ARKANSAS MEDICAID

PRESCRIPTION DRUG PROGRAM
PRIOR AUTHORIZATION CRITERIA

This document is an informational listing of the medications requiring a Prior Authorization through the Arkansas Medicaid Pharmacy Program, and a description of the associated criteria. Inclusion in this document does not guarantee market availability, and products must meet the Centers for Medicare and Medicaid Services (CMS) definition of a covered outpatient drug and pay CMS rebate to be covered by Arkansas Medicaid. Select over the counter medications are covered pursuant to a valid prescription.

Revised 10/01/2026

Arkansas Medicaid Clinical Criteria

Revised: October 1, 2026

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GENERAL INFORMATION

For provider assistance, including how to obtain a prior authorization (PA) or to check PA status, please contact the Prime Help Desk at 800-424-7895.

Prior authorization requests may be submitted electronically through **CoverMyMeds** or faxed to the **Prime Therapeutics State Government Solutions Pharmacy Unit** at **800-424-7976**, unless otherwise noted on the specific medication page.

Please refer to the Arkansas Medicaid Pharmacy Webpage for a complete list of drugs at: ar.primetherapeutics.com/provider-documents

The Arkansas Medicaid Preferred Drug List may be found at: ar.primetherapeutics.com/documents/d/arkansas/crm-attachment_pdl-document

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ACITRETIN (SORIATANE)

Updated 1/15/2025

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must be diagnosed with severe psoriasis
- The medication must be prescribed by or in consultation with a dermatologist
- The beneficiary must be unresponsive to other therapies or have a clinical contraindication to the use of other treatments
- The beneficiary should not be approved or continue this therapy with any of the following:
  - Severely impaired liver or kidney function
  - Abnormally elevated blood lipids
  - Requires concomitant tetracycline use
  - Develops capillary leak syndrome
  - Pregnant; **OR**
  - Females of reproductive potential who will not use reliable contraception during treatment and for at least 3 years following discontinuation
- The prescriber must submit the following:
  - Current chart notes
  - Previous therapies tried
  - Description of body surface area (BSA) and severity of psoriasis
  - Two negative pregnancy tests for beneficiaries of reproductive potential with the 2nd being during the first 5 days of the menstrual period
  - Documentation of the two forms of contraception that will be used
  - Attestation that the female of reproductive potential will have monthly pregnancy tests; **AND**
  - Letter of medical necessity over all other medications used for psoriasis
- Initial PA is for 3 months

RENEWAL REQUIREMENTS

- The beneficiary must be compliant with therapy (defined as 75% utilization)
- The beneficiary must demonstrate an improvement in psoriasis with a decrease in body surface area (BSA) and/or severity
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of response to treatment
  - Current negative pregnancy test for females of reproductive potential; **AND**
  - Attestation that the beneficiary remains on two forms of contraception

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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QUANTITY EDITS

60 capsules per 30 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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ACORAMIDIS HCL (ATTRUBY)

Updated 4/16/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must have the diagnosis of cardiomyopathy of wild-type or variant transthyretin-mediated amyloidosis (ATTR-CM) confirmed with **two** of the following:
  - Echocardiogram; **OR**
  - Tissue biopsy confirming the presence of transthyretin amyloid deposits; **OR**
  - Cardiovascular magnetic resonance imaging
    - If consistent with cardiac amyloidosis, the following should be done to document the presence or absence of monoclonal protein confirmed by **all** of the following:
      - Serum kappa/lambda free light chain ratio analysis
      - Serum protein immunofixation
      - Urine protein immunofixation
    - If monoclonal protein is not found, bone tracer cardiac scintigraphy (pyrophosphate scan) should be performed. The presence of grade 2 or 3 is highly specific for ATTR cardiac disease and tissue biopsy is not needed, but genetic testing is needed to confirm TTR variant.
- The medication must be prescribed by or in consultation with a cardiologist
- The beneficiary must have New York Heart Association (NYHA) class I, II, or III heart failure with symptoms of cardiomyopathy and heart failure (e.g., dyspnea, fatigue, orthostatic hypotension, syncope, peripheral edema)
- The beneficiary must have left ventricular wall (interventricular septum or left ventricular posterior wall) thickness ≥ 12 mm
- The beneficiary should not be approved or continue the medication if one of the following is met:
  - Impaired renal function (eGFR < 15 mL/min/1.73m^2)
  - Baseline NT-proBNP < 300 pg/mL or ≥ 8,500 pg/mL; **OR**
  - Goal of treatment is strictly polyneuropathy
- The prescriber must submit the following:
  - Current chart notes
  - Symptoms specific to this beneficiary to support diagnosis
  - Baseline 6-minute walk distance (6MWD)
  - Current labs, including baseline eGFR and NT-proBNP level (≥ 300 pg/mL)

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- Baseline echocardiogram with NYHA classification and documentation of tests results to confirm diagnosis; **AND**
- Baseline Kansas City Cardiomyopathy Questionnaire-Overall Summary (KCCQ-OS) score

RENEWAL REQUIREMENTS

- The beneficiary must remain compliant with therapy (defined as 75% utilization)
- The beneficiary must demonstrate a positive response to treatment
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of beneficiary specific symptoms compared to baseline
  - Updated 6-minute walk distance (6MWD); **AND**
  - Current Kansas City Cardiomyopathy Questionnaire-Overall Summary (KCCQ-OS) score

QUANTITY EDITS

120 tablets per 30 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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ACYCLOVIR CREAM AND OINTMENT

Updated 3/19/2013

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

DRUGS THAT DO NOT REQUIRE PRIOR AUTHORIZATION

docosanol 10% cream (generic for ABREVA)

DRUGS THAT REQUIRE MANUAL REVIEW FOR PRIOR AUTHORIZATION

- acyclovir 5% cream (generic for ZOVIRAX)
- acyclovir 5% ointment (generic for ZOVIRAX)
- penciclovir 1% cream 5 g (generic for DENAVIR)

ADDITIONAL CRITERIA

Quantity edits apply

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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AFICAMTEN (MYQORZO)

Updated 4/15/2026

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- The beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert or based on support from the official Compendia
- The beneficiary must be diagnosed with symptomatic obstructive hypertrophic cardiomyopathy (oHCM) with both of the following:
  - Left ventricular ejection fraction (LVEF) ≥ 55%; **AND**
  - Resting left ventricular outflow tract (LVOT) should be ≥ 30 and post Valsalva peak gradient (LVOT-G) should be ≥ 50 mmHg at screening
- Must be prescribed by, or in consultation with, a cardiologist
- The beneficiary must have tried and had an inadequate response to a beta blocke**r AND** calcium channel blocker unless patient is intolerant or has a contraindication to their use
- The beneficiary will not be approved if prescribed concomitantly with rifampin, and the use of aficamten concomitantly with strong inhibitors of CYP2C9 or moderate/strong inducers of CYP3A may require aficamten dose modification
- The beneficiary will not be approved if NOT NYHA class II or III
- The beneficiary will not be approved if have known infiltrative or storage disorder causing cardiac hypertrophy such as Noonan syndrome, Fabry disease or amyloidosis
- The beneficiary, prescriber, and pharmacy must be enrolled in the MYQORZO REMS program
- The prescriber must submit the following:
  - Current chart notes
  - Previous therapies tried with response
  - Baseline echocardiogram (subsequent echocardiograms two to eight weeks after initiation of therapy and every six months when on maintenance dose)

RENEWAL REQUIREMENTS

- The beneficiary must remain compliant on therapy (defined as 75% utilization)
- The beneficiary must demonstrate a clinical benefit with no worsening in heart failure symptoms and LVEF must remain ≥ 50%
- The prescriber must submit the following:
  - Current chart notes
  - Echocardiogram reports since previous prior authorization approval

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- Dose requested based on current LVEF and Valsalva LVOT-G (see the package insert)

APPROVAL CRITERIA

- Each strength: #31 tablets per 31 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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ALBUTEROL IR AND ER ORAL TABLETS AND SYRUP (VOSPIRE)

Updated 1/15/2025

DRUGS THAT REQUIRE MANUAL REVIEW FOR PRIOR AUTHORIZATION

- albuterol IR tablet
- albuterol ER tablet (generic for VOSPIRE ER)
- albuterol syrup

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must be diagnosed with reversible obstructive airway disease experiencing bronchospasms
- The prescriber must submit the following:
  - Current chart notes
  - Diagnosis
  - Previous therapies tried; **AND**
  - Letter of medical necessity for albuterol oral tablets over inhaled bronchodilators such as single agent (e.g., VENTOLIN HFA) and combination agent (e.g., SYMBICORT) products which are available without prior authorization

QUANTITY EDITS

- 2 mg and 4 mg IR - 120 tablets for 30 days
- 4 mg ER - 60 tablets for 30 days
- 8 mg ER - 120 tablets for 30 days
- Syrup - 120 mL per claim

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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ALLERGEN INDUCED RHINITIS (RAGWITEK, GRASTEK, ORALAIR, ODACTRA)

Updated 7/17/2024

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must have a diagnosis consistent with the FDA-approved package insert. Any off-label requests will be reviewed on a case-by-case basis.
  - **GRASTEK** – immunotherapy for the treatment of grass pollen-induced allergic rhinitis with or without conjunctivitis confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for Timothy grass or cross-reactive grass pollens
  - **ODACTRA** – immunotherapy for the treatment of house dust mite (HDM)-induced allergic rhinitis, with or without conjunctivitis, confirmed by positive in vitro testing for IgE antibodies to Dermatophagoides farinae or Dermatophagoides pteronyssinus house dust mites, or by positive skin testing to licensed house dust mite allergen extracts
  - **ORALAIR** – immunotherapy for the treatment of grass pollen-induced allergic rhinitis with or without conjunctivitis confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for any of the five grass species contained in this product
  - **RAGWITEK** – immunotherapy for the treatment of short ragweed pollen-induced allergic rhinitis, with or without conjunctivitis, confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for short ragweed pollen
- The beneficiary must have appropriate testing for specific allergens (e.g., grass, pollen, ragweed, dust mites) for the drug requested. The testing can be either serum testing for the specific IgE antibodies or skin test and must be positive for the specific allergen.
- For GRASTEK, ORALAIR, and RAGWITEK, the previous allergy season for either ragweed or grass pollen will be reviewed for Medicaid drug claims that are used to treat allergy symptoms. For ODACTRA, the Medicaid drug claims for the past six months will be reviewed. The beneficiary must have filled drugs to treat allergy symptoms in at least two of the following categories during the previous allergy season for GRASTEK, ORALAIR, and RAGWITEK or in the last six months for ODACTRA and have at least two claims in consecutive months in each category:
  - Nasal inhaled steroid
  - Oral (systemic) antihistamine
  - Leukotriene modifier; **OR**
  - Ophthalmic allergy drops (topical ocular mast cell stabilizers or antihistamines) for treating allergic conjunctivitis

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- The beneficiary should not be approved or continue this therapy with any of the following:
  - Duplication of therapy with allergy shots or other SL allergen extract tablet
  - Has severe, unstable or uncontrolled asthma; **OR**
  - For continued approval, beneficiary must remain compliant

QUANTITY EDITS

31 tablets per 31 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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ALPELISIB (VIJOICE)

Updated 7/20/2022

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary must be ≥ 2 years of age; **AND**
- The beneficiary must have a diagnosis of PIK3CA-Related Overgrowth Spectrum (PROS) that requires systemic therapy **or** a diagnosis consistent with any updated FDA-approved indications; **AND**
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Genetic testing results identifying a PIK3CA mutation and/or the clinical presentation confirming the diagnosis; **AND**
  - Identify which PROS disease has been confirmed; **AND**
  - Current labs, including fasting plasma glucose and HbA1c; **AND**
  - Previous treatment that includes surgery (provide explanation if surgery is not an option); **AND**
  - Baseline size and volume of target lesion(s); **AND**
  - Attestation that both males and females of reproductive potential have been counseled on the importance of contraception; **AND**
  - Current dose requested (beneficiaries unable to swallow tablets can use any dose to make a suspension based on preparation guidance from the package insert).
    - The beneficiary < 6 years of age – max of 50 mg daily
    - The beneficiary 6–17 years of age – 50 mg daily for at least 24 weeks before increasing to 125 mg daily
    - The beneficiary ≥ 18 years of age – max of 250 mg daily

DENIAL CRITERIA

- The beneficiary does not meet approval criteria **or** have a diagnosis supported on the official Compendia; **OR**
- The beneficiary is pregnant; **OR**
- The beneficiary has been diagnosed with severe cutaneous adverse reactions (SCARs) including Stevens-Johnson Syndrome, Erythema Multiforme or Toxic Epidermal Necrolysis or pneumonitis; **OR**
- The beneficiary cannot tolerate the minimum dose of 50 mg daily; **OR**
- The beneficiary requires a concomitant strong CYP3A4 inducer or BCRP inhibitor; **OR**
- The beneficiary has Type 1 or uncontrolled Type 2 diabetes

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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QUANTITY EDITS

- 50 mg – 31 per month
- 125 mg – 31 per month
- 250 mg – 62 per month

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ALPHA-1 PROTEINASE INHIBITORS

Updated 10/1/2019

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

DRUGS THAT REQUIRE MANUAL REVIEW FOR PRIOR AUTHORIZATION

- PROLASTIN-C
- ARALAST
- GLASSIA
- ZEMAIRA

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary is ≥ 18 years of age
- The request is from a pulmonologist
- The prescriber must submit the following:
  - Required diagnoses consistent with indication
    - Diagnosis of emphysema in the previous 2 years; **AND**
    - Diagnosis of alpha-1 antitrypsin deficiency in the previous 2 years
  - Documentation of smoking status – must be a current non-smoker and need confirmation with carbon monoxide test
  - Documentation of low serum concentration of AAT ≤ 11μM/L or ≤ 80 mg/dL
  - Documentation of high-risk homozygous protein phenotypes (i.e., PiZZ, PiSZ, or Pi null, null)
  - Baseline PFTs with an FEV1 of 30–65%
  - Current chart notes with weight for calculating dosage; **AND**
  - Continued optimal conventional treatment for emphysema (e.g., bronchodilators, supplemental oxygen if needed)

DENIAL CRITERIA

- The beneficiary does not meet above approval criteria
- The beneficiary is pregnant
- Request for diagnoses is considered investigational (i.e., Cystic Fibrosis, no AATD)
- Billed diagnosis of Immunoglobulin A (IgA) deficiency (IgA < 15 mg/dL)
  - D80.2 Selective deficiency of immunoglobulin A (IgA)

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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ALZHEIMER'S AGENTS

Updated 1/1/2026

PREFERRED AGENTS

- donepezil 5 mg and 10 mg tablet (generic for ARICEPT)
- EXELON (rivastigmine) – **brand only**
- memantine tablet (generic for NAMENDA)

NON-PREFERRED AGENTS

- ADLARITY (donepezil)
- ARICEPT (donepezil)
- donepezil ODT (generic for ARICEPT ODT)
- donepezil 23 mg tablet (generic for ARICEPT)
- galantamine (generic for RAZADYNE)
- galantamine ER (generic for RAZADYNE ER)
- memantine ER (generic for NAMENDA XR)
- memantine solution (generic for NAMENDA)
- memantine/donepezil (generic for NAMZARIC)
- NAMENDA XR (memantine ER)
- NAMZARIC (memantine/donepezil)
- rivastigmine (generic for EXELON)
- ZUNVEYL DR (benzgalantamine)

NON-PREFERRED AGENTS WITH CRITERIA

LEQEMBI IQLIK (lecanemab-irmb) – see criteria for LEQEMBI

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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AMIFAMPRIDINE (FIRDAPSE)

Updated 7/17/2019

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary is ≥ 6 years of age
- The prescriber must submit the following:
  - Confirmed diagnosis of LEMS based on either neurophysiology studies or a positive anti-P/Q type voltage-gated calcium channel antibody test
  - Current chart notes
  - If receiving peripherally acting cholinesterase inhibitors, a stable dose is required for at least 7 days
  - If receiving oral immunosuppressants, a stable dose is required for the last 30 days
  - Negative pregnancy test
  - Provide labs including renal and liver function
    - Creatinine clearance from 15–90 mL/min must start on lower dose of 15 mg per day; no dosage recommendations for ESRD
    - Any decrease in liver function requires a lower starting dose of 15 mg per day
  - Provide the Quantitative Myasthenia Gravis (QMG) score for baseline
  - Provide the medical necessity over guanidine hydrochloride, IVIG, and immunosuppressants (e.g., azathioprine) if not currently taking; **AND**
  - If diagnosed with cancer, provide treatment plan

DENIAL CRITERIA

- The beneficiary is < 6 years of age
- Has no confirmation of the LEMS diagnosis
- Has history of seizures or taking other medications that can lower the seizure threshold
- The beneficiary is pregnant
- Has end stage renal disease
- Has caution with lactation
- Has used guanidine hydrochloride in the last 7 days
- Currently uncontrolled asthma due to increased respiratory infections with this medication

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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AMIKACIN LIPOSOME (ARIKAYCE)

Updated 4/17/2019

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- Manual review PA will be on a case-by-case basis
- The beneficiary ≥ 18 years of age
- The beneficiary must be diagnosed with refractory Mycobacterium avium complex (MAC) lung disease
- Receiving ATS/IDSA guideline-based treatment with a multi-drug regimen for at least 6 months with persistently positive cultures
- Provide documentation of previous multi-drug MAC regimen
- The beneficiary must be diagnosed with non-tuberculosis mycobacterial lung disease in accordance with the 2007 ATS/IDSA criteria:
  - The beneficiary must have pulmonary symptoms with evidence of nodular bronchiectasis via radiograph and/or cavitary disease by CT
  - Appropriate exclusion of other diagnoses; **AND**
  - Positive culture results from at least 2 separate sputum samples or positive culture via bronchial lavage or wash or via transbronchial lung biopsy
- Provide current labs, including CBC and basic metabolic panel
- If child-bearing age, recommend a pregnancy test due to risk of congenital deafness

DENIAL CRITERIA

- The beneficiary has non-refractory MAC lung disease
- Currently takes medications associated with neurotoxicity, nephrotoxicity, and ototoxicity.
- Currently takes ethacrynic acid, furosemide, urea, or intravenous mannitol due to increased aminoglycoside toxicity.
- Pregnancy due to potential birth defects.
- FEV1 < 30% predicted
- Active pulmonary malignancy or active pulmonary TB
- The beneficiary has had a lung transplant
- Conditions requiring continuous oxygen supplementation
- Smoking within the last 6 months

QUANTITY EDITS

28 vials per 28 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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AMYOTROPHIC LATERAL SCLEROSIS (ALS) MEDICATIONS

Updated 5/10/2023

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

RILUZOLE TABLET

- No PA required
- Quantity limit applies

TIGLUTIK

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed a maximum dose based on support in manufacturer's package insert or official Compendia
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of previous and current therapies
  - Baseline ALS Functional Rating Scale-Revised score
  - Baseline PFTs; **AND**
  - Medical necessity over riluzole tablets

RADICAVA ORS (EDARAVONE)

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert or based on support in the official Compendia
- The beneficiary must have a diagnosis of amyotrophic lateral sclerosis (ALS) **or** a diagnosis consistent with any updated FDA-approved indications
- The beneficiary should meet the following at baseline:
  - The beneficiary has a disease duration < 2 years
  - The beneficiary has FVC $\geq$ 80% at baseline; **AND**
  - The baseline ALSFRS-R score documents the retention of functionality for most activities of daily living (defined as scores of 2 points or better on each individual item)
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of previous and current therapies

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- Baseline ALS Functional Rating Scale-Revised score
- Current PFTs
- Duration of symptoms; **AND**
- Documentation of concomitant medications for ALS (e.g., if they are planning on using riluzole)

RENEWAL REQUIREMENTS

(Pertains to TIGLUTIK and RADICAVA ORS)

- The beneficiary remains compliant with therapy (defined as 75% utilization)
- The beneficiary does not become dependent on invasive ventilation or tracheostomy
- The prescriber must submit the following:
  - Current chart notes
  - Current PFTs; **AND**
  - Current ALSFRS-R score

QUANTITY EDITS

riluzole

- 62 tablets per 31 days

TIGLUTIK

- 620 mL per 31 days

RADICAVA ORS

- 50 mL bottle – #50 mL per 28 days
- 70 mL bottle – #70 mL per 28 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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ANAPHYLAXIS AGENTS (EPINEPHRINE, SELF-ADMINISTERED)

Updated 10/1/2026

PREFERRED AGENTS

- EPIPEN (epinephrine)
- EPIPEN JR (epinephrine)
- epinephrine 0.15 mg, 0.3 mg (authorized generic for EPIPEN and EPIPEN JR)

NON-PREFERRED AGENTS

- AUVI-Q (epinephrine)
- epinephrine 0.15 mg, 0.3 mg (generic for ADRENACLICK)
- epinephrine 0.15 mg, 0.3 mg (unauthorized generic for EPIPEN JR and EPIPEN)
- NEFFY (epinephrine)

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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ANDROGENIC AGENTS

Updated 1/1/2026

PREFERRED AGENTS WITH CRITERIA

- testosterone cypionate vial (generic for DEPO-TESTOSTERONE)
- testosterone gel pump (generic for ANDROGEL)

NON-PREFERRED AGENTS

- AVEED (testosterone undecanoate)
- AZMIRO (testosterone cypionate)
- DEPO-TESTOSTERONE (testosterone cypionate)
- JATENZO (testosterone undecanoate)
- METHITEST (methyltestosterone)
- methyltestosterone (generic for ANDROID/TESTRED)
- NATESTO (testosterone)
- TESTIM (testosterone)
- testosterone enanthate (generic for DELATESTRYL)
- testosterone gel packet (generic for ANDROGEL/VOGELXO)
- testosterone gel pump (generic for FORTESTA/VOGELXO)
- testosterone gel tube (generic for TESTIM/VOGELXO)
- testosterone solution (generic for AXIRON)
- TLANDO (testosterone undecanoate)
- UNDECATREX (testosterone undecanoate)
- VOLGELXO (testosterone)
- XYOSTED (testosterone enanthate)

APPROVAL CRITERIA FOR PREFERRED AGENTS WITH CRITERIA

- The beneficiary is male
- Diagnosis of **one** of the following diagnoses in the previous 3 years:
  - Hypospadias
  - Klinefelter Syndrome
  - Kallmann Syndrome
  - Orchiectomy
  - Panhypopituitarism
  - Prader-Willi Syndrome; **OR**
  - Testicular cancer

Note: If the above criteria are not met, prior authorization is required.

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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DENIAL CRITERIA

- Diagnosis of **one** of the following in the previous 3 years:
  - Decreased libido
  - Impotence; **OR**
  - Any other sexual dysfunction diagnoses

ADDITIONAL CRITERIA

Quantity limits apply

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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ANGIOTENSIN RECEPTOR MODULATORS

Updated 10/1/2025

ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITORS/COMBINATION PRODUCTS

PREFERRED AGENTS

- benazepril (generic for LOTENSIN)
- benazepril/amlodipine (generic for LOTREL)
- benazepril/HCTZ (generic for LOTENSIN HCT)
- captopril (generic for CAPTOTEN)
- enalapril tablet (generic for VASOTEC)
- enalapril/HCTZ (generic for VASERETIC)
- fosinopril (generic for MONOPRIL)
- fosinopril/HCTZ (generic for MONOPRIL HCT)
- lisinopril (generic for ZESTRIL)
- lisinopril/HCTZ (generic for ZESTORETIC)
- quinapril (generic for ACCUPRIL)
- quinapril/HCTZ (generic for ACCURETIC)
- ramipril (generic for ALTACE)

NON-PREFERRED AGENTS

- ACCUPRIL (quinapril)
- ACCURETIC (quinapril/HCTZ)
- captopril/HCTZ (generic for CAPOZIDE)
- enalapril solution (generic for EPANED)
  - **Note**: Payable at Point of Sale (POS) for beneficiaries < 7 years of age or who have a diagnosis of NPO (Appendix A) in history
- EPANED (enalapril)
- LOTENSIN (benazepril)
- LOTENSIN HCT (benazepril/HCTZ)
- LOTREL (benazepril/amlodipine)
- moexipril (generic for UNIVASC)
- perindopril (generic for ACEON)
- QBRELIS (lisinopril)
  - **Note**: Payable at Point of Sale (POS) for beneficiaries < 7 years of age or who have a diagnosis of NPO (Appendix A) in history
- trandolapril (generic for MAVIK)

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- ZESTORETIC (lisinopril/HCTZ)
- ZESTRIL (lisinopril)

DIRECT RENIN INHIBITORS

PREFERRED AGENTS

None

NON-PREFERRED AGENTS

- aliskiren (generic for TEKTURNA)
- TEKTURNA (aliskiren)

ANGIOTENSIN II RECEPTOR BLOCKERS (ARB)/ARB COMBINATION PRODUCTS

PREFERRED AGENTS

- ENTRESTO SPRINKLE (valsartan/sacubitril)
  - **Note**: Age edits apply – payable for 1–6 years of age
- Irbesartan (generic for AVAPRO)
- Irbesartan/HCTZ (generic for AVALIDE)
- losartan (generic for COZAAR)
- losartan/HCTZ (generic for HYZAAR)
- olmesartan (generic for BENICAR)
- olmesartan/amlodipine (generic for AZOR)
- valsartan tablet (generic for DIOVAN)
- valsartan/HCTZ (generic for DIOVAN HCT)
- valsartan/amlodipine (generic for EXFORGE)
- valsartan/amlodipine/HCTZ (generic for EXFORGE HCT)
- valsartan/sacubitril (generic for ENTRESTO)

NON-PREFERRED AGENTS

- ARBLI (losartan)
  - **Note**: Payable at Point of Sale (POS) for beneficiaries 6 years of age or who have a diagnosis of NPO (Appendix A) in history
- ATACAND (candesartan)
- ATACAND HCT (candesartan/HCTZ)
- AVALIDE (irbesartan/HCTZ)
- AVAPRO (irbesartan)
- azilsartan (generic for EDARBI)
- AZOR (olmesartan/amlodipine)

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- BENICAR (olmesartan)
- BENICAR HCT (olmesartan/HCTZ)
- candesartan (generic for ATACAND)
- candesartan/HCTZ (generic for ATACAND HCT)
- COZAAR (losartan)
- DIOVAN (valsartan)
- DIOVAN HCT (valsartan/HCTZ)
- EDARBI (azilsartan) **– brand preferred over generic when approved**
- EDARBYCLOR (azilsartan/chlorthalidone)
- ENTRESTO tablet (valsartan/sacubitril)
- eprosartan (generic for TEVETAN)
- EXFORGE (valsartan/amlodipine)
- EXFORGE HCT (valsartan/amlodipine/HCTZ)
- HYZAAR (losartan/HCTZ)
- MICARDIS (telmisartan)
- MICARDIS HCT (telmisartan/HCTZ)
- olmesartan/HCTZ (generic for BENICAR HCT)
- olmesartan/amlodipine/HCTZ (generic for TRIBENZOR)
- telmisartan (generic for MICARDIS)
- telmisartan/amlodipine (generic for TWYNSTA)
- telmisartan/HCTZ (generic for MICARDIS HCT)
- TRIBENZOR (olmesartan/amlodipine/HCTZ)
- valsartan solution (generic for DIOVAN)

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ANIFROLUMAB-FNIA (SAPHNELO)

Updated 07/15/2026

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with moderate to severe systemic lupus erythematosus (SLE) while receiving standard therapy along with the following:
  - Positive autoantibody test (e.g., anti-nuclear antibody [ANA] or anti-double-stranded DNA [anti-dsDNA]); **AND**
  - SLEDAI-2K score ≥ 6 points or Physician's Global Assessment [PGA] score ≥ 1
- The drug is prescribed by or in consultation with a rheumatologist.
- The beneficiary must not be diagnosed with severe active lupus nephritis or severe active central nervous system lupus
- The beneficiary is not receiving SAPHNELO in combination with BENLYSTA or another biologic (e.g., ACTEMRA, CIMZIA, ENBREL, HUMIRA, KINERET, ORENCIA, REMICADE, RITUXAN, SIMPONI, STELARA).
- The beneficiary is currently receiving at least one standard of care treatment for active systemic lupus erythematosus (e.g., antimalarials, corticosteroids, or immunosuppressants) that is not a biologic, and the beneficiary will remain on standard of care concomitantly with SAPHNELO.
- The prescriber must submit the following:
  - Current chart notes with documentation of any corticosteroid use/dose
  - Current labs including autoantibody test to support the diagnosis
  - Medical necessity over supported immunosuppressive therapy alone (e.g., hydroxychloroquine, mycophenolate mofetil, or azathioprine).

RENEWAL REQUIREMENTS

- The beneficiary is not experiencing unacceptable toxicity (e.g., serious infections, malignancy, severe hypersensitivity reactions/anaphylaxis, etc.).
- The beneficiary has a documented positive clinical response as evidenced by disease stability or improvement compared to pre-treatment baseline (e.g., SLEDAI-2K score, PGA score, and decrease in corticosteroid dose/usage)
- The beneficiary remains on at least one standard of care treatment for active systemic lupus erythematosus (e.g., antimalarials, corticosteroids, or immunosuppressants) that is not a biologic.

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- The prescriber must submit the following:
  - Current chart notes
  - Documentation of response to treatment

QUANTITY EDITS

4 syringes/pens per month

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ANTHELMINTIC AGENTS

Updated 8/29/2016

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

DRUGS THAT DO NOT REQUIRE PRIOR AUTHORIZATION

- albendazole (generic for ALBENZA)
- praziquantel (generic for BILTRICIDE)
- ivermectin Rx tablet (generic for STROMECTOL)

DRUGS THAT REQUIRE MANUAL REVIEW FOR PRIOR AUTHORIZATION

EMVERM 100 mg chewable tablet (mebendazole)

APPROVAL CRITERIA FOR EMVERM

- Manual review on a case-by-case basis.
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Letter of medical necessity which includes the identification of the type of parasitic worm(s) (helminths) being treated

QUANTITY EDITS

- albendazole 200 mg – 4 tablets per claim
- EMVERM 100 mg – 1 tablet per month
- ivermectin 3 mg – 5 tablets per month
- ivermectin 6 mg – 3 tablets per month
- praziquantel 600 mg – 1 tablet per claim

Only medications prescribed to the Medicaid beneficiary can be billed using the beneficiary's Medicaid ID. The quantity billed to Medicaid cannot exceed the quantity prescribed by the prescriber for the beneficiary. Any quantity billed to Medicaid that exceeds the quantity prescribed to the beneficiary will be recouped. If medications are needed to treat remaining family members, each prescription must be billed according to each family member's Medicaid ID number or their own specific insurance plan. If a larger quantity is required than what is allowed by the quantity edits, the prescriber must submit the request in writing, provide the beneficiary's weight, and provide the diagnosis being treated for the request to be reviewed. Utilization of these agents will continue to be monitored.

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ANTIBIOTIC AGENTS – TOPICAL

Updated 1/1/2026

PREFERRED AGENTS

- bacitracin OTC ointment
- bacitracin zinc/neomycin/polymyxin B OTC ointment
- gentamicin 0.1% cream (generic for GARAMYCIN)
- gentamicin 0.1% ointment (generic for GARAMYCIN)
- mupirocin 2% ointment (generic for BACTROBAN)

NON-PREFERRED AGENTS

- bacitracin OTC packet
- CENTANY 2% ointment (mupirocin)
- mupirocin 2% cream (generic for BACTROBAN)
- XEPI cream (ozenoxacin)

Note: OTC topical antibiotics excluded from the list above are not covered by Arkansas Medicaid. Topical antibiotics only indicated for the treatment of acne are not covered by Arkansas Medicaid.

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ANTICOAGULANTS (ORAL AND LMWH)

Updated 10/1/2025

PREFERRED AGENTS

- dabigatran (generic for PRADAXA)
- ELIQUIS tablet (apixaban)
- enoxaparin (generic for LOVENOX)
- JANTOVEN (warfarin)
- warfarin (generic for COUMADIN)
- XARELTO tablet (rivaroxaban) – **brand only**

APPROVAL CRITERIA FOR PREFERRED AGENTS

- No therapeutic duplication allowed between different strengths of the same anticoagulant
- One therapeutic duplication with overlapping days' supply will be allowed once per 186 days for an inferred change in therapy between a preferred anticoagulant; **AND**
- The claims cannot have the same date of service.

NON-PREFERRED AGENTS

- ARIXTRA (fondaparinux)
- ELIQUIS sprinkle (apixaban)
- ELIQUIS tablet for suspension (apixaban)
- fondaparinux (generic for ARIXTRA)
- FRAGMIN (dalteparin)
- LOVENOX (enoxaparin)
- PRADAXA (dabigatran)
- rivaroxaban suspension and 2.5 mg tablet (generic for XARELTO)
- SAVAYSA (edoxaban)
- XARELTO suspension (rivaroxaban) – **brand only if approved**

ADDITIONAL CRITERIA

Quantity limits apply

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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ANTICONVULSANTS, GENERAL/MAINTENANCE

Updated 10/1/2026

PREFERRED AGENTS

Note: Beneficiaries compliant on taking a non-preferred agent will be able to continue that medication without a PA if there is a claim in their Medicaid profile in the previous 60 days. Many anticonvulsants have criteria established. See the notations below for clarification. Anticonvulsants have quantity limits as well based on the manufacturer's package inserts and support in MicroMedex.

***Point-of-sale criteria**

****Manual review criteria**

- carbamazepine 100 mg chew tablet (generic for TEGRETOL)
- carbamazepine tablet (generic for TEGRETOL)
- clobazam suspension and tablet (generic for ONFI)
- divalproex DR tablet (generic for DEPAKOTE DR)
- divalproex ER (generic for DEPAKOTE ER)
- ethosuximide capsule (generic for ZARONTIN)
- gabapentin capsule and tablet (generic for NEURONTIN)
- lacosamide solution and tablet (generic for VIMPAT)
- lamotrigine tablet (generic for LAMICTAL)
- levetiracetam solution and tablet (generic for KEPPRA)
- oxcarbazepine (generic for TRILEPTAL)
- phenytoin capsule (generic for DILANTIN)
- pregabalin capsule (generic for LYRICA)
- primidone (generic for MYSOLINE)
- ROWEEPRA (levetiracetam) – **HCFA termed 06/30/2027**
- SABRIL tablet (vigabatrin) – **brand only**
- SUBVENITE tablet (lamotrigine)
- TEGRETOL suspension (carbamazepine) – **brand only**
- topiramate tablet (generic for TOPAMAX)
- valproic acid (generic for DEPAKENE)
- vigabatrin powder pack (generic for SABRIL)
- zonisamide (generic for ZONEGRAN)

PREFERRED AGENTS WITH CRITERIA

- gabapentin solution (generic for NEURONTIN)

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  - **Note**: Payable at Point of Sale (POS) for beneficiaries < 7 years of age or who have a diagnosis of NPO (Appendix A) in history
- topiramate 15 mg and 25 mg sprinkle (generic for TOPAMAX sprinkle)
  - **Note**: Payable at Point of Sale (POS) for beneficiaries < 7 years of age or who have a diagnosis of NPO (Appendix A) in history

NON-PREFERRED AGENTS

- APTIOM (eslicarbazepine acetate)
- BANZEL (rufinamide)
- brivaracetam solution and tablet (generic for BRIVIACT)
- BRIVIACT solution and tablet (brivaracetam)
- carbamazepine 200 mg chew tab (generic for TEGRETOL)
- carbamazepine ER (generic for CARBATROL/TEGRETOL XR)
- carbamazepine suspension (generic for TEGRETOL)
- CARBATROL ER (carbamazepine ER)
- CELONTIN (methsuximide)
- DEPAKOTE DR (divalproex)
- DEPAKOTE ER (divalproex)
- DEPAKOTE SPRINKLE (divalproex)
- DIACOMIT (stiripentol)
- DILANTIN (phenytoin)
- divalproex sprinkle capsule (generic for DEPAKOTE)
- ELEPSIA XR (levetiracetam)
- EPIDIOLEX (cannabidiol)** – **see criteria for EPIDIOLEX**
- EPRONTIA (topiramate)
- EQUETRO (carbamazepine)
- eslicarbazepine (generic for APTIOM)
- ethosuximide solution (generic for ZARONTIN)
- felbamate (generic for FELBATOL)
- FELBATOL (felbamate)
- FINTEPLA (fenfluramine)** – **see criteria for FINTEPLA**
- FYCOMPA suspension (perampanel) – **brand preferred over generic when approved**
- FYCOMPA tablet (perampanel)
- gabapentin 200 mg capsule (generic for RELGAABI)
- GABARONE (gabapentin)
- KEPPRA solution and tablet (levetiracetam)
- KEPPRA XR (levetiracetam ER)

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- lacosamide vial (generic for VIMPAT)
- LAMICTAL (lamotrigine)
- LAMICTAL ODT (lamotrigine)
- LAMICTAL XR (lamotrigine ER)
- lamotrigine dispersible tablet (generic for LAMICTAL)
- lamotrigine dose pack (generic for LAMICTAL)
- lamotrigine ER (generic for LAMICTAL XR)
- lamotrigine ODT (generic for LAMICTAL ODT)
- levetiracetam (generic for SPRITAM)
- levetiracetam ER (generic for KEPPRA XR)
- LYRICA (pregabalin)
- methsuximide (generic for CELONTIN)
- MOTPOLY XR (lacosamide ER)
- NEURONTIN (gabapentin)
- ONFI (clobazam)
- oxcarbazepine ER (generic for OXTELLAR XR)
- OXTELLAR XR (oxcarbazepine) – **brand preferred over generic when approved**
- perampanel (generic for FYCOMPA)
- phenobarbital elixir and tablet
- PHENYTEK (phenytoin ER)
- phenytoin chew tablet (generic for DILANTIN INFATAB)
- phenytoin ER capsule (generic for PHENYTEK)
- phenytoin suspension (generic for DILANTIN)
- RELGAABI (gabapentin)
- rufinamide (generic for BANZEL)
- SABRIL powder packet (vigabatrin)
- SPRITAM (levetiracetam)
- SUBVENITE suspension and tablet starter kit (lamotrigine)
- SYMPAZAN (clobazam)**
- TEGRETOL tablet (carbamazepine)
- TEGRETOL XR tablet (carbamazepine ER)
- tiagabine (generic for GABITRIL)
- TOPAMAX (topiramate)
- topiramate ER (generic for QUDEXY and TROKENDI XR)
- topiramate solution (generic for EPRONTIA)
- topiramate 50 mg sprinkle (generic for TOPAMAX sprinkle)
- TRILEPTAL (oxcarbazepine)

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- TROKENDI XR (topiramate ER)
- vigabatrin tablet (generic for SABRIL)
- VIGADRONE (vigabatrin)
- VIGAFYDE (vigabatrin)
- VIMPAT (lacosamide)
- XCOPRI (cenobamate)
- ZARONTIN (ethosuximide)
- ZONISADE (zonisamide)
- ZTALMY (ganaxolone)** – **see criteria for ZTALMY**

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ANTICONVULSANTS, RESCUE

Updated 10/1/2026

PREFERRED AGENTS

- diazepam 2.5 mg rectal kit (generic for DIASTAT)
- diazepam rectal gel system (generic for DIASTAT ACUDIAL)
- NAYZILAM (midazolam)
- VALTOCO (diazepam)

NON-PREFERRED AGENTS

None

QUANTITY EDITS

- NAYZILAM – 10 doses per month
- VALTOCO – 10 doses per month
- DIASTAT – 3 doses per claim

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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ANTIDEPRESSANTS – SECOND-GENERATION (SGAD)

Updated 7/1/2026

PREFERRED AGENTS WITH CRITERIA

- bupropion extended-release (generic for WELLBUTRIN XL)
- bupropion regular-release (generic for WELLBUTRIN)
- bupropion sustained-release (generic for WELLBUTRIN SR)
- citalopram tablet and solution (generic for CELEXA)
- desvenlafaxine succinate ER (generic for PRISTIQ)
- duloxetine 20 mg, 30 mg, and 60 mg capsule (generic for CYMBALTA)
- escitalopram tablet and solution (generic for LEXAPRO)
- fluoxetine 10 mg, 20 mg, and 40 mg capsule (generic for PROZAC)
- fluoxetine solution (generic for PROZAC)
- fluoxetine/olanzapine capsule (generic for SYMBYAX)
- fluvoxamine maleate (generic for LUVOX)
- mirtazapine tablet (generic for REMERON)
- paroxetine HCl regular-release tablet (generic for PAXIL)
- sertraline HCl tablet and oral concentrate (generic for ZOLOFT)
- trazodone 50 mg, 100 mg, and 150 mg tablet (generic for DESYREL)
- venlafaxine extended-release capsule (generic for EFFEXOR ER)
- venlafaxine regular-release tablet (generic for EFFEXOR)

NON-PREFERRED AGENTS

- AUVELITY (dextromethorphan/bupropion)
- bupropion 450 mg extended-release (generic for FORFIVO XL)
- CELEXA (citalopram)
- citalopram capsule (generic for CELEXA)
- desvenlafaxine ER tablet
- duloxetine 40 mg DR capsule (generic for IRENKA DR)
- duloxetine 80 mg, 90 mg, 120 mg DR capsule
- EFFEXOR XR (venlafaxine)
- EMSAM (selegiline)
- escitalopram 15 mg capsule
- EXXUA ER
- FETZIMA (levomilnacipran)
- fluoxetine tablet (generic for PROZAC)
- fluoxetine 90 mg weekly capsule (generic for PROZAC)

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- fluvoxamine maleate extended-release capsule (generic for LUVOX CR)
- FORFIVO XL (bupropion) – **manufacturer obsolete 12/05/2025**
- LEXAPRO (escitalopram)
- MARPLAN (isocarboxazid)
- milnacipran (generic for SAVELLA)
- mirtazapine ODT (generic for REMERON SOLTAB)
- NARDIL (phenelzine)
- nefazodone (generic for SERZONE)
- paroxetine suspension (generic for PAXIL)
- paroxetine CR and ER tablet (generic for PAXIL)
- paroxetine mesylate capsule (generic for BRISDELLE)
- Paxil IR and CR (paroxetine)
- phenelzine (generic for NARDIL)
- PRISTIQ (desvenlafaxine)
- RALDESY (trazodone)
- REMERON (mirtazapine)
- SAVELLA (milnacipran) (see criteria for SAVELLA) – **brand preferred over generic when approved**
- sertraline capsule (generic for ZOLOFT)
- SPRAVATO (esketamine) (see criteria for SPRAVATO)
- tranylcypromine (generic for PARNATE)
- trazodone 25 mg, 75 mg, and 300 mg tablet (generic for DESYREL)
- TRINTELLIX (vortioxetine HBr)
- venlafaxine ER tablet (generic for EFFEXOR)
- venlafaxine besylate ER
- VIIBRYD (vilazodone)
- vilazodone (generic for VIIBRYD)
- WELLBUTRIN SR (bupropion)
- ZOLOFT (sertraline)
- ZURZUVAE (zuranolone) (see criteria for ZURZUVAE)

APPROVAL CRITERIA FOR PREFERRED AGENTS WITH CRITERIA

Drug daily dose ≤ maximum daily dose (see **Minimum and Maximum Dose for Second-Generation Antidepressants** below)

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APPROVAL CRITERIA FOR PREFERRED AGENTS INVOLVING THERAPEUTIC DUPLICATION

- If applicable for a change in therapy or concomitant therapy of two agents and only one or neither are SSRIs and/or SSNRIs (including combinations) (see **Selective Serotonin [norepinephrine] Reuptake Inhibitors [combinations]** below):
  - Drug in history reflects a minimal therapeutic dose (see **Minimum and Maximum Dose for Second-Generation Antidepressants** below) for at least four weeks; **OR**
- If applicable for a change in therapy for two SSRIs and/or SSNRIs (including combinations) (see **Selective Serotonin [norepinephrine] Reuptake Inhibitors [combinations]** below)
  - Drug in history reflects a minimal therapeutic dose (see **Minimum and Maximum Dose for Second-Generation Antidepressants** below) for at least four weeks; **AND**
  - No prior therapeutic duplication for two different SSRIs and/or SSNRIs (including combinations) (see **Selective Serotonin [norepinephrine] Reuptake Inhibitors [combinations]** below) within the past 365 days.

APPROVAL CRITERIA FOR ALL NON-PREFERRED AGENTS

Continuation criteria are defined as at least 90 days' supply in the previous 186 days for the same drug, strength, and daily dose with the denial exception of a therapeutic duplication between an SSRI and/or SNRI between incoming claim and history.

DENIAL CRITERIA FOR ALL AGENTS

- Preferred agents
  - Therapeutic duplication of three agents
  - Therapeutic duplication of two SSRIs and/or SSNRIs (including combinations) (see **Table 2 – Selective Serotonin [norepinephrine] Reuptake Inhibitors [combinations]** below) more than once per 365 days
- Non-preferred drugs for beneficiaries who do not meet continuation criteria of > 90 days' supply in the previous 186 days for the same drug, strength, and daily dose

MINIMUM AND MAXIMUM DOSE FOR SECOND-GENERATION ANTIDEPRESSANTS

Effective 7/1/2024, minimum daily therapeutic doses will be removed from the Approval Criteria. This table is for historical reference only.

Drug	Minimal daily therapeutic dose	Maximum daily dose
bupropion	150 mg	450 mg
citalopram	20 mg	40 mg
desvenlafaxine	50 mg	400 mg
duloxetine	40 mg	120 mg
escitalopram	10 mg	20 mg

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Drug	Minimal daily therapeutic dose	Maximum daily dose
fluoxetine	20 mg	80 mg
fluoxetine/olanzapine*	25 mg	75 mg
fluvoxamine	100 mg	300 mg
levomilnacipran	40 mg	120 mg
milnacipran	100 mg	200 mg
mirtazapine	15 mg	45 mg
nefazodone	200 mg	600 mg
paroxetine	20 mg	60 mg (CR 62.5 mg)
sertraline	50 mg	200 mg
venlafaxine	75 mg	375 mg
vilazodone	20 mg	40 mg
vortioxetine	10 mg	20 mg

*Minimum therapeutic dose and maximum dose based on SSRI component of the combination agent.

SELECTIVE SEROTONIN (NOREPINEPHRINE) REUPTAKE INHIBITORS (COMBINATIONS)

SSRI, SSNRI, or SSRI Combinations:

- citalopram
- desvenlafaxine er
- duloxetine
- escitalopram
- fluoxetine
- fluoxetine/olanzapine
- fluvoxamine
- paroxetine
- sertraline
- venlafaxine

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ANTIDIABETIC AGENTS

Updated 4/1/2025

ALPHA GLUCOSIDASE INHIBITORS

PREFERRED AGENTS

acarbose (generic for PRECOSE)

NON-PREFERRED AGENTS

- miglitol (generic for GLYSET)
- PRECOSE (acarbose)

AMYLIN ANALOGUES

PREFERRED AGENTS

None

NON-PREFERRED AGENTS

SYMLIN (pramlintide)

DPP-4 INHIBITORS

PREFERRED AGENTS

- JANUMET (sitagliptin/metformin) **– brand preferred**
- JANUVIA (sitagliptin) **– brand preferred**
- saxagliptin (generic for ONGLYZA)
- TRADJENTA (linagliptin)

NON-PREFERRED AGENTS

- alogliptin (generic for NESINA)
- alogliptin/metformin (generic for KAZANO)
- alogliptin/pioglitazone (generic for OSENI)
- BRYNOVIN (sitagliptin)
- GLYXAMBI (linagliptin/empagliflozin)
- JANUMET XR (sitagliptin/metformin ER) – **brand preferred over generic when approved**
- JENTADUETO (linagliptin/metformin)
- JENTADUETO XR (linagliptin/metformin ER)
- KAZANO (alogliptin/metformin)
- linagliptin/metformin (generic for JENTADUETO)

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- NESINA (alogliptin)
- OSENI (alogliptin/pioglitazone)
- saxagliptin/dapagliflozin (generic for QTERN)
- saxagliptin/metformin ER (generic for KOMBIGLYZE XR)
- sitagliptin (generic for JANUVIA)
- sitagliptin (generic for ZITUVIO)
- sitagliptin/metformin (generic for JANUMET)
- sitagliptin/metformin (generic for ZITUVIMET)
- sitagliptin/metformin ER (generic for JANUMET XR)
- sitagliptin/metformin XR (generic for ZITUVIMET XR)
- STEGLUJAN (sitagliptin/ertugliflozin)
- TRIJARDY XR (linagliptin/empagliflozin/metformin ER)
- ZITUVIMET (sitagliptin/metformin)
- ZITUVIMET XR (sitagliptin/metformin ER)
- ZITUVIO (sitagliptin)

APPROVAL CRITERIA FOR PREFERRED DPP-4 INHIBITORS

- Medicaid pharmacy profile indicates a paid claim in the last 60 days for a preferred DPP-4 Inhibitor
- Diagnosis of type 2 diabetes mellitus; **AND**
  - metformin claim in the last 186 days; **OR**
  - HbA1c $\geq$ 9 in the last 186 days

Note: Non-preferred products will continue to require prior authorization.

GLP-1 AGONISTS

PREFERRED AGENTS

- TRULICITY (dulaglutide)
- VICTOZA (liraglutide) – **brand only**

NON-PREFERRED AGENTS

- exenatide (generic for BYETTA)
- liraglutide (generic for VICTOZA)
- MOUNJARO (tirzepatide)
- OZEMPIC (semaglutide)
- RYBELSUS (semaglutide)
- SOLIQUA (lixisenatide/insulin glargine)
- XULTOPHY (insulin degludec/liraglutide)

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APPROVAL CRITERIA FOR PREFERRED GLP-1 AGONISTS

- Medicaid pharmacy profile indicates a paid claim in the last 60 days for a preferred GLP-1 receptor agonist
- Diagnosis of type 2 diabetes mellitus; **AND**
  - metformin claim in the last 186 days; **OR**
  - HbA1c ≥ 9 in the last 186 days; **OR**
  - Diagnosis of ASCVD (e.g., CABG, Angina, CHD, CAD, MI, heart failure, CVD, TIA, PAD, aortic atherosclerosis, thoracic or abdominal aortic aneurysm)

Note: Non-preferred products will continue to require prior authorization.

INSULINS

Please see Insulins

MEGLITINIDES

PREFERRED AGENTS

- nateglinide (generic for STARLIX)
- repaglinide (generic for PRANDIN)

NON-PREFERRED AGENTS

None

METFORMINS

PREFERRED AGENTS

- metformin 500 mg, 850 mg, 1,000 mg tablet (generic for GLUCOPHAGE)
- metformin ER 500 mg and 750 mg tablet (generic for GLUCOPHAGE XR)

NON-PREFERRED AGENTS

- metformin 625 mg and 750 mg tablet
- metformin ER gastric 500 mg and 1,000 mg tablet (generic for GLUMETZA)
- metformin ER osmotic 500 mg and 1,000 mg tablet (generic for FORTAMET)
- metformin solution (generic for RIOMET)
- RIOMET (metformin)

SGLT-2 INHIBITORS

PREFERRED AGENTS

- dapagliflozin (generic for FARXIGA)

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- JARDIANCE (empagliflozin)
- SYNJARDY (empagliflozin/metformin)
- XIGDUO ER (dapagliflozin/metformin ER) – **brand only**

NON-PREFERRED AGENTS

- dapagliflozin/metformin ER (generic for XIGDUO ER)
- dapagliflozin/saxagliptin (generic for QTERN)
- FARXIGA (dapagliflozin)
- INPEFA (sotagliflozin)
- INVOKAMET (canagliflozin/metformin)
- INVOKAMET XR (canagliflozin/metformin ER)
- INVOKANA (canagliflozin)
- SEGLUROMET (ertugliflozin/metformin)
- STEGLATRO (ertugliflozin)
- SYNJARDY XR (empagliflozin/metformin ER)

SULFONYLUREAS

PREFERRED AGENTS

- glimepiride 1 mg, 2 mg, and 4 mg (generic for AMARYL)
- glimepiride/pioglitazone (generic for DUETACT)
- glipizide 2.5 mg, 5 mg, and 10 mg (generic for GLUCOTROL)
- glipizide ER (generic for GLUCOTROL XL)
- glipizide/metformin (generic for METAGLIP)
- glyburide (generic for DIABETA)
- glyburide micronized (generic for MICRONASE/GLYNASE)
- glyburide/metformin (generic for GLUCOVANCE)

NON-PREFERRED AGENTS

- DUETACT (glimepiride/pioglitazone)
- glimepiride 3 mg (generic for AMARYL)
- glipizide 15 mg (generic for GLUCOTROL)
- GLUCOTROL XL (glipizide)

THIAZOLIDINEDIONES

PREFERRED AGENTS

- pioglitazone (generic for ACTOS)
- pioglitazone/glimepiride (generic for DUETACT)
- pioglitazone/metformin (generic for ACTOPLUS MET)

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NON-PREFERRED AGENTS

- ACTOS (pioglitazone)
- ACTOPLUS MET (pioglitazone/metformin)
- DUETACT (pioglitazone/glimepiride)

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ANTIEMETIC AGENTS – (HT3 OR NK1 RECEPTOR ANTAGONISTS)

Updated 4/1/2025

PREFERRED AGENTS WITH CRITERIA

- ondansetron 4 mg and 8 mg orally disintegrating tablet (generic for ZOFRAN ODT)
- ondansetron tablet (generic for ZOFRAN)
- ondansetron preservative-free vial (generic for ZOFRAN)
- ondansetron vial (generic for ZOFRAN)

NON-PREFERRED AGENTS

- AKYNZEO (netupitant-palonosetron HCl)
- aprepitant (generic for EMEND)
- EMEND (aprepitant)
- granisetron (generic for KYTRIL)
- GRANISOL (granisetron)
- NEREUS (tradipitant) **– manual review criteria pending**
- ondansetron 16 mg orally disintegrating tablet
- ondansetron ampule and syringe (generic for ZOFRAN)
- ondansetron oral solution (generic for ZOFRAN)
- SANCUSO (granisetron)

APPROVAL CRITERIA FOR PREFERRED AGENTS WITH CRITERIA

No therapeutic duplication with other 5-HT3 receptor antagonists

ADDITIONAL CRITERIA

Quantity limits apply

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ANTIFUNGALS – TOPICAL

Updated 7/1/2025

PREFERRED TOPICAL ANTIFUNGAL AGENTS

- clotrimazole 1% Rx cream (generic for LOTRIMIN)
- clotrimazole/betamethasone cream (generic for LOTRISONE)
- ketoconazole 2% Rx shampoo (generic for NIZORAL)
- nystatin ointment, cream, and powder (generic for MYCOSTATIN)
- nystatin/triamcinolone ointment (generic for MYCOLOG)
- tolnaftate 1% OTC topical cream, powder, and solution (generic for TINACTIN)

NON-PREFERRED TOPICAL ANTIFUNGAL AGENTS

- CICLODAN 0.77% (ciclopirox)
- ciclopirox 0.77% (generic for LOPROX)
- ciclopirox 1% (generic for LOPROX)
- clotrimazole 1% Rx solution (generic for LOTRIMIN) – **may be approved upon request after receiving documentation/attestation of otomycosis within the past 60 days**
- clotrimazole/betamethasone lotion (generic for LOTRISONE)
- econazole (generic for SPECTAZOLE)
- ERTACZO (sertaconazole)
- ketoconazole cream (generic for NIZORAL)
- ketoconazole foam (generic for EXTINA)
- KLAYESTA (nystatin)
- LOPROX (ciclopirox)
- miconazole 0.25%/zinc oxide 15%/petrolatum 81.35% (generic for VUSION)
- NAFTIN 2% (naftifine)
- naftifine (generic for NAFTIN)
- nystatin/triamcinolone cream (generic for MYCOLOG)
- oxiconazole (generic for OXISTAT)
- OXISTAT (oxiconazole)
- VUSION (miconazole/zinc oxide/petrolatum)

NON-PREFERRED TOPICAL ANTIFUNGAL AGENTS FOR ONYCHOMYCOSIS

- CICLODAN 8% (ciclopirox)
- ciclopirox 8% (generic for PENLAC nail lacquer)
- tavaborole (generic for KERYDIN)

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ANTIHISTAMINES – ORAL (SECOND-GENERATION)

Updated 4/1/2025

PREFERRED AGENTS

- cetirizine HCl 1 mg/mL solution and 10 mg swallow tablet (generic for ZYRTEC)
- loratadine (generic for CLARITIN)

NON-PREFERRED AGENTS

- cetirizine OTC 5 mg swallow tablet (generic for ZYRTEC)
- cetirizine OTC chewable tablet (generic for ZYRTEC)
- CLARINEX (desloratadine)
- desloratadine (generic for CLARINEX)
- fexofenadine OTC 180 mg tablet (generic for ALLEGRA)
- levocetirizine (Rx only) (generic for XYZAL)

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ANTI-HYPERURICEMICS

Updated 7/1/2025

PREFERRED AGENTS

- allopurinol 100 mg and 300 mg tablet (generic for ZYLOPRIM)
- colchicine tablet (generic for COLCRYS)
- probenecid
- probenecid/colchicine

NON-PREFERRED AGENTS

- allopurinol 200 mg tablet (generic for ZYLOPRIM)
- colchicine capsule (generic for MITIGARE)
- COLCRYS (colchicine)
- febuxostat (generic for ULORIC)
- GLOPERBA (colchicine)
- MITIGARE (colchicine)
- ULORIC (febuxostat)
- ZYLOPRIM (allopurinol)

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ANTI-INFLAMMATORY AGENTS (NSAIDS)

Updated 7/1/2025

PREFERRED AGENTS

- celecoxib (generic for CELEBREX)
- diclofenac sodium 25 mg, 50 mg, and 75 mg tablet (generic for VOLTAREN)
- diclofenac sodium topical 1% gel (generic for VOLTAREN) – as of 3/20/2026, there are no rebate eligible products.
- ibuprofen oral suspension (generic for MOTRIN)
- ibuprofen 400 mg, 600 mg, and 800 mg tablet (generic for MOTRIN)
- indomethacin 25 mg and 50 mg capsule (generic for INDOCIN)
- meloxicam tablet (generic for MOBIC)
- nabumetone (generic for RELAFEN)
- naproxen 250 mg, 375 mg, and 500 mg tablet (generic for NAPROSYN)
- naproxen 375 mg and 500 mg enteric coated tablet (generic for EC-NAPROSYN)
- naproxen 275 mg and 550 mg tablet (generic for ANAPROX)

PREFERRED AGENT WITH CRITERIA

- ketorolac (generic for TORADOL)

NON-PREFERRED AGENTS

- ARTHROTEC (diclofenac sodium/misoprostol)
- CELEBREX (celecoxib)
- COXANTO (oxaprozin)
- DAYPRO (oxaprozin)
- diclofenac epolamine 1.3% patch (generic for FLECTOR)
- diclofenac potassium tablet (generic for CATAFLAM)
- diclofenac potassium capsule (generic for ZIPSOR)
- diclofenac sodium ER tablet (generic for VOLTAREN XR)
- diclofenac sodium 1.5% and 2% topical (generic for PENNSAID)
- diclofenac sodium/misoprostol (generic for ARTHROTEC)
- diflunisal (generic for DOLOBID)
- DOLOBID (diflunisal)
- etodolac (generic for LODINE)
- etodolac ER (generic for LODINE XL)
- FELDENE (piroxicam)
- fenoprofen (generic for NALFON)

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- FENOPRON (fenoprofen calcium)
- flurbiprofen (generic for ANSAID)
- ibuprofen 300 mg tablet (generic for MOTRIN)
- ibuprofen/famotidine (generic for DUEXIS)
- indomethacin suppository and suspension (generic for INDOCIN)
- indomethacin ER capsule (generic for INDOCIN)
- ketoprofen (generic for ORUDIS)
- ketoprofen ER (generic for ORUVAIL)
- LURBIRO (flurbiprofen)
- meclofenamate sodium (generic for MECLOMEN)
- mefenamic acid (generic for PONSTEL)
- meloxicam capsule (generic for VIVLODEX)
- NALFON (fenoprofen)
- NAPRELAN CR (naproxen)
- naproxen ER/CR (generic for NAPRELAN)
- naproxen/esomeprazole (generic for VIMOVO)
- ORUDIS (ketoprofen)
- oxaprozin capsule (generic for COXANTO)
- oxaprozin tablet (generic for DAYPRO)
- PENNSAID (diclofenac sodium)
- piroxicam (generic for FELDENE)
- RELAFEN DS (nabumetone)
- salsalate (generic for DISALCID)
- sulindac (generic for CLINORIL)
- TOLECTIN (tolmetin)
- TOLECTIN DS (tolmetin)
- tolmetin (generic for TOLECTIN/TOLECTIN DS)
- VYSCOXA (celecoxib)
- ZYBIC (meloxicam)

NON-PREFERRED AGENTS WITH CRITERIA

- diclofenac sodium 3% gel (generic for SOLARAZE)
- naproxen suspension (generic for NAPROSYN)

APPROVAL CRITERIA FOR NON-PREFERRED AGENTS WITH CRITERIA

- diclofenac sodium 3% gel (generic for SOLARAZE)
  - Diagnosis of Actinic Keratosis in the past two months
- naproxen 125 mg/mL suspension (generic for NAPROSYN suspension)

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- < 7 years of age **or** nothing by mouth (NPO) (Appendix A) in the past year

DENIAL CRITERIA FOR PREFERRED AGENT WITH CRITERIA

- ketorolac (generic for TORADOL)
  - History of ketorolac use in the last 60 days; **OR**
  - NSAID claim in the past 30 days; **OR**
  - Dose greater than four per day; **OR**
  - Day supply greater than five; **OR**
  - Quantity greater than 20; **OR**
  - Greater than 20 units per 60 days

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ANTIPARKINSON'S AGENTS

Updated 1/1/2026

PREFERRED AGENTS

- amantadine capsule (generic for SYMMETREL)
- amantadine solution (generic for SYMMETREL)
- benztropine tablet (generic for COGENTIN)
- carbidopa/levodopa tablet (generic for SINEMET)
- carbidopa/levodopa ER tablet (generic for SINEMET CR)
- pramipexole (generic for MIRAPEX)
- ropinirole (generic for REQUIP)
- trihexyphenidyl (generic for ARTANE)

NON-PREFERRED AGENTS

- amantadine tablet (generic for SYMMETREL)
- APOKYN (apomorphine)
- apomorphine (generic for APOKYN)
- AZILECT (rasagiline)
- bromocriptine (generic for PARLODEL)
- carbidopa (generic for LODOSYN)
- carbidopa/levodopa ER capsule (generic for RYTARY ER)
- carbidopa/levodopa ODT (generic for PARCOPA)
- carbidopa/levodopa/entacapone (generic for STALEVO)
- CREXONT ER (carbidopa/levodopa)
- DHIVY (carbidopa/levodopa)
- DUOPA (carbidopa/levodopa)
- entacapone (generic for COMTAN)
- GOCOVRI (amantadine)
- NEUPRO (rotigotine)
- pramipexole ER (generic for MIRAPEX ER)
- rasagiline (generic for AZILECT)
- ropinirole ER (generic for REQUIP XL)
- RYTARY ER (carbidopa/levodopa ER) – **brand preferred over generic when approved**
- selegiline capsule (generic for ELDEPRYL)
- selegiline tablet (generic for ZELAPAR)
- SINEMET (carbidopa/levodopa)
- tolcapone (generic for TASMAR)

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- XADAGO (safinamide)

NON-PREFERRED AGENTS WITH CRITERIA

- INBRIJA (levodopa) (see criteria for INBRIJA)
- NOURIANZ (istradefylline) (see criteria for NOURIANZ)
- ONAPGO (apomorphine) (see criteria for ONAPGO)
- ONGENTYS (opicapone) (see criteria for ONGENTYS)
- VYALEV (foscarbidopa/foslevodopa) (see criteria for VYALEV)

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ANTIPSYCHOTICS, INJECTABLE LONG-ACTING

Updated 1/1/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

PREFERRED AGENTS WITH CRITERIA

- ABILIFY ASIMTUFII (aripiprazole ER)
- ABILIFY MAINTENA (aripiprazole ER)
- ARISTADA (aripiprazole lauroxil ER)
- ARISTADA INITIO (aripiprazole lauroxil ER)
- fluphenazine decanoate (generic for PROLIXIN)
- haloperidol decanoate (generic for HALDOL)
- INVEGA HAFYERA (paliperidone palmitate)
- INVEGA SUSTENNA (paliperidone palmitate)
- INVEGA TRINZA (paliperidone palmitate)
- PERSERIS ER (risperidone)
- RISPERDAL CONSTA (risperidone microspheres) – **brand only**
- UZEDY ER (risperidone)

NON-PREFERRED AGENTS WITH CRITERIA

- ERZOFRI (paliperidone palmitate)
- risperidone ER microsphere (generic of RISPERDAL CONSTA)
- RYKINDO ER (risperidone)
- ZYPREXA RELPREVV (olanzapine)

GENERAL APPROVAL CRITERIA

Long-Acting injectable antipsychotics will be available through POS edits for the preferred agents based on requirements in the package insert. Non-preferred agents follow the criteria below and documentation is required for the medical necessity over preferred options.

- All requests for beneficiaries < 18 years of age will continue to require manual review.
- Each product will require a trial of oral tolerability
- No therapeutic duplication with another long-acting antipsychotic allowed in the past 23 days
- Allowed ≤ 1 oral antipsychotic used concomitantly
- If medication is changed between LAIs, the proper time between doses must have elapsed to prevent overlapping of doses.
- The beneficiary must either meet criterion 1 or criterion 2 for the claim to process without a PA.

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ABILIFY ASIMTUFII 720 MG AND 960 MG

- Maximum of 1 injection every 2 months

Criterion 1

- Requires at least two weeks of oral aripiprazole in the previous 732 days prior to approval to assess tolerability
- After the first ABILIFY ASIMTUFII injection, administer oral aripiprazole for 14 consecutive days **or** if already stable on another oral antipsychotic, continue treatment with that medication for 14 consecutive days
- If changing from ABILIFY MAINTENA to ABILIFY ASIMTUFII, no oral doses are required. Dose can be given at next scheduled ABILIFY MAINTENA dosing interval.

Criterion 2

- ABILIFY ASIMTUFII claim in the last 93 days or ABILIFY MAINTENA in the last 45 days

ABILIFY MAINTENA 300 MG AND 400 MG

- Monthly dosing for 300 mg and 400 mg

Criterion 1

- Requires at least two weeks of oral aripiprazole in the previous 732 days prior to approval to assess tolerability
- After the first ABILIFY MAINTENA injection, administer oral aripiprazole for 14 consecutive days **or** if already stable on another oral antipsychotic, continue treatment with that medication for 14 consecutive days

Criterion 2

- ABILIFY MAINTENA claim in history within the last 45 days or ABILIFY ASIMTUFII within the last 93 days

ARISTADA 441 MG, 662 MG, 882 MG AND 1064 MG

- Monthly dosing for 441 mg and 662 mg; maximum duration of 6 weeks for 882 mg and maximum of every 8 weeks for 1,064 mg.

Criterion 1

- Requires at least two weeks of oral aripiprazole in the previous 732 days prior to approval to assess tolerability
- Initiation of treatment after tolerability has been established requires **one** of the following:
  - Administer ARISTADA INITIO 675 mg injection and one dose of oral aripiprazole 30 mg with first ARISTADA injection; **OR**
  - Administer 21 consecutive days of oral aripiprazole in conjunction with first ARISTADA injection

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Criterion 2

- ARISTADA 441 mg and 662 mg claim in history in last 45 days; ARISTADA 882 mg and 1,064 mg claim in history in the last 93 days.

ARISTADA INITIO 675 MG

- Requires at least two weeks of oral aripiprazole in the previous 732 days prior to approval to assess tolerability
- Administer with one dose of oral aripiprazole 30 mg with first dose of ARISTADA injection
- Limit 1 per year

FLUPHENAZINE DECANOATE 25 MG/ML

- Dosing is individualized but many dose every 3 weeks

Criterion 1

- Requires previous history of a short-acting form of fluphenazine in the previous 732 days to assess tolerability

Criterion 2

- Fluphenazine decanoate claim in the last 186 days (5 mL vials)

HALOPERIDOL DECANOATE 50 MG AND 100 MG

- Monthly dosing

Criterion 1

- Requires previous history of a short-acting form of haloperidol in the previous 732 days to assess tolerability

Criterion 2

- Haloperidol decanoate claim in the last 45 days

INVEGA HAFYERA 1,092 MG AND 1,560 MG

- Maximum dosing every 6 months

Criterion 1

- Requires previous history of INVEGA SUSTENNA for at least 120 days in the last 186 days **or** INVEGA TRINZA for at least 90 days in the last 124 days

Criterion 2

- INVEGA HAFYERA claim in the last 217 days

INVEGA SUSTENNA 39 MG, 78 MG, 117 MG, 156 MG AND 234 MG

- Monthly dosing

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Criterion 1

- Prior to approval must have taken oral paliperidone, oral risperidone, or injectable risperidone in the previous 732 days to assess tolerability

Criterion 2

- INVEGA SUSTENNA claim in the last 45 days, INVEGA HAFYERA in the last 217 days, or INVEGA TRINZA in the last 124 days

INVEGA TRINZA 273 MG, 410 MG, 546 MG, AND 819 MG

- Maximum dosing every 3 months

Criterion 1

- Request requires adequate treatment of INVEGA SUSTENNA for at least 120 out of 186 days

Criterion 2

- INVEGA TRINZA claim in the last 124 days, INVEGA HAFYERA in the last 217 days, or INVEGA SUSTENNA in the last 45 days

PERSERIS 90 MG AND 120 MG

- Monthly dosing

Criterion 1

- Requires previous history of oral risperidone in the previous 732 days to assess tolerability

Criterion 2

- PERSERIS claim in the last 45 days, RISPERDAL CONSTA in the last 45 days, or UZEDY 50 mg, 75 mg, and 125 mg claim in the last 45 days; UZEDY 100 mg, 150 mg, 200 mg and 250 mg claim in the last 93 days

RISPERDAL CONSTA 12.5 MG, 25 MG, 37.5 MG, AND 50 MG

- Maximum of 2 doses per month

Criterion 1

- Requires previous history of oral risperidone in the previous 732 days to assess tolerability
- Treatment requires concomitant oral risperidone or other antipsychotic medication for 3 weeks

Criterion 2

- RISPERDAL CONSTA claim in the last 45 days, PERSERIS in the last 45 days, or UZEDY 50 mg, 75 mg, and 125 mg claim in the last 45 days; UZEDY 100 mg, 150 mg, 200 mg and 250 mg claim in the last 93 days

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UZEDY ER 50 MG, 75 MG, 100 MG, 125 MG, 150 MG, 200 MG, AND 250 MG

- 50 mg, 75 mg, 100 mg, and 125 mg may be filled monthly; 150 mg, 200 mg and 250 mg may be filled every 2 months

Criterion 1

- Requires previous history of oral risperidone in the previous 732 days to assess tolerability

Criterion 2

- UZEDY 50 mg, 75 mg, and 125 mg claim in the last 45 days; UZEDY 100 mg, 150 mg, 200 mg and 250 mg claim in the last 93 days, PERSERIS in the last 45 days, or RISPERDAL CONSTA in the last 45 days

ZYPREXA RELPREVV 210 MG, 300 MG, AND 405 MG

- 150 mg, 210 mg and 300 mg may have two doses per month; 405 mg requires one dosage per month
- Requires the medical necessity over preferred options

Criterion 1

- Requires previous history of oral olanzapine in the previous 732 days to assess tolerability

Criterion 2

- ZYPREXA RELPREVV claim in the last 45 days

DENIAL CRITERIA

Therapeutic duplication with another long-acting antipsychotic in the past 23 days

ADDITIONAL CRITERIA

Quantity limits apply

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ANTIPSYCHOTICS, ORAL (ALL AGES)

Updated 1/1/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

FIRST GENERATION ORAL ANTIPSYCHOTIC AGENTS – PREFERRED

- chlorpromazine tablet (generic for THORAZINE)
- fluphenazine tablet (generic for PROLIXIN)
- haloperidol lactate concentrate solution (generic for HALDOL)
  - ODT and Solutions are preferred **only** for ages < 7 years of age or beneficiaries with a diagnosis of NPO (Appendix A) in history
- haloperidol tablet (generic for HALDOL)
- loxapine (generic for LOXITANE)*
- perphenazine (generic for TRILAFON)*
- thioridazine (generic for MELLARIL)*

SECOND GENERATION ORAL ANTIPSYCHOTIC AGENTS – PREFERRED

- aripiprazole tablet (generic for ABILIFY)
- clozapine tablet (generic for CLOZARIL)
- lurasidone (generic for LATUDA)
- olanzapine ODT (generic for ZYPREXA ZYDIS)
  - ODT and Solutions are preferred **only** for beneficiaries < 7 years of age or beneficiaries with a diagnosis of NPO (Appendix A) in history
- olanzapine tablet (generic for ZYPREXA)
- olanzapine/fluoxetine (generic for SYMBYAX)
  - Refer to the Second Generation Antidepressant criteria.
- paliperidone (generic for INVEGA)
- quetiapine (generic for SEROQUEL)
- risperidone ODT (generic for RISPERDAL)
  - ODT and Solutions are preferred **only** for beneficiaries < 7 years of age or beneficiaries with a diagnosis of NPO (Appendix A) in history
- risperidone solution (generic for RISPERDAL)
  - ODT and Solutions are preferred **only** for beneficiaries < 7 years of age or beneficiaries with a diagnosis of NPO (Appendix A) in history
- risperidone tablet (generic for RISPERDAL)
- ziprasidone capsule (generic for GEODON)

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PREFERRED AGENTS WITH CRITERIA

VRAYLAR (cariprazine)

VRAYLAR HAS THE FOLLOWING POINT-OF-SALE (POS) EDITS

- The beneficiary must have a billed diagnosis of **one** of the FDA-approved indications:
  - Treatment of schizophrenia in adults
  - Acute treatment of manic or mixed episodes associated with bipolar I disorder in adults
  - Treatment of depressive episodes associated with bipolar I disorder (bipolar depression) in adults
  - Adjunctive therapy to antidepressants for the treatment of major depressive disorder (MDD) in adults
- The beneficiary with schizophrenia or bipolar disorder must have at least one antipsychotic in their Medicaid profile in the last 2 years
- The beneficiary with major depressive disorder must have at least two different antidepressants in their Medicaid profile in the last 2 years

FIRST GENERATION ORAL ANTIPSYCHOTIC AGENTS – NON-PREFERRED

- chlorpromazine oral concentrate (generic for THORAZINE)
- fluphenazine elixir and solution (generic for PROLIXIN)
- molindone (generic for MOBAN)
- perphenazine/amitriptyline (generic for TRIAVIL)
- pimozide (generic for ORAP)
- thiothixene (generic for NAVANE)
- trifluoperazine (generic for STELAZINE)

SECOND GENERATION ORAL ANTIPSYCHOTIC AGENTS – NON-PREFERRED

- ABILIFY (aripiprazole)
- ABILIFY MYCITE (aripiprazole)
- aripiprazole ODT and solution (generic for ABILIFY)
- asenapine SL (generic for SAPHRIS)
- BYSANTI (milsaperidone)
- CAPLYTA (lumateperone)
- clozapine ODT (generic for FAZACLO)
- CLOZARIL (clozapine)
- COBENFY (xanomeline/trospium) – **see approval criteria below**
- FANAPT (iloperidone)
- GEODON (ziprasidone)
- INVEGA (paliperidone)
- LATUDA (lurasidone)

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- LYBALVI (olanzapine/samidorphan)
- NUPLAZID (pimavanserin)
- OPIPZA (aripiprazole)
- quetiapine extended-release (generic for SEROQUEL XR)
- REXULTI (brexpiprazole)
- RISPERDAL (risperidone)
- SAPHRIS SL (asenapine)
- SECUADO (asenapine)
- SEROQUEL IR (quetiapine)
- Seroquel XR (quetiapine)
- VERSACLOZ (clozapine)
- ZYPREXA (olanzapine)
- ZYPREXA ZYDIS (olanzapine)

FROM THE GENERAL MEDICATION COVERAGE POLICY JULY 2023

Refer to the General Medication Coverage Policy July 2023

Before moving to a non-preferred oral antipsychotic medication, the beneficiary must have documentation of trial and failure of at least **two** different chemical entities **unless otherwise noted**.

COBENFY APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with schizophrenia **or** a diagnosis consistent with any new FDA-approved indications. Any off-label requests will be reviewed on a case-by-case basis.
- The beneficiary must have a trial and failure of two other antipsychotics with differing mechanisms of action
- The beneficiary should not be approved or continue the medication if **one** or more of the following is met:
  - Has urinary retention
  - Has moderate or severe hepatic impairment
  - Has gastric retention; **OR**
  - Has untreated narrow-angle glaucoma
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of previous therapies tried and results; **AND**
  - Medical necessity over preferred antipsychotics

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ANTIPSYCHOTICS, ORAL – CRITERIA FOR ADULTS

Updated 2/23/2022

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA FOR ADULTS ≥ 18 YEARS OF AGE

- New starts for **preferred** medications that are **below** the maximum therapeutic dose (**see dosing charts**) will process at point-of sale (POS).
- The beneficiary may continue a drug or dose that is outside of the established criteria (e.g., continue a non-preferred status drug, continue dose higher than the maximum therapeutic dose), or continue therapy with > 2 antipsychotic agents if the beneficiary is "stable and compliant" on all antipsychotic drug therapies
  - For the purposes of these criteria, "stable and compliant" is defined as the beneficiary has received at least two claims in the previous 120 days.
- Preferred oral liquids and orally disintegrating tablets (ODTs): beneficiaries ≥ 18 years of age must have an NPO diagnosis code (Appendix A) in the past year.

DENIAL CRITERIA FOR ADULTS ≥ 18 YEARS OF AGE

- New starts to non-preferred medications will deny.
- New starts **above** the maximum therapeutic dose of a medication will deny (**see dosing charts below**).
  - Therapeutic Duplication
  - TD with three or more oral antipsychotic agents will deny for new startsTD for **two or more** oral antipsychotics and **one** long-acting injectable antipsychotic agents
- Failure to meet approval criteria

ANTIPSYCHOTICS, ORAL – ADULT DOSING CHARTS

Atypical Antipsychotic Maximum Therapeutic Dosing and Quantities for Adults (≥ 18 Years Of Age)			
Drug Name	**Medicaid Max Daily Dose by Strength**	**Medicaid Max Daily Quantity Edit**	**Medicaid Monthly Max Cumulative Quantity**
Aripiprazole (e.g., Abilify) Tablet Medicaid Max Daily Dose = 30 mg			
Aripiprazole (e.g., Abilify) 2 mg Tablet	8 mg	4	124
Aripiprazole (e.g., Abilify) 5 mg Tablet	5 mg	1	31

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Atypical Antipsychotic Maximum Therapeutic Dosing and Quantities for Adults (≥ 18 Years Of Age)			
Drug Name	**Medicaid Max Daily Dose by Strength**	**Medicaid Max Daily Quantity Edit**	**Medicaid Monthly Max Cumulative Quantity**
Aripiprazole (e.g., Abilify) 10 mg Tablet and Discmelt	10 mg	1	31
Aripiprazole (e.g., Abilify) 15 mg Tablet and Discmelt	15 mg	1	31
Aripiprazole (e.g., Abilify) 20 mg Tablet	20 mg	1	31
Aripiprazole (e.g., Abilify) 30 mg Tablet	30 mg	1	31
Aripiprazole (e.g., Ablify) 1 mg/mL	25 mg	25 mL	750 mL
Asenapine (e.g., Saphris) SL Tablet Medicaid Max Daily Dose = 20 mg			
Asenapine (e.g., Saphris) 2.5 mg SL Tablet	5 mg	2	62
Asenapine (e.g., Saphris) 5 mg SL Tablet	10 mg	2	62
Asenapine (e.g., Saphris) 10 mg SL Tablet	20 mg	2	62
Brexpiprazole (e.g., Rexulti) Tablet Medicaid Max Daily dose = 4 mg			
Brexpiprazole (e.g., Rexulti) 0.25 mg Tablet	0.25 mg	1	31
Brexpiprazole (e.g., Rexulti) 0.5 mg Tablet	0.5 mg	1	31
Brexpiprazole (e.g., Rexulti) 1 mg Tablet	1 mg	1	31
Brexpiprazole (e.g., Rexulti) 2 mg Tablet	2 mg	1	31
Brexpiprazole (e.g., Rexulti) 3 mg Tablet	3 mg	1	31
Brexpiprazole (e.g., Rexulti) 4 mg Tablet	4 mg	1	31
Cariprazine (e.g., Vraylar) Capsule Medicaid Max Daily Dose = 6 mg			
Cariprazine (e.g., Vraylar) 0.5 mg Capsule	0.5 mg	1	31
Cariprazine (e.g., Vraylar) 0.75 mg Capsule	0.75 mg	1	31
Cariprazine (e.g., Vraylar) 1.5 mg Capsule	1.5 mg	1	31
Cariprazine (e.g., Vraylar) 3 mg Capsule	3 mg	1	31
Cariprazine (e.g., Vraylar) 4.5 mg Capsule	4.5 mg	1	31
Cariprazine (e.g., Vraylar) 6 mg Capsule	6 mg	1	31
Clozapine (e.g., Clozaril) Tablet Medicaid Max Daily Dose = 900 mg			
Clozapine (e.g., Clozaril) 25 mg Tablet	75 mg	3	93
Clozapine (e.g., Clozaril) 50 mg Tablet	50 mg	1	31
Clozapine (e.g., Clozaril) 100 mg Tablet	900 mg	9	279
Clozapine (e.g., Clozaril) 200 mg Tablet	800 mg	4	124
Iloperidone (e.g., Fanapt) Tablet Medicaid Max Daily Dose = 24 mg			
Iloperidone (e.g., Fanapt) 1 mg Tablet	2 mg	2	62

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Atypical Antipsychotic Maximum Therapeutic Dosing and Quantities for Adults (≥ 18 Years Of Age)			
Drug Name	**Medicaid Max Daily Dose by Strength**	**Medicaid Max Daily Quantity Edit**	**Medicaid Monthly Max Cumulative Quantity**
Iloperidone (e.g., Fanapt) 2 mg Tablet	4 mg	2	62
Iloperidone (e.g., Fanapt) 4 mg Tablet	8 mg	2	62
Iloperidone (e.g., Fanapt) 6 mg Tablet	12 mg	2	62
Iloperidone (e.g., Fanapt) 8 mg Tablet	16 mg	2	62
Iloperidone (e.g., Fanapt) 10 mg Tablet	20 mg	2	62
Iloperidone (e.g., Fanapt) 12 mg Tablet	24 mg	2	62
Lurasidone (e.g., Latuda) Tablet Medicaid Max Daily Dose = 80 mg			
Lurasidone (e.g., Latuda) 20 mg Tablet	20 mg	1	31
Lurasidone (e.g., Latuda) 40 mg Tablet	40 mg	1	31
Lurasidone (e.g., Latuda) 60 mg Tablet	60 mg	1	31
Lurasidone (e.g., Latuda) 80 mg Tablet	80 mg	2	62
Lurasidone (e.g., Latuda) 120 mg Tablet	120 mg	1	31
Milsaperidone (e.g., Bysanti) Tablet Medicaid Max Daily Dose = 24 mg			
Milsaperidone (e.g., Bysanti) 1 mg Tablet	2 mg	2	62
Milsaperidone (e.g., Bysanti) 2 mg Tablet	4 mg	2	62
Milsaperidone (e.g., Bysanti) 4 mg Tablet	8 mg	2	62
Milsaperidone (e.g., Bysanti) 6 mg Tablet	12 mg	2	62
Milsaperidone (e.g., Bysanti) 8 mg Tablet	16 mg	2	62
Milsaperidone (e.g., Bysanti) 10 mg Tablet	20 mg	2	62
Milsaperidone (e.g., Bysanti) 12 mg Tablet	24 mg	2	62
Olanzapine (e.g., Zyprexa) Tablet Medicaid Max Daily Dose = 20 mg			
Olanzapine (e.g., Zyprexa) 2.5 mg Tablet	2.5 mg	1	31
Olanzapine (e.g., Zyprexa) 5 mg Tablet and ODT	5 mg	1	31
Olanzapine (e.g., Zyprexa) 7.5 mg Tablet	7.5 mg	1	31
Olanzapine (e.g., Zyprexa) 10 mg Tablet and ODT	10 mg	1	31
Olanzapine (e.g., Zyprexa) 15 mg Tablet and ODT	15 mg	1	31
Olanzapine (e.g., Zyprexa) 20 mg Tablet and ODT	20 mg	1	31
Paliperidone ER (e.g., Invega) Tablet Medicaid Max Daily dose = 12 mg			
Paliperidone ER (e.g., Invega) 1.5 mg Tablet	1.5 mg	1	31
Paliperidone ER (e.g., Invega) 3 mg Tablet	3 mg	1	31
Paliperidone ER (e.g., Invega) 6 mg Tablet	12 mg	2	62
Paliperidone ER (e.g., Invega) 9 mg Tablet	9 mg	1	31

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Atypical Antipsychotic Maximum Therapeutic Dosing and Quantities for Adults (≥ 18 Years Of Age)			
Drug Name	**Medicaid Max Daily Dose by Strength**	**Medicaid Max Daily Quantity Edit**	**Medicaid Monthly Max Cumulative Quantity**
Quetiapine (e.g., Seroquel) Tablet Medicaid Max Daily Dose = 800 mg			
Quetiapine (e.g., Seroquel) 25 mg Tablet	75 mg	3	93
Quetiapine (e.g., Seroquel) 50 mg Tablet	150 mg	3	93
Quetiapine (e.g., Seroquel) 100 mg Tablet	200 mg	2	62
Quetiapine (e.g., Seroquel) 150 mg Tablet	750 mg	5	155
Quetiapine (e.g., Seroquel) 200 mg Tablet	400 mg	2	62
Quetiapine (e.g., Seroquel) 300 mg Tablet	600 mg	2	62
Quetiapine (e.g., Seroquel) 400 mg Tablet	800 mg	2	62
Quetiapine ER (e.g., Seroquel XR) Tablet Medicaid Max Daily Dose = 800 mg			
Quetiapine ER (e.g., Seroquel XR) 50 mg Tablet	100 mg	2	62
Quetiapine ER (e.g., Seroquel XR) 150 mg Tablet	150 mg	1	31
Quetiapine ER (e.g., Seroquel XR) 200 mg Tablet	200 mg	1	31
Quetiapine ER (e.g., Seroquel XR) 300 mg Tablet	600 mg	2	62
Quetiapine ER (e.g., Seroquel XR) 400 mg Tablet	800 mg	2	62
Risperidone (e.g., Risperdal) Tablet Medicaid Max Daily Dose = 16 mg			
Risperidone (e.g., Risperdal) 0.25 mg Tablet	0.5 mg	2	62
Risperidone (e.g., Risperdal) 0.5 mg Tablet and ODT	1 mg	2	62
Risperidone (e.g., Risperdal) 1 mg Tablet and ODT	2 mg	2	62
Risperidone (e.g., Risperdal) 2 mg Tablet and ODT	4 mg	2	62
Risperidone (e.g., Risperdal) 3 mg Tablet and ODT	9 mg	3	93
Risperidone (e.g., Risperdal) 4mg Tablet and ODT	16 mg	4	124
Risperidone (e.g., Risperdal) 1 mg/mL Oral Solution (30 mL)	4 mg	4 mL	120
Xanomeline/trospium (e.g., Cobenfy) Capsule Medicaid Max Daily Dose = 250 mg/60 mg			
Xanomeline/trospium (e.g., Cobenfy) 50/20 mg Capsule	100 mg/40 mg	2	62
Xanomeline/trospium (e.g., Cobenfy) 100/20 mg Capsule	200 mg/40 mg	2	62
Xanomeline/trospium (e.g., Cobenfy) 125/30 mg Capsule	250 mg/60 mg	2	62
Ziprasidone (e.g., Geodon) Capsule Medicaid Max Daily Dose = 160 mg			
Ziprasidone (e.g., Geodon) 20 mg Capsule	40 mg	2	62

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Atypical Antipsychotic Maximum Therapeutic Dosing and Quantities for Adults (≥ 18 Years Of Age)			
Drug Name	**Medicaid Max Daily Dose by Strength**	**Medicaid Max Daily Quantity Edit**	**Medicaid Monthly Max Cumulative Quantity**
Ziprasidone (e.g., Geodon) 40 mg Capsule	80 mg	2	62
Ziprasidone (e.g., Geodon) 60 mg Capsule	120 mg	2	62
Ziprasidone (e.g., Geodon) 80 mg Capsule	160 mg	2	62

Typical Antipsychotic Maximum Therapeutic Dosing and Quantities for Adults (≥ 18 Years Of Age)			
Drug Name	**Medicaid Max Daily Dose by Strength**	**Medicaid Max Daily Quantity Edit**	**Medicaid Monthly Max Cumulative Quantity**
Chlorpromazine (e.g., Thorazine) Tablet Medicaid Max Daily Dose = 800 mg			
Chlorpromazine (e.g., Thorazine) 10 mg Tablet	40 mg	4	124
Chlorpromazine (e.g., Thorazine) 25 mg Tablet	75 mg	3	93
Chlorpromazine (e.g., Thorazine) 50 mg Tablet	200 mg	4	124
Chlorpromazine (e.g., Thorazine) 100 mg Tablet	700 mg	7	217
Chlorpromazine (e.g., Thorazine) 200 mg Tablet	800 mg	4	124
Fluphenazine (e.g., Prolixin) Tablet Medicaid Max Daily Dose = 40 mg			
Fluphenazine (e.g., Prolixin) 1 mg Tablet	4 mg	4	124
Fluphenazine (e.g., Prolixin) 2.5 mg Tablet	10 mg	4	124
Fluphenazine (e.g., Prolixin) 5 mg Tablet	20 mg	4	124
Fluphenazine (e.g., Prolixin) 10 mg Tablet	40 mg	4	124
Fluphenazine (e.g., Prolixin) Elixir	40 mg	80ml	2,365 mL
Fluphenazine (e.g., Prolixin) Concentrate	40 mg	8ml	240 mL
Haloperidol (e.g., Haldol) Tablet Medicaid Max Daily Dose = 40 mg			
Haloperidol (e.g., Haldol) 0.5 mg Tablet	1.5 mg	3	93
Haloperidol (e.g., Haldol) 1 mg Tablet	3 mg	3	93
Haloperidol (e.g., Haldol) 2 mg Tablet	6 mg	3	93
Haloperidol (e.g., Haldol) 5 mg Tablet	15 mg	3	93
Haloperidol (e.g., Haldol) 10 mg Tablet	30 mg	3	93
Haloperidol (e.g., Haldol) 20 mg Tablet	40 mg	2	62
Loxapine (e.g., Loxitane) Capsule Medicaid Max Daily Dose = 250 mg			
Loxapine (e.g., Loxitane) 5 mg Capsule	20 mg	4	124

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Typical Antipsychotic Maximum Therapeutic Dosing and Quantities for Adults (≥ 18 Years Of Age)			
Drug Name	**Medicaid Max Daily Dose by Strength**	**Medicaid Max Daily Quantity Edit**	**Medicaid Monthly Max Cumulative Quantity**
Loxapine (e.g., Loxitane) 10 mg Capsule	60 mg	6	186
Loxapine (e.g., Loxitane) 25 mg Capsule	100 mg	4	124
Loxapine (e.g., Loxitane) 50 mg Capsule	250 mg	5	155
Perphenazine (e.g., Trilafon) Tablet Medicaid Max Daily Dose = 64 mg			
Perphenazine (e.g., Trilafon) 2 mg Tablet	8 mg	4	124
Perphenazine (e.g., Trilafon) 4 mg Tablet	16 mg	4	124
Perphenazine (e.g., Trilafon) 8 mg Tablet	32 mg	4	124
Perphenazine (e.g., Trilafon) 16 mg Tablet	64 mg	4	124
Perphenazine-Amitriptyline (e.g., Etrafon) Tablet Medicaid Max Daily Dose = 16 mg/100 mg			
Perphenazine-Amitriptyline (e.g., Etrafon) 2 mg/10 mg Tablet	8 mg/40 mg	4	124
Perphenazine-Amitriptyline (e.g., Etrafon) 2 mg/25 mg Tablet	8 mg/100 mg	4	124
Perphenazine-Amitriptyline (e.g., Etrafon) 4 mg/10 mg Tablet	16 mg/40 mg	4	124
Perphenazine-Amitriptyline (e.g., Etrafon) 4 mg/25 mg Tablet	16 mg/100 mg	4	124
Perphenazine-Amitriptyline (e.g., Etrafon) 4 mg/50 mg Tablet	8 mg/100 mg	2	62
Pimozide (e.g., Orap) Tablet Medicaid Max Daily Dose = 10 mg			
Pimozide (e.g., Orap) 1 mg Tablet	3 mg	3	93
Pimozide (e.g., Orap) 2 mg Tablet	10 mg	5	155
Thioridazine (e.g., Mellaril) Tablet Medicaid Max Daily Dose = 800 mg			
Thioridazine (e.g., Mellaril) 10 mg Tablet	40 mg	4	124
Thioridazine (e.g., Mellaril) 25 mg Tablet	100 mg	4	124
Thioridazine (e.g., Mellaril) 50 mg Tablet	200 mg	4	124
Thioridazine (e.g., Mellaril) 100 mg Tablet	800 mg	8	248
Thiothixene (e.g., Navane) Capsule Medicaid Max Daily Dose = 60 mg			
Thiothixene (e.g., Navane) 1 mg Capsule	3 mg	3	93
Thiothixene (e.g., Navane) 2 mg Capsule	8 mg	4	124
Thiothixene (e.g., Navane) 5 mg Capsule	15 mg	3	93
Thiothixene (e.g., Navane) 10 mg Capsule	60 mg	6	186

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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Typical Antipsychotic Maximum Therapeutic Dosing and Quantities for Adults (≥ 18 Years Of Age)			
Drug Name	**Medicaid Max Daily Dose by Strength**	**Medicaid Max Daily Quantity Edit**	**Medicaid Monthly Max Cumulative Quantity**
Trifluoperazine (e.g., Stelazine) Tablet Medicaid Max Daily Dose = 40 mg			
Trifluoperazine (e.g., Stelazine) 1 mg Tablet	3 mg	3	93
Trifluoperazine (e.g., Stelazine) 2 mg Tablet	8 mg	4	124
Trifluoperazine (e.g., Stelazine) 5 mg Tablet	15 mg	3	93
Trifluoperazine (e.g., Stelazine) 10 mg Tablet	40 mg	4	124

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ANTIPSYCHOTICS, ORAL – CRITERIA FOR CHILDREN

Preferred and Non-Preferred Agents Apply to All – Refer to PDL Drugs Antipsychotics, Oral – Preferred Agents for all Ages

Updated 10/1/2019

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA FOR CHILDREN (< 18 YEARS OF AGE)

- At least one paid claim for an oral antipsychotic in the past 45 days, and monitoring for both glucose and lipid screening in the past 9 months (see **CPT Codes for Glucose and Lipid Monitoring** below)
- Typical and Atypical antipsychotics:
  - All new start beneficiaries or beneficiaries who have changed to a different chemical entity will require signed informed consent and a copy of a baseline metabolic lab test data (effective 11/08/2011)
    - **Medication Informed Consent Document**: https://ar.primetherapeutics.com/documents/268611/269351/Medication%20Informed%20Consent%20Document%20for%20Behavioral%20or%20Psychiatric%20Conditions%20-%20Clients%20under%2018%20years%20of%20age/b36b6864-5a6e-a661-ae93-52ab33495ee1
  - One therapeutic duplication for a change in therapy between two antipsychotics (oral or injectable) with > 25% remaining on the last fill on different dates of service allowed per 93 days.
  - PA required through manual review for beneficiaries < 10 years of age.
- Oral liquids and orally disintegrating tablets (ODTs):
  - The beneficiary must have an NPO code (Appendix A) in the past year; **OR**
  - < 7 years of age **and** meet criteria for atypical antipsychotics
- Seroquel XR continuation criteria requires ≥ 2 claims on the beneficiary's profile of the same GSN in the past 120 days. Immediate-release quetiapine (Seroquel) is covered via existing criteria.
- Requested dose must meet the dosing requirements by age on the dosing table. (see **Approved Doses per Age Range** below)
- Requested maximum daily dose must be approved for age range (see **Max Daily Doses for Age Categories < 18 Years of Age** below)

DENIAL CRITERIA FOR CHILDREN (< 18 YEARS OF AGE)

- Claims with a therapeutic duplication on the same date of service
- Requests for combination antipsychotic products for beneficiaries < 18 years of age
- Failure to meet approval criteria

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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APPROVED DOSES PER AGE RANGE

Drug	Strength	FDA Dosing	< 6* years of age	6*–9 years of age	10–12 years of age	13–17 years of age
Abilify	2 mg	QD	2 tabs	2 tabs	2 tabs	2 tabs
Abilify	5 mg	QD	1 tab	1 tab	1 tab	1 tab
Abilify	10 mg	QD		1 tab	1 tab	1 tab
Abilify	15 mg	QD		1 tab	1 tab	1 tab
Abilify	20 mg	QD			1 tab	1 tab
Abilify	30 mg	QD				1 tab
Abilify Discmelt	10 mg	QD		1 tab	2 tabs	2 tabs
Abilify Discmelt	15 mg	QD		1 tab	1 tab	2 tabs
Abilify Solution	1 mg/mL	QD	5 mL	15 mL	20 mL	30 mL
Chlorpromazine	10 mg	BID-QID	4 tabs	4 tabs	4 tabs	4 tabs
Chlorpromazine	25 mg	BID-QID	4 tabs	4 tabs	4 tabs	4 tabs
Chlorpromazine	50 mg	BID-QID	2 tabs	4 tabs	4 tabs	4 tabs
Chlorpromazine	100 mg	BID-QID	1 tab	2 tabs	4 tabs	4 tabs
Chlorpromazine	200 mg	BID-QID		1 tab	2 tabs	3 tabs
Fanapt	1 mg	BID	2 tabs	2 tabs	2 tabs	2 tabs
Fanapt	2 mg	BID	1 tab	2 tabs	2 tabs	2 tabs
Fanapt	4 mg	BID		1 tab	2 tabs	2 tabs
Fanapt	6 mg	BID			1 tab	2 tabs
Fanapt	8 mg	BID			1 tab	2 tabs
Fanapt	10 mg	BID				1 tab
Fanapt	12 mg	BID				1 tab
Fluphenazine	1 mg	BID-QID	2 tabs	4 tabs	4 tabs	4 tabs
Fluphenazine	2.5 mg	BID-QID		2 tabs	4 tabs	4 tabs
Fluphenazine	5 mg	BID-QID		1 tab	2 tabs	4 tabs
Fluphenazine	10 mg	BID-QID			1 tab	2 tabs
Fluphenazine Elixir	2.5 mg/5 mL	BID-QID	4 mLs	10 mL	20 mL	40 mL
Fluphenazine Soln	5 mg/mL	BID-QID	0.4 mL	1 mL	2 mL	4 mL
Geodon	20 mg	BID	2 caps	2 caps	2 caps	2 caps
Geodon	40 mg	BID		1 cap	2 caps	2 caps
Geodon	60 mg	BID		1 cap		2 caps
Geodon	80 mg	BID				2 caps
Haloperidol	0.5 mg	BID-TID	3 tabs	3 tabs	3 tabs	3 tabs

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Drug	Strength	FDA Dosing	< 6* years of age	6*–9 years of age	10–12 years of age	13–17 years of age
Haloperidol	1 mg	BID-TID	2 tabs	3 tabs	3 tabs	3 tabs
Haloperidol	2 mg	BID-TID	1 tab	2 tabs	3 tabs	3 tabs
Haloperidol	5 mg	BID-TID		1 tab	2 tabs	3 tabs
Haloperidol	10 mg	BID-TID			1 tab	2 tabs
Haloperidol	20 mg	BID-TID				1 tab
Haloperidol Soln	2 mg/mL	BID-TID	1 mL	2.5 mL	5 mL	10 mL
Invega	1.5 mg	QD	1 tab	1 tab	1 tab	1 tab
Invega	3 mg	QD	1 tab	1 tab	1 tab	1 tab
Invega	6 mg	QD			1 tab	1 tab
Invega	9 mg	QD				1 tab
Latuda	20 mg	QD	1 tab	1 tab	1 tab	1 tab
Latuda	40 mg	QD		1 tab	1 tab	1 tab
Latuda	60 mg	QD				1 tab
Latuda	80 mg	QD				1 tab
Latuda	120 mg	QD				
Loxapine	5 mg	BID	2 caps	2 caps	2 caps	2 caps
Loxapine	10 mg	BID	1 cap	2 caps	2 caps	2 caps
Loxapine	25 mg	BID				2 caps
Loxapine	50 mg	BID				1 cap
Orap	1 mg	QD-BID	1 tab	1 tab	1 tab	1 tab
Orap	2 mg	QD-BID		1 tab	2 tabs	5 tabs
Perphenazine	2 mg	BID-QID	2 tabs	3 tabs	4 tabs	4 tabs
Perphenazine	4 mg	BID-QID	1 tab	1 tab	2 tabs	4 tabs
Perphenazine	8 mg	BID-QID			1 tab	2 tabs
Perphenazine	16 mg	BID-QID				1 tab
Rexulti	0.25 mg	QD				1 tab
Rexulti	0.5 mg	QD				1 tab
Rexulti	1 mg	QD				1 tab
Rexulti	2 mg	QD				1 tab
Rexulti	3 mg	QD				1 tab
Rexulti	4 mg	QD				1 tab
Risperdal	0.25 mg	BID	2 tabs	2 tabs	2 tabs	2 tabs
Risperdal	0.5 mg	BID	2 tabs	2 tabs	2 tabs	2 tabs
Risperdal	1 mg	BID	2 tabs	2 tabs	2 tabs	2 tabs
Risperdal	2 mg	BID	1 tab	2 tabs	2 tabs	2 tabs

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Drug	Strength	FDA Dosing	< 6* years of age	6*–9 years of age	10–12 years of age	13–17 years of age
Risperdal	3 mg	BID			2 tabs	2 tabs
Risperdal	4 mg	BID		1 tab	1 tab	2 tabs
Risperdal M Tab	0.25 mg	BID	2 tabs	2 tabs	2 tabs	2 tabs
Risperdal M Tab	0.5 mg	BID	2 tabs	2 tabs	2 tabs	2 tabs
Risperdal M Tab	1 mg	BID	2 tabs	2 tabs	2 tabs	2 tabs
Risperdal M Tab	2 mg	BID	1 tab	2 tabs	2 tabs	2 tabs
Risperdal M Tab	3 mg	BID			2 tabs	2 tabs
Risperdal M Tab	4 mg	BID		1 tab	1 tab	2 tabs
Risperdal Soln	1 mg/mL	BID	2 mL	4 mL	6 mL	8 mL
Saphris SL	5 mg	BID	1 tab	1 tab	2 tabs	2 tabs
Saphris SL	10 mg	BID			1 tab	2 tabs
Saphris SL	2.5 mg	BID	2 tabs	2 tabs	2 tabs	2 tabs
Seroquel	25 mg	TID	3 tabs	3 tabs	3 tabs	3 tabs
Seroquel	50 mg	TID	3 tabs	3 tabs	3 tabs	3 tabs
Seroquel	100 mg	TID	1 tab	3 tabs	3 tabs	3 tabs
Seroquel	200 mg	TID		1 tab	3 tabs	3 tabs
Seroquel	300 mg	TID		1 tab	2 tabs	2 tabs
Seroquel	400 mg	TID			1 tab	2 tabs
Seroquel XR	50 mg	QD	2 tabs	2 tabs	2 tabs	2 tabs
Seroquel XR	150 mg	QD	1 tab	1 tab	1 tab	1 tab
Seroquel XR	200 mg	QD		1 tab	1 tab	1 tab
Seroquel XR	300 mg	QD		1 tab	2 tabs	2 tabs
Seroquel XR	400 mg	QD			1 tab	2 tabs
Thioridazine	10 mg	BID-TID	3 tabs	3 tabs	3 tabs	3 tabs
Thioridazine	25 mg	BID-TID	2 tabs	3 tabs	3 tabs	3 tabs
Thioridazine	50 mg	BID-TID	1 tab	2 tabs	3 tabs	3 tabs
Thioridazine	100 mg	BID-TID		1 tab	1 tab	2 tabs
Thiothixene	1 mg	TID	3 caps	3 caps	3 caps	3 caps
Thiothixene	2 mg	TID	3 caps	3 caps	3 caps	3 caps
Thiothixene	5 mg	TID	1 cap	1 cap	1 cap	3 caps
Thiothixene	10 mg	TID				1 cap
Trifluoperazine	1 mg	QD-BID	1 tab	2 tabs	2 tabs	2 tabs
Trifluoperazine	2 mg	QD-BID		1 tab	2 tabs	2 tabs
Trifluoperazine	5 mg	QD-BID			1 tab	2 tabs
Trifluoperazine	10 mg	QD-BID				1 tab

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Drug	Strength	FDA Dosing	< 6* years of age	6*–9 years of age	10–12 years of age	13–17 years of age
Vraylar	0.5 mg	QD			1 cap	1 cap
Vraylar	0.75 mg	QD			1 cap	1 cap
Vraylar	1.5 mg	QD			1 cap	1 cap
Vraylar	3 mg	QD			1 cap	1 cap
Vraylar	4.5 mg	QD			1 cap	1 cap
Zyprexa	2.5 mg	QD	1 tab	1 tab	1 tab	1 tab
Zyprexa	5 mg	QD	1 tab	1 tab	1 tab	1 tab
Zyprexa	7.5 mg	QD		1 tab	1 tab	1 tab
Zyprexa	10 mg	QD		1 tab	1 tab	1 tab
Zyprexa	15 mg	QD			1 tab	1 tab
Zyprexa	20 mg	QD				1 tab
Zyprexa Zydis	5 mg	QD	1 tab	1 tab	1 tab	1 tab
Zyprexa Zydis	10 mg	QD		1 tab	1 tab	1 tab
Zyprexa Zydis	15 mg	QD			1 tab	1 tab
Zyprexa Zydis	20 mg	QD				1 tab
*Prior authorization required through manual review for beneficiaries < 10 years of age.						

