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ACE Inhibitors



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-144369
<b>Guideline Name</b>	ACE Inhibitors
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	4/1/2024
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## 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
<b>Approval Criteria</b>			
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



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-137509
<b>Guideline Name</b>	Acne Agents
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	1/1/2024
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## 1 . Criteria

Product Name: Brand Absorica, Amnesteem, Claravis, generic isotretinoin, Myorisan, Zenatane, Accutane, 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, Avita, 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, clindamycin/benzoyl peroxide, Acanya, Onexton, Benzamycin, erythromycin/benzoyl peroxide, Brand Aczone, generic dapson, 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

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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
ACUTANE	ISOTRETINOIN CAP 10 MG	90050013000110	Generic
ACUTANE	ISOTRETINOIN CAP 20 MG	90050013000120	Generic
ACUTANE	ISOTRETINOIN CAP 30 MG	90050013000130	Generic
ACUTANE	ISOTRETINOIN CAP 40 MG	90050013000140	Generic
ADAPALENE/BENZOYL PEROXIDE	ADAPALENE-BENZOYL PEROXIDE GEL 0.1-2.5%	90059902034020	Generic

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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

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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

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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
AVITA	TRETINOIN CREAM 0.025%	90050030003703	Brand
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

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TRETINOIN	TRETINOIN GEL 0.01%	90050030004005	Generic
AVITA	TRETINOIN GEL 0.025%	90050030004010	Brand
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

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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

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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



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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

**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: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>
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**Product Name: adapalene, generic adapalene, Brand Differin, Differin**

Approval Length	12 month(s)
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Guideline Type	Prior Authorization
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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: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>
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## 2 . Revision History

Date	Notes
12/11/2023	Updated GPI and product name lists, cleaned up criteria.

Actimmune



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-127783
<b>Guideline Name</b>	Actimmune
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	9/1/2023
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## 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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Patient has ONE of the following diagnoses:			
<ul style="list-style-type: none"> <li>• Mycosis fungoides (MF)</li> <li>• Sézary syndrome (SS)</li> </ul>			

Product Name: Actimmune
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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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-106361
<b>Guideline Name</b>	Aemcolo
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	7/1/2022
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### 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
<b>Approval Criteria</b>			
1 - Diagnosis of travelers' diarrhea			

**AND**

**2** - ONE of the following:

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

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

**OR**

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

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

Afinitor



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-127110
<b>Guideline Name</b>	Afinitor
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	8/1/2023
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## 1 . Criteria

Product Name: Brand Afinitor, generic everolimus, 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

**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

**OR**

**2 - BOTH** 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 distant metastatic disease
- Used as preoperative therapy of locoregional insulinoma with or without diazoxide

Product Name: Brand Afinitor, generic everolimus, 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

**Approval Criteria**

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

Product Name: Brand Afinitor, generic everolimus, 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

**Approval Criteria**

1 - Diagnosis of advanced renal cell cancer/kidney cancer

**AND**

2 - Disease is ONE of the following:

- Relapsed
- Stage IV disease

Product Name: Brand Afinitor, generic everolimus, 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

**Approval Criteria**

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

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

Diagnosis	Renal Angiomyolipoma with Tuberous Sclerosis Complex
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

**Approval Criteria**

1 - Diagnosis of renal angiomyolipoma and tuberous sclerosis complex (TSC), not requiring immediate surgery



Product Name: Brand Afinitor, generic everolimus, Brand Afinitor Disperz, generic everolimus TBSO	
Diagnosis	Renal Angiomyolipoma with Tuberous Sclerosis Complex
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

**Approval Criteria**

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

Product Name: Brand Afinitor, generic everolimus, Brand Afinitor Disperz, generic everolimus TBSO	
Diagnosis	Subependymal Giant Cell Astrocytoma Associated with Tuberous Sclerosis Complex

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

**Approval Criteria**

1 - Diagnosis of subependymal giant cell astrocytoma (SEGA) associated with tuberous sclerosis (TS)

**AND**

2 - Patient is not a candidate for curative surgical resection

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

Diagnosis	Subependymal Giant Cell Astrocytoma Associated with Tuberos Sclerosis Complex		
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
<b>Approval Criteria</b>			
1 - Patient does not show evidence of progressive disease while on Afinitor therapy			

Product Name: Brand Afinitor, generic everolimus, 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

**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

Product Name: Brand Afinitor, generic everolimus, 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
<b>Approval Criteria</b>			
1 - Patient does not show evidence of progressive disease while on Afinitor therapy			

Product Name: Brand Afinitor, generic everolimus, 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

**Approval Criteria**

1 - Diagnosis of breast cancer

**AND**

2 - One of the following:

2.1 Disease is recurrent

**OR**

2.2 Disease is metastatic

**AND**

**3** - One of the following:

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

**OR**

**3.2** BOTH of the following:

- Disease is hormone receptor negative (HR-)
- Disease has clinical characteristics that predict a HR+ tumor

**AND**

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

**AND**

**5** - One of the following:

**5.1** Patient is a postmenopausal woman

**OR**

**5.2** BOTH of the following:

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

**OR**

**5.3** Patient is male

**AND**

**6** - One of the following:

**6.1** Both of the following:

**6.1.1** Used in combination with exemestane (generic Aromasin)

**AND**

**6.1.2** One of the following:

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

**OR**

**6.1.2.2** Patient was treated with tamoxifen at any time, as confirmed by claims history or submission of medical records

**OR**

**6.2** Used in combination with ONE of the following:

- Fulvestrant
- Tamoxifen

Product Name: Brand Afinitor, generic everolimus, 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

**Approval Criteria**

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

Product Name: Brand Afinitor, generic everolimus, 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

**Approval Criteria**

1 - Diagnosis of classical Hodgkin lymphoma

**AND**

2 - Disease is refractory to at least 3 prior lines of therapy

Product Name: Brand Afinitor, generic everolimus, 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

**Approval Criteria**

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

Product Name: Brand Afinitor, generic everolimus, Brand Afinitor Disperz, generic everolimus TBSO			
Diagnosis	PEComa (perivascular epithelioid cell tumor), recurrent angiomyolipoma, lymphangioliomyomatosis, or 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

**Approval Criteria**

1 - Diagnosis of PEComa (perivascular epithelioid cell tumor)

**OR**

2 - Diagnosis of recurrent angiomyolipoma

**OR**

3 - Diagnosis of lymphangi leiomyomatosis

**OR**

4 - All of the following:

4.1 Diagnosis of Gastrointestinal Stromal Tumor (GIST)

**AND**

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

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

**AND**

**4.3** Used in combination with ONE of the following:

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

Product Name: Brand Afinitor, generic everolimus, Brand Afinitor Disperz, generic everolimus TBSO			
Diagnosis	PEComa (perivascular epithelioid cell tumor), recurrent angiomyolipoma, lymphangiomyomatosis, or 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

**Approval Criteria**

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

Product Name: Brand Afinitor, generic everolimus, 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

**Approval Criteria**

**1** - One of the following:

- Diagnosis of thymic carcinoma
- Diagnosis of thymoma

**AND**

**2** - ONE of the following:

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

**OR**

**2.2** Patient has extrathoracic metastatic disease

Product Name: Brand Afinitor, generic everolimus, 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

**Approval Criteria**

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

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

Diagnosis	Follicular carcinoma, Hürthle cell 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

**Approval Criteria**

1 - Diagnosis of ONE of the following:

- Follicular carcinoma
- Hürthle cell carcinoma
- Papillary carcinoma

**AND**

2 - ONE of the following:

- Unresectable locoregional recurrent disease
- Persistent disease
- Metastatic disease

**AND**

3 - ONE of the following:

- Patient has symptomatic disease
- Patient has progressive disease

**AND**

4 - Disease is refractory to radioactive iodine treatment

Product Name: Brand Afinitor, generic everolimus, Brand Afinitor Disperz, generic everolimus TBSO	
Diagnosis	Follicular carcinoma, Hürthle cell 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

**Approval Criteria**

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

Product Name: Brand Afinitor, generic everolimus, 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

**Approval Criteria**

1 - Diagnosis of meningioma

**AND**

2 - Disease is recurrent or progressive

**AND**

3 - Surgery and/or radiation is not possible

**AND**

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

Product Name: Brand Afinitor, generic everolimus, 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
<b>Approval Criteria</b>			
1 - Patient does not show evidence of progressive disease while on Afinitor therapy			

Product Name: Brand Afinitor, generic everolimus, 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

**Approval Criteria**

**1** - Diagnosis of endometrial carcinoma

**AND**

**2** - Used in combination with letrozole

Product Name: Brand Afinitor, generic everolimus, 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

**Approval Criteria**

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

Product Name: Brand Afinitor, generic everolimus, 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

**Approval Criteria**

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

**AND**

2 - Used as adjunctive therapy

Product Name: Brand Afinitor, generic everolimus, 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

**Approval Criteria**

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

Product Name: Brand Afinitor, generic everolimus, 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

**Approval Criteria**

1 - Diagnosis of osteosarcoma

**AND**

2 - Disease is ONE of the following:

- Relapsed
- Refractory
- Metastatic

**AND**

3 - Used in combination with Nexavar (sorafenib)

**AND**

4 - Not used as first-line therapy

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

Diagnosis	Osteosarcoma
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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
<b>Approval Criteria</b>			
1 - Patient does not show evidence of progressive disease while on Afinitor therapy			

Product Name: Brand Afinitor, generic everolimus, 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

**Approval Criteria**

1 - Diagnosis of ONE of the following

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

Product Name: Brand Afinitor, generic everolimus, 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

**Approval Criteria**

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

Product Name: Brand Afinitor, generic everolimus, 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

**Approval Criteria**

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

Product Name: Brand Afinitor, generic everolimus, 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

**Approval Criteria**

1 - Documentation of positive clinical response to Afinitor therapy

**2 . Revision History**

Date	Notes
6/26/2023	Copy NY

Agents for the Treatment of Opioid Use Disorder



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-137578
<b>Guideline Name</b>	Agents for the Treatment of Opioid Use Disorder
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	1/1/2024
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## 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

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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
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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)

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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: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>
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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** - Dose requested does not exceed the following:

**3.1** Weekly dose does not exceed ONE of the following:

- 8 mg/week (1 injection/6 days)
- 16 mg/week (1 injection/6 days)
- 24 mg/week (1 injection/6 days)
- 32 mg/week (1 injection/6 days)

**OR**

**3.2** Monthly dose does not exceed ONE of the following:

- 64 mg/month (1 injection/28 days)
- 96 mg/month (1 injection/28 days)
- 128 mg/month (1 injection/28 days)

**AND**

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

Notes	*PDL link: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>
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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 Dose requested does not exceed the following:

- 8 mg/week (1 injection/6 days)
- 16 mg/week (1 injection/6 days)
- 24 mg/week (1 injection/6 days)
- 32 mg/week (1 injection/6 days)

**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 Dose requested does not exceed the following:

- 64 mg/month (1 injection/28 days)
- 96 mg/month (1 injection/28 days)
- 128 mg/month (1 injection/28 days)

**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**



<b>4 - The patient is not using other injectable products (e.g., Brixadi) for opioid use disorder concurrently</b>	
Notes	*PDL link: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>

<b>Product Name: Sublocade</b>			
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**

UnitedHealthcare Community Plan of Indiana – Clinical Pharmacy Guidelines

Date	Notes
12/11/2023	Added criteria sections for Brixadi and Sublocade.

Akeega



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-138128
<b>Guideline Name</b>	Akeega
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	2/1/2024
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## 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
<b>Approval Criteria</b>			

**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
<b>Approval Criteria</b>			
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

<b>Guideline ID</b>	GL-134128
<b>Guideline Name</b>	Alecensa
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	11/1/2023
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### 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
<b>Approval Criteria</b>			
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: 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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to Alecensa therapy			

## 2 . Revision History

Date	Notes
10/2/2023	Added criteria for B-Cell lymphoma, CNS cancer and IMT tumors per NCCN guidelines.

Alfa Interferons



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-136313
<b>Guideline Name</b>	Alfa Interferons
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	1/1/2024
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## 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
<b>Approval Criteria</b>			

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
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Approval Length	48 Week(s)
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Guideline Type	Prior Authorization
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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
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Approval Length	12 month(s)
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Guideline Type	Prior Authorization
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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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to Intron A therapy			

## 2 . Revision History

Date	Notes
11/14/2023	Removed Pegasys.



Allergy-Specific Immunotherapy



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-121687
<b>Guideline Name</b>	Allergy-Specific Immunotherapy
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

**Guideline Note:**

Effective Date:	4/1/2023
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### 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
<b>Approval Criteria</b>			
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 EACH 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 EACH 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: 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 EACH 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 4 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 EACH 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
2/24/2023	Updated Odactra age criteria, cleaned up all criteria.

Alunbrig



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-134508
<b>Guideline Name</b>	Alunbrig
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	12/1/2023
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## 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
<b>Approval Criteria</b>			
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
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of metastatic brain cancer from NSCLC</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Tumor is anaplastic lymphoma kinase (ALK)-positive</p>			

Product Name: Alunbrig			
Diagnosis	Non-Small Cell Lung Cancer (NSCLC), Soft Tissue Sarcoma/Uterine Neoplasms, Histiocytic Neoplasms, Central Nervous System (CNS) Cancers		
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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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

Angiotensin Receptor Blocker Combinations



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-124995
<b>Guideline Name</b>	Angiotensin Receptor Blocker Combinations
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

**Guideline Note:**

Effective Date:	7/1/2023
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### 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

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TELMISARTAN/AMLODIPINE	TELMISARTAN-AMLODIPINE TAB 80-10 MG	3699300270035 0	Generic
AMLODIPINE BESYLATE/VALSARTAN	AMLODIPINE BESYLATE-VALSARTAN TAB 5-160 MG	3699300210031 0	Generic
EXFORGE	AMLODIPINE BESYLATE-VALSARTAN TAB 5-160 MG	3699300210031 0	Brand
AMLODIPINE BESYLATE/VALSARTAN	AMLODIPINE BESYLATE-VALSARTAN TAB 5-320 MG	3699300210032 0	Generic
EXFORGE	AMLODIPINE BESYLATE-VALSARTAN TAB 5-320 MG	3699300210032 0	Brand
AMLODIPINE BESYLATE/VALSARTAN	AMLODIPINE BESYLATE-VALSARTAN TAB 10-160 MG	3699300210033 0	Generic
EXFORGE	AMLODIPINE BESYLATE-VALSARTAN TAB 10-160 MG	3699300210033 0	Brand
AMLODIPINE BESYLATE/VALSARTAN	AMLODIPINE BESYLATE-VALSARTAN TAB 10-320 MG	3699300210034 0	Generic
EXFORGE	AMLODIPINE BESYLATE-VALSARTAN TAB 10-320 MG	3699300210034 0	Brand
EXFORGE HCT	AMLODIPINE-VALSARTAN-HYDROCHLOROTHIAZIDE TAB 5-160-12.5 MG	3699450320032 0	Brand
AMLODIPINE/VALSARTAN/HYDROCHLOROTHIAZIDE	AMLODIPINE-VALSARTAN-HYDROCHLOROTHIAZIDE TAB 5-160-12.5 MG	3699450320032 0	Generic
EXFORGE HCT	AMLODIPINE-VALSARTAN-HYDROCHLOROTHIAZIDE TAB 5-160-25 MG	3699450320032 5	Brand
AMLODIPINE/VALSARTAN/HYDROCHLOROTHIAZIDE	AMLODIPINE-VALSARTAN-HYDROCHLOROTHIAZIDE TAB 5-160-25 MG	3699450320032 5	Generic

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EXFORGE HCT	AMLODIPINE- VALSARTAN- HYDROCHLOROTHIAZ IDE TAB 10-160-12.5 MG	3699450320033 0	Brand
AMLODIPINE/VALSARTAN/HYDROCHLOROTHIAZIDE	AMLODIPINE- VALSARTAN- HYDROCHLOROTHIAZ IDE TAB 10-160-12.5 MG	3699450320033 0	Generic
EXFORGE HCT	AMLODIPINE- VALSARTAN- HYDROCHLOROTHIAZ IDE TAB 10-160-25 MG	3699450320033 5	Brand
AMLODIPINE/VALSARTAN/HYDROCHLOROTHIAZIDE	AMLODIPINE- VALSARTAN- HYDROCHLOROTHIAZ IDE TAB 10-160-25 MG	3699450320033 5	Generic
EXFORGE HCT	AMLODIPINE- VALSARTAN- HYDROCHLOROTHIAZ IDE TAB 10-320-25 MG	3699450320034 0	Brand
AMLODIPINE/VALSARTAN/HYDROCHLOROTHIAZIDE	AMLODIPINE- VALSARTAN- HYDROCHLOROTHIAZ IDE TAB 10-320-25 MG	3699450320034 0	Generic
TRIBENZOR	OLMESARTAN- AMLODIPINE- HYDROCHLOROTHIAZ IDE TAB 20-5-12.5 MG	3699450345031 0	Brand
OLMESARTAN MEDOXOMIL/AMLODIPINE/HYDROCHLOROTHIAZIDE	OLMESARTAN- AMLODIPINE- HYDROCHLOROTHIAZ IDE TAB 20-5-12.5 MG	3699450345031 0	Generic
TRIBENZOR	OLMESARTAN- AMLODIPINE- HYDROCHLOROTHIAZ IDE TAB 40-5-12.5 MG	3699450345032 0	Brand
OLMESARTAN MEDOXOMIL/AMLODIPINE/HYDROCHLOROTHIAZIDE	OLMESARTAN- AMLODIPINE- HYDROCHLOROTHIAZ IDE TAB 40-5-12.5 MG	3699450345032 0	Generic
TRIBENZOR	OLMESARTAN- AMLODIPINE- HYDROCHLOROTHIAZ IDE TAB 40-5-25 MG	3699450345033 0	Brand
OLMESARTAN MEDOXOMIL/AMLODIPINE/HYDROCHLOROTHIAZIDE	OLMESARTAN- AMLODIPINE- HYDROCHLOROTHIAZ IDE TAB 40-5-25 MG	3699450345033 0	Generic
TRIBENZOR	OLMESARTAN- AMLODIPINE-	3699450345034 0	Brand

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	HYDROCHLOROTHIAZIDE TAB 40-10-12.5 MG		
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-OLMESARTAN	36993002050340	Generic

	MEDOXOMIL TAB 10-40 MG		
<p><b>Approval Criteria</b></p> <p>1 - Trial and failure of the individual components</p>			

## 2 . Revision History

Date	Notes
4/25/2023	New

Angiotensin Receptor Blockers (ARBs)



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-144397
<b>Guideline Name</b>	Angiotensin Receptor Blockers (ARBs)
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	4/1/2024
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### 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
<b>Approval Criteria</b>			
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	New guideline



Antiemetic, Antivertigo Agents



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-124875
<b>Guideline Name</b>	Antiemetic, Antivertigo Agents
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	7/1/2023
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### 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
<b>Approval Criteria</b>			
1 - Documentation indicating oral medications are unsuitable for patient use			

Product Name: Emend suspension
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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
<p><b>Approval Criteria</b></p> <p>1 - Patient has tried Emend oral capsules</p> <p style="text-align: center;"><b>OR</b></p> <p>2 - Patient is unable to swallow or tolerate the capsule formulation</p>			

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
<p><b>Approval Criteria</b></p> <p>1 - Patient has tried and failed combination therapy with preferred* agents of the same classes</p> <p style="text-align: center;"><b>OR</b></p> <p>2 - Medical justification for use</p>			
Notes	* PDL Link: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>		

## 2 . Revision History

Date	Notes
4/20/2023	New

Antihistamine-Decongestant Combinations - 2nd Generation Antihistamines



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-125088
<b>Guideline Name</b>	Antihistamine-Decongestant Combinations - 2nd Generation Antihistamines
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

**Guideline Note:**

Effective Date:	7/1/2023
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### 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
<b>Approval Criteria</b>			
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



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-132649
<b>Guideline Name</b>	Antimicrobials for Treatment of Vaginal Infections
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

**Guideline Note:**

Effective Date:	10/1/2023
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### 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
<p><b>Approval Criteria</b></p> <p>1 - One of the following:</p> <p>1.1 Diagnosis of acute vulvovaginal candidiasis and the request does not exceed 4 tablets per treatment course</p>			

**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
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of recurrent vulvovaginal candidiasis (defined as 3 or more episodes of vulvovaginal candidiasis within a year)</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Patient is 18 years of age or older</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - Provider attests patient is not considered to be of reproductive potential</p> <p style="text-align: center;"><b>AND</b></p> <p>4 - ONE of the following:</p> <p style="padding-left: 20px;">4.1 Patient has tried and failed oral fluconazole within the past year</p> <p style="text-align: center;"><b>OR</b></p> <p style="padding-left: 20px;">4.2 Provider has submitted medical rationale supporting the use of Vivjoa over oral fluconazole</p> <p style="text-align: center;"><b>AND</b></p> <p>5 - Request does not exceed 18 tablets per treatment course</p>			



## 2 . Revision History

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

Antimigraine Agents



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-132607
<b>Guideline Name</b>	Antimigraine Agents
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

**Guideline Note:**

Effective Date:	10/1/2023
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### 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
<b>Approval Criteria</b>			

**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 Greater than or equal to 60 days of therapy with ONE of the following:**

- Ajovy (fremanezumab-vfrm)
- Emgality (galcanezumab-gnlm)

**OR**

**3.2 Both of the following:**

**3.2.1 Medical justification for use over Ajovy (fremanezumab-vfrm) and Emgality (galcanezumab-gnlm)**

**AND**

**3.2.2 Previous trial and failure of an agent listed within TWO 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)

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
<p><b>Approval Criteria</b></p> <p>1 - History of Aimovig for at least 90 days within the past 120 days, confirmed by claims history or chart documentation</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - ONE of the following:</p> <ul style="list-style-type: none"> <li>• Prior history of at least ONE preferred* injectable prophylaxis agent</li> <li>• Medical justification for use over ALL preferred* injectable prophylaxis agents</li> </ul>			
Notes	*PDL link: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>		

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
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of migraine with or without aura requiring prophylaxis</p>			

**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 TWO 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
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**Approval Criteria**

1 - History of Ajoyv 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 TWO 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
<p><b>Approval Criteria</b></p> <p>1 - History of Emgality for at least 90 days within the past 120 days, confirmed by claims history or chart documentation</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - ONE of the following:</p> <ul style="list-style-type: none"> <li>• Dose requested does not exceed 120mg per month for diagnosis of migraine with or without aura</li> <li>• Dose requested does not exceed 300mg per month for diagnosis of episodic cluster headache</li> </ul>			

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:**

- Greater than or equal to 60 days of therapy with each of the preferred\* injectable prophylaxis agents
- 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: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>
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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	ATOGEANT TAB 10 MG	67701010000310	Brand
QULIPTA	ATOGEANT TAB 30 MG	67701010000320	Brand
QULIPTA	ATOGEANT 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:

- Greater than or equal to 60 days of therapy with each of the preferred\* injectable prophylaxis agents
- Medical justification for use over preferred\* injectable prophylaxis agents

**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:

- Greater than or equal to 60 days of therapy with each of the preferred\* injectable prophylaxis agents
- Medical justification for use over preferred\* injectable prophylaxis agents

Notes	*IN PDL Link: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>
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Product Name: Qulipta	
Approval Length	1 year(s)

Therapy Stage	Reauthorization		
Guideline Type	Prior Authorization		
Product Name	Generic Name	GPI	Brand/Generic
QULIPTA	ATOGEPA <span style="text-decoration: underline;">NT</span> TAB 10 MG	67701010000310	Brand
QULIPTA	ATOGEPA <span style="text-decoration: underline;">NT</span> TAB 30 MG	67701010000320	Brand
QULIPTA	ATOGEPA <span style="text-decoration: underline;">NT</span> TAB 60 MG	67701010000330	Brand
<p><b>Approval Criteria</b></p> <p>1 - History of Qulipta for at least 90 days within the past 120 days, confirmed by claims history or chart documentation</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - ONE of the following:</p> <ul style="list-style-type: none"> <li>• Prior history of at least one preferred* injectable prophylaxis agent</li> <li>• Medical justification for use over preferred* injectable prophylaxis agents</li> </ul>			
Notes	*IN PDL Link: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>		

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
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of migraine with or without aura requiring acute treatment</p>			

**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: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>
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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: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>
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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
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of migraine with or without aura requiring acute treatment</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Patient is 18 years of age or older</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - ONE of the following:</p> <ul style="list-style-type: none"> <li>• Previous trial and failure of one triptan agent</li> <li>• Medical justification for use over triptan agents</li> </ul>			

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
<p><b>Approval Criteria</b></p>			



1 - History of Ubrely 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
<b>Approval Criteria</b>			
1 - Diagnosis of migraine with or without aura requiring acute treatment			
<b>AND</b>			
2 - Patient is 18 years of age or older			
<b>AND</b>			
3 - ONE of the following:			
<ul style="list-style-type: none"> <li>• Previous trial and failure of one triptan agent</li> </ul>			

- 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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Diagnosis of migraine with or without aura requiring acute treatment			
<b>AND</b>			
2 - Patient is 18 years of age or older			

<b>AND</b>	
<p><b>3 - ONE of the following:</b></p> <ul style="list-style-type: none"> <li>• Previous trial and failure of ALL preferred* acute migraine treatments</li> <li>• Medical justification for use over ALL preferred* acute migraine treatments</li> </ul>	
Notes	*IN PDL Link: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>

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
<p><b>Approval Criteria</b></p> <p><b>1 - History of Zavzpret within the past 90 days, confirmed by claims history or chart documentation</b></p> <p style="text-align: center;"><b>AND</b></p> <p><b>2 - One of the following:</b></p> <ul style="list-style-type: none"> <li>• Prior history of ALL preferred* acute migraine treatments</li> <li>• Medical justification for use over ALL preferred* acute migraine treatments</li> </ul>			
Notes	*IN PDL Link: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>		

## 2 . Revision History

Date	Notes
9/6/2023	Updated T/F language on Aimovig, Ajoyv and Emgality to read "an two agents within the following categories." Added Elyxyb and Zavzpret and drug specific criteria, added diagnosis of migraine with or w/o aura to Qulipta criteria

Antiseizure Agents



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-126580
<b>Guideline Name</b>	Antiseizure Agents
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

**Guideline Note:**

Effective Date:	7/1/2023
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### 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, 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, generic vigabatrin, generic vigadrone, 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

UnitedHealthcare Community Plan of Indiana – Clinical Pharmacy Guidelines

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

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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

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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



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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

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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
SABRIL	VIGABATRIN POWD PACK 500 MG	72170085003020	Brand
VIGADRONE	VIGABATRIN POWD PACK 500 MG	72170085003020	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

**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: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>
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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, 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, generic vigabatrin, generic vigadrone, Brand Zonegran, Brand Spritam, generic pregabalin	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

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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

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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

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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

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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

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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
SABRIL	VIGABATRIN POWD PACK 500 MG	72170085003020	Brand
VIGADRONE	VIGABATRIN POWD PACK 500 MG	72170085003020	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



**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.)

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
<p><b>Approval Criteria</b></p> <p>1 - ONE of the following:</p> <p>1.1 Patient is less than 18 years of age</p> <p style="text-align: center;"><b>OR</b></p> <p>1.2 BOTH of the following:</p> <p>1.2.1 Patient is 18 years of age or older</p> <p style="text-align: center;"><b>AND</b></p> <p>1.2.2 Rationale justifying use over other oral formulations (e.g., capsule, sprinkle capsules, tablets, etc.)</p>			

Product Name: Fintepla
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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-Gestaut 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
<p><b>Approval Criteria</b></p> <p>1 - Patient is less than 18 years of age</p> <p style="text-align: center;"><b>OR</b></p> <p>2 - BOTH of the following:</p> <p style="padding-left: 20px;"><b>2.1</b> Patient is 18 years of age or older</p> <p style="text-align: center;"><b>AND</b></p> <p style="padding-left: 20px;"><b>2.2</b> Rationale justifying use over other oral formulations (e.g., capsule)</p>			

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
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of seizure disorder associated with cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - ONE of the following:</p> <p>    <b>2.1</b> Trial and failure of at least 2 other medications (e.g., clobazam, levetiracetam, valproic acid, vigabatrin)</p> <p style="text-align: center;"><b>OR</b></p> <p>    <b>2.2</b> Medical justification for use of Ztalmy</p>			

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
<p><b>Approval Criteria</b></p>			

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
<b>Approval Criteria</b>			
1 - History of the requested medication for 30 of the past 60 days confirmed by claims history or chart documentation			
<b>AND</b>			
2 - ONE of the following:			
2.1 Patient is less than 18 years of age			
<b>OR</b>			
2.2 BOTH of the following:			
2.2.1 Patient is 18 years of age or older			
<b>AND</b>			
2.2.2 Rationale justifying use over other oral formulations (e.g., capsule, sprinkle capsules, tablets, etc.)			

## 2 . Revision History

Date	Notes
6/12/2023	Removed the word submitted before "rational justification"



Antiulcer Agents



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-137617
<b>Guideline Name</b>	Antiulcer Agents
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	1/1/2024
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## 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
<p><b>Approval Criteria</b></p> <p>1 - BOTH of the following:</p> <p>1.1 Patient is 1 year of age or older</p>			

<b>AND</b>
<b>1.2</b> Patient is less than 12 years of age
<b>OR</b>
<b>2</b> - Patient is unable to swallow tablets

## 2 . Revision History

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

Antiviral Monoclonal Antibodies



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-133715
<b>Guideline Name</b>	Antiviral Monoclonal Antibodies
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

**Guideline Note:**

Effective Date:	11/1/2023
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### 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
<p><b>Approval Criteria</b></p> <p>1 - One of the following:</p> <p>1.1 Patient was born before 29 weeks, 0 days' gestation</p>			

**OR**

**1.2 BOTH of the following:**

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

**OR**

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

**OR**

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

**OR**

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

**OR**

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

**OR**

**1.7 BOTH of the following:**

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

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

**OR**

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

**AND**

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

**AND**

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

**AND**

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

**AND**

**5** - Administered during RSV season\*\*\*

**AND**

**6** - The patient is not hospitalized for RSV disease

Notes

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

\*\*For the 2023-2024 RSV season, lack of Beyfortus availability from the manufacturer will be considered a medically justifiable reason for use.

\*\*\* Information regarding RSV season may be found at: • Centers for

	Disease and Prevention (CDC) surveillance reports ( <a href="http://www.cdc.gov/surveillance/nrevss/rsv/index.html">http://www.cdc.gov/surveillance/nrevss/rsv/index.html</a> ) • <a href="http://uhc-cs-10.uhc.com/sites/cspm/CSSP/Pages/Synagis.aspx">http://uhc-cs-10.uhc.com/sites/cspm/CSSP/Pages/Synagis.aspx</a>
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**Product Name: Synagis\***

Diagnosis	Patients less than 24 months of age at start of RSV season***
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Guideline Type	Prior Authorization
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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	<p>*Approval duration will be up to a maximum of 5 doses or through the end of the defined RSV season, whichever comes first.</p> <p>** For the 2023-2024 RSV season, lack of Beyfortus availability from the manufacturer will be considered a medically justifiable reason for use.</p> <p>*** Information regarding RSV season may be found at: • Centers for Disease and Prevention (CDC) surveillance reports (<a href="http://www.cdc.gov/surveillance/nrevss/rsv/index.html">http://www.cdc.gov/surveillance/nrevss/rsv/index.html</a>) • <a href="http://uhc-cs-10.uhc.com/sites/cspm/CSSP/Pages/Synagis.aspx">http://uhc-cs-10.uhc.com/sites/cspm/CSSP/Pages/Synagis.aspx</a></p>
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## 2 . Revision History

Date	Notes
9/27/2023	Renamed from previous Synagis. Added criteria for Beyfortus and updated all criteria to match policy

Antivirals - Anti-herpetic



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-125105
<b>Guideline Name</b>	Antivirals - Anti-herpetic
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	7/1/2023
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## 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
<b>Approval Criteria</b>			
1 - Patient has a diagnosis of HIV			



<b>OR</b>
<b>2</b> - Patient has tried and failed acyclovir
<b>OR</b>
<b>3</b> - Medical justification for use

## 2 . Revision History

Date	Notes
4/27/2023	New

Antivirals, Influenza



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-125099
<b>Guideline Name</b>	Antivirals, Influenza
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	7/1/2023
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## 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
<p><b>Approval Criteria</b></p> <p>1 - One of the following:</p> <p>1.1 Patient is under 60 years of age and one of the following*:</p> <p>1.1.1 History of failure to at least THREE preferred alternatives as confirmed by claims</p>			

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	<p>*This criteria comes from the Non-Preferred Drugs Policy.                  **PDL link: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a></p>
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## 2 . Revision History

Date	Notes
4/27/2023	New guideline

Apokyn



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-127856
<b>Guideline Name</b>	Apokyn
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	9/1/2023
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## 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	A POMORPHINE HCL SOLN CARTRIDGE 30 MG/3ML	7320301010E220	Brand
A POMORPHINE HYDROCHLORIDE	A POMORPHINE HCL SOLN CARTRIDGE 30 MG/3ML	7320301010E220	Generic
<b>Approval Criteria</b>			
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	A POMORPHINE HCL SOLN CARTRIDGE 30 MG/3ML	7320301010E220	Brand
A POMORPHINE HYDROCHLORIDE	A POMORPHINE HCL SOLN CARTRIDGE 30 MG/3ML	7320301010E220	Generic
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to the requested therapy			
<b>AND</b>			
2 - Patient will continue to receive treatment with a carbidopa/levodopa-containing medication			

Arikayce



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-123310
<b>Guideline Name</b>	Arikayce
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	5/1/2023
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## 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
<b>Approval Criteria</b>			
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

Ayvakit



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-129002
<b>Guideline Name</b>	Ayvakit
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	10/1/2023
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## 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-PDGFR $\alpha$  (platelet-derived growth factor receptor alpha) rearrangement

**AND**

3 - Presence of a PDGFR $\alpha$  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 50 x 10<sup>9</sup>/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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to Ayvakit therapy			

Balversa



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-81911
<b>Guideline Name</b>	Balversa
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	4/1/2021
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## 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 - Patient has fibroblast growth factor receptor (FGFR) 3 or FGFR2 genetic alterations

**AND**

4 - Patient has progressed during or following at least one line of prior chemotherapy or immunotherapy, or within 12 months of neoadjuvant or adjuvant platinum-containing chemotherapy

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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to Balversa therapy			

## 2 . Revision History

Date	Notes
3/5/2021	Bulk Load

Benefit Determination Mifeprex



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-123261
<b>Guideline Name</b>	Benefit Determination Mifeprex
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Florida MMA</li> <li>• Medicaid - Community &amp; State Indiana</li> <li>• Medicaid - Community &amp; State Kansas</li> <li>• Medicaid - Community &amp; State Louisiana</li> <li>• Medicaid - Community &amp; State Michigan</li> <li>• Medicaid - Community &amp; State Mississippi</li> <li>• Medicaid - Community &amp; State Pennsylvania</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP</li> <li>• Medicaid - Community &amp; State Rhode Island</li> <li>• Medicaid - Community &amp; State Texas</li> <li>• Medicaid - Community &amp; State Virginia</li> <li>• Medicaid - Community &amp; State Arizona</li> <li>• Medicaid - Community &amp; State Nebraska</li> </ul>

**Guideline Note:**

Effective Date:	3/19/2023
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**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

<b>Guideline ID</b>	GL-128544
<b>Guideline Name</b>	Benlysta
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	10/1/2023
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## 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
<b>Approval Criteria</b>			

**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
<b>Approval Criteria</b>			

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
<b>Approval Criteria</b>			



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 presence of antibodies. Updated not used in combination from biologic DMARD to targeted immunomodulator without change in clinical intent.

Berinert



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-106394
<b>Guideline Name</b>	Berinert
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	7/1/2022
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## 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
<b>Approval Criteria</b>			
1 - Diagnosis of hereditary angioedema (HAE) confirmed by ONE of the following:			

**1.1** C1 inhibitor (C1-INH) deficiency or dysfunction (Type I or II HAE) as documented by ONE of the following (per laboratory standard):

- C1-INH antigenic level below the lower limit of normal
- C1-INH functional level below the lower limit of normal

**OR**

**1.2** HAE with normal C1 inhibitor levels and ONE of the following:

- Confirmed presence of a FXII, angiotensin-1, plasminogen gene mutation, or kininogen mutation
- Recurring angioedema attacks that are refractory to high-dose antihistamines with confirmed family history of angioedema

**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 specify 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)
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Therapy Stage	Reauthorization
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Guideline Type	Prior Authorization
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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

**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

Beta Adrenergic and Anticholinergic Combinations



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-132758
<b>Guideline Name</b>	Beta Adrenergic and Anticholinergic Combinations
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

**Guideline Note:**

Effective Date:	10/1/2023
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### 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
<b>Approval Criteria</b>			
1 - Diagnosis of asthma			

Product Name: Spiriva Respimat 2.5 mcg
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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
<p><b>Approval Criteria</b></p> <p>1 - Trial and failure of Spiriva Handihaler for at least 14 days</p>			

## 2 . Revision History

Date	Notes
9/11/2023	New GL

Beta Adrenergic Blockers



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-144411
<b>Guideline Name</b>	Beta Adrenergic Blockers
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

**Guideline Note:**

Effective Date:	4/1/2024
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### 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
<b>Approval Criteria</b>			
1 - Patient is 5 weeks of age or older AND less than or equal to 1 year of age			

Product Name: Sotylize
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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
<p><b>Approval Criteria</b></p> <p>1 - One of the following:</p> <p>1.1 Patient is under 12 years of age</p> <p style="text-align: center;"><b>OR</b></p> <p>1.2 Patient is unable to swallow tablets/capsules</p>			

## 2 . Revision History

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

Beta Adrenergics and Corticosteroids



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-144247
<b>Guideline Name</b>	Beta Adrenergics and Corticosteroids
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	4/1/2024
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## 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
<b>Approval Criteria</b>			
1 - All of the following:			

<p><b>1.1</b> Diagnosis of Asthma</p> <p style="text-align: center;"><b>AND</b></p> <p><b>1.2</b> Patient has tried and failed Advair or Symbicort therapy for at least 90 of the past 120 days</p> <p style="text-align: center;"><b>OR</b></p> <p><b>2</b> - All of the following:</p> <p><b>2.1</b> Diagnosis of COPD</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2.2</b> Patient has tried and failed Anoro Ellipta therapy for at least 90 of the past 120 days</p>
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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
<p><b>Approval Criteria</b></p> <p><b>1</b> - Patient has tried and failed Trelegy Ellipta</p> <p style="text-align: center;"><b>OR</b></p> <p><b>2</b> - Patient has contraindication or intolerance to use of Trelegy Ellipta</p>			

Product Name: fluticasone/salmeterol (generic Airduo Resplick)			
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
<b>Approval Criteria</b>			
1 - Trial of at least 90 days of therapy with Airduo Resplick			

## 2 . Revision History

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

Beta-Agonists - Short Acting



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-125103
<b>Guideline Name</b>	Beta-Agonists - Short Acting
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	7/1/2023
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## 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
<b>Approval Criteria</b>			
1 - Patient has tried albuterol HFA in the past 90 days			

## 2 . Revision History

Date	Notes
4/27/2023	New

Biktarvy



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-120162
<b>Guideline Name</b>	Biktarvy
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	1/15/2023
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## 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
<b>Approval Criteria</b>			

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
<b>Approval Criteria</b>			
1 - Diagnosis of post-exposure prophylaxis			

## 2 . Revision History



UnitedHealthcare Community Plan of Indiana – Clinical Pharmacy Guidelines

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

Biltricide



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-82070
<b>Guideline Name</b>	Biltricide
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	4/1/2021
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## 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	PRAZICUANTEL TAB 600 MG	15000050000305	Brand
PRAZICUANTEL	PRAZICUANTEL TAB 600 MG	15000050000305	Generic
<p><b>Approval Criteria</b></p> <p>1 - ONE of the following:</p> <p>1.1 Infections due to schistosoma</p>			

**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



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-126246
<b>Guideline Name</b>	Bone Formation Stimulating Agents
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

**Guideline Note:**

Effective Date:	7/1/2023
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### 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	ROMOSUZUMAB-AQQG INJ SOLN PREFILLED SYRINGE 105 MG/1.17ML	3004486010E520	Brand
<b>Approval Criteria</b>			
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 member does NOT have any of the following conditions:

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

Notes	*Up to 1 year approval duration; approval duration should not exceed the maximum allowable lifetime duration of 1 year (12 monthly doses) of total therapy with Evenity. **PDL Link: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>
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Product Name: Evenity			
Approval Length	1 Year*		
Therapy Stage	Reauthorization		
Guideline Type	Prior Authorization		
Product Name	Generic Name	GPI	Brand/Generic
EVENITY	ROMOSUZUMAB-AQQG INJ SOLN PREFILLED SYRINGE 105 MG/1.17ML	3004486010E520	Brand
<p><b>Approval Criteria</b></p> <p>1 - History of Evenity (romosozumab) for at least 90 days within the past 120 days, confirmed by claims history or chart documentation</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Prescriber attests that the patient remains a candidate for treatment, by indicating that they have NOT developed any of the following conditions:</p> <ul style="list-style-type: none"> <li>• Myocardial infarction or stroke within the previous year</li> <li>• Osteonecrosis of the jaw</li> <li>• Pre-existing hypocalcemia</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p>3 - One of the following:</p> <p>3.1 Total length of therapy has not exceeded 1 year</p> <p style="text-align: center;"><b>OR</b></p> <p>3.2 Documentation of a medical rationale for continued use beyond 1 year</p>			
Notes	*Up to 1 year approval duration; approval duration should not exceed the maximum allowable lifetime duration of 1 year (12 monthly doses) of total therapy with Evenity.		

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, and/or Tymlos. **PDL Link: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>
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Product Name: Forteo, 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

**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, and/or Tymlos. **PDL Link: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>
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Product Name: Forteo, 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

**Approval Criteria**

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

**AND**

**2** - Prescriber attests that the member 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, and/or Tymlos. **PDL Link: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>
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## 2 . Revision History

Date	Notes
6/6/2023	Revised criteria based upon updated policy changes. Added T/F language to Tymlos and Evenity, added look back period to reauth

Bone Resorption Inhibitors



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-137547
<b>Guideline Name</b>	Bone Resorption Inhibitors
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2024
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### 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
<p><b>Approval Criteria</b></p> <p>1 - Trial and failure of calcitonin-salmon nasal</p> <p style="text-align: center;"><b>OR</b></p> <p>2 - Medical justification for use</p>			

## 2 . Revision History

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

Bosulif



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-123834
<b>Guideline Name</b>	Bosulif
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	5/1/2023
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## 1 . Criteria

Product Name: Bosulif			
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
BOSULIF	BOSUTINIB TAB 100 MG	21531812000320	Brand
BOSULIF	BOSUTINIB TAB 400 MG	21531812000327	Brand
BOSULIF	BOSUTINIB TAB 500 MG	21531812000340	Brand

<p><b>Approval Criteria</b></p> <p>1 - Patient must have a diagnosis of chronic myeloid leukemia</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - One of the following:</p> <p>    <b>2.1</b> Patient is not a candidate for imatinib as attested by physician</p> <p style="text-align: center;"><b>OR</b></p> <p>    <b>2.2</b> Patient is currently on Bosulif therapy</p>
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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
<p><b>Approval Criteria</b></p> <p>1 - Patient must have a diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia</p>			

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
<p><b>Approval Criteria</b></p> <p>1 - Patient must have a diagnosis of myeloid/lymphoid neoplasms with eosinophilia</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Presence of ABL1 (gene) rearrangement</p>			

Product Name: Bosulif			
Diagnosis	Chronic Myelogenous/Myeloid Leukemia, Philadelphia Chromosome-Positive Acute Lymphoblastic Leukemia, Myeloid/Lymphoid Neoplasms		
Approval Length	12 month(s)		
Therapy Stage	Reauthorization		
Guideline Type	Prior Authorization		
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
<p><b>Approval Criteria</b></p> <p>1 - Patient does not show evidence of progressive disease while on Bosulif therapy</p>			

Product Name: Bosulif
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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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to Bosulif therapy			

## 2 . Revision History

UnitedHealthcare Community Plan of Indiana – Clinical Pharmacy Guidelines

Date	Notes
3/27/2023	Copy NY

BPH Agents



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-125064
<b>Guideline Name</b>	BPH Agents
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	7/1/2023
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## 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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Patient has had a trial of BOTH of the following:			
<ul style="list-style-type: none"> <li>• Alfuzosin ER</li> <li>• Tamsulosin</li> </ul>			
<b>OR</b>			
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
<b>Approval Criteria</b>			
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
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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



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-143198
<b>Guideline Name</b>	Braftovi
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	3/1/2024
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## 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
<b>Approval Criteria</b>			
1 - The patient must have ONE of the following diagnoses:			



- Unresectable melanoma
- Metastatic melanoma

**AND**

**2** - Patient is positive for BRAF V600 mutation

**AND**

**3** - Braftovi will be used in combination with Mektovi (binimetinib)

**AND**

**4** - ONE of the following:

**4.1** 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**

**4.2** 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**

**4.3** 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
<p><b>Approval Criteria</b></p> <p>1 - Patient does not show evidence of progressive disease while on Braftovi therapy</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Braftovi is used in combination with Mektovi (binimetinib)</p>			

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
<p><b>Approval Criteria</b></p> <p>1 - Patient must have a diagnosis of colon cancer</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Cancer is positive for BRAF V600E mutation</p>			

**AND**

**3 - ONE of the following:**

- Unresectable or advanced disease
- Metastatic disease

**AND**

**4 - Patient has received prior therapy**

**AND**

**5 - Braftovi will be used in combination with ONE of the following:**

- Erbitux (cetuximab)
- Vectibix (panitumumab)

<b>Product Name: Braftovi</b>			
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** - Patient must have a diagnosis of rectal cancer

**AND**

**2** - Cancer is positive for BRAF V600E mutation

**AND**

**3** - ONE of the following:

- Unresectable or advanced disease
- Metastatic disease

**AND**

**4** - Patient has received prior therapy

**AND**

**5** - Braftovi will be 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
<b>Approval Criteria</b>			
1 - Patient does not show evidence of progressive disease while on Braftovi therapy			
<b>AND</b>			
2 - Used in combination with ONE of the following:			
<ul style="list-style-type: none"> <li>• Erbitux (cetuximab)</li> <li>• Vectibix (panitumumab)</li> </ul>			

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
<p><b>Approval Criteria</b></p> <p>1 - Patient must have a diagnosis of non-small cell lung cancer (NSCLC)</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Disease is metastatic</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - Cancer is positive for BRAF V600E mutation</p> <p style="text-align: center;"><b>AND</b></p> <p>4 - Braftovi will be used in combination with Mektovi (binimetinib)</p>			

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
<p><b>Approval Criteria</b></p> <p>1 - Patient does not show evidence of progressive disease while on Braftovi therapy</p>			

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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to Braftovi therapy			

## 2 . Revision History

Date	Notes
2/15/2024	Updated criteria to include new FDA approved use in BRAF V600E N SCLC.





Bronchitol



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-124644
<b>Guideline Name</b>	Bronchitol
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	6/1/2023
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## 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
<b>Approval Criteria</b>			

**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**

<b>Product Name: Bronchitol</b>			
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
<b>Approval Criteria</b>			
<b>1 - Documentation of positive clinical response to Bronchitol therapy</b>			

Brukinsa



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-136320
<b>Guideline Name</b>	Brukinsa
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	1/1/2024
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## 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
<b>Approval Criteria</b>			
1 - Diagnosis of mantle cell lymphoma (MCL)			

**OR**

**2** - ALL of the following:

**2.1** Diagnosis of 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 ONE of the following:

**3.1.1** Extranodal marginal zone lymphoma (EMZL) of the stomach

**OR**

**3.1.2** Extranodal marginal zone lymphoma of nongastric sites (noncutaneous)

**AND**

**3.2** Disease is relapsed, refractory, or progressive

**AND**

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

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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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

Bylvay



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-136485
<b>Guideline Name</b>	Bylvay
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	1/1/2024
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## 1 . Criteria

Product Name: Bylvay			
Diagnosis	Progressive Familial Intrahepatic Cholestasis		
Approval Length	6 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., cholestyramine, rifampin, naltrexone, sertraline, phenobarbital)

**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	6 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
<b>Approval Criteria</b>			
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., cholestyramine, rifampin, naltrexone, sertraline, phenobarbital).

**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
11/17/2023	Removed requirement that PFIC must be type 1 or 2. Expanded prescriber requirement to include gastroenterologist.

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



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-136011
<b>Guideline Name</b>	C&S Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Clinical Review
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

**Guideline Note:**

Effective Date:	1/14/2024
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### 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: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>
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## 2 . Revision History

Date	Notes
11/6/2023	New guideline

Cablivi



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-86368
<b>Guideline Name</b>	Cablivi
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### 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
<b>Approval Criteria</b>			
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**

UnitedHealthcare Community Plan of Indiana – Clinical Pharmacy Guidelines

Date	Notes
5/3/2021	Copy of NY

Cabometyx



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-138441
<b>Guideline Name</b>	Cabometyx
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	2/1/2024
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## 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
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of Ewing sarcoma (including mesenchymal chondrosarcoma)</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Patient has relapsed, progressive, or metastatic disease</p>			

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
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of gastrointestinal stromal tumors (GIST)</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Patient has ONE of the following:</p> <ul style="list-style-type: none"> <li>• Gross residual disease (R2 resection)</li> <li>• Unresectable primary disease</li> <li>• Tumor rupture</li> </ul>			

- 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



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-144448
<b>Guideline Name</b>	Calcium Channel Blockers
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

**Guideline Note:**

Effective Date:	4/1/2024
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### 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
<p><b>Approval Criteria</b></p> <p>1 - Patient is 6 years of age or older AND less than 12 years of age</p>			

**OR**

**2** - 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
<b>Approval Criteria</b>			
1 - Patient is 18 years of age or older			
<b>AND</b>			
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
<b>Approval Criteria</b>			
1 - One of the following:			
1.1 Patient is 6 years of age or older AND less than 12 years of age			

<p><b>OR</b></p> <p><b>1.2</b> Patient is unable to swallow tablets</p> <p><b>AND</b></p> <p><b>2</b> - One of the following:</p> <p><b>2.1</b> Previous trial and failure of Norliqva</p> <p><b>OR</b></p> <p><b>2.2</b> Medical rationale for use of Katerzia</p>
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<b>Product Name: Brand Caduet, generic amlodipine/atorvastatin</b>			
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
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3/15/2024	Updated Norliqva, Nymalize and Katerzia criteria
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Calquence



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-127149
<b>Guideline Name</b>	Calquence
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	8/1/2023
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## 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
<b>Approval Criteria</b>			

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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			

**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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to Calquence therapy			

## 2 . Revision History

Date	Notes
6/27/2023	Copy NY

Caprelsa



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-136674
<b>Guideline Name</b>	Caprelsa
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	1/1/2024
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## 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
<b>Approval Criteria</b>			

**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
<b>Approval Criteria</b>			
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



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-132891
<b>Guideline Name</b>	Cardiac Agents
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Indiana</li> <li>• Medicaid - Community &amp; State Indiana SP</li> </ul>

**Guideline Note:**

Effective Date:	10/1/2023
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### 1 . Criteria

Product Name: Corlanor tablets			
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
<b>Approval Criteria</b>			

**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: Corlanor tablets	
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

**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: Corlanor tablets	
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
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of heart failure</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Patient is 18 years of age or older</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - Documentation of both of the following:</p> <ul style="list-style-type: none"> <li>• Left ventricular ejection fraction is less than or equal to 35%</li> <li>• Resting heart rate is greater than or equal to 70 beats per minute</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p>4 - One of the following:</p> <ul style="list-style-type: none"> <li>• Patient is currently maximized on beta-blocker therapy</li> <li>• Patient has contraindication to beta-blocker use</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p>5 - Both of the following:</p> <p><b>5.1</b> Requested dose does not exceed 15mg/day (milligrams per day)</p>			

**AND**

**5.2** Requested dose does not exceed 2 tablets/day

Product Name: Corlanor tablets			
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

**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: Corlanor tablets			
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

**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: Corlanor tablets			
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

**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: 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: Entresto			
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
<p><b>Approval Criteria</b></p> <p>1 - One of the following:</p> <p>1.1 Patient is not using an angiotensin converting enzyme (ACE) inhibitors or angiotensin II receptor blockers (ARBs) concurrently with Entresto</p> <p style="text-align: center;"><b>OR</b></p> <p>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 sacubitril/valsartan</p>			

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
<p><b>Approval Criteria</b></p> <p>1 - All of the following:</p> <p>1.1 Patient is 18 years of age or older</p> <p style="text-align: center;"><b>AND</b></p> <p>1.2 Diagnosis of symptomatic obstructive hypertrophic cardiomyopathy (HCM)</p>			



**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
9/11/2023	Updated Corlanor criteria, dosing criteria and reauthorization criteria f or all except for Entresto.

