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	2/1/2024

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

2 . Revision History

Date	Notes
1/10/2024	Updated guideline name; Minor cosmetic/formatting cleanup of criteria; Removed reference to "Targretin" in reauthorization criterion for NCCN Recommended Regimens section. No changes to clinical intent.

Tasigna

Prior Authorization Guideline

Guideline ID	GL-138880
Guideline Name	Tasigna
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	2/1/2024

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

2 . Revision History

Date	Notes
1/11/2024	Updated criteria for GIST. Updated criteria for Myeloid/Lymphoid Neo plasms with Eosinophilia and Tyrosine Kinase Gene Fusions. Added Melanoma Cutaneous and Soft Tissue Sarcoma as indications for crit eria per NCCN recommendations.

Tasmar

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-124763
Guideline Name	Tasmar
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2023

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-120247
Guideline Name	Tavalisse
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	3/1/2023

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

2 . Revision History

Date	Notes
1/18/2023	Copy NY

Tavneos

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-121823
Guideline Name	Tavneos
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2023

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-147185
Guideline Name	Tazverik
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2024

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	Added criteria to relapsed/refractory follicular lymphoma based on N CCN recommendations.

Tegsedi

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-138862
Guideline Name	Tegsedi
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	2/1/2024

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)

2 . Revision History

Date	Notes
1/10/2024	Update to simplify reauthorization criteria.

Temodar

Prior Authorization Guideline

Guideline ID	GL-136460
Guideline Name	Temodar
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2024

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

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

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

2 . Revision History

Date	Notes
11/16/2023	Updated coverage criteria and classifications for CNS Tumor, Melanoma, and Neuroendocrine and Adrenal Tumors.

Tepmetko

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-106490
Guideline Name	Tepmetko
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	7/1/2022

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

Test Strips

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-127170
Guideline Name	Test Strips
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	8/1/2023

1 . Criteria

Product Name: Non-preferred Test Strip Products	
Approval Length	12 month(s)
Guideline Type	Step Therapy

Product Name	Generic Name	GPI	Brand/Generic
ACCU-CHEK AVIVA PLUS	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

BLULINK GLUCOSE TEST STRIPS	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

CVS 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
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
EASY TRAK II 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
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 ADVANCE PRO 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
FORA 6 CONNECT	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
FORTISCARE G1 BLOOD GLUCOSE TEST STRIP	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FREESTYLE PRECISION NEO BLOOD GLUCOSE 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
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
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 HEALTHPRO GLUCOSE TEST STRIPS	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 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
MICRODOT TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
MICRODOT XTRA 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 ULTRA	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
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 GS333 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 PRO GLUCOSE TEST 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
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
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
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
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 TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

Approval Criteria

1 - BOTH of the following:

1.1 One of the following:

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

- Accu-Chek Guide Retail Test Strips
- True Metrix Test Strips
- ReliOn Rx TMX Test Strips

OR

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

- Accu-Chek Guide Retail Test Strips
- True Metrix Test Strips
- ReliOn Rx TMX Test Strips

AND

1.2 Documentation provided from the prescriber of the medical necessity rationale for the non-preferred test strips

OR

2 - Patient is on an insulin pump

Product Name: Preferred or non-preferred test strip products	
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
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
BLULINK GLUCOSE TEST STRIPS	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
CVS 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
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
EASY TRAK II 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
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 ADVANCE PRO 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
FORA 6 CONNECT	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
FORTISCARE G1 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
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
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
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 HEALTHPRO GLUCOSE TEST STRIPS	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 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
MICRODOT TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
MICRODOT XTRA 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 ULTRA	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
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 TRUE METRIX 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 GS333 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 PRO GLUCOSE TEST 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
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
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
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 For Insulin Dependent or Pregnant patients, the physician must confirm the patient requires a greater quantity because of more frequent blood glucose testing (e.g., patients on intravenous insulin infusions)

OR

1.2 For Non-Insulin Dependent Patients, ONE the following:

1.2.1 The patient is experiencing or is prone to hypoglycemia or hyperglycemia and requires additional testing to achieve glycemic control

OR

1.2.2 The patient's physician is adjusting medications and the patient requires additional blood glucose testing during this time

OR

1.2.3 The patient's physician is adjusting MNT (medical nutrition therapy) and the patient requires additional blood glucose testing during this time **OR** **1.2.4** The patient requires additional testing due to fluctuations in blood glucose due to physical activity or exercise **OR** **1.2.5** Other circumstances where prescribing physician confirms that the patient requires a greater quantity because of more frequent blood glucose testing (clinical review required by UnitedHealthcare reviewing pharmacist and/or medical director)

Notes	NOTE: The quantity limit for insulin-dependent and pregnant patients i s 6 test strips/day. The quantity limit for non-insulin dependent and no n-pregnant patients is 2 test strips/day.

2 . Revision History

Date	Notes
6/27/2023	Added new GPIs to market since last update. Changed from a step t hrough one to a step through all preferred products. Updated IN pref erred products.

Testosterones

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-161869
Guideline Name	Testosterones
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2025

1 . Criteria

Product Name: Brand Depo-Testosterone, generic testosterone cypionate, Testosterone cypionate	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization*
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
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 CYPIONATE	TESTOSTERONE CYP IM OR SUBCUTANEOUS INJ IN OIL 200 MG/ML	23100030102070	Brand

Approval Criteria

1 - ONE of the following:

1.1 Diagnosis of delayed puberty

OR

1.2 Submission of documentation of total testosterone level less than or equal to 350 ng/dL (nanograms/deciliter) within the past 3 months

AND

2 - Provider attests that the patient does NOT have any of the following contraindications to therapy:

- Breast cancer in a patient assigned male at birth
- Pregnancy
- Prostate cancer

Notes	*If patient has had history with injectable/topical product within the pas t 120 days, confirmed by claims history, and switching formulations to preferred injectable formulation, use reauthorization criteria.

Product Name: Brand Depo-Testosterone, generic testosterone cypionate, Testosterone cypionate	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
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 CYPIONATE	TESTOSTERONE CYP IM OR SUBCUTANEOUS INJ IN OIL 200 MG/ML	23100030102070	Brand

Approval Criteria

1 - History of injectable or topical testosterone agent(s) within the past 120 days, confirmed by claims history or chart documentation

AND

2 - Submission of documentation of total testosterone level less than or equal to 1000 ng/dL within the past 6 months

AND

3 - Prescriber attests that the patient remains a candidate for treatment, indicating that they have NOT developed any of the contraindication(s) listed in initial authorization criteria (breast cancer in a patient assigned male at birth, pregnancy, prostate cancer)

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

Product Name	Generic Name	GPI	Brand/Generic
TESTOSTERONE ENANTHATE	TESTOSTERONE ENANTHATE IM INJ IN OIL 200 MG/ML	23100030202010	Generic

Approval Criteria

1 - ALL of the following:

1.1 ONE of the following:

- Diagnosis of delayed puberty
- Submission of documentation of total testosterone level less than or equal to 350 ng/dL (nanograms/deciliter) within the past 3 months

AND

1.2 ONE of the following:

- Previous trial and failure of ALL preferred** injectable testosterone agents, as confirmed by claims history, chart documentation, or provider attestation including dates of trial
- Medical justification for use of the requested medication over ALL preferred** injectable testosterone agents

AND

1.3 Provider attests that the patient does NOT have any of the following contraindications to therapy:

- Breast cancer in a patient assigned male at birth
- Pregnancy
- Prostate cancer

OR

2 - BOTH of the following:

2.1 Palliative treatment of metastatic breast cancer

AND

2.2 Provider attests that the patient does NOT have any of the following contraindications to therapy:

- Breast cancer in a patient assigned male at birth
- Pregnancy
- Prostate cancer

Notes	*If patient has had history with injectable/topical product within the pas t 120 days, confirmed by claims history, and are switching formulation s to nonpreferred injectable formulation, use reauthorization criteria. **PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indi ana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

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

Product Name	Generic Name	GPI	Brand/Generic
TESTOSTERONE ENANTHATE	TESTOSTERONE ENANTHATE IM INJ IN OIL 200 MG/ML	23100030202010	Generic

Approval Criteria

1 - ONE of the following:

1.1 History of the requested medication within the past 120 days, confirmed by claims history or chart documentation

OR

1.2 Patient has had history with injectable/topical product within the past 120 days, confirmed by claims history, and are switching formulations to the requested agent

AND

2 - Submission of documentation of total testosterone level less than or equal to 1000 ng/dL within the past 6 months

AND

3 - ONE of the following: (not required for palliative treatment of breast cancer)

- Previous trial and failure of at least one preferred* injectable testosterone agent, as confirmed by claims history, chart documentation, or provider attestation including dates of trial
- Medical justification for use of the requested medication over ALL preferred* injectable testosterone agents

AND

4 - Prescriber attests that the patient remains a candidate for treatment, indicating that they have NOT developed any of the contraindication(s) listed in initial authorization criteria (breast cancer in a patient assigned male at birth, pregnancy, prostate cancer)

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

Product Name: Aveed, Testopel, Xyosted	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization*
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AVEED	TESTOSTERONE UNDECANOATE IM INJ IN OIL 750 MG/3ML (250MG/ML)	23100030802030	Brand
TESTOPEL	TESTOSTERONE IMPLANT PELLETS 75 MG	23100030008920	Brand
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

Approval Criteria

1 - ONE of the following:

- Diagnosis of delayed puberty
- Submission of documentation of total testosterone level less than or equal to 350 ng/dL (nanograms/deciliter) within the past 3 months

AND

2 - ONE of the following:

- Previous trial and failure of ALL preferred** injectable testosterone agents, as confirmed by claims history, chart documentation, or provider attestation including dates of trial
- Medical justification for use of the requested medication over ALL preferred** injectable testosterone agents

AND

3 - Provider attests that the patient does NOT have any of the following contraindications to therapy:

- Breast cancer in a patient assigned male at birth
- Hypogonadal conditions not associated with structural or genetic etiologies (Xyosted ONLY)
- Pregnancy
- Prostate cancer

Notes	*If patient has had history with injectable/topical product within the pas t 120 days, confirmed by claims history, and are switching formulation s to nonpreferred injectable formulation, use reauthorization criteria. **PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indi ana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name: Aveed, Testopel, Xyosted	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AVEED	TESTOSTERONE UNDECANOATE IM INJ IN OIL 750 MG/3ML (250MG/ML)	23100030802030	Brand
TESTOPEL	TESTOSTERONE IMPLANT PELLETS 75 MG	23100030008920	Brand
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

Approval Criteria

1 - ONE of the following:

1.1 History of the requested medication within the past 120 days, confirmed by claims history or chart documentation

OR

1.2 Patient has had history with injectable/topical product within the past 120 days, confirmed by claims history, and are switching formulations to the requested agent