MAX DAILY DOSES FOR AGE CATEGORIES < 18 YEARS OF AGE

Drug	< 6* years of age	6*–9 years of age	10–12 years of age	13–17 years of age
Abilify	5 mg daily	15 mg daily	20 mg daily	30 mg daily
Geodon	40 mg daily	60 mg daily	80 mg daily	160 mg daily
Invega	3 mg daily	3 mg daily	6 mg daily	9 mg daily
Risperdal	2 mg daily	4 mg daily	6 mg daily	8 mg daily
Seroquel	150 mg daily	300 mg daily	600 mg daily	800 mg daily
Zyprexa	5 mg daily	10 mg daily	15 mg daily	20 mg daily
*Prior authorization required through manual review for beneficiaries < 10 years of age.				

CPT CODES FOR GLUCOSE AND LIPID MONITORING

Glucose codes: Criteria require **one** of the following CPT codes that contain glucose monitoring in the previous 9 months from claim date of in-process claim:

- 83036 (HbA1c); **OR**
- 80050 (General Health Panel); **OR**
- 80069 (Renal Function Panel); **OR**
- 80047 (Basic Metabolic Panel); **OR**
- 80048 (Basic Metabolic Panel); **OR**

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- 80053 (Comprehensive metabolic panel); **OR**
- 82962 (Glucose, blood by glucose monitoring device(s) cleared by the FDA specifically for home use); **OR**
- 82948 (Glucose; blood, reagent strip); **OR**
- 82947 (Glucose; quantitative, blood); **AND**
- Criteria require **one** of the following lipid panel tests or all of the individual lipid test monitoring codes in previous 9 months from claim date of the in-process claim:

Lipid codes:

- 80061 (Lipid panel); **OR**
- 83701 (High resolution fractionation and quantitation of lipoproteins panel); **OR**
- 82465 (Cholesterol, serum or whole blood, total); **AND**
  - 83718 (HDL cholesterol); **AND**
  - 84478 (Triglycerides); **AND**
  - 83721 (LDL Cholesterol); **OR**
- 83700 (Lipoprotein blood electrophoretic); **OR**
- 83704 (Lipoprotein blood quantitation particles); **OR**
- 83715 (Assay of blood lipoproteins); **OR**
- 83716 (Assay of blood lipoproteins); **OR**
- 83719 (Assay of blood lipoproteins); **OR**
- 83722 (Lipoprotein, direct measurement small dense LDL cholesterol)

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ANTIVIRAL AGENTS, GENERAL

Updated 10/1/2025

PREFERRED AGENTS

PAXLOVID (nirmatrelvir/ritonavir)

NON-PREFERRED AGENTS

XOCOVA (ensitrelvir)

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ANTIVIRAL AGENTS, ORAL

Updated 10/1/2025

PREFERRED AGENTS

- acyclovir tablet and capsule (generic for ZOVIRAX)
- acyclovir oral suspension (generic for ZOVIRAX)
- oseltamivir (generic for TAMIFLU)
- valacyclovir (generic for VALTREX)

NON-PREFERRED AGENTS

- famciclovir (generic for FAMVIR)
- FLUMADINE (rimantadine)
- RELENZA (zanamivir)
- rimantadine (generic for FLUMADINE)
- TAMIFLU (oseltamivir)
- VALTREX (valacyclovir)
- XOFLUZA (baloxavir)

AGE EDITS

- acyclovir suspension – Available for beneficiaries < 7 years of age without a prior authorization
- oseltamivir suspension – Available for beneficiaries < 13 years of age without a prior authorization

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ATRASENTIN HCL (VANRAFIA)

Updated 7/16/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary is diagnosed with primary immunoglobulin A nephropathy (IgAN) confirmed by biopsy and at risk for rapid disease progression, generally a urine protein-to-creatinine ratio (UPCR) ≥ 1.5 g/g
- The medication must be prescribed by or in consultation with a nephrologist
- The beneficiary must demonstrate continued risk for disease progression with proteinuria ≥ 0.5 g/day, despite at least 3 months of maximally tolerated supportive care (i.e., angiotensin-converting enzyme [ACE] inhibitor or angiotensin-receptor blocker [ARB], immunosuppressive therapy, sodium-glucose co-transporter 2 [SGLT2] inhibitor)
- The beneficiary must remain on supportive care at maximally tolerated doses unless contraindicated
- The beneficiary of reproductive potential should have a negative pregnancy test prior to beginning this medication and use effective contraception throughout the use of this medication
- The beneficiary does not have severe hepatic impairment
- The prescriber must submit the following:
  - Current chart notes
  - Previous therapies
  - Current labs, including LFTs, eGFR (≥ 30 mL/min/1.73 m^2), lipid panel, and urine protein or UPCR
  - Confirmation of the IgAN diagnosis with renal biopsy results and labs; **AND**
  - Attestation that the beneficiary has tested negative for pregnancy if of reproductive potential

RENEWAL REQUIREMENTS

- The beneficiary has been compliant with therapy (defined as 75% utilization)
- The beneficiary has documented improvement in proteinuria with a reduction in urine protein-to-creatinine ratio (UPCR) or urine protein from baseline
- The prescriber must submit the following:
  - Current chart notes
  - Current labs, including LFTs, eGFR, lipid panel, and urine protein or UPC; **AND**

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- Attestation that the beneficiary of reproductive potential has tested negative for pregnancy and beneficiary remains on contraception

QUANTITY EDITS

31 tablets per 31 days

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APOMORPHINE 98 MG/20 ML INJECTION (ONAPGO)

Updated 4/16/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with advanced Parkinson's disease and experiencing continued motor fluctuations despite compliance on carbidopa/levodopa **or** a diagnosis consistent with any new FDA-approved indications. Any off-label requests will be reviewed on a case-by-case basis.
- The prescriber must attest that the beneficiary and caregivers have been counseled on potential adverse effects that require monitoring and a dose reduction or discontinuation (i.e., hemolytic anemia, reduced resting blood pressure, increase in falls, psychotic-like behavior)
- The beneficiary must continue to have motor fluctuations with a minimum of 3 hours of "off" time per day.
- The beneficiary should not be approved or continue the medication if meet **one** of the following:
  - Requires the concomitant use of 5HT3 antagonists (e.g., ondansetron, granisetron, dolasetron, palonosetron)
  - Develops significant daytime sleepiness that interferes with normal daily function (e.g., conversations, eating, driving)
  - Drinks alcohol
  - Has severe renal or severe hepatic impairment; **OR**
  - Pregnant
- The prescriber must submit the following:
  - Current chart notes
  - Current symptoms of Parkinson's Disease
  - Negative pregnancy test for female beneficiary of reproductive potential
  - Average number of "off" hours per day; **AND**
  - Medical necessity over increasing the dose on long and short acting oral carbidopa/levodopa products

RENEWAL REQUIREMENTS

- The beneficiary is compliant with therapy (defined as 75% utilization)
- The beneficiary demonstrates a decrease in "off" hours compared to baseline
- The prescriber must submit the following:

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- Current chart notes
- Documentation of response to therapy; **AND**
- Attestation that the beneficiary continues to be monitored for potential adverse reactions (i.e., excessive daytime sleepiness, increase in falls, hemolytic anemia, psychotic-like behavior)

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APROCITENTAN (TRYVIO)

Updated 7/17/2024

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary is diagnosed with hypertension that is not adequately controlled on at least 3 other antihypertensive drugs **or** a diagnosis consistent with any new FDA-approved indications. Any off-label requests will be reviewed on a case-by-case basis.
- The beneficiary must continue standard of care antihypertensive medications in combination with TRYVIO
- The prescriber and dispensing pharmacy must be enrolled in the TRYVIO REMS program
- The beneficiary should not be approved or continue this therapy with any of the following:
  - Pregnancy
  - Baseline ALT/AST 3 times ULN or moderate to severe hepatic impairment
  - New York Heart Association (NYHA) class III to IV heart failure, unstable cardiac function, or NTproBNP $\geq$ 500 pg/mL; **OR**
  - Non-compliant on standard of care pharmacologic treatment at maximally tolerated doses with 3 antihypertensive medications at the same time. Therapies vary by beneficiary, but they typically include ACE inhibitor/ARB, calcium channel blocker, and thiazide diuretic. Optional medications may include beta blockers, alpha blockers, spironolactone, hydralazine, or minoxidil.
- The prescriber must submit the following:
  - Current chart notes
  - Current and previous pharmacologic therapies with pharmacy printouts if new to Medicaid
  - Current blood pressure and blood pressure history if available along with blood pressure cuff size
  - Current labs, including CBC (for hemoglobin), LFTs, pregnancy test if female of reproductive potential; **AND**
  - Current weight to monitor for fluctuations due to potential edema

RENEWAL REQUIREMENTS

- The beneficiary must remain compliant on therapy as ordered by the prescriber (defined as 75% utilization)
- The beneficiary should demonstrate improvement in blood pressure compared to baseline
- The prescriber should submit the following:
  - Current chart notes

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- Current blood pressure
- Current labs, including CBC and LFTs; **AND**
- Current weight

QUANTITY EDITS

31 tablets per 31 days

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ARIMOCLOMAL CITRATE (MIPLYFFA)

Updated 01/15/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must have a diagnosis of Niemann-Pick disease type C (NPC) with variants in the NPC1 or NPC2 genes with neurological manifestations (e.g., gait problems, ataxia, cognitive deterioration, or vertical gaze palsy) and prescribed concomitant miglustat **or** a diagnosis consistent with any new FDA-approved indications. Any off-label requests will be reviewed on a case-by-case basis.
- The medication must be prescribed by or in consultation with a geneticist, neurologist, or other specialist with expertise in the treatment of NPD
- The beneficiary with eGFR ≥ 15 to < 50 mL/minute should decrease MIPLYFFA dose frequency
- The beneficiary should not be approved or continue the medication if they meet **one** of the following:
  - Weighs < 8 kg
  - Pregnant
  - Dose requested does not match weight-based dosing found in the package insert
  - Prescribed AQNEURSA (levacetylleucine) to be used concomitantly; **OR**
  - eGFR< 15 mL/minute
- The prescriber must submit the following:
  - Current chart notes
  - Previous therapies tried with response
  - Molecular genetic testing results confirming biallelic pathogenic variants in the NPC1 or NPC2 genes
  - Current labs, including eGFR
  - Current weight and dose requested
  - Neurological symptoms for this specific beneficiary
  - Negative pregnancy test results if applicable
  - Attestation that female beneficiary of reproductive potential has been counseled on the importance of effective contraception; **AND**
  - Letter of medical necessity for the use over AQNEURSA (levacetylleucine) for this specific beneficiary

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RENEWAL REQUIREMENTS

- The beneficiary remains compliant with therapy (defined as 75% utilization)
- The beneficiary demonstrates a positive response with a decrease or slowed progression in neurological symptoms compared to baseline
- The prescriber must submit the following:
  - Current chart notes
  - Response to treatment with updated description of symptoms; **AND**
  - Attestation that female beneficiary of reproductive potential has been counseled on the importance of continuing effective contraception and is not currently pregnant

QUANTITY EDITS

90 capsules per 30 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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ASFOTASE ALFA INJECTION (STRENSIQ)

Updated 1/15/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must be diagnosed with perinatal/infantile- or juvenile-onset hypophosphatasia (HPP) confirmed by both of the following:
  - Clinical manifestations consistent with hypophosphatasia (e.g., radiographic evidence, rachitic chest deformity, vitamin B6-dependent seizures, or failure to thrive); **AND**
  - Both biochemical and molecular genetic testing confirm diagnosis
- The prescriber must submit the following:
  - Current chart notes with the following parameters as baseline:
    - Current height and weight
    - Current respiratory status (e.g., PFTs, vent settings)
    - Baseline detailed radiology report to compare for efficacy on PA renewal (e.g., x-rays, or other scans)
    - Baseline ophthalmology exam
    - Baseline renal ultrasound; **AND**
    - Attestation that the caregiver has been trained in administration
  - Outlined treatment plan
    - Document how response to treatment will be determined when compared to baseline parameters (specifically growth and radiographical findings) as improvement or lack of improvement could determine if the medication will be continued or if a dose change is needed.
    - Timeline for reassessment of response to treatment compared to baseline
- Since dosing is weight-based, initial prior authorizations may require a more frequent review. Once the beneficiary's weight becomes stable, longer prior authorization durations may be approved.

RENEWAL REQUIREMENTS

- The prescriber must submit the following:
  - Current chart notes with updated height and weight to confirm weight-based dose is correct
  - Updated respiratory status, new radiology reports and ophthalmology reports if available (updated information expected at least every 6 months); **AND**
  - Requested dose
- The beneficiary must demonstrate a positive response in growth or radiographical findings to continue treatment beyond 12 months

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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IMMUNOMODULATORS, ATOPIC DERMATITIS (TOPICALS AND BIOLOGICS)

Updated 10/1/2026

PREFERRED AGENTS

tacrolimus ointment (generic for PROTOPIC)

PREFERRED INJECTABLES WITH CRITERIA (*SPECIFIC MANUAL REVIEW CRITERIA)

- ADBRY* (tralokinumab-ldrm)
- DUPIXENT* (dupilumab)
- EBGLYSS* (lebrikizumab-lbkz)

PREFERRED TOPICAL AGENTS WITH CRITERIA

- EUCRISA (crisaborole)
- OPZELURA (ruxolitinib) (see OPZELURA cream for nonsegmental vitiligo)
- VTAMA (tapinarof) (see VTAMA cream for plaque psoriasis)

NON-PREFERRED AGENTS WITH CRITERIA (*SPECIFIC MANUAL REVIEW CRITERIA)

- ADQUEY* (difamilast)
- ANZUPGO* (delgocitinib)
- CIBINQO* (abrocitinib)
- NEMLUVIO* (nemolizumab-ilto)
- pimecrolimus (generic for ELIDEL)
- RINVOQ* (upadacitinib)
- ZORYVE* cream (roflumilast) (see ZORYVE 0.3% cream)
- ZORYVE* foam (roflumilast) (see ZORYVE foam)

APPROVAL CRITERIA FOR ATOPIC DERMATITIS

For ADBRY, CIBINQO, DUPIXENT, EBGLYSS, NEMLUVIO, AND RINVOQ

- The medication must be prescribed by or in consultation with a dermatologist, rheumatologist, or other specialist treating atopic dermatitis
- The beneficiary has a documented diagnosis of moderate to severe atopic dermatitis with at least **one** of the following (baseline at time of biologic request documented on the request):
  - Baseline impacted body surface area (BSA) ≥ 10%
  - Baseline Eczema Area and Severity Index (EASI) total score of ≥ 16
  - Baseline weekly averaged peak pruritis Numeric Rating Scale (NRS) ≥ 7
  - Baseline Investigator's Global Assessment (IGA) score ≥ 3
  - Baseline Scoring Atopic Dermatitis (SCORAD) score ≥ 25

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- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed a dose that meets the package insert requirements for indication, age, and weight or supported in the official Compendia
- The beneficiary has no therapeutic duplication with other monoclonal antibodies prescribed for atopic dermatitis
- If the request is for a non-preferred medication, the beneficiary must have tried and failed at least two preferred biologics with this indication before non-preferred options can be approved unless there is a beneficiary specific contraindication to the preferred option(s).
- The beneficiary must have a trial and failure of topical therapy and at a minimum must include the following:
  - One topical corticosteroid entity over a minimum of 60 days' use, with topical corticosteroids being either "high" potency (Class 2) **or** superpotent (Class 1) for adults **or** medium potency for children (unless contraindicated); **AND**
  - One topical calcineurin inhibitor (TCI) over a minimum of 30 days (e.g., pimecrolimus or tacrolimus)
- The prescriber must submit **all** of the following:
  - Current chart notes
  - Documentation of previous therapies with trial length of each medication
  - BSA prior to topical/systemic therapies and current impacted BSA
  - Baseline EASI, NRS, IGA and/or SCORAD and updated score with previous treatment
  - Drug claims data or retail pharmacy printout if the drug claims are not available in Medicaid drug claims history; **AND**
  - Letter of medical necessity over other treatment options for atopic dermatitis

RENEWAL REQUIREMENTS FOR ATOPIC DERMATITIS

For ADBRY, CIBINQO, DUPIXENT, EBGLYSS, NEMLUVIO, and RINVOQ

- The beneficiary is compliant on this medication
- The beneficiary must show continued positive treatment response with each PA request for continued prior approval with at least **one** of the following compared to baseline:
  - Decrease in severity scores
  - Decrease in BSA impacted; **OR**
  - Decrease in need for systemic or topical rescue treatment
- The beneficiary has no therapeutic duplication with other monoclonal antibodies prescribed for atopic dermatitis
- The prescriber must submit:
  - Current chart notes; **AND**
  - Current BSA and EASI, NRS, IGA or SCORAD (compared to baseline severity score)

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APPROVAL CRITERIA FOR TOPICAL ATOPIC DERMATITIS AGENTS

POINT OF SALE (POS) CRITERIA FOR EUCRISA

- Billed diagnosis of atopic dermatitis within the last two years
- One year lookback in Medicaid pharmacy history for topical therapy, including a trial of at least **ONE** of the following:
  - One topical corticosteroid that is considered either high potency (Class 2) or super potent (Class 1), depending on location of atopic dermatitis, for a minimum of 30 days; **OR**
  - At least one topical calcineurin inhibitor (TCI) for a minimum of 30 days (e.g., tacrolimus, pimecrolimus); **OR**
  - At least one claim for EUCRISA (crisaborole)
- If beneficiary does not meet the above, a prior authorization request will be required.

APPROVAL CRITERIA FOR EUCRISA (IF BENEFICIARY DOES NOT MEET POS EDIT)

- The beneficiary must be ≥ 3 months of age
- The beneficiary should have uncontrolled mild to moderate atopic dermatitis defined by an Investigator's Global Assessment (IGA) score of 2–3 out of a 0–4 scale, or a diagnosis consistent with FDA indications with recent claim(s) for topical steroids **OR** topical calcineurin inhibitors (TCI), defined as:
  - One topical corticosteroid that is considered either high potency (Class 2) or super potent (Class 1), depending on location of atopic dermatitis, for a minimum of 30 days; **OR**
  - At least one trial of a topical calcineurin inhibitor (TCI) for a minimum of 30 days (e.g., tacrolimus, pimecrolimus)
- The prescriber must submit all of the following:
  - Current chart notes
  - Documentation of previous therapies
  - Current IGA score; **AND**
  - Current baseline Itch Numerical Rating Scale (Itch NRS)

POINT OF SALE (POS) CRITERIA FOR OPZELURA

- Billed diagnosis of atopic dermatitis within the last two years
- One year lookback in Medicaid pharmacy history for **ONE** of the following:
  - One topical corticosteroid that is considered either high potency (Class 2) or super potent (Class 1), depending on location of atopic dermatitis, for a minimum of 30 days; **OR**
  - One trial of a topical calcineurin inhibitor (TCI) for a minimum of 30 days (e.g., tacrolimus, pimecrolimus); **OR**
  - One claim for OPZELURA (ruxolitinib)
- If beneficiary does not meet the above, a prior authorization request will be required.

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APPROVAL CRITERIA FOR OPZELURA (IF BENEFICIARY DOES NOT MEET POS EDIT)

- The beneficiary must be ≥ 2 years of age
- The beneficiary should have uncontrolled mild to moderate atopic dermatitis defined by an Investigator's Global Assessment (IGA) score of 2–3 out of a 0–4 scale with recent claim(s) for topical steroids **OR** topical calcineurin inhibitors (TCI), defined as:
  - One topical corticosteroid that is considered either high potency (Class 2) or super potent (Class 1), depending on location of atopic dermatitis, for a minimum of 30 days; **OR**
  - One topical calcineurin inhibitor (TCI) for a minimum of 30 days (e.g., tacrolimus, pimecrolimus)
- The prescriber must submit all of the following:
  - Current chart notes
  - Documentation of previous therapies
  - Current IGA score; **AND**
  - Current baseline Itch Numerical Rating Scale (Itch NRS)
- If approved, PA will be approved for 2 months

POINT OF SALE (POS) CRITERIA FOR VTAMA

- Billed diagnosis of atopic dermatitis within the last two years
- One year lookback in Medicaid pharmacy history for topical therapy, including a trial of at least **ONE** of the following:
  - One topical corticosteroid that is considered either high potency (Class 2) or super potent (Class 1), depending on location of atopic dermatitis, for a minimum of 30 days; **OR**
  - One topical calcineurin inhibitor (TCI) for a minimum of 30 days (e.g., tacrolimus, pimecrolimus); **OR**
  - One claim for VTAMA (tapinarof)
- If beneficiary does not meet the above, a prior authorization request will be required.

APPROVAL CRITERIA FOR VTAMA (IF BENEFICIARY DOES NOT MEET POS EDIT)

- The beneficiary must be ≥ 2 years of age
- The beneficiary must have uncontrolled atopic dermatitis with recent claim(s) for topical steroids **OR** topical calcineurin inhibitors (TCI), defined as:
  - One topical corticosteroid that is considered either high potency (Class 2) or super potent (Class 1), depending on location of atopic dermatitis, for a minimum of 30 days; **OR**
  - One topical calcineurin inhibitor (TCI) over a minimum of 30 days (e.g., tacrolimus, pimecrolimus)
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of previous therapies
  - Current IGA score; **AND**

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  - Current baseline Itch Numerical Rating Scale (Itch NRS)
- If approved, PA will be approved for 2 months

APPROVAL CRITERIA FOR ADQUEY AND ZORYVE 0.05%/0.15% CREAM (FOAM AND 0.3% CREAM CRITERIA ARE LISTED SEPARATELY)

- The beneficiary must be ≥ 2 years of age for ADQUEY **OR** 2–5 years of age for ZORYVE 0.05% and ≥ 6 years of age for ZORYVE 0.15%
- The beneficiary should have uncontrolled mild to moderate atopic dermatitis, defined by an Investigator's Global Assessment (IGA) score of 2–3 out of a 0–4 scale with a trial and failure of topical therapy and at a minimum must include at least **TWO** of the following:
  - One topical corticosteroid that is considered either high potency (Class 2) or super potent (Class 1), depending on location of atopic dermatitis, for a minimum of 30 days
  - One topical calcineurin inhibitor (TCI) for a minimum of 30 days (e.g., tacrolimus, pimecrolimus)
  - One other preferred topical atopic dermatitis product for a minimum of 30 days (e.g., crisaborole, ruxolitinib, tapinarof)
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of previous therapies
  - Current IGA score; **AND**
  - Current baseline Itch Numerical Rating Scale (Itch NRS); **AND**
  - Medical necessity over preferred topical products for atopic dermatitis
- If approved, PA will be approved for 2 months

QUANTITY EDITS FOR ATOPIC DERMATITIS

- ADQUEY: 6 tubes per year (1 tube per claim)
- EUCRISA: Max of 300 grams per year
  - 60 gm tube: 5 tubes per year
  - 100 gm tube: 3 tubes per year
- OPZELURA: 4 tubes per year (1 tube per claim)
- VTAMA: 6 tubes per year (1 tube per claim)
- ZORYVE: 6 tubes per year (1 tube per claim)

APPROVAL CRITERIA FOR CHRONIC HAND ECZEMA

For ANZUPGO:

- The beneficiary must be ≥ 18 years of age
- The beneficiary should have moderate to severe chronic hand eczema (CHE) defined by an Investigator's Global Assessment (IGA) score of 3–4 out of a 0–4 scale **or** Investigator's Global Assessment of Chronic Hand Eczema (IGA-CHE) score of 3–4 out of a 0–4 scale with recent topical therapy claims including at least the following:

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  - One topical corticosteroid either high potency (Class 2) or super potent (Class 1) over a minimum of 30 days; **AND**
  - One topical calcineurin inhibitor TCI (e.g., tacrolimus, pimecrolimus) OR PDE4 inhibitor (e.g., crisaborole) over a minimum of 30 days
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of previous therapies; **AND**
  - Current Investigator's Global Assessment (IGA) score **or** Investigator's Global Assessment of Chronic Hand Eczema (IGA-CHE)
- If approved, PA will be approved for 2 months

RENEWAL REQUIREMENTS FOR CHRONIC HAND ECZEMA

For ANZUPGO:

- The beneficiary must have documented improvement in symptoms (i.e., reduced IGA or IGA-CHE score)
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Current Investigator's Global Assessment (IGA) score **or** Investigator's Global Assessment of Chronic Hand Eczema (IGA-CHE) score

QUANTITY EDITS FOR CHRONIC HAND ECZEMA

ANZUPGO: 1 tube (30 grams per 30 days)

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ATOVAQUONE (MEPRON)

Updated 9/21/2009

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

DRUGS THAT DO NOT REQUIRE PRIOR AUTHORIZATION

Generic MAC'd sulfamethoxazole-trimethoprim tablets are available without a prior authorization.

DRUGS THAT REQUIRE MANUAL REVIEW FOR PRIOR AUTHORIZATION

MEPRON suspension

APPROVAL CRITERIA (CONTINUATION CRITERIA)

- One or more claims in the previous 60 days for MEPRON suspension
- Look back in pharmacy claims history 60 days for MEPRON suspension

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ATTENTION DEFICIT DISORDER AND ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADD/ADHD) AGENTS FOR CHILDREN (< 19 YEARS OF AGE)

Updated 7/1/2026

PREFERRED AGENTS WITH CRITERIA

- ADDERALL XR (amphetamine/dextroamphetamine salts)
- amphetamine/dextroamphetamine salts ER (generic for ADDERALL XR)
- amphetamine/dextroamphetamine salts IR (generic for ADDERALL IR)
- atomoxetine (generic for STRATTERA)
- clonidine IR 0.1 mg, 0.2 mg, and 0.3 mg tablet (generic for CATAPRES)
- clonidine ER (generic for KAPVAY ER)
- CONCERTA (methylphenidate ER)
- dexmethylphenidate ER (generic for FOCALIN XR)
- dexmethylphenidate IR (generic for FOCALIN)
- dextroamphetamine 5 mg and 10 mg tablet (generic for ZENZEDI)
- FOCALIN (dexmethylphenidate)
- FOCALIN XR (dexmethylphenidate ER)
- guanfacine IR (generic for TENEX)
- guanfacine ER (generic for INTUNIV ER)
- lisdexamfetamine (generic for VYVANSE)
- methylphenidate IR (generic for METHYLIN/RITALIN IR)
- methylphenidate ER (generic for CONCERTA)
- VYVANSE (lisdexamfetamine)

NON-PREFERRED AGENTS

- ADDERALL IR (amphetamine/dextroamphetamine salts)
- ADZENYS XR-ODT (amphetamine)
- amphetamine sulfate (generic for EVEKEO)
- amphetamine ER ODT (generic for ADZENYS XR-ODT)
- amphetamine/dextroamphetamine ER (generic for MYDAYIS ER)
- APTENSIO XR (methylphenidate)
- ARYNTA (lisdexamfetamine)
- atomoxetine (generic for ATONCY)
- ATONCY (atomoxetine)
- AZSTARYS (serdexmethylphenidate/dexmethylphenidate)
- clonidine ER (generic for NEXICLON XR)
- clonidine IR 0.05 mg tablet

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- COTEMPLA XR-ODT (methylphenidate)
- DEXEDRINE (dextroamphetamine)
- dextroamphetamine ER (generic for DEXEDRINE spansule)
- dextroamphetamine solution (generic for PROCENTRA)
- dextroamphetamine 2.5 mg, 7.5 mg, 15 mg, 20 mg, and 30 mg tablet (generic for ZENZEDI)
- DYANAVEL XR (amphetamine)
- EVEKEO (amphetamine)
- INTUNIV ER (guanfacine)
- JORNAY PM (methylphenidate)
- methamphetamine (generic for DESOXYN)
- METHYLIN solution (methylphenidate)
- methylphenidate chewable tablet (generic for METHYLIN chew tablet)
- methylphenidate CD/ER/LA capsule (generic for METADATE CD/RITALIN LA/APTENSIO XR)
- methylphenidate ER ODT (generic for COTEMPLA XR-ODT)
- methylphenidate ER tablet (generic for RELEXXII ER)
- methylphenidate ER tablet (generic for METADATE ER/RITALIN SR)
- methylphenidate patch (generic for DAYTRANA)
- methylphenidate solution (generic for METHYLIN)
- MYDAYIS ER (dextroamphetamine/amphetamine)
- NEXICLON XR (clonidine)
- ONYDA XR (clonidine)
- PROCENTRA (dextroamphetamine)
- QELBREE (viloxazine)
- QUILLICHEW ER (methylphenidate)
- QUILLIVANT XR (methylphenidate)
- RELEXXII ER (methylphenidate)
- RITALIN IR (methylphenidate)
- XELSTRYM (dextroamphetamine)
- ZENZEDI (dextroamphetamine)

APPROVAL CRITERIA FOR PREFERRED AGENTS WITH CRITERIA FOR CHILDREN < 19 YEARS OF AGE

- Beneficiaries < 6 years of age require a prior authorization request for all CII stimulants and non-stimulant medications.

All preferred **extended-release** CII stimulants:

- ≤ One therapeutic duplication between long-acting CII stimulants with 75% of the last fill per 93 days; **AND**

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- If an incoming long-acting CII stimulant claim overlaps with a short-acting CII stimulant that was filled at a dose of ≥ to 2 units per day, the long-acting product will require prior authorization

All preferred **immediate-release** CII stimulants:

- ≤ One therapeutic duplication between short-acting CII stimulants with 75% of the last fill per 93 days; **AND**
- If an incoming short-acting CII stimulant claim overlaps with a long-acting CII stimulant, the short-acting product will only be approved for a dose of one unit per day

ADDITIONAL CRITERIA

Quantity limits apply

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ATTENTION DEFICIT DISORDER AND ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADD/ADHD) AGENTS FOR ADULTS (19 YEARS OF AGE OR GREATER)

Updated 7/1/2026

PREFERRED AGENTS: MANUALLY REVIEWED AGENTS FOR ADULTS ≥ 19 YEARS OF AGE

- ADDERALL XR (amphetamine/dextroamphetamine salts)
- amphetamine/dextroamphetamine salts ER (generic for ADDERALL XR)
- amphetamine/dextroamphetamine salts IR (generic for ADDERALL IR)
- atomoxetine (generic for STRATTERA)
- clonidine 0.1 mg, 0.2 mg, and 0.3 mg tablet (generic for CATAPRES)
- clonidine ER (generic for KAPVAY ER)
- CONCERTA ER (methylphenidate ER)
- dexmethylphenidate ER (generic for FOCALIN XR)
- dexmethylphenidate IR (generic for FOCALIN)
- dextroamphetamine 5 mg and 10 mg tablet (generic for ZENZEDI)
- FOCALIN (dexmethylphenidate)
- FOCALIN XR (dexmethylphenidate ER)
- guanfacine IR (generic for TENEX)
- guanfacine ER (generic for INTUNIV ER)
- lisdexamfetamine (generic for VYVANSE)
- methylphenidate IR (generic for METHYLIN and RITALIN IR)
- methylphenidate ER (generic for CONCERTA)
- VYVANSE (lisdexamfetamine)

NON-PREFERRED AGENTS

- ADDERALL IR (amphetamine/dextroamphetamine salts)
- ADZENYS XR-ODT (amphetamine)
- amphetamine sulfate (generic for EVEKEO)
- amphetamine ER ODT (generic for ADZENYS XR-ODT)
- amphetamine/dextroamphetamine ER (generic for MYDAYIS ER)
- APTENSIO XR (methylphenidate)
- ARYNTA (lisdexamfetamine)
- atomoxetine (generic for ATONCY)
- ATONCY (atomoxetine)
- AZSTARYS (serdexmethylphenidate/dexmethylphenidate)
- clonidine 0.05 mg tablet

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- clonidine ER tablet (generic for NEXICLON XR)
- COTEMPLA XR-ODT (methylphenidate)
- DEXEDRINE (dextroamphetamine)
- dextroamphetamine ER capsule (generic for DEXEDRINE)
- dextroamphetamine solution (generic for PROCENTRA)
- dextroamphetamine 2.5 mg, 7.5 mg, 15 mg, 20 mg, and 30 mg tablet (generic for ZENZEDI)
- DYANAVEL XR (amphetamine)
- EVEKEO (amphetamine)
- INTUNIV ER (guanfacine)
- JORNAY PM (methylphenidate)
- methamphetamine (generic for DESOXYN)
- METHYLIN solution (methylphenidate)
- methylphenidate chewable tablet (generic for METHYLIN chew tablet)
- methylphenidate CD/ER/LA capsule (generic for METADATE CD, RITALIN LA, and APTENSIO XR)
- methylphenidate ER ODT (generic for COTEMPLA XR-ODT)
- methylphenidate ER tablet (generic for RELEXXII ER)
- methylphenidate ER tablet (generic for METADATE ER and RITALIN SR)
- methylphenidate patch (generic for DAYTRANA)
- methylphenidate solution (generic for METHYLIN)
- MYDAYIS ER (dextroamphetamine/amphetamine)
- NEXICLON XR (clonidine)
- ONYDA XR (clonidine)
- PROCENTRA (dextroamphetamine)
- QELBREE (viloxazine)
- QUILLICHEW ER (methylphenidate)
- QUILLIVANT XR (methylphenidate)
- RELEXXII ER (methylphenidate)
- RITALIN IR (methylphenidate)
- XELSTRYM (dextroamphetamine)
- ZENZEDI (dextroamphetamine)

APPROVAL CRITERIA FOR CII STIMULANTS AND NON-STIMULANTS FOR ADULTS

- Completed CII stimulant form is required for beneficiaries ≥ 19 years of age: https://ar.primetherapeutics.com/forms-documents
- Currently, atomoxetine does not require a prior authorization
- The beneficiary has ADHD

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- The beneficiary must have signs/symptoms in two or more settings using a standardized rating scale with at least **one** of the following:
  - Currently attends school (high school, college, or vocational)
  - Currently employed; **OR**
  - Currently searching for employment (approval for a maximum of 3 months without documentation of employment)
- The beneficiary must have multiple symptoms of inattention and/or hyperactivity/impulsivity from the DSM-5 documented on the form for initial approval
- The beneficiary with co-morbid conditions of bipolar disorder or schizophrenia must be controlled and adherent with appropriate medication therapy, or prescriber must provide adequate documentation as to why the co-morbid condition is no longer being treated
- The pescriber must submit the following:
  - Completed CII stimulant form
  - Current chart notes; **AND**
  - Documentation needed to support the diagnosis of ADHD

- The beneficiary without ADHD may be approved for **one** of the following (each request is reviewed on a case-by-case basis for medical necessity):
  - Narcolepsy with sleep study results confirming diagnosis
  - Traumatic Brain Injury (TBI)
  - Fatigue due to underlying illness (i.e., cancer or multiple sclerosis); **OR**
  - Binge Eating Disorder (BED) – Vyvanse only

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AURANOFIN CAPSULE (RIDAURA)

Updated 1/15/2025

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must be diagnosed with rheumatoid arthritis and had an insufficient response to, or intolerance of, an adequate trial of full doses of one or more nonsteroidal anti-inflammatory drugs (NSAIDs).
- The beneficiary should not be approved or continue this therapy with any of the following:
  - Inadequate response after six month trial; **OR**
  - The prescriber requests a dose > 9 mg daily
- The prescriber must submit the following:
  - Current chart notes
  - Previous therapies tried with response; **AND**
  - Letter of medical necessity over NSAIDs

RENEWAL REQUIREMENTS

- The beneficiary must be compliant on therapy (defined as 75% utilization)
- The beneficiary must demonstrate a positive response after 6 months of usage
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Documentation of response to therapy

QUANTITY EDITS

60 capsules per 30 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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AVACOPAN (TAVNEOS)

Updated 1/19/2022

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary must be ≥ 18 years of age; **AND**
- The beneficiary must have a diagnosis of severe active anti-neutrophil cytoplasmic autoantibody (ANCA)-associated vasculitis with granulomatosis with polyangiitis (GPA) or microscopic polyangiitis (MPA) **or** a diagnosis consistent with FDA indications; **AND**
- The beneficiary had previous therapy with an immunosuppressant (i.e., rituximab or cyclophosphamide) and corticosteroids based on treatment guidelines; **AND**
- The beneficiary must be concomitantly prescribed standard therapy; **AND**
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Documentation of previous therapy; **AND**
  - Current labs, including positive ANCA test results, anti-PR3 and anti-MPO if available, baseline LFTs, and Hepatitis B serology (HBsAg and anti-HBc); **AND**
  - If available, chest x-ray or CT scan results are used for confirmation of diagnosis; **AND**
  - If available, biopsy reports are used for confirmation of diagnosis

DENIAL CRITERIA

- The beneficiary does not meet approval criteria **or** have a diagnosis supported on the official Compendia; **OR**
- The beneficiary has severe hepatic impairment **or** AST/ALT > 5 times the ULN **or** AST/ALT > 3 times the ULN with bilirubin > 2 times the ULN; **OR**
- The beneficiary should avoid the use of CYP3A4 inhibitors (e.g., ketoconazole, cyclosporine, erythromycin) if possible. If concomitant use is required, TAVNEOS dose should be decreased to 30 mg once daily; **OR**
- The beneficiary develops reactivation of HBV while on TAVNEOS; **OR**
- The beneficiary has an active, serious infection, including localized infections; **OR**
- The beneficiary is pregnant or breastfeeding

QUANTITY EDITS

180 capsules per 30 days

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AZITHROMYCIN 1 GRAM POWDER PACKET

Updated 1/15/2025

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must be diagnosed with a sexually transmitted disease caused by *C. trachomatis* **or** used for prevention of *Mycobacterium avium complex* (MAC) disease **or** used for treatment of *Mycobacterium avium complex* (MAC) disease
- Dose requested must be consistent with diagnosis
- The prescriber must submit the following:
  - Current chart notes
  - Dosage requested; **AND**
  - Medical necessity over other azithromycin products available without a PA

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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BAXDROSTAT (BAXFENDY)

Updated 7/15/2026

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert
- The beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert, or dosing is based on support from the official Compendia
- The beneficiary must have uncontrolled hypertension (defined as systolic blood pressure ≥ 140) while on at least 2 antihypertensive agents, including one diuretic
- The beneficiary must have eGFR ≥ 45 mL/min and serum potassium of ≥ 3.5 and < 5.0 mEq/L as baseline
- The beneficiary must be prescribed other antihypertensive drugs to be used concomitantly
- The prescriber must submit the following:
  - Current chart notes
  - Previous blood pressure medications trialed
  - Current labs, including renal function, serum potassium, and serum sodium
  - If the beneficiary has not tried spironolactone, medical necessity over the use of that medication must be provided
- Initial approval for 3 months with subsequent PA renewals for 6 months if medication is effective

RENEWAL REQUIREMENTS

- The beneficiary must remain compliant with therapy (defined as 75% utilization)
- The beneficiary must demonstrate a positive response with a decrease in blood pressure compared to baseline
- The prescriber must submit the following:
  - Current chart notes
  - Current medication list
  - Current blood pressure

QUANTITY EDITS

Both strengths: 31 tablets per 31 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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BEDAQUILINE FUMARATE (SIRTURO)

Updated 1/15/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must be diagnosed with pulmonary tuberculosis (TB) due to *Mycobacterium tuberculosis* which is resistant to at least rifampin and isoniazid.
- The beneficiary should not be approved or continue this therapy with any of the following:
  - Latent infection due to *Mycobacterium tuberculosis (M. tuberculosis)*
  - Drug-sensitive pulmonary TB
  - Extra-pulmonary TB; **OR**
  - Infections caused by non-tuberculous mycobacteria
- The prescriber must coordinate with the Arkansas Department of Health
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Previous therapies tried and failed

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BELIMUMAB (BENLYSTA)

Updated 4/21/2021

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must have a diagnosis of either active, autoantibody-positive systemic lupus erythematosus (SLE) who are receiving standard therapy **or** active lupus nephritis (LN) who are receiving standard therapy **or** a diagnosis consistent with any new FDA-approved indications. Any off-label requests will be reviewed on a case-by-case basis.
- The beneficiary with SLE must have:
  - Safety of Estrogens in Lupus Erythematosus National Assessment-Systemic Lupus Erythematosus Disease Activity Index (SELENA-SLEDAI) score of ≥ 8; **AND**
  - Positive autoantibody test (anti-nuclear antibody [ANA] and/or anti-double-stranded DNA [anti-dsDNA])
- The beneficiary with LN must have:
  - Clinical diagnosis of SLE; **AND**
  - Biopsy confirmed active lupus nephritis
- The beneficiary must take concomitant standard therapy which could include corticosteroids (e.g., prednisone), antimalarials (e.g., hydroxychloroquine), NSAIDs, and immunosuppressive (e.g., azathioprine, methotrexate, mycophenolate)
- The beneficiary should not be approved or continue this therapy with any of the following:
  - Progressive multifocal leukoencephalopathy (PML)
  - SELENA-SLEDAI score of < 8 and does not have a positive autoantibody test
  - Prescribed biologic therapies, anti-tumor necrosis factor therapy, interleukin-1 receptor antagonist, IVIG, or plasmapheresis in the previous 3 months; **OR**
  - Severe active CNS lupus
  - Pregnancy
  - Not taking concomitant standard therapy
- The prescriber must submit the following:
  - Current chart notes
  - Current labs, including CBC with differential, urine protein to creatinine (UPCR) ratio for LN beneficiary, serum potassium levels, and baseline estimated glomerular filtration rate (eGFR) for

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LN beneficiary. eGFR must be assessed every two weeks for the first month, and every four weeks thereafter
  - Current blood pressure; **AND**
  - Medical necessity over supported immunosuppressive therapy alone for SLE beneficiaries (i.e., mycophenolate mofetil or azathioprine).

RENEWAL REQUIREMENTS

- The beneficiary must be a responder with a decrease in corticosteroids usage/dosage **or** improved SELENA-SLEDAI score (for SLE) **or** improvement in UPCR or eGFR (for LN)
- The beneficiary is compliant with therapy (defined as 75% utilization)
- The prescriber must submit the following:
  - Current chart notes
  - Current labs, including eGFR and UPCR; **AND**
  - Current blood pressure

QUANTITY EDITS

4 syringes per 28 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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BENIGN PROSTATIC HYPERTROPHY (BPH) DRUGS

Updated 10/1/2025

PREFERRED AGENTS

- alfuzosin ER (generic for UROXATRAL)
- doxazosin (generic for CARDURA)
- dutasteride (generic for AVODART)
- finasteride (generic for PROSCAR)
  - Diagnosis of benign prostatic hypertrophy in the past 3 years
- tamsulosin (generic for FLOMAX)
- terazosin (generic for HYTRIN)

NON-PREFERRED AGENTS

- CARDURA (doxazosin)
- CARDURA XL (doxazosin)
- CIALIS (tadalafil)
  - Denial for diagnosis of erectile dysfunction
- dutasteride/tamsulosin (generic for JALYN)
- PROSCAR (finasteride)
- RAPAFLO (silodosin)
- silodosin (generic for RAPAFLO)
- tadalafil (generic for CIALIS)
  - Denial for diagnosis of erectile dysfunction
- TEZRULY (terazosin)

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BENZNIDAZOLE

Updated 1/15/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must be a pediatric beneficiary 2 to 12 years of age diagnosed with Chagas disease (American trypanosomiasis) caused by *Trypanosoma cruzi* **or** a diagnosis consistent with any new FDA-approved indications or support in the official Compendia. Any off-label requests will be reviewed on a case-by-case basis.
- The medication must be prescribed by or in consultation with an infectious disease specialist
- The beneficiary should not be approved or continue this therapy with any of the following:
  - Dose or duration of therapy that exceeds FDA-approved dose and duration
  - Taken disulfiram within the last two weeks
  - Diagnosed with Cockayne Syndrome; **OR**
  - Pregnancy
- The prescriber must submit the following:
  - Current chart notes
  - The prescriber must submit current weight. Weight-based dose will be calculated and monthly quantity entered at the time the PA is approved; **AND**
  - Attestation that females of reproductive potential are using effective contraception
- Length of PA shall not exceed 60 days

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BENZODIAZEPINE ORAL SOLID DOSAGE FORMS

Updated 3/08/2016

APPROVAL CRITERIA

- Unless otherwise stated, no therapeutic duplication is allowed between two benzodiazepines with > 10% of the days' supply remaining on the last fill
- Unless otherwise stated, the quantity edit of the single highest strength of a benzodiazepine tablet or capsule has been reduced to a maximum daily quantity of 2 units per day or a cumulative quantity of 62 units for a 31-day supply
- Unless otherwise stated, all other strengths of tablet or capsule forms of benzodiazepines have been reduced to a maximum daily quantity edit of 3 units per day or a cumulative quantity of 93 units for a 31-day supply
- Approval criteria for temazepam 7.5 mg capsule:
  - Long term care beneficiaries; **OR**
  - Beneficiaries who are 65 years of age or older

No PA required for requests for temazepam 7.5 mg capsule for the beneficiaries listed above

- Additional approval criteria for alprazolam XR (XANAX XR):
  - > 18 years of age; **AND**
  - ≥ 90 days of alprazolam XR therapy in the past 120 days
- Approval criteria for alprazolam orally disintegrating tablet (NIRAVAM):
  - > 18 years of age; **AND**
  - **One** of the following:
    - Long term care
    - NPO (Appendix A) within past 365 days
- An incoming claim for any benzodiazepine medication will trigger a search of the beneficiary's Medicaid medical diagnoses history for diagnosis of poisoning or overdose the previous 12 months.
- If a diagnosis for **poisoning (overdose) for opioids, narcotics, barbiturates, benzodiazepines, or "unspecified drug or substance"** is found in the Medicaid medical history in the previous 12 months, an incoming claim for an opioid pain medication or an incoming claim for a benzodiazepine medication will deny at point of sale.
- Beneficiaries who have a diagnosis of malignant cancer in the past 12 months are exempt from the diagnosis check for a poisoning (overdose) of opioids, narcotics, barbiturates, benzodiazepines, or unspecified drug or substance.

ADDITIONAL CRITERIA

- Quantity limits apply
- See chart below for summary of maximum daily quantity edits of solid oral dosage forms of benzodiazepines:

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Generic Name (Brand Name Reference Only)	Strength	Maximum Daily Quantity Edit (and Maximum Cumulative Quantity Edit per 31-Day Supply)
Alprazolam (Xanax) tablet and ODT	0.25 mg, 0.5 mg, 1 mg	3 units per day, (93)
Alprazolam (Xanax) tablet and ODT	2 mg	2 units per day, (62)
Chlordiazepoxide (Librium) Capsule	5 mg, 10 mg,	3 units per day, (93)
Chlordiazepoxide (Librium) Capsule	25 mg	2 units per day, (62)
Clonazepam (Klonopin) Tablet	0.125 mg, 0.25 mg, 0.5 mg, 1 mg	3 units per day, (93)
Clonazepam (Klonopin) Tablet	2 mg	2 units per day, (62)
Clonazepam ODT	0.125 mg, 0.25 mg, 0.5 mg, 1 mg	3 units per day, (93)
Clonazepam ODT	2 mg	2 units per day, (62)
Clorazepate (Tranxene) Tablet	3.75 mg, 7.5 mg,	3 units per day, (93)
Clorazepate (Tranxene) Tablet	15 mg	2 units per day, (62)
Diazepam (Valium) Tablet	2 mg, 5 mg	3 units per day, (93)
Diazepam (Valium) Tablet	10 mg	2 units per day, (62)
Lorazepam (Ativan) Tablet	0.5 mg, 1 mg	3 units per day, (93)
Lorazepam (Ativan) Tablet	2 mg	2 units per day, (62)
Oxazepam (Serax) Capsule	10 mg, 15 mg	3 units per day, (93)
Oxazepam (Serax) Capsule	30 mg	2 units per day, (62)
Clobazam (Onfi) Tablet	10 mg, 20 mg	2 units per day, (62)
Alprazolam (Xanax) ER and XR Tablet	0.5 mg, 1 mg, 2 mg, 3 mg	1 unit per day, (31)
Flurazepam (Dalmane) Capsule	15 mg, 30 mg	1 unit per day (31)
Temazepam (Restoril) Capsule	7.5 mg, 15 mg 30 mg 22.5 mg	1 unit per day (31)
Triazolam (Halcion) Tablet	0.125 mg, 0.25 mg	1 unit per day (31)
Estazolam (Prosom) Tablet	1 mg, 2 mg	1 unit per day (31)

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BENZODIAZEPINE ORAL LIQUID DOSAGE FORMS

Updated 12/07/2010

APPROVAL CRITERIA

- < 7 years of age; **OR**
- NPO (Appendix A) within the past 365 days

ADDITIONAL CRITERIA

Quantity limits apply

EXEMPTION CRITERIA

- midazolam 2 mg/mL syrup
- Claims for 30 mL or less will pay at point-of-sale for any age.

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BERDAZIMER (ZELSUVMI)

Updated 10/15/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with molluscum contagiosum (MC)
- The prescriber must submit the following:
  - Current chart notes
  - Previous therapies tried; **AND**
  - Medical necessity over cryotherapy and CONDYLOX

QUANTITY EDITS

3 tubes per year

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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BEREMAGENE GEPERPAVEC (VYJUVEK)

Updated 1/17/2024

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with dystrophic epidermolysis bullosa (DEB) with mutation(s) in the collagen type VII alpha 1 chain (COL7A1) gene **or** a diagnosis consistent with any new FDA-approved indications. Any off-label requests will be reviewed on a case-by-case basis.
- The beneficiary must have **one** or more chronic or recurrent open wounds with all of the following:
  - Adequate granulation tissue
  - Excellent vascularization
  - No evidence of active wound infection; **AND**
  - No evidence or history of squamous cell carcinoma
- The prescriber must be a dermatologist or wound care specialist with expertise in DEB
- VYJUVEK gel must be prepared by a pharmacy and delivered to the clinic or home setting to be administered by a healthcare professional or caregiver, and it should be used within 8 hours if left unrefrigerated. If immediate use is not possible, Vyjuvek gel can be refrigerated for up to 48 hours.
- The prescriber must submit **all** of the following:
  - Current chart notes
  - Documentation reporting the presence of the COL7A1 gene mutation
  - Plan for acquiring the medication and timeframe for application (application no more than 8 hours after prepared by the pharmacy if left unrefrigerated; administration syringes can be stored for up to 48 hours in the refrigerator)
    - Provide the name of specialty pharmacy/distributor
    - Provide expected delivery date
    - Provide date of Vyjuvek application
    - Provide the method of delivery (verify information with prescriber or beneficiary); **AND**
  - Baseline description of the wounds
- Initial PA will be for a maximum of 6 months

RENEWAL REQUIREMENTS

- The prescriber must submit the following:
  - Current chart notes

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- Response to therapy with description of the wounds; **AND**
- Medical necessity for continued use

- Treated wounds will be evaluated at 6 months for a positive clinical response with request for PA continuation reviewed on a case-by-case basis. Positive response may include:
  - Decrease in wound size
  - Increase in granulation tissue; **AND**
  - Complete wound closure

QUANTITY EDITS

1 kit per week

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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BETA ADRENERGIC BLOCKING AGENTS

Updated 10/1/2025

PREFERRED AGENTS

- acebutolol (generic for SECTRAL)
- atenolol (generic for TENORMIN)
- atenolol/chlorthalidone (generic for TENORETIC)
- bisoprolol fumarate 5 mg and 10 mg (generic for ZEBETA)
- bisoprolol/HCTZ (generic for ZIAC)
- carvedilol (generic for COREG)
- labetalol HCl 100 mg, 200 mg, and 300 mg tablet (generic for NORMODYNE)
- metoprolol succinate ER (generic for TOPROL XL)
- metoprolol tartrate 25 mg, 37.5 mg, 50 mg, 75 mg, and 100 mg tablet (generic for LOPRESSOR)
- nebivolol HCl (generic for BYSTOLIC)
- propranolol HCl ER (generic for INDERAL LA/INNOPRAN XL)
- propranolol HCl IR tablet (generic for INDERAL)
- sotalol (generic for BETAPACE)
- sotalol AF (generic for BETAPACE AF)

NON-PREFERRED AGENTS

- BETAPACE (sotalol)
- BETAPACE AF (sotalol)
- betaxolol (generic for KERLONE)
- bisoprolol fumarate 2.5 mg (generic for ZEBETA)
- BYSTOLIC (nebivolol)
- carvedilol ER (generic for COREG CR)
- HEMANGEOL (propranolol)
- INDERAL LA (propranolol ER)
- INDERAL XL (propranolol ER)
- INNOPRAN XL (propranolol ER)
- KAPSPARGO (metoprolol)
- labetalol 400 mg tablet (generic for NORMODYNE)
- LOPRESSOR solution (metoprolol)
  - **Note**: Payable at Point of Sale (POS) for beneficiaries with a diagnosis of NPO (Appendix A) in history
- LOPRESSOR tablet (metoprolol)
- metoprolol tartrate 12.5 mg (generic for LOPRESSOR)

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- metoprolol/HCTZ (generic for LOPRESSOR HCT)
- nadolol (generic for CORGARD)
- pindolol (generic for VISKEN)
- propranolol HCl solution
  - **Note**: Payable at Point of Sale (POS) for beneficiaries < 7 years of age or who have a diagnosis of NPO (Appendix A) in history
- propranolol HCTZ (generic for INDERIDE)
- SOTYLIZE (sotalol) (see criteria for SOTYLIZE)
- TENORETIC (atenolol/chlorthalidone)
- TENORMIN (atenolol)
- timolol maleate (generic for BLOCADREN)
- TOPROL XL (metoprolol XL)

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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BETAINE POWDER FOR ORAL SOLUTION (CYSTADANE)

Updated 11/15/2017

APPROVAL CRITERIA

Diagnosis of homocystinuria in the previous 2 years.

ADDITIONAL CRITERIA

Quantity limits apply

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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BIRCH TRITERPENES (FILSUVEZ)

Updated 04/17/2024

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with dystrophic epidermolysis bullosa (DEB) or junctional epidermolysis bullosa (JEB) **or** a diagnosis consistent with any new FDA-approved indications. Any off-label requests will be reviewed on a case-by-case basis.
- The prescriber must be a dermatologist or wound care specialist with expertise in DEB and JEB
- The beneficiary must have wounds that are 10–50 cm^2 and lasting 21 days–9 months
- The beneficiary should not be approved or continue this therapy with any of the following:
  - Ordered concomitant beremagene geperpavec-svdt (VYJUVEK); **OR**
  - Diagnosed with EB simplex
- The prescriber must submit the following:
  - Current chart notes
  - Genetic testing results confirming DEB or JEB
  - Previous therapies tried
  - Baseline description of wounds; **AND**
  - Number of tubes expected per month
    - **Note**: For the initial 3 months, the beneficiary may be authorized #30 tubes every 30 days to determine response to treatment. If the beneficiary responds to FILSUVEZ at the 3-month evaluation, more than one tube per dressing change will be approved, if needed.
  - Directions on frequency of application
  - Attestation that beneficiary/caregiver has been counseled on proper use
- Initial PA for 3 months; if demonstrates efficacy, subsequent PAs can be approved for 6 months

RENEWAL REQUIREMENTS

- The prescriber must submit the following:
  - Current chart notes
  - Response to therapy with description of wounds; **AND**
  - Medical necessity for continued use

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- Treated wounds will be evaluated at 3 months for a positive clinical response with request for PA continuation reviewed on a case-by-case basis. Positive response may include:
  - Decrease in wound size
  - Increase in granulation tissue; **OR**
  - Complete wound closure
- If the beneficiary receives a positive clinical response at 3 months, the next PA can be approved for 6 months.

QUANTITY EDITS

30 tubes per 30 days initially to determine response to treatment. If the beneficiary responds to FILSUVEZ, more than 1 tube per dressing change will be approved, if needed

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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BOWEL PREP AGENTS AND KITS

Updated 1/1/2026

PREFERRED AGENTS

- GAVILYTE-C
- GAVILYTE-G
- GAVILYTE-N
- PEG-3350 with electrolytes solution (generic for GOLYTELY and NULYTELY)

NON-PREFERRED AGENTS

- CLENPIQ
- GOLYTELY
- PEG-3350 with electrolytes powder pack (generic for MOVIPREP)
- sodium sulfate/potassium sulfate/magnesium sulfate (generic for SUPREP)
- SUFLAVE
- SUPREP
- SUTAB

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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BRENSOCATIB (BRINSUPRI)

Updated 10/15/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose from as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with non-cystic fibrosis bronchiectasis confirmed by computed tomography (CT) scan and clinical history consistent with bronchiectasis with at least two of the following in the last 12 months
  - Cough
  - Chronic sputum production; **OR**
  - Recurrent respiratory infections
- The beneficiary is 18 years of age or older and must have ≥ 2 exacerbations requiring antibiotic treatment in the last 12 months; those 12–17 years of age must have ≥ 1 exacerbation requiring antibiotic treatment in the last 12 months
- The medication must be prescribed by or in consultation with a pulmonologist
- The prescriber must submit the following:
  - Current chart notes
  - Previous therapies tried
  - CT scan report confirming diagnosis
  - Beneficiary specific symptoms associated with bronchiectasis including documentation of exacerbations; **AND**
  - Current pulmonary function tests
- Initial PA for 3 months

RENEWAL REQUIREMENTS

- The beneficiary has been compliant with therapy (defined as 75% utilization)
- The beneficiary has documented improvement demonstrated by at least **one** of the following:
  - Improvement in beneficiary specific symptoms compared to baseline
  - Reduction in frequency, severity or duration of exacerbations compared to baseline; **OR**
  - Improvement or stabilization of FEV1 compared to baseline
- The prescriber must submit the following:
  - Current chart notes

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- Documentation of current beneficiary specific symptoms; **AND**
- Current pulmonary function tests

QUANTITY EDITS

30 tablets per 30 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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BRONCHODILATORS, INHALED BETA AGONISTS

Updated 4/1/2026

PREFERRED SHORT-ACTING BETA AGONISTS

- albuterol nebulization solution (all strengths)
- PROAIR RESPICLICK (albuterol)
- VENTOLIN HFA (albuterol) – **brand only**
- XOPENEX HFA (levalbuterol) – **brand only**

NON-PREFERRED SHORT-ACTING BETA AGONISTS

- albuterol HFA (all generics)
- levalbuterol HFA (generic for XOPENEX HFA)
- levalbuterol inhalation solution (generic for XOPENEX)

PREFERRED LONG-ACTING BETA AGONISTS WITH CRITERIA

SEREVENT DISKUS (salmeterol)

NON-PREFERRED LONG-ACTING BETA AGONISTS

- arformoterol (generic for BROVANA)
- BROVANA (arformoterol)
- formoterol (generic for PERFOROMIST)
- PERFOROMIST (formoterol fumarate)
- STRIVERDI RESPIMAT (olodaterol)

APPROVAL CRITERIA FOR PREFERRED LONG-ACTING BETA AGONISTS WITH CRITERIA

- COPD diagnosis in history in previous 2 years; **AND**
- The beneficiary is ≥ 40 years of age; **AND**
- No Therapeutic Duplication (TD) with overlapping days' supply between drugs in the same drug classification.

ADDITIONAL CRITERIA

Quantity edits apply

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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BRONCHODILATORS, INHALED SHORT ACTING MUSCARINIC ANTAGONIST (SAMA)

Updated 4/1/2026

PREFERRED AGENTS WITH CRITERIA

- ATROVENT HFA (ipratropium bromide) **– brand preferred**
- COMBIVENT RESPIMAT (ipratropium/albuterol)
- ipratropium inhalation solution (generic for ATROVENT)
- ipratropium/albuterol (generic for DUONEB)

NON-PREFERRED AGENTS

ipratropium bromide HFA (generic for ATROVENT HFA)

APPROVAL CRITERIA FOR PREFERRED AGENTS WITH CRITERIA

- **One** of the following diagnoses or procedures:
  - Acute respiratory distress syndrome (J80)
  - Acute and chronic respiratory failure (J96.21, J96.22)
  - Anoxic brain injury (G93.1)
  - Chronic bronchitis (J41.0, J41.1, J41.8, J42)
  - Chronic respiratory failure (J96.10, J96.11, J96.12, J96.20)
  - COPD (J44.9, J44.1, J44.0)
  - Emphysema (J43.0, J43.1, J43.2, J43.8, J43.9)
  - Heart transplant (Z94.1)
  - Quadriplegic cerebral palsy (G80.0)
  - Respiratory insufficiency
  - Tracheostomy (Z93.0)
  - Tracheomalacia congenital (Q31.1, Q31.2, Q31.3, Q31.5, Q31.8, Q31.9, Q32.0, Q32.1, Q32.2, Q32.3, Q32.4)

ADDITIONAL CRITERIA

Quantity limits apply

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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BRONCHODILATORS, INHALED LONG-ACTING MUSCARINIC ANTAGONISTS (LAMA)

Updated 4/1/2026

PREFERRED AGENT WITH CRITERIA

SPIRIVA HANDIHALER (tiotropium bromide) – **brand only**

NON-PREFERRED AGENTS

- INCRUSE ELLIPTA (umeclidinium bromide) **– brand preferred over generic when approved**
- SPIRIVA RESPIMAT (tiotropium bromide)
- tiotropium bromide (generic of SPIRIVA)
- TUDORZA PRESSAIR (aclidinium bromide)
- umeclidinium bromide (generic for INCRUSE ELLIPTA)
- YUPELRI (revefenacin)

APPROVAL CRITERIA FOR PREFERRED AGENT WITH CRITERIA

- Diagnosis of COPD in Medicaid history in previous 2 years; **AND**
- No therapeutic duplication with overlapping days' supply between any medications in the same class; **AND**
- Medicaid beneficiary is ≥ 40 years of age

APPROVAL CRITERIA FOR SPIRIVA RESPIMAT 1.25 MCG

- The beneficiary is ≥ 6 years of age; **AND**
- The beneficiary has diagnosis of severe asthma or refractory asthma with persistent asthma symptoms despite use of appropriate controller drugs (per GINA guidelines) (e.g., moderate/high-dose ICS/LABA) and beneficiary requires a higher level of care and/or add-on treatment; **AND**
- The beneficiary's asthma is poorly controlled despite correct inhaler technique; **AND**
- The beneficiary must be adherent with two or more asthma controller medications (e.g., moderate/high dose of ICS/LABA) as maintenance treatment plus use of an as-needed reliever medication; good adherence to controller inhaler(s), for purposes of these criteria, is defined as the Medicaid drug profile history shows controller inhaler(s) filled monthly at least 4 months out of previous 6 months. A combination inhaler of ICS/LABA is considered as two asthma controller medications; **AND**
- The beneficiary is a non-smoker.

RENEWAL CRITERIA FOR SPIRIVA RESPIMAT 1.25 MCG

- The beneficiary continues to meet the above initial criteria; **AND**
- Claims history shows at least 120-day supply in the last 180 days of the requested medication; **AND**
- The beneficiary has experienced a positive clinical response to treatment but continues to have persistent asthma symptoms that require add-on treatment.

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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ADDITIONAL CRITERIA

Quantity edits apply

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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BRONCHODILATORS, INHALED COMBINATION PRODUCTS (LABA/LAMA)

Updated 4/1/2026

PREFERRED AGENTS WITH CRITERIA

- ANORO ELLIPTA (umeclidinium/vilanterol) – **brand only**
- BEVESPI AEROSPHERE (formoterol/glycopyrrolate)
- STIOLTO RESPIMAT (tiotropium/olodaterol)

NON-PREFERRED AGENTS

- DUAKLIR PRESSAIR (aclidinium/formoterol)
- umeclidinium/vilanterol (generic for ANORO ELLIPTA)

APPROVAL CRITERIA FOR PREFERRED AGENTS WITH CRITERIA

Criterion 1:

- COPD diagnosis in the past two years; **AND**
- ≥ 40 years of age; **AND**
- No therapeutic duplications within same class; **OR**

Criterion 2:

- Paid drug claim in drug history for ANORO, BEVESPI or STIOLTO in the last six months

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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BRONCHODILATORS, INHALED COMBINATION PRODUCTS (ICS/LABA)

Updated 7/1/2024

PREFERRED AGENTS WITH CRITERIA

- ADVAIR DISKUS (fluticasone propionate/salmeterol) – **brand only**
- ADVAIR HFA (fluticasone propionate/salmeterol) – **brand only**
- DULERA HFA (mometasone furoate/formoterol fumarate)
- SYMBICORT HFA (budesonide/formoterol fumarate) – **brand only**

POINT OF SALE (POS) APPROVAL CRITERIA FOR ADVAIR HFA/DISKUS, DULERA, AND SYMBICORT

Criterion 1:

- COPD diagnosis in the past two years; **AND**
- ≥ 40 years of age

Criterion 2:

- Paid drug claim in drug history in the last six months for:
  - ADVAIR DISKUS
  - ADVAIR HFA
  - DULERA; **OR**
  - SYMBICORT

Criterion 3:

- > 4 years of age; **AND**
- Asthma diagnosis in the past two years

Criterion 4:

- > 4 years of age; **AND**
- **One** of the following criteria below:
  - ≥ Three inhaled corticosteroid claims in the last 120 days; **OR**
  - ≥ Three oral steroid claims in the last 120 days; **OR**
  - Combination of ≥ three claims (as defined below) in the last 120 days:
    - One Inhaled corticosteroid and two oral steroids
    - Two Inhaled corticosteroids and one oral steroids

NON-PREFERRED AGENTS

- AIRSUPRA (budesonide/albuterol)
- BREO ELLIPTA (fluticasone furoate/vilanterol)

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- BREYNA (budesonide/formoterol)
- budesonide/formoterol (generic for SYMBICORT) – **generic only**
- fluticasone/salmeterol (generic for ADVAIR DISKUS) – **generic only**
- fluticasone/salmeterol HFA (generic for ADVAIR HFA) – **generic only**
- fluticasone/salmeterol (generic for AIRDUO RESPICLICK)
- fluticasone/vilanterol (generic for BREO ELLIPTA)
- WIXELA Inhub (fluticasone/salmeterol)

QUANTITY LIMITS

- SYMBICORT – #2 inhalers per month for 120 actuation size. If the beneficiary needs > 8 puffs per day, a PA can be submitted to approve an additional inhaler.
- DULERA – #2 inhalers per month
- ADVAIR DISKUS and ADVAIR HFA – #1 inhaler per month

Note: ADVAIR DISKUS and ADVAIR HFA are not recommended for SMART therapy and should not be used for rescue.

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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BRONCHODILATORS, INHALED COMBINATION PRODUCTS (ICS/LAMA/LABA)

Updated 4/1/2026

PREFERRED AGENTS

None

NON-PREFERRED AGENTS

- BREZTRI (budesonide/glycopyrrolate/formoterol)
- TRELEGY ELLIPTA (fluticasone furoate/umeclidinium/vilanterol)

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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BUDESONIDE EC 3 MG CAPSULE (ENTOCORT EC)

Updated 07/09/2013

APPROVAL CRITERIA

Submitted diagnosis of Crohn's Disease in the past 2 years

ADDITIONAL CRITERIA

Quantity limits apply

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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BUDESONIDE DELAYED RELEASE CAPSULE (TARPEYO)

Updated 4/20/2022

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary must be ≥18 years of age; **AND**
- The medication must be prescribed by or in consultation with a nephrologist; **AND**
- The beneficiary must have a diagnosis of immunoglobulin A nephropathy (IgAN) with proteinuria **or** a diagnosis consistent with the FDA-approved indication; **AND**
- The beneficiary must have eGFR ≥ 35 mL/min/1.73 m^2 and proteinuria (defined as either ≥ 1 g/day or UPCR ≥ 0.8 g/g) at baseline despite ACEi or ARB therapy; **AND**
- The beneficiary must be on a stable dose of maximally tolerated RAS inhibitor unless contraindicated for at least 90 days; **AND**
- The beneficiary must be prescribed in combination with an ACEi or ARB; **AND**
- The beneficiary must have trialed and failed corticosteroids; **AND**
- The beneficiary will take a maximum of 9 months of therapy at the maximum dose of 16 mg per day followed by 2 weeks of tapered dose at a maximum dose of 8 mg per day (unless new data supports continued use); **AND**
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Previous treatment; **AND**
  - Confirmation for the diagnosis of IgAN with renal biopsy and labs; **AND**
  - Current labs, including eGFR, urine protein or UPCR; **AND**
  - Medical necessity over corticosteroids and immunosuppressants available without a PA; **AND**
- Initial PA for 3 months

DENIAL CRITERIA

- The beneficiary does not meet approval criteria **or** have a diagnosis supported in the official Compendia; **OR**
- The beneficiary has severe hepatic impairment; **OR**
- The prescriber orders for > 9 months of therapy (unless new data supports continued use)

QUANTITY EDITS

#124 capsules per 31 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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BULEVIRTIDE (HEPCLUDEX)

Updated 7/15/2026

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert
- The beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert, or dosing is based on support from the official Compendia
- The beneficiary must be diagnosed with chronic hepatitis delta virus (HDV) infection without cirrhosis or with compensated cirrhosis as confirmed by all of the following:
  - Detectable serum HDV RNA level; **AND**
  - Elevated liver function tests (LFT) specifically ALT
- The medication must be prescribed by a hepatologist, gastroenterologist, or infectious disease specialist
- The beneficiary must not have decompensated cirrhosis or hepatocellular carcinoma (HCC)
- The beneficiary must be treated for hepatitis B virus (HBV) infection concomitantly as clinically appropriate
- The prescriber must submit the following:
  - Current chart notes
  - Lab work confirming diagnosis of HBV and HDV along with liver function tests
  - Previous treatment for HBV, if applicable (e.g., entecavir, tenofovir, and plan for treating HBV)
  - Attestation that the beneficiary has been counseled on potential severe acute exacerbations of hepatitis D or hepatitis B if HEPCLUDEX is discontinued, which would need to be monitored for at least 6 months after discontinuation
- Attestation that the beneficiary or caregiver has been trained on proper reconstitution and administration

RENEWAL REQUIREMENTS

- The beneficiary must be responding to HDV treatment after 52 weeks of treatment
  - Undetectable HDV RNA **OR** a ≥ 2 $\log_{10}$ IU/mL decline from baseline; **AND**
  - ALT normalization
- The beneficiary must not have developed decompensated cirrhosis or HCC
- The prescriber must submit the following:
  - Current chart notes
  - Current labs including HDV RNA and LFTs

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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QUANTITY EDITS

30 vials per 30 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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BUMETANIDE (ENBUMYST)

Updated 7/1/2026

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- The beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert or based on support from the official Compendia
- The beneficiary must be diagnosed with edema associated with congestive heart failure (CHF), hepatic and renal disease, including nephrotic syndrome
- The medication must be prescribed by, or in consultation with, a cardiologist, hepatologist, or nephrologist
- The beneficiary must be adherent to standard of care therapies including CHF therapies (i.e., ACE/ARB, beta blockers, salt restrictions) or medications for renal disease (i.e., SGLT-2 inhibitors, diuretics), if applicable
- The beneficiary must have documented recent weight gain and increased edema or other symptoms of extracellular volume expansion (e.g., jugular venous distention, pulmonary congestion or rales)
- The beneficiary must have tried and failed oral furosemide (160 mg) **AND one** of the following oral antidiuretics:
  - torsemide (40 mg)
  - bumetanide (4 mg)
- The prescriber must submit the following:
  - Current chart notes with diagnosis contributing to edema noted
  - Current and previous therapies tried
  - Medical necessity over oral antidiuretics
  - Current and baseline weight
  - Confirmation that beneficiary has a history of at least one prior hospitalization or emergency department visit due to heart failure or chronic kidney disease exacerbations and/or fluid overload
  - Current labs
  - Attestation that ENBUMYST will be used short-term then transitioned back to oral diuretics as soon as practical

RENEWAL REQUIREMENTS

- The beneficiary continues to have episodes of edema due to underlying illness
- The meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- The beneficiary has documented positive response to the use of ENBUMYST with a decrease in edema to prevent hospitalization
- The prescriber must submit the following:
  - Current chart notes
  - Continued treatment plan for edema
  - Current weight and description of edema

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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BUROSUMAB-TWZA (CRYSVITA)

Updated 7/17/2024

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- Must be prescribed by or in consultation with a nephrologist or endocrinologist
- The beneficiary must be diagnosed with either:
  - X-linked hypophosphatemia (XLH); **OR**
  - FGF23-related hypophosphatemia in tumor-induced osteomalacia (TIO) associated with a phosphaturic mesenchymal tumor that cannot be curatively resected or localized; **OR**
  - Diagnosis consistent with any new FDA-approved indications
- Diagnosis must be confirmed by identifying at least **one** of the following:
  - Serum fibroblast growth factor-23 (FGF23) level > 30 pg/mL
  - Phosphate regulating gene with homology to endopeptidases located on the X chromosome (PHEX-gene) mutations in the beneficiary; **OR**
  - Clinical, radiographic, and laboratory findings that support the diagnosis (e.g., evidence of Rickets, evidence of skeletal demineralization, low phosphate and high alkaline phosphatase activity for age)
- The beneficiary must have a baseline fasting serum phosphorus level with current hypophosphatemia, defined as a phosphate level below the lower limit of normal for the beneficiary's age
- Adults must have an inadequate response from oral phosphate and active vitamin D analogs
- Beneficiaries with TIO must have a tumor that cannot be curatively resected or localized
- The beneficiary should not be approved or continue this therapy with any of the following:
  - Continues to take oral phosphate or active vitamin D analogs; **OR**
  - Severe renal impairment (Glomerular Filtration Rate [GFR] < 30 mL/min)
- The prescriber must submit the following:
  - Current chart notes
  - Baseline labs including serum phosphorus, serum total alkaline phosphatase activity, and vitamin D
  - Baseline symptoms (e.g., pain, mobility, growth rate, rickets on radiographic evaluation [Rickets Severity Score])

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- Medical necessity for beneficiaries with closed epiphyses over oral phosphate and vitamin D supplementation
- Attestation that the beneficiary has discontinued oral phosphate supplement and active vitamin D analogs; **AND**
- Documentation of treatment plan
  - Where the dose be given (i.e., doctor's office, home health, infusion center)
  - Where the labs will be drawn
  - If this PA request originates outside of specialist clinic, provide a plan for consulting with specialist
- Information on tumor resection for TIO beneficiary
- Clarification if this will be billed as a medical claim through "buy and bill" or billed as a pharmacy claim through a specialty pharmacy.

Note: If this medication is intended to be billed as a medical claim, follow the physician administered drugs procedure. Contact Prime Therapeutics with any questions.

RENEWAL REQUIREMENTS

- The beneficiary must be compliant with treatment (defined as 75% utilization)
- The beneficiary must not demonstrate unacceptable toxicity (e.g., severe hypersensitivity reactions, hyperphosphatemia or nephrocalcinosis, severe injection site reactions)
- The beneficiary must demonstrate a positive response with at least **one** of the following:
  - Serum phosphate levels increased compared to baseline
  - Symptom improvement (e.g., pain, mobility, growth); **OR**
  - Radiographic imaging indicates improvement in Rickets/osteomalacia
- The prescriber must submit the following:
  - Current chart notes
  - Current labs, including serum phosphorus, serum total alkaline phosphatase activity, and vitamin D; **AND**
  - Current symptoms (e.g., pain, mobility, growth, rickets on radiographic evaluation with RSS)
- If the beneficiary has closed epiphyses, they must have documentation of medical necessity for continuation. Reassessment for efficacy with oral phosphate and active vitamin D analogs may be warranted.

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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BUSPIRONE CAPSULE (BUCAPSOL)

Updated 7/16/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with anxiety disorders
- The beneficiary must have tried and failed first-line maintenance medication for the treatment of anxiety (e.g., SSRI, SNRI) unless there is a contraindication
- The beneficiary must have a history of buspirone generic tablet use
- The prescriber must submit the following:
  - Current chart notes
  - Long-term treatment plan (buspirone is not typically used long-term); **AND**
  - Medical necessity over buspirone generic tablets

QUANTITY EDITS

- 5 mg: #62 capsules per 31 days
- 7.5 mg: #62 capsules per 31 days
- 10 mg: #124 capsules per 31 days
- 15 mg: #124 capsules per 31 days

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BUTALBITAL AGENTS WITHOUT CODEINE

Updated 1/1/2026

PREFERRED AGENTS

butalbital/acetaminophen/caffeine 50/325/40 mg tablet (generic for ESGIC)

NON-PREFERRED AGENTS

- butalbital/acetaminophen capsule
- butalbital/acetaminophen tablet (generic for BUPAP/MARTIN-TAB)
- butalbital/acetaminophen/caffeine capsule (generic for ESGIC/FIORICET)
- butalbital/acetaminophen/caffeine solution (generic for VANATOL)
- butalbital/aspirin/caffeine (generic for FIORINAL)
- FIORICET (butalbital-acetaminophen-caffeine)

AGE EDIT

The beneficiary must be at least 12 years of age or older

QUANTITY EDITS

- Solid oral dosage forms of butalbital products will be limited to a maximum of 6 units per day
- Solid oral dosage forms of butalbital products will have a cumulative quantity limit of 90 units per 31 days' supply
- Oral liquid forms of butalbital will be limited to 60 mL per day or up to 240 mL per prescription

The DUR Board voted to decrease the total quantity of butalbital (non-codeine) pills per month to be more closely aligned with the manufacturer package inserts. The scheduled changes for the maximum allowed per month are as follows:

- October 1, 2026: maximum per month will be #90 total
- April 1, 2027: maximum per month will be #60 total
- October 1, 2027: maximum per month will be #30 total

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CAPLACIZUMAB-YHDP (CABLIVI)

Updated 10/16/2019

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary must be ≥ 12 years of age; **AND**
- The beneficiary has a clinical diagnosis of acquired thrombotic thrombocytopenic purpura (aTTP) (initial or recurrent); **AND**
- Provide the medical necessity over high dose glucocorticoids and rituximab with PEX; **AND**
- The beneficiary is currently taking immunosuppressive therapy; **AND**
- The beneficiary has initiated plasma exchange; **AND**
- Provide chart notes/hospitalization notes with treatment plan; **AND**
- Provide current labs with minimum of the following: CBCs with platelets, LFTs, and ADAMTS13 activity level (may not have immediately but should be drawn and pending results); **AND**
- Provide treatment plan if beneficiary has clinically significant bleeding; **AND**
- The beneficiary should not be pregnant or breastfeeding (until at least 2 months after last dose); **AND**
- The beneficiary considered high-risk and hospitalized and has at least **one** of the following (per UpToDate):
  - Neurologic abnormalities
  - Decreased level of consciousness
  - Serum troponin level; **OR**
  - Other signs of critical illness
- Approve 1 month at a time (maximum quantity would be ≥ 58 days of getting PEX)

DENIAL CRITERIA

- Diagnosed with congenital thrombotic thrombocytopenic purpura or has other cause for thrombocytopenia; **OR**
- Pregnant or breastfeeding; **OR**
- Not receiving PEX or immunosuppressive therapy; **OR**
- The beneficiary is classified as standard risk and responds to PEX/glucocorticoids
- Interrupt treatment if clinically significant bleeding occurs; **OR**
- Concomitant use with anticoagulant (or require INR/PT and close monitoring); **OR**
- Discontinue if more than 2 recurrences of aTTP while on Cablivi; **OR**
- ADAMTS13 activity level > 10%; **OR**
- Platelet count ≥ 100 x 10^9/L

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QUANTITY EDITS

Maximum of 58 days after plasma exchange is complete

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CALCIPOTRIENE (DOVONEX/SORILUX) AND CALCITROL (VECTICAL)

Updated 6/19/2006

APPROVAL CRITERIA

- Diagnosis of psoriasis in Medicaid history in previous 365 days; **AND**
- Two paid claims of a topical corticosteroid in previous 27–60 days; **AND**
- At least one paid claim for a topical corticosteroid must be from the class 1 potency category.

CONTINUATION CRITERIA

- Diagnosis of psoriasis in Medicaid history in previous 365 days; **AND**
- The incoming claim matches claim in history in the previous 45 days; **AND**
- At least two claims of a topical corticosteroid in previous 60 days in drug claim history with at least one topical corticosteroid claim 14–60 days back in history.

DENIAL CRITERIA FOR CALCIPOTRIENE (GENERIC FOR DOVONEX)

History of vitiligo in previous two years

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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CALCIPOTRIENE AND BETAMETHASONE DIPROPIONATE (TACLONEX)

Updated 1/09/2008

APPROVAL CRITERIA

- ≥ 18 years of age; **AND**
- History of three paid claims in the past 90 days for calcipotriene (DOVONEX); **AND**
- History of three paid claims in the past 90 days for a topical steroid

DENIAL CRITERIA

- < 18 years of age
- Concurrent use of a topical corticosteroid
- Failure to meet the approval criteria

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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CALCIUM CHANNEL BLOCKERS

Updated 10/1/2025

DIHYDROPYRIDINE AND COMBINATION PRODUCTS

PREFERRED AGENTS

- amlodipine (generic for NORVASC)
- amlodipine/benazepril (generic for LOTREL)
- amlodipine/olmesartan (generic for AZOR)
- amlodipine/valsartan (generic for EXFORGE)
- amlodipine/valsartan/HCTZ (generic for EXFORGE HCT)
- nifedipine IR (generic for PROCARDIA)
- nifedipine ER (generic for ADALAT CC/PROCARDIA XL)

NON-PREFERRED AGENTS

- amlodipine/atorvastatin (generic for CADUET)
- amlodipine/olmesartan/HCTZ (generic for TRIBENZOR)
- AZOR (amlodipine/olmesartan)
- CADUET (amlodipine/atorvastatin)
- EXFORGE (amlodipine/valsartan)
- EXFORGE HCT (amlodipine/valsartan/HCTZ)
- felodipine ER (generic for PLENDIL)
- isradipine (generic for DYNACIRC)
- KATERZIA (amlodipine)
  - **Note**: Payable at Point of Sale (POS) for beneficiaries < 7 years of age or who have a diagnosis of NPO (Appendix A) in history
- levamlodipine (generic for CONJUPRI)
- LOTREL (amlodipine/benazepril)
- nicardipine (generic for CARDENE)
- nimodipine (generic for NYMALIZE)
- nisoldipine ER (generic for SULAR)
- NORLIQVA (amlodipine)
  - **Note**: Payable at Point of Sale (POS) for beneficiaries < 7 years of age or who have a diagnosis of NPO (Appendix A) in history
- NORVASC (amlodipine)
- NYMALIZE (nimodipine)
- PROCARDIA XL (nifedipine ER)

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- SDAMLO (amlodipine)
- SULAR ER (nisoldipine)
- TRIBENZOR (amlodipine/olmesartan/HCTZ)

NON-DIHYDROPYRIDINE AND COMBINATION PRODUCTS

PREFERRED AGENTS

- CARTIA XT 24 HR (diltiazem)
- diltiazem CD 24 HR (generic for CARDIZEM CD)
- DILT-XR 24 HR (diltiazem)
- diltiazem ER 24 HR (generic for TIAZAC)
- diltiazem XR 24 HR (generic for DILACOR XR)
- diltiazem tablet (generic for CARDIZEM)
- TIADYLT ER 24 HR (diltiazem)
- verapamil tablet (generic for CALAN)
- verapamil ER tablet (generic for CALAN SR)

NON-PREFERRED AGENTS

- CARDAMYST (etripamil) (see criteria for CARDAMYST)
- CARDIZEM (diltiazem)
- diltiazem ER 12 HR (generic for CARDIZEM SR)
- diltiazem LA 24 HR (generic for CARDIZEM LA/MATZIM LA)
- MATZIM LA (diltiazem ER)
- TIAZAC (diltiazem ER)
- verapamil ER/SR capsule (generic for VERELAN/VERELAN PM)

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CANNABIDIOL (CBD) EXTRACT (EPIDIOLEX)

Updated 10/1/2026

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary has documented history of seizures associated with Lennox-Gastaut syndrome (LGS), Dravet syndrome (DS), or Tuberous Sclerosis Complex (TSC)
- For Lennox-Gastaut Syndrome: the prescriber must submit written documentation of electroencephalogram (EEG) showing slow (< 3.0 hertz [Hz]) spike-and-wave pattern
- For Dravet Syndrome: the prescriber must submit written documentation showing convulsive status epilepticus, alternating hemiconvulsions, **or** myoclonic seizures and include genetic testing results for Dravet Syndrome that shows mutations within SCN1A gene.
- For Tuberous Sclerosis Complex: the prescriber must provide documentation confirming the diagnosis
- The beneficiary is currently adherent to prescribed dose and frequency of antiepileptic drugs and was on stable dose(s) for at least 4 weeks
- The prescriber must submit chart notes and documentation that beneficiary is refractory to antiepileptic drugs with documented failures on more than one anticonvulsant drug (≥ 2 antiepileptic drugs)
- The prescriber must submit baseline liver function tests including liver enzyme test results (ALT AST) and total bilirubin
- Initial approval will be for 1 month
- The beneficiary is not pregnant, planning to become pregnant, or lactating

DENIAL CRITERIA

- The beneficiary does not meet approval criteria
- The beneficiary does not have seizures associated with Lennox-Gastaut syndrome or Dravet syndrome or Tuberous Sclerosis Complex
- The etiology of the beneficiary's seizures is determined to be a progressive neurologic disease
- The beneficiary has significantly impaired hepatic function, defined as any of the following:
  - Alanine aminotransferase (ALT) or aspartate aminotransferase (AST) > 5 times the ULN; **OR**
  - ALT or AST > 3 times the ULN and total bilirubin > 2 times the ULN or international normalized ratio (INR) > 1.5; ALT or AST > 3 times the ULN with the presence of fatigue, nausea, vomiting, right upper quadrant pain or tenderness, fever, rash, and/or eosinophilia (> 5%)
- The beneficiary is pregnant (confirmed with positive pregnancy test), lactating or planning pregnancy for 3 months thereafter

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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QUANTITY LIMITS

- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in manufacturer's package insert or supported in the official Compendia
- The prescriber must submit the beneficiary's weight and prescribed dose at every PA request
- Calculating the dose and the quantity limit for the number of 100 mL bottles per month will be entered at the time of PA approval
- Dose adjustment is recommended for beneficiaries with moderate (Child-Pugh B) hepatic impairment or severe (Child-Pugh C) hepatic impairment, and the quantity limit of 100 mL bottles will be implemented at the time of PA approval
- Per the package insert, it may be necessary to have slower dose titration in beneficiaries with moderate or severe hepatic impairment than in beneficiaries without hepatic impairment, so quantity limit will be adjusted accordingly

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CAPSAICIN 8% KIT (QUTENZA)

Updated 1/18/2023

APPROVAL CRITERIA

- The prescriber must be a specialist in treating neuropathic pain
- The beneficiary must be diagnosed with neuropathic pain associated with postherpetic neuralgia (PHN) or neuropathic pain associated with diabetic peripheral neuropathy (DPN) of the feet **or** a diagnosis consistent with any updated FDA-approved indications or supported in the official Compendia
- QUTENZA may be purchased through buy and bill from specialty distributor or by prescription from specialty pharmacy. QUTENZA must be delivered to prescriber directly.
- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- Maximum dose based on support in manufacturer's package insert or an official Compendia
- Application time must be consistent with the actual diagnosis (60 minutes for postherpetic neuralgia and 30 minutes for diabetic peripheral neuropathy)
- The beneficiary being treated for PHN pain must have continued pain at least 6 months after healing of herpes zoster rash
- The beneficiary must have tried and failed at least three of the following prior to consideration for this medication:
  - Postherpetic neuralgia (PHN)
    - Topical capsaicin or lidocaine
    - Gabapentin and/or pregabalin
    - Tricyclic antidepressants (e.g., amitriptyline, nortriptyline)
    - Antiepileptic agents (e.g., valproic acid, carbamazepine, lamotrigine); **OR**
    - Serotonin-norepinephrine reuptake inhibitors (e.g., duloxetine, venlafaxine)
  - Diabetic peripheral neuropathy (DPN)
    - Topical capsaicin or lidocaine
    - Gabapentin and/or pregabalin
    - Tricyclic antidepressants (e.g., amitriptyline, nortriptyline)
    - Antiepileptic agents (e.g., valproic acid, carbamazepine, lamotrigine)
    - Serotonin-norepinephrine reuptake inhibitors (e.g., duloxetine, venlafaxine)
    - Electrical nerve stimulation
    - Spinal cord stimulation; **OR**
    - Alpha-lipoic acid
- The prescriber must submit **all** of the following:
  - Current chart notes with documentation if treating PHN or DPN

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- Previous therapies tried
- Medical necessity over other treatment options
- Size of area to be treated. PA will be entered for a specific package size pertaining to the amount needed based on treatment area size; **AND**
- If received from the specialty pharmacy as an outpatient prescription, prescriber must attest that the beneficiary will not have access to this medication. The prescription must be delivered directly to the prescriber's office.

- If approved, PA will be entered for one treatment at a time. Subsequent treatments will require additional PA review.
- PAs will be entered for one treatment at a time and only one treatment is allowed every 3 months

RENEWAL REQUIREMENTS

- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Documented improvement in neuropathic pain

QUANTITY EDITS

One single use topical system per 90 days (carton can include 1, 2, or 4 systems)

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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CARBINOXAMINE (CARBZAH) OR DEXCHLORPHENIRAMINE (CORPHENA/RYCLORA)

Updated 7/1/2026

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The prescriber must submit explanation and documentation of medical necessity of beneficiary receiving this antihistamine over other antihistamines with anticholinergic (drying) and sedative side effects, OTC or legend (e.g., chlorpheniramine syrup, carbinoxamine liquid, or diphenhydramine liquid) that are covered by AR Medicaid without prior authorization criteria **and** over the preferred status non-sedating antihistamines listed on the Medicaid PDL
- The beneficiary is ≥ 2 years of age and ≤ 6 years of age
- Length of PA approval determined at the time of PA approval

DENIAL CRITERIA

- The beneficiary is < 2 years of age or > 6 years of age
- The beneficiary has not tried other sedating antihistamines covered by AR Medicaid without prior authorization and available in liquid form
- The beneficiary has not tried the preferred non-sedating antihistamines on the PDL

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CARISOPRODOL 250 MG AND 350 MG TABLET

Updated 7/16/2025

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must have an acute, painful musculoskeletal condition requiring a muscle relaxer
- The beneficiary must have tried and failed all preferred skeletal muscle relaxers on PDL
- The prescriber must submit the following:
  - Current chart notes
  - The beneficiary's diagnosis that requires a muscle relaxer; **AND**
  - Letter of medical necessity outlining the rationale for carisoprodol over all other preferred muscle relaxers on the PDL
- If this medication is approved, the beneficiary will only be allowed up to a 3-week supply.