Carisoprodol Agents



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-126509
<b>Guideline Name</b>	Carisoprodol Agents
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

**Guideline Note:**

Effective Date:	7/1/2023
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### 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
<b>Approval Criteria</b>			

**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	<p>Approvals will be granted for up to 21 days' supply, to be used within a 90-day period, every 180 days.                  *PDL link: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a></p>
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## 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

<b>Guideline ID</b>	GL-123638
<b>Guideline Name</b>	Cayston
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	5/1/2023
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## 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
<b>Approval Criteria</b>			
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

<b>Guideline ID</b>	GL-136327
<b>Guideline Name</b>	Cerdelga and Zavesca
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	1/1/2024
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## 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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of mild to moderate type 1 Gaucher disease</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Patient is unable to receive enzyme replacement therapy due to ONE of the following conditions:</p> <p>2.1 Allergy or hypersensitivity to enzyme replacement therapy</p> <p style="text-align: center;"><b>OR</b></p> <p>2.2 Poor venous access</p> <p style="text-align: center;"><b>OR</b></p> <p>2.3 Unavailability of enzyme replacement therapy (e.g., Cerezyme, VPRIV)</p>			

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
<p><b>Approval Criteria</b></p>			

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

<b>Guideline ID</b>	GL-127506
<b>Guideline Name</b>	Cholbam
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	8/1/2023
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## 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
<b>Approval Criteria</b>			
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

<b>Product Name: Cholbam</b>			
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
<b>Approval Criteria</b>			

**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

<b>Guideline ID</b>	GL-127887
<b>Guideline Name</b>	Cinryze
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	9/1/2023
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## 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
<b>Approval Criteria</b>			
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 a FXII, angiotensin-1, plasminogen gene mutation, or kininogen mutation
- Recurring angioedema attacks that are refractory to high-dose antihistamines with confirmed family history of angioedema

**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, defined as a clinically significant reduction in the rate and/or number of hereditary angioedema (HAE) attacks, while on Cinryze therapy

**AND**

**2** - Reduction in the utilization of on-demand therapies used for acute attacks (e.g., Berinert, Firazyf, 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
7/12/2023	Corrected spelling of Orladeyo, added "confirmed by claims history or submitted medical records" to the COT criteria

Cipro Suspension and Levaquin Solution



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-123771
<b>Guideline Name</b>	Cipro Suspension and Levaquin Solution
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	7/1/2023
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## 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

<b>Guideline ID</b>	GL-127888
<b>Guideline Name</b>	Cometriq
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	9/1/2023
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## 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
<b>Approval Criteria</b>			
1 - Diagnosis of non-small cell lung cancer (NSCLC)			
<b>AND</b>			
2 - Positive for RET gene rearrangements			

Product Name: Cometriq
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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
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to Cometriq therapy			

Complera



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-115710
<b>Guideline Name</b>	Complera
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	1/1/2023
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## 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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Diagnosis of post-exposure prophylaxis			

Compounds and Bulk Powders



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-105739
<b>Guideline Name</b>	Compounds and Bulk Powders
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

**Guideline Note:**

Effective Date:	6/1/2022
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### 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			
<b>Approval Criteria</b>			
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 Anhydrous
- (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

<b>Guideline ID</b>	GL-139638
<b>Guideline Name</b>	Continuous Glucose Monitors
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

**Guideline Note:**

Effective Date:	2/1/2024
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### 1 . Criteria

Product Name: Freestyle Libre reader, Freestyle Libre 14 reader/sensor, Freestyle Libre 2 reader/sensor, Freestyle Libre 3 reader/sensor, Guardian receiver/sensor/transmitter, Enlite sensor, Eversense sensor/transmitter, Minilink transmitter, Minimed 630G Guardian transmitter, Paradigm transmitter			
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 BLOOD GLUCOSE SYSTEM RECEIVER***	97202012026200	Brand
GUARDIAN REAL-TIME REPLACEMENT MONITOR PEDIATRIC	*CONTINUOUS BLOOD GLUCOSE SYSTEM RECEIVER***	97202012026200	Brand

FREESTYLE LIBRE 3/READER/GLUCOSE MONITORING SYSTEM	*CONTINUOUS BLOOD GLUCOSE SYSTEM RECEIVER***	97202012026200	Brand
FREESTYLE LIBRE 2/READER/FLASH GLUCOSE MONITORING SYSTEM	*CONTINUOUS BLOOD GLUCOSE SYSTEM RECEIVER***	97202012026200	Brand
FREESTYLE LIBRE/READER/FLASH MONITORING SYSTEM	*CONTINUOUS BLOOD GLUCOSE SYSTEM RECEIVER***	97202012026200	Brand
GUARDIAN 4 GLUCOSE SENSOR	*CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
EVERSENSE SENSOR/HOLDER	*CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
EVERSENSE E3 SENSOR/HOLDER	*CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
FREESTYLE LIBRE 2/SENSOR/FLASH GLUCOSE MONITORING SYSTEM	*CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
FREESTYLE LIBRE 14 DAY/SENSOR/FLASH MONITORING SYSTEM	*CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
ENLITE GLUCOSE SENSOR	*CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
FREESTYLE LIBRE 3/SENSOR/GLUCOSE MONITORING SYSTEM	*CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
GUARDIAN SENSOR (3)	*CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
GUARDIAN SENSOR 3	*CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
MINILINK REAL-TIME TRANSMITTER	*CONTINUOUS BLOOD GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
EVERSENSE SMART TRANSMITTER	*CONTINUOUS BLOOD GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
GUARDIAN 4 TRANSMITTER KIT	*CONTINUOUS BLOOD GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
MINIMED 630G GUARDIAN PRESS STARTER TRANSMITTER KIT	*CONTINUOUS BLOOD GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
PARADIGM REAL-TIME TRANSMITTER	*CONTINUOUS BLOOD GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand

EVERSENSE E3 SMART TRANSMITTER	*CONTINUOUS BLOOD GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
GUARDIAN CONNECT TRANSMITTER	*CONTINUOUS BLOOD GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
GUARDIAN LINK 3 TRANSMITTER KIT	*CONTINUOUS BLOOD GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
GUARDIAN CONNECT TRANSMITTER KIT	*CONTINUOUS BLOOD 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: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>
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Product Name: Freestyle Libre reader, Freestyle Libre 14 reader/sensor, Freestyle Libre 2 reader/sensor, Freestyle Libre 3 reader/sensor, Guardian receiver/sensor/transmitter, Enlite sensor, Eversense sensor/transmitter, Minilink transmitter, Minimed 630G Guardian transmitter, Paradigm transmitter

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 BLOOD GLUCOSE SYSTEM RECEIVER***	97202012026200	Brand
GUARDIAN REAL-TIME REPLACEMENT MONITOR PEDIATRIC	*CONTINUOUS BLOOD GLUCOSE SYSTEM RECEIVER***	97202012026200	Brand
FREESTYLE LIBRE 3/READER/GLUCOSE MONITORING SYSTEM	*CONTINUOUS BLOOD GLUCOSE SYSTEM RECEIVER***	97202012026200	Brand

FREESTYLE LIBRE 2/READER/FLASH GLUCOSE MONITORING SYSTEM	*CONTINUOUS BLOOD GLUCOSE SYSTEM RECEIVER***	97202012026200	Brand
FREESTYLE LIBRE/READER/FLASH MONITORING SYSTEM	*CONTINUOUS BLOOD GLUCOSE SYSTEM RECEIVER***	97202012026200	Brand
GUARDIAN 4 GLUCOSE SENSOR	*CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
EVERSENSE SENSOR/HOLDER	*CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
EVERSENSE E3 SENSOR/HOLDER	*CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
FREESTYLE LIBRE 2/SENSOR/FLASH GLUCOSE MONITORING SYSTEM	*CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
FREESTYLE LIBRE 14 DAY/SENSOR/FLASH MONITORING SYSTEM	*CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
ENLITE GLUCOSE SENSOR	*CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
FREESTYLE LIBRE 3/SENSOR/GLUCOSE MONITORING SYSTEM	*CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
GUARDIAN SENSOR (3)	*CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
GUARDIAN SENSOR 3	*CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
MINILINK REAL-TIME TRANSMITTER	*CONTINUOUS BLOOD GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
EVERSENSE SMART TRANSMITTER	*CONTINUOUS BLOOD GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
GUARDIAN 4 TRANSMITTER KIT	*CONTINUOUS BLOOD GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
MINIMED 630G GUARDIAN PRESS STARTER TRANSMITTER KIT	*CONTINUOUS BLOOD GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
PARADIGM REAL-TIME TRANSMITTER	*CONTINUOUS BLOOD GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
EVERSENSE E3 SMART TRANSMITTER	*CONTINUOUS BLOOD GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand

GUARDIAN CONNECT TRANSMITTER	*CONTINUOUS BLOOD GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
GUARDIAN LINK 3 TRANSMITTER KIT	*CONTINUOUS BLOOD GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
GUARDIAN CONNECT TRANSMITTER KIT	*CONTINUOUS BLOOD GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response			

## 2 . Revision History

Date	Notes
1/25/2024	Corrected duration of therapy to 12 months.

Copiktra



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-127439
<b>Guideline Name</b>	Copiktra
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	8/1/2023
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## 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
<b>Approval Criteria</b>			

**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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to Copiktra therapy</p>			

Copper Chelating Agents



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-138197
<b>Guideline Name</b>	Copper Chelating Agents
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

**Guideline Note:**

Effective Date:	2/1/2024
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### 1 . Criteria

Product Name: Brand Depen Titratab, generic penicillamine tablets			
Diagnosis	Severe active rheumatoid arthritis		
Approval Length	12 month(s)		
Therapy Stage	Initial Authorization		
Guideline Type	Prior Authorization		
Product Name	Generic Name	GPI	Brand/Generic
DEPEN TITRATABS	PENICILLAMINE TAB 250 MG	99200030000305	Brand
PENICILLAMINE	PENICILLAMINE TAB 250 MG	99200030000305	Generic
<b>Approval Criteria</b>			

1 - Diagnosis of severe active rheumatoid arthritis

Product Name: Brand Depen Titratab, generic penicillamine tablets

Diagnosis	Severe active rheumatoid arthritis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

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 Titratab, 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 - Patient has ONE of the following diagnoses:

- Wilson’s disease (i.e., hepatolenticular degeneration)
- Cystinuria

Product Name: Brand Cuprimine, generic penicillamine capsules			
Diagnosis	Wilson’s disease, 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
<p><b>Approval Criteria</b></p> <p>1 - Patient has ONE of the following diagnoses:</p> <ul style="list-style-type: none"> <li>• Wilson’s disease (i.e., hepatolenticular degeneration)</li> <li>• Cystinuria</li> <li>• Severe active rheumatoid arthritis</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p>2 - One of the following:</p> <p><b>2.1</b> Failure to penicillamine tablets (generic Depen Titratab) as confirmed by claims history or submission of medical records</p> <p style="text-align: center;"><b>OR</b></p> <p><b>2.2</b> History of intolerance to penicillamine tablets (generic Depen Titratab) (please specify intolerance)</p>			

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

- Penicillamine tablets (generic Depen Titratub)
- Penicillamine capsules (generic Cuprimine)

**OR**

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

- Penicillamine tablets (generic Depen Titratab)
- Penicillamine capsules (generic Cuprimine)

<b>Product Name: Brand Syprine, generic trientine</b>			
Diagnosis	Wilson's disease		
Approval Length	12 month(s)		
Therapy Stage	Reauthorization		
Guideline Type	Prior Authorization		
<b>Product Name</b>	<b>Generic Name</b>	<b>GPI</b>	<b>Brand/Generic</b>
TRIENTINE HYDROCHLORIDE	TRIENTINE HCL CAP 250 MG	99200020100110	Generic
SYPRINE	TRIENTINE HCL CAP 250 MG	99200020100110	Brand
TRIENTINE HYDROCHLORIDE	TRIENTINE HCL CAP 500 MG	99200020100130	Generic
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to therapy			

Cotellic



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-138210
<b>Guideline Name</b>	Cotellic
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	2/1/2024
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## 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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Patient does not show evidence of progressive disease while on Cotellic therapy			
<b>AND</b>			
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
<b>Approval Criteria</b>			
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

<b>Guideline ID</b>	GL-125996
<b>Guideline Name</b>	Cuvrior
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	7/1/2023
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## 1 . Criteria

Product Name: Cuvrior			
Approval Length	3 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
<b>Approval Criteria</b>			
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

**AND**

**5** - Patient will NOT use penicillamine in conjunction with Cuvrior

<b>Product Name: Cuvrior</b>			
Approval Length	6 month(s)		
Therapy Stage	Reauthorization		
Guideline Type	Prior Authorization		
Product Name	Generic Name	GPI	Brand/Generic
CUVRIOR	TRIENTINE TETRAHYDROCHLORIDE TAB 300 MG	99200020200330	Brand
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to Cuvrior therapy			

## 2 . Revision History

UnitedHealthcare Community Plan of Indiana – Clinical Pharmacy Guidelines

Date	Notes
5/24/2023	Updated formulary to SP. No other changes.

Cystaran, Cystadrops



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-81932
<b>Guideline Name</b>	Cystaran, Cystadrops
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	4/1/2021
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## 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
<b>Approval Criteria</b>			



1 - Diagnosis of cystinosis

## 2 . Revision History

Date	Notes
3/5/2021	Bulk Load

Daliresp (roflumilast)



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-138285
<b>Guideline Name</b>	Daliresp (roflumilast)
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

#### Guideline Note:

Effective Date:	2/1/2024
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#### 1 . Criteria

Product Name: Brand Daliresp, generic roflumilast			
Approval Length	12 month(s)		
Therapy Stage	Initial Authorization		
Guideline Type	Prior Authorization		
Product Name	Generic Name	GPI	Brand/Generic
DALIRESP	ROFLUMILAST TAB 250 MCG	44450065000310	Brand
DALIRESP	ROFLUMILAST TAB 500 MCG	44450065000320	Brand
ROFLUMILAST	ROFLUMILAST TAB 250 MCG	44450065000310	Generic
ROFLUMILAST	ROFLUMILAST TAB 500 MCG	44450065000320	Generic

**Approval Criteria**

1 - Diagnosis of severe to very severe chronic obstructive pulmonary disease (COPD) (i.e., FEV1 less than or equal to 50% of predicted)

**AND**

2 - COPD is associated with chronic bronchitis

**AND**

3 - History of COPD exacerbation(s)

Product Name: Brand Daliresp, generic roflumilast			
Approval Length	12 month(s)		
Therapy Stage	Reauthorization		
Guideline Type	Prior Authorization		
Product Name	Generic Name	GPI	Brand/Generic
DALIRESP	ROFLUMILAST TAB 250 MCG	44450065000310	Brand
DALIRESP	ROFLUMILAST TAB 500 MCG	44450065000320	Brand
ROFLUMILAST	ROFLUMILAST TAB 250 MCG	44450065000310	Generic
ROFLUMILAST	ROFLUMILAST TAB 500 MCG	44450065000320	Generic
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to therapy			

**2 . Revision History**

Date	Notes
12/28/2023	Updated guideline name; Updated product names; Removed reference to "Daliresp" in reauthorization criterion.

Daurismo



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-82053
<b>Guideline Name</b>	Daurismo
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	4/1/2021
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## 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
<b>Approval Criteria</b>			

**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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			

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

<b>Product Name: Daurismo</b>			
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
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to Daurismo therapy			

## 2 . Revision History

Date	Notes
3/5/2021	Bulk Load

Daybue



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-127151
<b>Guideline Name</b>	Daybue
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	8/1/2023
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## 1 . Criteria

Product Name: Daybue			
Approval Length	6 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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to Daybue therapy			

## 2 . Revision History

UnitedHealthcare Community Plan of Indiana – Clinical Pharmacy Guidelines

Date	Notes
6/27/2023	New guideline.

Descovy



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-127163
<b>Guideline Name</b>	Descovy
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	8/1/2023
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## 1 . Criteria

Product Name: Descovy			
Diagnosis	Human Immunodeficiency Virus (HIV)		
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
<b>Approval Criteria</b>			

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

**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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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
6/27/2023	Copy NY

Dificid



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-123772
<b>Guideline Name</b>	Dificid
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	7/1/2023
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## 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
<b>Approval Criteria</b>			
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 pseudomembranous 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



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-137624
<b>Guideline Name</b>	Direct Oral Anticoagulants
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2024
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### 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
<b>Approval Criteria</b>			
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 PELLETT PACK 20 MG	83337030203020	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLETT PACK 30 MG	83337030203025	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLETT PACK 40 MG	83337030203030	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLETT PACK 50 MG	83337030203035	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLETT PACK 110 MG	83337030203040	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLETT 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



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-121638
<b>Guideline Name</b>	Disposable Insulin Delivery Devices
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

**Guideline Note:**

Effective Date:	3/19/2023
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### 1 . Criteria

Product Name: Omnipod Classic (Gen 3) pods and kits, Omnipod Dash (Gen 4) pods and kits, 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 CLASSIC PODS (GEN 3)	*INSULIN INFUSION DISPOSABLE PUMP SUPPLIES***	97201030506300	Brand
OMNIPOD DASH PODS (GEN 4)	*INSULIN INFUSION DISPOSABLE PUMP SUPPLIES***	97201030506300	Brand

OMNIPOD DASH PDM KIT (GEN 4)	*INSULIN INFUSION DISPOSABLE PUMP KIT***	97201030506400	Brand
V-GO 40	*INSULIN INFUSION DISPOSABLE PUMP KIT***	97201030506400	Brand
V-GO 30	*INSULIN INFUSION DISPOSABLE PUMP KIT***	97201030506400	Brand
OMNIPOD DASH INTRO KIT (GEN 4)	*INSULIN INFUSION DISPOSABLE PUMP KIT***	97201030506400	Brand
V-GO 20	*INSULIN INFUSION DISPOSABLE PUMP KIT***	97201030506400	Brand
CEQR SIMPLICITY 2U	INJECTION DEVICE FOR INSULIN	97051050126220	Brand
CEQR SIMPLICITY INSERTER	*INJECTION DEVICE FOR INSULIN - ACCESSORIES***	97051050126300	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 (hyper or hypo) 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)

<b>OR</b>	
3.3 Patient has diabetic complications leading to difficulty with self-injection of insulin (e.g., retinopathy, neuropathy)	
<b>OR</b>	
3.4 Patient is pregnant	
<b>OR</b>	
3.5 Prescriber has provided other valid medical justification for use of a disposable insulin delivery device	
<b>AND</b>	
4 - Other long-acting insulins/insulin analogs will be discontinued	
Notes	*For Omnipod 5 see Omnipod 5 guideline

## 2 . Revision History

Date	Notes
2/23/2023	Addition of CeQur. Removed insulin capacity table to match policy.



Doptelet



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-120802
<b>Guideline Name</b>	Doptelet
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

**Guideline Note:**

Effective Date:	4/1/2023
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### 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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
<b>1</b> - 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
<b>Approval Criteria</b>			
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

<b>Guideline ID</b>	GL-137562
<b>Guideline Name</b>	DPP4 Inhibitors and Combination Agents
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2024
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### 1 . Criteria

Product Name: Januvia, Brand Onglyza, Tradjenta, Janumet, Janumet XR, Jentadueto, Jentadueto XR, Kazano, Brand Kombiglyze 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
ONGLYZA	SAXAGLIPTIN HCL TAB 2.5 MG (BASE EQUIV)	27550065100320	Brand
ONGLYZA	SAXAGLIPTIN HCL TAB 5 MG (BASE EQUIV)	27550065100330	Brand

TRADJENTA	LINAGLIPTIN TAB 5 MG	27550050000320	Brand
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
KAZANO	ALOGLIPTIN-METFORMIN HCL TAB 12.5-500 MG	27992502100320	Generic
KAZANO	ALOGLIPTIN-METFORMIN HCL TAB 12.5-1000 MG	27992502100330	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

**Approval Criteria**

1 - Patient has tried metformin

Product Name: Nesina, Brand Alogliptin, generic saxagliptin			
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	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
SAXAGLIPTIN HYDROCHLORIDE	SAXAGLIPTIN HCL TAB 2.5 MG (BASE EQUIV)	27550065100320	Generic
SAXAGLIPTIN HYDROCHLORIDE	SAXAGLIPTIN HCL TAB 5 MG (BASE EQUIV)	27550065100330	Generic

**Approval Criteria**

1 - Patient has tried a preferred\* medication for 60 days of the past 100 days

Notes	*PDL link: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>
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**Product Name: Brand Alogliptin/Metformin, generic saxagliptin/metformin ER**

Approval Length	12 month(s)
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Guideline Type	Prior Authorization
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Product Name	Generic Name	GPI	Brand/Generic
ALOGLIPTIN/METFORMIN HCL	ALOGLIPTIN-METFORMIN HCL TAB 12.5-500 MG	27992502100320	Generic
ALOGLIPTIN/METFORMIN HYDROCHLORIDE	ALOGLIPTIN-METFORMIN HCL TAB 12.5-1000 MG	27992502100330	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

**Approval Criteria**

1 - Patient has tried a preferred\* combination medication for 60 days of the past 100 days

Notes	*PDL link: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>
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<b>Product Name: Oseni, Brand Alogliptin/Pioglitazone</b>
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Approval Length	12 month(s)
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Guideline Type	Prior Authorization
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Product Name	Generic Name	GPI	Brand/Generic
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 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
ALOGLIPTIN/PIOGLITAZONE	ALOGLIPTIN-PIOGLITAZONE TAB 12.5-15 MG	27994002100320	Generic
OSENI	ALOGLIPTIN-PIOGLITAZONE TAB 12.5-15 MG	27994002100320	Brand
ALOGLIPTIN/PIOGLITAZONE	ALOGLIPTIN-PIOGLITAZONE TAB 12.5-45 MG	27994002100330	Brand
OSENI	ALOGLIPTIN-PIOGLITAZONE TAB 12.5-45 MG	27994002100330	Generic

**Approval Criteria**

1 - Patient has tried and failed combination therapy with preferred\* medications of the same classes for 60 days of the past 100 days

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



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-126573
<b>Guideline Name</b>	Dronabinol
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	7/1/2023
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## 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
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of malignant cancer</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - History of an antineoplastic or radiation therapy in the past 45 days</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - One of the following:</p> <p>3.1 Patient has tried and failed ONE of the following in the past 6 months:</p> <ul style="list-style-type: none"> <li>• An oral selective 5HT3 receptor antagonist</li> <li>• A substance P/NK-1 receptor antagonist</li> </ul> <p style="text-align: center;"><b>OR</b></p> <p>3.2 Medical justification for use of dronabinol over BOTH of the following:</p> <ul style="list-style-type: none"> <li>• Selective 5-HT3 receptor antagonists</li> <li>• Substance P/NK-1 receptor antagonists</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p>4 - Patient is NOT currently receiving megestrol acetate suspension</p>			

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



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-137633
<b>Guideline Name</b>	Dry Eye Disease or Keratoconjunctivitis Agents
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2024
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### 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 - Must meet all of the following:

- 1.1 Diagnosis of keratoconjunctivitis sicca (dry eye disease)



**AND**

**1.2** Trial of artificial tears within the past 90 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 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 Trial of artificial tears within the past 90 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 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
<p><b>Approval Criteria</b></p> <p>1 - Must meet both of the following:</p> <p>1.1 Diagnosis of keratoconjunctivitis sicca (dry eye disease)</p> <p style="text-align: center;"><b>AND</b></p> <p>1.2 Trial of artificial tears within the past 90 days</p>			

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
<p><b>Approval Criteria</b></p> <p>1 - Must meet both of the following:</p> <p>1.1 Diagnosis of keratoconjunctivitis sicca (dry eye disease)</p>			

**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 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: 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
<b>Approval Criteria</b>			
1 - Must meet both of the following:			
1.1 Diagnosis of keratoconjunctivitis sicca (dry eye disease)			
<b>AND</b>			
1.2 Trial of artificial tears within the past 90 days			

Product Name: Cequa, Miebo, Restasis Multidose, Brand Restasis Single-Dose Vials, generic cyclosporine single-dose vials, Tyrvaya, 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 MULTIDOSE	CYCLOSPORINE (OPHTH) EMULSION 0.05%	86720020001620	Brand
RESTASIS	CYCLOSPORINE (OPHTH) EMULSION 0.05%	86720020001620	Brand
XIIDRA	LIFITEGRAST OPHTH SOLN 5%	86734050002020	Brand
CEQUA	CYCLOSPORINE (OPHTH) SOLN 0.09% (PF)	86720020002040	Brand
CYCLOSPORINE	CYCLOSPORINE (OPHTH) EMULSION 0.05%	86720020001620	Generic
VERKAZIA	CYCLOSPORINE (OPHTH) EMULSION 0.1%	86720020001630	Brand
TYRVAYA	VARENICLINE TARTRATE NASAL SOLN 0.03 MG/ACT	86280080202020	Brand
CYCLOSPORINE IN KLARITY	CYCLOSPORINE (OPHTH) EMULSION 0.1%	86720020001630	Brand
MIEBO	PERFLUOROHEXYLOCTANE OPHTH SOLN 1.338 GM/ML	86807018002020	Brand

**Approval Criteria**

1 - History of the requested agent in the past 180 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 keratoconjunctivitis sicca (dry eye disease)

**AND**

1.2 Trial of artificial tears within the past 90 days

**AND**

**1.3** Requested duration of therapy does not exceed 14 days

**AND**

**1.4** One of the following:

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

**OR**

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

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

**Approval Criteria**

**1** - Must meet all of the following:

**1.1** History of the requested agent

**AND**

**1.2** Requested duration of therapy does not exceed 14 days

**AND**

**1.3** 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
12/11/2023	Added Miebo with PA criteria.



Duopa



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-115342
<b>Guideline Name</b>	Duopa
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	12/1/2022
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## 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
<b>Approval Criteria</b>			
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
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to Duopa therapy</p>			

## 2 . Revision History

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

Egrifta



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-86261
<b>Guideline Name</b>	Egrifta
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### 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
<b>Approval Criteria</b>			
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



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-144364
<b>Guideline Name</b>	Electrolyte Depleters
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Indiana</li> <li>• Medicaid - Community &amp; State Indiana SP</li> </ul>

**Guideline Note:**

Effective Date:	4/1/2024
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### 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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Patient has tried and failed preferred phosphate binders			
<b>OR</b>			
2 - Medical rationale for use of requested medication over all preferred phosphate binders			
Notes	PDL Link: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>		

## 2 . Revision History

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

Elmiron



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-97793
<b>Guideline Name</b>	Elmiron
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	1/1/2022
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### 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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Patient has history of the requested medication within the past 90 days			
<b>AND</b>			
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



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-134129
<b>Guideline Name</b>	Empaveli
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	11/1/2023
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## 1 . Criteria

Product Name: Empaveli			
Approval Length	6 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 is not receiving Empaveli in combination with another complement inhibitor used for the treatment of PNH (e.g., Soliris, Ultomiris)

**OR**

**2.2** ONE of the following:

**2.2.1** Patient is currently receiving Soliris (eculizumab), which will be discontinued after an initial 4 week overlap period with Empaveli

**OR**

**2.2.2** Patient is currently receiving Ultomiris (ravulizumab-cwvz), which will be stopped, and Empaveli will be initiated no more than 4 weeks after the last dose

**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
<p><b>Approval Criteria</b></p> <p><b>1</b> - 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.]</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Patient is not receiving Empaveli in combination with another complement inhibitor used for the treatment of paroxysmal nocturnal hemoglobinuria (PNH) (e.g., Soliris, Ultomiris)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - Prescribed by or in consultation with ONE of the following:</p> <ul style="list-style-type: none"> <li>• Hematologist</li> <li>• Oncologist</li> </ul>			

## 2 . Revision History

Date	Notes
10/2/2023	Copy Core.

Emverm



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-108749
<b>Guideline Name</b>	Emverm
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	8/1/2022
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### 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
<b>Approval Criteria</b>			
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)

<b>Product Name: Emverm</b>			
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
<b>Approval Criteria</b>			
1 - Diagnosis of Hydatid Disease [Echinococcosis (Tapeworm)]			

<b>Product Name: Emverm</b>			
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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Diagnosis of Baylisascaris			

## 2 . Revision History

Date	Notes
6/28/2022	Updated trial/failure language

Endari



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-123757
<b>Guideline Name</b>	Endari
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	5/1/2023
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## 1 . Criteria

Product Name: Endari			
Diagnosis	Sickle cell disease		
Approval Length	12 month(s)		
Therapy Stage	Initial Authorization		
Guideline Type	Prior Authorization		
<b>Product Name</b>	<b>Generic Name</b>	<b>GPI</b>	<b>Brand/Generic</b>
ENDARI	GLUTAMINE (SICKLE CELL) POWD PACK 5 GM	82801020003020	Brand
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to Endari therapy			

## 2 . Revision History

Date	Notes
3/24/2023	Copy NY

Enspryng



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-138859
<b>Guideline Name</b>	Enspryng
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	2/1/2024
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## 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
<b>Approval Criteria</b>			
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

<b>Guideline ID</b>	GL-117570
<b>Guideline Name</b>	Enspryng
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	1/1/2023
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## 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
<b>Approval Criteria</b>			
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

<b>Guideline ID</b>	GL-117571
<b>Guideline Name</b>	Erivedge
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	1/1/2023
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## 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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to Erivedge therapy</p>			

Erleada



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-138263
<b>Guideline Name</b>	Erleada
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	2/1/2024
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## 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
<b>Approval Criteria</b>			

**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



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-124641
<b>Guideline Name</b>	Esbriet, Ofev
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	6/1/2023
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## 1 . Criteria

Product Name: Brand Esbriet, generic pirfenidone, Ofev			
Diagnosis	Idiopathic Pulmonary Fibrosis		
Approval Length	12 month(s)		
Therapy Stage	Initial Authorization		
Guideline Type	Prior Authorization		
Product Name	Generic Name	GPI	Brand/Generic
ESBRIET	PIRFENIDONE CAP 267 MG	45550060000120	Brand
ESBRIET	PIRFENIDONE TAB 267 MG	45550060000325	Brand
ESBRIET	PIRFENIDONE TAB 801 MG	45550060000345	Brand
OFEV	NINTEDANIB ESYLATE CAP 100 MG (BASE EQUIVALENT)	45554050200120	Brand

OFEV	NINTEDANIB ESYLATE CAP 150 MG (BASE EQUIVALENT)	45554050200130	Brand
PIRFENIDONE	PIRFENIDONE CAP 267 MG	45550060000120	Generic
PIRFENIDONE	PIRFENIDONE TAB 267 MG	45550060000325	Generic
PIRFENIDONE	PIRFENIDONE TAB 801 MG	45550060000345	Generic
PIRFENIDONE	PIRFENIDONE TAB 534 MG	45550060000333	Generic

**Approval Criteria**

**1 -** Diagnosis of idiopathic pulmonary fibrosis (IPF) as documented by ALL of the following:

**1.1** Exclusion of other known causes of interstitial lung disease (e.g., domestic and occupational environmental exposures, connective tissue disease, and drug toxicity), as documented by an ICD-10 Code of J84.112 (idiopathic pulmonary fibrosis)

**AND**

**1.2** ONE of the following:

**1.2.1** If the patient was NOT subjected to surgical lung biopsy, the presence of a usual interstitial pneumonia (UIP) pattern on high-resolution computed tomography (HRCT) revealing IPF or probable IPF

**OR**

**1.2.2** If the patient was subjected to a lung biopsy, both HRCT and surgical lung biopsy pattern reveal IPF or probable IPF

**AND**

**2 -** ONE of the following:

**2.1** If the request is for Esbriet (pirfenidone), it is not being used in combination with Ofev

**OR**

**2.2** If the request is for Ofev, it is not being used in combination with Esbriet (pirfenidone)

**AND**

**3** - The prescriber is a pulmonologist

Product Name: Brand Esbriet, generic pirfenidone, Ofev			
Diagnosis	Idiopathic Pulmonary Fibrosis		
Approval Length	12 month(s)		
Therapy Stage	Reauthorization		
Guideline Type	Prior Authorization		
Product Name	Generic Name	GPI	Brand/Generic
ESBRIET	PIRFENIDONE CAP 267 MG	45550060000120	Brand
ESBRIET	PIRFENIDONE TAB 267 MG	45550060000325	Brand
ESBRIET	PIRFENIDONE TAB 801 MG	45550060000345	Brand
OFEV	NINTEDANIB ESYLATE CAP 100 MG (BASE EQUIVALENT)	45554050200120	Brand
OFEV	NINTEDANIB ESYLATE CAP 150 MG (BASE EQUIVALENT)	45554050200130	Brand
PIRFENIDONE	PIRFENIDONE CAP 267 MG	45550060000120	Generic
PIRFENIDONE	PIRFENIDONE TAB 267 MG	45550060000325	Generic
PIRFENIDONE	PIRFENIDONE TAB 801 MG	45550060000345	Generic
PIRFENIDONE	PIRFENIDONE TAB 534 MG	45550060000333	Generic

**Approval Criteria**

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

**AND**

**2** - ONE of the following:

**2.1** If the request is for Esbriet (pirfenidone), it is not being used in combination with Ofev

**OR**

**2.2** If the request is for Ofev, it is not being used in combination with Esbriet (pirfenidone)

**AND**

**3** - The prescriber is a pulmonologist

Product Name: Ofev			
Diagnosis	Systemic Sclerosis-Associated Interstitial Lung Disease		
Approval Length	12 month(s)		
Therapy Stage	Initial Authorization		
Guideline Type	Prior Authorization		
Product Name	Generic Name	GPI	Brand/Generic
OFEV	NINTEDANIB ESYLATE CAP 100 MG (BASE EQUIVALENT)	45554050200120	Brand
OFEV	NINTEDANIB ESYLATE CAP 150 MG (BASE EQUIVALENT)	45554050200130	Brand

**Approval Criteria**

**1** - Diagnosis of systemic sclerosis-associated interstitial lung disease (SSc-ILD) as documented by ALL of the following:

**1.1** ONE of the following:

**1.1.1** Skin thickening of the fingers of both hands extending proximal to the metacarpophalangeal joints

**OR**

**1.1.2** At least TWO of the following:

- Skin thickening of the fingers (e.g., puffy fingers, sclerodactyly of the fingers)

- Fingertip lesions (e.g., digital tip ulcers, fingertip pitting scars)
- Telangiectasia
- Abnormal nailfold capillaries
- Pulmonary arterial hypertension
- Raynaud’s phenomenon
- SSc-related autoantibodies [e.g., anticontromere, anti-topoisomerase I, anti-RNA (ribonucleic acid) polymerase III]

**AND**

**1.2** Presence of interstitial lung disease as determined by finding evidence of pulmonary fibrosis on high-resolution computed tomography (HRCT), involving at least 10% of the lungs

**AND**

**2** - Ofev is not being used in combination with Esbriet (pirfenidone)

**AND**

**3** - The prescriber is a pulmonologist

Product Name: Ofev			
Diagnosis	Chronic Fibrosing Interstitial Lung Disease with a Progressive Phenotype		
Approval Length	12 month(s)		
Therapy Stage	Initial Authorization		
Guideline Type	Prior Authorization		
Product Name	Generic Name	GPI	Brand/Generic
OFEV	NINTEDANIB ESYLATE CAP 100 MG (BASE EQUIVALENT)	45554050200120	Brand
OFEV	NINTEDANIB ESYLATE CAP 150 MG (BASE EQUIVALENT)	45554050200130	Brand
<b>Approval Criteria</b>			

**1** - Diagnosis of chronic fibrosing interstitial lung disease (ILD) with a progressive phenotype as documented by BOTH of the following:

**1.1** Presence of fibrotic ILD as determined by finding evidence of pulmonary fibrosis on HRCT (high-resolution computed tomography), involving at least 10% of the lungs

**AND**

**1.2** Patient is presenting with clinical signs of progression as defined by ONE of the following in the previous 24 months:

**1.2.1** Forced vital capacity (FVC) decline of greater than 10%

**OR**

**1.2.2** TWO of the following:

- FVC decline of greater than or equal to 5%, but less than 10%
- Patient is experiencing worsening respiratory symptoms
- Patient is exhibiting increasing extent of fibrotic changes on chest imaging

**AND**

**2** - Ofev is not being used in combination with Esbriet (pirfenidone)

**AND**

**3** - The prescriber is a pulmonologist

Product Name: Ofev	
Diagnosis	Systemic Sclerosis-Associated Interstitial Lung Disease, Chronic Fibrosing Interstitial Lung Disease with a Progressive Phenotype
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OFEV	NINTEDANIB ESYLATE CAP 100 MG (BASE EQUIVALENT)	45554050200120	Brand
OFEV	NINTEDANIB ESYLATE CAP 150 MG (BASE EQUIVALENT)	45554050200130	Brand

**Approval Criteria**

1 - Documentation of positive clinical response to Ofev therapy

**AND**

2 - Ofev is not being used in combination with Esbriet (pirfenidone)

**AND**

3 - The prescriber is a pulmonologist

**2 . Revision History**

Date	Notes
4/13/2023	Added GPI for generic pirfenidone. Updated Esbriet language through out criteria to include generic pirfenidone.



Exkivity



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-99462
<b>Guideline Name</b>	Exkivity
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	2/1/2022
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## 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		
<b>Product Name</b>	<b>Generic Name</b>	<b>GPI</b>	<b>Brand/Generic</b>
EXKIVITY	MOBOCERTINIB SUCCINATE CAP 40 MG	21360050600120	Brand
<b>Approval Criteria</b>			
1 - Diagnosis of non-small cell lung cancer (NSCLC)			

<b>AND</b>
<b>2</b> - Disease is locally advanced or metastatic
<b>AND</b>
<b>3</b> - Disease is epidermal growth factor receptor (EGFR) exon 20 insertion mutation positive
<b>AND</b>
<b>4</b> - Subsequent therapy for disease that has progressed on or after platinum-based chemotherapy

<b>Product Name: Exkivity</b>			
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
<b>Approval Criteria</b>			
<b>1</b> - Patient does not show evidence of progressive disease while on Exkivity therapy			

<b>Product Name: Exkivity</b>	
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

Febuxostat



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-128909
<b>Guideline Name</b>	Febuxostat
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	10/1/2023
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## 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
<b>Approval Criteria</b>			
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

<b>Guideline ID</b>	GL-126579
<b>Guideline Name</b>	Fentanyl IR
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

#### Guideline Note:

Effective Date:	7/1/2023
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### 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

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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/samidorpham) 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.
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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

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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/samidorpham) 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

<ul style="list-style-type: none"> <li>The prescriber acknowledges the risk of adverse event(s), including respiratory depression, coma, and death, associated with concurrent utilization</li> </ul>	
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



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-96662
<b>Guideline Name</b>	Fexofenadine
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

#### Guideline Note:

Effective Date:	10/15/2021
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### 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

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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

Firazyr, Sajazir



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-125876
<b>Guideline Name</b>	Firazyr, Sajazir
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	7/1/2023
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## 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 a FXII, angiotensin-1, plasminogen gene mutation, or kininogen mutation
- Recurring angioedema attacks that are refractory to high-dose antihistamines with confirmed family history of angioedema

**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, 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

**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, Ruconest)

**AND**

4 - Prescribed by ONE of the following:

- Immunologist
- Allergist

**2 . Revision History**

UnitedHealthcare Community Plan of Indiana – Clinical Pharmacy Guidelines

Date	Notes
5/18/2023	Copy NY

Firdapse



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-138521
<b>Guideline Name</b>	Firdapse
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	2/1/2024
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### 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
<b>Approval Criteria</b>			
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)]

Furoscix



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-124115
<b>Guideline Name</b>	Furoscix
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	6/1/2023
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## 1 . Criteria

Product Name: Furoscix			
Approval Length	1 month(s)		
Guideline Type	Prior Authorization		
Product Name	Generic Name	GPI	Brand/Generic
FUROSCIX	FUROSEMIDE SUBCUTANEOUS CARTRIDGE KIT 80 MG/10ML	3720003000F720	Brand
<b>Approval Criteria</b>			
1 - Diagnosis of chronic heart failure			



**AND**

**2** - Heart failure is classified as ONE of the following:

**2.1** New York Heart Association (NYHA) class II heart failure

**OR**

**2.2** New York Heart Association (NYHA) class III heart failure

**AND**

**3** - Patient has signs or symptoms of congestion due to fluid overload

**AND**

**4** - Patient is established on background loop diuretic therapy (e.g., furosemide, torsemide, bumetanide)

**AND**

**5** - Both of the following:

**5.1** Patient does not require ongoing emergency care or hospitalization for heart failure, acute pulmonary edema, or other conditions

**AND**

**5.2** Patient is currently a candidate for parenteral diuresis outside of the hospital

**AND**

**6** - Patient has an estimated creatine clearance greater than 30ml/min

**AND**

**7** - Furoscix is prescribed by or in consultation with a cardiologist

## **2 . Revision History**

Date	Notes
4/3/2023	Copy NY

Galafold



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-136357
<b>Guideline Name</b>	Galafold
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	1/1/2024
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## 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
<b>Approval Criteria</b>			
1 - Diagnosis of Fabry disease			

<p><b>AND</b></p> <p><b>2</b> - Patient has an amenable galactosidase alpha gene (GLA) variant based on in vitro assay data</p> <p><b>AND</b></p> <p><b>3</b> - Patient is not receiving Galafold in combination with Fabrazyme (agalsidase beta) or Elfabrio (pegunigalsidase alfa-iwxj)</p>
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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
<p><b>Approval Criteria</b></p> <p><b>1</b> - Documentation of positive clinical response to Galafold therapy</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Patient is not receiving Galafold in combination with Fabrazyme (agalsidase beta) or Elfabrio (pegunigalsidase alfa-iwxj)</p>			

## 2 . Revision History

Date	Notes
11/15/2023	Added Elfabrio as a drug to not be used in combination



Gattex



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-134512
<b>Guideline Name</b>	Gattex
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	12/1/2023
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### 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
<b>Approval Criteria</b>			
1 - Diagnosis of Short Bowel Syndrome (SBS)			

**AND**

**2** - Dependent on parenteral support

Product Name: Gattex			
Approval Length	12 month(s)		
Therapy Stage	Reauthorization		
Guideline Type	Prior Authorization		
Product Name	Generic Name	GPI	Brand/Generic
GATTEX	TEDUGLUTIDE (RDNA) FOR INJ KIT 5 MG	52533070006420	Brand

**Approval Criteria**

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

Gavreto



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-138218
<b>Guideline Name</b>	Gavreto
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	2/1/2024
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## 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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to Gavreto therapy</p>			

## 2 . Revision History

Date	Notes
12/27/2023	Updated NSCLC, hepatobiliary cancer, and thyroid carcinoma criteria

Genvoya and Stribild



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-115880
<b>Guideline Name</b>	Genvoya and Stribild
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	1/1/2023
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## 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
<b>Approval Criteria</b>			

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
<b>Approval Criteria</b>			
1 - Diagnosis of post-exposure prophylaxis			

Gilotrif



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-127916
<b>Guideline Name</b>	Gilotrif
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	9/1/2023
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## 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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			

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 updated policy

Gleevec



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-135837
<b>Guideline Name</b>	Gleevec
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	1/1/2024
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## 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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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-PDGFR A 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
<b>Approval Criteria</b>			
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-PDGFRB 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



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-142078
<b>Guideline Name</b>	GLP-1 Receptor Agonists and Combinations
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

**Guideline Note:**

Effective Date:	3/1/2024
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### 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
<b>Approval Criteria</b>			
1 - Diagnosis of type 2 diabetes mellitus			



**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

<b>Product Name: Byetta</b>			
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
<b>Approval Criteria</b>			
<b>1</b> - Diagnosis of type 2 diabetes mellitus			

**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

**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	Non-alcoholic steatohepatitis		
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
<b>Approval Criteria</b>			
<b>1</b> - Patient is 18 years of age or older			

**AND**

**2** - Diagnosis of non-alcoholic steatohepatitis with or without diabetes

**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 member 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 member 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
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Product Name: Ozempic	
Diagnosis	Type 2 diabetes, non-alcoholic steatohepatitis

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 non-alcoholic steatohepatitis with or without diabetes

**OR**

1.2 Diagnosis of type 2 diabetes mellitus with or without cardiovascular disease

**AND**

2 - History of Ozempic 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 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	2717001500D220	Brand
TRULICITY	DULAGLUTIDE SOLN PEN-INJECTOR 1.5 MG/0.5ML	2717001500D230	Brand
TRULICITY	DULAGLUTIDE SOLN PEN-INJECTOR 3 MG/0.5ML	2717001500D240	Brand
TRULICITY	DULAGLUTIDE SOLN PEN-INJECTOR 4.5 MG/0.5ML	2717001500D250	Brand

**Approval Criteria**

**1** - Diagnosis of type 2 diabetes mellitus with or without cardiovascular disease or cardiovascular disease risk factors

**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	2717001500D220	Brand
TRULICITY	DULAGLUTIDE SOLN PEN-INJECTOR 1.5 MG/0.5ML	2717001500D230	Brand
TRULICITY	DULAGLUTIDE SOLN PEN-INJECTOR 3 MG/0.5ML	2717001500D240	Brand
TRULICITY	DULAGLUTIDE SOLN PEN-INJECTOR 4.5 MG/0.5ML	2717001500D250	Brand
<p><b>Approval Criteria</b></p> <p><b>1</b> - Diagnosis of type 2 diabetes mellitus with or without cardiovascular disease or cardiovascular disease risk factors</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - History of Trulicity for at least 90 days within the past 120 days, confirmed by claims history, chart documentation, or provider attestation including dates of trial</p> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - Dose requested does not exceed ONE of the following:</p> <ul style="list-style-type: none"> <li>• 0.75 mg injection: 2 injections/week</li> <li>• 1.5 mg, 3 mg, or 4.5 mg injection: 1 injection/week</li> </ul>			

Product Name: Victoza	
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

**Approval Criteria**

1 - The patient is 10 years of age or older

**AND**

2 - One of the following diagnoses:

- 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

Product Name: Victoza	
Diagnosis	Non-alcoholic fatty liver disease
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

**Approval Criteria**

1 - Patient is 10 years of age or older

**AND**

2 - Diagnosis of non-alcoholic fatty liver disease with or without diabetes

**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 member 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 member and prescriber has a monitoring plan in place

- Amiodarone
- Glucocorticoids
- Methotrexate
- Synthetic estrogens
- Tamoxifen

<b>AND</b>	
7 - Dose requested does not exceed 1.8 mg/day	
Notes	*MRI-PDFF= Magnetic Resonance Imaging Proton Density Fat Fraction

Product Name: Victoza			
Diagnosis	Type 2 diabetes, polycystic ovary syndrome, Non-alcoholic fatty liver disease		
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

**Approval Criteria**

1 - One of the following:

1.1 Diagnosis of non-alcoholic fatty liver disease with or without diabetes

**OR**

1.2 Diagnosis of type 2 diabetes mellitus with or without cardiovascular disease

**OR**

1.3 Diagnosis of polycystic ovary syndrome

**AND**

**2** - History of Victoza 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

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

**AND**

**2** - Member is 18 years of age and 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: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>
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<b>Product Name: Soliqua</b>			
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
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of type 2 diabetes mellitus</p> <p style="text-align: center;"><b>AND</b></p> <p>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</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - Dose requested does not exceed 60 units insulin glargine/20 mcg lixisenatide per day</p>			

<b>Product Name: Bydureon BCise</b>			
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

**AND**

2 - Member is 10 years of age and older

**AND**

3 - One of the following:

**3.1** Trial and failure of at least 90 days of therapy EACH with TWO different preferred\* GLP-1 receptor agonist agents, one of which is either Ozempic (semaglutide) or Trulicity (dulaglutide), as confirmed by claims history, chart documentation, or provider attestation including dates of trial

**OR**

**3.2** Medical justification for use of Bydureon BCise over ALL of the following:

- Byetta
- Ozempic
- Trulicity
- Victoza

**AND**

4 - Dose requested does not exceed 2 mg/week

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

**AND**

**2** - One of the following:

**2.1** Trial and failure of at least 90 days of therapy EACH with TWO different preferred\* GLP-1 receptor agonist agents, one of which is either Ozempic (semaglutide) or Trulicity (dulaglutide), as confirmed by claims history, chart documentation, or provider attestation including dates of trial

**OR**

**2.2** Medical justification for use of Bydureon BCise over ALL of the following:

- Byetta
- Ozempic
- Trulicity
- Victoza

**AND**

**3** - History of Bydureon BCise 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 2 mg/week



Notes	*PDL Link: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>
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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	2717308000D210	Brand
MOUNJARO	TIRZEPATIDE SOLN PEN-INJECTOR 5 MG/0.5ML	2717308000D215	Brand
MOUNJARO	TIRZEPATIDE SOLN PEN-INJECTOR 7.5 MG/0.5ML	2717308000D220	Brand
MOUNJARO	TIRZEPATIDE SOLN PEN-INJECTOR 10 MG/0.5ML	2717308000D225	Brand
MOUNJARO	TIRZEPATIDE SOLN PEN-INJECTOR 12.5 MG/0.5ML	2717308000D230	Brand
MOUNJARO	TIRZEPATIDE SOLN PEN-INJECTOR 15 MG/0.5ML	2717308000D235	Brand

**Approval Criteria**

1 - Diagnosis of type 2 diabetes mellitus

**AND**

2 - Member is 18 years of age and older

**AND**

3 - One of the following:

**3.1** Trial and failure of at least 90 days of therapy EACH with TWO different preferred\* GLP-1 receptor agonist agents, one of which is either Ozempic (semaglutide) or Trulicity (dulaglutide), as confirmed by claims history, chart documentation, or provider attestation including dates of trial

**OR**

**3.2** Medical justification for use of Mounjaro over ALL of the following:

- Byetta
- Ozempic
- Trulicity
- Victoza

**AND**

**4** - Dose requested does not exceed 15 mg/week

Notes	*PDL Link: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>
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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	2717308000D210	Brand
MOUNJARO	TIRZEPATIDE SOLN PEN-INJECTOR 5 MG/0.5ML	2717308000D215	Brand
MOUNJARO	TIRZEPATIDE SOLN PEN-INJECTOR 7.5 MG/0.5ML	2717308000D220	Brand
MOUNJARO	TIRZEPATIDE SOLN PEN-INJECTOR 10 MG/0.5ML	2717308000D225	Brand
MOUNJARO	TIRZEPATIDE SOLN PEN-INJECTOR 12.5 MG/0.5ML	2717308000D230	Brand
MOUNJARO	TIRZEPATIDE SOLN PEN-INJECTOR 15 MG/0.5ML	2717308000D235	Brand

**Approval Criteria**

**1** - Diagnosis of type 2 diabetes mellitus

**AND**

**2** - One of the following:

**2.1** Trial and failure of at least 90 days of therapy EACH with TWO different preferred\* GLP-

1 receptor agonist agents, one of which is either Ozempic (semaglutide) or Trulicity (dulaglutide), as confirmed by claims history, chart documentation, or provider attestation including dates of trial

**OR**

**2.2** Medical justification for use of Mounjaro over ALL of the following:

- Byetta
- Ozempic
- Trulicity
- Victoza

**AND**

**3** - History of Mounjaro 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 15 mg/week

Notes	*PDL Link: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>
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<b>Product Name: Rybelsus</b>			
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
<b>Approval Criteria</b>			

1 - Diagnosis of type 2 diabetes mellitus

**AND**

2 - Member is 18 years of age and older

**AND**

3 - One of the following:

**3.1** Trial and failure of at least 90 days of therapy EACH with TWO different preferred\* GLP-1 receptor agonist agents, one of which is either Ozempic (semaglutide) or Trulicity (dulaglutide), as confirmed by claims history, chart documentation, or provider attestation including dates of trial

**OR**

**3.2** Medical justification for the use of Rybelsus over ALL of the following:

- Byetta
- Ozempic
- Trulicity
- Victoza

**AND**

4 - Dose requested does not exceed 1 tablet/day

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

**AND**

2 - One of the following:

**2.1** Trial and failure of at least 90 days of therapy EACH with TWO different preferred\* GLP-1 receptor agonist agents, one of which is either Ozempic (semaglutide) or Trulicity (dulaglutide), as confirmed by claims history, chart documentation, or provider attestation including dates of trial

**OR**

**2.2** Medical Justification for use of Rybelsus over ALL of the following:

- Byetta
- Ozempic
- Trulicity
- Victoza

**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	*PDL Link: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>
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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
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of type 2 diabetes mellitus</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Member is 18 years of age and older</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - One of the following:</p> <p style="padding-left: 20px;"><b>3.1</b> Trial and failure of Soliqua as confirmed by claims history, chart documentation, or provider attestation including dates of trial</p> <p style="text-align: center;"><b>OR</b></p> <p style="padding-left: 20px;"><b>3.2</b> Both of the following:</p> <p style="padding-left: 40px;"><b>3.2.1</b> Medical justification for use of Xultophy over Soliqua</p> <p style="text-align: center;"><b>AND</b></p>			

**3.2.2** Patient has had a previous trial of BOTH 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: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>
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Product Name: Xultophy

Approval Length	1 year(s)
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Therapy Stage	Reauthorization
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Guideline Type	Prior Authorization
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Product Name	Generic Name	GPI	Brand/Generic
XULTOPHY 100/3.6	INSULIN DEGLUDEC-LIRAGLUTIDE SOL PEN-INJ 100-3.6 UNIT-MG/ML	2799100225D220	Brand

**Approval Criteria**

**1** - Diagnosis of type 2 diabetes mellitus

**AND**

**2** - 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 . Revision History

Date	Notes
2/11/2024	Additional "initial" criteria added for liver Disease for Ozempic and Victoza.



