Umpqua Health Alliance

Pharmacy Utilization Management Guidelines

Effective April 1, 2026

Contents

General Utilization Management Criteria 4
Stimulants 7
Opiate Agonists 10
Glucagon-Like Peptide-1 (GLP-1) Receptor Agonists (i.e. Incretin Mimetics) 14
Sodium-Glucose Cotransporter-2 (SGLT2) Inhibitors 25
Insulins 29
Topical Antifungals 32
Clonazepam 24
Topical Corticosteroids 38
Neoplastic Disease 40
Hepatitis C Direct Acting Antivirals 44
Tryvio (aprocitentan) 45
Skeletal Muscle Relaxants 47
Monoclonal Antibodies for Alzheimer's Disease 49
Selective Serotonin Agonists 52
Ropinirole 54
Interferon Beta-1a 55
Dimethyl Fumarate 56
Antineoplastic Gonadotropin Releasing Hormone Agonist 57
Desmopressin 62
Growth Hormones 63
Pancreatic Enzymes 67
Aprepitant 69
Sedatives 71
Pulmonary Antihypertensive Phosphodiesterase Inhibitors 74
Omalizumab 77
Topical Immunosuppressants 79
Topical Antipsoriatic Agents 81
Acitretin 83
Tolterodine 85
Biologics for Inflammatory Disease 86
Long-Acting Muscarinic Antagonist/Long-acting Beta-agonist/ Inhaled Corticosteroid (LAMA/LABA/ICS) Combinations 99
Erythropoiesis-Stimulating Agents (ESA) 102

Colony-Stimulating Factors 104
Nicotine Replacement Preparations 107
Testosterone 109
Oral Antifungals 111
Rifaximin 113
Palivizumab 115
Lacosamide 117
Mesalamine 118
Calcitonin Gene-Related Peptide (CGRP) Antagonists 122
Sacubitril-Valsartan 127
Acne Agents 130
Cystic Fibrosis Modulators 132
Varenicline 134
Insulin Delivery Devices 135
C1 Esterase Inhibitors 138
Finerenone 140
Buprenorphine & Opioid Concurrent Use 142
Pharmaceutical Weight Management 143
Vesicular Monoamine Transporter 2 (VMAT2) Inhibitors 145
Diabetic Diagnostics 148

General Utilization Management Criteria

Policy Number: Rx001

I. MEDICATION NAME(S):

- Multiple

II. LENGTH OF AUTHORIZATION:

- Variable

III. QUANTITY LIMITS:

- Multiple (see formulary)

IV. INITIAL CRITERIA:

1. Is the member under age 21?
    a. Yes (go to #2)
    b. No (go to #3)
2. Is there documentation that treating the condition is medically appropriate and necessary in which it will enhance the member's ability to grow, develop, or participate in school per the EPSDT Medicaid benefit?
    a. Yes (go to #4)
    b. No (forward to pharmacist for review [deny 5a])
3. Is the drug prescribed for a condition funded by the Oregon Health Plan (OHP) in a manner consistent with the Health Evidence Review Commission (HERC) Prioritized List of Health Services OR is there a comorbid condition for which coverage would be allowed?
    a. Yes (go to #4)
    b. No (go to #forward to pharmacist for review [deny 3a/3c])
4. Is the drug used for an FDA-approved indication or a medically appropriate off-label use with strong evidence supporting safety and efficacy? (Refer to Table 1 in 'Additional Information' for recommendation, evidence and efficacy ratings: the strength of recommendation must be class IIa or higher; the strength of evidence must be category B or higher; and the efficacy must be IIa or higher.)
    a. Yes (go to #5)
    b. No (forward to pharmacist for review [deny 12a if drug not FDA-approved, or 8a if indication not FDA-approved])
5. Is the drug prescribed at the appropriate FDA-approved dose to treat the covered condition?
    a. Yes (go to #6)

    b. No (forward to pharmacist for review)
6. Is the prescribed dose within UHA's quantity limits?
    a. Yes (go to #7)
    b. No (forward to pharmacist for review)
7. Is the medication prescribed by or in consultation with an appropriate health care provider with expertise in treating this condition?
    a. Yes (go to #8)
    b. No (forward to pharmacist for review)
8. Does the member have any contraindications to therapy according to FDA-approved labeling?
    a. Yes (deny)
    b. No (go to #9)
9. If FDA-approved labeling or national clinical guidelines categorize this drug as a second line therapy, has there been trial and failure of or contraindication to the first-line therapies?
    a. Yes or N/A (go to #10)
    b. No (forward to pharmacist for review)
10. Has the member tried and failed all less costly alternative therapies that are similar or identical to the requested therapy (within the same drug class, therapeutic class, or used to treat the member's condition according to UpToDate)?
    a. Yes (go to #11)
    b. No (forward to pharmacist for review [deny 7a, or deny 5k for formulary exception requests])
11. Has documentation been submitted to support medical necessity, including chart notes, a treatment plan, monitoring parameters, and laboratory values (if applicable)?
    a. Yes or N/A (go to #12)
    b. No (forward to pharmacist for review [deny 5a])
12. Has the member been adherent to first-line therapies used to treat this condition? (Adherent is defined as a MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes or N/A (go to #13)
    b. No (forward to pharmacist for review [deny 5u])
13. Is the drug requested primarily for the convenience of the member and not medically necessary?
    a. Yes (deny 5o)
    b. No (approve)

V. RENEWAL CRITERIA:

1. Is the requested drug being used outside of the FDA-approved treatment duration?
    a. Yes (deny 8a)
    b. No (go to #2)
2. Has documentation been submitted to support the continued medical necessity and safety, including chart notes, a treatment plan, monitoring parameters, and laboratory values (if applicable)?
    a. Yes or N/A (go to #3)
    b. No (forward to pharmacist for review [deny 5a])

3. When appropriate, has the member been non-adherent to therapy and unlikely to benefit from additional therapy? (Non-adherent is defined as a MPR less than 80% or gaps between fills that exceed 5 days.)
    a. Yes (deny 5u)
    b. No or N/A (approve)

VI. ADDITIONAL INFORMATION:

- Table 1. Recommendation, Evidence and Efficacy Ratings

1. Strength Of Recommendation		
Class I	Recommended	The given test or treatment has been proven to be useful, and should be performed or administered.
Class IIa	Recommended, In Most Cases	The given test, or treatment is generally considered to be useful, and is indicated in most cases.
Class IIb	Recommended, In Some Cases	The given test, or treatment may be useful, and is indicated in some, but not most, cases.
Class III	Not Recommended	The given test, or treatment is not useful, and should be avoided.
Class Indeterminate	Evidence Inconclusive	
2. Strength Of Evidence		
Category A	Category A evidence is based on data derived from: Meta-analyses of randomized controlled trials with homogeneity with regard to the directions and degrees of results between individual studies. Multiple, well-done randomized clinical trials involving large numbers of patients.	
Category B	Category B evidence is based on data derived from: Meta-analyses of randomized controlled trials with conflicting conclusions with regard to the directions and degrees of results between individual studies. Randomized controlled trials that involved small numbers of patients or had significant methodological flaws (e.g., bias, drop-out rate, flawed analysis, etc.). Nonrandomized studies (e.g., cohort studies, case-control studies, observational studies).	
Category C	Category C evidence is based on data derived from: Expert opinion or consensus, case reports or case series.	
No Evidence		
3. Efficacy		
Class I	Effective	Evidence and/or expert opinion suggests that a given drug treatment for a specific indication is effective.
Class IIa	Evidence Favors Efficacy	Evidence and/or expert opinion is conflicting as to whether a given drug treatment for a specific indication is effective, but the weight of evidence and/or expert opinion favors efficacy.
Class IIb	Evidence is Inconclusive	Evidence and/or expert opinion is conflicting as to whether a given drug treatment for a specific indication is effective, but the weight of evidence and/or expert opinion argues against efficacy.
Class III	Ineffective	Evidence and/or expert opinion suggests that a given drug treatment for a specific indication is ineffective.

VII. REVISION HISTORY:

- **Last Reviewed Date:** 12/7/2022
- **Last Updated Date:** 12/7/2022

Stimulants

Policy Number: Rx002

I. MEDICATION NAME(S):

- dexmethylphenidate HCl ER
- Zenzedi (dextroamphetamine sulfate)
- Vyvanse (lisdexamfetamine dimesylate)
- methylphenidate LA
- methylphenidate HCl CD

II. LENGTH OF AUTHORIZATION:

- Initial, members age 19 and older: six months
- Initial, members age 18 and younger: one year
- Renewal, members age 19 and older: six months
- Renewal, members age 18 and younger: one year

III. QUANTITY LIMITS:

- Multiple (see formulary)

IV. INITIAL CRITERIA:

1. Is the drug prescribed for a diagnosis of ADD/ADHD by a licensed mental health provider?
    a. Yes (go to #8)
    b. No (go to #2)
2. Is the drug prescribed for a diagnosis of ADD/ADHD by the member's primary care provider using a validated symptom checklist or in consultation with a licensed mental health provider or substance use disorder treatment provider? (See Additional Information section for validated symptom checklists.)
    a. Yes (go to #4)
    b. No (go to #3)
3. Does the member have an established diagnosis of narcolepsy from a neurologist or pulmonologist?
    a. Yes (go to #8)
    b. No (forward to pharmacist for review [deny 5z])
4. Is the member using any medications or substances that have the potential to cause sedation or lack of focus including opiates (with the exception of buprenorphine for SUD), benzodiazepines, marijuana, and alcohol?)
    a. Yes (forward to pharmacist for review [deny 5z])

b. No (go to #5)

5. Is the member age 19 or older?
    a. Yes (go to #6)
    b. No (go to #7)
6. Has the requesting provider performed a urine drug screen and provided appropriate results at the initial visit when the stimulant was initially prescribed? (Appropriate results would include the absence of THC, opiates, benzodiazepines, cocaine.)
    a. Yes (go to #8)
    b. No (forward to pharmacist for review [deny 5z])
7. Is the member age 5 and under with a documented trial of structured "parent-behavior training" OR is the member age 6 or older? (Note: For children age 5 and under diagnosed with disruptive behavior disorders, including those at risk for ADHD, first line therapy is evidenced-based, structured parent behavior training. Second line therapy is pharmacotherapy.)
    a. Yes (go to #8)
    b. No (forward to pharmacist for review [deny 5a])
8. Is the medication being prescribed in a manner that is supported by the FDA approved indications and dosing recommendations?
    a. Yes (go to #9)
    b. No (forward to pharmacist for review [deny 8a])
9. Does the member have any co-morbid conditions such as uncontrolled hypertension, cardiac arrhythmias, untreated or uncontrolled anxiety or agitation, or hyperthyroidism? (Note: uncontrolled anxiety or agitation is allowed when the medication is managed by a liscensed mental health provider.)
    a. Yes (forward to pharmacist for review)
    b. No (go to #10)
10. Has the member failed less costly alternative stimulants?
    a. Yes (for members age 19 and older: approve for six months; for members age 18 and younger: approve for one year)
    b. No (forward to pharmacist for review [deny 7a or 5k])

V. RENEWAL CRITERIA:

1. Is the drug prescribed by a licensed mental health provider?
    a. Yes (for members age 19 and older: approve for six months; for members age 18 and younger: approve for one year)
    b. No (go to #2)
2. Is the member currently using any medications or substances that have the potential to cause sedation or lack of focus including opiates (with the exception of buprenorphine for SUD), benzodiazepines, marijuana, and alcohol?
    a. Yes (forward to pharmacist for review [deny 5z])
    b. No (go to #3)
3. Is the member age 19 or older?
    a. Yes (go to #4)
    b. No (approve for one year)
4. Is the requesting provider performing random urine drug screens at least every six months and has the provider included documentation of an appropriate UDS within the

last three months? (Appropriate results would include the absence of THC, opiates, benzodiazepines, cocaine, and presence of the prescribed stimulant if applicable.)

a. Yes (approve for six months)
b. No (forward to pharmacist for review [deny 5z])

VI. ADDITIONAL INFORMATION:

- Accepted validated symptom checklists, Adults: Adult ADHD Self-Report Scale (ASRS-v1.1); Copeland Symptom List for Adult Attention Deficit Disorder; Conners' Adult ADHD Rating Scale (CAARS)
- Accepted validated symptom checklists, Children: Conners 3rd Edition; Behavior Assessment System for Children (BASC); Child Behavior Checklist/Teacher Report Form; ADHD Comprehensive Teacher's Rating Scale (ACTeRS); ADHD Rating Scale; Childhood Attention Problem Scale; Vanderbilt Assessment Scales
- If the member has ever had a history of substance abuse, we recommend considering use of an alternative medication: TCA (desipramine, nortriptyline), Strattera, or bupropion if a TCA is not tolerated. However, this is not a requirement.

VII. REVISION HISTORY:

- **Last Reviewed Date:** 12/7/2022
- **Last Updated Date:** 12/7/2022

Opiate Agonists

Policy Number: Rx005

I. MEDICATION NAME(S):

- acetaminophen with codeine
- Capital W-Codeine (acetaminophen with codeine)
- butalbital/acetaminophen/caffeine/codeine
- codeine sulfate
- codeine/butalbital/aspirin/caffeine
- Ascomp With Codeine (codeine/butalbital/aspirin/caffeine)
- fentanyl
- fentanyl citrate
- Vicodin HP (hydrocodone/acetaminophen)
- hydrocodone/acetaminophen
- Co-Gesic (hydrocodone/acetaminophen)
- Lorcet (hydrocodone/acetaminophen)
- Lorcet Plus (hydrocodone/acetaminophen)
- Lorcet HD (hydrocodone/acetaminophen)
- Stagesic (hydrocodone/acetaminophen)
- Zydone (hydrocodone/acetaminophen)
- hydrocodone/ibuprofen
- hydromorphone HCl
- meperidine HCl
- methadone HCl
- morphine sulfate
- morphine sulfate ER
- oxycodone HCl
- oxycodone HCl ER
- Oxycontin (oxycodone HCl ER)
- oxycodone HCl/acetaminophen
- Roxicet (oxycodone HCl/acetaminophen)
- Endocet (oxycodone HCl/acetaminophen)
- oxycodone HCl/aspirin
- Endodan (oxycodone HCl/aspirin)
- oxymorphone HCl
- tramadol HCl
- Multiple Non-Formulary Opiates

II. LENGTH OF AUTHORIZATION:

- Initial and renewal: six weeks up to 90 days for conditions of the spine and back, six months for cancer pain or palliative care, and three months for all other diagnoses

III. QUANTITY LIMITS:

- 90 mg morphine equivalents per day, 7 days per 60 days (short-acting opioids), 30 days per 180 days
- tramadol: 8 tablets per day
- oxycodone 5 mg/5 mL oral solution: 100 mL per year

- acetaminophen with codeine 120-12 mg/5 oral solution: 300 mL per year
- hydrocodone/acetaminophen 7.5-325/15 oral solution: 480 mL per year
- For treatment of acute pain for all opioid naïve members (except for cancer pain or palliative care): limit to 7 days per fill
    - Opioid naïve is defined as no opioid fills within the past 60 days
- Additional quantity limits for dose optimization will apply to all long-acting opioids, including but not limited to the following formulary agents:
    - fentanyl transdermal patches: 1 patch per 3 days
    - morphine ER capsules: 2 capsules per day
    - morphine ER tablets: 3 tablets per day
    - oxycodone ER, Oxycontin: 2 tablets per day

IV. INITIAL CRITERIA:

1. Is the member under age 21?
    a. Yes (go to #2)
    b. No (go to #3)
2. Is there documentation that treating the condition is medically appropriate and necessary in which it will enhance the member's ability to grow, develop, or participate in school per the EPSDT Medicaid benefit?
    a. Yes (go to #6)
    b. No (forward to pharmacist for review [deny 5a])
3. Is the drug prescribed for a condition funded by the Oregon Health Plan (OHP) in a manner consistent with the Health Evidence Review Commission (HERC) Prioritized List of Health Services?
    a. Yes (go to #4)
    b. No (forward to pharmacist for review [deny 3a])
4. Does Prioritized List of Health Services Guideline Note 60 apply (opioid prescribing for conditions of the back and spine)?
    a. Yes (go to #5)
    b. No (go to #6)
5. Does the request meet Guideline Note #60, Opioid for Conditions of the Back and Spine? For acute use, the following provisions must be met: for immediate-release opiates, trial and failure of non-opiates such as NSAIDs, APAP, muscle relaxants; use of other interventions such as physical therapy; no current or history of opiate abuse and documented verification that the patient is not high risk for opioid misuse or abuse. For acute use greater than 6 weeks and less than 90 days post injury or flare, there must be documented evidence of improvement of function of at least thirty percent as compared to baseline based on a validated tool (e.g. Oswestry, Neck Disability Index, SF-MPQ, and MSPQ). Chronic use (greater than 90 days) requires an individual treatment plan considering biological, behavioral, psychological, and social factors. The plan must follow the latest Oregon Chronic Opioid Prescribing Guidelines and include maintaining activity with therapies such as chiropractic care, physical therapy, yoga, or acupuncture. A taper plan may be indicated if and when clinically appropriate.
    a. Yes (go to #6)
    b. No (forward to pharmacist for review [deny GLN 60])
6. Is the drug prescribed for migraine headache?

    a. Yes (forward to pharmacist for review [deny 5a])
    b. No (go to #7)
7. Has the member failed less costly alternative opioids? (For example, morphine ER must be tried and failed before fentanyl or oxycodone ER.)
    a. Yes (go to #8)
    b. No (forward to pharmacist for review [deny 7a])
8. Is the drug prescribed for cancer pain, or is the patient receiving hospice or end-or-life care?
    a. Yes (approve for six months)
    b. No (go to #9)
9. Does the patient have a history of diversion, history of opioid abuse, active substance abuse as defined as any illicit or non-prescribed substance (including alcohol and marijuana) within the past year?
    a. Yes (forward to pharmacist for review [deny 5a])
    b. No (go to #10)
10. Is there a pain contract in place limiting the patient to one provider and one pharmacy?
    a. Yes (go to #11)
    b. No (forward to pharmacist for review [deny 5g])
11. Has the prescriber submitted a written treatment plan stating goals used to determine treatment successes such as pain relief and improved physical and psychosocial function?
    a. Yes (go to #12)
    b. No (forward to pharmacist for review [deny 5g])
12. Has the member had a mental health screening within the last year?
    a. Yes (go to #13)
    b. No (forward to pharmacist for review [deny 5g])
13. Has the requesting provider performed a urine drug screen and provided appropriate results and is the member free from any duplicative or contraindicated medications? (Appropriate results would include the absence of THC, cocaine, benzodiazepines, other opioids, and any non-prescribed substances. Concurrent opioid and benzodiazepine use will not be approved due to risk of respiratory depression. Duplicative opioids are not covered unless clinically appropriate.)
    a. Yes (go to #14)
    b. No (forward to pharmacist for review [deny 5g])
14. Has the provider reviewed the Oregon Prescription Monitoring Program registry and documented appropriate results?
    a. Yes (go to #15)
    b. No (forward to pharmacist for review [deny 5g])
15. Is the member taking greater than 90 MED per day?
    a. Yes (forward to pharmacist for review [deny for QL over 90 MED])
    b. No (approve for six weeks for back pain and three months for all other conditions)

V. RENEWAL CRITERIA:

1. Is the drug prescribed for cancer pain, or is the patient receiving hospice or end-or-life care?

    a. Yes (approve for six months)
    b. No (go to #2)
2. Does Prioritized List of Health Services Guideline Note 60 apply (opioid prescribing for conditions of the back and spine)?
    a. Yes (go to #3)
    b. No (go to #4)
3. Does the request meet Guideline Note #60, Opioid for Conditions of the Back and Spine? For acute use, the following provisions must be met: for immediate-release opiates, trial and failure of non-opiates such as NSAIDs, APAP, muscle relaxants; use of other interventions such as physical therapy; no current or history of opiate abuse and documented verification that the patient is not high risk for opioid misuse or abuse. For acute use greater than 6 weeks and less than 90 days post injury or flare, there must be documented evidence of improvement of function of at least thirty percent as compared to baseline based on a validated tool (e.g. Oswestry, Neck Disability Index, SF-MPQ, and MSPQ). Chronic use (greater than 90 days) requires an individual treatment plan considering biological, behavioral, psychological, and social factors. The plan must follow the latest Oregon Chronic Opioid Prescribing Guidelines and include maintaining activity with therapies such as chiropractic care, physical therapy, yoga, or acupuncture. A taper plan may be indicated if and when clinically appropriate.
    a. Yes (go to #5)
    b. No (forward to pharmacist for review [deny GLN 60])
4. Is the request for acute use (treatment less than 90 days), OR is the request for chronic use and the requesting provider has submitted documentation of reduction in pain and a taper plan or rational explaining why a taper plan is not medically indicated?
    a. Yes (go to #5)
    b. No (forward to pharmacist for review [deny 5g])
5. Has the requesting provider performed a urine drug screen within the last six months and provided appropriate results? (Appropriate results would include the absence of THC, cocaine, benzodiazepines, and any non-prescribed substances.)
    a. Yes (go to #6)
    b. No (forward to pharmacist for review [deny 5g])
6. Has the provider reviewed the Oregon Prescription Monitoring Program registry regularly, at least once since the last approval, and documented appropriate results?
    a. Yes (approve for six weeks for back pain and three months for all other conditions)
    b. No (forward to pharmacist for review [deny 5g])

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 7/2/24
- **Last Updated Date:** 7/2/24

Prior Authorization Criteria
Formulary Exception Criteria

Glucagon-Like Peptide-1 (GLP-1) Receptor Agonists and Glucose-Dependent Insulinotropic Polypeptide(GIP) Receptor Agonist- *FOR TYPE 2 DIABETES MELLITUS*

Policy Number: Rx007a

I. MEDICATION NAME(S):

- Rybelsus (oral semaglutide) *preferred*
- Ozempic Pen Injector (semaglutide) *preferred*
- Exenatide Pen Injector *preferred*
- Trulicity (dulaglutide) *preferred*
- Victoza (liraglutide) Pen Injector *preferred*
- Mounjaro (tirzepatide)* *non preferred*

***Tirzepatide is a combination glucose-dependent insulinotropic polypeptide (GIP) receptor and GLP-1 receptor agonist.

This criteria is specifically used for GLP-1 receptor agonists (GLP-1 RA) and combo GIP/GLP-1 receptor agonists products indicated for Type 2 Diabetes Mellitus. Appendix has additional information regarding DM diagnosis and treatment.