AND

2 - Submission of documentation of total testosterone level less than or equal to 1000 ng/dL within the past 6 months

AND

3 - ONE of the following:

- Previous trial and failure of at least one preferred* injectable testosterone agent, as confirmed by claims history, chart documentation, or provider attestation including dates of trial
- Medical justification for use of the requested medication over ALL preferred* injectable testosterone agents

AND

4 - Prescriber attests that the patient remains a candidate for treatment, indicating that they have NOT developed any of the contraindication(s) listed in initial authorization criteria (breast cancer in a patient assigned male at birth, hypogonadal conditions not associated with structural or genetic etiologies [Xyosted ONLY], pregnancy, prostate cancer)

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

Product Name: Androderm, generic testosterone gel, Brand Androgel, Brand Testim, Brand Vogelxo, testosterone topical soln, Brand Fortesta, Natesto	
Approval Length	1 year(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
TESTIM	TESTOSTERONE TD GEL 50 MG/5GM (1%)	23100030004030	Brand
TESTOSTERONE	TESTOSTERONE TD GEL 50 MG/5GM (1%)	23100030004030	Generic
VOGELXO	TESTOSTERONE TD GEL 50 MG/5GM (1%)	23100030004030	Brand
TESTOSTERONE	TESTOSTERONE TD SOLN 30 MG/ACT	23100030002020	Generic
TESTOSTERONE	TESTOSTERONE TD GEL 10MG/ACT (2%)	23100030004070	Generic
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 40.5 MG/2.5GM (1.62%)	23100030004047	Generic
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
TESTOSTERONE	TESTOSTERONE TD GEL 20.25 MG/1.25GM (1.62%)	23100030004044	Generic
TESTOSTERONE TOPICAL SOLUTION	TESTOSTERONE TD SOLN 30 MG/ACT	23100030002020	Generic
FORTESTA	TESTOSTERONE TD GEL 10MG/ACT (2%)	23100030004070	Brand
ANDROGEL PUMP	TESTOSTERONE TD GEL 20.25 MG/ACT (1.62%)	23100030004050	Brand
NATESTO	TESTOSTERONE NASAL GEL 5.5 MG/ACT	23100030004080	Brand

Approval Criteria

1 - Patient is 16 years of age or older

AND

2 - Submission of documentation of total testosterone level is less than or equal to 350 ng/dL (nanograms/deciliter) within the past 3 months

AND

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

- Previous trial and failure of ALL preferred** topical testosterone agents, as confirmed by claims history, chart documentation, or provider attestation including dates of trial
- Medical justification for use of the requested medication over ALL preferred** topical testosterone agents

AND

4 - Provider attests that the patient does NOT have any of the following contraindications to therapy:

- Breast cancer in a patient assigned male at birth
- Pregnancy
- Prostate cancer

Notes	*If patient has had history with injectable/topical product within the pas t 120 days, confirmed by claims history, and are switching formulation s to a topical formulation, use reauthorization criteria. **PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indi ana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

Product Name: Androderm, generic testosterone gel, Brand Androgel, Brand Testim, Brand Vogelxo, testosterone topical soln, Brand Fortesta, Natesto	
Approval Length	1 year(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
TESTIM	TESTOSTERONE TD GEL 50 MG/5GM (1%)	23100030004030	Brand
TESTOSTERONE	TESTOSTERONE TD GEL 50 MG/5GM (1%)	23100030004030	Generic
VOGELXO	TESTOSTERONE TD GEL 50 MG/5GM (1%)	23100030004030	Brand
TESTOSTERONE	TESTOSTERONE TD SOLN 30 MG/ACT	23100030002020	Generic
TESTOSTERONE	TESTOSTERONE TD GEL 10MG/ACT (2%)	23100030004070	Generic
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 40.5 MG/2.5GM (1.62%)	23100030004047	Generic
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
TESTOSTERONE	TESTOSTERONE TD GEL 20.25 MG/1.25GM (1.62%)	23100030004044	Generic
TESTOSTERONE TOPICAL SOLUTION	TESTOSTERONE TD SOLN 30 MG/ACT	23100030002020	Generic
FORTESTA	TESTOSTERONE TD GEL 10MG/ACT (2%)	23100030004070	Brand
ANDROGEL PUMP	TESTOSTERONE TD GEL 20.25 MG/ACT (1.62%)	23100030004050	Brand
NATESTO	TESTOSTERONE NASAL GEL 5.5 MG/ACT	23100030004080	Brand

Approval Criteria

1 - ONE of the following:

1.1 If the request is preferred*, patient has a history of topical or injectable testosterone agent(s) within the past 120 days, confirmed by claims history or chart documentation

OR

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

1.2.1 ONE of the following:

1.2.1.1 Patient has a history of the requested medication within the past 120 days, confirmed by claims history or chart documentation

OR

1.2.1.2 Patient has had history with injectable/topical product within the past 120 days, confirmed by claims history, and are switching formulations to the requested nonpreferred topical formulation

AND

1.2.2 ONE of the following:

- Previous trial and failure of at least one preferred* topical testosterone agent, as confirmed by claims history, chart documentation, or provider attestation including dates of trial
- Medical justification for use of the requested medication over ALL preferred* topical testosterone agents

AND

2 - Submission of documentation of total testosterone is less than or equal to 1000 ng/dL within the past 6 months

AND

3 - Prescriber attests that the patient remains a candidate for treatment, indicating that they have NOT developed any of the contraindications listed in initial authorization criteria (breast cancer in a patient assigned male at birth, pregnancy, prostate cancer)

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

Product Name: Androderm, generic testosterone gel, Brand Androgel, Brand Testim, Brand Vogelxo, testosterone topical soln, Brand Fortesta, Natesto	
Approval Length	1 year(s)
Therapy Stage	Initial Authorization
Guideline Type	Quantity Limit

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
TESTIM	TESTOSTERONE TD GEL 50 MG/5GM (1%)	23100030004030	Brand
TESTOSTERONE	TESTOSTERONE TD GEL 50 MG/5GM (1%)	23100030004030	Generic
VOGELXO	TESTOSTERONE TD GEL 50 MG/5GM (1%)	23100030004030	Brand
TESTOSTERONE	TESTOSTERONE TD SOLN 30 MG/ACT	23100030002020	Generic
TESTOSTERONE	TESTOSTERONE TD GEL 10MG/ACT (2%)	23100030004070	Generic
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 40.5 MG/2.5GM (1.62%)	23100030004047	Generic
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
TESTOSTERONE	TESTOSTERONE TD GEL 20.25 MG/1.25GM (1.62%)	23100030004044	Generic
TESTOSTERONE TOPICAL SOLUTION	TESTOSTERONE TD SOLN 30 MG/ACT	23100030002020	Generic
FORTESTA	TESTOSTERONE TD GEL 10MG/ACT (2%)	23100030004070	Brand
ANDROGEL PUMP	TESTOSTERONE TD GEL 20.25 MG/ACT (1.62%)	23100030004050	Brand
NATESTO	TESTOSTERONE NASAL GEL 5.5 MG/ACT	23100030004080	Brand

Approval Criteria

1 - Patient is 16 years of age or older

AND

2 - Patient has utilized at least 14 days of topical testosterone therapy

AND

3 - Submission of documentation of total testosterone level is less than or equal to 400 ng/dL (nanograms/deciliter) while on topical testosterone therapy

Product Name: Androderm, generic testosterone gel, Brand Androgel, Brand Testim, Brand Vogelxo, testosterone topical soln, Brand Fortesta, Natesto	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Quantity Limit

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
TESTIM	TESTOSTERONE TD GEL 50 MG/5GM (1%)	23100030004030	Brand
TESTOSTERONE	TESTOSTERONE TD GEL 50 MG/5GM (1%)	23100030004030	Generic
VOGELXO	TESTOSTERONE TD GEL 50 MG/5GM (1%)	23100030004030	Brand
TESTOSTERONE	TESTOSTERONE TD SOLN 30 MG/ACT	23100030002020	Generic
TESTOSTERONE	TESTOSTERONE TD GEL 10MG/ACT (2%)	23100030004070	Generic
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 40.5 MG/2.5GM (1.62%)	23100030004047	Generic
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
TESTOSTERONE	TESTOSTERONE TD GEL 20.25 MG/1.25GM (1.62%)	23100030004044	Generic
TESTOSTERONE TOPICAL SOLUTION	TESTOSTERONE TD SOLN 30 MG/ACT	23100030002020	Generic
FORTESTA	TESTOSTERONE TD GEL 10MG/ACT (2%)	23100030004070	Brand
ANDROGEL PUMP	TESTOSTERONE TD GEL 20.25 MG/ACT (1.62%)	23100030004050	Brand
NATESTO	TESTOSTERONE NASAL GEL 5.5 MG/ACT	23100030004080	Brand

Approval Criteria

1 - Patient has historical approval to exceed the established quantity limits

Product Name: danazol	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DANAZOL	DANAZOL CAP 50 MG	23100005000105	Generic
DANAZOL	DANAZOL CAP 100 MG	23100005000110	Generic
DANAZOL	DANAZOL CAP 200 MG	23100005000115	Generic

Approval Criteria

1 - Must have ONE of the following indications for treatment:

- Angioedema prophylaxis for hereditary angioedema
- Autoimmune hemolytic anemia
- Discoid lupus erythematosus
- Endometriosis
- Fibrocystic breast disease
- Myelosclerosis with myeloid metaplasia

AND

2 - Provider attests that the patient does NOT have any of the following contraindications to therapy

- Active or history of thrombosis or thromboembolic disease
- Androgen-dependent tumor
- Cardiac disease
- Porphyria
- Pregnancy or breast-feeding
- Severe hepatic disease
- Severe renal disease
- Undiagnosed genital bleeding

Product Name: danazol	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DANAZOL	DANAZOL CAP 50 MG	23100005000105	Generic
DANAZOL	DANAZOL CAP 100 MG	23100005000110	Generic
DANAZOL	DANAZOL CAP 200 MG	23100005000115	Generic

Approval Criteria

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

AND

2 - Documentation from prescriber indicating continued benefit from the medication without significant adverse events

AND

3 - Prescriber attests that the patient remains a candidate for treatment, indicating that they have NOT developed any of the contraindication(s) listed in initial authorization criteria (active or history of thrombosis or thromboembolic disease, androgen-dependent tumor, cardiac disease, porphyria, pregnancy or breast-feeding, severe hepatic disease, severe renal disease, undiagnosed genital bleeding)

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

Product Name	Generic Name	GPI	Brand/Generic
JATENZO	TESTOSTERONE UNDECANOATE CAP 158 MG	23100030800130	Brand
JATENZO	TESTOSTERONE UNDECANOATE CAP 198 MG	23100030800135	Brand
JATENZO	TESTOSTERONE UNDECANOATE CAP 237 MG	23100030800140	Brand