Gonadotropin-Releasing Hormone Agonists



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-127739
<b>Guideline Name</b>	Gonadotropin-Releasing Hormone Agonists
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

**Guideline Note:**

Effective Date:	9/1/2023
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### 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
LEUPROLIDE ACETATE	LEUPROLIDE ACETATE INJ KIT 5 MG/ML	21405010106407	Generic
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
LUPRON DEPOT-PED	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 Fensolvi, ONE of the following:

**4.1** Failure to Lupron-Depot Ped as confirmed by claims history or submission of medical records

**OR**

**4.2** History of intolerance or contraindication to Lupron-Depot Ped (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
LEUPROLIDE ACETATE	LEUPROLIDE ACETATE INJ KIT 5 MG/ML	21405010106407	Generic
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
LUPRON DEPOT-PED	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

**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
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of endometriosis or endometriosis is suspected</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Recurrence of symptoms following an initial course of therapy</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - Concurrently to be used with add-back therapy (e.g., progestin, estrogen, or bone sparing agents)</p> <p style="text-align: center;"><b>AND</b></p> <p>4 - Treatment duration has not exceeded a total of 12 months, as confirmed by claims history or submission of medical records</p>			
Notes	Approval Length - Authorization will be issued for 6 months. Duration of both the initial and recurrent course of therapies is no longer than 12 months total.		

Product Name: Lupron Depot 3.75 mg and 3-month 11.25 mg	
Diagnosis	Uterine Leiomyomata (Fibroids)

Approval Length	3 month(s)		
Guideline Type	Prior Authorization		
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 INJ KIT 5 MG/ML	21405010106407	Generic
LEUPROLIDE ACETATE	LEUPROLIDE ACETATE (3 MONTH) FOR INJ 22.5 MG	21405010152230	Brand

**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 INJ KIT 5 MG/ML	21405010106407	Generic
LEUPROLIDE ACETATE	LEUPROLIDE ACETATE (3 MONTH) FOR INJ 22.5 MG	21405010152230	Brand

**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 INJ KIT 5 MG/ML	21405010106407	Generic
LEUPROLIDE ACETATE	LEUPROLIDE ACETATE (3 MONTH) FOR INJ 22.5 MG	21405010152230	Brand
LUPRON DEPOT-PED	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 INJ KIT 5 MG/ML	21405010106407	Generic
LEUPROLIDE ACETATE	LEUPROLIDE ACETATE (3 MONTH) FOR INJ 22.5 MG	21405010152230	Brand
LUPRON DEPOT-PED	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.
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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*
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Approval Length	12 month(s)
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Therapy Stage	Initial Authorization
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Guideline Type	Prior Authorization
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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 INJ KIT 5 MG/ML	21405010106407	Generic
LEUPROLIDE ACETATE	LEUPROLIDE ACETATE (3 MONTH) FOR INJ 22.5 MG	21405010152230	Brand
LUPRON DEPOT-PED	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
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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*
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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 INJ KIT 5 MG/ML	21405010106407	Generic
LEUPROLIDE ACETATE	LEUPROLIDE ACETATE (3 MONTH) FOR INJ 22.5 MG	21405010152230	Brand

LUPRON DEPOT-PED	LEUPROLIDE ACET (6 MONTH) FOR IM INJ PEDIATRIC KIT 45 MG	30080050256460	Brand
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**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
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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
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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 INJ KIT 5 MG/ML	21405010106407	Generic
LEUPROLIDE ACETATE	LEUPROLIDE ACETATE (3 MONTH) FOR INJ 22.5 MG	21405010152230	Brand

LUPRON DEPOT-PED	LEUPROLIDE ACET (6 MONTH) FOR IM INJ PEDIATRIC KIT 45 MG	30080050256460	Brand
<p><b>Approval Criteria</b></p> <p>1 - For use in pre-menopausal women</p> <p style="text-align: center;"><b>AND</b></p> <p>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]</p>			

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 INJ KIT 5 MG/ML	21405010106407	Generic
LEUPROLIDE ACETATE	LEUPROLIDE ACETATE (3 MONTH) FOR INJ 22.5 MG	21405010152230	Brand
LUPRON DEPOT-PED	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., Cytosan (cyclophosphamide), procarbazine, vinblastine, cisplatin]

Product Name: leuprolide acetate inj kit 5 mg/mL	
Diagnosis	Salivary Gland Tumors
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type		Prior Authorization	
Product Name	Generic Name	GPI	Brand/Generic
LEUPROLIDE ACETATE	LEUPROLIDE ACETATE INJ KIT 5 MG/ML	21405010106407	Generic
<p><b>Approval Criteria</b></p> <p>1 - Disease is androgen receptor positive</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - ONE of the following:</p> <p>    <b>2.1</b> Disease is metastatic and patient has a performance status of 0-3</p> <p style="text-align: center;"><b>OR</b></p> <p>    <b>2.2</b> Disease is ONE of the following:</p> <ul style="list-style-type: none"> <li>• Recurrent unresectable locoregional</li> <li>• Second primary with prior radiation therapy</li> </ul>			

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 5 MG/ML	21405010106407	Generic
<p><b>Approval Criteria</b></p>			



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 5 MG/ML	21405010106407	Generic

LUPRON DEPOT-PED	LEUPROLIDE ACET (6 MONTH) FOR IM INJ PEDIATRIC KIT 45 MG	30080050256460	Brand
<b>Approval Criteria</b>			
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 5 MG/ML	21405010106407	Generic
LUPRON DEPOT-PED	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
7/7/2023	Added new Lupron Depot-Ped kit GPI

Gralise, Horizant, and Lyrica CR



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-132243
<b>Guideline Name</b>	Gralise, Horizant, and Lyrica CR
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	10/1/2023
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## 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
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**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
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**Approval Criteria**

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

**AND**

2 - One of the following:

2.1 All of the following:

2.1.1 Diagnosis of diabetic peripheral neuropathy (DPN)

**AND**

2.1.2 Both of the following:

2.1.2.1 Dose requested does not exceed 330 mg/day

**AND**

2.1.2.2 Dose requested does not exceed one of the following:

- 82.5 mg strength - max of 3 tablets/day
- 165 mg strength - max of 1 tablet/day
- 330 mg strength - max of 1 tablet/day

**OR**

2.2 All of the following:

2.2.1 Diagnosis of postherpetic neuralgia (PHN)

**AND**

**2.2.2** Both of the following:

**2.2.2.1** Dose requested does not exceed 660 mg/day

**AND**

**2.2.2.2** Dose requested does not exceed one of the following:

- 82.5 mg strength - max of 3 tablets/day
- 165 mg strength - max of 3 tablets/day
- 330 mg strength - max of 2 tablets/day

## 2 . Revision History

Date	Notes
9/1/2023	Updated T/F for Horizant RLS to include gabapentin IR and look back of 90 in the last 180 days

Growth Hormones



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-137571
<b>Guideline Name</b>	Growth Hormones
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2024
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### 1 . Criteria

Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ Nuspin, Omnitrope, Saizen, Saizenprep, Serostim, Zomacton, Zorbtive			
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
SAIZEN	SOMATROPIN (NON-REFRIGERATED) FOR INJ 5 MG	30100020102120	Brand

SAIZENPREP RECONSTITUTIONKIT	SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG	30100020102130	Brand
SAIZEN	SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG	30100020102130	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
ZORBTIVE	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 8.8 MG	30100020102132	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	<p>*PDL link: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a></p> <p>**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.</p>
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Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ Nuspin, Omnitrope, Saizen, Saizenprep, Serostim, Zomacton, Zorbtive			
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

UnitedHealthcare Community Plan of Indiana – Clinical Pharmacy Guidelines

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
SAIZEN	SOMATROPIN (NON-REFRIGERATED) FOR INJ 5 MG	30100020102120	Brand
SAIZENPREP RECONSTITUTIONKIT	SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG	30100020102130	Brand
SAIZEN	SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG	30100020102130	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
ZORBTIVE	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 8.8 MG	30100020102132	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	<p>*PDL link: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a></p> <p>**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.</p>
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Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ Nuspin, Omnitrope, Saizen, Saizenprep, Serostim, Zomacton, Zorbtive

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 FLEXP	SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/1.5ML	3010002000D212	Brand
NORDITROPIN FLEXP	SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/1.5ML	3010002000D230	Brand
NORDITROPIN FLEXP	SOMATROPIN SOLUTION PEN-INJECTOR 15 MG/1.5ML	3010002000D240	Brand
NORDITROPIN FLEXP	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
SAIZEN	SOMATROPIN (NON-REFRIGERATED) FOR INJ 5 MG	30100020102120	Brand
SAIZENPREP RECONSTITUTIONKIT	SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG	30100020102130	Brand
SAIZEN	SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG	30100020102130	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
ZORBTIVE	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 8.8 MG	30100020102132	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	<p>*PDL link: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a></p> <p>**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.</p>
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Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ Nuspin, Omnitrope, Saizen, Saizenprep, Serostim, Zomacton, Zorbtive

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

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HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 6 MG (18 UNIT)	3010002000E120	Brand
HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 12 MG (36 UNIT)	3010002000E130	Brand
HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 24 MG	3010002000E140	Brand
NORDITROPIN FLEXPPO	SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/1.5ML	3010002000D212	Brand
NORDITROPIN FLEXPPO	SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/1.5ML	3010002000D230	Brand
NORDITROPIN FLEXPPO	SOMATROPIN SOLUTION PEN-INJECTOR 15 MG/1.5ML	3010002000D240	Brand
NORDITROPIN FLEXPPO	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
SAIZEN	SOMATROPIN (NON-REFRIGERATED) FOR INJ 5 MG	30100020102120	Brand
SAIZENPREP RECONSTITUTIONKIT	SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG	30100020102130	Brand
SAIZEN	SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG	30100020102130	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
ZORBTIVE	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 8.8 MG	30100020102132	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: Zorbtive			
Diagnosis	Short Bowel Syndrome		
Approval Length	1 year(s)		
Therapy Stage	Initial Authorization		
Guideline Type	Prior Authorization		
Product Name	Generic Name	GPI	Brand/Generic
ZORBTIVE	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 8.8 MG	30100020102132	Brand

**Approval Criteria**

**1** - Documentation supporting diagnosis of short bowel syndrome

**AND**

**2** - Patient is an adult 18 years of age or older or has closed epiphyses

**AND**

**3** - Documentation indicating patient is receiving specialized nutritional support

**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

Product Name: Zorbtive			
Diagnosis	Short Bowel Syndrome		
Approval Length	1 year(s)		
Therapy Stage	Reauthorization		
Guideline Type	Prior Authorization		
Product Name	Generic Name	GPI	Brand/Generic
ZORBTIVE	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 8.8 MG	30100020102132	Brand

**Approval Criteria**

**1** - Diagnosis of short bowel syndrome

**AND**

**2** - Patient is an adult 18 years of age or older or has closed epiphyses

**AND**

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

**AND**

**4** - Documentation stating that the patient is continuing to receive specialized nutritional support

**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:

**2.1** Patient is at least 3 years of age

**AND**

**2.2** 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 have performed all necessary testing to ensure there are no expanding intracranial lesions or tumors prior to initiating growth hormone therapy

**AND**

**5** - ONE of the following:

**5.1** Trial and failure of Skytrofa (lonapegsomatropin), confirmed by claims history or chart documentation

**OR**

**5.2** Prescriber has documented valid medical justification as to why Skytrofa (lonapegsomatropin) is unsuitable for use

Product Name: Ngenla			
Approval Length	1 year(s)		
Therapy Stage	Reauthorization		
Guideline Type	Prior Authorization		
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	LONAPEG SOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CARTRIDGE 3 MG	3010000380E110	Brand
SKYTROFA	LONAPEG SOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CARTRIDGE 3.6 MG	3010000380E115	Brand
SKYTROFA	LONAPEG SOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CARTRIDGE 4.3 MG	3010000380E120	Brand
SKYTROFA	LONAPEG SOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CARTRIDGE 5.2 MG	3010000380E125	Brand
SKYTROFA	LONAPEG SOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CARTRIDGE 6.3 MG	3010000380E130	Brand
SKYTROFA	LONAPEG SOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CARTRIDGE 7.6 MG	3010000380E135	Brand
SKYTROFA	LONAPEG SOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CARTRIDGE 9.1 MG	3010000380E140	Brand
SKYTROFA	LONAPEG SOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CARTRIDGE 11 MG	3010000380E145	Brand
SKYTROFA	LONAPEG SOMATROPIN-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: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>
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Product Name: Skytrofa	
Approval Length	1 year(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SKYTROFA	LONAPEG SOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CARTRIDGE 3 MG	3010000380E110	Brand
SKYTROFA	LONAPEG SOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CARTRIDGE 3.6 MG	3010000380E115	Brand
SKYTROFA	LONAPEG SOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CARTRIDGE 4.3 MG	3010000380E120	Brand
SKYTROFA	LONAPEG SOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CARTRIDGE 5.2 MG	3010000380E125	Brand
SKYTROFA	LONAPEG SOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CARTRIDGE 6.3 MG	3010000380E130	Brand
SKYTROFA	LONAPEG SOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CARTRIDGE 7.6 MG	3010000380E135	Brand
SKYTROFA	LONAPEG SOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CARTRIDGE 9.1 MG	3010000380E140	Brand
SKYTROFA	LONAPEG SOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CARTRIDGE 11 MG	3010000380E145	Brand
SKYTROFA	LONAPEG SOMATROPIN-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:

**1.2.1** Patient is at least 2.5 years of age

**AND**

**1.2.2** Patient is less than 18 years of age

**AND**

**1.3** Submission of a radiology report showing BOTH of the following:

- Bone age of 14-15 or less in females, 16-17 or less in males
- If patient is nearing or at puberty (estimated age range 10-17 years of age), open epiphyses

**AND**

**1.4** Prescriber attestation that they have performed all necessary testing to ensure there are no expanding intracranial lesions or tumors prior to initiating growth hormone therapy

**AND**

**1.5** ONE of the following:

- Trial and failure of Skytrofa (lonapegsomatropin), confirmed by claims history or chart documentation
- Prescriber has submitted valid medical justification as to why Skytrofa (lonapegsomatropin) is unsuitable for use

**OR**

**2** - ALL of the following:

**2.1** Diagnosis of adult growth hormone deficiency (documentation of biochemical evidence or other applicable testing supporting the diagnosis is required)

**AND**

**2.2** Patient is 18 years of age or older



**AND**

**2.3** Prescriber attestation that they have performed all necessary testing to ensure there are no expanding intracranial lesions or tumors prior to initiating growth hormone therapy

**AND**

**2.4** ONE of the following:

- Trial and failure of all preferred\* somatropin products
- Prescriber has documented valid medical justification as to why all of the available preferred\* somatropin agent(s) are unsuitable for use

Notes	*PDL link: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>
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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
<b>Approval Criteria</b>			
<b>1 - Documented diagnosis of achondroplasia</b>			

<p><b>AND</b></p> <p><b>2</b> - Submission of radiology report confirming open epiphyses</p> <p><b>AND</b></p> <p><b>3</b> - Patient is less than 18 years of age</p> <p><b>AND</b></p> <p><b>4</b> - Documentation of baseline height and weight</p>
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<b>Product Name: Voxzogo</b>			
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
<p><b>Approval Criteria</b></p> <p><b>1</b> - History of the requested medication for at least 90 days within the past 120 days, confirmed by claims history or chart documentation</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Patient is less than 18 years of age</p>			

**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
12/11/2023	Updated GPI and product name lists, added Ngenla, updated all criteria.

H2 Receptor Antagonists



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-137625
<b>Guideline Name</b>	H2 Receptor Antagonists
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2024
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### 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
<b>Approval Criteria</b>			
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



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-124485
<b>Guideline Name</b>	Haegarda
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	6/1/2023
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## 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
<b>Approval Criteria</b>			

**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 a FXII, angiotensin-1, plasminogen gene mutation, or kininogen mutation

**OR**

**1.2.2** Recurring angioedema attacks that are refractory to high-dose antihistamines with confirmed family history of angioedema

**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, defined as a clinically significant reduction in the rate and/or number of hereditary angioedema (HAE) attacks, while on 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

HCG



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-138448
<b>Guideline Name</b>	HCG
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	2/1/2024
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## 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	30062022052220	Brand
PREGNYL W/DILUENT	CHORIONIC GONADOTROPIN FOR IM INJ 10000 UNIT	30062020002140	Brand

BENZYL ALCOHOL/NACL			
PREGNYL	CHORIONIC GONADOTROPIN FOR IM INJ 10000 UNIT	30062020002140	Brand

**Approval Criteria**

1 - Diagnosis of prepubertal cryptorchidism not due to anatomical obstruction

Hematonic Agents



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-124339
<b>Guideline Name</b>	Hematonic Agents
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

**Guideline Note:**

Effective Date:	7/1/2023
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### 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
<b>Approval Criteria</b>			
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: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>
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**Product Name: Procrit**

Approval Length	6 month(s)
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Guideline Type	Prior Authorization
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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: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>
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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



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-121635
<b>Guideline Name</b>	Hepatitis B Agents
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

**Guideline Note:**

Effective Date:	3/19/2023
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### 1 . Criteria

Product Name: Vemlidy			
Diagnosis	Chronic Hepatitis B Infection		
Approval Length	Lifetime approval		
Guideline Type	Prior Authorization		
Product Name	Generic Name	GPI	Brand/Generic
VEMLIDY	TENOFOVIR ALAFENAMIDE FUMARATE TAB 25 MG	12352083200320	Brand
<b>Approval Criteria</b>			
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 12 years of age or older

**AND**

**4** - 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
2/22/2023	Changed minimum age requirement. Updated verbiage for approval length.

Hetlioz



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-124146
<b>Guideline Name</b>	Hetlioz
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	7/1/2023
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## 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
<p><b>Approval Criteria</b></p> <p>1 - One of the following:</p> <p>1.1 Diagnosis of non-24-hour sleep-wake disorder and all of the following:</p>			

**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
<b>Approval Criteria</b>			
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



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-127982
<b>Guideline Name</b>	HIV
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

#### Guideline Note:

Effective Date:	9/1/2023
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### 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.  
\*This criteria does not apply to Maryland, the medication is open access

Product Name: Aptivus, Viracept, nevirapine, nevirapine ER

Diagnosis	HIV
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Approval Length	12 month(s)
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Guideline Type	Prior Authorization
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Product Name	Generic Name	GPI	Brand/Generic
NEVIRAPINE	NEVIRAPINE TAB 200 MG	12109050000320	Generic
NEVIRAPINE	NEVIRAPINE SUSP 50 MG/5ML	12109050001820	Generic
NEVIRAPINE ER	NEVIRAPINE TAB ER 24HR 100 MG	12109050007510	Generic
NEVIRAPINE ER	NEVIRAPINE TAB ER 24HR 400 MG	12109050007520	Generic
APTIVUS	TIPRANAVIR CAP 250 MG	12104585000120	Brand
VIRACEPT	NELFINAVIR MESYLATE TAB 250 MG	12104545200320	Brand
VIRACEPT	NELFINAVIR MESYLATE TAB 625 MG	12104545200340	Brand

**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 Eпивir, 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	ENFUVRTIDE 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

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ISENTRRESS	RALTEGRAVIR POTASSIUM CHEW TAB 100 MG (BASE EQUIV)	12103060100540	Brand
ISENTRRESS	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

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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

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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
RETROVIR IV INFUSION	ZIDOVUDINE IV SOLN 10 MG/ML	12108085002020	Brand
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

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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-ZIDOVUDINE TAB 300-150-300 MG	12109903200320	Brand
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
SYM TUZA	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	<p>This guideline does NOT include Biktarvy, Complera, Descovy, Genvo ya, Rukobia, and Stribild. These medications have drug specific guidelines.</p> <p>Approval Duration: 12 months for HIV; 4 weeks for PEP.</p> <p>*PDL link: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a></p>
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## 2 . Revision History

Date	Notes
7/14/2023	Updated PDL links

HMG CoA Reductase Inhibitors



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-132806
<b>Guideline Name</b>	HMG CoA Reductase Inhibitors
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	10/1/2023
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### 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
<b>Approval Criteria</b>			
1 - Patient is 10 years of age or older AND less than 12 years of age			



**OR**

**2** - Patient is unable to swallow tablets

## **2 . Revision History**

Date	Notes
9/8/2023	New

Hycamtin



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-138238
<b>Guideline Name</b>	Hycamtin
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	2/1/2024
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## 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
HYCAMPIN	TOPOTECAN HCL CAP 0.25 MG (BASE EQUIV)	21550080100120	Brand
HYCAMPIN	TOPOTECAN HCL CAP 1 MG (BASE EQUIV)	21550080100140	Brand
HYCAMPIN	TOPOTECAN HCL FOR INJ 4 MG (BASE EQUIV)	21550080102120	Brand
TOPOTECAN HCL	TOPOTECAN HCL FOR INJ 4 MG (BASE EQUIV)	21550080102120	Generic
<b>Approval Criteria</b>			
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
HYCAMPIN	TOPOTECAN HCL CAP 0.25 MG (BASE EQUIV)	21550080100120	Brand
HYCAMPIN	TOPOTECAN HCL CAP 1 MG (BASE EQUIV)	21550080100140	Brand
HYCAMPIN	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



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-123808
<b>Guideline Name</b>	Ibrance
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	5/1/2023
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## 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
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of advanced, recurrent, or metastatic breast cancer</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Disease is hormone-receptor (HR)-positive</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - Disease is human epidermal growth factor receptor 2 (HER2)-negative</p> <p style="text-align: center;"><b>AND</b></p> <p>4 - ONE of the following:</p> <ul style="list-style-type: none"> <li>• Used in combination with an aromatase inhibitor (e.g., anastrozole, letrozole, exemestane)</li> <li>• Used in combination with Faslodex (fulvestrant)</li> </ul>			

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 well-differentiated/dedifferentiated liposarcoma (WD-DDLS)

**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
3/27/2023	Added tablet GPI's to product details.

Iclusig



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-138750
<b>Guideline Name</b>	Iclusig
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	2/1/2024
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## 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 Tassigna (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



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-134566
<b>Guideline Name</b>	Idhifa
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	12/1/2023
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## 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
<b>Approval Criteria</b>			

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

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 Regimen		
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
<b>Approval Criteria</b>			
1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium			

Product Name: Idhifa			
Diagnosis	NCCN Recommended Regimen		
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

Imbruvica



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-136395
<b>Guideline Name</b>	Imbruvica
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	1/1/2024
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## 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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
<b>1</b> - 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



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-141428
<b>Guideline Name</b>	Immunoglobulin A Nephropathy (IgAN) Agents
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

**Guideline Note:**

Effective Date:	3/1/2024
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### 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
<b>Approval Criteria</b>			
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

<b>Guideline ID</b>	GL-123761
<b>Guideline Name</b>	Inbrija
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	5/1/2023
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## 1 . Criteria

Product Name: Inbrija			
Approval Length	6 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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to Inbrija therapy			
<b>AND</b>			
2 - Patient will continue to receive treatment with a carbidopa/levodopa-containing medication			

## 2 . Revision History

Date	Notes
3/24/2023	Updated trial/failure language.

Injectable and Transdermal Antipsychotics



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-136579
<b>Guideline Name</b>	Injectable and Transdermal Antipsychotics
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2024
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### 1 . Criteria

Product Name: (All Antipsychotics) Abilify Asimtufii, Abilify Maintena, Aristada, Aristada Initio, Brand Zyprexa inj, generic olanzapine inj, Zyprexa Relprevv, Invega Sustenna, prochlorperazine inj, Risperdal Consta, 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

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ZIPRASIDONE MESYLATE	ZIPRASIDONE MESYLATE FOR INJ 20 MG (BASE EQUIVALENT)	59400085202120	Generic
INVEGA SUSTENNA	PALIPERIDONE PALMITATE ER SUSP PEF SYR 39 MG/0.25ML	5907005010E626	Brand
INVEGA SUSTENNA	PALIPERIDONE PALMITATE ER SUSP PEF SYR 78 MG/0.5ML	5907005010E629	Brand
INVEGA SUSTENNA	PALIPERIDONE PALMITATE ER SUSP PEF SYR 117 MG/0.75ML	5907005010E632	Brand
INVEGA SUSTENNA	PALIPERIDONE PALMITATE ER SUSP PEF SYR 156 MG/ML	5907005010E635	Brand
INVEGA SUSTENNA	PALIPERIDONE PALMITATE ER SUSP PEF SYR 234 MG/1.5ML	5907005010E638	Brand
ABILIFY MAINTENA	ARIPIRAZOLE IM FOR ER SUSP PREFILLED SYRINGE 300 MG	5925001500E430	Brand
ABILIFY MAINTENA	ARIPIRAZOLE IM FOR ER SUSP PREFILLED SYRINGE 400 MG	5925001500E440	Brand
ABILIFY MAINTENA	ARIPIRAZOLE IM FOR EXTENDED RELEASE SUSP 300 MG	5925001500G230	Brand
ABILIFY MAINTENA	ARIPIRAZOLE IM FOR EXTENDED RELEASE SUSP 400 MG	5925001500G240	Brand
ARISTADA	ARIPIRAZOLE LAUROXIL IM ER SUSP PREFILLED SYR 441 MG/1.6ML	5925001520E420	Brand
ARISTADA	ARIPIRAZOLE LAUROXIL IM ER SUSP PREFILLED SYR 662 MG/2.4ML	5925001520E430	Brand
ARISTADA INITIO	ARIPIRAZOLE LAUROXIL IM ER SUSP PREFILLED SYR 675 MG/2.4ML	5925001520E435	Brand
ARISTADA	ARIPIRAZOLE LAUROXIL IM ER SUSP PREFILLED SYR 882 MG/3.2ML	5925001520E440	Brand
ARISTADA	ARIPIRAZOLE 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

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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	ARIPIRAZOLE IM ER SUSP PREFILLED SYRINGE 720 MG/2.4ML	5925001500E455	Brand
ABILIFY ASIMTUFII	ARIPIRAZOLE 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

**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
- 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

**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

**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 \*

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; \*\*Requests to utilize more than two antipsychotics concurrently will be denied

Product Name: (All Antipsychotics) Abilify Asimtufii, Abilify Maintena, Aristada, Aristada Initio, Brand Zyprexa inj, generic olanzapine inj, Zyprexa Relprevv, Invega Sustenna, prochlorperazine inj, Risperdal Consta, 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 PEF SYR 39 MG/0.25ML	5907005010E626	Brand
INVEGA SUSTENNA	PALIPERIDONE PALMITATE ER SUSP PEF SYR 78 MG/0.5ML	5907005010E629	Brand
INVEGA SUSTENNA	PALIPERIDONE PALMITATE ER SUSP PEF SYR 117 MG/0.75ML	5907005010E632	Brand
INVEGA SUSTENNA	PALIPERIDONE PALMITATE ER SUSP PEF SYR 156 MG/ML	5907005010E635	Brand
INVEGA SUSTENNA	PALIPERIDONE PALMITATE ER SUSP PEF SYR 234 MG/1.5ML	5907005010E638	Brand
ABILIFY MAINTENA	ARIPIRAZOLE IM FOR ER SUSP PREFILLED SYRINGE 300 MG	5925001500E430	Brand
ABILIFY MAINTENA	ARIPIRAZOLE IM FOR ER SUSP PREFILLED SYRINGE 400 MG	5925001500E440	Brand
ABILIFY MAINTENA	ARIPIRAZOLE IM FOR EXTENDED RELEASE SUSP 300 MG	5925001500G230	Brand
ABILIFY MAINTENA	ARIPIRAZOLE IM FOR EXTENDED RELEASE SUSP 400 MG	5925001500G240	Brand
ARISTADA	ARIPIRAZOLE LAUROXIL IM ER SUSP PREFILLED SYR 441 MG/1.6ML	5925001520E420	Brand
ARISTADA	ARIPIRAZOLE LAUROXIL IM ER SUSP PREFILLED SYR 662 MG/2.4ML	5925001520E430	Brand
ARISTADA INITIO	ARIPIRAZOLE LAUROXIL IM ER SUSP PREFILLED SYR 675 MG/2.4ML	5925001520E435	Brand
ARISTADA	ARIPIRAZOLE LAUROXIL IM ER SUSP PREFILLED SYR 882 MG/3.2ML	5925001520E440	Brand

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ARISTADA	ARIPIRAZOLE 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	ARIPIRAZOLE IM ER SUSP PREFILLED SYRINGE 720 MG/2.4ML	5925001500E455	Brand
ABILIFY ASIMTUFII	ARIPIRAZOLE 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

**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

Notes	*Requests to utilize more than two antipsychotics concurrently will be denied
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Product Name: (All Antipsychotics) Abilify Asimtufii, Abilify Maintena, Aristada, Aristada Initio, Brand Zyprexa inj, generic olanzapine inj, Zyprexa Relprevv, Invega Sustenna, prochlorperazine inj, Risperdal Consta, 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

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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	ARIPIRAZOLE IM FOR ER SUSP PREFILLED SYRINGE 300 MG	5925001500E430	Brand
ABILIFY MAINTENA	ARIPIRAZOLE IM FOR ER SUSP PREFILLED SYRINGE 400 MG	5925001500E440	Brand
ABILIFY MAINTENA	ARIPIRAZOLE IM FOR EXTENDED RELEASE SUSP 300 MG	5925001500G230	Brand
ABILIFY MAINTENA	ARIPIRAZOLE IM FOR EXTENDED RELEASE SUSP 400 MG	5925001500G240	Brand
ARISTADA	ARIPIRAZOLE LAUROXIL IM ER SUSP PREFILLED SYR 441 MG/1.6ML	5925001520E420	Brand
ARISTADA	ARIPIRAZOLE LAUROXIL IM ER SUSP PREFILLED SYR 662 MG/2.4ML	5925001520E430	Brand
ARISTADA INITIO	ARIPIRAZOLE LAUROXIL IM ER SUSP PREFILLED SYR 675 MG/2.4ML	5925001520E435	Brand
ARISTADA	ARIPIRAZOLE LAUROXIL IM ER SUSP PREFILLED SYR 882 MG/3.2ML	5925001520E440	Brand
ARISTADA	ARIPIRAZOLE 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

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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
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ABILIFY ASIMTUFII	ARIPIRAZOLE 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 PEF SYR 75 MG/0.21ML	5907007000E618	Brand
UZEDY	RISPERIDONE SUBCUTANEOUS ER SUSP PEF SYR 100 MG/0.28ML	5907007000E626	Brand
UZEDY	RISPERIDONE SUBCUTANEOUS ER SUSP PEF SYR 125 MG/0.35ML	5907007000E634	Brand
UZEDY	RISPERIDONE SUBCUTANEOUS ER SUSP PEF SYR 150 MG/0.42ML	5907007000E642	Brand
UZEDY	RISPERIDONE SUBCUTANEOUS ER SUSP PEF SYR 200 MG/0.56ML	5907007000E658	Brand
UZEDY	RISPERIDONE SUBCUTANEOUS ER SUSP PEF 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

**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 - Adequate Dose

Description	Adequate Dose
ARIPIPIRAZOLE	>/=5 mg/day
ASENAPINE	>/= 10 mg/day
BREXPIPIRAZOLE	>= 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	$\geq 6$ mg/day	
	TRIFLUOPERAZINE HCL	$\geq 2$ mg/day	
	ZIPRASIDONE	$\geq 80$ mg/day	

### 3 . Revision History

Date	Notes
11/21/2023	Added Rykindo.

Inlyta



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-134774
<b>Guideline Name</b>	Inlyta
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	12/1/2023
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## 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
<b>Approval Criteria</b>			

**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 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** - Patient's 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** - Patient's 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
<b>Approval Criteria</b>			
1 - Diagnosis of alveolar soft part sarcoma (ASPS)			
<b>AND</b>			
2 - The requested medication will be used in combination with Keytruda (pembrolizumab)			

Product Name: Inlyta			
Diagnosis	Advanced 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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Inlyta will be approved for uses 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
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to Inlyta therapy			

Inqovi



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-123560
<b>Guideline Name</b>	Inqovi
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	5/1/2023
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## 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
<b>Approval Criteria</b>			

**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
<b>Approval Criteria</b>			
1 - Patient does not show evidence of progressive disease while on Inqovi therapy			

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

Product Name	Generic Name	GPI	Brand/Generic
INQOVI	DECITABINE-CEDAZURIDINE TAB 35-100 MG	21990002250320	Brand

**Approval Criteria**

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

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

  

Product Name	Generic Name	GPI	Brand/Generic
INQOVI	DECITABINE-CEDAZURIDINE TAB 35-100 MG	21990002250320	Brand

**Approval Criteria**

1 - Documentation of positive clinical response to Inqovi therapy

Inrebic



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-117342
<b>Guideline Name</b>	Inrebic
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	1/1/2023
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## 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
<b>Approval Criteria</b>			

**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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-135122
<b>Guideline Name</b>	Insulin Pen Needles and Syringes
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

**Guideline Note:**

Effective Date:	12/1/2023
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### 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

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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

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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

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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

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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/ULTRAFINE/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

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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 NEEDEDLES 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



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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

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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

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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

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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

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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

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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

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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 ULTRAFINE/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

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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 SAFEPAK 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 SAFEPAK 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 ULTRAFINE/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



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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

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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

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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

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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

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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 SYRINGE/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

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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

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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

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ZEV RX 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
ZEV RX INSULIN SYRINGE/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand



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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

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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/27GX1/2"	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

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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

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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

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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

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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

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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

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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



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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

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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

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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

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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 SAFEPAK 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

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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

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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

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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 NEEDLES 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

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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



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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 SAFEPAK/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

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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

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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 NEEDLES 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

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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

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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 SAFEPAK/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

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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

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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

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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



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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

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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

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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

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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 ULTRAFINE/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 ULTRAFINE/0.3ML/31G X 8MM	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
BD INSULIN SYRINGE ULTRAFINE/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 ULTRAFINE/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 ULTRAFINE/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

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

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DROPLET PEN NEEDLES 29GX10MM	INSULIN PEN NEEDLE 29 G X 10 MM	97051050146326	Brand
TECHLITE PEN NEEDLES 29G X 10MM	INSULIN PEN NEEDLE 29 G X 10 MM	97051050146326	Brand
AURORA PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
CAREFINE PEN NEEDLES 29GX1/2"	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
CAREONE UNIFINE PENTIPS PLUS PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
CAREONE UNIFINE PENTIPS 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
CARETOUCH PEN NEEDLE 29GX1/2"	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
DROPLET PEN NEEDLES 29G X1/2"	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
DROPLET PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
DRUG MART UNIFINE PENTIPS29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
EASY TOUCH PEN NEEDLES 29GX1/2"	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
EXEL COMFORT POINT INSULIN PEN NEEDLES 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
GLOBAL EASE INJECT PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
H-E-B INCONTROL PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
HEALTHWISE PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
HEALTHY ACCENTS UNIFINE PENTIPS PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
INSUPEN 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
KROGER PEN NEEDLES 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
MARATHON MEDICAL PENTIPS 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
MEDICINE SHOPPE PEN NEEDLES 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
MEIJER PEN NEEDLES 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
PC UNIFINE PENTIPS 29G X 1/2"	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand

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PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
PEN NEEDLES/29G X 1/2"	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
PENTIPS 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
PENTIPS 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
PREFERRED PLUS UNIFINE PENTIPS 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
PX PEN NEEDLE 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
QC PEN NEEDLES 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
RAYA SURE PEN NEEDLE 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
RELION PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
SHOPKO UNIFINE PENTIPS PEN NEEDLES/ORIGINAL/29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
SHOPKO UNIFINE PENTIPS PLUS PEN NEEDLES/REMOVER/29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
TECHLITE PEN NEEDLES 29G X 12 MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
TODAYS HEALTH ORIGINAL PEN NEEDLES 29G X 1/2"	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
TRUEPLUS PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
ULTRA FLO INSULIN PEN NEEDLES	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
UNIFINE PENTIPS PLUS 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
UNIFINE PENTIPS 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
VALUMARK PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
VIDA MIA UNIFINE PENTIPS ORIGINAL 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
1ST TIER UNIFINE PENTIPS PLUS/ORIGINAL/29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
1ST TIER UNIFINE PENTIPS 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
ADVOCATE INSULIN PEN NEEDLES 29GX12.7MM	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand

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BD PEN NEEDLE/ORIGINAL/ULTRA-FINE/29G X 12.7MM	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand
LITETOUCH PEN NEEDLES 29GX12.7MM	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand
SURE COMFORT PEN NEEDLES 29GX1/2" 12.7MM	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand
TRUEPLUS 5-BEVEL PEN NEEDLES 29GX12.7MM	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand
ULTICARE ORIGINAL PEN NEEDLES ULTI-FINE	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand
ULTICARE PEN NEEDLES/29G X 12.7MM	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand
ULTIGUARD SAFEPACK PEN NEEDLE/29G X 1/2"/SHARPS CONTAINER	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand
ULTILET PEN NEEDLE 29GX12.7MM	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand
ULTRA-THIN II PEN NEEDLES 29GX1/2"	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand
BD AUTOSHIELD DUO 30G X 5MM	INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16")	97051050146340	Brand
EASY TOUCH PEN NEEDLE/30 G X 3/16"	INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16")	97051050146340	Brand
PEN NEEDLES 30GX5MM	INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16")	97051050146340	Brand
SAFETY PEN NEEDLES/30G X 3/16"	INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16")	97051050146340	Brand
ULTICARE MINI SAFETY PEN NEEDLES 30G X 3/16"	INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16")	97051050146340	Brand
UNIFINE PENTIPS PLUS/30G X 3/16"	INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16")	97051050146340	Brand
UNIFINE PENTIPS/30G X 3/16"	INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16")	97051050146340	Brand
UNIFINE SAFECONTROL PEN NEEDLE/30G X 3/16"	INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16")	97051050146340	Brand
EASY TOUCH SAFETY PEN NEEDLES/30G X 1/4"	INSULIN PEN NEEDLE 30 G X 6 MM (1/4" OR 15/64")	97051050146341	Brand
ABOUTTIME PEN NEEDLES 30GX 5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
ASSURE ID SAFETY PEN NEEDLES 30G X 5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
CAREFINE PEN NEEDLES 30GX5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
DROPLET PEN NEEDLES 30G X 5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand



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EASY TOUCH PEN NEEDLE 30 G X 5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
EASY TOUCH SAFETY PEN NEEDLES/30G X 5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
INSUPEN ULTRAFIN 30GX8MM	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
NOVOFINE AUTOCOVER PEN NEEDLE 30G X 8MM	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
PEN NEEDLES 30GX8MM	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
SAFETY PEN NEEDLES/30G X 5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
SECURESAFE SAFETY PEN NEEDLES/30G X 5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
SURE COMFORT PEN NEEDLES 30GX5/16" SHORT	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
ULTICARE SHORT SAFETY PEN NEEDLES 30G X 5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
UNIFINE SAFECONTROL PEN NEEDLE/30G X 5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
AUM SAFETY PEN NEEDLE/31 G X 4MM	INSULIN PEN NEEDLE 31 G X 4 MM (1/6" OR 5/32")	97051050146354	Brand
COMFORT TOUCH PEN NEEDLES/31G X 4MM	INSULIN PEN NEEDLE 31 G X 4 MM (1/6" OR 5/32")	97051050146354	Brand
RAYA SURE PEN NEEDLE 31G X 4MM	INSULIN PEN NEEDLE 31 G X 4 MM (1/6" OR 5/32")	97051050146354	Brand
ABOUTTIME PEN NEEDLES 31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
ADVOCATE INSULIN PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
AUM SAFETY PEN NEEDLE/31 G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
AURORA UNIFINE PENTIPS/MINI/31GX3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
BD PEN NEEDLE/MINI/ULTRA-FINE/31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
CAREONE UNIFINE PENTIPS PLUS PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
CAREONE UNIFINE PENTIPS 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
CARETOUCH PEN NEEDLES 31GX 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
CLICKFINE PEN NEEDLES 31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand

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COMFORT EZ/31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
COMFORT TOUCH PEN NEEDLES/31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
DIATHRIVE PEN NEEDLE/31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
DROPLET PEN NEEDLES 31G X3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
DROPLET PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
DROPSAFE SAFETY PEN NEEDLE/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
DRUG MART UNIFINE PENTIPS 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
EASY COMFORT PEN NEEDLES 31GX3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
EASY TOUCH PEN NEEDLES/31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
FIFTY50 PEN NEEDLES 31G X3/16" (5MM)	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
FIFTY50 PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
FREDS PHARMACY UNIFINE PENTIPS PLUS 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
GLOBAL EASE INJECT PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
GNP ULTICARE PEN NEEDLES 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
GNP ULTIGUARD SAFEPACK/MINI PEN NEEDLE/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
GOODSENSE CLICKFINE SAFETY PEN NEEDLE/31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
GOODSENSE PEN NEEDLE/PENFINE CLASSIC/31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
H-E-B IN CONTROL PEN NEEDLE 31GX3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
H-E-B IN CONTROL PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
H-E-B IN CONTROL UNIFINE PENTIPS PLUS 31GX3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
H-E-B IN CONTROL UNIFINE PENTIPS PLUS 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
HEALTHWISE SHORT PEN NEEDLES/31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand

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HEALTHY ACCENTS UNIFINE PENTIPS PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
HM ULTICARE MINI PEN NEEDLES/31G X 5MM (3/16")	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
INSUPEN 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
KROGER PEN NEEDLES/31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
LEADER UNIFINE PENTIPS PLUS/MINI/31GX3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
LEADER UNIFINE PENTIPS/MINI/31GX3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
LITETOUCH PEN NEEDLES/31 G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
LITETOUCH PEN NEEDLES/31G X 5MM/MINI	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
MARATHON MEDICAL PENTIPS 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
MM PEN NEEDLES 31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PC UNIFINE PENTIPS 31G X 5MM MINI	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PEN NEEDLES 31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PEN NEEDLES 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PEN NEEDLES/31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PENTIPS 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PENTIPS 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PREFERRED PLUS UNIFINE PENTIPS/MINI/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PX MINI PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
RA PEN NEEDLES 31G X 5MM 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
RAYA SURE PEN NEEDLE 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
SHOPKO UNIFINE PENTIPS PEN NEEDLES/MINI/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
SHOPKO UNIFINE PENTIPS PLUS PEN NEEDLES/MINI/REMOVER/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand

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SURE COMFORT PEN NEEDLES 31GX3/16" (5MM)	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
TECHLITE PEN NEEDLES 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
TECHLITE PEN NEEDLES/31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
TRUE COMFORT PEN NEEDLES 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
TRUE COMFORT PRO PEN NEEDLES 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
TRUEPLUS PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
TRUEPLUS 5-BEVEL PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
ULTICARE PEN NEEDLES 31G X 5MM/MINI	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
ULTIGUARD SAFEPACK MINI PEN NEEDLE/31G X 3/16"/SHARPS CONTAI	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
ULTIGUARD SAFEPACK/MINI PEN NEEDLE/31G X 3/16"/SHARPS CONTAI	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
ULTILET PEN NEEDLE 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
ULTILET SHORT PEN NEEDLES31GX3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
ULTRA FLO INSULIN PEN NEEDLE 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
ULTRA-THIN II MINI PEN NEEEDLES/31GX3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
ULTRACARE PEN NEEDLES/31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
UNIFINE PENTIPS PLUS 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
UNIFINE PENTIPS 31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
UNIFINE PENTIPS 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
UNIFINE ULTRA PEN NEEDLE/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
WEGMANS UNIFINE PENTIPS PLUS/MINI/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
ZEVRX PEN NEEDLES 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
1ST TIER UNIFINE PENTIPS /MINI/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand

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1ST TIER UNIFINE PENTIPS PLUS/MINI/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
AURORA PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
CAREFINE PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
CAREONE UNIFINE PENTIPS PLUS PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
CAREONE UNIFINE PENTIPS 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
CARETOUCH PEN NEEDLES 31 G X 6 MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
CLICKFINE PEN NEEDLE UNIVERSAL/31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
CLICKFINE PEN NEEDLES 31G X 1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
COMFORT EZ/31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
COMFORT TOUCH PEN NEEDLES/31G X 6 MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
DIATHRIVE PEN NEEDLE/31 G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
DROPLET PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
DROPSAFE SAFTEY PEN NEEDLES/31G X 1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
DRUG MART UNIFINE PENTIPS31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
EASY COMFORT PEN NEEDLES 31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
EASY TOUCH PEN NEEDLES 31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
EXEL COMFORT POINT INSULIN PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
GNP CLICKFINE UNIVERSAL PEN NEEDLES 31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
H-E-B IN CONTROL PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
H-E-B IN CONTROL UNIFINE PENTIPS PLUS 31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
HEALTHWISE MINI PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
HEALTHY ACCENTS UNIFINE PENTIPS PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand

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INCONTROL ULTICARE MINI PEN NEEDLES/31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
INSUPEN ULTRAFIN 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
KROGER PEN NEEDLES 31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
KROGER PEN NEEDLES/31G X 1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
LITETOUCH PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
LITETOUCH PEN NEEDLES 31G X 6MM/ULTRA SHORT	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
MAXICOMFORT II PEN NEEDLES/31G X 1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
MEDICINE SHOPPE PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
MEIJER PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
MICRODOT PEN NEEDLE/31G X 6 MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
MM PEN NEEDLES 31G X 1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PC UNIFINE PENTIPS 31G X 6MM ULTRA SHORT	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PEN NEEDLES 31GX6MM (1/4")	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
BD INSULIN SYRINGE/U-500/0.5ML/31G X 6MM	INSULIN SYRINGE/NEEDLE U-500 0.5 ML 31G X 6MM (15/64")	97051030956330	Brand
ADVOCATE INSULIN SYRINGE/U-100/0.3ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
BD INSULIN SYRINGE ULTRAFINE/U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
BD INSULIN SYRINGE/0.3ML/29G X 12.7MM	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
BD SAFETYGLIDE INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
DROPLET INSULIN SYRINGE 0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
EQL INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand

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EXEL COMFORT POINT INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
GNP INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
INSULIN SYRINGE/U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
KROGER INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
LEADER INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
LITETOUCH INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
MAGELLAN INSULIN SAFETY SYRINGE/U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
MONOJECT INSULIN SYRINGE/SAFETY/PERM NEEDLE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
MONOJECT INSULIN SYRINGE/SAFETY/PERM NEEDLE/0.3ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
PREFERRED PLUS INSULIN SYRINGE/U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
TECHLITE INSULIN SYRINGE U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
TOPCARE ULTRA COMFORT INSULIN SYRINGE/U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
TRUEPLUS INSULIN SYRINGE/U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
ULTICARE INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
ULTRA FLO INSULIN SYRINGE 0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
VP INSULIN SYRINGE/U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
ADVOCATE INSULIN SYRINGE/U-100/0.3ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand

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DROPLET INSULIN SYRINGE U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
EASY TOUCH INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
EQL INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
EXEL COMFORT POINT INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
GLOBAL INSULIN SYRINGES/U-100/0.3ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
GLUCOPRO INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
GNP INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
GNP INSULIN SYRINGES/0.3ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
HEALTHWISE INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
INSULIN SYRINGE/NEEDLE 0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
KROGER INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
LEADER INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
LITETOUCH INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
LITETOUCH INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
MAGELLAN INSULIN SAFETY SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
MEDIC INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
MM INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
MONOJECT INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
PRECISION SURE-DOSE INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand



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PREFERRED PLUS INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
TECHLITE INSULIN SYRINGE U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
TOPCARE ULTRA COMFORT INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
TRUEPLUS INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
ULTICARE INSULIN SYRINGE/SHORT/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
ULTICARE INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
ULTRA COMFORT INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
ULTRA FLO INSULIN SYRINGE 0.3ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
ULTRA FLO INSULIN SYRINGE 1/2 UNIT/0.3ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
ULTRA-THIN II INSULIN SYRINGE SHORT/U-100/0.3ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
ULTRACARE INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
B-D INSULIN SYRINGE ULTRAFINE/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
BD INSULIN SYRINGE ULTRAFINE/0.3ML/30G X 12.7MM	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
BD INSULIN SYRINGE ULTRAFINE/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
CAREONE INSULIN SYRINGES/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
DROPLET INSULIN SYRINGE U-100/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
EASY TOUCH INSULIN SYRINGE/U-100/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
GLOBAL INSULIN SYRINGE/U-100/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
GLUCOPRO INSULIN SYRINGE/U-100/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand

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SURE COMFORT INSULIN SYRINGE/U-100/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
ULTICARE INSULIN SYRINGE/U-100/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
ULTICARE INSULIN SYRINGE/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
ULTIGUARD SAFEPACK INSULIN SYRINGE 0.3ML/30G X 1/2"/SHARPS C	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
ULTIGUARD SAFEPACK INSULIN SYRINGE/0.3ML/30G X 1/2"/SHARPS C	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
ULTRA FLO INSULIN SYRINGE 0.3ML/30GX1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
ULTRA FLO INSULIN SYRINGE 1/2 UNIT/0.3ML/30GX1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
EASY TOUCH INSULIN SYRINGE/U-100/0.5ML/27G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 27 X 1/2"	97051030906310	Brand
INSULIN SYRINGES/0.5ML/27GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 27 X 1/2"	97051030906310	Brand
MAXICOMFORT INSULIN SYRINGES 27G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 27 X 1/2"	97051030906310	Brand
ADVOCATE INSULIN SYRINGE/U-100/0.5ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
B-D INSULIN SYRINGE ULTRAFINE II/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
BD INSULIN SYRINGE ULTRAFINE/0.5ML/31G X 8MM	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
BD INSULIN SYRINGE ULTRAFINE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
CAREONE INSULIN SYRINGES/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
CARETOUCH INSULIN SYRINGE/0.5ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
COMFORT EZ INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
DROPLET INSULIN SYRINGE U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
DROPLET INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
EASY COMFORT INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand

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EASY TOUCH INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
EQL INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
FIFTY50 SUPERIOR COMFORT INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
GLUCOPRO INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
GNP INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
HEALTHWISE INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
INSULIN SYRINGE/NEEDLE 0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
INSULIN SYRINGES/0.5ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
KINRAY INSULIN SYRINGE PREFERRED PLUS/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
KROGER INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
LEADER INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
LITETOUCH INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
LITETOUCH INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
LONGS INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
MM INSULIN SYRINGE/U-100/1/2ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
MS INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
PRO COMFORT INSULIN SYRINGES/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
PRODIGY INSULIN SYRINGE/1/2ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand

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RELION INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.5ML/31G X 5/16	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
TECHLITE INSULIN SYRINGE U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
TOPCARE ULTRA COMFORT INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
TRUE COMFORT INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
TRUE COMFORT PRO INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
TRUEPLUS INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
ULTICARE INSULIN SYRINGE ULTRAFINE U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
ULTICARE INSULIN SYRINGE/SHORT/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
ULTICARE INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
ULTIGUARD SAFEPACK/SYRINGE/NEEDLE/31G X 5/16"/SHARPS CONTAIN	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
ULTRA FLO INSULIN SYRINGE 0.5ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
ULTRA-THIN II INSULIN SYRINGE SHORT/U-100/0.5ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
ULTRACARE INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
BD LO-DOSE INSULIN SYRINGE MICROFINE IV/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
BD INSULIN SYRINGE MICROFINE IV/U-100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
EASY TOUCH INSULIN SYRINGE/U-100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
EXEL COMFORT POINT INSULIN SYRINGE/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
GNP INSULIN SYRINGE/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
INSULIN SYRINGE/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand

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INSULIN SYRINGES/0.5ML/28GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
LEADER INSULIN SYRINGE/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
LITETOUCH INSULIN SYRINGE/U- 100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
MAXI-COMFORT INSULIN SYRINGE/U-100/0.5ML/28GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
MONOJECT INSULIN SYRINGE/PERM NEEDLE/U- 100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
MONOJECT INSULIN SYRINGE/SOFTPACK/U- 100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
PREFERRED PLUS INSULIN SYRINGE/U-100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
REALITY INSULIN SYRINGE/U- 100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
TRUEPLUS INSULIN SYRINGE/U- 100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
ULTICARE INSULIN SYRINGE/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
ADVOCATE INSULIN SYRINGE/U- 100/0.5ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
BD INSULIN SYRINGE ULTRAFINE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
BD INSULIN SYRINGE/0.5ML/29G X 12.7MM	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
BD SAFETY-GLIDE INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
BD SAFETYGLIDE INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
DROPLET INSULIN SYRINGE 0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
EASY TOUCH INSULIN SYRINGE/SAFETY/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
EASY TOUCH INSULIN SYRINGE/U- 100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand

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EASY TOUCH INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
EQL INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
EXEL COMFORT POINT INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
GNP INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
GNP INSULIN SYRINGES/1/2ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
INSULIN SYRINGE/NEEDLE 0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
INSULIN SYRINGES/0.5ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
KINRAY INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
KROGER INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
LEADER INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
LITETOUCH INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
MAGELLAN INSULIN SAFETY SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
MONOJECT INSULIN SYRINGE/SAFETY/PERM NEEDLE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
PREFERRED PLUS INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
RA INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
REALITY INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
RELION INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
SB INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
SECURESAFE SAFETY INSULIN SYRINGES/U-100/0.5ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand

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SURE COMFORT INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
TECHLITE INSULIN SYRINGE U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
TOPCARE ULTRA COMFORT INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
TRUEPLUS INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
ULTICARE INSULIN SAFETY SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
ULTICARE INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
ULTRA FLO INSULIN SYRINGE 0.5ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
ULTRA-THIN II INSULIN SYRINGE/U-100/0.5ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
VALUE HEALTH INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
ADVOCATE INSULIN SYRINGE/U-100/0.5ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
BD SAFETYGLIDE INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
CARETOUCH INSULIN SYRINGE0.5ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
DROPLET INSULIN SYRINGE U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
EASY COMFORT INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
EASY TOUCH INSULIN SYRINGE/SAFETY/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
EASY TOUCH INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
EQL INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
EXEL COMFORT POINT INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
KMART VALU PLUS INSULIN SYRINGE/0.3ML/30G	INSULIN SYRINGE (DISP) U-100 0.3 ML	97051030056305	Brand

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KMART VALU PLUS INSULIN SYRINGE/0.5ML/29G	INSULIN SYRINGE (DISP) U-100 1/2 ML	97051030056310	Brand
KMART VALU PLUS INSULIN SYRINGE/0.5ML/30G	INSULIN SYRINGE (DISP) U-100 1/2 ML	97051030056310	Brand
BD INSULIN SYRINGE LUER-LOK/U-100/1ML	INSULIN SYRINGE (DISP) U-100 1 ML	97051030056320	Brand
BD INSULIN SYRINGE SLIP TIP/U-100/1ML	INSULIN SYRINGE (DISP) U-100 1 ML	97051030056320	Brand
KMART VALU PLUS INSULIN SYRINGE/1ML/29G	INSULIN SYRINGE (DISP) U-100 1 ML	97051030056320	Brand
KMART VALU PLUS INSULIN SYRINGE/1ML/30G	INSULIN SYRINGE (DISP) U-100 1 ML	97051030056320	Brand
MONOJECT INSULIN SYRINGE REGULAR LUER TIP/SOFTPACK/1ML	INSULIN SYRINGE (DISP) U-100 1 ML	97051030056320	Brand
MONOJECT INSULIN SYRINGE/1ML	INSULIN SYRINGE (DISP) U-100 1 ML	97051030056320	Brand
DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 31GX8MM 0.5ML	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
INSULIN SYRINGES/U-100/0.5ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
VERIFINE INSULIN SYRINGE 0.5ML/31G X 8MM	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
INSULIN SYRINGES/U-100/0.5ML/28GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
INSULIN SYRINGES/U-100/0.5ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
VERIFINE INSULIN SYRINGE 0.5ML/29G X 12MM	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
AQ INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
GLUCOPRO INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
GNP INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
HEALTHWISE INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
INSULIN SYRINGE/NEEDLE 0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
INSULIN SYRINGES/U-100/0.5ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
KROGER INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand



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LEADER INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
LITETOUCH INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
LITETOUCH INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
MAGELLAN INSULIN SAFETY SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
MEDIC INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
MM INSULIN SYRINGE/U-100/1/2ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
MONOJECT INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
PREFERRED PLUS INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
PRO COMFORT INSULIN SYRINGES/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
RA INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
SB INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
TECHLITE INSULIN SYRINGE U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
TOPCARE ULTRA COMFORT INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
TRUE COMFORT PRO INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
TRUEPLUS INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
ULTICARE INSULIN SYRINGE/SHORT/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
ULTICARE INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
ULTRA FLO INSULIN SYRINGE 0.5ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
ULTRA-THIN II INSULIN SYRINGE SHORT/U-100/0.5ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
ULTRACARE INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand

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VANISHPOINT INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
ZEVRX INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
CAREONE INSULIN SYRINGES/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
DROPLET INSULIN SYRINGE U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
DROPLET INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
EASY COMFORT INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
EASY TOUCH INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
GLUCOPRO INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
PRO COMFORT INSULIN SYRINGES/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
PX INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
TECHLITE INSULIN SYRINGE U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
TRUE COMFORT PRO INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
ULTICARE INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
ULTICARE INSULIN SYRINGE/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
ULTIGUARD SAFEPACK INSULIN SYRINGE 1/2ML 30G X 1/2"/SHARPS C	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
ULTIGUARD SAFEPACK INSULIN SYRINGE/0.5ML/30G X 1/2"/SHARPS C	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
ULTRA FLO INSULIN SYRINGE 0.5ML/30GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
ULTRACARE INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
VANISHPOINT INSULIN SYRINGE/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand

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ZEVRX INSULIN SYRINGE/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
MONOJECT INSULIN SYRINGE/DETACH NEEDLE/1ML/25G X 5/8"	INSULIN SYRINGE/NEEDLE U-100 1 ML 25 X 5/8"	97051030906330	Brand
BD SAFETYGLIDE INSULIN SYRINGE/0.3ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
BD VEO INSULIN SYRINGE ULTRA-FINE/U-100/0.3ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
BD VEO INSULIN SYRINGE ULTRA-FINE/0.3ML/31G X 6MM	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
BD VEO INSULIN SYRINGE ULTRA-FINE/1/2 UNIT/0.3ML/31G X 6MM	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
DROPLET INSULIN SYRINGE U-100/0.3ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
DROPLET INSULIN SYRINGE/U-100/0.3ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 31GX6MM 0.3ML	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
GLOBAL EASY GLIDE INSULIN SYRINGE/0.3ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
RELION INSULIN SYRINGE/U-100/0.3ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
TECHLITE INSULIN SYRINGE U-100/0.3ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
INSULIN SYRINGES 0.3ML/31G X 1/4"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 1/4" (6 MM)	97051030906334	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.3ML/31GX1/4"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 1/4" (6 MM)	97051030906334	Brand
ULTICARE U-100 INSULIN SYRINGES/HALF UNIT/0.3ML/31G X1/4"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 1/4" (6 MM)	97051030906334	Brand
ULTICARE U-100 INSULIN SYRINGES/0.3ML/31G X 1/4"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 1/4" (6 MM)	97051030906334	Brand
ULTICARE U-100 INSULIN SYRINGES/0.3ML/31G X1/4"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 1/4" (6 MM)	97051030906334	Brand
INSULIN SYRINGES 0.5ML/31G X 1/4"	INSULIN SYRINGE/NEEDLE U-100 0.5 ML 31 X 1/4" (6 MM)	97051030906336	Brand
SURE COMFORT INSULIN SYRINGES/0.5ML/31G X 6MM	INSULIN SYRINGE/NEEDLE U-100 0.5 ML 31 X 1/4" (6 MM)	97051030906336	Brand

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ULTICARE U-100 INSULIN SYRINGES/0.5ML/31G X 1/4"	INSULIN SYRINGE/NEEDLE U-100 0.5 ML 31 X 1/4" (6 MM)	97051030906336	Brand
INSULIN SYRINGE 1ML/31G X1/4"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 1/4" (6 MM)	97051030906337	Brand
SURE COMFORT INSULIN SYRINGES/U-100/1ML/31GX6MM	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 1/4" (6 MM)	97051030906337	Brand
ULTICARE U-100 INSULIN SYRINGES/1ML/31G X 1/4"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 1/4" (6 MM)	97051030906337	Brand
VANISHPOINT INSULIN SYRINGE/1ML/30G X 3/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 3/16" (5 MM)	97051030906338	Brand
EASY COMFORT INSULIN SYRINGE/0.3ML/31G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 1/2"	97051030906341	Brand
EASY COMFORT INSULIN SYRINGES/0.5ML/32GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.5 ML 32 X 5/16"	97051030906343	Brand
TRUE COMFORT PRO INSULIN SYRINGE/0.5ML/32G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.5 ML 32 X 5/16"	97051030906343	Brand
EASY COMFORT INSULIN SYRINGE/1ML/32GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 32 X 5/16"	97051030906344	Brand
TRUE COMFORT PRO INSULIN SYRINGE/1ML/32GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 32 X 5/16"	97051030906344	Brand
EASY TOUCH INSULIN SYRINGE/U-100/1ML/27G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 1/2"	97051030906350	Brand
INSULIN SYRINGES/U-100/1ML/27GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 1/2"	97051030906350	Brand
MAXICOMFORT INSULIN SYRINGES 27G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 1/2"	97051030906350	Brand
MONOJECT INSULIN SYRINGE/DETACH NEEDLE/1ML/27G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 1/2"	97051030906350	Brand
MONOJECT INSULIN SYRINGE/SOFTPACK/1ML/27G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 1/2"	97051030906350	Brand
VANISHPOINT INSULIN SYRINGE/0.5ML/30G X 3/16"	INSULIN SYRINGE/NEEDLE U-100 0.5 ML 30 X 3/16" (5 MM)	97051030906355	Brand
DROPLET INSULIN SYRINGE U-100/0.3ML/30G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 15/64"	97051030906359	Brand
EASY TOUCH INSULIN SYRINGE/U-100/1ML/27G X 5/8"	INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 5/8"	97051030906360	Brand
DROPLET INSULIN SYRINGE U-100/0.5ML/30G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 0.5 ML 30 X 15/64"	97051030906361	Brand
DROPLET INSULIN SYRINGE U-100/1ML/30G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 15/64"	97051030906362	Brand
CARETOUCH INSULIN SYRINGE/U-100/1ML/28G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 5/16"	97051030906368	Brand

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BD INSULIN SYRINGE MICROFINE/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
EASY TOUCH INSULIN SYRINGE/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
GNP INSULIN SYRINGES/1ML/28GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
GNP ULTRA COMFORT INSULIN SYRINGE/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
INSULIN SYRINGES/U-100/1ML/28GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
LEADER INSULIN SYRINGE/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
LITETOUCH INSULIN SYRINGE/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
MAXI-COMFORT INSULIN SYRINGE/U-100/1ML/28GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
MONOJECT INSULIN SYRINGE/PERM NEEDLE/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
MONOJECT INSULIN SYRINGE/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
MONOJECT ULTRA COMFORT INSULIN SYRINGE/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
PREFERRED PLUS INSULIN SYRINGE/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
PRODIGY INSULIN SYRINGE/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
REALITY INSULIN SYRINGE/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
SURE COMFORT INSULIN SYRINGE/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
TRUEPLUS INSULIN SYRINGE/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
ULTICARE INSULIN SYRINGE/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
ADVOCATE INSULIN SYRINGE/U-100/1ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
AQ INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand

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DROPLET INSULIN SYRINGE 1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 29GX12.5MM 1ML	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
EASY TOUCH FLIPLOCK SAFETY INSULIN SYRINGE 1ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
EASY TOUCH INSULIN SYRINGE/SAFETY/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
EASY TOUCH INSULIN SYRINGE/U- 100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
EASY TOUCH SHEATHLOCK SAFETY INSULIN SYRINGE 1ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
EQL INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
GNP INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
GNP INSULIN SYRINGES/1ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
INSULIN SYRINGE/NEEDLE 1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
INSULIN SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
INSULIN SYRINGES/U- 100/1ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
KROGER INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
LEADER INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
LITETOUCH INSULIN SYRINGE/U- 100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
MAGELLAN INSULIN SAFETY SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
MONOJECT INSULIN SYRINGE/SAFETY/PERM NEEDLE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
MONOJECT ULTRA COMFORT INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
PREFERRED PLUS INSULIN SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand

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RA INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
REALITY INSULIN SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
SB INSULIN SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
SECURESAFE SAFETY INSULIN SYRINGES/U-100/1ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
SURE COMFORT INSULIN SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
TECHLITE INSULIN SYRINGE U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
TOPCARE ULTRA COMFORT INSULIN SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
TRUEPLUS INSULIN SYRINGE /U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
ULTICARE INSULIN SAFETY SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
ULTICARE INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
ULTRA FLO INSULIN SYRINGE 1M/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
ULTRA-THIN II INSULIN SYRINGE/U-100/1ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
VALUE HEALTH INSULIN SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
VANISHPOINT INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
VERIFINE INSULIN SYRINGE 1ML/29G X 12MM	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
CARETOUCH INSULIN SYRINGE/U-100/1ML/29G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 5/16"	97051030906382	Brand
VANISHPOINT INSULIN SYRINGE/1ML/29G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 5/16"	97051030906382	Brand
ADVOCATE INSULIN SYRINGE/U-100/1ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
CARETOUCH INSULIN SYRINGE/1ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
DROPLET INSULIN SYRINGE U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
EASY COMFORT INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand

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EASY TOUCH FLIPLOCK SAFETY INSULIN SYRINGE 1ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
EASY TOUCH INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
EASY TOUCH SHEATHLOCK SAFETY INSULIN SYRINGE 1ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
EQL INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
GLUCOPRO INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
GNP INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
GNP INSULIN SYRINGES/1ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
HEALTHWISE INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
INSULIN SYRINGE/NEEDLE 1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
KROGER INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
LEADER INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
LITETOUCH INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
LITETOUCH INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
MAGELLAN INSULIN SAFETY SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
MM INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
MONOJECT INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
PREFERRED PLUS INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
PRO COMFORT INSULIN SYRINGES/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
RA INSULIN SYRINGE/U-100/1 ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand



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SB INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
SURE COMFORT INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
TOPCARE ULTRA COMFORT INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
TRUE COMFORT PRO INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
TRUEPLUS INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
ULTICARE INSULIN SYRINGE/SHORT/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
ULTICARE INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
ULTRA FLO INSULIN SYRINGE 1ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
ULTRA-THIN II INSULIN SYRINGE SHORT/U-100/1ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
ULTRACARE INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
VANISHPOINT INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
ZEVRX INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
BD INSULIN SYRINGE ULTRA FINE/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
BD INSULIN SYRINGE ULTRA-FINE/1ML/30G X 12.7MM	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
BD INSULIN SYRINGE ULTRAFINE/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
CAREONE INSULIN SYRINGES/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/1.0ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
DROPLET INSULIN SYRINGE U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
DROPLET INSULIN SYRINGE/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
EASY COMFORT INSULIN SYRINGE/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
EASY TOUCH FLIPLOCK SAFETY INSULIN SYRINGE 1ML/30GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
EASY TOUCH INSULIN SYRINGE/SAFETY/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand

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EASY TOUCH INSULIN SYRINGE/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
EASY TOUCH SHEATHLOCK SAFETY SYRINGE 1ML/30GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
GLUCOPRO INSULIN SYRINGE/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
HM ULTICARE INSULIN SYRINGE/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
INSULIN SYRINGES/U-100/1ML/30GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
PRO COMFORT INSULIN SYRINGES/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
SURE COMFORT INSULIN SYRINGE/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
TECHLITE INSULIN SYRINGE U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
TRUE COMFORT PRO INSULIN SYRINGE/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
ULTICARE INSULIN SYRINGE/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
ULTICARE INSULIN SYRINGE/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
ULTIGUARD SAFEPACK INSULIN SYRINGE 1ML 30G X 1/2"/SHARPS CON	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
ULTRA FLO INSULIN SYRINGE 1ML/30GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
ULTRACARE INSULIN SYRINGE/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
ZEVRX INSULIN SYRINGE/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
ADVOCATE INSULIN SYRINGE/U-100/1ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
AQ INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
BD INSULIN SYRINGE ULTRA-FINE/1ML/31G X 8MM	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
BD INSULIN SYRINGE ULTRAFINE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
CAREONE INSULIN SYRINGES/1ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
CARETOUCH INSULIN SYRINGE/1ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand

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CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/U-100/1ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
COMFORT EZ INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
DROPLET INSULIN SYRINGE U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
DROPLET INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 31GX8MM 1ML	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
EASY COMFORT INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
EASY TOUCH FLIPLOCK SAFETY INSULIN SYRINGE 1ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
EASY TOUCH INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
EASY TOUCH SHEATHLOCK SAFETY INSULIN SYRINGE 1ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
EQL INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
FIFTY50 SUPERIOR COMFORT INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
GLUCOPRO INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
GNP INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
HEALTHWISE INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
INSULIN SYRINGE/NEEDLE 1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
INSULIN SYRINGES/U-100/1ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
KINRAY INSULIN SYRINGE PREFERRED PLUS/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
KROGER INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
LEADER INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand

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LITETOUCH INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
MM INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
MONOJECT INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
MS INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
PRO COMFORT INSULIN SYRINGES/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
RELION INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
SB INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
SURE COMFORT INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
TECHLITE INSULIN SYRINGE U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
TOPCARE ULTRA COMFORT INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
TRUE COMFORT INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
TRUE COMFORT PRO INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
TRUEPLUS INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
ULTICARE INSULIN SYRINGE ULTRAFINE U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
ULTICARE INSULIN SYRINGE/SHORT/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
ULTICARE INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
ULTIGUARD SAFEPACK INSULIN SYRINGE 1ML 31G X 5/16"/SHARPS CO	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
ULTRA FLO INSULIN SYRINGE 1ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
ULTRA-THIN II INSULIN SYRINGE SHORT/U-100/1ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
ULTRACARE INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
VERIFINE INSULIN SYRINGE 1ML/31G X 8MM	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
ADVOCATE INSULIN SYRINGE/U-100/0.3ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand

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CAREONE INSULIN SYRINGES/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
CARETOUCH INSULIN SYRINGE/0.3ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
COMFORT ASSIST INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
DROPLET INSULIN SYRINGE U-100/0.3/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
DROPLET INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 31GX8MM 0.3ML	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
EASY COMFORT INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
EASY TOUCH INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
EQL INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
FIFTY50 SUPERIOR COMFORT INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
GLOBAL EASY GLIDE INSULINSYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
GLUCOPRO INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
GNP INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
GNP INSULIN SYRINGES/3ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
HEALTHWISE INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
HM ULTICARE INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
INSULIN SYRINGE/NEEDLE 0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand

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KINRAY INSULIN SYRINGE PREFERRED PLUS/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
KROGER INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
LEADER INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
LITETOUCH INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
LITETOUCH INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
MM INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
MS INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
PRODIGY INSULIN SYRING/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
RELION INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
TECHLITE INSULIN SYRINGE U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
TOPCARE ULTRA COMFORT INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
TRUEPLUS INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
ULTICARE INSULIN SYRINGE ULTRAFINE U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
ULTICARE INSULIN SYRINGE/SHORT/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
ULTICARE INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
ULTIGUARD SAFEPACK INSULIN SYRINGE/0.3ML/31G X 5/16"/SHARPS	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
ULTRA FLO INSULIN SYRINGE 0.3ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
ULTRA FLO INSULIN SYRINGE 1/2 UNIT/0.3ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand

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ULTRA-THIN II INSULIN SYRINGE SHORT/U-100/0.3ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
ULTRACARE INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
VERIFINE INSULIN SYRINGE 0.3ML/31G X 8MM	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
ASSURE ID INSULIN SAFETY SYRINGE U-100/0.5ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64"	97051030906391	Brand
DROPLET INSULIN SYRINGE/U-100/0.5ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64"	97051030906391	Brand
DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 31GX6MM 0.5ML	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64"	97051030906391	Brand
GLOBAL EASY GLIDE INSULIN SYRINGE/0.5ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64"	97051030906391	Brand
RELION INSULIN SYRINGE 0.5ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64"	97051030906391	Brand
TECHLITE INSULIN SYRINGE U-100/0.5ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64"	97051030906391	Brand
ASSURE ID INSULIN SAFETY SYRINGE/1ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
DROPLET INSULIN SYRINGE U-100/1ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
DROPLET INSULIN SYRINGE/U-100/1ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 31GX6MM 1ML	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
GLOBAL EASY GLIDE INSULIN SYRINGE/1ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
RELION INSULIN SYRINGE 1ML/31GX15/64"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
RELION INSULIN SYRINGE/U-100/1ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
TECHLITE INSULIN SYRINGE U-100/1ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
EMBRACE PEN NEEDLES/29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
VERIFINE INSULIN PEN NEEDLE 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
EMBRACE PEN NEEDLES/30G X 5MM	INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16")	97051050146340	Brand
COMFORT EZ PRO SAFETY PEN NEEDLES 30G X 8MM	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
EMBRACE PEN NEEDLES/30G X 8MM	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand

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PEN NEEDLES	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
AUM INSULIN SAFETY PEN NEEDLE/31GX4MM	INSULIN PEN NEEDLE 31 G X 4 MM (1/6" OR 5/32")	97051050146354	Brand
COMFORT EZ PRO SAFETY PEN NEEDLES 31G X 4MM	INSULIN PEN NEEDLE 31 G X 4 MM (1/6" OR 5/32")	97051050146354	Brand
AQINJECT PEN NEEDLE/31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
AUM INSULIN SAFETY PEN NEEDLE/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
COMFORT EZ PRO SAFETY PEN NEEDLES 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
EMBRACE PEN NEEDLES/31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PIP PEN NEEDLES 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PURE COMFORT SAFETY PEN NEEDLE 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
TRUE COMFORT SAFETY PEN NEEDLES 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
VERIFINE INSULIN PEN NEEDLE 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
VERIFINE PLUS INSULIN PEN NEEDLE 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
EMBRACE PEN NEEDLES/31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PEN NEEDLES/31G X 1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PEN NEEDLES/31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PENTIPS 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PREVENT DROPSAFE SAFETY PEN NEEDLES 31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PREVENT SAFETY PEN NEEDLES 31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PURE COMFORT SAFETY PEN NEEDLE 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PX EXTRA SHORT PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
QC PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
RAYA SURE PEN NEEDLE 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand



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RELION MINI PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
RELION PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
RELION PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
RELION PEN NEEDLES/31G X 1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
SURE COMFORT AUTOKEEPER SAFETY PEN NEEDLES 31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
TECHLITE PEN NEEDLES/31G X 6 MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
TOPCARE CLICKFINE UNIVERSAL PEN NEEDLES 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 NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
ULTIGUARD SAFEPACK/MINI PEN NEEDLE/31G X 1/4"/SHARPS CONTAIN	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
ULTIGUARD SAFEPACK/MINI PEN NEEDLE/31G X 6MM/SHARPS CONTAIN	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
ULTRACARE PEN NEEDLES/31G X 1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
UNIFINE PENTIPS PLUS 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
UNIFINE PENTIPS 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand

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UNIFINE ULTRA PEN NEEDLE/31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
WEGMANS UNIFINE PENTIPS PLUS/ULTRA SHORT/31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
ZEVRX PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
1ST TIER UNIFINE PENTIPS PLUS/ULTRA SHORT/31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
1ST TIER UNIFINE PENTIPS 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
ABOUTTIME PEN NEEDLES 31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ADVOCATE INSULIN PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
AURORA PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
CAREFINE PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
CAREONE UNIFINE PENTIPS PLUS PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
CARETOUCH PEN NEEDLES 31GX 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
CLEVER CHOICE COMFORT EZ INSULIN PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
CLICKFINE PEN NEEDLE UNIVERSAL/31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
CLICKFINE PEN NEEDLES 31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
CLICKFINE PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
CLICKFINE UNIVERSAL PEN NEEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
COMFORT EZ SHORT/31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
COMFORT TOUCH PEN NEEDLES/31G X 8 MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
DIATHRIVE PEN NEEDLE/31 GX 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
DROPLET PEN NEEDLES 31G X5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
DROPLET PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
DROPSAFE SAFETY PEN NEEDLES/31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand

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DRUG MART UNIFINE PENTIPS31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
EASY COMFORT PEN NEEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
EASY TOUCH PEN NEEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
EMBRACE PEN NEEDLES/31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
FIFTY50 PEN NEEDLES 31G X5/16" (8MM)	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
FIFTY50 PEN NEEDLES/31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
GLOBAL EASE INJECT PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
GNP CLICKFINE UNIVERSAL PEN NEEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
GNP ULTICARE PEN NEEDLES /31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
GNP ULTIGUARD SAFEPACK/SHORT PEN NEEDLE/31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
GOODSENSE PEN NEEDLE/PENFINE CLASSIC/31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
H-E-B IN CONTROL PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
H-E-B IN CONTROL UNIFINE PENTIPS PLUS 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
HEALTHWISE SHORT PEN NEEDLES/31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
HM ULTICARE SHORT PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
INCONTROL ULTICARE MINI PEN NEEDLES/31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
INSUPEN ULTRAFIN 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
INSUPEN 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
KROGER PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
KROGER PEN NEEDLES/31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
LEADER UNIFINE PENTIPS PLUS/SHORT/31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
LITETOUCH PEN NEEDLES 31GX8MM SHORT	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand

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LITETOUCH PEN NEEDLES/31G X 8MM/SHORT	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
MARATHON MEDICAL PENTIPS 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
MEDICINE SHOPPE PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
MEIJER PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
MM PEN NEEDLES 31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PC UNIFINE PENTIPS 31G X 8MM SHORT	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PEN NEEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PEN NEEDLES 31GX8MM (5/16")	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PEN NEEDLES/31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PENTIPS 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PENTIPS 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PREVENT DROPSAFE SAFETY PEN NEEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PREVENT SAFETY PEN NEEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PRO COMFORT PEN NEEDLES/ 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PX PEN NEEDLE 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PX SHORTLENGTH PEN NEEDLES/31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
QC PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
RA PEN NEEDLES 31G X 8MM 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
RAYA SURE PEN NEEDLE 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
RELION PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
RELION PEN NEEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand

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RELION PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
RELION SHORT PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
SURE COMFORT PEN NEEDLES 31GX5/16" (8MM)	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
TECHLITE PEN NEEDLES/31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
TODAYS HEALTH SHORT PEN NEEDLES 31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
TOPCARE CLICKFINE UNIVERSAL PEN NEEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
TRUE COMFORT PRO PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
TRUEPLUS PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
TRUEPLUS 5-BEVEL PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTICARE MICRO PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTICARE MICRO PEN NEEDLES/31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTICARE SHORT PEN NEEDLES ULTI-FINE IV	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTICARE SHORT PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTICARE SHORT PEN NEEDLES/31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTIGUARD SAFEPACK/SHORT PEN NEEDLE/31G X 5/16"/SHARPS CONTA	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTIGUARD SAFEPACK/SHORT PEN NEEDLE/31G X 8MM/SHARPS CONTAIN	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTILET PEN NEEDLE 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTILET SHORT PEN NEEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTRA FLO INSULIN PEN NEELE 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTRA-THIN II PEN NEEDLES/SHORT/31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTRACARE PEN NEEDLES/31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
UNIFINE PENTIPS PLUS 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand

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UNIFINE PENTIPS 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
UNIFINE ULTRA PEN NEEDLE/31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
VERIFINE INSULIN PEN NEEDLE 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
VERIFINE PLUS INSULIN PEN NEEDLE 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
WEGMANS UNIFINE PENTIPS PLUS/SHORT/31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ZEVRX PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
1ST TIER UNIFINE PENTIPS PLUS 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
1ST TIER UNIFINE PENTIPS 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ABOUTTIME PEN NEEDLE 32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
AQINJECT PEN NEEDLE/32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
AUM MINI INSULIN PEN NEEDLE/32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
AUM PEN NEEDLE/32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
AUM READYGARD DUO SAFETY PEN NEEDLE/32GX4MM/DUAL AUTO PROTEC	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
CAREFINE PEN NEEDLE 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
CAREONE UNIFINE PENTIPS PLUS PEN NEEDLES 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
CARETOUCH PEN NEEDLES 32GX 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
CLICKFINE PEN NEEDLE 32GX5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
CLICKFINE PEN NEEDLES 32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
COMFORT EZ MICRO/32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
COMFORT TOUCH PEN NEEDLES/32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
DIATHRIVE PEN NEEDLE/32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand

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DROPLET PEN NEEDLES 32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
DROPLET PEN NEEDLES 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
DRUG MART UNIFINE PENTIPSPLUS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
DRUG MART UNIFINE PENTIPS32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
EASY COMFORT PEN NEEDLES 32GX5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
EASY TOUCH PEN NEEDLES 32GX5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
EMBRACE PEN NEEDLES/32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
FIFTY50 PEN NEEDLES/32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
GLOBAL EASE INJECT PEN NEEDLES 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
GLOBAL EASY GLIDE PEN NEEDLES 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
GNP ULTICARE PEN NEEDLES/32GX 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
GNP ULTIGUARD SAFEPACK/MICRO PEN NEEDLE/32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
GOODSENSE PEN NEEDLE/PENFINE CLASSIC/32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
H-E-B IN CONTROL PEN NEEDLES/NANO/32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
H-E-B IN CONTROL UNIFINE PENTIPS PLUS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
H-E-B IN CONTROL UNIFINE PENTIPS PLUS 32GX5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
HEALTHWISE MICRON PEN NEEDLES/32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
INCONTROL ULTICARE MINI PEN NEEDLES/32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
INSUPEN PEN NEEDLES 32G X4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
INSUPEN 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
KROGER PEN NEEDLES/32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
LEADER UNIFINE PENTIPS/NANO/32GX5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand

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LEADER UNIFINE PENTIPS/PLUS/32GX5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
LITETOUCH INSULIN PEN NEEDLES/32G X 4MM/MINI	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
MARATHON MEDICAL PENTIPS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
MICRODOT PEN NEEDLE/32G X 4 MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
MM PEN NEEDLES 32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
NOVOFINE PLUS PEN NEEDLE 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
PEN NEEDLES 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
PEN NEEDLES/32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
PENTIPS 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
PENTIPS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
PIP PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
PRO COMFORT PEN NEEDLES/ 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
PURE COMFORT PEN NEEDLE/32G X4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
PURE COMFORT SAFETY PEN NEEDLE 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
QC UNIFINE PENTIPS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
RELION PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
RELION PEN NEEDLES 32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
RELION PEN NEEDLES 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
SURE COMFORT AUTOKEEPER SAFETY PEN NEEDLES 32GX5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
SURE COMFORT PEN NEEDLES 32GX5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
SURE COMFORT PEN NEEDLES 32GX5/32" (4MM)	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
TECHLITE PEN NEEDLES/32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand



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TRUE COMFORT PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
TRUE COMFORT PRO PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
TRUE COMFORT SAFETY PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
TRUEPLUS PEN NEEDLES 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
TRUEPLUS 5-BEVEL PEN NEEDLES 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTICARE MICRO PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTICARE MICRO PEN NEEDLES/32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTICARE MICRO PEN NEEDLES/32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTIGUARD SAFEPACK/MICRO PEN NEEDLE/32G X 4 MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTIGUARD SAFEPACK/MICRO PEN NEEDLE/32G X 4MM/SHARPS CONTAIN	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTIGUARD SAFEPACK/MICRO PEN NEEDLE/32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTIGUARD SAFEPACK/MICRO PEN NEEDLE/32G X 5/32"/SHARPS CNTR	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTIGUARD SAFEPACK/MICRO PEN NEEDLE/32G X 5/32"/SHARPS CONTA	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTILET PEN NEEDLE 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTILET PEN NEEDLE 32GX4MM/SHORT	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTRA FLO INSULIN PEN NEEDLE 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTRA THIN PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTRACARE PEN NEEDLES/32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
UNIFINE PENTIPS PLUS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
UNIFINE PENTIPS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
UNIFINE SAFECONTROL PEN NEEDLE 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
UNIFINE ULTRA PEN NEEDLE/32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand

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VERIFINE INSULIN PEN NEEDLE 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
VERIFINE PLUS INSULIN PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
WEGMANS UNIFINE PENTIPS PLUS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ZEVX PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
1ST TIER UNIFINE PENTIPS PLUS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
1ST TIER UNIFINE PENTIPS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
AUM MINI INSULIN PEN NEEDLE/32GX5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
AUM PEN NEEDLE/32GX5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
CAREFINE PEN NEEDLES 32GX5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
CARETOUCH PEN NEEDLES 32GX 5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 32GX5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
COMFORT TOUCH PEN NEEDLES/32G X 5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
DROPLET PEN NEEDLES 32G X 3/16"	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
DROPLET PEN NEEDLES 32GX5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
EASY TOUCH PEN NEEDLES 32GX3/16"	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
EASY TOUCH 32GX5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
PEN NEEDLES 32G X 5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
PRO COMFORT PEN NEEDLES/ 32G X 5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
PURE COMFORT PEN NEEDLE/32G X 5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
TRUE COMFORT PRO PEN NEEDLES 32G X 5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
ULTRACARE PEN NEEDLES/32G X 3/16"	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
AUM MINI INSULIN PEN NEEDLE/32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
AUM PEN NEEDLE/32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand

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CAREFINE PEN NEEDLES 32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
COMFORT TOUCH PEN NEEDLES/32G X 6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
DROPLET PEN NEEDLES 32G X 1/4"	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
DROPLET PEN NEEDLES 32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
EASY TOUCH PEN NEEDLES 32GX1/4"	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
EASY TOUCH 32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
FIFTY50 PEN NEEDLES/32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
GNP ULTICARE PEN NEEDLES/32GX1/4"	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
GNP ULTIGUARD SAFEPACK/MINI PEN NEEDLE/32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
GOODSENSE PEN NEEDLE/PENFINE CLASSIC/32G X 1/4"	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
INSUPEN SENSITIVE 32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
NOVOFINE PEN NEEDLE 32G X 6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
PEN NEEDLES 32G X 6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
PENTIPS 32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
PRO COMFORT PEN NEEDLES/ 32G X 6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
PURE COMFORT PEN NEEDLE 32G X6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
SURE COMFORT PEN NEEDLES 32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
TECHLITE PEN NEEDLES/32G X 6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
TRUE COMFORT PRO PEN NEEDLES 32G X 6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
ULTICARE MINI PEN NEEDLES/32G X 1/4"	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
ULTIGUARD SAFEPACK/MINI PEN NEEDLE/32G X 1/4"/SHARPS CONTAIN	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand

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ULTRACARE PEN NEEDLES/32G X 1/14"	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
UNIFINE PENTIPS 32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
VERIFINE INSULIN PEN NEEDLE 32G X 6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
BD PEN NEEDLE/MICRO/ULTRA-FINE/32G X 6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
1ST TIER UNIFINE PENTIPS 32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
AUM MINI INSULIN PEN NEEDLE/32GX8MM	INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16")	97051050146372	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 32GX8MM	INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16")	97051050146372	Brand
COMFORT TOUCH PEN NEEDLES/32G X 8MM	INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16")	97051050146372	Brand
DROPLET PEN NEEDLES 32G X 5/16"	INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16")	97051050146372	Brand
DROPLET PEN NEEDLES 32GX8MM	INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16")	97051050146372	Brand
INSUPEN SENSITIVE 32GX8MM	INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16")	97051050146372	Brand
PURE COMFORT PEN NEEDLE 32G X8MM	INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16")	97051050146372	Brand
TECHLITE PEN NEEDLES/32G X 8MM	INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16")	97051050146372	Brand
ADVOCATE INSULIN PEN NEEDLES	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
AUM MINI INSULIN PEN NEEDLE/33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
AUM PEN NEEDLE/33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
CAREONE UNIFINE PENTIPS PLUS PEN NEEDLES/33G X 5/32"	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
CARETOUCH PEN NEEDLE 33GX5/32"	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
CLEVER CHOICE COMFORT EZ INSULIN PEN NEEDLES 33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
COMFORT TOUCH PEN NEEDLES/33G X 5/32"	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
EASY COMFORT PEN NEEDLES 33G X 4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
EASY GLIDE PEN NEEDLES 33G X 5/32"	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand

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H-E-B IN CONTROL UNIFINE PENTIPS PLUS 33GX5/32"	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
INSUPEN 33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
KROGER PEN NEEDLES/33G X 5/32"	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
MICRODOT PEN NEEDLE/33G X 4 MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
PEN NEEDLES 33G X 5/32"	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
TRUE COMFORT PRO PEN NEEDLES 33G X 4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
ULTRA FLO INSULIN PEN NEEDLE 33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
ULTRACARE PEN NEEDLES/33G X 5/32"	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
UNIFINE PENTIPS PLUS 33G X 5/32"	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
UNIFINE PENTIPS PLUS 33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
UNIFINE PENTIPS 33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
1ST TIER UNIFINE PENTIPS PLUS 33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
1ST TIER UNIFINE PENTIPS 33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
AUM MINI INSULIN PEN NEEDLE/33GX5MM	INSULIN PEN NEEDLE 33 G X 5 MM (1/5" OR 3/16")	97051050146377	Brand
AUM PEN NEEDLE/33GX5MM	INSULIN PEN NEEDLE 33 G X 5 MM (1/5" OR 3/16")	97051050146377	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 33GX5MM	INSULIN PEN NEEDLE 33 G X 5 MM (1/5" OR 3/16")	97051050146377	Brand
COMFORT TOUCH PEN NEEDLES/33GX 3/16"	INSULIN PEN NEEDLE 33 G X 5 MM (1/5" OR 3/16")	97051050146377	Brand
EASY COMFORT PEN NEEDLES 33G X 5MM	INSULIN PEN NEEDLE 33 G X 5 MM (1/5" OR 3/16")	97051050146377	Brand
TRUE COMFORT PRO PEN NEEDLES 33G X 5MM	INSULIN PEN NEEDLE 33 G X 5 MM (1/5" OR 3/16")	97051050146377	Brand
AUM MINI INSULIN PEN NEEDLE/33GX6MM	INSULIN PEN NEEDLE 33 G X 6 MM (1/4" OR 15/64")	97051050146378	Brand
AUM PEN NEEDLE/33GX6MM	INSULIN PEN NEEDLE 33 G X 6 MM (1/4" OR 15/64")	97051050146378	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 33GX6MM	INSULIN PEN NEEDLE 33 G X 6 MM (1/4" OR 15/64")	97051050146378	Brand
COMFORT TOUCH PEN NEEDLES/33GX1/4"	INSULIN PEN NEEDLE 33 G X 6 MM (1/4" OR 15/64")	97051050146378	Brand

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EASY COMFORT PEN NEEDLES 33G X 6MM	INSULIN PEN NEEDLE 33 G X 6 MM (1/4" OR 15/64")	97051050146378	Brand
TRUE COMFORT PRO PEN NEEDLES 33G X 6MM	INSULIN PEN NEEDLE 33 G X 6 MM (1/4" OR 15/64")	97051050146378	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 33GX8MM	INSULIN PEN NEEDLE 33 G X 8 MM (1/3" OR 5/16")	97051050146380	Brand
DROPLET MICRON 34G X 9/64"	INSULIN PEN NEEDLE 34 G X 3.5 MM (9/64")	97051050146385	Brand
B-D INSULIN SYRINGE ULTRAFINE/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
BD INSULIN SYRINGE ULTRAFINE/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 ULTRAFINE/0.3ML/31G X 8MM	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
BD INSULIN SYRINGE ULTRAFINE/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 ULTRAFINE/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
<b>Approval Criteria</b>			
1 - Physician confirmation that the patient requires a greater quantity because of more frequent delivery of insulin			
Notes	*The quantity limit for both pen needles and syringes is 6 of each per day.		

## 2 . Revision History

Date	Notes
10/17/2023	Added updated GPIs to GPI Tables.

Insulins - Long Acting



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-137602
<b>Guideline Name</b>	Insulins - Long Acting
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2024
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### 1 . Criteria

Product Name: Insulin Degludec Flextouch, Insulin Degludec			
Approval Length	12 month(s)		
Guideline Type	Prior Authorization		
Product Name	Generic Name	GPI	Brand/Generic
INSULIN DEGLUDEC FLEXTOUCH	INSULIN DEGLUDEC SOLN PEN-INJECTOR 100 UNIT/ML	2710400700D210	Brand
INSULIN DEGLUDEC FLEXTOUCH	INSULIN DEGLUDEC SOLN PEN-INJECTOR 200 UNIT/ML	2710400700D220	Brand
INSULIN DEGLUDEC	INSULIN DEGLUDEC INJ 100 UNIT/ML	27104007002020	Brand



**Approval Criteria**

1 - Patient has had a trial of Lantus or Levemir for 90 of the past 120 days

**2 . Revision History**

Date	Notes
12/11/2023	Updated GPI and product name list, cleaned up guideline name.

Iressa



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-136328
<b>Guideline Name</b>	Iressa
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	1/1/2024
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## 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
<b>Approval Criteria</b>			

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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Diagnosis of central nervous system (CNS) cancer with metastatic lesions			
<b>AND</b>			
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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to Iressa therapy			

Iron Chelators



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-109711
<b>Guideline Name</b>	Iron Chelators
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

**Guideline Note:**

Effective Date:	9/1/2022
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### 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
<p><b>Approval Criteria</b></p> <p>1 - BOTH of the following</p> <p>1.1 Diagnosis of transfusional iron overload due to thalassemia syndromes, sickle cell disease or other anemias</p> <p style="text-align: center;"><b>AND</b></p> <p>1.2 Ferriprox (deferiprone) will not be used for the treatment of transfusional iron overload due to myelodysplastic syndrome or Diamond Blackfan anemia</p>			

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
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to therapy</p>			

Product Name: Brand Exjade, Brand Jadenu, generic deferasirox
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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 approved label. Added generic deferiprone 1000 mg tablet. Clarified listing of generics throughout guideline.

Irritable Bowel Syndrome - Diarrhea



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-121858
<b>Guideline Name</b>	Irritable Bowel Syndrome - Diarrhea
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	4/1/2023
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## 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
LOTROXEX	ALOSETRON HCL TAB 0.5 MG (BASE EQUIV)	52554015100310	Brand
ALOSETRON HYDROCHLORIDE	ALOSETRON HCL TAB 1 MG (BASE EQUIV)	52554015100320	Generic
LOTROXEX	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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Diagnosis of irritable bowel syndrome with diarrhea (IBS-D)			
<b>AND</b>			
2 - ONE of the following:			
<b>2.1</b> Failure to a tricyclic antidepressant (e.g., amitriptyline) as confirmed by claims history or submitted medical records			
<b>OR</b>			
<b>2.2</b> 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
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to Viberzi therapy</p>			



Isturisa



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-109317
<b>Guideline Name</b>	Isturisa
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	9/1/2022
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## 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
<b>Approval Criteria</b>			

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
<b>Approval Criteria</b>			
1 - Documentation of positive response to Isturisa therapy			

Jakafi



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-138575
<b>Guideline Name</b>	Jakafi
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	2/1/2024
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## 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
<b>Approval Criteria</b>			

1 - Documentation that patient has evidence of symptom improvement or reduction in spleen volume while on Jakafi\*

Notes	*If documentation does not provide evidence of symptom improvement or reduction in spleen volume while on Jakafi, authorization will be issued for 2 months to allow for dose titration with discontinuation of the rapy.
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**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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
<b>1</b> - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium			

Product Name: Jakafi			
Diagnosis	NCCN Recommended Regimens		
Approval Length	6 month(s)		
Therapy Stage	Reauthorization		
Guideline Type	Prior Authorization		
Product Name	Generic Name	GPI	Brand/Generic

JAKAFI	RUXOLITINIB PHOSPHATE TAB 5 MG (BASE EQUIVALENT)	21537560200310	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 15 MG (BASE EQUIVALENT)	21537560200325	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 20 MG (BASE EQUIVALENT)	21537560200330	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 25 MG (BASE EQUIVALENT)	21537560200335	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 10 MG (BASE EQUIVALENT)	21537560200320	Brand

**Approval Criteria**

1 - Documentation of positive clinical response to Jakafi therapy

Jaypirca



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-124492
<b>Guideline Name</b>	Jaypirca
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	6/1/2023
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## 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
<b>Approval Criteria</b>			



**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	Mantle Cell Lymphoma (MCL)
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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to Jaypirca therapy			

## 2 . Revision History

Date	Notes
4/11/2023	New guideline

Jesduvroq (daprodustat)



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-137548
<b>Guideline Name</b>	Jesduvroq (daprodustat)
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	1/1/2024
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## 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
<p><b>Approval Criteria</b></p> <p>1 - History of the requested agent within the past 90 days, confirmed by claims history or chart documentation</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - ONE of the following:</p> <ul style="list-style-type: none"> <li>• Patient has tried and failed an erythropoiesis-stimulating agent (ESA) (e.g., Aranesp, Epogen, Retacrit, Mircera, Procrit), confirmed by claims history or chart documentation</li> <li>• Prescriber has submitted valid medical justification for the use of Jesduvroq (daprodustat) over all ESA agents listed above</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p>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)</p>			

## 2 . Revision History

Date	Notes
12/11/2023	Updated patient to prescriber in second bullet of step 4 initial authorization.

Joenja



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-127419
<b>Guideline Name</b>	Joenja
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	8/1/2023
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## 1 . Criteria

Product Name: Joenja			
Approval Length	6 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
<b>Approval Criteria</b>			
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
6/30/2023	New guideline.

Jynarque



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-81962
<b>Guideline Name</b>	Jynarque
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	4/1/2021
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## 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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to Jynarque therapy			

## 2 . Revision History

Date	Notes
3/5/2021	Bulk Load

Keveyis



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-123510
<b>Guideline Name</b>	Keveyis
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	5/1/2023
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## 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
KEYEYIS	DICHLORPHENAMIDE TAB 50 MG	37100020000305	Brand
DICHLORPHENAMIDE	DICHLORPHENAMIDE TAB 50 MG	37100020000305	Generic
<b>Approval Criteria</b>			
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
KEYEYIS	DICHLORPHENAMIDE TAB 50 MG	37100020000305	Brand
DICHLORPHENAMIDE	DICHLORPHENAMIDE TAB 50 MG	37100020000305	Generic
<b>Approval Criteria</b>			
<b>1</b> - Documentation of positive clinical response to the requested therapy			

Kisqali



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-123828
<b>Guideline Name</b>	Kisqali
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	5/1/2023
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## 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	Breast Cancer		
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
<b>Approval Criteria</b>			
1 - Patient does not show evidence of progressive disease while on Kisqali therapy			

Product Name: Kisqali			
Diagnosis	NCCN Recommended Regimen		
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
<b>Approval Criteria</b>			



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

Product Name: Kisqali			
Diagnosis	NCCN Recommended Regimen		
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
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to Kisqali therapy			

## 2 . Revision History

Date	Notes
3/27/2023	Updated T/F language

Kisqali Femara Co-Pack



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-123823
<b>Guideline Name</b>	Kisqali Femara Co-Pack
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	5/1/2023
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## 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 TBP	2199000260B730	Brand
KISQALI FEMARA 400 DOSE	RIBOCICLIB 400 MG DOSE (200 MG TAB) & LETROZOLE 2.5 MG TBP	2199000260B740	Brand

KISQALI FEMARA 600 DOSE	RIBOCICLIB 600 MG DOSE (200 MG TAB) & LETROZOLE 2.5 MG TBPK	2199000260B760	Brand
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**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	Breast Cancer
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
<b>Approval Criteria</b>			
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 Regimen		
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
<b>Approval Criteria</b>			
1 - Kisqali Femara Co-Pack will be approved for uses supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium			

Product Name: Kisqali Femara Co-Pack			
Diagnosis	NCCN Recommended Regimen		
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
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to Kisqali Femara Co-Pack therapy			

## 2 . Revision History

Date	Notes
3/27/2023	Updated T/F language

Korlym



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-124432
<b>Guideline Name</b>	Korlym
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	6/1/2023
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## 1 . Criteria

Product Name: Korlym			
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
<b>Approval Criteria</b>			
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: Korlym			
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

**Approval Criteria**

**1** - Documentation of ONE of the following:

- Patient has improved glucose tolerance while on Korlym therapy
- Patient has stable glucose tolerance while on Korlym therapy

Koselugo



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-134582
<b>Guideline Name</b>	Koselugo
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	12/1/2023
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## 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
<b>Approval Criteria</b>			



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
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Approval Length	12 month(s)
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Therapy Stage	Initial Authorization
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Guideline Type	Prior Authorization
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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, Pilocytic Astrocytoma, 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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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

Krazati



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-133921
<b>Guideline Name</b>	Krazati
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	9/28/2023
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## 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		
<b>Product Name</b>	<b>Generic Name</b>	<b>GPI</b>	<b>Brand/Generic</b>
KRAZATI	ADAGRASIB TAB 200 MG	21532410000320	Brand
<b>Approval Criteria</b>			
1 - Diagnosis of non-small cell lung cancer (NSCLC)			

<b>AND</b>
<b>2</b> - Presence of KRAS G12C mutation
<b>AND</b>
<b>3</b> - Disease is ONE of the following: <ul style="list-style-type: none"> <li>• Recurrent</li> <li>• Advanced</li> <li>• Metastatic</li> </ul>
<b>AND</b>
<b>4</b> - Patient has received at least one prior systemic therapy

<b>Product Name: Krazati</b>			
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
KRAZATI	ADAGRASIB TAB 200 MG	21532410000320	Brand
<b>Approval Criteria</b>			
<b>1</b> - Patient does not show evidence of progressive disease while on Krazati therapy			

<b>Product Name: Krazati</b>	
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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to Krazati therapy			

## 2 . Revision History

Date	Notes
9/28/2023	Corrected diagnosis of 2nd reauthorization box from NSCLC to NCC N.

Kuvan



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-93265
<b>Guideline Name</b>	Kuvan
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	11/1/2021
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## 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
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of phenylketonuria (PKU)</p>			

## 2 . Revision History

Date	Notes
9/8/2021	Updated GPI's and product name list

Kynmobi



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-123486
<b>Guideline Name</b>	Kynmobi
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	5/1/2023
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## 1 . Criteria

Product Name: Kynmobi			
Approval Length	6 month(s)		
Therapy Stage	Initial Authorization		
Guideline Type	Prior Authorization		
Product Name	Generic Name	GPI	Brand/Generic
KYNMOBI TITRATION KIT	APOMORPHINE HCL FILM 10/15/20/25/30 MG TITRATION KIT	73203010106420	Brand
KYNMOBI	APOMORPHINE HYDROCHLORIDE FILM 10 MG	73203010108210	Brand
KYNMOBI	APOMORPHINE HYDROCHLORIDE FILM 15 MG	73203010108215	Brand
KYNMOBI	APOMORPHINE HYDROCHLORIDE FILM 20 MG	73203010108220	Brand
KYNMOBI	APOMORPHINE HYDROCHLORIDE FILM 25 MG	73203010108225	Brand

KYNMOBI	APOMORPHINE HYDROCHLORIDE FILM 30 MG	73203010108230	Brand
<b>Approval Criteria</b>			
1 - Diagnosis of Parkinson's disease			
<b>AND</b>			
2 - Kynmobi will be used as intermittent treatment for OFF episodes			
<b>AND</b>			
3 - Prescribed by or in consultation with a neurologist or specialist in the treatment of Parkinson's disease			
<b>AND</b>			
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			
<b>AND</b>			
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:			
<b>5.1</b> 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			
<b>AND</b>			
<b>5.2</b> Dose and dosing interval optimization			
<b>AND</b>			

**6 - ONE of the following:**

**6.1** Failure to TWO anti-Parkinson’s disease therapies from the following adjunctive pharmacotherapy classes (trial must be from TWO different classes) as confirmed by claims history or submission of medical records:

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

**OR**

**6.2** Contraindication or intolerance to ALL anti-Parkinson’s disease therapies from the following adjunctive pharmacotherapy classes (please specify contraindication or intolerance):

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

**Product Name: Kynmobi**

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

Product Name	Generic Name	GPI	Brand/Generic
KYNMOBI TITRATION KIT	APOMORPHINE HCL FILM 10/15/20/25/30 MG TITRATION KIT	73203010106420	Brand
KYNMOBI	APOMORPHINE HYDROCHLORIDE FILM 10 MG	73203010108210	Brand
KYNMOBI	APOMORPHINE HYDROCHLORIDE FILM 15 MG	73203010108215	Brand
KYNMOBI	APOMORPHINE HYDROCHLORIDE FILM 20 MG	73203010108220	Brand
KYNMOBI	APOMORPHINE HYDROCHLORIDE FILM 25 MG	73203010108225	Brand
KYNMOBI	APOMORPHINE HYDROCHLORIDE FILM 30 MG	73203010108230	Brand

**Approval Criteria**

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

**AND**

**2** - Patient will continue to receive treatment with a carbidopa/levodopa-containing medication

Lampit



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-82103
<b>Guideline Name</b>	Lampit
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	4/1/2021
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## 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
<b>Approval Criteria</b>			
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

<b>Guideline ID</b>	GL-137627
<b>Guideline Name</b>	Laxatives and Cathartics
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2024
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### 1 . Criteria

Product Name: Brand Amitiza, Linzess			
Approval Length	12 month(s)		
Guideline Type	Step Therapy		
Product Name	Generic Name	GPI	Brand/Generic
AMITIZA	LUBIPROSTONE CAP 8 MCG	52450045000110	Brand
AMITIZA	LUBIPROSTONE CAP 24 MCG	52450045000120	Brand
LINZESS	LINACLOTIDE CAP 72 MCG	52557050000110	Brand
LINZESS	LINACLOTIDE CAP 145 MCG	52557050000120	Brand
LINZESS	LINACLOTIDE CAP 290 MCG	52557050000140	Brand



**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
MOTTEGRITY	PRUCALOPRIDE SUCCINATE TAB 1 MG (BASE EQUIVALENT)	52560060200320	Brand
MOTTEGRITY	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: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>
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**Product Name: Movantik, Relistor tabs, Symproic**

Approval Length	12 month(s)
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Guideline Type	Prior Authorization
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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: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>
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**Product Name: generic lubiprostone**

Approval Length	12 month(s)
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Guideline Type		Prior Authorization	
Product Name	Generic Name	GPI	Brand/Generic
LUBIPROSTONE	LUBIPROSTONE CAP 8 MCG	52450045000110	Generic
LUBIPROSTONE	LUBIPROSTONE CAP 24 MCG	52450045000120	Generic

**Approval Criteria**

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

- Lactulose
- Sorbitol
- Polyethylene glycol

**AND**

2 - The generic is medically necessary due to ONE of the following:

**2.1** The generic is being requested because of an adverse reaction, allergy, or sensitivity to the brand (specify the adverse reaction, allergy, or sensitivity)

**OR**

**2.2** The generic is being requested due to an incomplete response with the brand, as documented by submission of medical records

**OR**

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

**OR**

**2.4** Special clinical circumstances exist that preclude the use of the brand equivalent of the generic 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
<p><b>Approval Criteria</b></p> <p>1 - Patient had a trial of ONE of the following:</p> <ul style="list-style-type: none"> <li>• Lactulose</li> <li>• Sorbitol</li> <li>• Polyethylene glycol</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p>2 - Diagnosis of opioid-induced constipation</p>			

## 2 . Revision History

Date	Notes
12/11/2023	Added Relistor inj to GPI and criteria, added lubiprostone criteria, cleaned up criteria.