GLP-1 receptor agonists and combo GIP/GLP-1 receptor agonists are not considered as initial therapy for most members with type 2 diabetes. GLP-1 RAs should not be initiated in a member with a history of pancreatitis. Combination therapy with GLP1 RA and dipeptidyl peptidase-4 (DPP-4) inhibitors does not provide additive glucose-lowering effects, and thus, the combination should be avoided.

Select GLP-1 receptor agonists and combo GIP/GLP-1 receptor agonists are indicated as adjunct to diet and exercise to improve glycemic control with type 2 diabetes mellitus.

- Trulicity, Exenatide ER, Mounjaro and Victoza are indicated in members ≥10 yrs.
- Exenatide IR, Ozempic, and Rybelsus are indicated in only adults.

NON-DIABETES INDICATIONS: GLP-1 receptor agonists and combo GIP/GLP-1 receptor agonists products indicated for non-diabetes conditions have their own unique criteria; see *PA Criteria*

Policy Number Rx007b: Non-Diabetes Indications (this includes Wegovy and Zepbound coverage pathways).

NOTE: GLP-1 receptor agonists and combo GIP/GLP-1 receptor agonists products are not covered for weight loss as use of medications for weight loss is not a covered benefit on OHP. For additional information on coverage pathways for weight loss medications, please see *PA Criteria Policy Rx060: Pharmaceutical Weight Management.*

II. LENGTH OF AUTHORIZATION:

- Initial: six months
- Renewal: one year

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA: TYPE 2 DIABETES MELLITUS

1. Is the drug prescribed for glycemic control in a member diagnosed with Type 2 diabetes mellitus and the member's age is one of the following: Trulicity, Exenatide ER, Mounjaro and Victoza: ≥ 10 years; All other GLP-1 receptor agonists: ≥ 18 years? (See Appendix: Table 1. Criteria for Diagnosis of Diabetes)
    a. Yes (go to #2)
    b. No (forward to pharmacist for review; *see PA Criteria Policy Number Rx007b: Non-Diabetes Indications and/or PA Criteria Policy Rx060: Pharmaceutical Weight Management*)
2. Has the member had an adequate trial and failure of, contraindication to, or intolerance to metformin dosed at 2,000mg per day? (Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days. (See Appendix: Table 2 for metformin initiation guidance.)
    a. Yes (go to #3)
    b. No (forward to pharmacist for review)
3. Does the member have established atherosclerotic cardiovascular disease (ASCVD) [documented with a history of one or more of the following: coronary heart diease (heart attack (MI), angina), ischemic cerebrovascular disease (stroke, transiant ischemic attack), ischemic heart disease, revascularization procedure (coronary artery bypass grafting: CABG, percutaneous coronary intervention: PCI, angioplasty), amputation due to atherosclerotic disease, aortic aneurysms, and peripheral artery disease]]?
    a. Yes (go to #8)
    b. No (go to #4)
4. Does the member have a high risk for ASCVD defined as age 55 years or older AND two or more traditional risk factors including obesity, hypertension, dyslipidemia (LDL > 130 mg/dL or taking lipid-lowering therapies), albuminuria, or tobacco use?
    a. Yes (go to #8)
    b. No (go to #5)

5. Is the member above their individual glycemic target despite an adequate trial and failure of, contraindication to, or intolerance to a drug in at least one of the following drug classes: (a) sulfonylurea (e.g. glipizide), (b) TZD (e.g. pioglitazone), (c) dipeptidyl peptidase-4 (DPP-4) inhibitor (e.g. alogliptin)? (Contraindication may include risk of hypoglycemia with appropriate documentation.)
    a. Yes (go to #6)
    b. No (forward to pharmacist for review)
6. Is the member's most recent A1c (within the last six months) equal to or greater than 9%?
    a. Yes (go to #7)
    b. No (go to #8)
7. Has the member had an adequate trial and failure of, contraindication to, or intolerance to insulin, OR has the the provider submitted an acceptable, medical rationale for why insulin cannot be used?
    a. Yes (go to #8)
    b. No (forward to pharmacist for review)
8. Has the member had an adequate trial and failure of, contraindication to, or intolerance to the maximum tolerated dose of an SGLT2 inhibitor such as Steglatro (ertugliflozin or Farxiga (dapagliflozin)? (Adequate trial is defined as adherent to therapy for at least three to six consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (go to #9)
    b. No (forward to pharmacist for review)
9. Is the member actively participating in a lifestyle or nutrition support program? (Note: UHA requires attestation of partipation in a program such as Diabetes Self Management, Mastering Diabetes, Weight Watchers, YMCA, Oregon Wellness Network or a similar clinic based program.)
    a. Yes (go to #10)
    b. No (forward to pharmacist for review and medication therapy management/CM)
10. Is the member using a concurrent DPP-4 agent or GLP-1?
    a. Yes (forward to pharmacist for review)
    b. No (go to #11)
11. Is the requested medication on formulary?
    a. Yes (approve for six months)
    b. No (go to #12)
12. Has the member tried and failed all the formulary alternative medications?
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review)

V. RENEWAL CRITERIA: TYPE 2 DIABETES MELLITUS

1. Has the member demonstrated ongoing adherence to the prescribed diabetes treatment regimen? (Adherence defined as a MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (go to #2)
    b. No (forward to pharmacist for review)
2. Has the member had a positive clinical response to therapy (such as a reduction in HgA1c within the past 6 months compared to the immediately preceding HgA1c level), OR has the prescriber submitted documentation of continued medical necessity in accordance with the initial criteria?
    a. Yes (go to #3)
    b. No (forward to pharmacist for review)
3. Is the member using a concurrent DPP-4 agent or GLP-1?

UHA Glucagon-Like Peptide-1 (GLP-1) Receptor Agonists (i.e. Incretin Mimetics)

a. No (approve for one year)
b. Yes (forward to pharmacist for review)

VI. ADDITIONAL INFORMATION:

Table 1: Criteria for Diagnosis of Diabetes

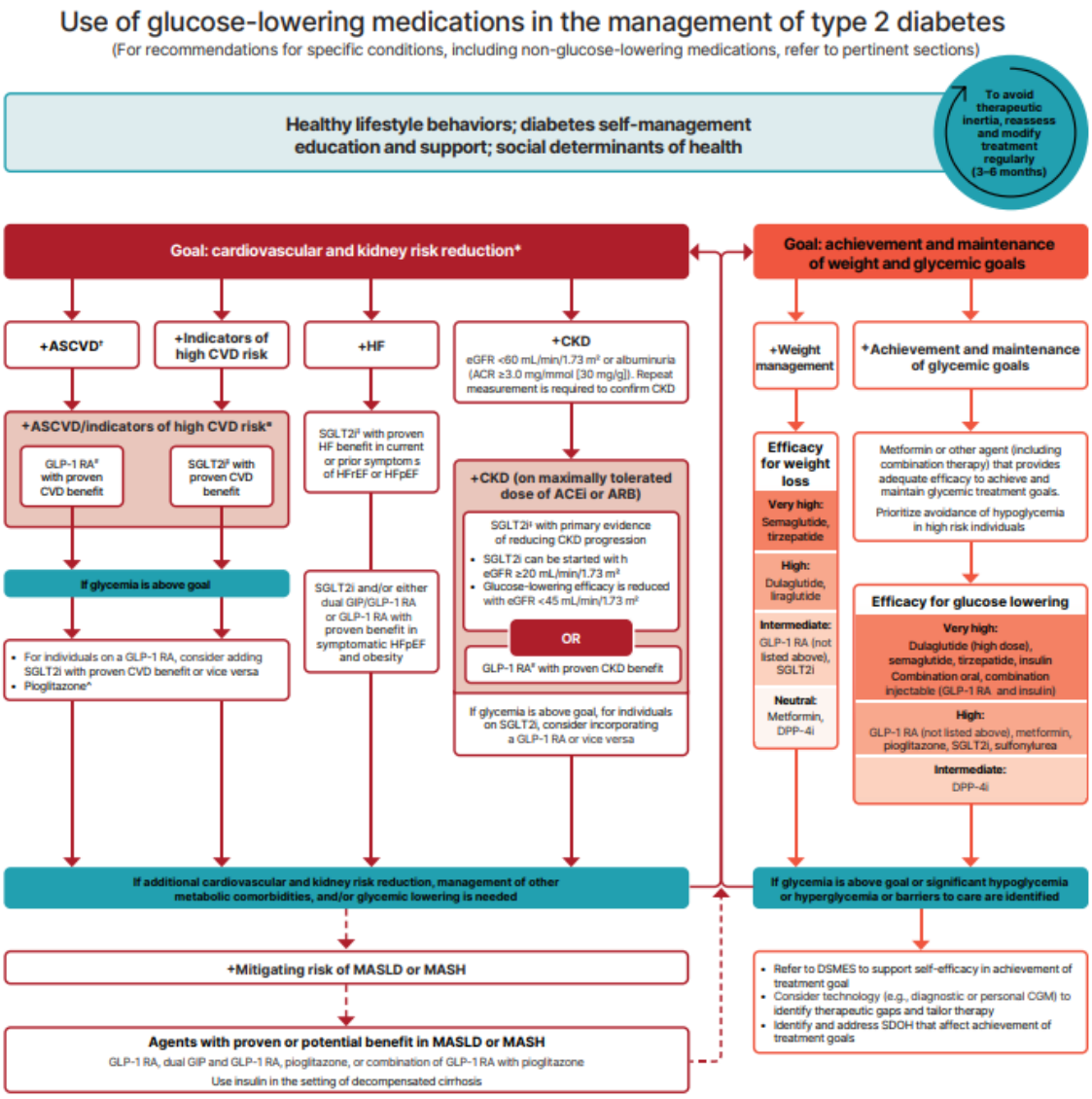
TESTS TO DIAGNOSE DIABETES

STAGE	For all the below tests, in the absence of unequivocal hyperglycemia, Confirm results by repeat testing.			
	A1C *NGSP certified & standardized assay*	**Fasting* Plasma Glucose (FPG)** **No intake 8 hrs.*	**Random Plasma Glucose**	**Oral Glucose Tolerance Test (OGTT) 75-g** (Carb intake of ≥ 150 g/day for 3 days prior to test.)
Diabetes	A1C ≥ 6.5%	FPG ≥ 126 mg/dl	Random plasma glucose ≥ 200 mg/dl plus symptoms[1] [1]Random = any time-of-day w/out regard to time since last meal; symptoms include usual polyuria, polydipsia, and unexplained wt. loss.	Two-hour plasma glucose (2hPG) ≥ 200 mg/dl
Prediabetes	A1C 5.7 – 6.4%	Impaired Fasting BG (IFG) = FPG 100-125 mg/dl		Impaired Glucose Tolerance (IGT) = 2hPG 140 -199 mg/dl
Normal	A1C < 5.7%	FPG < 100 mg/dl		2hPG < 140 mg/dl

Table 2: Initiating Metformin

1.	Begin with low-dose metformin (500 mg) taken once or twice per day with meals (breakfast and/or dinner) or 850 mg once per day.
2.	After 5-7 days, if gastrointestinal side effects have not occurred, advance dose to 850 mg, or two 500 mg tablets, twice per day (medication to be taken before breakfast and/or dinner).
3.	If gastrointestinal side effects appear with increasing doses, decrease to previous lower dose and try to advance the dose at a later time.
4.	The maximum effective dose can be up to 1,000 mg twice per day. Modestly greater effectiveness has been observed with doses up to about 2,500 mg/day. Gastrointestinal side effects may limit the dose that can be used.

Table 3: ADA Pharmacologic Therapy for Adults with Type 2 Diabetes



* In people with HF, CKD, established CVD, or multiple risk factors for CVD, the decision to use a GLP-1 RA or SGLT2i with proven benefit should be made irrespective of attainment of glycemic goal.

† ASCVD: Defined differently across CVOTs but all included individuals with established CVD (e.g., MI, stroke, and arterial revascularization procedure) and variably included conditions such as transient ischemic attack, unstable angina, amputation, and symptomatic or asymptomatic coronary artery disease. Indicators of high risk: While definitions vary, most comprise ≥55 years of age with two or more additional risk factors (including obesity, hypertension, smoking, dyslipidemia, or albuminuria).

≈ A strong recommendation is warranted for people with CVD and a weaker recommendation for those with indicators of high risk CVD. Moreover, a higher absolute risk reduction and thus lower numbers needed to treat are seen at higher levels of baseline risk and should be factored into the shared decision-making process. See text for details.

For GLP-1 RAs, CVOTs demonstrate their efficacy in reducing composite MACE, CV death, all-cause mortality, MI, stroke, and kidney end points in individuals with T2D with established or high risk of CVD. One kidney outcome trial demonstrated benefit in reducing persistent eGFR reduction and CV death for a GLP-1 RA in individuals with CKD and T2D.

‡ For SGLT2is, CV and kidney outcomes trials demonstrate their efficacy in reducing the risks of composite MACE, CV death, all-cause mortality, MI, HHF, and kidney outcomes in individuals with T2D and established or high risk of CVD.

^ Low-dose pioglitazone may be better tolerated and similarly effective as higher doses.

IX. REVISION HISTORY:

- **Created**: 1/14/26
- **Last Reviewed Date:** 3/27/26
- **Last Updated Date:** 1/14/26

Prior Authorization Criteria
Formulary Exception Criteria

Glucagon-Like Peptide-1 (GLP-1) Receptor Agonists and Glucose-Dependent Insulinotropic Polypeptide(GIP) Receptor Agonist- *FOR NON-DIABETES INDICATIONS*

Policy Number: Rx007b

I. MEDICATION NAME(S):

- Wegovy Pen Injector (semaglutide) and Wegovy oral tablets (semaglutide) *non preferred*
- Zepound (tirzepatide)* *non preferred*

***Tirzepatide is a combination glucose-dependent insulinotropic polypeptide (GIP) receptor and GLP-1 receptor agonist.

This criteria is specifically used for GLP-1 receptor agonists (GLP-1 RA) and combo GIP/GLP-1 receptor agonists products indicated for <u>Non-Diabetes Indications</u>.

Wegovy is indicated for the following:

- reduce major adverse cardiovascular events risk in adults with established ASCVD who are obese or overweight.
- the treatment of noncirrhotic metabolic dysfunction associated steatohepatitis (MASH), formerly known as nonalcoholic steatohepatitis (NASH), with moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis) in adults.

Zepbound is indicated to improve moderate to severe obstructive sleep apnea (OSA) in adults with obesity.

TYPE 2 DIABETES MELLITUS: Select GLP-1 receptor agonists and combo GIP/GLP-1 receptor agonists are indicated as adjunct to diet and exercise to improve glycemic control with type 2 diabetes mellitus and have their own unique criteria; see *PA Criteria Policy Number Rx007a: Type 2 Diabetes Mellitus*.

NOTE: GLP-1 receptor agonists and combo GIP/GLP-1 receptor agonists products are not covered for weight loss as use of medications for weight loss is not a covered benefit on OHP.

For additional information on coverage pathways for weight loss medications, please see *PA Criteria Policy Rx060: Pharmaceutical Weight Management*.

II. LENGTH OF AUTHORIZATION:

- Initial: six months
- Renewal: one year

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA: WEGOVY

1. Is the request for a qualifying EPSDT member AND is the requested medication FDA approved for their age?
    a. Yes (go to #2)
    b. No (go to #8)
2. Is the request for the indication of reducing the risk of major cardiovascular events in an adult 18 years and older with established ASCVD AND either obesity or overweight?
    a. Yes (go to #15)
    b. No (go to #3)
3. Is the request for the indication of noncirrhotic nonalcoholic (MASH) in adults 18 years and older?
    a. Yes (go to #9)
    b. No (go to #4)
4. Is the request for weight management and does the member have a BMI corresponding to one of the following: 1) ≥30 kg/m2 or 2) ≥25 kg/m2 and comorbid conditions [e.g., diabetes mellitus, hypertension, dyslipidemia, fatty liver disease, or cardiovascular disease] or 3) a BMI at the 95th percentile or greater for age and sex?
    a. Yes (go to #5)
    b. No (forward to pharmacist)
5. Will the member be engaged in a weight management lifestyle modification program in addition to pharmacotherapy?
    a. Yes (go to #6)
    b. No (forward to pharmacist, all drugs approved for weight loss are indicated as an adjunct to diet and exercise)
6. Does the member have comorbidities (e.g., hypertension, dyslipidemia, diabetes, fatty liver disease, depression, or sleep apnea)?
    c. Yes (approve for 6 months)
    d. No (go to #7)

7. Has the member previously tried a weight loss treatment plan administered by a health care provider (e.g., diet and exercise program, nutritional counseling, and/or a calorie restricted diet) for a time period of at least 3 months within the previous 6- month timeframe?
    a. Yes (approve for 6 months)
    b. No (forward to pharmacist, lifestyle modifications are recommended by guidelines)
8. Is the request for the indication of reducing the risk of major cardiovascular events in an adult with established ASCVD and either obesity or overweight?
    c. Yes (go to #15)
    d. No (go to #9)
9. Does the member have biopsy proven noncirrhotic nonalcoholic steatohepatitis (MASH)?
    e. Yes (go to #13)
    f. No (go to #10)
10. Is there documentation that the member does NOT have ongoing or recent (within 2 years) significant alcohol use or chronic or active viral hepatitis (Significant alcohol use can be member-specific but is typically defined as greater than 21 drinks/week (or >30 g/day) in men and greater than 14 drinks/week (or >20 g/day) in women)?
    g. Yes (go to #11)
    h. No (forward to pharmacist for review)
11. Is there provider attestation or documentation that other causes of hepatic steatosis are not suspected based on member history/presentation or have been ruled out (Examples of other secondary causes of hepatic steatosis include, but are not limited to, Wilson's disease, lipodystrophy, abetalipoproteinemia, medications (e.g., amiodarone, methotrexate, tamoxifen, corticosteroids))?
    i. Yes (go to #12)
    j. No (forward to pharmacist for review)
12. Is there documentation that the member has, or is receiving drug treatment for, at least 3 of the 5 metabolic risk factors associated with MASH. Risk factors include:
    - Overweight, obesity or increased waist circumference (BMI ≥ 27 kg/m2 or ethnicity adjusted equivalent)
    - Hypertension
    - Type 2 diabetes mellitus
    - Hypertriglyceridemia
    - Decreased level of high-density lipoprotein (HDL)

    k. Yes (go to #13)
    l. No (forward to pharmacist for review)
13. Is the request from, or in consultation with, a hepatologist, gastroenterologist, or other liver specialist?
    m. Yes (go to #14)
    n. No (forward to pharmacist for review)
14. Does the member have advanced liver fibrosis (F2 or F3) as shown by appropriate diagnostic test within past 24 months?
    o. Yes (go to #18)
    p. No (forward to pharmacist for review)
15. Does the member have a BMI of 27 kg/m2 or greater?

   q. Yes (go to #16)
   r. No (forward to pharmacist for review)