Approval Criteria

1 - ALL of the following:

- Patient is 18 years of age or older
- Diagnosis of hypogonadism
- Submission of documentation of total testosterone level less than or equal to 350 ng/dL (nanograms/deciliter) within the past 3 months

AND

2 - Provider attests that the patient does NOT have any of the following contraindications to therapy:

- Breast cancer in a patient assigned male at birth
- Hypogonadal conditions not associated with structural or genetic etiologies
- Pregnancy

- Prostate cancer

AND

3 - ONE of the following:

- Previous trial and failure of at least one preferred* injectable agent, as confirmed by claims history, chart documentation, or provider attestation including dates of trial
- Medical justification for use of the requested medication over ALL preferred* injectable testosterone agents

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

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

Product Name	Generic Name	GPI	Brand/Generic
JATENZO	TESTOSTERONE UNDECANOATE CAP 158 MG	23100030800130	Brand
JATENZO	TESTOSTERONE UNDECANOATE CAP 198 MG	23100030800135	Brand
JATENZO	TESTOSTERONE UNDECANOATE CAP 237 MG	23100030800140	Brand

Approval Criteria

1 - Must meet BOTH of the following:

1.1 History of the requested medication within the past 120 days, confirmed by claims history or chart documentation

AND

1.2 Submission of documentation of total testosterone less than or equal to 1000 ng/dL within the past 6 months

AND

2 - ONE of the following:

- Previous trial and failure of at least one preferred* injectable agent, as confirmed by claims history, chart documentation, or provider attestation including dates of trial
- Medical justification for use of the requested medication over ALL preferred* injectable testosterone agents

AND

3 - Prescriber attests that the patient remains a candidate for treatment, indicating that they have NOT developed any of the contraindication(s) listed in initial authorization criteria (breast cancer in a patient assigned male at birth, hypogonadal conditions not associated with structural or genetic etiologies, pregnancy, prostate cancer)

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

Product Name: Methitest, methyltestosterone caps	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
METHITEST	METHYLTESTOSTERONE ORAL TAB 10 MG	23100020000310	Brand
METHYLTESTOSTERONE	METHYLTESTOSTERONE CAP 10 MG	23100020000105	Generic

Approval Criteria

1 - Must have ONE of the following indications for treatment:

- Cryptorchidism
- Delayed puberty
- Hypogonadism (primary or hypogonadotropic) with submission of documentation of a total testosterone level less than or equal to 350 ng/dL within the past 3 months

- Palliative treatment of metastatic breast cancer

AND

2 - Provider attests that the patient does NOT have any of the following contraindications to therapy:

- Breast cancer in a patient assigned male at birth
- Pregnancy
- Prostate cancer

AND

3 - ONE of the following:

- Previous trial and failure of a preferred* injectable agent, as confirmed by claims history, chart documentation, or provider attestation including dates of trial
- Medical justification for use over ALL preferred* injectable agents

AND

4 - ONE of the following:

4.1 If the request is for breast cancer indication, the requested dose does NOT exceed 50 capsules or tablets per day

OR

4.2 For all other indications, the requested dose does NOT exceed 5 capsules or tablets per day

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

Product Name: Methitest, methyltestosterone caps	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
METHITEST	METHYLTESTOSTERONE ORAL TAB 10 MG	23100020000310	Brand
METHYLTESTOSTERONE	METHYLTESTOSTERONE CAP 10 MG	23100020000105	Generic

Approval Criteria

1 - Diagnosis of delayed puberty, palliative treatment of metastatic breast cancer, or cryptorchidism AND all of the following:

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

AND

1.2 Documentation from prescriber indicating continued benefit from the medication without significant adverse events

AND

1.3 ONE of the following:

- Previous trial and failure of a preferred* injectable agent, as confirmed by claims history, chart documentation, or provider attestation including dates of trial
- Medical justification for use over ALL preferred* injectable agents

AND

1.4 Prescriber attests that the patient remains a candidate for treatment, indicating that they have NOT developed any of the contraindication(s) listed in initial authorization criteria (breast cancer in a patient assigned male at birth, pregnancy, prostate cancer)

AND

1.5 ONE of the following:

1.5.1 If the request is for breast cancer indication, the requested dose does NOT exceed 50 capsules or tablets per day

OR

1.5.2 For all other indications, the requested dose does NOT exceed 5 capsules or tablets per day

OR

2 - Diagnosis of hypogonadism AND all of the following:

2.1 History of the requested medication within the past 120 days, confirmed by claims history or chart documentation

AND

2.2 Submission of documentation of total testosterone level less than or equal to 1000 ng/dL within the past 6 months

AND

2.3 ONE of the following:

- Previous trial and failure of a preferred* injectable agent, as confirmed by claims history, chart documentation, or provider attestation including dates of trial
- Medical justification for use over ALL preferred* injectable agents

AND

2.4 Prescriber attests that the patient remains a candidate for treatment, indicating that they have NOT developed any of the contraindication(s) listed in initial authorization criteria (breast cancer in a patient assigned male at birth, pregnancy, prostate cancer)

AND

2.5 The requested dose does NOT exceed 5 capsules or tablets per day

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

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

Product Name	Generic Name	GPI	Brand/Generic
TLANDO	TESTOSTERONE UNDECANOATE CAP 112.5 MG	23100030800125	Brand

Approval Criteria

1 - ALL of the following:

- Patient is 18 years of age or older
- Diagnosis of hypogonadism
- Submission of documentation of total testosterone level less than or equal to 350 ng/dL (nanograms/deciliter) within the past 3 months

AND

2 - Provider attests that the patient does NOT have any of the following contraindications to therapy:

- Breast cancer
- Hypogonadal conditions not associated with structural or genetic etiologies
- Pregnancy
- Prostate cancer

AND

3 - ONE of the following:

- Previous trial and failure of a preferred* injectable agent, as confirmed by claims history, chart documentation, or provider attestation including dates of trial

• Medical justification for use over ALL preferred* injectable agents	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

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

Product Name	Generic Name	GPI	Brand/Generic
TLANDO	TESTOSTERONE UNDECANOATE CAP 112.5 MG	23100030800125	Brand

Approval Criteria

1 - History of the requested medication within the past 120 days, confirmed by claims history or chart documentation

AND

2 - Submission of documentation of total testosterone less than or equal to 1000 ng/dL within the past 6 months

AND

3 - ONE of the following:

- Previous trial and failure of a preferred* injectable agent, as confirmed by claims history, chart documentation, or provider attestation including dates of trial
- Medical justification for use over ALL preferred* injectable agents

AND

4 - Prescriber attests that the patient remains a candidate for treatment, indicating that they have NOT developed any of the contraindication(s) listed in initial authorization criteria (breast

cancer, hypogonadal conditions not associated with structural or genetic etiologies, pregnancy, prostate cancer)

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

Product Name	Generic Name	GPI	Brand/Generic
UNDECATREX	TESTOSTERONE UNDECANOATE CAP 200 MG	23100030800136	Generic

Approval Criteria

1 - ALL of the following:

- Patient is 18 years of age or older
- Diagnosis of hypogonadism
- Submission of documentation of total testosterone level less than or equal to 350 ng/dL (nanograms/deciliter) within the past 3 months

AND

2 - Provider attests that the patient does NOT have any of the following contraindications to therapy:

- Breast cancer in a patient assigned male at birth
- Hypogonadal conditions not associated with structural or genetic etiologies
- Pregnancy
- Prostate cancer

AND

3 - ONE of the following:

- Previous trial and failure of Jatenzo AND Tlando, as confirmed by claims history, chart documentation, or provider attestation including dates of trial
- Medical justification for use of the requested medication over Jatenzo AND Tlando

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

Product Name	Generic Name	GPI	Brand/Generic
UNDECATREX	TESTOSTERONE UNDECANOATE CAP 200 MG	23100030800136	Generic

Approval Criteria

1 - History of the requested medication within the past 120 days, confirmed by claims history or chart documentation

AND

2 - Submission of documentation of total testosterone less than or equal to 1000 ng/dL within the past 6 months

AND

3 - ONE of the following:

- Previous trial and failure of Jatenzo AND Tlando, as confirmed by claims history, chart documentation, or provider attestation including dates of trial
- Medical justification for use of the requested medication over Jatenzo AND Tlando

AND

4 - Prescriber attests that the patient remains a candidate for treatment, indicating that they have NOT developed any of the contraindication(s) listed in initial authorization criteria (breast cancer in a patient assigned male at birth, hypogonadal conditions not associated with structural or genetic etiologies, pregnancy, prostate cancer)

2 . Revision History

Date	Notes
12/11/2024	Added criteria for new target drug, Undecatrex. Cleaned up GPIs, wh ere applicable. Updated reauth history language for danazol and met hitest and updated contraindication language for xyosted and methite st to align with state policy. Minor cosmetic updates.

Thalomid

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-151785
Guideline Name	Thalomid
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	9/1/2024

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
8/14/2024	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)

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-162199
Guideline Name	Therapeutic Duplication (Subtype A)
Formulary	• Medicaid - Community & State Indiana

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, Zituvimet, Sitagliptin/metformin, Brand Tanlor, Dolobid, generic diflunisal, Zituvimet XR, Tresni

Diagnosis	DUR: Therapeutic Duplication
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
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
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
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
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
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
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
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
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
ARNUITY ELLIPTA	FLUTICASONE FUROATE AEROSOL POWDER BREATH ACTIV 100 MCG/ACT	44400033108020	Brand
ARNUITY ELLIPTA	FLUTICASONE FUROATE AEROSOL POWDER	44400033108030	Brand

	BREATH ACTIV 200 MCG/ACT		
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
FLUTICASONE PROPIONATE/SALMETEROL DISKUS	FLUTICASONE-SALMETEROL AER POWDER BA 100-50 MCG/ACT	44209902708020	Generic
WIXELA INHUB	FLUTICASONE-SALMETEROL AER	44209902708020	Generic

	POWDER BA 100-50 MCG/ACT		
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
BUDESONIDE/FORMOTEROL FUMARATE DIHYDRATE	BUDESONIDE-FORMOTEROL FUMARATE DIHYD AEROSOL 160-4.5 MCG/ACT	44209902413240	Generic
AIRDUO DIGIHALER 55/14	FLUTICASONE-SALMETEROL AER	44209902718020	Brand