Lenvima



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-123329
<b>Guideline Name</b>	Lenvima
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	5/1/2023
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## 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	LENVATINIB CAP THERAPY PACK 10 MG (10 MG DAILY DOSE)	2133505420B220	Brand

DAILY DOSE			
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
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**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 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 ALL of the following:

1.1.1 Diagnosis of ONE of the following:

- Follicular carcinoma
- Hürthle cell carcinoma
- Papillary carcinoma

**AND**

1.1.2 ONE of the following:

- Unresectable or locally recurrent disease
- Metastatic disease
- Persistent locoregional disease

**AND**

1.1.3 ONE of the following:

- Patient has symptomatic disease
- Patient has progressive disease

**AND**

1.1.4 ONE of the following:

- Disease is refractory to radioactive iodine

- Distant metastatic disease not amenable to radioactive iodine treatment

**OR**

**1.2 ALL of the following:**

**1.2.1** Diagnosis of medullary thyroid carcinoma

**AND**

**1.2.2 ONE of the following:**

- Disease is progressive
- Disease is symptomatic with distant metastases

**AND**

**1.2.3 ONE of the following:**

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

- Caprelsa (vandetanib)
- Cometriq (cabozantinib)

**OR**

**1.2.3.2** History of contraindication or intolerance to BOTH of the following (please specify contraindication or intolerance)

- Caprelsa (vandetanib)
- Cometriq (cabozantinib)

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
- 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 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 thymic carcinoma

**AND**

2 - ONE of the following:

- Used for postoperative treatment
- Disease is unresectable or potentially resectable
- Disease is metastatic

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
<b>Approval Criteria</b>			
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 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 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
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**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
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to Lenvima therapy</p>			

## 2 . Revision History

Date	Notes
3/16/2023	Updated criteria to include NCCN recommended use for cutaneous melanoma. Updated step therapy language.

Leukotriene Receptor Antagonists



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-125086
<b>Guideline Name</b>	Leukotriene Receptor Antagonists
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

**Guideline Note:**

Effective Date:	7/1/2023
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### 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
<b>Approval Criteria</b>			
1 - Documentation indicating tablet formulations are unsuitable for use			

## 2 . Revision History

Date	Notes
4/27/2023	New

Lipotropics



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-132785
<b>Guideline Name</b>	Lipotropics
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	10/1/2023
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## 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: Brand Vascepa, generic icosapent ethyl**

Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ICOSAPENT ETHYL	ICOSAPENT ETHYL CAP 0.5 GM	39500035100110	Generic
ICOSAPENT ETHYL	ICOSAPENT ETHYL CAP 1 GM	39500035100120	Generic
VASCEPA	ICOSAPENT ETHYL CAP 0.5 GM	39500035100110	Brand
VASCEPA	ICOSAPENT ETHYL CAP 1 GM	39500035100120	Brand

**Approval Criteria**

1 - Patient is 18 years of age or older

**AND**

2 - If the request is for generic icosapent ethyl, the patient has tried and failed brand Vascepa

**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)
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Guideline Type	Prior Authorization
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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
9/8/2023	Updated trial language in Brand Vytorin, generic ezetimibe/simvastatin section

Livmarli



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-121740
<b>Guideline Name</b>	Livmarli
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	4/1/2023
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## 1 . Criteria

Product Name: Livmarli			
Approval Length	6 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
<b>Approval Criteria</b>			
1 - Diagnosis of Alagille syndrome (ALGS) confirmed by presence of the JAG1 or Notch2 gene mutation			

**AND**

**2** - Evidence of cholestasis by at least ONE of the following:

- Total serum bile acid greater than 3x ULN (upper limit of normal) for age
- Conjugated bilirubin greater than 1 mg/dL (milligrams/deciliter)
- Fat soluble vitamin deficiency otherwise unexplainable
- GGT (gamma-glutamyl transferase) greater than 3x ULN for age
- Intractable pruritus explainable only by liver disease

**AND**

**3** - Patient is experiencing moderate to severe pruritus

**AND**

**4** - Patient has had an inadequate response to at least TWO medications to treat pruritus (e.g., ursodeoxycholic acid, rifampin, cholestyramine, colesevelam), as confirmed by claims history or submission of medical records

**AND**

**5** - Prescribed by a hepatologist

Product Name: Livmarli			
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
<b>Approval Criteria</b>			

**1** - Documentation of positive clinical response to Livmarli therapy (e.g., reduced serum bile acids, reduced pruritis severity score)

**AND**

**2** - Prescribed by a hepatologist

Livtency



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-123296
<b>Guideline Name</b>	Livtency
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	5/1/2023
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## 1 . Criteria

Product Name: Livtency			
Approval Length	2 month(s)		
Guideline Type	Prior Authorization		
Product Name	Generic Name	GPI	Brand/Generic
LIVTENCITY	MARIBAVIR TAB 200 MG	12200050000320	Brand
<b>Approval Criteria</b>			
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



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-95056
<b>Guideline Name</b>	Lonsurf
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	9/29/2021
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## 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-TIPRACIL TAB 15-6.14 MG	21990002750320	Brand
LONSURF	TRIFLURIDINE-TIPRACIL TAB 20-8.19 MG	21990002750330	Brand
<b>Approval Criteria</b>			

**1 - Diagnosis of 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-TIPRACIL TAB 15-6.14 MG	21990002750320	Brand
LONSURF	TRIFLURIDINE-TIPRACIL TAB 20-8.19 MG	21990002750330	Brand

**Approval Criteria**

1 - Diagnosis of ONE of the following:

- Metastatic gastric cancer
- 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-TIPRACIL TAB 15-6.14 MG	21990002750320	Brand
LONSURF	TRIFLURIDINE-TIPRACIL TAB 20-8.19 MG	21990002750330	Brand
<b>Approval Criteria</b>			
1 - Patient does not show evidence of progressive disease while on Lonsurf therapy			

Product Name: Lonsurf
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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-TIPRACIL TAB 15-6.14 MG	21990002750320	Brand
LONSURF	TRIFLURIDINE-TIPRACIL TAB 20-8.19 MG	21990002750330	Brand
<b>Approval Criteria</b>			
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-TIPRACIL TAB 15-6.14 MG	21990002750320	Brand
LONSURF	TRIFLURIDINE-TIPRACIL TAB 20-8.19 MG	21990002750330	Brand
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to Lonsurf therapy			

Lorbrena



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-123285
<b>Guideline Name</b>	Lorbrena
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	5/1/2023
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## 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
<b>Approval Criteria</b>			

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
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of Erdheim-Chester Disease (ECD)</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Disease is BOTH of the following:</p> <ul style="list-style-type: none"> <li>• Symptomatic, relapsed, or refractory</li> <li>• ALK-positive</li> </ul>			

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
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of inflammatory myofibroblastic tumor (IMT) with ALK translocation</p>			

Product Name: Lorbrena	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC), Histiocytic Neoplasms, Soft Tissue Sarcoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LORBRENA	LORLATINIB TAB 25 MG	21530556000320	Brand
LORBRENA	LORLATINIB TAB 100 MG	21530556000330	Brand

**Approval Criteria**

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

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

  

Product Name	Generic Name	GPI	Brand/Generic
LORBRENA	LORLATINIB TAB 25 MG	21530556000320	Brand
LORBRENA	LORLATINIB TAB 100 MG	21530556000330	Brand

  

**Approval Criteria**

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

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

  

Product Name	Generic Name	GPI	Brand/Generic
LORBRENA	LORLATINIB TAB 25 MG	21530556000320	Brand
LORBRENA	LORLATINIB TAB 100 MG	21530556000330	Brand



**Approval Criteria**

1 - Documentation of positive clinical response to Lorbrena therapy

Lovenox



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-120242
<b>Guideline Name</b>	Lovenox
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	3/1/2023
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## 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 PEF SYR 30 MG/0.3ML	8310102010E520	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PEF SYR 30 MG/0.3ML	8310102010E520	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PEF SYR 40 MG/0.4ML	8310102010E525	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PEF 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 PEF SYR 40 MG/0.4ML	8310102010E525	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PEF SYR 60 MG/0.6ML	8310102010E530	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PEF SYR 60 MG/0.6ML	8310102010E530	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PEF SYR 80 MG/0.8ML	8310102010E535	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PEF SYR 80 MG/0.8ML	8310102010E535	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PEF SYR 100 MG/ML	8310102010E540	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PEF SYR 100 MG/ML	8310102010E540	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PEF SYR 120 MG/0.8ML	8310102010E560	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PEF SYR 120 MG/0.8ML	8310102010E560	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PEF SYR 150 MG/ML	8310102010E565	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PEF 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 PEF SYR 30 MG/0.3ML	8310102010E520	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PEF SYR 30 MG/0.3ML	8310102010E520	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PEF SYR 40 MG/0.4ML	8310102010E525	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PEF SYR 40 MG/0.4ML	8310102010E525	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PEF SYR 60 MG/0.6ML	8310102010E530	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PEF SYR 60 MG/0.6ML	8310102010E530	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PEF SYR 80 MG/0.8ML	8310102010E535	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PEF SYR 80 MG/0.8ML	8310102010E535	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PEF SYR 100 MG/ML	8310102010E540	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PEF SYR 100 MG/ML	8310102010E540	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PEF SYR 120 MG/0.8ML	8310102010E560	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PEF SYR 120 MG/0.8ML	8310102010E560	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PEF SYR 150 MG/ML	8310102010E565	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PEF 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 PEF SYR 30 MG/0.3ML	8310102010E520	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PEF SYR 30 MG/0.3ML	8310102010E520	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PEF SYR 40 MG/0.4ML	8310102010E525	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PEF SYR 40 MG/0.4ML	8310102010E525	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PEF SYR 60 MG/0.6ML	8310102010E530	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PEF SYR 60 MG/0.6ML	8310102010E530	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PEF SYR 80 MG/0.8ML	8310102010E535	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PEF SYR 80 MG/0.8ML	8310102010E535	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PEF SYR 100 MG/ML	8310102010E540	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PEF SYR 100 MG/ML	8310102010E540	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PEF SYR 120 MG/0.8ML	8310102010E560	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PEF SYR 120 MG/0.8ML	8310102010E560	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PEF SYR 150 MG/ML	8310102010E565	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PEF 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
<p><b>Approval Criteria</b></p> <p>1 - For prophylaxis of ischemic complications in ONE of the following:</p> <ul style="list-style-type: none"> <li>• Unstable angina</li> <li>• Non-Q-Wave myocardial infarction</li> </ul>			

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 PEF SYR 30 MG/0.3ML	8310102010E520	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PEF SYR 30 MG/0.3ML	8310102010E520	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PEF SYR 40 MG/0.4ML	8310102010E525	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PEF SYR 40 MG/0.4ML	8310102010E525	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PEF SYR 60 MG/0.6ML	8310102010E530	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PEF SYR 60 MG/0.6ML	8310102010E530	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PEF SYR 80 MG/0.8ML	8310102010E535	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PEF SYR 80 MG/0.8ML	8310102010E535	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PEF SYR 100 MG/ML	8310102010E540	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PEF SYR 100 MG/ML	8310102010E540	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PEF SYR 120 MG/0.8ML	8310102010E560	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PEF 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.
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Lucemyra



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-126584
<b>Guideline Name</b>	Lucemyra
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	7/1/2023
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## 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
<b>Approval Criteria</b>			
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 rationale 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
<b>Approval Criteria</b>			
1 - Prescriber has provided valid medical rationale for continued use of Lucemyra			
<b>AND</b>			
2 - The request does not exceed the plan limitation maximum of 14 days supply (two separate 7 day fills)			

## 2 . Revision History

UnitedHealthcare Community Plan of Indiana – Clinical Pharmacy Guidelines

Date	Notes
6/14/2023	Added T/F language and plan limitations (Two 7-day supplies in 180 days)

Lumakras



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-128914
<b>Guideline Name</b>	Lumakras
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	10/1/2023
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## 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
<b>Approval Criteria</b>			

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
<b>Approval Criteria</b>			
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	Non-Small Cell Lung Cancer (NSCLC), Pancreatic Adenocarcinoma		
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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to Lumakras therapy			

Lynparza



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-128952
<b>Guideline Name</b>	Lynparza
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	10/1/2023
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## 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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Diagnosis of ONE of the following:			

- Epithelial ovarian cancer
- Fallopian tube cancer
- Primary peritoneal cancer

**AND**

**2** - Disease is advanced or recurrent

**AND**

**3** - ONE of the following:

**3.1** Patient has had a complete or partial response to platinum-based chemotherapy

**OR**

**3.2** BOTH of the following:

**3.2.1** Patient has had a complete or partial response to first-line platinum-based chemotherapy

**AND**

**3.2.2** ONE of the following:

**3.2.2.1** Presence of deleterious or suspected deleterious germline or somatic BRCA (breast cancer gene)-mutations

**OR**

**3.2.2.2** BOTH of the following:

**3.2.2.2.1** Cancer is associated with homologous recombination deficiency (HRD)-positive status defined by either a deleterious or suspected deleterious BRCA mutation or genomic instability

**AND**

**3.2.2.2.2** Used in combination with bevacizumab (e.g., Avastin, Mvasi)

**AND**

**4** - 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
<b>Approval Criteria</b>			
1 - Diagnosis of uterine sarcoma			
<b>AND</b>			
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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to Lynparza therapy			

Lytgobi



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-138740
<b>Guideline Name</b>	Lytgobi
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	2/1/2024
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## 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
<b>Approval Criteria</b> 1 - Documentation of positive clinical response to Lytgobi therapy			

Macrolides



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-144304
<b>Guideline Name</b>	Macrolides
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	4/1/2024
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## 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
<b>Approval Criteria</b>			
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**

<b>2.2</b> There is medical justification for use over the preferred* medications	
Notes	*PDL link: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>

## 2 . Revision History

Date	Notes
3/13/2024	Updated the NP criteria.

Mekinist



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-128969
<b>Guideline Name</b>	Mekinist
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	10/1/2023
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## 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 Tafenlar (dabrafenib)

**AND**

1.1.2 Cancer is positive for BRAF V600 (gene) mutation

**OR**

1.2 Distant metastatic uveal melanoma

**AND**

**2** - If the request is for Mekinist solution, there is a reason or special circumstance why the patient is unable to use Mekinist tablets (document reason or special circumstance)

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

**AND**

**5** - If the request is for Mekinist solution, there is a reason or special circumstance why the patient is unable to use Mekinist tablets (document reason or special circumstance)

Product Name: Mekinist			
Diagnosis	Thyroid Cancer		
Approval Length	12 month(s)		
Therapy Stage	Initial Authorization		
Guideline Type	Prior Authorization		
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
<p><b>Approval Criteria</b></p> <p><b>1 - Diagnosis of ONE of the following:</b></p> <ul style="list-style-type: none"> <li>• Epithelial Ovarian Cancer</li> <li>• Fallopian Tube Cancer</li> <li>• Primary Peritoneal Cancer</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p><b>2 - ONE of the following:</b></p> <ul style="list-style-type: none"> <li>• Persistent disease</li> <li>• Recurrence in BRAF V600E positive tumors</li> <li>• Recurrence of low-grade serous carcinoma</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p><b>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)</b></p>			

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, Ampullary 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	Melanoma, NSCLC, Thyroid Cancer, CNS Cancers, Epithelial Ovarian Cancer/Fallopian Tube Cancer/Primary Peritoneal Cancer, Hepatobiliary Cancers, Histiocytic Neoplasms, Solid Tumors, Pancreatic Cancer/Ampullary Cancer
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
<b>Approval Criteria</b>			
1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium			
<b>AND</b>			
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
<b>Approval Criteria</b>			

1 - Documentation of positive clinical response to Mekinist therapy

Mektovi



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-140123
<b>Guideline Name</b>	Mektovi
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	3/1/2024
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## 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
<b>Approval Criteria</b>			
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
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of ONE of the following:</p> <ul style="list-style-type: none"> <li>• Multisystem Langerhans Cell Histiocytosis</li> <li>• Single-system lung Langerhans Cell Histiocytosis</li> <li>• Langerhans Cell Histiocytosis with CNS (central nervous system) lesions</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p>2 - ONE of the following:</p> <ul style="list-style-type: none"> <li>• Disease is positive for mitogen-activated protein (MAP) kinase pathway mutation</li> <li>• No detectable mutation</li> <li>• Testing is not available</li> </ul>			

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
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of low-grade serous carcinoma</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Disease is recurrent</p>			

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
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of succinate dehydrogenase (SDH)-deficient gastrointestinal stromal tumor (GIST)</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Disease is ONE of the following:</p> <ul style="list-style-type: none"> <li>• Gross residual disease (R2 resection)</li> <li>• Unresectable primary disease</li> <li>• Tumor rupture</li> <li>• Progressive</li> <li>• Recurrent</li> <li>• Metastatic</li> </ul>			



**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)

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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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
1/29/2024	Added new criteria for non-small cell lung cancer (NSCLC).

Mepron



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-98050
<b>Guideline Name</b>	Mepron
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	1/1/2022
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### 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
<b>Approval Criteria</b>			
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
<p><b>Approval Criteria</b></p> <p>1 - Patient has history of the requested medication within the past 90 days</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Documentation from prescriber indicating improvement (including stabilization) in current clinical status</p>			

## 2 . Revision History

Date	Notes
11/5/2021	Updated all criteria to match state policy.

Migranal, Trudhesa



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-138766
<b>Guideline Name</b>	Migranal, Trudhesa
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	2/1/2024
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## 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
<b>Approval Criteria</b>			
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**

<b>4.2</b> Physician acknowledges that the potential benefit outweighs the risk associated with the higher dose or quantity	
Notes	<p>*Nadolol and timolol are non-preferred and should not be included in denial to provider.</p> <p>**Candesartan is non-preferred and should not be included in denial to provider.</p> <p>***This is a medical benefit, should not be included in denial to provider.</p>

## 2 . Revision History

Date	Notes
1/9/2024	Updated QL criteria section because nadolol is non-preferred.

Miotics-Intraocular Pressure Reducers



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-137663
<b>Guideline Name</b>	Miotics-Intraocular Pressure Reducers
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2024
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### 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
<b>Approval Criteria</b>			
1 - Documentation that separate components are not suitable for use			

Product Name: Iyuzeh
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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
<p><b>Approval Criteria</b></p> <p>1 - Trial and failure of latanoprost</p> <p style="text-align: center;"><b>OR</b></p> <p>2 - Prescriber has provided medical justification for use of lyuzeh over latanoprost</p>			

## 2 . Revision History

Date	Notes
12/12/2023	Added lyuzeh and criteria.

Miscellaneous Oral Antidiabetic Agents



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-137614
<b>Guideline Name</b>	Miscellaneous Oral Antidiabetic Agents
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2024
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### 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
<b>Approval Criteria</b>			
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



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-137489
<b>Guideline Name</b>	Movement Disorder Agents
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2024
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### 1 . Criteria

Product Name: Austedo, Austedo 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 TITRATION KIT	DEUTETRABENAZINE TAB TITRATION PACK 6 MG & 9 MG & 12 MG	6238003000B720	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 (milligrams)/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

**OR**

**1.3** Diagnosis of Tourette's syndrome and both of the following:

**1.3.1** Patient is 12 years of age or older

**AND**

**1.3.2** Dose does not exceed 36 mg/day

Product Name: Austedo, Austedo Patient Titration Kit

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

**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 48 mg/day

**OR**

**2.2** Both of the following:

**2.2.1** Diagnosis of tardive dyskinesia

**AND**

**2.2.2** Dose does not exceed 48 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 36 mg/day

Product Name: 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 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 24 MG	62380030007530	Brand
AUSTEDO XR PATIENT TITRATION KIT	DEUTETRABENAZINE TAB ER TITRATION PACK 6 MG & 12 MG & 24 MG	6238003000C120	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 XR, Austedo XR Patient Titration Kit

Approval Length	1 year(s)
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Therapy Stage	Reauthorization
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Guideline Type	Prior Authorization
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Product Name	Generic Name	GPI	Brand/Generic
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 24 MG	62380030007530	Brand
AUSTEDO XR PATIENT TITRATION KIT	DEUTETRABENAZINE TAB ER TITRATION PACK 6 MG & 12 MG & 24 MG	6238003000C120	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)
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Therapy Stage	Initial Authorization
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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

**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
<b>Approval Criteria</b>			
1 - History of the requested medication for at least 90 days within the past 120 days, confirmed by claims history or chart documentation			
<b>AND</b>			

**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)
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Therapy Stage	Reauthorization
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Guideline Type	Prior Authorization
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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
12/8/2023	Updated GPI and product name lists, updated and cleaned up criteria.

Mozobil



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-121277
<b>Guideline Name</b>	Mozobil
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	4/1/2023
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## 1 . Criteria

Product Name: Mozobil			
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
<b>Approval Criteria</b>			
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: Mozobil			
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
<b>Approval Criteria</b>			
1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium			

Product Name: Mozobil	
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

**Approval Criteria**

1 - Documentation of positive clinical response to Mozobil therapy

Mulpleta



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-116812
<b>Guideline Name</b>	Mulpleta
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	1/1/2023
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## 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
<b>Approval Criteria</b>			
1 - Diagnosis of thrombocytopenia			

**AND**

**2** - Patient has chronic liver disease

**AND**

**3** - Patient is scheduled to undergo a procedure



Multaq



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-82110
<b>Guideline Name</b>	Multaq
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	4/1/2021
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## 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
<p><b>Approval Criteria</b></p> <p>1 - ONE of the following:</p> <p>1.1 All of the following:</p>			

**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



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-144252
<b>Guideline Name</b>	Multiple Sclerosis
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	4/1/2024
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## 1 . Criteria

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			
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

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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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Diagnosis of multiple sclerosis			
<b>AND</b>			
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	6240555006520	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

Notes	*Do not include Ocrevus in denial language. It is medical.
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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 a history of at least 28 days of therapy with ONE of the following preferred medications:

- Aubagio (teriflunomide)
- Avonex (interferon beta-1a)
- Betaseron (interferon beta-1b)
- Copaxone, Glatopa (glatiramer)
- Gilenya (fingolimod)
- Rebif (interferon beta-1a)
- Tecfidera (dimethyl fumarate)

**OR**

2.3 Medical justification for use of the requested medication over ALL of the following preferred medications:

- Aubagio (teriflunomide)
- Avonex (interferon beta-1a)

- Betaseron (interferon beta-1b)
- Copaxone, Glatopa (glatiramer)
- Gilenya (fingolimod)
- Rebif (interferon beta-1a)
- Tecfidera (dimethyl fumarate)

**AND**

**3** - Prescribed by or in consultation with a neurologist

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	6240307530D220	Brand
PLEGRIDY STARTER PACK	PEGINTERFERON BETA-1A SOLN PEN-INJ 63 & 94 MCG/0.5ML PACK	6240307530D250	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
<b>Approval Criteria</b>			
1 - Diagnosis of multiple sclerosis			
<b>AND</b>			
2 - ONE of the following:			
2.1 Trial and failure of Avonex within the past 180 days			



**OR**

**2.2** Medical justification for use of the requested medication over Avonex

**AND**

**3** - Prescribed by or in consultation with a neurologist

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** Trial of at least 28 days of therapy with ONE of the following preferred medications:

- Aubagio (teriflunomide)
- Avonex (interferon beta-1a)
- Betaseron (interferon beta-1b)
- Copaxone, Glatopa (glatiramer)
- Gilenya (fingolimod)
- Rebif (interferon beta-1a)
- Tecfidera (dimethyl fumarate)

**OR**

**2.2** Medical justification for use of the requested medication over ALL of the following preferred medications:

- Aubagio (teriflunomide)
- Avonex (interferon beta-1a)
- Betaseron (interferon beta-1b)
- Copaxone, Glatopa (glatiramer)
- Gilenya (fingolimod)
- Rebif (interferon beta-1a)

- Tecfidera (dimethyl fumarate)

**AND**

**3** - Prescribed by or in consultation with a neurologist

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 a trial of at least 28 days of therapy with Betaseron (interferon beta-1b) within the past 180 days

**AND**

**2.2.2** Trial of at least ONE of the following medications:

- Aubagio (teriflunomide)
- Avonex (interferon beta-1a)
- Copaxone, Glatopa (glatiramer)
- Gilenya (fingolimod)
- Rebif (interferon beta-1a)
- Tecfidera (dimethyl fumarate)
- Bafiertam (monomethyl fumarate)
- Kesimpta (ofatumumab)
- Ocrevus (ocrelizumab)\*
- Plegridy (interferon beta-1a)
- Tascenso ODT (fingolimod)
- Zeposia (ozanimod)

**OR**

**2.3** Medical justification for the use of the requested medication over ALL of the following medications:

- Aubagio (teriflunomide)
- Avonex (interferon beta-1a)
- Betaseron (interferon beta-1b)
- Copaxone, Glatopa (glatiramer)
- Gilenya (fingolimod)
- Rebif (interferon beta-1a)
- Tecfidera (dimethyl fumarate)
- Bafiertam (monomethyl fumarate)
- Kesimpta (ofatumumab)
- Ocrevus (ocrelizumab)\*
- Plegridy (interferon beta-1a)
- Tascenso ODT (fingolimod)
- Zeposia (ozanimod)

**AND**

**3** - Prescribed by or in consultation with a neurologist

Notes	*Do not include Ocrevus in denial language; it is medical.
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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

**AND**

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

**AND**

3 - One of the following:

**3.1** Patient has a history of individual trials of at least 28 days of therapy with TWO of the following medications:

- Aubagio (teriflunomide)
- Avonex (interferon beta-1a)
- Betaseron (interferon beta-1b)
- Copaxone, Glatopa (glatiramer)
- Gilenya (fingolimod)
- Rebif (interferon beta-1a)
- Tecfidera (dimethyl fumarate)
- Bafiertam (monomethyl fumarate)
- Kesimpta (ofatumumab)
- Ocrevus (ocrelizumab)\*
- Plegridy (interferon beta-1a)
- Tascenso ODT (fingolimod)
- Zeposia (ozanimod)

**OR**

**3.2** Medical justification for use of the requested medication over ALL of the following medications:

- Aubagio (teriflunomide)
- Avonex (interferon beta-1a)
- Betaseron (interferon beta-1b)
- Copaxone, Glatopa (glatiramer)
- Gilenya (fingolimod)
- Rebif (interferon beta-1a)
- Tecfidera (dimethyl fumarate)
- Bafiertam (monomethyl fumarate)
- Kesimpta (ofatumumab)
- Ocrevus (ocrelizumab)\*
- Plegridy (interferon beta-1a)
- Tascenso ODT (fingolimod)
- Zeposia (ozanimod)

Notes

\*Do not include Ocrevus in denial language; it is medical.

**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 a history of individual trials of at least 28 days of therapy with TWO of the following medications:

- Aubagio (teriflunomide)
- Avonex (interferon beta-1a)
- Betaseron (interferon beta-1b)
- Copaxone, Glatopa (glatiramer)
- Gilenya (fingolimod)
- Rebif (interferon beta-1a)
- Tecfidera (dimethyl fumarate)
- Bafiertam (monomethyl fumarate)
- Kesimpta (ofatumumab)
- Ocrevus (ocrelizumab)\*
- Plegridy (interferon beta-1a)
- Tascenso ODT (fingolimod)
- Zeposia (ozanimod)

**OR**

**2.3** Medical justification for use of the requested medication over ALL of the following medications:

- Aubagio (teriflunomide)
- Avonex (interferon beta-1a)
- Betaseron (interferon beta-1b)
- Copaxone, Glatopa (glatiramer)
- Gilenya (fingolimod)
- Rebif (interferon beta-1a)
- Tecfidera (dimethyl fumarate)
- Bafiertam (monomethyl fumarate)
- Kesimpta (ofatumumab)
- Ocrevus (ocrelizumab)\*
- Plegridy (interferon beta-1a)
- Tascenso ODT (fingolimod)
- Zeposia (ozanimod)

**AND**

<b>3 - Prescribed by or in consultation with a neurologist</b>	
Notes	*Do not include Ocrevus in denial language; it is medical.

<b>Product Name: Ponvory</b>			
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 had individual trials of at least 28 days of therapy with TWO of the following medications:

- Aubagio (teriflunomide)
- Avonex (interferon beta-1a)
- Betaseron (interferon beta-1b)
- Copaxone, Glatopa (glatiramer)
- Gilenya (fingolimod)
- Rebif (interferon beta-1a)
- Tecfidera (dimethyl fumarate)
- Bafiertam (monomethyl fumarate)

- Kesimpta (ofatumumab)
- Ocrevus (ocrelizumab)\*
- Plegridy (interferon beta-1a)
- Tascenso ODT (fingolimod)
- Zeposia (ozanimod)

**OR**

**2.3** Medical justification for use of the requested medication over ALL of the following medications:

- Aubagio (teriflunomide)
- Avonex (interferon beta-1a)
- Betaseron (interferon beta-1b)
- Copaxone, Glatopa (glatiramer)
- Gilenya (fingolimod)
- Rebif (interferon beta-1a)
- Tecfidera (dimethyl fumarate)
- Bafiertam (monomethyl fumarate)
- Kesimpta (ofatumumab)
- Ocrevus (ocrelizumab)\*
- Plegridy (interferon beta-1a)
- Tascenso ODT (fingolimod)
- Zeposia (ozanimod)

**AND**

**3** - Prescribed by or in consultation with a neurologist

Notes	*Do not include Ocrevus in denial language; it is medical.
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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 Previous trial and failure of at least 28 days of therapy with dimethyl fumarate (generic of Tecfidera)

**AND**

2.1.2 Previous trial and failure of at least 28 days of therapy with ONE of the following medications:

- Aubagio (teriflunomide)
- Avonex (interferon beta-1a)
- Betaseron (interferon beta-1b)
- Copaxone, Glatopa (glatiramer)
- Gilenya (fingolimod)
- Rebif (interferon beta-1a)
- Bafiertam (monomethyl fumarate)
- Kesimpta (ofatumumab)
- Ocrevus (ocrelizumab)\*
- Plegridy (interferon beta-1a)
- Tascenso ODT (fingolimod)
- Zeposia (ozanimod)

**OR**

2.2 Medical justification for the use of the requested medication over ALL of the following medications:

- Aubagio (teriflunomide)
- Avonex (interferon beta-1a)
- Betaseron (interferon beta-1b)
- Copaxone, Glatopa (glatiramer)
- Gilenya (fingolimod)
- Rebif (interferon beta-1a)
- Tecfidera (dimethyl fumarate)

- Bafiertam (monomethyl fumarate)
- Kesimpta (ofatumumab)
- Ocrevus (ocrelizumab)\*
- Plegridy (interferon beta-1a)
- Tascenso ODT (fingolimod)
- Zeposia (ozanimod)

**AND**

**3** - Prescribed by or in consultation with a neurologist

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

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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	6240307530D220	Brand
PLEGRIDY STARTER PACK	PEGINTERFERON BETA-1A SOLN PEN-INJ 63 & 94 MCG/0.5ML PACK	6240307530D250	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
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3/13/2024	Updated GPs. Corrected product name list for reauth box.
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Muscular Dystrophy Agents



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-124412
<b>Guideline Name</b>	Muscular Dystrophy Agents
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

**Guideline Note:**

Effective Date:	7/1/2023
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### 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
<b>Approval Criteria</b>			

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



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-108459
<b>Guideline Name</b>	Myalept
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	8/1/2022
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## 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
<b>Approval Criteria</b>			
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



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-82111
<b>Guideline Name</b>	Mytesi
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	4/1/2021
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## 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
<b>Approval Criteria</b>			
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



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-124375
<b>Guideline Name</b>	Narcolepsy Agents
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Indiana</li> <li>• Medicaid - Community &amp; State Indiana SP</li> </ul>

**Guideline Note:**

Effective Date:	7/1/2023
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### 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)
- Excessive daytime sleepiness
- Narcolepsy
- 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

**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)
- Excessive daytime sleepiness
- Obstructive sleep apnea/hypopnea syndrome with residual excessive daytime sleepiness in conjunction with appropriate medical intervention(s)
- Shift work sleep disorder
- Sleep deprivation
- 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
<b>Approval Criteria</b>			
1 - Patient is 18 years of age or older			
<b>AND</b>			
2 - One of the following:			
2.1 Patient has a diagnosis of narcolepsy			

**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
<b>Approval Criteria</b>			
1 - Patient is 18 years of age or older			
<b>AND</b>			
2 - Patient has a diagnosis of narcolepsy			

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
<b>Approval Criteria</b>			
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 and 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 30kg
- 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)

<ul style="list-style-type: none"> <li>Acetaminophen</li> </ul>	
<p><b>OR</b></p>	
<p><b>1.2.2.2</b> Prescriber has provided valid medical justification for the use of sodium oxybate over therapy with amitriptyline, SNRI, SSRI, anticonvulsant (gabapentin/pregabalin), NSAID, AND acetaminophen</p>	
<p><b>AND</b></p>	
<p><b>1.2.3</b> Requested dose does NOT exceed 12 milliliters per day</p>	
Notes	*PDL Link: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>

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
<p><b>Approval Criteria</b></p> <p><b>1</b> - ONE of the following:</p> <p><b>1.1</b> Patient is 7 years of age or older and BOTH of the following:</p> <p><b>1.1.1</b> Diagnosis of narcolepsy with cataplexy and excessive daytime sleepiness</p>			
<p><b>AND</b></p>			
<p><b>1.1.2</b> Requested dose does NOT exceed ONE of the following:</p> <ul style="list-style-type: none"> <li>12 milliliters per day for patients weighing 20 kilograms (kg) to less than 30kg</li> </ul>			



- 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
<b>Approval Criteria</b>			
1 - History of the requested medication within the past 90 days			
<b>AND</b>			
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
4/7/2023	Addition of generic Xyrem. Changed reauth duration for Xyway.

Natpara



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-117265
<b>Guideline Name</b>	Natpara
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	1/1/2023
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## 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** - ALL of the following:

**1.1** Diagnosis of hypocalcemia resulting from chronic hypoparathyroidism

**AND**

**1.2** 25-hydroxy vitamin D level is above the lower limit of the normal laboratory reference range

**AND**

**1.3** Patient is currently on active vitamin D (calcitriol) therapy

**AND**

**1.4** Total serum calcium level (albumin corrected) is above 7.5 milligrams per deciliter

**AND**

**2** - ONE of the following:

**2.1** Patient is currently on calcium supplementation of 1-2 grams per day of elemental calcium in divided doses as confirmed by claims history or submission of medical records

**OR**

**2.2** Patient has a contraindication to calcium supplementation (please specify contraindication)

**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** - Total serum calcium level (albumin corrected) within the lower half of the normal range (approximately 8 to 9 milligrams per deciliter)

**AND**

**2** - Patient continues to take concomitant calcium supplementation that is sufficient to meet daily requirements

**AND**

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

- Endocrinologist
- Nephrologist

## 2 . Revision History

Date	Notes
11/23/2022	Copy NY

Nerlynx



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-129005
<b>Guideline Name</b>	Nerlynx
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	10/1/2023
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## 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
<b>Approval Criteria</b>			
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** Patient has received adjuvant trastuzumab-based 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

**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.
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**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** Hormone receptor-positive, (HER2)-negative disease in patients who 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
<b>Approval Criteria</b>			
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

Nexavar



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-134704
<b>Guideline Name</b>	Nexavar
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	12/1/2023
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## 1 . Criteria

Product Name: Nexavar			
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: Nexavar			
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
<b>Approval Criteria</b>			
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: Nexavar			
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
<p><b>Approval Criteria</b></p> <p><b>1 - ALL of the following:</b></p> <p><b>1.1 Diagnosis of ONE of the following:</b></p> <ul style="list-style-type: none"><li>• Follicular carcinoma</li><li>• Oncocytic carcinoma</li><li>• Papillary carcinoma</li></ul> <p style="text-align: center;"><b>AND</b></p> <p><b>1.2 ONE of the following:</b></p> <ul style="list-style-type: none"><li>• Unresectable recurrent disease</li><li>• Persistent locoregional disease</li><li>• Metastatic disease</li></ul> <p style="text-align: center;"><b>AND</b></p> <p><b>1.3 ONE of the following:</b></p> <ul style="list-style-type: none"><li>• Patient has symptomatic disease</li><li>• Patient has progressive disease</li></ul> <p style="text-align: center;"><b>AND</b></p> <p><b>1.4 Disease is refractory to radioactive iodine treatment</b></p> <p style="text-align: center;"><b>OR</b></p> <p><b>2 - ALL of the following:</b></p> <p><b>2.1 Diagnosis of medullary thyroid carcinoma</b></p>			



**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: Nexavar**

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
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of angiosarcoma</p> <p style="text-align: center;"><b>OR</b></p> <p>2 - Diagnosis of desmoid tumors/aggressive fibromatosis</p> <p style="text-align: center;"><b>OR</b></p> <p>3 - BOTH of the following:</p> <p>3.1 Diagnosis of progressive gastrointestinal stromal tumors (GIST)</p> <p style="text-align: center;"><b>AND</b></p> <p>3.2 ONE of the following:</p> <p>3.2.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:</p> <ul style="list-style-type: none"><li>• imatinib (generic for Gleevec)</li><li>• sunitinib (generic for Sutent)</li><li>• Stivarga (regorafenib)</li><li>• Qinlock (ripretinib)</li></ul> <p style="text-align: center;"><b>OR</b></p> <p>3.2.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):</p> <ul style="list-style-type: none"><li>• imatinib (generic for Gleevec)</li><li>• sunitinib (generic for Sutent)</li><li>• Stivarga (regorafenib)</li><li>• Qinlock (ripretinib)</li></ul>			

**OR**

**4 - Diagnosis of solitary fibrous tumor/hemangiopericytoma**

Product Name: Nexavar	
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: Nexavar			
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: Nexavar			
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:

<ul style="list-style-type: none"> <li>• Patient has persistent disease</li> <li>• Patient has recurrent disease</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - Disease is platinum-resistant</p> <p style="text-align: center;"><b>AND</b></p> <p><b>4</b> - Used in combination with topotecan</p>
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Product Name: Nexavar			
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

<p><b>Approval Criteria</b></p> <p><b>1</b> - Diagnosis of salivary gland tumor</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Disease is ONE of the following:</p> <ul style="list-style-type: none"> <li>• Recurrent and unresectable</li> </ul>
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- Metastatic

Product Name: Nexavar			
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
<b>Approval Criteria</b>			
1 - Diagnosis of myeloid/lymphoid neoplasm with eosinophilia and FLT3 rearrangement			

Product Name: Nexavar			
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 Nexavar therapy

**Product Name: Nexavar**

Diagnosis	NCCN Recommended Regimen
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: Nexavar**

Diagnosis	NCCN Recommended Regimen
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
<b>Approval Criteria</b> 1 - Documentation of positive clinical response to Nexavar therapy			

Ninlaro



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-105846
<b>Guideline Name</b>	Ninlaro
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	6/1/2022
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## 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

**AND**

2 - ONE of the following:

2.1 BOTH of the following:

- Patient has received at least one prior therapy for multiple myeloma [e.g., Velcade (bortezomib)]
- Used as part of a combination regimen including dexamethasone [Note: combination regimen may include additional agents, such as Revlimid (lenalidomide)]

**OR**

2.2 BOTH of the following:

- Used as primary therapy
- Used in combination with dexamethasone and Revlimid (lenalidomide)

**OR**

2.3 BOTH of the following:

2.3.1 Patient is a transplant candidate

**AND**

2.3.2 ONE of the following:

2.3.2.1 Patient has symptomatic disease following response to primary myeloma therapy

**OR**

2.3.2.2 Response or stable disease following autologous stem cell transplant

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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Diagnosis of Waldenström macroglobulinemia/lymphoplasmacytic lymphoma			
<b>AND</b>			
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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to Ninlaro therapy			

Nityr



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-81981
<b>Guideline Name</b>	Nityr
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	4/1/2021
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## 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
<b>Approval Criteria</b>			
1 - Diagnosis of hereditary tyrosinemia type 1			

## 2 . Revision History

Date	Notes
3/5/2021	Bulk Load



Nocdurna



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-123491
<b>Guideline Name</b>	Nocdurna
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	5/1/2023
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## 1 . Criteria

Product Name: Nocdurna			
Approval Length	6 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
<b>Approval Criteria</b>			

**1** - Diagnosis of nocturia due to nocturnal polyuria (as defined by nighttime urine production that exceeds one-third of the 24-hour urine production)

**AND**

**2** - Patient wakes at least twice per night on a reoccurring basis to void

**AND**

**3** - Documented serum sodium level is currently within normal limits of the normal laboratory reference range and has been within normal limits over the previous six months

**AND**

**4** - The patient has been evaluated for other medical causes and has either not responded to, tolerated, or has a contraindication to treatments for identifiable medical causes [e.g., overactive bladder, benign prostatic hyperplasia/lower urinary tract symptoms (BPH/LUTS), elevated post-void residual urine, and heart failure]

**AND**

**5** - Prescriber attests that the risks have been assessed and benefits outweigh the risks

Product Name: Nocdurna			
Approval Length	12 month(s)		
Therapy Stage	Reauthorization		
Guideline Type	Prior Authorization		
Product Name	Generic Name	GPI	Brand/Generic
NOCDURNA	DESMOPRESSIN ACETATE SUBLINGUAL TAB 27.7 MCG	30201010100710	Brand
NOCDURNA	DESMOPRESSIN ACETATE SUBLINGUAL TAB 55.3 MCG	30201010100715	Brand

**Approval Criteria**

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

**AND**

**2** - Patient has routine monitoring for serum sodium levels

**AND**

**3** - Prescriber attests that the risks of hyponatremia have been assessed and benefits outweigh the risks

Non-Preferred Drugs



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-108436
<b>Guideline Name</b>	Non-Preferred Drugs
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

**Guideline Note:**

Effective Date:	8/1/2022
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### 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			
<b>Approval Criteria</b>			

**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: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a> . 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.
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**2 . Revision History**

Date	Notes
6/20/2022	Copy NY

Northera



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-106441
<b>Guideline Name</b>	Northera
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	7/1/2022
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## 1 . Criteria

Product Name: Brand Northera, generic droxidopa			
Approval Length	3 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

Nourianz



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-120138
<b>Guideline Name</b>	Nourianz
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	3/1/2023
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## 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
<b>Approval Criteria</b>			
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



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-115268
<b>Guideline Name</b>	Nubeqa
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	12/1/2022
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## 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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to Nubeqa therapy</p>			

Nuedexta



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-81266
<b>Guideline Name</b>	Nuedexta
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

#### Guideline Note:

Effective Date:	4/1/2021
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### 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
<b>Approval Criteria</b>			
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



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-121795
<b>Guideline Name</b>	Nuzyra
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	4/1/2023
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## 1 . Criteria

Product Name: Nuzyra			
Guideline Type	Prior Authorization		
Product Name	Generic Name	GPI	Brand/Generic
NUZYRA	OMADACYCLINE TOSYLATE TAB 150 MG (BASE EQUIVALENT)	04200050200320	Brand
<p><b>Approval Criteria</b></p> <p>1 - For continuation of therapy upon hospital discharge</p> <p style="text-align: center;"><b>OR</b></p>			

**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.

Ocaliva



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-109292
<b>Guideline Name</b>	Ocaliva
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	9/1/2022
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### 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
<b>Approval Criteria</b>			
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
<p><b>Approval Criteria</b></p> <p>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</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - ONE of the following:</p> <p>2.1 Patient does not have cirrhosis</p> <p style="text-align: center;"><b>OR</b></p> <p>2.2 Patient has compensated cirrhosis without evidence of portal hypertension</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - Prescribed by ONE of the following:</p> <ul style="list-style-type: none"> <li>• Hepatologist</li> <li>• Gastroenterologist</li> </ul>			

**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



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-96978
<b>Guideline Name</b>	Odomzo
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	1/1/2022
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## 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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
<b>1</b> - 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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to Odomzo therapy			

## 2 . Revision History

Date	Notes
10/19/2021	Updated



Ojjaara



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-138627
<b>Guideline Name</b>	Ojjaara
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	2/1/2024
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## 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
<b>Approval Criteria</b>			

**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
<p><b>Approval Criteria</b></p> <p>1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium</p>			

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
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to Ojjaara therapy</p>			

Omnipod 5



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-124952
<b>Guideline Name</b>	Omnipod 5
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	7/1/2023
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## 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

**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
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**Product Name: Omnipod 5**

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

**Approval Criteria**

**1** - Documentation of positive clinical response

Notes	If patient meets criteria, approve using NDC List OMNIPOD5
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**Product Name: Omnipod 5 G6 pods**

Approval Length	12 month(s)
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Guideline Type	Quantity Limit
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Product Name	Generic Name	GPI	Brand/Generic
OMNIPOD 5 G6 PODS (GEN 5)	*INSULIN INFUSION DISPOSABLE PUMP RESERVOIR***	97201030506300	Brand
<p><b>Approval Criteria</b></p> <p>1 - Physician confirmation that the patient requires a greater quantity</p>			
Notes	Authorization for quantity limit overrides should be entered at the NDC level for the Omnipod 5 G6 pods, for the requested quantity.		

Ophthalmic Antibiotics



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-144311
<b>Guideline Name</b>	Ophthalmic Antibiotics
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

**Guideline Note:**

Effective Date:	4/1/2024
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### 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
<b>Approval Criteria</b>			
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: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>
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## 2 . Revision History

Date	Notes
3/13/2024	Removed Moxeza.