QUANTITY EDITS

#63 tablets per 21 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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CENEGERMIN-BKBJ (OXERVATE)

Updated 04/20/2022

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary must be ≥ 2 years of age; **AND**
- The beneficiary must have a diagnosis of neurotrophic keratitis **or** a diagnosis consistent with FDA-approved indication, or be supported by the official Compendia; **AND**
- The beneficiary must have stage 2 or stage 3 neurotrophic keratitis; **AND**
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Documented trials of the following; **AND**
    - Stage 2: Artificial tears, lubricant ointments, prophylactic antibiotic eye drops, and topical corticosteroids (if inflammation)
    - Stage 3: All products for stage 2 plus N-acetylcysteine, tetracycline, or medroxyprogesterone
- Stage of neurotrophic keratitis; **AND**
- Medical necessity over surgery with amniotic membrane; **AND**
- Medical necessity if requesting for > 8 weeks of therapy

QUANTITY EDITS

#1 vial per day per affected eye

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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CEPHALOSPORINS

Updated 4/1/2026

PREFERRED AGENTS

- cefadroxil capsule and suspension (generic for DURICEF)
- cefdinir (generic for OMNICEF)
- cefpodoxime (generic for VANTIN)
- cefprozil (generic for CEFZIL)
- cefuroxime tablet (generic for CEFTIN)
- cephalexin capsule and suspension (generic for KEFLEX)

NON-PREFERRED AGENTS

- cefaclor/cefaclor ER (generic for CECLOR)
- cefadroxil tablet (generic for DURICEF)
- cefixime (generic for SUPRAX)
- cephalexin tablet (generic for KEFLEX)

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CHENODIOL TABLET (CTEXLI)

Updated 7/16/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with cerebrotendinous xanthomatosis (CTX) confirmed by genetic testing and elevated serum cholestanol and bile alcohols (23S-pentol)
- The prescribers must submit the following:
  - Current chart notes
  - Clinical presentation specific to the beneficiary
  - Genetic testing results confirming a CYP27A1 variant is present; **AND**
  - Baseline labs including LFTs, serum cholestanol and serum/urine bile alcohols levels

RENEWAL REQUIREMENTS

- The beneficiary has been compliant with therapy (defined as 75% utilization)
- The beneficiary has documented improvement of beneficiary's specific symptoms and serum cholestanol and serum/urine bile alcohols levels (23S-pentol)
- The prescriber must submit the following:
  - Current chart notes
  - Clinical presentation specific to the beneficiary after starting CTEXLI; **AND**
  - Current labs, including LFTs, serum cholestanol and serum/urine bile alcohols levels

QUANTITY EDITS

#93 tablets per 31 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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CHOLIC ACID CAPSULE (CHOLBAM)

Updated 1/15/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must be diagnosed with **one** of the following:
  - Bile acid synthesis disorders due to single enzyme defects (SEDs)
  - Peroxisomal disorders (PDs) including Zellweger spectrum disorders in beneficiaries who exhibit manifestations of liver disease, steatorrhea or complications from decreased fat-soluble vitamin absorption.
- The beneficiary should not be approved or continue this therapy with any of the following:
  - Worsening liver function or cholestasis
  - Requested dose is not supported in the package insert
  - No liver improvement after 3 months of treatment; **OR**
  - Develops complete biliary obstruction
- The prescriber must submit the following:
  - Current chart notes
  - Previous therapies with response
  - Liver function tests (AST, ALT, GGT, alkaline phosphatase, bilirubin, INR); **AND**
  - Serum or urinary bile acid levels
- Initial PA for 3 months

RENEWAL REQUIREMENTS

- The beneficiary must be compliant on therapy (defined as 75% utilization)
- The beneficiary must demonstrate a positive response after 6 months of usage
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Documentation of response to therapy

QUANTITY EDITS

#120 capsules per 30 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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CHRONIC GI MOTILITY AGENTS

Updated 10/1/2025

PREFERRED AGENTS

- LINZESS (linaclotide)
- lubiprostone (generic for AMITIZA)
- MOVANTIK (naloxegol)

NON-PREFERRED AGENTS

- alosetron (generic for LOTRONEX)
- AMITIZA (lubiprostone)
- IBSRELA (tenapanor)
- LOTRONEX (alosetron)
- MOTEGRITY (prucalopride)
- prucalopride (generic for MOTEGRITY)
- SYMPROIC (naldemedine)
- VIBERZI (eluxadoline)

APPROVAL CRITERIA FOR PREFERRED AGENTS

LINZESS, MOVANTIK, GENERIC AMITIZA (PA REVIEW AND POINT-OF-SALE [POS] EDIT)

Note: Criteria for irritable bowel syndrome with constipation (IBS-C), chronic idiopathic constipation (CIC), opioid-induced constipation (OIC), or functional constipation (FC)

- The beneficiary has a history of a preferred product within the past 60 days; **OR**
  - The beneficiary has a history of polyethylene glycol (e.g., MiraLAX, GlycoLAX) or lactulose within the past 14–60 days; **AND**
- The beneficiary will not be taking the requested medication with other chronic GI motility agents in the same class as the requested agent; **AND**
- The beneficiary has not had a mechanical gastrointestinal obstruction in the last 30 days; **AND**
- **For AMITIZA**, the beneficiary is at least 18 years of age; **AND**
- **For LINZESS**, the beneficiary does not have history of opioid use in the past 60 days; **AND**
  - The beneficiary is at least 2 years of age if 72 mcg is requested; **OR**
  - The beneficiary is at least 7 years of age if 145 mcg is requested; **OR**
  - The beneficiary is at least 18 years of age if 290 mcg is requested; **AND**
- **For MOVANTIK**, the beneficiary has a history of an opioid or buprenorphine use in the past 60 days; **AND**
  - The beneficiary is at least 18 years of age.

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APPROVAL CRITERIA FOR NON-PREFERRED AGENTS

VIBERZI AND GENERIC LOTRONEX (PA REVIEW ONLY, NOT IN POS)

- The beneficiary has diagnosis of irritable bowel syndrome with diarrhea (IBS-D); **AND**
- The beneficiary has tried and failed at least three agents from any of the following classes:
  - Bulk Producing Agents (e.g., Metamucil [psyllium], Citrucel [methylcellulose])
  - Antispasmodic Agents (e.g., dicyclomine, hyoscyamine)
  - Antidiarrheal Agents (e.g., loperamide, diphenoxylate/atropine); **AND**
- If LOTRONEX, the beneficiary is female; **AND**
- The beneficiary will not be using the requested agent concomitantly with other chronic GI motility agents in the same class as the requested agent; **AND**
- The beneficiary is at least 18 years of age.

ALL OTHER AGENTS

- Must meet the criteria for specific indication (IBS-C, CIC, OIC, FC or IBS-D); **AND**
- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication; **AND**
- Meets routine PDL Criteria.

ADDITIONAL CRITERIA

Quantity limits apply

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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CINACALCET (SENSIPAR)

Updated 4/15/2020

APPROVAL CRITERIA

Criterion 1: POS PA approval criteria for Treatment of Secondary Hyperparathyroidism (HPT) In Adult Beneficiaries with Chronic Kidney Disease (CKD) On Dialysis:

- Diagnosis in Medicaid medical history in previous 2 years of **both** diagnosis codes for:
  - "Secondary HTP of renal origin" (ICD-10 code N25.81); **AND**
  - "ESRD CKD requiring Chronic Dialysis" (ICD-10 code N18.6 or Z99.2).
- Manual review PA will be on a case-by-case basis if either diagnoses code is not found in the Medicaid system for POS approval.
- The prescriber must submit a letter explaining the medical necessity and submit documentation to support the diagnosis not found.

Criterion 2: POS PA approval criteria for Treatment of Hypercalcemia in Adult Beneficiaries with Parathyroid Carcinoma:

- Diagnosis in Medicaid medical history in previous 2 years of **both** diagnosis codes for:
  - "Cancer of the parathyroid gland" (ICD-10 code C75.0); **AND**
  - Diagnosis in medical history of "Hypercalcemia" (ICD-10 code E83.52); **OR**
  - Hypercalcemia level with Calcium > 10 mg/dL drawn in previous 30 days
- Manual review PA will be on a case-by-case basis if either diagnosis code is not found in the Medicaid system for POS approval.
- The prescriber must submit a letter explaining the medical necessity and submit documentation to support the diagnosis not found.

Criterion 3: POS PA approval criteria for treatment of hypercalcemia in adult beneficiaries with primary HPT for whom parathyroidectomy would be indicated based on serum calcium levels, but who are unable to undergo parathyroidectomy:

- Absence of a Parathyroidectomy in the beneficiary's medical history
- No Procedure Code for Parathyroidectomy in the past 2 years; **AND**
  - Diagnosis in Medicaid medical history in previous 2 years
    - "Hypercalcemia" (ICD-10 code E83.52); **OR**
    - Hypercalcemia Level with calcium > 10 mg/dL drawn in the previous 30 days
- Manual review PA will be on a case-by-case basis if above criteria are not found in the Medicaid system for POS approval.
- The prescriber must submit a letter explaining the medical necessity and submit documentation to support the diagnosis not found.

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CLINDAMYCIN PHOSPHATE 2% GEL (XACIATO)

Updated 10/19/2022

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary is a female 12 years of age and older **or** updated age allowance if indication changes
- The beneficiary has a confirmed diagnosis of bacterial vaginosis with the following:
  - Off-white vaginal discharge
  - Clue cells > 20% of total epithelial cells
  - Discharge pH > 4.5; **AND**
  - Positive whiff test
- The prescriber must submit the following:
  - Current chart notes
  - Previous therapies tried; **AND**
  - Medical necessity over other treatment options available without a PA (e.g., oral or vaginal metronidazole, oral or vaginal clindamycin)

QUANTITY EDITS

1 tube (8 gm) per 30 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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CLONIDINE VIAL

Updated 7/8/2014

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

DRUGS THAT REQUIRE MANUAL REVIEW FOR PRIOR AUTHORIZATION

- clonidine HCl PF vial 5,000 mcg/10 mL
- clonidine HCl PF vial 1,000 mcg/10 mL

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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COLCHICINE 0.5 MG TABLET (LODOCO)

Updated 1/15/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with atherosclerotic disease or have multiple risk factors for cardiovascular disease
- The beneficiary is currently taking standard of care treatment for chronic coronary disease (e.g., antiplatelet, anticoagulant, lipid-lower agent, beta blocker, renin-angiotensin inhibitor)
- The beneficiary should not be approved or continue the medication if meet **one** of the following:
  - Renal failure (CrCl < 15 mL/minute); beneficiaries with renal impairment should be monitored
  - Severe hepatic impairment
  - Requires strong CYP3A4 inhibitors or P-gp inhibitors
  - Has pre-existing blood dyscrasias (i.e., myelosuppression, leukopenia, granulocytopenia, thrombocytopenia, pancytopenia, and aplastic anemia)
  - Develops neuromuscular toxicity or rhabdomyolysis
- The prescriber must submit the following:
  - Current chart notes
  - Current labs, including creatinine clearance and eGFR
  - Previous therapies for atherosclerotic disease; **AND**
  - Letter of medical necessity over the use of colchicine 0.6 mg capsule or tablet

RENEWAL REQUIREMENTS

- The beneficiary is compliant with therapy (defined as 75% utilization)
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Documentation of any change to cardiovascular status

QUANTITY EDITS

#30 tablets per 30 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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COLONY STIMULATING FACTORS

Updated 10/1/2026

PREFERRED AGENTS

- FYLNETRA (pegfilgrastim-pbbk)
- NEUPOGEN (filgrastim)

NON-PREFERRED AGENTS

- ARMLUPEG (pegfilgrastim-unne)
- FILKRI (filgrastim-laha)
- FULPHILA (pegfilgrastim-jmbd)
- GRANIX (tbo-filgrastim)
- LEUKINE (sargramostim)
- NEULASTA (pegfilgrastim)
- NEULASTA ONPRO (pegfilgrastim)
- NIVESTYM (filgrastim-aafi)
- NYPOZI (filgrastim-txid)
- NYVEPRIA (pegfilgrastim-apgf)
- RELEUKO (filgrastim-ayow)
- ROLVEDON (eflapegrastim-xnst)
- RYZNEUTA (efbemalenograstim alfa-vuxw)
- STIMUFEND (pegfilgrastim-fpgk)
- UDENYCA (pegfilgrastim-cbqv)
- UDENYCA ONBODY (pegfilgrastim-cbqv)
- ZARXIO (filgrastim-sndz)
- ZIEXTENZO (pegfilgrastim-bmez)

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COPPER HISTIDINATE (ZYCUBO)

Updated 4/15/2026

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- The beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert or based on support from the official Compendia
- The beneficiary must be a child diagnosed with Menkes disease confirmed by **one** of the following:
  - Expected disease with genetic confirmation of the mutation in the ATP7A gene in the mother or patient
  - Expected disease with low serum copper levels, urine homovanillic acid/vanillylmandelic acid ratio of > 4, and/or x-rays with bone abnormalities or hair sample consistent with Menkes
- Prescribed by, or in consultation with, a specialist in treating Menkes disease
- The prescriber must submit the following:
  - Current chart notes
  - Previous therapies tried
  - Confirmation of diagnosis as listed above
  - Baseline labs including serum copper and ceruloplasmin levels, serum electrolytes, kidney and liver function, and complete blood count (CBC)
- Initial prior authorization for 3 months, if tolerating can approve 6 months with next approval.

RENEWAL REQUIREMENTS

- The beneficiary must be compliant on therapy (defined as 75%)
- The beneficiary must demonstrate an improved serum copper level and not have lab abnormalities that would require discontinuation
- The prescriber must submit the following:
  - Current chart notes
  - Current labs including serum copper and ceruloplasmin levels, serum electrolytes, kidney and liver function, and complete blood count (CBC) which should be monitored every 6 weeks for the first 6 months, then every 3 months for 18 months, and then every 6 months thereafter

QUANTITY EDITS

#2 vials per day

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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CORTICOSTEROIDS, ORAL INHALED (ICS)

Updated 7/1/2024

PREFERRED AGENTS

- ARNUITY ELLIPTA (fluticasone furoate) – **brand only**
- ASMANEX HFA (mometasone furoate)
- ASMANEX TWISTHALER (mometasone furoate)
- PULMICORT FLEXHALER (budesonide) –**H2 Pharma only until no more product is available on the market**
- QVAR REDIHALER (beclomethasone dipropionate)

PREFERRED AGENTS WITH CRITERIA

- ALVESCO HFA (ciclesonide)
- budesonide ampules for nebulizer (generic for PULMICORT RESPULES)

NON-PREFERRED AGENTS WITHOUT CRITERIA

- beclomethasone (generic for QVAR)
- fluticasone diskus (generic for FLOVENT DISKUS)
- fluticasone furoate (generic for ARNUITY ELLIPTA)
- PULMICORT RESPULES (budesonide)

NON-PREFERRED AGENTS WITH CRITERIA

fluticasone HFA (generic for FLOVENT HFA)

APPROVAL CRITERIA FOR ALVESCO HFA

- The beneficiary must be ≥ 12 years of age or the minimum age recommended in the manufacturer's package insert
- The prescriber must submit documentation of the medical necessity for ALVESCO HFA over the preferred inhaled powder ICS formulation or preferred ICS/LABA product

APPROVAL CRITERIA FOR BUDESONIDE RESPULES POINT-OF-SALE (POS)

Criteria 1: The beneficiary < 4 years of age (maximum dose is 2 mg/day); **OR**

Criteria 2: Regardless of age, the beneficiary has a billed diagnosis of eosinophilic esophagitis

- Age < 10 years – maximum dose is 2 mg/day
- Age ≥ 10 years – maximum dose is 4 mg/day

APPROVAL CRITERIA FOR FLUTICASONE HFA POINT-OF-SALE (POS)

If neither of the following criteria are met, a prior authorization request will be required:

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- **Criteria 1:**
  - Claim for beneficiary < 7 years of age for fluticasone HFA will pay without prior authorization
  - Beneficiaries < 7 years of age should transition to a preferred inhaled powder ICS formulation or preferred ICS/LABA product when possible; **OR**
- **Criteria 2:**
  - Point-of-sale criteria for fluticasone HFA for eosinophilic esophagitis (EoE)
    - Regardless of age, beneficiary with a billed diagnosis of EoE will not require prior authorization
    - If there is no billed diagnosis of EoE, a prior authorization request must be submitted with documentation of medical necessity

Eosinophilic esophagitis (EoE): Submit documentation supporting an EoE diagnosis.

Asthma: Beneficiaries ≥ 7 years of age with asthma should transition to an inhaled powder ICS formulation or ICS/LABA product that is available without a PA if possible (consider the GINA guidelines). If ICS HFA product is still needed, submit documentation of medical necessity over preferred powder ICS products or preferred ICS/LABA combination products. ASMANEX HFA is the preferred ICS HFA product when an ICS HFA formulation is deemed medically necessary.

Note: Consider SMART therapy with a preferred ICS-formoterol for use as an as needed (PRN) and regular daily treatment instead of a single agent inhaled corticosteroid (per GINA and EPR-3 Guidelines).

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CORTICOSTEROIDS – TOPICAL

Updated 7/1/2025

The **quantity limit** for topical corticosteroids, in general, for each topical corticosteroid agent will be limited to **one package size for the NDC** (e.g., one 15 gm tube, one 30 gm tube), up to a 240 gm package size if the agent is available in a 240 gm size. Topical solutions and lotions will be limited to the smaller package size available for that drug entity.

POTENCY CLASS 1 – SUPERPOTENT, PREFERRED STATUS ONLY FOR PACKAGE SIZES NOTED

- clobetasol prop 0.05% cream/ointment 15 gm, 30 gm, 45 gm, and 60 gm (generic for TEMOVATE)
- clobetasol prop 0.05% cream-emollient 15 gm, 30 gm, and 60 gm (generic for TEMOVATE-E)
- clobetasol prop 0.05% solution 25 mL and 50 mL (generic for TEMOVATE)
- fluocinonide 0.1% cream 30 gm, 60 gm, and 120 gm (generic for LIDEX)
- halobetasol prop 0.05% cream 15 gm and 50 gm (generic for ULTRAVATE)

POTENCY CLASS 1 – SUPERPOTENT, NON-PREFERRED STATUS FOR ALL PACKAGE SIZES UNLESS OTHERWISE NOTED

- betamethasone dip augmented 0.05% gel/lotion/ointment (generic for DIPROLENE)
- clobetasol prop 0.05% emollient foam (generic for OLUX-E)
- clobetasol prop 0.05% foam/gel/lotion (generic for OLUX/TEMOVATE)
- clobetasol prop 0.05% shampoo/spray (generic for CLOBEX)
- CLOBEX (clobetasol propionate)
- CLODAN (clobetasol propionate)
- desoximetasone 0.25% spray (generic for TOPICORT)
- diflorasone diacetate 0.05% ointment (generic for APEXICON)
- DIPROLENE (betamethasone dip augmented)
- halobetasol prop 0.05% foam/lotion/ointment (generic for LEXETTE/ULTRAVATE)
- TOVET (clobetasol propionate)
- ULTRAVATE (halobetasol propionate)

POTENCY CLASS 2 – POTENT, PREFERRED STATUS ONLY FOR PACKAGE SIZES NOTED

- betamethasone dip augmented 0.05% cream 15 gm and 50 gm (generic for DIPROLENE)
- fluocinonide 0.05% cream 15 gm, 30 gm, 60 gm, and 120 gm (generic for LIDEX)
- fluocinonide 0.05% ointment 15 gm, 30 gm, and 60 gm (generic for LIDEX)
- triamcinolone 0.5% ointment 15 gm (generic for KENALOG)

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POTENCY CLASS 2 – POTENT, NON-PREFERRED STATUS FOR ALL PACKAGE SIZES UNLESS OTHERWISE NOTED

- APLEXICON E (diflorasone diacetate)
- clobetasol prop 0.025% cream
- desoximetasone 0.05% gel (generic for TOPICORT)
- desoximetasone 0.25% cream/ointment (generic for TOPICORT)
- diflorasone 0.05% cream (generic for APEXICON)
- fluocinonide 0.05% gel/solution (generic for LIDEX)
- halcinonide 0.1% cream/solution (generic for HALOG)
- HALOG (halcinonide)
- TOPICORT (desoximetasone)

POTENCY CLASS 3 – UPPER-MID STRENGTH, PREFERRED STATUS ONLY FOR PACKAGE SIZES NOTED

- betamethasone dip 0.05% (not augmented) lotion 60 mL (generic for DIPROSONE)
- betamethasone val 0.1% ointment 15 gm and 45 gm (generic for VALISONE)
- mometasone furoate 0.1% ointment 15 gm and 45 gm (generic for ELOCON)
- triamcinolone 0.5% cream 15 gm (generic for KENALOG)
- triamcinolone 0.1% ointment 15 gm, 30 gm, and 80 gm (generic for KENALOG)

POTENCY CLASS 3 – UPPER-MID STRENGTH, NON-PREFERRED STATUS FOR ALL PACKAGE SIZES UNLESS OTHERWISE NOTED

- amcinonide 0.1% cream (generic for CYCLOCORT)
- betamethasone dip 0.05% (not augmented) cream/ointment (generic for DIPROSONE)
- betamethasone valerate 0.12% foam (generic for LUXIQ)
- fluocinonide 0.05% emollient cream (generic for LIDEX-E)
- fluticasone prop 0.005% ointment
- triamcinolone 0.1% ointment 453.6 gm and 454 gm (generic for KENALOG)

POTENCY CLASS 4 – MID STRENGTH, PREFERRED STATUS ONLY FOR PACKAGE SIZES NOTED

- fluocinolone 0.025% ointment 15 gm and 60 gm (generic for SYNALAR)
- mometasone furoate 0.1% cream 15 gm and 45 gm (generic for ELOCON)
- mometasone furoate 0.1% solution/lotion 30 mL and 60 mL (generic for ELOCON)
- triamcinolone 0.1% cream 15 gm, 30 gm, and 80 gm (generic for KENALOG)

POTENCY CLASS 4 – MID STRENGTH, NON-PREFERRED STATUS FOR ALL PACKAGE SIZES UNLESS OTHERWISE NOTED

- clocortolone pivalate 0.1% cream (generic for CLODERM)

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- desoximetasone 0.05% cream/ointment (generic for TOPICORT)
- flurandrenolide 0.05% ointment (generic for CORDRAN)
- hydrocortisone valerate 0.2% ointment (generic for WESTCORT)
- SYNALAR 0.025% ointment (fluocinolone)
- triamcinolone acetonide 0.1% aerosol spray (generic for KENALOG)
- triamcinolone 0.1% cream 453.6 gm and 454 gm (generic for KENALOG)

POTENCY CLASS 5 – LOWER-MID STRENGTH, PREFERRED STATUS ONLY FOR PACKAGE SIZES NOTED

- betamethasone valerate 0.1% cream 15 gm and 45 gm (generic for VALISONE)
- fluocinolone 0.01% cream 15 gm and 60 gm (generic for SYNALAR)
- fluocinolone 0.025% cream 15 gm and 60 gm (generic for SYNALAR)
- fluticasone propionate 0.05% cream 15 gm, 30 gm, and 60 gm (generic for CUTIVATE)
- triamcinolone 0.025% lotion 60 mL (generic for KENALOG)
- triamcinolone 0.025% ointment 15 gm and 80 gm (generic for KENALOG)
- triamcinolone 0.1% lotion 60 mL (generic for KENALOG)

POTENCY CLASS 5 – LOWER-MID STRENGTH, NON-PREFERRED STATUS FOR ALL PACKAGE SIZES UNLESS OTHERWISE NOTED

- BESER (fluticasone)
- betamethasone valerate 0.1% lotion (generic for VALISONE)
- CAPEX (fluocinolone)
- desonide 0.05% lotion/ointment (generic for DESOWEN)
- flurandrenolide 0.05% lotion (generic for CORDRAN)
- fluticasone prop 0.05% lotion (generic for CUTIVATE)
- hydrocortisone butyrate 0.1% cream/lotion/ointment/solution (generic for LOCOID)
- hydrocortisone valerate 0.2% cream (generic for WESTCORT)
- prednicarbate 0.1% ointment (generic for DERMATOP)
- SYNALAR 0.025% cream (fluocinolone)
- triamcinolone 0.025% ointment 454 gm and 430 gm (generic for KENALOG)
- triamcinolone 0.05% ointment 430 gm (generic for KENALOG)

POTENCY CLASS 6 – MILD, PREFERRED STATUS ONLY FOR PACKAGE SIZES NOTED

- desonide 0.05% cream 15 gm and 60 gm (generic for DESOWEN)
- fluocinolone 0.01% solution 60 mL (generic for SYNALAR)
- triamcinolone 0.025% cream 15 gm and 80 gm (generic for KENALOG)

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POTENCY CLASS 6 – MILD, NON-PREFERRED STATUS FOR ALL PACKAGE SIZES UNLESS OTHERWISE NOTED

- alclometasone dipropionate 0.05% cream/ointment (generic for ACLOVATE)
- DERMA-SMOOTH FS (fluocinolone)
- fluocinolone scalp/body oil (generic for DERMA-SMOOTHE FS)
- SYNALAR 0.1% solution (fluocinolone)
- triamcinolone 0.025% cream 454 gm (generic for KENALOG)

POTENCY CLASS 7 – LEAST POTENT, PREFERRED STATUS ONLY FOR PACKAGE SIZES NOTED

- hydrocortisone acetate 0.5% cream OTC 28.4 gm
- hydrocortisone 0.5% cream OTC 28.4 gm and 28.35 gm
- hydrocortisone 1% cream 28.35 gm and 28.4 gm (generic for CORTISONE)
- hydrocortisone 1% ointment 28.35 gm and 28.4 gm (generic for CORTISONE)
- hydrocortisone 2.5% cream 20 gm, 28 gm, 28.35 gm, and 30 gm (generic for HYTONE)
- hydrocortisone 2.5% ointment 20 gm 28.35 gm, and 28.4 gm (generic for HYTONE)

POTENCY CLASS 7 – LEAST POTENT, NON-PREFERRED STATUS FOR ALL PACKAGE SIZES UNLESS OTHERWISE NOTED

- hydrocortisone 1% cream 453.6 gm and 454 gm (generic for CORTISONE)
- hydrocortisone 1% ointment 453.6 gm (generic for CORTISONE)
- hydrocortisone 2.5% cream 453.6 gm (generic for HYTONE)
- hydrocortisone 2.5% ointment 453.6 gm and 454 gm (generic for HYTONE)
- hydrocortisone 2.5% lotion/solution (generic for HYTONE/TEXACORT)
- TEXACORT (hydrocortisone)

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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CORTICOTROPIN GEL INJECTION (ACTHAR HP AND CORTROPHIN)

Updated 1/21/2026

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary must be ≤ 2 years of age
- The beneficiary must have a diagnosis for infantile spasms (West Syndrome) as indicated by:
  - Epileptic spasms
  - Developmental problems; **AND**
  - Hypsarrhythmia on electroencephalography (EEG)
- Prior authorization request should be submitted prior to beginning ACTHAR if being hospitalized and sent again upon discharge
- The beneficiary has a history of previous vigabatrin (SABRIL) **and** corticosteroid usage with failure
- PA requests for indications outside of infantile spasms will be considered on a case-by-case basis
- Requests for PURIFIED CORTROPHIN gel (repository corticotropin injection) will require a beneficiary specific, clinically significant reason why ACTHAR gel (repository corticotropin injection) or ACTHAR Gel SelfJect (repository corticotropin auto-injector) cannot be used
- PA will be approved at the time of discharge for the amount needed for completion of the taper. Beneficiaries cannot fill ACTHAR as a pharmacy benefit and use during hospitalization.
- The prescriber must submit the following:
  - Admission clinical notes with initial prior authorization request and discharge summary notes prior to discharge
  - ACTHAR form with initial request and resubmit the form at time of discharge with specific taper directions; **AND**
  - Current body surface area (BSA)

DENIAL CRITERIA

- The beneficiary has not trialed vigabatrin (SABRIL) **and** corticosteroids
- The prescriber has not submitted all of the required information as outlined on the ACTHAR form; **OR**
- The prescriber intends to use ACTHAR purchased as a pharmacy benefit during an inpatient stay

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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CRINECERFONT (CRENESSITY)

Updated 4/16/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with classic congenital adrenal hyperplasia with 21-hydroxylase deficiency and meets **one** of the following:
  - Requires supraphysiological glucocorticoid doses and has normal androgen levels; **OR**
  - Glucocorticoids provide inadequate androgen control
- The medication must be prescribed by or in consultation with an endocrinologist
- The beneficiary must remain on glucocorticoid replacement therapy
- The beneficiary requiring concomitant moderate or strong CYP3A4 inducer (e.g., carbamazepine, phenobarbital, bosentan, modafinil) will need dose modification
- The beneficiary should not be approved or continue the medication if meets **one** of the following:
  - Has severe renal impairment or end-stage renal disease
  - Is not prescribed concomitant glucocorticoids
- The prescriber must submit the following:
  - Current chart notes with documentation to support the diagnosis
  - Previous therapies tried with doses
  - Current glucocorticoid dose
  - Current serum androgen levels
  - Current comprehensive lab panel; **AND**
  - Current weight to confirm proper dosing
- Initial prior authorization will be for 3 months, subsequent approvals may be up to 6 months

RENEWAL REQUIREMENTS

- The beneficiary must remain compliant with therapy (defined as 75% utilization)
- The beneficiary must demonstrate a positive response to treatment with a decrease in required glucocorticoid daily doses compared to baseline and decrease in androgen levels (if elevated at baseline)
- The prescriber must submit the following:
  - Current chart notes
  - Current glucocorticoid dose; **AND**

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- Current serum androgen levels

QUANTITY EDITS

- #60 capsules per 30 days for each strength (PA override for exceeding this quantity if requires a CYP3A4 inducer)
- #120 mL per 30 days for oral solution (PA override for exceeding this quantity if requires a CYP3A4 inducer)

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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CROFELEMER (MYTESI)

Updated 1/15/2025

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary diagnosed with HIV/AIDS and taking anti-retroviral therapy must be diagnosed with symptomatic non-infectious diarrhea
- The beneficiary should not be approved or continue this therapy with any of the following:
  - Diarrhea is caused by an infection; **OR**
  - Has not tried anti-diarrheal medication
- The prescriber must submit the following:
  - Current chart notes
  - Results of gastrointestinal biopsy, gastrointestinal culture, or stool test; **AND**
  - Medical necessity over anti-diarrheal medication

RENEWAL REQUIREMENTS

- The beneficiary must be compliant on therapy (defined as 75% utilization)
- The beneficiary must demonstrate a positive response
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Documentation of response to therapy

QUANTITY EDITS

#60 tablets per 30 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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CROMOLYN SODIUM ORAL SOLUTION (GASTROCROM)

Updated 09/21/2009

APPROVAL CRITERIA

Diagnosis of mastocytosis (congenital pigmentary anomalies or malignant mast cell tumors) in the past three years

ADDITIONAL CRITERIA

Age edit: > 2 years of age

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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CYSTEAMINE (PROCYSBI)

Updated 1/15/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must be diagnosed with nephropathic cystinosis and be at least 1 year of age or older
- The beneficiary should not be approved or continue this therapy with any of the following:
  - Develops skin or bone lesions (Ehlers-Danlos-like syndrome) – interrupt and start at lower dose
  - Develops severe skin rashes (e.g., erythema multiforme bullosa or toxic epidermal necrolysis)
  - Develops fibrosing colonopathy
  - Confirmed benign intracranial hypertension
  - Develops severe GI ulcers or bleeding – decrease dose
  - Develops leukopenia or elevated alkaline phosphatase levels – decrease dose or discontinue until values normalize; **OR**
  - Dose requested is not supported in the package insert for beneficiary body surface area
- The prescriber must submit the following:
  - Current chart notes
  - Current labs, including CBC and alkaline phosphatase levels
  - Current body surface area for dose calculation; **AND**
  - Medical necessity over CYSTAGON (cysteamine bitartrate IR)

RENEWAL REQUIREMENTS

- The beneficiary must be compliant on therapy (defined as 75% utilization)
- The beneficiary must demonstrate a positive response
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of response to therapy; **AND**
  - Current body surface area

QUANTITY EDITS

- 25 mg – #120 capsules per 30 days
- 75 mg– #800 capsules or granules per 30 days (based on max dose of 2,000 mg per day)
- 300 mg – #210 granules per 30 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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CYSTEAMINE OPHTHALMIC DROPS (CYSTARAN AND CYSTADROPS)

Updated 1/15/2025

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must be diagnosed with cystinosis and has corneal cystine crystal accumulation
- The prescriber must submit the following:
  - Current chart notes
  - Baseline description of corneal cystine crystals
  - Test results confirming the diagnosis; **AND**
  - If the requested drug is CYSTADROPS, provide the medical necessity of CYSTADROPS over CYSTARAN

RENEWAL REQUIREMENTS

- The beneficiary must be compliant on therapy (defined as 75% utilization)
- The beneficiary must demonstrate a positive response with a decrease in corneal cystine crystals
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Documentation of response to therapy

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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CYSTIC FIBROSIS TRANSMEMBRANE CONDUCTANCE REGULATOR AGENTS (CFTR) – ALYFTREK, KALYDECO, ORKAMBI, SYMDEKO, AND TRIKAFTA

Updated 7/1/2023

POINT-OF-SALE (POS) EDITS

Criterion 1:

- The beneficiary has a billed diagnosis of cystic fibrosis in the last 2 years
- The beneficiary meets the minimum age recommended in the manufacturer's package insert for the specific requested medication
- The beneficiary is prescribed a maximum dose based on support in manufacturer's package insert; **OR**

Criterion 2:

- The beneficiary Medicaid profile includes a claim for either ALYFTREK, KALYDECO, ORKAMBI, SYMDEKO, **or** TRIKAFTA in the last 90 days

The beneficiaries not meeting the POS edits will require prior authorization. The prescriber must submit a request with current chart notes documenting a cystic fibrosis diagnosis.

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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DANICOPAN (VOYDEYA)

Updated 7/17/2024

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with paroxysmal nocturnal hemoglobinuria (PNH) and require treatment for extravascular hemolysis (EVH) and concomitant therapy with ravulizumab or eculizumab **or** diagnosis consistent with any new FDA-approved indications. Any off-label requests will be reviewed on a case-by-case basis.
- The beneficiary must be vaccinated against encapsulated bacteria, including *Streptococcus pneumoniae* and *Neisseria meningitidis* types A, C, W, Y, and B, at least 2 weeks prior to initiation of VOYDEYA, and beneficiary must be provided antibiotics if vaccines were administered less than 2 weeks before starting therapy
- The prescriber and pharmacy must be enrolled in the REMS program
- The medication is prescribed by or in consultation with a hematologist
- The beneficiary must have clinically significant EVH defined as anemia with hemoglobin ≤ 9.5 g/dL and absolute reticulocyte count ≥ 120 x 10^9/L with or without transfusion support
- The beneficiary must have been on a stable dose of either ravulizumab or eculizumab for at least the previous 6 months.
- The beneficiary should not be approved or continue this therapy with any of the following:
  - Severe hepatic impairment (Child-Pugh C)
  - Not on a stable dose of a C5 inhibitor
  - Treatment plan does not include continuation of a C5 inhibitor
  - Active infection caused by an encapsulated bacteria (e.g.,*Streptococcus pneumoniae*, *Neisseria meningitidis*, and *Haemophilus influenzae* type b)
  - No vaccinations against encapsulated bacteria (e.g., *Streptococcus pneumoniae* and *Neisseria meningitidis*) at least 2 weeks prior to initiation of Fabhalta and no antibiotic drug prophylaxis
  - Pregnant or breastfeeding
- The prescriber must submit the following:
  - Current chart notes
  - Documented symptoms as a baseline
  - Documentation of previous therapies
  - Current labs, including complete blood count (CBC), comprehensive metabolic panel (CMP)

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- Recent history of blood transfusions
- Pregnancy test results (if applicable); **AND**
- Dose requested

RENEWAL REQUIREMENTS

- The beneficiary is compliant with therapy (defined as 75% utilization)
- The beneficiary remains on C5 inhibitor
- The beneficiary has an improvement in hemoglobin and/or reticulocyte count compared to baseline
- The beneficiary has an improvement in overall clinical presentation (e.g., fatigue, dyspnea, reduction in transfusions)
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Current labs, including CBC and CMP

QUANTITY EDITS

- 150 mg dose (100 mg and 50 mg taken three times daily) – #180 tablets per 30 days
- 200 mg dose (two 100 mg taken three times daily) – #180 tablets per 30 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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DEFERASIROX (JADENU)

Updated 1/15/2025

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must be diagnosed with **one** of the following:
  - Chronic iron overload due to blood transfusions (transfusional iron overload) with both of the following:
    - Transfusion of at least 100 mL/kg of packed reb blood cells (e.g., at least 20 units of packed red blood cells for a 40 kg person or more in individuals weighing more than 40 kg); **AND**
    - Serum ferritin consistently greater than 1,000 mcg/L
  - Chronic iron overload in non-transfusion-dependent thalassemia syndromes with both of the following:
    - Liver Iron Concentration (LIC) of at least 5 mg Fe/g dw; **AND**
    - Serum ferritin greater than 300 mcg/L
- The beneficiary should not be approved or continue this therapy with any of the following:
  - Has eGFR $\leq$ 40 mL/min/1.73 m^2
  - Has suspected GI ulceration or hemorrhage
  - Has severe hepatic impairment; dose reduction in moderate hepatic impairment
  - Has high-risk myelodysplastic syndrome
  - Has advanced malignancies
  - Has platelet counts $\leq$ 50 x 10^9/L; **OR**
  - Serum ferritin falls below 500 mcg/L in benenficiaries with transfusional iron overload or below 300 mcg/L in beneficiaries with thalassemia (must interrupt and monitor)
- The prescriber must submit the following:
  - Current chart notes
  - Previous therapies tried with response
  - Baseline renal function with eGFR and serum creatinine
  - Baseline serum ferritin level and liver iron concentration (LIC) in the beneficiary with thalassemia.
  - Other Current labs, including liver function tests and platelets
  - Current weight; **AND**
  - Medical necessity over EXJADE which is available without a PA

RENEWAL REQUIREMENTS

- The beneficiary must be compliant on therapy (defined as 75% utilization)
- The beneficiary must demonstrate a positive response (i.e., decrease in liver iron concentration (LIC) and/or serum ferritin)

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- The prescriber must submit the following:
  - Current chart notes
  - Documentation of response to therapy; **AND**
  - Updated labs (i.e., renal function, LFTs, platelets, serum ferritin, LIC)

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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DEFERIPRONE (FERRIPROX)

Updated 1/15/2025

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must be diagnosed with thalassemia syndromes, sickle cell disease or other anemia and need treatment for transfusional iron overload
- The beneficiary should not be approved or continue this therapy with any of the following:
  - Has myelodysplastic syndrome
  - Has Diamond Blackfan anemia
  - Develops agranulocytosis with ANC < 0.5 x 10^9/L **or** neutropenia with ANC < 1.5 x 10^9/L and > 0.5 x 10^9/L
  - Interrupt therapy if neutropenic with ANC < 1.5 x 10^9/L; **OR**
  - Is pregnant
- The prescriber must submit the following:
  - Current chart notes
  - Previous therapies with response
  - Current labs, including absolute neutrophil count (ANC), serum ferritin, liver function tests (LFTs), zinc; **AND**
  - Current weight

RENEWAL REQUIREMENTS

- The beneficiary must be compliant on therapy (defined as 75% utilization)
- The beneficiary must demonstrate a positive response with decrease in liver iron concentration (LIC) and/or serum ferritin
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of response to therapy; **AND**
  - Updated labs (i.e., LFTs, serum ferritin, ANC)

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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DELAFLOXACIN TABLET AND VIAL (BAXDELA)

Updated 1/15/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must be diagnosed with **one** of the following:
  - **Acute Bacterial Skin and Skin Structure Infections**: BAXDELA is indicated in adults for the treatment of acute bacterial skin and skin structure infections (ABSSSI) caused by the following susceptible microorganisms: *Staphylococcus aureus* (including methicillin-resistant [MRSA] and methicillin-susceptible [MSSA] isolates), *Staphylococcus haemolyticus*, *Staphylococcus lugdunensis*, *Streptococcus agalactiae*, *Streptococcus anginosus* Group (including *Streptococcus anginosus*, *Streptococcus intermedius*, and *Streptococcus constellatus*), *Streptococcus pyogenes*, *Enterococcus faecalis*, *Escherichia coli*, *Enterobacter cloacae*, *Klebsiella pneumoniae*, and *Pseudomonas aeruginosa*.; **OR**
  - **Community-Acquired Bacterial Pneumonia**: BAXDELA is indicated in adults for the treatment of community-acquired bacterial pneumonia (CABP) caused by the following susceptible microorganisms: *Streptococcus pneumoniae*, *Staphylococcus aureus* (methicillin-susceptible [MSSA] isolates only), *Klebsiella pneumoniae*, *Escherichia coli*, *Pseudomonas aeruginosa*, *Haemophilus influenzae*, *Haemophilus parainfluenzae*, *Chlamydia pneumoniae*, *Legionella pneumophila*, and *Mycoplasma pneumoniae*.
- The beneficiary should not be approved or continue this therapy with any of the following:
  - End Stage Renal Disease (ESRD) (< 15 mL/min/1.73 m^2), including beneficiaries on hemodialysis (HD); **AND**
  - Infection does not culture with a bacteria listed in the indications
- The prescriber must submit the following:
  - Current chart notes
  - Confirmation of diagnosis with culture; **AND**
  - Medical necessity over other fluoroquinolones or one of the many other available antibiotics available without a PA

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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DESMOPRESSIN NASAL SPRAY (DDAVP)

Updated 03/26/2008

APPROVAL CRITERIA

Diagnosis in Medicaid history of diabetes insipidus in the past three years.

DENIAL CRITERIA

- Diagnosis in Medicaid history of nocturnal enuresis in the past three years.
- Diagnosis in Medicaid history of urinary incontinence in the past three years.

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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DESMOPRESSIN ORAL SOLUTION (DESMODA)

Updated 7/15/2026

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert
- The beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert or dosing is based on support from the official Compendia
- The beneficiary must be diagnosed with central diabetes insipidus (arginine vasopressin deficiency [AVP-D]) requiring antidiuretic replacement
- The beneficiary is not diagnosed with nephrogenic diabetes insipidus
- The beneficiary must not have a history of hyponatremia
- The beneficiary must not have moderate to severe renal impairment (defined as creatinine clearance less than 50 mL/min)
- The prescriber must submit the following:
  - Current chart notes
  - Therapies tried
  - If pediatric beneficiary, treatment plan for ensuring fluid restriction
  - Current labs and baseline 24-hour urine volume
  - Patient specific medical necessity over desmopressin tablets or nasal spray
- Initial PA approval for 3 months with subsequent approvals for 6 months

RENEWAL REQUIREMENTS

- The beneficiary must be compliant on therapy (defined as 75% utilization)
- The beneficiary must exhibit an improvement in symptoms (e.g., polyuria, nocturia, polydipsia) and urine volume
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of response to therapy
  - Documentation of continued need for the medication
  - Current labs, if warranted
  - Current 24-hour urine volume

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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DEXAMETHASONE DOSE PACK (TAPERDEX)

Updated 10/11/2011

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

DRUGS THAT DO NOT REQUIRE MANUAL REVIEW FOR PRIOR AUTHORIZATION

dexamethasone 1.5 mg tablet

DRUGS THAT REQUIRE MANUAL REVIEW FOR PRIOR AUTHORIZATION

- dexamethasone dose pack
- TAPERDEX dose pack

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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DEXTROMETHORPHAN AND QUINIDINE (NUEDEXTA)

Updated 1/15/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must be diagnosed with pseudobulbar affect (PBA) secondary to a neurological condition (e.g., ALS, MS, Parkinson's disease, stroke, traumatic brain injury)
- The medication must be prescribed by or in consultation with a neurologist or psychiatrist
- The beneficiary should not be approved or continue this therapy with any of the following:
  - Requires concomitant quinidine, quinine, or mefloquine
  - Requires concomitant monoamine oxidase inhibitors (MAOI) therapy or stopped the MAOI in the last 14 days (e.g., phenelzine and selegiline)
  - Requires concomitant use with drugs that both prolong QT interval and are metabolized by CYP2D6 (e.g., thioridazine or pimozide)
  - History of prolonged QT interval, congenital long QT syndrome, torsades de pointes, heart failure, or has high risk of complete AV block; **OR**
  - Pregnancy
- The prescriber must submit the following:
  - Current chart notes
  - Rationale for diagnosis of PBA; **AND**
  - Baseline number of PBA laughing or crying episodes per day
- Initial PA for 60 days

RENEWAL REQUIREMENTS

- The beneficiary must be compliant on therapy (defined as 75% utilization)
- The beneficiary must demonstrate a positive response with a documented decrease in PBA laughing or crying episodes
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of response to therapy; **AND**
  - Current PBA episodes per day (laughing and crying)

QUANTITY EDITS

#60 capsules per 30 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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DICHLORPHENAMIDE (KEVEYIS AND ORMALVI)

Updated 1/15/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must be diagnosed with primary hyperkalemic periodic paralysis, primary hypokalemic periodic paralysis or related variants
- The beneficiary must have a trial and failure of acetazolamide along with the appropriate diuretic needed for the beneficiary's diagnosis
- The beneficiary should not be approved or continue this therapy with any of the following:
  - Requires concomitant high dose aspirin
  - If metabolic acidosis develops or persists, consider reducing the dose or discontinuing; **OR**
  - If hypokalemia develops or persists, consider reducing the dose or discontinuing
- The prescriber must submit the following:
  - Current chart notes
  - Baseline labs including serum potassium and sodium bicarbonate; **AND**
  - Baseline symptoms with description of muscle weakness attack frequency and severity
- Initial PA for 2 months

RENEWAL REQUIREMENTS

- The beneficiary must be compliant on therapy (defined as 75% utilization)
- The beneficiary must demonstrate a positive response with reduced frequency and severity of attacks
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of response to therapy; **AND**
  - Current description of frequency and severity of muscle weakness attacks

QUANTITY EDITS

#120 tablets per 30 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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DIGOXIN 62.5 MCG (LANOXIN)

Updated 1/15/2025

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must be diagnosed with heart failure or atrial fibrillation
- The prescriber must submit the following:
  - Current chart notes
  - Previous therapies tried; **AND**
  - Medical necessity over other digoxin strengths that are available without a PA
- Initial PA for 6 months

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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DIOZOXIDE TABLET (VYKAT XR)

Updated 7/16/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with hyperphagia associated with Prader-Willi syndrome (PWS)
- The beneficiary must not be pregnant or breastfeeding
- The beneficiary should not exceed a dose of 5.8 mg/kg/day or 525 mg per day
- The beneficiary must exhibit hyperphagia with food seeking behavior, including beneficiary specific behaviors such as the following:
  - Frequency of foraging through trash for food
  - Frequency of sneaking or stealing food
  - Frequency of continued asking for food despite being told "no"
  - Becomes upset or distressed when denied food; **OR**
  - Seems to constantly think about food
- The prescriber must submit the following:
  - Current chart notes
  - Genetic testing results confirming diagnosis of PWS
  - Beneficiary specific clinical manifestations with examples of food seeking behavior
  - Current weight and BMI as baseline and dose verification
  - Current labs, including fasting blood glucose (FBG) and HbA1c as a baseline (FBG should be monitored at least once every week for the first 2 weeks, then at least once every 4 weeks, and as clinically indicated); **AND**
  - Specific plan to ensure that the beneficiary is in a food-secure environment with strict limitation of food intake
- Initial PA for 4 months

RENEWAL REQUIREMENTS

- The beneficiary must remain compliant with therapy (defined as 75% utilization)
- The beneficiary must demonstrate a positive response to treatment with a decrease in caregiver identified hyperphagia events compared to baseline
- The prescriber must submit the following:
  - Current chart notes

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- Current food seeking behavior update
- Current weight and BMI
- Current fasting blood glucose and HbA1c; **AND**
- Documentation of signs of fluid overload

QUANTITY EDITS

- 25 mg - #120 tablets per 30 days
- 75 mg - #90 tablets per 30 days
- 150 mg - #90 tablets per 30 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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DISOPYRAMIDE CR (NORPACE CR)

Updated 4/8/2014

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

≥ 90 days of disopyramide CR therapy in the past 120 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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DIURETICS

Updated 7/1/2026

PREFERRED AGENTS

- amiloride (generic for MIDAMOR)
- bumetanide tablet (generic for BUMEX)
- chlorthalidone (generic for THALITONE)
- eperenone (generic for INSPRA)
- furosemide oral solution and tablet (generic for LASIX)
- HCTZ (generic for HYDRODIURIL)
- indapamide (generic for LOZOL)
- metolazone (generic for ZAROXOLYN)
- spironolactone tablet (generic for ALDACTONE)
- spironolactone/HCTZ (generic for ALDACTAZIDE)
- torsemide (generic for DEMADEX)
- triamterene/HCTZ capsule (generic for DYAZIDE)
- triamterene/HCTZ tablet (generic for MAXZIDE)

PREFERRED AGENT WITH CRITERIA

- LASIX ONYU kit (furosemide) – (see criteria for LASIX ONYU)

NON-PREFERRED AGENTS

- ALDACTONE (spironolactone)
- amiloride/HCTZ (generic for MODURETIC)
- BAXFENDY (baxdrostat) – (see criteria for BAXFENDY)
- CAROSPIR (spironolactone)
- ENBUMYST (bumetanide) – (see criteria for ENBUMYST)
- ethacrynic acid tablet (generic for EDECRIN)
- FUROSCIX (furosemide) – (see criteria for FUROSCIX)
- HEMICLOR (CHLORTHALIDONE)
- INSPRA (eplerenone)
- INZIRQO (HCTZ) – (see criteria for INZIRQO)
- KERENDIA (finerenone) – (see criteria for KERENDIA)
- LASIX (furosemide)
- spironolactone oral suspension (generic for CAROSPIR) – POS Approval Criteria on next page
- THALITONE (chlorthalidone)
- triamterene (generic for DYRENIUM)

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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POS APPROVAL CRITERIA FOR SPIRONOLACTONE SUSPENSION (CAROSPIR)

- The beneficiary is < 7 years of age or has a diagnosis of NPO (Appendix A) in the last 365 days

DENIAL CRITERIA

- Hyperkalemia diagnosis in the previous 60 days
- The beneficiary has concomitant administration with potassium supplementation drug claim in previous 60 days; **OR**
- Addison's disease diagnosis in the previous 2 years; **OR**
- Concomitant use of eplerenone claim in previous 60 days; **OR**
- The beneficiary has lithium drug claim in history in the previous 60 days; **OR**
- The beneficiary is pregnant

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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DORNASE ALFA INHALATION SOLUTION (PULMOZYME)

Updated 1/9/2008

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

Diagnosis of cystic fibrosis in medical history

ADDITIONAL CRITERIA

Quantity limits apply

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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DOXECITINE AND DOXRIBTIMINE (KYGEVVI)

Updated 7/15/2026

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert
- The beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert or dosing is based on support from the official Compendia
- The beneficiary must be diagnosed with thymidine kinase 2 deficiency (TK2d) with symptom onset on or before 12 years of age confirmed by genetic mutation in the TK2 gene
- Must be prescribed by a specialist with experience in treating TK2d (e.g., geneticist, neurologist, endocrinologist)
- Beneficiaries with signs/symptoms of liver injury must have therapy interrupted until liver function tests return to baseline or stabilize. Consider restarting at the last tolerated dose and increase the dose as tolerated.
- The prescriber must submit the following:
  - Current chart notes with documentation of patient specific symptoms attributed to TK2d as baseline
  - Genetic testing confirming the TK2d diagnosis
  - Current labs including liver function tests
  - Current weight
  - Dose requested

RENEWAL REQUIREMENTS

- The beneficiary must be compliant on therapy (defined as 75% utilization)
- The beneficiary must have demonstrated a positive response, defined as either slowing the rate of motor function decline or regaining motor milestones previously lost (e.g., less ventilatory support is required or the beneficary was able to remove feeding tube)
- The prescriber must submit the following:
  - Current chart notes with documentation of patient specific symptoms to compare to baseline
  - Current labs including liver function tests
  - Current weight
  - Dose requested

QUANTITY EDITS

None since dosing is variable

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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DOXEPIN 5% CREAM (ZONALON AND PRUDOXIN)

Updated 9/21/2009

APPROVAL CRITERIA

History of > 2 claims for a steroidal product (Class 5 or higher) in the past 60 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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DOXYLAMINE SUCCINATE/PYRIDOXINE (DICLEGIS DR)

Updated 4/20/2022

POINT-OF-SALE (POS) APPROVAL CRITERIA

- The beneficiary has a billed diagnosis of pregnancy or a lab value confirming pregnancy within the last 9 months without documentation of delivery or pregnancy termination.
- The beneficiary not meeting point-of-sale criteria will require a PA request with documentation of current pregnancy.

QUANTITY EDITS

#124 tablets per 31 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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DOXYLAMINE SUCCINATE/PYRIDOXINE (BONJESTA)

Updated 4/20/2022

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- Confirmation of pregnancy
- Medical necessity over DICLEGIS

QUANTITY EDITS

#62 tablets per 31 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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DRONABINOL (MARINOL)

Updated 6/27/2007

APPROVAL CRITERIA

Criterion 1:

- Age > 18 years of age; **AND**
- Submitted diagnosis HIV within the past 730 days; **AND**
- Submitted diagnosis for cachexia within the past 730 days; **AND**
- At least three paid drug claims in history identifying antiretrovirals (either as single entity or combo drug) within the past 31 days; **AND**
- Paid claim for megestrol acetate (MEGACE) within the past 31 days (four weeks) (Showing concomitant treatment)

Criterion 2:

- Age > 18 years of age; **AND**
- Submitted diagnosis malignant cancer within the past 365 days; **AND**
- Procedure code indicating radiation treatment within the past 45 days; **AND**
- Paid drug claim in history within the past 45 days for an oral 5-HT3 (serotonin) receptor antagonist; **OR**
- Paid drug claim in history within the past 45 days for a NK1 (neurokinin-1) receptor antagonist

DENIAL CRITERIA

- Absence of approval criteria
- Submitted diagnosis of bipolar in medical history.
- Submitted diagnosis of depression in medical history.
- Submitted diagnosis of schizophrenia in medical history.
- Submitted diagnosis of substance or alcohol abuse in medical history.

ADDITIONAL CRITERIA

Quantity limits apply

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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DROXIDOPA CAPSULE (NORTHERA)

Updated 1/15/2025

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must be diagnosed with symptomatic neurogenic orthostatic hypotension caused by primary autonomic failure (Parkinson's disease, multiple system atrophy, and pure autonomic failure), dopamine beta-hydroxylase deficiency, or non-diabetic autonomic neuropathy
- The beneficiary must have tried and failed at least two of the following medications (unless contraindication to all medications):
  - midodrine
  - fludrocortisone; **OR**
  - pyridostigmine
- The prescriber must submit the following:
  - Current chart notes
  - Document of previous therapies with response; **AND**
  - Baseline documentation of symptoms
- The initial request should be for 2 weeks

RENEWAL REQUIREMENTS

The prescriber must submit documentation of positive response to treatment with decreased symptoms to continue with authorization.

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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DUCHENNE MUSCULAR DYSTROPHY AGENTS

Updated 4/1/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

PREFERRED AGENTS WITH CRITERIA (MANUAL REVIEW)

- EMFLAZA suspension (deflazacort) – **brand only**
- EMFLAZA tablet (deflazacort) – **brand only**

NON-PREFERRED AGENTS

- AGAMREE (vamorolone)
- deflazacort (generic for EMFLAZA)
- DUVYZAT (givinostat)
- JAYTHARI (deflazacort)
- KYMBEE (deflazacort)
- PYQUVI (deflazacort)

APPROVAL CRITERIA FOR EMFLAZA

- The beneficiary has a confirmed genetic diagnosis of Duchenne muscular dystrophy (DMD)
- Age ≥ 2 years of age
- Provide documentation of the mutation in the dystrophin gene
- The prescriber must specialize in the treatment of DMD and/or neuromuscular disorders
- Provide a letter of medical necessity with a significant reason specific to the beneficiary that EMFLAZA is needed over other glucocorticosteroids, such as prednisone or prednisolone
- The prescriber must submit documentation to substantiate the medical necessity request of EMFLAZA over other glucocorticoid agents, including submitting chart notes, data on all previous glucocorticosteroid(s) tried, and include explanation of failure or explanation of an adverse effect caused by prednisone or prednisolone that is not also caused by EMFLAZA
- Provide documentation of current weight and dosage requested
- Provide documentation that beneficiary has received a baseline eye examination
- Provide documentation that the beneficiary is currently receiving, or planning to receive, physical therapy and provide physical therapy notes
- Provide documentation of Child-Pugh Score (no clinical experience in beneficiaries with severe hepatic impairment)

DENIAL CRITERIA FOR EMFLAZA

- The beneficiary is < 2 years of age
- The beneficiary does not meet above approval criteria

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- The beneficiary has not received prednisone or prednisolone
- The beneficiary did not receive the weight-based dose on a daily schedule of prednisone or prednisolone (0.75 mg/kg/day)
- The beneficiary is classified as Child Pugh C

APPROVAL CRITERIA FOR AGAMREE

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with Duchenne Muscular Dystrophy (DMD) **or** a diagnosis consistent with any new FDA-approved indication. Any off-label requests will be reviewed on a case-by-case basis.
- The beneficiary has received all appropriate immunizations according to current ACIP guidelines at least two weeks prior to initiation (at least 4 to 6 weeks prior for live attenuated or live vaccines)
- Dose modifications
  - Mild to moderate hepatic impairment – 2 mg/kg once daily with a maximum of 100 mg for beneficiaries more than 50 kg (severe hepatic impairment will be denied)
  - Coadministration with CYP3A4 inhibitors – 4 mg/kg once daily with a maximum of 200 mg for beneficiaries more than 50 kg
- The prescriber must specialize in the treatment of DMD and/or neuromuscular disorders
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of the mutation in the dystrophin gene
  - Information on previous glucocorticosteroids tried including explanation of failure or adverse effect caused by the steroid that is not also caused by AGAMREE
  - Letter of medical necessity with a significant reason specific to the beneficiary that AGAMREE is needed over other glucocorticosteroids (e.g., prednisone, prednisolone, deflazacort)
  - Current weight and dose requested
  - Documentation that the beneficiary is currently receiving, or planning to receive, physical therapy and provide physical therapy notes; **AND**
  - A baseline assessment of ambulatory function using the Time to Stand Test (TTSTAND) has been documented prior to initiating AGAMREE therapy
- Requests for non-preferred agents require the medical necessity over brand name EMFLAZA.

RENEWAL REQUIREMENTS FOR AGAMREE

- The beneficiary demonstrates a positive response to vamorolone treatment with clinical improvement in ambulatory function as measured by the Time to Stand Test (TTSTAND) compared to baseline after 24 weeks

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- The beneficiary lacks clinically significant or intolerable adverse effects related to treatment
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Current weight and dose requested

QUANTITY EDITS FOR AGAMREE

#3 bottles per 30 days

APPROVAL CRITERIA FOR DUVYZAT

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with Duchenne Muscular Dystrophy (DMD) **or** a diagnosis consistent with any new FDA-approved indication. Any off-label requests will be reviewed on a case-by-case basis.
- The prescriber must specialize in the treatment of DMD and/or neuromuscular disorders
- The beneficiary must have been stable on prednisone, deflazacort, or vamorolone for at least 6 months unless there is a documented contraindication
- The beneficiary will continue corticosteroid therapy concomitantly unless contraindicated
- The beneficiary should not be approved or continue the medication if meet **one** of the following:
  - Baseline platelet count less than 150 x 10^9/L
  - Triglycerides remain elevated despite adequate dietary intervention and dosage adjustment
  - Previous gene therapy for the treatment of DMD (e.g., Elevidys); **OR**
  - Currently non-ambulatory
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of the mutation in the dystrophin gene
  - Previous therapies tried with timeframe and response
  - Current labs, including platelets and lipids
  - Baseline ECG results if has underlying cardiac disease or taking concomitant medications that cause QT prolongation
  - Current weight
  - Dose requested
  - Baseline assessment of ambulatory function to be used throughout treatment for consistent monitoring (e.g., Time to Stand Test (TTSTAND), 4-stair climb (4SC) time, North Star Ambulatory Assessment (NSAA)

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- Documentation that the beneficiary is currently receiving, or planning to receive, physical therapy and provide physical therapy notes; **AND**
- Letter of medical necessity with a significant clinical reason specific to the beneficiary that DUVYZAT is needed over the preferred medications and of medications available as a medical claim (i.e., eteplirsen, golodirsen, casimersen, and viltolarsen)

- Requests for non-preferred agents require the medical necessity over brand name EMFLAZA.

RENEWAL REQUIREMENTS FOR DUVYZAT

- The beneficiary must be compliant with therapy (defined as 75% utilization)
- The beneficiary demonstrates a positive response with either clinical improvement or a decrease in the rate of function decline compared to baseline
- The beneficiary lacks clinically significant or intolerable adverse effects related to treatment (i.e., platelets remain > 150 x 10^9/L)
- The prescriber must submit the following:
  - Current chart notes with documentation of response to therapy
  - Current labs, including platelets and lipids
  - Attestation that the beneficiary continues physical therapy

QUANTITY EDITS FOR DUVYZAT

#420 mL (3 bottles) per 35 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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EFGARTIGIMOD-HYALURONIDASE-QVFC SYRINGE (VYVGART HYTRULO)

Updated 7/16/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

Note: Vials are medical benefit only.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with **one** of the following:
  - Generalized myasthenia gravis (gMG); **OR**
  - Chronic inflammatory demyelinating polyneuropathy (CIDP)
- The medication must be prescribed by or in consultation with a neurologist or a specialist in treating gMG or CIDP
- The beneficiary must not be prescribed concomitant treatment with a complement inhibitor (e.g., SOLIRIS, ULTOMIRIS, ZILBRYSQ) or another neonatal Fc receptor blocker (e.g., RYSTIGGO)
- The beneficiary with gMG must have all the following:
  - Myasthenia Gravis Foundation of America (MGFA) Clinical Classification II to IV
  - MG-Activities of Daily Living (MGADL) total score $\geq$ 5
  - Tried and failed while on stable doses either an acetylcholinesterase (AChE) inhibitor (e.g., pyridostigmine) or immunosuppressive therapy (e.g., glucocorticoids, azathioprine, or mycophenolate) or the beneficiary has a documented contraindication or intolerance to those agents; **AND**
  - Administer subsequent treatment cycles according to clinical evaluation.
- The beneficiary with CIDP must have all the following:
  - Other possible disease states (e.g., Guillain–Barré syndrome) ruled out; **AND**
  - Previously been treated with intravenous immunoglobin (IVIG) and glucocorticoids unless there is a contraindication to their use
- The prescriber must submit the following:
  - Current chart notes
  - Previous therapies tried
  - Attestation that the beneficiary is up to date on required vaccines prior to beginning therapy
  - Documentation of the benenficiary's clinical presentation with specific symptoms
  - For gMG beneficiaries, test results documenting baseline MGFA classification and baseline MGADL total score; **AND**

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- For CIDP beneficiaries, baseline disability score (e.g., Inflammatory Neuropathy Cause and Treatment (INCAT) disability score, Rasch-built overall disability scale (RODS), Modified Rankin Score (mRS), Grip strength with Martin Vigorimeter, or Medical Research Council (MRC) scale, etc.)

RENEWAL REQUIREMENTS

- The beneficiary has been compliant with therapy (defined as 75% utilization)
- The beneficiary has documented improvement of beneficary's specific symptoms
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of beneficiary's current clinical presentation after starting the requested medication
  - For gMG beneficiaries, provide current baseline MGFA classification, current MGADL total score, and documentation of continued need for treatment of gMG
  - For CIDP beneficiaries, current disability test scores with the same test used for baseline (e.g., Inflammatory Neuropathy Cause and Treatment (INCAT) disability score, Rasch-built overall disability scale (RODS), Modified Rankin Score (mRS), Grip strength with Martin Vigorimeter, or Medical Research Council (MRC) scale)

QUANTITY EDITS

#4 injections per 28 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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ELAFIBRANOR (IQIRVO)

Updated 10/16/2024

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with primary biliary cholangitis (PBC) confirmed by **two** of the following:
  - An alkaline phosphatase (ALP) level of at least 1.67 times the ULN
  - Presence of antimitochondrial antibodies (AMA) at a titer of 1:40 or higher; **OR**
  - Histologic evidence of PBC (nonsuppurative destructive cholangitis and destruction of interlobular bile ducts)
- The medication must be prescribed by or in consultation with a hepatologist or gastroenterologist
- The beneficiary must have had an inadequate response to ursodeoxycholic acid (UDCA) without improvement in LFTs and documented PBC related symptoms after a 1-year trial or the beneficiary must demonstrate intolerance to UDCA (e.g., Ursodiol)
- The beneficiary with an inadequate response to UDCA alone must take IQIRVO concomitantly with UDCA unless intolerant to UDCA
- The beneficiary should not be approved or continue this therapy with any of the following:
  - Decompensated cirrhosis (e.g., ascites, variceal bleeding, hepatic encephalopathy)
  - Pregnancy; **OR**
  - Complete biliary obstruction
- The prescriber must submit the following:
  - Current chart notes with beneficiary's specific symptoms
  - Documentation of previous therapies tried with response
  - Baseline description of muscle pain or myopathy (evaluate periodically for new onset or worsening muscle pain, myopathy, or rhabdomyolysis)
  - Labs including liver function tests with baseline alkaline phosphatase
  - Current treatment plan; **AND**
  - Medical necessity over UDCA taken as monotherapy

RENEWAL REQUIREMENTS

- The beneficiary must remain compliant with therapy (defined as 75% utilization)
- The beneficiary must demonstrate a positive response to IQIRVO with an improvement in symptoms and corresponding labs while experiencing no intolerable side effects

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- The beneficiary must remain on ursodeoxycholic acid (UDCA) concomitantly unless there are tolerability issues
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of response to therapy with summary of current symptoms
  - Current labs, including liver function tests with alkaline phosphatase; **AND**
  - Description of muscle pain or myopathy

QUANTITY EDITS

#30 tablets per 30 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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ELAMIPRETIDE (FORZINITY)

Updated 4/15/2026

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- The beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert or based on support from the official Compendia
- The beneficiary must weigh at least 30 kg and be diagnosed with Barth syndrome genetically confirmed by the presence of a TAFAZZIN gene pathogenic variant, and the beneficiary exhibits skeletal muscle weakness or functional impairment
- Must be prescribed by a fellowship trained specialist (e.g., cardiologist, neurologist, hematologist, geneticist)
- The beneficiary must be receiving physical therapy
- The beneficiary must not be on dialysis, and beneficiary with severe renal impairment (eGFR < 30 mL/min) must be prescribed 20 mg daily
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of patient-specific symptoms especially muscle strength
  - Confirmation of diagnosis with genetic testing results
  - Attestation that the patient and/or caregiver has been trained on administration
  - Renal function labs
- Initial approval for 6 months

RENEWAL REQUIREMENTS

- The beneficiary must be compliant on therapy (defined as 75% utilization)
- The beneficiary must demonstrate muscle strength improvement or disease stabilization
- The prescriber must submit the following:
  - Current chart notes
  - Updated documentation of symptoms compared to baseline especially muscle strength

QUANTITY EDITS

- 4 vials per 28 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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ELAPEGADEMASE-LVLR VIAL (REVCOVI)

Updated 1/21/2026

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
  - For beneficiaries transitioning from ADAGEN to REVCOVI, the starting dose of REVCOVI is 0.2 mg/kg weekly, intramuscularly.
  - For ADAGEN-naïve beneficiaries, the starting dose of REVCOVI is 0.4 mg/kg weekly based on ideal body weight or actual weight whichever is greater, divided into two doses (0.2 mg/kg twice a week), intramuscularly.
- The beneficiary must be diagnosed with adenosine deaminase severe combined immune deficiency (ADA-SCID) with diagnosis confirmed by **one** of the following:
  - Deficiency or absence of adenosine deaminase (ADA) in plasma, lysed erythrocytes, fibroblasts (cultured from amniotic fluid), or chorionic villus sample
  - Increase in either deoxyadenosine triphosphate (dATP) levels or in total deoxyadenosine nucleotides (dAXP) in erythrocytes.
  - Decrease in ATP concentration in erythrocytes.
  - Molecular genetic confirmation of mutations in both alleles of the ADA1 gene; **OR**
  - Positive screening by T-cell receptor excision circles (TRECs).
- The medication must be prescribed by, or in consultation with, a specialist knowledgeable in the treatment of immune deficiency disorders (e.g., immunologist, hematologist, oncologist)
- REVCOVI will be used only until definitive therapy with hematopoietic stem cell transplantation (HSCT), or if the beneficiary is not a suitable candidate or has previously failed HSCT.
- The beneficiary does not have severe thrombocytopenia (< 50,000/microL)
- The prescriber must submit the following:
  - Current chart notes
  - Previous therapies tried
  - Current labs including trough plasma adenosine deaminase (ADA) activity, red blood cell deoxyadenosine triphosphate (dATP), trough deoxyadenosine nucleotides (dAXP) levels, total lymphocyte counts, and/or documentation of mutation in the ADA gene
  - Current weight; **AND**
  - Requested dose

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- Initial approval for 6 months

RENEWAL REQUIREMENTS

- The beficiary must remain compliant with therapy (defined as 75% utilization)
- The beneficiary must have documented disease stability or improvement as indicated by **one** or more of the following:
  - Normalization or increase in plasma ADA activity (target trough level ≥ 15 mmol/hr/L).
  - Red blood cell dATP level decreased (target ≤ 0.005 to 0.015 mmol/L).
  - Improvement in immune function with diminished frequency or complications of infection as evidenced in improvement in the ability to produce antibodies; **OR**
  - Improvement in red blood cell dAXP levels (target trough level ≤ 0.02 mmol/L).
- The beneficiary must not have unacceptable toxicity (i.e., severe thrombocytopenia)
- The prescriber must submit the following:
  - Current chart notes
  - Response to therapy
  - Current labs
  - Current weight; **AND**
  - Requested dose

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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ELIGLUSTAT (CERDELGA)

Updated 1/15/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must be diagnosed with Gaucher disease type 1 (GD1), and either be CYP2D6 extensive metabolizers (EMs), intermediate metabolizers (IMs), or poor metabolizers (PMs)
- The beneficiary should not be approved or continue the medication if meets **one** of the following based on CYP2D6 metabolizer status:
  - Extensive metabolizers
    - Taking strong or moderate CYP2D6 inhibitor concomitantly with a strong or moderate CYP3A inhibitor
    - Moderate or severe hepatic impairment
    - Mild hepatic impairment and taking a strong or moderate CYP2D6 inhibitor; **OR**
    - End-stage renal disease (CrCl < 15 mL/min)
  - Intermediate metabolizers
    - Taking a strong or moderate CYP2D6 inhibitor concomitantly with a strong or moderate CYP3A inhibitor
    - Taking a strong CYP3A inhibitor; **OR**
    - Any degree of hepatic or renal impairment
  - Poor metabolizers
    - Taking a strong CYP3A inhibitor; **OR**
    - Any degree of hepatic or renal impairment
  - Any metabolizer status
    - Pre-existing cardiac disease (congestive heart failure, recent acute myocardial infarction, bradycardia, heart block, ventricular arrhythmia)
    - Long QT syndrome; **OR**
    - In combination with Class IA (e.g., quinidine, procainamide) or Class III (e.g., amiodarone, sotalol) antiarrhythmic medications
- The prescriber must submit the following:
  - Current chart notes
  - Previous therapies tried
  - Test results confirming type of metabolizer
  - Baseline spleen and liver volume; **AND**
  - Current labs for kidney and liver function, hemoglobin, and platelets

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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RENEWAL REQUIREMENTS

- The beneficiary must be compliant with therapy (defined as 75% utilization)
- The beneficiary must demonstrate a positive response with reduction in spleen and/or liver size and increase in hemoglobin and/or platelets
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Documentation of response to therapy

QUANTITY EDITS

- CYP2D6 EMs and IMs – #56 capsules per 28 days
- CYP2D6 PMs – #28 capsules per 28 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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ELINZANETANT (LYNKUET) AND FEZOLINETANT (VEOZAH)

Updated 1/21/2026

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with menopause and experiencing moderate to severe vasomotor symptoms **or** a diagnosis consistent with any new FDA-approved indications. Any off-label requests will be reviewed on a case-by-case basis.
- Documentation that moderate to severe vasomotor symptoms have been disruptive to daily life must be provided (e.g., sleep disruption, night sweats, daytime hot flashes, palpitations)
- The beneficiary must be confirmed as menopausal with **one** of the following:
  - Spontaneous amenorrhea for ≥ 12 consecutive months
  - Spontaneous amenorrhea for ≥ 6 months with biochemical criteria of menopause (follicle-stimulating hormone [FSH] > 40 IU/L); **OR**
  - Having had bilateral oophorectomy ≥ 6 weeks prior to the screening visit.
- The beneficiary must have tried and failed hormone replacement therapy or have a contraindication to hormone replacement therapy
- The beneficiary on VEOZAH should not have cirrhosis or severe renal impairment or end-stage renal disease (eGFR < 30 mL/min/1.73 m^2) and beneficiary on LYNKUET should not have moderate to severe hepatic impairment or end-stage renal disease (eGFR < 15 mL/min/1.73 m^2).
- The beneficiary must not take VEOZAH concomitantly with CYP1A2 inhibitors (e.g., ciprofloxacin, fluvoxamine)
- The beneficiary must not take LYNKUET concomitantly with CYP3A4 inducers (e.g., carbamazepine, modafinil)
- The prescriber must submit **all** of the following:
  - Current chart notes
  - Current labs, including FSH level, LFTs, and CMP
  - Duration of symptoms; **AND**
  - Medical necessity over hormone replacement therapy and other options supported in literature (i.e., SSRIs, SNRIs, anti-epileptics, clonidine)
- Initial PA for 3 months

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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RENEWAL REQUIREMENTS

- The beneficiary is compliant with the medication (defined as 75% utilization)
- The beneficiary has documented improvement in symptoms
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of response to treatment (e.g., sleep disruption, night sweats, daytime hot flashes, palpitations)
- Renewal PAs can be approved for 6 months

QUANTITY EDITS

- LYNKUET #62 capsules per 31 days
- VEOZAH #31 tablets per 31 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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ENSIFENTRINE (OHTUVAYRE)

Updated 10/16/2024

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary must be ≥ 40 years of age
- The beneficiary must be diagnosed with chronic obstructive pulmonary disease with severity defined by:
  - Pre- and post-bronchodilator FEV1/FVC ratio of < 0.70; **AND**
  - Post-bronchodilator FEV1 ≥ 30% and ≤ 70% predicted normal; **AND**
  - History of ≥ 2 moderate or ≥ 1 severe exacerbation(s) requiring hospitalization within the past 12 months
- The beneficiary has exacerbation while compliant for at least 3 months on **one** of the following with continued pulmonary function tests meeting the defined severity listed above:
  - LAMA/LABA combination; **OR**
  - LAMA/LABA/ICS combination
- The beneficiary must remain on standard maintenance therapy and use this medication as add-on therapy
- The beneficiary should not be approved or continue this therapy with any of the following:
  - Current smoker that refuses to start a cessation plan
- The prescriber must submit the following:
  - Current chart notes with previous and current therapies
  - Current pulmonary function tests as baseline
  - Documentation of smoking history
  - If currently smoking, provide smoking cessation plan
  - Medical necessity over Daliresp (roflumilast) tablet

RENEWAL REQUIREMENTS

- The beneficiary is compliant with therapy (defined as 50% utilization or 90 days of therapy in 186 days)
- The beneficiary must demonstrate a positive response to therapy as indicated by at least **one** of the following:
  - Decrease in quantity and/or severity of exacerbations; **OR**
  - Improvement in lung function/FEV1 over baseline; **OR**
  - Improvement in COPD-related symptoms and/or quality of life
- The beneficiary must remain a non-smoker

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- The prescriber must submit the following:
  - Current chart notes
  - Current PFTs; **AND**
  - Attestation that the beneficiary continues to refrain from smoking

QUANTITY EDITS

#60 ampules (1 carton) per 30 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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ENTECAVIR (BARACLUDE)

Updated 9/24/2008

APPROVAL CRITERIA

- No history of HIV/AIDS diagnosis in medical history; **OR**
- HIV/AIDS diagnosis in medical history; **AND**
- At least one paid Medicaid drug claim for antiretroviral in past 45 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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EOSINOPHILIC ESOPHAGITIS

Updated 7/1/2024

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

POINT-OF-SALE (POS) APPROVAL CRITERIA FOR CORTICOSTEROIDS

- fluticasone HFA (generic for FLOVENT) – no point-of-sale criteria required for EoE
- budesonide respules
  - **Criteria 1:** The beneficiary < 4 years of age (maximum dose is 2 mg/day); **OR**
  - **Criteria 2:** Regardless of age, beneficiary has a billed diagnosis of EOE in the last 2 years:
    - Age < 10 years – maximum dose is 2 mg/day
    - Age ≥ 10 years – maximum dose is 4 mg/day
- Dose recommendations for budesonide slurry
  - 1–2 mg once daily for beneficiaries < 10 years of age
  - 2 mg once daily for beneficiaries ≥ 10 years of age; may titrate to 4 mg daily
  - Documentation suggests the use of 0.5 mg/2 mL to ensure enough liquid volume to coat the esophagus.
- EOHILIA (budesonide) 2 mg/10 mL suspension
  - The beneficiary must have a billed diagnosis of eosinophilic esophagitis (EoE) in the last 2 years
  - The beneficiary must be ≥ 11 years of age or meet the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
  - The beneficiary must be prescribed no more than 4 mg per day
  - The beneficiary will be allowed up to 12 weeks of treatment (request for more than 12 weeks will require prior authorization)
- Renewal Requirements for EOHILIA:
  - Currently, the data for treatment with EOHILIA beyond 12 weeks has not been shown to be safe and effective for the treatment of EoE.
  - If beneficiary is positively responding to EOHILIA, continuation may be considered after EGD at 12 weeks.
  - The prescriber must submit the following:
    - Current chart notes
    - EGD report after 12 weeks of therapy; **AND**
    - Medical necessity over fluticasone HFA and budesonide respules
- Quantity Edit for EOHILIA: #60 doses (1 carton) per 30 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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MANUAL REVIEW APPROVAL CRITERIA FOR DUPIXENT (DUPILUMAB)

- The beneficiary must be 1 year of age and older, weighing at least 15 kg, **or** the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary must have a confirmed diagnosis of eosinophilic esophagitis (EOE) with an esophageal biopsy that indicates ≥ 15 eosinophils per high-power field (eos/hpf) and **one** of the following:
  - Symptoms of esophageal dysfunction (e.g., dysphagia, food impaction, chest pain); **OR**
  - Endoscopy features consistent with eosinophilic esophagitis (e.g., stacked circular rings, esophageal strictures, linear furrows)
- The beneficiary must have at least a 12-week trial and failure of swallowed corticosteroids (e.g., fluticasone or budesonide)
- The beneficiary has no therapeutic duplication with any other monoclonal antibodies prescribed for EOE
- If the request is for a non-preferred medication, the beneficiary must have tried and failed at least two preferred biologics with this indication (if applicable) before non-preferred options can be approved, unless there is a beneficiary specific contraindication to the preferred options
- The prescriber must submit the following:
  - Current chart notes
  - Previous therapies including dietary restrictions, procedures, or pharmacological treatment
  - Baseline eos/hpf after corticosteroid and PPI trials; **AND**
  - Baseline beneficiary determined Dysphagia Symptom Questionnaire (DSQ) score

CONTINUATION CRITERIA FOR DUPIXENT (DUPILUMAB)

- The beneficiary demonstrates a positive response with **one** of the following after 6 months of treatment:
  - Achieved remission with ≤ 6 eos/hpf; **OR**
  - Decrease in DSQ score from baseline
- The prescriber must submit the following:
  - Current chart notes
  - Current beneficiary determined DSQ score; **AND**
  - Current eos/hpf

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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EPLONTERSEN SODIUM (WAINUA)

Updated 4/17/2024

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with polyneuropathy of hereditary transthyretin-mediated amyloidosis (hATTR) **or** a diagnosis consistent with any new FDA-approved indications. Any off-label requests will be reviewed on a case-by-case basis.
- The beneficiary with multisystem symptoms and/or family history with the diagnosis confirmed with **one** of the following:
  - Confirmation of a transthyretin (TTR) variant by genetic testing; **OR**
  - Tissue biopsy confirming the presence of amyloid deposits
- The medication must be prescribed by or in consultation with a neurologist
- The beneficiary should not be approved or continue this therapy with any of the following:
  - Severe renal impairment or end-stage renal disease; **OR**
  - Moderate or severe hepatic impairment
- The prescriber must submit the following:
  - Current chart notes
  - Medical necessity over preferred neuropathic pain agents
  - Attestation that Vitamin A is being monitored for possible supplementation
  - Baseline modified Neuropathy Impairment Score +7 (mNIS+7) and Norfolk Quality of Life-Diabetic neuropathy (QoL-DN) total score
  - Previous therapies tried; **AND**
  - Current labs, including liver function tests (LFTs) and basic metabolic panel (BMP)

RENEWAL REQUIREMENTS

- The beneficiary must remain compliant on therapy (defined as 75%)
- The beneficiary must demonstrate a positive response with either reduced or stable mNIS+7 and/or QoL-DN scores with improvement in neuropathy
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Current labs, including LFTs and BMP

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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QUANTITY EDITS

#1 injection per 30 days

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ESKETAMINE SOLUTION (SPRAVATO)

Updated 5/10/2023

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with **one** of the following:
  - Treatment resistant depression (TRD) with Spravato to be used as monotherapy or in conjunction with an oral antidepressant
  - Depressive symptoms with major depressive disorder with acute suicidal ideation or behavior with Spravato used in conjunction with an oral antidepressant
  - Diagnosis consistent with any new FDA-approved indications or supported in the official Compendia
- The beneficiary must have failed treatment with a minimum of **three** separate therapeutic trials including antidepressants from at least **two** different drug classes (SSRI, SNRI and bupropion) as well as at least **one** trial of augmentation therapy with **one** of the following:
  - Atypical antipsychotic
  - Lithium; **OR**
  - Antidepressant from a different class
- The beneficiary's profile will be reviewed for compliance on previous therapies with at least **eight** weeks each for the nonconcurrent monotherapies at maximally tolerated doses
- The prescriber must be enrolled as a Spravato REMS-certified prescriber and must make arrangements with the beneficiary's pharmacy for delivery of the medication
- The beneficiary must be enrolled in the Spravato REMS program
- Medication must be administered under the direct supervision of a healthcare provider with post-administration observation for a minimum of 2 hours
- The prescriber must review the beneficiary's PDMP for evidence of abuse potential and attest that the beneficiary will be monitored for signs of abuse or misuse
- The beneficiary must not be pregnant or breastfeeding
- The beneficiary must not have active moderate or severe substance or alcohol use disorder
- The beneficiary must not have aneurysmal vascular disease, a history of intracerebral hemorrhage or a hypersensitivity to esketamine/ketamine
- The prescriber must submit **all** of the following:
  - Current chart notes

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- Documentation of previous failed therapies
- If beneficiary tried IV Ketamine, provide documentation of trial and response
- Baseline depression assessment using a validated depression rating scale; **AND**
- Treatment plan for possible serious cardiac adverse events during treatment session (i.e., access to emergency care)

- Initial approval for 4 weeks only for twice weekly dosing. If twice weekly dosing is required for longer than 4 weeks, an additional prior authorization request will need to be submitted.

QUANTITY EDITS

- Initial PA (weeks 1–4) – 2 kits per week
- Renewal PA (week 5 and after) – 1 kit per week

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ERYTHROPOIESIS STIMULATING AGENTS

Updated 10/1/2026

PREFERRED AGENTS WITH CRITERIA

- ARANESP syringe (darbepoetin alfa in polysorbate)
- EPOGEN (epoetin alfa)
- RETACRIT (epoetin alfa) Pfizer brand

NON-PREFERRED AGENTS

- ARANESP vial (darbepoetin alfa in polysorbate)
- MIRCERA (methoxy peg-epoetin beta)
- PROCRIT (epoetin alfa)
- REBLOZYL (luspatercept)
- RETACRIT (epoetin alfa) Vifor brand

APPROVAL CRITERIA FOR PREFERRED AGENTS WITH CRITERIA

- The Prime system reviews lab results for the previous 30 days for a hemoglobin (Hgb) level.
- If a Hgb level is available and ≤ 10 g/dL, a claim will be processed at point-of-sale without prior authorization.
- If hemoglobin level is not available in the Prime system or the beneficiary does not meet the above lab requirement, a prior authorization request must be submitted.

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ESTROGEN-REPLACEMENT AGENTS

Updated 10/1/2025

PREFERRED AGENTS

- CLIMARA PRO (estradiol/levonorgestrel)
- DOTTI (estradiol)
- estradiol oral tablet (generic for ESTRACE)
- estradiol once weekly transdermal (generic for CLIMARA)
- estradiol twice weekly transdermal (generic for ALORA, VIVELLE-DOT, and MINIVELLE)
- LYLLANA (estradiol)
- PREMARIN (conjugated estrogens) – **brand only**
- PREMPRO (conjugated estrogen/medroxyprogesterone)

NON-PREFERRED AGENTS

- ABIGALE (estradiol/norethindrone)
- ABIGALE LO (estradiol/norethindrone)
- ACTIVELLA (estradiol/norethindrone)
- BIJUVA (estradiol/progesterone)
- CLIMARA (estradiol)
- COMBIPATCH (estradiol/norethindrone)
- conjugated estrogens (generic for PREMARIN)
- DIVIGEL (estradiol)
- DUAVEE (estrogens, conjugated/bazedoxifene)
- ELESTRIN (estradiol)
- ESTRACE tablet (estradiol)
- estradiol gel (generic for ESTROGEL)
- EVAMIST (estradiol)
- FYAVOLV (ethinyl estradiol/norethindrone)
- JINTELI (ethinyl estradiol/norethindrone)
- MENEST (estrogens, esterified)
- MENOSTAR (estradiol)
- MIMVEY (estradiol/norethindrone)
- MINIVELLE (estradiol)
- VIVELLE-DOT (estradiol)

NON-PREFERRED AGENTS WITH CRITERIA

- ANGELIQ (estradiol/drospirenone)

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- estradiol/norethindrone (generic for ACTIVELLA, AMABELZ, LOPREEZA, and MIMVEY)
- ethinyl estradiol/norethindrone (FEMHRT, JINTELLI, and FYAVOLV)
- PREMPHASE (estrogens, conjugated/medroxyprogesterone)

APPROVAL CRITERIA FOR NON-PREFERRED AGENTS WITH CRITERIA

≥ 120 days of therapy in the previous 180 days for the same drug, strength, and dosage form

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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ETRIPAMIL SPRAY (CARDAMYST)

Updated 4/15/2026

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- The beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert or based on support from the official Compendia
- The beneficiary must be diagnosed with acute symptomatic episodes of paroxysmal supraventricular tachycardia (PSVT) needing conversion to sinus rhythm
- Must be prescribed by, or in consultation with, a cardiologist
- The beneficiary must continue to have PSVT episodes despite oral preventative therapies unless contraindicated (e.g., calcium channel blockers, beta blockers)
- The beneficiary will not be approved with any of the following:
  - New York Heart Association heart failure class II to IV
  - Wolff-Parkinson-White (WPW), Lown-Ganong-Levine (LGL) syndromes, or manifest pre-excitation (delta wave) on a 12-lead electrocardiogram (ECG)
  - Sick sinus syndrome without a permanent pacemaker
  - Second degree atrioventricular (AV) Mobitz 2 block or higher degree of AV block
- The prescriber must submit the following:
  - Current chart notes
  - Previous therapies tried
  - Description of symptoms associated with PSVT along with typical frequency of episodes
  - Attestation that beneficiary and/or caregiver has been counseled on timing of administration, proper administration technique, proper dosing, and when to seek additional medical care

APPROVAL CRITERIA

- The prescriber must submit the following:
  - Documentation of a positive response while using CARDAMYST with history of PSVTs converted to sinus rhythm
  - Current chart notes

QUANTITY EDITS

- 1 carton per claim containing 2 nasal devices (2 doses) with maximum of 3 claims (6 devices) per month

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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EVEROLIMUS TABLET (ZORTRESS)

Updated 04/10/2019

POINT-OF-SALE (POS) APPROVAL CRITERIA

- The beneficiary is 18 years of age or greater; **AND**
- Diagnosis in Medicaid history of kidney transplant (Z94.0) **or** liver transplant (Z94.4) in previous 2 years; **AND**
- No therapeutic duplication between different strengths of ZORTRESS or between other brand names of everolimus (e.g., AFINITOR)

QUANTITY EDITS

2 tablets per day **and** #60 tablets per 30 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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FECAL MICROBIOTA SPORES, LIVE-BRPK CAPSULE (VOWST)

Updated 7/19/2023

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with *Clostridioides difficile* infection (CDI) following antibacterial treatment for recurrent CDI (rCDI) **or** a diagnosis consistent with any new FDA-approved indications. Any off-label requests will be reviewed on a case-by-case basis.
- The beneficiary must have at least three separate confirmed *C difficile* infections within 12 months (definition of recurrent CDI) and given prior therapy with vancomycin and/or fidaxomicin. *C difficile* should be diagnosed based on positive diagnostic laboratory assay and typical manifestations with ≥ 3 loose stools in 24 hours.
- The beneficiary must have completed antibacterial treatment for recurrent CDI 2–4 days before initiating treatment with VOWST
- The beneficiary must be prescribed magnesium citrate to take the day prior to beginning VOWST
- The beneficiary should not be approved if any of the following are met:
  - Prescribed concomitant antibacterial therapy
  - Does not meet the requirements for recurrent CDI; **OR**
  - Has not been treated with either vancomycin or fidaxomicin
- The prescriber must submit **all** of the following:
  - Current chart notes
  - Documentation of treatment for previous CDI episodes
  - Previous laboratory assay results noting *C difficile*; **AND**
  - Medical necessity over vancomycin and fidaxomicin if have not been tried and failed
- PA for 1 claim

QUANTITY EDITS

#12 capsules per claim

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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FENFLURAMINE (FINTEPLA)

Updated 10/1/2026

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary must be ≥ 2 and ≤ 18 years of age; **AND**
- The beneficiary has a diagnosis of seizures associated with Dravet syndrome **or** a diagnosis consistent with FDA indications; **AND**
- The prescriber must submit written documentation showing convulsive status epilepticus, alternating hemiconvulsions, **or** myoclonic seizures and include genetic testing results for Dravet Syndrome that shows mutations within SCN1A gene.
- The prescriber, pharmacy, and beneficiary must **all** be enrolled in the FINTEPLA REMS program; **AND**
- The beneficiary must have inadequately controlled seizures while on at least one anti-epileptic drug (trials require a minimum of 6 convulsive seizures in a 6-week baseline period while stable on current AEDs); **AND**
- Maximum dose for beneficiaries **not** taking stiripentol is 0.35 mg/kg twice daily (26 mg per day), and maximum dose for beneficiaries taking stiripentol is 0.2 mg/kg twice daily (17 mg per day); **AND**
- The prescriber must submit the following:
  - Current chart notes with documentation of weight and blood pressure
  - Current list of medications with doses and all other therapies tried
  - Current baseline seizure activity
  - Current labs, including CBC, BMP and LFTs
  - Results from echocardiogram (must evaluate for valvular heart disease and pulmonary arterial hypertension); **AND**
  - Current dose needed based on weight and stiripentol usage

DENIAL CRITERIA

- The beneficiary does not meet the FDA-approved indication **or** have a diagnosis supported in the official Compendia
- The beneficiary has moderate or severe renal impairment
- The beneficiary has hepatic impairment
- The beneficiary has valvular heart disease or pulmonary arterial hypertension
- The beneficiary requires concomitant monoamine oxidase inhibitors
- The beneficiary develops acute decrease in visual acuity or ocular pain; **OR**
- The prescriber orders dosing not consistent with FDA-approved labeling.

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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QUANTITY EDITS

360 mL bottle - 1 bottle per 30 days – gives maximum dose of 26 mg per day.

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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FERRIC MALTOL (ACCRUFER)

Updated 4/17/2024

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with iron deficiency **or** a diagnosis consistent with any new FDA-approved indications. Any off-label requests will be reviewed on a case-by-case basis.
- The beneficiary must have a baseline hemoglobin less than 12 mg/dL and baseline ferritin < 30 mcg/L
- The beneficiary must have tried and failed other ferrous products (i.e., sulfate, gluconate, or fumarate) or have a contraindication
- The prescriber must submit the following:
  - Current chart notes
  - Current labs, including CBC and ferritin panel; **AND**
  - Expected cause of iron deficiency

RENEWAL REQUIREMENTS

- The beneficiary continues to be at risk for iron deficiency (e.g., chronic kidney disease, inflammatory bowel disease)
- The beneficiary had a positive response with increased ferritin and/or hemoglobin
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Current labs, including CBC and ferritin panel

QUANTITY EDITS

#60 capsules per 30 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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FINERENONE (KERENDIA)

Updated 7/1/2026

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary must be ≥ 18 years of age; **AND**
- The beneficiary must be diagnosed with **one** of the following:
  - Type 2 diabetes mellitus and chronic kidney disease (CKD) with a risk of sustained estimated glomerular filtration rate (eGFR) decline, end stage kidney disease, cardiovascular death, non-fatal myocardial infarction, and hospitalization for heart failure;
  - Type 1 diabetes mellitus and chronic kidney disease (CKD) with elevated urinary albumin-to-creatinine ratio (UACR) with a risk of sustained eGFR decline and end-stage kidney disease; **OR**
  - Heart failure (HF) with left ventricular ejection fraction (LVEF) ≥ 40% with risk of cardiovascular death, hospitalization for heart failure, or urgent heart failure visits
- The beneficiary must have eGFR ≥ 25 mL/min/1.73m^2
- The beneficiary with CKD must have UACR of ≥ 30 mg/g
- The beneficiary's dose must be consistent with the package insert based on current eGFR and potassium levels
- The beneficiary with CKD should be taking an angiotensin-converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) unless contraindicated
- The beneficiary with HF should be taking standard of care heart failure medications
- The beneficiary must be a non-smoker or must be participating in a tobacco cessation program
- The beneficiary must have a normal serum potassium level (< 5 mEq/L)
- The beneficiary is not receiving concomitant strong CYP3A4 inhibitors (e.g., fluconazole) and strong or moderate CYP3A4 inducers (e.g., efavirenz, rifampicin)
- The beneficiary has not been diagnosed with adrenal insufficiency (Addison's disease)
- The beneficiary must not have severe hepatic impairment (Child Pugh C)
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of previous therapies tried, and symptoms associated with HF or CKD
  - Current labs, including potassium and eGFR
  - For beneficiary with HF: current blood pressure, weight, LVEF and documentation of HF events; **AND**
  - For beneficiary with CKD: current Urinary Albumin-to-Creatinine Ratio (UACR)
- Initial approval for 3 months

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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RENEWAL REQUIREMENTS

- The beneficiary with CKD must demonstrate a decrease in UACR and sustained or improved eGFR after dose titration
- The beneficiary must be a non-smoker or remain in a tobacco cessation program
- The beneficiary must have a potassium level that remains < 5.5 mEq/L
- The prescriber must submit the following:
  - Current chart notes and updated potassium level and eGFR
  - For beneficiary with HF – current blood pressure, weight, LVEF and any change in HF symptoms
  - For beneficiary with CKD – current Urinary Albumin-to-Creatinine Ratio (UACR); **AND**
  - Attestation that HF beneficiary has demonstrated stabilization or improvement based on functional status (e.g., improved HF symptoms, improved LVEF, decrease in hospitalizations)
- Approval for 6 months

QUANTITY EDITS

- 20 mg – #31 tablets per 31 days
- 10 mg – #31 tablets per 31 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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FIDAXOMICIN (DIFICID)

Updated 1/12/2012

APPROVAL CRITERIA

At least one paid claim in Medicaid history for vancomycin (oral or injectable compounded for oral use) in the previous 10–30 days.

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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FLUOROURACIL SOLUTION/CREAM (EFUDEX)

Updated 1/15/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

Please note that effective 10/1/2025, this manufacturer is terminating participation in the federal rebate program, and, therefore, brand EFUDEX can no longer be covered by Arkansas Medicaid.