	POWDER BA 55-14 MCG/ACT W/ SENSOR		
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
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
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
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
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
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
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
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 CHEW TAB 100 MG	66100020000520	Generic
IBUPROFEN INFANTS	IBUPROFEN SUSP 40 MG/ML	66100020001810	Generic
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
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
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
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
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
IBUPROFEN	IBUPROFEN TAB 400 MG	66100020000320	Generic
IBUPROFEN	IBUPROFEN TAB 600 MG	66100020000330	Generic
IBUPROFEN	IBUPROFEN TAB 800 MG	66100020000340	Generic
ALEVE	NAPROXEN SODIUM CAP 220 MG	66100060100127	Brand
ALEVE	NAPROXEN SODIUM TAB 220 MG	66100060100303	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
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
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
BRENZAVVY	BEXAGLIFLOZIN TAB 20 MG	27700010000320	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
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
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
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
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
DAPAGLIFLOZIN PROPANEDIOL	DAPAGLIFLOZIN PROPANEDIOL TAB 5 MG (BASE EQUIVALENT)	27700040200310	Generic
DAPAGLIFLOZIN PROPANEDIOL	DAPAGLIFLOZIN PROPANEDIOL TAB 10 MG (BASE EQUIVALENT)	27700040200320	Generic
DAPAGLIFLOZIN PROPANEDIOL/METFORMIN HYDROCHLORIDE	DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 5-1000 MG	27996002307515	Generic
DAPAGLIFLOZIN PROPANEDIOL/METFORMIN HYDROCHLORIDE	DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 10-1000 MG	27996002307525	Generic
ZITUVIO	SITAGLIPTIN TAB 25 MG	27550070000320	Brand
ZITUVIO	SITAGLIPTIN TAB 50 MG	27550070000330	Brand
ZITUVIO	SITAGLIPTIN TAB 100 MG	27550070000340	Brand
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
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-162159
Guideline Name	Therapeutic Duplication (Subtype B)
Formulary	• Medicaid - Community & State Indiana

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

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

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

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

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

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

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

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

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

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

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

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-147550
Guideline Name	Tibsovo
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2024

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

2 . Revision History

Date	Notes
5/21/2024	Added criteria for Myelodysplastic Syndrome.

Tobramycin Inhalation

Prior Authorization Guideline

Guideline ID	GL-134478
Guideline Name	Tobramycin Inhalation
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	12/1/2023

1 . Criteria

Product Name: Brand Bethkis, Kitabis Pak, Tobi Podhaler, Brand Tobi, generic tobramycin 300 mg/5mL nebu soln, Brand Tobramycin 300 mg/5mL nebu soln	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BETHKIS	TOBRAMYCIN NEBU SOLN 300 MG/4ML	07000070002530	Brand
KITABIS PAK	TOBRAMYCIN NEBU SOLN 300 MG/5ML	07000070002520	Generic
TOBI PODHALER	TOBRAMYCIN INHAL CAP 28 MG	07000070000120	Brand
TOBI	TOBRAMYCIN NEBU SOLN 300 MG/5ML	07000070002520	Brand

TOBRAMYCIN	TOBRAMYCIN NEBU SOLN 300 MG/5ML	07000070002520	Generic

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: Brand Bethkis, Kitabis Pak, Tobi Podhaler, Brand Tobi, generic tobramycin 300 mg/5mL nebu soln, Brand Tobramycin 300 mg/5mL nebu soln	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BETHKIS	TOBRAMYCIN NEBU SOLN 300 MG/4ML	07000070002530	Brand
KITABIS PAK	TOBRAMYCIN NEBU SOLN 300 MG/5ML	07000070002520	Generic
TOBI PODHALER	TOBRAMYCIN INHAL CAP 28 MG	07000070000120	Brand
TOBI	TOBRAMYCIN NEBU SOLN 300 MG/5ML	07000070002520	Brand
TOBRAMYCIN	TOBRAMYCIN NEBU SOLN 300 MG/5ML	07000070002520	Generic

Approval Criteria

1 - Documentation of positive clinical response to therapy

2 . Revision History

Date	Notes
10/10/2023	Updated product name lists, added criteria for noncystic fibrosis bron chiectasis with recurrent exacerbations.

Topical Anti-Inflammatory Agents, NSAIDs

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-161715
Guideline Name	Topical Anti-Inflammatory Agents, NSAIDs
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2025

1 . Criteria

Product Name: Diclofenac epolamine patch, generic diclofenac topical solution	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DICLOFENAC EPOLAMINE	DICLOFENAC EPOLAMINE PATCH 1.3%	90210030205920	Generic
DICLOFENAC SODIUM	DICLOFENAC SODIUM SOLN 1.5%	90210030302025	Generic
DICLOFENAC SODIUM	DICLOFENAC SODIUM SOLN 2%	90210030302030	Generic

Approval Criteria **1** - ONE of the following: **1.1** BOTH of the following: **1.1.1** Physician documentation indicating oral medications are unsuitable for use **AND** **1.1.2** Trial and failure of BOTH of the following: • Diclofenac 1% gel • Pennsaid topical solution **OR** **1.2** Medical justification for use over the preferred* agents	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

2 . Revision History

Date	Notes
12/5/2024	Removed Flector patch and Licart as targets from the guideline. Updated product name list and GPI table accordingly. Updated criteria and notes sections. Minor cosmetic updates.

Topical Immunomodulator Agents

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-161797
Guideline Name	Topical Immunomodulator Agents
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2025

1 . Criteria

Product Name: Brand Elidel, generic pimecrolimus, generic tacrolimus 0.03%	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
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 - Patient is 2 years of age or older

AND

2 - ONE of the following:

2.1 Greater than or equal to 30 days of drug therapy with topical corticosteroids supported by chart documentation, claims history, or prescriber attestation including dates of trial

OR

2.2 Prescriber has provided valid medical justification for the use of the requested agent over topical corticosteroids

Product Name: Brand Elidel, generic pimecrolimus, generic tacrolimus 0.03%	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
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 - History of the requested agent within the past 180 days

Product Name: generic tacrolimus 0.1%	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TACROLIMUS	TACROLIMUS OINT 0.1%	90784075004230	Generic

Approval Criteria

1 - Patient is 16 years of age or older

AND

2 - ONE of the following:

2.1 Greater than or equal to 30 days of drug therapy with topical corticosteroids supported by chart documentation, claims history, or prescriber attestation including dates of trial

OR

2.2 Prescriber has provided valid medical justification for the use of the requested agent over topical corticosteroids

Product Name: generic tacrolimus 0.1%	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TACROLIMUS	TACROLIMUS OINT 0.1%	90784075004230	Generic

Approval Criteria

1 - History of the requested agent within the past 180 days

Product Name: Eucrisa

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

Product Name	Generic Name	GPI	Brand/Generic
EUCRISA	CRISABOROLE OINT 2%	90230025004220	Brand

Approval Criteria

1 - Patient is 3 months of age or older

AND

2 - ONE of the following:

2.1 Greater than or equal to 30 days of drug therapy with ONE of the following, supported by chart documentation, claims history, or prescriber attestation including dates of trial:

- Topical corticosteroids
- Topical calcineurin inhibitors (pimecrolimus OR tacrolimus)*

OR

2.2 Prescriber has provided valid medical justification for the use of the requested agent over topical corticosteroids, tacrolimus, AND pimecrolimus

Notes	*Those under 2 years of age are exempt from tacrolimus and pimecrolimus step therapy requirement (topical corticosteroids are still required).

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

Product Name	Generic Name	GPI	Brand/Generic

EUCRISA	CRISABOROLE OINT 2%	90230025004220	Brand

Approval Criteria

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

Product Name: Opzelura	
Approval Length	1 year(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 - Patient is 12 years of age or older

AND

2 - Patient will NOT be using concurrently with therapeutic biologics, other Janus kinase inhibitors, or potent immunosuppressants such as azathioprine or cyclosporine

AND

3 - ONE of the following:

3.1 Patient has a diagnosis of atopic dermatitis AND one of the following:

3.1.1 Greater than or equal to 30 days of drug therapy with each of the following, supported by chart documentation, claims history, or prescriber attestation including dates of trial:

- Topical corticosteroids
- Topical calcineurin inhibitors (pimecrolimus OR tacrolimus)

OR

3.1.2 Prescriber has provided valid medical justification for the use of the requested agent over topical corticosteroids, tacrolimus, AND pimecrolimus

OR

3.2 Patient has a diagnosis of non-segmental vitiligo AND one of the following:

3.2.1 Greater than or equal to 90 days of drug therapy with each of the following, supported by chart documentation, claims history, or prescriber attestation including dates of trial:

- Topical corticosteroids
- Topical tacrolimus

OR

3.2.2 Prescriber has provided valid medical justification for the use of the requested agent over topical corticosteroids AND tacrolimus

AND

4 - Requested quantity does NOT exceed 360 grams per year

Product Name: Opzelura	
Approval Length	1 year(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 - History of the requested agent within the past 180 days

AND

2 - Requested quantity does NOT exceed 360 grams per year

Product Name: Zoryve 0.15% cream	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZORYVE	ROFLUMILAST CREAM 0.15%	90230060003720	Brand

Approval Criteria

1 - Patient is 6 years of age or older

AND

2 - ONE of the following:

2.1 Greater than or equal to 90 days of drug therapy with topical crisaborole, supported by chart documentation, claims history, or prescriber attestation including dates of trial

OR

2.2 Prescriber has provided valid medical justification for the use of the requested agent over topical crisaborole

AND

3 - Requested quantity does NOT exceed 180 grams per 30 days

Product Name: Zoryve 0.15% cream	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZORYVE	ROFLUMILAST CREAM 0.15%	90230060003720	Brand

Approval Criteria

1 - History of the requested agent within the past 180 days

AND

2 - Requested quantity does NOT exceed 180 grams per 30 days

Product Name: Zoryve 0.3% cream	
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 - Patient is 6 years of age or older

AND

2 - ONE of the following:

2.1 Greater than or equal to 90 days of drug therapy with each of the following, supported by chart documentation, claims history, or prescriber attestation including dates of trial:

- Topical corticosteroids
- Topical calcineurin inhibitors (pimecrolimus OR tacrolimus)

OR

2.2 Prescriber has provided valid medical justification for the use of the requested agent over topical corticosteroids, tacrolimus, AND pimecrolimus

AND

3 - Requested quantity does NOT exceed 180 grams per 30 days

Product Name: Zoryve 0.3% cream	
Approval Length	1 year(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 - History of the requested agent within the past 180 days

AND

2 - Requested quantity does NOT exceed 180 grams per 30 days

Product Name: Zoryve foam	
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 - Patient is 9 years of age or older

AND

2 - ONE of the following:

2.1 Greater than or equal to 30 days of drug therapy with a product from each of the following categories, supported by chart documentation, claims history, or prescriber attestation including dates of trial:

- Topical antifungal (ciclopirox OR ketoconazole)
- Topical corticosteroid
- Topical calcineurin inhibitors (pimecrolimus OR tacrolimus)

OR

2.2 Prescriber has provided valid medical justification for the use of the requested agent over topical antifungals, topical corticosteroids, tacrolimus, AND pimecrolimus

AND

3 - Requested quantity does NOT exceed 60 grams per 30 days

Product Name: Zoryve foam	
Approval Length	1 year(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 - History of the requested agent within the past 180 days

AND

2 - Requested quantity does NOT exceed 60 grams per 30 days

2 . Revision History

Date	Notes
12/9/2024	Updated GL name. Added new criteria for Zoryve 0.15% cream. Updated initial auth t/f language throughout guideline. Updated initial auth duration for Opzelura to 12 months. Added QL criterion to Opzelura and Zoryve products. Update to notes section where applicable and minor cosmetic updates.