16. Does the member have established atherosclerotic cardiovascular disease (ASCVD) [documented with a history of one or more of the following: coronary heart diease (heart attack (MI), angina), ischemic cerebrovascular disease (stroke, transiant ischemic attack), ischemic heart disease, revascularization procedure (coronary artery bypass grafting: CABG, percutaneous coronary intervention: PCI, angioplasty), amputation due to atherosclerotic disease, aortic aneurysms, and peripheral artery disease]]?
   s. Yes (go to #17)
   t. No (forward to pharmacist for review)
17. Has the member been screened for diabetes within the past year and do screening results indicate they do not have diabetes (e.g., HbA1c <6.5% or fasting blood glucose <126 mg/dl (7 mmol/L)?
   u. Yes (go to #18)
   v. No (forward to pharmacist; *Recommend screening; positive recommend a GLP-1 indicated for glucose lowering (seePA Criteria Policy Number Rx007a: Type 2 Diabetes Mellitus))*
18. Has the member previously tried a weight loss treatment plan administered by a health care provider (e.g., diet and exercise program, nutritional counseling, and/or a calorie restricted diet) for a time period of at least 3 months within the previous 6- month timeframe?
   w. Yes (go to #19)
   x. No (forward to pharmacist for review)
19. Is the member using a concurrent DPP-4 agent or GLP-1?
   y. Yes (forward to pharmacist for review)
   z. No (approve for 6 months)

V. RENEWAL CRITERIA: WEGOVY

1. Has the member demonstrated ongoing adherence to Wegovy therapy? (Adherence defined as a MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
   a. Yes (go to #2)
   b. No (forward to pharmacist for review)
2. Has the member lost or maintained a BMI reducation of 5% or more?
   a. Yes (go to #3)
   b. No (forward to pharmacist for review)
3. Is the member continuing with a weight loss treatment plan (e.g., diet and exercise program, nutritional counseling, and/or a calorie restricted diet)?
   a. Yes (approve for one year)
   b. No (forward to pharmacist for review)

VI. INITIAL CRITERIA: ZEPBOUND FOR OSA

1. Is the request for a qualifying EPSDT member AND is the requested medication FDA approved for their age?
    a. Yes (go to #2)
    b. No (go to #7)
2. Is the request for the indication of moderate to severe obstructive sleep apnea (OSA) in an adult aged 18 years or older with obesity?

    a. Yes (go to #7)
    b. No (go to #3)
3. Is the request for weight management and does the member have a BMI corresponding to one of the following: 1) ≥30 kg/m2 or 2) ≥25 kg/m2 and comorbid conditions [e.g., diabetes mellitus, hypertension, dyslipidemia, fatty liver disease, or cardiovascular disease] or 3) a BMI at the 95th percentile or greater for age and sex?
    a. Yes (go to #4)
    b. No (forward to pharmacist for review)
4. Will the member be engaged in a weight management lifestyle modification program in addition to pharmacotherapy?
    a. Yes (go to #5)
    b. No (forward to pharmacist, all drugs approved for weight loss are indicated as an adjunct to diet and exercise)
5. Does the member have comorbidities (e.g., hypertension, dyslipidemia, diabetes, fatty liver disease, depression, or sleep apnea)?
    a. Yes (approve for 6 months)
    b. No (go to #6)
6. Has the member previously tried a weight loss treatment plan administered by a health care provider (e.g., diet and exercise program, nutritional counseling, and/or a calorie restricted diet) for a time period of at least 3 months within the previous 6- month timeframe?
    a. Yes (approve for 6 months)
    b. No (forward to pharmacist, lifestyle modifications are recommended by guidelines)
7. Does the member have a BMI of 30 kg/m2 or greater?
    a. Yes (go to #8)
    b. No (forward to pharmacist for review)
8. Will the member be engaged in a weight management lifestyle modification program in addition to pharmacotherapy?
    a. Yes (go to #9)
    b. No (forward to pharmacist for review)
9. Has the member previously tried a weight loss treatment plan administered by a health care provider (e.g., diet and exercise program, nutritional counseling, and/or a calorie

restricted diet) for a time period of at least 3 months within the previous 6-month timeframe?
    a. Yes (go to #10)
    b. No (forward to pharmacist for review)
10. Has the member been screened for diabetes within the past year and do screening results indicate they do not have diabetes (e.g., HbA1c <6.5% or fasting blood glucose <126 mg/dl (7 mmol/L)?
    a. Yes (go to #11)
    b. No (forward to pharmacist; *Recommend screening and if positive recommend a GLP-1 indicated for glucose lowering (see PA Criteria Policy Number Rx007a: Type 2 Diabetes Mellitus)*)
11. Does the member have moderate to severe obstructive sleep apnea (OSA)? (Note: Moderate OSA is defined as an apnea-hypopnea index (AHI) of 15 events/hour or more; Severe OSA is defined as an AHI of 30 events/hour or more.)
    c. Yes (go to #12)
    d. No (forward to pharmacist for review)
12. Is the member using a concurrent DPP-4 agent or GLP-1?
    a. Yes (forward to pharmacist for review)
    b. No (approve for six months)

VII. RENEWAL CRITERIA: ZEPBOUND FOR OSA

1. Has the member demonstrated ongoing adherence to Zepbound therapy? (Adherence defined as a MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (go to #2)
    b. No (forward to pharmacist for review)
2. Has the member lost or maintained a BMI reducation of 5% or more?
    a. Yes (go to #3)
    b. No (forward to pharmacist for review)
3. Is the member continuing with a weight loss treatment plan (e.g., diet and exercise program, nutritional counseling, and/or a calorie restricted diet)?
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review)

VIII. ADDITIONAL INFORMATION:

- N/A

IX. REVISION HISTORY:

- **Created**: 1/14/26
- **Last Reviewed Date:** 03/27/26
- **Last Updated Date:** 02/01/26

Sodium-Glucose Cotransporter-2 (SGLT2) Inhibitors

Policy Number: Rx008

I. MEDICATION NAME(S):

Formulary

- **Steglatro (ertugliflozin)** [Indicated for DM only] *preferred (no PA required)*
- **Dapagliflozin propanediol** [Indicated for DM, HF, Chronic Kidney disease] *preferred (PA required)*
- **Brenzavvy (bexagliflozin)** [Indicated for DM only] *preferred (no PA required)*
- **Jardiance (empagliflozin)** [Indicated for DM, HF, Chronic Kidney disease] *preferred (PA required)*

Non Formulary

- **Invokana (canagliflozin)** [Indicated for DM, HF, Chronic Kidney disease] *non-preferred (PA required)*
- **Inpefa (sotogliflizon)** [Indicated for HF, Chronic Kidney disease] non-preferred *(PA required)*

Sodium-glucose cotransporter 2 (SGLT2) inhibitors, are indicated for the management of type 2 diabetes mellitus (T2DM) by providing glucose-lowering efficacy. Initially approved as adjuncts to diet and exercise for glycemic control, these agents now have expanded indications that include reducing hospitalizations for heart failure and preserving renal function in those with chronic kidney disease (CKD). See Table 1- FDA Approved Indications of SGLT2 Inhibitors in the Additional Information section, for specific indications).

II. LENGTH OF AUTHORIZATION:

- Initial: six months
- Renewal: one year

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the requested medication dapagliflozin propanediol or Jardiance (empagliflozin) prescribed as secondary therapy for a diagnosis of heart failure and within New York Heart Association class II-IV or initiated at hospital discharge? (Note: Member should continue all initial therapy including a diuretic; an ACE/ARB or ARNI; and a beta-blocker.)
    a. Yes (approve for six months)
    b. No (go to #2)
2. Is the requested medication dapagliflozin propanediol or Jardiance (empagliflozin) prescribed as secondary therapy for a diagnosis of chronic kidney disease (CKD) (eGFR 25–60 mL/min/1.73 m² OR urinary albumin-to creatinine ratio ≥200 mg/g)?
    a. Yes (go to #3)
    b. No (go to #4)
3. Is the drug prescribed by or in consultation with a nephrologist or kidney care specialist?
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review)
4. Is the drug prescribed for glycemic control in a member diagnosed with Type 2 diabetes mellitus? (See Table 2. Criteria for Diagnosis of Diabetes in the Additional Information section.)
    a. Yes (go to #5)
    b. No (forward to pharmacist)
5. Has the member had an adequate trial and failure of, contraindication to, or intolerance to metformin dosed at 2,000mg per day? (Note: Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days. See Table 3 – Metformin Titration in the Additional Information section for guidance.)
    a. Yes (go to #6)
    b. No (forward to pharmacist for review)
6. Does the member have established atherosclerotic cardiovascular disease (ASCVD) defined as ischemic heart disease, ischemic cerebrovascular disease, or peripheral artery disease? (Note: examples of ASCVD include MI, stroke, revascularization prodecure, transiant ischemic attack, unstable angina, amputation, coronary artery disease.)
    a. Yes (approve for six months)
    b. No (go to #7)
7. Does the member have a high risk for ASCVD defined as age 55 years or older AND two or more traditional risk factors including obesity, hypertension, dyslipidemia (LDL > 130 mg/dL or taking lipid-lowering therapies), albuminuria, or tobacco use?
    a. Yes (approve for six months)
    b. No (go to #8)
8. Has the member had an adequate trial and failure of or contraindication to a dipeptidyl peptidase-4 (DPP-4) inhibitor? (Note: Alogliptin is available without a prior authorization.)
    a. Yes (go to #9)
    b. No (forward to pharmacist for review)
9. Has the member had an adequate trial and failure of, contraindication to, or intolerance to Steglatro (ertugliflozin) or Brenzavvy (bexagliflozin)?
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review)

V. RENEWAL CRITERIA:

1. Is the member adherent to therapy? (Note: Adherence is defined as a MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (go to #2)
    b. No (forward to pharmacist for review)
2. Has the member had a positive clinical response to therapy (such as at least a 10% reduction in A1c or A1c is at goal), OR has the prescriber submitted documentation of continued medical necessity in accordance with the initial criteria? (Note; If prescribed for T2DM, A1c value must be recently measured within the last six months.)
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review)

VI. ADDITIONAL INFORMATION:

Table 1. FDA Approved Indications of SGLT2 Inhibitors*

Indication	Bexagliflozin	Canagliflozin	Dapagliflozin	Empagliflozin	Ertugliflozin	Sotagliflozin
Adults with Type 2 Diabetes Mellitus						
Glucose lowering	X	X	X	X	X	
Heart failure		X	X	X		X
Kidney disease		X	X	X		X
Children with Type 2 Diabetes Mellitus						
Patients 10 years and older		X		X		
Adults without Diabetes Mellitus						
Heart failure			X	X		X
Kidney disease			X	X		

Table 2: Criteria for Diagnosis of Diabetes

TESTS TO DIAGNOSE DIABETES

STAGE	For all the below tests, in the absence of unequivocal hyperglycemia, Confirm results by repeat testing.			
	A1C *NGSP certified & standardized assay*	**Fasting* Plasma Glucose (FPG)** **No intake 8 hrs.*	**Random Plasma Glucose**	**Oral Glucose Tolerance Test (OGTT) 75-g** (Carb intake of ≥ 150 g/day for 3 days prior to test.)
Diabetes	A1C ≥ 6.5%	FPG ≥ 126 mg/dl	Random plasma glucose ≥ 200 mg/dl plus symptoms[1] [1]Random = any time-of-day w/out regard to time since last meal; symptoms include usual polyuria, polydipsia, and unexplained wt. loss.	Two-hour plasma glucose (2hPG) ≥ 200 mg/dl
Prediabetes	A1C 5.7 – 6.4%	Impaired Fasting BG (IFG) = FPG 100-125 mg/dl		Impaired Glucose Tolerance (IGT) = 2hPG 140 -199 mg/dl
Normal	A1C < 5.7%	FPG < 100 mg/dl		2hPG < 140 mg/dl

Table 3: Metformin Titration

Initiating Metformin

1.	Begin with low-dose metformin (500 mg) taken once or twice per day with meals (breakfast and/or dinner) or 850 mg once per day.
2.	After 5-7 days, if gastrointestinal side effects have not occurred, advance dose to 850 mg, or two 500 mg tablets, twice per day (medication to be taken before breakfast and/or dinner).
3.	If gastrointestinal side effects appear with increasing doses, decrease to previous lower dose and try to advance the dose at a later time.
4.	The maximum effective dose can be up to 1,000 mg twice per day. Modestly greater effectiveness has been observed with doses up to about 2,500 mg/day. Gastrointestinal side effects may limit the dose that can be used.

Nathan, et al. Medical management of hyperglycemia in Type 2 Diabetes: a consensus algorithm for the initiation and adjustment of therapy. *Diabetes Care*. 2008; 31;1-11.

VII. REVISION HISTORY:

- **Last Reviewed Date:** 3/27/2026
- **Last Updated Date:** 3/6/2026

UMPQUA HEALTH

Prior Authorization Criteria
Formulary Exception Criteria

Insulins

Policy Number: Rx009

I. MEDICATION NAME(S):

FORMULARY INSULINS:

- Insulin aspart pen/cartridge
- Insulin aspart protamine mix 70/30 pen/vial

- Insulin lispro Kwikpen/vials
- Insulin lispro Junior Kwikpen
- insulin lispro protamine Mix75-25

- Insulin glargine-yfgn pen
- Lantus Solostar pen
- Humulin N vial
- Novolin N vial
- Humulin N Mix 70-30 vial
- Novolin 70-30 vial

NON-FORMULARY INSULINS:

- Novolog (insulin aspart) cartridge
- Novolog Flexpen (insulin aspart) pen
- Novolog Mix 70-30 Flexpen (insulin aspart protamine/insulin aspart) pen
- Basaglar (insulin glargine)
- Toujeo Solostar U-300 (insulin glargine) pen
- Admelog Solostar (insulin lispro) pen
- Humalog (insulin lispro) cartridge
- Humalog Mix 50-50 Kwikpen (insulin lispro protamine/lispro) pen
- Humalog Mix 75-25 Kwikpen (insulin lispro protamine/lispro) pen
- Humulin 70-30 Kwikpen (insulin NPH/insulin regular) pen
- Novolin 70-30 Flexpen (insulin NPH/insulin regular) pen
- Humulin N Kwikpen (insulin NPH) pen
- Humulin R U-500 (insulin regular) pen
- Humulin R U-500 Kwikpen (insulin regular) pen
- Tresiba U-100 and U-200
- Insulin degludec U-100 and U-200

II. LENGTH OF AUTHORIZATION:

- Initial: length of benefit (LOB)

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug prescribed for diabetes mellitus (type 1 or 2)?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 5a])

2. Is the request for a non-formulary insulin U-100 insulin?
    a. Yes (go to #3)
    b. No (go to #4)

3. Has the member had an adequate trial and failure of or contraindication to one formulary insulin?
    a. Yes (approve for LOB)
    b. No (forward to pharmacist for review [deny 7a])

4. Is the request for Humulin R U-500?
    a. Yes (go to #5)
    b. No (go to #6)

5. Does the member have insulin resistance requiring greater than 200 units per day? (Documentation must include rationale for Humulin R U-500 cartridge vs pen).
    a. Yes (approve for LOB)
    b. No (forward to pharmacist for review [deny 5a])

6. Is request for concentrated insulin (U-200 and U-300) and does the member require greater than 80 units per day? For insulin degludec U-200, maximum dose must be equal to or less than 200 units per day.
    a. Yes (approve for LOB)
    b. No (forward to pharmacist [deny 5a])

V. RENEWAL CRITERIA:

VI. ADDITIONAL INFORMATION:

For members already started and stabilized on a non-preferred insulin, UHA will allow a transition fill allow time to switch to the preferred insulin.

VII. REVISION HISTORY:

- **Last Reviewed Date:** 09/04/2025
- **Last Updated Date:** 10/17/2025

Topical Antifungals

Policy Number: Rx010

I. MEDICATION NAME(S):

- ciclopirox
- naftifine HCl
- Lamisil (terbinafine HCl)

II. LENGTH OF AUTHORIZATION:

- Initial: six months
- Renewal: six months

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug used for an FDA-approved indication or a medically appropriate off-label use with strong evidence supporting safety and efficacy?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review)
2. Is the member under age 21?
    a. Yes (go to #3)
    b. No (go to #4)
3. Is there documentation that treating the condition is medically appropriate and necessary in which it will enhance the member's ability to grow, develop, or participate in school per the EPSDT Medicaid benefit?
    a. Yes (go to #6)
    b. No (forward to pharmacist for review)
4. Is the drug prescribed for a condition funded by the Oregon Health Plan (OHP) in a manner consistent with the Health Evidence Review Commission (HERC) Prioritized List of Health Services? (Fungal infections of the skin, scalp, groin and nails are not funded for most members. Some conditions are covered if the member is immunocompromised, like those with AIDS or cancer.)
    a. Yes (go to #6)
    b. No (go to #5)
5. Is there a comorbid condition for which coverage would be allowed? For example, type 2 diabetes or other conditions that may increase the risk of serious secondary skin infections.
    a. Yes (go to #6)

    b. No (forward to pharmacist for review)
6. Has the member tried and failed clotrimazole 1% cream; nystatin cream, ointment, or powder; miconazole 2% cream; terbinafine 1% cream; and ketoconazole 2% cream or shampoo (on formulary without PA) or are these medications not appropriate to treat the member's condition?
    a. Yes (go to #7)
    b. No (forward to pharmacist for review)
7. Is the requested medication on formulary?
    a. Yes (approve for six months)
    b. No (go to #8)
8. Has the member tried and failed all less-costly formulary alternative medications?
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review)

V. RENEWAL CRITERIA:

1. Is the requested drug being used outside of the FDA-approved treatment duration?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review)
2. Has documentation been submitted to support the continued use of this medication in accordance with clinical guidelines? (Refer to UpToDate or product labeling for appropriate treatment duration.)
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review)

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 12/7/2022
- **Last Updated Date:** 12/7/2022

Clonazepam

Policy Number: Rx013

I. MEDICATION NAME(S):

- clonazepam

II. LENGTH OF AUTHORIZATION:

- Initial: one to six months (one year for seizures, oncology, or palliative care)
- Renewal: up to six months (one year for seizures, oncology, or palliative care)

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug used for a member with a malignant neoplasm or other end-of-life diagnosis?
    a. Yes (approve for one year)
    b. No (go to #2)
2. Is the drug used for a member with a diagnosed seizure disorder OR is the patient enrolled in a program for short-term outpatient management of alcohol withdrawal syndrome? Note: benzodiazepines are not indicated for alcohol dependence.
    a. Yes (approve for length of benefit for seizure disorder OR up to 1 month for alcohol withdrawal)
    b. No (go to #3)
3. Has the provider reviewed the Oregon Prescription Monitoring Program registry within the last three months and documented appropriate results?
    a. Yes (go to #4)
    b. No (forward to pharmacist [deny])
4. Is the request for treatment of post traumatic stress disorder (PTSD)? Note: Risks of benzodiazepine treatment outweigh benefits for patients with PTSD. Treatment with benzodiazepines is not recommended.
    a. Yes (forward to pharmacist for review [deny])
    b. No (got to #5)
5. Is the drug used for anxiety or panic disorder?
    a. Yes (go to #6)
    b. No (go to #7)
6. Is the medication prescribed by or in consultation with a prescribing mental health specialist OR does the patient have a documented trial and failure, contraindication, intolerance, or inability to access recommended first-line treatment options (first-line options include antidepressants AND psychotherapy [e.g. behavioral therapy, relaxation response training, mindfulness meditation training, eye movement desensitization and reprocessing]? Note: An adequate trial to determine efficacy of an SSRI or SNRI is 4-6 weeks.
    a. Yes (go to #9)

No (forward to pharmacist for review)

7. Is the request for treatment of psychosis, schizophrenia or schizoaffective disorder?
    a. Yes (go to to #8)
    b. No (go to #9
8. Is the medication prescribed by or in consultation with a prescribing mental health specialist OR does the patient have an adequate trial and failure, contraindication, intolerance, or inability to access recommended first-line treatment options (first-line options include second generation antipsychotics AND psychotherapy [e.g. counseling, cognitive behavioral therapy, social skills training, or psychoeducation]?
   Note: For continued symptoms, assess adherence and dose optimization. For patients on an adequate dose of antipsychotic, guidelines recommend trial of a second antipsychotic or augmentation with a mood stabilizer.
    a. Yes (go to #9)
    b. No (forward to pharmacist [deny])
9. Is the member taking a concurrent sedative, hypnotic, muscle relaxant, or opioid?
    a. Yes (go to # 10)
    b. No (go to #11)
10. Is concurrent sedative therapy part of a plan to switch and taper off a long-acting benzodiazepine (such as diazepam, clonazepam, or chlordiazepoxide) AND has the provider included a detailed strategy to taper?
    Note: a documented taper strategy should include planned dose reductions and length of time between each dose modification for at least the next few weeks. It should also include a documented follow-up plan to monitor progress and manage withdrawal symptoms (regular check-ins are essential for a successful taper). Triazolam may be discontinued without a taper in most cases (2-hour half-life prevents physical dependence).
    a. Yes (Approve duplicate benzodiazepine therapy for the duration specified in the taper plan (not to exceed 6 months).
    b. No (forward to pharmacist [deny])
11. Is there appropriate rationale to support long-term benzodiazepine use for this indication?
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review)