APPROVAL CRITERIA FOR FLUOROURACIL 2% SOLUTION

- Diagnosis of actinic keratosis in Medicaid history in the past 2 months; **AND**
- No therapeutic duplication with diclofenac sodium 3% gel (SOLARAZE); **OR**
- No therapeutic duplication with other strengths of fluorouracil cream or solution (CARAC, EFUDEX); **OR**
- No therapeutic duplication with imiquimod cream (ALDARA, ZYCLARA)

APPROVAL CRITERIA FOR FLUOROURACIL 5% CREAM OR SOLUTION

- Diagnosis of actinic keratosis or basal cell carcinoma in Medicaid history in the past 2 months; **AND**
- No therapeutic duplication with diclofenac sodium 3% gel (SOLARAZE); **OR**
- No therapeutic duplication with other strengths of fluorouracil cream or solution (CARAC, EFUDEX); **OR**
- No therapeutic duplication with imiquimod cream (ALDARA, ZYCLARA)

ADDITIONAL CRITERIA

Quantity limits may apply

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FLUOROURACIL CREAM (CARAC 0.5%)

Updated 1/15/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

Please note that effective 10/1/2025, this manufacturer is terminating participation in the federal rebate program, and, therefore, brand CARAC can no longer be covered by Arkansas Medicaid.

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- Diagnosis of actinic or solar keratosis in Medicaid history in the past 2 months; **AND**
- No therapeutic duplication with diclofenac sodium 3% gel (SOLARAZE); **OR**
- No therapeutic duplication with other strengths of fluorouracil cream or solution (EFUDEX); **OR**
- No therapeutic duplication with imiquimod cream (ALDARA, ZYCLARA)
- PA for 1 month only
- Max quantity of 1 tube per claim

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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FOLIC ACID ORAL SOLUTION (QUIOFIC)

Updated 7/15/2026

APPROVAL CRITERIA

POINT OF SALE (POS) EDITS

- The beneficiary is < 7 years of age; **OR**
- The beneficiary has a diagnosis of NPO (Appendix A) in history

BENEFICIARY NOT MEETING POS EDITS

- The prescriber must submit chart notes; **AND**
- The prescriber must submit patient specific medical necessity over solid oral tablets of folic acid.

QUANTITY EDITS

5 mL (1 mg) per day = 2 bottles per month

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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FOSCARBIDOPA/FOSLEVODOPA INJECTION (VYALEV)

Updated 1/15/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with advanced Parkinson's disease and experiencing continued motor fluctuations despite compliance on carbidopa/levodopa **or** a diagnosis consistent with any new FDA-approved indications. Any off-label requests will be reviewed on a case-by-case basis.
- The beneficiary must have demonstrated a previous response to levodopa but continue to have motor fluctuations with a minimum of 2.5 hours of "off time" per day
- The prescriber must attest that the beneficiary/caregivers have been counseled on potential adverse effects that require monitoring that could require a dose reduction or discontinuation (i.e., impulsive behaviors, infusion site reactions, dyskinesia, and glaucoma)
- The beneficiary should not be approved or continue the medication if meet **one** of the following:
  - Requires non-selective monoamine oxidase (MAO) inhibitor; **OR**
  - Has a major psychiatric disorder
- The prescriber must submit the following:
  - Current chart notes
  - Current symptoms of Parkinson's Disease
  - Average number of "off" hours per day; **AND**
  - Medical necessity over increasing the dose on long and short acting oral carbidopa/levodopa products

RENEWAL REQUIREMENTS

- The beneficiary is compliant with therapy (defined as 75% utilization)
- The beneficiary demonstrates a decrease in "off" hours compared to baseline
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of response to therapy; **AND**
  - Attestation that the beneficiary continues to be monitored for potential adverse reactions (i.e., impulsive behaviors, infusion site reactions, dyskinesia, and glaucoma

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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FOSFOMYCIN DISODIUM (CONTEPO)

Updated 7/15/2026

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert, or dosing is supported in the official Compendia
- The beneficiary must be diagnosed with complicated urinary tract infections (cUTI), including acute pyelonephritis, that are caused by susceptible isolates of *Escherichia coli* and *Klebsiella pneumoniae*
- Beneficiaries with creatinine clearance < 50 mL/min must have a reduced dose as outlined in the package insert
- The beneficiary must have serum electrolyte levels (sodium, potassium, calcium, magnesium, and phosphorus) monitored during treatment due to the high sodium content of CONTEPO
- Beneficiaries with known QT prolongation or ventricular arrhythmias, including a history of torsade de pointes, should not take this medication
- Beneficiaries who develop neutropenia (absolute neutrophil count less than 1500 cells/mm^3) should discontinue CONTEPO
- The prescriber must submit the following:
  - Current chart notes
  - Culture/sensitivity results documenting resistance to typical first-line agents
  - Current labs including CBC, renal function, and electrolytes (monitor throughout treatment)
  - Letter of medical necessity for the rationale of use over typical first-line agents
  - Number of doses received if hospitalized

RENEWAL REQUIREMENTS

- If a female beneficiary has had multiple complicated urinary tract infections (cUTI) in the last 1-2 months or if a male beneficiary has had a second cUTI, additional information must be provided, including:
  - Consideration of anatomic abnormalities contributing to recurrent, complicated infections; **OR**
  - Consult with infectious disease specialist

QUANTITY EDITS

42 vials per claim

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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FUROSEMIDE 80 MG/ML INJECTION (FUROSCIX KIT AND READYFLOW)

Updated 7/1/2026

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with fluid overload and with **one** of the following:
  - New York Heart Association (NYHA) class III chronic heart failure
  - Chronic Kidney Disease (CKD); **OR**
  - Diagnosis consistent with any new FDA-approved indications. Any off-label requests will be reviewed on a case-by-case basis.
- The medication must be prescribed by or in consultation with a cardiologist
- The beneficiary must have tried and failed oral furosemide (160 mg) **and one** of the following:
  - torsemide (40 mg); **OR**
  - bumetanide (4 mg)
- The beneficiary must be adherent to CHF therapies (i.e., ACE/ARB, beta blockers, salt restrictions) or medications for CKD (i.e., SGLT-2 inhibitors, diuretics)
- The beneficiary must have documented recent weight gain and increased edema or other symptoms of extracellular volume expansion (e.g., jugular venous distention, pulmonary congestion or rales)
- The prescriber must submit **all** of the following:
  - Current chart notes
  - Current and previous therapies for heart failure
  - Medical necessity over oral and IV furosemide and other preferred diuretics
  - Current and baseline weight
  - Confirmation that beneficiary has a history of at least one prior hospitalization or emergency department visit due to heart failure or chronic kidney disease exacerbations and/or fluid overload, and the beneficiary is stable enough to avoid hospitalization at the time of administration
  - Current labs; **AND**
  - Attestation that FUROSCIX will be used short-term then transitioned back to oral diuretics as soon as practical.

RENEWAL REQUIREMENTS

- The beneficiary continues to have fluid overload

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- The prescriber must submit the following:
  - Current chart notes
  - Continued treatment plan for fluid overload; **AND**
  - Current weight and description of edema

QUANTITY EDITS

#2 kits per claim

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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FUROSEMIDE 80 MG/ML CARTRIDGE (LASIX ONYU)

Updated 7/1/2026

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- The beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert or based on support from the official Compendia
- The beneficiary must be diagnosed with chronic heart failure
- The medication must be prescribed by, or in consultation with, a cardiologist
- The beneficiary must have tried and failed oral furosemide (160 mg) **AND one** of the following:
  - torsemide (40 mg)
  - bumetanide (4 mg)
- The beneficiary must be adherent to CHF therapies (i.e., ACE/ARB, beta blockers, salt restrictions)
- The beneficiary must have documented recent weight gain and increased edema or other symptoms of extracellular volume expansion (e.g., jugular venous distention, pulmonary congestion or rales)
- The prescriber must submit ALL the following:
  - Current chart notes
  - Current and previous therapies for heart failure
  - Medical necessity over oral and IV furosemide and other diuretics
  - Current and baseline weight
  - Confirmation that beneficiary has a history of at least one prior hospitalization or emergency department visit due to heart failure
  - Current labs
  - Attestation that LASIX ONYU will be used short-term then transitioned back to oral diuretics as soon as practical

RENEWAL REQUIREMENTS

- The beneficiary continues to have episodes of edema associated with heart failure
- The beneficiary has documented positive response to the use of LASIX ONYU with a decrease in edema to prevent hospitalization
- The prescriber must submit the following:
  - Current chart notes
  - Continued treatment plan for edema
  - Current weight and description of edema

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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GABAPENTIN QUANTITY EDITS

Updated 7/15/2020

December 19, 2019: The U.S. Food and Drug Administration (FDA) is warning that serious breathing difficulties may occur in beneficiaries using gabapentin (NEURONTIN, GRALISE, HORIZANT) or pregabalin (LYRICA, LYRICA CR) who have respiratory risk factors. These include the use of opioid pain medicines and other drugs that depress the central nervous system, and conditions such as chronic obstructive pulmonary disease (COPD) that reduce lung function. The elderly are also at higher risk.

APPROVAL CRITERIA

- For NEURONTIN (gabapentin), limit of 3,600 mg per day.
- For GRALISE, limit of 1,800 mg per day
- For HORIZANT, limit of 1,200 mg per day.

QUANTITY EDITS

- gabapentin 100 mg – 8 capsules per day
- gabapentin 250 mg/5 ml – 3 bottles (1,410 mL) per 30 days
- gabapentin 300 mg – 12 capsules per day
- gabapentin 400 mg – 9 capsules per day
- gabapentin 600 mg – 6 tablets per day
- gabapentin 800 mg – 140 tablets per 31 days
- GRALISE 300 mg – 155 tablets per 31 days
- GRALISE 450 mg – 93 tablets per 31 days
- GRALISE 600 mg – 93 tablets per 31 days
- GRALISE 750 mg – 62 tablets per 31 days
- GRALISE 900 mg– 62 tablets per 31 days
- HORIZANT 300 mg – 31 tablets per 31 days
- HORIZANT 600 mg – 62 tablets per 31 days
- RELGAABI 200 mg – 9 capsules per day
- RELGAABI 300 mg – 12 capsules per day
- RELGAABI 400 mg – 9 capsules per day

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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GANAXOLONE (ZTALMY)

Updated 10/1/2026

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary must be ≥ 2 years of age
- The beneficiary must have a diagnosis of seizures associated with cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder (CDD) **or** a diagnosis consistent with any updated FDA-approved indications or supported in the official Compendia
- The beneficiary's seizures are refractory to current antiepileptic therapy with at least two previous trials with different MOA
- Beneficiaries requiring a CYP3A4 inducer should avoid this medication. If unavoidable, the ZTALMY dose should be increased.
- The prescriber must order a dose titration and should not order a dose that exceeds the dose supported in the FDA-approved package insert or MicroMedex:
  - Weight ≤ 28 kg: maximum dose is 63 mg/kg/day
  - Weight > 28 kg: maximum dose is 1,800 mg/day
- The prescriber must submit **all** of the following:
  - Current chart notes
  - Current weight
  - Genetic testing results confirming the presence of the CDKL5 mutation
  - Previous therapies tried with response
  - Baseline average daily seizure count; **AND**
  - Attestation that the beneficiary/caregiver has been educated on titration schedule

QUANTITY EDITS

For max dose of 1,800 mg daily = 36 mL per day (1,116 mL per 31 days)

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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GEPOTIDACIN (BLUJEPA) AND SULOPENEM/PROBENECID (ORLYNVAH)

Updated 1/21/2026

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA FOR BLUJEPA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with uncomplicated urinary tract infections (uUTI) caused by the following susceptible microorganisms: *Escherichia coli, Klebsiella pneumoniae, Citrobacter freundii complex, Staphylococcus saprophyticus*, or *Enterococcus faecalis.*
- The beneficiary with a history of QTc interval prolongation or relevant pre-existing cardiac disease, taking antiarrhythmic medications or medications that prolong the QTc interval should not take this medication.
- The beneficiary should not take concomitant strong CYP3A4 inhibitors (e.g., ketoconazole, itraconazole) or inducers (e.g., rifampin, carbamazepine, phenytoin, St. John's wort)
- The beneficiary requiring digoxin, acetylcholinesterase inhibitors, or non-depolarizing neuromuscular blocking agents should be evaluated on risk versus benefit for the concomitant use.
- The beneficiary must have tried and failed therapy with typical first-line antibiotics used for uUTI (e.g., nitrofurantoin, sulfamethoxazole/trimethoprim, fosfomycin) unless contraindicated
- The prescriber must submit the following:
  - Current chart notes
  - Culture/sensitivity results documenting resistance to typical first-line agents; **AND**
  - Letter of medical necessity for the rationale of use over typical first-line agents (e.g., nitrofurantoin, sulfamethoxazole/trimethoprim, fosfomycin)

APPROVAL CRITERIA FOR ORLYNVAH

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with uncomplicated urinary tract infections (uUTI) caused by the designated microorganisms *Escherichia coli, Klebsiella pneumoniae,* or *Proteus mirabilis* and have limited or no alternative oral antibacterial treatment options
- The beneficiary with **one** of the following will not meet approval criteria:

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  - Complicated urinary tract infections (cUTI) or as step-down treatment after intravenous antibacterial treatment of cUTI; **OR**
  - Complicated intra-abdominal infections (cIAI) or as step-down treatment after intravenous antibacterial treatment of cIAI
- The beneficiary must not have known blood dyscrasias or uric acid kidney stones
- The beneficiary must not be prescribed ORLYNVAH concomitantly with ketorolac tromethamine
- The beneficiary must not have severe renal impairment (CrCl < 15 mL/min) or be on hemodialysis
- The beneficiary must have tried and failed therapy with typical first-line antibiotics used for uUTI (e.g., nitrofurantoin, sulfamethoxazole/trimethoprim, fosfomycin) unless contraindicated
- The prescriber must submit the following:
  - Current chart notes
  - Culture/sensitivity results documenting resistance to typical first-line agents; **AND**
  - Letter of medical necessity for the rationale of use over typical first-line agents (e.g., nitrofurantoin, sulfamethoxazole/trimethoprim, fosfomycin)

RENEWAL REQUIREMENTS

- PA renewals will be reviewed on a case-by-case basis.

QUANTITY EDITS

- BLUJEPA – #20 tablets per claim
- ORLYNVAH – #10 tablets per claim

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GLAUCOMA AGENTS

Updated 7/1/2025

PREFERRED STATUS ONLY FOR STRENGTHS AND PACKAGE SIZES NOTED

- ALPHAGAN P 0.15% (brimonidine) – **brand only**
- carteolol (generic for OCUPRESS)
- COMBIGAN (brimonidine-/timolol) – **brand only**
- dorzolamide (generic for TRUSOPT)
- dorzolamide/timolol 22.3/6.8 mg per mL drops (generic for COSOPT)
- latanoprost (generic for XALATAN)
- levobunolol (generic for BETAGAN)
- LUMIGAN 2.5 mL and 5 mL (bimatoprost) **– brand only**
- RHOPRESSA (netarsudil)
- ROCKLATAN (netarsudil/latanoprost)
- timolol 0.25% and 0.5% solution (generic for TIMOPTIC)
- TRAVATAN Z (travoprost) – **brand only**

NON-PREFERRED STATUS FOR ALL PACKAGE SIZES UNLESS OTHERWISE NOTED

- ALPHAGAN P 0.1% (brimonidine)
- apraclonidine (generic for IOPIDINE)
- AZOPT (brinzolamide)
- betaxolol solution (generic for BETOPTIC)
- BETIMOL (timolol)
- BETOPTIC S (betaxolol)
- bimatoprost solution (generic for LUMIGAN)
- brimonidine drops (generic for ALPHAGAN/ALPHAGAN P)
- brimonidine/timolol (generic for COMBIGAN)
- brinzolamide (generic for AZOPT)
- COSOPT 22.3/6.8 mg/mL (dorzolamide/timolol)
- COSOPT PF (dorzolamide 2%/timolol)
- dorzolamide 2%/timolol 0.5% solution (generic for COSOPT PF)
- ISTALOL (timolol maleate)
- IYUZEH (latanoprost)
- LUMIGAN 7.5 mL (bimatoprost)
- pilocarpine solution (generic for PILOCAR)
- SIMBRINZA (brimonidine/brinzolamide)
- tafluprost (generic for ZIOPTAN)

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- timolol gel forming solution (generic for TIMOPTIC-XE)
- timolol 0.5% drops (generic for BETIMOL)
- timolol maleate 0.5% drops (generic for ISTALOL)
- timolol preservative free 0.25% and 0.5% (generic for TIMOPTIC OCUDOSE)
- TIMOPTIC OCUDOSE (timolol)
- travoprost (generic for TRAVATAN Z)
- VYZULTA (latanoprostene bunod)
- XALATAN (latanoprost)
- XELPROS (latanoprost)
- ZIOPTAN (tafluprost)
- ZOLYMBUS (bimatoprost)

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GLUCAGON AGENTS

Updated 4/1/2025

PREFERRED AGENTS

- BAQSIMI (glucagon)
- PROGLYCEM (diazoxide) – **brand only**
- ZEGALOGUE (dasiglucagon)

PREFERRED AGENT WITH CRITERIA

GVOKE pre-filled syringe and autoinjector (glucagon)

POINT-OF-SALE (POS) APPROVAL CRITERIA FOR GVOKE PFS AND AUTOINJECTOR

- The beneficiary is 2–5 years of age.
- If the beneficiary does not meet the age limitation, a prior authorization request is needed from the prescriber.

NON-PREFERRED AGENTS

- diazoxide suspension (generic for PROGLYCEM)
- GLUCAGON 1 mg emergency kit
- GVOKE (glucagon) vial

QUANTITY EDITS

#2 doses per prescription fill

AGE EDITS

FDA-approved minimum requirements apply

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GLUTAMINE POWDER (ENDARI)

Updated 1/15/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must be diagnosed with sickle cell disease and is at least 5 years of age
- The beneficiary must be compliant on hydroxyurea for a minimum of 6 months prior to prior authorization request unless discontinued for failed response while compliant or experiences intolerable toxicity
- The beneficiary must experience at least two painful sickle cell crises in the previous 12 months while compliant on hydroxyurea with ER or hospital admissions requiring parentally administered narcotics or ketorolac
- The beneficiary should not be approved or continue this therapy with any of the following:
  - Not compliant on hydroxyurea for a minimum of 6 months unless discontinued by prescriber due to intolerance or lack of efficacy while compliant
  - Pregnancy; **OR**
  - Dose not supported in package insert for weight
- The prescriber must submit the following:
  - Current chart notes
  - Previous therapies tried with treatment duration and response including current hydroxyurea dose
  - If hydroxyurea has been discontinued, provide documentation of either failure (with supporting labs/documentation of sickle cell crises compared with prior to trial of hydroxyurea) or intolerable toxicity with required intervention
  - Provide baseline summary pf painful crises, blood transfusions, and hospitalizations with documentation and medical records for hospitalizations and ER visits
  - Current weight
  - Treatment plan for handling acute complications of sickle cell disease
  - Letter of medical necessity for adding ENDARI to treatment plan; **AND**
  - Current labs, including:
    - INR
    - Serum albumin
    - Baseline fetal hemoglobin (HbF) level prior to hydroxyurea
    - Current HbF while on hydroxyurea; **AND**
- Initial PA for 3 months unless an adult with stable weight then can be approved for 6 months

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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RENEWAL REQUIREMENTS

- The beneficiary must be compliant with therapy (defined as 75% utilization) for both ENDARI and hydroxyurea
- The beneficiary must demonstrate a positive response with any of the following by 6 months of treatment (beneficiary's Medicaid profile will be reviewed along with submitted documentation):
  - Decreased chronic pain with decreased opioid use
  - Reduction of painful sickle cell crises compared with prior to starting ENDARI
  - Decrease in ER admissions or hospitalizations for sickle cell anemia or related pain requiring transfusions and/or parenteral pain treatment; **OR**
  - Reduction in occurrence of Acute Chest Syndrome or a reduction in total cumulative inpatient hospital days
  - The prescriber must submit the following:
  - Current chart notes
  - Documentation of response to therapy
  - Current weight
  - Current labs; **AND**
  - Summary of transfusions, ER visits, or hospitalizations since previous approval

QUANTITY EDITS

Maximum of 6 packets per day: #180 packets per 30 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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GLYCOPYRROLATE 0.2 MG/ML VIAL

Updated 7/8/2014

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

DRUGS THAT DO NOT REQUIRE PRIOR AUTHORIZATION

glycopyrrolate 1 mg/5 mL oral solution (generic for CUVPOSA)

DRUGS THAT REQUIRE MANUAL REVIEW FOR PRIOR AUTHORIZATION

glycopyrrolate 0.2 mg/mL vial

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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GLYCOPYRROLATE TABLET (DARTISLA ODT AND GLYCATE)

Updated 5/10/2023

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with peptic ulcer disease and used as an adjunct to other treatment to reduce symptoms **or** a diagnosis consistent with any new FDA-approved indications or supported in the official Compendia
- The beneficiary should not be approved if at risk for anticholinergic toxicity (e.g., glaucoma, obstructive uropathies, mechanical obstructive diseases of GI tract, GI motility disorders, active inflammatory or infectious colitis, history of or current toxic megacolon, myasthenia gravis)
- The prescriber must submit **all** of the following:
  - Current chart notes
  - Documentation of previous and current therapies; **AND**
  - Medical necessity of DARTISLA ODT or GLYCATE over regular glycopyrrolate tablets which are available without a PA

RENEWAL REQUIREMENTS

- The prescriber must submit the following:
  - Current chart notes
  - Documentation of response to therapy (if asymptomatic, provide rationale for continued use)
  - Continued medical necessity of DARTISLA ODT or GLYCATE (over glycopyrrolate tablets)

QUANTITY EDITS

#124 tablets per 31 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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GNRH RECEPTOR ANTAGONISTS – UTERINE DISORDERS

Updated 4/1/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

PREFERRED AGENTS WITH CRITERIA (MANUAL REVIEW)

- MYFEMBREE (relugolix/estradiol/norethindrone acetate)
- ORIAHNN (elagolix/estradiol/norethindrone acetate)
- ORILISSA (elagolix)

NON-PREFERRED AGENTS

None

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be prescribed **one** of the following medications with corresponding indications:
  - ORILISSA
    - Moderate to severe pain associated with endometriosis
  - ORIAHNN
    - Heavy menstrual bleeding associated with uterine leiomyomas (fibroids) in premenopausal women
  - MYFEMBREE
    - Heavy menstrual bleeding associated with uterine leiomyomas (fibroids) in premenopausal women
    - Moderate to severe pain associated with endometriosis in premenopausal women
- Attestation that beneficiary of reproductive potential will use effective non-hormonal contraception during treatment and for 1 week after discontinuing therapy
- The beneficiary must have tried and failed at least two of the following treatment options with at least a 3-month history (unless documentation of contraindication is provided):
  - NSAIDs and/or acetaminophen usage (for endometriosis associated pain)
  - Contraceptives (i.e., combined estrogen-progestin treatments include combined oral contraceptive pills, transdermal patches, and vaginal rings)
  - Progesterone-only therapy (e.g., medroxyprogesterone, norethindrone, dienogest); **OR**
  - Intrauterine device
- The beneficiary should not be approved or continue the medication if meet **one** of the following:

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- Postmenopausal
- Pregnant
- Known osteoporosis because of risk for further bone loss (T-score < -1.0 SD)
- Severe hepatic impairment (Child-Pugh C); dose modifications may be needed for moderate hepatic impairment
- Requires concomitant organic anion transporting polypeptide (OATP) 1B1 (a hepatic uptake transporter) (e.g., cyclosporine and gemfibrozil)
- History of major depression or PTSD in the last two years **or** history of a major psychiatric disorder (i.e., schizophrenia or bipolar) **or** history of suicide attempt in the last year; **OR**
- Exceeds the following dosing:
  - ORILISSA
    - 150 mg once daily for 24 months – no hepatic impairment or dyspareunia
    - 200 mg twice daily for 6 months – has dyspareunia
    - 150 mg once daily for 6 months – has moderate hepatic impairment (Child-Pugh B)
  - MYFEMBREE – 1 tablet daily for maximum of 24 months
  - ORIAHNN – 1 capsule twice daily for maximum of 24 months
- Request for ORILISSA
  - Chronic pelvic pain that is not caused by endometriosis (e.g., pelvic inflammatory disease, inflammatory bowel disease, ovarian cysts)
- Request for ORIAHNN or MYFEMBREE
  - High risk of arterial, venous thrombotic, or thromboembolic disorders which is defined as having at least **one** of the following
    - Female over 35 years of age who smokes
    - Current or history of deep vein thrombosis or pulmonary embolism
    - Vascular disease (e.g., cerebrovascular disease, coronary artery disease, peripheral vascular disease)
    - Thrombogenic valvular or thrombogenic rhythm diseases of the heart (for example, subacute bacterial endocarditis with valvular disease, or atrial fibrillation)
    - Inherited or acquired hypercoagulopathies
    - Uncontrolled hypertension; **OR**
    - Headaches with focal neurological symptoms or have migraine headaches with aura if over 35 years of age
  - Current or history of breast cancer or other hormonally sensitive malignancies, and with increased risk of hormonally sensitive malignancies
  - Undiagnosed abnormal uterine bleeding
  - History of heavy bleeding associated with uterine fibroids that has not caused anemia (hemoglobin level ≤ 12 g/dL)
  - Concomitant use with oral P-gp inhibitors for MYFEMBREE

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- The prescriber must submit the following:
  - Name of the medication being requested
  - Current chart notes with symptom history
  - Documentation of previous therapies tried with duration and response
  - Confirmation of diagnosis with pelvic exam results and imaging/biopsy results (e.g., transvaginal US, MRI, laparoscopy, CT scan)
  - Current labs, including CBCs and LFTs
  - Confirmation of negative pregnancy status (i.e., current negative pregnancy test, beginning medication within 7 days of onset of menses, or tubal ligation)
  - Letter of medical necessity outlining the need for one of these medications over other treatment options (e.g., OTC pain medications, hormonal contraception, progestin therapy, and surgery); **AND**
  - If requesting a non-preferred medication, provide the necessity of the chosen medication over the preferred option(s).

RENEWAL REQUIREMENTS

- The beneficiary must be compliant with therapy (defined as 75% utilization)
- The beneficiary must demonstrate improvement of symptoms (i.e., reduction in endometriosis related pain, decrease in heavy menstrual bleeding and/or improvement in hemoglobin)
- The beneficiary remains free from hepatic impairment, osteoporosis, psychiatric disorders, and pregnancy
- The beneficiary has not surpassed the maximum treatment duration as noted in the package insert
- The beneficiary of reproductive potential remains on non-hormonal contraception
- The prescriber must submit the following:
  - Current chart notes with documentation of current symptoms
  - Current labs, including CBCs and LFTs; **AND**
  - Documentation of negative pregnancy status

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GROWTH HORMONE

Updated 4/1/2026

PREFERRED AGENTS THAT REQUIRE MANUAL REVIEW FOR PRIOR AUTHORIZATION

- GENOTROPIN (somatropin)
- NORDITROPIN (somatropin)

NON-PREFERRED AGENTS

- HUMATROPE (somatropin)
- NGENLA (somatrogon-ghla)
- NUTROPIN AQ (somatropin)
- OMNITROPE (somatropin)
- SKYTROFA (lonapegsomatropin-tcgd)
- SOGROYA (somapacitan-beco)
- ZOMACTON (somatropin)

APPROVAL CRITERIA FOR PREFERRED AGENTS

For children, continuation of therapy may require additional information when growth velocity is ≤ 2.5 cm/year

Criterion 1:

- The beneficiary < 18 years of age
- The beneficiary has **one** of the following diagnoses:
  - Diagnosis of Prader-Willi Syndrome (PWS) with the following exceptions:
    - Severe obesity (> 225% of IBW)
    - Untreated severe obstructive sleep apnea
    - History of severe respiratory impairment; **OR**
    - Untreated or uncontrolled diabetes, hypothyroidism, or adrenal insufficiency
  - Diagnosis of Turner Syndrome
  - Diagnosis of Noonan Syndrome; **OR**
  - Diagnosis of chronic renal insufficiency or end-stage renal disease awaiting transplant
- Provocative GH stimulation test is not required
- Epiphyses should remain open during treatment and should be monitored beginning at 13–14 years of age. Bone age should be done at least yearly to verify that the epiphyses are open. Growth velocity can be taken into consideration to determine efficacy. If the growth velocity has slowed regardless of epiphyses status, use your best judgement on continuation.

Criterion 2:

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- The beneficiary < 18 years of age
- The beneficiary has **one** of the following diagnoses:
  - Panhypopituitarism
  - Craniopharyngioma; **OR**
  - Septo-optic dysplasia
- Provocative GH stimulation test and bone age are not required

Criterion 3:

- The beneficiary < 18 years of age
- The beneficiary has abnormal growth velocity and height below the mean for gender and age
- The beneficiary has **one** of the following diagnoses:
  - Growth Hormone Deficiency/Pituitary Dwarfism
  - Iatrogenic Pituitary Disorder; **OR**
  - Unspecified disorder of the pituitary gland
- Epiphyses should remain open during treatment and should be monitored beginning at 12–14 years of age. Bone age should be done at least yearly to verify that the epiphyses are open. Growth velocity can be taken into consideration to determine efficacy. If the growth velocity has slowed regardless of epiphyses status, use your best judgement on continuation.
- Expected tests/labs for initial approval:
  - Low growth hormone
  - Low IGF-1 and/or IFGBP-3 in addition to stim tests
  - Thyroid function test to rule out hypothyroidism
  - Delayed bone age – typically determined from x-ray of hand and wrist
  - MRI or CT scan to rule out pituitary gland issues; **AND**
  - Provocative GH stimulation test unless beneficiary has **one** of the following:
    - Pituitary abnormality (pituitary anomaly, tumor, or irradiation)
    - Newborn with congenital pituitary abnormality, hypoglycemia, and GH < 5 mcg/L; **OR**
    - Extreme short stature (e.g., height < -3 SD), normal nutrition, significantly reduced IGF-1 and/or IGFBP-3, and delayed bone age

Criterion 4:

- The beneficiary > 18 years of age and diagnosed with child onset GHD
- Has **one** of the following diagnoses:
  - Growth Hormone Deficiency/Pituitary Dwarfism
  - Iatrogenic Pituitary Disorder; **OR**
  - Unspecified disorder of the pituitary gland
- Expected tests/labs

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- Failure of two provocative GH stimulation tests as an adult or after documented epiphyses closure; **AND**
- Low IGF-1 and/or IGFBP-3

Criterion 5:

- The beneficiary > 18 years of age
- Has **one** of the following diagnoses:
  - Panhypopituitarism
  - Craniopharyngioma; **OR**
  - Septo-optic dysplasia
- Continued symptoms with low GH and IGF-1. Labs should be measured yearly to determine GH dose.

DENIAL CRITERIA

- Any of the following:
  - Age > 65 years
  - History of malignancy in the past 365 days
  - History of renal transplant in the past 365 days; **OR**
  - Pregnancy

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HEMOPHILIA A/B PRODUCTS

Updated 7/16/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

DRUGS THAT REQUIRE A MANUAL REVIEW FOR PRIOR AUTHORIZATION

- ALHEMO
- FEIBA
- HEMLIBRA
- HYMPAVZI
- NOVOSEVEN RT
- QFITLIA
- SEVENFACT

APPROVAL CRITERIA FOR ALHEMO

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary requires routine prophylaxis to prevent or reduce the frequency of bleeding episodes and is diagnosed with **one** of the following:
  - Hemophilia A (congenital factor VIII deficiency) with or without factor VIII inhibitors; **OR**
  - Hemophilia B (congenital factor IX deficiency) with or without factor IX inhibitors.
- The beneficiary must meet **one** of the following:
  - High factor VIII or IX inhibitor titer (≥ 5 Bethesda units per mL [BU]); **OR**
  - Factor VIII or IX inhibitor titer < 5 BU/ml with inadequate response to high dose factor
- The beneficiary must have been prescribed or need treatment with bypassing agents.
- The beneficiary must meet **one** of the following for confirming disease severity:
  - Severe disease with < 1% of factor VIII or factor IX in blood; **OR**
  - Moderate disease with 1–5% of factor VIII or factor IX in blood with **one** of the following (prescriber must submit letter of medical necessity and chart notes to support):
    - History of spontaneous bleeding episodes into the central nervous system or other serious life-threatening bleed; **OR**
    - At least two joint bleeds causing hemophilia-related joint damage; **OR**
    - Poor venous access; **OR**
    - High Factor VIII or Factor IX dose
- The beneficiary should not be approved or continue the medication if meets **one** of the following:

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- Continues to receive prophylaxis bypassing agents (e.g., rFVIIa or aPCC)
- ALHEMO is ordered for breakthrough bleeding; **OR**
- Pregnancy

- Request must be submitted by or in consultation with a hemophilia specialist or hemophilia treatment center
- The prescriber must submit the following:
  - Chart notes for the last 24 weeks with summary of bleeding events
  - Previous therapies tried with episodic or prophylactic bypassing agents (e.g., Feiba, NovoSeven RT, or Sevenfact)
  - Documentation of **one** of the following for beneficiaries with inhibitors:
    - Inadequate response to Immune Tolerance Induction (ITI); **OR**
    - Rationale why the beneficiary is not a candidate for ITI
  - Baseline factor activity and annualized bleeding rate
  - Current labs, including CBC
  - Negative pregnancy test results if applicable
  - Attestation that the female beneficiary of reproductive potential has been counseled on the importance of effective contraception
  - Attestation that beneficiary has been counseled on proper technique on episodic treatment with bypassing agents as needed for breakthrough bleeding episodes; **AND**
  - Medical necessity over prophylaxis factor products and Hemlibra for hemophilia A
- Initial PA will be for 3 months, renewal PAs may be approved for up to 6 months.

RENEWAL REQUIREMENTS FOR ALHEMO

- The beneficiary is compliant with therapy (defined as 75% utilization)
- The beneficiary must demonstrate a decrease in annualized bleeding rate compared to baseline
- The prescriber must submit the following:
  - Current chart notes
  - Current labs, including CBC; **AND**
  - Summary of bleeds since last PA

APPROVAL CRITERIA FOR FEIBA

- The beneficiary must have a diagnosis of hemophilia A or B with high factor VIII or factor IX titer inhibitors (≥ 5 Bethesda Units) requiring treatment for **one** of the following:
  - Control and prevention of bleeding episodes; **OR**
  - Peri-operative management; **OR**
  - Routine prophylaxis to prevent or reduce the frequency of bleeding episodes
- Request must be submitted by or in consultation with a hemophilia specialist or hemophilia treatment center; **AND**

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- The beneficiary has a documented trial and failure of Immune Tolerance Induction (ITI) therapy (If not a candidate for ITI, provide documentation) and emicizumab-kxwh (HEMLIBRA)
- FEIBA may be taken as breakthrough for beneficiaries taking emicizumab – **Hemophilia A only**
- The beneficiary has a documented trial and failure of the combination of highly immunosuppressive regimens and Immune Tolerance Induction (ITI) therapy (If not a candidate for ITI, provide documentation) – **Hemophilia B only**
- The prescriber must submit the following:
  - If doses above 100 units/kg or daily doses of 200 units/kg are required, provide the treatment plan to monitor for Disseminated Intravascular Coagulation (DIC) or signs of ischemia and thromboembolic events; **AND**
  - Chart notes with history of bleeds and treatment for the last 24 weeks; **AND**
  - Current labs; **AND**
  - Current weight for dosing; **AND**
  - Provide requested dose as PA will be entered for specific dosing requirements

APPROVAL CRITERIA FOR HEMLIBRA FOR HEMOPHILIA A WITH INHIBITORS

- The beneficiary must have a diagnosis of congenital hemophilia A **with** inhibitors **and one** of the following:
  - High factor VIII inhibitor titer (≥ 5 Bethesda units per mL [BU]); **OR**
  - Factor VIII inhibitor titer < 5 BU/mL with inadequate response to high dose factor
- Request must be submitted by or in consultation with a hemophilia specialist or hemophilia treatment center; **AND**
- The prescriber must submit the following:
  - Chart notes for the last 24 weeks; **AND**
  - Current labs, including CBCs and LFTs; **AND**
  - Documentation that HEMLIBRA is prescribed for the prevention of bleeding episodes (not acute treatment); **AND**
  - Documentation of any previous treatment with episodic and prophylactic bypassing agents (e.g., FEIBA, NOVOSEVEN RT, or SEVENFACT); **AND**
  - Documentation of **one** of the following:
    - Inadequate response to Immune Tolerance Induction (ITI); **OR**
    - Rationale why the beneficiary is not a candidate for ITI
  - Attestation that beneficiary will **not** be receiving concurrent prophylactic treatment with bypassing agents or has possibility of receiving ITI while taking HEMLIBRA; **AND**
  - Attestation that the beneficiary has been counseled on proper technique on episodic treatment with bypassing agents as needed for breakthrough bleeding episodes; **AND**
  - Current weight; **AND**

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- Initial PA will be for 1 month for the FDA-approved loading dose of 3 mg/kg once weekly for 4 weeks; subsequent PAs will be determined on a case-by-case basis

APPROVAL CRITERIA FOR HEMLIBRA FOR HEMOPHILIA A WITHOUT INHIBITORS

- The beneficiary must have a diagnosis of congenital hemophilia A **without** inhibitors **and with one** of the following:
  - Severe disease with < 1% of factor VIII in blood; **OR**
  - Moderate disease with 1–5% of factor VIII in blood with **one** of the following (prescriber must submit letter of medical necessity and chart notes to support):
    - History of spontaneous bleeding episodes into the central nervous system or other serious life-threatening bleed
    - At least two joint bleeds causing hemophilia-related joint damage
    - Poor venous access; **OR**
    - High Factor VIII dose
- Request must be submitted by or in consultation with a hemophilia specialist or hemophilia treatment center; **AND**
- The prescriber must submit the following:
  - Chart notes for the last 24 weeks; **AND**
  - Baseline factor activity and annualized bleeding rate; **AND**
  - Current labs, including CBCs and LFTs; **AND**
  - Documentation that HEMLIBRA is prescribed for the prevention of bleeding episodes (not acute treatment); **AND**
  - Documentation of any previous prophylactic and/or episodic FVIII infusions; **AND**
  - Attestation that beneficiary will **not** be receiving concurrent prophylaxis factor VIII; **AND**
  - Attestation that beneficiary has been counseled on proper technique on episodic treatment with factor VIII products as needed for breakthrough bleeding episodes; **AND**
  - Current weight; **AND**
- Initial PA will be for 1 month for the FDA-approved loading dose of 3 mg/kg once weekly for 4 weeks; subsequent PAs will be determined on a case-by-case basis

DENIAL CRITERIA FOR HEMLIBRA

- The beneficiary does not have a diagnosis of congenital hemophilia A
- The beneficiary continues to receive prophylaxis doses (e.g., FVIII, FIX, or bypassing agents)
- If approved and the beneficiary is not compliant on prescribed Hemlibra dose
- The prescriber requests dose above FDA-approved dose or prescribes the use of HEMLIBRA for PRN dosing; **OR**
- If approved and the beneficiary has no positive response with the decrease of bleeding episodes and/or decrease of episodic agent use

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APPROVAL CRITERIA FOR HYMPAVZI

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary requires routine prophylaxis to prevent or reduce the frequency of bleeding episodes and is diagnosed with **one** of the following:
  - Hemophilia A (congenital factor VIII deficiency) with or without factor VIII inhibitors; **OR**
  - Hemophilia B (congenital factor IX deficiency) with or without factor IX inhibitors.
- Beneficiaries must meet **one** of the following for confirming disease severity:
  - Severe disease with < 1% of factor VIII or factor IX in blood; **OR**
  - Moderate disease with 1–5% of factor VIII or factor IX in blood with **one** of the following (prescriber must submit letter of medical necessity and chart notes to support):
    - History of spontaneous bleeding episodes into the central nervous system or other serious life-threatening bleed
    - At least two joint bleeds causing hemophilia-related joint damage
    - Poor venous access; **OR**
    - High Factor VIII or Factor IX dose
- Request must be submitted by or in consultation with a hemophilia specialist or hemophilia treatment center
- The beneficiary should not be approved or continue the medication if meets **one** of the following:
  - Continues to receive prophylaxis Factor doses (e.g., FVIII, FIX, or bypassing agents)
  - HYMPAVZI is ordered for breakthrough bleeding; **OR**
  - Pregnant
- The prescriber must submit the following:
  - Chart notes for the last 24 weeks with summary of bleeding events
  - Previous therapies tried with timeline and response (prophylaxis and acute treatment)
  - Baseline factor activity and annualized bleeding rate
  - Current labs, including CBC
  - Negative pregnancy test results if applicable
  - Attestation that female beneficiary of reproductive potential has been counseled on the importance of effective contraception
  - Attestation that beneficiary has been counseled on proper technique on episodic treatment with factor VIII or factor IX products as needed for breakthrough bleeding episodes; **AND**
  - Medical necessity over prophylaxis factor products and HEMLIBRA for hemophilia A

RENEWAL REQUIREMENTS FOR HYMPAVZI

- The beneficiary is compliant with therapy (defined as 75% utilization)

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- The beneficiary must demonstrate a decrease in annualized bleeding rate compared to baseline
- The prescriber must submit the following:
  - Current chart notes
  - Current labs, including CBC; **AND**
  - Summary of bleeds since last PA

QUANTITY EDITS FOR HYMPAVZI

75 mg/0.5 mL: #4 pens per 28 days

150 mg/mL: #8 pens per 28 days

APPROVAL CRITERIA FOR NOVOSEVEN RT AND SEVENFACT

HEMOPHILIA A AND B WITH INHIBITORS (NOVOSEVEN RT OR SEVENFACT)

- The beneficiary must have a diagnosis of congenital or acquired hemophilia A or B with inhibitors confirmed by blood coagulation testing that requires treatment of bleeding episodes or peri-operative management; **AND**
- Request must be submitted by or in consultation with a hemophilia specialist or hemophilia treatment center; **AND**
- The beneficiary has a documented trial and failure of Immune Tolerance Induction (ITI) therapy (If not a candidate for ITI, provide documentation) and emicizumab-kxwh (HEMLIBRA) (NOVOSEVEN or SEVENFACT may be taken as breakthrough for beneficiaries taking emicizumab) – **Hemophilia A only**
- The beneficiary has a documented trial and failure of the combination of highly immunosuppressive regimens and Immune Tolerance Induction (ITI) therapy (If not a candidate for ITI, provide documentation) – **Hemophilia B only**
- The prescriber must submit the following:
  - Chart notes with history of bleeds and treatment for the last 24 weeks
  - Current labs
  - Current weight for dosing; **AND**
  - Provide requested dose as PA will be entered for specific dosing requirements

CONGENITAL FACTOR VII DEFICIENCY (NOVOSEVEN RT)

- The beneficiary has a diagnosis of congenital factor VII deficiency confirmed by blood coagulation testing requiring treatment of bleeding episodes or peri-operative management; **AND**
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Documentation of prothrombin time and factor VII coagulant activity prior to administration as baseline

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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GLANZMANN'S THROMBASTHENIA (NOVOSEVEN RT)

- The beneficiary has a diagnosis of Glanzmann's thrombasthenia, and condition is refractory to platelet transfusions; **AND**
- Used for the treatment of **one** of the following:
  - Control of bleeding episodes; **OR**
  - Peri-operative management

ACQUIRED HEMOPHILIA (NOVOSEVEN RT)

- The beneficiary has a diagnosis of Acquired Hemophilia; **AND**
- Used for the treatment of **one** of the following:
  - Control of bleeding episodes; **OR**
  - Peri-operative management

APPROVAL CRITERIA FOR QFITLIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary requires routine prophylaxis to prevent or reduce the frequency of bleeding episodes and is diagnosed with hemophilia A or B with or without factor VIII or factor IX inhibitors
- Beneficiaries must meet **one** of the following for confirming disease severity:
  - Severe disease with < 1% of factor VIII or factor IX in blood; **OR**
  - Moderate disease with 1–5% of factor VIII or factor IX in blood with **one** of the following (prescriber must submit letter of medical necessity and chart notes to support):
    - History of spontaneous bleeding episodes into the central nervous system or other serious life-threatening bleed
    - At least two joint bleeds causing hemophilia-related joint damage
    - Poor venous access; **OR**
    - High Factor VIII or Factor IX dose
- The beneficiary with inhibitors must meet **one** of the following:
  - High factor VIII or IX inhibitor titer (≥ 5 Bethesda units per mL [BU]); **OR**
  - Factor VIII or IX inhibitor titer < 5 BU/mL with inadequate response to high dose factor
- The beneficiary must have an antithrombin (AT) activity ≥ 60% prior to beginning QFITLIA
- Request must be submitted by or in consultation with a hemophilia specialist or hemophilia treatment center
- The beneficiary should not be prescribed prophylaxis Factor doses (e.g., FVIII, FIX, or bypassing agents)
- The beneficiary should not be prescribed QFITLIA for breakthrough bleeding

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- For a beneficiary with history of symptomatic gallbladder disease, the prescriber should consider an alternative treatment and consider interruption or discontinuation if gallbladder disease occurs after beginning treatment
- The beneficiary should not have hepatic impairment (Child-Pugh A, B, or C)
- The prescriber must submit the following:
  - Chart notes for the last 24 weeks with summary of bleeding events
  - Previous therapies were tried with timeline and response (prophylaxis and acute treatment)
  - Baseline factor activity, current antithrombin activity, and annualized bleeding rate
  - Current labs, including CBC and LFTs
  - Documentation of **one** of the following for beneficiaries with inhibitors:
    - Inadequate response to Immune Tolerance Induction (ITI); **OR**
    - Rationale why the beneficiary is not a candidate for ITI
  - Negative pregnancy test results if applicable
  - Attestation that female beneficiary of reproductive potential has been counseled on the importance of effective contraception
  - Attestation that beneficiary has been counseled on proper technique on episodic treatment with factor VIII or factor IX products as needed for breakthrough bleeding episodes; **AND**
  - Medical necessity over prophylaxis factor products and HEMLIBRA for hemophilia A
- Initial PA will be for 3 months; renewal PAs may be approved for up to 6 months.

RENEWAL REQUIREMENTS FOR QFITLIA

- The beneficiary is compliant with therapy (defined as 75% utilization)
- The beneficiary must demonstrate a decrease in annualized bleeding rate and antithrombin (AT) activity compared to baseline
- The beneficiary with antithrombin activity outside of the desired range of 15–35% will require dose modification
  - AT activity < 15% will require a dose decrease
  - AT activity > 35% after 6 months will require a dose increase
- The beneficiary should discontinue the medication if the AT level remains < 15% despite a 10 mg dose every 2 months
- The prescriber must submit the following:
  - Current chart notes
  - Current labs, including CBC and antithrombin activity
  - Current requested dose; **AND**
  - Summary of bleeds since last PA

QUANTITY EDITS FOR QFITLIA

- 20 mg – #1 vial 2 months

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- 50 mg – #1 pen every 2 months
- Dose modification to monthly dosing will require an additional override

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HEMORRHOID PREPARATIONS

Updated 7/1/2025

PREFERRED AGENTS

- hydrocortisone 1% cream
- hydrocortisone 2.5% cream
- hydrocortisone/pramoxine 1%/1% cream
- PROCTOFOAM HC 1/1% (hydrocortisone/pramoxine)
- PROCTO-MED HC 2.5% cream (hydrocortisone)
- PROCTO-SOL HC 2.5% cream (hydrocortisone)

NON-PREFERRED AGENTS

- CORTIFOAM 10% foam (hydrocortisone)
- PROCTOZONE HC 2.5% cream (hydrocortisone)

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HEPATITIS C MEDICATIONS

Updated 1/1/2026

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

PREFERRED AGENTS THAT REQUIRE MANUAL REVIEW FOR PRIOR AUTHORIZATION

- MAVYRET tablet and pellet packet (glecaprevir/pibrentasvir)
- ribavirin capsule
- ribavirin tablet
- sofosbuvir/velpatasvir (generic for EPCLUSA)
- ZEPATIER (elbasvir/grazoprevir)

NON-PREFERRED AGENTS

- EPCLUSA (sofosbuvir/velpatasvir)
- HARVONI (ledipasvir/sofosbuvir)
- ledipasvir/sofosbuvir (generic for HARVONI)
- PEGASYS (peginterferon alfa-2a)
- SOVALDI (sofosbuvir)
- VOSEVI (sofosbuvir/velpatasvir/voxilaprevir)

Hepatitis C prior authorization form:
https://ar.primetherapeutics.com/documents/268611/269351/Hepatitis%20C%20Virus%20Medication%20Therapy%20Request%20Form/b0b28e2d-f05a-ea1d-16a4-6c0502aa4a8d

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HEREDITARY ANGIOEDEMA AGENTS – ACUTE TREATMENT

Updated 4/1/2026

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

PREFERRED AGENTS WITH CRITERIA

- BERINERT kit (human C1-esterase inhibitor)
- icatibant (generic for SAJAZIR and FIRAZYR)

NON-PREFERRED AGENTS

- EKTERLY (sebetralstat)
- FIRAZYR (icatibant)
- RUCONEST (C1 esterase inhibitor)
- SAJAZIR (icatibant)

APPROVAL CRITERIA FOR ACUTE TREATMENT

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with hereditary angioedema (HAE) type 1 or type 2 due to C1-esterase inhibitor (C1-INH) deficiency with diagnosis confirmed by a mutation in the C1- INH gene. HAE with normal C1-INH (HAE type III) will be reviewed on a case-by-case basis.
- Type 1 and type 2 HAE are defined as follows:
  - Type 1 HAE: Decreased quantities of C4 level, C1-INH protein level and C1-INH function level; **OR**
  - Type 2 HAE: Decreased quantities of C4 level **AND** decreased C1-INH function (C1- INH protein level may be normal or elevated)
- The beneficiary must have ≥ 1 severe or life-threatening laryngeal attack or had 2–3 moderate attacks causing extremity, facial or abdominal swelling in the last year
- The beneficiary must **not** be on an ACEi, estrogens, any other medication determined to precipitate an angioedema attack
- The medication must be prescribed by or in consultation with an allergist, immunologist, or hematologist
- The prescriber must submit the following:
  - Current chart notes with documentation of exacerbations over the last 12 months including ER discharge summaries with history of angioedema attack severity, location, frequency, treatment and duration of attack after treatment

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- Previous therapies tried (i.e., HAE meds, antihistamines, glucocorticoids, epinephrine)
- Proposed treatment plan for both acute and prophylaxis treatment
- Documentation of expected angioedema triggers and plan for avoidance; **AND**
- Provide the following labs:
  - Complement C1 esterase inhibitor level
  - Complement C4 level; **AND**
  - Functional C1 inhibitor activity

- For non-preferred medications, medical necessity over the preferred agents for the requested indication is required.

RENEWAL REQUIREMENTS

- The beneficiary must have a positive response when taken for acute exacerbation
- The prescriber must submit the following:
  - Current chart notes with documentation of response to acute medication
  - Pharmacy records will be reviewed for utilization

QUANTITY EDITS

#2 doses per claim

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HEREDITARY ANGIOEDEMA AGENTS – PREVENTATIVE TREATMENT

Updated 4/1/2026

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

PREFERRED AGENT WITH CRITERIA

HAEGARDA (human C1-esterase inhibitor)

NON-PREFERRED AGENTS

- ANDEMBRY (garadacimab)
- CINRYZE (human c1-esterase inhibitor)
- DAWNZERA (donidalorsen)
- ORLADEYO (berotralstat)
- TAKHZYRO (lanadelumab-flyo)

APPROVAL CRITERIA FOR PREVENTATIVE TREATMENT

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with hereditary angioedema (HAE) type 1 or type 2 due to C1-esterase inhibitor (C1-INH) deficiency with diagnosis confirmed by a mutation in the C1-INH gene. HAE with normal C1-INH (HAE type III) will be reviewed on a case-by-case basis.
- Type 1 and type 2 HAE are defined as follows:
  - Type 1 HAE: Decreased quantities of C4 level, C1-INH protein level and C1-INH function level; **OR**
  - Type 2 HAE: Decreased quantities of C4 level AND decreased C1-INH function (C1- INH protein level may be normal or elevated)
- The beneficiary must have ≥ 1 severe or life-threatening laryngeal attack per month or had 2-3 moderate attacks causing extremity, facial or abdominal swelling in the last year **OR** has been approved for acute medication treatment for HAE
- The beneficiary must **not** be on an ACEi, estrogens, any other medication determined to precipitate an angioedema attack
- This medication must be used for prophylaxis only
- The prescriber must submit the following:
  - Current chart notes with documentation of exacerbations over the last 12 months including ER discharge summaries with history of angioedema attack severity, location, frequency, treatment and duration of attack after treatment

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- Previous therapies tried (i.e., HAE meds, antihistamines, glucocorticoids, epinephrine)
- Proposed treatment plan for both acute and prophylaxis treatment
- Documentation of expected angioedema triggers and plan for avoidance
- Provide the following labs:
  - Complement C1 esterase inhibitor level
  - Complement C4 level
  - Functional C1 inhibitor activity
- If the beneficiary has tried and had an insufficient response or contraindication to **both** of the following classes of medication, provide that documentation.
  - 17α-alkylated androgens (e.g., danazol, stanozolol, oxandrolone, methyltestosterone)
  - Antifibrinolytic agents (e.g., ε-aminocaproic acid, tranexamic acid)
- For non-preferred medications, medical necessity over the preferred agents for the requested indication is required.

- Initial PA will be for 3 months with response to therapy required on renewal

RENEWAL REQUIREMENTS

- The beneficiary must be compliant with therapy (defined as 75% utilization)
- The beneficiary must have a positive response with decrease in acute exacerbations
- The prescriber must submit the following:
  - Current chart notes with documentation of response to therapy; **AND**
  - Pharmacy records will be reviewed for utilization

QUANTITY EDITS

- ANDEMBRY - #1 autoinjector per 30 days
- DAWNZERA - #1 autoinjector per 28 days
- ORLADEYO - #31 capsule or pelet per 31 days

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HISTAMINE H-2 RECEPTOR ANTAGONISTS

Updated 7/1/2026

PREFERRED AGENTS

- famotidine (OTC and Rx) tablet (generic for PEPCID)
- famotidine/calcium carbonate/magnesium hydroxide OTC (generic for PEPCID COMPLETE)

PREFERRED AGENT WITH CRITERIA

- famotidine suspension (generic for PEPCID)

NON-PREFERRED AGENTS

- cimetidine (generic for TAGAMET) – **may be approved upon request for beneficiaries < 18 years of age after receiving documentation/attestation of viral warts within the past 90 days**
- nizatidine (generic for AXID)
- ranitidine (generic for ZANTAC)

FAMOTIDINE SUSPENSION POINT-OF-SALE (POS) APPROVAL CRITERIA

- < 7 years of age; **OR**
- NPO (Appendix A) within the past 365 days

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HMG-COA REDUCTASE INHIBITORS

Updated 1/1/2026

PREFERRED AGENTS

- atorvastatin (generic for LIPITOR)
- lovastatin (generic for MEVACOR)
- pravastatin (generic for PRAVACHOL)
- rosuvastatin (generic for CRESTOR)
- simvastatin (generic for ZOCOR)

NON-PREFERRED AGENTS

- ALTOPREV (lovastatin ER)
- ATORVALIQ (atorvastatin)
- atorvastatin/amlodipine (generic for CADUET)
- CADUET (atorvastatin/amlodipine)
- CRESTOR (rosuvastatin)
- fluvastatin (generic for LESCOL)
- fluvastatin ER (generic for LESCOL XL)
- LESCOL XL (fluvastatin)
- LIPITOR (atorvastatin)
- LIVALO (pitavastatin)
- pitavastatin (generic for LIVALO)
- simvastatin/ezetimibe (generic for VYTORIN)
- VYTORIN (simvastatin/ezetimibe)
- ZOCOR (simvastatin)
- ZYPITAMAG (pitavastatin magnesium)

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HUMAN IMMUNODEFICIENCY VIRUS (HIV)

Updated 4/1/2026

PREFERRED AGENTS

- abacavir (generic for ZIAGEN)
- abacavir/lamivudine (generic for EPZICOM)
- atazanavir (generic for REYATAZ)
- BIKTARVY (bictegravir/emtricitabine/tenofovir)
- CIMDUO (lamivudine/tenofovir)
- COMPLERA (emtricitabine/rilpivirine/tenofovir) – **brand only**
- darunavir ethanolate 600 mg and 800 mg tablet (generic for PREZISTA)
- DELSTRIGO (doravirine/lamivudine/tenofovir)
- DESCOVY (emtricitabine/tenofovir alafenamide)
- DOVATO (dolutegravir/lamivudine)
- EDURANT tablet (rilpivirine) – **brand only**
- efavirenz (generic for SUSTIVA)
- efavirenz/emtricitabine/tenofovir disoproxil fumarate (generic for ATRIPLA)
- emtricitabine/tenofovir disoproxil fumarate (generic for TRUVADA)
- EMTRIVA solution (emtricitabine)
- EVOTAZ (atazanavir/cobicistat)
- fosamprenavir (generic for LEXIVA)
- GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir)
- ISENTRESS (raltegravir potassium)
- JULUCA (dolutegravir/rilpivirine)
- lamivudine (generic for EPIVIR)
- lamivudine/zidovudine (generic for COMBIVIR)
- lopinavir/ritonavir (generic for KALETRA)
- nevirapine (generic for VIRAMUNE)
- nevirapine ER (generic for VIRAMUNE XR)
- NORVIR powder (ritonavir)
- ODEFSEY (emtricitabine/rilpivirine/tenofovir)
- PIFELTRO (doravirine)
- PREZCOBIX (darunavir/cobicistat)
- PREZISTA suspension (darunavir)
- PREZISTA 75 mg and 150 mg tablet (darunavir)
- REYATAZ powder (atazanavir)

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- ritonavir (generic for NORVIR)
- STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir)
- SYMFI (efavirenz/lamivudine/tenofovir) – **brand only**
- SYMTUZA (darunavir/cobicistat/emtricitabine/tenofovir)
- tenofovir disoproxil fumarate (generic for VIREAD)
- TIVICAY/TIVICAY PD (dolutegravir)
- TRIUMEQ/ TRIUMEQ PD (abacavir/dolutegravir/lamivudine)
- TYBOST (cobicistat)
- zidovudine tablet and syrup (generic for RETROVIR)

NON-PREFERRED AGENTS

- APTIVUS (tipranavir)
- BIXLENVO (bictegravir/lenacapavir)
- EDURANT PED tablet for suspension (rilpivirine)
- efavirenz/lamivudine/tenofovir (generic for SYMFI/SYMFI LO)
- emtricitabine (generic for EMTRIVA)
- emtricitabine/rilpivirine/tenofovir (generic for COMPLERA)
- EMTRIVA capsule (emtricitabine)
- EPIVIR (lamivudine)
- etravirine (generic for INTELENCE)
- FUZEON (enfuvirtide) – **manufacturer obsolete 11/30/2025**
- IDVYNSO (doravirine/islatravir)
- INTELENCE (etravirine)
- KALETRA (lopinavir/ritonavir)
- NORVIR tablet (ritonavir)
- PREZISTA 600 mg and 800 mg tablet (darunavir)
- RETROVIR (zidovudine)
- REYATAZ capsule (atazanavir)
- rilpivirine (generic for EDURANT)
- RUKOBIA (fostemsavir tromethamine)
- TRUVADA (emtricitabine/tenofovir)
- VIRACEPT (nelfinavir)
- VIREAD tablet (tenofovir)
- VOCABRIA (cabotegravir)
- ZIAGEN (abacavir)
- zidovudine capsule (generic for RETROVIR)

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NON-PREFERRED AGENTS WITH CRITERIA

- APRETUDE (cabotegravir)
- CABENUVA (cabotegravir/rilpivirine)
- maraviroc (generic for SELZENTRY)
- SELZENTRY (maraviroc)
- SUNLENCA (lenacapavir sodium)
- YEZTUGO (lenacapavir sodium)

Note: TROGARZO is available as a medical claim only. Prior authorization criteria may apply.

APPROVAL CRITERIA FOR CABENUVA

- The beneficiary meets the minimum age and weight recommended in the manufacturer's package insert for this FDA-approved indication (as of 7/27/2023, minimum age is 12 years of age and weighs 35 kg).
- The beneficiary has a diagnosis of human immunodeficiency virus type 1 (HIV-1) infection and is virologically suppressed (HIV-1 RNA less than 50 copies per mL) on a stable antiretroviral regimen with no history of treatment failure or suspected resistance to cabotegravir or rilpivirine **or** a diagnosis consistent with any new FDA-approved indications. Any off-label requests will be reviewed on a case-by-case basis.
- The beneficiary should not be approved or continue this therapy if requires coadministration with any of the following:
  - Anticonvulsants: carbamazepine, oxcarbazepine, phenobarbital, phenytoin
  - Antimycobacterials: rifabutin, rifampin, rifapentine
  - Glucocorticoid (systemic): dexamethasone (more than a single-dose treatment); **OR**
  - Herbal product: St John's wort (Hypericum perforatum)
- The prescriber must submit **all** of the following:
  - Current chart notes
  - Labs including current RNA documenting viral suppression
  - Attestation that beneficiary has been counseled on the importance of compliance
  - Confirmation whether beneficiary will start with oral lead in doses or move directly to the injection; **AND**
- Prior authorization will be approved for 12 months.

RENEWAL REQUIREMENTS

- The beneficiary remains compliant on all antiretroviral medications
- The beneficiary has demonstrated continued virological suppression
- The prescriber must submit **all** of the following:
  - Current chart notes; **AND**
  - Current labs, including viral load

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QUANTITY EDITS

- 600 mg/900 mg – 1 kit per 30 days
- 400 mg/600 mg – 1 kit per 30 days

APPROVAL CRITERIA FOR APRETUDE AND YEZTUGO

- The beneficiary meets the minimum age and weight recommended in the manufacturer's package insert for this FDA-approved indication
  - For APRETUDE, the minimum age is 12 years of age and weight is 35 kg.
  - For YEZTUGO, the minimum weight is 35 kg.
- The beneficiary must be considered at risk for sexually acquired HIV-1 infections requiring pre-exposure prophylaxis (PrEP)
- The beneficiary must have a current negative HIV-1 test
- The beneficiary should not be approved or continue this therapy with any of the following:
  - Has a positive HIV-1 test either prior to initiating APRETUDE or during treatment
- The prescriber must submit **all** of the following:
  - Current chart notes
  - Current HIV test results
  - Document whether the beneficiary will have the 28-day oral lead-in therapy or begin with APRETUDE; **AND**
  - Attestation that the prescriber has counseled the beneficiary about the importance of compliance
- Prior authorization will be approved for 12 months.

QUANTITY EDIT

1 injection every 2 months (quantity override will be needed for first 2 months loading dose)

INFORMATION FROM THE SELZENTRY FORM

Part 1: Initial Approval Criteria

Use of maraviroc for treatment-experienced or treatment-naïve beneficiary (Check all that apply and all information must be true for the beneficiary to be eligible):

- Under the care of an experienced HIV practitioner
- Evidence of virologic failure (documented by viral load > 1,000 copies/mL not related to non-adherence to prescribed ARV)
- Unable to construct a multi-drug regimen from preferred, alternative*, or acceptable^ regimens as defined by the Department of Health and Human Services Guidelines for Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents that includes at least two additional active antiretroviral drugs in addition to maraviroc.

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Preferred Regimens (Regimens with optimal and durable efficacy, favorable tolerability and toxicity profile, and ease of use)

*Alternative Regimens (Regimens that are effective and tolerable but have potential disadvantages compared with preferred regimens. An alternative regimen may be the preferred regimen for some beneficiaries.)

^Acceptable Regimens (CI) (Regimens that may be selected for some beneficiaries but are less satisfactory than preferred or alternative regimens)

Part 2: Medicaid Approval Requirements for Trofile Assay Test:

This section to be completed by AR Medicaid only. The beneficiary meets criteria stated in Part 1 above.

If the beneficiary meets Part 1 criteria, Medicaid Utilization Review will be notified that the beneficiary meets Medicaid criteria for proceeding with Trofile Assay Test.

- A highly sensitive tropism assay at baseline is required prior to initiation of maraviroc; the results of the tropism assay may take approximately 3 weeks and a prescription for maraviroc should not be written until the results indicate only CCR5 tropism.
- Prior approval from Medicaid is required for a repeat tropism assay. A repeat tropism assay should only be performed if the prescriber is considering a change of treatment due to increasing VL and/or decreasing CD4 count. If CXCR4 or DM virus is detected during therapy, the PA for maraviroc will be discontinued. In failing beneficiaries who have CCR5 virus, a maraviroc resistance assay may also be necessary.

Part 3: Approval or Denial for SELZENTRY (maraviroc):

- Does the beneficiary have confirmed infection with only CCR5 tropic virus as determined by Trofile Assay Test result screening prior to maraviroc initiation? A copy of lab test results are required as part of the manual review process.
- The prior approval is NDC and dose specific. AR Medicaid will allow up to a maximum of 1,200 mg/day in the following dosing regimens. Please indicate intended dose*:
  - 150 mg tablet, 1 tablet twice daily
  - 300 mg tablet, 1 tablet twice daily
  - 300 mg tablet, 2 tablets twice daily

*Caution and/or dosing adjustments may be warranted in beneficiaries with renal or hepatic impairment. Please refer to prescribing information in manufacturer's package insert for dosing and contraindications.

APPROVAL CRITERIA FOR SUNLENCA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication

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- The beneficiary is prescribed no more than the maximum dose as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with HIV-1 infection and heavily treatment-experienced with multidrug resistant disease failing their current antiretroviral regimen due to resistance, intolerance, or safety considerations **or** a diagnosis consistent with any new FDA-approved indications or support in the official Compendia
- Multidrug resistance is defined as resistance to 2 agents from 3 of the 4 main classes of ARV
- ARV classes include nucleoside reverse transcriptase inhibitors (NRTI), non-nucleoside reverse transcriptase inhibitors (NNRTI), protease inhibitors (PI) and integrase strand transfer inhibitor (INSTI)
- The beneficiary should not be approved with any of the following:
  - Concomitant administration of strong CYP3A inducers is required
  - Baseline HIV-1 RNA levels < 400 copies/mL
  - Prior to starting SUNLENCA, there is no current antiretroviral therapy; **AND**
  - Not prescribed a concomitant optimized background regimen
- The prescriber must submit **all** of the following:
  - Current chart notes
  - Documentation of previous therapies tried
  - Current labs, including viral load
  - Documentation of which regimen prescribed; **AND**
  - Documentation of concomitant antiretrovirals prescribed
- PA will be approved for 1 year

RENEWAL REQUIREMENTS

- The beneficiary remains compliant on all antiretroviral medications
- The beneficiary has demonstrated improvement in viral load
- The prescriber must submit **all** of the following:
  - Current chart notes; **AND**
  - Current labs, including viral load

QUANTITY EDITS

- #1 oral tablet pack per year (quantity 4 or 5 depending on regimen chosen)
- #1 injection kit (2 vials) every 6 months

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HYDROCHLOROTHIAZIDE 10 MG/ML SUSPENSION (INZIRQO)

Updated 7/1/2026

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

POINT-OF-SALE (POS) EDITS

- The beneficiary is < 7 years of age or has a diagnosis of NPO (Appendix A) in the last 365 days; **AND**
- Billed diagnosis of hypertension or edema in the last 2 years

BENEFICIARY NOT MEETING POS CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with hypertension or edema associated with congestive heart failure, hepatic cirrhosis, or renal disease **or** a diagnosis consistent with any new FDA-approved indications. Any off-label requests will be reviewed on a case-by-case basis.
- The prescriber must submit the following:
  - Current chart notes
  - Baseline blood pressure or description of edema
  - Medical necessity over hydrochlorothiazide tablets and capsules; **AND**
  - For beneficiaries 7 years of age and older, attestation of NPO status will be required every 6 months

RENEWAL REQUIREMENTS

- The beneficiary is compliant with therapy (defined as 75% utilization)
- The beneficiary should have an improvement with underlying diagnosis
- The prescriber must submit the following:
  - Current chart notes
  - Current blood pressure or description of edema; **AND**
  - Continued medical necessity of INZIRQO suspension over oral solid dosage forms

QUANTITY EDITS

2 bottles per month (if the beneficiary requires a higher dose, a quantity override can be entered)

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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HYDROCORTISONE SPRINKLE (ALKINDI) AND SOLUTION (KHINDIVI)

Updated 10/16/2024

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary does not exceed the maximum age recommended in the manufacturer's package insert
- The beneficiary must be diagnosed with adrenocortical insufficiency
- The prescriber must submit the following:
  - Current chart notes
  - Dose requested; **AND**
  - Medical necessity over hydrocortisone tablets or prednisolone solution which are available without prior authorization

RENEWAL REQUIREMENTS

The beneficiary continues to demonstrate the medical necessity of the sprinkle or solution formulation

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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HYDROXYUREA 100 MG FILM COATED TABLET (SIKLOS)

Updated 1/15/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must be diagnosed with sickle cell anemia with moderate to severe painful crises
- The beneficiary should not be approved or continue this therapy with any of the following:
  - Medical necessity over hydroxyurea 500 mg and DROXIA has not been established; **AND**
  - Dose must be reduced by 50% in beneficiaries with creatinine clearance of less than 60 mL/min or with end-stage renal disease (ESRD)
- The prescriber must submit the following:
  - Current chart notes
  - Current labs
  - Current weight
  - Baseline summary of pain crises with documentation of hospitalizations, ER visits, and transfusions for sickle cell diagnosis for the past 12 months; **AND**
  - Letter of medical necessity for SIKLOS over hydroxyurea 500 mg capsule or DROXIA which are both available without prior authorization. Products have the same black-box warnings.

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HYDRODROXYUREA 100 MG/ML SOLUTION (XROMI)

Updated 4/16/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

POINT-OF-SALE (POS) EDITS

- The beneficiary is < 7 years of age or have a diagnosis of NPO (Appendix A) in the last 365 days; **AND**
- Billed diagnosis of sickle cell disease in the last 2 years

BENEFICIARY NOT MEETING POS CRITERIA

- The beneficiary must be diagnosed with moderate to severe, painful crises associated with sickle cell anemia
- The medication must be prescribed by or in consultation with a specialist in the treatment of sickle cell.
- The prescriber must submit the following:
  - Current chart notes with documentation of pain crises and blood transfusion frequency
  - Medical necessity for the use of solution over capsules which are available without prior authorization
  - For beneficiaries 7 years of age and older, attestation of NPO status will be required every 6 months
  - Negative pregnancy test if a female of reproductive potential
  - Attestation that female beneficiaries of reproductive potential will be using effective contraception; **AND**
  - Attestation that labs will be monitored throughout treatment

RENEWAL REQUIREMENTS

- The beneficiary is compliant with therapy (defined as 75% utilization)
- The beneficiary must demonstrate an improvement in frequency of pain crises and transfusions
- The prescriber must submit the following:
  - Current chart notes
  - Continued medical necessity for the use of oral solution over capsules; **AND**
  - Attestation that female beneficiaries of reproductive potential will continue to use effective contraception

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IDIOPATHIC PULMONARY FIBROSIS AGENTS

Updated 4/1/2026

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

PREFERRED AGENT WITH CRITERIA

pirfenidone tablet (generic for ESBRIET)

NON-PREFERRED AGENTS

- ESBRIET (pirfenidone)
- JASCAYD (nerandomilast)
- nintedanib (generic for OFEV)
- OFEV (nintedanib)
- pirfenidone capsule (generic for ESBRIET)

APPROVAL CRITERIA FOR ESBRIET (PIRFENIDONE)

- The beneficiary meets the minimum age recommended in the manufacturer's package insert
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The medication must be prescribed by or in consultation with a pulmonologist
- The beneficiary must be diagnosed with idiopathic pulmonary fibrosis (IPF). Confirmation will require the following:
  - Confirmed by either a lung biopsy or high-resolution computed tomography (CT) scan of the lungs with presence of the usual interstitial pneumonia (UIP) pattern with documentation of some of the following:
    - Basal and peripheral dominance
    - Honeycombing (usually subpleural)
    - Reticular opacities or ground-glass opacities
    - Traction bronchiectasis; **OR**
    - Airspace enlargement with fibrosis
  - Baseline Pulmonary Function Tests (PFTs)
    - Forced vital capacity (FVC) is ≥ 50% predicted; **AND**
    - Carbon monoxide diffusing capacity (DLCO) is ≥ 30% predicted
  - Other known causes of interstitial lung disease (e.g., environmental exposures, connective tissue disease, drug toxicity) have been ruled out
- The beneficiary should not be approved or continue the medication if any of the following apply:
  - Likely to receive a lung transplant or previously had a lung transplant

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- Has relevant airways obstruction (i.e., pre-bronchodilator FEV1/FVC < 0.8)
- Currently smoking
- Severe hepatic impairment (Child Pugh C). Beneficiaries with mild to moderate hepatic impairment (Child Pugh A or B) should use ESBRIET with caution and consider dose modification or discontinuation if needed.
- End-stage renal disease requiring dialysis. For beneficiaries with mild to severe renal impairment, monitor for adverse events and modify dose or discontinue as needed; **OR**
- Develops Severe Cutaneous Adverse Reactions (SCAR)

- The prescriber must submit the following:
  - Current chart notes and documentation to support the diagnosis (e.g., CT scan results and/or biopsy results)
  - Strength of medication and dosage form requested (PA is entered for specific dose)
  - Current labs, including liver function tests
  - Baseline pulmonary function tests (PFTs)
  - Baseline 6-minute walk test (6MWT); **AND**
  - Documentation verifying the smoking status with **one** of the following:
    - Exhaled carbon monoxide level (eCO) < 6 ppm
    - Carboxyhemoglobin (COHb) levels < 3%; **OR**
    - Urine continine concentration < 200 mg/mL

RENEWAL REQUIREMENTS

- The beneficiary must remain compliant with therapy (defined as 75% utilization)
- The beneficiary must remain a non-smoker
- The beneficiary must demonstrate a positive response with improved, stable or slowed progression based on radiographic results, pulmonary function tests, and/or clinical presentation
- The prescriber must submit the following:
  - Current chart notes
  - Current labs, including LFTs; **AND**
  - Documentation of response to therapy with any of the following:
    - Current pulmonary function tests
    - Current 6MWT; **AND**
    - Current CT scan results of lung

QUANTITY EDITS

- 267 mg - #270 tablets or capsules per 30 days
- 801 mg - #90 tablets per 30 days

APPROVAL CRITERIA FOR OFEV (NINTEDANIB)

- The beneficiary meets the minimum age recommended in the manufacturer's package insert

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- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The medication must be prescribed by or in consultation with a pulmonologist
- The beneficiary must be diagnosed with idiopathic pulmonary fibrosis, chronic fibrosing interstitial lung disease with progressive phenotype, **or** systemic sclerosis-associated interstitial lung disease. Confirmation will require the following depending on diagnosis:
  - **Idiopathic pulmonary fibrosis (IPF)**
    - Confirmed by either a lung biopsy or high-resolution computed tomography (CT) scan of the lungs with presence of the usual interstitial pneumonia (UIP) pattern with documentation of some of the following:
      - Basal and peripheral dominance
      - Honeycombing (usually subpleural)
      - Reticular opacities or ground-glass opacities
      - Traction bronchiectasis; **OR**
      - Airspace enlargement with fibrosis
    - Baseline Pulmonary Function Tests (PFTs)
      - Forced vital capacity (FVC) is ≥ 50% predicted; **AND**
      - Carbon monoxide diffusing capacity (DLCO) corrected for hemoglobin is 30–79% of predicted
    - Other known causes of interstitial lung disease (e.g., environmental exposures, connective tissue disease, drug toxicity) have been ruled out
  - **Chronic fibrosing interstitial lung diseases with progressive phenotype (also called progressive pulmonary fibrosis)** with a high-resolution CT scan indicating pulmonary fibrosis is affecting ≥ 10% of the lungs with at least **two** of the following criteria with at least **one** of the examples listed with the criteria in the last 24 months:
    - Worsening respiratory symptoms (e.g., increased dyspnea on exertion); **OR**
    - Radiological evidence of disease progression with at least **one** of the following examples:
      - Increased extent or severity of traction bronchiectasis and bronchiolectasis
      - New ground-glass opacity with traction bronchiectasis
      - New fine reticulation
      - Increased extent or increased coarseness of reticular abnormality
      - New or increased honeycombing; **OR**
      - Increased lobar volume loss
    - PFTs indicate disease progression with at least **one** of the following examples:
      - FVC decline ≥ 10% predicted
      - FVC decline ≥ 5% and < 10% predicted with worsening symptoms or imaging; **OR**
      - DLCO decline (corrected for Hb) ≥ 10% predicted

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- **Systemic sclerosis-associated interstitial lung disease (SSC-ILD)** requires a diagnosis of systemic sclerosis (SSC) based on rheumatology guidelines and interstitial lung disease with the following:
  - High-resolution CT scan indicates pulmonary fibrosis is affecting ≥ 10% of the lungs; **AND**
  - Baseline PFTs
    - Forced vital capacity (FVC) is ≥ 40% predicted; **AND**
    - Carbon monoxide diffusing capacity (DLCO) corrected for hemoglobin is 30–89% of predicted

- The beneficiary should not be approved or continue the medication if **one** of the following is met:
  - Likely to receive a lung transplant or previously had a lung transplant
  - Has relevant airways obstruction (i.e., pre-bronchodilator FEV1/FVC < 0.7)
  - Pregnant or breastfeeding
  - Currently smoking
  - Moderate or severe hepatic impairment (Child-Pugh B or C). Beneficiaries with mild hepatic impairment (Child-Pugh A) can be treated with a reduced dose of OFEV.
  - Has gastrointestinal perforation
  - Severe renal impairment (CrCl < 30 mL/min) or end-stage renal disease; **OR**
  - Caution in beneficiaries with known risk of bleeding (benefit outweighing the risk should be provided)
- The prescriber must submit the following:
  - Current chart notes and documentation to support the diagnosis (e.g., CT scan results and/or biopsy results)
  - Dose requested (PA is entered for specific dose)
  - Current labs, including liver function test
  - Baseline pulmonary function tests (PFTs)
  - Baseline 6-minute walk test (6MWT)
  - Letter of medical necessity over immunosuppressant for SSC-ILD beneficiaries (i.e., mycophenolate); **AND**
  - Documentation verifying the smoking status with **one** of the following:
    - Exhaled carbon monoxide level (eCO) < 6 ppm
    - Carboxyhemoglobin (COHb) levels of < 3%; **OR**
    - Urine continine concentration < 200 mg/mL
  - For non-preferred medications, medical necessity over the preferred agents for the requested indication is required.

RENEWAL REQUIREMENTS

- The beneficiary must remain compliant with therapy (defined as 75% utilization)
- The beneficiary must remain a non-smoker

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- The beneficiary must demonstrate a positive response with improved, stable or slowed progression based on radiographic results, pulmonary function tests, and/or clinical presentation
- The prescriber must submit the following:
  - Current chart notes
  - Current labs, including LFTs; **AND**
  - Documentation of response to therapy with any of the following:
    - Current pulmonary function tests
    - Current 6MWT
    - Current CT scan results of lungs

QUANTITY EDITS

- 100 mg – #60 capsules per 30 days
- 150 mg – #60 capsules per 30 days

APPROVAL CRITERIA FOR JASCAYD (NERANDOMILAST)

- The beneficiary meets the minimum age recommended in the manufacturer's package insert
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The medication must be prescribed by or in consultation with a pulmonologist
- The beneficiary must be diagnosed with idiopathic pulmonary fibrosis or progressive pulmonary fibrosis. Confirmation will require the following depending on diagnosis:
  - **Idiopathic pulmonary fibrosis (IPF)**
    - Confirmed by either a lung biopsy or high-resolution computed tomography (CT) scan of the lungs with presence of the usual interstitial pneumonia (UIP) pattern with documentation of some of the following:
      - Basal and peripheral dominance
      - Honeycombing (usually subpleural)
      - Reticular opacities or ground-glass opacities
      - Traction bronchiectasis; **OR**
      - Airspace enlargement with fibrosis
    - Baseline Pulmonary Function Tests (PFTs)
      - Forced vital capacity (FVC) is ≥ 50% predicted; **AND**
      - Carbon monoxide diffusing capacity (DLCO) corrected for hemoglobin is 30–79% of predicted
    - Other known causes of interstitial lung disease (e.g., environmental exposures, connective tissue disease, drug toxicity) have been ruled out
  - **Progressive pulmonary fibrosis (PPF)**

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        - With a high-resolution CT scan indicating pulmonary fibrosis is affecting ≥ 10% of the lungs with at least **two** of the following criteria with at least **one** of the examples listed with the criteria in the last 24 months:
            - Worsening respiratory symptoms (e.g., increased dyspnea on exertion); **OR**
            - Radiological evidence of disease progression with at least **one** of the following examples:
                - Increased extent or severity of traction bronchiectasis and bronchiolectasis
                - New ground-glass opacity with traction bronchiectasis
                - New fine reticulation
                - Increased extent or increased coarseness of reticular abnormality
                - New or increased honeycombing; **OR**
                - Increased lobar volume loss
        - PFTs indicate disease progression with at least **one** of the following examples:
            - FVC decline ≥ 10% predicted
            - FVC decline ≥ 5% and < 10% predicted with worsening symptoms or imaging; **OR**
            - DLCO decline (corrected for Hb) ≥ 10% predicted
- The beneficiary should not be approved if **one** of the following is met:
    - Likely to receive a lung transplant or previously had a lung transplant
    - Has relevant airways obstruction (i.e., pre-bronchodilator FEV1/FVC < 0.8)
    - Currently smoking; **OR**
    - End-stage renal disease (eGFR < 15 mL/min/1.73 m^2) or severe hepatic impairment (Child Pugh C)
- The prescriber must submit the following:
    - Current chart notes and documentation to support the diagnosis (e.g., CT scan results and/or biopsy results)
    - Baseline pulmonary function tests (PFTs)
    - Baseline 6-minute walk test (6MWT)
    - Documentation verifying the smoking status with **one** of the following:
        - Exhaled carbon monoxide level (eCO) < 6 ppm
        - Carboxyhemoglobin (COHb) levels of < 3%; **OR**
        - Urine continine concentration < 200 mg/mL
    - For non-preferred medications, medical necessity over the preferred agents for the requested indication is required.

RENEWAL REQUIREMENTS

- The beneficiary must remain compliant with therapy (defined as 75% utilization)
- The beneficiary must remain a non-smoker
- The beneficiary must demonstrate a positive response with improved, stable or slowed progression based on radiographic results, pulmonary function tests, and/or clinical presentation

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- The prescriber must submit the following:
  - Current chart notes
  - Current labs, including LFTs; **AND**
  - Documentation of response to therapy with any of the following:
    - Current pulmonary function tests
    - Current 6MWT
    - Current CT scan results of lungs

QUANTITY EDITS

- 62 tablets per 31 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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IMIQUIMOD (ALDARA)

Updated 6/27/2007

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- > 12 years of age; **AND**
- Submitted diagnosis for superficial basal cell carcinoma (sBCC) within the past two months; **OR**
- Submitted diagnosis for actinic keratosis (AK) within the past two months; **OR**
- Submitted diagnosis for condyloma acuminata (or commonly known as external genital or perianal warts) within the past two months; **AND**
- No therapeutic duplication with diclofenac sodium 3% gel
- No therapeutic duplication with fluorouracil cream/solution topical
- No therapeutic duplication with other strengths of imiquimod cream topical
- No therapeutic duplication with ingenol gel topical

ADDITIONAL CRITERIA

Quantity limits apply

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IMIQUIMOD (ZYCLARA)

Updated 4/27/2010

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

Please note that effective 10/1/2025, this manufacturer is terminating participation in the federal rebate program and therefore brand ZYCLARA can no longer be covered by Arkansas Medicaid.

APPROVAL CRITERIA

- > 12 years of age; **AND**
- Submitted diagnosis for actinic keratosis (AK) within the past two months; **OR**
- Submitted diagnosis for condyloma acuminata (commonly known as external genital or perianal warts) within the past two months; **AND**
- No therapeutic duplication with diclofenac sodium 3% gel
- No therapeutic duplication with fluorouracil cream/solution topical
- No therapeutic duplication with other strengths of imiquimod cream topical
- No therapeutic duplication with ingenol gel topical

ADDITIONAL CRITERIA

Quantity limits apply

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IMMUNE GLOBULINS (IVIG)

Updated 1/1/2026

PREFERRED AGENTS WITH CRITERIA

- GAMMAGARD liquid vial
- GAMUNEX-C
- HIZENTRA

POINT-OF-SALE (POS) APPROVAL CRITERIA FOR PREFERRED AGENTS

- All IVIG and SCIG products will be subject to point-of-sale edits
- For a claim to process at POS, the beneficiary must have a billed diagnosis for an indication found in Table A in the last two years
- Beneficiaries without a billed diagnosis from the **FDA-approved and Non-FDA Supported Immune Globulin Indications** table below will require a prior authorization request to be submitted by the prescriber. Each PA request will be reviewed on a case-by-case basis. The prescriber must submit the following:
  - Current chart notes
  - Diagnosis requiring immune globulin; **AND**
  - Criteria does not pertain to medically billed claims; only pertains to pharmacy claims

NON-PREFERRED AGENTS

- ALYGLO
- ASCENIV
- BIVIGAM
- CUTAQUIG
- CUVITRU
- CYTOGAM
- FLEBOGAMMA DIF
- GAMASTAN
- GAMMAGARD LIQUID ERC
- GAMMAGARD S-D
- GAMMAKED
- GAMMAPLEX
- HYPERRHO S-D
- HYQVIA
- OCTAGAM
- PANZYGA
- PRIVIGEN

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- QIVIGY
- RHOGAM ULTRA-FILTERED PLUS
- RHOPHYLAC
- WINRHO SDF
- XEMBIFY

FDA-APPROVED AND NON-FDA-SUPPORTED IMMUNE GLOBULIN INDICATIONS

From DailyMed and MicroMedex (9/20/2021)

FDA-Approved and Non-FDA-Supported Immune Globulin Indications
FDA-Approved Indications
Primary humoral Immunodeficiency
• Common variable immunodeficiency • X-linked agammaglobinemia • Congenital agammaglobinemia • Wiskott-Aldrich syndrome • Severe combined immunodeficiency
Chronic immune thrombocytopenic purpura
Chronic inflammatory demyelinating polyneuropathy
Kawasaki syndrome
Multifocal motor neuropathy
B-cell chronic lymphocytic leukemia
Dermatomyositis
Supported Non-FDA-Approved Indications
Acquired epidermolysis bullosa
Autoimmune hemolytic anemia
Autoimmune neutropenia
Bone marrow transplant
Bullous pemphigoid
Cytomegalovirus infection (treatment and prophylaxis)
Disseminated encephalomyelitis
Guillain-Barre syndrome
Herpes gestationis
Kidney disease (severe IgA nephropathy)
Linear IgA dermatosis
Lumbosacral radiculoplexus neuropathy
Lymphoproliferative disorder following transplantation
Myasthernia gravis
Ocular cicatricial pemphigoid

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FDA-Approved and Non-FDA-Supported Immune Globulin Indications
Pemphigus vulgaris
Polyarteritis nodosa
Pyoderma gangrenosum
Renal transplant
Respiratory syncytial virus infection
Stiff person syndrome
Toxic shock syndrome
Uveitis
von Willebrand disorder

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IMMUNOLOGIC AGENTS (MULTIPLE SCLEROSIS)

Updated 10/1/2024

PREFERRED AGENTS WITHOUT CRITERIA

- AMPYRA ER (dalfampridine ER)
- AVONEX (interferon beta – 1A)
- COPAXONE **20 mg** – **brand only**
- dalfampridine ER (generic for AMPYRA ER)
- dimethyl fumarate (generic for TECFIDERA)
- fingolimod (generic for GILENYA)
- teriflunomide (generic for AUBAGIO)

PREFERRED AGENT WITH CRITERIA

KESIMPTA (ofatumumab)

NON-PREFERRED AGENTS

- AUBAGIO (teriflunomide)
- BAFIERTAM (monomethyl fumarate)
- BETASERON (interferon beta – 1B)
- cladribine (generic for MAVENCLAD)
- COPAXONE 40 mg (glatiramer)
- EXTAVIA (interferon beta – 1B)
- GILENYA (fingolimod)
- glatiramer acetate (generic for COPAXONE)
- glatiramer acetate (generic for GLATOPA)
- GLATOPA (glatiramer)
- MAVENCLAD (cladribine) – **brand preferred over generic when approved**
- MAYZENT (siponimod)
- PLEGRIDY (peginterferon beta – 1A)
- PONVORY (ponesimod)
- REBIF/REBIF REBIDOSE (interferon beta – 1A/albumin)
- TASCENSO ODT (fingolimod)
- TECFIDERA (dimethyl fumarate)
- VUMERITY (diroximel fumarate)
- ZEPOSIA (ozanimod)

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AGENTS COVERED UNDER MEDICAL CLAIMS ONLY

As of 1/1/2026, Prime Therapeutics reviews Medical Claim Prior Authorization requests. For more information, please visit ar.primetherapeutics.com/documents/d/arkansas/arkansas_medicaid_pad_criteria.