Topical Post-Herpetic Neuralgia Agents

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-161834
Guideline Name	Topical Post-Herpetic Neuralgia Agents
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2025

1 . Criteria

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

Product Name	Generic Name	GPI	Brand/Generic
QUTENZA	CAPSAICIN PATCH 8% & CLEANSING GEL KIT	90850025306420	Brand

Approval Criteria

1 - Patient has tried lidocaine patches

AND

2 - Patient has tried over-the-counter capsaicin cream

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

Product Name	Generic Name	GPI	Brand/Generic
ZTLIDO	LIDOCAINE PATCH 1.8% (36 MG)	90850060005910	Brand

Approval Criteria

1 - Patient has previous trial of at least 30 days of therapy with preferred lidocaine 5% patches*

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

2 . Revision History

Date	Notes
12/10/2024	Added Ztlido

Truqap

Prior Authorization Guideline

Guideline ID	GL-146955
Guideline Name	Truqap
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2024

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

2 . Revision History

Date	Notes
5/1/2024	New program.

Tryvio

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-154416
Guideline Name	Tryvio
Formulary	• Medicaid - Community & State Indiana

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-124512
Guideline Name	Tukysa
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2023

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-97076
Guideline Name	Turalio
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2022

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 200 MG (BASE EQUIVALENT)	21533045010120	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 200 MG (BASE EQUIVALENT)	21533045010120	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 200 MG (BASE EQUIVALENT)	21533045010120	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 200 MG (BASE EQUIVALENT)	21533045010120	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 200 MG (BASE EQUIVALENT)	21533045010120	Brand

Approval Criteria

1 - Documentation of positive clinical response to Turalio therapy

Tykerb

Prior Authorization Guideline

Guideline ID	GL-136419
Guideline Name	Tykerb
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2024

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 - BOTH of the following:

1.1 Diagnosis of recurrent or stage IV hormone receptor positive, human epidermal growth factor receptor 2-positive (HER2+) breast cancer

AND

1.2 Used in combination with an aromatase inhibitor [e.g., Aromasin (exemestane), Femara (letrozole), Arimidex (anastrozole)]

OR

2 - BOTH of the following:

2.1 Diagnosis of recurrent or stage IV HER2+ breast cancer

AND

2.2 Used 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 recurrent intracranial or spinal ependymoma (excluding subependymoma)

AND

2.2 Patient has received previous radiation therapy

AND

2.3 Patient has received ONE of the following:

- Gross total or subtotal resection
- Localized recurrence
- Evidence of metastasis (brain, spine, or cerebral spinal fluid)

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 epidermal growth factor receptor (EGFR)-positive, recurrent chordoma

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 unresectable, advanced, or metastatic colon cancer [human epidermal growth factor receptor 2 (HER2)-amplified and RAS and BRAF wild type]

AND

2 - Patient has not previously been treated with a HER2 inhibitor [e.g., trastuzumab, Perjeta (pertuzumab), Nerlynx (neratinib)]

AND

3 - ONE of the following:

3.1 Patient has previously been treated with ONE of the following regimens:

- Oxaliplatin-based therapy without irinotecan
- Irinotecan-based therapy without oxaliplatin
- FOLFOXIRI (fluorouracil, leucovorin, oxaliplatin, and irinotecan) regimen
- A fluoropyrimidine without irinotecan or oxaliplatin

OR

3.2 Patient is not appropriate for intensive therapy

AND

4 - Used in combination with trastuzumab

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 unresectable, advanced, or metastatic rectal cancer [human epidermal growth factor receptor 2 (HER2)-amplified and RAS and BRAF wild type]

AND

2 - Patient has not previously been treated with a HER2 inhibitor [e.g., trastuzumab, Perjeta (pertuzumab), Nerlynx (neratinib)]

AND

3 - Used in combination with trastuzumab

AND

4 - ONE of the following:

4.1 Patient has previously been treated with ONE of the following regimens:

- Oxaliplatin-based therapy without irinotecan
- Irinotecan-based therapy without oxaliplatin
- FOLFOXIRI (fluorouracil, leucovorin, oxaliplatin, and irinotecan) regimen
- A fluoropyrimidine without irinotecan or oxaliplatin

OR

4.2 Patient is not appropriate for intensive therapy

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
11/16/2023	Updated coverage criteria for colon cancer

Urea Cycle Disorder Agents

Prior Authorization Guideline

Guideline ID	GL-148986
Guideline Name	Urea Cycle Disorder Agents
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Carbaglu, generic carglumic acid	
Diagnosis	Acute hyperammonemia due to N-acetylglutamate synthase (NAGS) deficiency
Approval Length	6 month(s)
Guideline Type	Prior Authorization

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 acute hyperammonemia due to N-acetylglutamate synthase (NAGS) deficiency (submission of chart documentation required)

AND

2 - Dose requested does not exceed 250 mg/kg/day (milligrams per kilogram per day)

AND

3 - Submission of medical records (e.g., chart notes, assessments) confirming patient will be using Carbaglu (carglumic acid) as adjunctive therapy with standard ammonia lowering therapies

AND

4 - Prescribed by, or in consultation with, a metabolic geneticist or practitioner specialized in treating metabolic disorders

Product Name: Brand Carbaglu, generic carglumic acid	
Diagnosis	Acute hyperammonemia due to propionic acidemia (PA) or methylmalonic acidemia (MMA) hyperammonemia
Approval Length	6 month(s)
Guideline Type	Prior Authorization

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 acute hyperammonemia due to propionic acidemia (PA) or methylmalonic acidemia (MMA) hyperammonemia (submission of chart documentation required)

AND

2 - ONE of the following:

2.1 Patient weighs less than or equal to 15 kg (kilograms) and the requested dose does not exceed 150 mg/kg/day (milligrams per kilograms per day)

OR

2.2 Patients weighs greater than 15 kg and the requested dose does not exceed 3.3 grams/m^2/day (grams per square meter per day)

AND

3 - Submission of medical records (e.g., chart notes, assessments) confirming patient will be using Carbaglu (carglumic acid) as adjunctive therapy with standard ammonia lowering therapies

AND

4 - Prescribed by, or in consultation with, a metabolic geneticist or practitioner specialized in treating metabolic disorders

Product Name: Brand Carbaglu, generic carglumic acid	
Diagnosis	Chronic hyperammonemia due to N-acetylglutamate synthase (NAGS) deficiency
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

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 chronic hyperammonemia due to N-acetylglutamate synthase (NAGS) deficiency (submission of chart documentation required)

AND

2 - Dose requested does not exceed 100 mg/kg/day (milligrams per kilogram per day)

AND

3 - Prescribed by, or in consultation with, a metabolic geneticist or practitioner specialized in treating metabolic disorders

Product Name: Brand Carbaglu, generic carglumic acid	
Diagnosis	Chronic hyperammonemia due to N-acetylglutamate synthase (NAGS) deficiency
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

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 - History of the requested agent within the past 90 days, confirmed by claims history or chart documentation

AND

2 - Dose requested does not exceed 100 mg/kg/day (milligrams per kilogram per day)

Product Name: Brand Buphenyl, generic sodium phenylbutyrate	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SODIUM PHENYLBUTYRATE	SODIUM PHENYLBUTYRATE TAB 500 MG	30908060000320	Generic
BUPHENYL	SODIUM PHENYLBUTYRATE TAB 500 MG	30908060000320	Brand
SODIUM PHENYLBUTYRATE	SODIUM PHENYLBUTYRATE ORAL POWDER 3 GM/TEASPOONFUL	30908060002950	Generic
BUPHENYL	SODIUM PHENYLBUTYRATE ORAL POWDER 3 GM/TEASPOONFUL	30908060002950	Brand

Approval Criteria

1 - Diagnosis of chronic urea cycle disorder requiring management in patients with at least ONE of the following enzymatic deficiency(ies) (submission of chart documentation required):

- Argininosuccinic acid synthetase (AS)
- Carbamylphosphate synthetase (CPS)
- Ornithine transcarbamylase (OTC)

AND

2 - Submission of medical records (e.g., chart notes, assessments) confirming patient will be using Buphenyl (sodium phenylbutyrate) as adjunctive therapy with standard ammonia lowering therapies

AND

3 - Prescribed by, or in consultation with, a metabolic geneticist or practitioner specialized in treating metabolic disorders

AND

4 - Requested dose does not exceed 20 grams per day

AND

5 - ONE of the following:

5.1 The request is for powder for oral solution and does not exceed 2 bottles per 25 days

OR

5.2 The request is for tablets, and BOTH of the following:

- The patient is an adult or pediatric patient weighing greater than or equal to 20 kg (kilograms)
- The requested dose does not exceed 40 tablets per day

Product Name: Brand Buphenyl, generic sodium phenylbutyrate	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SODIUM PHENYLBUTYRATE	SODIUM PHENYLBUTYRATE TAB 500 MG	30908060000320	Generic
BUPHENYL	SODIUM PHENYLBUTYRATE TAB 500 MG	30908060000320	Brand
SODIUM PHENYLBUTYRATE	SODIUM PHENYLBUTYRATE ORAL POWDER 3 GM/TEASPOONFUL	30908060002950	Generic
BUPHENYL	SODIUM PHENYLBUTYRATE ORAL POWDER 3 GM/TEASPOONFUL	30908060002950	Brand

Approval Criteria

1 - History of the requested agent within the past 90 days, confirmed by claims history or chart documentation

AND

2 - Submission of medical records (e.g., chart notes, assessments) confirming patient has been using Buphenyl (sodium phenylbutyrate) as adjunctive therapy and will continue to use standard of care therapies while on Buphenyl therapy

AND

3 - Requested dose does not exceed 20 grams per day

AND

4 - ONE of the following:

4.1 The request is for powder for oral solution and does not exceed 2 bottles per 25 days

OR

4.2 The request is for tablets, and BOTH of the following:

- The patient is an adult or pediatric patient weighing greater than or equal to 20 kg (kilograms)
- The requested dose does not exceed 40 tablets per day