V. RENEWAL CRITERIA:

1. Is the drug used for a member with a malignant neoplasm or other end-of-life diagnosis?
    a. Yes (approve for one year)
    b. No (go to #2)
2. Is the drug used for a member with a diagnosed seizure disorder?
    a. Yes (approve for length of benefit)
    b. No (go to #3)
3. Is the member taking a concurrent sedative, muscle relaxant, hypnotic or opioid?
    a. Yes (forward to pharmacist for review)
    b. No (go to #4)
4. Has the provider reviewed the Oregon Prescription Monitoring Program registry within the last three months and documented appropriate results?

    a. Yes (go to #5)
    b. No (forward to pharmacist for review)
5. Is there documentation based on medical records that provider and patient have discussed whether benefits of long-term therapy (e.g. symptom improvement, social function, number of hospitalizations, etc.) continue to outweigh risks of therapy (e.g. sedation, dependence, cognitive dysfunction and/or psychiatric instability)?
    a. Yes (approve for up to 12 months)
    b. No (forward to pharmacist for review)

V. ADDITIONAL INFORMATION:

VI. REVISION HISTORY:

- **Last Reviewed Date:** 9/23/2025
- **Last Updated Date:** 10/17/2025

Topical Corticosteroids

Policy Number: Rx015

I. MEDICATION NAME(S):

- amcinonide
- betamethasone dipropionate
- clobetasol propionate
- clobetasol emollient
- clobetasol emulsion
- clocortolone pivalate
- Apexicon E (diflorasone diacetate/emoll)
- fluocinolone acetonide
- fluocinonide
- Scalacort DK (hydrocort/sal acid/sulf/shamp1)
- hydrocortisone (Ala-Cort, Ala-Scalp, Anti-Itch, Cortaid, Cortisone, Cortizone-10, Cortizone-10 Plus, Eczema Anti-Itch, Hydrocream, Noble Formula HC, Preparation H, Procto-Pak, Scalp Relief, Scalpicin, Soothing Care)
- Texacort (hydrocortisone)
- Nucort (hydrocortisone acet/aloe vera)
- hydrocortisone acetate
- hydrocortisone butyrate
- Pandel (hydrocortisone probutate)
- hydrocortisone/aloe vera (Cortizone-10, Hydrocortisone Plus, Hydrocortisone-Aloe, Hydroskin)
- mometasone furoate
- triamcinolone acetonide (Trianex, Triderm)

II. LENGTH OF AUTHORIZATION:

- Initial: six months
- Renewal: one year

III. QUANTITY LIMITS:

- Multiple (see formulary)

IV. INITIAL CRITERIA:

1. Is the drug used for an FDA-approved indication or a medically appropriate off-label use with strong evidence supporting safety and efficacy?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 8a])
2. Is the member under age 21?
    a. Yes (go to #3)
    b. No (go to #4)

3. Is there documentation that treating the condition is medically appropriate and necessary in which it will enhance the member's ability to grow, develop, or participate in school per the EPSDT Medicaid benefit?
    a. Yes (go to #6)
    b. No (forward to pharmacist for review [deny 5a])
4. Is the drug prescribed for a condition funded by the Oregon Health Plan (OHP) in a manner consistent with the Health Evidence Review Commission (HERC) Prioritized List of Health Services? (Mild to moderate inflammatory skin conditions are not funded. Refer to Guideline Note 21 for coverage of severe inflammatory skin disease: functional impairment as indicated by Dermatology Life Quality Index (DLQI) ≥ 11 or Children's Dermatology Life Quality Index (CDLQI) ≥ 13 (or severe score on other validated tool) AND one or more of the following: (1) at least 10% of body surface area involved; OR (2) hand, foot, face, or mucous membrane involvement.)
    a. Yes (go to #6)
    b. No (go to #5)
5. Is there a comorbid condition for which coverage would be allowed?
    a. Yes (go to #6)
    b. No (forward to pharmacist for review [deny 3a/3c and/or 5a GLN21 for mild/moderate skin conditions])
6. Has the member tried and failed triamcinolone 0.1% cream or ointment (on formulary without PA) or is this medication not appropriate to treat the member's condition?
    a. Yes (go to #7)
    b. No (forward to pharmacist for review [deny 7a])
7. Has the member tried and failed all less-costly formulary alternative medications?
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review [deny 7a or 5k])

V. RENEWAL CRITERIA:

1. Is the requested drug being used outside of the FDA-approved treatment duration?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 8a])
2. Has documentation been submitted to support the continued use of this medication in accordance with clinical guidelines? (Refer to UpToDate or product labeling for appropriate treatment duration.)
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 5a])

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 12/7/2022
- **Last Updated Date:** 12/7/2022

Neoplastic Disease

Policy Number: Rx018

I. MEDICATION NAME(S):

- abiraterone acetate
- Hexalen (altretamine)
- azacitidine
- Treanda (bendamustine HCl)
- bexarotene
- Myleran (busulfan)
- Jevtana (cabazitaxel)
- capecitabine
- Erbitux (cetuximab)
- Leukeran (chlorambucil)
- cyclophosphamide
- dactinomycin
- Sprycel (dasatinib)
- Docefrez (docetaxel)
- docetaxel
- Tarceva (erlotinib HCl)
- Emcyt (estramustine phosphate sodium)
- Afinitor (everolimus)
- Iressa (gefitinib)
- gemcitabine HCl
- imatinib mesylate
- Camptosar (irinotecan HCl)
- Tykerb (lapatinib ditosylate)
- Revlimid (lenalidomide)
- Gleostine (lomustine)
- lomustine
- Lysodren (mitotane)
- Tasigna (nilotinib HCl)
- nilutamide
- oxaliplatin
- Votrient (pazopanib HCl)
- Sylatron (peginterferon alfa-2b)
- Sylatron 4-Pack (peginterferon alfa-2b)
- Folotyn (pralatrexate)
- Matulane (procarbazine HCl)
- romidepsin
- Nexavar (sorafenib tosylate)
- Sutent (sunitinib malate)
- temozolomide
- Tabloid (thioguanine)
- Hycamtin (topotecan HCl)
- topotecan HCl
- toremifene citrate
- tretinoin
- Caprelsa (vandetanib)
- Zolinza (vorinostat)
- Multiple non-formulary antineoplastics (must first try and fail formulary alternatives if applicable)

II. LENGTH OF AUTHORIZATION:

- Variable

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug used for an FDA-approved indication, OR a medically appropriate off-label use with strong evidence supporting safety and efficacy, AND listed as a preferred intervention by NCCN with quality and consistency of evidence of at least 3, OR listed as an alternative options with additional compelling information provided? NOTE: Includes all information required in the FDA approval or NCCN recommendation, including but not limited to diagnosis, stage of cancer, biomarkers, place in therapy, and use as monotherapy or combination therapy. (Refer to Table 1 in 'Additional Information' for NCCN quality of evidence and consistency of evidence ratings.)
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 8a])
2. Is the member under age 21?
    a. Yes (go to #3)
    b. No (go to #4)
3. Is there documentation that treating the condition is medically appropriate and necessary in which it will enhance the member's ability to grow, develop, or participate in school per the EPSDT Medicaid benefit?
    a. Yes (go to #7)
    b. No (forward to pharmacist for review [deny 5a])
4. Is the drug prescribed for a condition funded by the Oregon Health Plan (OHP) in a manner consistent with the Health Evidence Review Commission (HERC) Prioritized List of Health Services?
    a. Yes (go to #6)
    b. No (go to #5)
5. Is there a comorbid condition for which coverage would be allowed?
    a. Yes (go to #6)
    b. No (forward to pharmacist for review [deny 3a/3c])
6. If applicable, does the request meet criteria for treatment coverage specified in Guideline Note 12 of the Health Evidence Review Commission (HERC) Prioritized List of Health Services, considering treatment of cancer with little or no benefit (see 'Additional Information' section for Guideline Note 12)?
    a. Yes (go to #7)
    b. No (forward to pharmacist for review [deny 5a GLN12])
7. Is the medication prescribed by or in consultation with a hematologist or oncologist, as appropriate, for the type of cancer?
    a. Yes (go to #8)
    b. No (forward to pharmacist for review)
8. Does the member have a Karnofsky Performance Status 50% or less or ECOG performance score 3 or greater?
    a. Yes (forward to pharmacist for review)
    b. No (go to #9)
9. According to NCCN guidelines, are there alternative less-costly therapies recommended at the same or better evidence level?
    a. No (approve for three months or other appropriate duration based on indication, treatment regimen, and monitoring requirements)
    b. Yes (forward to pharmacist for review [deny 7a])

V. RENEWAL CRITERIA:

1. According to FDA labeling and NCCN guidelines, is treatment still indicated?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 5a])
2. Has there been evidence of disease responsiveness to therapy?
    a. Yes (approve for appropriate duration up to one year)
    b. No (forward to pharmacist for review [deny 5a])

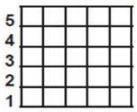
VI. ADDITIONAL INFORMATION:

- Prioritized List of Health Services Guideline Note 12, Patient-Centered Care of Advanced Cancer:
    - Cancer is a complex group of diseases with treatments that vary depending on the specific subtype of cancer and the patient's unique medical and social situation. Goals of appropriate cancer therapy can vary from intent to cure, disease burden reduction, disease stabilization and control of symptoms. Cancer care must always take place in the context of the patient's support systems, overall heath, and core values. Patients should have access to appropriate peer-reviewed clinical trials of cancer therapies. A comprehensive multidisciplinary approach to treatment should be offered including palliative care services (see STATEMENT OF INTENT 1, PALLIATIVE CARE).
    - Treatment with intent to prolong survival is not a covered service for patients who have progressive metastatic cancer with:
        - Severe co-morbidities unrelated to the cancer that result in significant impairment in two or more major organ systems which would affect efficacy and/or toxicity of therapy; OR
        - A continued decline in spite of best available therapy with a non reversible Karnofsky Performance Status or Palliative Performance score of <50% with ECOG performance status of 3 or higher which are not due to a pre-existing disability.
    - Treatments with intent to relieve symptoms or improve quality of life are covered as defined in STATEMENT OF INTENT 1, PALLIATIVE CARE. Examples:
        - Single-dose radiation therapy for painful bone metastases with the intent to relieve pain and improve quality of life.
        - Surgical decompression for malignant bowel obstruction. Single fraction radiotherapy should be given strong consideration for use over multiple fraction radiotherapy when clinically appropriate (e.g., not contraindicated by risk of imminent pathologic fracture, worsening neurologic compromise or radioresistant histologies such as sarcoma, melanoma, and renal cell carcinoma).
        - Medication therapy such as chemotherapy with low toxicity/low side effect agents with the goal to decrease pain from bulky disease or other identified complications. Cost of chemotherapy and alternative medication(s) should also be considered.
    - To qualify for treatment coverage, the cancer patient must have a documented discussion about treatment goals, treatment prognosis and the side effects, and

knowledge of the realistic expectations of treatment efficacy. This discussion may take place with the patient's oncologist, primary care provider, or other health care provider, but preferably in a collaborative interdisciplinary care coordination discussion. Treatment must be provided via evidence-driven pathways (such as NCCN, ASCO, ASH, ASBMT, or NIH Guidelines) when available.

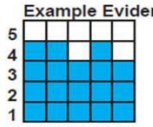
- Table 1. NCCN Evidence Blocks Categories and Definitions

NCCN EVIDENCE BLOCKS CATEGORIES AND DEFINITIONS



E = Efficacy of Regimen/Agent
S = Safety of Regimen/Agent
Q = Quality of Evidence
C = Consistency of Evidence
A = Affordability of Regimen/Agent

Example Evidence Block



E = 4
S = 4
Q = 3
C = 4
A = 3

Efficacy of Regimen/Agent

5	**Highly effective:** Cure likely and often provides long-term survival advantage
4	**Very effective:** Cure unlikely but sometimes provides long-term survival advantage
3	**Moderately effective:** Modest impact on survival, but often provides control of disease
2	**Minimally effective:** No, or unknown impact on survival, but sometimes provides control of disease
1	**Palliative:** Provides symptomatic benefit only

Safety of Regimen/Agent

5	**Usually no meaningful toxicity:** Uncommon or minimal toxicities; no interference with activities of daily living (ADLs)
4	**Occasionally toxic:** Rare significant toxicities or low-grade toxicities only; little interference with ADLs
3	**Mildly toxic:** Mild toxicity that interferes with ADLs
2	**Moderately toxic:** Significant toxicities often occur but life threatening/fatal toxicity is uncommon; interference with ADLs is frequent
1	**Highly toxic:** Significant toxicities or life threatening/fatal toxicity occurs often; interference with ADLs is usual and severe

Note: For significant chronic or long-term toxicities, score decreased by 1

Quality of Evidence

5	**High quality:** Multiple well-designed randomized trials and/or meta-analyses
4	**Good quality:** One or more well-designed randomized trials
3	**Average quality:** Low quality randomized trial(s) or well-designed non-randomized trial(s)
2	**Low quality:** Case reports or extensive clinical experience
1	**Poor quality:** Little or no evidence

Consistency of Evidence

5	**Highly consistent:** Multiple trials with similar outcomes
4	**Mainly consistent:** Multiple trials with some variability in outcome
3	**May be consistent:** Few trials or only trials with few patients, whether randomized or not, with some variability in outcome
2	**Inconsistent:** Meaningful differences in direction of outcome between quality trials
1	**Anecdotal evidence only:** Evidence in humans based upon anecdotal experience

Affordability of Regimen/Agent (includes drug cost, supportive care, infusions, toxicity monitoring, management of toxicity)

5	**Very inexpensive**
4	**Inexpensive**
3	**Moderately expensive**
2	**Expensive**
1	**Very expensive**

VII. REVISION HISTORY:

- **Last Reviewed Date:** 12/7/2022
- **Last Updated Date:** 12/7/2022

Hepatitis C Direct Acting Antivirals

Policy Number: Rx019

I. MEDICATION NAME(S):

- Daklinza (daclatasvir dihydrochloride)
- Zepatier (elbasvir/grazoprevir)
- Mavyret (glecaprevir/pibrentasvir)*
- Harvoni (ledipasvir/sofosbuvir)
- ledipasvir/sofosbuvir
- Viekira Pak (ombita/paritap/riton/dasabuvir)
- Sovaldi (sofosbuvir)
- Vosevi (sofosbuvir/velpatas/voxilaprev)
- Epclusa (sofosbuvir/velpatasvir)*
- sofosbuvir/velpatasvir*

**preferred agents according to the Oregon Health Authority (OHA) fee-for-service (FFS) preferred drug list (PDL)*

II. LENGTH OF AUTHORIZATION:

- 8-24 weeks (internal note: extend the PA end date for 4 weeks to allow for a delayed start)

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. See FFS Approval Criteria: https://www.orpdl.org/durm/PA_Docs/HCV_directactingantivirals.pdf

V. RENEWAL CRITERIA:

VI. ADDITIONAL INFORMATION:

- UHA aligns with the OHA FFS PDL and prior authorization criteria.

VII. REVISION HISTORY:

- **Last Reviewed Date:** 12/7/2022
- **Last Updated Date:** 12/7/2022

Tryvio (aprocitentan)

Policy Number: Rx020

I. MEDICATION NAME(S):

- Tryvio (aprocitentan)

II. LENGTH OF AUTHORIZATION:

- Initial: 6 months
- Renewal: one year

III. QUANTITY LIMITS:

- 30 tablets/30 days

IV. INITIAL CRITERIA:

1. Is the member 18 years of age or older?
    a. Yes (go to #2)
    b. No (deny 8a)
2. Provider attestation that the member's blood pressure remains above target goal despite appropriate adherence to standard therapies.
    a. Yes (go to #3)
    b. No (Deny 5a)
3. Provider attestation that secondary causes of hypertension have been ruled out, such as pseudo-resistant hypertension, white coat hypertension, obstructive sleep apnea, primary aldosteronism, renal artery stenosis.
    a. Yes (go to #4)
    b. No (deny 5a)
4. Provider attests to a review of medications that may be exacerbating hypertension and a removal or reduction in contributing medication, such as NSAIDs, oral contraceptives, chemotherapy agents, etc.
    a. Yes (go to #5)
    b. No (deny 5a)
5. Treatment with at least one agent in <u>all</u> the following groups has been ineffective or not tolerated or are contraindicated:
        - RAS inhibitors (lisinopril, losartan, enalapril, valsartan)
        - Calcium channel blocker (amlodipine, felodipine, nifedipine, verapamil, diltiazem)
        - Thiazide/thiazide-like diuretic (hydrochlorothiazide, chlorthalidone,

indapamide)
        - Mineralocorticoid receptor antagonist (spironolactone, eplerenone)
    a. Yes (go to #6)
    b. No (deny 5a/7a)
6. Treatment with an additional antihypertensive agent of a different mechanism of action, beta-blockers, hydralazine, clonidine has been ineffective, not tolerated or contraindicated.
    a. Yes (go to #7)
    b. No (deny 5a)
7. Provider indicates the patient does not have moderate to severe hepatic impairment or elevated aminotransferases (>3 times ULN)
    a. Yes (go to #8)
    b. No (deny 8a/5a)
8. Has the prescribing provider been enrolled in the Tryvio REMS program?
    a. Yes (approve for 6 months)
    b. No (deny 5a)

V. RENEWAL CRITERIA:

1. Patient is not currently pregnant and is enrolled in the REMS program
    a. Yes (go to #2)
    b. No (deny 5a)
2. Patient has documented adherence to medication
    a. Yes (go to #3)
    b. No (deny 5u)
3. Provider has documented a positive clinical response to therapy, such as achieving and maintaining goal blood pressure on medication.
    a. Yes (approve for 1 year)
    b. No (deny 5a)

VI. ADDITIONAL INFORMATION:

Tryvio is an endothelin receptor antagonist indicated for the treatment of hypertension in combination with at least three other antihypertensive medications to lower blood pressure in adults who are not adequately controlled on other medications. Lowering blood pressure reduces risk of fatal and non-fatal cardiovascular events, primarily stroke and myocardial infarctions. This medication is a last line agent with many other medications available without prior authorization available.