- BRIUMVI
- LEMTRADA
- OCREVUS
- TYSABRI

APPROVAL CRITERIA FOR KESIMPTA

Medicaid prescription history contains at least one preferred multiple sclerosis medication (AMPYRA ER and dalfampridine ER are not included) in the previous year

POINT OF SALE (POS) APPROVAL CRITERIA FOR KESIMPTA

Medicaid prescription history contains a claim for KESIMPTA in the last 2 months (continuation criteria)

NON-PREFERRED MEDICATIONS APPROVAL CRITERIA

ALL NON-PREFERRED MEDICATIONS

- The beneficiary meets the minimum age recommended in the manufacturer's package insert
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary has a confirmed diagnosis of a relapsing form of multiple sclerosis (MS) including clinically isolated syndrome, relapsing-remitting disease, or active secondary progressive disease
- The initial request must be submitted by or in consultation with a neurologist or other appropriate specialist
- The beneficiary with moderately active disease must have tried and failed multiple preferred products with different mechanisms of action. If KESIMPTA was previously tried, the beneficiary must have taken it for at least 6 months. Failure is defined by any of the following:
  - At least one relapse during therapy with preferred medications
  - MRI indicates additional lesions compared to baseline
  - The beneficiary demonstrates an increased disability as measured by the Expanded Disability Status Scale (EDSS) compared to baseline; **AND**
  - Documented adverse effects to the preferred agents
- The beneficiary with highly active or rapidly evolving aggressive disease will be reviewed on a case-by-case basis
- The beneficiary is not prescribed other Disease-Modifying Therapies (DMTs) for the treatment of MS to be used concomitantly

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- The prescriber must submit **all** of the following:
  - Current chart notes
  - Documentation of previous therapies with response
  - Letter of medical necessity over the preferred medications
  - Baseline MRI with documentation of lesions; **AND**
  - Baseline Expanded Disability Status Scale (EDSS)
- See additional criteria noted below for specific medications

FUMARATES: BAFIERTAM, VUMERITY

- The beneficiary does **not** have any of the following:
  - Moderate to severe renal impairment
  - Moderate to severe hepatic impairment; **OR**
  - Previous failure with any fumarate product;
- Prescribed concomitant fumarate therapies
- The prescriber must submit **all** of the following (in addition to info requested above):
  - Current labs, including a CBC including lymphocyte count and LFTs
  - Confirmed negative for pregnancy and attestation of contraception use in beneficiary of reproductive potential; **AND**
  - Medical necessity over dimethyl fumarate

INTERFERONS: BETASERON, EXTAVIA, PLEGRIDY, REBIF/REBIF REBIDOSE

- The prescriber must submit **all** of the following (in addition to the info requested above):
  - Current labs, including CBC with differential and LFTs
  - Attestation that the beneficiary has been counseled about depression; **AND**
  - Medical necessity over AVONEX

GLATIRAMER: COPAXONE 40 MG, GLATOPA 20 MG OR 40 MG

The prescriber must submit the necessity over COPAXONE 20 mg daily (convenience would not be considered medically necessary)

SPHINGOSINE 1-PHOSPHATE RECEPTOR MODULATORS: MAYZENT, PONVORY, TASCENSO ODT, ZEPOSIA

- The beneficiary does **not** have any of the following:
  - Current systemic or clinically significant infection
  - Use of any other antineoplastic, immunosuppressive or immunomodulator drugs to treat other conditions
  - Baseline heart rate $\leq$ 55 bpm
  - Moderate to severe hepatic impairment (Child-Pugh class B or C)

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- MI, unstable angina, stroke, TIA, decompensated heart failure requiring hospitalization or Class II or IV heart failure in the last 6 months
- Presence of Mobitz type II second-degree, third-degree AV block, sick sinus syndrome, or sino-atrial block, unless the beneficiary has a pacemaker; **OR**
- Previous treatment with alemtuzumab

- The prescriber must submit **all** of the following (in addition to info requested above):
  - Current labs, including a CBC including lymphocyte count and LFTs
  - Documentation of CYP2C9 genotype to determine dose for MAYZENT
  - Documentation of cardiac evaluation with ECG if beneficiary has preexisting conditions (contraindicated in recent MI, angina, stroke, TIA, severe HF, baseline QTc interval ≥ 500 msec, or cardiac arrhythmias requiring therapy).
  - Baseline eye exam report
  - Vaccinate for varicella zoster virus before initiation if VZV antibody negative
  - Confirmed negative for pregnancy and attestation of contraception use in beneficiary of reproductive potential; **AND**
  - Medical necessity over fingolimod
- MAYZENT beneficiary must **not** have a CYP2C9 *3/*3 genotype (homozygous)

PURINE ANTIMETABOLITE: MAVENCLAD

- The beneficiary should **not** have a diagnosis of clinically isolated syndrome
- The beneficiary does **not** have any of the following:
  - Human immunodeficiency virus (HIV), hepatitis B or C, TB or other current systemic or clinically significant infection
  - Current malignancy
  - Use of any other antineoplastic, immunosuppressive or immunomodulator drugs to treat other conditions
  - Moderate to severe renal impairment (CrCl < 60 mL/min)
  - Moderate to severe hepatic impairment (Child-Pugh score > 6)
- The prescriber must submit **all** of the following (in addition to info request above):
  - Medical necessity over all other DMTs
  - Treatment plan after two years of therapy
  - Current labs, including a CBC with differential including lymphocyte count and LFTs
  - Confirmed negative for pregnancy and attestation of contraception use in beneficiary of reproductive potential
  - Reports for screening hepatitis B and C, HIV, and tuberculosis; **AND**
  - Vaccinate for varicella zoster virus before initiation if VZV antibody negative

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RENEWAL REQUIREMENTS

- The prescriber must submit current chart notes with documentation of response to therapy
- The beneficiary must have a positive response to therapy which may include any of the following:
  - Decrease in the number of relapses
  - Improvement or no decline in Expanded Disability Status Scale (EDSS); **OR**
  - Improvement in MRI findings since initiating therapy

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IMMUNOMODULATORS, ASTHMA AND MISCELLANEOUS INDICATIONS

Updated criteria 10/1/2026

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

PREFERRED AGENTS WITH CRITERIA

- DUPIXENT (dupilumab)
- FASENRA (benralizumab)
- RHAPSIDO (remibrutinib)
- TEZSPIRE (tezepelumab-ekko)
- XOLAIR autoinjector and syringe (omalizumab)

NON-PREFERRED AGENTS

- NEMLUVIO (nemolizumab-ilto)
- NUCALA (mepolizumab)
- OMLYCLO (omalizumab-igec)
- XOLAIR vial (omalizumab)

FDA-APPROVED INDICATIONS

DUPIXENT:

- Moderate to severe atopic dermatitis
- Chronic rhinosinusitis with nasal polyposis
- Chronic spontaneous urticaria
- Moderate-to-severe asthma (either eosinophilic phenotype or oral steroid dependent)
- Eosinophilic esophagitis
- Prurigo nodularis
- Eosinophilic phenotype chronic obstructive pulmonary disease (COPD)
- Bullous pemphigoid
- Allergic fungal rhinosinusitis

FASENRA:

- Severe asthma with an eosinophilic phenotype
- Eosinophilic granulomatosis with polyangiitis
- Hypereosinophilic syndrome

RHAPSIDO:

- Chronic spontaneous urticaria

XOLAIR:

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- Moderate to severe asthma with positive skin test or in vitro reactivity to allergen
- Nasal polyps
- Chronic spontaneous urticaria
- IgE-mediated food allergies

NEMLUVIO:

- Moderate to severe atopic dermatitis
- Prurigo nodularis

NUCALA:

- Eosinophilic phenotype chronic obstructive pulmonary disease (COPD)
- Hypereosinophilic syndrome
- Maintenance treatment of chronic rhinosinusitis with nasal polyps
- Severe asthma with an eosinophilic phenotype
- Eosinophilic eranulomatosis with polyangiitis

TEZSPIRE:

- Severe asthma
- Nasal polyps

APPROVAL CRITERIA FOR ASTHMA (FOR DUPIXENT, FASENRA, NUCALA, TEZSPIRE, AND XOLAIR)

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed a dose that meets the package insert requirements for indication, age, and weight or supported in MicroMedex
- The medication must be prescribed by or in consultation with specialist in pulmonology, allergy or immunology
- The beneficiary must have a diagnosis consistent with FDA indications.
  - NUCALA – add-on maintenance treatment of adult and pediatric beneficiaries 6 years of age and older with severe asthma and with an eosinophilic phenotype
  - FASENRA – add-on maintenance treatment of beneficiaries with severe asthma 6 years of age and older and with an eosinophilic phenotype
  - DUPIXENT – add-on maintenance treatment of adult and pediatric beneficiaries 6 years of age and older with moderate-to-severe asthma characterized by an eosinophilic phenotype or with oral corticosteroid dependent asthma
  - TEZSPIRE – add-on maintenance treatment of adult and pediatric beneficiaries 12 years of age and older with severe asthma

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- XOLAIR – adults and pediatric beneficiaries 6 years of age and older with moderate to severe persistent asthma who have a positive skin test or in vitro reactivity to a perennial aeroallergen and whose symptoms are inadequately controlled with inhaled corticosteroids

- The beneficiary must have uncontrolled moderate to severe asthma while compliant with at least two asthma maintenance medications, with one being an inhaled corticosteroid at a maximum dose (ICS/LABA combination products count as two medications) **AND** one of the following:
  - One or more exacerbations in the previous year defined as:
    - Requires treatments with systemic corticosteroids; **OR**
    - Requires medical treatment (e.g., emergency room visits or hospitalizations)
  - The beneficiary has oral corticosteroid dependent asthma
- The beneficiary has no therapeutic duplication with any other monoclonal antibodies prescribed for asthma
- If the request is for a non-preferred medication, the beneficiary must have tried and failed at least two preferred biologics with this indication before non-preferred options can be approved, unless there is a beneficiary-specific contraindication to the preferred options
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of previous therapies tried for asthma with response
  - Baseline labs (must fall within the manufacturer's requirements in the package insert)
    - Baseline blood eosinophil count for FASENRA, NUCALA, and DUPIXENT (if eosinophilic type) with eosinophils ≥ 150
    - Baseline serum IgE levels, body weight, and completed form for XOLAIR
  - Baseline Asthma Control Questionnaire (ACQ-5) for all beneficiaries **or** Asthma Quality of Life Questionnaire (AQLQ) scores for adults only; **AND**
  - Current Pulmonary Function Test results

RENEWAL REQUIREMENTS FOR ASTHMA (FOR DUPIXENT, FASENRA, NUCALA, TEZSPIRE, AND XOLAIR)

- The beneficiary is compliant on asthma controller medication (ICS or ICS/LABA) and immunomodulator injection
- The prescriber must submit the following:
  - Current chart notes with documentation of response to therapy after 12 months of treatment
  - Current PFTs
  - Current blood eosinophil count for FASENRA, DUPIXENT (if eosinophilic type), and NUCALA
  - Current serum IgE level and body weight for XOLAIR; **AND**
  - Current Asthma Control Questionnaire (ACQ-5) for all beneficiaries **or** Asthma Quality of Life Questionnaire (AQLQ) scores for adults only
- Renewal requires prescriber to submit updated notes with documentation of a positive response to therapy as indicated by at least **one** of the following:

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- The beneficiary must have an improvement in FEV1 over baseline after 12 months
- The beneficiary must have fewer exacerbations
- The beneficiary must have a decrease in blood eosinophil count **or** serum IgE **or** decrease in oral corticosteroid usage (depending on medication)
- The beneficiary must have improved asthma control and quality of life scores

APPROVAL CRITERIA FOR EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS (EGPA) (FOR FASENRA AND NUCALA)

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary must be diagnosed with EGPA for at least 6 months based on the presence of asthma plus eosinophilia (> 1.0 x 10^9/L and/or > 10% of leucocytes)
- The beneficiary has a history of relapsing or refractory disease with at least one confirmed EGPA relapse within the last 2 years while taking oral corticosteroids
- The beneficiary must be on a stable dose of oral prednisolone or prednisone of ≥ 7.5 mg/day for at least four weeks
- If the beneficiary is receiving immunosuppressive therapy (excluding cyclophosphamide), the dosage must be stable for four weeks
- The beneficiary is prescribed a dose that meets the package insert requirements for indication, age, and weight or supported in MicroMedex
- The beneficiary has no therapeutic duplication with any other monoclonal antibodies prescribed for EPGA
- If the request is for a non-preferred medication, the beneficiary must have tried and failed at least two preferred biologics with this indication before non-preferred options can be approved unless there is a beneficiary-specific contraindication to the preferred options
- The beneficiary does not have life-threatening EGPA. Life-threatening EGPA would be defined as:
  - Severe alveolar hemorrhage or hemoptysis requiring transfusion or ventilation, or hemoglobin is < 8 g/dL
  - Rapidly progressive glomerulonephritis with creatinine > 2.5 mg/dL
  - Severe cardiac involvement including life-threatening arrhythmia, LVEF < 20%, NUHA Class III/IV or acute myocardial infarction
- The prescriber must submit the following:
  - Current chart notes
  - Current labs, including CBCs and LFTs if on methotrexate or azathioprine
  - Baseline Birmingham Vasculitis Activity Score (BVAS)
  - Medical necessity over corticosteroids and/or immunosuppressive therapy

RENEWAL REQUIREMENTS FOR EGPA (FOR FASENRA AND NUCALA)

- The beneficiary must be compliant with this medication

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- The beneficiary must show a positive response to therapy with at least **one** of the following:
  - BVAS = 0 (no vasculitis); **OR**
  - Corticosteroid dose has been decreased to ≤ 4 mg/day
- The prescriber must submit the following:
  - Current chart notes
  - Current corticosteroid dose; **AND**
  - Current BVAS

APPROVAL CRITERIA FOR ATOPIC DERMATITIS (FOR DUPIXENT)

For complete Atopic Dermatitis criteria, refer to Immunomodulators, Atopic Dermatitis

- The medication must be prescribed by or in consultation with a dermatologist, rheumatologist, or other specialist treating atopic dermatitis
- The beneficiary has a documented diagnosis of moderate to severe atopic dermatitis with at least **one** of the following (baseline at time of biologic request documented on the request):
  - Baseline impacted body surface area (BSA) ≥ 10%
  - Baseline Eczema Area and Severity Index (EASI) total score of ≥ 16
  - Baseline weekly averaged peak pruritis Numeric Rating Scale (NRS) ≥ 7
  - Baseline Investigator's Global Assessment (IGA) score ≥ 3; **AND**
  - Baseline Scoring Atopic Dermatitis (SCORAD) score ≥ 25
- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed a dose that meets the package insert requirements for indication, age, and weight or supported in the official Compendia
- The beneficiary has no therapeutic duplication with monoclonal antibodies prescribed for atopic dermatitis
- If the request is for a non-preferred medication, the beneficiary must have tried and failed at least two preferred biologics with this indication before non-preferred options can be approved unless there is a beneficiary-specific contraindication to the preferred options
- The beneficiary must have a trial and failure of topical therapy and at a minimum must include:
  - One opical corticosteroid entity over a minimum of 60 days' use that is considered either "high" potency (Class 2) or superpotent (Class 1) for adults **or** medium potency for children (unless contraindicated); **AND**
  - One topical calcineurin inhibitor (TCI) over a minimum of 30 days (e.g., pimecrolimus or tacrolimus)
- The prescriber must submit **all** of the following:
  - Current chart notes
  - Documentation of previous therapies with trial length of each medication

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- BSA prior to topical/systemic therapies and current impacted BSA
- Baseline EASI, NRS, IGA and/or SCORAD and updated score with previous treatment
- Drug claims data or retail pharmacy printout if the drug claims are not available in Medicaid drug claims history; **AND**
- Letter of medical necessity over other treatment options for atopic dermatitis

RENEWAL REQUIREMENTS FOR ATOPIC DERMATITIS (FOR DUPIXENT)

- The beneficiary is compliant with this medication
- The beneficiary must show continued positive treatment response with each PA request for continued prior approval with at least **one** of the following compared to baseline:
  - Decrease in severity scores
  - Decrease in BSA impacted; **OR**
  - Decrease in need for systemic or topical rescue treatment
- The beneficiary has no therapeutic duplication with other monoclonal antibodies prescribed for atopic dermatitis
- The prescriber must submit:
  - Current chart notes; **AND**
  - Current BSA and EASI, NRS, IGA or SCORAD (compared to baseline severity score)

APPROVAL CRITERIA FOR CHRONIC SPONTANEOUS URTICARIA (FOR DUPIXENT, RHAPSIDO, AND XOLAIR)

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with chronic spontaneous urticaria (CSU) with wheals/hives with or without angioedema for > 6 consecutive weeks
- The medication must be prescribed by or in consultation with a dermatologist, allergist, or immunologist
- The beneficiary must minimize factors that can exacerbate CSU (i.e., NSAIDs, alcohol, stress, and friction from clothing)
- The beneficiary has no therapeutic duplication with any other monoclonal antibodies prescribed for CSU
- If the request is for a non-preferred medication, the beneficiary must have tried and failed at least two preferred biologics with this indication before non-preferred options can be approved unless there is a beneficiary-specific contraindication to the preferred options
- The beneficiary must have at least **one** of the following despite treatment listed below:
  - Baseline Urticaria Activity Score-7 (UAS7) must be ≥ 16
  - Baseline Itch Severity Score-7 (ISS7) must be ≥ 8; **OR**

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- Baseline Urticaria Control Test (UCT) must be < 12

- The beneficiary must have tried and failed the following unless there is a contraindication to their use:
  - Non-sedating H1-antihistamine (nsAH) for a minimum of 2 weeks; **AND**
  - nsAH at 4 times the normal daily dose for a minimum of 4 weeks
- The prescriber must submit the following:
  - Current chart notes
  - Baseline description of urticaria
  - Baseline UAS7 and/or ISS7 and/or UCT scores
  - Previous therapies that were tried with treatment duration

RENEWAL REQUIREMENTS FOR CHRONIC SPONTANEOUS URTICARIA (FOR DUPIXENT, RHAPSIDO, AND XOLAIR)

- The beneficiary has been compliant with therapy (defined as 75% utilization)
- The beneficiary taking RHAPSIDO who develops bleeding should be evaluated for continuation considering the benefit versus the risk
- The beneficiary must have a positive response with a decrease in urticaria symptoms and an improvement in **one** of the following (must use same test as baseline):
  - UAS7
  - ISS7; **OR**
  - UCT
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of current symptoms; **AND**
  - Current CSU test with at least **one** of the following (must use the same test as baseline):
    - Urticaria Activity Score-7 (UAS7)
    - Itch Severity Score-7 (ISS7) score: **OR**
    - Urticaria Control Test (UCT)

APPROVAL CRITERIA FOR NASAL POLYPS (FOR DUPIXENT, NUCALA, TEZSPIRE, AND XOLAIR)

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary must have a diagnosis of chronic rhinosinusitis with nasal polyposis
- The beneficiary is prescribed a dose that meets the package insert requirements for indication, age, and weight or supported in MicroMedex
- The medication is prescribed by or in consultation with specialist in pulmonology, allergy, immunology, or otolaryngology

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- The beneficiary must have a trial and failure of three months of nasal corticosteroids (e.g., fluticasone, beclomethasone, budesonide)
- The beneficiary must have met **one** of the following:
  - Previous treatment with oral corticosteroids for nasal polyps in the last two years; **OR**
  - Previous nasal surgery for nasal polyps
- The beneficiary has no therapeutic duplication with any other monoclonal antibodies prescribed for chronic rhinosinusitis with nasal polyposis
- If the request is for a non-preferred medication, the beneficiary must have tried and failed at least two preferred biologics with this indication before non-preferred options can be approved unless there is a beneficiary-specific contraindication to the preferred options.
- The prescriber must submit the following:
  - Current chart notes with description of size/quantity of nasal polyps
  - Documentation of previous therapies tried
  - Requested dose
  - Drug claims data or retail pharmacy printout if the drug claims are not available in Medicaid drug claims history
  - Current IgE and weight for XOLAIR request
  - Medical necessity over nasal corticosteroids, antileukotrienes, and surgery; **AND**
  - Documentation that concomitant nasal corticosteroids are prescribed

RENEWAL REQUIREMENTS FOR NASAL POLYPS (FOR DUPIXENT, NUCALA, TEZSPIRE, AND XOLAIR)

- The beneficiary must demonstrate an improvement in size/quantity of polyps with an improvement of symptoms compared to baseline
- The beneficiary must be compliant with this medication and nasal corticosteroids
- The prescriber must submit the following:
  - Current chart notes with description of polyps
  - Current body weight for dose determination for XOLAIR; **AND**
  - Requested dose

APPROVAL CRITERIA FOR EOSINOPHILIC ESOPHAGITIS (EOE) (FOR DUPIXENT)

For complete Eosinophilic Esophagitis (EOE) criteria, please refer to Eosinophilic Esophagitis

- The beneficiary must be aged 1 year and older, weighing at least 15 kg, **or** the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary must have a confirmed diagnosis of eosinophilic esophagitis (EOE) with an esophageal biopsy that indicates ≥ 15 eosinophils per high-power field (eos/hpf) and **one** of the following:
  - Symptoms of esophageal dysfunction (e.g., dysphagia, food impaction, chest pain); **OR**

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- Endoscopy features consistent with eosinophilic esophagitis (e.g., stacked circular rings, esophageal strictures, linear furrows)

- The beneficiary must have at least a 12-week trial and failure of swallowed corticosteroids (e.g., fluticasone or budesonide)
- The beneficiary has no therapeutic duplication with any other monoclonal antibodies prescribed for EOE
- If the request is for a non-preferred medication, the beneficiary must have tried and failed at least two preferred biologics with this indication (if applicable) before non-preferred options can be approved unless there is a beneficiary-specific contraindication to the preferred options.
- The prescriber must submit the following:
  - Current chart notes
  - Previous therapies including dietary restrictions, procedures, or pharmacological treatment
  - Baseline eos/hpf after corticosteroid and PPI trials; **AND**
  - Baseline beneficiary determined Dysphagia Symptom Questionnaire (DSQ) score

RENEWAL REQUIREMENTS FOR EOSINOPHILIC ESOPHAGITIS (FOR DUPIXENT)

- The beneficiary demonstrates a positive response with **one** of the following after 6 months of treatment:
  - Achieved remission with ≤ 6 eos/hpf; **OR**
  - Decrease in DSQ score from baseline
- The prescriber must submit the following:
  - Current chart notes
  - Current beneficiary determined DSQ score; **AND**
  - Current eos/hpf

APPROVAL CRITERIA FOR COPD (FOR DUPIXENT AND NUCALA)

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The medication must be prescribed by or in consultation with a pulmonologist
- The beneficiary has been diagnosed with eosinophilic phenotype chronic obstructive pulmonary disease (COPD) that is inadequately controlled on maintenance therapy with moderate to severe airflow limitation defined by the following:
  - Post-bronchodilator FEV1/FVC ratio < 0.7
  - Post-bronchodilator FEV1 of 30% to 70% predicted; **AND**
  - History of ≥ 2 moderate or ≥ 1 severe exacerbation within the past 12 months

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- The beneficiary must have a trial and failure of maintenance triple therapy consisting of a long-acting muscarinic antagonist (LAMA), long-acting beta agonist (LABA), and inhaled corticosteroid (ICS) (unless contraindicated) with a trial lasting for at least 3 months
- The beneficiary must have a blood eosinophilic count of at least 300 cells/µL as a baseline drawn in the last 12 months
- The beneficiary has no therapeutic duplication with any other monoclonal antibodies prescribed for COPD
- The beneficiary must remain on standard maintenance therapy and use this medication as add-on therapy
- If the request is for a non-preferred medication, the beneficiary must have tried and failed at least two preferred biologics with this indication before non-preferred options can be approved unless there is a beneficiary-specific contraindication to the preferred options
- The prescriber must submit the following:
  - Current chart notes with description of COPD symptoms and history of exacerbations for the last 12 months
  - Documentation of previous therapies tried
  - Current pulmonary function tests
  - Baseline labs including CBC with differential; **AND**
  - Documentation of smoking history

RENEWAL REQUIREMENTS FOR COPD (FOR DUPIXENT AND NUCALA)

- The beneficiary remains compliant on COPD maintenance therapy (inhalers and immunomodulator injection)
- The beneficiary must demonstrate a positive response to therapy as indicated by at least **one** of the following:
  - Decrease in quantity and/or severity of exacerbations; **OR**
  - Improvement in lung function/FEV1 over baseline; **OR**
  - Improvement in COPD-related symptoms and/or quality of life
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of response to therapy compared to previous baseline with information on any exacerbations since last PA review; **AND**
  - Current PFTs

APPROVAL CRITERIA FOR HYPEREOSINOPHILIC SYNDROME (FOR FASENRA AND NUCALA)

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication

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- The beneficiary must have a diagnosis of hypereosinophilic syndrome (HES) for ≥ 6 months without an identifiable non-hematologic secondary cause
- The beneficiary is prescribed a dose that meets the package insert requirements for indication, age, and weight or supported in MicroMedex
- The beneficiary has documented at least 2 HES flares within the past 12 months while on stable HES therapy with at least **two** of the following:
  - Chronic or episodic corticosteroids
  - Immunosuppressants; **OR**
  - Cytotoxic therapy
- The beneficiary has no therapeutic duplication with any other monoclonal antibodies prescribed for HES
- If the request is for a non-preferred medication, the beneficiary must have tried and failed at least two preferred biologics with this indication before non-preferred options can be approved unless there is a beneficiary-specific contraindication to the preferred options
- The beneficiary has a baseline blood eosinophil count of at least 1,000 cells/µL
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of previous therapies tried and response; **AND**
  - Current labs, including CBCs and LFTs if on methotrexate or azathioprine

RENEWAL REQUIREMENTS FOR HYPEREOSINOPHILIC SYNDROME (FOR NUCALA)

- The beneficiary must be compliant with this medication
- The beneficiary has a positive response with a decrease in HES flares and a decrease in blood eosinophil count
- The prescriber must submit the following:
  - Current chart notes
  - Current labs, including CBCs; **AND**
  - Documentation of HES flares since beginning treatment

APPROVAL CRITERIA FOR PRURIGO NODULARIS (FOR DUPIXENT AND NEMLUVIO)

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary must have a diagnosis of prurigo nodularis with widespread or recalcitrant disease **or** has a comorbidity of moderate to severe atopic dermatitis
- The medication must be prescribed by or in consultation with a dermatologist, rheumatologist, or other specialist treating atopic dermatitis/prurigo nodularis
- The beneficiary is prescribed a dose that meets the package insert requirements for indication, age, and weight or supported in MicroMedex

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- If the request is for a non-preferred medication, the beneficiary must have tried and failed at least two preferred biologics with this indication before non-preferred options can be approved unless there is a beneficiary-specific contraindication to the preferred options
- The beneficiary has no therapeutic duplication with any other monoclonal antibodies prescribed for prurigo nodularis
- The beneficiary must have a trial and failure of topical medications and at a minimum must include (unless contraindicated or inappropriate for the beneficiary's age):
  - At least **one** topical corticosteroid entity over a minimum of 60 days use with topical corticosteroids being "high" potency (Class-2) **or** superpotent (Class-1) **or** medium potency for children; **AND**
  - At least **one** trial of a topical calcineurin inhibitor (TCI) with either pimecrolimus or tacrolimus over a minimum of 30 days
- The prescriber must submit the following:
  - Current chart notes
  - Description of current status for baseline (i.e., BSA of nodules, peak pruritis Numeric Rating Scale (NRS), Investigator's Global Assessment (IGA)
  - Previous therapies tried; **AND**
  - If there is no history of atopic dermatitis, provide documentation that other systemic causes for pruritis have been ruled out (i.e., chronic kidney disease, liver disease)

RENEWAL REQUIREMENTS FOR PRURIGO NODULARIS (FOR DUPIXENT AND NEMLUVIO)

- The beneficiary must show continued positive treatment response with each PA request for continued prior approval with at least **one** of the following compared to baseline:
  - Decrease in pruritis
  - Decrease in BSA impacted; **OR**
  - Decrease in need for systemic or topical rescue treatment
- The prescriber must submit:
  - Current chart notes; **AND**
  - Current BSA and pruritis test scores (i.e., NRS, IGA)

APPROVAL CRITERIA FOR IGE-MEDIATED FOOD ALLERGIES (FOR XOLAIR)

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with one or more IgE-mediated food allergies **or** a diagnosis consistent with any new FDA-approved indications. Any off-label requests will be reviewed on a case-by-case basis.

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- The prescriber must be an Allergy and Immunology specialist
- The beneficiary has no therapeutic duplication with any other monoclonal antibodies prescribed for IgE-mediated food allergies
- The prescriber must attest that the beneficiary has been counseled to continue to avoid the foods that cause allergic reactions as this medication is for accidental exposure only
- The beneficiary must continue to have injectable epinephrine on hand with a pharmacy claim within the last year
- If the request is for a non-preferred medication, the beneficiary must have tried and failed at least two preferred biologics with this indication (if applicable) before non-preferred options can be approved unless there is a beneficiary-specific contraindication to the preferred options.
- The prescriber must submit the following:
  - Current chart notes
  - Baseline serum IgE level
  - Current weight
  - Dose requested (must be supported by the dosing chart in the package insert); **AND**
  - Skin prick test results confirming food allergies

RENEWAL REQUIREMENTS FOR IGE-MEDIATED FOOD ALLERGIES (FOR XOLAIR)

- The beneficiary remains compliant based on pharmacy claims (defined as 75%). If not compliant, the medical necessity for restarting therapy should be provided.
- The prescriber must submit the following:
  - Current chart notes
  - Serum IgE level is not required for compliant beneficiaries or those with a dose in the last year; dose interruptions lasting one year or more require a new serum IgE level
  - Current weight; **AND**
  - Dose requested (must be supported by the dosing chart in the package insert)

APPROVAL CRITERIA FOR BULLOUS PEMPHIGOID (FOR DUPIXENT)

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed a dose that meets the package insert requirements for indication, age, and weight or supported in MicroMedex
- The beneficiary must have a diagnosis of bullous pemphigoid with confirmation from tissue biopsy results
- The beneficiary must have tried and failed oral corticosteroids (e.g., prednisone or prednisolone)
- The beneficiary must use the requested biologics in combination with a tapering course of oral corticosteroids
- The beneficiary has no therapeutic duplication with any other monoclonal antibodies prescribed for bullous pemphigoid

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- If the request is for a non-preferred medication, the beneficiary must have tried and failed at least two preferred biologics with this indication (if applicable) before non-preferred options can be approved unless there is a beneficiary-specific contraindication to the preferred options
- The prescriber must submit the following:
  - Current chart notes
  - Tissue biopsy report confirming diagnosis read
  - Documentation of status at baseline (e.g., location of lesions, estimated BSA of lesions, description of lesions)
  - Previous therapies tried (e.g., topical corticosteroids, oral corticosteroids, doxycycline, dapsone, methotrexate, mycophenolate, azathioprine); **AND**
  - Plan for corticosteroid taper
- Initial PA approved for 3 months. If responsive, renewal PAs can be approved for 6 months

RENEWAL REQUIREMENTS FOR BULLOUS PEMPHIGOID (FOR DUPIXENT)

- The beneficiary is compliant with therapy (defined as 75% utilization)
- The beneficiary must demonstrate a positive response with decrease in quantity and severity of BP lesions compared to baseline
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of the current status for a comparison to baseline (e.g., location of lesions, estimated BSA of lesions, description of lesions); **AND**
  - Status of corticosteroid taper

APPROVAL CRITERIA FOR ALLERGIC FUNGAL RHINOSINUSITIS (FOR DUPIXENT)

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- The beneficiary is prescribed a dose that meets the package insert requirements for indication, age, and weight or supported in MICROMEDEX
- The beneficiary must be diagnosed with allergic fungal rhinosinusitis (AFRS) with a history for sino-nasal surgery
- Prescribed by or in consultation with a specialist in pulmonology, allergy, immunology, or otolaryngology
- The beneficiary must have a trial and failure of at least 3 months of nasal corticosteroids after surgery (e.g., fluticasone, beclomethasone, budesonide)
- The prescriber must submit the following:
  - Current chart notes with description of symptoms including sinus opacification, nasal congestion, and documentation of either unilateral or bilateral polyps with quantity
  - Documentation of previous therapies tried including information on sino-nasal surgery with results
  - Current weight and requested dose

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- Drug claims data or retail pharmacy printout if the drug claims are not available in Medicaid drug claims history
- Medical necessity over nasal corticosteroids and surgery

RENEWAL REQUIREMENTS FOR ALLERGIC FUNGAL RHINOSINUSITIS (FOR DUPIXENT)

- The beneficiary must demonstrate an improvement in sinus opacification, sinus congestion, and/or size/quantity of nasal polyps compared to baseline
- The beneficiary must be compliant on therapy
- The prescriber must submit the following:
  - Current chart notes with description of symptoms
  - Current weight and requested dose

QUANTITY EDITS

- FASENRA – #1 pen/vial per 8 weeks (will need quantity override for first 3 months)
- DUPIXENT – #5 syringes per 50 days
- NUCALA – #3 prefilled syringes/autoinjectors per 28 days
- RHAPSIDO – #60 tablets per 30 days
- TEZSPIRE – #1 syringe/vial per 28 days
- XOLAIR
  - #4 300 mg prefilled syringes/autoinjectors per 28 days
  - #2 150 mg prefilled syringes/autoinjectors per 28 days
  - #4 150 mg vials per 28 days
  - #2 75 mg prefilled syringes/autoinjectors per 28 days

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INHALED ANTIBIOTICS

Updated 4/1/2026

PREFERRED AGENTS WITH CRITERIA

- BETHKIS (tobramycin) – **brand only**
- KITABIS PAK (tobramycin) – **brand only**
- tobramycin (generic for TOBI)

NON-PREFERRED AGENTS

- ARIKAYCE (amikacin liposome) – see criteria for ARIKAYCE
- CAYSTON (aztreonam)
- TOBI (tobramycin)
- TOBI PODHALER (tobramycin)
- tobramycin (generic for BETHKIS)
- tobramycin pak (generic for KITABIS PAK)

APPROVAL CRITERIA FOR PREFERRED AGENTS

Diagnosis of cystic fibrosis in medical history

DENIAL CRITERIA FOR PREFERRED AGENTS

- History of CAYSTON in the past 50 days
- History of J-Code for tobramycin Injection in the past 60 days

ADDITIONAL CRITERIA

Quantity limits apply

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INSULINS

Updated 7/1/2025

PREFERRED AGENTS – RAPID-ACTING INSULIN

- insulin aspart (generic for NOVOLOG) **– until no longer available**
- insulin lispro (generic for HUMALOG)
- insulin lispro JR (generic for HUMALOG JR)
- NOVOLOG (insulin aspart)

NON-PREFERRED AGENTS – RAPID-ACTING INSULIN

- ADMELOG (insulin lispro)
- AFREZZA (insulin human)
- APIDRA (insulin glulisine)
- FIASP (insulin aspart)
- HUMALOG (insulin lispro)
- HUMALOG JR (insulin lispro)
- KIRSTY (insulin aspart-xjhz)
- LYUMJEV (insulin lispro-aabc)
- MERILOG (insulin aspart-szjj)

PREFERRED AGENTS – RAPID/INTERMEDIATE-ACTING COMBINATIONS

- insulin aspart mix (generic for NOVOLOG MIX) **– until no longer available**
- insulin lispro mix (generic for HUMALOG MIX)
- NOVOLOG MIX (insulin aspart/aspart protamine)

NON-PREFERRED AGENTS – RAPID/INTERMEDIATE-ACTING COMBINATIONS

- HUMALOG MIX (insulin lispro/lispro protamine)

PREFERRED AGENTS – REGULAR INSULIN

- HUMULIN R U-100 (OTC) (insulin regular)
- HUMULIN R U-500 (insulin regular)

NON-PREFERRED AGENTS – REGULAR INSULIN

NOVOLIN R U-100 (OTC)

PREFERRED AGENTS – INTERMEDIATE INSULIN

HUMULIN N U-100 vial (OTC) (insulin NPH)

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NON-PREFERRED AGENTS – INTERMEDIATE INSULIN

- HUMULIN N U-100 kwikpen (OTC) (insulin NPH)
- NOVOLIN N U-100 (OTC) (insulin NPH)

PREFERRED AGENTS – REGULAR/INTERMEDIATE-ACTING COMBINATIONS

- HUMULIN 70/30 (OTC) (insulin NPH/regular)

NON-PREFERRED AGENTS – REGULAR/INTERMEDIATE-ACTING COMBINATIONS

- NOVOLIN 70/30 (OTC) (insulin NPH/regular)

PREFERRED AGENTS – LONG-ACTING INSULIN

- LANTUS (insulin glargine)
- LANTUS SOLOSTAR (insulin glargine)

NON-PREFERRED AGENTS – LONG-ACTING INSULIN

- AWIQLI (insulin icodec-abae)
- BASAGLAR (insulin glargine)
- insulin degludec (generic for TRESIBA)
- insulin glargine (generic for TOUJEO)
- Insulin glargine max (generic for TOUJEO MAX)
- Insulin glargine-yfgn (generic for SEMGLEE)
- REZVOGLAR (insulin glargine-aglr)
- SEMGLEE (insulin glargine-yfgn)
- SOLIQUA (insulin glargine/lixisenatide)
- TOUJEO (insulin glargine)
- TOUJEO MAX (insulin glargine)
- TRESIBA (insulin degludec)
- XULTOPHY (insulin degludec/liraglutide)

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INTRANASAL RHINITIS AGENTS

Updated 4/1/2025

PREFERRED AGENTS

- azelastine nasal spray (generic for ASTELIN/ASTEPRO)
- fluticasone nasal spray (generic for FLONASE) Rx only
- ipratropium nasal spray (generic for ATROVENT)

NON-PREFERRED AGENTS

- azelastine/fluticasone (generic for DYMISTA)
- budesonide nasal spray (generic for RHINOCORT)
- DYMISTA (azelastine/fluticasone)
- flunisolide (generic for NASAREL/NASALIDE)
- olopatadine nasal spray (generic for PATANASE)
- OMNARIS (ciclesonide)
- QNASL/QNASL CHILDREN (beclomethasone)
- RYALTRIS (olopatadine/mometasone)
- XHANCE (fluticasone)
- ZETONNA (ciclesonide)

PREFERRED AGENTS WITH CRITERIA

mometasone furoate nasal spray (generic for NASONEX)

POINT-OF-SALE (POS) CRITERIA FOR PREFERRED AGENTS WITH CRITERIA

- The beneficiary is 2–3 years of age
- If the beneficiary does not meet the age limitation, a prior authorization request is needed from the prescriber.

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IPTACOPAN (FABHALTA)

Updated 7/16/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication.
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia.
- The beneficiary must be diagnosed with **one** of the following:
  - Paroxysmal nocturnal hemoglobinuria (PNH)
  - Proteinuria with Immunoglobulin A Nephropathy (IgAN) at risk of rapid disease progression, generally a urine protein-to-creatinine ratio (UPCR) ≥ 1.5 g/g; **OR**
  - Proteinuria with Complement 3 Glomerulopathy (C3G)
- The beneficiary must be vaccinated against encapsulated bacteria, including *Streptococcus pneumoniae*, *Neisseria meningitidis* types A, C, W, Y, and B, at least 2 weeks prior to initiation of FABHALTA, and beneficiary must be provided antibiotics if vaccines were administered less than 2 weeks before starting therapy
- The prescriber and pharmacy must be enrolled in the FABHALTA REMS program.
- The medication must be prescribed by or in consultation with the following:
  - For PNH beneficiaries – hematologist or oncologist
  - For IgAN beneficiaries – nephrologist; **OR**
  - For C3G beneficiaries – nephrologist
- The beneficiary does not have severe hepatic impairment (Child-Pugh class C)
- The beneficiary does not have an active serious infection caused by encapsulated bacteria, including *Streptococcus pneumonia*, *Neisseria meningitidis*, or *Haemophilus influenzae* type b
- The beneficiary of reproductive potential should not be pregnant or breastfeeding
- The beneficiary with PNH
  - The beneficiary currently taking eculizumab (SOLIRIS) or ravulizumab (ULTOMIRIS) must follow the required dose initiation per the package insert
  - The beneficiary must be clinically symptomatic (e.g., fatigue, dyspnea, pain, thrombosis) and have abnormal labs (e.g., low hemoglobin [Hgb], high lactate dehydrogenase [LDH])
  - The beneficiary has baseline Hgb level < 10 g/dL with or without previous C5 inhibitors
  - The beneficiary must not be receiving Fabhalta in combination with other complement inhibitors used to treat PNH (i.e., Empaveli, Piasky, Soliris, Ultomiris, Voydeya)
  - The prescriber must submit the following:

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- Current chart notes
- Documented symptoms as a baseline
- Previous therapies
- Current labs, including complete blood count (CBD), comprehensive metabolic panel, and lactate dehydrogenase; **AND**
- Recent history of blood transfusions

- The beneficiary with IgAN must meet the following:
  - The beneficiary must demonstrate continued risk for disease progression with proteinuria ≥ 0.5 g/day, despite at least 3 months of maximally tolerated supportive care (i.e., angiotensin-converting enzyme (ACE) inhibitor or angiotensin-receptor blocker (ARB), immunosuppressive therapy, sodium-glucose co-transporter 2 (SGLT2) inhibitor)
  - The beneficiary must remain on supportive care at maximally tolerated doses unless contraindicated
  - The beneficiary must have had a previous trial and failure of Tarpeyo (budesonide delayed-release capsule) unless contraindicated; **AND**
  - The prescriber must submit the following:
    - Current chart notes
    - Previous therapies
    - Current labs, including LFTs, eGFR, lipid panel, and urine protein or UPCR
    - Confirmation of IgAN diagnosis with renal biopsy results and labs; **AND**
    - Medical necessity over the use of typical supportive care (i.e., ACEi, ARB, SGLT2), TARPEYO, FILSPARI, and VANRAFIA.
- The beneficiary with C3G must meet the following:
  - The beneficiary must have tried and failed mycophenolate and/or cyclophosphamide and oral glucocorticoids unless there is a contraindication
  - The beneficiary should have tried and failed an angiotensin-converting enzyme (ACE) inhibitor or angiotensin-receptor blocker (ARB) at maximally tolerated doses unless contraindicated; **AND**
  - The prescriber must submit the following:
    - Current chart notes
    - Previous therapies (e.g., RAS inhibitors, corticosteroids, mycophenolate)
    - Documented symptoms
    - Current labs, including LFTs, eGFR, lipid panel, and urine protein or UPCR
    - Confirmation of C3G diagnosis with renal biopsy results and labs (protein-to-creatinine ratio (UPCR) ≥ 1 g/g and eGFR ≥ 30 mL/min/1.73 m^2); **AND**
    - Medical necessity over immunosuppressants and glucocorticoids

RENEWAL REQUIREMENTS

- The beneficiary is compliant with therapy (defined as 75% utilization)

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- The beneficiary with PNH must meet the following:
  - The beneficiary has an improvement in hemoglobin and/or LDH levels compared to baseline; **AND**
  - The beneficiary has an improvement in overall clinical presentation (e.g., fatigue, dyspnea, reduction in transfusions)
  - The prescriber must submit the following:
    - Current chart notes; **AND**
    - Current labs, including CBC, CMP, and LDH
- The beneficiary with IgAN must meet the following:
  - The beneficiary has documented improvement in proteinuria with a reduction in UPCR or urine protein compared to baseline; **AND**
  - The prescriber must submit the following:
    - Current chart notes
    - Current labs, including LFTs, eGFR, lipid panel, and urine protein or UPCR; **AND**
    - Attestation that the beneficiary has tested negative for pregnancy if of reproductive potential
- The beneficiary with C3G must mee the following:
  - The beneficiary has documented improvement of proteinuria with a reduction in UPCR or urine protein; **AND**
  - The prescriber must submit the following:
    - Current chart notes
    - Current labs, including LFTs, eGFR, lipid panel, and urine protein or UPCR; **AND**
    - Attestation that the beneficiary has tested negative for pregnancy if of reproductive potential

QUANTITY EDITS

#60 capsules per 30 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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ISOTRETINOIN (ABSORICA, AMNESTEEM, CLARAVIS, MYORISAN, ZENATANE)

Updated 10/01/2026

APPROVAL CRITERIA

- The beneficiary must be ≥ 12 years of age; **AND**
- The prescriber must be a dermatologist; **AND**
- The beneficiary must have a diagnosis of severe recalcitrant nodular acne with many inflammatory nodules measuring a diameter of 5 mm or greater; **AND**
- The beneficiary has been unresponsive to conventional therapy, including ideally three consecutive months using at least two of the following (history of each beneficiary will be reviewed on a case-by-case basis):
  - Oral antibiotics (e.g., doxycycline, minocycline)
  - Oral contraceptives (females only)
  - Oral spironolactone (females only)
  - Topical retinoids, topical antibiotics, and/or benzoyl peroxide; **OR**
  - Combination of oral antibiotics with benzoyl peroxide
- The prescriber, pharmacy, wholesaler, and beneficiary must all be registered with the iPLEDGE Program. Pharmacy claims will not be processed without all registrations being active; **AND**
- Requests for ABSORICA 25 mg and 35 mg or ABSORICA LD require medical necessity over other options; **AND**
- The prescriber must submit the following:
  - Current chart notes with documentation of severity of acne along with previous therapies including any OTC topical options; **AND**
  - Current labs, including CBC, lipid profile, LFTs, and glucose; **AND**
  - Documentation of the iPLEDGE number from the iPLEDGE REMS program enrollment; **OR**
    - Signed copy of iPLEDGE Informed Consent form; **AND**
  - Requested dose (PA is dose specific); **AND**
- Initial PA will be approved for a maximum of 165 days. One renewal is possible only after at least 8 weeks following completion of the first course with a new PA request; **AND**
- Requests for diagnoses other than acne will be reviewed by DHS clinical review team on a case-by-case basis.

RENEWAL REQUIREMENTS

- The beneficiary must be medication-free for at least 8 weeks between the first and second course of therapy; **AND**
- The prescriber must submit the following:
  - Current chart notes documenting that the beneficiary has persistent or recurring severe nodular acne despite the initial 20–24 weeks of therapy; **AND**

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- Documentation of the iPLEDGE number from the iPLEDGE REMS program enrollment; **OR**
  - Signed copy of iPLEDGE Informed Consent form

CURRENT LABS, INCLUDING CBC, LIPID PROFILE, LFTS, AND GLUCOSEDENIAL CRITERIA

- The beneficiary does not meet approval criteria **or** have a diagnosis supported in the official Compendia
- The prescriber is requesting more than two courses of therapy
- The beneficiary is pregnant
- All required information is not provided; **OR**
- The beneficiary has uncontrolled hypertriglyceridemia (prescriber should submit a treatment plan for beneficiaries with high triglycerides).

QUANTITY EDITS

#60 per 30 days for max of 165 days per authorization

Topical acne medications are not covered by Arkansas Medicaid per Social Security Act 1927.

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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ISTRADEFYLLINE (NOURIANZ)

Updated 1/15/2020

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- Must be at least 18 years of age; **AND**
- Must provide current chart notes; **AND**
- Must provide Liver Function Tests; **AND**
- Must provide smoking status with average number of cigarettes per day; **AND**
- Should be in Parkinson's Disease stages 2 to 4 in the "off" state in the modified Hoehn and Yahr Scale; **AND**
- Must be on levodopa/carbidopa for at least one year with a stable dose at least 4 weeks prior to starting NOURIANZ; **AND**
- Must be taking at least three doses of levodopa per day; **AND**
- NOURIANZ will be used in combination with levodopa/carbidopa; **AND**
- Must be experiencing at least two hours of "off time" per day; **AND**
- If taking other PD medications, the beneficiary must be on a stable dose for at least 4 weeks prior to starting NOURIANZ (although beneficiaries can be on levodopa/carbidopa without the concomitant use of other PD medications including COMT inhibitors, MAO-B inhibitors, anticholinergics, and/or amantadine); **AND**
- Medical necessity over the increase in levodopa/carbidopa dose or changing to extended-release formulations.

DENIAL CRITERIA

- Currently taking strong CYP3A4 Inducers; **OR**
- Diagnosed with severe hepatic impairment (Child-Pugh C); **OR**
- Diagnosed with a major psychotic disorder
- < 2 hours a day of "off time"; **OR**
- Atypical parkinsonism or secondary parkinsonism variants; **OR**
- Pregnant or lactating females (females of childbearing potential should be advised to use contraception during treatment with NOURIANZ)

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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ITRACONAZOLE ORAL SOLUTION (SPORANOX)

Updated 10/11/2011

APPROVAL CRITERIA

- History of at least two claims for fluconazole (tablets or suspension) in the previous 7–30 days; **OR**
- One claim each of nystatin suspension and fluconazole (tablets or suspension) in the previous 7–30 days; **OR**
- NPO diagnosis (Appendix A) within the past 365 days.

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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IVABRADINE (CORLANOR)

Updated 1/15/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must be diagnosed with **one** of the following:
  - Adults with stable, symptomatic chronic heart failure with left ventricular ejection fraction ≤ 35%, who are in sinus rhythm with resting heart rate ≥ 70 beats per minute and either on maximally tolerated doses of beta-blockers or have a contraindication to beta-blockers
  - Pediatrics with stable, symptomatic heart failure due to dilated cardiomyopathy and are in sinus rhythm with an elevated heart rate
- The beneficiary resting heart rate goals:
  - Adults: 50–60 beats per minute
  - Pediatrics: 20% reduction from baseline
- The beneficiary should not be approved or continue this therapy with any of the following:
  - Acute decompensated heart failure
  - Clinically significant hypotension
  - Sick sinus syndrome, sinoatrial block or 3rd degree AV block, unless the beneficiary has a pacemaker
  - Clinically significant bradycardia
  - Severe hepatic impairment
  - Pacemaker dependence (heart rate maintained exclusively by pacemaker)
  - Concomitant use of strong cytochrome P450 3A4 (CYP3A4) inhibitors
  - Pregnancy; **OR**
  - If atrial fibrillation develops
- The prescriber must submit the following:
  - Current chart notes
  - Previous therapies tried
  - Current blood pressure on beta-blocker therapy
  - If beta blockers are contraindicated, provide documentation for reason; **AND**
  - Attestation that female beneficiaries of reproductive potential are counseled on effective contraception use

RENEWAL REQUIREMENTS

- The beneficiary must be compliant with therapy (defined as 75% utilization)

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- The beneficiary must demonstrate a positive response with a decreased heart rate compared to baseline (preferably in target range of 50–60 bpm in adults and 20% decrease in pediatrics)
- The prescriber must submit the following:
  - Current chart notes
  - Current blood pressure; **AND**
  - Attestation that female beneficiaries of reproductive potential are counseled on effective contraception use

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KITS

Updated 8/17/2010

All requests for “kits” or “combo pack” products (products that consist of packaging multiple products under one NDC) require a manual review. The individual active ingredients (listed next to the product) ***in italics and orange text*** do not require a PA.

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

DRUGS THAT REQUIRE A MANUAL PA

- **CENTANY AT 2% ointment kit** (***mupirocin 2% ointment*** – STERILE GAUZE – TAPE)
- **lidocaine-prilocaine 2.5%–2.5% cream kit** (***lidocaine- prilocaine 2.5%–2.5% cream*** – occlusive dressings)
- **ROSADAN 0.75% cream kit** (***metronidazole 0.75% cream*** – moisturizing skin wash)
- **ROSADAN 0.75% gel kit** (***metronidazole 0.75% gel*** – moisturizing skin wash)
- **SYNALAR 0.025% cream kit** (***fluocinolone acetonide 0.025% topical cream*** – emollient cream)
- **SYNALAR 0.025% ointment kit** (***fluocinolone acetonide 0.025% topical ointment*** – emollient cream)
- **SYNALAR TS 0.01% kit** (***fluocinolone acetonide 0.01% topical solution*** – hair and body cleanser)
- **ULTRAVATE X cream combo pack** (***halobetasol propionate 0.05% topical cream*** – ammonium lactate 10% moisturizing cream)
- **ULTRAVATE X ointment combo pack** (halobetasol propionate 0.05% topical ointment – ammonium lactate 10% moisturizing cream)

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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LANREOTIDE ACETATE (SOMATULINE DEPOT)

Updated 7/1/2026

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

Available as a pharmacy and medical claim

- **J1930**

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- The beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert or based on support from the official Compendia
- The beneficiary must be diagnosed with **one** of the following:
  - Acromegaly confirmed by elevated IGF-1 and inadequate suppression of growth hormone (GH) after a glucose load with an inadequate response to surgery and/or radiotherapy, or for whom surgery and/or radiotherapy, is not an option.
  - Gastroenteropancreatic Neuroendocrine Tumors (GEP-NETs) that are unresectable, well or moderately differentiated, and locally advanced or metastatic
  - Carcinoid Syndrome (flushing or diarrhea) to reduce the frequency of short-acting somatostatin analog rescue therapy
- The medication must be prescribed by, or in consultation with an endocrinologist or oncologist
- The prescriber must submit the following:
  - Current chart notes
  - Previous therapies tried with response
  - If no surgery or radiation, provide rationale for requesting in acromegaly patients
  - Baseline labs including Growth Hormone, IGF-1 (somatomedin C) for acromegaly patients

RENEWAL REQUIREMENTS

- Authorizations can be renewed based on the following:
  - Absence of unacceptable toxicity from the drug (e.g., formation of gallstones, cardiovascular abnormalities [bradycardia, sinus bradycardia, and hypertension], uncontrolled blood glucose abnormalities [hyperglycemia or hypoglycemia], thyroid disorders [hypothyroidism], etc.)
  - **Acromegaly:**
    - Disease response, as indicated by an improvement in signs and symptoms compared to baseline:
      - Reduction of growth hormone
      - Age-adjusted normalization of serum IGF-1

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- **Gastroenteropancreatic neuroendocrine tumors (GEP-NETs):**
  - Disease response with treatment, as indicated by an improvement in symptoms, including reduction in symptomatic episodes (e.g., diarrhea, rapid gastric dumping, flushing, bleeding, etc.), stabilization of glucose levels, or decrease in tumor size or tumor spread.
- **Carcinoid syndrome:**
  - Disease response with treatment, as indicated by reduction in use of short-acting somatostatin analog rescue medication (e.g., octreotide), an improvement in symptoms, including reduction in symptomatic episodes is prescribed (such as diarrhea, flushing), or decrease in tumor size or tumor spread.

- The prescriber must submit the following:
  - Current chart notes
  - Provide current labs

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LANSOPRAZOLE, AMOXICILLIN, AND CLARITHROMYCIN COMBINATION (PREVPAC)

Updated 1/12/2005

APPROVAL CRITERIA

Criteria 1:

- No history of lansoprazole, amoxicillin, and clarithromycin combination (PREVPAC) in the last 365 days; **AND**
- No history of omeprazole, amoxicillin, and clarithromycin combination (OMECLAMOX Pak) in the last 365 days; **AND**
- No concurrent proton pump inhibitor therapy within the past 30 days.

Criterion 2:

- No history of metronidazole, tetracycline, and bismuth combination (PYLERA) in the last 365 days.

ADDITIONAL CRITERIA

Quantity limits apply

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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LECANEMAB-IRMB AUTO-INJECTION (LEQEMBI IQLIK)

Updated 1/21/2026

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA (CONSISTENT WITH LEQEMBI FOR INFUSION)

- The beneficiary must be ≥ 50 years of age
- The beneficiary must be diagnosed with mild cognitive impairment or mild dementia associated with Alzheimer's disease confirmed by **one** of the following:
  - Clinical Dementia Rating (CDR) Global Score of 0.5–1.0 with Memory Box Score of at least 0.5
  - Mini-Mental Status Exam (MMSE) score 20–28; **OR**
  - Montreal Cognitive Assessment (MoCA) score 16–25
- The beneficiary must have the following:
  - **Baseline brain Magnetic Resonance Imaging (MRI)** within one year prior to initiating treatment to evaluate for pre-existing Amyloid Related Imaging Abnormalities (ARIA) with **one** of the following:
    - Had genotype testing prior to treatment to assess apolipoprotein E ε4 (ApoE ε4) status (e.g., homozygote, heterozygote, or noncarrier); **OR**
    - Genotype testing has not been performed, and the physician has informed the patient that it cannot be determined if they are ApoE ε4 homozygotes and, therefore, if they are higher risk for developing ARIA
  - **Positron Emission Tomography (PET) scan** confirming the presence of amyloid beta plaque
  - **Lumbar puncture** results confirming at least **one** of the following in cerebrospinal fluid (CSF) assessment
    - Presence of elevated phosphorylated tau (P-tau) protein or elevated tau (T-tau) protein, and reduced beta amyloid-42 (Aβ 42)
    - Low Aβ 42/40 ratio
    - Elevated P-tau/Aβ 42 ratio; **OR**
    - Elevated T-tau/Aβ 42 ratio
- The medication must be prescribed by, or in consultation with, a specialist in neurology, neuropsychiatry, or gerontology
- The beneficiary must not have had a stroke, transient ischemic attack (TIA), or seizures in the past 12 months
- The beneficiary will not be approved for non-Alzheimer's dementia with cognitive impairment or dementia caused by other neurodegenerative diseases (e.g., Lewy body dementia, frontotemporal lobar degeneration, vascular dementia, metabolic impairment, traumatic brain injury)

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- The beneficiary will not be approved for non-Alzheimer's causes of cognitive impairment (e.g., chronic psychiatric illness, chronic cardiovascular disease, or past history of psychotropic drug dependence)
- The beneficiary will not be approved with the following MRI findings: more than 4 microhemorrhages, any macrohemorrhage > 10 mm, superficial siderosis, vasogenic edema, multiple lacunar infarcts or major strokes, severe small vessel disease, or subcortical hyperintensities consistent with severe white matter disease (e.g., Fazekas score of 3).
- The beneficiary will not be approved for LEQEMBI to be used concomitantly with other amyloid beta-directed antibodies (e.g., aducanumab, donanemab-azbt)
- The beneficiary will not be approved for LEQEMBI if receiving direct-acting oral anticoagulants (e.g., apixaban, dabigatran, edoxaban, rivaroxaban), anticoagulants (e.g., Factor Xa inhibitors), anti-platelet agents (except for prophylactic aspirin or clopidogrel), or anti-thrombins (e.g., heparin, warfarin).
- The beneficiary will not be approved if they have an uncontrolled bleeding disorder (e.g., platelets 1.5 < 50,000 or INR > 1.5)
- The prescriber must submit the following:
  - Current chart notes
  - Previous therapies tried
  - Required documentation to support diagnosis as listed above (i.e., dementia/cognition score, brain MRI, PET, and Lumbar puncture)
  - Behavioral health diagnoses have been assessed for contributions to memory deficits; **AND**
  - Current and history of alcohol and nicotine use and alcohol or chronic substance use including prescription medications, cannabis, or other illicit drugs
- The beneficiary must have previous LEQEMBI infusions for 18 months before beginning LEQEMBI IQLIK

RENEWAL REQUIREMENTS

- The beneficiary has been compliant with therapy (defined as 75% utilization)
- The beneficiary has a positive response to therapy compared to pretreatment baseline as evidenced by improvement, stability, or slowing in cognitive or functional impairment in one or more of the following:
  - MMSE
  - CDR-SB; **OR**
  - MoCA
- The beneficiary has not progressed to moderate or severe Alzheimer's disease
- The prescriber must submit the following:
  - Current chart notes
  - Current dementia/cognition score (e.g., MMSE, CDR-SB, MoCA); **AND**
  - Any MRI or PET scan reports since previous approval

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QUANTITY EDITS

- LEQEMBI IQLIK 360 mg/1.8 mL: #4 injections per 28 days
- LEQEMBI IQLIK 250 mg/1.25 mL: #8 injections per 28 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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LENIOLISIB (JOENJA)

Updated 7/19/2023

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with activated phosphoinositide 3-kinase delta (PI3Kδ) syndrome (APDS) with a documented variant in either PIK3CD or PIK3R1 **or** a diagnosis consistent with any new FDA-approved indications. Any off-label requests will be reviewed on a case-by-case basis.
- The prescriber must be a specialist with experience in APDS such as immunology, hematology/oncology, or pulmonology
- In addition to the APDS diagnosis, the beneficiary must demonstrate symptoms consistent with the diagnosis (e.g., sino-pulmonary infection, lymphoproliferation, enteropathy, organ dysfunction)
- The beneficiary should not be approved or continue with this therapy with any of the following:
  - Pregnancy
  - Weight less than 45 kg
  - Requires concomitant strong CYP3A4 inhibitors (e.g., itraconazole)
  - Requires concomitant moderate or strong CYP3A4 inducers (e.g., carbamazepine, phenytoin); **OR**
  - Moderate to severe hepatic impairment
- The prescriber must submit **all** of the following:
  - Current chart notes with documentation of specific symptoms for this beneficiary and documentation of variant
  - Previous therapies including surgery
  - Current negative pregnancy test for females of reproductive potential
  - Current weight
  - MRI or CT imaging results documenting lesions with descriptions
  - Current labs, including LFTs
  - Medical necessity over IVIG and sirolimus; **AND**
  - Baseline % naïve B cell
- Initial PA for 3 months

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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RENEWAL REQUIREMENTS

- The prescriber must submit **all** of the following:
  - The prescriber must submit current chart notes; **AND**
  - Response to therapy
- The beneficiary has a positive response with symptoms with documented decrease in lymph node lesions and/or increase in % naïve B cells

QUANTITY EDITS

#62 tablets per 31 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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LETERMOVIR (PREVYMIS)

Updated 1/15/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must have **one** of the following:
  - Needs CMV prophylaxis after hematopoietic stem cell transplant (HSCT) and are CMV-seropositive (R+)
  - Needs CMV prophylaxis after kidney transplant for those at high risk (i.e., donor CMV seropositive/beneficiary CMV seronegative [D+/R-])
- HSCT beneficiary must start on PREVYMIS between day 0 and day 28 post-HSCT and continue through day 100 post HSCT. Patients at risk for late CMV infection may continue through day 200 post HSCT.
- For a kidney transplant, beneficiary must start on PREVYMIS between day 0 and day 7 post-transplant and continue through day 200 post-transplant
- The beneficiary started on cyclosporine must have dose adjustment.
- The beneficiary should not be approved or continue this therapy with any of the following:
  - Has CMV viremia prior to initiation
  - End stage renal disease (CrCl < 10 mL/min)
  - Severe hepatic impairment (Child-Pugh C)
  - Request to start after day 28 for HSCT and after day 7 for kidney transplant
  - Ordered concomitant pimozide or ergot alkaloids; **OR**
  - Ordered concomitant pitavastatin or simvastatin and cyclosporine
- The prescriber must submit the following:
  - Current chart notes and/or discharge summary
  - Documentation of type of transplant
  - Documentation testing for viremia
  - Length of treatment requested with dose
  - If requesting IV vials, provide the medical necessity over oral therapy and treatment plan with home care; **AND**
  - Current labs, including kidney function and hepatic function

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LEUCOVORIN TABLET AND VIAL

Updated 7/15/2020

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

POINT-OF-SALE (POS) DENIAL CRITERIA

The beneficiary with a billed diagnosis of autistic disorder would cause a point-of-sale denial requiring manual review. Additional studies will be monitored for efficacy and safety. MicroMedex will be monitored for support of this current off-label use.

QUANTITY EDITS

Tablets: #30 per 30 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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LEUKOTRIENE RECEPTOR ANTAGONISTS

Updated 4/1/2026

PREFERRED AGENTS WITH CRITERIA

montelukast tablet (generic for SINGULAIR)

NON-PREFERRED AGENTS

- ACCOLATE (zafirlukast)
- SINGULAIR (montelukast)
- zafirlukast (generic for ACCOLATE)
- zileuton ER (generic for ZYFLO CR)
- ZYFLO (zileuton) – manufacturer obsolete 9/30/2025

APPROVAL CRITERIA FOR PREFERRED AGENTS

Criteria 1:

- Diagnosis of asthma in the previous 2 years; **OR**
- AR Medicaid pharmacy claim for any of the following in the previous 186 days:
  - Inhaled corticosteroid (ICS)
  - Inhaled long-acting beta2 agonist (LABA)
  - Inhaled short-acting beta2 agonist (SABA)
  - Inhaled ICS/LABA; **OR**

Criteria 2:

- Diagnosis of allergic rhinitis in the previous 2 years; **OR**
- AR Medicaid pharmacy claim for any of the following within the previous 60 days:
  - ≥ 1 claim for an inhaled nasal steroid
  - ≥ 1 claim for a first or second-generation antihistamine
  - ≥ 1 claim for azelastine nasal spray or ipratropium nasal spray; **OR**

Criteria 3:

- Diagnosis of Chronic Idiopathic Urticaria in the previous 2 years

DENIAL CRITERIA

- Failure to meet approval criteria
- Therapeutic duplication with a LTRA other than the one on the incoming claim if > 25% of the days' supply of the claim in history remains
- An age edit is implemented for the montelukast 10 mg tablet of beneficiary is ≥ 15 years
- Maximum age edit of 16 years on the 4 mg and 5 mg chew tablets

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- Claims for infants ≤ 23 months of age will reject at point of sale for the 4 mg and 5 mg chewable tablets
- The age edit is implemented for the montelukast 4 mg granule for beneficiaries is ≥ 6 months of age < 24 months of age
- Claims for pediatric beneficiaries < 6 months of age will be denied at point of sale.

ADDITIONAL CRITERIA

Quantity limits apply

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LEVACETYLLEUCINE (AQNEURSA)

Updated 1/15/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must have a diagnosis of Niemann-Pick disease type C (NPC) with variants in the NPC1 or NPC2 genes with neurological manifestations (e.g., gait problems, ataxia, cognitive deterioration, or vertical gaze palsy) **or** a diagnosis consistent with any new FDA-approved indications. Any off-label requests will be reviewed on a case-by-case basis.
- The medication must be prescribed by or in consultation with a geneticist, neurologist, or other specialist with expertise in the treatment of NPD
- The beneficiary should not be approved or continue the medication if meet one of the following:
  - Weighs < 15 kg
  - Pregnant
  - Dose requested does not match weight-based dosing found in the package insert; **OR**
  - Prescribed MIPLYFFA (arimoclomol) to be used concomitantly
- The prescriber must submit the following:
  - Current chart notes
  - Previous therapies tried with response
  - Molecular genetic testing results confirming biallelic pathogenic variants in the NPC1 or NPC2 genes
  - Current weight and dose requested
  - Neurological symptoms for this specific beneficiary
  - Negative pregnancy test results if applicable; **AND**
  - Attestation that female beneficiary of reproductive potential has been counseled on the importance of effective contraception

RENEWAL REQUIREMENTS

- The beneficiary remains compliant with therapy (defined as 75% utilization)
- The beneficiary demonstrates a positive response with a decrease or slowed progression in neurological symptoms compared to baseline
- The prescriber must submit the following:
  - Current chart notes

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- Response to treatment with updated description of symptoms; **AND**
- Attestation that female beneficiary of reproductive potential has been counseled on the importance of continuing effective contraception and is not currently pregnant

QUANTITY EDITS

#120 packets per 30 days

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LEVODOPA (INBRIJA)

Updated 5/17/2019

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- Will require manual review PA on a case-by-case basis
- Age ≥ 30 years of age and ≤ 85 years of age*
- Baseline labs including CBC, BMP and LFTs
- At baseline, the beneficiary has at least 2 hours per day of “off time” per day excluding wakening each morning with motor fluctuations
- Carbidopa/levodopa medication did not exceed 1,600 mg levodopa per day.
- Hoehn and Yahr Stage 1–3 in an “on” state (see stages below)*
- Must be compliant on current carbidopa/levodopa therapy
- Baseline Unified Parkinson’s Disease Rating Scale (UPDRS) Part III motor score from pre-dose “OFF” state. The UPDRS part III is designed to assess the severity of the cardinal motor findings (e.g., tremor, rigidity, bradykinesia, postural instability) in beneficiaries with Parkinson's disease.
- Provide the medical necessity of adding this medication over increasing current Carbidopa/Levodopa dose

DENIAL CRITERIA

- Taking a nonselective monoamine oxidase (MAO) inhibitor
- Diagnosed with a major psychotic disorder or suicide ideation/attempt in last year
- Not recommended in beneficiaries with asthma, COPD or another chronic lung disease
- Pregnant
- ≤ 2 hours per day of “off time”
- Hoehn and Yahr Stage > 3 in an “on” state

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LEVOKETOCONAZOLE (RECORLEV)

Updated 04/20/2022

APPROVAL CRITERIA

- The beneficiary must be ≥ 18 years of age; **AND**
- The beneficiary must have a diagnosis of Cushing's syndrome with hypercortisolemia, and surgery is not an option or has not been curative **or** a diagnosis consistent with the FDA-approved indication; **AND**
- The prescriber must be an endocrinologist; **AND**
- If the beneficiary has hypokalemia or hypomagnesemia, initiation will be delayed until it is resolved; **AND**
- The prescriber must submit the following:
  - Current chart notes with documentation of surgery status; **AND**
  - Current labs, including:
    - Urine free cortisol levels (normal is < 150 nmol/24 hours **or** 3.5–45 mcg/24 hours); **AND**
    - Liver function tests; **AND**
    - Comprehensive metabolic panel; **AND**
  - Baseline electrocardiogram; **AND**
- The beneficiary should have a trial and failure of ketoconazole and mitotane unless contraindicated or beneficiary cannot tolerate both medications

DENIAL CRITERIA

- The beneficiary does not meet approval criteria **or** have a diagnosis supported on the official Compendia; **OR**
- The beneficiary has cirrhosis, acute liver disease or poorly controlled chronic liver disease, recurrent symptomatic cholelithiasis, or history of drug induced liver injury due to ketoconazole; **OR**
- If the beneficiary developed hypocortisolemia, the dose should decrease or discontinue the medication; **OR**
- The beneficiary continues to have hypercortisolemia despite maximum recommended dosage of 1,200 mg per day; **OR**
- The beneficiary takes other medications that cause QT prolongation or has any of the following:
  - Prolonged QTcF interval > 470 msec at baseline
  - History of torsade's de pointes
  - Ventricular tachycardia
  - Ventricular fibrillation; **AND**
  - Long QT syndrome

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QUANTITY EDITS

#248 tablets per 31 days

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LEVOTHYROXINE SOLUTION (ERMEZA AND THYQUIDITY)

Updated 7/1/2026

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must be diagnosed with **one** of the following:
  - Primary (thyroidal), secondary (pituitary), and tertiary (hypothalamic) congenital or acquired hypothyroidism; **OR**
  - Adjunct to surgery and radioiodine therapy in the management of thyrotropin-dependent well-differentiated thyroid cancer
- The prescriber must submit the following:
  - Current chart notes
  - Current labs (TSH, T4); **AND**
  - Letter of medical necessity over levothyroxine tablets

RENEWAL REQUIREMENTS

- The beneficiary must be compliant with therapy (defined as 75% utilization)
- The prescriber must submit the following:
  - Current chart notes
  - Current labs (TSH, T4); **AND**
  - Continued need over levothyroxine tablets

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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LIDOCAINE 5% OINTMENT

Updated 6/29/2017

APPROVAL CRITERIA

- Quantity limit to only allow one package size per NDC
- No therapeutic duplication allowed

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LIDOCAINE-PRILOCAINE 2.5%–2.5% CREAM (EMLA)

Updated 7/9/2012

QUANTITY EDITS

- Quantity limit to only allow one package size per NDC

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LIPOTROPICS (EXCLUDING STATINS)

Updated 7/1/2026

PREFERRED AGENTS WITHOUT CRITERIA

BILE ACID SEQUESTRANTS

- cholestyramine (generic for QUESTRAN)
- cholestyramine light (generic for QUESTRAN LIGHT/PREVALITE)
- colestipol (generic for COLESTID)

CHOLESTEROL ABSORPTION INHIBITOR

- ezetimibe (generic for ZETIA)

FIBRIC ACIDS

- fenofibrate 48 mg and 145 mg tablet (generic for TRICOR)
- fenofibrate 54 mg and 160 mg tablet (generic for LOFIBRA)
- gemfibrozil (generic for LOPID)

NIACIN

niacin ER (generic for NIASPAN ER)

NON-PREFERRED AGENTS

BILE ACID SEQUESTRANTS

- colesevelam (generic for WELCHOL)
- COLESTID (colestipol)
- PREVALITE (cholestyramine)
- QUESTRAN (cholestyramine)
- QUESTRAN LIGHT (cholestyramine)
- WELCHOL (colesevelam)

CHOLESTEROL ABSORPTION INHIBITOR

ZETIA (ezetimibe)

FIBRIC ACIDS

- fenofibrate capsule (generic for ANTARA/LOFIBRA/LIPOFEN/TRICOR)
- fenofibrate 40 mg and 120 mg tablet (generic for FENOGLIDE)
- fenofibric acid DR capsule (generic for TRILIPIX)
- fenofibric acid tablet (generic for FIBRICOR)

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- FIBRICOR (fenofibric acid)
- LIPOFEN (fenofibrate)
- LOPID (gemfibrozil)

PREFERRED AGENTS WITH CRITERIA

**** Manual review criteria**

^^ POS edits

ACL INHIBITOR AND ACL INHIBITOR/CHOLESTEROL ABSORPTION INHIBITOR

None

APOLIPOPROTEIN B SYNTHESIS INHIBITOR

None

APOLIPOPROTEIN C-III SYNTHESIS INHIBITOR

None

OMEGA-3 FATTY ACIDS

omega-3 acid ethyl esters (generic for LOVAZA)^^

PROPROTEIN CONVERTASE SUBTILISIN/KEXIN TYPE 9 (PCSK9) INHIBITOR

- PRALUENT (alirocumab)**
- REPATHA (evolocumab)**

PCSK9-DIRECTED SMALL INTERFERING RNA (SIRNA)

None

NON-PREFERRED AGENTS WITH CRITERIA

**** Manual review criteria**

ACL INHIBITOR AND ACL INHIBITOR/CHOLESTEROL ABSORPTION INHIBITOR

- NEXLETOL (bempedoic acid)**
- NEXLIZET (bempedoic acid/ezetimibe)**

APOLIPOPROTEIN B SYNTHESIS INHIBITOR

JUXTAPID (lomitapide)**

APOLIPOPROTEIN C-III SYNTHESIS INHIBITOR

- REDEMPLO (plozasirin)**

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- TRYNGOLZA (olezarsen)**

OMEGA-3 FATTY ACIDS

- icosapent ethyl (generic for VASCEPA)**

PROPROTEIN CONVERTASE SUBTILISIN/KEXIN TYPE 9 (PCSK9) INHIBITOR

LIPFENDRA (enlicitide)**

PCSK9-DIRECTED SMALL INTERFERING RNA (SIRNA)

LEQVIO (inclisiran)**

APPROVAL CRITERIA FOR OMEGA-3 ACID ETHYL ESTERS (GENERIC FOR LOVAZA)

Approval Criteria for POS Edit:

- Diagnosis in Medicaid medical history in previous 3 years of hypertriglyceridemia; **AND**
- Triglyceride level ≥ 500 mg/dL in the last 180 days; **AND**
- The beneficiary's Medicaid pharmacy drug history indicates at least three claims of fibric acid derivatives in the last 365 days; **AND**
- The beneficiary's Medicaid pharmacy drug history indicates at least one paid claim for one of the following in the past 14–60 days preferably containing a seven day overlap with a fibric acid derivative:
  - Maximally tolerated statin dose
  - ezetimibe; **OR**

Manual review PA will be on a case-by-case basis if the above requirements are not found in the Medicaid system for POS approval. The prescriber must submit a letter explaining the medical necessity and submit documentation to support the diagnosis not found.

APPROVAL CRITERIA FOR PRALUENT AND REPATHA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must have one of the following diagnoses (any off-label requests will be reviewed on a case-by-case basis):
  - Established cardiovascular disease and at risk of myocardial infarction, stroke, or unstable angina requiring hospitalization – PRALUENT
  - Increased risk for cardiovascular disease and at risk of major adverse cardiovascular events (e.g., CV death, MI, stroke, unstable angina requiring hospitalization, coronary revascularization) – REPATHA

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- Primary hyperlipidemia including heterozygous familial hypercholesterolemia (HeFH) – PRALUENT and REPATHA; **OR**
- Homozygous familial hypercholesterolemia (HoFH) – PRALUENT and REPATHA

- The beneficiary must have a trial and failure of **all** of the following:
  - High dose statin therapy (LDL reduction capability equivalent to rosuvastatin 40 mg) **or** maximally tolerated statin therapy **or** alternative dosing options to mitigate side effects unless a documented contraindication
  - Ezetimibe with statin therapy
- The beneficiary must have complied with previous lipid therapy required unless contraindicated (defined as 90 out of 120 days). The beneficiary's Medicaid claims history will be consulted, and a pharmacy printout may be requested to ensure compliance
- The beneficiary should have an LDL-C ≥ 70 mg/dL and/or non-HDL-C ≥ 100 mg/dL after a compliant trial of moderate-high intensity statins and ezetimibe unless the beneficiary has a contraindication
- The prescriber must submit **all** of the following:
  - Current chart notes with documentation of previous treatments
  - Chart notes during trials of statins **and** ezetimibe
  - Current labs, including lipids as well as labs corresponding with previous trials of statins **and** ezetimibe taken concomitantly; **AND**
  - Diet plan for lowering cholesterol
- If the beneficiary smokes, the prescriber should submit a smoking cessation plan or documentation that the beneficiary has been counseled on smoking cessation
- Initial approval for 2 months

RENEWAL REQUIREMENTS FOR PRALUENT AND REPATHA

- After initial approval, the beneficiary should demonstrate an improvement in the LDL-C levels
- The beneficiary must be compliant with therapy
- Renewals may be approved for 6 months with required response to therapy provided on each PA review
- The prescriber must submit **all** of the following:
  - Current chart notes; **AND**
  - Current lipid panel

APPROVAL CRITERIA FOR LEQVIO

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must use this medication as an adjunct to diet and exercise to reduce low-density lipoprotein cholesterol (LDL-C) with **one** of the following diagnoses:

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  - Hypercholesterolemia
  - Heterozygous familial hypercholesterolemia (HeFH)
  - Homozygous familial hypercholesterolemia (HoFH)
- The beneficiary must have a trial and failure of **all** of the following:
  - High dose statin therapy (LDL reduction capability equivalent to rosuvastatin 40 mg) **or** maximally tolerated statin therapy **or** alternative dosing options to mitigate side effects unless a documented contraindication
  - Ezetimibe with statin therapy; **AND**
  - Proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor (e.g., PRALUENT or REPATHA)
- The beneficiary should have an LDL-C ≥ 70 mg/dL and/or non-HDL-C ≥ 100 mg/dL after a compliant trial (defined as 90 out of 120 days) of statins, ezetimibe, and PCSK9 inhibitors as defined above
- If approved, the beneficiary must continue statin therapy at maximally tolerated dose
- The prescriber must submit **all** of the following:
  - Current chart notes with documentation of previous treatments
  - Current labs, including lipids along with labs corresponding with previous trials of statin and ezetimibe used concomitantly and with the addition of a PCSK9 inhibitor
  - Treatment plan with goal LDL-C; **AND**
  - Diet plan for lowering cholesterol
- If the beneficiary smokes, the prescriber should submit a smoking cessation plan or documentation that the beneficiary has been counseled on smoking cessation
- Initial approval for 3 months

RENEWAL REQUIREMENTS FOR LEQVIO

- After initial approval, the beneficiary should demonstrate an improvement in the LDL-C levels
- The beneficiary must be compliant with therapy
- Renewals may be approved for 6 months with required response to therapy provided on each PA review
- The prescriber must submit **all** of the following:
  - Current chart notes; **AND**
  - Current lipid panel

APPROVAL CRITERIA FOR JUXTAPID

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with homozygous familial hypercholesterolemia (HoFH) and use this medication as an adjunct to a low-fat diet and other lipid-lowering treatments, including LDL

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apheresis where available, to reduce low-density lipoprotein cholesterol (LDL-C), total cholesterol (TC), apolipoprotein B (apo B), and non-high-density lipoprotein cholesterol (non-HDL-C)

- The beneficiary must have a trial and failure of **all** of the following:
  - High dose statin therapy (LDL reduction capability equivalent to rosuvastatin 40 mg) **or** maximally tolerated statin therapy **or** alternative dosing options to mitigate side effects unless a documented contraindication
  - Ezetimibe with statin therapy; **AND**
  - Proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor (e.g., PRALUENT or REPATHA)
- The prescriber must submit **all** of the following:
  - Current chart notes with documentation of previous treatments
  - Current labs, including lipids along with labs corresponding with previous trials of statin and ezetimibe used concomitantly and with the addition of a PCSK9 inhibitor
  - Treatment plan with goal LDL-C
  - Diet plan for lowering cholesterol
  - Medical necessity over all other treatments for high cholesterol

RENEWAL REQUIREMENTS FOR JUXTAPID

- After initial approval, the beneficiary should demonstrate an improvement in cholesterol levels
- The beneficiary must be compliant with therapy
- Renewals may be approved for 6 months with required response to therapy provided on each PA review
- The prescriber must submit **all** of the following:
  - Current chart notes
  - Current lipid panel

APPROVAL CRITERIA FOR NEXLETOL OR NEXLIZET

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with primary hyperlipidemia with heterozygous familial hypercholesterolemia or atherosclerotic cardiovascular disease who require additional lowering of LDL-C **or** a diagnosis consistent with any new FDA-approved indications. Any off-label requests will be reviewed on a case-by-case basis.
- The beneficiary must have a trial and failure of **all** of the following:
  - High dose statin therapy (LDL reduction capability equivalent to rosuvastatin 40 mg) **or** maximally tolerated statin therapy **or** alternative dosing options to mitigate side effects unless a documented contraindication
  - Ezetimibe with statin therapy; **AND**

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  - Proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor (e.g., PRALUENT or REPATHA)
- The beneficiary should have an LDL-C ≥ 70 mg/dL and/or non-HDL-C ≥ 100 mg/dL after compliant trials (defined as 90 out of 120 days) of moderate-high intensity statins, ezetimibe, and PCSK9 inhibitors per current treatment guidelines unless the beneficiary has a contraindication
- The beneficiary must be prescribed concomitant statin therapy unless contraindicated or beneficiary demonstrated statin intolerance
- The prescriber must submit **all** of the following:
  - Current chart notes with documentation of previous treatments
  - Current labs, including lipids along with labs corresponding with previous trials of statin and ezetimibe used concomitantly and with the addition of a PCSK9 inhibitor and uric acid levels for beneficiaries with a gout diagnosis
  - Treatment plan with goal LDL-C
  - Diet plan for lowering cholesterol; **AND**
  - Medical necessity over the use of medication outlined in current treatment guidelines
- If the beneficiary smokes, the prescriber should submit a smoking cessation plan or documentation that the beneficiary has been counseled on smoking cessation
- Initial approval for 2 months

RENEWAL REQUIREMENTS FOR NEXLETOL OR NEXLIZET

- After initial approval, the beneficiary should demonstrate an improvement in the LDL-C levels
- The beneficiary must be compliant with therapy
- Renewals may be approved for 6 months with required response to therapy provided on each PA review
- The prescriber must submit **all** of the following:
  - Current chart notes; **AND**
  - Current lipid panel

APPROVAL CRITERIA FOR ICOSAPENT ETHYL (GENERIC FOR VASCEPA)

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must meet **one** of the following:
  - Use as an adjunct to maximally tolerated statin therapy to reduce the risk of myocardial infarction, stroke, coronary revascularization, and unstable angina requiring hospitalization in adult beneficiaries with elevated triglyceride levels **and** both of the following:
    - Laboratory documentation of fasting triglycerides ≥ 150 mg/dL and LDL-C ≤ 100 mg/dL; **AND**
    - Must be diagnosed with either established cardiovascular disease or diabetes mellitus and two or more additional risk factors for CVD

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  - Use as an adjunct to diet to reduce TG with severe (≥ 500 mg/dL) hypertriglyceridemia.
- The beneficiary must be compliant taking a maximally tolerated statin therapy for at least 4 weeks
- The prescriber must submit **all** of the following:
  - Current chart notes with documentation of previous treatments
  - Current labs, including lipids along with labs
  - Treatment plan with goal LDL-C and triglycerides
  - Diet plan for lowering triglycerides; **AND**
  - Medical necessity over omega-3 acid ethyl esters and fibric acid agents

RENEWAL REQUIREMENTS FOR ICOSAPENT ETHYL (GENERIC FOR VASCEPA)

- After initial approval, the beneficiary should demonstrate an improvement in the triglyceride levels
- The beneficiary must be compliant with therapy
- Renewals may be approved for 6 months with required response to therapy provided on each PA review
- The prescriber must submit **all** of the following:
  - Current chart notes; **AND**
  - Current lipid panel

APPROVAL CRITERIA FOR REDEMPLO

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- The beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert or based on support from the official Compendia
- The beneficiary must be diagnosed with familial chylomicronemia syndrome (FCS) with elevated triglycerides (≥ 880 mg/dL) despite previous lipid lowering therapy
- The beneficiary must be instructed to have a diet low in fat (10 to 15 g per day)
- The prescriber must be, or in consultation with, a cardiologist
- The beneficiary must have tried and failed standard lipid-lowering therapy taken compliantly (defined as 90 out of 120 days)
- The prescriber must submit the following:
  - Current chart notes with documentation of previous treatments
  - Genetic testing results to confirm the diagnosis of FCS
  - Current triglyceride level (≥880 mg/dL) while on lipid-lowering therapy
  - Patient specific symptoms (e.g., pancreatitis, xanthomas, hepatosplenomegaly)
  - Dietary plan
- If beneficiary smokes, provider should submit a smoking cessation plan or documentation that the beneficiary has been counseled on smoking cessation
- Initial approval for 6 months

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RENEWAL REQUIREMENTS FOR REDEMPLO

- After initial approval, the beneficiary should demonstrate an improvement in triglyceride levels
- The beneficiary must be compliant with therapy
- The prescriber must submit the following:
  - Current chart notes
  - Current triglyceride level

QUANTITY EDITS FOR REDEMPLO

#1 injection every 3 months

APPROVAL CRITERIA FOR TRYNGOLZA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with familial chylomicronemia syndrome (FCS) confirmed by molecular genetic test with fasting triglycerides level ≥ 880 mg/dL and multifactorial (polygenic) chylomicronemia has been ruled out
- The medication must be prescribed by or in consultation with a cardiologist, endocrinologist, or specialist experienced in treating severe hypertriglyceridemia
- The beneficiary should not be approved or continue the medication if meets **one** of the following:
  - Not on a low-fat diet of ≤ 20 gm of fat per day; **OR**
  - Currently a smoker
- The prescriber must submit the following:
  - Current chart notes with genetic testing to confirm diagnosis
  - Previous medications tried for lowering triglycerides
  - Current fasting labs including lipid panel
  - Documentation of symptoms associated with FCS (e.g., fatigue, pancreatitis/abdominal pain, eruptive xanthomas, lipemia retinalis, hepatosplenomegaly); **AND**
  - Attestation that beneficiary is on a low-fat diet with ≤ 20 gm of fat per day
- Initial PA will be for 3 months, renewal PAs may be up to 6 months

RENEWAL REQUIREMENTS FOR TRYNGOLZA

- The beneficiary is compliant with therapy (defined as 75% utilization)
- The beneficiary must demonstrate a positive response with decrease in fasting triglycerides and decrease in symptoms documented at baseline
- The prescriber must submit the following:
  - Current chart notes

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- Current fasting labs including lipid panel
- Current documentation of symptoms; **AND**
- Attestation that the beneficiary remains on low-fat diet with ≤ 20 gm of fat per day

QUANTITY EDITS FOR TRYNGOLZA

#1 injection per 30 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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LOFEXIDINE (LUCEMYRA)

Updated 7/18/2018

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary is an adult ≥ 18 years years of age
- The beneficiary is physically dependent on opioid drugs and currently has acute withdrawal symptoms due to abrupt opioid discontinuation
- The beneficiary is not currently receiving any opioid medications
- The prescribed dose will not exceed 16 tablets (2.88 mg) per day, or 4 tablets (0.72 mg) in a single dose, or 14 days of treatment with LUCEMYRA
- The beneficiary is not hospitalized during this treatment
- The prescriber must submit chart notes and treatment plan

DENIAL CRITERIA

- The beneficiary does not meet approval criteria
- The beneficiary is hospitalized at time of request
- Request is for greater than 96 tablets
- Request is for greater than 14 days of treatment in previous 365 days

QUANTITY LIMITS

- One 14-day treatment allowed once per 365 days
- The quantity allowed for one-time treatment will not exceed 96 tablets
- One claim allowed per 365 days
- One claim will pay for one bottle of 96 tablets or one bottle of 36 tablets

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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LOTILANER (XDEMVY)

Updated 1/17/2024

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary has been diagnosed with *Demodex* blepharitis verified by presence of collarettes through a slit lamp exam **or** a diagnosis consistent with any new FDA-approved indications. Any off-label requests will be reviewed on a case-by-case basis.
- XDEMVY must be prescribed by or in consultation with an optometrist or ophthalmologist
- The prescriber must submit **all of** the following:
  - Documentation of results seen with slit lamp examination
  - Other therapies tried; **AND**
  - Medical necessity over topical tea tree oil/shampoo and oral ivermectin

RENEWAL REQUIREMENTS

- The beneficiary had a previous positive response with a reduction in collarettes and mites.
- Maximum of two treatments per year

QUANTITY EDITS

1 bottle per 6 weeks

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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MARALIXIBAT (LIVMARLI)

Updated 7/16/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication; **AND**
- The beneficiary must have a confirmed diagnosis of **one** of the following:
  - Alagille syndrome with a baseline presence of cholestatic pruritis
  - Progressive Familial Intrahepatic Cholestasis with a baseline presence of cholestatic pruritics; **OR**
  - Diagnosis consistent with any new FDA indication
- The beneficiary has elevated serum bile acid concentration; **AND**
- The beneficiary has documented failure of ursodeoxycholic acid (URSODIOL) **and** a bile acid sequestrant unless there is a documented contraindication; **AND**
- The beneficiary should continue ursodeoxycholic acid concomitantly; **AND**
- The beneficiary should be limited to the following doses:
  - ALGS beneficiary using 9.5 mg/mL solution – max of 28.5 mg per day
  - ALGS beneficiary using tablets – max of 30 mg per day
  - PFIC beneficiary using 19 mg/mL solution – max of 38 mg per day
  - PFIC beneficiary using tablets – max of 40 mg per day
- The beneficiary should not be approved or continue with any of the following:
  - Documented hepatic decompensation
  - Not concurrently ordered ursodeoxycholic acid; **OR**
  - If continued pruritis or has no decrease in serum bile acid after trial with maximum dose of 380 mcg/kg per day
- The prescriber must submit the following:
  - Current chart notes
  - Current labs, including serum bile acid level, LFTs, and fat-soluble vitamins (A, D, E, and INR); **AND**
  - Current weight for dose determination
- Initial approval for 3 months

RENEWAL REQUIREMENTS

- The beneficiary must be compliant with therapy (defined as 75% utilization)
- The beneficiary must demonstrate a positive response with decrease in pruritis or decrease in serum bile acid after trial with maximum dose of 380 mcg/kg per day

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- The prescriber should provide the following:
  - Current chart notes
  - Current labs, including serum bile acid level, LFTs, and fat-soluble vitamins (A, D, E, and INR); **AND**
  - Current weight for dose determination

QUANTITY EDITS

- 9.5 mg/mL = 3 bottles (90 mL) per 30 days
- 19 mg/mL = 2 bottles (60 mL) per 30 days
- 10 mg, 15 mg, and 20 mg = #62 tablets per 31 days
- 30 mg = #31 tablets per 31 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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MARIBAVIR (LIVTENCITY)

Updated 4/20/2022

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary must be ≥ 12 years of age and weigh at least 35 kg; **AND**
- The beneficiary must have received either a hematopoietic stem cell transplant (HSCT) or solid organ transplant (SOT) with diagnosed CMV that is refractory to treatment with ganciclovir, valganciclovir, cidofovir, foscarnet **or** a diagnosis consistent with the FDA-approved indication; **AND**
- The beneficiary must not exceed the following dosages:
  - 800 mg per day
  - If co-administered with carbamazepine: 1,600 mg per day; **OR**
  - If co-administered with phenytoin or phenobarbital: 2,400 mg per day
- The prescriber must submit the following:
  - Current chart notes
  - Labs confirming active CMV infection with CMV DNA level and CBC
  - Negative pregnancy test if of reproductive potential
  - Documentation of previous therapies
  - Current weight; **AND**
- Initial PA request approved for maximum of 2 months

DENIAL CRITERIA

- The beneficiary does not meet approval criteria **or** have a diagnosis supported in the official Compendia
- The beneficiary is pregnant
- The beneficiary's treatment plan includes concomitant use with valganciclovir or ganciclovir
- The beneficiary has end state renal disease or severe hepatic impairment
- The prescriber ordered as prophylaxis therapy
- The beneficiary has been diagnosed with central nervous system CMV disease including CMS retinitis; **OR**
- The prescriber orders for dose outside of recommendation by the manufacturer

QUANTITY EDITS

#124 tablets per 31 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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MAVACAMTAN (CAMZYOS)

Updated 7/20/2022

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary must be at least 18 years of age
- The beneficiary must have a diagnosis of NYHA Class II and III obstructive hypertrophic cardiomyopathy **or** a diagnosis consistent with any updated FDA indications
- The prescriber, beneficiaries, and pharmacies must be enrolled in the Camzyos REMS program due to risk of heart failure due to systolic dysfunction
- The beneficiary must have tried and failed beta blockers and calcium channel blockers unless contraindicated; **AND**
- The prescriber must submit the following:
  - Current chart notes
  - Previous treatment
  - Confirmation for absence of pregnancy and attestation that females of reproductive potential will use effective contraception; **AND**
  - Baseline LVEF, Valsalva LVOT peak gradient, and mixed peak oxygen consumption

DENIAL CRITERIA

- The beneficiary does not meet approval criteria **or** have a diagnosis supported in the official Compendia
- The beneficiary has a baseline LVEF < 55% or Valsalva LVOT peak gradient < 50 mmHg; **OR**
- The beneficiary requires moderate to strong CYP2C19 inhibitors or inducers, **or** strong CYP3A4 inhibitors, **or** moderate to strong CYP3A4 inducers; **OR**
- The beneficiary is pregnant

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MAVORIXAFOR (XOLREMDI)

Updated 10/16/2024

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with WHIM syndrome (warts, hypogammaglobulinemia, infections, and myelokathexis) that has genotype-confirmed variant of CXC chemokine receptor 4 (CXCR4) with low number of circulating mature neutrophils and lymphocytes **or** a diagnosis consistent with any new FDA-approved indications. Any off-label requests will be reviewed on a case-by-case basis.
- The beneficiary must have an absolute neutrophil count (ANC) ≤ 400 cells/μL at baseline
- The medication is prescribed by or in consultation with an immunologist, hematologist or dermatologist
- The beneficiary should not be approved or continue the medication if meet **one** of the following:
  - Pregnant
  - Breastfeeding
  - Severe renal impairment (CrCl < 30 mL/min); **OR**
  - Moderate to severe hepatic impairment
- The prescriber must submit the following:
  - Current chart notes with documentation of previous therapies
  - Current labs, including CBC with differential, liver function tests, and basic metabolic panel
  - Current weight
  - Dose requested
  - Pregnancy test for female beneficiaries of reproductive potential; **AND**
  - Attestation that the female beneficiaries of reproductive potential has been counseled on the use of an effective method of contraception during treatment for 3 weeks after the final dose.

RENEWAL REQUIREMENTS

- The beneficiary must remain compliant with therapy (defined as 75% utilization)
- The beneficiary must demonstrate a clinical benefit based on any of the following (compared to baseline):
  - Reduced frequency, duration or severity of infections
  - Fewer warts; **AND**

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- Improved labs (e.g., absolute neutrophil count, white blood cell count, and absolute lymphocyte count)

- The prescriber must submit the following:
  - Current chart notes
  - Documentation of clinical response to treatment; **AND**
  - Current labs, including CBC with differential, liver function tests, and basic metabolic panel

QUANTITY EDITS

#120 capsules per 30 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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MECASERMIN (INCRELEX)

Updated 1/15/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must be diagnosed with **one** of the following:
  - Primary IGF-1 deficiency with **all** of the following:
    - Height > 3 standard deviations (SD) below the mean
    - Basal IGF-1 > 3 SD below the mean; **AND**
    - Normal or elevated growth hormone (GH)
  - Growth hormone gene deletion and have developed neutralizing antibodies to growth hormone
- The beneficiary should not be approved or continue this therapy with any of the following:
  - Diagnosed with secondary IGF-1 deficiency related to GH deficiency, malnutrition, hypothyroidism, or chronic steroid therapy
  - Has evidence of malignant neoplasm; **OR**
  - Has closed epiphyses
- The prescriber must submit the following:
  - Current chart notes
  - Previous therapies tried
  - Baseline growth velocity charts
  - Current weight to confirm requested dose
  - Current bone age with documentation of epiphyses status; **AND**
  - Documentation of diagnosis with any of the following:
    - Mutation in GH receptor
    - Mutation in the post-GHR signaling pathway; **OR**
    - IGF-1 gene defects (i.e., Laron Syndrome)

RENEWAL REQUIREMENTS

- The beneficiary has been compliant with therapy (defined as 75% utilization)
- The beneficiary has a positive response to treatment with improvement in growth velocity compared to baseline
- The beneficiary must continue to have open epiphyses for renewal
- The prescriber must submit the following:
  - Current chart notes
  - Current calculated growth velocity; **AND**

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- Documentation of open epiphyses

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MEDICATION ASSISTED TREATMENT MEDICATIONS

Updated 10/1/2026

PREFERRED OPIOID DEPENDENCE AGENTS WITH NO CRITERIA

- buprenorphine sublingual tablet (generic for SUBUTEX)
- naltrexone
- SUBOXONE film (buprenorphine/naltrexone) – **brand only**
- ZUBSOLV SL (buprenorphine/naltrexone)

As of 1/1/2020 the preferred oral agents for MAT therapy will no longer require a PA

Effective 1/1/2025, the maximum daily allowed dose will increase to the equivalent of 32 mg of buprenorphine. At that time, a therapeutic duplication edit will be implemented for oral opioid use disorder (OUD) agents to prevent overlapping claims for multiple oral dosage forms. There will not be a therapeutic duplication edit place between the oral and injectable products.

PREFERRED INJECTABLE MEDICATION ASSISTED TREATMENT (MAT) AGENTS

- BRIXADI SQ buprenorphine)
- SUBLOCADE SQ (buprenorphine)
- VIVITROL IM (naltrexone)

Preferred Injectable MAT Agents may be billed at point-of-sale in a pharmacy setting or through the beneficiary's medical benefits. No PA is required at the pharmacy.

PREFERRED OPIATE OVERDOSE AGENTS/RESCUE MEDICATIONS WITH NO CRITERIA

- KLOXXADO (naloxone)
- naloxone nasal spray
- naloxone syringe
- naloxone vial
- NARCAN (naloxone)
- REXTOVY (naloxone)

PREFERRED ALCOHOL DEPENDENCE AGENTS WITH NO CRITERIA

- acamprosate DR (generic for CAMPRAL)
- disulfiram (generic for ANTABUSE)
- naltrexone

NON-PREFERRED OPIOID DEPENDENCE AGENTS

- buprenorphine-naloxone SL tablet (generic for SUBOXONE)
- buprenorphine-naloxone SL film (generic for SUBOXONE)

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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NON-PREFERRED INJECTABLE MAT AGENTS

None

NON-PREFERRED OPIATE OVERDOSE AGENTS/RESCUE MEDICATIONS

- LIFEMS NALOXONE (naloxone)
- lofexidine (generic for LUCEMYRA) – (see criteria for LUCEMYRA)
- LUCEMYRA (lofexidine)
- nalmefene
- naloxone carpuject
- OPVEE (nalmefene)
- REZENOPY (naloxone)
- ZURNAI (nalmefene)

ADDITIONAL CRITERIA

Quantity limits apply

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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MEDROXYPROGESTERONE (DEPO-PROVERA)

Updated 2/12/2013

APPROVAL CRITERIA

No Therapeutic Duplication with any other injectable DEPO-PROVERA

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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MEGESTROL (MEGACE AND MEGACE ES)

Updated 10/18/2006

APPROVAL CRITERIA

- The beneficiary has a history of HIV/AIDS in the past two years
- The beneficiary has a history of a paid claim for an antiviral HIV agent in the past 60 days; **OR**
- The beneficiary has a history of malignancy in the past two years

ADDITIONAL CRITERIA

Quantity limits apply

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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MEPROBAMATE (EQUANIL)

Updated 7/9/2012

ADDITIONAL CRITERIA

Quantity limits apply

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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MEROPENEM-VABORBACTAM (VABOMERE)

Updated 3/1/2018

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

DRUG THAT REQUIRES A MANUAL REVIEW FOR PRIOR AUTHORIZATION

VABOMERE injection

ADDITIONAL CRITERIA

- Age limits apply
- Quantity limits apply

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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METHOTREXATE INJECTION (OTREXUP AND REDITREX)

Updated 1/15/2025

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must be diagnosed with **one** of the following:
  - Rheumatoid arthritis (RA)
  - Polyarticular juvenile idiopathic arthritis (pJIA); **OR**
  - Psoriasis
- The beneficiary should not be approved or continue this therapy with any of the following:
  - Prescribed for treatment of neoplastic disease
  - RA and pJIA beneficiaries that have not trialed and failed full dose non-steroidal anti-inflammatory agents (unless documented contraindication)
  - Dosing is not supported by the package insert or official Compendia for the specific beneficiary indication; **OR**
  - Pregnancy
- The prescriber must submit the following:
  - Current chart notes with documentation of diagnosis
  - Previous therapies tried with timeframe and response
  - Confirmation of negative pregnancy status for female beneficiary of reproductive potential; **AND**
  - Letter of medical necessity for the use over oral methotrexate and methotrexate vials which are both available without prior authorization

RENEWAL REQUIREMENTS

- The beneficiary must remain compliant with therapy (defined as 75% utilization)
- The beneficiary must demonstrate a significant improvement in the treated diagnosis
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of response to therapy; **AND**
  - Continued medical necessity over oral methotrexate or methotrexate vials

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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METHOTREXATE SODIUM (TREXALL)

Updated 1/15/2025

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must be diagnosed with **one** of the following:
  - Acute lymphoblastic leukemia (ALL)
  - Mycosis fungoides (cutaneious T-cell lymphoma)
  - Relapsed or refractory non-Hodgkin lymphomas
  - Rheumatoid arthritis (RA)
  - Polyarticular juvenile idiopathic arthritis (pJIA); **OR**
  - Psoriasis
- The beneficiary should not be approved if pregnant
- The prescriber must submit the following:
  - Current chart notes
  - Previous therapies tried with timeframe and response
  - Current labs to monitor myelosuppression, renal toxicity, and liver toxicity
  - Confirmation of negative pregnant status for female beneficiary of reproductive potential; **AND**
  - Letter of medical necessity for the use over generic oral methotrexate which is available without a PA

RENEWAL REQUIREMENTS

- The beneficiary must remain compliant with therapy (defined as 75% utilization)
- The beneficiary must demonstrate a significant improvement in the treated diagnosis
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of response to therapy; **AND**
  - Continued medical necessity over oral generic methotrexate

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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METHOXSALEN (OXSORALEN-ULTRA)

Updated 1/15/2025

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must be diagnosed with severe, recalcitrant, disabling psoriasis
- The beneficiary must be getting concomitant long wave ultraviolet radiation
- The medication must be prescribed by or in consultation with a dermatologist knowledgeable in treatment with photochemotherapy
- The beneficiary should not be approved or continue the medication if meet **one** of the following:
  - Has a disease that is associated with photosensitivity (e.g., lupus, xeroderma pigmentosum, albinism)
  - Has history of melanoma
  - Has invasive squamous cell carcinoma
  - Has aphakia; **OR**
  - Has not had an ophthalmologic examination prior to starting therapy then yearly thereafter
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Previous therapies tried with timeline and response

RENEWAL REQUIREMENTS

- The beneficiary is compliant with therapy (defined as 75% utilization)
- The beneficiary has a positive response with improvement in psoriasis without intolerable side effects
- The prescriber must submit the following:
  - Current chart notes

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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METHSCOPOLAMINE (PAMINE, PAMINE FORTE, PAMINE FQ)

Updated 6/19/2008

APPROVAL CRITERIA

- History of peptic ulcer disease in Medicaid medical history in previous 6 months; **AND**
- CPT code for H. Pylori in procedure history in the past 6 months; **AND**
- At least 112 days of PPI therapy in the last 120 days.

DENIAL CRITERIA

History of glaucoma

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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METOCLOPRAMIDE SPRAY (GIMOTI)

Updated 1/15/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must be diagnosed with recurrent diabetic gastroparesis
- The beneficiary should not be approved or continue this therapy with any of the following:
  - < 18 years of age
  - Moderate or severe hepatic impairment (Child-Pugh B or C)
  - Moderate or severe renal impairment (CrCl < 60 mL/minute)
  - Requires concomitant strong CYP2D6 inhibitors
  - Prescribed a treatment duration > 12 weeks
  - History of tardive dyskinesia
  - Has seizures
  - Caution in gastrointestinal hemorrhage, mechanical obstruction or perforation; **OR**
  - Initial therapy for gastroparesis in beneficiaries ≥ 65 years of age
- The prescriber must submit the following:
  - Current chart notes
  - Previous therapies tried; **AND**
  - Letter of medical necessity for the use over metoclopramide tablets or metoclopramide oral solution. The prescriber must provide a beneficiairy specific and clinically significant reason this dosage form is required.