Product Name: Olpruva	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

OLPRUVA	SODIUM PHENYLBUTYRATE PACKET FOR SUSP 2 GM THERAPY PACK	3090806000B120	Brand
OLPRUVA	SODIUM PHENYLBUTYRATE PACKET FOR SUSP 3 GM THERAPY PACK	3090806000B130	Brand
OLPRUVA	SODIUM PHENYLBUTYRATE PACKET FOR SUSP 4 GM THERAPY PACK	3090806000B140	Brand
OLPRUVA	SODIUM PHENYLBUTYRATE PACKET FOR SUSP 5 GM THERAPY PACK	3090806000B150	Brand
OLPRUVA	SODIUM PHENYLBUTYRATE PACKET FOR SUSP 6 GM THERAPY PACK	3090806000B160	Brand
OLPRUVA	SODIUM PHENYLBUTYRATE PACKET FOR SUSP 6.67 GM THERAPY PACK	3090806000B170	Brand

Approval Criteria

1 - Diagnosis of chronic urea cycle disorder requiring management in patients with at least ONE of the following enzymatic deficiency(ies) (submission of chart documentation required):

- Argininosuccinic acid synthetase (AS)
- Carbamylphosphate synthetase (CPS)
- Ornithine transcarbamylase (OTC)

AND

2 - Patients weighs 20 kg (kilograms) or greater

AND

3 - Submission of medical records (e.g., chart notes, assessments) confirming patient will be using Olpruva (sodium phenylbutyrate) as adjunctive therapy with standard ammonia lowering therapies

AND

4 - Prescribed by, or in consultation with, a metabolic geneticist or practitioner specialized in treating metabolic disorders

AND

5 - ONE of the following:

5.1 Patient has tried and failed at least 30 days of Buphenyl (sodium phenylbutyrate) AND 30 days Pheburane (sodium phenylbutyrate) therapy, confirmed by claims history or chart documentation

OR

5.2 Prescriber has submitted valid medical justification for the use of Olpruva (sodium phenylbutyrate) over Buphenyl (sodium phenylbutyrate) AND Pheburane (sodium phenylbutyrate)

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

Product Name	Generic Name	GPI	Brand/Generic
OLPRUVA	SODIUM PHENYLBUTYRATE PACKET FOR SUSP 2 GM THERAPY PACK	3090806000B120	Brand
OLPRUVA	SODIUM PHENYLBUTYRATE PACKET FOR SUSP 3 GM THERAPY PACK	3090806000B130	Brand
OLPRUVA	SODIUM PHENYLBUTYRATE PACKET FOR SUSP 4 GM THERAPY PACK	3090806000B140	Brand
OLPRUVA	SODIUM PHENYLBUTYRATE PACKET FOR SUSP 5 GM THERAPY PACK	3090806000B150	Brand
OLPRUVA	SODIUM PHENYLBUTYRATE PACKET FOR SUSP 6 GM THERAPY PACK	3090806000B160	Brand
OLPRUVA	SODIUM PHENYLBUTYRATE PACKET FOR SUSP 6.67 GM THERAPY PACK	3090806000B170	Brand

Approval Criteria

1 - History of the requested agent within the past 90 days, confirmed by claims history or chart documentation

AND

2 - ONE of the following:

2.1 Patient has previous trial and failure of at least 30 days of Buphenyl (sodium phenylbutyrate) OR 30 days of Pheburane (sodium phenylbutyrate) therapy, confirmed by claims history or chart documentation

OR

2.2 Prescriber has submitted valid medical justification for the use of Olpruva (sodium phenylbutyrate) over Buphenyl (sodium phenylbutyrate) AND Pheburane (sodium phenylbutyrate)

AND

3 - Submission of medical records (e.g., chart notes, assessments) confirming patient has been using Olpruva (sodium phenylbutyrate) as adjunctive therapy and will continue to use standard of care therapies while on Olpruva therapy

Product Name: Pheburane	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PHEBURANE	SODIUM PHENYLBUTYRATE ORAL PELLETS 483 MG/GM	30908060008920	Brand

Approval Criteria

1 - Management of chronic urea cycle disorder in patients at least ONE of the following enzymatic deficiency(ies) (submission of chart documentation required):

- Argininosuccinic acid synthetase (AS)
- Carbamylphosphate synthetase (CPS)
- Ornithine transcarbamylase (OTC)

AND

2 - Submission of medical records (e.g., chart notes, assessments) confirming patient will be using Pheburane (sodium phenylbutyrate) as adjunctive therapy with standard ammonia lowering therapies

AND

3 - Prescribed by, or in consultation with, a metabolic geneticist or practitioner specialized in treating metabolic disorders

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

Product Name	Generic Name	GPI	Brand/Generic
PHEBURANE	SODIUM PHENYLBUTYRATE ORAL PELLETS 483 MG/GM	30908060008920	Brand

Approval Criteria

1 - History of the requested agent within the past 90 days, confirmed by claims history or chart documentation

AND

2 - Submission of medical records (e.g., chart notes, assessments) confirming patient has been using Pheburane (sodium phenylbutyrate) as adjunctive therapy and will continue to use standard of care therapies while on Pheburane therapy

Product Name: Ravicti	
Approval Length	6 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 chronic urea cycle disorder requiring management in patients who cannot be managed by dietary protein restriction and/or amino acid supplementation alone with at least ONE of the following enzymatic deficiency(ies) (submission of chart documentation required):

- Argininosuccinic acid synthetase (AS)
- Carbamylphosphate synthetase (CPS)
- Ornithine transcarbamylase (OTC)

AND

2 - Patient is 2 months of age or older

AND

3 - Prescriber attests patient is NOT being treated for N-acetylglutamate synthase (NAGS) deficiency

AND

4 - Submission of medical records (e.g., chart notes, assessments) confirming patient will be using Ravicti (glycerol phenylbutyrate) as adjunctive therapy with standard ammonia lowering therapies

AND

5 - Prescribed by, or in consultation with, a metabolic geneticist or practitioner specialized in treating metabolic disorders

AND

6 - ONE of the following:

6.1 Patient has tried and failed at least 30 days of sodium phenylbutyrate therapy (can cumulate Buphenyl, Pheburane, Olpruva), confirmed by claims history or chart documentation

OR

6.2 Prescriber has submitted valid medical justification for the use of Ravicti (glycerol phenylbutyrate) over all sodium phenylbutyrate products

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 - History of the requested agent within the past 90 days, confirmed by claims history or chart documentation

AND

2 - ONE of the following:

2.1 Patient has previous trial and failure of at least 30 days of sodium phenylbutyrate therapy (can cumulate Buphenyl, Pheburane, Olpruva), confirmed by claims history or chart documentation

OR

2.2 Prescriber has submitted valid medical justification for the use of Ravicti (glycerol phenylbutyrate) over all sodium phenylbutyrate products

AND

3 - Submission of medical records (e.g., chart notes, assessments) confirming patient has been using Ravicti (glycerol phenylbutyrate) as adjunctive therapy and will continue to use standard of care therapies while on Ravicti therapy

2 . Revision History

Date	Notes
6/26/2024	Criteria updated to require submission of notes confirming the use of standard ammonia lowering therapies

Urinary Tract Antispasmodic, Anti-incontinence agents

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-137642
Guideline Name	Urinary Tract Antispasmodic, Anti-incontinence agents
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Mybetriq 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 - Patient is 3 years of age or older AND less than 13 years of age

OR

2 - Patient is unable to swallow tablets

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 - Patient is 2 years of age or older AND less than 12 years of age

OR

2 - Patient is unable to swallow tablets

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

Product Name	Generic Name	GPI	Brand/Generic
GEMTESA	VIBEGRON TAB 75 MG	54200080000320	Brand

Approval Criteria

1 - Patient has tried and failed Myrbetriq

OR **2** - Patient has an intolerance or contraindication to Myrbetriq

2 . Revision History

Date	Notes
12/12/2023	Removed medical rational for use option from Myrbetriq and updated age. Updated Vesicare LS age.

Uterine Disorders

Prior Authorization Guideline

Guideline ID	GL-161798
Guideline Name	Uterine Disorders
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2025

1 . Criteria

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

Product Name	Generic Name	GPI	Brand/Generic
MYFEMBREE	RELUGOLIX-ESTRADIOL-NORETHINDRONE ACETATE TAB 40-1-0.5 MG	24993503800320	Brand

Approval Criteria

1 - Patient is 18 years of age or older

AND

2 - ONE of the following:

2.1 BOTH of the following:

2.1.1 Diagnosis of menorrhagia associated with uterine leiomyomas (fibroids) in a premenopausal female

AND

2.1.2 Previous trial and failure of hormonal contraceptives/therapy [oral tablets, vaginal ring, patch, intrauterine contraception (IUD)]

OR

2.2 BOTH of the following:

2.2.1 Diagnosis of moderate to severe pain associated with endometriosis in a premenopausal female

AND

2.2.2 One of the following:

2.2.2.1 Previous trial and failure of BOTH of the following:

- Hormonal contraceptives/therapy [oral tablets, vaginal ring, patch, intrauterine contraception (IUD)]
- NSAID (non-steroidal anti-inflammatory drug) therapy

OR

2.2.2.2 Prescriber has submitted valid medical rationale against the use of both hormonal contraceptives/therapy AND NSAID therapy

AND

3 - Must have a negative pregnancy test in the past 30 days

AND

4 - Must have laboratory tests confirming no hepatic disease in the past 30 days

AND

5 - Requested dose does not exceed 1 tablet (40/1/0.5mg) per day

AND

6 - Patient does NOT have current diagnosis of, risk factors for, or previous history of thromboembolic disorders or vascular events

AND

7 - Patient does NOT have a current diagnosis or history of breast cancer or other hormone-sensitive malignancies

AND

8 - Patient does NOT have increased risk factors for hormone-sensitive malignancies

AND

9 - Patient does NOT have a diagnosis of osteoporosis

AND

10 - Patient does NOT have undiagnosed abnormal uterine bleeding

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

Product Name	Generic Name	GPI	Brand/Generic
MYFEMBREE	RELUGOLIX-ESTRADIOL-NORETHINDRONE ACETATE TAB 40-1-0.5 MG	24993503800320	Brand

Approval Criteria

1 - Patient has a history of the requested medication for at least 90 days within the past 120 days, confirmed by claims history or chart documentation

AND

2 - Patient will not be exceeding 24 total months of therapy per lifetime with relugolix/estradiol/norethindrone acetate (Myfembree)

AND

3 - Prescriber states that the patient remains a candidate for treatment, indicating that they have NOT developed any of the contraindication(s) listed below:

- Current diagnosis of, risk factors for, or previous history of thromboembolic disorders or vascular events
- Current diagnosis or history of breast cancer or other hormone-sensitive malignancies
- Increased risk factors for hormone-sensitive malignancies
- Diagnosis of osteoporosis
- Undiagnosed abnormal uterine bleeding

Product Name: Oriahnn

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

Product Name	Generic Name	GPI	Brand/Generic
ORIAHNN	ELAGOLIX-ESTRAD-NORETH 300-1-0.5MG & ELAGOLIX 300MG CAP PACK	2499350340B220	Brand

Approval Criteria

1 - Patient is 18 years of age or older

AND

2 - Diagnosis of menorrhagia associated with uterine leiomyomas (fibroids) in a premenopausal female

AND

3 - Previous trial and failure of hormonal contraceptives/therapy [oral tablets, vaginal ring, patch, intrauterine contraception (IUD)]

AND

4 - Must have a negative pregnancy test in the past 30 days

AND

5 - Must have laboratory tests confirming no hepatic disease in the past 30 days

AND

6 - Requested dose does not exceed 2 capsules [1 x 300/1/0.5 mg (milligrams); 1 x 300 mg] per day

AND

7 - Patient will NOT have concurrent use of organic anion transporting polypeptide (OATP)1B1 inhibitors that are known or expected to significantly increase elagolix plasma concentrations (e.g., cyclosporine, gemfibrozil)

AND

8 - Patient does NOT have current diagnosis of, risk factors for, or previous history of thromboembolic disorders or vascular events

AND

9 - Patient does NOT have a current diagnosis or history of breast cancer or other hormone-sensitive malignancies

AND

10 - Patient does NOT have increased risk factors for hormone-sensitive malignancies

AND

11 - Patient does NOT have a diagnosis of osteoporosis

AND

12 - Patient does NOT have undiagnosed abnormal uterine bleeding

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

Product Name	Generic Name	GPI	Brand/Generic
ORIAHNN	ELAGOLIX-ESTRAD-NORETH 300-1-0.5MG & ELAGOLIX 300MG CAP PACK	2499350340B220	Brand

Approval Criteria

1 - Patient has a history of the requested medication for at least 90 days within the past 120 days, confirmed by claims history or chart documentation

AND

2 - Patient will not be exceeding 24 total months of therapy per lifetime with elagolix/estradiol/norethindrone acetate (Oriahnn)

AND

3 - Prescriber states that the patient remains a candidate for treatment, indicating that they have NOT developed any of the contraindication(s) listed below:

- Concurrent use of organic anion transporting polypeptide (OATP)1B1 inhibitors that are known or expected to significantly increase elagolix plasma concentrations (e.g., cyclosporine, gemfibrozil)
- Current diagnosis of, risk factors for, or previous history of thromboembolic disorders or vascular events
- Current diagnosis or history of breast cancer or other hormone-sensitive malignancies
- Increased risk factors for hormone-sensitive malignancies
- Diagnosis of osteoporosis
- Undiagnosed abnormal uterine bleeding

Product Name: Orilissa 150 mg	
Diagnosis	Endometriosis
Approval Length	Endometriosis alone: 12 month ; Endometriosis-related dyspareunia: 6 month approval maximum *
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ORILISSA	ELAGOLIX SODIUM TAB 150 MG (BASE EQUIV)	30090030100320	Brand

Approval Criteria

1 - Patient is 18 years of age or older

AND

2 - ONE of the following:

2.1 BOTH of the following:

2.1.1 Diagnosis of moderate to severe pain associated with endometriosis

AND

2.1.2 Requested dose does not exceed 150 mg (milligrams) daily

OR

2.2 BOTH of the following:

2.2.1 Diagnosis of moderate to severe pain associated with endometriosis with co-existing endometriosis-related dyspareunia

AND

2.2.2 Requested dose does not exceed 400 mg daily for a maximum of 6 months

AND

3 - ONE of the following:

3.1 Previous trial and failure of BOTH of the following:

- Hormonal contraceptives/therapy [oral tablets, vaginal ring, patch, intrauterine contraception (IUD)]
- NSAID (non-steroidal anti-inflammatory drug) therapy

OR

3.2 Prescriber has submitted valid medical justification for the use of Orilissa (elagolix) over both hormonal contraceptives/therapy AND NSAID therapy

AND

4 - Patient has a negative pregnancy test in the past 30 days

AND

5 - ONE of the following:

5.1 Laboratory tests confirming no hepatic disease worse than Child-Pugh A in the past 30 days

OR

5.2 Patient has Child-Pugh B hepatic disease, and adjusted dosing will be limited to 150 mg daily for a maximum of 6 months**

AND

6 - Patient will NOT have concurrent use of organic anion transporting polypeptide (OATP)1B1 inhibitors that are known or expected to significantly increase elagolix plasma concentrations (e.g., cyclosporine, gemfibrozil)

AND

7 - Patient does NOT have a diagnosis of osteoporosis

Notes	* Patients with Child-Pugh class B hepatic impairment will be limited t o the 150mg daily dose for a maximum of 6 months irrespective of indi cation.

Product Name: Orilissa 150 mg	
Diagnosis	Endometriosis
Approval Length	12 month(s)
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 - Patient has a history of the requested medication for at least 90 days within the past 120 days, confirmed by claims history or chart documentation

AND

2 - Patient will not be exceeding 24 total months of therapy per lifetime with elagolix (Orilissa)

AND

3 - Prescriber states that the patient remains a candidate for treatment, indicating that they do NOT have concurrent use of organic anion transporting polypeptide (OATP)1B1 inhibitors that are known or expected to significantly increase elagolix plasma concentrations (e.g., cyclosporine, gemfibrozil)

AND

4 - Patient does NOT have a diagnosis of osteoporosis

Product Name: Orilissa 200 mg

Diagnosis	Endometriosis with Co-existing Endometriosis-Related Dyspareunia
Approval Length	6 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ORILISSA	ELAGOLIX SODIUM TAB 200 MG (BASE EQUIV)	30090030100330	Brand

Approval Criteria

1 - Patient is 18 years of age or older

AND

2 - BOTH of the following:

2.1 Diagnosis of moderate to severe pain associated with endometriosis with co-existing endometriosis-related dyspareunia

AND

2.2 Requested dose does not exceed 400 mg (milligrams) daily for a maximum of 6 months

AND

3 - ONE of the following:

3.1 Previous trial and failure of BOTH of the following:

- Hormonal contraceptives/therapy [oral tablets, vaginal ring, patch, intrauterine contraception (IUD)]
- NSAID (non-steroidal anti-inflammatory drug) therapy

OR

3.2 Prescriber has submitted valid medical justification for the use of Orilissa (elagolix) over both hormonal contraceptives/therapy AND NSAID therapy

AND

4 - Patient has a negative pregnancy test in the past 30 days

AND

5 - Laboratory tests confirming no hepatic disease worse than Child-Pugh A in the past 30 days

AND

6 - Patient will NOT have concurrent use of organic anion transporting polypeptide (OATP)1B1 inhibitors that are known or expected to significantly increase elagolix plasma concentrations (e.g., cyclosporine, gemfibrozil)

AND

7 - Patient does NOT have a diagnosis of osteoporosis

2 . Revision History

Date	Notes
12/10/2024	Updated Myfembree criteria

Vafseo

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-161835
Guideline Name	Vafseo
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2025

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
12/10/2024	New program

Vaginal Antimicrobials

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-154729
Guideline Name	Vaginal Antimicrobials
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

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

Product Name	Generic Name	GPI	Brand/Generic
XACIATO	CLINDAMYCIN PHOSPHATE VAGINAL GEL 2%	55100018104020	Brand

Approval Criteria

1 - Previous trial and failure of a preferred topical antibacterial agent*

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

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

Product Name	Generic Name	GPI	Brand/Generic
TINIDAZOLE	TINIDAZOLE TAB 250 MG	16000053000310	Generic
TINIDAZOLE	TINIDAZOLE TAB 500 MG	16000053000320	Generic

Approval Criteria

1 - Patient has tried and failed metronidazole

OR

2 - Prescriber has provided medical justification as to why metronidazole is not appropriate for use (e.g., infection being treated is not susceptible to preferred agent)

2 . Revision History

Date	Notes
9/11/2024	New

Valchlor

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-97113
Guideline Name	Valchlor
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2022

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-161254
Guideline Name	Vanflyta
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2025

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

11/25/2024	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-82030
Guideline Name	Vecamyl
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2021

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

2 . Revision History

Date	Notes
3/5/2021	Bulk Load

Venclexta

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-150892
Guideline Name	Venclexta
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	8/2/2024

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
8/2/2024	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 (fezolinetant)

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-137497
Guideline Name	Veozah (fezolinetant)
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Veozah	
Approval Length	6 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 - Patient is 18 years of age or older

AND

3 - ONE of the following:

3.1 Patient has tried and failed at least 90 days of therapy with ONE hormonal agent (e.g., oral, injectable, topical, transdermal, or vaginal), confirmed by claims history or chart documentation

OR

3.2 BOTH of the following:

3.2.1 Patient has contraindication to hormonal therapy (submission of supporting chart documentation required)

AND

3.2.2 Patient has tried and failed at least 90 days of therapy with ONE non-hormonal agent (e.g., gabapentin, paroxetine, venlafaxine, oxybutynin), confirmed by claims history or chart documentation

OR

3.3 Prescriber has submitted valid medical justification for the use of Veozah (fezolinetant) over hormonal therapy AND other non-hormonal therapy

AND

4 - Prescriber attests to ALL of the following:

- Patient does not have cirrhosis
- Patient does not have severe renal impairment or end-stage renal disease (ESRD)

- Patient is not currently utilizing a CYP1A2 inhibitor and will not be initiated on CYP1A2 inhibitor therapy while on concomitant Veozah (fezolinetant) therapy

Product Name: Veozah	
Approval Length	6 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 - History of the requested agent for at least 90 days of the past 120 days, confirmed by claims history or chart documentation

AND

2 - ONE of the following:

2.1 Patient has previously tried and failed at least 90 days of therapy with ONE hormonal agent (e.g., oral, injectable, topical, transdermal, or vaginal), confirmed by claims history or chart documentation

OR

2.2 Patient has contraindication to hormonal therapy and has previously tried and failed at least 90 days of therapy with ONE non-hormonal agent (e.g., gabapentin, paroxetine, venlafaxine, oxybutynin), confirmed by claims history or chart documentation

OR

2.3 Prescriber has submitted valid medical justification for the use of Veozah (fezolinetant) over hormonal therapy AND other non-hormonal therapy

AND

3 - Prescriber attests to ALL of the following:

- Patient does not have cirrhosis
- Patient does not have severe renal impairment or end-stage renal disease (ESRD)
- Patient is currently not on a CYP1A2 inhibitor and will not be initiated on a CYP1A2 inhibitor while on concomitant Veozah (fezolinetant) therapy

2 . Revision History

Date	Notes
12/8/2023	New guideline

Verzenio

Prior Authorization Guideline

Guideline ID	GL-151751
Guideline Name	Verzenio
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	9/1/2024

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	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
8/14/2024	Updated background and added clinical criteria for endometrial carci noma per NCCN

Vijoice

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-152574
Guideline Name	Vijoice
Formulary	• Medicaid - Community & State Indiana

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 na me list and GPI table accordingly. Updated initial authorization criteri a. Updated initial authorization duration to 12 months.