VII. REVISION HISTORY:

- **Last Reviewed Date:** 12/16/24
- **Last Updated Date:** 12/16/24

Skeletal Muscle Relaxants

Policy Number: Rx021

I. MEDICATION NAME(S):

- chlorzoxazone 500 mg tablet
- orphenadrine citrate ER 100 mg tablet
- multiple nonformulary medications

II. LENGTH OF AUTHORIZATION:

- Initial and renewal: three months

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug used for treatment of muscle spasm or pain associated with an acute musculoskeletal condition?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 8a])
2. Is the request for a nonformulary medication?
    a. Yes (go to #4)
    b. No (go to #3)
3. Has the member tried and failed baclofen, cyclobenzaprine, methocarbamol, and tizanidine or are these medications not appropriate to treat the member's condition?
    a. Yes (approve for three months)
    b. No (forward to pharmacist for review [deny 7a])
4. Has the member had an adequate trial and failure of, contraindication to, or intolerance to all formulary medications: baclofen, cyclobenzaprine, methocarbamol, tizanidine, chlorzoxazone (requires PA), and orphenadrine (requires PA)? (Adequate trial is defined as compliant with therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (approve for three months)
    b. No (forward to pharmacist for review [deny 5k])

V. RENEWAL CRITERIA:

1. Has documentation been submitted to support the continued use of this medication in accordance with clinical guidelines? (Refer to UpToDate or product labeling for appropriate treatment duration.)
    a. Yes (approve for three months)

b. No (forward to pharmacist for review [deny 5a])

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 9/20/2023
- **Last Updated Date:** 12/11/2019

Monoclonal Antibodies for Alzheimer's Disease

Policy Number: Rx022

I. MEDICATION NAME(S):

- Donanemab (Kisunla)
- Lecanemab (Leqembi)

II. LENGTH OF AUTHORIZATION:

- Initial: 6 months
  Renewal: 1 year

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug to be used for treatment of a patient diagnosed with Alzheimer's Dementia AND has the prescriber ruled out other types of dementia, such as vascular dementia, Lewy body and frontotemporal?
   a. Yes (go to #2)
   b. No (deny 5a/8a)
2. Is the therapy prescribed by or in consultation with a neurologist?
   a. Yes (go to #3)
   b. No (deny 5a)
3. Is the patient between 50 and 90 years of age?
   a. Yes (go to #4)
   b. No (deny 8a)
4. Is there documented evidence that the patient has mild cognitive impairment due to Alzheimer's disease or mild Alzheimer's dementia as evidence by the following assessments performed within the last 6 months:
   - Clinical Dementia Rating-Global Score (CDR-GS) of 5.0 or 1.0 AND
   - Mini-Mental Status Exam score between 22 and 30 (inclusive) AND
   - Positron Emission Tomography (PET) scan positive for elevated amyloid beta plaque or presence of elevated amyloid and/or elevated phosphorylated tau confirmed in cerebrospinal fluid (CSF)?

   a. Yes (go to #5)
   b. No (deny 5a)

5. Has the prescriber assessed and documented baseline disease severity within the last 6 months utilizing an objective measure/tool (ADAS-Cog, ADCS-ADL-MCI, CDR-SB, MMSE or other validated AD monitoring tools?
    a. Yes (go to #6)
    b. No (deny 5a)
6. Has the patient received a baseline brain magnetic resonance imaging (MRI) within 1 year prior to initiating treatment with no evidence of pre-treatment localized superficial siderosis or brain hemorrhage?
    a. Yes (go to #7)
    b. No (deny 5a)
7. Has the prescriber scheduled additional brain MRIs to be obtained as described in table 1 to evaluate for the presence of asymptomatic amyloid related imaging abnormalities (ARIA-E) edema and/or ARIA-H hemorrhage?
    a. Yes (go to #8)
    b. No (deny for 5a)
8. Is the patient currently receiving anticoagulant or antiplatelet therapy (excluding aspirin 81mg)?
    a. Yes (pass to RPh for review)
    b. No (go to #9)
9. Is there documentation based on medical records that the prescriber has tested the patient for the presence of ApoE4 and if a carrier has discussed benefits and risks associated with therapy?
    a. Yes (Approve for 6 months)
    b. No (pass to RPh for review)

V. RENEWAL CRITERIA:

1. Is there documented evidence that the patient has mild cognitive impairment due to Alzheimer's disease or mild Alzheimer's dementia as evidence by the following assessments performed within the last 30 days:

- CDR-GS of 0.5 or 1.0 AND
- Objective evidence of cognitive impairment at screening AND
- MMSE score between 22 and 30 (inclusive)
    a. Yes (go to #2)
    b. No (deny 5a)

2. IS there documented evidence of follow-up MRIs performed and/or scheduled as recommended in Table 1 for therapy safety surveillance?
    a. Yes (go to #3)
    b. No (Deny 5a)
3. Was there a serious adverse event (symptomatic moderate to severe ARIA-H or ARIA-e observed or reported with therapy?
    a. Yes (Deny 5a)
    b. No (go to #4)
4. Has the patient received at least 6 months of uninterrupted therapy?
    a. Yes (go to #5)
    b. No (approve the remaining duration of 6 months titration period)
5. Is the request of donanemab?

    a. Yes (Go to #6)
    b. No (Go to #8)
6. Has PET imaging been performed within the last 6 months to confirm the presence of amyloid plaques?
    a. Yes (go to #7)
    b. No (Deny 5a)
7. Doe the patient have amyloid plaque levels at <11 centoloids on a single PET scan or 11 to <25 on consecutive months?
    a. Yes (deny 5a)
    b. No (go to #8)
8. Is there documentation that compared to baseline assessment, therapy has resulted in: cognitive or functional improvement OR disease stabilization or a reduction in rate of clinical decline compared to the natural disease progression?
    a. Yes (Approved for up to 6 months)
    b. No (pass to RPh for review)

VI. ADDITIONAL INFORMATION:

TABLE 1

DRUG	MRI TIMING FOR ARIA MONITORING	DOSING	FREQUENCY OF ADMIN
Donanemab	Prior to Infusion 2 (no longer that 1 year)	Month 1: 350mg IV over 30 minutes	Every 4 weeks
	Prior to Infusion 3	Month 2: 700mg IV over 30 min	
	Prior to Infusion 4	Month 3: 1050mg IV over 30 min	
	Prior to Infusion 7	Month 4 and beyond: 1400mg IV over 30 min	
	Annually		
Lecanemab	Prior to Infusion 2 (no longer that 1 year)	10mg/kg IV over 60 min	Every 2 weeks
	Prior to Infusion 3		
	Prior to Infusion 4		
	Prior to Infusion 7		
	Annually		

VII. REVISION HISTORY:

- **Last Reviewed Date:** 1/8/25
- **Last Updated Date:** 1/8/25

Selective Serotonin Agonists

Policy Number: Rx023

I. MEDICATION NAME(S):

- *almotriptan oral tablet (non-formulary)*
- *eletriptan oral tablet (non-formulary)*
- *frovatriptan (non-formulary)*
- Reyvow (lasmiditan) oral tablet (PA, QL)
- naratriptan HCl oral tablet (QL)
- rizatriptan oral tablet (QL)
- rizatriptan ODT (QL)
- sumatriptan oral tablet (QL)
- sumatriptan nasal spray (PA, QL)
- sumatriptan SQ pen (PA, QL)
- sumatriptan SQ cartridge (PA, QL)
- sumatriptan SQ vial (PA, QL)
- zolmitriptan oral tablet (QL)
- zolmitriptan ODT (QL)

II. LENGTH OF AUTHORIZATION:

- Initial: length of benefit (LOB)

III. QUANTITY LIMITS:

- Reyvow (lasmiditan) oral tablets: 4 tablets per 30 days
- almotriptan, eletriptan, frovatriptan, naratriptan, rizatriptan, sumatriptan and zolmitriptan oral tablets and ODT: 9 tablets per 30 days
- sumatriptan nasal spray: 1 package (6 mL) per 30 days
- sumatriptan SQ pen and cartridge: 1 package (1 ml) per 30 days
- sumatriptan SQ vial: 1 vial (2.5 mL) per 30 days

IV. INITIAL CRITERIA:

1. Is the drug used for the treatment of migraine headaches?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review)
2. Is the request for an oral formulary triptan (naratriptan, rizatriptan, sumatriptan, or zolmitriptan)?
    a. Yes (go to #4)
    b. No (go to #3)
3. Has the member tried and failed at least three oral formulary triptans (naratriptan, rizatriptan, sumatriptan, or zolmitriptan) or has the prescriber submitted appropriate documentation explaining why these medications cannot be used?
    a. Yes (go to #4)
    b. No (forward to pharmacist for review)
4. Is the request for a quantity exception to exceed the quantity limit (QL)?

a. Yes (forward to pharmacist for review)
b. No (approve for LOB)

V. RENEWAL CRITERIA:

VI. ADDITIONAL INFORMATION:

- According to product labeling, the safety and effectiveness of treating more than 4 headaches in a 30-day period. Furthermore, triptans should be used less than ten days per month to avoid medication overuse headaches. UHA will not exceed our quantity limits which are in alignment with these guidelines and product labeling.

VII. REVISION HISTORY:

- **Last Reviewed Date:** 3/15/2023
- **Last Updated Date:** 9/30/2020

Ropinirole

Policy Number: Rx024

I. MEDICATION NAME(S):

- ropinirole ER

II. LENGTH OF AUTHORIZATION:

- Initial: length of benefit (LOB)

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug used for an FDA-approved indication or a medically appropriate off-label use with strong evidence supporting safety and efficacy?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 8a])
2. Is the drug prescribed for a condition funded by the Oregon Health Plan (OHP) in a manner consistent with the Health Evidence Review Commission (HERC) Prioritized List of Health Services? (Restless legs syndrome is not a funded condition.)
    a. Yes (approve for LOB)
    b. No (go to #3)
3. Is there a comorbid condition for which coverage would be allowed?
    a. Yes (approve for LOB)
    b. No (forward to pharmacist for review [deny 3a, RLS])

V. RENEWAL CRITERIA:

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 9/20/2023
- **Last Updated Date:** 6/12/2019

Interferon Beta-1a

Policy Number: Rx025

I. MEDICATION NAME(S):

- Avonex Kit (interferon beta-1a/albumin)
- Avonex Pen (interferon beta-1a)

II. LENGTH OF AUTHORIZATION:

- Initial: length of benefit (LOB)

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug used for the treatment of relapsing forms of multiple sclerosis (MS), including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease?
    a. Yes (approve for LOB)
    b. No (forward to pharmacist for review [deny 8a])

V. RENEWAL CRITERIA:

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 3/30/2022
- **Last Updated Date:** 12/11/2019

Dimethyl Fumarate

Policy Number: Rx026

I. MEDICATION NAME(S):

- dimethyl fumarate

II. LENGTH OF AUTHORIZATION:

- Initial: length of benefit (LOB)

III. QUANTITY LIMITS:

- 120-240 mg: 60 capsules in 30 days
- 120 mg: 14 capsules in 7 days
- 240 mg: 60 capsules in 30 days

IV. INITIAL CRITERIA:

1. Is the drug used for the treatment of relapsing forms of multiple sclerosis (MS), including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 8a])
2. Is the request for monotherapy and is not intended to be used in combination with other MS drugs?
    a. Yes (approve for LOB)
    b. No (forward to pharmacist for review [deny 5a])

V. RENEWAL CRITERIA:

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 3/30/2022
- **Last Updated Date:** 3/30/2022

Prior Authorization Criteria
Formulary Exception Criteria

Antineoplastic Gonadotropin Releasing Hormone Agonist

Policy Number: Rx028

I. MEDICATION NAME(S):

- Zoladex (goserelin acetate)
- Vantas (histrelin acetate)
- Eligard (leuprolide acetate)
- leuprolide acetate
- Lupron depot (leuprolide acetate)
- Lupaneta (leuprolide/norethindrone)
- Trelstar (triptorelin pamoate)

II. LENGTH OF AUTHORIZATION:

- Cancer: initial and renewal: one year

- Endometriosis: initial and renewal: six months (max duration is one year)
- Leiomyoma: initial: three months (max duration)
- Gender dysphoria: initial and renewal: one year (up to age 18 years)
- Precocious puberty: initial and renewal: one year (up to age 11 years for females and 12 years for males)

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug used for an FDA-approved indication or a medically appropriate off-label use with strong evidence supporting safety and efficacy (cancer, endometriosis, gender dysphoria, leiomyoma, precocious puberty)?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 8a])
2. Is the treatment appropriate for the member's age and condition according to product labeling?
    a. Yes (go to #3)
    b. No (forward to pharmacist for review [deny 5a])
3. Is the medication prescribed by or in consultation with an appropriate health care provider with expertise in treating this condition: hematologist/oncologist for cancer; obstetrician/gynecologist for endometriosis and leiomyoma; or pediatric

endocrinologist for gender dysphoria and precocious puberty?

   a. Yes (go to #4)
   b. No (forward to pharmacist for review [deny 5a])

4. Is the request for a leuprolide product?
   a. Yes (go to #6)
   b. No (go to #5)

5. Has the member had an adequate trial and failure of, contraindication to, or intolerance to a leuprolide product, or is leuprolide not indicated? (Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (go to #6)
    b. No (forward to pharmacist for review [deny 5k])
6. Is the drug prescribed for a diagnosis of cancer?
    a. Yes (go to #12)
    b. No (go to #7)
7. Is the drug prescribed for a diagnosis of endometriosis?
    a. Yes (go to #15)
    b. No (go to #8)
8. Is the drug prescribed for a diagnosis of leiomyoma?
    a. Yes (go to #17)
    b. No (go to #9)
9. Is the drug prescribed for a diagnosis of gender dysphoria?
    a. Yes (go to #18)
    b. No (go to #10)
10. Is the drug prescribed for a diagnosis of precocious puberty)?
    a. Yes (go to #19)
    b. No (forward to pharmacist for review [deny 8a])
11. Is the drug used for an FDA-approved indication, OR a medically appropriate off-label use with strong evidence supporting safety and efficacy, AND listed as a preferred intervention by NCCN with quality and consistency of evidence of at least 3, OR listed as an alternative options with additional compelling information provided? NOTE: Includes all information required in the FDA approval or NCCN recommendation, including but not limited to diagnosis, stage of cancer, biomarkers, place in therapy, and use as monotherapy or combination therapy. (Refer to Table 1 in 'Additional Information' for NCCN quality of evidence and consistency of evidence ratings.)
    a. Yes (go to #12)
    b. No (forward to pharmacist for review [deny 8a])
12. Is the member under age 21?
    a. Yes (go to #13)
    b. No (go to #14)
13. Is the intent of treatment to prolong survival for progressive metastatic cancer with: A) Severe co-morbidities unrelated to the cancer that result in significant impairment in two or more major organ systems which would affect efficacy and/or toxicity of therapy; OR B) A continued decline in spite of best available therapy with a non-reversible Karnofsky Performance Status or Palliative Performance score of <50% with ECOG performance status of 3 or higher which are not due to a pre-existing disability.
    a. Yes (forward to pharmacist for review [deny 5a])
    b. No (approve for one year)
14. If applicable, does the request meet criteria for treatment coverage specified in Guideline Note 12 of the Health Evidence Review Commission (HERC) Prioritized List of

Health Services, considering treatment of cancer with little or no benefit (Refer to Guideline Note 12)?
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 5a GLN 12])
15. Has the endometriosis diagnosis been confirmed by laparoscopy?
    a. Yes (go to #16)
    b. No (forward to pharmacist for review [deny 5a])
16. Has the member had an adequate trial and failure of, contraindication to, or intolerance to hormonal therapies (combined oral contraceptives, progestins, or levonorgestrel IUD)? (Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review [deny 7a])
17. Is the request for preoperative treatment of anemia caused by fibroids (uterine leiomyoma)?
    a. Yes (approve for three months)
    b. No (forward to pharmacist for review [deny 8a])
18. Is the member's age less than 18 years?
    a. Yes (approve up to one year or until the age of 18, whichever comes first)
    b. No (forward to pharmacist for review [deny 5a])
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 5a])
19. Is the member's age less than 11 years for females and 12 years for males?
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 8a])

V. RENEWAL CRITERIA:

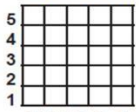
1. Is the drug prescribed for a diagnosis of cancer?
    a. Yes (go to #6)
    b. No (go to #2)
2. Is the drug prescribed for a diagnosis of endometriosis?
    a. Yes (go to #7)
    b. No (go to #3)
3. Is the drug prescribed for a diagnosis of leiomyoma?
    a. Yes (forward to pharmacist for review [deny 8a, max treatment duration is three months])
    b. No (go to #4)
4. Is the drug prescribed for a diagnosis of gender dysphoria?
    a. Yes (go to #8)
    b. No (go to #5)
5. Is the drug prescribed for a diagnosis of precocious puberty)?
    a. Yes (go to #9)
    b. No (forward to pharmacist for review [deny 8a])
6. Has there been evidence of disease responsiveness to therapy?
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 5a])

7. Has the length of therapy been less than one year?
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review [deny 8a])
8. Is the member's age less than 18 years?
    a. Yes (approve up to one year or until the age of 18, whichever comes first)
    b. No (forward to pharmacist for review [deny 5a])
9. Is the member's age less than 11 years for females and 12 years for males?
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 8a])

VI. ADDITIONAL INFORMATION:

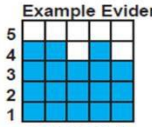
- Table 1. NCCN Evidence Blocks Categories and Definitions

NCCN EVIDENCE BLOCKS CATEGORIES AND DEFINITIONS



E = Efficacy of Regimen/Agent
S = Safety of Regimen/Agent
Q = Quality of Evidence
C = Consistency of Evidence
A = Affordability of Regimen/Agent

Example Evidence Block



E = 4
S = 4
Q = 3
C = 4
A = 3

Efficacy of Regimen/Agent

5	**Highly effective:** Cure likely and often provides long-term survival advantage
4	**Very effective:** Cure unlikely but sometimes provides long-term survival advantage
3	**Moderately effective:** Modest impact on survival, but often provides control of disease
2	**Minimally effective:** No, or unknown impact on survival, but sometimes provides control of disease
1	**Palliative:** Provides symptomatic benefit only

Safety of Regimen/Agent

5	**Usually no meaningful toxicity:** Uncommon or minimal toxicities; no interference with activities of daily living (ADLs)
4	**Occasionally toxic:** Rare significant toxicities or low-grade toxicities only; little interference with ADLs
3	**Mildly toxic:** Mild toxicity that interferes with ADLs
2	**Moderately toxic:** Significant toxicities often occur but life threatening/fatal toxicity is uncommon; interference with ADLs is frequent
1	**Highly toxic:** Significant toxicities or life threatening/fatal toxicity occurs often; interference with ADLs is usual and severe

Note: For significant chronic or long-term toxicities, score decreased by 1

Quality of Evidence

5	**High quality:** Multiple well-designed randomized trials and/or meta-analyses
4	**Good quality:** One or more well-designed randomized trials
3	**Average quality:** Low quality randomized trial(s) or well-designed non-randomized trial(s)
2	**Low quality:** Case reports or extensive clinical experience
1	**Poor quality:** Little or no evidence

Consistency of Evidence

5	**Highly consistent:** Multiple trials with similar outcomes
4	**Mainly consistent:** Multiple trials with some variability in outcome
3	**May be consistent:** Few trials or only trials with few patients, whether randomized or not, with some variability in outcome
2	**Inconsistent:** Meaningful differences in direction of outcome between quality trials
1	**Anecdotal evidence only:** Evidence in humans based upon anecdotal experience

Affordability of Regimen/Agent (includes drug cost, supportive care, infusions, toxicity monitoring, management of toxicity)

5	**Very inexpensive**
4	**Inexpensive**
3	**Moderately expensive**
2	**Expensive**
1	**Very expensive**

VII. REVISION HISTORY:

- **Last Reviewed Date:** 7/2/24
- **Last Updated Date:** 7/2/24

Desmopressin

Policy Number: Rx029

I. MEDICATION NAME(S):

- desmopressin acetate nasal spray

II. LENGTH OF AUTHORIZATION:

- Initial: length of benefit (LOB)

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug used for a diagnosis of hemophilia A with factor VIII level greater than 5% or von Willebrand disease type 1 with factor VIII levels greater than 5%?
    a. Yes (approve nasal spray for LOB)
    b. No (forward to pharmacist for review [deny 8a])

V. RENEWAL CRITERIA:

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 12/7/2022
- **Last Updated Date:** 12/7/2022

Growth Hormones

Policy Number: Rx030

I. MEDICATION NAME(S):

- Norditropin (somatropin) (*preferred)*
- Genotropin (somatropin)
- Humatrope (somatropin) cartridge
- Omnitrope (somatropin)
- Multiple non-formulary drugs

II. LENGTH OF AUTHORIZATION:

- Initial and renewal: one year

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug used for an FDA-approved indication or a medically appropriate off-label use with strong evidence supporting safety and efficacy (see chart under Additional Information section)?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 8a])
2. Is the member under age 21?
    a. Yes (go to #3)
    b. No (go to #4)
3. Is there documentation that treating the condition is medically appropriate and necessary in which it will enhance the member's ability to grow, develop, or participate in school per the EPSDT Medicaid benefit?
    a. Yes (go to #5)
    b. No (forward to pharmacist for review [deny 5a])
4. Is the drug prescribed for a condition funded by the Oregon Health Plan (OHP) in a manner consistent with the Health Evidence Review Commission (HERC) Prioritized List of Health Services, OR is there a comorbid condition for which coverage would be allowed? (Treatment with a growth hormone is not funded for most adult conditions. Refer to Guideline Note 74 of the Health Evidence Review Commission (HERC) Prioritized List of Health Services for coverage of hypopituitarism.)
    a. Yes (go to #10)

b. No (forward to pharmacist for review [deny 3a, and 5a GLN 74])

5. Is the drug used for a member who is less than 18 years of age OR a member with bone age that is less than or equal to 14 years for females or 16 years for males?

a. Yes (go to #6)
b. No (forward to pharmacist for review [deny 5a])

6. Does the member have documented biochemical Growth Hormone Deficiency (GHD) by one of the following tests: (1) Two growth hormone (GH) stimulations tests < 10 ng/mL (microgram/L); OR (2) One GH stimulation test < 15 ng/mL and IGF – 1 below normal for bone age and sex?
    a. Yes (go to #7)
    b. No (forward to pharmacist for review [deny 5a])
7. Is the member over 12 years of age?
    a. Yes (go to #8)
    b. No (go to #9)
8. Is there evidence of non-closure of epiphyses confirmed by X-ray?
    a. Yes (go to #9)
    b. No (forward to pharmacist for review [deny 5a])
9. Is the medication prescribed by or in consultation with a pediatric endocrinologist or a pediatric nephrologist?
    a. Yes (go to #10)
    b. No (forward to pharmacist for review [deny 5a])
10. Has the member had an adequate trial and failure of, contraindication to, or intolerance to Norditropin, OR is Norditropin not appropriate for the diagnosis (see chart under Additional Information section)? (Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 7a])