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METRELEPTIN (MYALEPT)

Updated 1/15/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must be diagnosed with congenital or acquired generalized lipodystrophy and experiencing complications of leptin deficiency
- The beneficiary must be prescribed this medication as an adjunct to diet as replacement therapy
- The prescriber and pharmacy must be enrolled in the MYALEPT REMS program
- The beneficiary should not be approved or continue this therapy with any of the following:
  - Diagnosed with partial lipodystrophy
  - Prescribed for the treatment of liver disease (i.e., nonalcoholic steatohepatitis)
  - Diagnosed with HIV-related lipodystrophy
  - Diagnosed with metabolic disease (i.e., diabetes and hypertriglyceridemia) without concurrent evidence of congenital or acquired generalized lipodystrophy
  - Diagnosed with general obesity not associated with congenital leptin deficiency; **OR**
  - At risk of pancreatitis
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Current labs, including fasting leptin concentration, baseline HbA1c, fasting glucose and fasting triglycerides

RENEWAL REQUIREMENTS

- The beneficiary is compliant with therapy (defined as 75% utilization)
- The beneficiary has a positive response with improvement in serum leptin, HbA1c, and triglycerides
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Documentation of response to treatment

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METRONIDAZOLE 375 MG CAPSULE (FLAGYL)

Updated 8/17/2010

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- Diagnosis of NPO (Appendix A) in the previous year; **OR**
- < 7 years of age

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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METRONIDAZOLE 500MG/5ML SUSPENSION (LIKMEZ)

Updated 1/17/2024

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with trichomoniasis, amebiasis, or anaerobic bacterial infection with **one** of the following specific bacteria:
  - Intra-abdominal infections, including peritonitis, intra-abdominal abscess, and liver abscess, caused by Bacteroides species including the *B. fragilis* group (*B. fragilis*, B. ovatus, *B. thetaiotaomicron*, *B. vulgatus*), *Parabacteroides distasonis*, *Clostridium* species, *Eubacterium* species, *Peptococcus* species, and *Peptostreptococcus* species.
  - Skin and skin structure infections caused by *Bacteroides* species including the *B. fragilis* group, *Clostridium* species, *Peptococcus* species, *Peptostreptococcus* species, and *Fusobacterium* species.
  - Gynecologic infections, including endometritis, endomyometritis, tubo-ovarian abscess, and postsurgical vaginal cuff infection, caused by *Bacteroides* species including the *B. fragilis* group, *Clostridium* species, *Peptococcus* species, *Peptostreptococcus* species, and *Fusobacterium* species.
  - Bacterial septicemia caused by *Bacteroides* species including the *B. fragilis* group and *Clostridium* species.
  - Bone and joint infections, (as adjunctive therapy), caused by *Bacteroides* species including the *B. fragilis* group.
  - Central nervous system (CNS) infections, including meningitis and brain abscess, caused by *Bacteroides* species including the *B. fragilis* group.
  - Lower respiratory tract infections, including pneumonia, empyema, and lung abscess, caused by *Bacteroides* species including the *B. fragilis* group; **OR**
  - Endocarditis caused by *Bacteroides* species including the *B. fragilis* group.
- The prescriber must submit **all** of the following:
  - Current chart notes
  - Report indicating diagnosis/bacteria requiring treatment
  - Culture and sensitivity if available
  - Medical necessity over other antibiotics available without a PA including metronidazole tablets; **AND**

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- Dose requested

RENEWAL REQUIREMENTS

Continuation requires a report that documents continued bacteria positivity

QUANTITY EDITS

No set maximum quantity since based on dose required

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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METRONIDAZOLE-TETRACYCLINE-BISMUTH (PYLERA)

Updated 1/12/2005

APPROVAL CRITERIA

Criteria 1:

- No history of lansoprazole, amoxicillin, and clarithromycin combination (PREVPAC) in the last 365 days; **AND**
- No history of omeprazole, amoxicillin, and clarithromycin combination
- (OMECLAMOX-Pak) in the last 365 days; **AND**

Criterion 2:

- No history of metronidazole, tetracycline, and bismuth combination (PYLERA) in the last 365 days.

DENIAL CRITERIA

Criteria 1:

- History of lansoprazole, amoxicillin, and clarithromycin combination (PREVPAC) in the last 365 days; **OR**
- History of omeprazole, amoxicillin, and clarithromycin combination
- (OMECLAMOX-Pak) in the last 365days; **AND**

Criterion 2:

- History of metronidazole, tetracycline, and bismuth combination (PYLERA) in the last 365 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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MIFEPRISTONE 300 MG TABLET (KORLYM)

Updated 1/15/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must be diagnosed with hyperglycemia secondary to hypercortisolism due to endogenous Cushing's syndrome and has type 2 diabetes mellitus or glucose intolerance
- The beneficiary must have failed surgery intended to correct the cause of endogenous Cushing's syndrome or not be a candidate for surgery that is expected to correct the cause of endogenous Cushing's syndrome
- The medication must be prescribed by or in consultation with an endocrinologist
- The beneficiary should not be approved or continue this therapy with any of the following:
  - Pregnancy
  - Requires concomitant drugs metabolized by CYP3A (e.g., simvastatin, cyclosporine, tacrolimus)
  - Requires systemic corticosteroids for lifesaving purposes (e.g., immunosuppression after organ transplantation)
  - History of unexplained vaginal bleeding or endometrial hyperplasia with atypia or endometrial carcinoma
  - Suspected adrenal insufficiency (KORLYM can be restarted at a lower dose after resolution of adrenal insufficiency)
  - Prescribed more than 600 mg per day when renally impaired or has mild to moderate hepatic impairment
  - Has severe hepatic impairment; **OR**
  - Has hypokalemia (must be corrected prior to initiating KORLYM)
- The prescriber must submit the following:
  - Current chart notes with beneficiary specific symptoms of Cushing's syndrome
  - Pregnancy test results for female beneficiaries of reproductive potential
  - Current labs, including baseline HbA1c, fasting glucose, renal function, hepatic function, and baseline cortisol and ACTH levels
  - Attestation that female beneficiaries of reproductive potential are using a non-hormonal method of contraception or have undergone surgical sterilization
  - Current weight (maximum dose is 1,200 mg per day but should not exceed 20 mg/kg per day)

RENEWAL REQUIREMENTS

- The beneficiary is compliant with therapy (defined as 75% utilization)
- The beneficiary has demonstrated a positive response to treatment without intolerable side effects

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- The prescriber must submit the following:
  - Current chart notes with documentation of response to therapy
  - Current labs to support response to therapy including HbA1c, fasting glucose, renal function, hepatic function, cortisol and ACTH levels; **AND**
  - Current weight for dose verification

QUANTITY EDITS

#120 tablets per 30 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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MIGALASTAT 123 MG CAPSULE (GALAFOLD)

Updated 2/14/2019

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

DRUGS THAT REQUIRE MANUAL REVIEW FOR PRIOR AUTHORIZATION

Galafold

APPROVAL CRITERIA

- The beneficiary is an adult ≥ 18 years of age
- The prescriber must submit documentation that beneficiary has diagnosis of Fabry disease with renal manifestations, **and** has an amenable galactosidase alpha gene (GLA) variant based on in vitro assay data, **and** the amenable variant must be a disease- causing variant
- The beneficiary is on a low protein diet
- The prescriber must submit beneficiary's urine albumin, urinary creatinine, serum creatinine, glomerular filtration rate (GFR), serum BUN, serum electrolytes, plasma globotriaosylsphingosine (lyso-Gb3) for the last 12 months
- The beneficiary must have tried Enzyme Replacement Therapy and the prescriber must submit Medication Administration Records (MARs) and response to therapy in the previous 12 months
- The prescriber must submit beneficiary specific measurable treatment goals for outcomes with GALAFOLD and include the treatment plan if the measurable treatment goals are not met and GALAFOLD is discontinued
- Initial approval can be for 6 months

DENIAL CRITERIA

- The beneficiary does not have Fabry disease with an amenable galactosidase alpha gene (GLA) variant
- The GLA variant is not a disease-causing variant
- The beneficiary did not show positive response to therapy
- Request for doses exceeding one capsule every other day

QUANTITY EDITS

- Limited to 1 capsule every 2 days (dose is 1 capsule every other day)
- Quantity limited to 14 capsules for a 28-day supply

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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MIGLUSTAT 65 MG CAPSULE (OPFOLDA)

Updated 1/17/2024

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or based on support in the official Compendia
- The beneficiary must be an adult diagnosed with late-onset Pompe disease (LOPD) based on documentation of **one** of the following:
  - Deficiency of GAA enzyme; **OR**
  - GAA genotyping
- The beneficiary must have tried enzyme replacement therapy (ERT) for at least 24 months without improvement (e.g., improved FVC or 6MWT) with **one** of the following:
  - Lumizyme (alglucosidase alfa) intravenous infusion; **OR**
  - Nexviazyme (avalglucosidase alfa-ngpt) intravenous infusion
- The medication must be prescribed by or in consultation with a geneticist, neurologist, or provider that specializes in the treatment of lysosomal storage disorders
- The beneficiary should not be approved or continue this therapy with any of the following:
  - Pregnancy
  - Not prescribed concomitant Pombiliti infusions (medical billing will be verified)
  - End stage renal disease (moderate-severe impairment requires dose decrease)
  - < 40 kg
- The prescriber must submit the following:
  - Current chart notes with beneficiary's specific symptoms
  - Generic testing to confirm LOPD
  - Attestation that both female subjects of childbearing potential and male subjects are using contraception
  - Baseline pulmonary function tests (specifically FVC %predicted) and labs for renal function; **AND**
  - Baseline 6 minute walk test (6MWT)
- Initial PA for 6 months

RENEWAL REQUIREMENTS

- The beneficiary must continue to receive Pombiliti infusions every 2 weeks and is compliant with therapy

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- The prescriber must submit the following:
  - Current chart notes with beneficiary's specific symptoms
  - Attestation that both female subjects of childbearing potential and male subjects continue to use contraception
  - Updated PFTs and renal function labs; **AND**
  - Updated 6MWT

QUANTITY EDITS

8 capsules per 28 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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MIGLUSTAT 100 MG CAPSULE (ZAVESCA)

Updated 1/15/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must be diagnosed with **one** of the following:
  - Mild to moderate type 1 Gaucher disease for whom enzyme replacement therapy is not a therapeutic option (e.g., due to allergy, hypersensitivity, or poor venous access).
  - Niemann-Pick Disease to use concomitantly with MIPLYFFA (arimoclomol citrate) – (off-label use of this medication)
- The beneficiary should not be approved or continue this therapy with any of the following:
  - Severe renal impairment (creatinine clearance < 30 mL/min/1.73 m^2); mild-moderate renal impairment requires dosage adjustment
- The prescriber must submit the following:
  - Current chart notes
  - Previous therapies tried including enzyme replacement therapy for Gaucher disease beneficiaries
  - For Gaucher disease – Baseline liver and spleen volume, platelet count, and hemoglobin (used for determining response to treatment)
  - For Niemann-Pick Disease – beneficiary specific neurological symptoms and molecular genetic testing results confirming biallelic pathogenic variants in the NPC1 or NPC2 genes; **AND**
  - Letter of medical necessity for the use of this medication over enzyme replacement therapy for Gaucher disease and over the use of Aqneursa (levacetylleucine) for Niemann-Pick disease

RENEWAL REQUIREMENTS

- The beneficiary is compliant with therapy (defined as 75% utilization)
- The beneficiary has demonstrated a positive response to treatment without intolerable side effects
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Documentation of response to therapy
    - Gaucher disease – current liver and spleen volume, platelet count, and hemoglobin
    - Niemann-Pick disease – updated description of symptoms

QUANTITY EDITS

#90 capsules per 30 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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MIGRAINE TREATMENT (ACUTE) – OTHER

Updated 10/1/2026

PREFERRED AGENT WITH CRITERIA

- NURTEC ODT (rimegepant)
- UBRELVY (ubrogepant)

NON-PREFERRED AGENTS

- BREKIYA (dihydroergotamine)
- CAFERGOT (ergotamine/caffeine)
- diclofenac potassium powder pack (generic for CAMBIA)
- dihydroergotamine injection (generic for D.H.E.45)
- dihydroergotamine nasal spray (generic for MIGRANAL)
- ELYXYB (celecoxib)
- ERGOMAR SL (dihydroergotamine)
- MIGERGOT (ergotamine/caffeine)
- REYVOW (lasmiditan) – **manufacturer obsolete 05/31/2026**
- ZAVZPRET (zavegepant)

APPROVAL CRITERIA

- Any new medications for acute migraine treatment released will follow this same criterion and follow documentation in the manufacturer's label. Preferred drug list status will apply.
- The beneficiary meets the minimum age recommended in the manufacturer's package insert
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must have a diagnosis of acute migraines with or without auras as defined by the International Classification of Headache Disorders 3rd edition (ICHD-3)
- The beneficiary must have a failure of at least **two** preferred 5HT1B/1D receptor agonists (triptans) using **two** different chemical agents (not just different dosage forms) at maximally tolerated doses unless beneficiary has **one** of the following contraindications:
  - Ischemic coronary artery disease
  - Arrhythmias
  - History of stroke or transient ischemic attack (TIA)
  - Peripheral vascular disease
  - Ischemic bowel disease; **OR**
  - Uncontrolled hypertension
- The beneficiary should not be approved or continue the medication if **one** of the following is met:

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- Requires continued use of a strong CYP3A4 inhibitor (i.e., ketoconazole, itraconazole, clarithromycin) – UBRELVY and NURTEC ODT
- Requires continued use of a strong CYP3A4 inducer (i.e., rifampin) – UBRELVY and NURTEC ODT
- Requires continued use of P-gp substrate (i.e., digoxin) – REYVOW
- End stage renal disease (CrCl < 15mL/min) – UBRELVY, NURTEC ODT, and ELYXYB
- Severe hepatic impairment (Child-Pugh Class C) – REYVOW, NURTEC ODT, and ELYXYB
- NSAID allergy or recent coronary artery bypass graft (CABG) surgery – ELYXYB
- If the beneficiary prescribed UBRELVY 100 mg and has severe hepatic impairment (Child-Pugh Class C) or severe renal impairment (CrCl 15–29 mL/min)

- The prescriber must submit the following:
  - Current chart notes
  - Documentation of migraine frequency and severity/duration
  - List of all therapies trialed with timeframes; **AND**
  - Attestation that medication overuse headaches have been ruled out

RENEWAL REQUIREMENTS

- The beneficiary demonstrates a positive response with a decrease in the severity/duration of migraines; **AND**
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Documentation of current migraine frequency and severity/duration.

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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MIGRAINE TREATMENT (ACUTE) – TRIPTANS

Updated 10/1/2026

PREFERRED AGENTS

- naratriptan (generic for AMERGE)
- rizatriptan (generic for MAXALT)
- rizatriptan ODT (generic for MAXALT MLT)
- sumatriptan tablet (generic for IMITREX)
- zolmitriptan ODT (generic for ZOMIG ZMT)
- zolmitriptan tablet (generic for ZOMIG)

PREFERRED AGENTS WITH CRITERIA

- sumatriptan nasal spray (generic for IMITREX)
- sumatriptan pen autoinjector (generic for IMITREX)
- sumatriptan vial (generic for IMITREX)

NON-PREFERRED AGENTS

- almotriptan (generic for AXERT)
- eletriptan (generic for RELPAX)
- FROVA (frovatriptan)
- frovatriptan (generic for FROVA)
- IMITREX (sumatriptan)
- MAXALT (rizatriptan)
- MAXALT MLT (rizatriptan)
- RELPAX (eletriptan)
- sumatriptan/naproxen (generic for TREXIMET)
- SYMBRAVO (meloxicam/rizatriptan)
- TOSYMRA (sumatriptan)
- ZEMBRACE (sumatriptan)
- zolmitriptan nasal spray (generic for ZOMIG)
- ZOMIG (zolmitriptan)

APPROVAL CRITERIA FOR PREFERRED AGENTS WITH CRITERIA

- Preferred Injection (sumatriptan injection 4 mg or 6 mg)
- Any serotonin 5-HT 1 receptor agonist within past 365 days
- Preferred nasal spray (sumatriptan nasal spray 5 mg or 20 mg) must meet **one** of the following criteria:

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- Trial and failure of two different chemical entities for 5-HT 1 receptor agonists in the last 12 months with either of the following:
  - One preferred oral tablet **and** one preferred oral disintegrating tablet (ODT) from two different chemical entities; **OR**
  - One preferred oral disintegrating tablets (ODT) from two different chemical entities; **OR**
- 5-HT 1 receptor agonist nasal spray in history within past 365 days with history

DENIAL CRITERIA FOR ALL AGENTS

Therapeutic duplication of any serotonin 5-HT 1 receptor agonist

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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MIGRAINE TREATMENT (PROPHYLACTIC AGENTS)

Updated 10/1/2026

PREFERRED AGENTS WITH CRITERIA

- AIMOVIG (erenumab-aooe)
- EMGALITY 120 mg pen and syringe (galcanezumab-gnlm)
- NURTEC ODT (rimegepant)
- QULIPTA (atogepant)

NON-PREFERRED AGENTS

- AJOVY (fremanezumab-vfrm)
- EMGALITY100 mg syringe (galcanezumab-gnlm)

APPROVAL CRITERIA FOR PREFERRED AGENTS WITH CRITERIA

Any new medications for migraine prevention released will follow these same criteria and follow documentation in the manufacturer's label. Preferred drug list status will apply.

- The beneficiary meets the minimum age recommended in the manufacturer's package insert
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia.
- The beneficiary must have a diagnosis of either:
  - Chronic migraines with or without auras as defined by the International Classification of Headache Disorders 3rd edition (ICHD-3) with ≥ 15 headache days per month with ≥ 8 migraine days per month; **OR**
  - Episodic migraine or episodic cluster headache; **OR**
  - Diagnosis consistent with FDA indication
- The beneficiary requesting an oral CGRP agent (including preferred medications) must have a documented failure of a **6-month trial** (defined as 186 days of therapy in the past 270 days) with at least **one** injectable CGRP agent or a contraindication to the use
- The beneficiary should not be approved or continue the medication if **one** of the following is met:
  - Continuation should not be approved if there is no reduction from baseline in monthly migraine days or migraine severity after 3 months
  - Diagnosed with medication overuse headache caused by opiate overuse or other headache medication overuse as identified by the prescriber
  - Requires continued use of a strong CYP3A4 inhibitor (i.e., ketoconazole, itraconazole, clarithromycin, etc.) – NURTEC ODT
  - Requires continued use of a strong CYP3A inducer (i.e., rifampin) – NURTEC ODT
  - End stage renal disease (CrCl < 15 mL/min) – NURTEC ODT
  - Severe hepatic impairment (Child-Pugh Class C) – NURTEC ODT and QULIPTA

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- The prescriber must submit **all** of the following:
  - Current chart notes
  - Documentation of migraine frequency and severity/duration
  - List of all therapies trialed with timeframes
  - Attestation that medication overuse headaches have been ruled out; **AND**
  - Medical necessity over other preventative classes (i.e., anticonvulsants, antidepressants, and beta blockers)

RENEWAL REQUIREMENTS

- The beneficiary must have a reduction in monthly migraine days and migraine severity after 3rd month of treatment while remaining compliant on therapy
- The prescriber must submit the following:
  - Chart notes since previous PA approval
  - Documentation of current migraine frequency and severity; **AND**
  - The beneficiary has decreased claims of acute migraine treatment

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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MILNACIPRAN (SAVELLA)

Updated 7/16/2025

APPROVAL CRITERIA

- The request is for SAVELLA (milnacipran); **AND**
  - The beneficiary has a diagnosis of fibromyalgia (ICD-10 M79.7) within the previous 2 years of history, submitted on the incoming pharmacy claim, or documented on the request; **AND**
  - The beneficiary has a history of a 90-day trial of at least three of the following within the past 2 years, substantiated by claims history or documented on the request:
    - SNRI
    - Gabapentin or pregabalin
    - Tricyclic antidepressant
    - Muscle relaxer; **AND**
- If previous trials cannot be substantiated via claims, the prescriber provides attestation that the beneficiary adhered to previous therapies, and the trial period was sufficient to allow for a positive treatment outcome or that the drug was discontinued due to an adverse event; **AND**
- The prescriber attests that the trial/failures of the preferred medications are documented in the beneficiary's medical record (evidence of such is subject to audit)

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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MISOPROSTOL (CYTOTEC)

Updated 1/9/2008

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

Criteria 1:

- Female; **AND**
- Long Term Care; **OR**
- Current birth control drug claim (within the past 30 days); **OR**
- Current injectable birth control drug claim; **OR**
- Medical history of tubal ligation; **OR**
- Medical history of hysterectomy; **OR**
- Medical history of menopause; **OR**
- Hormone replacement therapy in the past 45 days; **OR**
- Age > 55; **AND**
- NSAID claim in past 30 days

Criteria 2:

- Male; **AND**
- NSAID claim in the past 30 days

DENIAL CRITERIA

Medical history of current pregnancy

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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MITAPIVAT (AQVESME)

Updated 4/15/2026

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- The beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert or based on support from the official Compendia
- The beneficiary must be diagnosed with anemia (hemoglobin ≤10 g/dL) and either alpha- or beta-thalassemia
- The beneficiary's diagnosis must be confirmed by lab findings of overall reduction in hemoglobin and hematocrit and **one** of the following:
  - Genetic testing; **OR**
  - Electrophoresis or high-performance liquid chromatography (HPLC)
- The beneficiary must meet **one** of the following:
  - Transfusion-dependent thalassemia defined as 6 or more red blood cell (RBC) units transfused in 24 weeks with no longer than a 6-week transfusion free period during the 24 weeks
  - Non-transfusion-dependent thalassemia defined as no more than 5 RBC units transfused in 24 weeks AND a baseline hemoglobin ≤ 10 g/dL
- Must be prescribed by, or in consultation with, a specialist in treating thalassemia (e.g., hematologist)
- The prescriber, pharmacy and patient must be enrolled in the REMS program
- The beneficiary must have iron deficiency anemia ruled out
- The beneficiary should not be diagnosed with cirrhosis (Child-Pugh Class A, B, or C)
- The beneficiary requiring concomitant strong CYP3A inhibitors (e.g., ketoconazole, ritonavir), moderate CYP3A inhibitors (i.e., cyclosporine, verapamil) or strong CYP3A inducers (e.g., phenytoin, rifampin) should not be approved as coadministration is not recommended
- The prescriber must submit the following:
  - Current chart notes with transfusion history for the last 6 months
  - Current labs including complete blood count (CBC), liver function tests (LFTs), and iron to monitor for iron deficiency
  - Attestation that LFTs will be drawn every 4 weeks for the first 24 weeks of therapy and that therapy will be discontinued if the patient's labs increase significantly or the alanine aminotransferase is > 5 times upper limit of normal
  - Baseline patient-specific symptoms attributed to the anemia

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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RENEWAL REQUIREMENTS

- The beneficiary must be compliant on therapy (defined as 75% utilization)
- The beneficiary must have an improvement or stabilization in hemolytic anemia based on lab work and patient-specific symptoms
- The beneficiary has not developed hepatocellular injury or other severe adverse reaction
- Prescriber must submit the following:
  - Current chart notes
  - Current labs including complete blood count (CBC), liver function tests (LFTs), and iron to monitor for iron overload
  - Change in patient-specific symptoms since starting the medication

QUANTITY EDITS

- #62 tablets per 31 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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MITAPIVAT (PYRUKYND)

Updated 4/20/2022

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary must be ≥ 18 years of age; **AND**
- The beneficiary must have a confirmed diagnosis of pyruvate kinase (PK) deficiency with hemolytic anemia **or** a diagnosis consistent with FDA-approved indication or Compendia support; **AND**
- The beneficiary baseline hemoglobin should be ≤ 10 g/dL; **AND**
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Current labs, including baseline hemoglobin, LFTs; **AND**
  - Dose requested (initial dose should be 5 mg twice daily); **AND**
  - Test results for variants of the PKLR gene; **AND**
  - Previous treatment including transfusion frequency and RBC units required for baseline; **AND**
  - Medical necessity over other treatment options; **AND**
  - Attestation that prescriber has counseled the beneficiary on compliance importance and the requirement to taper if discontinuing

DENIAL CRITERIA

- The beneficiary does not meet approval criteria **or** have a diagnosis supported in the official Compendia; **OR**
- The prescriber is requesting a dose > 50 mg twice daily; **OR**
- The beneficiary has moderate or severe hepatic impairment; **OR**
- The beneficiary requires either a strong CYP3A inhibitor or strong CYP3A inducer and a dose modification may be needed for use with a moderate CYP3A inhibitor or moderate CYP3A inducer; **OR**
- The beneficiary has two non-missense variants; **OR**
- The beneficiary has seen no benefit by 24 weeks of therapy based on hemoglobin level or transfusion frequency

QUANTITY EDITS

#62 tablets per month of each strength

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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MYCOPHENOLATE SUSPENSION (CELLCEPT)

Updated 10/1/2018

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- < 7 years of age; **OR**
- NPO (Appendix A) within the last 365 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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MYCOPHENOLATE MOFETIL 200 MG/ML SUSPENSION (MYHIBBIN)

Updated 7/17/2024

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary has had an allogeneic kidney transplant, heart transplant or liver transplant **or** a diagnosis consistent with any new FDA-approved indications. Any off-label requests will be reviewed on a case-by-case basis.
- The beneficiary should not be approved with any of the following:
  - Doesn't meet the minimum age and dose per the package insert
  - Medical necessity over generic mycophenolate was not established
  - ≥ 7 years of age and no reason why the beneficiary could not use a solid oral dosage form
- The prescriber must submit the following:
  - Current chart notes with a medical reason for immunosuppressant
  - Current labs to monitor kidney function and watch for neutropenia
  - Medical necessity of MYHIBBIN over generic CELLCEPT suspension and solid oral formulations

RENEWAL REQUIREMENTS

- The beneficiary must remain compliant (defined as 75% utilization)
- The prescriber must submit the following:
  - Current chart notes
  - Continued need for suspension dosage form over solid oral form; **AND**
  - Current labs to monitor kidney function and watch for neutropenia

QUANTITY EDITS

3 bottles per 35 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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NARCOLEPSY AGENTS

Updated 10/1/2023

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

PREFERRED AGENTS THAT REQUIRE MANUAL REVIEW FOR PRIOR AUTHORIZATION

- armodafinil (generic for NUVIGIL)
- XYREM (sodium oxybate) – **brand only**

NON-PREFERRED AGENTS

- modafinil (generic for PROVIGIL)
- NUVIGIL (armodafinil)
- PROVIGIL (modafinil)
- sodium oxybate (generic for XYREM)
- SUNOSI (solriamfetol)
- WAKIX (pitolisant)
- XYWAV (calcium, magnesium, potassium, and sodium oxybates)

APPROVAL CRITERIA

All requests for non-FDA-approved diagnoses or for new indications without developed criteria will be reviewed on a case-by-case basis.

NARCOLEPSY

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with excessive sleepiness associated with narcolepsy. Diagnosis of narcolepsy is based on International Classification of Sleep Disorders (ICSD-3) or Diagnostic and Statistical Manual of Mental Disorders (DSM-5) criteria. Requests for any other diagnosis will be reviewed on a case-by-case basis.
- The beneficiary profile will be reviewed for medications or diagnoses that may be attributing to excessive daytime sleepiness besides narcolepsy
- The prescriber should submit the following for initial request for narcolepsy:
  - Most recent polysomnogram (PSG) results
  - Most recent multiple sleep latency test (MSLT) from morning after PSG with the following:
    - Mean sleep latency of less than 8 minutes per nap

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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        - Documented sleep onset rapid eye movement (SOREM) periods in more than 2 naps (one MSLT SOREM may be replaced by SOREM during PSG the night preceding MSLT)
    - Current chart notes
    - Baseline Epworth Sleepiness Scale (ESS)
- Requests for non-preferred medications require a documented trial and failure of CII and CIV stimulants in the last year with documentation of the medical necessity over the preferred medications.

OBSTRUCTIVE SLEEP APNEA (OSA)

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with excessive sleepiness associated with obstructive sleep apnea (OSA)
- The beneficiary profile will be reviewed for medications or diagnoses that may be attributing to excessive daytime sleepiness besides OSA
- The prescriber should submit the following for initial request for obstructive sleep apnea (OSA):
    - Most recent polysomnogram (PSG) results
    - Current chart notes
    - Documentation of plan for monitoring compliance of positive airway treatment; **AND**
    - CPAP or BiPAP usage report for documentation of compliance for at least 1 month
- Requests for non-preferred medications require a documented trial and failure of CII and CIV stimulants in the last year with documentation of the medical necessity over the preferred medications.
- PA renewal requires CPAP or BiPAP compliance

SHIFT WORK DISORDER (SWD)

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with excessive sleepiness associated with shift work disorder (SWD)
- The beneficiary profile will be reviewed for medications or diagnoses that may be attributing to excessive daytime sleepiness besides SWD
- The prescriber must submit the following for initial request for shift work disorder (SWD):
    - Most recent polysomnogram (PSG) results with sleep study performed during the beneficiary's normal sleep time

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- Most recent multiple sleep latency test (MSLT) performed during beneficiary's normal worktime
  - Mean sleep latency of less than 8 minutes per nap
  - Documented sleep onset rapid eye movement (SOREM) periods in more than 2 naps (one MSLT SOREM may be replaced by SOREM during PSG the night preceding MSLT)
- Current chart notes
- Baseline Epworth Sleepiness Scale (ESS); **AND**
- Current work schedule

NARCOLEPSY WITH CATAPLEXY

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with narcolepsy with cataplexy
- The beneficiary ages ≥ 7 years and < 19 years must have a trial of a CII stimulant in the last year
- The beneficiary ≥ 19 years must have both of the following unless contraindicated:
  - Trial and failure of CII stimulant in the last year
  - Trial and failure of a preferred CIV stimulant in the last year
- The prescriber must submit the following for initial request:
  - Most recent polysomnogram (PSG) results; **AND**
  - Most recent multiple sleep latency test (MSLT) from morning after PSG with the following:
    - Mean sleep latency of less than 8 minutes per nap; **AND**
    - Documented sleep onset rapid eye movement (SOREM) periods in more than 2 naps (one MSLT SOREM may be replaced by SOREM during PSG the night preceding MSLT)
  - Current labs, including LFTs
  - Current chart notes
  - Baseline Epworth Sleepiness Scale (ESS) Score for excessive daytime sleepiness associated with narcolepsy; **AND**
  - Baseline description of cataplexy events for beneficiaries with cataplexy diagnosis
- Requests for non-preferred medications for beneficiary ≥ 19 years of age require a documented trial and failure of CII and CIV stimulants in the last year with documentation of the medical necessity over the preferred medications.
- Requests for non-preferred medications for beneficiary ≥ 7 years of age and < 19 years of age require a documented trial and failure of CII in the last year with documentation of the medical necessity over the preferred medications.

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NAVEPEGRITIDE (YUVIWEL)

Updated 7/15/2026

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert
- The beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert, or dosing is based on support from the official Compendia
- The beneficiary must be diagnosed with achondroplasia (ACH) confirmed by both of the following:
  - Clinical presentation consistent with achondroplasia (e.g., proximal shortened arms and legs, macrocephaly, short fingers/toes) and radiographic findings (e.g., tubular bones, short pedicles on lateral spine, short femoral neck)
  - Genetic testing confirming the presence of fibroblast growth factor receptor 3 (FGFR3) gene variant
- The beneficiary must have open epiphyses
- YUVIWEL will not be approved for use concomitantly with vosoritide (VOXZOGO) or any growth hormone medication
- Must be prescribed by or in consultation with a specialist knowledgeable in treating achondroplasia (e.g., geneticist or endocrinologist)
- The beneficiary must not have moderate or severe renal impairment (eGFR < 60 mL/min/1.73 m^2)
- The prescriber must submit the following:
  - Current chart notes
  - Current height, weight, and growth velocity as baseline
  - Genetic test results and radiographic findings confirming the diagnosis
  - Requested dose
  - X-ray report demonstrating epiphyses status for patients 13-14 years of age or older

RENEWAL REQUIREMENTS

- The beneficiary must be compliant on therapy (defined as 75% utilization)
- The beneficiary demonstrates a positive clinical response with an increase in height or increase in annualized growth velocity compared to baseline after 1 year
- The prescriber must submit the following:
  - Current chart notes
  - Current standing height, weight, and growth velocity
  - Confirmation of open epiphyses for patients 13-14 years of age and older
  - Requested dose

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- Letter of medical necessity for continued approval

QUANTITY EDITS

4 kits per 28 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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NEDOSIRAN SODIUM (RIVFLOZA)

Updated 4/17/2024

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with primary hyperoxaluria type 1 (PH1) **or** a diagnosis consistent with any new FDA-approved indications. Any off-label requests will be reviewed on a case-by-case basis.
- PH1 must be confirmed by **one** of the following:
  - Molecular genetic testing confirming a mutation in the alanine-glyoxylate aminotransferase (AGXT) gene
  - Liver biopsy results demonstrated reduced alanine-glyoxylate aminotransferase (AGXT) activity
- The beneficiary must have relatively preserved kidney function (≥ 30 mL/min/1.73 m^2)
- The medication must be prescribed by or in consultation with a urologist or nephrologist
- The beneficiary has tried high dose pyridoxine and did not obtain an adequate response (defined as had < 30% reduction in urinary or plasma oxalate concentration)
- The beneficiary should not be approved or continue this therapy with any of the following:
  - eGFR < 30 mL/min/1.73 m^2
  - Prescribed concomitant lumasiran (OXLUMO)
  - Does not have genetic testing confirming a mutation in the AGXT gene or liver biopsy confirming reduced AGXT activity
  - Dose is not consistent with weight-based dosing in the package insert
  - Moderate or severe hepatic impairment; **AND**
  - Diagnosed with any other primary hyperoxaluria type besides PH1
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of previous therapies tried
  - Current labs, including eGFR, urinary or plasma oxalate levels
  - Genetic testing results confirming a mutation in the AGXT gene or liver biopsy results; **AND**
  - Current weight and dose requested

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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RENEWAL REQUIREMENTS

- The beneficiary must have reduced urinary or plasma oxalate levels
- The beneficiary continues to have stable kidney function (continues to meet approval criteria)
- The prescriber must submit the following:
  - Current chart notes
  - Current labs, including eGFR, urinary or plasma oxalate levels; **AND**
  - Current weight and dose requested

QUANTITY EDITS

- 80 mg (0.5 mL) single-dose vial – 2 vials per month (for beneficiaries 9–11 years of age weighing less than 50 kg)
- 128 mg (0.8 mL) single-dose pre-filled syringe – 1 syringe per month

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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NEOMYCIN 0.5%/FLUOCINOLONE 0.025% CREAM (NEO-SYNALAR)

Updated 1/15/2025

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must have a diagnosis of corticosteroid-responsive dermatoses with secondary infection
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Letter of medical necessity for the use of NEO-SYNALAR over other treatment options available without prior authorization

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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NEUROPATHIC PAIN AGENTS

Updated 1/1/2026

PREFERRED AGENTS

- duloxetine 20 mg, 30 mg, and 60 mg capsule (generic for CYMBALTA)
- gabapentin capsule and tablet (generic for NEURONTIN)
- pregabalin capsule (generic for LYRICA)

PREFERRED AGENT WITH CRITERIA

- gabapentin solution (generic for NEURONTIN)
  - **Note**: Payable at Point of Sale (POS) for beneficiaries < 7 years of age or who have a diagnosis of NPO (Appendix A) in history

NON-PREFERRED AGENTS

- CYMBALTA (duloxetine)
- DRIZALMA (duloxetine)
- duloxetine 40 mg DR capsule (generic for INREKA DR)
- duloxetine 80 mg, 90 mg, and 120 mg DR capsule
- gabapentin 200 mg capsule (generic for RELGAABI)
- gabapentin ER (generic for GRALISE)
- GABARONE (gabapentin)
- GRALISE (gabapentin ER)
- HORIZANT (gabapentin ER)
- LYRICA (pregabalin)
- LYRICA CR (pregabalin ER)
- milnacipran (generic for SAVELLA)
- NEURONTIN (gabapentin)
- pregabalin solution (generic for LYRICA)
- pregabalin ER (generic for LYRICA CR)
- RELGAABI (gabapentin)
- SAVELLA (milnacipran) (see criteria for SAVELLA) **brand preferred over generic when approved**
- ZTLIDO (lidocaine)

NON-PREFERRED AGENTS WITH CRITERIA

lidocaine patch (generic for LIDODERM)

APPROVAL CRITERIA FOR GENERIC LIDODERM PATCH

PA review and Point-of-Sale (POS) edit

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- Submitted diagnosis post-herpetic neuralgia (ICD-10 codes: B0222 POSTHERPETIC TRIGEMINAL NEURALGIA and B0223 POSTHERPETIC POLYNEUROPATHY) within the past 12 months; **OR**
- Paid claim in history identifying appropriate antiviral medication (see **Antivirals** table below) for post- herpetic neuralgia within the past 30 days

Antivirals
acyclovir 200 mg
acyclovir 400 mg
acyclovir 800 mg
famciclovir 125 mg
famciclovir 250 mg
famciclovir 500 mg
valacyclovir 500 mg caplet
valacyclovir 1 g caplet

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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NIFURTIMOX (LAMPIT)

Updated 1/15/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must be a pediatric beneficiary less than 18 years of age diagnosed with Chagas disease (American trypanosomiasis) caused by Trypanosoma cruzi **or** a diagnosis consistent with any new FDA-approved indications or support in the official Compendia. Any off-label requests will be reviewed on a case-by-case basis.
- The beneficiary should not be approved or continue this therapy with any of the following:
  - Diagnosed with other treatment subgroups outside for the FDA-approved indication; **AND**
  - Dose or duration of therapy that exceeds FDA-approved dose and duration
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - The prescriber must submit current weight. Weight-based dose will be calculated and monthly quantity entered at the time the PA is approved
- Length of PA does not not exceed 60 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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NIMODIPINE SOLUTION (NYMALIZE)

Updated 1/15/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must be diagnosed with subarachnoid hemorrhage (SAH), and this medication must be ordered to help with improvement of neurological outcome by reducing the incidence and severity of ischemic deficits
- The prescriber must submit the following:
  - Current chart notes
  - Baseline blood pressure; **AND**
  - Letter of medical necessity over preferred dihydropyridine agents and nimodipine oral capsules

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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NITISINONE CAPSULE/SUSPENSION (ORFADIN)

Updated 1/15/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must be diagnosed with hereditary tyrosinemia type 1 (HT-1) and must take this medication in combination with dietary restrictions of tyrosine and phenylalanine.
- The prescriber must submit the following:
  - Current chart notes
  - Attestation that the beneficiary follows dietary restrictions of tyrosine and phenylalanine; **AND**
  - Current labs, including CBC, platelets, and serum tyrosine (goal plasma tyrosine levels below 500 micromol/L)

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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NITISINONE TABLET (HARLIKU)

Updated 10/15/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with alkaptonuria and have increased urine homogentisic acid (HGA) excretion (> 0.4 g/24 hr)
- The prescriber must submit the following:
  - Current chart notes
  - Current labs, including CBC to check for leukopenia and thrombocytopenia
  - Baseline urine HGA level; **AND**
  - Baseline beneficiary specific symptoms
- Initial approvals will be for 90 days

RENEWAL REQUIREMENTS

- The beneficiary has been compliant with therapy (defined as 75% utilization)
- The beneficiary has documented improvement with a decrease in urine homogentisic acid (HGA) excretion compared to baseline
- The beneficiary who develops keratopathies during treatment will need plasma tyrosine levels monitored and implement a diet restricted in tyrosine and phenylalanine
- The prescriber must submit the following:
  - Current chart notes
  - Current labs, including CBC to check for leukopenia and thrombocytopenia
  - Documentation if beneficiary has keratopathy development and plasma tyrosine levels if beneficiary does develop keratopathies. The goal is to reach tyrosine levels < 500 micromol/L; **AND**
  - Current beneficiary specific symptoms

QUANTITY EDITS

#31 tablets per 31 days

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NITROFURANTOIN SUSPENSION (FURADANTIN)

Updated 10/11/2011

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- < 7 years of age; **OR**
- NPO (Appendix A) within the past 365 days.

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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NITROGLYCERIN 0.4% RECTAL OINTMENT (RECTIV)

Updated 1/15/2025

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must be diagnosed with moderate to severe pain associated with chronic anal fissure
- Treatment prescribed longer than 3 weeks will not be approved
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Letter of medical necessity over other topical anesthetics available without prior authorization (e.g., lidocaine ointment, lidocaine-prilocaine cream)

QUANTITY EDITS

#1 tube every 60 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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OBETICHOLIC ACID (OCALIVA)

Updated 1/15/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must be diagnosed with primary biliary cholangitis (PBC) confirmed by **two** of the following:
  - An alkaline phosphatase (ALP) level of at least 1.67 times the ULN
  - Presence of antimitochondrial antibodies (AMA) at a titer of 1:40 or higher; **OR**
  - Histologic evidence of PBC (nonsuppurative destructive cholangitis and destruction of interlobular bile ducts)
- The medication must be prescribed by or in consultation with a hepatologist or gastroenterologist
- The beneficiary must have had an inadequate response to ursodeoxycholic acid (UDCA) without improvement in LFTs and documented PBC related symptoms after a 1-year trial or the beneficiary must demonstrate intolerance to UDCA (e.g., Ursodiol)
- The beneficiary with an inadequate response to UDCA alone must take OCALIVA concomitantly with UDCA unless intolerant to UDCA
- The beneficiary should not be approved or continue this therapy with any of the following:
  - Decompensated cirrhosis (e.g., ascites, variceal bleeding, hepatic encephalopathy)
  - Pregnancy; **AND**
  - Complete biliary obstruction
- The prescriber must submit the following:
  - Current chart notes with beneficiary's specific symptoms
  - Documentation of previous therapies tried with response
  - Baseline description of muscle pain or myopathy (evaluate periodically for new onset or worsening muscle pain, myopathy, or rhabdomyolysis)
  - Labs including liver function tests with baseline alkaline phosphatase
  - Current treatment plan; **AND**
  - Medical necessity over UDCA taken as monotherapy

RENEWAL REQUIREMENTS

- The beneficiary must remain compliant with therapy (defined as 75% utilization)
- The beneficiary must demonstrate a positive response to OCALIVA with an improvement in symptoms and corresponding labs while experiencing no intolerable side effects
- The beneficiary must remain on ursodeoxycholic acid (UDCA) concomitantly unless there are tolerability issues

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- The prescriber must submit the following:
  - Current chart notes
  - Documentation of response to therapy with summary of current symptoms
  - Current labs, including liver function tests with alkaline phosphatase; **AND**
  - Description of muscle pain or myopathy

QUANTITY EDITS

#30 tablets per 30 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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OCTREOTIDE AND RELATED PRODUCTS

Updated 7/1/2026

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

PREFERRED AGENTS WITH CRITERIA

- octreotide acetate syringe (generic for SANDOSTATIN) (see criteria for octreotide)
- SANDOSTATIN LAR DEPOT (octreotide) – **brand only** (see criteria for SANDOSTATIN LAR)

NON-PREFERRED AGENTS

- BYNFEZIA (octreotide) (see criteria for BYNFEZIA)
- lanreotide acetate (generic for SOMATULINE DEPOT) (see criteria for lanreotide)
- MYCAPSSA (octreotide) (see criteria for MYCAPSSA)
- octreotide acetate ampule and vial (generic for SANDOSTATIN)
- octreotide ER (generic for SANDOSTATIN LAR DEPOT)
- PALSONIFY (paltusotine) (see criteria for PALSONIFY)
- SANDOSTATIN (octreotide)
- SIGNIFOR (pasireotide) (see criteria for SIGNIFOR)
- SOMATULINE DEPOT (lanreotide) (see criteria for SOMATULINE)
- SOMAVERT (pegvisomant) (see criteria for SOMAVERT)

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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OCTREOTIDE (MYCAPSSA)

Updated 7/1/2026

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary is diagnosed with acromegaly and has responded to and tolerated treatment with octreotide or lanreotide
- The beneficiary has elevated insulin-like growth factor-1 (IGF-1) levels for age and/or gender
- The medication must be prescribed by or in consultation with an endocrinologist or oncologist
- The beneficiary should not be approved or continue this therapy with any of the following:
  - Has not tried either octreotide or lanreotide injections; **OR**
  - Has end stage renal disease (must start at 20 mg daily)
- The prescriber must submit the following:
  - Current chart notes
  - Previous therapies tried
  - Baseline IGF-1 level
  - Documentation that beneficiary has had an inadequate response to surgery or is not a candidate for surgery; **AND**
  - Letter of medical necessity with clinically significant reason the beneficiary cannot continue their current injectable medication or start therapy on a preferred product

RENEWAL REQUIREMENTS

- The beneficiary has been compliant with therapy (defined as 75% utilization)
- The beneficiary has a positive response to treatment similar to the injection somatostatin product with decrease or normalized IGF-1 level
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Current IGF-1 level

QUANTITY EDITS

#120 capsules per 30 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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OCTREOTIDE ACETATE IR/LAR (SANDOSTATIN IR/LAR AND BYNFEZIA)

Updated 7/1/2026

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

Available as a pharmacy and medical claim

- **J2353 for SANDOSTATIN LAR Depot/octreotide ER vial**
- **J2354 for octreotide ampule, vial, syringe, SANDOSTATIN ampule, or BYNFEZIA pen**

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must be diagnosed with **one** of the following:
  - Acromegaly confirmed by elevated IGFF-1 and inadequate suppression of growth hormone (GH) after a glucose load with an inadequate response to surgery and/or radiotherapy, or for whom surgery and/or radiotherapy, is not an option.
  - Severe diarrhea and flushing episodes associated with metastatic carcinoid/neuroendocrine tumors; **OR**
  - Profuse watery diarrhea associated with vasoactive intestinal peptide tumors (VIPomas)
- The medication must be prescribed by or in consultation with an endocrinologist, oncologist, hematologist, or palliative care specialist
- The beneficiary should not be approved or continue this therapy with any of the following:
  - Developing complications of cholelithiasis; **AND**
  - If request is for the LAR Depot and has not tried regular octreotide injection to ensure tolerability
- The prescriber must submit the following:
  - Current chart notes with documentation of diagnosis
  - Previous therapies tried with response
  - If the beneficiary has no prior surgery or radiation, provide rationale for requesting in acromegaly beneficiaries; **AND**
  - Baseline labs – Monitor the following at baseline and throughout treatment:
    - Acromegaly: Growth Hormone, IGF-1 (somatomedin C)
    - Carcinoid: 5-HIAA (urinary 5-hydroxyindole acetic acid), plasma serotonin, plasma Substance P
    - VIPoma: VIP (plasma vasoactive intestinal peptide) baseline and periodic total and/or free T4 measurements should be performed during chronic therapy; **AND**
    - Additional monitoring – blood glucose, TSH, total and/or free T4, vitamin B12, zinc

RENEWAL REQUIREMENTS

- The beneficiary must be compliant with therapy (defined as 75% utilization)

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- The beneficiary must demonstrate a positive response to treatment with an improvement in symptoms, including reduction in symptomatic episodes (e.g., diarrhea, rapid gastric dumping, flushing, bleeding, etc.), stabilization of glucose levels, or decrease in size of tumor or tumor spread
- The beneficiary must have an absence of unacceptable toxicity from the drug (e.g., biliary tract abnormalities, hypothyroidism, goiter, sinus bradycardia, cardiac arrhythmias, cardiac conduction abnormalities, pancreatitis, etc.)
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Provide current labs as listed below:
    - Acromegaly: Growth Hormone, IGF-1 (somatomedin C)
    - Carcinoid: 5-HIAA (urinary 5-hydroxyindole acetic acid), plasma serotonin, plasma Substance P
    - VIPoma: VIP (plasma vasoactive intestinal peptide) baseline and periodic total and/or free T4 measurements should be performed during chronic therapy; **AND**
    - Additional monitoring – blood glucose, TSH, total and/or free T4, vitamin B12, zinc

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ODEVIXIBAT (BYLVAY)

Updated 10/20/2021

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary must be ≥ 3 months of age; **AND**
- The beneficiary must have a confirmed diagnosis of progressive familial intrahepatic cholestasis (PFIC) with a baseline presence of pruritus **or** a diagnosis consistent with FDA indication; **AND**
- The beneficiary has elevated serum bile acid concentration; **AND**
- The beneficiary has documented failure of ursodeoxycholic acid (URSODIOL) **and** cholestyramine unless there is a documented contraindication; **AND**
- The beneficiary should continue ursodeoxycholic acid concomitantly; **AND**
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Current labs, including serum bile acids, serum levels of vitamins A, D, E, and INR (for vitamin K) and LFTs; **AND**
  - Genetic testing results with PFIC type and presence or absence of the ABCB11 variant
- Initial approval for 3 months

DENIAL CRITERIA

- The beneficiary does not meet approval criteria **or** have a diagnosis supported on the official Compendia; **OR**
- The beneficiary has PFIC type 2 with ABCB11 variants resulting in non-functional or complete absence of bile salt export pump protein (BSEP-3); **OR**
- The beneficiary has decompensated liver disease; **OR**
- The beneficiary should discontinue BYLVAY if continued pruritis or has no decrease in serum bile acid after trial with maximum dose of 120 mcg/kg per day; **OR**
- The beneficiary is not concurrently ordered ursodeoxycholic acid

QUANTITY EDITS

- 200 mcg pellet – #62 per 31 days
- 600 mcg pellet – #31 per 31 days
- 400 mcg capsule – #155 per 31 days
- 1,200 mcg capsule – #155 per 31 days

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OMADACYCLINE (NUZYRA)

Updated 7/17/2019

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary is > 18 years of age
- The beneficiary has a diagnosis of: Community-Acquired Bacterial Pneumonia (CABP) **or** Acute Bacterial Skin and Skin Structure Infections (ABSSSI)
- The prescriber should provide culture and susceptibility reports if available
- The prescriber must provide explanation of medical necessity for use of this antibiotic over a different agent that does not require prior authorization
- The prescriber must submit documentation of loading dose of IV infusion or loading dose of oral tablets the beneficiary received

DENIAL CRITERIA

- No diagnosis of CABP or ABSSSI with an organism listed in the approval criteria
- Age < 18 years
- Tetracycline allergy
- Susceptibility report shows organism is resistant
- Female beneficiary is in 2nd or 3rd trimester of pregnancy or breastfeeding
- Known or suspected healthcare associated infection
- Request is for greater than 14 days of therapy

QUANTITY LIMITS

- Quantity limit for either tablets or vials for length of therapy (7 to 14 days) will be entered at the time of the PA approval
- Length of therapy will not exceed 14 days

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OMAVELOXOLONE (SKYCLARYS)

Updated 10/18/2023

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with Friedreich's ataxia confirmed by detection of a mutation of the FXN gene **or** a diagnosis consistent with any new FDA-approved indications. Any off-label requests will be reviewed on a case-by-case basis.
- The beneficiary must exhibit clinical symptoms consistent with Friedreich's ataxia (e.g., muscle weakness, decline in coordination, frequent falling)
- SKYCLARYS is prescribed by a neurologist
- The beneficiary should not be approved or continue on this therapy with any of the following:
  - Severe hepatic impairment (Child-Pugh C); dosage adjustment for moderate hepatic impairment (Child-Pugh B)
  - Require treatment with a strong or moderate CYP3A4 inducer
  - Require treatment with a strong or moderate CYP3A4 inhibitor (may use concomitantly with a dose adjustment)
  - Consider discontinuation with signs and symptoms of fluid overload and/or heart failure; **OR**
  - B-type Natriuretic Peptide (BNP) > 200 pg/mL
- The prescriber must submit **all** of the following:
  - Current chart notes
  - Current labs, including ALT, AST, bilirubin, B-type Natriuretic Peptide (BNP), and lipid parameters prior to initiating therapy (ALT, AST, bilirubin monthly for the first 3 months)
  - Specific symptoms associated with Friedreich's ataxia for this beneficiary as a baseline with a description concerning bulbar function, upper limb coordination, lower limb coordination, and upright stability; **AND**
  - Genetic test results confirming the diagnosis

RENEWAL REQUIREMENTS

- The prescriber must submit the following:
  - Current chart notes with documentation of current clinical presentation
  - Current labs (monitor every 3 months) including ALT, AST, and bilirubin

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- The beneficiary must demonstrate a reduction in rate of disease progression or stabilization in clinical presentation compared to baseline; **AND**
- The beneficiary must continue to meet approval criteria

QUANTITY EDITS

90 capsules per 30 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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OMEPRAZOLE, AMOXICILLIN, AND CLARITHROMYCIN (OMECLAMOX-PAK)

Updated 05/21/2012

APPROVAL CRITERIA

Criteria 1:

- No history of lansoprazole, amoxicillin, and clarithromycin combination (PREVPAC) in the last 365 days; **AND**
- No history of omeprazole, amoxicillin, and clarithromycin combination (OMECLAMOX-PAK) in the last 365 days; **AND**
- No concurrent proton pump inhibitor therapy within the past 30 days.

Criterion 2:

- No history of metronidazole/tetracycline/bismuth combination (PYLERA) in the last 365 days.

DENIAL CRITERIA

Criteria 1:

- History of lansoprazole, amoxicillin, and clarithromycin combination (PREVPAC) in the last 365 days; **OR**
- Current proton pump inhibitor therapy has been given within the past 30 days.

Criteria 2:

- No history of omeprazole, amoxicillin, and clarithromycin combination (OMECLAMOX-PAK) in the last 365 days; **AND**
- No concurrent proton pump inhibitor therapy within the past 30 days.

Criterion 3:

- No history of metronidazole, tetracycline, and bismuth combination (PYLERA) in the last 365 days.

ADDITIONAL CRITERIA

Quantity limits apply

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ONCOLOGY, ORAL (ARIMIDEX, FEMARA, GOMEKLI, KOSELUGO, REZUROCK, TURALIO)

Updated 4/17/2024

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

Information concerning oral Oncology Medications (not limited to just the medications listed above) may be found at these links:

- **Oncology Drug Management Policy**: https://ar.primetherapeutics.com/documents/d/arkansas/oncology_policy_04172024
- **Prior Authorization Criteria for Select Oncology Medications**: prior-authorization-criteria-for-select-oncology-medications-05172024
- **Oncology Prior Authorization Form**: https://ar.primetherapeutics.com/documents/d/arkansas/ar_oncology_medication_pa_form-2

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OPHTHALMICS – ALLERGIC CONJUNCTIVITIS AGENTS

Updated 7/1/2025

PREFERRED AGENTS

- azelastine 0.05% eye drops (generic for OPTIVAR)
- cromolyn sodium 4% eye drops (generic for OPTICROM)
- ketotifen fumarate 0.025% eye drops (generic for ALAWAY/ZADITOR)
- olopatadine HCl 0.1% eye drops (generic for PATANOL) – **HCFA termed**
- olopatadine HCl 0.2% eye drops (generic for PATADAY) RX only

NON-PREFERRED AGENTS

- ALAWAY (ketotifen fumarate)
- ALREX (loteprednol)
- bepotastine (generic for BEPREVE)
- BEPREVE (bepotastine besilate)
- epinastine (generic for ELESTAT)
- loteprednol etabonate (generic for ALREX)
- PATADAY (olopatadine)
- ZERVIATE (cetirizine)
- ZADITOR (ketotifen fumarate)

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OPHTHALMICS – ANTIBIOTIC DROPS

Updated 10/1/2026

PREFERRED AGENTS

- bacitracin/polymyxin B ophthalmic ointment (generic for POLYCIN)
- CILOXAN (ciprofloxacin)
- ciprofloxacin 0.3% ophthalmic solution (generic for CILOXAN)
- erythromycin 0.5% ophthalmic ointment (generic for ILOTYCIN)
- gentamicin 0.3% ophthalmic solution (generic for GARAMYCIN)
- moxifloxacin 0.5% ophthalmic solution (generic for VIGAMOX)
- polymyxin B/trimethoprim ophthalmic solution (generic for POLYTRIM)
- tobramycin 0.3% ophthalmic solution (generic for TOBREX)

NON-PREFERRED AGENTS

- AZASITE (azithromycin)
- bacitracin ophthalmic ointment
- besifloxacin (generic for BESIVANCE)
- BESIVANCE (besifloxacin) – **brand preferred over generic when approved**
- gatifloxacin (generic for ZYMAXID)
- levofloxacin ophthalmic drops (generic for QUIXIN)
- moxifloxacin 0.5% ophthalmic solution (generic for MOXEZA)
- NATACYN (natamycin) – **may be approved upon request after receiving documentation/attestation of fungal infection of the eye**
- NEO-POLYCIN (neomycin/bacitracin/polymyxin B)
- neomycin/polymyxin B/bacitracin ophthalmic ointment
- neomycin/polymyxin B/gramicidin ophthalmic solution
- OCUFLOX (ofloxacin)
- ofloxacin 0.3% ophthalmic solution (generic for OCUFLOX)
- POLYCIN (bacitracin/polymyxin B) – **manufacturer obsolete 12/26/2025**
- sulfacetamide 10% ophthalmic drops
- sulfacetamide 10% ophthalmic ointment
- TOBREX (tobramycin)
- VIGAMOX (moxifloxacin)

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OPHTHALMICS – ANTIBIOTIC-STEROID COMBINATION DROPS

Updated 7/1/2025

PREFERRED AGENTS

- neomycin sulfate/polymyxin B/dexamethasone eye ointment (generic for MAXITROL)
- neomycin sulfate/polymyxin B/dexamethasone 0.1% eye suspension (generic for MAXITROL)
- sulfacetamide sodium 10%/prednisolone sodium phosphate 0.23% eye solution
- TOBRADEX eye ointment (tobramycin 0.3%-dexamethasone 0.1%)
- tobramycin 0.3%/dexamethasone 0.1% eye suspension (generic for TOBRADEX)

NON-PREFERRED AGENTS

- MAXITROL (neomycin/polymyxin B/dexamethasone)
- neomycin sulfate/polymyxin B/bacitracin/hydrocortisone eye ointment (generic for CORTISPORIN)
- neomycin/polymyxin B/hydrocortisone eye suspension (generic for CORTISPORIN)
- TOBRADEX ST (tobramycin/dexamethasone)
- tobramycin/loteprednol (generic for ZYLET)
- ZYLET (tobramycin/loteprednol)– **brand preferred over generic when approved**

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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OPHTHALMICS – ANTI-INFLAMMATORY DROPS

Updated 7/1/2025

PREFERRED AGENTS

- bromfenac 0.09% eye drops (generic for BROMDAY)
- dexamethasone sodium phosphate eye drops (generic for DECADRON)
- diclofenac eye drops (generic for VOLTAREN)
- fluorometholone eye suspension drops (generic for FML LIQUIFILM)
- flurbiprofen eye drops (generic for OCUFEN)
- FML FORTE (fluorometholone)
- ketorolac 0.5% eye drops (generic for ACULAR)
- prednisolone acetate susp eye drops (generic for PRED FORTE)
- prednisolone sodium eye drops (generic for AK-PRED)

NON-PREFERRED AGENTS

- ACULAR/ACULAR LS (ketorolac)
- ACUVAIL (ketorolac)
- bromfenac 0.07% (generic for PROLENSA)
- bromfenac 0.075% (generic for BROMSITE)
- BROMSITE (bromfenac)
- BYQLOVI (clobetasol)
- difluprednate (generic for DUREZOL)
- DUREZOL (difluprednate)
- FLAREX (fluorometholone)
- FML (fluorometholone)
- ILEVRO (nepafenac)
- INVELTYS (loteprednol)
- ketorolac 0.4% (generic for ACULAR LS)
- LOTEMAX/LOTEMAX SM (loteprednol)
- loteprednol etabonate (generic for LOTEMAX)
- MAXIDEX (dexamethasone)
- NEVANAC (nepafenac)
- PRED FORTE (prednisolone)
- Pred MILD (prednisolone)
- PROLENSA (bromfenac)

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OPHTHALMICS, DRY EYE AGENTS

Updated 10/1/2025

PREFERRED AGENTS WITH CRITERIA

RESTASIS 0.05% single dose emulsion vial (cyclosporine) – **brand only**

NON-PREFERRED AGENTS

- CEQUA (cyclosporine)
- cyclosporine 0.05% emulsion (generic for RESTASIS)
- EYSUVIS (loteprednol etabonate)
- MIEBO (perfluorohexyloctane drops)
- RESTASIS multidose (cyclosporine)
- TRYPTYR (acoltremon)
- TYRVAYA (varenicline tartrate)
- VERKAZIA (cyclosporine)
- VEVYE (cyclosporine)
- XIIDRA (lifitegrast)

APPROVAL CRITERIA FOR PREFERRED AGENTS WITH CRITERIA

- Diagnosis of **one** of the following diagnoses associated with dry eye in the past two years:
  - Keratoconjunctivitis sicca, non-Sjogren's syndrome
  - Keratoconjunctivitis sicca, Sjogren's syndrome
  - Keratoconjunctivitis, exposure
  - Tear film insufficiency, unspecified (dry eye syndrome); **OR**
  - Xerosis

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OPICAPONE (ONGENTYS)

Updated 1/20/2021

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary must be ≥ 18 years of age; **AND**
- The beneficiary must have a diagnosis of Parkinson's Disease for at least 3 years and experiencing "off" episodes while compliant on levodopa/carbidopa **or** a diagnosis consistent with FDA indications; **AND**
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Current labs, including LFTs and renal function; **AND**
- The beneficiary should be in Parkinson's Disease stages 2 to 4 in the "off" state in the modified Hoehn and Yahr Scale; **AND**
- The beneficiary must be on levodopa/carbidopa for at least one year with a stable dose at least 4 weeks prior to starting ONGENTYS; **AND**
- The beneficiary must be taking at least 3 doses of levodopa per day; **AND**
- The beneficiary must take ONGENTYS in combination with levodopa/carbidopa; **AND**
- The beneficiary must be experiencing at least 2 hours of "off time" per day excluding in the morning prior to first dose of the day; **AND**
- If taking other PD medications along with levodopa/carbidopa, beneficiary must be on a stable dose for at least 4 weeks prior to starting ONGENTYS (e.g., COMT inhibitors, MAO-B inhibitors, anticholinergics, and/or amantadine); **AND**
- The prescriber must provide the medical necessity over the increase in levodopa/carbidopa dose, changing to extended-release formulations, and changing to Stalevo/entacapone or levodopa/carbidopa.

DENIAL CRITERIA

- The beneficiary does not meet approval criteria **or** have a diagnosis supported in the official Compendia; **OR**
- The beneficiary is diagnosed with severe hepatic impairment (Child-Pugh C); **OR**
- The beneficiary is diagnosed with end stage renal disease; **OR**
- The beneficiary has a history of pheochromocytoma, paraganglioma, or other catecholamine secreting neoplasms; **OR**
- The beneficiary takes concomitant non-selective monoamine oxidase (MAO) inhibitors; **OR**
- The beneficiary is diagnosed with a major psychotic disorder in the last year (i.e., major depressive disorder, bipolar, psychosis, generalized anxiety disorder); **OR**

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- The beneficiary has < 2 hours a day of “off time”; **OR**
- The beneficiary has a diagnosis of atypical parkinsonism or secondary parkinsonism variants; **OR**
- The beneficiary is pregnant or breastfeeding.

QUANTITY EDITS

30 capsules per 30 days

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OPIOIDS, LONG-ACTING

Updated 7/1/2025

PREFERRED AGENTS WITH CRITERIA

- BUTRANS (buprenorphine) – **brand only**
- morphine sulfate ER tablet (generic for MS CONTIN)
- tramadol ER tablet (generic for ULTRAM ER)

NON-PREFERRED AGENTS WITH CRITERIA

- BELBUCA (buprenorphine)
- buprenorphine patch (generic for BUTRANS)
- fentanyl patch (generic for DURAGESIC)
- hydrocodone ER (generic for ZOHYDRO ER/HYSINGLA ER)
- hydromorphone ER (generic for EXALGO ER)
- methadone intensol concentrate (generic for METHADOSE)
- methadone solution
- methadone tablet (generic for DOLOPHINE)
- morphine sulfate ER capsule (generic for AVINZA/KADIAN)
- oxycodone ER (generic for OXYCONTIN)
- OXYCONTIN (oxycodone)
- oxymorphone ER (generic for OPANA ER)
- tapentadol ER (generic for NUCYNTA ER)
- tramadol ER capsule (generic for CONZIP)
- tramadol ER tablet (generic for RYZOLT)

NON-PREFERRED AGENTS WITHOUT CRITERIA

- CONZIP (tramadol ER)
- HYSINGLA ER (hydrocodone ER)
- METHADOSE (methadone)
- MS CONTIN (morphine sulfate)

APPROVAL CRITERIA

Note: Requests for non-preferred, multi-source brand medications will still need to meet Brand Medically Necessary criteria in addition to the criteria below.

- The beneficiary is established on a long-acting opioid (LAO), defined as use in the last 60 days; **AND**
  - Routine PDL Criteria; **OR**
- The beneficiary is established on chronic, daily use of a short-acting opioid (SAO); **AND**

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- The SAO will be discontinued or decreased upon starting the LAO; **AND**
- The total daily MME will be reduced upon starting the LAO to account for incomplete opioid cross-tolerance; **AND**
- Medical necessity of using a long-acting opiate for chronic, non-cancer pain; **AND**
- Routine PDL Criteria are met; **OR**

- If the beneficiary is not established on a long-acting or short-acting opioid meeting the criteria above, then **one** of the following:
  - The beneficiary has diagnosis of malignant cancer in the last 365 days; **OR**
  - For all **except methadone**, the beneficiary currently resides in long-term care; **OR**
  - For **fentanyl patches only**, the beneficiary meets NPO (Appendix A) criteria; **AND**
- The beneficiary does not have a history of SUBOXONE or SUBUTEX in the past 90 days (*State Review Required if not met*); **AND**
- For all other diagnoses other than cancer, none of the following apply:
  - 90 cumulative MME across all opioids filled in the previous 30 days, including the incoming claim
  - Two or more claims for Narcan/naloxone in the past 90 days (*State Review Required if not met*)
  - A diagnosis for poisoning or overdose for opioids, narcotics, barbiturates, benzodiazepines, or unspecified drug or substance in the last 365 days (*State Review Required if not met*)
- Length of authorization is 6 months.

METHADONE ORAL SOLUTION

- The beneficiary is less than or equal to 90 days of age; **AND**
- The beneficiary has a diagnosis of neonatal abstinence syndrome; **AND**
- The quantity of methadone oral solution dispensed is not more than 10 mL; **AND**
- The accumulated methadone oral solution quantity between the incoming claim and any other claims within the previous 30 days do not equal more than 10 mL total; **OR**
- The prescriber provides medical necessity, quantity requested, dose, and taper plan schedule.
- Length of authorization is 1 month for methadone oral solution.

Note: Routine PDL Criteria do not apply.

THERAPEUTIC DUPLICATION

No therapeutic duplication in drug history between long-acting narcotics

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OPIOIDS, SHORT-ACTING

Updated 7/1/2025

APPROVAL CRITERIA

- Accumulation quantity limit will allow up to a maximum of 93 units of any solid oral short acting opioid paid by Medicaid per the previous 31 calendar days. ****Additional information listed under Exemptions****
- No drug claim in the past 90 days for SUBUTEX; **OR**
- No drug claim in the past 90 days for SUBOXONE; **AND**
- Therapeutic duplication between short-acting opioids with less than 25% of the days' supply remaining on the previous claim; **OR**
- Therapeutic duplication between a short-acting opioid and tramadol IR (ULTRAM) with less than 25% of the days' supply remaining on the previous claim; **OR**
- Therapeutic duplication between a short-acting opioid and tramadol/acetaminophen (ULTRACET) with less than 25% of the days' supply remaining on the previous claim
- Therapeutic duplication between a short-acting opioid and tramadol ODT (RYBIX) with less than 25% of the days' supply remaining on the previous claim

****Additional information listed under Exemptions****

DENIAL CRITERIA

- Therapeutic duplication between two short-acting opioids with more than 25% of the days' supply remaining on previous claim
- Therapeutic duplication between a short-acting opioid and tramadol (UTRAM and ULTRACET) with more than 25% of the days' supply remaining on previous claim
- Therapeutic duplication between a short-acting opioid and tramadol ODT (RYBIX) with more than 25% of the days' supply remaining on previous claim
- Drug claim in history for SUBUTEX
- Drug claim in history for SUBOXONE
- Solid oral dosage forms for short-acting opioids will be rejected for children less than 6 years of age.
- Greater than 93 units of any solid oral short acting opioid paid by Medicaid per the previous 31 calendar days.
- An incoming claim for any opioid pain medication will trigger a search of the beneficiary's Medicaid medical diagnoses history for diagnosis of poisoning or overdose the previous 12 months.
- If a diagnosis for **poisoning (overdose) for opioids, narcotics, barbiturates, benzodiazepines, or "unspecified drug or substance"** is found in the Medicaid medical history in the previous 12 months, an incoming claim for an opioid pain medication or an incoming claim for a benzodiazepine medication will deny at point of sale.

****Additional information listed under Exemptions****

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EXEMPTIONS

- Beneficiaries who have had a diagnosis of malignant cancer in the past 12 months:
  - Are exempt from the therapeutic duplication requirement.
  - Are exempt from the diagnosis check for a poisoning (overdose) of opioids, narcotics, barbiturates, benzodiazepines, or unspecified drug or substance; **AND**
  - Accumulation quantity limit will allow up to a maximum of 124 units of any solid oral short acting opioid paid by Medicaid per the previous 31 calendar days.

PREFERRED STATUS ONLY FOR STRENGTHS NOTED

Quantity edits, MME edits, accumulation edits, and refill too soon edits apply.

- acetaminophen/codeine oral solution 473 ml bottle
- acetaminophen/codeine tablet
- codeine tablet
- hydrocodone/acetaminophen 7.5/325 mg per 15 mL oral solution (generic for HYCET)
- hydrocodone/acetaminophen 5 mg/325 mg, 7.5 mg/325 mg, and 10 mg/325 mg tablet (generic for NORCO)
- hydrocodone/ibuprofen 7.5 mg/200 mg tablet (generic for VICOPROFEN)
- hydromorphone tablet (generic for DILAUDID)
- meperidine oral solution (generic for DEMEROL)
- meperidine tablet (generic for DEMEROL)
- morphine IR tablet (generic for MSIR)
- morphine oral solution
- oxycodone 5 mg per 5 mL oral solution (generic for ROXICODONE)
- oxycodone IR tablet (generic for ROXICODONE)
- oxycodone/acetaminophen oral solution (generic for ROXICET)
- oxycodone/acetaminophen 5/325 mg, 7.5/325mg, and 10/325 mg tablet (generic for PERCOCET)
- tramadol 50 mg tablet (generic for ULTRAM)
- tramadol/acetaminophen (generic for ULTRACET)

NON-PREFERRED STATUS FOR ALL STRENGTHS UNLESS OTHERWISE NOTED

- acetaminophen/codeine oral solution (unit dose cups)
- butalbital/caffeine/APAP with codeine (generic for FIORICET with CODEINE)
- butalbital/caffeine/ASA with codeine (generic for FIORINAL WITH CODEINE)
- butorphanol nasal spray (generic for STADOL)
- DILAUDID (hydromorphone)
- FIORICET with CODEINE (butalbital/caffeine/APAP with codeine)
- hydrocodone/APAP 10/325 mg per 15 mL oral solution (generic for ZAMICET)

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- hydrocodone/APAP oral solution (unit dose cups)
- hydrocodone/APAP 5/300 mg, 7.5/300 mg, and 10/300 mg tablet (generic for XODOL)
- hydrocodone/APAP 2.5/325 mg tablet
- hydrocodone/ibuprofen 5/200 mg and 10/200 mg tablet (generic for IBUDONE/REPREXAIN)
- hydromorphone oral solution and rectal supp (generic for DILAUDID)
- levorphanol (generic for XYVONA)
- oxycodone capsule (generic for OXYIR)
- oxycodone 20 mg per mL concentrated oral solution (generic for ROXICODONE INTENSOL)
- oxycodone 5 mg per 5 mL solution unit dose cups
- oxycodone/APAP 2.5/325 mg tablet (generic for PERCOCET)
- oxymorphone (generic for OPANA)
- pentazocine/naloxone tablet (generic for TALWIN NX)
- PERCOCET (oxycodone/APAP)
- PROLATE (oxycodone/APAP)
- ROXICODONE (oxycodone)
- ROXYBOND (oxycodone)
- tapentadol (generic for NUCYNTA)
- tramadol 25 mg, 75 mg, and 100 mg tablet
- tramadol oral solution (generic for QDOLO)
- XYVONA (levorphanol)

ADDITIONAL CRITERIA

- Quantity limits apply
- Age restrictions apply

TRAMADOL IR AGE EDIT

> 17 years of age

TRAMADOL/APAP AGE EDIT

> 16 years of age

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ORAL ASTHMA MEDICATIONS (TERBUTALINE TABLET AND VIAL)

Updated 1/17/2017

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

DRUGS THAT REQUIRE MANUAL REVIEW FOR PRIOR AUTHORIZATION

- terbutaline 2.5 mg tablet
- terbutaline 5 mg tablet
- terbutaline vial

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OSILODROSTAT (ISTURISA)

Updated 7/15/2020

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication; **AND**
- The beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert or based on support in the official Compendia; **AND**
- Diagnosis of Cushing's syndrome and pituitary surgery **OR** pituitary radiation are not options or have not been curative **or** diagnosis consistent with FDA indication; **AND**
- The prescriber must be an endocrinologist; **AND**
- The beneficiary should have a trial and failure of ketoconazole and mitotane unless contraindicated or beneficiary cannot tolerate both medications; **AND**
- Current labs should indicate the beneficiary does not have hypokalemia or Hypomagnesemia; **AND**
- Beneficiaries with risk factors for QT prolongation should have more frequent ECG monitoring; **AND**
- The beneficiary must not be showing symptoms of adrenal insufficiency; **AND**
- The prescriber must provide the following:
  - Current chart notes with documentation of surgery status; **AND**
  - Current labs, including:
    - Urine free cortisol levels (normal is < 150 nmol/24 hours **or** 3.5–45 mcg/24 hours); **AND**
    - Liver function tests; **AND**
    - Comprehensive metabolic panel; **AND**
  - Baseline electrocardiogram; **AND**
  - Assessment for Adrenalectomy

QUANTITY EDITS

- Due to titration and variety of doses, do not recommend quantity edits on 1 mg and 5 mg
- 10 mg – #180 tablets per 30 days

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OSTEOPOROSIS, BONE RESORPTION SUPPRESSION AND RELATED AGENTS

Updated 7/1/2026

PREFERRED AGENTS

- alendronate sodium tablet (generic for FOSAMAX)

PREFERRED AGENTS WITH CRITERIA

- BONSITY (teriparatide) – **brand only**
- ENOBY (denosumab-qbde)*
- FORTEO (teriparatide) – **brand only**
- XTRENBO (denosumab-qbde)**

*** Biosimilar for PROLIA**

****Biosimilar for XGEVA**

NON-PREFERRED AGENTS

- ACTONEL (risedronate)
- alendronate solution (generic for FOSAMAX)
- ATELVIA (risedronate DR)
- AUKELSO (denosumab-kyqq)**
- BILDYOS (denosumab-nxxp)*
- BILPREVDA (denosumab-nxxp)**
- BINOSTO (alendronate)
- BOMYNTRA (denosumab-bnht)**
- BOSAYA (denosumab-kyqq)*
- calcitonin-salmon (generic for MIACALCIN)
- CONEXXENCE (denosumab-bnht)*
- EVENITY (romosozumab-aqqg)
- EVISTA (raloxifene)
- FOSAMAX (alendronate)
- FOSAMAX PLUS D (alendronate plus cholecalciferol)
- ibandronate (generic for BONIVA)
- JUBBONTI (denosumab-bbdz)*
- JUBEREQ (denosumab-desu)**
- MIACALCIN (calcitonin-salmon)
- OSENVELT (denosumab-bmwo)**
- OSVYRTI (denosumab-desu)*
- PROLIA (denosumab)

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- raloxifene (generic for EVISTA)
- risedronate (generic for ACTONEL)
- risedronate DR (generic for ATELVIA)
- STOBOCLO (denosumab-bmwo)*
- teriparatide (generic for FORTEO)
- TYMLOS (abaloparatide)
- WYOST (denosumab-bbdz)**
- XGEVA (denosumab)

APPROVAL CRITERIA FOR NON-PREFERRED BISPHOSPHONATES

- Requires chart notes for manual review
- Requires documentation of medical necessity over preferred options

GENERAL CRITERIA FOR THE CLASS

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for the FDA approved indication
- The beneficiary must follow the preferred drug list
- The beneficiary has a documented contraindication, intolerance, treatment failure, or ineffective response to oral bisphosphonates or intravenous (IV) bisphosphonates (e.g., alendronate, risedronate, ibandronate, or zoledronic acid).
  - Ineffective response is defined as a further decrease in T-score or new fracture after 12 months of therapy
  - If oral bisphosphonate is contraindicated or patient is intolerant, intravenous bisphosphonate should be tried
  - Therapy should consist of the bisphosphonate along with adequate calcium and vitamin D
- The beneficiary meets **one** of the following pertaining to osteoporosis:
  - History of fragility or low trauma fracture (other than skull, facial bone, finger, or toes) as an adult
  - Bone mineral density scan (BMD) via bone density scan (DXA) T-score ≤ -2.5 at the conventional skeletal sites including the total hip, femoral neck, lumbar spine (posterior-anterior, not lateral), or radius
  - Bone mineral density (BMD) T-score of -1.0 to -2.5 at the femoral neck or lumbar spine and a 10-year probability of hip fracture > 3% or a 10-year probability of a major osteoporosis-related fracture > 20%
  - Prostate cancer treated with androgen deprivation therapy with bone mineral density (BMD) T-score of ≤ -1.0 at the conventional skeletal sites including the total hip, femoral neck, lumbar spine (posterior-anterior, not lateral) or radius
- The prescriber must submit the following information for any request:
  - Current chart notes
  - Bone mineral density (BMD) T-scores (e.g., DXA scan)

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- Medical necessity for the use of the prescribed medication over the use of preferred bisphosphonates with calcium and vitamin D

- If approved, approval for 6 months

ADDITIONAL DRUG SPECIFIC CRITERIA

- Additional approval criteria for denosumab (PROLIA and biosimilars)
  - The beneficiary must be diagnosed with **one** of the following:
    - Osteoporosis (men and women)—women should be postmenopausal
    - Osteoporosis (men and women) due to sustained systemic glucocorticoid therapy with high risk of fracture
    - Osteoporosis for prostate cancer patient receiving androgen deprivation therapy
    - Osteoporosis for breast cancer patient receiving aromatase inhibitor therapy
  - Continuation criteria applies if denosumab claim (PROLIA or biosimilars) is found in the Medicaid drug history in the previous 12 months
  - Therapeutic duplication is not allowed with XGEVA or its biosimilars, and claim will deny at point-of-sale if a claim for XGEVA or biosimilars is seen in history in previous 6 months
  - After completion of therapy, sequential therapy with an oral or injectable antiresorptive agent is recommended.
- Additional approval criteria for FORTEO (teriparatide) or biosimilars, TYMLOS (abaloparatide), and BONSITY (teriparatide)
  - The beneficiary must be diagnosed with **one** of the following:
    - Postmenopausal women with osteoporosis and high risk of fracture (FORTEO, TYMLOS, and BONSITY)
    - Primary or hypogonadal osteoporosis (men) with high risk for fracture (FORTEO and BONSITY)
    - Osteoporosis (men or women) due to sustained systemic glucocorticoid therapy with high risk of fracture (FORTEO and BONSITY)
    - Osteoporosis in men with high risk for fracture (TYMLOS)
  - Beneficiary cannot exceed 24 months of therapy in their lifetime
  - Medical necessity over the use of denosumab and preferred bisphosphonates
  - For TYMLOS, provide the medical necessity over FORTEO/BONSITY if other criteria are met
  - After completion of therapy, sequential therapy with an oral or injectable antiresorptive agent is recommended.
- Additional approval criteria for EVENITY (romosozumab-aqqg)
  - The beneficiary must be a postmenopausal woman with osteoporosis at high risk for fracture
  - The beneficiary must not have uncontrolled hypocalcemia, and pre-existing hypocalcemia has been corrected and will be monitored. Labs must be provided.
  - The beneficiary must not have a history of myocardial infarction or stroke within the previous year

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- The beneficiary must take adequate calcium and vitamin D concomitantly
- The beneneficiary cannot exceed 12 months of therapy
- The provider must submit the medical necessity over preferred products (e.g., bisphosphonates, denosumab, etc.)
- After completion of therapy, sequential therapy with an oral or injectable antiresorptive agent is recommended.

- Additional approval criteria for MIACALCIN/FORTICAL (calcitonin)
  - The beneficiary must be diagnosed with **one** of the following:
    - Paget's disease of the bone
    - Hypercalcemia
    - Postmenopausal osteoporosis
  - Reserve for women greater than 5 years postmenopause at high risk of fracture with osteoporosis who cannot tolerate raloxifene, bisphosphonates, estrogen, denosumab, abaloparatide, or teriparatide
  - The provider must submit the medical necessity over all other alternatives
- Additional approval criteria for EVISTA
  - Diagnosis of post-menopause in the previous 2 years; **AND**
    - Diagnosis of carcinoma in situ of breast in the previous 2 years; **OR**
    - Diagnosis of atypical hyperplasia of breast in the previous 2 years; **OR**
    - Diagnosis of Family History of Malignant Neoplasm of Breast in previous 2 years; **OR**
  - Diagnosis of post-menopause in the previous 2 years; **AND**
    - Diagnosis of osteoporosis in the previous 2 years; **AND**
      - Diagnosis of esophageal strictures in the previous 2 years; **OR**
      - Diagnosis of esophageal achalasia in the previous 2 years

APPROVAL CRITERIA FOR XGEVA AND BIOSIMILARS (DENOSUMAB)

- The beneficiary must be diagnosed with **one** of the following:
  - Multiple myeloma or bone metastases from solid tumors
  - Giant cell tumor of the bone that is unresectable or where surgical resection is likely to result in severe morbidity and patient is skeletally mature
  - Hypercalcemia of malignancy refractory to IV bisphosphonate therapy with albumin-corrected calcium of > 12.5 mg/dL (3.1 mmol/L)
    - Must have trial and failure of IV bisphosphonates; OR
    - Have documented contraindication or intolerance to intravenous bisphosphonates (e.g., ibandronate, pamidronate, zoledronic acid)
- Therapeutic duplication is not allowed with PROLIA or its biosimilars, and claim will deny at point-of-sale if a claim for PROLIA or biosimilars is seen in history in previous 6 months
- The beneficiary must follow the preferred drug list

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- The beneficiary should delay therapy if has pre-existing hypocalcemia until corrected
- The prescriber must submit the following:
  - Current chart notes
  - Previous therapies tried with response
  - Documentation of medical necessity
  - Current labs including albumin-corrected calcium for hypercalcemia diagnosis
  - Approval for 6 months

RENEWAL REQUIREMENTS

- The beneficiary must be compliant on therapy (defined as 75% utilization)
- The beneficiary must have a positive response without intolerable side effects
  - For osteoporosis medications—absence of fractures or increase in bone mineral density (BMD) compared to pretreatment baseline
  - For XGEVA or biosimilars—absence/delay in skeletal-related events, disease stabilization, or corrected serum calcium ≤ 11.5 mg/dL
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of response to therapy
  - Current BMD score if available
  - Current labs if applicable

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OTESECONAZOLE (VIVJOA)

Updated 1/18/2023

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary is an adult, female with a history of recurrent vulvovaginal candidiasis (RVVC) defined as ≥ 4 episodes of vulvovaginal candidiasis in as 12-month period **or** a diagnosis consistent with any updated FDA-approved indications or supported in the official Compendia
- The beneficiary must have permanent infertility (e.g., tubal ligation, hysterectomy, salpingo-oophorectomy, or post-menopausal)
- The beneficiary should not be approved with any of the following:
  - Severe renal impairment (eGFR 15–29 mL/min) or ESRD (eGFR < 15 mL/min)
  - Moderate to severe hepatic impairment (Child-Pugh B or C)
- For diabetic beneficiaries with HbA1c > 9%, the prescriber must provide efforts taken to achieve better glycemic control
- The beneficiary must have continued vulvovaginal candidiasis despite a minimum of fluconazole 150 mg once weekly for 6 months
- The prescriber must submit **all** of the following:
  - Current chart notes
  - History of symptomatic vulvovaginal candidiasis with previous treatment
  - Vaginal discharge culture or microscopy report
  - Current HbA1c
  - Documentation verifying that the current infection is recurrent and not a non-clearance of a previous infection
  - Medical necessity over fluconazole; **AND**
  - Note which therapy will be initiated
    - VIVJOA only; **OR**
    - fluconazole/VIVJOA
- PA will be approved for a maximum of 12 weeks

RENEWAL REQUIREMENTS

- Reviewed on a case-by-case basis
- The prescriber must submit the following:
  - Current chart notes with confirmation of RVVC despite previous treatment
  - Diabetic beneficiaries must maintain glycemic control with HbA1c < 9%

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- Rationale for a subsequent treatment when the package insert does not support beyond one 12-week course

QUANTITY EDITS

#18 capsules for a full course over 12 weeks

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OTIC PREPARATIONS

Updated 10/1/2026

PREFERRED AGENTS

- acetic acid otic (generic for VOSOL)
- acetic acid/HC otic (generic for VOSOL HC)
- ciprofloxacin/dexamethasone otic (generic for CIPRODEX)
- neomycin/polymyxin/HC otic (generic for CORTISPORIN)
- ofloxacin otic (generic for FLOXIN)

NON-PREFERRED AGENTS

- CIPRO HC (ciprofloxacin/hydrocortisone) – **brand preferred over generic when approved**
- ciprofloxacin/hydrocortisone otic (generic for CIPRO HC)
- CLOTIC (clotrimazole)
- CORTISPORIN-TC (neomycin/colist/hydrocortisone/thonzonium)
- ciprofloxacin otic (generic for CETRAXAL)

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OVERACTIVE BLADDER AGENTS

Update 1/1/2025

PREFERRED AGENTS

- fesoterodine ER (generic for TOVIAZ)
- MYRBETRIQ tablet (mirabegron ER) – **brand name only**
- oxybutynin syrup and 5 mg tablet (generic for DITROPAN)
- oxybutynin ER (generic for DITROPAN XL)
- solifenacin (generic for VESICARE)

NON-PREFERRED AGENTS

- darifenacin ER (generic for ENABLEX)
- DETROL (tolterodine tartrate)
- DETROL LA (tolterodine tartrate ER)
- flavoxate (generic for URISPAS)
- GEMTESA (vibegron)
- mirabegron ER (generic for MYRBETRIQ)
- MYRBETRIQ granules (mirabegron ER) **– brand preferred over generic when approved**
- oxybutynin 2.5 mg tablet
- OXYTROL (oxybutynin)
- tolterodine (generic for DETROL)
- tolterodine ER (generic for DETROL LA)
- TOVIAZ (fesoterodine fumarate)
- trospium (generic for SANCTURA)
- trospium ER (generic for SANCTURA XR)
- VESICARE (solifenacin succinate)
- VESICARE LS (solifenacin succinate)

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PAIN MEDICATIONS, INJECTABLE (HISTORICAL REFERENCE ONLY)

Updated 4/12/2011

INJECTABLE AGENTS

- buprenorphine injectable
- butorphanol injectable
- hydromorphone injectable
- levorphanol injectable
- meperidine injectable
- morphine injectable
- nalbuphine injectable
- pentazocine Injectable

APPROVAL CRITERIA

- No drug claim in the past 90 days for SUBUTEX; **OR**
- No drug claim in the past 90 days for SUBOXONE; **AND**
- Therapeutic duplication between short-acting opioids with less than 25% of the days' supply remaining on the previous claim; **OR**
- Therapeutic duplication between a short-acting opioid and tramadol IR (ULTRAM) with less than 25% of the days' supply remaining on the previous claim; **OR**
- Therapeutic duplication between a short-acting opioid and tramadol/acetaminophen (ULTRACET) with less than 25% of the days' supply remaining on the previous claim; **OR**
- Therapeutic duplication between a short-acting opioid and tramadol ODT (RYBIX) with less than 25% of the days' supply remaining on the previous claim

DENIAL CRITERIA

- Therapeutic duplication between two short-acting opioids with more than 25% of the days' supply remaining on previous claim; **OR**
- Therapeutic duplication between a short-acting opioid and tramadol (UTRAM and ULTRACET) with more than 25% of the days' supply remaining on previous claim; **OR**
- Therapeutic duplication between a short-acting opioid and tramadol ODT (RYBIX) with more than 25% of the days' supply remaining on previous claim; **OR**
- Drug claim in history for SUBUTEX; **OR**
- Drug claim in history for SUBOXONE

EXEMPTIONS

Beneficiaries who have a diagnosis of malignant cancer in the past 12 months are exempt.

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ADDITIONAL CRITERIA

Quantity limits apply

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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PALTUSOTINE (PALSONIFY)

Updated 7/1/2026

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must have a diagnosis of acromegaly with **one** of the following:
  - Had an inadequate response to surgical resection as indicated by growth hormone and serum insulin-like growth factor 1 (IGF-1) are above the reference ranges; **OR**
  - Not a candidate for surgical resection
- The medication must be prescribed by, or in consultation with, a specialist knowledgeable in acromegaly (e.g., endocrinologist, oncologist)
- The beneficiary with concomitant moderate or strong CYP3A4 inducers or proton pump inhibitors may require a dose modification for PALSONIFY
- The prescriber must submit the following:
  - Current chart notes
  - Previous therapies tried with response
  - Rationale for prescribing if the beneficiary has not had surgery
  - Current labs including baseline IGF-1 level, growth hormone; **AND**
  - Letter of medical necessity with clinically significant reason the beneficiary cannot continue their current injectable medication or start therapy on a preferred product

RENEWAL REQUIREMENTS

- The beneficiary must remain compliant with therapy (defined as 75% utilization)
- The beneficiary must have a positive clinical response (e.g., decrease in symptom severity/frequency, reduction in adenoma size, reduction in IGF-1 and/or growth hormone levels)
- The beneficiary that develops cholelithiasis should discontinue
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of response to therapy; **AND**
  - Current labs including baseline IGF-1, growth hormone

QUANTITY EDITS

- #60 tablets per 30 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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PEANUT ALLERGEN POWDER-DNFP (PALFORZIA)

Updated 1/19/2022

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary must be ≥ 1 year of age and ≤ 17 years of age to initiate treatment; **AND**
- The beneficiary must have a confirmed diagnosis of a peanut allergy; **AND**
- The prescriber must be an Allergy and Immunology specialist; **AND**
- The prescriber, clinic, pharmacy, and beneficiary must be enrolled in the Risk Evaluation and
- Mitigation Strategy (REMS) program and remain compliant with program requirements; **AND**
- The prescriber must attest that the beneficiary has been counseled to continue a peanut-avoiding diet as this medication is for accidental exposure to peanuts; **AND**
- The beneficiary must continue to have injectable epinephrine on hand with a pharmacy claim within the last year; **AND**
- The prescriber must require Initial Dose Escalation and first dose of each up-dosing stage to occur in the office to monitor for anaphylaxis for at least 60 minutes and provide a plan on how to manage potential anaphylaxis reactions while in the office; **AND**
- The prescriber must provide the following:
  - Current chart notes; **AND**
  - Documentation of a systemic reaction to peanuts AND at least **one** of the following:
    - Positive serum immunoglobulin E (IgE) to peanuts within the past 12 months; **OR**
  - Skin prick test (SPT) to peanut with a mean wheal diameter of ≥ 8 mm compared to control; **OR**
  - Documented reaction to peanut upon supervised oral food challenge at a dose of ≤ 100 mg peanut protein (≤ 200 mg peanut flour).
- PA will be approved for 2 months at a time with correct dosages per the taper. Compliance, response to therapy, and tolerance will be reviewed on renewal request.

DENIAL CRITERIA

- The beneficiary does not meet the FDA-approved indication **or** have a diagnosis supported in the official Compendia; **OR**
- The beneficiary has uncontrolled asthma, markedly compromised lung function, severe mast cell disorder or cardiovascular disease (decreased ability to survive anaphylaxis); **OR**
  - Uncontrolled asthma is defined per the 2007 NHLBI, and involves: asthma symptoms throughout the day, nighttime awakenings often (7 times per week), poor lung function (FEV1 < 60% predicted; FEV1/FVC reduced > 5%), extreme limitation on normal activity, and the need to use a short-acting beta agonist (rescue inhaler) several times a day.

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- The beneficiary has suspected eosinophilic esophagitis and/or other eosinophilic gastrointestinal disease; **OR**
- The beneficiary cannot tolerate doses up to and including the 3 mg dose during Initial Dose Escalation; **OR**
- The beneficiary had severe or life-threatening anaphylaxis within the previous 60 days

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PALOPEGTERIPARATIDE (YORVIPATH)

Updated 1/15/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with hypoparathyroidism
- Must be prescribed by, or consultation with, an endocrinologist, nephrologist or other specialist knowledgeable in treating hypoparathyroidism
- The beneficiary must not have adequate control of hypocalcemia with calcium and vitamin D supplements prior to approval
- The beneficiary must have a baseline albumin-corrected serum calcium of at least 7.8 mg/dL while using calcium and active vitamin D treatment
- The beneficiary should not be approved or continue the medication if meet **one** of the following:
  - At increased risk of osteosarcoma
  - Open epiphyses. YORVIPATH is not approved in pediatric beneficiaries
  - Metabolic bone diseases other than hypoparathyroidism, including Paget's disease of bone.
  - Unexplained elevations of alkaline phosphatase.
  - Bone metastases or a history of skeletal malignancies.
  - History of external beam or implant radiation therapy involving the skeleton.
  - Hereditary disorders predisposed to osteosarcoma
  - Has acute post-surgical hypoparathyroidism
  - Requested dose exceeds 30 mcg per day or dose requested requires more than 1 injection; **OR**
  - Prescribed concomitant teriparatide (FORTEO)
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of previous therapies tried
  - Dose requested
  - Current labs, including calcium, vitamin D, magnesium; **AND**
  - Treatment plan that includes monitoring calcium levels 7–10 days after first dose and after any dose change of YORVIPATH, active vitamin D, or calcium supplements. For maintenance, labs should be checked at a minimum every 4–6 weeks or when the beneficiary experiences symptoms of hypocalcemia or hypercalcemia

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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RENEWAL REQUIREMENTS

- The beneficiary must remain compliant with therapy including calcium and vitamin D supplements if prescribed concomitantly (compliance defined as 75% utilization)
- The beneficiary has a positive response with albumin-corrected serum calcium within normal limits
- If labs are not within desired range and beneficiary takes 30 mcg daily dose along with calcium and vitamin D supplements, provide medical necessity for continuing the medication.
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Current labs, including calcium, vitamin D, magnesium

QUANTITY EDITS

#2 pens per 28 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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PALOVAROTENE (SOHONOS)

Updated 1/17/2024

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication (as of 1/3/2024, minimum age is 8 years of age for females and 10 years of age for males.)
- The beneficiary is prescribed no more than the maximum dose as specified in the manufacturer's package insert or supported in the official Compendia.
- The beneficiary must be diagnosed with fibrodysplasia ossificans progressive (FOP) **or** a diagnosis consistent with any new FDA-approved indications. Any off-label requests will be reviewed on a case-by-case basis.
- The medication must be prescribed by or in consultation with a specialist knowledgeable in FOP
- Growing pediatric beneficiaries should have baseline assessment of skeletal maturity via hand/wrist and knee x-rays, standard growth curves and pubertal staging. Continued monitoring is recommended every 6–12 months until skeletal maturity. Palovarotene can cause premature epiphyseal closure and risk versus benefit may need to be determined.
- Female beneficiaries of reproductive potential should have highly effective contraception.
- The beneficiary should not be approved or continue this therapy with any of the following:
  - Pregnancy
  - Moderate to severe hepatic impairment or severe renal impairment
  - Vertebral fractures (consider the benefit versus risk)
  - Require strong CYP3A inhibitors (e.g., ritonavir, ketoconazole) and moderate or strong CYP3A inducers (e.g., carbamazepine, phenytoin)
  - Requires tetracycline derivatives; **OR**
  - Requires high dose Vitamin A
- The prescriber must submit **all** of the following:
  - Current chart notes with previous therapies tried.
  - Description of this beneficiary's symptoms and disease progression (volume of heterotopic ossification if available as a baseline)
  - Negative pregnancy test within 1 week of initiating therapy
  - Baseline assessment of bone maturity; **AND**
  - Dose requested (PA is specific to NDC)

RENEWAL REQUIREMENTS

- The beneficiary continues to meet approval criteria.

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- The prescriber has considered the benefit versus risk on epiphyseal closure.
- The prescriber must submit the following:
  - Current chart notes
  - Negative pregnancy test results
  - Skeletal maturity test results at least once a year; **AND**
  - Dose requested (PA is specific to NDC)

QUANTITY EDITS

Multiple doses must be available depending on need of the beneficiary.