Vitrakvi

Prior Authorization Guideline

Guideline ID	GL-121922
Guideline Name	Vitrakvi
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2023

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

Vizimpro

Prior Authorization Guideline

Guideline ID	GL-118477
Guideline Name	Vizimpro
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	2/1/2023

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

Votrient

Prior Authorization Guideline

Guideline ID	GL-138935
Guideline Name	Votrient
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	2/1/2024

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

2 . Revision History

Date	Notes
1/12/2024	Copy NY

Vowst

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-139287
Guideline Name	Vowst
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	3/1/2024

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

Voydeya

Prior Authorization Guideline

Guideline ID	GL-151749
Guideline Name	Voydeya
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	9/1/2024

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

2 . Revision History

Date	Notes
8/14/2024	New guideline

Vyndaqel and Vyndamax

Prior Authorization Guideline

Guideline ID	GL-121540
Guideline Name	Vyndaqel and Vyndamax
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	3/19/2023

1 . Criteria

Product Name: Vyndaqel, Vyndamax	
Approval Length	6 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 - Patient is 18 years of age or older

AND

2 - Diagnosis of cardiomyopathy secondary to transthyretin-mediated amyloidosis (ATTR-CM)

AND

3 - Diagnosis confirmed either histologically OR by genetic testing

AND

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

Product Name: Vyndaqel, Vyndamax	
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 - History of the requested medication in the past 90 days

2 . Revision History

Date	Notes

2/21/2023	Added prescriber check in initial authorization and updated approval l ength. Added reauthorization criteria.

Wainua

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146138
Guideline Name	Wainua
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2024

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)

2 . Revision History

Date	Notes
4/24/2024	New program.

Wegovy

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146956
Guideline Name	Wegovy
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2024

1 . Criteria

Product Name: Wegovy	
Approval Length	1 year(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 - Patient is 45 years of age or older

AND

2 - Diagnosis of cardiovascular disease (CVD) in an obese or overweight patient who needs risk reduction of major adverse cardiovascular events (MACE) and all of the following:

2.1 Submission of clinical documentation (e.g., chart notes) of patient having a BMI (body mass index) of greater than or equal to 27 kg/m2 (kilograms per square meter) within the past 3 months

AND

2.2 Submission of clinical documentation (e.g., chart notes) of patient having one of the following within the past year:

2.2.1 Prior myocardial infarction (MI)

OR

2.2.2 Prior stroke (ischemic or hemorrhagic)

OR

2.2.3 Symptomatic peripheral arterial disease (PAD) as evidenced by one of the following:

- Amputation due to atherosclerotic disease
- History of peripheral arterial revascularization procedure
- Intermittent claudication with ankle-brachial index (ABI) less than 0.85 (at rest)

AND

2.3 One of the following:

2.3.1 Submission of clinical documentation (e.g., chart notes) or confirmation by claims history that patient is optimized on guideline directed-therapy, including beta-blockers and/or renin-angiotensin system (RAS) inhibitors AND lipid-lowering agents

OR

2.3.2 Prescriber has provided medical justification as to why patient cannot use beta-blockers, RAS inhibitors, AND lipid-lowering therapies (please document dates of trial, if applicable)

AND

2.4 Prescriber attests to all of the following:

- Patient does not have Type 1 or Type 2 diabetes
- Patient will use Wegovy (semaglutide) in combination with reduced calorie diet and increased physical activity
- Patient will not use with other semaglutide products or with any other GLP-1 Receptor Agonists or combination products

AND

3 - Dose requested does not exceed 2.4 mg/week (milligrams per week)

Product Name: Wegovy	
Approval Length	1 year(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 - History of requested agent for at least 90 days within the past 120 days, as confirmed by claims history, chart documentation, or provider attestation including dates of trial

AND

2 - Diagnosis of cardiovascular disease (CVD) in an obese or overweight patient who needs risk reduction of major adverse cardiovascular events (MACE) and both of the following:

2.1 Prescriber attests to all of the following:

- Patient does not have Type 1 or Type 2 diabetes
- Patient will continue to use Wegovy (semaglutide) in combination with reduced calorie diet and increased physical activity
- Patient will not use with other semaglutide products or with any other GLP-1 RA or combination agents

AND

2.2 One of the following:

2.2.1 Submission of clinical documentation (e.g., chart notes) or confirmation by claims history that patient continues to utilize optimized on guideline directed-therapy, including beta-blockers and/or renin-angiotensin system (RAS) inhibitors AND lipid-lowering agents

OR

2.2.2 Prescriber has provided medical justification as to why patient cannot use beta-blockers, RAS inhibitors, AND lipid-lowering therapies (please document dates of trial, if applicable)

AND **3** - Dose requested does not exceed 2.4 mg/week (milligrams per week)

2 . Revision History

Date	Notes
5/1/2024	New guideline

Xalkori

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-147469
Guideline Name	Xalkori
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2024

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

2 . Revision History

Date	Notes
5/17/2024	Added criteria for melanoma. Added the sprinkle caps.

Xdemvy

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-147056
Guideline Name	Xdemvy
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2024

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

2 . Revision History

Date	Notes

5/2/2024	Updated criteria to include eyelash loss as an example of eyelash an omalies and added tearing/lacrimation, dryness, and purulence/disch arge to the list of symptoms of Demodex infestation.

Xenleta

Prior Authorization Guideline

Guideline ID	GL-121344
Guideline Name	Xenleta
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2023

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)

2 . Revision History

Date	Notes

2/15/2023	Updated trial/failure language. Moved approval duration from notes t o approval length box for Off-Label Uses.

Xermelo

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-151734
Guideline Name	Xermelo
Formulary	• Medicaid - Community & State Indiana

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

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-150103
Guideline Name	Xifaxan
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	8/1/2024

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
7/22/2024	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.

Xolremdi

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-156893
Guideline Name	Xolremdi
Formulary	• Medicaid - Community & State Indiana

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

Xospata

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-147515
Guideline Name	Xospata
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2024

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

2 . Revision History

Date	Notes
5/20/2024	Updated treatment criteria for AML to include additional NCCN recommendations.

Xpovio

Prior Authorization Guideline

Guideline ID	GL-147551
Guideline Name	Xpovio
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2024

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

2 . Revision History

Date	Notes
5/21/2024	Updated indicated formatting for consistency. Included coverage criteria for diffuse large B-cell lymphoma according to NCCN recommendations.

Xtandi

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-152524
Guideline Name	Xtandi
Formulary	• Medicaid - Community & State Indiana

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

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-82040
Guideline Name	Xuriden
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2021

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

2 . Revision History

Date	Notes
3/5/2021	Bulk Load

Yonsa

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146977
Guideline Name	Yonsa
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2024

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

2 . Revision History

Date	Notes
5/1/2024	Replaced GPI "21406010200310" with new GPI "21406010250310". No changes to criteria.

Zejula

Prior Authorization Guideline

Guideline ID	GL-127930
Guideline Name	Zejula
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	9/1/2023

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

2 . Revision History

Date	Notes
7/13/2023	Added new Zejula tablet formulation. Updated background to reflect t he changes in FDA indications. Updated clinical guidelines for Ovaria n cancer (treatment and maintenance).

Zelboraf

Prior Authorization Guideline

Guideline ID	GL-147404
Guideline Name	Zelboraf
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2024

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.

Zilbrysq

Prior Authorization Guideline

Guideline ID	GL-147575
Guideline Name	Zilbrysq
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2024

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 **1.2** Reduction in signs and symptoms of myasthenia gravis **AND** **1.3** Maintenance, reduction, or discontinuation of dose(s) of baseline immunosuppressive therapy (IST) prior to starting Zilbrysq* **AND** **2** - Patient is not receiving Zilbrysq in combination with another complement inhibitor (e.g., Soliris, Ultomiris) or a neonatal Fc receptor blocker (e.g., Rystiggo, Vyvgart,Vyvgart Hytrulo) **AND** **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

2 . Revision History

Date	Notes
5/21/2024	New guideline

Zolinza

Prior Authorization Guideline

Guideline ID	GL-96942
Guideline Name	Zolinza
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	1/1/2022

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

Zurzuvae

Prior Authorization Guideline

Guideline ID	GL-143437
Guideline Name	Zurzuvae
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	4/1/2024

1 . Criteria

Product Name: Zurzuvae	
Approval Length	14 Day(s)
Guideline Type	Prior Authorization

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 - Patient is 18 years of age or older

AND

3 - Patient is within 12 months (365 days) of being postpartum (Documentation of date of delivery required)

AND

4 - Patient is not exceeding one treatment course (14 days of therapy) per 365 days

AND

5 - Requested dose dose not exceed one of the following:

5.1 If the request is for 20 mg OR 25 mg capsules: 28 capsules for 14-day period (2 capsules per day)

OR

5.2 If the request is for 30 mg capsules, BOTH of the following:

5.2.1 Dose does not exceed 14 capsules for 14-day period (1 capsule per day)

AND

5.2.2 Submission of medical records (e.g., chart notes, laboratory tests/values, assessments) confirming one of the following:

- Severe hepatic impairment (Child-Pugh C)
- Moderate to severe renal impairment (eGFR less than 60 mL/min/1.73m2)

2 . Revision History

Date	Notes
2/22/2024	New

Zydelig

Prior Authorization Guideline

Guideline ID	GL-127469
Guideline Name	Zydelig
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	8/1/2023

1 . Criteria

Product Name: Zydelig	
Diagnosis	Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

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

2 . Revision History

Date	Notes
7/3/2023	Clarified criteria for CLL/SLL per NCCN guidelines. Updated Markets in Scope

Zykadia

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-147517
Guideline Name	Zykadia
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	6/1/2024

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

2 . Revision History

Date	Notes
5/20/2024	Added coverage criteria for inoperable inflammatory myofibroblastic tumor and anaplastic large cell lymphoma per NCCN. Corrected Erdheim-Chester Disease spelling.

Zytiga

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-151386
Guideline Name	Zytiga
Formulary	• Medicaid - Community & State Indiana

Guideline Note:

Effective Date:	9/1/2024

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	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

2 . Revision History

Date	Notes
8/13/2024	Added criteria for salivary gland tumor per NCCN