V. RENEWAL CRITERIA:

1. Is there evidence of growth velocity (GV) greater than 2.5 cm/year?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 5a])
2. Is the member over 12 years of age?
    a. Yes (go to #3)
    b. No (go to #4)
3. Is there evidence of non-closure of epiphyses confirmed by X-ray?
    a. Yes (go to #4)
    b. No (forward to pharmacist for review [deny 5a])
4. Has the member's bone age not reached height potential defined as bone age not exceeding 16 years for males (required annually when chronological age reaches 15) and bone age not exceeding 14 years for females (required annually when chronological age reaches 13)?
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 5a)

VI. ADDITIONAL INFORMATION:

- **Pediatric and Adult FDA Approved Indications for Growth Hormone**

	Genotropin®	Humatrope®	Norditropin®	Nutropin	Omnitrope®	Saizen®	Serostim®	Zomacton®	Zorbtive®
Pediatric Indications									
GHD	x	x	x	x	x	x		x	
Prader-Willi Syndrome	x		x		x				
Noonan Syndrome			x						
Turner Syndrome	x	x	x	x	x			x	
Idiopathic Short Stature	x	x	x	x	x			x	
SHOX Deficiency		x						x	
CKD with Growth Failure				x					
Small for Gestational Age	x	x	x		x			x	
HIV Associated Cachexia							x		
Adult Indications (not funded)									
GHD	x	x	x	x	x	x		x	
HIV Associated Cachexia							x		
Short Bowel Syndrome									x

ABBREVIATIONS: CKD = CHRONIC KIDNEY DISEASE; FDA = FOOD AND DRUG ADMINISTRATION; GHD = GROWTH HORMONE DEFICIENCY; HIV = HUMAN IMMUNODEFICIENCY VIRUS; SHOX = SHORT STATURE HOMEOBOX-CONTAINING GENE

VII. REVISION HISTORY:

- **Last Reviewed Date:** 12/7/2022
- **Last Updated Date:** 12/7/2022

Prior Authorization Criteria
Formulary Exception Criteria

Pancreatic Enzymes

Policy Number: Rx031

I. MEDICATION NAME(S):

- Creon (lipase/protease/amylase)
- Pancreaze (lipase/protease/amylase)
- Zenpep (lipase/protease/amylase)
- Multiple non-formulary drugs (Pertzye, Viokace)

II. LENGTH OF AUTHORIZATION:

- Initial: length of benefit (LOB)

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug being used for a diagnosis of cystic fibrosis?
    a. Yes (go to #6)
    b. No (go to #2)
2. Has the member had a pancreatectomy?
    a. Yes (go to #6)
    b. No (go to #3)
3. Is the drug being used for a diagnosis of exocrine pancreatic cancer?
    a. Yes (go to #6)
    b. No (go to #4)
4. Is the drug being used for a diagnosis of chronic pancreatitis confirmed by imaging?
    a. Yes (go to #6)
    b. No (go to #5)
5. Does the member have exocrine pancreatic insufficiency confirmed with one of the following methods: (1) Confirmed steatorrhea with fecal fat determination; (2) Measurement of fecal elastase; OR (3) Secretin or CCK pancreatic function testing?
    a. Yes (go to #6)
    b. No (forward to pharmacist for review [deny 5a, 8a])
6. Is the request for a drug that is on the UHA formulary (Creon, Pancreaze, or Zenpep)?
    a. Yes (approve for LOB)
    b. No (go to #7)
7. Is the request for Viokace?
    a. Yes (go to #8)
    b. No (go to #9)

8. Is the member taking a proton pump inhibitor like omeprazole or pantoprazole? (Note: Viokace must be administered with a proton pump inhibitor (PPI) since it is not enteric coated.)
    a. Yes (go to #9)
    b. No (forward to pharmacist for review [deny 5a])
9. Has the member had an adequate trial and failure of, contraindication to, or intolerance to all formulary drugs (Creon, Pancreaze, and Zenpep)? (Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 5k])

V. RENEWAL CRITERIA:

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 9/14/2022
- **Last Updated Date:** 12/11/2019

Aprepitant

Policy Number: Rx032

I. MEDICATION NAME(S):

- aprepitant capsules

II. LENGTH OF AUTHORIZATION:

- Initial and renewal: six months

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the member currently receiving moderate to highly emetogenic chemotherapy (refer to NCCN antiemesis guidelines)?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 5a, 7a])
2. Is the member receiving concurrent treatment with IV or oral ondansetron, granisetron, or palonosetron, AND dexamethasone?
    a. Yes (approve for three months)
    b. No (deny 5a)

V. RENEWAL CRITERIA:

See Initial Criteria

VI. ADDITIONAL INFORMATION:

LEVEL	AGENT		
Low emetic risk (10%–30% frequency of emesis)[b]	• Ado-trastuzumab emtansine • Aldesleukin ≤12 million IU/m² • Amifostine ≤300 mg/m² • Atezolizumab • Belinostat • Blinatumomab • Brentuximab vedotin • Cabazitaxel • Carfilzomib • Cytarabine (low dose) 100–200 mg/m² • Docetaxel • Doxorubicin (liposomal) • Eribulin	• Etoposide • 5-Fluorouracil (5-FU) • Floxuridine • Gemcitabine • Interferon alfa >5 - <10 million international units/m² • Irinotecan (liposomal) • Ixabepilone • Methotrexate >50 mg/m² - <250 mg/m² • Mitomycin • Mitoxantrone • Necitumumab • Olaratumab	• Omacetaxine • Paclitaxel • Paclitaxel-albumin • Pemetrexed • Pentostatin • Pralatrexate • Romidepsin • Talimogene laherparepvec • Thiotepa • Topotecan • Ziv-aflibercept
Minimal emetic risk (<10% frequency of emesis)[b]	• Alemtuzumab • Avelumab • Asparaginase • Bevacizumab • Bleomycin • Bortezomib • Cetuximab • Cladribine • Cytarabine <100 mg/m² • Daratumumab • Decitabine • Denileukin diftitox • Dexrazoxane • Durvalumab	• Elotuzumab • Fludarabine • Interferon alpha ≤5 million IU/m² • Ipilimumab • Methotrexate ≤50 mg/m² • Nelarabine • Nivolumab • Obinutuzumab • Ofatumumab • Panitumumab • Pegaspargase • Peginterferon • Pembrolizumab • Pertuzumab	• Ramucirumab • Rituximab • Rituximab and hyaluronidase human injection for SQ use • Siltuximab • Temsirolimus • Trastuzumab • Valrubicin • Vinblastine • Vincristine • Vincristine (liposomal) • Vinorelbine

VII. REVISION HISTORY:

- **Last Reviewed Date:** 9/14/2022
- **Last Updated Date:** 12/11/2019

Sedatives

Policy Number: Rx033

I. MEDICATION NAME(S):

- temazepam capsules
- zolpidem

II. LENGTH OF AUTHORIZATION:

- Initial: one to six months (one year for malignant neoplasm, other end-of-life diagnosis or under palliative care services)
- Renewal: up to six months (one year for malignant neoplasm, other end-of-life diagnosis or under palliative care services)

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug used for a member with a malignant neoplasm, other end-of-life diagnosis or under palliative care services?
    a. Yes (approve for one year)
    b. No (go to #2)
2. Is the request for melatonin in an adult over 18 years of age
    a. Yes (forward to pharmacist for review)
    b. No (go to #3)
3. Is the request for zolpidem at a higher dose than covered by UHA?
    a. Yes (forward to pharmacist)
    b. No (go to #4)
4. Has the member been treated with a different non-benzodiazepine sedative, benzodiazepine, or opioid within the past 30 days?
    a. Yes (go to #5)
    b. No (go to #7)
5. Is this a switch in sedative therapy due to intolerance, allergy, or ineffectiveness?
    a. Yes (go to #7)
    b. No (go to #6)
6. Is concurrent sedative therapy part of a plan to switch and taper off a long-acting benzodiazepine (such as diazepam, clonazepam, or chlordiazepoxide) AND has the provider included a detailed strategy to taper?
    a. Yes (approve for the duration specified in the taper plan (not to exceed 6 months)
    b. No (forward to pharmacist)

7. Does the member have a diagnosis of insomnia with obstructive sleep apnea?
    a. Yes (go to #8)
    b. No (go to #9)
8. Is the member on CPAP?
    a. Yes (go to #9)
    b. No (forward to pharmacist; sedative/hypnotics are contraindicated due to depressant effect)
9. Is the request for treatment of insomnia?
    a. Yes (go to #10)
    b. No (go to #11)
10. Is the member currently engaged in cognitive behavioral therapy focused on insomnia treatment (CBT-I), failed to have benefit in symptoms after 5-6 CBT interventions, OR have inability to access CBT-I?
    a. Yes (approve for 30 days; long-term treatment must document that benefits outweigh risks)
    b. No (forward to pharmacist, GLN 233)
11. Is member eligible for EPSDT review?
    a. Yes (go to #13)
    b. No (go to #12)
12. Is diagnosis being treated a funded condition and is there medical evidence of benefit for the prescribed sedative?
    a. Yes (approve for 30 days; document supporting literature)
    b. No (forward to pharmacist)
13. Is there documentation that the condition is of sufficient severity that it impacts the member's health (e.g., quality of life, function, growth, development, ability to participate in school, perform activities of daily living, etc.)?
    a. Yes (go to #14)
    b. No (forward to pharmacist)
14. Is the request for a melatonin agonist (e.g., melatonin, ramelteon, tasimelteon) for treatment of one of the following circadian rhythm sleep-wake disorders (People with delayed sleep-wake; phase disorder; or adults with non-24-hour sleep-wake disorder; or children and adolescents with neurologic disorders and irregular sleep-wake rhythm disorder)?
    a. Yes (approve for 30 days)
    b. No (forward to pharmacist)

V. RENEWAL CRITERIA:

1. Is the request for a slow taper plan?
    a. Yes (approve for duration of taper (not to exceed 3 months; future renewals should document progress toward discontinuation)
    b. No (go to #2)
2. Is member eligible for EPSDT review?
    a. Yes (go to #3)
    b. No (go to # 4)
3. Is there documentation of improvement (e.g., symptoms, function, quality of life, etc.) since treatment was started?
    a. Yes (go to #4)
    b. No (forward to pharmacist)
4. Is there documentation based on medical records that the member and provider have discussed whether benefits of ongoing therapy (hospitalizations, function, quality of life) continue to outweigh risks (memory problems, dementia, cognitive impairment, daytime sedation, falls, fractures, dependence, and reduced long-term efficacy)?
    a. Yes (approve for 3 months)
    b. No (forward to pharmacist)

VI. ADDITIONAL INFORMATION:

GUIDELINE NOTE 233, INSOMNIA: *LINE 201*

Insomnia is included on this line for pairing with cognitive behavioral therapy (CBT). Short term (up to 1 month per year) treatment with sedative-hypnotic medications is included on this line only if the patient is currently in CBT or has failed to respond to recent CBT (in the past year). Long-term (more than 1 month) treatment with sedative-hypnotic medications is not included on this line.

VII. REVISION HISTORY:

- **Last Reviewed Date:** 12/03/2025
- **Last Updated Date:** 12/12/2025

Pulmonary Antihypertensive Phosphodiesterase Inhibitors

Policy Number: Rx034

I. MEDICATION NAME(S):

- sildenafil citrate (generic Revatio)
- Alyq (tadalafil)
- tadalafil (generic Adcirca)

II. LENGTH OF AUTHORIZATION:

- Initial: length of benefit (LOB)

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug used for a diagnosis of pulmonary arterial hypertension WHO Group I diagnosed by right heart catheterization? (Note: Sexual dysfunction is not a condition funded by the Oregon Health Plan (OHP) according to the Health Evidence Review Commission (HERC) Prioritized List of Health Services.)
    a. Yes (go to #2)
    b. No (forward to pharmacist for review)
2. Is the drug prescribed by or in consultation with a pulmonologist or cardiologist?
    a. Yes (go to #3)
    b. No (forward to pharmacist for review)
3. Is the request for sildenafil (generic Revatio)?
    a. Yes (approve for LOB)
    b. No (go to #4)
4. Has the member had an adequate trial and failure of, contraindication to, or intolerance to sildenafil? (Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (approve for LOB)
    b. No (forward to pharmacist for review)

V. RENEWAL CRITERIA:

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 3/15/2023
- **Last Updated Date:** 12/11/2019

Omalizumab

Policy Number: Rx035

I. MEDICATION NAME(S):

- Xolair (omalizumab)

II. LENGTH OF AUTHORIZATION:

- Initial: four months
- Renewal: six months

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug being used for a diagnosis of moderate to severe persistent asthma?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review)
2. Is the member six years of age or older?
    a. Yes (go to #3)
    b. No (forward to pharmacist for review)
3. Is the drug prescribed by or in consultation with a pulmonologist or immunologist?
    a. Yes (go to #4)
    b. No (forward to pharmacist for review)
4. Is the member a current smoker?
    a. Yes (forward to pharmacist for review)
    b. No (go to #5)
5. Does the member have a positive skin test or RAST to a perennial aeroallergen?
    a. Yes (go to #6)
    b. No (forward to pharmacist for review)
6. Is the member's baseline IgE serum level between 30 to 1,300 IU/mL for members age 6 to 11, OR between 30 to 700 IU/mL for members age 12 and older?
    a. Yes (go to #7)
    b. No (forward to pharmacist for review)
7. Have the provider and member taken all steps to reduce and maximally manage environmental allergens and other triggers (e.g., tobacco smoke, dust mites, pets, molds, occupational exposures, GERD)?
    a. Yes (go to #8)
    b. No (forward to pharmacist for review)

8. Has the member had an adequate trial and failure of, contraindication to, or intolerance to all of the following agents used as combination therapy: (1) High-dose inhaled corticosteroid with a long-acting beta agonist (such as fluticasone-salmeterol [generic Advair] or Symbicort); (2) Long-acting muscarinic antagonist (such as Incruse Ellipta, Tudorza, or Spiriva); AND (3) Leukotriene inhibitor (such as montelukast)? (Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (go to #9)
    b. No (forward to pharmacist for review)
9. Has the member tried and failed or have contraindications to allergen immunotherapy?
    a. Yes (go to #10)
    b. No (forward to pharmacist for review)
10. Does the member have a history of compliance with all asthma medications?
    a. Yes (go to #11)
    b. No (forward to pharmacist for review)
11. In the past year has the member had frequent asthma exacerbations resulting in repeated use of health care services, such as urgent care or ED visits or hospitalization?
    a. Yes (go to #12)
    b. No (forward to pharmacist for review)
12. Will this drug be professionally administered and billed under the medical benefit?
    a. Yes (approve for four months)
    b. No (forward to pharmacist for review)

V. RENEWAL CRITERIA:

1. Has the member had a reduction in asthma exacerbations necessitating frequent office visits, ED or urgent care visits, hospitalizations, oral steroids and demonstrated sustained clinical improvement from baseline while on omalizumab?
    a. Yes (go to #12)
    b. No (forward to pharmacist for review)
2. Will this drug be professionally administered and billed under the medical benefit?
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review)

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 3/15/2023
- **Last Updated Date:** 12/11/2019

Topical Immunosuppressants

Policy Number: Rx036

I. MEDICATION NAME(S):

- tacrolimus oint.

II. LENGTH OF AUTHORIZATION:

- Initial: length of benefit (LOB)

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the member under age 21?
    a. Yes (go to #2)
    b. No (go to #3)
2. Is there documentation that treating the condition is medically appropriate and necessary in which it will enhance the member's ability to grow, develop, or participate in school per the EPSDT Medicaid benefit?
    a. Yes (go to #5)
    b. No (forward to pharmacist for review)
3. Is the drug prescribed for chronic, severe atopic dermatitis with functional impairment as indicated by Dermatology Life Quality Index (DLQI) ≥ 11 (or severe score on other validated tool) AND one or more of the following: (1) at least 10% body surface area involved; or (2) hand, foot, face, or mucous membrane involvement?
    a. Yes (go to #5)
    b. No (go to #4)
4. Is there a comorbid condition for which coverage would be allowed?
    a. Yes (go to #5)
    b. No (forward to pharmacist for review)
5. Has the member experienced an adequate trial and failure of, contraindication to, or intolerance to high-potency topical corticosteroids – betamethasone dipropionate, clobetasol, fluocinonide (may require prior authorization) (Adequate trial is defined as compliant with therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (approve for LOB)
    b. No (forward to pharmacist for review)

V. RENEWAL CRITERIA:

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 7/2/24
- **Last Updated Date:** 7/2/24

Topical Antipsoriatic Agents

Policy Number: Rx037

I. MEDICATION NAME(S):

- calcipotriene cream
- calcipotriene oint.
- calcipotriene solution
- tazarotene cream

II. LENGTH OF AUTHORIZATION:

- Initial: length of benefit (LOB)

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the member under age 21?
    a. Yes (go to #2)
    b. No (go to #3)

2. Is there documentation that treating the condition is medically appropriate and necessary in which it will enhance the member's ability to grow, develop, or participate in school per the EPSDT Medicaid benefit?
    a. Yes (go to #5)
    b. No (forward to pharmacist for review)
3. Is the drug prescribed for chronic, moderate to severe plaque psoriasis with functional impairment as indicated by Dermatology Life Quality Index (DLQI) ≥ 11 (or severe score on other validated tool) AND one or more of the following: (1) at least 10% body surface area involved; or (2) hand, foot, face, or mucous membrane involvement?
    a. Yes (go to #5)
    b. No (go to #4)
4. Is there a comorbid condition for which coverage would be allowed?
    a. Yes (go to #3)
    b. No (forward to pharmacist for review)
5. Has the member experienced an adequate trial and failure of, contraindication to, or intolerance to high-potency topical corticosteroids – betamethasone dipropionate, clobetasol, fluocinonide (may require prior authorization)? (Adequate trial is defined as compliant with therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (approve for LOB)
    b. No (forward to pharmacist for review)

V. RENEWAL CRITERIA:

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 7/2/24
- **Last Updated Date:** 7/2/24

Acitretin

Policy Number: Rx038

I. MEDICATION NAME(S):

- acitretin capsule

II. LENGTH OF AUTHORIZATION:

- Initial: six months
- Renewal: one year

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug prescribed for chronic, moderate to severe plaque psoriasis with functional impairment as indicated by Dermatology Life Quality Index (DLQI) ≥ 11 or Children's Dermatology Life Quality Index (CDLQI) ≥ 13 (or severe score on other validated tool) AND one or more of the following: (1) at least 10% body surface area involved; or (2) hand, foot, face, or mucous membrane involvement?
    a. Yes (go to #3)
    b. No (go to #2)
2. Is there a comorbid condition for which coverage would be allowed?
    a. Yes (go to #3)
    b. No (forward to pharmacist for review [deny 5a])
3. Is the medication prescribed by or in consultation with a dermatologist?
    a. Yes (go to #4)
    b. No (forward to pharmacist for review [deny 5a (prescriber)])
4. Has the member had an adequate trial and failure of, contraindication to, or intolerance to **all** of the following: (1) high-potency topical corticosteroids – betamethasone dipropionate, clobetasol, fluocinonide (all require prior authorization); (2) at least one other topical – calcipotriene, tazarotene, anthralin (all require prior authorization); (3) PUVA or UVB phototherapy; (4) methotrexate; and (5) at least one other second line systemic agent such as cyclosporine? (Adequate trial is defined as compliant with therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review [deny 7a])

V. RENEWAL CRITERIA:

1. Has the prescriber submitted documentation of at least a 50% reduction in plaques and/or is there evidence of functional improvement?
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 5a (renewal)])

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 12/20/2023
- **Last Updated Date:** 3/31/2021

Tolterodine

Policy Number: Rx039

I. MEDICATION NAME(S):

- tolterodine tartrate tablets
- tolterodine tartrate ER capsules

II. LENGTH OF AUTHORIZATION:

- Length of benefit (LOB)

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug prescribed for overactive bladder that is a condition funded by the Oregon Health Plan (OHP) in a manner consistent with the Health Evidence Review Commission (HERC) Prioritized List of Health Services?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review)
2. Has the member had an adequate trial and failure of, contraindication to, or intolerance to oxybutynin IR, oxybutynin ER, solifenacin succinate, or trospium IR? (Adequate trial is defined as compliant with therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (approve for LOB)
    b. No (forward to pharmacist for review [deny 7a, oxybutynin IR/ER or trospium IR])