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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PANCREATIC ENZYMES

Updated 4/1/2026

PREFERRED AGENTS

- CREON (pancrelipase)
- ZENPEP (pancrelipase)

NON-PREFERRED AGENTS

- PERTZYE (pancrelipase)
- VIOKACE (pancrelipase)

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PASIREOTIDE DIASPARTATE AMPULE (SIGNIFOR)

Updated 1/15/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

Pharmacy claim only

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- The beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert or based on support from the official Compendia
- The beneficiary must be diagnosed with Cushing's disease and pituitary surgery is not an option or has not been curative
- The medication must be prescribed by or in consultation with an endocrinologist
- The beneficiary should be monitored and therapy adjusted with the following:
  - Consider interrupting therapy if beneficiary develops hypocortisolism
  - Consider discontinuing if beneficiary develops uncontrolled hyperglycemia
  - If cholelithiasis is suspected, discontinue therapy
  - Consider altering other therapy if bradycardia or QT prolongation develops; **AND**
  - Moderate hepatic impairment (Child-Pugh B) requires dose adjustment
- The beneficiary should not be approved or continue this therapy with any of the following:
  - Has severe hepatic impairment (Child-Pugh C)
- The prescriber must submit the following:
  - Current chart notes with beneficiary specific symptoms of Cushing's syndrome; **AND**
  - Baseline labs – monitor the following at baseline and throughout treatment:
    - Urinary free cortisol (UFC) level
    - Fasting plasma glucose, hemoglobin A1c, liver tests, serum potassium and magnesium level; **AND**
    - Pituitary function (TSH/free T4, GH/IGF-1)
  - Baseline ECG

RENEWAL REQUIREMENTS

- The beneficiary must remain compliant with therapy (defined as 75% utilization)
- The beneficiary must have a positive response from therapy with decrease in urine free cortisol (UFC) compared to baseline after 6 months of therapy
- The prescriber must submit the following:
  - Current chart notes with updated beneficiary specific symptoms of Cushing's syndrome

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- Current labs
  - Urinary free cortisol (UFC) level
  - Fasting plasma glucose, hemoglobin A1c, liver tests, serum potassium and magnesium level; **AND**
  - Pituitary function (TSH/free T4, GH/IGF-1)

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PATIROMER POWDER (VELTASSA)

Updated 1/15/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must be diagnosed with hyperkalemia
- The beneficiary has either discontinued or decreased the dose on medications known to cause hyperkalemia to the lowest effective dose (e.g., aldosterone antagonists, nonsteroidal anti-inflammatory drugs [NSAIDs])
- The beneficiary must be prescribed a low potassium diet
- The beneficiary should not be approved or continue this therapy with any of the following:
  - Has severe constipation, bowel obstruction or impaction, including abnormal post-operative bowel motility disorders
  - Prescribed as an emergency treatment; **OR**
  - Dose requested exceeds 25.2 gm per day
- The prescriber must submit the following:
  - Current chart notes
  - Previous treatments tried
  - Current potassium and magnesium levels; **AND**
  - Letter of medical necessity over other products available for lowering potassium that do not require prior authorization (e.g., sodium polystyrene, potassium-depleting diuretics)

RENEWAL REQUIREMENTS

- The beneficiary must remain compliant with therapy (defined as 75% utilization)
- The beneficiary must have a positive response to therapy with a decrease in potassium levels
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Current potassium and magnesium

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PEGCETACOPLAN (EMPAVELI)

Updated 10/15/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with **one** of the following:
  - Paroxysmal Nocturnal Hemoglobinuria (PNH)
  - Proteinuria with Complement 3 Glomerulopathy (C3G); **OR**
  - Proteinuria with Primary Immune-Complex Membranoproliferative Glomerulonephritis (IC-MPGN)
- The beneficiary must be vaccinated against encapsulated bacteria, including *Streptococcus pneumoniae* and *Neisseria meningitidis* types A, C, W, Y, and B at least 2 weeks prior to initiation of EMPAVELI, and beneficiary must be provided antibiotics if vaccines were administered less than 2 weeks before starting therapy
- The prescriber and pharmacy must be enrolled in the REMS program
- The medication must be prescribed by or in consultation with the following:
  - For PNH beneficiaries – hematologist or oncologist
  - For C3G beneficiaries – nephrologist
  - For IC-MPGN – nephrologist
- Beneficiary's with PNH must meet the following:
  - The beneficiary currently taking eculizumab (Soliris) or ravulizumab (Ultomiris) must follow the required dose initiation per the package insert
  - The beneficiary must be clinically symptomatic (e.g., fatigue, dyspnea, pain, thrombosis) and have abnormal labs (e.g., low hemoglobin (Hgb), high lactate dehydrogenase (LDH))
  - The beneficiary has baseline Hgb level < 10 g/dL with or without previous C5 inhibitors
  - The beneficiary must not be receiving Empaveli in combination with other complement inhibitors used to treat PNH (i.e., FABHALTA, PIASKY, SOLIRIS, ULTOMIRIS, VOYDEYA)
  - The prescriber must submit the following:
    - Current chart notes
    - Documented symptoms as a baseline
    - Previous therapies
    - Current labs, including complete blood count (CBD), comprehensive metabolic panel, and lactate dehydrogenase; **AND**
    - Recent history of blood transfusions

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- Beneficiaries with C3G must meet the following:
  - The beneficiary has tried and failed mycophenolate and/or cyclophosphamide and oral glucocorticoids unless there is a contraindication for this specific beneficiary
  - The beneficiary has tried and failed an angiotensin-converting enzyme (ACE) inhibitor or angiotensin-receptor blocker (ARB) at maximally tolerated doses unless contraindicated
  - The prescriber must submit the following:
    - Current chart notes
    - Previous therapies (e.g., RAS inhibitors, corticosteroids, mycophenolate)
    - Documented symptoms
    - Current labs, including LFTs, eGFR, lipid panel, and urine protein or UPCR
    - Confirmation of C3G diagnosis with renal biopsy results and labs (protein-to-creatinine ratio (UPCR) ≥ 1 g/g and eGFR ≥ 30 mL/min/1.73 m^2); **AND**
    - Medical necessity over immunosuppressants and glucocorticoids
- Beneficiaries with IC-MPGN must meet the following:
  - The beneficiary should have tried and failed an angiotensin-converting enzyme (ACE) inhibitor or angiotensin-receptor blocker (ARB) at maximally tolerated doses unless contraindicated; **AND**
  - The beneficiary must be treated with immunosuppressants if underlying cause is an autoimmune disorder, nephrotic syndrome with normal kidney function, and beneficiaries with active glomerulonephritis but no significant chronic changes
  - The prescriber must submit the following:
    - Current chart notes
    - Previous therapies (e.g., RAS inhibitors, immunosuppressants, steroids)
    - Documented symptoms
    - Current labs, including LFTs, eGFR, lipid panel, and urine protein or UPCR; **AND**
    - Confirmation of IC-MPGN diagnosis with renal biopsy results immunosuppressants and glucocorticoidsC3G

RENEWAL REQUIREMENTS

- The beneficiary is compliant with therapy (defined as 75% utilization)
- Beneficiary's with PNH must meet the following:
  - The beneficiary has an improvement in hemoglobin and/or LDH levels compared to baseline
  - The beneficiary has an improvement in overall clinical presentation (e.g., fatigue, dyspnea, reduction in transfusions); **AND**
  - The prescriber must submit the following:
    - Current chart notes
    - Current labs, including CBC, CMP, and LDH
- Beneficiaries with C3G and IC-MPGN must meet the following:

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- The beneficiary has documented improvement of proteinuria with a reduction in UPCR or urine protein; **AND**
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Current labs, including LFTs, eGFR, lipid panel, and urine protein or UPCR

QUANTITY EDITS

10 vials per 30 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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PEGVALIASE-PQPZ (PALYNZIQ)

Updated 7/18/2018

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary is ≥ 12 years of age
- The beneficiary has phenylketonuria and has uncontrolled blood phenylalanine concentrations greater than 600 micromol/L while adherent to a strict Phenylalanie (Phe)-limited diet
- The prescriber must submit beneficiary's blood phenylalanine concentration with PA request
- The beneficiary is adherent to a Phe-restricted diet that restricts phenylalanine protein
- The prescriber must submit chart notes to substantiate that beneficiary was a non-responder to KUVAN while adherent to the Phe-restricted diet
- If female beneficiary is of child-bearing age, she must be willing to use two acceptable methods of contraception while receiving PALYNZIQ
  - Females who have been in menopause for at least 2 years, have had a tubal ligation at least 1 year prior to first dose of PALYNZIQ, or have had a total hysterectomy do not need to use any other forms of contraception while receiving PALYNZIQ.
  - Males post vasectomy 2 years with no known pregnancies for at least 2 years do not need to use any other forms of birth control while receiving PALYNZIQ.
- The prescriber must administer the initial dose of PALYNZIQ and closely observe the beneficiary for at least 60 minutes following the injection
- The prescriber must ensure beneficiary can recognize signs and symptoms of anaphylaxis and can administer the autoinjector of epinephrine
- The prescriber must prescribe and ensure beneficiary filled the Medicaid preferred autoinjector of epinephrine
- If approved, due to the recommended dosing schedule, the initial PA will be approved for 5 weeks at 2.5 mg once weekly for 4 weeks, and 2.5 mg twice weekly for 1 week, for a total of six 2.5 mg syringes; quantity will be entered at the time of the PA approval

DENIAL CRITERIA

- HIV positive
- The beneficiary is pregnant
- The beneficiary is < 18 years of age
- The beneficiary has a history of substance abuse in the past 12 months or current alcohol or drug abuse
- The beneficiary was not adherent to a strict Phe-restricted diet
- The beneficiary did not have adequate trial of KUVAN

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- The beneficiary was not adherent to prescribed dose of PALYNZIQ
- The beneficiary did not show at least a 20% reduction in blood phenylalanine concentration from pretreatment baseline or a blood phenylalanine concentration less than or equal to 600 micromol/L after 16 weeks of continuous treatment with the maximum dosage of 40 mg once daily

QUANTITY EDITS

Quantity limit for the required strength to be entered at the time of each PA approval

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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PEGVISOMANT (SOMAVERT)

Updated 7/1/2026

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

Pharmacy claim only

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- The beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert or based on support from the official Compendia
- The beneficiary must be diagnosed with elevated serum insulin-like growth factor-1 (IGF-1) due to acromegaly with an inadequate response to surgery and/or radiotherapy, or for whom surgery and/or radiotherapy, is not an option.
- The medication must be prescribed by or in consultation with an endocrinologist or oncologist
- The beneficiary's dose should not be based on growth hormone concentrations or sign/symptoms. The dose should be titrated to normalize serum IGF-1 concentration.
- The prescriber must submit the following:
  - Current chart notes with documentation of diagnosis
  - Previous therapies tried with response
  - If surgery or radiation has not been performed, provide rationale for requesting in acromegaly beneficiaries; **AND**
  - Baseline labs – Monitor the following at baseline and throughout treatment:
    - IGF-1; **AND**
    - Baseline liver function tests

RENEWAL REQUIREMENTS

- The beneficiary must remain compliant with therapy (defined as 75% utilization)
- The beneficiary must have a positive response to therapy with a decrease in serum IGF-1
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Updated labs including IGF-1 and liver function tests

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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PEGZILARGINASE-NBLN (LOARGYS)

Updated 4/15/2026

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- The beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert or based on support from the official Compendia
- The beneficiary must be diagnosed with hyperargininemia due to Arginase 1 Deficiency (ARG1-D) while on a dietary protein restriction with diagnosis confirmed by **ALL** of the following:
  - Elevated plasma arginine levels (> 115 µmol/L);
  - Pathogenic variants in ARG1; **AND**
  - Decreased erythrocyte ARG1 activity
- Must be prescribed by, or in consultation with, a metabolic disease specialist or neurologist experienced in treating urea cycle disorders
- The beneficiary must start therapy with IV infusion in a healthcare setting (minimum of 8 weeks) and maintenance subcutaneous injections in a healthcare setting before moving to in-home subcutaneous injections once the provider deems at home administration is safe
- The beneficiary should not exceed the dosage of 0.2 mg/kg once weekly
- The prescriber must submit the following:
  - Current chart notes
  - Previous therapies tried (e.g., sodium phenylbutyrate or glycerol phenylbutyrate)
  - Baseline plasma arginine level and ammonia level prior to starting infusions and current plasma arginine level
  - Dietary plan for protein restriction
  - Current body weight and dose requested
  - Attestation that the patient/caregiver has been trained on proper administration procedure
- Approvals for 6 months on in-home subcutaneous doses

RENEWAL REQUIREMENTS

- The beneficiary must be compliant on therapy (defined as 75% utilization)
- The beneficiary must have a decrease in plasma arginine levels compared to baseline
- The prescriber must submit the following:
  - Current chart notes
  - Current labs including plasma arginine level

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- Current body weight and dose requested

QUANTITY EDITS

None since dosing is based on weight

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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PENICILLAMINE/CYSTINE DEPLETING AGENTS

Updated 1/1/2026

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

PREFERRED AGENTS

- DEPEN (penicillamine) – **brand name only**
- potassium citrate ER (generic for UROCIT-K)
- THIOLA (tiopronin) – **brand name only**
- THIOLA EC (tiopronin) – **brand name only**

NON-PREFERRED AGENTS

- penicillamine capsule (generic for CUPRIMINE)
- penicillamine tablet (generic for DEPEN)
- tiopronin (generic for THIOLA)
- tiopronin DR (generic for THIOLA EC)
- UROCIT-K ER (potassium citrate)
- VENXXIVA DR (tiopronin)

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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PHENOXYBENZAMINE CAPSULE (DIBENZYLINE)

Updated 1/15/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must be experiencing hypertension and sweating due to pheochromocytoma
- The prescriber must submit the following:
  - Current chart notes with beneficiary specific symptoms
  - Current blood pressure and heart rate
  - Treatment plan (DIBENZYLINE is not intended for long-term use); **AND**
  - Medical necessity over other treatment options including surgery to remove pheochromocytoma

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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PHOSPHATE REMOVING AGENTS

Updated 1/1/2026

PREFERRED AGENTS

- calcium acetate (generic for PHOSLO)
- CALPHRON (calcium acetate)
- sevelamer carbonate tablet (generic for RENVELA)

NON-PREFERRED AGENTS

- AURYXIA (ferric citrate)
- ferric citrate (generic for AURYXIA)
- FOSRENOL (lanthanum carbonate)
- lanthanum carbonate (generic for FOSRENOL)
- RENVELA powder pack (sevelamer carbonate)
- RENVELA tablet (sevelamer carbonate)
- sevelamer carbonate powder pack (generic for RENVELA)
- sevelamer HCl (generic for RENAGEL)
- VELPHORO (sucroferric oxyhydroxide)
- XPHOZAH (tenapanor)

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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PILOCARPINE (VUITY)

Updated 1/19/2022

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary must be ≥ 18 years of age; **AND**
- The beneficiary must have a diagnosis of presbyopia **or** a diagnosis consistent with FDA-approved indication; **AND**
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Medical necessity over other treatment options for presbyopia

DENIAL CRITERIA

- The beneficiary does not meet approval criteria **or** have a diagnosis supported by the official Compendia; **OR**
- The beneficiary has a history of glaucoma or ocular hypertension; **OR**
- The beneficiary has a history of cataract surgery, phakic intraocular lens surgery, corneal inlay surgery, radial keratotomy, or any intraocular surgery

QUANTITY EDITS

1 bottle per 22 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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PITUITARY SUPPRESSIVE AGENTS

Updated 7/1/2026

Note: All medications with a prostate cancer indication will be available as a medical bill option only. The medications available as medical bill for prostate cancer include:

- CAMCEVI (leuprolide)
- ELIGARD (leuprolide)
- leuprolide (generic for LUPRON)
- LUPRON DEPOT 7.5 mg, 22.5 mg – 3 month, 30 mg – 4 month, 45 mg – 6 month, and LUPRON 2 week kit (leuprolide)
- TRELSTAR (triptorelin)

ENDOMETRIOSIS OR UTERINE LEIOMYOMA

PREFERRED AGENTS

- LUPRON DEPOT 3.75 mg and 11.25 mg – 3 month (leuprolide)

NON-PREFERRED AGENTS

None

POINT-OF-SALE (POS) APPROVAL CRITERIA

- Billed diagnosis of endometriosis or uterine leiomyoma (fibroids); **AND**
  - < 12 billed claims of 3.75 mg leuprolide injection in the previous 3 year Medicaid history; **OR**
  - < 4 billed claims of 11.25 mg leuprolide injection in the previous 3 year Medicaid history; **AND**
- No Therapeutic Duplication with other leuprolide products

DENIAL CRITERIA

- Diagnosis of infertility in Medicaid history (3 year look back)
- Thrombophlebitis
- Thromboembolic disorders
- Cerebral apoplexy in Medicaid history
- Carcinoma of the breast in Medicaid history

BREAST CANCER OR OVARIAN CANCER

PREFERRED AGENTS

LUPRON-DEPOT 3.75 mg, 7.5 mg, and 11.25 mg – 3 month (leuprolide)

NON-PREFERRED AGENTS

None

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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POINT-OF-SALE (POS) APPROVAL CRITERIA (BREAST CANCER OR OVARIAN CANCER)

- Billed diagnosis in Medicaid history of breast cancer or ovarian cancer in the last 2 years
- No Therapeutic Duplication with other leuprolide products

CENTRAL PRECOCIOUS PUBERTY – MANUAL REVIEW

PREFERRED AGENTS

- FENSOLVI (leuprolide)
- LUPRON DEPOT-PED 7.5 mg, 11.25 mg, 15 mg, 11.25 mg – 3 month kit, 30 mg – 3 month kit, and 45 mg – 6 month kit (leuprolide)
- SYNAREL (nafarelin)

NON-PREFERRED AGENTS

TRIPTODUR (triptorelin)

APPROVAL CRITERIA

Requests for LUPRON DEPOT-PED, SYNAREL, FENSOLVI, TRIPTODUR or other gonadotropin-releasing hormone (GnRH) agonist drugs, for treating CPP, will require manual review prior authorization on a case-by-case basis.

- The beneficiary is diagnosed with Central Precocious Puberty (CPP)
- The beneficiary must demonstrate full activation of the hypothalamus-pituitary-gonadal (HPG) axis before 8 years of age in females and before 9 years of age in males
- Females shall be less than 8 years of age and males shall be less than 9 years of age when initiating treatment with GnRH agonists for treatment of CPP
- The beneficiary should not be approved or continue on this therapy with any of the following:
  - When the goal is for the treatment of premature adrenarche (PA) associated with normal rate of growth and no evidence of clitoromegaly, penile growth or testicular enlargement
  - When the goal is for the treatment of premature menarche in the young girl with vaginal bleeding but no or little breast development and no evidence of endocrinopathy on the basis of pelvic ultrasonography or concentrations of LH, FSH and estradiol
  - There is no activation of the HPG axis, and FSH, LH and estradiol or testosterone concentrations are at prepubertal levels.
  - When the goal is for the treatment of premature thelarche (PT) in the very young females (e.g., age < 2 years) without additional indicators for CPP
  - If the only signs of sexual development are pubic and/or axillary hair and/or axillary odor
  - When the child's predicted adult height is within the normal range
  - When pubertal suppression is being used for increasing linear growth; **OR**
  - When initial age for females ≥ 11 years and males ≥ 12 years

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- The prescriber must submit the following:
  - Current chart notes
  - Letter of medical necessity
  - Documentation of growth rate acceleration above normal growth rate for age
  - All testing and documentation used to determine CPP (e.g., notes on Tanner stage of development, progressive female breast development confirmed by palpation before 8 years of age, progressive penis and testicular enlargement, etc.)
  - Bone age determination and predicted adult height
  - Baseline labs tests for luteinizing hormone (LH), and either estradiol or testosterone, and follicle stimulating hormone (FSH) (e.g., LH of > 0.3 IU/L is the most reliable screening test for CPP on a random blood sample). If LH is < 0.3 and CPP is suspected, a stimulation test with a gonadotrophin-releasing hormone (GnRH) analog may be necessary.
  - TSH test for hypothyroidism if the growth velocity is slow instead of rapid (to exclude hypothyroidism as the cause of CPP); **AND**
  - If requesting a non-preferred medication, provide the medical necessity over the preferred option(s)

RENEWAL REQUIREMENTS

- Female < 11 years of age or male < 12 years of age for continuation of GnRH therapy previously initiated for treatment of CPP
- The prescriber must provide data showing that the child demonstrates a positive response to drug therapy (e.g., slowing of growth velocity to < 7 cm/year; shrinkage or softening of glandular breast tissue or the testes; or documentation of suppression of the HPG axis).

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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PIVMECILLINAM (PIVYA)

Updated 4/15/2026

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- The beneficiary is prescribed no more than the maximum dose from the manufacturer's package insert or based on support from the official Compendia
- The beneficiary must be diagnosed with uncomplicated urinary tract infections (uUTI) caused by the susceptible isolates of *Escherichia coli (E. coli), Proteus mirabilis, or Staphylococcus saprophyticus*
- The beneficiary with **one** of the following will not meet approval criteria:
  - Carnitine deficiency due to inherited disorders of mitochondrial fatty acid oxidation and carnitine metabolism (e.g., methylmalonic aciduria or propionic acidemia)
  - Acute porphyria
- The beneficiary must not be prescribed concomitant valproic acid or valproate
- The beneficiary must have tried and failed therapy with typical first-line antibiotics used for uUTI (e.g., nitrofurantoin, sulfamethoxazole/trimethoprim, fosfomycin) unless contraindicated
- The prescriber must submit the following:
  - Current chart notes
  - Culture/sensitivity results documenting resistance to typical first-line agents
  - Letter of medical necessity for the rationale of use over typical first-line agents (e.g., nitrofurantoin, sulfamethoxazole/trimethoprim, fosfomycin)

RENEWAL REQUIREMENTS

- Any PA renewals will be reviewed on a case-by-case basis

QUANTITY EDITS

- #3 tablets per day for a maximum of 7 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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PLATELET AGGREGATION INHIBITORS

Updated 1/1/2026

PREFERRED AGENTS

- aspirin/dipyridamole (generic for AGGRENOX)
- clopidogrel (generic for PLAVIX)
- dipyridamole tablet (generic for PERSANTINE)
- prasugrel (generic for EFFIENT)
- ticagrelor (generic for BRILINTA)

NON-PREFERRED AGENTS

- BRILINTA (ticagrelor)
- EFFIENT (prasugrel)
- PLAVIX (clopidogrel)

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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PODOFILOX 0.5% TOPICAL SOLUTION AND GEL (CONDYLOX)

Updated 01/09/2008

APPROVAL CRITERIA

Podofilox 0.5% topical solution (CONDYLOX)

- ≥ 18 years of age; **AND**
- No therapeutic duplication with podofilox 0.5% gel; **AND**
- Diagnosis of Condyloma Acuminata (commonly known as external genital or perianal warts) within the past two months

Podofilox 0.5% topical gel (CONDYLOX) – Plan Prefers Brand

- ≥ 18 years of age; **AND**
- No therapeutic duplication with podofilox 0.5% solution; **AND**
- Diagnosis of of Condyloma Acuminata (commonly known as external genital or perianal warts) within the past two months

DENIAL CRITERIA

- Absence of approval criteria
- < 18 years of age
- Therapeutic duplication of gel/solution

ADDITIONAL CRITERIA

Quantity limits apply

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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POSACONAZOLE SUSPENSION (NOXAFIL)

Updated 1/9/2008

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

Criteria 1:

- Diagnosis code in Medicaid history for at least **one** of the following in the past 365 days:
  - ≥ 13 years of age; **AND**
  - HIV/AIDS; **OR**
  - Organ transplant procedure; **OR**
  - Graft versus host disease; **OR**
  - Neutropenia

Criteria 2:

- The following drug claims in Medicaid history in the past 365 days:
  - ≥ 13 years of age; **AND**
  - HIV/AIDS pharmacotherapy drug claims in history; **OR**
  - Anti-rejection/Immunosuppression medication

Criteria 3:

- ≥ 13 years of age; **AND**
- At least **one** paid claim for fluconazole in the past 30 days; **AND**
- At least **one** paid claim for itraconazole in the past 30 days.

Criteria 4:

- ≥ 13 years of age; **AND**
- History of paid claim for requested drug (NOXAFIL) in the past 180 days.

DENIAL CRITERIA

- < 13 years of age
- Absence of approval criteria
- History of a paid drug claim for the any of the following in the last 30 days:
  - Ergot alkaloids
  - pimozide; **OR**
  - quinidine

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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POSACONAZOLE 100 MG TABLET AND 300 MG VIAL (NOXAFIL)

Updated 7/8/2014

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

DRUGS THAT REQUIRE MANUAL REVIEW FOR PRIOR AUTHORIZATION

- NOXAFIL DR 100 mg tablet
- NOXAFIL 300 mg vial

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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POTASSIUM CHLORIDE PACKET (KLOR-CON AND POKONZA PACKET AND LIQUID)

Updated 1/15/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must be diagnosed with hypokalemia and dietary management with potassium-rich foods or diuretic dose reduction is insufficient.
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Letter of medical necessity for the powder packets/POKONZA liquid over other potassium supplement products available without prior authorization (e.g., capsules, tablets)

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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POTASSIUM CHLORIDE ORAL LIQUID AND EFFERVESCENT TABLET (POKONZA LIQUID IS NOT INCLUDED)

Updated 1/17/2017

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- < 7 years of age; **OR**
- NPO (Appendix A) within the past 365 days.

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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PREDNISOLONE

Updated 7/8/2011

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

DRUGS THAT DO NOT REQUIRE PRIOR AUTHORIZATION

- prednisolone sodium phosphate 15 mg/5 mL (generic for ORAPRED solution)
- methylprednisolone dose pack
- methylprednisolone tablet
- prednisone dose pack
- prednisone tablet

DRUGS THAT REQUIRE MANUAL REVIEW FOR PRIOR AUTHORIZATION

- FLO-PRED
- MILLIPRED
- ORAPRED ODT
- VERIPRED

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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PREDNISONE DR TABLET (RAYOS)

Updated 1/15/2025

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary is diagnosed with a disease or condition that is typically treated with corticosteroids
- The prescriber must submit the following:
  - Current chart notes with diagnosis needing steroids; **AND**
  - Letter of medical necessity for prednisone DR over the numerous oral corticosteroids available without prior authorization (e.g., prednisone, dexamethasone)

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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PRETOMANID TABLETS

Updated 4/1/2020

The Arkansas Department of Health reviews all TB therapy. If you have not contacted the ADH, please do so.

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- Diagnosed with pulmonary extensively drug resistant (XDR) or treatment- intolerant or nonresponsive multidrug-resistant (MDR) tuberculosis (TB); **AND**
- Age ≥ 18 years; **AND**
- Taking SIRTURO (bedaquiline) and ZYVOX (linezolid) concomitantly unless otherwise contraindicated; **AND**
- Provide baseline ECG if also taking other medications that prolong QT interval; **AND**
- Request must have been reviewed and submitted by the Arkansas Department of Health's TB Control Program. If a prescriber outside of the Department of Health requests this medication, the TB control program must be notified.

DENIAL CRITERIA

- Does not meet FDA-approved diagnosis; **OR**
- Clinically significant ventricular arrhythmia or QTcF interval > 500 ms; **OR**
- Coadministration of moderate or strong CYP3A4 inducers

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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PRIMAQUINE TABLETS

Updated 5/17/2019

QUANTITY LIMIT

Primaquine – #14 tablets per claim

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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PROPAFENONE SR (RYTHMOL SR)

Updated 4/8/2014

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

≥ 90 days of propafenone SR therapy in the past 120 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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PROTON PUMP INHIBITORS

Updated 1/1/2026

PREFERRED AGENTS WITH CRITERIA

- omeprazole capsule (generic for PRILOSEC [Rx only])
- pantoprazole tablet (generic for PROTONIX)

NON-PREFERRED AGENTS

- DEXILANT (dexlansoprazole)
- dexlansoprazole (generic for DEXILANT)
- esomeprazole capsule (generic for NEXIUM)
- esomeprazole packet (generic for NEXIUM packet)
- esomeprazole/naproxen (generic for VIMOVO)
- KONVOMEP (omeprazole/sodium bicarbonate)
- lansoprazole (generic for PREVACID)
- lansoprazole ODT (generic for PREVACID solutab)
- NEXIUM (esomeprazole)
- omeprazole/sodium bicarbonate (generic for ZEGERID)
- pantoprazole suspension (generic for PROTONIX)
- PREVACID (lansoprazole)
- PRILOSEC (omeprazole)
- PROTONIXtablet (pantoprazole)
- rabeprazole (generic for ACIPHEX)

NON-PREFERRED AGENTS WITH CRITERIA

- NEXIUM packet for suspension (esomeprazole) – **brand name only**
- PROTONIX suspension (pantoprazole) – **brand name only**

APPROVAL CRITERIA FOR PREFERRED AGENTS WITH CRITERIA

- Approve up to 93 days of proton pump inhibitor therapy per year for all beneficiaries age 24 months or older
- Approve treatment beyond 93 days for beneficiaries 24 months or older who have a diagnosis in history for Zollinger-Ellison Syndrome, Barrett's esophagus, esophageal varices, or an endoscopy (Appendix D) in the past 24 months
- Approve treatment beyond 93 days for beneficiaries 24 months or older who have a diagnosis in history for Cystic Fibrosis, pancreatic insufficiency, or pancreatic disease in the past 24 months

APPROVAL CRITERIA FOR NON-PREFERRED AGENTS WITH CRITERIA

- NEXIUM packet for suspension

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- The beneficiary ≤ 4 years of age
- PROTONIX suspension
  - The beneficiary < 7 years of age; **OR**
  - History of NPO (Appendix A) within the past 365 days

DENIAL CRITERIA

- NEXIUM packet for suspension
  - The beneficiary is > 4 years of age
- PROTONIX suspension
  - No documented history of NPO (Appendix A) within past 365 days
  - The beneficiary is ≥ 7 years of age
- All Proton Pump Inhibitors
  - 93 days of PPI therapy in the past 365 days for beneficiaries 24 months or older, unless there is a diagnosis in history for Zollinger- Ellison Syndrome, Barrett's esophagus, Cystic Fibrosis, pancreatic insufficiency, pancreatic disease, or an endoscopy (Appendix D) in the past 24 months

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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PULMONARY ARTERIAL HYPERTENSION (PAH) AGENTS

Updated 1/1/2023

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

PREFERRED PAH AGENTS WITHOUT CRITERIA

- epoprostenol (generic for VELETRI)
- treprostinil (generic for REMODULIN)

PREFERRED PAH AGENTS WITH CRITERIA

- ambrisentan (generic for LETAIRIS)
- sildenafil tablet and vial (generic for REVATIO) (see criteria for sildenafil)
- tadalafil (generic for ADCIRCA/ALYQ) (see criteria for tadalafil)
- bosentan tablet (generic for TRACLEER)

NON-PREFERRED PAH AGENTS

- ADCIRCA (tadalafil)
- ADEMPAS (riociguat)
- bosentan tablet for suspension (generic for TRACLEER)
- epoprostenol (generic for FLOLAN)
- FLOLAN (epoprostenol)
- LETAIRIS (ambrisentan)
- macitentan (generic for OPSUMIT)
- OPSUMIT (macitentan)
- OPSYNVI (macitentan/tadalafil)
- ORENITRAM ER (treprostinil)
- REMODULIN (treprostinil)
- REVATIO (sildenafil)
- sildenafil suspension (generic for REVATIO)
- TADLIQ (tadalafil)
- TRACLEER
- TYVASO and TYVASO DPI (treprostinil)
- UPTRAVI (selexipag)
- VELETRI (epoprostenol)
- VENTAVIS (iloprost)
- WINREVAIR (sotatercept-csrk) (see criteria for WINREVAIR)
- YUTREPIA (treprostinil)

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DENIAL CRITERIA

- **Therapeutic Duplication (TD) edit** for the preferred drugs to not allow therapeutic duplication within same drug class type (ERA, PDE5, and Prostacyclin) or same pathway (endothelin, NO/cGMP, and prostacyclin).

PDL Status	Drug	Drug class	Pathway
Preferred	LETAIRIS (ambrisentan) tablet	endothelin receptor type A (ERA)	endothelin pathway
Preferred	TRACLEER (bosentan) tablet	endothelin receptor type A (ERA)	endothelin pathway
Preferred	REVATIO (sildenafil) tablet	phosphodiesterase type 5 (PDE-5is)	NO/cGMP pathway
Preferred	ADCIRCA (tadalafil) tablet	phosphodiesterase type 5 (PDE-5is)	NO/cGMP pathway

- LETAIRIS (ambrisentan), TRACLEER (bosentan), ADCIRCA (tadalafil), or generic sildenafil (aka REVATIO): Deny claim for diagnosis of current pregnancy in Medicaid medical history.
- LETAIRIS: Deny incoming LETAIRIS claim if diagnosis of idiopathic pulmonary fibrosis (ICD-10 code J84.112) is in Medicaid medical history in previous 2 years.
- TRACLEER: Deny incoming TRACLEER claim if beneficiary has a drug claim for glyburide in Medicaid drug history in previous 45 days, and vice-versa (deny incoming claim for glyburide if beneficiary has drug claim for TRACLEER in Medicaid drug history in previous 45 days.)
- ADCIRCA: Deny incoming ADCIRCA claim if beneficiary has a drug claim for ADEMPAS (riociguat) in Medicaid drug history in previous 45 days.

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PYRIDOSTIGMINE (MESTINON TIMESPAN)

Updated 4/8/2014

Please note that effective 10/1/2025, this manufacturer is terminating participation in the federal rebate program and therefore brand Mestinon can no longer be covered by Arkansas Medicaid.

APPROVAL CRITERIA

≥ 90 days of Pyridostigmine ER therapy in the past 120 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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PYRIMETHAMINE (DARAPRIM)

Updated 1/15/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must be diagnosed with toxoplasmosis
- The beneficiary must be prescribed a sulfonamide antibiotic to be taken concomitantly with pyrimethamine
- Dose and treatment duration must be supported by the manufacturer's package insert or MicroMedex
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Test results confirming toxoplasmosis

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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QUININE SULFATE (QUALAQUIN)

Updated 6/27/2007

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- Submitted diagnosis of uncomplicated plasmodium falciparum malaria in the previous 6 months; **AND**
- Concurrent therapy with seven days of tetracycline; **OR**
- Concurrent therapy with seven days of doxycycline; **OR**
- Concurrent therapy with seven days of clindamycin.

DENIAL CRITERIA

Absence of approval criteria

ADDITIONAL CRITERIA

Quantity limits apply

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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RANOLAZINE ER TABLET (RANEXA)

Updated 10/18/2006

APPROVAL CRITERIA

Diagnosis of hepatic impairment in the last 12 months

ADDITIONAL CRITERIA

Quantity limits apply

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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RESPIRATORY SYNCYTIAL VIRUS (RSV) MEDICATIONS

Updated 10/1/2025

American Academy of Pediatrics (AAP) no longer recommends SYNAGIS for prevention of RSV disease in infants and children. All claims for RSV immunizations in children (VFC) should be medically billed using CPT codes. No outpatient pharmacy billing claims should be submitted to Arkansas Medicaid. Please review medical billing policies for more information.

Palivizumab is a short-acting monoclonal antibody product that is administered in monthly doses during the RSV season. ***Palivizumab is no longer routinely recommended for use.*** *Shortages of nirsevimab occurred in the season after it was first recommended. If future shortages occur, and palivizumab is available, additional guidance will be provided.*

BEYFORTUS (NIRSEVIMAB)

- BEYFORTUS is available through the Vaccines for Children (VFC) program, and no prior authorization is required.
- ACIP recommends one dose of nirsevimab for all infants aged < 8 months born during or entering their first RSV season (50 mg for infants weighing < 5 kg [< 11 lbs] and 100 mg for infants weighing ≥ 5 kg [≥ 11 lbs]). Prescribers should bill with procedure code 90380 or 90381.
- Either maternal vaccination during pregnancy or nirsevimab administration to the infant is recommended, but both are not needed for most infants.
- ACIP recommends one dose of nirsevimab (200 mg, administered as two 100 mg injections given at the same time at different injection sites) for infants and children aged 8–19 months who are increased risk for severe RSV disease and entering their second RSV season. Prescribers should bill with procedure code 90380 or 90381.
- The recommendations for nirsevimab apply to infants and children recommended to receive palivizumab by AAP.
- If BEYFORTUS has been given, the beneficiary cannot be given SYNAGIS.

ENFLONSIA (CLESROVIMAB-CFOR)

- ENFLONSIA is available through the Vaccines for Children (VFC) program, and no prior authorization is required.
- ACIP recommends one dose of clesrovimab-cfor for all infants aged < 8 months who are not protected by maternal vaccination born during or entering their first RSV season (105 mg for all infants regardless of weight). Prescribers should bill with the procedure code 90382.
- An additional 105 mg dose is recommended for infants undergoing cardiac surgery with cardiopulmonary bypass.
- If ENFLONSIA has been given, the beneficiary cannot be given SYNAGIS.

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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ARKANSAS MEDICAID RSV PREVENTION COVERAGE FOR ADULTS

ABRYSVO

- ABRYSVO is a vaccine indicated for active immunization of pregnant individuals at 32 through 36 weeks gestational age for the prevention of lower respiratory tract disease (LRTD) and severe LRTD caused by respiratory syncytial virus (RSV) in infants from birth through 6 months of age. Also, ABRYSVO is indicated for active immunization for the prevention of LRTD caused by RSV in individuals 60 years of age and older.
  - For beneficiaries who are also VFC eligible, the prescriber will bill 90678 with VFC modifiers.
  - For adults, the prescriber will bill 90678 and use 90471/90472 for administration.

AREXVY

- AREXVY is a vaccine indicated for active immunization for the prevention of lower respiratory tract disease (LRTD) caused by respiratory syncytial virus (RSV) in:
  - Individuals 60 years of age and older; the prescriber will bill 90679 and 90471-90472 for administration.

MRESVIA

- MRESVIA is indicated for active immunization for the prevention of lower respiratory tract disease (LRTD) caused by respiratory syncytial virus (RSV) in individuals 60 years of age and older.
  - For 60 years of age and older, manual pricing is required and most prescribers will submit the clinical information and invoice when they initially bill. If denial occurs (error code 6000-manual pricing), they will then submit documentation required per explanation of benefits.
  - Prescribers will bill 90471 for administration.

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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RESMETIROM (REZDIFFRA)

Updated 10/15/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The medication must be prescribed by or in consultation with an endocrinologist, gastroenterologist, or hepatologist
- The beneficiary must be diagnosed with metabolic-associated steatohepatitis (MASH) (formerly known as noncirrhotic nonalcoholic steatohepatitis [NASH]) with moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis) **or** a diagnosis consistent with any new FDA-approved indications. Any off-label requests will be reviewed on a case-by-case basis.
- Fibrosis staging documentation requires the following:
  - Liver biopsy results; **OR**
  - Fibrosis score results from **two** testing modalities with at least **one** blood-based non-invasive test (NITs) **and** at least **one** imaging test from the lists below:
    - NITs
      - Fibrosis-4 index (FIB-4)
      - AST to platelet ratio index (APRI)
      - NAFLD fibrosis score (NFS)
      - Enhanced liver fibrosis (ELF) or simplified ELF index
      - FibroSure
    - Imaging tests
      - Vibration-controlled transient elastography (VCTE) (e.g., FibroSCAN)
      - Two-dimensional shear weave elastography
      - Point shear wave elastography
      - Magnetic Resonance Elastography (MRE)
- The beneficiary must use this medication in conjunction with appropriate diet and exercise
- The prescriber must rule out any other cause of fibrosis (e.g., alcohol, hepatitis C)
- The beneficiary should not be prescribed concomitant use with a strong CYP2C8 inhibitor (e.g., gemfibrozil) **or** moderate CYP2C8 inhibitor (e.g., clopidogrel) without a REZDIFFRA dose adjustment.
- The beneficiary must not have decompensated cirrhosis
- The prescriber must submit the following:

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- Current chart notes
- Fibrosis staging documentation as listed above and baseline non-alcoholic fatty liver disease (NAFLD) Activity Score (NAS) if biopsy was done
- Current treatment plan including medication therapy, reduced calorie diet, and physical activity plan along with attestation that the beneficiary has been coundeled on lifestyle modifications needed
- Current labs, including comprehensive metabolic panel
- Documentation of past and current alcohol intake
- Attestation that metabolic comorbidities are being appropriately managed, including treatment of Type 2 diabetes, dyslipidemia, and hypertension if applicable
- Medical necessity over the use of a GLP-1 agonist if the beneficiary has type 2 diabetes; **AND**
- Current weight for dose verification
  - < 100 kg, the recommended dosage is 80 mg orally once daily.
  - ≥ 100 kg, the recommended dosage is 100 mg orally once daily.

RENEWAL REQUIREMENTS

- The beneficiary must remain compliant with therapy (defined as 75% utilization)
- To continue the medication after 12 months of therapy, the beneficiary should demonstrate a positive response to the medication as defined by:
  - Reduction in steatohepatitis without worsening liver fibrosis; **OR**
  - At least one stage improvement in liver fibrosis without worsening steatohepatitis
- The beneficiary must continue to refrain from excessive alcohol use
- The prescriber must submit the following:
  - Current chart notes
  - Current weight
  - Current labs
  - Attestation that the beneficiary continues with diet and exercise plan
  - Current non-alcoholic fatty liver disease (NAFLD) Activity Score (NAS) if new biopsy was done; **AND**
  - Current fibrosis staging documentation requires the following:
    - Liver biopsy results; **OR**
    - Fibrosis score results from **two** testing modalities with at least **one** blood-based non-invasive test (NITs) **and** at least **one** imaging test from the lists below:
      - NITs
        - Fibrosis-4 index (FIB-4)
        - AST to platelet ratio index (APRI)
        - NAFLD fibrosis score (NFS)
        - Enhanced liver fibrosis (ELF) or simplified ELF index

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- FibroSure
- Imaging results
  - Vibration-controlled transient elastography (VCTE) (e.g., FibroSCAN)
  - Two-dimensional shear weave elastography
  - Point shear wave elastography
  - Magnetic Resonance Elastography (MRE)

QUANTITY EDITS

Each strength #31 tablets per 31 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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RISDIPLAM TABLET/SOLUTION (EVRYSDI)

Updated 10/16/2024

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with spinal muscular atrophy (SMA) by genetic testing with the following:
  - Documentation of SMN1 gene deletion or mutation; **AND**
  - Documentation of ≤ 4 copies of SMN2 gene whether a pre-symptomatic infant or symptomatic beneficiary (SMA Type 1, 2, or 3)
- The medication must be prescribed by or in consultation with a neurologist experienced in treating SMA
- The beneficiary should not be approved or continue the medication if meet **one** of the following:
  - Dosage requested is not consistent with the beneficiary's age and weight
  - Pregnant
  - Requires a Multidrug and Toxin Extrude (MATE1) substrate such as metformin, cimetidine or acyclovir. If concomitant use cannot be avoided, monitor for drug-related toxicities and consider dosage reduction of the co-administered drug
  - The beneficiary had previous administration of gene therapy (i.e., Zolgensma [onasemnogene abeparvovec-xioi]) either in a clinical study or as part of medical care
  - The prescriber requests concomitant treatment with a SMN2-targeting antisense oligonucleotide (i.e., Spinraza [nusinersen])
- The prescriber must submit the following:
  - Current chart notes with documentation of previous therapies tried
  - Documentation of symptoms and age of onset if not pre-symptomatic
  - Current weight to verify dose requested
  - Genetic testing results
  - Documentation of pulmonary status (e.g., tracheostomy, hours on ventilation)
  - Negative pregnancy test for a female beneficiary of childbearing potential prior to beginning EVRYSDI therapy and/or has documentation of contraception use
  - Attestation that a female beneficiary of childbearing potential has been counseled about contraception

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- Attestation that a male beneficiary has been counseled about potential infertility with EVRYSDI therapy
- Documentation that the beneficiary is receiving physical therapy; **AND**
- Baseline motor ability assessment results of **one** of the following:
  - Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOPINTEND**)**
  - Motor Function Measure Score (MFM-32)
  - Revised Upper Limb Module (RULM)
  - Hammersmith Infant Neurological Examination Module 2 (HINE-2)
  - Hammersmith Functional Motor Scale Expanded (HFMSE); **OR**
  - Bayley Scales of Infant and Toddler Development, Third Addition (BSID-III or Bayley-III)

RENEWAL REQUIREMENTS

- The beneficiary must be compliant with therapy (defined as 75% utilization)
- A symptomatic beneficiary must demonstrate a positive response in SMA associated signs and symptoms by either an improvement or no significant decline in motor function score compared to baseline assessment by using the same measuring scale as the baseline score **or** demonstrating improvement or no significant decline in pulmonary function
- A beneficiary starting treatment prior to onset of symptoms must demonstrate a new motor milestone or maintained muscle function compared to pretreatment baseline with better outcomes than would be expected without treatment.
- The beneficiary has not received Zolgensma since began Evrysdi and beneficiary has not been ordered Spinraza to be given concomitantly
- The prescriber must submit the following:
  - Current chart notes
  - Current weight
  - Female beneficiaries of childbearing potential must have a negative pregnancy test prior to PA renewal **or** has documentation of contraception usage
  - Documentation of continued physical therapy; **AND**
  - Documentation of response to therapy using the same measuring scale as the baseline

QUANTITY EDITS

- Based on max dose of 5 mg per day, #3 bottles (240 mL total) per 31 days
- #30 tablets per 30 days

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ROFLUMILAST TABLET (DALIRESP)

Updated 1/15/2025

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must be diagnosed with severe chronic obstructive pulmonary disease (COPD) associated with chronic bronchitis and a history of exacerbations despite compliance with GOLD guidelines recommended maintenance therapy (i.e., LAMA/LABA or LAMA/LABA/ICS)
- The beneficiary must remain on standard maintenance therapy and use this medication as add-on therapy
- The beneficiary should not be approved or continue this therapy with any of the following:
  - Moderate to severe liver impairment (Child-Pugh B or C)
  - Prescribed for relief of acute bronchospasm
  - Require concomitant strong CYP3A4 inducers (e.g., rifampicin, phenobarbital, carbamazepine, phenytoin)
  - FEV1 > 50% predicted; **OR**
  - Current smoker that refused to start a cessation plan
- The prescriber must submit the following:
  - Current chart notes with previous and current therapies
  - Current pulmonary function tests as baseline
  - History of exacerbations
  - Documentation of smoking history; **AND**
  - If currently smoking, provide smoking cessation plan

RENEWAL REQUIREMENTS

- The beneficiary is compliant with therapy (defined as 75% utilization)
- The beneficiary must demonstrate a positive response to therapy as indicated by at least **one** of the following:
  - Decrease in quantity and/or severity of exacerbations; **OR**
  - Improvement in lung function/FEV1 over baseline; **OR**
  - Improvement in COPD-related symptoms and/or quality of life
- The beneficiary must remain a non-smoker
- The prescriber must submit the following:
  - Current chart notes
  - Current PFTs; **AND**
  - Attestation that the beneficiary continues to refrain from smoking

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ROFLUMILAST 0.3% CREAM AND FOAM (ZORYVE)

Updated 4/17/2024

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA FOR CREAM AND FOAM

- The medication must be prescribed by or in consultation with a dermatologist, rheumatologist, or other specialist treating plaque psoriasis
- The beneficiary has a documented diagnosis of moderate to severe plaque psoriasis
- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary must trial ≥ 6 months of topical drug therapy with either corticosteroids, calcipotriene, calcitriol, tazarotene, or a combination
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of previous therapies tried with duration and response
  - Current BSA
  - Current Investigator's Global Assessment (IGA) score
  - Current Worst Itch-Numeric Rating Score (WI-NRS); **AND**
  - Medical necessity over all other topical treatment options

APPROVAL CRITERIA FOR FOAM ONLY

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with seborrheic dermatitis **or** a diagnosis consistent with any new FDA-approved indications. Any off-label requests will be reviewed on a case-by-case basis.
- Based on the Investigator Global Assessment (IGA), the beneficiary must have moderate to severe seborrheic dermatitis which would be an IGA score of 3–4 with current standard of care treatment (i.e., topical antifungals, topical corticosteroids, topical calcineurin inhibitors)
- Beneficiaries with scalp seborrheic dermatitis must have tried and failed a 30-day trial for all of the following within the last 6 months:
  - Over the counter (OTC) antifungal shampoo (e.g., selenium sulfide, zinc pyrithione)
  - Prescription antifungal shampoo (e.g., ketoconazole); **AND**
  - High-potency topical corticosteroids
- Beneficiaries with non-scalp seborrheic dermatitis (body and face) must have tried and failed a 30-day trial for all of the following within the last 6 months:

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- Topical antifungal (e.g., ketoconazole, ciclopirox)
- Low-potency topical corticosteroids for face and medium-potency topical corticosteroids for body; **AND**
- Topical calcineurin inhibitor (e.g., tacrolimus)

- The prescriber must submit the following:
  - Current chart notes
  - Documentation of previous therapies tried with duration and response
  - Current BSA impacted
  - Current Investigator's Global Assessment (IGA) score (between 0–4)
  - Current Worst Itch-Numeric Rating Score (WI-NRS) (between 0–10); **AND**
  - Medical necessity over all other topical treatment options
- Initial approval will be for 2 months

RENEWAL REQUIREMENTS

- For continuation, the beneficiary must demonstrate clinical improvement with decreased IGA score and WI-NRS. IGA score must show a 2-grade improvement compared to baseline.
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of response to therapy; **AND**
  - Medical necessity for continuation of therapy

QUANTITY EDITS FOR CREAM AND FOAM

6 tubes per year (1 tube per claim)

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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ROSACEA AGENTS

Updated 10/1/2025

PREFERRED AGENTS

- metronidazole 0.75% cream (generic for METROCREAM/ROSADAN)
- metronidazole 0.75% gel (generic for METROGEL/ROSADAN)
- metronidazole 1% gel (generic for METROGEL)

NON-PREFERRED AGENTS

- azelaic acid (generic for FINACEA)
- brimonidine gel (generic for MIRVASO)
- EPSOLAY (benzoyl peroxide)
- FINACEA (azelaic acid)
- ivermectin 1% cream (generic for SOOLANTRA)
- METROCREAM (metronidazole)
- METROGEL (metronidazole)
- metronidazole lotion (generic for METROLOTION)
- MIRVASO (brimonidine)
- oxymetazoline (generic for RHOFADE)
- RHOFADE (oxymetazoline)
- ROSADAN (metronidazole)
- SOOLANTRA 1% cream (ivermectin)

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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RUXOLITINIB (OPZELURA)

Updated 7/17/2024

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA FOR NONSEGMENTAL VITILIGO

- The beneficiary meets the minimum age recommended in the manufacturer's package insert
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with nonsegmental vitiligo
- The beneficiary must meet the following:
  - Body surface area (BSA) involvement must be ≤ 10%
  - Trial and failure of the following within the last 6 months with 12 weeks trial each:
    - Medium to superpotent topical corticosteroid used continuously or intermittently
    - Topical calcineurin inhibitor (i.e., pimecrolimus or tacrolimus); **AND**
  - Treatment area includes face, neck, eyelids, or hands
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of previous therapies tried
  - Baseline description of vitiligo with location
  - BSA of vitiligo; **AND**
  - Letter of medical necessity over other treatment options
- Beneficiaries that do not meet the above criteria will require prior authorization review on a case-by-case basis
- Initial approval will be 24 weeks

RENEWAL REQUIREMENTS

- The beneficiary must remain compliant with therapy (defined as 75% utilization)
- The beneficiary must have documented at least 50% improvement (clinical trial measured 75% and 90%)
- The prescriber must submit the following:
  - Current chart notes
  - Current BSA; **AND**
  - Current description of vitiligo

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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SALICYLIC ACID GEL (SALICATE)

Updated 10/16/2024

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with excessive keratin in hyperkeratotic skin disorders (e.g., verrucae and the various ichthyoses, keratosis palmaris and plantaris, keratosis pilaris, pityriasis rubra pilaris, and psoriasis)
- At a minimum, beneficiary must have trial and failure of salicylic acid products over the counter
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of previous therapies tried
  - Description of beneficiary's skin disorder as a baseline; **AND**
  - Letter of medical necessity of this product over other treatment options available including products available over the counter

RENEWAL REQUIREMENTS

- The beneficiary must demonstrate an improvement of excessive keratin compared to baseline
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Documentation of response to therapy

QUANTITY EDITS

1 bottle every 30 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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SAPROPTERIN DIHYDROCHLORIDE (KUVAN, JAVYGTOR, AND ZELVYSIA)

Updated 1/15/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must be diagnosed with tetrahydrobiopterin-(BH4-) responsive Phenylketonuria (PKU) with elevated blood phenylalanine (Phe) levels
- The medication must be prescribed by or in consultation with an endocrinologist, geneticist, or other specialist knowledgeable in treating PKU
- The beneficiary must use a Phe-restricted diet
- The beneficiary should not be approved or continue this therapy with any of the following:
  - Dose requested is not supported for beneficiary's weight
- The prescriber must submit the following:
  - Current chart notes
  - Previous therapies tried
  - Current blood phenylalanine (Phe) level drawn within 30 days of prior authorization request
  - Current weight; **AND**
  - Attestation that the beneficiary is ordered a Phe-restricted diet
- Initial approvals will be for 30 days. After 30 days, the prescriber must verify that the beneficiary responded to treatment as defined as ≥ 30% decrease in blood phenylalanine levels from baseline.
  - If the beneficiary was initiated at 10 mg/kg/day dose, then a subsequent trial of 20 mg/kg/day for 30 days can be approved. Then the prescriber must verify that the beneficiary responded to treatment.
  - If the beneficiary does not meet the requirement improvement of 20 mg/kg/day dose after 30 days, then no additional prior authorization approvals will be approved as this beneficiary would be considered a non-responder.

RENEWAL REQUIREMENTS

- The beneficiary must be compliant with therapy (defined as 75% utilization)
- The beneficiary must demonstrate a positive response with ≥ 30% decrease in blood phenylalanine levels from baseline
- The prescriber must submit the following:
  - Current chart notes
  - Updated blood Phe levels; **AND**
  - Current weight

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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SECNIDAZOLE (SOLOSEC)

Updated 4/18/2018

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary must be female
- The beneficiary must be ≥ 18 years of age
- The prescriber must submit documentation to substantiate the medial necessity of beneficiary receiving SOLOSEC over other more cost-effective medications that do not require prior authorization and are indicated for treating bacterial vaginosis or the DrugDex information supports the effectiveness of treating bacterial vaginosis.

QUANTITY EDITS

1 dose per claim

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SEDATIVE HYPNOTICS

Updated 1/1/2026

PREFERRED AGENTS WITH CRITERIA IN BENZODIAZEPINE CLASS

- temazepam 15 mg and 30 mg capsule (generic for RESTORIL)
- triazolam (generic for HALCION)

NON-PREFERRED AGENTS IN BENZODIAZEPINE CLASS

- DORAL (quazepam)
- estazolam (generic for PROSOM)
- flurazepam (generic for DALMANE)
- HALCION (triazolam)
- quazepam (generic for DORAL)
- RESTORIL (temazepam)
- temazepam 7.5 and 22.5 mg capsule (generic for RESTORIL)

PREFERRED AGENTS WITH CRITERIA IN NON-BENZODIAZEPINE CLASS

- eszopiclone (generic for LUNESTA)
- zaleplon (generic for SONATA)
- zolpidem tablet (generic for AMBIEN)

NON-PREFERRED AGENTS IN NON-BENZODIAZEPINE CLASS

- AMBIEN (zolpidem)
- AMBIEN CR (zolpidem ER)
- BELSOMRA (suvorexant)
- DAYVIGO (lemborexant)
- doxepin tablet (generic for SILENOR)
- EDLUAR SL (zolpidem)
- HETLIOZ (tasimelteon)
- QUVIVIQ (daridorexant)
- ramelteon (generic for ROZEREM)
- ROZEREM (ramelteon)
- tasimelteon (generic for HETLIOZ) (see criteria for HETLIOZ)
- zolpidem capsule
- zolpidem (generic for AMBIEN CR)
- zolpidem SL (generic for EDLUAR)

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ADDITIONAL CRITERIA

Quantity limits apply

AGE EDITS

Product	Minimum Age	Product	Minimum Age
daridorexant (QUVIVIQ)	18	suvorexant (BELSOMRA)	18
doxepin (SILENOR)	18	temazepam (RESTORIL)	18
estazolam (PROSOM)	18	triazolam (HALCION)	N/A
eszopiclone (LUNESTA)	18	zaleplon (SONATA)	18
flurazepam (DALMANE)	18	zolpidem (AMBIEN)	18
lemborexant (DAYVIGO)	18	zolpidem ER (AMBIEN CR)	18
ramelteon (ROZEREM)	18	zolpidem SL (EDLUAR)	18

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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SELADELPAR LYSINE (LIVDELZI)

Updated 10/16/2024

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with primary biliary cholangitis (PBC) confirmed by **two** of the following:
  - An alkaline phosphatase (ALP) level of at least 1.67 times ULN
  - Presence of antimitochondrial antibodies (AMA) at a tier of 1:40 or higher; **OR**
  - Histologic evidence of PBC (nonsuppurative destructive cholangitis and destruction of interlobular bile ducts)
- The medication must be prescribed by or in consultation with a hepatologist or gastroenterologist
- The beneficiary must have had an inadequate response to ursodeoxycholic acid (UDCA) without improvement in LFTs and documented PBC related symptoms after a 1-year trial or the beneficiary must demonstrate intolerance to UDCA (e.g., Ursodiol)
- The beneficiary with an inadequate response to UDCA alone must take Livdelzi concomitantly with UDCA unless intolerant to UDCA
- The beneficiary should not be approved or continue this therapy with any of the following:
  - Has decompensated cirrhosis (e.g., ascites, variceal bleeding, hepatic encephalopathy)
  - Is pregnant
  - Has complete biliary obstruction
  - Requires OAT3 inhibitors (e.g., probenecid) or strong CYP2C9 inhibitors; **AND**
  - Has end-stage renal disease and on dialysis
- The prescriber must submit the following:
  - Current chart notes with beneficiary's specific symptoms
  - Documentation of previous therapies tried with response
  - Labs including liver function tests with baseline alkaline phosphatase
  - Current treatment plan; **AND**
  - Medical necessity over UDCA taken as monotherapy

RENEWAL REQUIREMENTS

- The beneficiary must remain compliant with therapy (defined as 75% utilization)

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- The beneficiary must demonstrate a positive response to Livdelzi with an improvement in symptoms and corresponding labs while experiencing no intolerable side effects
- The beneficiary must remain on ursodeoxycholic acid concomitantly unless there are tolerability issues
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of response to therapy with summary of current symptoms; **AND**
  - Current labs, including liver function tests with alkaline phosphatase

QUANTITY EDITS

#30 capsules per 30 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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SEMAGLUTIDE INJECTION (OZEMPIC) (TYPE 2 DIABETES MELLITUS WITH CHRONIC KIDNEY DISEASE ONLY)

Updated 7/16/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with type 2 diabetes mellitus and chronic kidney disease
- The beneficiary must have urine albumin-creatinine ratio (UACR) of ≥ 30 mg/g and eGFR < 60 mL/min/1.73 m^2
- The beneficiary should be taking an angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) at maximally tolerated doses or have a contraindication to their use.
- The beneficiary must have a history of a sodium-glucose cotransporter 2 (SGLT-2) inhibitor use prior to beginning this medication or a has a contraindication to their use
- The prescriber must submit the following:
  - Current chart notes
  - Previous therapies tried
  - Current labs, including urine albumin-creatinine ratio (UACR), eGFR, and HbA1c; **AND**
  - Current weight

RENEWAL REQUIREMENTS

- The beneficiary must remain compliant with therapy (defined as 75% utilization)
- The prescriber must submit the following:
  - Current chart notes
  - Current labs, including urine albumin-creatinine ratio (UACR), eGFR, and HbA1c
  - Current weight; **AND**
  - Response to therapy

QUANTITY EDITS

1 pen per month

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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SEMAGLUTIDE INJECTION AND ORAL TABLET (WEGOVY)

Updated 10/15/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

Note: Arkansas Medicaid does not currently cover medications solely for the use of weight loss. PA requests for this medication must demonstrate that the beneficiary has established cardiovascular disease and is at risk for a major cardiovascular event.

APPROVAL CRITERIA FOR MACE (INJECTION AND TABLET)

- The beneficiary meets the minimum age recommended in the manufacturer's package insert
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- For initial approval, beneficiary must meet all of the following:
  - Diagnosed with established cardiovascular disease with at least **one** of the following:
    - History of myocardial infarction **or** history of stent placement or bypass surgery
    - History of stroke
    - Symptomatic peripheral arterial disease
      - Intermittent claudication with an ABI (ankle brachial index) of less than or equal to 0.9; **OR**
      - Peripheral arterial revascularization procedure or amputation due to atherosclerotic disease
  - Considered either obese or overweight (defined as baseline BMI of $\geq$ 27 kg/m^2)
  - Considered to be at risk for major cardiovascular events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke); **AND**
  - Has outlined treatment plan including reduced calorie diet and increased physical activity.
- The beneficiary must not be a current smoker or has started a smoking cessation program
- The beneficiary should not be approved or continue this therapy with any of the following:
  - No documented risk for MACE
  - Not considered overweight or obese (baseline BMI < 27 kg/m^2)
  - Personal or family history of medullary thyroid carcinoma (MTC)
  - Diagnosed with Multiple Endocrine Neoplasia syndrome type 2 (MEN 2)
  - Requested for weight loss only; **AND**
  - Current smoker without a cessation plan
- The prescriber must submit the following:
  - Current chart notes
  - Current labs, including HbA1c and lipid panel
  - Current and previous therapy for cardiovascular disease
  - Baseline BMI and weight

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- Baseline waist circumference, blood pressure, and heart rate; **AND**
- Current treatment plan, including medication therapy, reduced calorie diet, and physical activity plan along with attestation that beneficiary has been counseled on lifestyle modifications needed to assist with weight loss and improvement in cardiovascular disease

RENEWAL REQUIREMENTS FOR MACE (INJECTION AND TABLET)

- The beneficiary must be compliant with therapy (defined as 75% utilization)
- Renewal requires the following:
  - Improvement in cardiometabolic parameters (e.g., blood pressure, heart rate, labs) and body measurements; **AND**
  - Continues with lifestyle modifications
- The prescriber must provide the following:
  - Current chart notes
  - Current BMI and weight
  - Current labs, including HbA1c and lipid panel; **AND**
  - Current waist circumference, blood pressure, and heart rate

APPROVAL CRITERIA FOR MASH (INJECTION ONLY)

- The beneficiary meets the minimum age recommended in the manufacturer's package insert
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with noncirrhotic metabolic dysfunction-associated steatohepatitis (MASH) with moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis)
- Fibrosis staging documentation requires the following:
  - Liver biopsy results; **OR**
  - Fibrosis score results from **two** testing modalities with at least **one** blood-based non-invasive test (NITs) **and** at least **one** imaging test from the lists below:
    - NITs
      - Fibrosis-4 index (FIB-4)
      - AST to platelet ratio index (APRI)
      - NAFLD fibrosis score (NFS)
      - Enhanced liver fibrosis (ELF) or simplified ELF index
      - FibroSure
    - Imaging tests
      - Vibration-controlled transient elastography (VCTE) (e.g., FibroScan)
      - Two-dimensional shear weave elastography
      - Point shear wave elastography

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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    - Magnetic Resonance Elastography (MRE)
- The medication must be must be prescribed by or in consultation with an endocrinologist, gastroenterologist or hepatologist
- The beneficiary must be considered either overweight or obese (defined as baseline BMI of ≥ 27 kg/m^2)
- The beneficiary must receive standard of care treatment for cardiometabolic comorbidities and healthy lifestyle counseling with an appropriate diet and exercise plan
- The prescriber must rule out any other causes of fibrosis (e.g., alcohol, hepatitis C)
- The beneficiary must not have a personal or family history of medullary thyroid carcinoma (MTC) or should not be diagnosed with Multiple Endocrine Neoplasia syndrome type 2 (MEN 2)
- The beneficiary with type 2 diabetes mellitus and MASH must utilize a GLP-1 agonist indicated for diabetes
- Prior authorization request should not be for weight loss only
- The prescriber must submit the following:
  - Current chart notes
  - Current labs, including HbA1c and lipid panel
  - Fibrosis staging documentation as listed above and baseline non-alcoholic fatty liver disease (NAFLD) Activity Score (NAS) if biopsy was done
  - Current and previous therapy for MASH
  - Baseline BMI and weight
  - Documentation of past and current alcohol intake; **AND**
  - Current treatment plan including medication therapy, reduced calorie diet, and physical activity plan along with attestation that beneficiary has been counseled on lifestyle modifications needed to assist with weight loss and metabolic syndrome
- Initial PA will be for 6 months to monitor for compliance. Renewal PAs may be for 12 months if approved.

RENEWAL REQUIREMENTS FOR MASH (INJECTION ONLY)

- The beneficiary has been compliant with therapy (defined as 75% utilization)
- The beneficiary must have a positive response defined as **one** of the following:
  - Reduction in steatohepatitis without worsening liver fibrosis; **OR**
  - At least one stage improvement in liver fibrosis without worsening steatohepatitis
- The prescriber must submit the following:
  - Current chart notes
  - Current BMI and weight
  - Current labs
  - Attestation that beneficiary continues with diet and exercise plan

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- Current non-alcoholic fatty liver disease (NAFLD) Activity Score (NAS) if new biopsy was done; **AND**
- Current fibrosis staging documentation requires the following:
  - Liver biopsy results; **OR**
  - Fibrosis score results from **two** testing modalities with at least **one** blood-based non-invasive test (NITs) **and** at least **one** imaging test from the lists below:
  - NITs
    - Fibrosis-4 index (FIB-4)
    - AST to platelet ratio index (APRI)
    - NAFLD fibrosis score (NFS)
    - Enhanced liver fibrosis (ELF) or simplified ELF index
    - FibroSure
  - Imaging tests
    - Vibration-controlled transient elastography (VCTE) (e.g., FibroScan)
    - Two-dimensional shear weave elastography
    - Point shear wave elastography
    - Magnetic Resonance Elastography (MRE

QUANTITY EDITS

Each strength: 4 injections per month or 31 tablets per month

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SEPIAPTERIN ORAL POWDER (SEPHIENCE)

Updated 10/15/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with sepiapterin-responsive phenylketonuria (PKU) with elevated blood phenylalanine (Phe) levels despite a Phe-restricted diet
- The medication must be prescribed by or in consultation with an endocrinologist, geneticist, or other specialist knowledgeable in treating PKU
- The beneficiary must use a Phe-restricted diet during treatment
- The beneficiary must meet **one** of the following:
  - Tried and had an inadequate response to sapropterin despite compliance on therapy (i.e., considered a non-responder); **OR**
  - Had intolerance or hypersensitivity to sapropterin that is not expected with SEPHIENCE; **OR**
  - Medical necessity over the use of sapropterin is supported in literature (provide supporting literature)
- The beneficiary may not use concomitantly with other medications used to treat PKU (e.g., sapropterin [KUVAN, JAVYGTOR] or pegvaliase-pqpz [PALYNZIQ])
- The beneficiary should not exceed a maximum dose of 60 mg/kg/day
- The prescriber must submit the following:
  - Current chart notes
  - Previous therapies tried with response
  - Current blood phenylalanine (Phe) level drawn within 30 days of prior authorization request
  - Attestation that the beneficiary has been ordered a Phe-restricted diet
- Initial approvals will be for 90 days. After 90 days, the prescriber must verify that the beneficiary responded to treatment as defined as ≥ 30% decrease in blood phenylalanine levels from baseline

RENEWAL REQUIREMENTS

- The beneficiary has been compliant with therapy (defined as 75% utilization)
- The beneficiary has documented improvement with a decrease in PHE level by at least 30% compared to baseline without intolerable side effects
- The prescriber must submit the following:
  - Current chart notes

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- Current blood phenylalanine (Phe) level
- Attestation that beneficiary remains on a Phe-restricted diet

QUANTITY EDITS

- 250 mg: #93 per 31 days
- 1,000 mg: #186 per 31 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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SETMELANOTIDE (IMCIVREE)

Updated 7/15/2026

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with **ONE** of the following:
  - Monogenic or syndromic obesity due to pro-opiomelanocortin (POMC), proprotein convertase subtilisin/kexin type 1 (PCSK1), or leptin receptor (LEPR) deficiency;
  - Monogenic or syndromic obesity due to Bardet-Biedl syndrome (BBS); **OR**
  - Acquired hypothalamic obesity (HO)
- Confirmation of diagnosis requires:
  - HO – Confirmed hypothalamic injury or dysfunction (e.g., craniopharyngioma) with rapid weight gain within the first year after injury/dysfunction onset
  - POMC, PCSK1, or LEPR deficiency – genetic testing that confirms variants in the POMC, PCSK1, or LEPR genes that are interpreted as pathogenic, likely pathogenic, or of uncertain significance
  - BBS – Confirmed by presence of four major features associated with BBS **or** three major features plus two minor features; **AND**
    - Major features associated with BBS:
      - Rod-cone dystrophy
      - Polydactyly
      - Obesity
      - Learning disabilities
      - Hypogonadism in males
      - Renal abnormalities
    - Minor features associated with BBS:
      - Speech disorder/delay
      - Strabismus/cataracts/astigmatism
      - Brachydactyly/syndactyly
      - Developmental delay
      - Polyuria/polydipsia (nephrogenic diabetes insipidus)
      - Ataxia/poor coordination/imbalance

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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    - Mild spasticity (especially lower limbs)
    - Diabetes mellitus
    - Dental crowding/hypodontia/small roots/high arched palate
    - Left ventricular hypertrophy/congenital heart disease
    - Hepatic fibrosis
- The beneficiary must meet the following for obesity diagnosis:
  - POMC, PCSK1, or LEPR deficiency must have a baseline body mass index (BMI) ≥ 30 kg/m^2 or pediatric weight ≥ 95th percentile using growth chart assessment
  - BBS must have a baseline BMI ≥30 kg/m² or pediatric weight ≥ 97th percentile using growth chart assessment; **OR**
  - HO must have a baseline BMI ≥ 30 kg/m^2 for adults, or pediatric patients must have a BMI ≥ 95th percentile for age and sex.
- The medication must be prescribed by or in consultation with a specialist (e.g., endocrinologist, geneticist, obesity specialist)
- The beneficiary should not be approved or continue this therapy with any of the following:
  - Genetic testing does not confirm POMC, PCSK1, or LEPR deficiency, or the variants are classified as benign or likely benign and clinical symptoms do not support the BBS diagnosis, and there is no evidence of hypothalamus injury to support the HO diagnosis
  - Doesn't meet obesity requirements
  - Obesity is not determined to be related to POMC, PCSK1 or LEPR deficiency, BBS, or HO; **OR**
  - End stage renal disease (eGFR < 15 mL/min/1.73 m^2)
- Beneficiaries with HO must be monitored closely if diagnosed with secondary adrenal insufficiency or central diabetes insipidus/arginine vasopressin deficiency
- The prescriber must submit **all** of the following:
  - Current chart notes
  - Current weight and BMI
  - Genetic testing confirming a diagnosis of pro-opiomelanocortin (POMC), proprotein convertase subtilisin/kexin type 1 (PCSK1), or leptin receptor (LEPR) deficiency, **or** clinical symptoms suggesting a BBS diagnosis, **or** evidence of hypothalamus injury suggesting HO diagnosis; **AND**
  - Current estimated glomerular filtration rate (eGFR)
- Initial PA for 4 months

RENEWAL REQUIREMENTS

- The beneficiary must remain compliant with therapy (defined as at least 75% utilization)
- Beneficiaries diagnosed with POMC, PCSK1, or LEPR deficiency must have lost at least 5% of baseline body weight or 5% of baseline BMI for beneficiaries with continued growth potential after 12–16 weeks

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- Beneficiaries diagnosed with BBS must have lost at least 5% of baseline body weight or 5% of baseline BMI for beneficiaries < 18 years of age after 1 year with some improvement at 4-month review
- Beneficiaries diagnosed with HO must at least a 5% reduction of BMI after 1 year with some improvement at 4-month review
- The beneficiary must continue to meet approval criteria
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Current weight and BMI

QUANTITY EDITS

10 vials per month

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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SIBEPRENLIMAB (VOYXACT)

Updated 4/15/2026

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary is diagnosed with primary immunoglobulin A nephropathy (IgAN) at risk for disease progression with proteinuria (either urine protein/creatinine ratio based on 24-hour urine collections [uPCR-24h] ≥ 0.75 g/g or urine protein ≥ 1.0 g/day)
- Must be prescribed by, or in consultation with, a nephrologist
- The beneficiary must demonstrate continued risk for disease progression despite at least 3 months of maximally tolerated supportive care (i.e., angiotensin-converting enzyme (ACE) inhibitor or angiotensin-receptor blocker (ARB), immunosuppressive therapy, sodium-glucose co-transporter 2 (SGLT2) inhibitor)
- The beneficiary must have had a previous trial and failure of TARPEYO (budesonide delayed-release capsule) unless contraindicated
- The beneficiary must remain on supportive care at maximally tolerated doses unless contraindicated
- The prescriber must submit all of the following:
  - Current chart notes
  - Previous therapies
  - Current labs, including LFTs, eGFR, urine protein or UPCR
  - Confirmation of the IgAN diagnosis with renal biopsy results and labs
  - Medical necessity over the use of typical supportive care (i.e., ACEi, ARB, SGLT2), TARPEYO, FILSPARI, and VANRAFIA

RENEWAL REQUIREMENTS

- The beneficiary has documented improvement in proteinuria with a reduction in UPCR or urine protein compared to baseline
- The prescriber must submit the following:
  - Current chart notes
  - Current labs, including LFTs, eGFR, lipid panel, and urine protein or UPC

QUANTITY EDITS

- #1 syringe per 28 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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SILDENAFIL TABLET (REVATIO)

Updated 2/13/2017

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- Diagnosis of pulmonary heart disease in the last 365 days; **OR**
- Diagnosis of persistent fetal circulation in the last 365 days; **OR**
- Diagnosis of chronic respiratory disease arising in the perinatal period in the last 365 days

DENIAL CRITERIA

- **One** of the following diagnoses in the last 180 days:
  - Cavernosal fibros; **OR**
  - Hypotension; **OR**
  - Leukemia; **OR**
  - Life-threatening arrhythmia; **OR**
  - Malignant hypertension; **OR**
  - Multiple myeloma; **OR**
  - Myocardial infarction; **OR**
  - Peyronie's disease; **OR**
  - Retinitis pigmentosa; **OR**
  - Sickle cell disease; **OR**
  - Stroke; **OR**
  - Unstable angina
- History of any of the following in the last 45 days:
  - Alpha-adrenergic blockers; **OR**
  - Nitrates; **OR**
  - tamsulosin
- Concurrent use of any of the following:
  - indinavir; **OR**
  - lopinavir-ritonavir; **OR**
  - ritonavir

ADDITIONAL CRITERIA – SEE PAH SECTION

- Pulmonary Arterial Hypertension
- Quantity limits apply

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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SINECATECHINS (VEREGEN)

Updated 6/19/2008

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- Diagnosis of Condyloma Acuminata (commonly known as external genital or perianal warts) within the past two months; **AND**
- ≤ 124 days of Veregen therapy in the past 365 days

ADDITIONAL CRITERIA

- Limited to 18 years of age and older
- Max quantity per claim: 30 grams
- Limited to 60 grams per 365 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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SIROLIMUS (HYFTOR)

Updated 1/18/2023

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- Maximum dose as specified in the manufacturer's package insert or support in the official Compendia
- The beneficiary is diagnosed with tuberous sclerosis with facial angiofibromas **or** a diagnosis consistent with any updated FDA-approved indications or supported in the official Compendia
- The beneficiary must have at least 3 angiofibromas measuring ≥ 2 mm in diameter
- The beneficiary should not be approved or continued on this therapy with any of the following:
  - Pregnancy
  - Requires live vaccine (should be completed prior to therapy initiation)
  - No improvement after 12 weeks of treatment; **OR**
  - Does not have at least three angiofibromas measuring ≥ 2 mm in diameter
- The prescriber must submit **all** of the following:
  - Current chart notes documenting a diagnosis of tuberous sclerosis
  - Baseline description of facial angiofibromas; **AND**
- If approved, PA duration will be 3 months

RENEWAL REQUIREMENTS

- The prescriber must submit current chart notes with documented change from baseline
- The beneficiary must have at least a 50% reduction in angiofibroma size and redness by 3 months of use.

QUANTITY EDITS

2 tubes per 31 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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SKELETAL MUSCLE RELAXANTS

Updated 10/1/2025

PREFERRED AGENTS

- baclofen 5 mg, 10 mg, and 20 mg tablet (generic for LIORESAL)
- chlorzoxazone 500 mg tablet (generic for PARAFON)
- cyclobenzaprine 5 and 10 mg tablet (generic for FLEXERIL)
- metaxalone 400 mg and 800 mg tablet (generic for SKELAXIN)
- methocarbamol 500 mg and 750 mg tablet (generic for ROBAXIN)
- tizanidine tablet (generic for ZANAFLEX)

NON-PREFERRED AGENTS

- AMRIX ER (cyclobenzaprine)
- ATMEKSI (methocarbamol)
- baclofen solution (generic for OZOBAX/OZOBAX DS)
  - **Note**: Payable at Point of Sale (POS) for beneficiaries < 7 years of age or who have a diagnosis of NPO (Appendix A) in history
- baclofen suspension (generic for FLEQSUVY)
  - **Note**: Payable at Point of Sale (POS) for beneficiaries < 7 years of age or who have a diagnosis of NPO (Appendix A) in history
- baclofen 15 mg tablet
- chlorzoxazone 250 mg, 375 mg, and 750 mg tablet (generic for LORZONE)
- cyclobenzaprine 7.5 mg tablet (generic for FEXMID)
- cyclobenzaprine ER (generic for AMRIX)
- DANTRIUM (dantrolene)
- dantrolene (generic for DANTRIUM)
- FEXMID (cyclobenzaprine)
- FLEQSUVY (baclofen)
- metaxalone 640 mg tablet
- methocarbamol 1,000 mg tablet (generic for TANLOR)
- NORGESIC (orphenadrine/aspirin/caffeine)
- NORGESIC FORTE (orphenadrine/aspirin/caffeine)
- ONTRALFY (tizanidine)
- orphenadrine citrate ER (generic for NORFLEX)
- orphenadrine/aspirin/caffeine (generic for NORGESIC)
- ORPHENGESIC FORTE (orphenadrine/aspirin/caffeine)
- TANLOR (methocarbamol)

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- tizanidine capsule (generic for ZANAFLEX)
- TONMYA SL (cyclobenzaprine)
- ZANAFLEX (tizanidine)

APPROVAL CRITERIA FOR PREFERRED AGENTS INVOLVING THERAPEUTIC DUPLICATION

- No therapeutic duplication with overlapping days' supply between any preferred medications unless the beneficiary has a diagnosis of at least one the following in the past three years:
  - Cerebral palsy (ICD-10 group G80)
  - Multiple sclerosis (ICD-10 group G35); **OR**
  - Quadriplegia/paraplegia (ICD-10 group G82)

QUANTITY EDITS

methocarbamol 500 mg and 750 mg, up to 8 tablets/24 hours; #248 tablets per 31 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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SODIUM CHLORIDE INHALATION SOLUTION (HYPER-SAL)

Updated 5/24/2011

APPROVAL CRITERIA

Diagnosis of cystic fibrosis within the past three years

ADDITIONAL CRITERIA

Quantity limits apply

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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SODIUM ZIRCONIUM CYCLOSILICATE (LOKELMA)

Updated 1/15/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must be diagnosed with hyperkalemia
- The beneficiary has either discontinued or decreased the dose on medications known to cause hyperkalemia to the lowest effective dose (e.g., aldosterone antagonists, nonsteroidal anti-inflammatory drugs [NSAIDs])
- The beneficiary must be prescribed a low potassium diet
- The beneficiary should not be approved or continue this therapy with any of the following:
  - Has severe constipation, bowel obstruction or impaction, including abnormal post-operative bowel motility disorders
  - Prescribed as an emergency treatment; **OR**
  - Develops clinically significant hypokalemia
- The prescriber must submit the following:
  - Current chart notes
  - Previous treatments tried
  - Current potassium levels; **AND**
  - Letter of medical necessity over other products available for lowering potassium that do not require prior authorization (e.g., sodium polystyrene, potassium-depleting diuretics)

RENEWAL REQUIREMENTS

- The beneficiary must remain compliant with therapy (defined as 75% utilization)
- The beneficiary must have a positive response to therapy with a decrease in potassium levels
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Current potassium level

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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SOFPIRONIUM BROMIDE (SOFDRA)

Updated 4/16/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with primary axillary hyperhidrosis with excessive sweating for at least 6 months despite the use of topical antiperspirants
- The beneficiary should not be approved or continue the medication if meets **one** of the following:
  - Diagnosed with secondary focal hyperhidrosis or Frey's Syndrome; **OR**
  - Diagnosed with generalized hyperhidrosis, night sweats, or excessive sweating
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of products tried with response; **AND**
  - Medical necessity over aluminum chloride-containing topical antiperspirants or has documented intolerance
- Initial approval would be for 3 months, subsequent approvals may be up to 6 months

RENEWAL REQUIREMENTS

- The beneficiary must remain compliant with therapy (defined as 75% utilization)
- The beneficiary must demonstrate a positive response to treatment with documentation of decreased sweating compared to baseline
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Documentation of response to treatment

QUANTITY EDITS

1 bottle (50 mL) per 30 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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SOMATROPIN VIAL (SEROSTIM)

Updated 1/15/2025

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must be diagnosed with HIV and exhibits wasting or cachexia with at least **two** of the following symptoms:
  - Chronic weakness or diarrhea
  - Fever that lingers for at least 1 month
  - Fatigue
  - Loss of more than 10% of body weight; **AND**
  - Loss of both lean body mass and fat mass
- The beneficiary must be compliant with antiretroviral therapy in the previous 120 days
- The beneficiary's Medicaid profile must indicate previous trials of medications used to increase appetite (e.g., megestrol, dronabinol)
- The prescriber must submit the following:
  - Current chart notes
  - Documentation that supports wasting/cachexia; **AND**
  - Letter of medical necessity
- Initial PA for 3 months then rest for 8 weeks before re-evaluating for continued necessity. Treatment should not exceed 48 weeks

RENEWAL REQUIREMENTS

- The beneficiary must be compliant with therapy
- The beneficiary must demonstrate improvement with increase in lean body mass and weight and decrease in fat mass.
- Treatment should not exceed 48 weeks.
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Documentation of response to therapy

QUANTITY EDITS

Each strength #30 vials per 30 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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SOTALOL SOLUTION (SOTYLIZE)

Updated 1/15/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must be diagnosed with life-threatening ventricular arrhythmias or atrial fibrillation/atrial flutter who is currently in sinus rhythm
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Current labs, including renal function tests (dose should adjust if there is renal impairment)
- Letter of medical necessity outlining the need for SOTYLIZE solution over sotalol tablets that are available without prior authorization

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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SOTATERCEPT INJECTION (WINREVAIR)

Updated 10/16/2024

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with pulmonary arterial hypertension (PAH, World Health Organization [WHO] Group 1) Functional Class (FC) II or III **or** a diagnosis consistent with any new FDA-approved indications. Any off-label requests will be reviewed on a case-by-case basis.
- The medication must be prescribed by or in consultation with a cardiologist or pulmonologist
- The beneficiary has tried and failed a preferred medication from each of the following categories given as triple therapy for at least 90 days unless contraindicated:
  - Phosphodiesterase Inhibitors
  - Endothelin Receptor Antagonists; **AND**
  - Prostacyclin Analogues
- The beneficiary should not be approved or continue the medication if meet **one** of the following:
  - The beneficiary is diagnosed with pulmonary hypertension WHO groups 2, 3, 4, or 5
  - Baseline platelet count is < 50,000/mm^2
  - Experiencing serious bleeding
  - Pregnant
  - Breastfeeding
  - Current smoker without a smoking cessation plan
  - Has restrictive, constrictive, or congestive cardiomyopathy
  - Left ventricular ejection fraction < 45% on an echocardiogram within the previous 6 months
  - Any symptomatic coronary disease events in the previous 6 months; **OR**
  - Considered Functional Class I or IV
- The prescriber must submit the following:
  - Current chart notes with documentation of previous therapies
  - Current labs, including hemoglobin (Hgb) and platelets
  - Attestation that Hgb and platelet levels are monitored before each dose for the first 5 doses, or longer if values are unstable, and periodically thereafter, to determine if dose adjustments are required
  - Attestation that the beneficiary has been counseled on signs and symptoms of blood loss

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- Attestation that the beneficiary of reproductive potential has been counseled that WINREVAIR can impair fertility (male or female)
- Attestation that a female beneficiary of reproductive potential has been counseled to use contraception due to embryo-fetal toxicity
- Attestation that a female beneficiary has been counseled that breastfeeding is not recommended during treatment with WINREVAIR, and for 4 months after the final dose.
- Baseline 6-minute walk distance (6MWD); **AND**
- Baseline echocardiogram

RENEWAL REQUIREMENTS

- The beneficiary must remain compliant with therapy (defined as 75% utilization)
- The beneficiary must demonstrate a positive response with stabilization of PAH
- The prescriber must submit the following:
  - Current chart notes
  - Current labs, including Hgb and platelets
  - Current 6-minute walk distance; **AND**
  - Documentation that female of reproductive potential is continuing contraception and is not pregnant

QUANTITY EDITS

Each strength #4 injections per month (doses of 90 mg or 120 mg every 3 weeks)

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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SPARSENTAN (FILSPARI)

Updated 7/15/2026

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary is diagnosed with **ONE** of the following:
  - Primary immunoglobulin A nephropathy (IgAN) at risk for disease progression; **OR**
  - Focal segmental glomerulosclerosis (FSGS) needing proteinuria reduction without nephrotic syndrome, defined as urine protein excretion < 3.5 g/day or nephrotic-range proteinuria and a normal serum albumin concentration
    - Designate FSGS subtype (i.e., primary, secondary, genetic)
- The beneficiary must discontinue any prescriptions of renin-angiotensin, aldosterone system (RAAS) inhibitors, endothelin receptor antagonists (ERAs), and aliskiren
- The beneficiary, prescriber, and pharmacy must all be certified with the FILSPARI REMS program
- The beneficiary should have tried and failed an angiotensin-converting enzyme (ACE) inhibitor or angiotensin-receptor blocker (ARB) at maximally tolerated doses unless contraindicated
- Beneficiaries diagnosed with primary FSGS should have tried and failed immunosuppression (e.g., glucocorticoid, calcineurin inhibitor [CNI]) unless contraindicated
- Prior to beginning FILSPARI, the beneficiary must receive the necessary supportive treatment as advised for all patients with persistent proteinuria, including the use of RAS blockade, optimal BP control, and dietary salt restriction
- The beneficiary should not be approved with any of the following:
  - Baseline elevated aminotransferases > 3 times the ULN
  - Pregnancy (should be tested monthly)
  - Prescribed concomitant ACEI or ARB (cannot be on an ACEI or ARB with this med); **AND**
  - Clinically significant decrease in kidney function compared to baseline
- The prescriber must submit **all** of the following:
  - Current chart notes
  - Previous therapies
  - Current labs, including LFTs, eGFR, urine protein or UPCR
  - Confirmation of the IgAN diagnosis with renal biopsy results and labs

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- Confirmation of FSGS diagnosis along with FSGS subtype (i.e., primary, secondary, genetic) with renal biopsy results and labs; **AND**
- Attestation that the beneficiary has tested negative for pregnancy if of reproductive potential

RENEWAL REQUIREMENTS

- The beneficiary has been compliant with therapy (defined as 75% utilization based on Medicaid claims)
- The beneficiary has documented improvement in proteinuria with a reduction in UPCR or urine protein from baseline
- The prescriber must submit the following:
  - Current chart notes
  - Current labs, including LFTs, eGFR, urine protein or UPCR; **AND**
  - Attestation that the beneficiary has tested negative for pregnancy if of reproductive potential

QUANTITY EDITS

- 200 mg – #31 tablets per 31 days
- 400 mg – #31 tablets per 31 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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SUCRALFATE SUSPENSION (CARAFATE)

Updated 10/11/2011

APPROVAL CRITERIA

- < 7 years of age; **OR**
- NPO (Appendix A) within the past 365 days.

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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SULFAMETHOXAZOLE-TRIMETHOPRIM 800 – 160/20 ML UNIT DOSE CUP

Updated 04/08/2014

APPROVAL CRITERIA

Currently LTC

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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TACROLIMUS (ASTAGRAF XL AND ENVARSUS XR)

Updated 1/15/2025

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must have received a kidney transplant
- The beneficiary must be prescribed to take this product concomitantly with other immunosuppressants
- The prescriber must submit the following:
  - Chart notes
  - Previous therapies tried; **AND**
  - Letter of medical necessity over immediate release formulations that are available without prior authorization

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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TAFENOQUINE (KRINTAFEL)

Updated 5/17/2019

QUANTITY LIMITS

#2 tablets per claim

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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TADALAFIL (ADCIRCA)

Updated 2/13/2017

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- Diagnosis of pulmonary heart disease in the last 365 days; **OR**
- Diagnosis of persistent fetal circulation in the last 365 days; **OR**
- Diagnosis of chronic respiratory disease arising in the perinatal period in the last 365 days

DENIAL CRITERIA

- **One** of the following diagnoses in the last 180 days:
  - Cavernosal fibros; **OR**
  - Hypotension; **OR**
  - Leukemia; **OR**
  - Life-threatening arrhythmia; **OR**
  - Malignant hypertension; **OR**
  - Multiple myeloma; **OR**
  - Myocardial infarction; **OR**
  - Peyronie's disease; **OR**
  - Retinitis pigmentosa; **OR**
  - Sickle cell disease; **OR**
  - Stroke; **OR**
  - Unstable angina
- History of any of the following in the last 45 days:
  - Alpha-adrenergic blockers; **OR**
  - Nitrates; **OR**
  - tamsulosin
- Concurrent use of any of the following:
  - indinavir; **OR**
  - lopinavir-ritonavir; **OR**
  - ritonavir

ADDITIONAL CRITERIA – SEE PAH SECTION

- Pulmonary Arterial Hypertension
- Quantity limits apply

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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TAFAMIDIS (VYDAQEL AND VYNDAMAX)

Updated 7/17/2019

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- Manual review on a case-by-case basis ≥ 18 years of age
- Negative pregnancy test if applicable
- Medical history of Heart Failure (HF) with at least one prior hospitalization for HF or clinical evidence of HF (without hospitalization) manifested by signs or symptoms of volume overload or elevated intracardiac pressures
- Baseline NYHA class
- Documentation of variant TTR genotype and/or TTR precursor protein identification by immunohistochemistry, scintigraphy and mass spectrometry
- Baseline 6-Minute Walk Test
- Baseline Kansas City Cardiomyopathy Questionnaire-Overall Summary (KCCQ-OS) score.

DENIAL CRITERIA

- NYHA class IV
- Does not meet the approval criteria
- If the beneficiary previously had liver or heart transplant or had implanted a cardiac mechanical assist device
- If the beneficiary is pregnant

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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TAPINAROF CREAM (VTAMA)

Updated 10/19/2022

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The medication must be prescribed by or in consultation with a dermatologist, rheumatologist, or other specialist treating plaque psoriasis
- The beneficiary has a documented diagnosis of moderate to severe plaque psoriasis (see Atopic Dermatitis criteria)
- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary must trial ≥ 6 months of topical drug therapy with either corticosteroids, calcipotriene, calcitriol, tazarotene, or a combination
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of previous therapies tried with duration and response
  - Current BSA
  - Current Investigator's Global Assessment (IGA) score
  - Current Worst Itch-Numeric Rating Score (WI-NRS); **AND**
  - Medical necessity over all other topical treatment options

QUANTITY EDITS

6 tubes per year (1 tube per claim)

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TARGETED IMMUNE MODULATORS

Updated 1/1/2026

PREFERRED AGENTS WITH CRITERIA

(*Designates biosimilar)

- ENBREL (etanercept)
- HUMIRA (adalimumab)
- OTEZLA (apremilast)
- PYZCHIVA syringe (ustekinumab-ttwe)+* – **brand only**
- PYZCHIVA 45 mg vial (ustekinumab-ttwe)+* – **brand only**
- STEQEYMA syringe (ustekinumab-stba)+*
- STEQEYMA 45 mg vial (ustekinumab-stba) +*
- TALTZ (ixekizumab)+
- XELJANZ tablet (tofacitinib)+ - **brand only**
- XELJANZ XR tablet (tofacitinib)+ - **brand only**

+ PYZCHIVA, STEQEYMA, TALTZ, **and** XELJANZ/XELJANZ XR must have trial and failure of at least **one** preferred tumor necrosis factor (TNF) blocker (i.e., HUMIRA or ENBREL) unless there is a contraindication to the use of a TNF blocker

CONTINUATION CRITERIA FOR PREFERRED AGENTS

- **ENBREL**: Look back in pharmacy claims history 45 days for ≥ 1 paid claims for ENBREL
- **HUMIRA**: Look back in pharmacy claims history 45 days for ≥ 1 paid claims for HUMIRA
- **OTEZLA**: Look back in pharmacy claims history 45 days for ≥ 1 paid claims for OTEZLA
- **PYZCHIVA**: Look back in pharmacy claims history 120 days for ≥ 1 paid claims for PYZCHIVA
- **STEQEYMA:** Look back in pharmacy claims history 120 days for ≥ 1 paid claims for STEQEYMA
- **TALTZ**: Look back in pharmacy claims history 45 days for ≥ 1 paid claims for TALTZ
- **XELJANZ or XELJANZ XR**: Look back in pharmacy claims history 45 days for ≥ 1 paid claims for XELJANZ or XELJANZ XR

NON-PREFERRED AGENTS

(*Designates biosimilar)

- ABRILADA (adalimumab-afzb)*
- ACTEMRA syringe/autoinjector (tocilizumab)
- adalimumab-aacf (generic for IDACIO)*
- adalimumab-aaty (generic for YUFLYMA)*
- adalimumab-adaz (generic for HYRIMOZ)*

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- adalimumab-adbm (generic for CYLTEZO)*
- adalimumab-fkjp (generic for HULIO)*
- adalimumab-ryvk (generic for SIMLANDI)*
- AMJEVITA (adalimumab-atto)*
- ARCALYST (rilonacept)
- AVTOZMA syringe/autoinjector (tocilizumab-anoh)*
- BIMZELX (bimekizumab-bkzx)
- CIMZIA syringe (certolizumab)
- COSENTYX syringe/pen (secukinumab)
- CYLTEZO (adalimumab-adbm)*
- ENSPRYNG (satralizumab-mwge)
- ENTYVIO pen (vedolizumab)
- HADLIMA (adalimumab-bwwd)*
- HULIO (adalimumab-fkjp)*
- HYRIMOZ (adalimumab-adaz)*
- ICOTYDE (icotrokinra)
- IDACIO (adalimumab-aacf)*
- ILARIS (canakinumab)
- IMULDOSA syringe (ustekinumab-srlf)*
- KEVZARA (sarilumab)
- KINERET (anakinra)
- LEQSELVI (deuruxolitinib)
- LITFULO (ritlecitinib)
- OLUMIANT (baricitinib)
- OMVOH syringe/pen (mirikizumab-mrkz)
- ORENCIA syringe/autoinjector (abatacept)
- OTEZLA XR (apremilast)
- OTULFI syringe/45 mg vial (ustekinumab-aauz)*
- RINVOQ (upadacitinib)
- SELARSDI syringe/45 mg vial (ustekinumab-aekn)*
- SIMLANDI (adalimumab-ryvk)*
- SIMPONI syringe/pen (golimumab)
- SKYRIZI syringe/on-body injector/pen (risankizumab-rzaa)
- SOTYKTU (deucravacitinib)
- SPEVIGO syringe (spesolimab-sbzo)
- STARJEMZA syringe/45 mg vial (ustekinumab-hmny)*
- STELARA syringe/45 mg vial (ustekinumab)

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- tofacitinib (generic for XELJANZ/XELJANZ XR)
- TREMFYA syringe/pen/autoinjector (guselkumab)
- TYENNE syringe/autoinjector (tocilizumab-aazg)*
- ustekinumab syringe/45 mg vial (generic for STELARA)
- ustekinumab-aauz (generic for OTULFI)*
- ustekinumab-aekn syringe (generic for SELARSDI)*
- ustekinumab-ttwe syringe/45 mg vial (generic for PYZCHIVA)*
- VELSIPITY (etrasimod)
- XELJANZ solution (tofacitinib)
- YESINTEK (ustekinumab-kfce)*
- YUFLYMA (adalimumab-aaty)*
- YUSIMRY (adalimumab-aqvh)*
- ZYMFENTRA (infliximab-dyyb)*

AGENTS COVERED UNDER MEDICAL CLAIMS ONLY

Prime Therapeutics reviews Medical Claim Prior Authorization requests. For more information, please visit ar.primetherapeutics.com/documents/d/arkansas/arkansas_medicaid_pad_criteria.

- ACTEMRA vial (tocilizumab)
- AVSOLA vial (infliximab-axxq)*
- AVTOZMA vial (tocilizumab-anoh)*
- CIMZIA vial (certolizumab)
- COSENTYX vial (secukinumab)
- ENTYVIO vial (vedolizumab)
- ILUMYA syringe (tildrakizumab-asmm)
- IMULDOSA vial (ustekinumab-srlf)*
- INFLECTRA vial (infliximab-dyyb)*
- infliximab vial (generic for REMICADE)
- OMVOH vial (mirikizumab-mrkz)
- ORENCIA vial (abatacept)
- OTULFI vial (ustekinumab-aauz)*
- PYZCHIVA vial (ustekinumab-ttwe)*
- REMICADE vial (infliximab)
- RENFLEXIS vial (infliximab-abda)*
- SELARSDI vial (ustekinumab-aekn)*
- SIMPONI ARIA vial (golimumab)
- SKYRIZI vial (risankizumab-rzaa)
- SPEVIGO vial (spesolimab-sbzo)

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- STARJEMZA vial (ustekinumab-hmny)*
- STELARA vial (ustekinumab)
- STEQEYMA vial (ustekinumab-stba)*
- TOFIDENCE vial (tocilizumab-bavi)*
- TREMFYA vial (guselkumab)
- TYENNE vial (tocilizumab-aazg)*

GENERAL APPROVAL REQUIREMENTS

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for the FDA-approved indication
- The beneficiary's dose should not exceed the maximum dose supported in the manufacturer's package insert or MicroMedex
- The beneficiary has no therapeutic duplication with any other cytokine and CAM antagonists

APPROVAL CRITERIA FOR PLAQUE PSORIASIS

Note: Bolded medications below are preferred on the Arkansas Medicaid Preferred Drug List (PDL).