Opiates



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-145573
<b>Guideline Name</b>	Opiates
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	5/1/2024
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## 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), within the past 45 days\*

**AND**

3 - The patient is not using concurrently with a carisoprodol-containing product

**AND**

4 - No concurrent claims for Lybalvi (olanzapine/samidorphane) 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.
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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/samidorphane) 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), within the past 45 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, Xtampza 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 HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 40 MG	65100080107440	Generic
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 9 MG	6510007500A310	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 13.5 MG	6510007500A315	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 18 MG	6510007500A320	Brand

XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 27 MG	6510007500A330	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 36 MG	6510007500A340	Brand
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), within the past 45 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:

<ul style="list-style-type: none"> <li>• History of trial with 2 different preferred long acting medications (2 different ingredients) in the past 90 days</li> <li>• History of trial with 2 different non-preferred long acting medications (2 different ingredients) in the past 90 days</li> </ul>	
Notes	<p>*Unless faxed documentation has been received from the opioid prescriber with approval for opioid therapy from the buprenorphine or buprenorphine/naloxone prescriber.</p> <p>IN PDL Link: <a href="https://www.uhcprovider.com/en/health-plans-by-state/in-diana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/in-diana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a></p>

Product Name: 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
<p><b>Approval Criteria</b></p> <p><b>1</b> - 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*</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - The patient is not using concurrently with a carisoprodol-containing product</p> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - No concurrent claims for Lybalvi (olanzapine/samidorphane) within the past 45 days</p> <p style="text-align: center;"><b>AND</b></p>			

**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.
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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), within the past 45 days\*

**AND**

**2** - The patient is not using concurrently with a carisoprodol-containing product

**AND**

**3** - No concurrent claims for Lybalvi (olanzapine/samidorpham) 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.
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Product Name: Long-Acting Opioids: brand Butrans, generic buprenorphine patch, brand MS Contin, generic morphine sulfate ER, generic morphine sulfate CR, Nucynta ER, Oxycotin, 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

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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

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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 40 MG	65100055107035	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
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 50 MG	65100091107420	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 100 MG	65100091107430	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 150 MG	65100091107440	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 200 MG	65100091107450	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 250 MG	65100091107460	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 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

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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

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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

**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), within the past 45 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/in-diana-health-plans/in-comm-plan-home/in-cp-pharmacy.html>

Product Name: Short-Acting Opioids: butorphanol, acetaminophen/codeine (soln and tabs), brand Fioricet/codeine, generic butalbital/acetaminophen/caffeine/codeine, ascomp/codeine, butalbital/aspirin/caffeine/codeine, 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, Nucynta, belladonna/Opium, Opium, Roxybond, 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

Diagnosis	Prior Authorization/Opioid Naive (days supply limit)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Gener ic
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

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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

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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

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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
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE	ACETAMINOPHEN- CAFFEINE- DIHYDROCODEINE TAB 325-30-16 MG	65991303050320	Generic
HYDROMORPHONE HCL	HYDROMORPHONE HCL TAB 2 MG	65100035100310	Generic
HYDROMORPHONE HCL	HYDROMORPHONE HCL TAB 4 MG	65100035100320	Generic

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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

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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



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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
NUCYNTA	TAPENTADOL HCL TAB 50 MG	65100091100320	Brand
NUCYNTA	TAPENTADOL HCL TAB 75 MG	65100091100330	Brand

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NUCYNTA	TAPENTADOL HCL TAB 100 MG	65100091100340	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
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 10 MG	65100075100320	Generic
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 5 MG	6510007510A53 0	Brand
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 15 MG	6510007510A54 0	Brand
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 30 MG	6510007510A56 0	Brand
OXYCODONE HYDROCHLORIDE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN SOLN 5-325 MG/5ML	65990002202005	Brand
TUZISTRA XR	CODEINE POLIST- CHLORPHEN POLIST ER SUSP 14.7-2.8 MG/5ML	4399520231G12 0	Brand
HYDROCODONE POLISTIREX/CHLORPHENIRAMINE POLISTIREX	HYDROCOD POLST- CHLORPHEN POLST ER SUSP 10- 8 MG/5ML	4399520236G11 0	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

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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	PSEUDOEPHEDRIN E-BROMPHEN- CODEINE LIQ 10- 1.33-6.33 MG/5ML	43995303190922	Brand
MAR-COF BP	PSEUDOEPHEDRIN E-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

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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	PSEUDOEPHEDRIN E 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	PSEUDOEPHEDRIN E 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

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
BELLADONNA	BELLADONNA (BULK) TINCTURE	96445036361500	Brand
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 25 MG	65100095100310	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), within the past 45 days\*

**AND**

2 - The patient is not using concurrently with a carisoprodol-containing product

**AND**

3 - No concurrent claims for Lybalvi (olanzapine/samidorphane) 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** For a narcotic antitussive therapy, one of the following diagnoses:

- Cancer
- Palliative care
- Other terminal diagnosis with concomitant irretractable cough

**OR**

**6.2** For all other short-acting opioids (not including narcotic antitussives), one of the following diagnoses:

- Cancer
- Sickle cell disease
- Palliative care
- Other terminal diagnosis associated with significant pain

**OR**

**6.3** ALL 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**

**6.4** 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/narcotic antitussive agent

**AND**

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

- For a narcotic antitussive, history of 2 different preferred antitussive products (2 different ingredients) in the past 6 months
- For all other short-acting opioids (not including narcotic antitussives), 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, tramadol-containing, or narcotic antitussive product, the patient is 18 years of age or older (if less than 18 years of age, please see Age Limit criteria)

Notes	<p>*Unless faxed documentation has been received from the opioid prescriber with approval for opioid therapy from the buprenorphine or buprenorphine/naloxone prescriber.</p> <p>IN PDL Link: <a href="https://www.uhcprovider.com/en/health-plans-by-state/in-diana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/in-diana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a></p>
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Product Name: fentanyl patch, brand Butrans, generic buprenorphine patch, brand MS Contin, generic morphine sulfate ER, generic morphine sulfate CR, Nucynta ER, Oxycotin, Oxycodone ER, hydromorphone ER, brand Hysingla ER, generic hydrocodone ER tab, Oxymorphone ER, Xtampza 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, Nucynta, tramadol oral soln, belladonna/Opium, Opium, Seglantis, Roxybond, 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/Gener ic	
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/COD EINE	BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-325-40-30 MG	65991004100115	Generic	
BUTALBITAL/ACETAMINOPHEN/CAFFEINE/COD EINE	BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-300-40-30 MG	65991004100113	Generic	
FIORICET/CODEINE	BUTALBITAL-ACETAMINOPHEN-	65991004100113	Brand	

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	CAFF W/ COD CAP 50-300-40-30 MG		
ASCOMP/CODEINE	BUTALBITAL- ASPIRIN-CAFF W/ CODEINE CAP 50- 325-40-30 MG	65991004300115	Generic
BUTALBITAL/ASPIRIN/CAFFEINE/CODEINE	BUTALBITAL- ASPIRIN-CAFF W/ CODEINE CAP 50- 325-40-30 MG	65991004300115	Generic
BENZHYDROCODONE/ACETAMINOPHEN	BENZHYDROCODO NE HCL- ACETAMINOPHEN TAB 4.08-325 MG	65990002020310	Brand
APADAZ	BENZHYDROCODO NE HCL- ACETAMINOPHEN TAB 4.08-325 MG	65990002020310	Brand
BENZHYDROCODONE/ACETAMINOPHEN	BENZHYDROCODO NE HCL- ACETAMINOPHEN TAB 6.12-325 MG	65990002020320	Brand
APADAZ	BENZHYDROCODO NE HCL- ACETAMINOPHEN TAB 6.12-325 MG	65990002020320	Brand
BENZHYDROCODONE/ACETAMINOPHEN	BENZHYDROCODO NE HCL- ACETAMINOPHEN TAB 8.16-325 MG	65990002020330	Brand
APADAZ	BENZHYDROCODO NE 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

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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

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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/DIHYDROCODEIN E	ACETAMINOPHEN- CAFFEINE-	65991303050115	Generic

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	DIHYDROCODEINE CAP 320.5-30-16 MG		
TREZIX	ACETAMINOPHEN- CAFFEINE- DIHYDROCODEINE CAP 320.5-30-16 MG	65991303050115	Brand
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE	ACETAMINOPHEN- CAFFEINE- DIHYDROCODEINE TAB 325-30-16 MG	65991303050320	Generic
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

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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

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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

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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
NUCYNTA	TAPENTADOL HCL TAB 50 MG	65100091100320	Brand
NUCYNTA	TAPENTADOL HCL TAB 75 MG	65100091100330	Brand
NUCYNTA	TAPENTADOL HCL TAB 100 MG	65100091100340	Brand
BELLADONNA/OPIUM	BELLADONNA ALKALOIDS & OPIUM SUPPOS 16.2-30 MG	49109902155210	Generic
BELLADONNA/OPIUM	BELLADONNA ALKALOIDS &	49109902155220	Generic



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	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

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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 40 MG	65100055107035	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	65100055207020	Generic

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	CAP ER 24HR 30 MG		
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

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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
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

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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
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 50 MG	65100091107420	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 100 MG	65100091107430	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 150 MG	65100091107440	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 200 MG	65100091107450	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 250 MG	65100091107460	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic

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OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A71 0	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A71 0	Brand
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 15 MG	6510007510A71 5	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 15 MG	6510007510A71 5	Generic
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A72 0	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A72 0	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A72 0	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A72 0	Brand
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 30 MG	6510007510A73 0	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 30 MG	6510007510A73 0	Generic
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A74 0	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A74 0	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A74 0	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 60 MG	6510007510A76 0	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 60 MG	6510007510A76 0	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 60 MG	6510007510A76 0	Brand

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OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A78 0	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A78 0	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A78 0	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE- DETERRENT 9 MG	6510007500A31 0	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE- DETERRENT 13.5 MG	6510007500A31 5	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE- DETERRENT 18 MG	6510007500A32 0	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE- DETERRENT 27 MG	6510007500A33 0	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE- DETERRENT 36 MG	6510007500A34 0	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	65100095107580	Generic

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	BIPHASIC RELEASE 300 MG		
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
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 5 MG	6510007510A53 0	Brand
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 15 MG	6510007510A54 0	Brand
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 30 MG	6510007510A56 0	Brand
OXYCODONE HYDROCHLORIDE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN SOLN 5-325 MG/5ML	65990002202005	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG	6510003010A81 0	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB	6510003010A82 0	Generic



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	ER 24HR DETER 30 MG		
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/ 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

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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	PSEUDOEPHEDRIN E-BROMPHEN- CODEINE LIQ 10- 1.33-6.33 MG/5ML	43995303190922	Brand
MAR-COF BP	PSEUDOEPHEDRIN E-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

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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 TABLET 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 TABLET 5-1.5 MG	43101010100310	Brand
HYDROCODONE BITARTRATE/HOMATROPINE METHYLBROMIDE	HYDROCODONE BITART-HOMATROPINE METHYLBROMIDE TABLET 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
BELLADONNA	BELLADONNA (BULK) TINCTURE	96445036361500	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

**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	<p>*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.</p> <p>**Reference Table 1 in background for MME Limits.</p>
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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, tramadol oral soln, Seglantis, 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/Gener ic
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/COD EINE	BUTALBITAL- ACETAMINOPHEN- CAFF W/ COD CAP 50-325-40-30 MG	65991004100115	Generic
BUTALBITAL/ACETAMINOPHEN/CAFFEINE/COD EINE	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/	65991004300115	Generic

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	CODEINE CAP 50-325-40-30 MG		
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
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE	ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE TAB 325-30-16 MG	65991303050320	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
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

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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	4399520231G12 0	Brand
HYDROCODONE POLISTIREX/CHLORPHENIRAMINE POLISTIREX	HYDROCOD POLST- CHLORPHEN POLST ER SUSP 10-8 MG/5ML	4399520236G11 0	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



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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	PSEUDOEPHEDRIN E-BROMPHEN- CODEINE LIQ 10- 1.33-6.33 MG/5ML	43995303190922	Brand
MAR-COF BP	PSEUDOEPHEDRIN E-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

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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 TABLET 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 TABLET 5-1.5 MG	43101010100310	Brand
HYDROCODONE BITARTRATE/HOMATROPINE METHYLBROMIDE	HYDROCODONE BITART-HOMATROPINE METHYLBROMIDE TABLET 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

**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
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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/Gener ic
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/COD EINE	BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-325-40-30 MG	65991004100115	Generic

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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

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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



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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
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE	ACETAMINOPHEN- CAFFEINE- DIHYDROCODEINE TAB 325-30-16 MG	65991303050320	Generic
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

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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	65990002202020	Generic

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	SOLN 10-300 MG/5ML		
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

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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
NUCYNTA	TAPENTADOL HCL TAB 50 MG	65100091100320	Brand
NUCYNTA	TAPENTADOL HCL TAB 75 MG	65100091100330	Brand
NUCYNTA	TAPENTADOL HCL TAB 100 MG	65100091100340	Brand
BELLADONNA/OPIUM	BELLADONNA ALKALOIDS & OPIUM SUPPOS 16.2-30 MG	49109902155210	Generic

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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

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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 40 MG	65100055107035	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

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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

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HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG	6510003010A81 0	Brand
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG	6510003010A82 0	Brand
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG	6510003010A83 0	Brand
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG	6510003010A84 0	Brand
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG	6510003010A85 0	Brand
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG	6510003010A86 0	Brand
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG	6510003010A87 0	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



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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
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 50 MG	65100091107420	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 100 MG	65100091107430	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 150 MG	65100091107440	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 200 MG	65100091107450	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 250 MG	65100091107460	Brand

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OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A71 0	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A71 0	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A71 0	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A71 0	Brand
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 15 MG	6510007510A71 5	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 15 MG	6510007510A71 5	Generic
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A72 0	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A72 0	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A72 0	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A72 0	Brand
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 30 MG	6510007510A73 0	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 30 MG	6510007510A73 0	Generic
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A74 0	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A74 0	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A74 0	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 60 MG	6510007510A76 0	Generic

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OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 60 MG	6510007510A76 0	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 60 MG	6510007510A76 0	Brand
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A78 0	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A78 0	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A78 0	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE- DETERRENT 9 MG	6510007500A31 0	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE- DETERRENT 13.5 MG	6510007500A31 5	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE- DETERRENT 18 MG	6510007500A32 0	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE- DETERRENT 27 MG	6510007500A33 0	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE- DETERRENT 36 MG	6510007500A34 0	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

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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	6510003010A81 0	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG	6510003010A82 0	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG	6510003010A83 0	Generic

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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
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 5 MG	6510007510A530	Brand
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 15 MG	6510007510A540	Brand
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 30 MG	6510007510A560	Brand
OXYCODONE HYDROCHLORIDE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN SOLN 5-325 MG/5ML	65990002202005	Brand
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

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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	PSEUDOEPHEDRIN E-BROMPHEN- CODEINE LIQ 10- 1.33-6.33 MG/5ML	43995303190922	Brand
MAR-COF BP	PSEUDOEPHEDRIN E-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

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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 TABLET 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 TABLET 5-1.5 MG	43101010100310	Brand
HYDROCODONE BITARTRATE/HOMATROPINE METHYLBROMIDE	HYDROCODONE BITART-HOMATROPINE METHYLBROMIDE TABLET 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
BELLADONNA	BELLADONNA (BULK) TINCTURE	96445036361500	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

**Approval Criteria**

- 1 - The patient has not used Lybalvi (olanzapine/samidorphane) within the past 45 days

**2 . Background**

**Benefit/Coverage/Program Information**



<b>Table 1: Planned Taper Schedule for MME Limit Reduction</b>	
<b>Date of Reduction</b>	<b>MME Daily Limit</b>
April 1, 2024	475
July 1, 2024	450
October 1, 2024	425
January 1, 2025	400
April 1, 2025	375
July 1, 2025	350
October 1, 2025	325

### 3 . Revision History

<b>Date</b>	<b>Notes</b>
4/19/2024	Updated MME note and added Table 1 in background for MME Limit reference.

Oral Antipsychotics



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-129185
<b>Guideline Name</b>	Oral Antipsychotics
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	10/1/2023
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## 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
<b>Approval Criteria</b>			
1 - Diagnosis of Nausea and Vomiting			

Notes	*For all psychiatry-based diagnoses utilize applicable criteria (e.g., Duplicate Therapy, Age Limit Exception)
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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)
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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, 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

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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

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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

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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

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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



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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

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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

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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

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ABILIFY MYCITE MAINTENANCE KIT	ARIPIRAZOLE TAB 2 MG WITH SENSOR&STRIPS (FOR POD) MAINT PAK	5925001503B706	Brand
ABILIFY MYCITE STARTER KIT	ARIPIRAZOLE TAB 5 MG WITH SENSOR, STRIPS & POD STARTER PAK	5925001503B710	Brand
ABILIFY MYCITE MAINTENANCE KIT	ARIPIRAZOLE TAB 5 MG WITH SENSOR&STRIPS (FOR POD) MAINT PAK	5925001503B711	Brand
ABILIFY MYCITE STARTER KIT	ARIPIRAZOLE TAB 10 MG WITH SENSOR, STRIPS & POD STARTER PAK	5925001503B720	Brand
ABILIFY MYCITE MAINTENANCE KIT	ARIPIRAZOLE TAB 10 MG WITH SENSOR&STRIPS(FOR POD) MAINT PAK	5925001503B721	Brand
ABILIFY MYCITE STARTER KIT	ARIPIRAZOLE TAB 15 MG WITH SENSOR, STRIPS & POD STARTER PAK	5925001503B730	Brand
ABILIFY MYCITE MAINTENANCE KIT	ARIPIRAZOLE TAB 15 MG WITH SENSOR&STRIPS(FOR POD) MAINT PAK	5925001503B731	Brand
ABILIFY MYCITE STARTER KIT	ARIPIRAZOLE TAB 20 MG WITH SENSOR, STRIPS & POD STARTER PAK	5925001503B740	Brand
ABILIFY MYCITE MAINTENANCE KIT	ARIPIRAZOLE TAB 20 MG WITH SENSOR&STRIPS(FOR POD) MAINT PAK	5925001503B741	Brand
ABILIFY MYCITE STARTER KIT	ARIPIRAZOLE TAB 30 MG WITH SENSOR, STRIPS & POD STARTER PAK	5925001503B750	Brand
ABILIFY MYCITE MAINTENANCE KIT	ARIPIRAZOLE 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
- 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

**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

**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 \*

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; **Requests to utilize more than two antipsychotics concurrently will be denied
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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, 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	ARIPIPAZOLE TAB 2 MG	59250015000305	Brand
ARIPIPAZOLE	ARIPIPAZOLE TAB 2 MG	59250015000305	Generic
ABILIFY	ARIPIPAZOLE TAB 5 MG	59250015000310	Brand
ARIPIPAZOLE	ARIPIPAZOLE TAB 5 MG	59250015000310	Generic
ABILIFY	ARIPIPAZOLE TAB 10 MG	59250015000320	Brand
ARIPIPAZOLE	ARIPIPAZOLE TAB 10 MG	59250015000320	Generic
ABILIFY	ARIPIPAZOLE TAB 15 MG	59250015000330	Brand
ARIPIPAZOLE	ARIPIPAZOLE TAB 15 MG	59250015000330	Generic
ABILIFY	ARIPIPAZOLE TAB 20 MG	59250015000340	Brand
ARIPIPAZOLE	ARIPIPAZOLE TAB 20 MG	59250015000340	Generic



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ABILIFY	ARIPIRAZOLE TAB 30 MG	59250015000350	Brand
ARIPIRAZOLE	ARIPIRAZOLE 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	BREXPIRAZOLE TAB 0.25 MG	59250020000310	Brand
REXULTI	BREXPIRAZOLE TAB 0.5 MG	59250020000320	Brand
REXULTI	BREXPIRAZOLE TAB 1 MG	59250020000330	Brand
REXULTI	BREXPIRAZOLE TAB 2 MG	59250020000340	Brand
REXULTI	BREXPIRAZOLE TAB 3 MG	59250020000350	Brand
REXULTI	BREXPIRAZOLE 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

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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

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ZYPREXA ZYDIS	OLANZAPINE ORALLY DISINTEGRATING TAB 15 MG	59157060007230	Brand
OLANZAPINE ODT	OLANZAPINE ORALLY DISINTEGRATING TAB 20 MG	59157060007240	Generic
ZYPREXA ZYDIS	OLANZAPINE ORALLY DISINTEGRATING TAB 20 MG	59157060007240	Brand
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

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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

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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

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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

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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

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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	ARIPIRAZOLE TAB 2 MG WITH SENSOR, STRIPS & POD STARTER PAK	5925001503B705	Brand
ABILIFY MYCITE MAINTENANCE KIT	ARIPIRAZOLE TAB 2 MG WITH SENSOR&STRIPS (FOR POD) MAINT PAK	5925001503B706	Brand
ABILIFY MYCITE STARTER KIT	ARIPIRAZOLE TAB 5 MG WITH SENSOR, STRIPS & POD STARTER PAK	5925001503B710	Brand
ABILIFY MYCITE MAINTENANCE KIT	ARIPIRAZOLE TAB 5 MG WITH SENSOR&STRIPS (FOR POD) MAINT PAK	5925001503B711	Brand
ABILIFY MYCITE STARTER KIT	ARIPIRAZOLE TAB 10 MG WITH SENSOR, STRIPS & POD STARTER PAK	5925001503B720	Brand
ABILIFY MYCITE MAINTENANCE KIT	ARIPIRAZOLE TAB 10 MG WITH SENSOR&STRIPS(FOR POD) MAINT PAK	5925001503B721	Brand
ABILIFY MYCITE STARTER KIT	ARIPIRAZOLE TAB 15 MG WITH SENSOR, STRIPS & POD STARTER PAK	5925001503B730	Brand
ABILIFY MYCITE MAINTENANCE KIT	ARIPIRAZOLE TAB 15 MG WITH SENSOR&STRIPS(FOR POD) MAINT PAK	5925001503B731	Brand
ABILIFY MYCITE STARTER KIT	ARIPIRAZOLE TAB 20 MG WITH SENSOR, STRIPS & POD STARTER PAK	5925001503B740	Brand



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ABILIFY MYCITE MAINTENANCE KIT	ARIPIRAZOLE TAB 20 MG WITH SENSOR&STRIPS(FOR POD) MAINT PAK	5925001503B741	Brand
ABILIFY MYCITE STARTER KIT	ARIPIRAZOLE TAB 30 MG WITH SENSOR, STRIPS & POD STARTER PAK	5925001503B750	Brand
ABILIFY MYCITE MAINTENANCE KIT	ARIPIRAZOLE 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

**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

Notes	*Requests to utilize more than two antipsychotics concurrently will be denied
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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, 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	ARIPIPAZOLE TAB 2 MG	59250015000305	Brand
ARIPIPAZOLE	ARIPIPAZOLE TAB 2 MG	59250015000305	Generic
ABILIFY	ARIPIPAZOLE TAB 5 MG	59250015000310	Brand
ARIPIPAZOLE	ARIPIPAZOLE TAB 5 MG	59250015000310	Generic
ABILIFY	ARIPIPAZOLE TAB 10 MG	59250015000320	Brand
ARIPIPAZOLE	ARIPIPAZOLE TAB 10 MG	59250015000320	Generic
ABILIFY	ARIPIPAZOLE TAB 15 MG	59250015000330	Brand
ARIPIPAZOLE	ARIPIPAZOLE TAB 15 MG	59250015000330	Generic
ABILIFY	ARIPIPAZOLE TAB 20 MG	59250015000340	Brand
ARIPIPAZOLE	ARIPIPAZOLE TAB 20 MG	59250015000340	Generic
ABILIFY	ARIPIPAZOLE TAB 30 MG	59250015000350	Brand
ARIPIPAZOLE	ARIPIPAZOLE 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	BREXPIPAZOLE TAB 0.25 MG	59250020000310	Brand
REXULTI	BREXPIPAZOLE TAB 0.5 MG	59250020000320	Brand
REXULTI	BREXPIPAZOLE TAB 1 MG	59250020000330	Brand
REXULTI	BREXPIPAZOLE TAB 2 MG	59250020000340	Brand
REXULTI	BREXPIPAZOLE TAB 3 MG	59250020000350	Brand

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REXULTI	BREXPIRAZOLE 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

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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

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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

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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

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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



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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

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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
ARIPIRAZOLE	ARIPIRAZOLE ORAL SOLUTION 1 MG/ML	59250015002020	Generic
ARIPIRAZOLE ODT	ARIPIRAZOLE ORALLY DISINTEGRATING TAB 10 MG	59250015007220	Generic
ARIPIRAZOLE ODT	ARIPIRAZOLE 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

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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

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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** - 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
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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
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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
<b>Approval Criteria</b>			
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		

## 2 . Background

<b>Benefit/Coverage/Program Information</b>
<b>Table 1 - Adequate Dose</b>



Description	Adequate Dose
ARIPIPIRAZOLE	>/=5 mg/day
ASENAPINE	>/= 10 mg/day
BREXPIPIRAZOLE	>= 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
8/1/2023	Updated reauthorization section of duplicate therapy and table 1 in background.

Orfadin



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-127398
<b>Guideline Name</b>	Orfadin
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	8/1/2023
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## 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

<b>Guideline ID</b>	GL-117568
<b>Guideline Name</b>	Orladeyo
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	1/1/2023
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## 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
<b>Approval Criteria</b>			
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 a FXII (factor XII), angiotensin-1, plasminogen gene mutation, or kininogen mutations
- Recurring angioedema attacks that are refractory to high-dose antihistamines with confirmed family history of angioedema

**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, defined as a clinically significant reduction in the rate and/or number of hereditary angioedema (HAE) attacks, while on Orladeyo therapy

**AND**

**2** - Reduction in the utilization of on-demand therapies used for acute attacks (e.g., Berinert, Firazyf, 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
12/1/2022	Updated reference and trial failure language.



Orserdu



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-124653
<b>Guideline Name</b>	Orserdu
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	6/1/2023
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## 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
<b>Approval Criteria</b>			

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
- Male

**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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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
4/13/2023	New guideline

Osphena



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-124497
<b>Guideline Name</b>	Osphena
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	6/1/2023
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### 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
<b>Approval Criteria</b>			
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: Osphe <sup>na</sup>			
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
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to therapy			



Oxervate



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-98032
<b>Guideline Name</b>	Oxervate
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	1/1/2022
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## 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)	867700202020	Brand
<b>Approval Criteria</b>			
1 - Patient is 2 years of age or older			

<b>AND</b>
<b>2</b> - Diagnosis of neurotrophic keratitis
<b>AND</b>
<b>3</b> - Prescribed by, or in consultation with, an ophthalmologist
<b>AND</b>
<b>4</b> - 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

<b>Guideline ID</b>	GL-111761
<b>Guideline Name</b>	Palynziq
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	10/1/2022
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## 1 . Criteria

Product Name: Palynziq			
Approval Length	6 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	6 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
8/17/2022	Updated trial/failure language.

Pancreatic Enzymes



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-125017
<b>Guideline Name</b>	Pancreatic Enzymes
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

**Guideline Note:**

Effective Date:	7/1/2023
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### 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
<b>Approval Criteria</b>			
1 - Patient has utilized 30 cumulative days of preferred* agent therapy in the past 180 days			
Notes	*PDL link: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>		

## 2 . Revision History

Date	Notes
4/25/2023	New



Panretin



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-82119
<b>Guideline Name</b>	Panretin
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	4/1/2021
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## 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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to Panretin therapy			

## 2 . Revision History

Date	Notes
3/5/2021	Bulk Load

PCSK9 Inhibitors and Select Lipotropics



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-132272
<b>Guideline Name</b>	PCSK9 Inhibitors and Select Lipotropics
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

**Guideline Note:**

Effective Date:	10/1/2023
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### 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** - Patient must have 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: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>
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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 (ANTIHYPERSLIPIDEMIC)	39450050000450	Generic
NIACIN ER	NIACIN TAB ER 750 MG (ANTIHYPERSLIPIDEMIC)	39450050000460	Generic
NIACIN ER	NIACIN TAB ER 1000 MG (ANTIHYPERSLIPIDEMIC)	39450050000470	Generic
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of severe hypertriglyceridemia [baseline triglycerides greater than or equal to 500 mg/dL (milligrams per deciliter)] and one of the following:</p> <p>1.1 Concurrent therapy with ALL of the following for at least 90 days:</p> <ul style="list-style-type: none"> <li>• Omega-3 fatty acid (omega-3-acid ethyl esters or icosapent ethyl)</li> <li>• Fibric acid derivative</li> <li>• Statin therapy</li> </ul> <p style="text-align: center;"><b>OR</b></p> <p>1.2 Documented intolerance of omega-3 fatty acid, fibric acid derivative, AND statin therapy</p> <p style="text-align: center;"><b>OR</b></p> <p>1.3 Medical rationale against the use of omega-3 fatty acid, fibric acid derivatives, AND statin therapy</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Patient is 17 years of age or older</p>			

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 (ANTIHYPERSLIPIDEMIC)	39450050000450	Generic
NIACIN ER	NIACIN TAB ER 750 MG (ANTIHYPERSLIPIDEMIC)	39450050000460	Generic
NIACIN ER	NIACIN TAB ER 1000 MG (ANTIHYPERSLIPIDEMIC)	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 from Table 1 and multiple (2 or more) high risk conditions from Table 2
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<b>Product Name: Praluent</b>			
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
<p><b>Approval Criteria</b></p> <p><b>1 - Diagnosis of primary hyperlipidemia, without clinical ASCVD (atherosclerotic cardiovascular disease)</b></p> <p style="text-align: center;"><b>AND</b></p> <p><b>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</b></p> <p style="text-align: center;"><b>AND</b></p> <p><b>3 - One of the following:</b></p> <p style="padding-left: 20px;"><b>3.1</b> Persistently elevated LDL-C (greater than or equal to 100 mg/dL) despite treatment with one of the following:</p> <p style="padding-left: 40px;"><b>3.1.1</b> For patient requiring greater than 25% additional lowering, one of the following:</p> <ul style="list-style-type: none"> <li>• At least 90 days of therapy with high intensity rosuvastatin (20 mg/40 mg) therapy</li> <li>• For those intolerant to rosuvastatin, at least 90 days of therapy with high intensity atorvastatin (40 mg/80 mg) therapy</li> </ul> <p style="text-align: center;"><b>OR</b></p>			

**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
<b>Approval Criteria</b>			
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 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

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

**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 from Table 1 and multiple (2 or more) high risk conditions from Table 2
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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 <sup>2</sup> )
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
9/5/2023	Added "or equal to" in a few spots it was not there. Updated Niacin diagnosis to "severe." Added requirement that patient be taking maximally tolerated statin therapy with juxtapid/Praluent/Repatha or have a n intolerance

Pemazyre



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-136384
<b>Guideline Name</b>	Pemazyre
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	1/1/2024
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## 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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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.

Piqray



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-113258
<b>Guideline Name</b>	Piqray
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	11/1/2022
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## 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 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
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**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 - Patient is ONE of the following:

- Postmenopausal
- Premenopausal with ovarian ablation/suppression
- Male

<p><b>AND</b></p> <p>7 - Used in combination with fulvestrant</p> <p><b>AND</b></p> <p>8 - Disease has progressed on or after an endocrine-based regimen</p>
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<b>Product Name: Piqray</b>			
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
<p><b>Approval Criteria</b></p> <p>1 - Patient does not show evidence of progressive disease while on Piqray therapy</p>			

<b>Product Name: Piqray</b>	
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 - Piqray will be approved for uses 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
9/2/2022	Updated coverage criteria for initial authorization for breast cancer to include premenopausal women treated with ovarian ablation/suppression per NCCN Guidelines.

Pomalyst



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-108534
<b>Guideline Name</b>	Pomalyst
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	8/1/2022
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## 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 BOTH 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)]

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 - ALL 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

**AND**

**2.3** NOT used as first-line therapy

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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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



Preferred Non-Solid Dosage Forms



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-122060
<b>Guideline Name</b>	Preferred Non-Solid Dosage Forms
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

**Guideline Note:**

Effective Date:	4/16/2023
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### 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			
<b>Approval Criteria</b>			

**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



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-123777
<b>Guideline Name</b>	Presbyopia Agents
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	7/1/2023
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## 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
<b>Approval Criteria</b>			
1 - Diagnosis of presbyopia			

<p><b>AND</b></p> <p><b>2 - Patient is 18 years of age or older</b></p> <p><b>AND</b></p> <p><b>3 - Prescribed by, or in consultation with, an optometrist or ophthalmologist</b></p> <p><b>AND</b></p> <p><b>4 - Previous trial/failure/intolerance of corrective lenses (e.g., eyeglasses, contact lenses)</b></p>
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<b>Product Name: Vuity</b>			
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
<b>Approval Criteria</b>			
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

<b>Guideline ID</b>	GL-129062
<b>Guideline Name</b>	Prevymis
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	10/1/2023
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## 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
<b>Approval Criteria</b>			
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 Prevyomis 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 Prevyomis 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

<b>Guideline ID</b>	GL-109261
<b>Guideline Name</b>	Procysbi
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	9/1/2022
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## 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.
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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
<b>Approval Criteria</b> 1 - Documentation of positive clinical response to Procysbi therapy			

Promacta



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-121891
<b>Guideline Name</b>	Promacta
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	4/1/2023
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## 1 . Criteria

Product Name: Promacta			
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

**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

Product Name: Promacta			
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

**Approval Criteria**

1 - Documentation of positive clinical response to Promacta therapy

**Product Name: Promacta**

Diagnosis	Chronic Hepatitis C-Associated Thrombocytopenia
Approval Length	6 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

**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

Product Name: Promacta			
Diagnosis	Chronic Hepatitis C-Associated Thrombocytopenia		
Approval Length	6 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
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to Promacta therapy			
<b>AND</b>			
2 - Patient is currently on antiviral interferon therapy for treatment of chronic hepatitis C			

Product Name: Promacta

Diagnosis	Aplastic Anemia
Approval Length	6 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

**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]

Product Name: Promacta	
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
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to Promacta therapy			



Proton Pump Inhibitors



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-137598
<b>Guideline Name</b>	Proton Pump Inhibitors
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2024
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### 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*		
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

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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	492700400006510	Brand
PREVACID 24HR	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	492700400006510	Brand
PREVACID	LANSOPRAZOLE CAP DELAYED RELEASE 30 MG	492700400006520	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

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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

**Approval Criteria**

1 - One of the following:

1.1 Trial of 2 preferred agents for a total cumulative length of 4 weeks of therapy

**OR**

1.2 Allergy to or intolerance of all the preferred agents

Notes	*Approval duration should not allow member to exceed 90 days of PPI therapy within 180 days
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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

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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	492700400006510	Generic
EQ LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	492700400006510	Generic
GNP LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	492700400006510	Generic
GOODSENSE LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	492700400006510	Generic
HEARTBURN TREATMENT 24 HOUR	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	492700400006510	Generic
HM LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	492700400006510	Generic
KLS LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	492700400006510	Generic

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LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Generic
PREVACID	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Brand
PREVACID 24HR	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Brand
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

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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

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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



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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

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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 of 2 preferred agents for a total cumulative length of 4 weeks of therapy

**OR**

**2.2** Allergy to or intolerance of all the preferred agents

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) Brand Prilosec susp packet, generic lansoprazole ODT, Brand Prevacid Solutab, Brand Aciphex sprinkle, generic esomeprazole susp packet, generic pantoprazole susp packet, generic omeprazole/sodium bicarb powd pack, Brand Zegerid powd pack, Konvomep

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Diagnosis	Non-Preferred Non-Solid Dosage Forms - NOT exceeding 90 days PPI therapy within past 180 days		
Approval Length	90 Days*		
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
ACIPHEX SPRINKLE	RABEPRAZOLE SODIUM CAPSULE SPRINKLE DR 5 MG	49270076106805	Brand
ACIPHEX SPRINKLE	RABEPRAZOLE SODIUM CAPSULE SPRINKLE DR 10 MG	49270076106810	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
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
KONVOMEK	OMEPRAZOLE-SODIUM BICARBONATE FOR ORAL SUSP 2-84 MG/ML	49996002601920	Brand

**Approval Criteria**

1 - If the request is for omeprazole/sodium bicarb powder, Zegerid Powder, or Konvomek, the patient is less than or equal to 18 years of age

**AND**

2 - Both of the following

2.1 Patient is unable to swallow

**AND**

2.2 One of the following:

2.2.1 Trial of both Nexium Packets and Protonix Pak (If request is for Konvomek must try Nexium Packets, Protonix Pak, and Brand or Generic Zegerid) for a total cumulative length of 4 weeks of therapy

**OR**

2.2.2 Allergy to or intolerance of Nexium Packets, and Protonix Pak (If request is for Konvomek, allergy or intolerance of Nexium Packets, Protonix Pak, and Brand or Generic Zegerid)

Notes	*Approval duration should not allow member to exceed 90 days of PPI therapy within 180 days
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Product Name: (All Rx and OTC Products per label name included) Brand Prilosec susp packet, generic lansoprazole ODT, Brand Prevacid Solutab, Brand Aciphex 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
ACIPHEX SPRINKLE	RABEPRAZOLE SODIUM CAPSULE SPRINKLE DR 5 MG	49270076106805	Brand
ACIPHEX SPRINKLE	RABEPRAZOLE SODIUM CAPSULE SPRINKLE DR 10 MG	49270076106810	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

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
KONVOMEPE	OMEPRAZOLE-SODIUM BICARBONATE FOR ORAL SUSP 2-84 MG/ML	49996002601920	Brand

**Approval Criteria**

1 - If the request is for omeprazole/sodium bicarb powder, Zegerid Powder, or Konvomep patient is 18 years of age or younger

**AND**

2 - One of the following

2.1 Patient has one of the following diagnoses:

- Barrett's esophagus
- Abnormality of secretion of gastrin
- Zollinger-Ellison syndrome



- Any disease leading to hypersecretion

**OR**

**2.2** Diagnosis of duodenal/gastric/peptic ulcer that has not healed\* (see notes)

**OR**

**2.3** Patient is on continuous drug therapy requiring gastroprotection (e.g. anticoagulants, corticosteroids, antiplatelet agents, NSAIDS, etc.)

**OR**

**2.4** Both of the following:

**2.4.1** Diagnosis of one of the following:

- Erosive esophagitis
- Gastroesophageal reflux disease (GERD)

**AND**

**2.4.2** 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**

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

**3.1** Patient is unable to swallow

**AND**

**3.2** One of the following:

**3.2.1** Trial of both Nexium Packets and Protonix Pak (If request is for Konvomep must try Nexium Packets, Protonix Pak, and Brand or Generic Zegerid) for a total cumulative length of 4 weeks of therapy

**OR**

**3.2.2** Allergy to or intolerance of Nexium Packets, and Protonix Pak (If request is for Konvomep, allergy or intolerance of Nexium Packets, Protonix Pak, and Brand or Generic Zegerid)

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).
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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, Brand Aciphex 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

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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

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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

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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

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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

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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
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

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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



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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
ACIPHEX SPRINKLE	RABEPRAZOLE SODIUM CAPSULE SPRINKLE DR 5 MG	49270076106805	Brand
ACIPHEX SPRINKLE	RABEPRAZOLE SODIUM CAPSULE SPRINKLE DR 10 MG	49270076106810	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

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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
KONVOMEF	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
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**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 T O 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.
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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, Brand Aciphex 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

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CVS OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
EQ OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
EQL OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
GNP OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
HM OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
KLS OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
PX OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
RA OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
SB OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
SM OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
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

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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

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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

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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



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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 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
ACIPHEX SPRINKLE	RABEPRAZOLE SODIUM CAPSULE SPRINKLE DR 5 MG	49270076106805	Brand
ACIPHEX SPRINKLE	RABEPRAZOLE SODIUM CAPSULE SPRINKLE DR 10 MG	49270076106810	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
KONVOMEF	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

**Approval Criteria**

1 - Patient has one of the following diagnoses:

- Barrett's esophagus
- Abnormality of secretion of gastrin

<ul style="list-style-type: none"> <li>• Zollinger-Ellison syndrome</li> <li>• Any disease leading to hypersecretion</li> </ul>	
<b>OR</b>	
2 - Diagnosis of duodenal/gastric/peptic ulcer that has not healed* (see notes)	
<b>OR</b>	
3 - Patient is on continuous drug therapy requiring gastroprotection (e.g. anticoagulants, corticosteroids, antiplatelet agents, NSAIDS, etc.)	
<b>OR</b>	
4 - Both of the following:	
4.1 Diagnosis of erosive esophagitis or Gastroesophageal reflux disease (GERD)	
<b>AND</b>	
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
12/11/2023	Removed esomeprazole strontium (no longer manufactured). Removed rabeprazole sprinkle (no longer in MDRP). Updated GPI and product name lists.

Pulmonary Antihypertensives



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-132188
<b>Guideline Name</b>	Pulmonary Antihypertensives
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

**Guideline Note:**

Effective Date:	10/1/2023
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### 1 . Criteria

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 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, must have a negative pregnancy test in 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 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, must have a negative pregnancy test in 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
<b>Approval Criteria</b>			

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 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, must have a negative pregnancy test in 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
<b>Approval Criteria</b>			

**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 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
<b>Approval Criteria</b>			
1 - Diagnosis of 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 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 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 Tadiq 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: Tادليق			
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
<b>Approval Criteria</b>			
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			
<b>AND</b>			
2 - Requested dose does not exceed 40 mg/day			
<b>AND</b>			
3 - Patient does not have an active claim for any of the following:			
<ul style="list-style-type: none"> <li>• Nitrate therapy</li> <li>• PDE-5 inhibitor (other than the one being requested)</li> <li>• Adempas (riociguat)</li> </ul>			

**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
<b>Approval Criteria</b>			
1 - Diagnosis of 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
<b>Approval Criteria</b>			

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 REFILL	TREPROSTINIL INHALATION SOLUTION 0.6 MG/ML	40170080002020	Brand
TYVASO STARTER	TREPROSTINIL INHALATION SOLUTION 0.6 MG/ML	40170080002020	Brand
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
<b>Approval Criteria</b>			

1 - Diagnosis of 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 REFILL	TREPROSTINIL INHALATION SOLUTION 0.6 MG/ML	40170080002020	Brand
TYVASO STARTER	TREPROSTINIL INHALATION SOLUTION 0.6 MG/ML	40170080002020	Brand
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
<b>Approval Criteria</b>			

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: Upravi, Upravi 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 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 Upravi over Orenitram

**Product Name: Upravi, Upravi Titration Pack**

Approval Length	1 year(s)
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Therapy Stage	Reauthorization
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Guideline Type	Prior Authorization
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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
<b>Approval Criteria</b>			
1 - Diagnosis of pulmonary hypertension			
<b>AND</b>			
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
<b>Approval Criteria</b>			
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 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, must have a negative pregnancy test in 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
<b>Approval Criteria</b>			
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			
<b>AND</b>			
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
9/6/2023	Added GPIs and criteria for Liqrev and Ventavis, added GPI for Oreni tram titration, adjusted childbearing and reauth criteria language, cleaned up and simplified all criteria, corrected product name lists.

Pulmozyme



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-82297
<b>Guideline Name</b>	Pulmozyme
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	5/1/2021
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### 1 . Criteria

Product Name: Pulmozyme			
Diagnosis	Cystic Fibrosis		
Approval Length	12 month(s)		
Guideline Type	Prior Authorization		
Product Name	Generic Name	GPI	Brand/Generic
PULMOZYME	DORNASE ALFA INHAL SOLN 1 MG/ML	45304020002010	Brand
<b>Approval Criteria</b>			
1 - Diagnosis of Cystic Fibrosis			

## 2 . Revision History

Date	Notes
3/8/2021	Added product name list.

Qbrexza



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-125831
<b>Guideline Name</b>	Qbrexza
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	7/1/2023
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## 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
<b>Approval Criteria</b>			
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



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-129126
<b>Guideline Name</b>	Qinlock
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	10/1/2023
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## 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
<b>Approval Criteria</b>			
1 - Diagnosis of gastrointestinal stromal tumor (GIST)			

**AND**

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

- Advanced
- Unresectable
- 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



<p><b>AND</b></p> <p><b>3</b> - Disease progression, intolerance, and/or projected risk of progression with BRAF-targeted therapy</p> <p><b>AND</b></p> <p><b>4</b> - Positive for activating mutations of KIT</p>
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<b>Product Name: Qinlock</b>			
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
<b>Approval Criteria</b>			
1 - Patient does not show evidence of progressive disease while on Qinlock therapy			

<b>Product Name: Qinlock</b>			
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

Quantity Limits



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-128960
<b>Guideline Name</b>	Quantity Limits
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

**Guideline Note:**

Effective Date:	10/1/2023
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### 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			
<b>Approval Criteria</b>			
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			
<p><b>Approval Criteria</b></p> <p><b>1</b> - The use of this drug is supported by information from ONE of the following appropriate compendia of current literature:</p> <ul style="list-style-type: none"> <li>• American Hospital Formulary Service Drug Information</li> <li>• National Comprehensive Cancer Network Drugs and Biologics Compendium</li> <li>• Thomson Micromedex DrugDex</li> <li>• Clinical pharmacology</li> <li>• United States Pharmacopoeia-National Formulary (USP-NF)</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - The drug is being prescribed for an indication that is recognized as a covered benefit by the applicable health plans' program.</p>			
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			
<b>Approval Criteria</b>			
1 - Medical necessity rationale provided for why the member requires 5 or more fills of the same drug or drug class within a month.			
Notes	*If deemed medically necessary, longer authorization duration is permitted		

Product Name: Quantity Limit, Prescription Limit			
Diagnosis	Topical products exceeding the allowable package size per fill OR the allowable quantity per month		
Approval Length	12 month(s)		
Guideline Type	Administrative		
Product Name	Generic Name	GPI	Brand/Generic
Quantity Limit			
Prescription Limit			
<b>Approval Criteria</b>			
1 - The physician attests that a larger quantity is needed for treatment of a larger surface area.			

## 2 . Revision History

Date	Notes
7/25/2023	Updated guideline name. Defined FDA and reformatted step 2 of Quantity limit review (General) section.

Radicava ORS



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-129139
<b>Guideline Name</b>	Radicava ORS
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	10/1/2023
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## 1 . Criteria

Product Name: Radicava ORS			
Approval Length	6 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
<b>Approval Criteria</b>			

**1 - BOTH of the following:**

**1.1** Patient has been established on therapy with Radicava for amyotrophic lateral sclerosis (ALS) under an active UnitedHealthcare 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	6 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

Rayos



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-115207
<b>Guideline Name</b>	Rayos
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	12/1/2022
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## 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
<b>Approval Criteria</b>			
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
10/10/2022	Copy NY

Rectiv



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-82128
<b>Guideline Name</b>	Rectiv
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	4/1/2021
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## 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
<b>Approval Criteria</b>			
1 - Diagnosis of moderate to severe pain associated with chronic anal fissures			

## 2 . Revision History

Date	Notes
3/5/2021	Bulk Load

Regranex



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-82129
<b>Guideline Name</b>	Regranex
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	4/1/2021
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## 1 . Criteria

Product Name: Regranex			
Approval Length	6 month(s)		
Guideline Type	Prior Authorization		
Product Name	Generic Name	GPI	Brand/Generic
REGANEX	BECAPLERMIN GEL 0.01%	90945020004020	Brand
<b>Approval Criteria</b>			
1 - Patient has a lower extremity diabetic neuropathic ulcer			

## 2 . Revision History



Date	Notes
3/5/2021	Bulk Load

Relyvrio



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-139117
<b>Guideline Name</b>	Relyvrio
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	3/1/2024
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## 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
<b>Approval Criteria</b>			
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

<b>Product Name: Relyvrio</b>			
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

<b>Guideline ID</b>	GL-114249
<b>Guideline Name</b>	Repository Corticotropins
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

**Guideline Note:**

Effective Date:	11/1/2022
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### 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
<b>Approval Criteria</b>			
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<sup>2</sup> (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<sup>2</sup> IM in the morning for 3 days; 15 U/m<sup>2</sup> IM in the morning for 3 days; 10 U/m<sup>2</sup> IM in the morning for 3 days; 10 U/m<sup>2</sup> 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
<b>Approval Criteria</b>			
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 treatment of acute exacerbations of multiple sclerosis. See Background for more information.
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## 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



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-145502
<b>Guideline Name</b>	Respiratory and Allergy Biologics
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	5/1/2024
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## 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	9027302000D220	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 200 MG/1.14ML	9027302000D215	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/0.67ML	9027302000E510	Brand



DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 200 MG/1.14ML	9027302000E515	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML	9027302000E520	Brand

**Approval Criteria**

1 - Diagnosis of 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	9027302000D220	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 200 MG/1.14ML	9027302000D215	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/0.67ML	9027302000E510	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 200 MG/1.14ML	9027302000E515	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML	9027302000E520	Brand

**Approval Criteria**

1 - Diagnosis of moderate to severe 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
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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	9027302000D220	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 200 MG/1.14ML	9027302000D215	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/0.67ML	9027302000E510	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 200 MG/1.14ML	9027302000E515	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML	9027302000E520	Brand

**Approval Criteria**

1 - Diagnosis of eosinophilic esophagitis

**AND**

2 - Patient is 1 year of age or older

**AND**

3 - Patient weighs 15 kg (kilograms) or more

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	9027302000D220	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 200 MG/1.14ML	9027302000D215	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/0.67ML	9027302000E510	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

<b>Product Name: Dupixent</b>	
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	9027302000D220	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 200 MG/1.14ML	9027302000D215	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/0.67ML	9027302000E510	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 200 MG/1.14ML	9027302000E515	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML	9027302000E520	Brand

**Approval Criteria**

1 - Diagnosis of prurigo nodularis

**AND**

2 - Patient 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	9027302000D220	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 200 MG/1.14ML	9027302000D215	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/0.67ML	9027302000E510	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 200 MG/1.14ML	9027302000E515	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML	9027302000E520	Brand

**Approval Criteria**

1 - 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

**Approval Criteria**

**1** - Diagnosis of asthma (eosinophilic phenotype)

**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** - Fasentra 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: Fasentra	
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

**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
<b>Approval Criteria</b>			
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 Polyposis (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 Polyposis (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
<b>Approval Criteria</b>			
<b>1</b> - History of Nucala within the past 90 days			

**AND**

**2** - ONE of the following:

- Patient 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 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
4/9/2024	Added IgE-mediated food allergy diagnosis for Xolair

Retevmo



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-118335
<b>Guideline Name</b>	Retevmo
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	2/1/2023
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## 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
<b>Approval Criteria</b>			

**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
<b>Approval Criteria</b>			
1 - Diagnosis of ONE of the following histiocytic neoplasms:			
<ul style="list-style-type: none"> <li>• Langerhans Cell Histiocytosis</li> <li>• Erdheim-Chester disease</li> <li>• Rosai-Dorfman disease</li> </ul>			
<b>AND</b>			
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
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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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to Retevmo therapy			

## 2 . Revision History

Date	Notes
12/13/2022	Copy NY

Revlimid



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-127500
<b>Guideline Name</b>	Revlimid
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	8/1/2023
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## 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 anemia due to myelodysplastic syndrome WITHOUT deletion 5q

**AND**

**2.2** ONE of the following:

**2.2.1** Serum erythropoietin levels greater than 500 mU (milliunits)/mL (milliliter)

**OR**

**2.2.2** ALL of the following:

**2.2.2.1** Serum erythropoietin levels less than or equal to 500 mU/mL

**AND**

**2.2.2.2** Ring sideroblasts less than 15%

**AND**

**2.2.2.3** ONE of the following:

- Revlimid therapy is in combination with an erythropoietin [e.g., Epogen, Procrit, Retacrit (epoetin alfa)]
- Failure to erythropoietin's [e.g., Epogen, Procrit, Retacrit (epoetin alfa)] as confirmed by claims history or submission of medical records

- History of contraindication or intolerance to erythropoietin's [e.g., Epogen, Procrit, Retacrit (epoetin alfa)] (please specify contraindication or intolerance)

**OR**

**2.2.3** ALL of the following:

**2.2.3.1** Serum erythropoietin levels less than or equal to 500 mU/mL

**AND**

**2.2.3.2** Ring sideroblasts greater than or equal to 15%

**AND**

**2.2.3.3** No response to an erythropoietin in combination with a granulocyte-colony stimulating factor (G-CSF)

**OR**

**3** - BOTH of the following:

**3.1** Diagnosis of myelodysplastic/myeloproliferative neoplasms (MDS/MPN) overlap neoplasm

**AND**

**3.2** 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)
- Diffuse large B-cell lymphoma (patients 60 to 80 years old)
- Extra nodal marginal zone lymphoma of nongastric sites (noncutaneous)
- Extra nodal marginal zone lymphoma (EMZL) of the stomach
- Follicular lymphoma
- Nodal marginal zone lymphoma
- Splenic marginal zone lymphoma

**OR**

2 - BOTH of the following:

2.1 ONE of the following diagnoses:

- Acquired immunodeficiency syndrome (AIDS)-related B-cell lymphoma
- Castleman’s Disease (CD)
- Diffuse large B-cell lymphoma (patients who are less than 60 years old)
- High-grade B-cell lymphoma
- Histologic transformation of marginal zone lymphoma to diffuse large B-cell lymphoma



- Post-transplant lymphoproliferative disorders

**AND**

**2.2 NOT used as first line 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 ONE of the following:

- Relapsed
- Refractory

**AND**

**3** - Used as third-line or subsequent 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 - ONE of the following:**

**2.1** Used in combination with dexamethasone

**OR**

**2.2** Used in combination with dexamethasone and bortezomib

**OR**

**2.3** Used in combination with dexamethasone and cyclophosphamide

**OR**

**2.4** Used in combination with 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

LLENALIDOMIDE	LLENALIDOMIDE CAP 10 MG	99394050000130	Generic
LLENALIDOMIDE	LLENALIDOMIDE CAP 15 MG	99394050000140	Generic
LLENALIDOMIDE	LLENALIDOMIDE CAP 25 MG	99394050000150	Generic
LLENALIDOMIDE	LLENALIDOMIDE CAPS 2.5 MG	99394050000110	Generic
LLENALIDOMIDE	LLENALIDOMIDE CAP 20 MG	99394050000145	Generic

**Approval Criteria**

1 - Patient has a diagnosis of chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL)

**AND**

2 - ONE of the following:

- Used for relapsed or refractory disease after prior therapy with Bruton Tyrosine Kinase (BTK) inhibitor and venetoclax-based regimens without del(17p)/TP53 mutation
- Used for second-line and subsequent therapy with del(17p)/TP53 mutation

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	LLENALIDOMIDE CAPS 2.5 MG	99394050000110	Brand
REVLIMID	LLENALIDOMIDE CAP 5 MG	99394050000120	Brand
REVLIMID	LLENALIDOMIDE CAP 10 MG	99394050000130	Brand
REVLIMID	LLENALIDOMIDE CAP 15 MG	99394050000140	Brand
REVLIMID	LLENALIDOMIDE CAP 20 MG	99394050000145	Brand
REVLIMID	LLENALIDOMIDE CAP 25 MG	99394050000150	Brand
LLENALIDOMIDE	LLENALIDOMIDE 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 - NOT used as first line 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 AIDS-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 NOT used as first line therapy**

Product Name: Brand Revlimid, generic lenalidomide			
Diagnosis	Langerhans Cell Histiocytosis		
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 Langerhans cell histiocytosis

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**



<b>1 - Patient does not show evidence of progressive disease while on Revlimid therapy</b>	
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

**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**

**AND**

**2 - ONE of the following:**

**2.1 BOTH of the following:**

**2.1.1** Serum erythropoietin levels less than 500 mU (milliunits)/mL (milliliter)

**AND**

**2.1.2 ONE of the following:**

**2.1.2.1** Failure to erythropoietin's [e.g., Procrit (epoetin alfa)] as confirmed by claims history or submission of medical records

**OR**

**2.1.2.2** History of contraindication or intolerance to erythropoietin's [e.g., Procrit (epoetin alfa)] (please specify contraindication or intolerance)

**OR**

**2.2** Serum erythropoietin levels greater than or equal to 500 mU/mL

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 that the patient has evidence of symptom improvement or reduction in spleen/liver volume 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
7/3/2023	Added new generic lenalidomide strengths. Updated erythropoietin spelling throughout. Revised the name of gastric and nongastric MALT lymphoma per NCCN guidelines. Updated Systemic Light Chain Amyloidosis and CLL/SLL criteria per NCCN guidelines.