V. RENEWAL CRITERIA:

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 12/20/2023
- **Last Updated Date:** 12/20/2023

Biologics for Inflammatory Disease

Policy Number: Rx040

I. MEDICATION NAME(S):

- Humira (adalimumab)
- Amjevita (adalimumab-atto)
- Simlandi (adalimumab-ryvk)
- Cimzia (certolizumab pegol)
- Enbrel (etanercept)
- Simponi (golimumab)
- Simponi Aria (golimumab)
- Remicade (infliximab)
- Renflexis (infliximab-abda)
- Inflectra (infliximab-dyyb)
- Avsola (infliximab-axxq)
- Siliq (brodalumab)
- Cimzia (certolizumab pegol)
- Tremfya (guselkumab)
- Taltz (ixekizumab)
- Skyrizi (risankizumab-rzaa)
- Cosentyx (secukinumab)
- Ilumya (tildrakizumab-asmn)
- Stelara (ustekinumab)
- Starjemza (ustekinumab-hmny)
- Entyvio (vedolizumab)
- Rinvoq (upadacitinib)
- Xeljanz (tofacitinib)

II. LENGTH OF AUTHORIZATION:

- Initial: six months
- Renewal: one year

III. QUANTITY LIMITS:

- N/A

IV. ALL DIAGNOSES - INITIAL CRITERIA

1. Is the drug age appropriate and used for an FDA-approved indication or a medically appropriate off-label use with strong evidence supporting safety and efficacy (see Table 1 – Drug Indications under the 'Additional Information' section)?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 8a])
2. Is the request for maintenance of remission in a patient who already achieved remission with the requested product or has already initiated therapy?
    a. Yes (go to 'Renewal Criteria')
    b. No (go to #3)

3. Is the medication prescribed by or in consultation with an appropriate health care provider with expertise in treating this condition (e.g. rheumatologist, gastroenterologist, dermatologist, or ophthalmologist)?
    a. Yes (go to #4)
    b. No (forward to pharmacist for review [deny 5a])
4. Has the risk of infection(s) been assessed, including: (a) Initial testing for latent TB and treatment (if necessary); (b) No current active infection; (c) Risks and benefits documented in cases of chronic or recurrent infection?
    a. Yes (go to #5)
    b. No (forward to pharmacist for review [deny 5a])
5. Is the requested drug to be used in combination with another biologic or systemic PDE-4 inhibitors (e.g. apremilast, roflumilast)?
    a. Yes (forward to pharmacist for review [deny 5a])
    b. No (proceed to specific criteria for the submitted indication)

V. ANKYLOSING SPONDYLITIS AND AXIAL SPONDYLOARTHRITIS - INITIAL CRITERIA

1. Does the member have a definitive diagnosis ankylosing spondylitis or axial spondyloarthritis (radiographic or non-radiographic)? Diagnosis is definitive if the following are met: (a) Back pain and stiffness for more than 3 months; AND (b) Signs of active inflammation on MRI, OR radiological evidence of sacroiliitis OR HLA-B27 positive.
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 5a])
2. Does the member have moderate to severe active disease at baseline, evidenced by a Bath AS Disease Activity Index (BASDAI) score of $\geq$ 4 or ASDAS score of $\geq$ 2.1?
    a. Yes (go to #3)
    b. No (forward to pharmacist for review [deny 5a])
3. Is the member transitioning to the requested drug from a different biologic product?
    a. Yes (go to #7)
    b. No (go to #5)
4. Has the member tried and failed conventional therapy with both of the following: (a) At least two NSAIDs for a minimum of 4 weeks each at maximum recommended or tolerated anti-inflammatory dose (unless contraindicated); AND (b) Physical therapy/exercise program?
    a. Yes (go to #5)
    b. No (forward to pharmacist for review)
5. Does the member have predominant peripheral manifestations, such as symptoms of arthritis, enthesitis, and/or dactylitis?
    a. Yes (go to #6)
    b. No (go to #7)
6. Has the member had an adequate trial and failure of, contraindication to, or intolerance to sulfasalazine (preferred) or other csDMARD?
    a. Yes (go to #8)
    b. No (forward to pharmacist for review)
7. Does the member have predominant axial manifestations, such as symptoms affecting the sacroiliac joints and/or spine?
    a. Yes (go to #8)

b. No (forward to pharmacist for review)

8. Has the member had an adequate trial and failure of, contraindication to, or intolerance to ALL of the following (order should be based on lowest cost): (a) the least costly infliximab biosimilar (e.g. Remicade, Inflectra or Renflexis); (b) the least costly adalimumab biosimilar (e.g. Humira, Amjevita, or Simlandi) or Enbrel (etanercept)? (Note: Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80%, or no gaps between fills that exceed 5 days.)
    a. Yes (go to #8)
    b. No (forward to pharmacist for review [deny 7a])
9. Has the member tried and failed other less costly biologics, if indicated (see Rx040 Indication, Dosing, and Pricing.xslx)?
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review [deny 7a])

VI. ANKYLOSING SPONDYLITIS AND AXIAL SPONDYLOARTHRITIS - RENEWAL CRITERIA

1. Does the member have significant improvement in signs and symptoms of AS/axSpA and/or functioning, such as 50% decrease or 2-point improvement in BASDAI score, or a decrease of > 1.1 in ASDAS score?
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 5a]

VII. ATOPIC DERMATITIS - INITIAL CRITERIA

1. Is the member transitioning to the requested treatment from a different biologic product?
    a. Yes (go to #6)
    b. No (go to #2)
2. Does the member have chronic, moderate to severe plaque psoriasis defined as having functional impairment as indicated by Dermatology Life Quality Index (DLQI) ≥ 11 AND one or more of the following: (a) At least 10% body surface area involved; OR (b) Hand, foot, face, or mucous membrane involvement?
    a. Yes (go to #5)
    b. No (go to #3)
3. Is the member eligible for EPSDT review (under age 21) and there is supporting documentation that the condition impacts the member's growth, learning, and/or development?
    a. Yes (go to #4)
    b. No (forward to pharmacist/medical director for review [deny 5a or 4aEPSDT depending on age])
4. Has the member had an adequate trial and failure of or intolerance to combination therapy with age-appropriate steroid and nonsteroid topical medication(s)?
    a. Yes (go to #6)
    b. No (forward to pharmacist for review [deny 5a/7a]
5. Has the member had an adequate trial and failure of at least TWO of the following: (a) combination of high-potency corticosteroid and topical calcineurin inhibitor (e.g. tacrolimus, pimecrolimus) for a minimum of 4 weeks; (b) Eucrisa (crisaborole); (c) an oral csDMARD (e.g. methotrexate, cyclosporine, azathioprine, or mycophenolate) for a minimum of 8 weeks; OR (d) phototherapy?
    a. Yes (go to #6)
    b. No (forward to pharmacist for review [deny 5a/7a])
6. Has the member the member had an adequate trial and failure, intolerance or contraindication to dupilumab?
    a. Yes (got to #7)

b. No (forward to pharmacist for review [deny 7a])

7. Has the member had an adequate trial and failure of other less costly biologics, if indicated (see Rx040 Indication, Dosing, and Pricing.xslx)?
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review [deny 7a])

VIII. RENEWAL CRITERIA: ATOPIC DERMATITIS

1. Has the member experienced a clinically significant response such as ≥ 50% reduction in symptoms and/or is there evidence of significant functional improvement?
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 5a])

IX. CROHN'S DISEASE - INITIAL CRITERIA

1. Does the member have a diagnosis of severe fistulizing Crohn's disease?
    a. Yes (go to #8)
    b. No (go to #2)
2. Does the member have moderate to severe Crohn's disease?
    a. Yes (go to #3)
    b. No (forward to pharmacist for review [deny 5a])
3. Is the member transitioning to the requested treatment from a different biologic product?
    a. Yes (go to #8)
    b. No (go to #4)
4. Is the request for induction of remission?
    a. Yes (go to #5)
    b. No (go to #6)
5. Has the member failed to achieve remission with a systemic corticosteroid?
    a. Yes (go to #8)
    b. No (forward to pharmacist for review [deny 7a])
6. Is the member currently stable on steroids and considered steroid-dependent?
    a. Yes (go to #7)
    b. No (forward to pharmacist for review [deny 5a])
7. Has the member had an adequate trial and failure of, contraindication to, or intolerance to azathioprine, 6-mercaptopurine, or methotrexate for maintenance? (Note: Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80%, or no gaps between fills that exceed 5 days.)
    a. Yes (go to #8)
    b. No (forward to pharmacist for review [deny 7a])
8. Has the member had an adequate trial and failure of, contraindication to, or intolerance to ALL of the following (order should be based on lowest cost): (a) the least costly infliximab biosimilar (e.g. Remicade, Inflectra or Renflexis); (b) the least costly adalimumab biosimilar (e.g. Humira, Amjevita, or Simlandi); and (c) the least costly ustekinumab biosimilar (e.g. Starjemza)? (Note: Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80%, or no gaps between fills that exceed 5 days.)
    a. Yes (go to #9)

b. No (forward to pharmacist for review [deny 7a])

9. Has the member tried and failed other less costly biologics, if indicated (see Rx040 Indication, Dosing, and Pricing.xslx)?
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review [deny 7a])

X. CROHN'S DISEASE - RENEWAL CRITERIA:

1. Has the member experienced a decrease in symptoms, reduction in enterocutaneous fistulas, or clinical remission?
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 5a])

XI. INITIAL CRITERIA: GIANT CELL ARTERITIS

1. Does the member have a diagnosis of giant cell arteritis diagnosed by temporal artery biopsy or imaging?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 5a])
2. Has the member tried high dose steroids (starting with prednisone 60mg per day) to induce remission?
    a. Yes (go to #3)
    b. No (forward to pharmacist for review [deny 5a/7a])
3. Is the member currently on steroids and has failed to respond or failed to maintain remission during a taper according to schedule?
    a. Yes (go to #4)
    b. No (forward to pharmacist for review [deny 5a])
4. Will the requested product be initiated in conjunction with a steroid taper?
    a. Yes (go to #5)
    b. No (forward to pharmacist for review [deny 5a])
5. Has the member failed, or has a contraindication to, tocilizumab?
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review [deny 7a])

XII. RENEWAL CRITERIA: GIANT CELL ARTERITIS

1. Is there medical record documentation of laboratory monitoring of neutrophils, platelets, liver function tests, and lipids?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 5a])
2. Has the member achieved clinical response, including normalization of erythrocyte sedimentation rate and c-reactive protein, successful steroid taper, or sustained absence of signs and symptoms?
    a. Yes (approve for one year)

XIII. HIDRADENITIS SUPPURATIVA - INITIAL CRITERIA

1. Does the member have a diagnosis of moderate to severe hidradenitis suppurativa (Hurley II/Hurley III stage), characterized by recurrent, painful, and suppurating lesions recurring at least twice in 6 months?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 5a])
2. Is the member transitioning to the requested treatment from a different biologic product?
    a. Yes (go to #5)
    b. No (go to #3)
3. Has the member tried and failed a three-month treatment course of ALL the following: (a) Oral antibiotics, such as dapsone, doxycycline, or clindamycin (or another tetracycline) with rifampin; (b) Intralesional corticosteroid injections; (c) Antiandrogen therapy (e.g. oral contraceptives, finasteride, or spironolactone) OR metformin; AND (d) acitretin if not of child-bearing potential?
    a. Yes (go to #4)
    b. No (forward to pharmacist for review [deny 5a/ 7a])
4. Has the member had an adequate trial and failure of, contraindication to, or intolerance to ALL of the following (order should be based on lowest cost): (a) the least costly infliximab biosimilar (e.g. Remicade, Inflectra or Renflexis), AND then (b) the least costly adalimumab biosimilar (e.g. Humira, Amjevita, or Simlandi)? (Note: Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80%, or no gaps between fills that exceed 5 days.)
    a. Yes (go to #5)
    b. No (forward to pharmacist for review [deny 7a])
5. Has the member tried and failed other less costly biologics, if indicated (see Rx040 Indication, Dosing, and Pricing.xslx)?
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review [deny 7a])

XIV. HIDRADENITIS SUPPURATIVA - RENEWAL CRITERIA:

1. Has there been a significant treatment response as defined as ALL the following: (a) A reduction of 25% or more in the total abscess and inflammatory nodule count; AND (b) No increase in abscesses and draining fistulas?
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 5a])

XV. JUVENILE IDIOPATHIC ARTHRITIS - INITIAL CRITERIA

1. Is the member transitioning to the requested treatment from a different biologic product?
    a. Yes (go to #6)
    b. No (go to #2)
2. Does the member have juvenile idiopathic arthritis with active systemic features of juvenile idiopathic arthritis, with a physician global assessment of 5 or higher (or any systemic activity in the absence of active joint involvement)?
    a. Yes (go to #4)
    b. No (go to #3)
3. Does the member have juvenile idiopathic arthritis without active systemic features of juvenile idiopathic arthritis?

a. Yes (go to #5)
b. No (forward to pharmacist for review [deny 5a])

4. Has the member tried and failed either: (a) Intra-articular glucocorticoid injections (if fewer than 4 joints affected); OR (b) NSAIDS for at least one month?
    a. Yes (go to #6)
    b. No (forward to pharmacist for review [deny 7a])
5. Has the member had an adequate trial and failure of, contraindication to, or intolerance to systemic corticosteroids? (Note: Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80%, or no gaps between fills that exceed 5 days.)
    a. Yes (go to #5)
    b. No (forward to pharmacist for review [deny 7a])
6. Has the member had an adequate trial and failure of methotrexate or leflunomide, or a contraindication to both? (Note: Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80%, or no gaps between fills that exceed 5 days.)
    a. Yes (go to #6)
    b. No (forward to pharmacist for review [deny 7a])
7. Has the member had an adequate trial and failure of, contraindication to, or intolerance to the least costly adalimumab biosimilar (e.g. Humira, Amjevita, or Simlandi)? (Note: Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80%, or no gaps between fills that exceed 5 days.)
    a. Yes (go to #7)
    b. No (forward to pharmacist for review [deny 7a])
7. Has the member had an adequate trial and failure of, contraindication to, or intolerance to Actemra/Tyenne?
    a. Yes (go to #8)
    b. No (forward to pharmacist for review [deny 7a])
8. Has the member had an adequate trial and failure of, contraindication to, or intolerance to Cosentyx?
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review [deny 7a])

XVI. JUVENILE IDIOPATHIC ARTHRITIS - RENEWAL CRITERIA

1. Has the member experienced 20% or greater improvement in tender joint count and swollen joint count or has there been an improvement in functional ability?
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 5a])

XVII. PLAQUE PSORIASIS - INITIAL CRITERIA

1. Does the member have chronic, moderate to severe plaque psoriasis defined as having functional impairment as indicated by Dermatology Life Quality Index (DLQI) ≥ 11 AND one or more of the following: (a) At least 10% body surface area involved; OR (b) Hand, foot, face, or mucous membrane involvement?
    a. Yes (go to #3)
    b. No (go to #2)
2. Is the member eligible for EPSDT review (under age 21) and there is supporting documentation that the condition impacts the member's growth, learning, and/or development?

    a. Yes (go to #3)
    b. No (forward to pharmacist for review [deny 5a or 4a EPSDT depending on age])
3. Is the member transitioning to the requested treatment from a different biologic product?
    a. Yes (go to #5)
    b. No (go to #4)
4. Has the member tried and failed or have contraindications to ALL of the following: (a) a high-potency topical corticosteroid such as betamethasone dipropionate 0.05%, clobetasol propionate 0.05%, fluocinonide 0.05%, triamcinolone 0.5%) ; (b) at least one non-steroidal topical agent such as calcipotriene, tazarotene, anthralin, or tar; (c) PUVA or UVB Phototherapy; AND (d) at least one other systemic therapy: acitretin, cyclosporine, or methotrexate for at least 12 weeks.
    a. Yes (go to #5)
    b. No (forward to pharmacist for review [deny 5a, and 7a])
5. Has the member had an adequate trial and failure of, contraindication to, or intolerance to ALL of the following (order should be based on lowest cost): (a) the least costly infliximab biosimilar (e.g. Remicade, Inflectra or Renflexis); (b) the least costly adalimumab biosimilar (e.g. Humira, Amjevita, or Simlandi) or Enbrel (etanercept); and (c) the least costly ustekinumab biosimilar (e.g. Starjemza)? (Note: Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80%, or no gaps between fills that exceed 5 days.)
    a. Yes (go to #6)
    b. No (forward to pharmacist for review [deny 7a])
6. Has the member tried and failed other less costly biologics, if indicated (see Rx040 Indication, Dosing, and Pricing.xslx)?
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review [deny 7a])

XVIII. PLAQUE PSORIASIS - RENEWAL CRITERIA

1. Has the member experienced a clinically significant response such as $\geq$ 50% reduction in PASI or 4 point reduction in DLQI, or is there evidence of functional improvement?
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 5a])

XIX. PSORIATIC ARTHRITIS - INITIAL CRITERIA

1. Does the member have psoriatic arthritis based on the presence of at least 3 out of 5 of the following: (a) Psoriasis (1 point for personal or family history, 2 points for current); (b) Psoriatic nail dystrophy; (c) Negative test result for rheumatoid factor; (d) Dactylitis (current or history); or (e) Radiological evidence of juxta-articular new bone formation?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 5a])
2. Is the member transitioning to the requested treatment from a different biologic product?
    a. Yes (go to #4)
    b. No (go to #3)
3. Has the member had an adequate trial and failure of, contraindication to, or intolerance to conventional therapy with ALL the following: (a) NSAIDs; AND (b) Methotrexate or other DMARD such as leflunomide,

sulfasalazine, or cyclosporine? (Note: Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80%, or no gaps between fills that exceed 5 days.)
    a. Yes (go to #4)
    b. No (forward to pharmacist for review [deny 7a])
4. Has the member had an adequate trial and failure of, contraindication to, or intolerance to ALL of the following (order should be based on lowest cost): (a) the least costly infliximab biosimilar (e.g. Remicade, Inflectra or Renflexis); (b) the least costly adalimumab biosimilar (e.g. Humira, Amjevita, or Simlandi) or Enbrel (etanercept); and (c) the least costly ustekinumab biosimilar (e.g. Starjemza)? (Note: Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80%, or no gaps between fills that exceed 5 days.)
    a. Yes (go to #5)
    b. No (forward to pharmacist for review [deny 7a])
5. Has the member tried and failed other less costly biologics, if indicated (see Rx040 Indication, Dosing, and Pricing.xslx)?
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review [deny 7a])

XX. RENEWAL CRITERIA: PSORIATIC ARTHRITIS

1. Has the member experienced 20% or greater improvement in tender joint count and swollen joint count or has there been an improvement in functional ability?
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 5a])

XXI. RHEUMATOID ARTHRITIS - INITIAL CRITERIA

1. Does the member have a baseline of moderate to high disease activity of rheumatoid arthritis measured as such by an accepted assessment instrument (e.g. PAS, PASII, RAPID3, CDAI >10, DAS28 >3.2, SDAI >11)?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 5a])
2. Is the member transitioning to the requested treatment from a different biologic product?
    a. Yes (go to #7)
    b. No (go to #3)
3. Has the member had either: (A) an adequate trial and failure of methotrexate dosed at least 20 mg per week; OR (B) a contraindication to MTX AND an adequate trial and failure of another csDMARD (e.g. leflunomide, hydroxychloroquine, or sulfasalazine)? (Note: Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80%, or no gaps between fills that exceed 5 days.)
    a. Yes (go to #4)
    b. No (forward to pharmacist for review [deny 5a/7a])
4. Does the patient have 3 or more poor prognostic factors? Poor prognostic factors include: autoantibody positivity, high disease activity, early bone erosions, failure of ≥2 csDMARDs, functional limitation, extraarticular disease (e.g. rheumatoid nodules, vasculitis, lung involvement), obesity, current smoker, and multiple comorbidities.
    a. Yes (go to #6)
    b. No (go to #5)

5. Has the member had an adequate trial and failure, intolerance, or contraindication to at least two csDMARDS (e.g. methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine? (Note: Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80%, or no gaps between fills that exceed 5 days.)
    a. Yes (go to #6)
    b. No (forward to pharmacist for review [deny 5a/7a])

6. Is the requested product being prescribed along with at least one of the following csDMARDs (unless contraindicated): methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine?
    a. Yes (go to #7)
    b. No (forward to pharmacist for review [deny 5a])
7. Has the member had an adequate trial and failure of, contraindication to, or intolerance to ALL of the following (order should be based on lowest cost): (a) the least costly infliximab biosimilar (e.g. Remicade, Inflectra or Renflexis), AND then (b) the least costly adalimumab biosimilar (e.g. Humira, Amjevita, or Simlandi) or Enbrel (etanercept)? (Note: Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80%, or no gaps between fills that exceed 5 days.)
    a. Yes (go to #8)
    b. No (forward to pharmacist for review [deny 7a])
8. Has the member tried and failed other less costly biologics, if indicated (see Rx040 Indication, Dosing, and Pricing.xslx)?
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review [deny 7a])