(Abrilada, Amjevita, Bimzelx, Cimzia, Cosentyx, Cyltezo, **Enbrel**, Hadlima, Hulio, **Humira**, Hyrimoz, Icotyde, Idacio, Imuldosa, **Otezla**, Otulfi, **Pyzchiva**, Selarsdi, Simlandi, Skyrizi, Sotyktu, Starjemza, Stelara, **Steqeyma**, **Taltz**, Tremfya, Yesintek, Yuflyma, or Yusimry)

- The medication must be prescribed by or in consultation with a dermatologist, rheumatologist, or other specialist treating plaque psoriasis
- The beneficiary has a documented diagnosis of moderate to severe plaque psoriasis
- The beneficiary must trial ≥ 6 months with at least **one** product from each of the following (6 months of topical and 6 months of systemic):
  - Topical drug therapy with corticosteroids, calcipotriene, calcitriol, tazarotene, roflumilast, or tapinarof; **AND**
  - Systemic drug therapy with methotrexate, acitretin, or cyclosporine
- The beneficiary must have tried and failed phototherapy or have a contraindication
- The beneficiary continues to have symptoms after trial of conventional therapy with at least **one** of the following:
  - Involvement of ≥ 10% body surface area (BSA)
  - Psoriasis Area and Severity Index (PASI) score ≥ 12; **OR**
  - Plaque location severely impacts quality of life (i.e., head/neck, palms, soles of feet, genitalia)
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of previous therapies; **AND**
  - Current psoriasis description with BSA and PASI score

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- For PYZCHIVA, STEQEYMA, or TALTZ, the beneficiary has a history of at least 3 months of **one** preferred tumor necrosis factor (TNF) blocker (i.e., HUMIRA or ENBREL) unless there is a contraindication (i.e., lupus) to the use of a TNF blocker
- Non-preferred medications require a trial and failure of at least **two** preferred agents with this indication for at least 3 months each, or a contraindication or intolerance to preferred agents
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR PSORIATIC ARTHRITIS AND RHEUMATOID ARTHRITIS

Note: Bolded medications below are preferred on the Arkansas Medicaid Preferred Drug List (PDL).

Psoriatic Arthritis:

- Abrilada, Amjevita, Bimzelx, Cimzia, Cosentyx, Cyltezo, **Enbrel**, Hadlima, Hulio, **Humira**, Hyrimoz, Idacio, Imuldosa, Orencia, **Otezla**, Otulfi, **Pyzchiva**, Rinvoq, Rinvoq LQ, Selarsdi, Simlandi, Simponi, Skyrizi, Sotyktu, Starjemza, Stelara, **Steqeyma**, **Taltz**, Tremfya, **Xeljanz**, **Xeljanz XR**, Yesintek, Yuflyma, or Yusimry

Rheumatoid Arthritis:

- Abrilada, Actemra, Amjevita, Cimzia, Cyltezo, **Enbrel**, Hadlima, Hulio, **Humira**, Hyrimoz, Idacio, Kevzara, Kineret, Olumiant, Orencia, Rinvoq, Simlandi, Simponi, Tyenne, **Xeljanz**, **Xeljanz XR**, Yuflyma, or Yusimry
- The medication must be prescribed by or in consultation with a rheumatologist or other specialist treating psoriatic arthritis or rheumatoid arthritis
- The beneficiary has a documented diagnosis of psoriatic arthritis or rheumatoid arthritis
- Trial and failure with NSAIDs
- Trial and failure with ≥ 6 months of any of the following:
  - hydroxychloroquine
  - methotrexate
  - sulfasalazine; **OR**
  - leflunomide
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of previous therapies
  - Current labs as baseline (e.g., Erythrocyte Sedimentation Rate, C-Reactive Protein level)
- For PYZCHIVA, STEQEYMA, TALTZ, XELJANZ IR, or XELJANZ XR, the beneficiary has a history of at least 3 months of **one** preferred tumor necrosis factor (TNF) blocker (i.e., HUMIRA or ENBREL) unless there is a contraindication (i.e., lupus) to the use of a TNF blocker
- Non-preferred medications require a trial and failure of at least **two** preferred agents with this indication for at least 3 months each, or a contraindication or intolerance to preferred agents

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- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR ULCERATIVE COLITIS

Note: Bolded medications below are preferred on the Arkansas Medicaid Preferred Drug List (PDL).

(Abrilada, Amjevita, Cyltezo, Entyvio, Hadlima, Hulio, **Humira**, Hyrimoz, Idacio, Imuldosa, Omvoh, Otulfi, **Pyzchiva**, Rinvoq, Selarsdi, Simlandi, Simponi, Skyrizi, Starjemza, Stelara, **Steqeyma**, Tremfya, Velsipity, **Xeljanz**, **Xeljanz XR**, Yesintek, Yuflyma, Yusimry, or Zymfentra)

- The medication must be prescribed by or in consultation with a gastroenterologist
- The beneficiary has a documented diagnosis of moderate to severe ulcerative colitis as defined by **one** of the following:
  - Fecal calprotectin > 150 µg/g
  - Endoscopy Mayo subscore ≥ 2 or modified Mayo score (mMS) ≥ 5
- The beneficiary has been hospitalized for ulcerative colitis **or** had a trial and failure with of ≥ 2 months of standard of care drug therapy with at least **two** of the following for induction or maintenance of remission:
  - Immunosuppressants (e.g., azathioprine, 6-mercaptopurine, cyclosporine)
  - Oral/rectal glucocorticoids (e.g., enteric coated budesonide, prednisone, hydrocortisone); **OR**
  - Oral/rectal 5-aminosalicyclic acid agents (e.g., mesalamine, sulfasalazine)
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of previous therapies; **AND**
  - Current labs, including inflammatory markers (i.e., fecal calprotectin, endoscopic Mayo subscore)
- For PYZCHIVA, STEQEYMA, XELJANZ IR, or XELJANZ XR, the beneficiary has a history of at least 3 months of **one** preferred tumor necrosis factor (TNF) blocker (i.e., HUMIRA) unless there is a contraindication (i.e., lupus) to the use of a TNF blocker
- Non-preferred medications require a trial and failure of at least **two** preferred agents with this indication for at least 3 months each, or a contraindication or intolerance to preferred agents
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR CROHN'S DISEASE

Note: Bolded medications below are preferred on the Arkansas Medicaid Preferred Drug List (PDL).

(Abrilada, Amjevita, Cimzia, Cyltezo, Entyvio, Hadlima, Hulio, **Humira**, Hyrimoz, Idacio, Imuldosa, Omvoh, Otulfi, **Pyzchiva**, Rinvoq, Selarsdi, Simlandi, Skyrizi, Starjemza, Stelara, **Steqeyma**, Tremfya, Yesintek, Yuflyma, Yusimry, or Zymfentra)

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- The medication must be prescribed by or in consultation with a gastroenterologist
- The beneficiary has a documented diagnosis of moderate to severe Crohn's Disease confirmed by assessment of stool frequency, abdominal pain score, and Simple Endoscopic Score for Crohn's Disease (SES-CD). Information for diagnosis is based on endoscopy and imagining results as well as elevated CRP and fecal calprotectin.
- The beneficiary has been hospitalized with Crohn's Disease **or** been diagnosed with a fistula or abscess **or** had a trial and failure with ≥ 2 months of standard of care drug therapy with at least **two** of the following for induction or maintenance of remission:
  - Immunosuppressants (e.g., azathioprine, 6-mercaptopurine, cyclosporine)
  - Oral/rectal glucocorticoids (e.g., enteric coated budesonide, prednisone, hydrocortisone)
  - Oral/rectal 5-aminosalicyclic acid agents (e.g., mesalamine, sulfasalazine); **OR**
  - methotrexate
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of previous therapies and surgeries
  - Current labs, including CBCs and inflammatory markers (i.e., fecal calprotectin, C-reactive protein)
  - Colonoscopy or imaging reports
  - Baseline stool frequency and abdominal pain score; **AND**
  - Baseline Crohn's Disease Activity Index (CDAI) (clinical trials included beneficiaries with score ≥ 220) or Simple Endoscopic Score for Crohn's disease (SES-CD) (clinical trials included beneficiaries with score ≥ 6 or ≥ 4 for isolated ileal disease)
- For PYZCHIVA or STEQEYMA, the beneficiary has a history of at least 3 months of **one** preferred tumor necrosis factor (TNF) blocker (i.e., HUMIRA) unless there is a contraindication (i.e., lupus) to the use of a TNF blocker
- Non-preferred medications require a trial and failure of at least **two** preferred agents with this indication for at least 3 months each, or a contraindication or intolerance to preferred agents
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR JUVENILE IDIOPATHIC ARTHRITIS

Note: Bolded medications below are preferred on the Arkansas Medicaid Preferred Drug List (PDL).

(Abrilada, Actemra, Amjevita, Cimzia, Cyltezo, **Enbrel**, Hadlima, Hulio, **Humira**, Hyrimoz, Idacio, Kevzara, Orencia, Rinvoq, Rinvoq LQ, Simlandi, Tofidence, Tyenne, **Xeljanz tablet**, Xeljanz oral solution, Yuflyma, or Yusimry)

- The medication must be prescribed by or in consultation with a rheumatologist or other specialist

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- The beneficiary has a documented diagnosis of moderate to severe polyarticular juvenile idiopathic arthritis (JIA)
- Trial and failure with NSAIDs (unless contraindication or intolerance)
- Trial and failure with ≥ 3 months of disease modifying anti-rheumatic drugs (DMARDs) with any of the following (unless contraindication or intolerance):
  - methotrexate
  - leflunomide; **OR**
  - cyclosporine
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of previous therapies with description of current symptoms; **AND**
  - Current labs, including CBCs and inflammatory markers
- For XELJANZ IR, the beneficiary has a history of at least 3 months of **one** preferred tumor necrosis factor (TNF) blocker (i.e., HUMIRA) unless there is a contraindication (i.e., lupus) to the use of a TNF blocker
- Non-preferred medications require a trial and failure of at least **two** preferred agents with this indication for at least 3 months each, or a contraindication or intolerance to preferred agents
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR DEFICIENCY OF IL-1 RECEPTOR ANTAGONIST

(Arcalyst and Kineret)

- The medication must be prescribed by or in consultation with a rheumatologist or other specialist
- The beneficiary has a documented diagnosis of deficiency of IL-1 receptor antagonist (DIRA)
- Trial and failure with NSAIDs (unless contraindication or intolerance)
- Trial and failure with ≥ 3 months of disease modifying anti-rheumatic drugs (DMARDs) with any of the following (unless contraindication or intolerance):
  - methotrexate
  - leflunomide; **OR**
  - cyclosporine
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of previous therapies with description of current symptoms; **AND**
  - Current labs, including CBCs and inflammatory markers
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

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APPROVAL CRITERIA FOR ANKYLOSING SPONDYLITIS

Note: Bolded medications below are preferred on the Arkansas Medicaid Preferred Drug List (PDL).

(Abrilada, Amjevita, Bimzelx, Cimzia, Cosentyx, Cyltezo, **Enbrel**, Hadlima, Hulio, **Humira**, Hyrimoz, Idacio, Rinvoq, Simlandi, Simponi, **Taltz**, **Xeljanz tablet**, **Xeljanz XR**, Yuflyma, or Yusimry)

- The medication must be prescribed by or in consultation with a rheumatologist or other specialist
- The beneficiary has a documented diagnosis of ankylosing spondylitis
- Trial and failure with ≥ 3 months of standard of care drug therapy (unless contraindication or intolerance) with nonsteroidal anti-inflammatory drugs at maximum doses (e.g., naproxen, celecoxib, ibuprofen)
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Documentation of previous therapies
- For TALTZ, XELJANZ IR and XELJANZ XR, the beneficiary has a history of at least 3 months of **one** preferred tumor necrosis factor (TNF) blocker (i.e., HUMIRA or ENBREL) unless there is a contraindication (i.e., lupus) to the use of a TNF blocker
- Non-preferred medications require a trial and failure of at least **two** preferred agents with this indication for at least 3 months each, or a contraindication or intolerance to preferred agents
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR NONRADIOGRAPHIC AXIAL SPONDYLOARTHRITIS

Note: Bolded medications below are preferred on the Arkansas Medicaid Preferred Drug List (PDL).

(Bimzelx, Cimzia, Cosentyx, Rinvoq, or **Taltz**)

- The medication must be prescribed by or in consultation with a rheumatologist or other specialist
- The beneficiary has a documented diagnosis of nonradiographic axial spondyloarthritis
- Trial and failure with ≥ 3 months of standard of care drug therapy (unless contraindication or intolerance) with nonsteroidal anti-inflammatory drugs at maximum doses (e.g., naproxen, celecoxib, ibuprofen)
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Documentation of previous therapies
- Non-preferred agents require a 3-month trial and failure or a contraindication or intolerance to at least **one** preferred agent with this indication.
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

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APPROVAL CRITERIA FOR CRYOPYRIN-ASSOCIATED PERIODIC SYNDROMES

(Arcalyst, Ilaris, or Kineret)

- The medication must be prescribed by or in consultation with a specialist in treating CAPS
- The beneficiary must have a diagnosis of cryopyrin-associated periodic syndromes (CAPS) including Familial Cold Autoinflammatory Syndrome (FCAS) or Muckle-Wells Syndrome (MWS) **or** neonatal onset multisystem inflammatory disease (NOMID)
- The prescriber must submit the following:
  - Current chart notes
  - Confirmation of the diagnosis with genetic test results if available
  - Baseline symptoms; **AND**
  - Previous therapies tried
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR GIANT CELL ARTERITIS

(Actemra, Rinvoq, or Tyenne)

- The medication must be prescribed by or in consultation with a rheumatologist or other specialist
- The beneficiary has a confirmed diagnosis of giant cell arteritis based on clinical symptoms and **one** of the following:
  - Temporal artery biopsy; **OR**
  - Ultrasound of vessels
- The prescriber must submit the following:
  - Current chart notes
  - Documentation to confirm diagnosis with biopsy results and/or ultrasound report along with labs (i.e., CRP, ESR)
  - Medical necessity over high dose corticosteroids; **AND**
  - Treatment plan for potential discontinuation in the future
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR SYSTEMIC SCLEROSIS-ASSOCIATED INTERSTITIAL LUNG DISEASE

(Actemra)

- The medication must be prescribed by or in consultation with a rheumatologist, pulmonologist, or other specialist
- The beneficiary has a confirmed diagnosis of SSc-ILD based on clinical symptoms and the following:
  - PFTs indicate a decreased lung volume and decreased DLCO

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  - High resolution CT indicates ground glass or reticular opacities; **AND**
  - Lab work consistent with scleroderma
- Trial and failure of immunosuppressant therapy with mycophenolate or cyclophosphamide unless a contraindication or intolerance
- The prescriber must submit the following:
  - Current chart notes
  - Current PFTs
  - High resolution CT report
  - Current labs
  - Baseline 6-minute walk test; **AND**
  - Medical necessity over immunosuppressant therapy with or without glucocorticoids
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR RECURRENT PERICARDITIS

(Arcalyst)

- The beneficiary is diagnosed with recurrent pericarditis based on previous episodes of acute pericarditis and has developed pleuritic chest pain. Lab work should support an inflammatory phenotype (elevated CRP, WBC, or ESR).
- The beneficiary should not receive this medication if not diagnosed with an inflammatory phenotype.
- The beneficiary should have trial and failure with **all** of the following (unless there is a contraindication):
  - Colchicine and NSAID or aspirin – first line therapy
  - Colchicine and glucocorticoid – second line therapy
  - Colchicine, glucocorticoid, and aspirin – third line therapy
- The prescriber must submit the following:
  - Current chart notes
  - Previous treatment for acute pericarditis
  - Electrocardiogram and echocardiogram results
  - Current labs, including CBC, ESR, and CRP; **AND**
  - Treatment plan including taper
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR UVEITIS

Note: Bolded medications below are preferred on the Arkansas Medicaid Preferred Drug List (PDL).

(Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, **Humira**, Hyrimoz, Idacio, Simlandi, or Yusimry)

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- The medication must be prescribed by or in consultation with a rheumatologist, ophthalmologist, or other specialist for treating uveitis
- The beneficiary must be diagnosed with non-infectious intermediate, posterior, or panuveitis
- Trial and failure with **all** of the following:
  - Topical glucocorticoid (e.g., prednisolone, triamcinolone)
  - Systemic glucocorticoid at the maximum indicated dose unless a contraindication or intolerance (e.g., prednisone); **AND**
  - Immunosuppressant (e.g., azathioprine, methotrexate, mycophenolate, cyclosporine)
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Documentation of previous therapies tried
- Non-preferred agents require a 3-month trial and failure or a contraindication or intolerance to at least **one** preferred agent with this indication.
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR TUMOR NECROSIS FACTOR RECEPTOR ASSOCIATED PERIODIC SYNDROME OR HYPERIMMUNOGLOBULIN D SYNDROME/MEVALONATE KINASE DEFICIENCY

(Ilaris)

- The medication must be prescribed by or in consultation with a rheumatologist or other rare disease specialist for treating TRAPS or HIDS/MKD
- The beneficiary must be diagnosed with **one** of the following:
  - TNF Receptor Associated Periodic Syndrome (TRAPS) after infectious or neoplastic causes of recurrent fevers are excluded; **OR**
  - Hyperimmunoglobulin D (Hyper-IgD) Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD)
- Trial and failure of NSAIDs and oral glucocorticoids at the maximum indicated dose unless a contraindication or intolerance
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of symptoms and criteria used for diagnosis
  - Previous therapies tried
  - Current weight for dose determination; **AND**
  - Medical necessity for the use of this medication over NSAIDs and oral glucocorticoids
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

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APPROVAL CRITERIA FOR FAMILIAL MEDITERRANEAN FEVER

(Ilaris)

- The medication must be prescribed by or in consultation with a rheumatologist or other rare disease specialist for treating FMF
- The beneficiary must be diagnosed with Familial Mediterranean Fever (FMF)
- Trial and failure of colchicine unless a contraindication or intolerance (treatment recommended indefinitely)
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of symptoms and criteria used for diagnosis
  - Previous therapies tried; **AND**
  - Current weight for dose determination
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR STILL'S DISEASE

(Actemra, Ilaris, or Tyenne)

- The medication must be prescribed by or in consultation with a rheumatologist or other specialist
- The beneficiary must be diagnosed with active Still's Disease (either Adult-Onset Still's Disease [AOSD] or Systemic Juvenile Idiopathic Arthritis [SJIA])
- New onset AOSD
  - Trial and failure of NSAIDs **or** oral glucocorticoids at the maximum indicated dose unless a contraindication or intolerance for mild to moderate disease
  - If macrophage activation syndrome is suspected, a biologic is warranted (UpToDate recommends anakinra in these beneficiaries)
- Established AOSD still needing therapy
  - Trial and failure with ≥ 3 months of disease modifying anti-rheumatic drugs (DMARDs) with any of the following (unless contraindication or intolerance):
    - methotrexate; **OR**
    - leflunomide
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of symptoms and criteria used for diagnosis
  - Previous therapies tried; **AND**
  - Current weight for dose determination
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

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APPROVAL CRITERIA FOR ALOPECIA AREATA

(Leqselvi, Litfulo, or Olumiant)

- The medication must be prescribed by or in consultation with a dermatologist
- The beneficiary has a documented diagnosis of alopecia areata with > 50% scalp hair loss or refractory disease
- The beneficiary does not have another cause of hair loss (i.e., androgenetic alopecia, chemotherapy-induced hair loss, or causes of hair loss other than alopecia areata)
- The beneficiary request would be denied if taking any of the following concomitantly:
  - JAK inhibitor
  - Other cytokine and CAM antagonists
  - Immunosuppressant
- Trial and failure of topical and/or intralesional corticosteroids
- Trial and failure with ≥ 6 months of disease modifying anti-rheumatic drugs (DMARDs) with any of the following (unless contraindicated):
  - methotrexate
  - leflunomide; **OR**
  - cyclosporine
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of previous therapies tried with duration
  - Medical necessity over intralesional corticosteroids, topical steroids, and DMARDs; **AND**
  - Letter of medical necessity
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR POLYMYALGIA RHEUMATICA

(Kevzara)

- The medication must be prescribed by or in consultation with a rheumatologist or other specialist
- The beneficiary must be diagnosed with polymyalgia rheumatica based on clinical symptoms and supporting lab findings with the following:
  - Elevated ESR and/or CRP
  - Pain and morning stiffness about the shoulders, hip girdle, and neck; **AND**
  - Limited range of motion in shoulders, cervical spine, or hips causing difficulties with activities of daily living (such as pulling on a shirt, putting on socks/shoes, or transferring from lying to seated position)
- The prescriber must submit the following:
  - Current chart notes

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- Documentation of symptoms
- Current labs, including ESR and CRP; **AND**
- Medical necessity over corticosteroids at maximum tolerated doses

- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR HIDRADENITIS SUPPURATIVA

Note: Bolded medications below are preferred on the Arkansas Medicaid Preferred Drug List (PDL).

(Abrilada, Amjevita, Bimzelx, Cimzia, Cosentyx, Cyltezo, Hadlima, Hulio, **Humira**, Hyrimoz, Idacio, Simlandi, Yuflyma, or Yusimry)

- Some medications/treatments recommended in Hidradenitis Suppurativa (HS) guidelines may not be a covered product/procedure by Arkansas Medicaid. Refer to the respective provider manual for additional information.
- The beneficiary with diagnosis of Hurley Stage I HS should use options from the following list (biologics are not recommended for Hurley Stage I):
  - Topical clindamycin
  - Oral tetracyclines (tetracycline, doxycycline, minocycline)
  - Antiandrogenic agents (combined oral contraceptives, spironolactone, finasteride)
  - Metformin
  - Alternatives for refractory beneficiaries – clindamycin with rifampin, acitretin, dapsone
  - Laser therapy
  - Intralesional corticosteroids
  - Topical resorcinol; **OR**
  - Surgical drainage
- The beneficiary with diagnosis of Hurley Stage II:
  - The beneficiary should follow treatment guidelines (e.g., Journal of the American Academy of Dermatology: https://www.jaad.org/action/showPdf?pii=S0190-9622%2819%2930368-8)
  - Prior to beginning biologics, the beneficiary should have tried at least two of the following:
    - Oral tetracyclines for a minimum of 3 months (unless contraindicated)
    - Combination of rifampin and clindamycin for a minimum of 3 months (unless contraindicated)
    - Oral contraceptives for a minimum of 3 months (females only)
    - Oral retinoids for a minimum of 3 months (unless contraindicated); **OR**
    - Refractory after treatment – antibiotic therapy with adjunctive treatment of an antiandrogen, metformin, or oral contraceptives (when choosing adjunctive options, consideration the beneficiary's comorbidities)
- Beneficiaries who are refractory after at least two 3-month therapies or have progressed to Stage III during treatment may be considered for therapy with biologics

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- The prescriber must submit the following:
  - Chart notes
  - Documentation of previous therapies tried including surgery or laser treatment; **AND**
  - Comorbidities that can increase HS severity must be addressed (list not all inclusive)
    - Tobacco use
    - Obesity; **OR**
    - PCOS
- Non-preferred agents require a 3-month trial and failure or a contraindication or intolerance to at least **one** preferred agent with this indication.
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR ENTHESITIS-RELATED ARTHRITIS

(Cosentyx)

- The medication must be prescribed by or in consultation with a rheumatologist or other specialist
- The beneficiary has a documented diagnosis of enthesitis-related arthritis
- Trial and failure with NSAIDs
- Trial and failure with ≥ 3 months of disease modifying anti-rheumatic drugs (DMARDs) with any of the following (unless contraindicated):
  - methotrexate
  - leflunomide
  - cyclosporine; **OR**
  - sulfasalazine
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR GOUT FLARES

(Ilaris)

- The medication must be prescribed by or in consultation with a rheumatologist or other specialist.
- The beneficiary must be diagnosed with gout flares.
- The beneficiary must have tried and failed non-steroidal anti-inflammatory drugs (NSAIDs), corticosteroids, and colchicine (unless contraindicated or not tolerated). Repeated courses of corticosteroids are not appropriate.
- The beneficiary with frequent gout flares (defined as three or more gout flares in the previous year) must be on a urate-lowering medication (e.g., allopurinol, febuxostat, probenecid).
- The prescriber must submit **all** of the following:
  - Current chart notes
  - Documentation of symptoms; **AND**

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- Current labs, including serum urate concentration and documentation of urate crystals in the synovial fluid (if available)

- PA will be approved for one dose.
- Renewal requires prescribers to submit updated notes with documentation of continued gout flare. Ilaris requires at least 12 weeks between doses.

APPROVAL CRITERIA FOR BEHÇET'S DISEASE

Note: Bolded medications below are preferred on the Arkansas Medicaid Preferred Drug List (PDL).

(**Otezla**)

- The medication must be prescribed by or in consultation with a rheumatologist or other specialist in the treatment of Behçet's Disease
- The beneficiary has a documented diagnosis of Behçet's Disease with oral ulcers
- Trial and failure with ≥ 3 months of the following:
  - Topical corticosteroids (e.g., triamcinolone acetonide cream 0.1% in orabase); **AND**
  - ≥ **one** of the following conventional oral therapies:
    - colchicine
    - azathioprine; **OR**
    - sulfasalazine
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of previous therapies tried with duration; **AND**
  - Medical necessity over topical corticosteroids and conventional oral therapies
- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

APPROVAL CRITERIA FOR NEUROMYELITIS OPTICA SPECTRUM DISORDER

(Enspryng)

- Prescribed by a specialist experienced with NMOSD
  - The beneficiary is diagnosed with neuromyelitis optica spectrum disorder (NMOSD) and is anti-aquaporin-4 (AQP4) antibody positive and confirmed with the following:
  - Test indicating beneficiary is seropositive for AQP4-IgG antibodies
  - The beneficiary has at least one core clinical characteristic (i.e., optic neuritis, acute myelitis, area postrema syndrome, acute brainstem syndrome, symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic MRI lesions, or symptomatic cerebral syndrome with NMOSD-typical brain lesions)
  - Exclusion of alternative diagnosis (i.e., Lupus, multiple sclerosis, sarcoidosis, cancer, chronic infection like HIV)

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- The beneficiary must have a history of at least one documented relapse (including first attack) in the last 12 months
- The beneficiary must have an Expanded Disability Status Scale (EDSS) score ≤ 6.5
- The beneficiary is not prescribed medication for the treatment of multiple sclerosis (i.e., interferon, dimethyl fumarate, fingolimod, glatiramer)
- The beneficiary is not prescribed other treatment options for NMOSD concomitantly (i.e., eculizumab or inebilizumab)
- Prescribed to prevent future attacks (not meant to treat an acute attack)
- The prescriber must submit **all** of the following:
  - Current chart notes
  - Documentation of previous therapies tried
  - Confirmation of NMOSD diagnosis
  - Baseline Expanded Disability Status Scale score
  - Medical necessity over the use of immunotherapy (e.g., rituximab, azathioprine, mycophenolate, or methotrexate); **AND**
  - Results for Hepatitis B virus and tuberculosis screens (should be negative for approval)

RENEWAL REQUIREMENTS

- Renewal requires prescriber to submit updated notes with documentation of a positive response to therapy which is defined by any of the following:
  - Decrease in acute relapses
  - Improvement in EDSS
  - Reduced hospitalizations; **AND**
  - Reduction/discontinuation in plasma exchange treatments or corticosteroids

QUANTITY EDITS

#1/28 days (first month will require a quantity override to allow three injections)

APPROVAL CRITERIA FOR GENERALIZED PUSTULAR PSORIASIS

(Spevigo)

- The medication must be prescribed by or in consultation with a dermatologist
- The beneficiary must have a diagnosis of generalized pustular psoriasis (GPP) with a history of at least two GPP flares of moderate-to-severe intensity in the past 5 years. Those two flares must meet the following criteria from the Effisayil-1 trial to be considered moderate-to-severe. Documentation of those flares must be provided.
  - Generalized Pustular Psoriasis Physician Global Assessment (GPPPGA) total score ≥ 3 (moderate)
  - GPPGA pustulation subscore of ≥ 2 (mild)

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- Presence of fresh pustules (new appearance or worsening of pustules); **AND**
- ≥ 5% of BSA covered with erythema and the presence of pustules

- The beneficiary must have **one** of the following treatment options. Document the correct treatment plan for the beneficiary.
  - Treatment and maintenance following an acute GPP flare
    - 900 mg IV infusion loading dose over 90 minutes; may repeat once after one week (requires medical prior authorization request review)
    - Followed by 300 mg SQ every 4 weeks
    - Any subsequent flares would require a medical prior authorization request review
  - Treatment and maintenance when not experiencing a GPP flare
    - 600 mg SQ loading dose
    - Followed by 300 mg SQ every 4 weeks
- The beneficiary should not be approved or continue this therapy with any of the following:
  - Has no history of at least two GPP flares of moderate-to-severe intensity as defined above; **OR**
  - Active tuberculosis
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of previous biologics or disease-modifying antirheumatic drugs (DMARDs) that have been tried with response
  - Documentation of other autoimmune diagnoses for the beneficiary and treatment plan
  - Documentation that the beneficiary has been evaluated for tuberculosis; **AND**
  - Clarification if this will be billed as a medical claim through “buy and bill” or billed as a pharmacy claim through a specialty pharmacy.

Note: If this medication is intended to be billed as a medical claim, follow the physician administered drugs procedure. Contact Prime Therapeutics with any questions.

- Renewal requires prescribers to submit updated notes with documentation of a positive response to therapy

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TASIMELTEON (HETLIOZ)

Updated 7/21/2021

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary with a non-24 diagnosis must be ≥ 18 years of age, and beneficiary with SMS diagnosis must be ≥ 3 years of age; **AND**
- The beneficiary must have a diagnosis of either non-24-Hour Sleep-Wake Disorder **or** Nighttime Sleep Disturbances in Smith-Magenis Syndrome or a diagnosis consistent with FDA indications; **AND**
- Non-24-hour Sleep-Wake Disorder
  - Blind beneficiary
    - Clinical trials provided in the package insert included totally blind beneficiaries and reference the Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5) diagnostic criteria
    - A persistent or recurrent pattern of sleep disruption that is primarily due to an alteration of the circadian system or to a misalignment between the endogenous circadian rhythm and the sleep-wake schedule required by an individual's physical environment or social or professional schedule; **AND**
    - The sleep disruption leads to excessive sleepiness or insomnia, or both; **AND**
    - The sleep disturbance causes clinically significant distress or impairment in social, occupational, and other important areas of functioning; **AND**
    - The beneficiary must have tried and failed melatonin and other sleep aids
  - Sighted beneficiary
    - The beneficiary must have tried and failed melatonin and other sleep aids; **AND**
    - The beneficiary must have tried and failed timed light exposure; **AND**
    - Sleep disturbance cannot be explained by other causes (i.e., neurological disorder, mental disorder, medication use, or substance use disorder)
- For Nighttime Sleep Disturbances in SMS requests:
  - Need confirmed diagnosis of SMS; **AND**
  - Need history of sleep disturbances; **AND**
  - The prescriber must submit the following:
  - Current chart notes; **AND**
  - Documentation of medications and therapies tried to improve sleep patterns; **AND**
  - Documentation as listed above to confirm diagnosis; **AND**
  - Daily sleep logs or actigraphy for confirmation of sleep disruption; **AND**

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- Initial PA for 3 months

DENIAL CRITERIA

- The beneficiary does not meet approval criteria **or** have a diagnosis supported in the official Compendia; **OR**
- The beneficiary requires the use of strong CYP1A2 inhibitors or strong CYP3A4 inducers; **OR**
- The beneficiary has severe hepatic impairment

QUANTITY EDITS

- 20 mg - #31 capsules per 31 days
- Suspension
  - 48 mL – 3 bottles per 31 days
  - 158 mL – 1 bottle per 31 days

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TAZAROTENE GEL/CREAM (TAZORAC)

Updated 6/19/2006

APPROVAL CRITERIA (NEW START)

- Diagnosis of psoriasis in Medicaid history in previous 365 days; **AND**
- Two paid claims of a topical corticosteroid in previous 27–60 days; **AND**
- At least one paid claim for a topical corticosteroid must be from the Class 1 potency category.

APPROVAL CRITERIA (CONTINUATION)

- Diagnosis of psoriasis in Medicaid history in previous 365 days; **AND**
- The incoming claim matches claim in history in the previous 45 days of TAZORAC; **AND**
- At least two claims of a topical corticosteroid in previous 60 days in drug claim history with at least one topical corticosteroid claim 14–60 days back in history.

DENIAL CRITERIA

The beneficiary has a history of acne vulgaris in the last 60 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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TEDIZOLID (SIVEXTRO)

Updated 1/13/2015

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

No therapeutic duplication between a claim of the tablets and claim of the vials within the same month

ADDITIONAL CRITERIA

- Age ≥ 18 years of age
- Quantity limits apply

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TEDUGLUTIDE KIT (GATTEX)

Updated 1/15/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must be diagnosed with Short Bowel Syndrome (SBS) and is dependent on parenteral support
  - Adult beneficiaries require parenteral nutrition at least three times per week
  - Pediatric beneficiaries must have parenteral nutrition to account for at least 30% of caloric/and/or fluid/electrolyte needs
- The beneficiary must have a history of using supportive therapies (e.g., anti-motility agents, proton pump inhibitors, bile acid sequestrants, and octreotide)
- The beneficiary should not be approved or continue this therapy with any of the following:
  - Weighs < 10 kg
  - Has intestinal or stomal obstruction; restart when obstructive presentation resolves; **OR**
  - Diagnosed with gastrointestinal cancer
- The prescriber must submit the following:
  - Current chart notes
  - Previous therapies tried with response
  - Baseline volume of parenteral nutrition/intravenous support
  - Current labs, including eGFR (dosage adjustment required for eGFR < 6 0 mL/min/1.73m^2); bilirubin and alkaline phosphatase (to monitor for biliary tract disease); lipase and amylase (to monitor for pancreatic disease); **AND**
  - Test results required 6 months prior to starting treatment
    - Adult – colonoscopy and upper gastrointestinal (GI) endoscopy with removal of polyps
    - Pediatric beneficiaries – fecal occult blood testing; if there is new or unexplained blood in the stool perform colonoscopy/sigmoidoscopy and upper GI endoscopy

RENEWAL REQUIREMENTS

- The beneficiary has been compliant on therapy (defined as 75% utilization)
- The beneficiary has a positive response to therapy with at least a 20% reduction in weekly parenteral nutrition/IV volume
- The prescriber must submit the following:
  - Current chart notes
  - Current volume of parenteral nutrition/intravenous support

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- Current labs to monitor kidney function, pancreatic disease, and biliary tract disease; **AND**
- After 1 year of treatment, adults require colonoscopy and upper GI endoscopy, and pediatric beneficiaries require at least a fecal occult blood test

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TESAMORELIN VIAL (EGRIFTA WR AND EGRIFTA SV)

Updated 10/15/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with human immunodeficiency virus (HIV) infection and have lipodystrophy with abdominal visceral adipose tissue (VAT) defined as:
  - Males: Waist circumference of at least 95 cm (37.4 in) and waist-to-hip ratio of at least 0.94; Females: Waist circumference of at least 94 cm (37 in) and waist-to-hip ratio of at least 0.88; **OR**
  - Documentation by computed tomography (CT) scan with abdominal visceral adipose tissue
- The beneficiary must be compliant with antiretroviral therapy with 75% utilization as demonstrated by pharmacy records
- The medication must be prescribed by or in consultation with an infectious disease specialist or endocrinologist
- The beneficiary should not be pregnant or have active malignancy, diabetes, or hypopituitarism
- The prescriber must submit the following:
  - Current chart notes and description of physical exam documenting areas of fat loss and deposition
  - Previous therapies including antiretroviral therapy
  - Medical necessity over changing therapy to a different antiretroviral medication
  - Current labs, including lipids and HbA1c
  - Provide a letter of medical necessity for the rationale for use
  - Baseline waist circumference and/or waist-to-hip ratio; **AND**
  - Pregnancy status if female of child-bearing potential
- Initial PA is 6 months

RENEWAL REQUIREMENTS

- The beneficiary has been compliant with therapy (defined as 75% utilization)
- The beneficiary has documented improvement demonstrated by a decrease in visceral adipose tissue (VAT) with a decrease in waist circumference compared to baseline or decrease in VAT as documented in a computed tomography (CT) scan
- The beneficiary should be monitored for increase in IGF-1 or HbA1c with renewal denied if evidence of diabetes or glucose intolerance develops

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- The prescriber must submit the following:
  - Current chart notes
  - Current labs, including lipids and HbA1c
  - Current waist circumference and waist-to-hip ratio; **AND**
  - Pregnancy status if female of child-bearing potential

QUANTITY EDITS

- EGRIFTA WR – 4 vials (1 pack) per 28 days
- EGRIFTA SV – 30 vials per 30 days

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TETRACYCLINE AGENTS

Updated 1/1/2026

PREFERRED AGENTS

- doxycycline hyclate 50 mg and 100 mg capsule (generic for VIBRAMYCIN)
- doxycycline hyclate 20 mg tablet (generic for PERIOSTAT)
- doxycycline hyclate 75 mg and 150 mg tablet (generic for ACTICLATE)
- doxycycline hyclate 100 mg tablet (generic for VIBRA-TAB)
- doxycycline monohydrate 50 mg and 100 mg capsule (generic for MONODOX)
- doxycycline monohydrate 50 mg, 75 mg, 100 mg, and 150 mg tablet (generic for ADOXA)
- minocycline HCl 50 mg and 100 mg capsule (generic for MINOCIN)
- minocycline HCl 75 mg capsule (generic for DYNACIN)

NON-PREFERRED AGENTS

- demeclocycline (generic for DECLOMYCIN)
- doxycycline hyclate 75 mg capsule
- DORYX (doxycycline hyclate)
- DORYX MPC (doxycycline hyclate)
- doxycycline hyclate DR tablet (generic for DORYX)
- doxycycline monohydrate 75 mg capsule (generic for MONODOX)
- doxycycline monohydrate 150 mg capsule (generic for ADOXA)
- doxycycline monohydrate suspension (generic for VIBRAMYCIN)
- doxycycline monohydrate IR/DR 40 mg capsule (generic for ORACEA)
- minocycline tablet (generic for DYNACIN)
- MORGIDOX (minocycline)
- NUZYRA (omadacycline tosylate) (see criteria for NUZYRA)
- ORACEA (doxycycline monohydrate)
- tetracycline (generic for SUMYCIN)

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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THROMBOPOIESIS STIMULATING PROTEINS

Updated 10/1/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

PREFERRED AGENTS WITH MANUAL REVIEW CRITERIA

PROMACTA tablet (eltrombopag olamine) – **brand only**

APPROVAL CRITERIA

- The beneficiary must have a diagnosis of thrombocytopenia with chronic immune thrombocytopenia with insufficient response to corticosteroids, immunoglobulin, or splenectomy, **or** chronic hepatitis C in which thrombocytopenia prevents the initiation of interferon-based therapies, **or** severe aplastic anemia in combination with standard immunosuppressive therapy as first-line therapy, **or** severe aplastic anemia with insufficient response to immunosuppressive therapy, **or** a diagnosis consistent with FDA indications; **AND**
- The beneficiary has a baseline platelet count of < 50,000/µL; **AND**
- The prescriber must submit the following:
  - Current chart notes with documentation of previous therapies tried with response; **AND**
  - Current labs:
    - LFTs prior to therapy initiation, every 2 weeks during dose adjustment, then monthly once dosing is stable (If abnormal, monitor weekly); **AND**
    - CBC with differential (including platelets) prior to therapy, every week until platelet count is stable, then monthly; **AND**
  - Documentation of medical necessity over other options for increasing platelets (e.g., steroids, IVIG, platelet transfusion); **AND**
  - If used previously, provide chart notes and labs with documentation of response; **AND**
  - Documentation that other causes for low platelets have been ruled out including myelodysplastic syndrome; **AND**
  - Verify required dose – dose reductions may be needed for beneficiaries with mild, moderate, or severe hepatic impairment and beneficiaries with Asian ancestry (e.g., Chinese, Japanese, Taiwanese, Korean, or Thai) with ITP or severe aplastic anemia; **AND**
- Initial PA for one month only.

CHRONIC IMMUNE THROMBOCYTOPENIA

- The beneficiary must be ≥ 1 year of age; **AND**
- Dose requirements:
  - 1–5 years of age, begin with 25 mg once daily
  - ≥ 6 years of age, begin with 50 mg once daily

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- Maximum of 75 mg daily
  - Asian ancestry **or** hepatic impairment, begin with 25 mg once daily
  - Asian ancestry **and** hepatic impairment, begin with 12.5 mg once daily

INTERFERON TREATMENT FOR HEPATITIS C BENEFICIARIES

- The beneficiary must be ≥ 18 years of age; **AND**
- Dose requirements; **AND**
  - Begin with 25 mg once daily
  - Max of 100 mg once daily
- The beneficiary must be prescribed interferon-based therapies.

SEVERE APLASTIC ANEMIA

- The beneficiary must be ≥ 2 years of age; **AND**
- Dose requirements; **AND**
- First-line with immunosuppressive therapy:
  - 2–5 years of age begin with 2.5 mg/kg
  - 6–11 years of age begin with 75 mg daily
  - ≥ 12 years of age begin with 150 mg daily
  - Do not exceed the initial dose (above are beginning and max doses per age)
- Refractory:
  - Begin with 50 mg once daily
  - Titrate based on platelet count
  - Max of 150 mg once daily
    - If there is no hematologic response after 16 weeks, discontinue PROMACTA
- Asian ancestry or hepatic impairment:
  - ≥ 12 years of age begin with 75 mg daily
  - 6–11 years of age begin with 37.5 mg daily
  - 2–5 years of age begin with 1.25 mg/kg daily
  - Refractory begin with 25 mg once daily
- Treatment duration is maximum of 6 months.

PROMACTA DENIAL CRITERIA

- The beneficiary does not meet approval criteria **or** have a diagnosis supported in the official Compendia; **OR**
- The beneficiary has a diagnosis of myelodysplastic syndrome; **OR**
- The beneficiary has Hepatits C and is not being treated for HCV infection or the beneficiary has been prescribed a direct-acting antiviral agent instead of interferon; **OR**
- The beneficiary platelet count is ≥ 50,000/μL at time of PA request; **OR**

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- The beneficiary has a history of arterial or venous thrombosis **or** congenital or acquired thrombotic disease; **OR**
- Platelet count is > 400,000/µL after 2 weeks at lowest PROMACTA dose; **OR**
- The beneficiary has aplastic anemia is not prescribed standard immunosuppressive therapy along with PROMACTA for first-line treatment; **OR**
- The prescriber has requested a dose > 150 mg daily for aplastic anemia, or > 75 mg daily for ITP, or > 100 mg daily for interferon treatment of hepatitis C; **OR**
- The prescriber requests PROMACTA for longer than 6 months in aplastic anemia

NON-PREFERRED AGENTS WITH MANUAL REVIEW CRITERIA

- ALVAIZ (eltrombopag choline)
- DOPTELET (avatrombopag maleate)
- eltrombopag olamine (generic for PROMACTA)
- MULPLETA (lusutrombopag)
- PROMACTA suspension (eltrombopag) – **brand preferred over generic when approved**
- TAVALISSE (fostamatinib disodium)
- WAYRILZ (rilzabrutinib)

QUANTITY LIMITS FOR PROMACTA

- 50 mg - #62 per 31 days
- All other strengths #31 per 31 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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THYROID HORMONES

Updated 7/1/2026

PREFERRED AGENTS

- ARMOUR THYROID (thyroid, pork)
- levothyroxine tablet (generic for SYNTHROID)
- liothyronine tablet (generic for CYTOMEL)
- NIVA THYROID (thyroid, pork)
- NP THYROID (thyroid, pork)
- thyroid, pork

NON-PREFERRED AGENTS

- ADTHYZA (thyroid, pork)
- AMERITHROID (thyroid, pork)
- CYTOMEL (liothyronine)
- ERMEZA (levothyroxine) – (see criteria for ERMEZA) – **manufacturer obsolete 11/14/2025**
- EVEXITHROID (thyroid, pork)
- LEVO-T (levothyroxine)
- levothyroxine vial
- LEVOXYL (levothyroxine)
- LIOMNY (liothyronine)
- liothyronine vial
- RENTHYROID (thyroid, pork)
- SYNTHROID (levothyroxine)
- THYQUIDITY (levothyroxine) – (see criteria for THYQUIDITY)
- UNITHROID (levothyroxine)

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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TIRZEPATIDE 10 MG AND 15 MG INJECTION (ZEPBOUND) – OSA ONLY

Updated 4/16/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

Arkansas Medicaid does not cover medications solely for weight loss. The criteria listed below pertain to the obstructive sleep apnea indication only.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with moderate to severe obstructive sleep apnea (OSA) defined as apnea-hypopnea index (AHI) ≥ 15 respiratory events per hour based on polysomnography (PSG) results.
- The beneficiary must have a baseline diagnosis of obesity defined as body mass index (BMI) ≥ 30 kg/m^2 **and** at least **one** of the following weight-related comorbid conditions:
  - Cardiovascular disease
  - Type II diabetes mellitus
  - Dyslipidemia; **OR**
  - Hypertension
- The medication must be prescribed by or in consultation with a neurologist, pulmonologist, otolaryngologist, or other sleep medicine specialist. PA requests are not required from a specialist, but the specialist should have performed the sleep study and provided a report.
- The beneficiary must have been participating in a comprehensive weight management program for at least 6 months with documented counseling on behavioral modification, reduced-calorie diet, and increased physical activity.
- The beneficiary should not be approved or continue the medication if meets **one** of the following:
  - Has not been on a weight management program for at least 6 months
  - Has not been compliant with nightly CPAP use
  - Prescribed another tirzepatide-containing product or any glucagon-like peptide 1 (GLP1) receptor agonist to be used concurrently
  - Personal or family history of medullary thyroid carcinoma (MTC)
  - Diagnosed with Multiple Endocrine Neoplasia syndrome type 2 (MEN 2)
  - Requested for weight loss only
  - Has been diagnosed with severe gastrointestinal disease including gastroparesis
  - Has a history of pancreatitis; **OR**
  - Has a history of suicidal attempts or active suicidal ideation

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- The beneficiary must have at least a 6-month history of compliant positive airway pressure (CPAP or BiPAP) use without a decrease in AHI below 15 events per hour.
- The prescriber must submit the following:
  - Current chart notes
  - Most recent polysomnography (PSG) results including AHI after CPAP or BiPAP trial
  - Beneficiary specific symptoms attributable to OSA (e.g., self-reported daytime sleepiness, snoring episodes, and AHI events)
  - CPAP/BiPAP usage report; **AND**
  - Current weight and body mass index (BMI)
- If approved, the PA will be approved for 6 months

RENEWAL REQUIREMENTS

- The beneficiary must be compliant with Zepbound usage (defined as 75% utilization) and compliant with positive airway pressure (CPAP or BiPAP) usage
- The beneficiary must demonstrate a positive response in OSA self-reported symptoms as compared to baseline (e.g., reduction in daytime sleepiness, reduction in snoring, or reduction in AHI) and decrease in weight/body mass index (BMI)
- The beneficiary continues with comprehensive weight management program with behavioral modification, reduced-calorie diet, and increased physical activity.
- The prescriber must submit the following:
  - Current chart notes
  - Current weight and body mass index (BMI)
  - Documentation of beneficiary specific symptoms improvement compared to baseline; **AND**
  - Current CPAP or BiPAP usage report

QUANTITY EDITS

#4 injections per 28 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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TOLVAPTAN TABLETS (JYNARQUE)

Updated 7/18/2018

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary is an adult ≥ 18 years of age
- The beneficiary has diagnosis of Autosomal Dominant Polycystic Kidney Disease (ADPKD) and is at risk of rapidly progressing in the disease
- The prescriber must submit chart notes indicating the beneficiary's PKD stage
- The beneficiary is not receiving kidney dialysis
- The prescriber must submit initial liver test results for ALT, AST, and bilirubin for the 1st one month PA
- The beneficiary has normal serum sodium concentrations prior to starting drug
- The prescriber must submit initial blood sodium test results
- The initial recommended dose is 60 mg/day (using the 45 mg – 15 mg package). If dose is tolerated, the dose can be titrated up at weekly intervals. The prescriber should work with the beneficiary during up-titration using the tablet strengths in the package before requesting the PA for the next strength.
  - 45 mg – 15 mg tablets
  - 60 mg – 30 mg tablets
  - 90 mg – 30 mg tablets
- Reduced dose adjustment as stated in package insert is required for co-administration with moderate CYP 3A inhibitors

DENIAL CRITERIA

- The beneficiary is already receiving kidney dialysis
- The beneficiary is not adherent to prescribed dose
- The beneficiary does not meet approval criteria
- The beneficiary has history of signs or symptoms of significant liver impairment or injury, does not include uncomplicated polycystic liver disease
- The beneficiary has concomitant use of strong CYP 3A inhibitors, which is contraindicated
- The beneficiary has uncorrected abnormal blood sodium concentrations
- The beneficiary is unable to sense or respond to thirst
- The beneficiary has hypovolemia
- The beneficiary has hypersensitivity to tolvaptan or any of its components
- The beneficiary has uncorrected urinary outflow obstruction

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- The beneficiary has anuria
- The beneficiary is breast feeding

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TOLVAPTAN 15 MG AND 30 MG TABLET (SAMSCA)

Updated 1/21/2026

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA approved indication
- The beneficiary is prescribed no more than the maximum dose as specified in the manufacturer's package insert or supported in the official Compendia
- The medication must be prescribed by a fellowship trained nephrologist
- The beneficiary must be diagnosed with clinically significant hypervolemic or euvolemic hyponatremia (serum sodium < 125 mEq/L that is symptomatic and has resisted correction with fluid restriction) including beneficiaries with heart failure and Syndrome of Inappropriate Antidiuretic Hormone (SIADH).
- The beneficiary must be initiated or re-initiated on tolvaptan while in a hospital
- The beneficiary should not be prescribed this medication for longer than 30 days including the days used while hospitalized
- Tolvaptan should not be used in beneficiaries with autosomal dominant polycystic kidney disease (ADPKD) outside of FDA-approved REMS
- The beneficiary must not have hypovolemic hyponatremia, anuria or end stage renal disease
- The beneficiary must not have an underlying liver disease, including cirrhosis
- The beneficiary must not use concomitant strong CYP3A inhibitors (e.g., clarithromycin, ketoconazole, ritonavir)
- The prescriber must submit the following:
  - Hospital admission to support the use of the medication
  - Number of days used during hospitalization and number of days needed upon discharge (no more than 30 days total)
  - Daily dose expected after discharge (maximum of 60 mg once daily); **AND**
  - Current labs including sodium, potassium, and liver function tests

RENEWAL REQUIREMENTS

- Renewal is not allowed as tolvaptan should be used for a maximum of 30 days per treatment.
- Further usage would require re-initiation in the hospital.

QUANTITY EDITS

- 15 mg – #30 tablets per claim (minus days while hospitalized)
- 30 mg – #60 tablets per claim (minus days while hospitalized)

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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TOPICAL ANTIPARASITIC MEDICATIONS (LICE TREATMENT)

Updated 4/1/2026

PREFERRED AGENTS

- permethrin 1% topical liquid OTC (e.g., LICE KILLING LIQUID, LICE TREATMENT)
- piperonyl butoxide 4%-pyrethrum extract 0.33% OTC (e.g., LICE KILLING SHAMPOO, COMPLETE LICE TREATMENT)
- permethrin 5% cream (generic for ELIMITE)
- NATROBA 0.9% (spinosad)
- spinosad 0.9% (generic for NATROBA)
  - Brand and generic NATROBA may be filled once every 60 days. This medication should not require retreatment. However, if retreatment is required additional chart notes documenting reason for retreatment (re-infestation, product did not completely kill all nits) will be needed.

NON-PREFERRED AGENTS

- CROTAN (crotamiton)
- EURAX (crotamiton)
- malathion (generic for OVIDE)
- OVIDE (malathion)
- PRURADIK (crotamiton)
- VANALICE OTC (piperonyl butoxide, pyrethrins)

ADDITIONAL CRITERIA

Quantity limits apply

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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TOBACCO-CESSATION PRODUCTS

Updated 1/1/2020

All smoking cessation products eligible for rebate are currently covered without a PA through Arkansas Medicaid. In addition, these products do not contribute toward the use of a slot nor do they have a copay. This includes the following:

- ZYBAN (bupropion)
- CHANTIX (varenicline)
- nicotine gum
- nicotine patches
- nicotine inhalers; **OR**
- nicotine lozenges

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TRANEXAMIC ACID (LYSTEDA)

Updated 7/15/2020

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

POINT-OF-SALE (POS) APPROVAL CRITERIA

- Diagnosis in Medicaid medical history in previous 3 years of cyclic heavy menstrual bleeding; **AND**
- The beneficiary's Medicaid pharmacy drug history indicates paid claims of contraceptives or hormonal therapy with any of the following:
  - 84 days' supply of oral, vaginal or patch contraceptive claims from 30–180 days in profile history (three pharmacy claims)
  - 90 days' supply of injectable birth control from 90–180 days in profile history (one pharmacy claim); **OR**
  - 91 days' supply for extended cycle oral contraceptive from 90–180 days in profile history (one pharmacy claim)
- The beneficiary's lab results in the Prime system for the previous 30 days indicates a hemoglobin (Hgb) level of ≤ 12 g/dL.

DENIAL CRITERIA

- Medicaid profile indicates a pharmacy claim for a combination hormonal contraception (estrogen and progestin combination) in the previous 30 days; **OR**
- Medicaid profile indicates a pharmacy claim for anticoagulants in the previous 30 days

ADDITIONAL CRITERIA

- Quantity limits apply – #30/21 days
- Manual review PA will be on a case-by-case basis if the above requirements are not found in the Medicaid system for POS approval. The prescriber must submit a letter explaining the medical necessity and submit documentation to support the diagnosis not found.

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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TRANSDERMAL SCOPOLAMINE PATCHES

Updated 3/9/2010

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- ≥ 12 years of age; **OR**
- History of at least one paid claim in the past 60 days for transderm scopolamine

ADDITIONAL CRITERIA

Quantity limits apply

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TRIENTINE CAPSULE (SYPRINE)

Updated 1/15/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

Please note that effective 10/1/2025, this manufacturer is terminating participation in the federal rebate program and therefore brand Syprine can no longer be covered by Arkansas Medicaid.

APPROVAL CRITERIA

- Manual review on a case-by-case basis
- The beneficiary must be diagnosed with Wilson's disease and be intolerant to penicillamine with intolerable or life endangering side effects
- Dose may be increased only when the clinical response is not adequate or the concentration of free serum copper is persistently above 20 mcg/dL.
- The prescriber must submit the following:
  - Current chart notes
  - Previous therapies tried
  - Response to penicillamine; **AND**
  - If the dose needs to be increased when the clinical response is not adequate, free serum copper should be checked and be above 20 mcg/dL.

RENEWAL REQUIREMENTS

- The beneficiary must remain compliant with therapy (defined as 75% utilization)
- The beneficiary must demonstrate a positive response
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Documentation of response to treatment

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TRIHEPTANOIN (DOJOLVI)

Updated 10/21/2020

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary has a confirmed diagnosis of long-chain fatty acid oxidation disorder **or** a diagnosis consistent with FDA indication; **AND**
- The beneficiary is under the care of a clinical specialist knowledgeable in appropriate disease related dietary management based upon current nutritional recommendations; **AND**
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Documentation confirming the diagnosis of LC-FAOD with **one** of the following:
    - Acylcarnitine profiles from a newborn screen; **OR**
    - Fatty acid oxidation probe studies in cultured fibroblasts (low enzyme activity); **OR**
    - Mutation analysis containing **one** of the following mutations – CPT2, ACADVL, HADHA, or HADHB
  - Total daily dose based on required daily caloric intake (DCI) times target percentage of DCI; **AND**
  - Documentation of symptoms; **AND**
  - Documentation of diet plan; **AND**
  - Baseline echocardiogram with documented left ventricular ejection fraction; **AND**
  - Medical necessity over other available options

DENIAL CRITERIA

- The beneficiary does not meet the FDA-approved indication **or** have a diagnosis supported in the official Compendia; **OR**
- The beneficiary has pancreatic insufficiency; **OR**
- The beneficiary requires concomitant pancreatic lipase inhibitors (e.g., orlistat); **OR**
- The beneficiary is receiving another medium-chain triglyceride product; **OR**
- The beneficiary has a feeding tube manufactured of polyvinyl chloride (PVC).

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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TROFINETIDE ORAL SOLUTION AND PACKETS (DAYBUE AND DAYBUE STIX)

Updated 7/19/2023

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with Rett syndrome **or** a diagnosis consistent with any new FDA-approved indications. Any off-label requests will be reviewed on a case-by-case basis.
- The prescriber must be a specialist with experience in Rett Syndrome (e.g., neurologist, geneticist) or prescriber must be in consultation with a specialist
- The prescriber must submit a detailed baseline clinical presentation of Rett syndrome including, but not limited to the following:
  - Abnormal muscle tone/dystonia
  - Abnormal respiration pattern
  - Feeding difficulties
  - Intellectual disability (i.e., I.Q. score < 70)
  - Loss of mobility or gait abnormalities
  - Partial or complete loss of acquired hand skills
  - Partial or complete loss of speech
  - Seizures; **AND**
  - Stereotypic hand movements such as hand wringing, squeezing, clapping, tapping, mouthing, and washing, and rubbing automatisms
- The beneficiary should not be approved or continue with this therapy with any of the following:
  - Moderate to severe renal impairment
  - Intolerable diarrhea
  - No improvement in clinical presentation compared to baseline; **OR**
  - Dose requested is not consistent with weight-based dose recommendation
- The prescriber must submit **all** of the following:
  - Current chart notes with description of specific symptoms present in this beneficiary
  - Documentation of the MECP2 mutation (if available)
  - Attestation of a clinical diagnosis of RTT in the absence of a MECP2 mutation
  - Current weight
  - Current dose requested

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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- Current labs to determine renal function
- Treatment plan for severe diarrhea and weight loss; **AND**
- Baseline Rett Syndrome Behavior Questionnaire (RSBQ) and the Clinical Global Impression-improvement (CGI-I) score if available

- Initial PA for 6 months

RENEWAL REQUIREMENTS

- The beneficiary remains compliant with therapy (defined as 75% utilization based on Medicaid claims)
- The prescriber must submit the following:
  - Current chart notes with documentation of current clinical presentation; **AND**
  - Current RSBQ and/or CGI-I if available
- The beneficiary continues to lack intolerable side effects
- The beneficiary must demonstrate an improvement in clinical presentation compared to baseline

QUANTITY EDITS

- 200 mg/mL solution – 3,600 mL per 30 days
- 5,000 mg packet – 120 per 30 days
- 6,000 mg packet – 120 per 30 days
- 8,000 mg packet – 60 per 30 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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UREA CYCLE DISORDER AGENTS

Updated 10/1/2026

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

PREFERRED AGENTS WITH CRITERIA

- CARBAGLU (carglumic acid) – **brand name**
- PHEBURANE (sodium phenylbutyrate)

NON-PREFERRED AGENTS

- BUPHENYL (sodium phenylbutyrate)
- carglumic acid (generic for CARBAGLU)
- glycerol phenylbutyrate (generic for RAVICTI)
- OLPRUVA (sodium phenylbutyrate)
- RAVICTI (glycerol phenylbutyrate)
- sodium phenylbutyrate (generic for BUPHENYL)

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with:
  - BUPHENYL: urea cycle disorders involving deficiencies of carbamoyl phosphate synthetase (CPS), ornithine transcarbamylase (OTC), or argininosuccunic acid synthetase (AS)
  - CARBAGLU:
    - Acute or chronic hyperammonemia due to N-acetylglutamate synthase (NAGS) deficiency; **AND**
      - Adjunctive therapy to standard of care for the treatment of acute hyperammonemia; **OR**
      - Maintenance therapy for the treatment of chronic hyperammonemia; **OR**
    - Acute hyperammonemia due to Propionic Acidemia (PA) or Methylmalonic Acidemia (MMA) as adjunctive therapy
  - OLPRUVA: urea cycle disorders involving deficiencies of carbamoyl phosphate synthetase (CPS), ornithine transcarbamylase (OTC), or argininosuccunic acid synthetase (AS) and weigh at least 7 kg
  - PHEBURANE: urea cycle disorders involving deficiencies of carbamoyl phosphate synthetase (CPS), ornithine transcarbamylase (OTC), or argininosuccinic acid synthetase (AS)

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  - RAVICTI: urea cycle disorders and cannot be managed by dietary protein restriction and/or amino acid supplementation alone
- The medication must be prescribed by or in consultation with a provider experienced in managing UCDs (e.g., geneticist)
- The beneficiary is unable to maintain a plasma ammonia level within normal range with standard of care treatment (i.e., protein restriction and essential amino acid supplementation when appropriate)
- The beneficiary must continue dietary management with protein restriction with dietary plan provided
- The prescriber must submit **all** of the following:
  - Current chart notes
  - Previous therapies tried with response
  - Current weight and body surface area (BSA)
  - Current labs, including plasma ammonia and complete metabolic panel; **AND**
  - Dose requested must fall within the parameters from the individual product package insert
    - PHEBURANE pellet or BUPHENYL tablet/powder (maximum daily dose of 20 gm)
      - 450 to 600 mg/kg/day orally in beneficiaries weighing < 20 kg
      - 9.5 to 13 g/m²/day orally in beneficiaries weighing ≥ 20 kg
    - CARBAGLU tablet
      - Acute treatment for NAGS – 100–250 mg/kg
      - Chronic treatment for NAGS – 10–100 mg/kg
      - Acute treatment for PA or MMA – 150 mg/kg/day for ≤ 15 kg **or** 3.3 g/m²/day for > 15 kg
      - If diagnosed with PA or MMA, provide number days treated while hospitalized. The beneficiary should have a maximum of 7 days total.
    - OLPRUVA pellet (maximum daily dose of 20 gm)
      - ≥ 20 kg = 9.9 to 13 g/m^2/day
      - 7 kg to < 20 kg = 450 to 600 mg/kg/day
    - RAVICTI liquid (maximum daily dose of 17.5 mL [19 gm])
      - 4.5 to 11.2 mL/m²/day (5 to 12.4 g/m²/day)
- For non-preferred products, beneficiary must have tried and failed preferred products with documented uncontrolled hyperammonemia despite compliance in the previous year or have documented contraindication/intolerance to preferred products.
- If the beneficiary has a G-tube, the medical necessity of Ravicti over sodium phenylbutyrate powder will need to be provided.

RENEWAL REQUIREMENTS

- The prescriber must submit the following:
  - Current chart notes with documentation of current clinical presentation
  - Current plasma ammonia level; **AND**
  - Current weight and/or BSA and dose requested

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- The beneficiary must demonstrate an improvement in clinical presentation and/or decrease in plasma ammonia compared to baseline
- The beneficiary must continue to meet approval criteria

QUANTITY EDITS

None since dose based on BSA

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ULCERATIVE COLITIS AGENTS (EXCLUDING BIOLOGICS)

Updated 4/1/2025

PREFERRED AGENTS

- mesalamine ER capsule (generic for APRISO)
- mesalamine suppository (generic for CANASA)
- PENTASA (mesalamine ER) – **brand name**
- sulfasalazine (generic for AZULFIDINE)
- sulfasalazine DR (generic for AZULFIDINE EN-tab)

PREFERRED AGENTS WITH CRITERIA

- budesonide ER 9 mg tablet (generic for UCERIS)

UCERIS (budesonide extended-release) tablets are indicated for the induction of remission in beneficiaries with active, mild to moderate ulcerative colitis.

The recommended dosage for the induction of remission in adult beneficiaries with active, mild to moderate ulcerative colitis is 9 mg taken orally once daily in the morning with or without food for up to 8 weeks.

POINT-OF-SALE APPROVAL CRITERIA FOR BUDESONIDE ER 9 MG TABLET

- The beneficiary must have a billed diagnosis of ulcerative colitis in the past 2 years; **AND**
- The beneficiary must have a pharmacy claim in their Arkansas Medicaid history over the last 186 days for **one** of following:
  - Oral or rectal mesalamine; **OR**
  - sulfasalazine
- The beneficiary will be limited to two claims of budesonide ER 9 mg tablet every 186 days for a total of 60 tablets.

For beneficiaries not meeting the above point-of-sale approval criteria, prior authorization approvals will be for 2 months only as indicated in the package insert dosing.

NON-PREFERRED AGENTS

- AZULFIDINE (sulfasalazine)
- AZULFIDINE EN-tab (sulfasalazine DR)
- balsalazide (generic for COLAZAL)
- budesonide (generic for UCERIS)
- CANASA (mesalamine)
- DELZICOL (mesalamine DR)
- DIPENTUM (olsalazine)

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- LIALDA (mesalamine DR)
- mesalamine DR tablet (generic for ASACOL HD)
- mesalamine DR capsule (generic for DELZICOL)
- mesalamine DR tablet (generic for LIALDA)
- mesalamine enema (generic for sfROWASA)
- mesalamine ER capsule (generic for PENTASA)
- mesalamine kit (generic for ROWASA)
- ROWASA (mesalamine)
- sfROWASA (mesalamine)

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VAGINAL HORMONES

Updated 10/1/2024

PREFERRED AGENTS

- estradiol cream (generic for ESTRACE)
- PREMARIN cream (estrogens, conjugated)

NON-PREFERRED AGENTS

- ESTRACE cream (estradiol)
- estradiol tablet (generic for VAGIFEM and YUVAFEM)
- ESTRING (estradiol)
- FEMRING (estradiol acetate)
- IMVEXXY (estradiol)
- VAGIFEM (estradiol)
- YUVAFEM (estradiol)

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VALGANCICLOVIR ORAL SOLUTION (VALCYTE)

Updated 1/18/2011

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- Less than 9 years of age; **OR**
- History of diagnosis of NPO (Appendix A) within the past 365 days.

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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VERICIGUAT (VERQUVO)

Updated 7/21/2021

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary must be ≥ 18 years of age; **AND**
- The beneficiary must be diagnosed with symptomatic chronic heart failure (New York Heart Association class III or IV) with an ejection fraction < 45% following a worsening HF event **or** a diagnosis consistent with FDA-approved indications; **AND**
- The beneficiary must have previously been hospitalized for heart failure in the last 6 months or required outpatient IV diuretics in the last 3 months; **AND**
- The beneficiary must remain on standard of care therapy; **AND**
- The beneficiary of reproductive potential should use contraception and have a negative pregnancy test; **AND**
- The beneficiary has continued heart failure symptoms while on ENTRESTO; **AND**
- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Discharge summary from hospital if recently hospitalized; **AND**
  - Documentation of previous therapies tried with outcomes; **AND**
  - Documentation of ejection fraction; **AND**
  - Pro-BNP confirms heart failure diagnosis; **AND**
  - Negative pregnancy test results for beneficiaries of reproductive potential

DENIAL CRITERIA

- The beneficiary does not meet approval criteria **or** have a diagnosis supported on the official Compendia; **OR**
- The beneficiary is pregnant; **OR**
- The beneficiary is taking another soluble guanylate cyclase (sGC) stimulator (i.e., ADEMPAS); **OR**
- The beneficiary is taking a PDE-5 inhibitor is not recommended to take with this product; **OR**
- The beneficiary has severe hepatic impairment (Child-Pugh C) or severe renal impairment (eGFR)

QUANTITY EDITS

#31 tablets per 31 days for each strength

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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VESICULAR MONOAMINE TRANSPORTER 2 (VMAT2) INHIBITORS

Updated 10/1/2026

PREFERRED AGENTS WITH CRITERIA

- AUSTEDO (deutetrabenazine)
- AUSTEDO XR tablet and titration pack (deutetrabenazine)
- INGREZZA capsule and sprinkle (valbenazine)
- INGREZZA initiation pack (valbenazine)
- tetrabenazine (generic for XENAZINE)

NON-PREFERRED AGENTS

XENAZINE (tetrabenazine)

APPROVAL CRITERIA FOR PREFERRED AGENTS WITH CRITERIA

TETRABENAZINE TABLET (POS EDITS)

- Requires a billed diagnosis of Huntington's Disease with Chorea in the past 3 years
- Quantity edits apply

AUSTEDO/AUSTEDO XR TABLET (DEUTETRABENAZINE) – REQUIRES A PA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must have **one** of the following diagnoses:
  - Chorea associated with Huntington's disease; **OR**
  - Moderate to severe tardive dyskinesia (must also meet **all** the following DSM-5 criteria)
    - Involuntary athetoid or choreiform movements
    - History of treatment with dopamine receptor blocking agent (DRBA) (e.g., antipsychotics or metoclopramide)
    - Symptoms duration lasting longer than 4 to 8 weeks
- The medication must be prescribed by or in consultation with a neurologist, psychiatrist, or gastroenterologist (chorea due to metoclopramide)
- The beneficiary should not be approved or continue with this therapy with any of the following:
  - Congenital long QT syndrome or cardiac arrhythmias associated with a prolonged QT interval
  - Hepatic impairment
  - Requires monoamine oxidase inhibitors (MAOIs), any other VMAT2 inhibitor, or reserpine
  - Requires strong CYP2D6 inhibitor (e.g., quinidine, paroxetine, fluoxetine, bupropion)

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- Poor CYP2D6 metabolizer requires a dose reduction to 36 mg daily
- Pregnant or breastfeeding
- Dose requested is > 48 mg/day
- Develops Neuroleptic Malignant Syndrome; **AND**
- Chorea associated with Huntington's disease beneficiary that is suicidal or has untreated or inadequately treated depression

- The prescriber must submit **all** the following:
  - Current chart notes with documentation on the impact of TD or chorea symptoms with activities of daily living
  - Completed Medicaid INGREZZA/AUSTEDO Statement of Medical Necessity form with the initial request: https://ar.primetherapeutics.com/forms-documents
  - Baseline Abnormal Involuntary Movement Scale (AIMS) form for tardive dyskinesia
  - Data documenting the response to benztropine or other agent of EPS symptoms if applicable; **AND**
  - Tapering plan with each PA request until beneficiary reaches a stable, maintenance dose
- The initial AUSTEDO PA will be approved for two months to allow time for titration. AUSTEDO 6 mg can be approved up to a maximum of #240 tablets (8 tablets per day) during the initial two months of treatment for titration. If additional titration time is needed beyond the original two months, another PA with quantity override would be required. Once compliant on a maintenance dose, PAs may be approved for a maximum of 6 months.

RENEWAL REQUIREMENTS

- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Current AIMS score for beneficiaries with tardive dyskinesia
- The beneficiary must have an improvement from baseline AIMS score or have a positive clinical response

INGREZZA CAPSULE AND SPRINKLE (VALBENAZINE) – REQUIRES A PA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must have **one** of the following diagnoses:
  - Chorea associated with Huntington's disease; **AND**
  - Moderate to severe tardive dyskinesia while meeting **all** the following DSM-5 criteria:
    - Involuntary athetoid or choreiform movements
    - History of treatment with dopamine receptor blocking agent (DRBA) (e.g., antipsychotics or metoclopramide); **AND**

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    - Symptoms duration lasting longer than 4 to 8 weeks
- The medication must be prescribed by or in consultation with a neurologist, psychiatrist, or gastroenterologist (chorea due to metoclopramide)
- The beneficiary should not be approved or continue with this therapy with any of the following:
  - Has violent behavior or is suicidal
  - Pregnant or breastfeeding
  - Requires monoamine oxidase inhibitors (MAOIs), any other VMAT2 inhibitor, or concomitant strong CYP3A4 inducers (e.g., rifampin, carbamazepine, and phenytoin)
  - Dose requested is > 80 mg/day
  - Dose requested is > 40 mg/day when requires strong SYP3A4 inhibitors (e.g., itraconazole, ketoconazole, and clarithromycin) **or** has moderate to severe hepatic impairment (Child-Pugh score 7–15)
  - Congenital long QT syndrome or cardiac arrhythmias associated with a prolonged QT interval; **OR**
  - Severe renal impairment (creatinine clearance < 30 mL/min)
- The prescriber must submit **all** the following:
  - Current chart notes with documentation on the impact of TD or chorea symptoms with activities of daily living
  - Completed Medicaid INGREZZA/AUSTEDO Statement of Medical Necessity form with the initial request: https://ar.primetherapeutics.com/forms-documents
  - Baseline Abnormal Involuntary Movement Scale (AIMS) form for tardive dyskinesia
  - Data documenting the response to benztropine or other agents of EPS symptoms, if applicable; **AND**
  - Requests for the sprinkle formulation should include documentation of the medical necessity over the capsule
- Initial INGREZZA PA should not exceed 3 months. Once compliant on maintenance dose, PAs may be approved for a maximum of 6 months.

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VOCLOSPORIN (LUPKYNIS)

Updated 4/21/2021

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must have a diagnosis of biopsy-proven active lupus nephritis (Class III, IV or V) **or** a diagnosis consistent with any new FDA-approved indications. Any off-label requests will be reviewed on a case-by-case basis.
- The beneficiary must also take mycophenolate mofetil (MMF) and corticosteroids concomitantly with LUPKYNIS
- The beneficiary must have an elevated urine protein to creatinine (UPCR) ratio
- The beneficiary should not be approved or continue this therapy with any of the following:
  - Pregnant
  - Baseline eGFR ≤ 45 mL/min/1.73 m^2
  - Baseline blood pressure > 165/105 mmHg or with hypertensive emergency
  - Not taking concomitant mycophenolate mofetil and corticosteroids
  - Taking cyclophosphamide
  - Requires concomitant strong CYP3A4 inhibitors (e.g., ketoconazole, clarithromycin)
  - Dose requested > 23.7 mg twice daily **or** < 7.9 mg twice daily; **OR**
  - Hepatic impairment
- The prescriber must submit the following:
  - Current chart notes
  - Current labs, including liver function tests, urine protein to creatinine (UPCR) ratio, serum potassium levels, and baseline estimated glomerular filtration rate (eGFR). eGFR must be assessed every two weeks for the first month, and every four weeks thereafter; **AND**
  - Current blood pressure

RENEWAL REQUIREMENTS

- The beneficiary is compliant with therapy (defined as 75% utilization)
- If approved, beneficiary has not experienced therapeutic benefit by 24 weeks.
- The prescriber must submit the following:
  - Current chart notes with response to treatment

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- Current labs; **AND**
- Current blood pressure

QUANTITY EDITS

#180 capsules per 30 days

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VOLTAGE-GATED SODIUM CHANNEL SELECTIVE INHIBITORS

Updated 2/10/2025

PREFERRED AGENTS

JOURNAVX (suzetrigine)

NON-PREFERRED AGENTS

None

QUANTITY EDITS

#30 tablets every 60 days

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VONOPRAZAN (VOQUEZNA)

Updated 10/16/2024

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary prescribed a VOQUEZNA Dual or Triple Pak must be diagnosed with *Helicobacter pylori* or beneficiary prescribed VOQUEZNA must be diagnosed with **one** of the following:
  - For healing of all grades of erosive esophagitis and relief of heartburn associated with erosive esophagitis in adults.
  - To maintain healing of all grades of erosive esophagitis and relief of heartburn associated with erosive esophagitis in adults.
  - For the relief of heartburn associated with non-erosive gastroesophageal reflux disease in adults.
  - In combination with amoxicillin and clarithromycin for the treatment of *Helicobacter pylori* (*H. pylori*) infection in adults; **OR**
  - In combination with amoxicillin for the treatment of *H. pylori* infection in adults.
- The beneficiary with erosive esophagitis or heartburn must have had previous treatment failure with or a contraindication to all preferred proton pump inhibitors
- Beneficiary's diagnosed with *H. pylori* must have tried and failed (defined as failure to eradicate *H. pylori* infection after 14-day course of therapy) **one** of the following:
  - Bismuth quadruple therapy unless contraindicated (e.g., bismuth, metronidazole, tetracycline and proton pump inhibitor); **OR**
  - Clarithromycin-based therapy unless contraindicated (e.g., clarithromycin, amoxicillin, and proton pump inhibitor)
- The medication must be prescribed by or in consultation with a gastroenterologist or infectious disease specialist
- The beneficiary should not be approved or continue this therapy with any of the following:
  - Requested duration of treatment for healing erosive esophagitis or relief of heartburn associated with erosive esophagitis exceeds 8 weeks
  - Requested duration of maintenance therapy for healed erosive esophagitis and relief of heartburn exceeds 6 months
  - Requested duration of treatment for heartburn associated with non-erosive gastroesophageal reflux disease exceeds 4 weeks; **OR**
  - Requested duration of treatment for *H. pylori* exceeds 14 days

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- The prescriber must submit the following:
  - Current chart notes
  - Previous therapies tried
  - Confirmation of *H. pylori* if that is the diagnosis
  - Letter of medical necessity requesting VOQUEZNA over guideline-recommended first-line treatment; **AND**
  - VOQUEZNA requests require an endoscopy report confirming:
    - Current erosive esophagitis with treatment prescribed to heal erosive esophagitis
    - Confirmed healed erosive esophagitis with treatment prescribed as maintenance therapy; **OR**
    - Confirmed lack of esophageal erosions but heartburn persists
- PA duration will be consistent with duration per the package insert

RENEWAL REQUIREMENTS

- The prescriber must submit the following:
  - Current chart notes; **AND**
  - Letter of medical necessity outlining the rationale for exceeding FDA-approved treatment duration

QUANTITY EDITS

10 mg and 20 mg – #31 tablets per 31 days; Dual and Triple Pak – #112 tablets per 14 days

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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VOSORITIDE (VOXZOGO)

Updated 01/19/2022

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary must have a diagnosis of achondroplasia (ACH) **or** a diagnosis consistent with any new FDA-approved indications. Any off-label requests will be reviewed on a case-by-case basis.
- The beneficiary must have open epiphyses
- The beneficiary should not be approved or continue this therapy with any of the following:
  - Has closed epiphyses
  - Has a diagnosis of hypochondroplasia or short stature condition other than ACH; **OR**
  - Has been treated with growth hormone in the previous 6 months
- The prescriber who specializes in skeletal dysplasia (orthopedics, geneticist, or endocrinologist) must submit the following:
  - Current chart notes
  - Genetic test results and radiologic findings confirming the diagnosis of achondroplasia
  - Baseline standing height
  - Current weight (must be at least 3 kg)
  - Requested dose; **AND**
  - X-ray report demonstrating epiphyses status for beneficiaries yearly

QUANTITY EDITS

Each strength – #30 vials per 30 days (packaged in 10 vials per kit)

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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VUTRISIRAN (AMVUTTRA)

Updated 7/16/2025

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

POLYNEUROPATHY – APPROVAL CRITERIA

- The medication must be prescribed by or in consultation with a neurologist or other specialist that treats polyneuropathy due to hATTR
- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is diagnosed with polyneuropathy due to hereditary transthyretin-mediated (hATTR) amyloidosis **or** a diagnosis consistent with any updated FDA-approved indications
- Beneficiaries with multisystem symptoms and/or family history must have the diagnosis confirmed with **one** of the following:
  - Confirmation of a TTR variant by genetic testing; **OR**
  - Tissue biopsy confirming the presence of amyloid deposits
- The beneficiary does not have any of the following:
  - Severe renal impairment or end-stage renal disease; **OR**
  - Moderate or severe hepatic impairment
- The prescriber must submit the following:
  - Current chart notes
  - Medical necessity over preferred neuropathic pain agents
  - Attestation that vitamin A is being monitored for possible supplementation
  - Baseline modified Neuropathy Impairment Score +7 (mNIS+7)
  - Norfolk Quality of Life-Diabetic Neuropathy (QoL-DN) total score
  - Previous therapies tried; **AND**
  - Current labs, including LFTs and BMP
- Renewal requires the prescriber to submit updated notes and labs with documentation of a positive response to therapy

CARDIOMYOPATHY – APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must have the diagnosis of cardiomyopathy of wild-type or hereditary transthyretin-mediated amyloidosis (ATTR-CM) confirmed with **two** of the following:
  - Echocardiogram

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  - Tissue biopsy confirming the presence of transthyretin amyloid deposits; **OR**
  - Cardiovascular magnetic resonance imaging
    - If consistent with cardiac amyloidosis, the following should be done to document the presence or absence of monoclonal protein confirmed by **one** of the following:
      - Serum kappa/lambda free light chain ratio analysis
      - Serum protein immunofixation; **OR**
      - Urine protein immunofixation
    - If monoclonal protein is not found, bone tracer cardiac scintigraphy (pyrophosphate scan) should be performed. The presence of grade 2 or 3 is highly specific for ATTR cardiac disease and tissue biopsy is not needed, but genetic testing is needed to confirm TTR variant.
- The medication must be prescribed by or in consultation with a cardiologist
- The beneficiary must have New York Heart Association (NYHA) class I, II, or III heart failure with symptoms of cardiomyopathy and heart failure (e.g., dyspnea, fatigue, orthostatic hypotension, syncope, peripheral edema)
- The beneficiary must have left ventricular wall (interventricular septum or left ventricular posterior wall) thickness ≥ 12 mm
- The beneficiary should not be approved or continue the medication if meets **one** of the following:
  - Impaired renal function (eGFR < 15 mL/min/1.73m^2); **OR**
  - Baseline NT-proBNP < 300 pg/mL or ≥ 8,500 pg/mL
- The prescriber must submit the following:
  - Current chart notes
  - Symptoms specific to this beneficiary to support diagnosis
  - Baseline 6-minute walk distance (6MWD)
  - Current labs, including baseline eGFR and NT-proBNP level (≥ 300 pg/mL)
  - Baseline echocardiogram with NYHA classification and documentation of tests results to confirm diagnosis
  - Baseline Kansas City Cardiomyopathy Questionnaire-Overall Summary (KCCQ-OS) score; **AND**
  - Medical necessity over ATTRUBY and VYNDAQEL/VYNDAMAX

RENEWAL REQUIREMENTS

- The beneficiary must remain compliant with therapy (defined as 75% utilization)
- The beneficiary must demonstrate a positive response to treatment
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of beneficiary specific symptoms compared to baseline
  - Updated 6-minute walk distance (6MWD); **AND**
  - Current Kansas City Cardiomyopathy Questionnaire-Overall Summary (KCCQ-OS) score

Prescribers with questions on how to obtain a prior authorization (PA) should call the Prime Help Desk at 800-424-7895. All PA requests may be submitted electronically via CoverMyMeds or faxed to the Prime Therapeutics State Government Solutions pharmacy unit at 800-424-7976 unless otherwise noted on the specific medication page.

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QUANTITY EDITS

1 injection per 90 days

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ZILUCOPLAN SODIUM SYRINGE (ZILBRYSQ)

Updated 4/17/2024

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with generalized myasthenia gravis (gMG) and are antiacetylcholine receptor (AChR) antibody positive **or** a diagnosis consistent with any new FDA-approved indications. Any off-label requests will be reviewed on a case-by-case basis.
- The medication must be prescribed by or in consultation with a neurologist or other specialist knowledgeable in treating gMG
- Prior to initiating treatment with ZILBRYSQ, the beneficiary must have a baseline Myasthenia Gravis Foundation of America (MGFA) Clinical Classification class II to IV and a MG-Activities of Daily Living (MG-ADL) total score ≥ 6
- The beneficiary must have completed or updated meningococcal vaccination (for serogroups A, C, W, and Y, and serogroup B) at least 2 weeks prior to first dose of ZILBRYSQ or the prescriber must administer the meningococcal vaccine as soon as possible and begin antibacterial drug prophylaxis
- The beneficiary must have tried and failed an acetylcholinesterase (AChE) inhibitor (e.g., pyridostigmine) **and** immunosuppressive therapies (e.g., glucocorticoids, azathioprine, or mycophenolate) while on a stable dose or have a documented contraindication or intolerance to those agents
- The prescriber and pharmacies must be certified in the ZILBRYSQ Risk Evaluation Mitigation Strategy (REMS) program
- The beneficiary should not be approved or continue this therapy with any of the following:
  - Dose requested is not consistent with weight-based dosing from the package insert
  - The beneficiary is not AChR antibody positive
  - The beneficiary has a current unresolved *Neisseria meningitidis* infection
  - The beneficiary has suspected or confirmed pancreatitis
  - Baseline MG-ADL total score is < 6 or designated as MGFA class I or class V
- The prescriber must submit the following:
  - Current chart notes
  - Documentation of previous therapies tried with response
  - Serologic test confirming the presence of anti-AChR antibodies
  - Baseline lipase and amylase levels

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  - Current body weight
  - Dose requested; **AND**
  - Baseline MG-ADL total score and MGFA class
- Initial PA will be for 3 months

RENEWAL REQUIREMENTS

- The beneficiary must demonstrate a positive clinical response compared to baseline with an improvement in symptoms and/or improvement in the MG-ADL total score
- The prescriber must submit the following:
  - Current chart notes
  - Current MG-ADL total score
  - Current body weight; **AND**
  - Dose requested
- Renewal PAs can be approved for 6 months

QUANTITY EDITS

- 16.6 mg/0.416 mL – #28 syringes per 28 days
- 23 mg/0.574 mL – #28 syringes per 28 days
- 32.4 mg/0.81 mL – #28 syringes per 28 days

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ZINC ACETATE 25 MG AND 50 MG CAPSULE (GALZIN)

Updated 1/21/2026

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with Wilson's disease with previous chelating agent treatment (e.g., penicillamine, trientine)
- The medication must be prescribed by, or in consultation with, a fellowship trained hepatologist
- The prescriber must submit the following:
  - Current chart notes
  - Previous therapies tried
  - Beneficiary specific symptoms associated with Wilson's disease; **AND**
  - Current labs including LFTs, ceruloplasmin, and 24-hour urinary copper excretion (24-hour urinary copper excretion > 40 mcg/24 hours)
- Initial PA for 6 months

RENEWAL REQUIREMENTS

- The beneficiary must remain compliant on therapy (defined as 75% utilization)
- The beneficiary must demonstrate an improvement in symptoms, improvement in LFTs and/or improvement in 24-hour urinary copper excretion
- The prescriber must submit the following:
  - Current chart notes
  - Current beneficiary specific symptoms; **AND**
  - Current labs including LFTs, ceruloplasmin, and 24-hour urinary copper excretion

QUANTITY EDITS

- #93 capsules per 31 days

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ZURANOLONE CAPSULE (ZURZUVAE)

Updated 04/17/2024

Prior authorization (PA) requests for this product may be submitted electronically via CoverMyMeds or faxed to the state pharmacy unit at 800-424-5851.

APPROVAL CRITERIA

- The beneficiary meets the minimum age recommended in the manufacturer's package insert for this FDA-approved indication
- The beneficiary is prescribed no more than the maximum dose or treatment duration as specified in the manufacturer's package insert or supported in the official Compendia
- The beneficiary must be diagnosed with moderate to severe postpartum depression (PPD) with onset of symptoms no earlier than the third trimester and no later than 4 weeks following delivery **or** a diagnosis consistent with any new FDA-approved indications. Any off-label requests will be reviewed on a case-by-case basis.
- The beneficiary must be ≤ 12 months postpartum (< 365 days)
- The beneficiary should not be approved with any of the following:
  - More than 12 months postpartum
  - Currently pregnant; **OR**
  - Requesting more than one 14-day course
- The prescriber must submit the following:
  - Current chart notes
  - Previous therapies tried
  - Date of delivery
  - Dose requested
    - Typical dose is 50 mg once daily in the evening for 14 days
    - If the beneficiary experiences CNS depressant effects within the 14-day period, dose may be decreased to 40 mg once daily in the evening for the remainder of the 14-day period. The prescriber should contact the specialty pharmacy that filled the beneficiary's initial ZURZUVAE prescription to obtain the 20 mg capsules from the manufacturer for the remainder of the beneficiary's treatment course.
    - Dose should be reduced to 30 mg for the following:
      - Concomitant use with strong CYP3A4 inhibitor (e.g., ketoconazole)
      - Severe hepatic impairment (Child-Pugh C); **OR**
      - Moderate or severe renal impairment (eGFR < 60 mL/min/1.73 m^2)
  - Attestation that the beneficiary has been counseled on CNS depression risk for infants during breastfeeding. Breastfeeding should be temporarily stopped during the 14-day treatment and for 7 days after if possible; **AND**

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- Attestation that the beneficiary is not currently pregnant

QUANTITY EDITS

One 14-day course

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APPENDIX A – NOTHING BY MOUTH (NPO)

Procedure codes	Description
B4034, B4035, B4036	Enteral feeding supplies
B4149, B4151-B4156	Enteral formula
B4160-B4162	Enteral formula for pediatrics
43752	Naso/Oro-gastric tube placement
43510	Surgical opening of stomach
43760	Change gastrostomy tube
43762	Replacement of stomach stoma tube accessed through skin
43763	Replacement of stomach stoma tube accessed through skin with revision of stoma opening
43831	Insertion of stomach feeding tube, open procedure for newborn feeding
44021	Incision of small bowel for insertion of tube
44300	Insertion of small bowel tube, open procedure
44310	Creation of small bowel feeding tube
49440	Insertion of stomach tube, accessed through skin using fluoroscopic guidance with contrast
49441	Insertion of small bowel tube, accessed through skin using fluoroscopic guidance with contrast
49442	Insertion of large bowel tube, accessed through skin using fluoroscopic guidance with contrast
49446	Conversion of stomach tube to stomach-to-small bowel tube, accessed through skin using fluoroscopic guidance with contrast
49452	Replacement of stomach-to-small bowel tube, accessed through skin using fluoroscopic guidance with contrast
43830, 43832	Gastrostomy tube
43761	G-tube repositioning
44373, 44372, 44015	J-Tube
43246 , 43750	PEG placement
43820	Partial removal of stomach, without vagotomy
43810	Removal of end portion of stomach with attachment to upper small bowel
43845	Partial removal of stomach, with partial gastrectomy
43825	Partial removal of stomach and severing of vagus nerve
B4087	Gastrostomy/Jejunostomy tube, standard
74350	G-tube placement

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APPENDIX B – CONGESTIVE HEART FAILURE DIAGNOSES

Description
Hypertensive heart disease with heart failure
Hypertensive heart disease with heart failure
Hypertensive heart disease with heart failure
Hypertensive heart and renal disease with heart failure
Hypertensive heart and renal disease with heart and renal failure
Hypertensive heart and renal disease with heart failure
Hypertensive heart and renal disease with heart and renal failure
Hypertensive heart and renal disease with heart failure
Hypertensive heart and renal disease with renal failure
Hypertensive heart and renal disease with heart and renal failure
Congestive heart failure, unspecified

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APPENDIX C – MALIGNANT CANCER DIAGNOSES

Description
Malignant neoplasm of lip
Malignant neoplasm of major salivary gland
Malignant neoplasm of oropharynx
Malignant neoplasm of nasopharynx
Malignant neoplasm of hypopharynx
Malignant neoplasm of other and ill-defined sites within the lip, oral cavity, and pharynx
Malignant neoplasm of esophagus
Malignant neoplasm of stomach
Malignant neoplasm of small intestine including duodenum
Malignant neoplasm of colon
Malignant neoplasm of rectum rectosigmoid junction
Malignant neoplasm of liver and intrahep
Malignant neoplasm of gall bladder and extrahepatic bile duct
Malignant neoplasm of pancreas
Malignant neoplasm of retroperitoneum and peritoneum
Malignant neoplasm of other and ill-defined sites within the digestive organs and peritoneum
Malignant neoplasm of nasal cavities middle ear and accessory sinuses
Malignant neoplasm of larynx
Malignant neoplasm of trachea bronchus and lung
Malignant neoplasm of pleura
Malignant neoplasm of thymus, heart, and mediastinum
Malignant neoplasm of other and ill-defined sites within the respiratory system and intrathoracic organs
Malignant neoplasm of bone and articular cartilage
Malignant neoplasm of connective and other soft tissue
Malignant melanoma of skin
Malignant neoplasm of female breast
Malignant neoplasm of male breast
Kaposis sarcoma
Malignant neoplasm of uterus, part unspecified
Malignant neoplasm of cervix uteri
Malignant neoplasm of placenta
Malignant neoplasm of body of uterus
Malignant neoplasm of ovary and other uterine adnexa
Malignant neoplasm other and unspecified female genital organs
Malignant neoplasm of prostate

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Description
Malignant neoplasm of testis
Malignant neoplasm of penis and other male genital
Malignant neoplasm of bladder
Malignant neoplasm of kidney and other unspecified urinary organs
Malignant neoplasm of eye
Malignant neoplasm of brain
Malignant neoplasm other and unspecified parts nervous system
Malignant neoplasm of thyroid gland
Malignant neoplasm of other endocrine glands and related structures
Malignant neoplasm of other and ill-defined sites
Secondary and unspecified malignant neoplasm of lymph
Secondary malignant neoplasm of respiratory and digestive
Secondary malignant neoplasm of other specified sites
Malignant neoplasm without specification
Lymphosarcoma and reticulosarcoma
Hodgkin’s disease
Other malignant neoplasms lymphoid and histiocytic tissue
Multiple myeloma and immunoproliferative neoplasms
Lymphoid leukemia
Myeloid leukemia
Monocytic leukemia
Other specified leukemia
Leukemia of unspecified cell type

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APPENDIX D – APPROVED ENDOSCOPY CODES

Endoscopy	
CPT	**Procedure**
43201	ESPHGSC RGD/FLX DIRED SBMCSL NJX ANY SBST
43234	UPR GI NDSC SMPL PRIM XM SPX
43235	UPR GI NDSC DX +-COLLJ SPEC BR/WA SPX
43236	UPR GI NDSC DIRED SBMCSL NJX ANY SBST
43237	UPR GI NDSC NDSC US XM LMTD ESOPH
43238	UPR GI NDSC TNDSC US FINE NDL ASPIR/BX ESOPH
43239	UPR GI NDSC BX 1/MLT
43240	UPR GI NDSC TRANSMURAL DRG PSEUDOCST
43241	UPR GI NDSC TNDSC INTRAL TUBE/CATH PLMT
43242	UPR GI NDSC TNDSC US FINE NDL ASPIR/BX W/US XM
43243	UPR GI NDSC NJX SCLEROSIS ESOPHGL&/GSTR VARC
43244	UPR GI NDSC BAND LIG ESOPHGL&/GSTR VARC
43245	UPR GI NDSC DILAT GSTR OUTLET FOR OBSTRCJ
43246	UPR GI NDSC DIRED PLMT PRQ GASTROSTOMY TUBE
43247	UPR GI NDSC RMVL FB
43248	UPR GI NDSC INSJ GD WIRE DILAT ESOPH GD WIRE
43249	UPR GI NDSC BALO DILAT ESOPH <30 MM DIAM
43250	UPR GI NDSC RMVL LES HOT BX/BIPOLAR CAUT
43251	UPR GI NDSC RMVL TUM POLYP/OTH LES SNARE TQ
43255	UPR GI NDSC CTRL BLD ANY METH
43256	UPR GI NDSC TNDSC STENT PLMT W/PREDILAT
43257	UPR GI NDSC DLVR THERMAL NRG SPHNCTR/CARDIA
43258	UPR GI NDSC ABLTJ LES X RMVL FORCEPS/CAUT/SNARE
43259	UPR GI NDSC W/US XM
43200	Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
43201	...with directed submucosal injection(s), any substance
43202	...with biopsy, single or multiple
43204	…with injection sclerosis of esophageal varices
43205	...with band ligation of esophageal varices
43220	...with balloon dilation (less than 30 mm diameter)
43226	...with insertion of guide wire followed by dilation over guide wire
43227	...with control of bleeding (e.g., injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)

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Endoscopy	
CPT	**Procedure**
43228	...with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
43216	... with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
43217	...with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
43219	...with insertion of plastic tube or stent
43231	...with endoscopic ultrasound examination
43232	...with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s)

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REVISION HISTORY

Date	Issues/Updates
10/01/2026	• Updated PDL classes: Anaphylaxis Agents – Epinephrine, Self-Administered; Anti-Migraine Agents, Other; Immunomodulators, Atopic Dermatitis; Immunomodulators, Asthma and Miscellaneous Indications; Anticonvulsants • Updated the following PDL classes to remove discontinued products: Medication Assisted Treatment Agents, Migraine Treatment (Acute) – Triptans, Colony Stimulating Factors, Erythropoiesis Stimulating Agents, Urea Cycle Disorder Agents, Vesicular Monoamine Transporter 2 (VMAT2) Inhibitors, Ophthalmic – Antibiotic Drops, Otic Anti-Infective and Antibiotic/Corticosteroid Combinations, Anticonvulsants, Rescue • Added new or revised Manual Review criteria to the following agents/disease states: QUIOFIC, DESMODA, YUVIWEL, KYGEVVI, IMCIVREE, CONTEPO, SAPHNELO, BAXFENDY, HEPCLUDEX, FILSPARI, Isotretinoin (for acne) • Butalbital (Non-Codeine) Quantity Limit decreased to 90/31 days. • FASENRA is indicated for the treatment of adult and pediatric patients aged 12 years and older with hypereosinophilic syndrome (HES) without an identifiable non hematologic secondary cause. Criteria for HES has already been DUR Board approved for NUCALA. FASENRA will be added. • VYVGART/VYVGART HYTRULO UPDATE WITH INDICATION CHANGE The criteria has been updated to match the current language with the removal of the requirement of patients needing to be AChR antibody positive. Also, test results documenting the presence of AChR antibodies will no longer be required.
07/01/2026	• Added new PDL classes: Histamine H2 Receptor Antagonists, Thyroid Hormones, Octreotide and Related Products, Diuretics; Expanded Osteoporosis class which is now called Osteoporosis, Bone Resorption Suppression and Related Agents • Updated the following PDL classes to remove discontinued products: Antidepressants - SGAD, ADD/ADHD, Antihyperlipidemics excluding Statins, and Pituitary Suppressive Agents. • Added new or revised Manual Review criteria to the following agents/disease states: Allergic Fungal Rhinosinusitis, CARDAMYST, VOYXACT, AQVESME, MYQORZO, FORZINITY, ZYCUBO, PIVYA, LOARGYS
04/01/2026	• Added PDL classes: HAE Agents – Acute and Preventative Treatments, Idiopathic Pulmonary Fibrosis Agents • Updated the following PDL classes to remove discontinued products: Bronchodilators – SABA, LABA, SAMA, LAMA, LABA/LAMA, ICS/LABA/LAMA, Cephalosporins, Growth Hormones, HIV, Inhaled Antibiotics, Leukotriene Receptor Antagonists, Pancreatic Enzymes, Lice Treatment • Added new or revised Manual Review criteria to the following agents/disease states: Chronic Spontaneous Urticaria, LYNKUET, VEOZAH, ACTHAR HP, CORTROPHIN, SAMSCA, ORLYNVAH, BLUJEPA, LEQEMBI IQLIK, GALZIN, PALSONIFY, REVCOVI; Butalbital (Non-Codeine) Quantity Limit decreased to 100/31 days.

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Date	Issues/Updates
	• Initial version

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