Rezlidhia



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-123358
<b>Guideline Name</b>	Rezlidhia
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	5/1/2023
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## 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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Patient does not show evidence of progressive disease while on Rezlidhia therapy			

Product Name: Rezlidhia			
Diagnosis	NCCN Recommended Regimens		
Approval Length	12 month(s)		
Therapy Stage	Initial Authorization		
Guideline Type	Prior Authorization		
Product Name	Generic Name	GPI	Brand/Generic
REZLIDHIA	OLUTASIDENIB CAP 150 MG	21534960000120	Brand

**Approval Criteria**

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

Product Name: Rezlidhia			
Diagnosis	NCCN Recommended Regimens		
Approval Length	12 month(s)		
Therapy Stage	Reauthorization		
Guideline Type	Prior Authorization		
Product Name	Generic Name	GPI	Brand/Generic
REZLIDHIA	OLUTASIDENIB CAP 150 MG	21534960000120	Brand

**Approval Criteria**

1 - Documentation of positive clinical response to Rezlidhia therapy



Rezurock



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-115131
<b>Guideline Name</b>	Rezurock
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	12/1/2022
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### 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
<b>Approval Criteria</b>			
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

**AND**

**3** - The patient is at least 12 years of age

Product Name: Rezero			
Approval Length	12 month(s)		
Therapy Stage	Reauthorization		
Guideline Type	Prior Authorization		
Product Name	Generic Name	GPI	Brand/Generic
REZERO	BELUMOSUDIL MESYLATE TAB 200 MG	99398510500320	Brand
<b>Approval Criteria</b>			
<b>1</b> - Documentation of positive clinical response to Rezero therapy			

Rozlytrek



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-121918
<b>Guideline Name</b>	Rozlytrek
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	4/1/2023
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## 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
<b>Approval Criteria</b>			

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

**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
<b>Approval Criteria</b>			
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

**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

**Approval Criteria**

1 - Documentation of positive clinical response to Rozlytrek therapy

Rubraca



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-125947
<b>Guideline Name</b>	Rubraca
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	7/1/2023
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## 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
<b>Approval Criteria</b>			



**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
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of BRCA altered uterine leiomyosarcoma (uLMS)</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Disease has progressed following prior treatment with ONE of the following:</p> <ul style="list-style-type: none"> <li>• Gemcitabine plus docetaxel</li> <li>• Doxorubicin</li> </ul>			

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
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to Rubraca therapy</p>			

## 2 . Revision History

Date	Notes
5/22/2023	Copy NY

Ruconest



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-86859
<b>Guideline Name</b>	Ruconest
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	7/1/2021
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## 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
<b>Approval Criteria</b>			
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 a FXII, angiotensin-1, plasminogen gene mutation, or kininogen mutation
- Recurring angioedema attacks that are refractory to high-dose antihistamines with confirmed family history of angioedema

**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
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Prescribed for the acute treatment of HAE attacks</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - Not used in combination with other products indicated for the acute treatment of HAE attacks (e.g., Berinert, Firazyr)</p> <p style="text-align: center;"><b>AND</b></p> <p>4 - Prescribed by ONE of the following:</p> <ul style="list-style-type: none"> <li>• Immunologist</li> <li>• Allergist</li> </ul>			

## 2 . Revision History

Date	Notes
5/12/2021	Added diagnosis criteria. Copied from NY



Rukobia



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-82134
<b>Guideline Name</b>	Rukobia
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	4/1/2021
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## 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
<p><b>Approval Criteria</b></p> <p>1 - Patient has been diagnosed with multidrug-resistant HIV-1 (human immunodeficiency virus) infection</p>			

**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

<b>Guideline ID</b>	GL-109388
<b>Guideline Name</b>	Rydapt
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	9/1/2022
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## 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
<b>Approval Criteria</b>			
1 - Diagnosis of acute myeloid leukemia (AML)			

<p><b>AND</b></p> <p><b>2 - AML is FLT3 mutation-positive</b></p> <p><b>AND</b></p> <p><b>3 - Rydapt will be used in combination with standard induction and consolidation therapy</b></p>
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<b>Product Name: Rydapt</b>			
Diagnosis	Systemic Mastocytosis		
Approval Length	12 month(s)		
Therapy Stage	Initial Authorization		
Guideline Type	Prior Authorization		
<b>Product Name</b>	<b>Generic Name</b>	<b>GPI</b>	<b>Brand/Generic</b>
RYDAPT	MIDOSTAURIN CAP 25 MG	21533030000130	Brand
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of ONE of the following:</p> <ul style="list-style-type: none"> <li>Aggressive systemic mastocytosis (ASM)</li> <li>Systemic mastocytosis with associated hematologic neoplasm (SM-AHN)</li> <li>Mast cell leukemia (MCL)</li> </ul>			

<b>Product Name: Rydapt</b>	
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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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

<b>Guideline ID</b>	GL-127874
<b>Guideline Name</b>	Samsca
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	9/1/2023
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## 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
<b>Approval Criteria</b>			

**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



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-139239
<b>Guideline Name</b>	Scemblix
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	3/1/2024
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## 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
SCSEMBLIX	ASCIMINIB HCL TAB 20 MG	21531806100320	Brand
SCSEMBLIX	ASCIMINIB HCL TAB 40 MG	21531806100340	Brand
<b>Approval Criteria</b>			

**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), Tassigna (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
SCSEMBLIX	ASCIMINIB HCL TAB 20 MG	21531806100320	Brand
SCSEMBLIX	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
SCSEMBLIX	ASCIMINIB HCL TAB 20 MG	21531806100320	Brand
SCSEMBLIX	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
SCSEMBLIX	ASCIMINIB HCL TAB 20 MG	21531806100320	Brand
SCSEMBLIX	ASCIMINIB HCL TAB 40 MG	21531806100340	Brand
<b>Approval Criteria</b>			
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
SCSEMBLIX	ASCIMINIB HCL TAB 20 MG	21531806100320	Brand
SCSEMBLIX	ASCIMINIB HCL TAB 40 MG	21531806100340	Brand
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to Scemblix therapy			

Sedative-Hypnotics and Benzodiazepines



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-136720
<b>Guideline Name</b>	Sedative-Hypnotics and Benzodiazepines
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2024
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### 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; generic diazepam rectal gel; Brand Diastat; 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

UnitedHealthcare Community Plan of Indiana – Clinical Pharmacy Guidelines

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

UnitedHealthcare Community Plan of Indiana – Clinical Pharmacy Guidelines

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

UnitedHealthcare Community Plan of Indiana – Clinical Pharmacy Guidelines

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



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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

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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
DIASTAT PEDIATRIC	DIAZEPAM RECTAL GEL DELIVERY SYSTEM 2.5 MG	72100030004030	Brand
DIAZEPAM RECTAL GEL	DIAZEPAM RECTAL GEL DELIVERY SYSTEM 2.5 MG	72100030004030	Generic
DIASTAT ACUDIAL	DIAZEPAM RECTAL GEL DELIVERY SYSTEM 10 MG	72100030004040	Brand
DIAZEPAM RECTAL GEL	DIAZEPAM RECTAL GEL DELIVERY SYSTEM 10 MG	72100030004040	Generic
DIASTAT ACUDIAL	DIAZEPAM RECTAL GEL DELIVERY SYSTEM 20 MG	72100030004060	Brand
DIAZEPAM RECTAL GEL	DIAZEPAM RECTAL GEL DELIVERY SYSTEM 20 MG	72100030004060	Generic

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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; generic diazepam rectal gel; Brand Diastat; 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

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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

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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

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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

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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
DIASTAT PEDIATRIC	DIAZEPAM RECTAL GEL DELIVERY SYSTEM 2.5 MG	72100030004030	Brand
DIAZEPAM RECTAL GEL	DIAZEPAM RECTAL GEL DELIVERY SYSTEM 2.5 MG	72100030004030	Generic
DIASTAT ACUDIAL	DIAZEPAM RECTAL GEL DELIVERY SYSTEM 10 MG	72100030004040	Brand
DIAZEPAM RECTAL GEL	DIAZEPAM RECTAL GEL DELIVERY SYSTEM 10 MG	72100030004040	Generic
DIASTAT ACUDIAL	DIAZEPAM RECTAL GEL DELIVERY SYSTEM 20 MG	72100030004060	Brand
DIAZEPAM RECTAL GEL	DIAZEPAM RECTAL GEL DELIVERY SYSTEM 20 MG	72100030004060	Generic
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
11/22/2023	Updated flurazepam GPI. Added Librax (chlordiazepoxide/clidinium), Onfi (clobazam) and Sympazan to therapeutic duplication section. Added seizure exemption for clobazam products for duplicate therapy review.

SGLT2 Inhibitors and Combinations



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-124980
<b>Guideline Name</b>	SGLT2 Inhibitors and Combinations
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

**Guideline Note:**

Effective Date:	7/1/2023
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### 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
<p><b>Approval Criteria</b></p> <p>1 - Patient has tried and failed combination therapy with preferred* agents of the same classes</p> <p style="text-align: center;"><b>OR</b></p> <p>2 - Medical justification for use</p>			
Notes	*PDL link: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>		

## 2 . Revision History

Date	Notes
4/24/2023	New

Signifor



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-82006
<b>Guideline Name</b>	Signifor
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	4/1/2021
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## 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
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to Signifor therapy			

**2 . Revision History**

Date	Notes
3/5/2021	Bulk Load



Sivextro



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-134164
<b>Guideline Name</b>	Sivextro
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	11/1/2023
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## 1 . Criteria

Product Name: Sivextro			
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
<b>Approval Criteria</b>			
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	
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
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10/3/2023	Updated Sivextro GPI listing. Combined dicloxacillin and amoxicillin/c lavulanate into one option as “A penicillin” without change to intent. Moved approval duration for Off-label Uses to Approval length box vs listing as a note in guideline.
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Skeletal Muscle Relaxants



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-126458
<b>Guideline Name</b>	Skeletal Muscle Relaxants
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

**Guideline Note:**

Effective Date:	7/1/2023
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### 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
<b>Approval Criteria</b>			
1 - One of the following:			

**1.1** Patient is 12 to 17 years of age

**OR**

**1.2** Patient is unable to swallow tablets

Product Name: Baclofen solution, Ozobax solution, Fleqsuvy

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	Generic

**Approval Criteria**

**1** - One of the following:

**1.1** Patient is 12 to 17 years of age

**OR**

**1.2** 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
<p><b>Approval Criteria</b></p> <p>1 - Trial of cyclobenzaprine (immediate release) within the past 30 days</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - One of the following:</p> <p style="padding-left: 20px;"><b>2.1</b> History of failure to at least TWO additional preferred alternatives as confirmed by claims history or submission of medical records.*</p> <p style="text-align: center;"><b>OR</b></p> <p style="padding-left: 20px;"><b>2.2</b> History of contraindication or intolerance to TWO additional preferred alternatives (please specify contraindication or intolerance).*</p>			
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
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6/8/2023	Lyvispah now preferred. Baclofen solution now non-preferred. Non-solid dosage forms only require trial of Lyvispah or medical rationale for use.
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Skyclarys



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-127234
<b>Guideline Name</b>	Skyclarys
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	8/1/2023
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## 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
<b>Approval Criteria</b>			
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



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-137508
<b>Guideline Name</b>	Smoking Deterrent Agents
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2024
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### 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

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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	NICOTINE TD PATCH 24HR 14 MG/24HR	62100005008530	Generic

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SYSTEM STEP 2			
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	NICOTINE TD PATCH 24HR 21 MG/24HR	62100005008540	Generic



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SYSTEM/STEP 1/CLEAR			
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

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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

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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: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>
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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
<b>Approval Criteria</b>			
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.



Solaraze



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-124376
<b>Guideline Name</b>	Solaraze
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	7/1/2023
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### 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
<b>Approval Criteria</b>			
1 - Diagnosis of actinic keratosis			

## 2 . Revision History

Date	Notes
4/7/2023	Updated GL type to PA



Somavert



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-129170
<b>Guideline Name</b>	Somavert
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	10/1/2023
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## 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
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to Somavert therapy (e.g., age-normalized serum IGF-1 level)			

Soriatane



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-98051
<b>Guideline Name</b>	Soriatane
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	1/1/2022
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### 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
<b>Approval Criteria</b>			
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.

Sprycel



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-136516
<b>Guideline Name</b>	Sprycel
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	1/1/2024
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## 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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Diagnosis of cutaneous melanoma			

<p><b>AND</b></p> <p><b>2</b> - Tumors are metastatic or unresectable</p> <p><b>AND</b></p> <p><b>3</b> - Contains activating mutations of KIT</p> <p><b>AND</b></p> <p><b>4</b> - Used as second-line or subsequent therapy for disease progression, intolerance, and/or projected risk of progression with BRAF-targeted therapy</p>
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<b>Product Name: Sprycel</b>			
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
<b>Approval Criteria</b>			

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
<b>Approval Criteria</b>			
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



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-124721
<b>Guideline Name</b>	SSRI and SNRI
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	7/1/2023
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## 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

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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

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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



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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

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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

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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

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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

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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

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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



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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

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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

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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

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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

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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

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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



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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

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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

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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

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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
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## 2 . Revision History

Date	Notes
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4/17/2023	Aligned criteria with with the policy and added the age limit criteria from the non-drug specific PA policy
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Stimulants



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-124893
<b>Guideline Name</b>	Stimulants
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

**Guideline Note:**

Effective Date:	7/1/2023
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### 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)



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Product Name	Generic Name	GPI	Brand/Generi c
DYANA VEL 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/DEXTROAMPHETAMI NE	AMPHETAMINE- DEXTROAMPHETAMINE TAB 5 MG	61109902100305	Generic
ADDERALL	AMPHETAMINE- DEXTROAMPHETAMINE TAB 7.5 MG	61109902100307	Brand
AMPHETAMINE/DEXTROAMPHETAMI NE	AMPHETAMINE- DEXTROAMPHETAMINE TAB 7.5 MG	61109902100307	Generic
ADDERALL	AMPHETAMINE- DEXTROAMPHETAMINE TAB 10 MG	61109902100310	Brand
AMPHETAMINE/DEXTROAMPHETAMI NE	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

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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

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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

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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

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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

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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

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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



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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-D-DEXMETHYLPHENIDATE CAP 26.1-5.2 MG	61409802800120	Brand
AZSTARYS	SERDEXMETHYLPHENIDATE-D-DEXMETHYLPHENIDATE CAP 39.2-7.8 MG	61409802800130	Brand
AZSTARYS	SERDEXMETHYLPHENIDATE-D-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

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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

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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
DYANA VEL XR	AMPHETAMINE CHEW TAB EXTENDED RELEASE 5 MG	6110001000H210	Brand
DYANA VEL XR	AMPHETAMINE CHEW TAB EXTENDED RELEASE 10 MG	6110001000H220	Brand
DYANA VEL XR	AMPHETAMINE CHEW TAB EXTENDED RELEASE 15 MG	6110001000H230	Brand
DYANA VEL XR	AMPHETAMINE CHEW TAB EXTENDED RELEASE 20 MG	6110001000H240	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
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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/Generi c

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DYANA VEL 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

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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

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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



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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

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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

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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

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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

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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

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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-D-DEXMETHYLPHENIDATE CAP 26.1-5.2 MG	61409802800120	Brand
AZSTARYS	SERDEXMETHYLPHENIDATE-D-DEXMETHYLPHENIDATE CAP 39.2-7.8 MG	61409802800130	Brand
AZSTARYS	SERDEXMETHYLPHENIDATE-D-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

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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

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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	6110001000H210	Brand
DYANAVEL XR	AMPHETAMINE CHEW TAB EXTENDED RELEASE 10 MG	6110001000H220	Brand
DYANAVEL XR	AMPHETAMINE CHEW TAB EXTENDED RELEASE 15 MG	6110001000H230	Brand
DYANAVEL XR	AMPHETAMINE CHEW TAB EXTENDED RELEASE 20 MG	6110001000H240	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\*

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Diagnosis	Age Limit Exception*		
Approval Length	12 month(s)		
Guideline Type	Prior Authorization		
Product Name	Generic Name	GPI	Brand/Generi c
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

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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

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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

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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

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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

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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

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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



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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

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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-D-DEXMETHYLPHENIDATE CAP 26.1-5.2 MG	61409802800120	Brand
AZSTARYS	SERDEXMETHYLPHENIDATE-D-DEXMETHYLPHENIDATE CAP 39.2-7.8 MG	61409802800130	Brand
AZSTARYS	SERDEXMETHYLPHENIDATE-D-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

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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

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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	6110001000H210	Brand
DYANAVEL XR	AMPHETAMINE CHEW TAB EXTENDED RELEASE 10 MG	6110001000H220	Brand
DYANAVEL XR	AMPHETAMINE CHEW TAB EXTENDED RELEASE 15 MG	6110001000H230	Brand
DYANAVEL XR	AMPHETAMINE CHEW TAB EXTENDED RELEASE 20 MG	6110001000H240	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



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-127953
<b>Guideline Name</b>	Stivarga
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	9/1/2023
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### 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
<b>Approval Criteria</b>			
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

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** - BOTH of the following:

**1.1** Diagnosis of soft tissue sarcoma (STS)

**AND**

**1.2** ONE of the following:

**1.2.1** Extremity/superficial trunk or head/neck that is non-adipocytic with advanced/metastatic disease with disseminated metastases

**OR**

**1.2.2** Retroperitoneal/intra-abdominal that is non-adipocytic with recurrent unresectable or stage IV disease

**OR**

**1.2.3** Advanced/metastatic pleomorphic rhabdomyosarcoma

**OR**

**1.2.4** Angiosarcoma

**OR**

**2** - ALL of the following:

**2.1** Diagnosis of gastrointestinal stromal tumor (GIST)

**AND**

**2.2** Disease is ONE of the following:

- Progressive
- Locally advanced
- Unresectable
- Metastatic

**AND**

**2.3** ONE of the following:

**2.3.1** First-line therapy as a single agent for SDH (succinate dehydrogenase)-deficient GIST with gross residual disease (R2 resection)

**OR**

**2.3.2** Failure of BOTH of the following confirmed by claims history or submitted medical records:

- Imatinib mesylate (generic Gleevec)
- Sunitinib maleate (generic Sutent)

**OR**

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

- Imatinib mesylate (generic Gleevec)
- Sunitinib maleate (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 - ALL of the following:

1.1 Diagnosis of ONE of the following:

- Gallbladder cancer
- Extrahepatic cholangiocarcinoma
- Intrahepatic cholangiocarcinoma

**AND**

1.2 Disease is unresectable or 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	Osteosarcoma		
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
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of ONE of the following:</p> <ul style="list-style-type: none"> <li>• Osteosarcoma</li> <li>• Dedifferentiated chondrosarcoma</li> <li>• High grade undifferentiated pleomorphic sarcoma (UPS)</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p>2 - Disease is ONE of the following:</p> <ul style="list-style-type: none"> <li>• Relapsed/refractory</li> <li>• Metastatic</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p>3 - Used as second-line therapy</p>			

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
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of recurrent or progressive glioblastoma</p>			

Product Name: Stivarga			
Diagnosis	Colorectal Cancer (CRC), Soft Tissue Sarcoma (STS), Hepatobiliary Cancers, Osteosarcoma, 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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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

<b>Guideline ID</b>	GL-136413
<b>Guideline Name</b>	Strensiq
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	1/1/2024
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## 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 diagnosis of HPP, however please note that the provider should confirm coverage status of any new genetic testing under the patient’s United Healthcare plan prior to ordering.
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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



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-103541
<b>Guideline Name</b>	Sucraid
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	4/1/2022
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## 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
<b>Approval Criteria</b>			
1 - Diagnosis of congenital sucrase-isomaltase deficiency (CSID) as confirmed by one of the following:			

**1.1** Biopsy of the distal duodenum or proximal jejunum demonstrating sucrase activity below the 10th percentile (less than 25U)

**OR**

**1.2** All of the following:

- Stool pH less than 6
- Negative lactose breath test
- Positive sucrose hydrogen-methane breath test (i.e., increase over 3 hours in exhaled hydrogen is greater than 20 ppm, methane is greater than 12 ppm, or both are greater than 15 ppm over a previous baseline level)

**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

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
<b>Approval Criteria</b>			
1 - Prescribed by or in consultation with a gastroenterologist or rare disease specialist			



**AND**

**2** - Will be used with a sucrose-free, low starch diet

**AND**

**3** - Provider attests that the patient has achieved a clinically meaningful response while on Sucraid therapy, defined as at least a 50 percent reduction in all of the following:

- Symptoms of abdominal pain, cramps, bloating, gas, vomiting
- Number of stools per day
- Watery, loose stool consistency
- Number of symptomatic days

Sunlenca



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-124759
<b>Guideline Name</b>	Sunlenca
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	6/1/2023
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### 1 . Criteria

Product Name: Sunlenca			
Approval Length	1 month(s)		
Guideline Type	Prior Authorization		
Product Name	Generic Name	GPI	Brand/Generic
SUNLENCA	LENACAPAVIR SODIUM TAB THERAPY PACK 4 X 300 MG	1210155520B720	Brand
SUNLENCA	LENACAPAVIR SODIUM TAB THERAPY PACK 5 X 300 MG	1210155520B725	Brand
<b>Approval Criteria</b>			
1 - Patient has been diagnosed with multidrug-resistant human immunodeficiency virus (HIV)-1 infection			

**AND**

**2** - Patient is currently taking, or will be prescribed, an optimized background antiretroviral regimen

## **2 . Revision History**

Date	Notes
4/17/2023	New guideline

Sutent



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-124768
<b>Guideline Name</b>	Sutent
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

#### Guideline Note:

Effective Date:	6/1/2023
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### 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** Failure to imatinib (generic Gleevec) as confirmed by claims history or submission of medical records

**OR**

**2.2** History of intolerance or contraindication to imatinib (generic Gleevec) (please specify intolerance or contraindication)

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)

**AND**

2 - Disease is ONE of the following:

- Unresectable, locally advanced
- Metastatic

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
- Hürthle cell 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** 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 contraindication or intolerance):

- 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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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
4/17/2023	Updated Myeloid/Lymphoid and Thymic cancer criteria per NCCN guidelines. Updated trial/failure language.



Synribo



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-118440
<b>Guideline Name</b>	Synribo
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	2/1/2023
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## 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
<b>Approval Criteria</b>			
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), Tassigna (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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to Synribo therapy			

Systemic Antifungals



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-132782
<b>Guideline Name</b>	Systemic Antifungals
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

**Guideline Note:**

Effective Date:	10/1/2023
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### 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
<b>Approval Criteria</b>			

1 - Patient is 12 years of age or under

**OR**

2 - Patient is unable to swallow tablets

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
<b>Approval Criteria</b>			
1 - Member is 2 years of age or older AND less than 13 years of age			

**2 . Revision History**

Date	Notes
9/8/2023	Updated age limit for itraconazole and voriconazole to 12. Added No xafil packet and added age limit criteria

Tabrecta



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-93732
<b>Guideline Name</b>	Tabrecta
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	11/1/2021
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## 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
<b>Approval Criteria</b>			

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
<b>Approval Criteria</b>			
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 - Tabrecta will be approved for uses supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

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

Product Name	Generic Name	GPI	Brand/Generic
TABRECTA	CAPMATINIB HCL TAB 150 MG	21533716200320	Brand
TABRECTA	CAPMATINIB HCL TAB 200 MG	21533716200330	Brand

**Approval Criteria**

1 - Documentation of positive clinical response to Tabrecta therapy

Tafinlar



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-129207
<b>Guideline Name</b>	Tafinlar
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	10/1/2023
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## 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
<p><b>Approval Criteria</b></p> <p><b>1 - Diagnosis of ONE of the following:</b></p> <ul style="list-style-type: none"> <li>• Langerhans Cell Histiocytosis</li> <li>• Erdheim-Chester Disease</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p><b>2 - Cancer is positive for BRAF V600E mutation</b></p> <p style="text-align: center;"><b>AND</b></p> <p><b>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)</b></p>			

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 Tafenlar tablets for oral solution, there is a reason or special circumstance why the patient is unable to use Tafenlar capsules (document reason or special circumstance)

Product Name: Tafenlar	
Diagnosis	Epithelial Ovarian Cancer/Fallopian Tube Cancer/Primary Peritoneal Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

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	Melanoma, CNS Cancers, NSCLC, Thyroid Cancer, Hepatobiliary Cancers, Histiocytic Neoplasms, Solid Tumors, Epithelial Ovarian Cancer/Fallopian Tube Cancer/Primary Peritoneal Cancer, Pancreatic Cancer / Ampullary Cancer		
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
<b>Approval Criteria</b>			
<b>1</b> - Patient does not show evidence of progressive disease while on Tafinlar therapy			

Product Name: Tafenlar			
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
<p><b>Approval Criteria</b></p> <p><b>1</b> - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - If the request is for Tafenlar tablets for oral solution, there is a reason or special circumstance why the patient is unable to use Tafenlar capsules (document reason or special circumstance)</p>			

Product Name: Tafenlar			
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
<b>Approval Criteria</b> 1 - Documentation of positive clinical response to Tafinlar therapy			



Tagrisso



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-138694
<b>Guideline Name</b>	Tagrisso
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	2/1/2024
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## 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
<b>Approval Criteria</b>			

**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
<b>Approval Criteria</b>			
<b>1 - Documentation of positive clinical response to Tagrisso therapy</b>			

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
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to Tagrisso therapy</p>			

Takhzyro



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-128095
<b>Guideline Name</b>	Takhzyro
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	9/1/2023
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## 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
<b>Approval Criteria</b>			

**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 a FXII, angiotensin-1, plasminogen gene mutation, or kininogen mutation**

**OR**

**1.2.2 Recurring angioedema attacks that are refractory to high-dose antihistamines with confirmed family history of angioedema**

**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 Takzyro**



**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	<p>*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.</p>
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**Product Name: Takhzyro**

Therapy Stage	Reauthorization
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Guideline Type	Prior Authorization
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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, defined as a clinically significant reduction in the rate and/or number of hereditary angioedema (HAE) attacks, 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 switched to every 4 week dosing will require additional review to allow for 2 weeks dosing.  
 \*\*\*Patient experienced 1 or more HAE attacks in the previous 6 months approval length: 6 months.

Talzenna



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-134182
<b>Guideline Name</b>	Talzenna
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	11/1/2023
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## 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
<b>Approval Criteria</b>			
1 - Diagnosis of metastatic castration-resistant prostate cancer			
<b>AND</b>			
2 - Presence of homologous recombination repair (HRR) gene mutations			
<b>AND</b>			
3 - Used in combination with Xtandi (enzalutamide)			
<b>AND</b>			

**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
<b>Approval Criteria</b>			
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
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to Talzenna therapy</p>			

## 2 . Revision History

Date	Notes
10/3/2023	Added new Talzenna 0.1 mg and 0.35 mg strengths. Added criteria for HRR gene-mutated mCRPC per label.

Tarceva



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-118486
<b>Guideline Name</b>	Tarceva
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	2/1/2023
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## 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
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of non-small cell lung cancer (NSCLC)</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Disease is ONE of the following:</p> <ul style="list-style-type: none"> <li>• Metastatic</li> <li>• Recurrent</li> <li>• Advanced</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p>3 - ONE of the following:</p> <ul style="list-style-type: none"> <li>• Tumors are positive for epidermal growth factor receptor (EGFR)exon 19 deletions</li> <li>• Tumors are positive for exon 21 (L858R) substitution mutations</li> <li>• Tumors are positive for a known sensitizing EGFR mutation (e.g., S768I, L861Q, G719X)</li> </ul>			

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
<b>Approval Criteria</b>			
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
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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
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to Tarceva therapy			

## 2 . Revision History

Date	Notes
12/16/2022	Copy NY

Targeted Immunomodulators



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-144413
<b>Guideline Name</b>	Targeted Immunomodulators
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

**Guideline Note:**

Effective Date:	
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### 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
<b>Approval Criteria</b>			

**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			
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	6627001500F420	Brand
HUMIRA PEN-CD/UC/HS STARTER	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML	6627001500F420	Brand
HUMIRA PEN	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.4ML	6627001500F430	Brand
HUMIRA PEN-PEDIATRIC UC STARTER PACK	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML	6627001500F440	Brand
HUMIRA PEN	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML	6627001500F440	Brand
HUMIRA PEN-CD/UC/HS STARTER	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML	6627001500F440	Brand

HUMIRA PEN-PS/UV STARTER	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML & 40 MG/0.4ML	6627001500F450	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

**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

**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

<b>Product Name: Kineret</b>			
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
<b>Approval Criteria</b>			
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
<p><b>Approval Criteria</b></p> <p>1 - History of the requested agent for at least 90 of the past 120 days, as confirmed by claims history or chart documentation</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - If the request is for reauthorization for treatment of severe alopecia areata, documentation of patient status and response to therapy (Document status/response)</p>			

Product Name: Orenzia			
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
<p><b>Approval Criteria</b></p> <p>1 - ONE of the following:</p> <p>1.1 ONE of the following diagnoses:</p> <ul style="list-style-type: none"> <li>• Polyarticular juvenile idiopathic arthritis</li> <li>• Psoriatic arthritis</li> </ul>			

**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

**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
<b>Approval Criteria</b>			
1 - ONE of the following:			
1.1 ONE of the following diagnoses:			
<ul style="list-style-type: none"> <li>• Ankylosing spondylitis</li> <li>• Polyarticular juvenile idiopathic arthritis</li> <li>• Psoriatic arthritis</li> </ul>			

- 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
<b>Approval Criteria</b>			
<b>1</b> - 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: 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
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**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	CERTOLIZUMAB PEGOL PREFILLED SYRINGE KIT 2 X 200 MG/ML	5250502010F840	Brand
CIMZIA STARTER KIT	CERTOLIZUMAB PEGOL PREFILLED SYRINGE KIT 6 X 200 MG/ML	5250502010F860	Brand
CIMZIA	CERTOLIZUMAB PEGOL FOR INJ KIT 2 X 200 MG	52505020106420	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)
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Therapy Stage	Initial Authorization
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Guideline Type	Prior Authorization
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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: 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** BOTH of the following:

**1.1.1** Diagnosis of polymyalgia rheumatica

**AND**

**1.1.2** At least 90 days of drug therapy with oral corticosteroids or methotrexate

**OR**

**1.2** BOTH of the following:

**1.2.1** Diagnosis of rheumatoid arthritis

**AND**

**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: 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
<p><b>Approval Criteria</b></p> <p>1 - Submission of chart notes showing a diagnosis of severe alopecia areata defined as greater than or equal to 50% of hair loss</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Patient is 12 years of age or older</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - Previous trial and failure of Olumiant</p> <p style="text-align: center;"><b>AND</b></p> <p>4 - Prescribed by, or in consultation with, a dermatologist</p> <p style="text-align: center;"><b>AND</b></p> <p>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</p>			

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
<p><b>Approval Criteria</b></p> <p>1 - History of the requested agent for at least 90 of the past 120 days, as confirmed by claims history or chart documentation</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Documentation of patient status and response to therapy (document status/response)</p> <p style="text-align: center;"><b>AND</b></p> <p>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</p>			

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
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of psoriasis</p> <p style="text-align: center;"><b>AND</b></p>			



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, Amjevita, Hulio, 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	ADALIMUMAB-ADAZ SOLN PREFILLED SYR 80 MG/0.8ML & 40 MG/0.4ML	6627001504E560	Brand

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CROHN'S DISEASE STARTER PACK			
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-ADBAM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
ADALIMUMAB-ADBAM	ADALIMUMAB-ADBAM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
CYLTEZO	ADALIMUMAB-ADBAM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
ADALIMUMAB-ADBAM CROHNS/UC/HS STARTER	ADALIMUMAB-ADBAM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
ADALIMUMAB-ADBAM PSORIASIS/UVEITIS STARTER	ADALIMUMAB-ADBAM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
CYLTEZO STARTER PACKAGE FOR	ADALIMUMAB-ADBAM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand

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CROHNS DISEASE/UC/HS			
ADALIMUMAB-ADB M	ADALIMUMAB-ADB M PREFILLED SYRINGE KIT 10 MG/0.2ML	6627001505F805	Brand
CYLTEZO	ADALIMUMAB-ADB M PREFILLED SYRINGE KIT 10 MG/0.2ML	6627001505F805	Brand
ADALIMUMAB-ADB M	ADALIMUMAB-ADB M PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001505F810	Brand
CYLTEZO	ADALIMUMAB-ADB M PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001505F810	Brand
ADALIMUMAB-ADB M	ADALIMUMAB-ADB M PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001505F820	Brand
CYLTEZO	ADALIMUMAB-ADB M 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	6627001509D240	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, Amjevita, Hulio, 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	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
IDACIO	ADALIMUMAB-AACF PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001502F840	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	6627001509D240	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	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand

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CROHNS/UC/HS STARTER			
ADALIMUMAB-ADB M	ADALIMUMAB-ADB M PREFILLED SYRINGE KIT 10 MG/0.2ML	6627001505F805	Brand
ADALIMUMAB-ADB M	ADALIMUMAB-ADB M PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001505F810	Brand
ADALIMUMAB-ADB M	ADALIMUMAB-ADB M PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001505F820	Brand
ADALIMUMAB-AACF	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	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	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
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
<p><b>Approval Criteria</b></p> <p>1 - History of the requested medication for at least 90 of the past 120 days, as confirmed by claims history or chart documentation</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Both of the following:</p> <ul style="list-style-type: none"> <li>• Previous trial of ALL preferred adalimumab product(s)</li> <li>• Prescriber has provided valid medical rationale for the use of the requested non-preferred adalimumab product over ALL of the preferred adalimumab product(s)</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p>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</p>			

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
<p><b>Approval Criteria</b></p> <p>1 - ONE of the following:</p> <p>1.1 Diagnosis of Cryopyrin-Associated Periodic Syndrome (CAPS) [including familial cold autoinflammatory syndrome (FCAS) and Muckle-Wells syndrome (MWS)]</p>			



**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

**AND**

**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
<b>Approval Criteria</b>			
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)
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Therapy Stage	Initial Authorization
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Guideline Type	Prior Authorization
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Product Name	Generic Name	GPI	Brand/Generic
OMVOH	MIRIKIZUMAB-MRKZ SUBCUTANEOUS SOLN AUTO-INJECTOR 100 MG/ML	5250405040D520	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: Rinvoq

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 weighing at least 40 kg (kilograms)

**AND**

1.1.2 ONE of the following:

1.1.2.1 Patient has tried and failed BOTH of the following:

- At least 60 days of therapy with Dupixent (dupilumab)
- At least 120 days of therapy with Adbry (tralokinumab-ldrm)

**OR**

1.1.2.2 If patient was unable to utilize Dupixent (dupilumab) and Adbry (tralokinumab-ldrm), 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 Dupixent (dupilumab), Adbry (tralokinumab-ldrm), AND 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
- Psoriatic arthritis
- Rheumatoid arthritis

**AND**

**1.2.2** Previous trial and failure of at least ONE tumor necrosis factor (TNF) blocker

**AND**

**1.2.3** Previous trial and failure of at least ONE other targeted immunomodulator agent

**OR**

**1.3** Diagnosis of Crohn's disease and BOTH of the following:

- Previous trial and failure of at least ONE TNF blocker with Crohn's disease indication (e.g. adalimumab agents, Cimzia (certolizumab), infliximab agents))
- Previous trial and failure of ONE other targeted immunomodulator agent



**OR**

**1.4** Diagnosis of ulcerative colitis and BOTH of the following:

- Previous trial and failure of at least ONE TNF blocker with ulcerative colitis indication (e.g. adalimumab agents, infliximab agents, Simponi (golimumab))
- Previous trial and failure of ONE other 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: 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

**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: 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
<b>Approval Criteria</b>			
1 - ONE of the following diagnoses:			
<ul style="list-style-type: none"> <li>• Crohn's disease</li> <li>• Psoriasis</li> <li>• Psoriatic arthritis</li> <li>• Ulcerative colitis</li> </ul>			
<b>AND</b>			
2 - Previous trial and failure of at least TWO other targeted immunomodulator agents			
<b>AND</b>			
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	9025054200D220	Brand
<p><b>Approval Criteria</b></p> <p>1 - ONE of the following diagnoses:</p> <ul style="list-style-type: none"> <li>• Psoriasis</li> <li>• Psoriatic arthritis</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p>2 - Previous trial and failure of at least TWO other targeted immunomodulator agents</p> <p style="text-align: center;"><b>AND</b></p> <p>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</p>			

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
<p><b>Approval Criteria</b></p>			

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, Cibinco, Cimzia, Cosentyx, Enbrel, Hadlima, Humira, Ilaris, Ilumya, Kevzara, Kineret, Oencia, Otezla, Rinvoq, Siliq, Simponi, Skyrizi, Sotyktu, Stelara, Taltz, Tremfya, 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

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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	9025054200D220	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	6627001500F420	Brand
HUMIRA PEN	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML	6627001500F420	Brand
HUMIRA PEN-CD/UC/HS STARTER	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML	6627001500F420	Brand
HUMIRA PEN	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.4ML	6627001500F430	Brand
HUMIRA PEN-PEDIATRIC UC STARTER PACK	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML	6627001500F440	Brand
HUMIRA PEN	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML	6627001500F440	Brand
HUMIRA PEN-CD/UC/HS STARTER	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML	6627001500F440	Brand
HUMIRA PEN-PS/UV STARTER	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML & 40 MG/0.4ML	6627001500F450	Brand

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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	CERTOLIZUMAB PEGOL PREFILLED SYRINGE KIT 2 X 200 MG/ML	5250502010F840	Brand
CIMZIA STARTER KIT	CERTOLIZUMAB PEGOL PREFILLED SYRINGE KIT 6 X 200 MG/ML	5250502010F860	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 PUSH TOUCH	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

**Approval Criteria**

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

**AND**

2 - Patient does not have a history of a targeted immunomodulator [except Otezla (apremilast)] other than the one on the incoming claim in the past 30 days

**2 . Revision History**

Date	Notes
3/16/2024	Addition of Bimzelx, Omvoh, Velsipity, and new Adalimumab products. Combined all the NP Adalimumab products into one box and the preferred Adalimumabs into one box. GPI updates and updated Drug names to not be packaging specific. Criteria updates throughout guide line.

Targretin (bexarotene)



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-138786
<b>Guideline Name</b>	Targretin (bexarotene)
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	2/1/2024
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## 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
<b>Approval Criteria</b>			

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

<b>Guideline ID</b>	GL-138880
<b>Guideline Name</b>	Tasigna
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	2/1/2024
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## 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

<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of chronic myeloid leukemia</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - ONE of the following:</p> <p>2.1 Patient is not a candidate for imatinib (Gleevec) as attested by physician</p> <p style="text-align: center;"><b>OR</b></p> <p>2.2 Patient is currently on Tasigna therapy</p>
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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

<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of progressive gastrointestinal stromal tumor (GIST)</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - ONE of the following:</p> <p>2.1 Failure to ALL of the following, as confirmed by claims history or submission of medical records:</p>
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- 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
<b>Approval Criteria</b>			
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
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of myeloid, lymphoid or mixed lineage neoplasms with eosinophilia and ABL1 (gene) rearrangement</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Neoplasm is in blast or chronic phase</p>			

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
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of metastatic or unresectable melanoma cutaneous tumors with activating mutations of KIT</p>			

**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
<b>Approval Criteria</b>			
<b>1</b> - 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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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 Tassigna therapy

**2 . Revision History**

Date	Notes
1/11/2024	Updated criteria for GIST. Updated criteria for Myeloid/Lymphoid Neoplasms with Eosinophilia and Tyrosine Kinase Gene Fusions. Added Melanoma Cutaneous and Soft Tissue Sarcoma as indications for criteria per NCCN recommendations.

Tasmar



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-124763
<b>Guideline Name</b>	Tasmar
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	6/1/2023
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## 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
<b>Approval Criteria</b>			
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

<b>Guideline ID</b>	GL-120247
<b>Guideline Name</b>	Tavalisse
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	3/1/2023
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## 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
<b>Approval Criteria</b>			



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
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to Tavalisse therapy			

## 2 . Revision History

Date	Notes
1/18/2023	Copy NY

Tavneos



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-121823
<b>Guideline Name</b>	Tavneos
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	4/1/2023
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## 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
<b>Approval Criteria</b>			

**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

<b>Guideline ID</b>	GL-106008
<b>Guideline Name</b>	Tazverik
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	6/1/2022
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## 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
<b>Approval Criteria</b>			
1 - Patient has a 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** - Patient has a diagnosis of follicular lymphoma

**AND**

**2** - Subsequent therapy for ONE of the following:

- EZH2 mutation positive relapsed/refractory disease after 2 prior therapies
- EZH2 wild-type or unknown relapsed/refractory disease and no satisfactory alternative treatment options

Product Name: Tazverik
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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
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to Tazverik therapy</p>			

Tegsedi



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-138862
<b>Guideline Name</b>	Tegsedi
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	2/1/2024
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## 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
<b>Approval Criteria</b>			

**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
<p><b>Approval Criteria</b></p> <p>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.)</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Patient is not receiving Tegsedi in combination with ONE of the following:</p> <ul style="list-style-type: none"> <li>• Oligonucleotide agents [e.g., Onpattro (patisiran), Amvuttra (vutrisiran)]</li> <li>• Tafamidis (e.g., Vyndaqel, Vyndamax)</li> </ul>			

## 2 . Revision History

Date	Notes
1/10/2024	Update to simplify reauthorization criteria.

Temodar



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-136460
<b>Guideline Name</b>	Temodar
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	1/1/2024
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## 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
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**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
<b>Approval Criteria</b>			



**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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-106490
<b>Guideline Name</b>	Tepmetko
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	7/1/2022
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## 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
<b>Approval Criteria</b>			
1 - Diagnosis of non-small cell lung cancer			

<p><b>AND</b></p> <p><b>2</b> - Disease is recurrent, advanced, or metastatic</p> <p><b>AND</b></p> <p><b>3</b> - Tumor is MET exon 14 skipping mutation positive</p>
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<b>Product Name: Tepmetko</b>			
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
<b>Approval Criteria</b>			
1 - Patient does not show evidence of progressive disease while on Tepmetko therapy			

<b>Product Name: Tepmetko</b>			
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



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-127170
<b>Guideline Name</b>	Test Strips
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

**Guideline Note:**

Effective Date:	8/1/2023
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### 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

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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

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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

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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 GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EMBRACE PRO BLOOD GLUCOSE TEST 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

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IGLUOSE 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



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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

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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 GLUCOSE TEST 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 BLOOD GLUCOSE 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

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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

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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

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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 GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EMBRACE PRO BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EMBRACE TALK BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand



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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

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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

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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 GLUCOSE TEST 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 BLOOD GLUCOSE 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 GLUCOSE TEST 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 is 6 test strips/day. The quantity limit for non-insulin dependent and non-pregnant patients is 2 test strips/day.
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## 2 . Revision History

Date	Notes
6/27/2023	Added new GPIs to market since last update. Changed from a step through one to a step through all preferred products. Updated IN preferred products.

Testosterones



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-138925
<b>Guideline Name</b>	Testosterones
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

**Guideline Note:**

Effective Date:	2/1/2024
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### 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
<p><b>Approval Criteria</b></p> <p>1 - One of the following:</p> <p>1.1 Diagnosis of delayed puberty</p> <p style="text-align: center;"><b>OR</b></p> <p>1.2 Total testosterone level less than or equal to 350 ng/dL within the past 3 months</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Provider attests that the patient does not have any of the following contraindications to therapy:</p> <ul style="list-style-type: none"> <li>• Breast cancer in a patient assigned male at birth</li> <li>• Pregnancy</li> <li>• Prostate cancer</li> </ul>			

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
<p><b>Approval Criteria</b></p> <p>1 - History of injectable or topical testosterone agent(s) within the past 120 days, confirmed by claims history or chart documentation</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Total testosterone level less than or equal to 1000 ng/dL within the past 6 months</p> <p style="text-align: center;"><b>AND</b></p> <p>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)</p>			

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
<p><b>Approval Criteria</b></p> <p>1 - All of the following:</p> <p>1.1 ONE of the following:</p> <ul style="list-style-type: none"> <li>• Diagnosis of delayed puberty</li> <li>• Total testosterone level less than or equal to 350 ng/dL within the past 3 months</li> </ul>			

**AND**

**1.2 ONE** of the following:

- Previous trial and failure of ALL preferred\* injectable testosterone agents
- Medical justification for use of 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	*PDL link: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>
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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
<p><b>Approval Criteria</b></p> <p>1 - History of the requested medication within the past 120 days, confirmed by claims history or chart documentation</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Total testosterone level less than or equal to 1000 ng/dL within the past 6 months</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - ONE of the following: (not required for palliative treatment of breast cancer)</p> <ul style="list-style-type: none"> <li>• Previous trial and failure of at least one preferred* injectable testosterone agent</li> <li>• Medical justification for use of requested medication over ALL preferred* injectable testosterone agents</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p>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)</p>			
Notes		*PDL link: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>	

Product Name: Aveded, 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
- Total testosterone level less than or equal to 350ng/dL within the past 3 months

**AND**

2 - ONE of the following:

- Previous trial and failure of ALL preferred\* injectable testosterone agents
- Medical justification for use of 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

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

Product Name: Aved, 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 - History of the requested medication within the past 120 days, confirmed by claims history or chart documentation

**AND**

2 - 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
- 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: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>

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
TESTOSTERONE	TESTOSTERONE TD GEL 25 MG/2.5GM (1%)	23100030004025	Generic
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
ANDROGEL	TESTOSTERONE TD GEL 20.25 MG/1.25GM (1.62%)	23100030004044	Brand
ANDROGEL	TESTOSTERONE TD GEL 40.5 MG/2.5GM (1.62%)	23100030004047	Brand
TESTOSTERONE	TESTOSTERONE TD SOLN 30 MG/ACT	23100030002020	Generic
TESTOSTERONE	TESTOSTERONE TD GEL 10MG/ACT (2%)	23100030004070	Generic
NATESTO	TESTOSTERONE NASAL GEL 5.5 MG/ACT	23100030004080	Brand
TESTOSTERONE PUMP	TESTOSTERONE TD GEL 12.5 MG/ACT (1%)	23100030004040	Generic
VOGELXO PUMP	TESTOSTERONE TD GEL 12.5 MG/ACT (1%)	23100030004040	Brand
TESTOSTERONE	TESTOSTERONE TD GEL 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
NATESTO	TESTOSTERONE NASAL GEL 5.5 MG/ACT	23100030004080	Generic
FORTESTA	TESTOSTERONE TD GEL 10MG/ACT (2%)	23100030004070	Brand

**Approval Criteria**

1 - Patient is 16 years of age or older

**AND**

2 - 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
- Medical justification for use of 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	*PDL link: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>
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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
ANDROGEL	TESTOSTERONE TD GEL 50 MG/5GM (1%)	23100030004030	Brand
VOGELXO	TESTOSTERONE TD GEL 50 MG/5GM (1%)	23100030004030	Brand
ANDROGEL	TESTOSTERONE TD GEL 20.25 MG/1.25GM (1.62%)	23100030004044	Brand
ANDROGEL	TESTOSTERONE TD GEL 40.5 MG/2.5GM (1.62%)	23100030004047	Brand
ANDROGEL PUMP	TESTOSTERONE TD GEL 20.25 MG/ACT (1.62%)	23100030004050	Brand
TESTOSTERONE	TESTOSTERONE TD SOLN 30 MG/ACT	23100030002020	Generic
TESTOSTERONE	TESTOSTERONE TD GEL 10MG/ACT (2%)	23100030004070	Generic
NATESTO	TESTOSTERONE NASAL GEL 5.5 MG/ACT	23100030004080	Brand
TESTOSTERONE PUMP	TESTOSTERONE TD GEL 12.5 MG/ACT (1%)	23100030004040	Generic
VOGELXO PUMP	TESTOSTERONE TD GEL 12.5 MG/ACT (1%)	23100030004040	Brand
TESTOSTERONE	TESTOSTERONE TD GEL 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
NATESTO	TESTOSTERONE NASAL GEL 5.5 MG/ACT	23100030004080	Generic
FORTESTA	TESTOSTERONE TD GEL 10MG/ACT (2%)	23100030004070	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** Patient has a history of the requested medication within the past 120 days, confirmed by claims history or chart documentation

**AND**

**1.2.2** One of the following:

- Previous trial and failure of at least one preferred\* topical testosterone agent
- Medical justification for use of requested medication over ALL preferred\* topical testosterone agents

**AND**

**2** - Total testosterone is less than or equal to 1000 ng/dL (nanograms/deciliter) 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: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>
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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
ANDROGEL	TESTOSTERONE TD GEL 50 MG/5GM (1%)	23100030004030	Brand
VOGELXO	TESTOSTERONE TD GEL 50 MG/5GM (1%)	23100030004030	Brand
ANDROGEL	TESTOSTERONE TD GEL 20.25 MG/1.25GM (1.62%)	23100030004044	Brand
ANDROGEL	TESTOSTERONE TD GEL 40.5 MG/2.5GM (1.62%)	23100030004047	Brand
ANDROGEL PUMP	TESTOSTERONE TD GEL 20.25 MG/ACT (1.62%)	23100030004050	Brand
TESTOSTERONE	TESTOSTERONE TD SOLN 30 MG/ACT	23100030002020	Generic
TESTOSTERONE	TESTOSTERONE TD GEL 10MG/ACT (2%)	23100030004070	Generic
NATESTO	TESTOSTERONE NASAL GEL 5.5 MG/ACT	23100030004080	Brand
TESTOSTERONE PUMP	TESTOSTERONE TD GEL 12.5 MG/ACT (1%)	23100030004040	Generic
VOGELXO PUMP	TESTOSTERONE TD GEL 12.5 MG/ACT (1%)	23100030004040	Brand
TESTOSTERONE	TESTOSTERONE TD GEL 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
NATESTO	TESTOSTERONE NASAL GEL 5.5 MG/ACT	23100030004080	Generic
FORTESTA	TESTOSTERONE TD GEL 10MG/ACT (2%)	23100030004070	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** - 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)
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Therapy Stage	Reauthorization
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Guideline Type	Quantity Limit
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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
ANDROGEL	TESTOSTERONE TD GEL 50 MG/5GM (1%)	23100030004030	Brand
VOGELXO	TESTOSTERONE TD GEL 50 MG/5GM (1%)	23100030004030	Brand
ANDROGEL	TESTOSTERONE TD GEL 20.25 MG/1.25GM (1.62%)	23100030004044	Brand
ANDROGEL	TESTOSTERONE TD GEL 40.5 MG/2.5GM (1.62%)	23100030004047	Brand
ANDROGEL PUMP	TESTOSTERONE TD GEL 20.25 MG/ACT (1.62%)	23100030004050	Brand
TESTOSTERONE	TESTOSTERONE TD SOLN 30 MG/ACT	23100030002020	Generic
TESTOSTERONE	TESTOSTERONE TD GEL 10MG/ACT (2%)	23100030004070	Generic
NATESTO	TESTOSTERONE NASAL GEL 5.5 MG/ACT	23100030004080	Brand
TESTOSTERONE PUMP	TESTOSTERONE TD GEL 12.5 MG/ACT (1%)	23100030004040	Generic

VOGELXO PUMP	TESTOSTERONE TD GEL 12.5 MG/ACT (1%)	23100030004040	Brand
TESTOSTERONE	TESTOSTERONE TD GEL 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
NATESTO	TESTOSTERONE NASAL GEL 5.5 MG/ACT	23100030004080	Generic
FORTESTA	TESTOSTERONE TD GEL 10MG/ACT (2%)	23100030004070	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
<b>Approval Criteria</b>			
1 - History of the requested medication within the past 120 days, confirmed by claims history or chart documentation			
<b>AND</b>			
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
- Total testosterone level less than or equal to 350ng/dL 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
- Medical justification for use of 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** Total testosterone less than or equal to 1000ng/dL within the past 6 months

**AND**

**2** - ONE of the following:

- Previous trial and failure of at least one preferred\* injectable agent
- Medical justification for use of 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: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>
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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 a total testosterone level less than or equal to 350ng/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
- Pregnancy
- Prostate cancer

**AND**

**3** - One of the following:

- Previous trial and failure of a preferred\* injectable agent
- 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: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>
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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
<b>Approval Criteria</b>			

**1** - Diagnosis of delayed puberty, palliative treatment of metastatic breast cancer, or cryptorchidism AND all of the following:

**1.1** History of requested medication 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
- 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** Total testosterone level less than or equal to 1000ng/dL within the past 6 months

**AND**

**2.3** One of the following:

- Previous trial and failure of a preferred\* injectable agent
- 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: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>
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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
<p><b>Approval Criteria</b></p> <p><b>1 - All of the following:</b></p> <ul style="list-style-type: none"> <li>• Patient is 18 years of age or older</li> <li>• Diagnosis of hypogonadism</li> <li>• Total testosterone level less than or equal to 350ng/dL within the past 3 months</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p><b>2 - Provider attests that the patient does not have any of the following contraindications to therapy:</b></p> <ul style="list-style-type: none"> <li>• Breast cancer</li> <li>• Hypogonadal conditions not associated with structural or genetic etiologies</li> <li>• Pregnancy</li> <li>• Prostate cancer</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p><b>3 - One of the following:</b></p> <ul style="list-style-type: none"> <li>• Previous trial and failure of a preferred* injectable agent</li> <li>• Medical justification for use over ALL preferred* injectable agents</li> </ul>			
Notes	*PDL link: <a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>		

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 requested medication within the past 120 days, confirmed by claims history or chart documentation

**AND**

**2** - Total testosterone less than or equal to 1000ng/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, hypogonadal conditions not associated with structural or genetic etiologies, pregnancy, prostate cancer)

**2 . Revision History**

Date	Notes
1/12/2024	Removed "for at least 90 days" throughout.



Thalomid



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-109196
<b>Guideline Name</b>	Thalomid
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	8/1/2022
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## 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 & suppression of cutaneous manifestations of ENL recurrence

Product Name: Thalomid

Diagnosis	Aphthous Stomatitis or Ulcer
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 severe, recurrent aphthous stomatitis or ulcer

**Product Name: Thalomid**

Diagnosis	Pyoderma Gangrenosum
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 pyoderma gangrenosum

**AND**

**2 - Used as third line treatment**

Product Name: Thalomid			
Diagnosis	Cutaneous Manifestations of Systemic Lupus Erythematosus (SLE)		
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
<b>Approval Criteria</b>			
1 - Diagnosis of cutaneous manifestations of systemic lupus erythematosus (SLE)			

Product Name: Thalomid			
Diagnosis	B-Cell Lymphomas		
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
<b>Approval Criteria</b>			

1 - Diagnosis of Castleman’s Disease (CD)

**AND**

2 - NOT used as first line therapy

Product Name: Thalomid			
Diagnosis	Myelofibrosis-Associated Anemia		
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 primary myelofibrosis

**AND**

2 - One of the following:

2.1 Both of the following:

2.1.1 Serum erythropoietin levels < 500 mU/mL (milliunits/milliliter)

**AND**

2.1.2 History of failure, contraindication, or intolerance to erythropoietins [e.g., Procrit (epoetin alfa)]

**OR**

**2.2** Serum erythropoietin levels greater than or equal to 500 mU/mL

Product Name: Thalomid			
Diagnosis	Myelofibrosis-Associated Anemia		
Approval Length	12 month(s)		
Therapy Stage	Reauthorization		
Guideline Type	Prior Authorization		
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
<b>Approval Criteria</b>			
1 - Documentation that the patient has evidence of symptom improvement or reduction in spleen/liver volume while on Thalomid			

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
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of HIV (human immunodeficiency virus)-negative Kaposi Sarcoma</p> <p style="text-align: center;"><b>OR</b></p> <p>2 - ALL of the following:</p> <p>    <b>2.1</b> Diagnosis of AIDS (acquired immunodeficiency syndrome)-Related Kaposi Sarcoma</p> <p style="text-align: center;"><b>AND</b></p> <p>    <b>2.2</b> Patient is currently being treated with antiretroviral therapy (ART)</p> <p style="text-align: center;"><b>AND</b></p> <p>    <b>2.3</b> Not used as first line therapy</p>			

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

<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of Langerhans cell histiocytosis</p> <p style="text-align: center;"><b>OR</b></p> <p>2 - Diagnosis of Rosai-Dorfman Disease</p>
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Product Name: Thalomid			
Diagnosis	Multiple Myeloma, B-Cell Lymphomas, 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
<p><b>Approval Criteria</b></p> <p>1 - Patient does not show evidence of progressive disease while on Thalomid therapy</p>			

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), Aphthous Stomatitis or Ulcer, Pyoderma Gangrenosum, Cutaneous Manifestations of Systemic Lupus Erythematosus (SLE), 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
7/8/2022	Updated criteria to add non-HIV Kaposi Sarcoma and histiocytic section. Combined reauth criteria sections.

Therapeutic Duplication (Subtype A)



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-144642
<b>Guideline Name</b>	Therapeutic Duplication (Subtype A)
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	4/1/2024
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## 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, Trelegly 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 Galise, 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

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

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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

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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	2717001500D220	Brand
TRULICITY	DULAGLUTIDE SOLN PEN-INJECTOR 1.5 MG/0.5ML	2717001500D230	Brand
TRULICITY	DULAGLUTIDE SOLN PEN-INJECTOR 3 MG/0.5ML	2717001500D240	Brand
TRULICITY	DULAGLUTIDE SOLN PEN-INJECTOR 4.5 MG/0.5ML	2717001500D250	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

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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

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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

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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	2717308000D210	Brand
MOUNJARO	TIRZEPATIDE SOLN PEN-INJECTOR 5 MG/0.5ML	2717308000D215	Brand
MOUNJARO	TIRZEPATIDE SOLN PEN-INJECTOR 7.5 MG/0.5ML	2717308000D220	Brand
MOUNJARO	TIRZEPATIDE SOLN PEN-INJECTOR 10 MG/0.5ML	2717308000D225	Brand
MOUNJARO	TIRZEPATIDE SOLN PEN-INJECTOR 12.5 MG/0.5ML	2717308000D230	Brand
MOUNJARO	TIRZEPATIDE SOLN PEN-INJECTOR 15 MG/0.5ML	2717308000D235	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



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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

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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
SEGLUOMET	ERTUGLIFLOZIN-METFORMIN HCL TAB 2.5-500 MG	27996002450310	Brand
SEGLUOMET	ERTUGLIFLOZIN-METFORMIN HCL TAB 2.5-1000 MG	27996002450320	Brand
SEGLUOMET	ERTUGLIFLOZIN-METFORMIN HCL TAB 7.5-500 MG	27996002450330	Brand
SEGLUOMET	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

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	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

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	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

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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

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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



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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

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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

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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

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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

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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

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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

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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

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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

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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

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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

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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

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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 PELLETT PACK 20 MG	83337030203020	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLETT PACK 30 MG	83337030203025	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLETT PACK 40 MG	83337030203030	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLETT PACK 50 MG	83337030203035	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLETT PACK 110 MG	83337030203040	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLETT 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	EDOXYBAN 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

**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
3/19/2024	Added generic dapagliflozin, dapagliflozin/metformin ER, Zituvio.



Therapeutic Duplication (Subtype B)



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-143496
<b>Guideline Name</b>	Therapeutic Duplication (Subtype B)
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	4/1/2024
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## 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, Simponi, Enbrel, Actemra, Cosentyx, Ilaris, Kineret, Kevzara, Taltz, Tremfya, Orencia, Xeljanz, Xeljanz XR, Xeljanz Solution, Siliq, Otezla, Olumiant, Ilumya, Skyrizi, Rinvoq, Sotyktu, Cibinco, Adbry, Dupixent, brand Copaxone, generic glatiramer acetate, generic glatopa, Mavenclad, Rebif, Avonex, Betaseron, Extavia, brand Aubagio, generic teriflunomide, Plegridy, Lemtrada, Tysabri, Ocrevus, brand Tecfidera, generic dimethyl fumarate, Vumerity, brand Gilenya, generic fingolimod, Tascenso ODT, Zeposia, Mayzent, Bafiertam, Kesimpta, Ponvory, Xolair, Fasenra, Nucala, Cinqair, Tezspire, Velsipity, Bimzelx, Omvoh			
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	6627001500F420	Brand
HUMIRA PEN- CD/UC/HS STARTER	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML	6627001500F420	Brand
HUMIRA PEN- PS/UV STARTER	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML	6627001500F420	Brand
HUMIRA PEN	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.4ML	6627001500F430	Brand
HUMIRA PEN	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML	6627001500F440	Brand
HUMIRA PEN- CD/UC/HS STARTER	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML	6627001500F440	Brand
HUMIRA PEN- PEDIATRIC UC STARTER PACK	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML	6627001500F440	Brand
HUMIRA PEN- PS/UV STARTER	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML & 40 MG/0.4ML	6627001500F450	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

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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

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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	9025054200D220	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

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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	9027302000D215	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 300 MG/2ML	9027302000D220	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

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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	6240307530D220	Brand
PLEGRIDY STARTER PACK	PEGINTERFERON BETA-1A SOLN PEN-INJ 63 & 94 MCG/0.5ML PACK	6240307530D250	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

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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

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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



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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-ADBIM PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001505F820	Brand
CYLTEZO	ADALIMUMAB-ADBIM PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001505F810	Brand
CYLTEZO	ADALIMUMAB-ADBIM PREFILLED SYRINGE KIT 10 MG/0.2ML	6627001505F805	Brand
CYLTEZO STARTER PACKAGE FOR PSORIASIS	ADALIMUMAB-ADBIM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
CYLTEZO	ADALIMUMAB-ADBIM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS	ADALIMUMAB-ADBIM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
YUSIMRY	ADALIMUMAB-AQVH SOLN PEN-INJECTOR 40 MG/0.8ML	6627001509D240	Brand
HADLIMA PUSHTOUCH	ADALIMUMAB-BWWD SOLN AUTO-INJECTOR 40 MG/0.4ML	6627001520D510	Brand
HADLIMA PUSHTOUCH	ADALIMUMAB-BWWD SOLN AUTO-INJECTOR 40 MG/0.8ML	6627001520D520	Brand
HADLIMA	ADALIMUMAB-BWWD SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001520E510	Brand
HADLIMA	ADALIMUMAB-BWWD SOLN PREFILLED SYRINGE 40 MG/0.8ML	6627001520E520	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.4ML	6627001504D515	Brand
ADALIMUMAB-ADAZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.4ML	6627001504D515	Brand
HYRIMOZ CROHN'S DISEASE AND ULCERATIVE COLITIS STARTER PACK	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001504D540	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001504D540	Brand
HYRIMOZ PLAQUE PSORIASIS STARTER PACK	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML & 40 MG/0.4ML	6627001504D560	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 10 MG/0.1ML	6627001504E508	Brand

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HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 20 MG/0.2ML	6627001504E513	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001504E515	Brand
ADALIMUMAB-ADAZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001504E515	Brand
HYRIMOZ PEDIATRIC CROHNS DISEASE STARTER PACK	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 80 MG/0.8ML	6627001504E540	Brand
HYRIMOZ PEDIATRIC CROHN'S DISEASE 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	5250308000D220	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-ADB M	ADALIMUMAB-ADB AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
ADALIMUMAB-ADB M CROHNS/UC/HS STARTER	ADALIMUMAB-ADB AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
ADALIMUMAB-ADB M PSORIASIS/UVEITIS STARTER	ADALIMUMAB-ADB AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
ADALIMUMAB-ADB M	ADALIMUMAB-ADB PREFILLED SYRINGE KIT 10 MG/0.2ML	6627001505F805	Brand
ADALIMUMAB-ADB M	ADALIMUMAB-ADB PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001505F810	Brand
ADALIMUMAB-ADB M	ADALIMUMAB-ADB 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

**Approval Criteria**

1 - The requested medication will be used exclusively, and the previously prescribed medication will be discontinued

**2 . Revision History**

Date	Notes
2/23/2024	Updated GPIs and Entyvio spelling in product name.

Tibsovo



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-136508
<b>Guideline Name</b>	Tibsovo
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	1/1/2024
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## 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
<b>Approval Criteria</b>			
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
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of chondrosarcoma</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Susceptible IDH1 (isocitrate dehydrogenase 1) mutation-positive</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - Disease is ONE of the following:</p> <ul style="list-style-type: none"> <li>• Conventional (grades 1-3)</li> <li>• Dedifferentiated</li> </ul>			

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
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of cholangiocarcinoma</p> <p style="text-align: center;"><b>AND</b></p>			

**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

<p><b>AND</b></p> <p><b>4 - Karnofsky Performance Status (KPS) greater than or equal to 60</b></p> <p><b>AND</b></p> <p><b>5 - Disease is WHO grade 2</b></p>
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<b>Product Name: Tibsovo</b>			
Diagnosis	Acute Myeloid Leukemia (AML), Bone Cancer, Biliary Tract Cancer, Oligodendroglioma, Astrocytoma		
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
<b>Approval Criteria</b>			
1 - Patient does not show evidence of progressive disease while on Tibsovo therapy			

<b>Product Name: Tibsovo</b>			
Diagnosis	NCCN Recommended Regimens		
Approval Length	12 month(s)		
Therapy Stage	Initial Authorization		
Guideline Type	Prior Authorization		
Product Name	Generic Name	GPI	Brand/Generic
TIBSOVO	IVOSIDENIB TAB 250 MG	21534940000320	Brand

**Approval Criteria**

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

Product Name: Tibsovo			
Diagnosis	NCCN Recommended Regimens		
Approval Length	12 month(s)		
Therapy Stage	Reauthorization		
Guideline Type	Prior Authorization		
Product Name	Generic Name	GPI	Brand/Generic
TIBSOVO	IVOSIDENIB TAB 250 MG	21534940000320	Brand

**Approval Criteria**

1 - Documentation of positive clinical response to Tibsovo therapy

Tobramycin Inhalation



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-134478
<b>Guideline Name</b>	Tobramycin Inhalation
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

**Guideline Note:**

Effective Date:	12/1/2023
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### 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 bronchiectasis with recurrent exacerbations.

Topical Anti-Inflammatory Agents, NSAIDs



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-126506
<b>Guideline Name</b>	Topical Anti-Inflammatory Agents, NSAIDs
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	7/1/2023
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## 1 . Criteria

Product Name: Flector patch, Diclofenac epolamine patch, generic diclofenac topical solution, Licart			
Approval Length	12 month(s)		
Guideline Type	Prior Authorization		
Product Name	Generic Name	GPI	Brand/Generic
DICLOFENAC EPOLAMINE	DICLOFENAC EPOLAMINE PATCH 1.3%	90210030205920	Generic
FLECTOR	DICLOFENAC EPOLAMINE PATCH 1.3%	90210030205920	Generic
DICLOFENAC SODIUM	DICLOFENAC SODIUM SOLN 1.5%	90210030302025	Generic
DICLOFENAC SODIUM	DICLOFENAC SODIUM SOLN 2%	90210030302030	Generic
LICART	DICLOFENAC EPOLAMINE PATCH 24HR 1.3%	90210030208520	Brand

**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

**2 . Revision History**

Date	Notes
6/9/2023	Removed diclofenac 1% gel, added solution products and Licart. Updated T/F criteria.



Topical Immunomodulators



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-137593
<b>Guideline Name</b>	Topical Immunomodulators
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2024
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### 1 . Criteria

Product Name: Brand Elidel, generic pimecrolimus, Brand Protopic 0.03%, 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
PROTOPIC	TACROLIMUS OINT 0.03%	90784075004210	Brand

**Approval Criteria**

1 - Patient is 2 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 corticosteroids

**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, Brand Protopic 0.03%, generic tacrolimus 0.03%

Approval Length	1 year(s)
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Therapy Stage	Reauthorization
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Guideline Type	Prior Authorization
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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
PROTOPIC	TACROLIMUS OINT 0.03%	90784075004210	Brand

**Approval Criteria**

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

Product Name: Brand Protopic 0.1%, generic tacrolimus 0.1%

Approval Length	6 month(s)
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Therapy Stage	Initial Authorization		
Guideline Type	Prior Authorization		
Product Name	Generic Name	GPI	Brand/Generic
TACROLIMUS	TACROLIMUS OINT 0.1%	90784075004230	Generic
PROTOPIC	TACROLIMUS OINT 0.1%	90784075004230	Brand
<p><b>Approval Criteria</b></p> <p>1 - Patient is 16 years of age or older</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - One of the following:</p> <p style="padding-left: 20px;"><b>2.1</b> Greater than or equal to 90 days of drug therapy with topical corticosteroids</p> <p style="text-align: center;"><b>OR</b></p> <p style="padding-left: 20px;"><b>2.2</b> Prescriber has provided valid medical justification for the use of the requested agent over topical corticosteroids</p>			

Product Name: Brand Protopic 0.1%, 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
PROTOPIC	TACROLIMUS OINT 0.1%	90784075004230	Brand
<p><b>Approval Criteria</b></p> <p>1 - History of the requested agent within the past 180 days</p>			

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
<p><b>Approval Criteria</b></p> <p>1 - Patient is 3 months of age or older</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - One of the following:</p> <p>2.1 Greater than or equal to 90 days of drug therapy with each of the following</p> <ul style="list-style-type: none"> <li>• Topical corticosteroids</li> <li>• Topical calcineurin inhibitors (pimecrolimus OR tacrolimus)*</li> </ul> <p style="text-align: center;"><b>OR</b></p> <p>2.2 Prescriber has provided valid medical justification for the use of the requested agent over topical corticosteroids, tacrolimus, AND pimecrolimus</p>			
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	6 month(s)		
Therapy Stage	Initial Authorization		
Guideline Type	Prior Authorization		
Product Name	Generic Name	GPI	Brand/Generic
OPZELURA	RUXOLITINIB PHOSPHATE CREAM 1.5%	90272060503720	Brand

**Approval Criteria**

1 - 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 90 days of drug therapy with each of the following:

- Topical corticosteroids
- Topical calcineurin inhibitors (pimecrolimus or tacrolimus)

- Topical crisaborole

**OR**

**3.1.2** Prescriber has provided valid medical justification for the use of Opzelura over topical corticosteroids, tarolimus, pimecrolimus, and crisaborole

**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:

- Topical corticosteroids
- Topical tacrolimus

**OR**

**3.2.2** Prescriber has provided valid medical justification for the use of Opzelura over topical corticosteroids and tacrolimus

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
<b>Approval Criteria</b>			
1 - History of the requested agent within the past 180 days			

Product Name: Zoryve	
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
<p><b>Approval Criteria</b></p> <p>1 - Patient is 6 years of age or older</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - One of the following:</p> <p>2.1 Greater than or equal to 90 days of drug therapy with each of the following:</p> <ul style="list-style-type: none"> <li>• Topical corticosteroids</li> <li>• Topical calcineurin inhibitors (pimecrolimus OR tacrolimus)*</li> </ul> <p style="text-align: center;"><b>OR</b></p> <p>2.2 Prescriber has provided valid medical justification for the use of the requested agent over topical corticosteroids, tacrolimus, AND pimecrolimus</p>			
Notes		*Those under 2 years of age are exempt from tacrolimus and pimecrolimus step therapy requirement (topical corticosteroids are still required)	

Product Name: Zoryve			
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

**2 . Revision History**

Date	Notes
12/11/2023	Update min age for Zoryve to 6 years.



Topical Post-Herpetic Neuralgia Agents



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-124863
<b>Guideline Name</b>	Topical Post-Herpetic Neuralgia Agents
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	7/1/2023
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## 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
<b>Approval Criteria</b>			
1 - Patient has tried lidocaine patches			

**AND**

**2** - Patient has tried over-the-counter capsaicin cream

## **2 . Revision History**

Date	Notes
4/20/2023	New

Tukysa



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-124512
<b>Guideline Name</b>	Tukysa
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	6/1/2023
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## 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
<b>Approval Criteria</b>			

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)**

<b>Product Name: Tukysa</b>			
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
<b>Approval Criteria</b>			
<b>1 - Patient does not show evidence of progressive disease while on Tukysa therapy</b>			

<b>Product Name: Tukysa</b>
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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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to Tukysa therapy			

Turalio



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-97076
<b>Guideline Name</b>	Turalio
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	1/1/2022
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## 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		
<b>Product Name</b>	<b>Generic Name</b>	<b>GPI</b>	<b>Brand/Generic</b>
TURALIO	PEXIDARTINIB HCL CAP 200 MG (BASE EQUIVALENT)	21533045010120	Brand
<b>Approval Criteria</b>			



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
<b>Approval Criteria</b>			
1 - Diagnosis of ONE of the following:			
<ul style="list-style-type: none"> <li>• Langerhans Cell Histiocytosis</li> <li>• Erdheim-Chester Disease</li> <li>• Rosai-Dorfman Disease</li> </ul>			
<b>AND</b>			
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

<b>Guideline ID</b>	GL-136419
<b>Guideline Name</b>	Tykerb
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	1/1/2024
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## 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
<b>Approval Criteria</b>			

**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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Diagnosis of unresectable, advanced, or metastatic colon cancer [human epidermal growth factor receptor 2 (HER2)-amplified and RAS and BRAF wild type]			
<b>AND</b>			

**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
<b>Approval Criteria</b>			

**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

<b>Guideline ID</b>	GL-142578
<b>Guideline Name</b>	Urea Cycle Disorder Agents
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	3/1/2024
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## 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
<b>Approval Criteria</b>			

**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 - Prescriber attests patient will be using Carbaglu (carglumic acid) as adjunctive therapy with standard ammonia lowering therapies (e.g., intravenous fluid rehydration, hemodialysis, protein restriction, etc.)**

**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<sup>2</sup>/day (grams per square meter per day)

**AND**

**3** - Prescriber attests patient will be using Carbaglu (carglumic acid) as adjunctive therapy with standard ammonia lowering therapies ( e.g., protein restriction, intravenous glucose, insulin, L-carnitine, etc.)

**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 PHENYL BUTYRATE	SODIUM PHENYL BUTYRATE TAB 500 MG	30908060000320	Generic
BUPHENYL	SODIUM PHENYL BUTYRATE TAB 500 MG	30908060000320	Brand
SODIUM PHENYL BUTYRATE	SODIUM PHENYL BUTYRATE ORAL POWDER 3 GM/TEASPOONFUL	30908060002950	Generic
BUPHENYL	SODIUM PHENYL BUTYRATE 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** - Prescriber attests patient will be using Buphenyl (sodium phenylbutyrate) as adjunctive therapy with standard ammonia lowering therapies (e.g., protein restriction, dialysis, essential amino acid supplementation, etc.)

**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
<b>Approval Criteria</b>			



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

**AND**

**2** - Prescriber attests patient has been using Buphenyl (sodium phenylbutyrate) as adjunctive therapy and will continue to use standard of care therapies while on Buphenyl (sodium phenylbutyrate) 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 PHENYL BUTYRATE PACKET FOR SUSP 3 GM THERAPY PACK	3090806000B130	Brand
OLPRUVA	SODIUM PHENYL BUTYRATE PACKET FOR SUSP 4 GM THERAPY PACK	3090806000B140	Brand
OLPRUVA	SODIUM PHENYL BUTYRATE PACKET FOR SUSP 5 GM THERAPY PACK	3090806000B150	Brand
OLPRUVA	SODIUM PHENYL BUTYRATE PACKET FOR SUSP 6 GM THERAPY PACK	3090806000B160	Brand
OLPRUVA	SODIUM PHENYL BUTYRATE 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** - Prescriber attests patient will be using Olpruva (sodium phenylbutyrate) as adjunctive therapy with standard ammonia lowering therapies ( e.g., protein restriction, dialysis, essential amino acid supplementation, etc.)

**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 PHENYL BUTYRATE PACKET FOR SUSP 2 GM THERAPY PACK	3090806000B120	Brand
OLPRUVA	SODIUM PHENYL BUTYRATE PACKET FOR SUSP 3 GM THERAPY PACK	3090806000B130	Brand
OLPRUVA	SODIUM PHENYL BUTYRATE PACKET FOR SUSP 4 GM THERAPY PACK	3090806000B140	Brand
OLPRUVA	SODIUM PHENYL BUTYRATE PACKET FOR SUSP 5 GM THERAPY PACK	3090806000B150	Brand
OLPRUVA	SODIUM PHENYL BUTYRATE PACKET FOR SUSP 6 GM THERAPY PACK	3090806000B160	Brand
OLPRUVA	SODIUM PHENYL BUTYRATE 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** - Prescriber attests patient has been using Olpruva (sodium phenylbutyrate) as adjunctive therapy and will continue to use standard of care therapies while on Olpruva (sodium phenylbutyrate) 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** - Prescriber attests patient will be using Pheburane (sodium phenylbutyrate) as adjunctive therapy with standard ammonia lowering therapies ( e.g., protein restriction, dialysis, essential amino acid supplementation, etc.)

**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** - Prescriber attests patient has been using Pheburane (sodium phenylbutyrate) as adjunctive therapy and will continue to use standard of care therapies while on Pheburane (sodium phenylbutyrate) 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 to BOTH of the following:

**3.1** Patient will be using Ravicti (glycerol phenylbutyrate) as adjunctive therapy with standard ammonia lowering therapies (e.g., protein restriction, dialysis, essential amino acid supplementation, etc.)

**AND**

**3.2** Patient is NOT being treated for N-acetylglutamate synthase (NAGS) deficiency

**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 sodium phenylbutyrate therapy (can cumulate Buphenyl, Pheburane, Olpruva), confirmed by claims history or chart documentation

**OR**

**5.2** 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** - Prescriber attests patient has been using Ravicti (glycerol phenylbutyrate) as adjunctive therapy and will continue to use standard of care therapies while on Ravicti (glycerol phenylbutyrate) therapy

## 2 . Revision History

Date	Notes
2/12/2024	Updated wording for use with adjunctive therapy.



Urinary Tract Antispasmodic, Anti-incontinence agents



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-137642
<b>Guideline Name</b>	Urinary Tract Antispasmodic, Anti-incontinence agents
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	1/1/2024
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### 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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Patient is 2 years of age or older AND less than 12 years of age			
<b>OR</b>			
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
<b>Approval Criteria</b>			
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

<b>Guideline ID</b>	GL-126706
<b>Guideline Name</b>	Uterine Disorders
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

**Guideline Note:**

Effective Date:	7/1/2023
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### 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
<b>Approval Criteria</b>			
1 - Patient is 18 years of age or older			

**AND**

**2** - ONE of the following:

**2.1** BOTH of the following:

- Diagnosis of menorrhagia associated with uterine leiomyomas (fibroids) in a premenopausal female
- Previous trial and failure of hormonal contraceptives/therapy [oral tablets, vaginal ring, patch, intrauterine contraception (IUD)]

**OR**

**2.2** Diagnosis of moderate to severe pain associated with endometriosis in a premenopausal female and ONE of the following:

**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** 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
<b>Approval Criteria</b>			
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)
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Therapy Stage	Reauthorization
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Guideline Type	Prior Authorization
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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 rationale against the use of both hormonal contraceptives/therapy AND NSAID therapy

**AND**

**4** - Patient has a negative pregnancy test in the past 30 days

**AND**

**5** - ONE of the following:

**5.1** Laboratory tests confirming no hepatic disease worse than Child-Pugh A in the past 30 days

**OR**

**5.2** Patient has Child-Pugh B hepatic disease, and adjusted dosing will be limited to 150 mg daily for a maximum of 6 months\*\*

**AND**

**6** - Patient will NOT have concurrent use of organic anion transporting polypeptide (OATP)1B1 inhibitors that are known or expected to significantly increase elagolix plasma concentrations (e.g., cyclosporine, gemfibrozil)

**AND**

**7** - Patient does NOT have a diagnosis of osteoporosis

Notes	* Patients with Child-Pugh class B hepatic impairment will be limited to the 150mg daily dose for a maximum of 6 months irrespective of indication.
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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
<p><b>Approval Criteria</b></p> <p>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</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Patient will not be exceeding 24 total months of therapy per lifetime with elagolix (Orilissa)</p> <p style="text-align: center;"><b>AND</b></p> <p>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)</p> <p style="text-align: center;"><b>AND</b></p> <p>4 - Patient does NOT have a diagnosis of osteoporosis</p>			

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
<p><b>Approval Criteria</b></p> <p>1 - Patient is 18 years of age or older</p>			

**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 rationale against the use of 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
6/15/2023	Removed criteria for negative bone mineral density test and added criteria of no dx of osteoporosis. Updated Re-auth criteria.

Valchlor



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-97113
<b>Guideline Name</b>	Valchlor
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	1/1/2022
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## 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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Diagnosis of Langerhans Cell Histiocytosis (LCH)			
<b>AND</b>			
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

Vancomycin



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-126028
<b>Guideline Name</b>	Vancomycin
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	7/1/2023
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## 1 . Criteria

Product Name: Firvanq, Brand Vancomycin oral soln, Brand Vancocin, generic vancomycin caps			
Diagnosis	Clostridioides Difficile-Associated Diarrhea (CDAD) [Previously Known as Clostridium Difficile-Associated Diarrhea]		
Approval Length	10 Day(s)		
Therapy Stage	Initial Authorization		
Guideline Type	Prior Authorization		
Product Name	Generic Name	GPI	Brand/Generic
VANCOMYCIN HYDROCHLORIDE	VANCOMYCIN HCL FOR ORAL SOLN 25 MG/ML (BASE EQUIVALENT)	16280080102160	Generic
FIRVANQ	VANCOMYCIN HCL FOR ORAL SOLN 25 MG/ML (BASE EQUIVALENT)	16280080102160	Generic
VANCOMYCIN HYDROCHLORIDE	VANCOMYCIN HCL FOR ORAL SOLN 50 MG/ML (BASE EQUIVALENT)	16280080102170	Generic

FIRVANQ	VANCOMYCIN HCL FOR ORAL SOLN 50 MG/ML (BASE EQUIVALENT)	16280080102170	Generic
VANCOGIN	VANCOMYCIN HCL CAP 125 MG (BASE EQUIVALENT)	16280080100110	Brand
VANCOMYCIN HYDROCHLORIDE	VANCOMYCIN HCL CAP 125 MG (BASE EQUIVALENT)	16280080100110	Generic
VANCOGIN	VANCOMYCIN HCL CAP 250 MG (BASE EQUIVALENT)	16280080100120	Brand
VANCOMYCIN HYDROCHLORIDE	VANCOMYCIN HCL CAP 250 MG (BASE EQUIVALENT)	16280080100120	Generic

**Approval Criteria**

**1** - Diagnosis of Clostridioides difficile-associated diarrhea (CDAD) [previously known as Clostridium difficile-associated diarrhea]

**AND**

**2** - If the request is for Brand Vancocin, generic vancomycin capsules, or vancomycin oral solution, the prescriber provides a reason or special circumstance the patient cannot use Firvanq\* (document reason why patient is unable to use Firvanq)

Notes	*Brand Vancocin, generic vancomycin capsules, and vancomycin oral solution are non-preferred. Firvanq is preferred.
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Product Name: Firvanq, Brand Vancomycin oral soln, Brand Vancocin, generic vancomycin caps			
Diagnosis	Clostridioides Difficile-Associated Diarrhea (CDAD) [Previously Known as Clostridium Difficile-Associated Diarrhea]		
Approval Length	12 Week(s)		
Therapy Stage	Reauthorization		
Guideline Type	Prior Authorization		
Product Name	Generic Name	GPI	Brand/Generic
VANCOMYCIN HYDROCHLORIDE	VANCOMYCIN HCL FOR ORAL SOLN 25 MG/ML (BASE EQUIVALENT)	16280080102160	Generic
FIRVANQ	VANCOMYCIN HCL FOR ORAL SOLN 25 MG/ML (BASE EQUIVALENT)	16280080102160	Generic
VANCOMYCIN HYDROCHLORIDE	VANCOMYCIN HCL FOR ORAL SOLN 50 MG/ML (BASE EQUIVALENT)	16280080102170	Generic

FIRVANQ	VANCOMYCIN HCL FOR ORAL SOLN 50 MG/ML (BASE EQUIVALENT)	16280080102170	Generic
VANCOGIN	VANCOMYCIN HCL CAP 125 MG (BASE EQUIVALENT)	16280080100110	Brand
VANCOMYCIN HYDROCHLORIDE	VANCOMYCIN HCL CAP 125 MG (BASE EQUIVALENT)	16280080100110	Generic
VANCOGIN	VANCOMYCIN HCL CAP 250 MG (BASE EQUIVALENT)	16280080100120	Brand
VANCOMYCIN HYDROCHLORIDE	VANCOMYCIN HCL CAP 250 MG (BASE EQUIVALENT)	16280080100120	Generic

**Approval Criteria**

1 - Recurrence of Clostridioides difficile infection [previously known as Clostridium difficile-associated diarrhea] after prior treatment with oral vancomycin

**AND**

2 - If the request is for Brand Vancocin, generic vancomycin capsules, or vancomycin oral solution, the prescriber provides a reason or special circumstance the patient cannot use Firvanq\* (document reason why patient is unable to use Firvanq)

Notes	*Brand Vancocin, generic vancomycin capsules, and vancomycin oral solution are non-preferred. Firvanq is preferred.
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Product Name: Firvanq, Brand Vancomycin oral soln, Brand Vancocin, generic vancomycin caps			
Diagnosis	Staphylococcal Enterocolitis		
Approval Length	1 month(s)		
Guideline Type	Prior Authorization		
Product Name	Generic Name	GPI	Brand/Generic
VANCOMYCIN HYDROCHLORIDE	VANCOMYCIN HCL FOR ORAL SOLN 25 MG/ML (BASE EQUIVALENT)	16280080102160	Generic
FIRVANQ	VANCOMYCIN HCL FOR ORAL SOLN 25 MG/ML (BASE EQUIVALENT)	16280080102160	Generic
VANCOMYCIN HYDROCHLORIDE	VANCOMYCIN HCL FOR ORAL SOLN 50 MG/ML (BASE EQUIVALENT)	16280080102170	Generic
FIRVANQ	VANCOMYCIN HCL FOR ORAL SOLN 50 MG/ML (BASE EQUIVALENT)	16280080102170	Generic

VANCOCIN	VANCOMYCIN HCL CAP 125 MG (BASE EQUIVALENT)	16280080100110	Brand
VANCOMYCIN HYDROCHLORIDE	VANCOMYCIN HCL CAP 125 MG (BASE EQUIVALENT)	16280080100110	Generic
VANCOCIN	VANCOMYCIN HCL CAP 250 MG (BASE EQUIVALENT)	16280080100120	Brand
VANCOMYCIN HYDROCHLORIDE	VANCOMYCIN HCL CAP 250 MG (BASE EQUIVALENT)	16280080100120	Generic

**Approval Criteria**

1 - Diagnosis of enterocolitis due to Staphylococcus aureus

**AND**

2 - If the request is for Brand Vancocin, generic vancomycin capsules, or vancomycin oral solution, the prescriber provides a reason or special circumstance the patient cannot use Firvanq\* (document reason why patient is unable to use Firvanq)

Notes	*Brand Vancocin, generic vancomycin capsules, and vancomycin oral solution are non-preferred. Firvanq is preferred.
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Vanflyta



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-134766
<b>Guideline Name</b>	Vanflyta
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	12/1/2023
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## 1 . Criteria

Product Name: Vanflyta			
Diagnosis	Acute Myeloid Leukemia		
Approval Length	12 month(s)		
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
<b>Approval Criteria</b>			
1 - Diagnosis of acute myeloid leukemia (AML)			

**AND**

**2** - Disease is FLT3 internal tandem duplication (ITD) positive

**AND**

**3** - Vanflyta will be used in combination with standard cytarabine and anthracycline induction and cytarabine consolidation, and as maintenance monotherapy following consolidation chemotherapy

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
<b>Approval Criteria</b>			
<b>1</b> - 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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to Vanflyta therapy			

## 2 . Revision History

Date	Notes
10/13/2023	New

Vecamyl



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-82030
<b>Guideline Name</b>	Vecamyl
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	4/1/2021
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### 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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Documentation of a positive clinical response to Vecamyl therapy			

## 2 . Revision History

Date	Notes
3/5/2021	Bulk Load

Venclexta



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-125905
<b>Guideline Name</b>	Venclexta
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	7/1/2023
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## 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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Diagnosis of mantle cell lymphoma (MCL)			
<b>AND</b>			
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 Newly-diagnosed acute myeloid leukemia (AML)

**AND**

1.2 ONE of the following:

1.2.1 BOTH of the following:

1.2.1.1 ONE of the following:

- Patient is greater than or equal to 60 years old
- Patient has significant comorbidities that preclude the use of intensive induction chemotherapy

**AND**

1.2.1.2 Venclexta therapy to be given in combination with ONE of the following:

- Azacitidine
- Decitabine
- Low-dose cytarabine

**OR**

1.2.2 BOTH of the following:

- Patient is less than 60 years old with unfavorable risk genetics and TP53-mutation
- Venclexta therapy to be given in combination with azacitidine

**OR**

**2** - ALL of the following:

**2.1** Diagnosis of relapsed/refractory acute myeloid leukemia (AML)

**AND**

**2.2** Relapse is greater than or equal to 12 months from most recent disease remission

**AND**

**2.3** Venclexta therapy to be given in combination with the patient's previous initial successful induction regimen (e.g., azacitidine, decitabine, low-dose cytarabine, etc.)

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
<b>Approval Criteria</b>			

1 - Diagnosis of relapsed or progressive multiple myeloma which has been previously treated

**AND**

2 - Used in combination with dexamethasone

**AND**

3 - Patient has t(11;14) translocation

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 acute lymphoblastic leukemia (ALL)

**AND**

2 - ALL is Philadelphia-chromosome negative (Ph-negative)



**AND**

**3** - Venclexta therapy to be given in combination with ONE of the following:

- Decitabine
- Hyper-CVAD
- Nelarabine
- Mini hyper-CVD

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
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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	Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma (CLL/SLL), Mantle Cell Lymphoma, Acute Myeloid Leukemia (AML), Multiple Myeloma, Acute Lymphoblastic Leukemia (ALL), Systemic Light Chain Amyloidosis, Waldenstrom Macroglobulinemia/Lymphoplasmac
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
<b>Approval Criteria</b>			
1 - Venclexta will be approved for uses 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

Veozah (fezolinetant)



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-137497
<b>Guideline Name</b>	Veozah (fezolinetant)
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	1/1/2024
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## 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
<b>Approval Criteria</b>			
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

<b>Guideline ID</b>	GL-127387
<b>Guideline Name</b>	Verzenio
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	8/1/2023
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## 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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to Verzenio therapy			

## 2 . Revision History

Date	Notes
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6/30/2023	Removed Ki-67 score requirement for patient selection per updated prescribing information.
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Vijoice



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-112122
<b>Guideline Name</b>	Vijoice
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	9/1/2022
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## 1 . Criteria

Product Name: Vijoice			
Approval Length	6 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

**Approval Criteria**

**1 - Diagnosis of PIK3CA-Related Overgrowth Spectrum (PROS) based on all of the following criteria**

**1.1 Confirmed presence of a mutation in the PIK3CA gene**

**AND**

**1.2 Patient is 2 years of age or older**

**AND**

**1.3 ONE of the following:**

**1.3.1 TWO or more of the following spectrum features**

- Overgrowth: adipose, muscle, nerve, skeletal
- Vascular malformations: capillary, venous, arteriovenous, lymphatic
- Epidermal nevus

**OR**

**1.3.2 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
- Seborrhic keratoses
- Benign lichenoid keratoses

**AND**

**2 - Patient has severe manifestations of PROS (e.g., severe vascular malformations, chronic gastrointestinal bleeding, severe dyspnea, disabling chronic pain, severe epilepsy, severe manifestations despite previous debulking surgery)**

**AND**

**3** - Prescribed by, or in consultation with, a clinical geneticist or a practitioner who has specialized expertise in the management of PROS manifestations

Product Name: Vioice			
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
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to Vioice therapy			
<b>AND</b>			
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
8/23/2022	New to IN



Vitrakvi



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-121922
<b>Guideline Name</b>	Vitrakvi
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	4/1/2023
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## 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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b> 1 - Documentation of positive clinical response to Vitrakvi therapy			

Vizimpro



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-118477
<b>Guideline Name</b>	Vizimpro
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	2/1/2023
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## 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
<b>Approval Criteria</b>			
1 - Patient does not show evidence of progressive disease while on Vizimpro therapy			

Product Name: Vizimpro
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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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to Vizimpro therapy			

Votrient



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-138935
<b>Guideline Name</b>	Votrient
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	2/1/2024
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## 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
<b>Approval Criteria</b>			



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
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of ONE of the following:</p> <ul style="list-style-type: none"> <li>• Epithelial ovarian cancer</li> <li>• Fallopian tube cancer</li> <li>• Primary peritoneal cancer</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p>2 - ONE of the following:</p> <ul style="list-style-type: none"> <li>• Disease is persistent</li> <li>• Disease is recurrent</li> </ul>			

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
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of chondrosarcoma</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Disease is metastatic and widespread</p>			

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
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of Merkel Cell Carcinoma</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Disease is M1 disseminated</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - One of the following:</p> <p style="padding-left: 20px;"><b>3.1</b> Anti-PD-L1 or anti-PD-1 therapy is contraindicated</p> <p style="text-align: center;"><b>OR</b></p> <p style="padding-left: 20px;"><b>3.2</b> Disease has progressed on anti-PD-L1 or anti-PD-1 therapy</p>			

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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to Votrient therapy</p>			

## 2 . Revision History

Date	Notes
1/12/2024	Copy NY

Vowst



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-139287
<b>Guideline Name</b>	Vowst
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	3/1/2024
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## 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
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of recurrent Clostridioides difficile infection (rCDI) as defined by BOTH of the following:</p> <p>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</p>			

**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

Vyndaqel and Vyndamax



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-121540
<b>Guideline Name</b>	Vyndaqel and Vyndamax
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	3/19/2023
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### 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
VYND AQEL	TAFAMIDIS MEGLUMINE (CARDIAC) CAP 20 MG	40550080200120	Brand
VYNDAMAX	TAFAMIDIS CAP 61 MG	40550080000120	Brand
<b>Approval Criteria</b>			
1 - Patient is 18 years of age or older			

<p><b>AND</b></p> <p><b>2 - Diagnosis of cardiomyopathy secondary to transthyretin-mediated amyloidosis (ATTR-CM)</b></p> <p><b>AND</b></p> <p><b>3 - Diagnosis confirmed either histologically OR by genetic testing</b></p> <p><b>AND</b></p> <p><b>4 - Prescribed by, or in consultation with, a cardiologist</b></p>
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Product Name: Vyndaqel, Vyndamax			
Approval Length	12 month(s)		
Therapy Stage	Reauthorization		
Guideline Type	Prior Authorization		
Product Name	Generic Name	GPI	Brand/Generic
VYND AQEL	TAFAMIDIS MEGLUMINE (CARDIAC) CAP 20 MG	40550080200120	Brand
VYNDAMAX	TAFAMIDIS CAP 61 MG	40550080000120	Brand
<b>Approval Criteria</b>			
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 length. Added reauthorization criteria.

Xalkori



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-123847
<b>Guideline Name</b>	Xalkori
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	5/1/2023
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## 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
<b>Approval Criteria</b>			

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
<b>Approval Criteria</b>			
1 - Diagnosis of non-small cell lung cancer (NSCLC)			
<b>AND</b>			
2 - Disease is ONE of the following:			
<ul style="list-style-type: none"> <li>• Metastatic</li> <li>• Recurrent</li> <li>• Advanced</li> </ul>			
<b>AND</b>			
3 - ONE of the following:			
<ul style="list-style-type: none"> <li>• Tumor is anaplastic lymphoma kinase (ALK)-positive</li> <li>• Tumor is ROS1-positive</li> <li>• Tumor is positive for mesenchymal-epithelial transition (MET) amplification</li> <li>• Tumor is positive for MET exon 14 skipping mutation</li> </ul>			



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
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of metastatic brain cancer from non-small cell lung cancer (NSCLC)</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - ONE of the following:</p> <ul style="list-style-type: none"> <li>• Tumor is anaplastic lymphoma kinase (ALK)-positive</li> <li>• Tumor is ROS1-positive</li> </ul>			

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
<p><b>Approval Criteria</b></p>			

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

**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	Inflammatory Myofibroblastic Tumor (IMT), Non-Small Cell Lung Cancer (NSCLC), Central Nervous System (CNS) Cancers, Anaplastic Large Cell Lymphoma, Histiocytic Neoplasms		
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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to Xalkori therapy</p>			

Xdemvy



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-138702
<b>Guideline Name</b>	Xdemvy
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	2/1/2024
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## 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
<b>Approval Criteria</b>			
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 (eyelash misdirection)

**AND**

**3** - Patient demonstrates **TWO** of the following symptoms of Demodex infestation:

- Itching/Burning
- Foreign body sensation
- Crusting/matter lashes
- Blurry vision
- Discomfort/irritation

**AND**

**4** - Patient is practicing good eye-lid hygiene (e.g., non-prescription tree-tea oil)

**AND**

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

- Ophthalmologist
- Optometrist

## 2 . Revision History

Date	Notes
1/8/2024	New guideline

Xenleta



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-121344
<b>Guideline Name</b>	Xenleta
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	4/1/2023
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## 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
<b>Approval Criteria</b>			
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 to approval length box for Off-Label Uses.



Xermelo



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-128097
<b>Guideline Name</b>	Xermelo
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	9/1/2023
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## 1 . Criteria

Product Name: Xermelo			
Diagnosis	Carcinoid Syndrome Diarrhea		
Approval Length	6 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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
<b>1</b> - Documentation of positive clinical response to Xermelo			

Xifaxan



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-127907
<b>Guideline Name</b>	Xifaxan
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	9/1/2023
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## 1 . Criteria

Product Name: Xifaxan 200mg			
Diagnosis	Travelers' Diarrhea		
Approval Length	1 Month		
Guideline Type	Prior Authorization		
Product Name	Generic Name	GPI	Brand/Generic
XIFAXAN	RIFAXIMIN TAB 200 MG	16000049000320	Brand
<b>Approval Criteria</b>			
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		
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
<b>Approval Criteria</b>			
1 - Diagnosis of hepatic encephalopathy			

**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		
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
<b>Approval Criteria</b>			
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
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to Xifaxan therapy</p>			

Xospata



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-123704
<b>Guideline Name</b>	Xospata
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	5/1/2023
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## 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
<b>Approval Criteria</b>			
1 - Diagnosis of acute myeloid leukemia (AML)			

<b>AND</b>
<b>2</b> - AML is FMS-like tyrosine kinase 3 (FLT3) mutation-positive
<b>AND</b>
<b>3</b> - 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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to Xospata therapy</p>			

## 2 . Revision History

Date	Notes
3/23/2023	Updated treatment criteria for myeloid/lymphoid neoplasms per NCCN recommendations. Updated NCCN initial auth language.

Xpovio



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-121932
<b>Guideline Name</b>	Xpovio
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	4/1/2023
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## 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** Used in combination with Pomalyst (pomalidomide) and dexamethasone

**AND**

**3.3** 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**

**3.4** Patient has demonstrated progression on or within 60 days of completion of the last therapy

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** - Diagnosis of relapsed or refractory diffuse large B-cell lymphoma (DLBCL) (including DLBCL arising from follicular lymphoma)

**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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to Xpovio therapy			

Xtandi



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-124780
<b>Guideline Name</b>	Xtandi
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	6/1/2023
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## 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** Used in combination with a gonadotropin-releasing hormone (GnRH) analog [e.g., Lupron (leuprolide), Zoladex (goserelin), Trelstar (triptorelin), Vantas (histrelin), Firmagon (degarelix)]

**OR**

**2.2** Patient has had bilateral orchiectomy

**AND**

**3** - ONE of the following:

**3.1** If the disease is metastatic, castration-resistant, ONE of the following:

**3.1.1** Failure to abiraterone (generic Zytiga) as confirmed by claims history or submission of medical records

**OR**

**3.1.2** History of contraindication or intolerance to abiraterone (generic Zytiga) (please specify contraindication or intolerance)

**OR**

**3.1.3** Continuation of ongoing Xtandi therapy

**OR**

**3.2** If the disease is non-metastatic, castration-resistant, ONE of the following:

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

- Erleada (apalutamide)
- Nubeqa (darolutamide)

**OR**

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

- Erleada (apalutamide)
- Nubeqa (darolutamide)

**OR**

**3.2.3** Continuation of ongoing Xtandi therapy

**OR**

**3.3** If the disease is metastatic, castration-sensitive, ONE of the following:

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

- Erleada (apalutamide)
- abiraterone (generic Zytiga)

**OR**

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

- Erleada (apalutamide)
- abiraterone (generic Zytiga)

**OR**

**3.3.3** 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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to Xtandi therapy			

Xuriden



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-82040
<b>Guideline Name</b>	Xuriden
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	4/1/2021
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## 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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to Xuriden therapy			

## 2 . Revision History

Date	Notes
3/5/2021	Bulk Load

Yonsa



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-123566
<b>Guideline Name</b>	Yonsa
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	5/1/2023
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### 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 TAB 125 MG	21406010200310	Brand
<b>Approval Criteria</b>			
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 TAB 125 MG	21406010200310	Brand
<b>Approval Criteria</b>			
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 TAB 125 MG	21406010200310	Brand
<b>Approval Criteria</b>			

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 TAB 125 MG	21406010200310	Brand
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to Yonsa therapy			

Zejula



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-127930
<b>Guideline Name</b>	Zejula
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	9/1/2023
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## 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
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of ONE of the following:</p> <ul style="list-style-type: none"> <li>• Epithelial ovarian cancer</li> <li>• Fallopian tube cancer</li> <li>• Primary peritoneal cancer</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p>2 - Disease is ONE of the following:</p> <ul style="list-style-type: none"> <li>• Recurrent, with deleterious or suspected deleterious germline BRCA (breast cancer) mutation</li> <li>• Advanced</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p>3 - Patient is in a complete or partial response to a platinum-based chemotherapy</p> <p style="text-align: center;"><b>AND</b></p> <p>4 - Request is for maintenance therapy</p>			

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 the changes in FDA indications. Updated clinical guidelines for Ovarian cancer (treatment and maintenance).

Zelboraf



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-124800
<b>Guideline Name</b>	Zelboraf
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	6/1/2023
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## 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
<b>Approval Criteria</b>			
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:

<ul style="list-style-type: none"> <li>• Incomplete resection, biopsy, or surgically inaccessible location</li> <li>• Disease is recurrent or progressive</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Cancer is positive for BRAF V600E mutation</p> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - Used in combination with Cotellic (cobimetinib)</p>
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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
<b>Approval Criteria</b>			
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
- Hürthle cell 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
<b>Approval Criteria</b>			
1 - Documentation of positive clinical response to Zelboraf therapy			

Zolinza



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-96942
<b>Guideline Name</b>	Zolinza
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	1/1/2022
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## 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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to Zolinza therapy</p>			

Zurzuvae



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-143437
<b>Guideline Name</b>	Zurzuvae
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana</li> </ul>

### Guideline Note:

Effective Date:	4/1/2024
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## 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
<b>Approval Criteria</b>			
1 - Diagnosis of postpartum depression (PPD)			



**AND**

**2** - Patient is 18 years of age or older

**AND**

**3** - Patient is within 12 months (365 days) of being postpartum (Documentation of date of delivery required)

**AND**

**4** - Patient is not exceeding one treatment course (14 days of therapy) per 365 days

**AND**

**5** - Requested dose does not exceed one of the following:

**5.1** If the request is for 20 mg OR 25 mg capsules: 28 capsules for 14-day period (2 capsules per day)

**OR**

**5.2** If the request is for 30 mg capsules, BOTH of the following:

**5.2.1** Dose does not exceed 14 capsules for 14-day period (1 capsule per day)

**AND**

**5.2.2** Submission of medical records (e.g., chart notes, laboratory tests/values, assessments) confirming one of the following:

- Severe hepatic impairment (Child-Pugh C)
- Moderate to severe renal impairment (eGFR less than 60 mL/min/1.73m<sup>2</sup>)

## 2 . Revision History

Date	Notes
2/22/2024	New

Zydelig



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-127469
<b>Guideline Name</b>	Zydelig
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	8/1/2023
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## 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
<b>Approval Criteria</b>			

**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
<b>Approval Criteria</b>			
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
<p><b>Approval Criteria</b></p> <p>1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium</p>			

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
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to Zydelig therapy</p>			

## 2 . Revision History

Date	Notes
7/3/2023	Clarified criteria for CLL/SLL per NCCN guidelines. Updated Markets in Scope

Zykadia



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-123721
<b>Guideline Name</b>	Zykadia
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	5/1/2023
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## 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
<b>Approval Criteria</b>			
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

<b>Product Name: Zykadia</b>			
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
<b>Approval Criteria</b>			
1 - Diagnosis of inflammatory myofibroblastic tumor (IMT) with anaplastic lymphoma kinase (ALK) translocation			

<b>Product Name: Zykadia</b>	
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
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of metastatic brain cancer from non-small cell lung cancer (NSCLC)</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Tumor is anaplastic lymphoma kinase (ALK)-positive</p>			

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
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of Erheim-Chester Disease</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Disease is positive for anaplastic lymphoma kinase (ALK) rearrangement</p>			

Product Name: Zykadia	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC), Soft Tissue Sarcoma, Central Nervous System (CNS) Cancers, Histiocytic Neoplasms



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
<b>Approval Criteria</b>			
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
<b>Approval Criteria</b>			
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
3/23/2023	Removed ROS-1 from CNS cancer as this is no longer NCCN recommended. Added criteria for ALK-positive Erdheim-Chester Disease per NCCN recommendations.

Zytiga



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-127312
<b>Guideline Name</b>	Zytiga
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Community &amp; State Indiana SP</li> </ul>

### Guideline Note:

Effective Date:	8/1/2023
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## 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
<b>Approval Criteria</b>			
1 - Patient does not show evidence of progressive disease while on the requested therapy			
<b>AND</b>			
2 - If the request is for the 500 mg tablet, the prescriber provides a reason or special circumstance the patient cannot take abiraterone 250 mg			

Product Name: Brand Zytiga, generic abiraterone

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

Product Name	Generic Name	GPI	Brand/Generic
ABIRATERONE ACETATE	ABIRATERONE ACETATE TAB 250 MG	21406010200320	Generic
ZYTIGA	ABIRATERONE ACETATE TAB 250 MG	21406010200320	Brand
ABIRATERONE ACETATE	ABIRATERONE ACETATE TAB 500 MG	21406010200330	Generic
ZYTIGA	ABIRATERONE ACETATE TAB 500 MG	21406010200330	Brand

**Approval Criteria**

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

**AND**

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

**Product Name: Brand Zytiga, generic abiraterone**

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

Product Name	Generic Name	GPI	Brand/Generic
ABIRATERONE ACETATE	ABIRATERONE ACETATE TAB 250 MG	21406010200320	Generic
ZYTIGA	ABIRATERONE ACETATE TAB 250 MG	21406010200320	Brand
ABIRATERONE ACETATE	ABIRATERONE ACETATE TAB 500 MG	21406010200330	Generic

ZYTIGA	ABIRATERONE ACETATE TAB 500 MG	21406010200330	Brand
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to Zytiga therapy</p> <p style="text-align: center;"><b>AND</b></p> <p>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</p>			