XXII. RENEWAL CRITERIA: RHEUMATOID ARTHRITIS

1. Has the member experienced a 20% or greater improvement in tender joint count and swollen joint count or has there been an improvement in functional ability?
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 5a])

XXIII. ULCERATIVE COLITIS - INITIAL CRITERIA

1. Does the member have a diagnosis of moderate to severe ulcerative colitis defined by the following criteria: (a) for moderate, greater than or equal to four stools daily; OR (b) for severe, greater than or equal to six bloody stools daily and evidence of toxicity such as fever, anemia, elevated ESR, or tachycardia?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 5a])
2. Is the member transitioning to the requested treatment from a different biologic product?
    a. Yes (go to #7)
    b. No (go to #3)
3. Is the request for induction of remission?
    a. Yes (go to #4)
    b. No (go to #5)
4. Has the member failed to achieve remission with a systemic corticosteroid?
    a. Yes (go to #7)

b. No (forward to pharmacist for review [deny 5a, 7a])

5. Is the member currently stable on steroids and considered steroid-dependent?
    a. Yes (go to #6)
    b. No (forward to pharmacist for review [deny 5a])
6. Has the member had an adequate trial and failure of, contraindication to, or intolerance to azathioprine, 6-mercaptopurine, or a 5-ASA for maintenance? (Note: Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80%, or no gaps between fills that exceed 5 days.)
    a. Yes (go to #7)
    b. No (forward to pharmacist for review [deny 7a])
7. Has the member had an adequate trial and failure of, contraindication to, or intolerance to ALL of the following (order should be based on lowest cost): (a) the least costly infliximab biosimilar (e.g. Remicade, Inflectra or Renflexis); (b) the least costly adalimumab biosimilar (e.g. Humira, Amjevita, or Simlandi); and (c) the least costly ustekinumab biosimilar (e.g. Starjemza)? (Note: Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80%, or no gaps between fills that exceed 5 days.)
    a. Yes (go to #8)
    b. No (forward to pharmacist for review [deny 7a])
8. Has the member tried and failed other less costly biologics, if indicated (see Rx040 Indication, Dosing, and Pricing.xslx)?
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review [deny 7a])

XXIV. RENEWAL CRITERIA: ULCERATIVE COLITIS

1. Has the member demonstrated a significant response including the following: (a) Decrease in bloody stools per day; OR (b) Elimination of signs of toxicity?
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 5a])

XXV. NON-INFECTIOUS UVEITIS - INITIAL CRITERIA

1. Does the member have a diagnosis of non-infectious, intermediate, posterior or panuveitis?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 5a])
2. Is the member transitioning to the requested treatment from a different biologic product?
    a. Yes (go to #4)
    b. No (go to #3)
3. Has the member had an adequate trial and failure of, contraindication to, or intolerance to ALL of the following: (a) Topical glucocorticoids for at least one month, or periocular steroid injections; (b) Oral corticosteroids; AND (c) one immunomodulatory – methotrexate, mycophenolate, tacrolimus, cyclosporine, or azathioprine for a minimum of 3 months?
    a. Yes (go to #4)
    b. No (forward to pharmacist for review [deny 7a])
4. Has the member had an adequate trial and failure of, contraindication to, or intolerance to the least costly adalimumab biosimilar (e.g. Humira, Amjevita, or Simlandi)? (Note: Adequate trial is defined as adherent to

therapy for at least three consecutive months, MPR greater than or equal to 80%, or no gaps between fills that exceed 5 days.)
    a. Yes (go to #5)
    b. No (forward to pharmacist for review [deny 7a])
5. Has the member had an adequate trial and failure of, contraindication to, or intolerance to the least costly infliximab biosimilar (e.g. Remicade, Inflectra or Renflexis)?
    a. Yes (go to #6)
    b. No (forward to pharmacist for review [deny 7a])
6. Has the member tried and failed other less costly biologics, if indicated (see Rx040 Indication, Dosing, and Pricing.xslx)?
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review [deny 7a])

XXVI. RENEWAL CRITERIA: NON-INFECTIOUS UVEITIS

1. Is there documentation that disease activity has been controlled, such as a lack of inflammation, no new inflammatory vascular lesions, no vitreous haze or decreases in visual acuity?
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 5a])

XXVII. ADDITIONAL INFORMATION

- Table 1 – Drug Indications

Drug	AS	axSpA	CD	HS	JIA	Ps	PsA	RA	UC	Uveitis
Humira (adalimumab)	x	x*	x	x	x	x	x	x	x	x
Siliq (brodalumab)						x				
Cimzia (certolizumab pegol)	x	x	x			x	x	x		
Enbrel (etanercept)	x				x	x	x	x		
Simponi, Simponi Aria (golimumab)	x	x*			x		x	x	x	
Tremfya (guselkumab)						x	x			
Remicade, Renflexis, Inflectra (infliximab)	x		x	x*		x	x	x	x	
Taltz (ixekizumab)	x	x				x	x			
Skyrizi (risankizumab)			x			x	x			
Cosentyx (secukinumab)	x	x				x	x			
Ilumya (tildrakizumab)						x				
Stelara (ustekinumab)			x			x	x		x	
Entyvio (vedolizumab)			x						x	

**Off-label*

Abbrebreviations:

AS = Ankylosing Spondylitis
axSpA = Axial Spondyloarthritis
CD = Crohn's Disease
HS = Hidradenitis Suppurativa
JIA = Juvenile Idiopathic Arthritis
Ps = Plaque Psoriasis
PsA = Psoriatic Arthritis

RA = Rheumatoid Arthritis
UC = Ulcerative Colitis

XXVIII. REVISION HISTORY:

- **Last Reviewed Date:** 03/27/26
- **Last Updated Date:** 03/27/26

Long-Acting Muscarinic Antagonist/Long-acting Beta-agonist/ Inhaled Corticosteroid (LAMA/LABA/ICS) Combinations

Policy Number: Rx041

I. MEDICATION NAME(S):

- Trelegy Ellipta (fluticasone/umeclidinium/vilanterol)
- Breztri Aerosphere (budesonide/glycopyrrolate/formoterol)

II. LENGTH OF AUTHORIZATION:

- Initial and renewal: one year

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug used for a diagnosis of asthma or COPD and prescribed at an FDA approved dose and indication?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review)
2. Has the member had an adequate trial and failure of either a combined LAMA/LABA (Bevespi Aerosphere, Utibron Neohaler, Stiolto Respimat, or Anoro Ellipta) OR a combined LABA/ICS (fluticasone/salmeterol, Dulera or Symbicort) inhaler? (Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days AND documentation of persistent symptoms or exacerbations.)
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review

V. RENEWAL CRITERIA:

1. Is the member adherent to therapy? (Adherence defined as a MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (go to #2)
    b. No (forward to pharmacist for review)

2. Has documentation been submitted stating this medication has been effective for reducing COPD or asthma symptoms or exacerbations?
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review)

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 3/15/2023
- **Last Updated Date:** 3/15/2023

Erythropoiesis-Stimulating Agents (ESA)

Policy Number: Rx042

I. MEDICATION NAME(S):

- Aranesp (darbepoetin alfa)
- Epogen (epoetin alfa)
- Procrit (epoetin alfa)
- Retacrit (epoetin alfa-epbx)

II. LENGTH OF AUTHORIZATION:

- Initial: three months
- Renewal: six months

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug being used for a diagnosis of chronic renal failure (CRF) OR anemia due to myelosuppressive chemotherapy?
    a. Yes (go to #2)
    b. No (go to #3)
2. Does the member meet all of the following criteria: (1) hemoglobin (HGB) less than 10 g/dL or hematocrit (HCT) less than 30%; (2) transferrin saturation greater than 20%; AND (3) ferritin greater than 100 ng/mL?
    a. Yes (go to #7)
    b. No (forward to pharmacist for review [deny 5a])
3. Is the drug being used for a diagnosis of anemia associated with HIV/AIDS zidovudine therapy?
    a. Yes (go to #4)
    b. No (go to #5)
4. Does the member meet all of the following criteria: (1) HGB less than 10 g/dL or HCT less than 30%; (2) transferrin saturation greater than 20%; (3) ferritin greater than 100 ng/mL; (4) endogenous erythropoietin levels of 500IU/L or less; AND (5) zidovudine dose of 4200 mg per week or less?
    a. Yes (go to #7)
    b. No (forward to pharmacist for review [deny 5a])
5. Is the drug being used for pre-operative treatment to raise hemoglobin and hematocrit prior to scheduled surgical procedures AND the member has religious beliefs that preclude blood product transfusions?
    a. Yes (go to #6)

b. No (forward to pharmacist for review [deny 8a])

6. Is the member currently anemic with a hemoglobin less than 13 g/dL for men or less than 12 g/dL for women?
    a. Yes (go to #7)
    b. No (forward to pharmacist for review [deny 5a])
7. Is the medication prescribed by or in consultation with an appropriate health care provider with expertise in treating this condition (e.g., hematologist/oncologist, nephrologist, surgeon etc.)?
    a. Yes (go to #8)
    b. No (forward to pharmacist for review [deny 5a])
8. Is the request for the least costly product (refer to DMAP fee schedule if professionally administered)?
    a. Yes (approve for three months)
    b. No (go to #9)
9. Has the member had an adequate trial and failure of, contraindication to, or intolerance to the less costly alternative agent(s)? (Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (approve for three months)
    b. No (forward to pharmacist for review [deny 7a])

V. RENEWAL CRITERIA:

1. Has the member maintained adequate iron stores (transferrin saturation greater than 20%)?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 5a])
2. Has the member continued to see a response to treatment demonstrated by an increase from baseline HGB/HCT or at HGB/HCT target?
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review [deny 5a])

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 12/20/2023
- **Last Updated Date:** 6/23/2021

Colony-Stimulating Factors

Policy Number: Rx043

I. MEDICATION NAME(S):

- Neupogen (filgrastim)
- Nivestym (filgrastim-aafi) *preferred*
- Zarxio (filgrastim-sndz) *preferred*
- Granix (tbo-filgrastim) *preferred*
- Neulasta (pegfilgrastim)
- Udenyca (pegfilgrastim-cbqv)
- Fulphila (pegfilgrastim-jmdb)
- Leukine (sargramostim)

II. LENGTH OF AUTHORIZATION:

- Initial and renewal: four months

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the request for pegfilgrastim?
    a. Yes (go to #2)
    b. No (go to #3)

2. Has the provider submitted medically appropriate rationale explaining why filgrastim cannot be used (i.e., dexterity issues)?
    a. Yes (go to #13)
    b. No (forward to pharmacist for review [deny 7a])
3. Is the request for Neupogen?
    a. Yes (go to #4)
    b. No (go to #5)
4. Has the provider submitted medically appropriate rationale explaining why a filgrastim biosimilar cannot be used (Nivestym, Zarxio, or Granix)?
    a. Yes (go to #5)
    b. No (forward to pharmacist for review [deny 7a])
5. Is the drug being used to treat chemotherapy-induced neutropenia?
    a. Yes (go to #6)
    b. No (go to #8)
6. Has the member been on prophylactic therapy with a colony-stimulating factor?
    a. Yes (approve for four months)
    b. No (go to #7)
7. Does the member have one or more of the following risk factors for developing infection-related complications: Sepsis Syndrome; age over 65 or older; absolute

neutrophil count [ANC] <100/mcL; duration of neutropenia expected to be greater than 10 days; pneumonia or other clinically documented infections; invasive fungal infection; hospitalization at the time of fever; prior episode of febrile neutropenia?
    a. Yes (approve for four months)
    b. No (forward to pharmacist for review [deny 5a])
8. Is the drug being used for Myelodysplastic Syndromes (MDS)?
    a. Yes (go to #9)
    b. No (go to #13)
9. Does the member have an endogenous serum erythropoietin level of 500 mU/mL or less?
    a. Yes (go to #10)
    b. No (forward to pharmacist for review [deny 5a])
10. Does the member have lower risk disease (i.e., defined as IPSS-R [Very Low, Low, Intermediate], IPSS [Low/Intermediate-1], WPSS [Very Low, Low, Intermediate])?
    a. Yes (go to #11)
    b. No (forward to pharmacist for review [deny 5a])
11. Is the drug being used for treatment of symptomatic anemia in members without del(5q)?
    a. Yes (go to #12)
    b. No (forward to pharmacist for review [deny 5a])
12. Is the member receiving concurrent therapy with an Erythropoiesis Stimulating Agent (ESA) and have one of the following: (1) Ring sideroblasts less than 15% and will use in combination with lenalidomide following no response (despite adequate iron stores) or loss of response to an ESA alone; OR (2) Ring sideroblasts greater than or equal to 15%?
    a. Yes (approve for four months)
    b. No (forward to pharmacist for review [deny 5a])
13. Is the drug being used prophylactically in a member with a non-myeloid malignancy?
    a. Yes (go to #14)
    b. No (go to #16)
14. Is the member undergoing myelosuppressive chemotherapy with an expected incidence of febrile neutropenia of 20% or greater? (See NCCN Guidelines for Management of Neutropenia https://www.nccn.org/professionals/physician_gls/pdf/growthfactors.pdf.)
    a. Yes (approve for four months)
    b. No (go to #15)
15. Is the member undergoing myelosuppressive chemotherapy with an expected incidence of febrile neutropenia of 10% or greater AND has one or more of the following comorbidities: age 65 or older receiving full dose intensity chemotherapy; history of recurrent febrile neutropenia from chemotherapy; extensive prior exposure to chemotherapy; previous exposure of pelvis, or other areas of large amounts of bone marrow, to radiation; pre-existing neutropenia (ANC ≤ 1000/mm3) or bone marrow involvement with tumor; patient has a condition that can potentially increase the risk of serious infection (i.e. HIV/AIDS); infection/open wounds; recent surgery; poor performance status; poor renal function (creatinine clearance <50); liver dysfunction (elevated bilirubin >2.0); chronic immunosuppression in the post-transplant setting including organ transplant? (See NCCN Guidelines for Management of Neutropenia https://www.nccn.org/professionals/physician_gls/pdf/growthfactors.pdf.)

a. Yes (approve for four months)
b. No (forward to pharmacist for review [deny 5a])

16. Is the drug being used for a member who experienced a neutropenic complication from a prior cycle of the same chemotherapy?
    a. Yes (approve for four months)
    b. No (go to #17)
17. Is the drug being used for Bone Marrow Transplantation (BMT) failure or Engraftment Delay?
    a. Yes (approve for four months)
    b. No (go to #18)
18. Is the drug being used for Peripheral Blood Stem Cell (PBSC) mobilization and transplant?
    a. Yes (approve for four months)
    b. No (go to #19)
19. Is the drug being used for members acutely exposed to myelosuppressive doses of radiation (Hematopoietic Subsyndrome of Acute Radiation Syndrome)?
    a. Yes (approve for four months)
    b. No (forward to pharmacist for review [deny 8a])

V. RENEWAL CRITERIA:

See Initial Criteria

VI. ADDITIONAL INFORMATION:

- Febrile neutropenia is defined as:
    - A single temperature ≥38.3 °C orally or ≥38.0 °C over 1 hour; AND
    - Neutropenia <500 neutrophils/mcL or <1,000 neutrophils/mcL and a predicted decline to ≤500 neutrophils/mcL over the next 48 hours.

VII. REVISION HISTORY:

- **Last Reviewed Date:** 9/14/2022
- **Last Updated Date:** 12/11/2019

UMPQUA HEALTH

Prior Authorization Criteria
Quantity Exception Criteria

Nicotine Replacement Preparations

Policy Number: Rx044

I. MEDICATION NAME(S):

- nicotine gum (QL)
- Nicorelief gum (QL)
- Quit 2 gum (QL)
- Quit 4 gum (QL)
- nicotine lozenge (QL)
- Nicorette lozenge (QL)
- Quit 2 lozenge (QL)
- Quit 4 lozenge (QL)
- Stop Smoking Aid lozenge (QL)
- nicotine patch (QL)
- Nicotrol inhaler (PA, non-preferred)
- Nicotrol NS nasal spray (PA, non-preferred)

II. LENGTH OF AUTHORIZATION:

- Initial and renewal: up to 12 weeks

III. QUANTITY LIMITS:

- All products are limited to two quit attempts per year
- Patches: 30 patches per 30 days; 180 patches per year
- Gum and lozenges: 120 units per 5 days; 4,320 units per year

IV. INITIAL CRITERIA:

1. Is the request for a quantity exception for nicotine gum, lozenge or patches?
    a. Yes (go to #2)
    b. No (go to #5)
2. Has the member completed two quit attempts in the past year?
    a. Yes (forward to pharmacist for review [deny 5q])
    b. No (go to #3)
3. Has the provider submitted documentation that the member has stopped using tobacco?
    a. Yes (go to #4)
    b. No (forward to pharmacist for review [deny 5a])
4. Is the member enrolled in a tobacco cessation support program, such as Quit 4 Life?
    a. Yes (approve up to 12 weeks [QL: patches 30/30; gum and lozenges 120/5])
    b. No (approve up to 12 weeks [QL: patches 30/30; gum and lozenges 120/5] and refer to tobacco cessation support program))
5. Has the member had a documented medical reason why they cannot use ALL of the following: nicotine gum, nicotine lozenge, AND nicotine patch?
    a. Yes (approve for 12 weeks)

b. No (forward to pharmacist for review [deny 7a])

V. RENEWAL CRITERIA:

See Initial Criteria

VI. ADDITIONAL INFORMATION:

- For tobacco cessation support, UHA recommends using Quit 4 Life. Quit 4 Life has a team of trained experts to help members develop a quit plan and provides tools for tobacco cessation. Expert support and assistance is available from coaches who specialize in tobacco cessation. For additonal details or for enrollment, call 1-866-QUIT-4-LIFE (1-866-784-8454), or visit www.quitnow.net.

VII. REVISION HISTORY:

- **Last Reviewed Date:** 6/22/2022
- **Last Updated Date:** 6/22/2022

Testosterone

Policy Number: Rx045

I. MEDICATION NAME(S):

- testosterone cypionate vials
- testosterone 1% topical gel
- all other products, see Additional Information section

II. LENGTH OF AUTHORIZATION:

- Initial and renewal: one year

III. QUANTITY LIMITS:

- N/A

1. Is the request for injectable testosterone cypionate?
    a. Yes (go to #4)
    b. No (go to #2)
2. Is the request for topical 1% testosterone gel?
    a. Yes(go to #3)
    b. No (forward to pharmacist for review)
3. Is there chart note documentation of at least one of the following: 1. Trial and failure of injectable testosterone, 2. An accepted reason to avoid injections, or 3. Contraindication to injectable testosterone?
    a. Yes (go to #4)
    b. No (deny 7a)
4. Is the drug used for a diagnosis of gender dysphoria, female-to-male transsexualism?
    a. Yes (approve for LOB)
    b. No (go to #5)
5. Is the drug used for a diagnosis of primary or secondary hypogonadism?
    a. Yes (go to #6)
    b. No (forward to pharmacist for review)
6. Is the member a male age 18 years or older?
    a. Yes (go to #7)
    b. No (forward to pharmacist for review)
7. Does the member have a total testosterone level < 300ng/dL or a free testosterone level < 50ng/dL? For obese members with a BMI greater than 30, use free testosterone levels only. (For renewals or new members previously taking testosterone, proceed to renewal criteria.)

a. Yes (go to #8)
b. No (forward to pharmacist for review)

8. Does the member have any of the following: Breast cancer or known/suspected prostate cancer, elevated hematocrit (>50%), untreated severe obstructive sleep apnea, severe lower urinary tract symptoms, uncontrolled or poorly-controlled heart failure.
    a. Yes (deny 5a)
    b. No (approve for 1 year)

V. RENEWAL CRITERIA:

1. Has testosterone levels been drawn after the member-initiated therapy and/or after any dose changes?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review)
2. Has the member had any of the following contraindications occur: breast cancer or known/suspected prostate cancer, elevated hematocrit (>50%), untreated severe obstructive sleep apnea, severe lower urinary tract symptoms, or uncontrolled or poorly-controlled heart failure?
    a. Yes (forward to pharmacist for review)
    b. No (approve for one year)

VI. ADDITIONAL INFORMATION:

- Oral testosterone products are not on the UHA formulary.These products must meet this criteria as well as the General Utilization Management criteria. Specifically, trial and failure of formulary alternatives (testosterone cypionate vials or topical testosterone 1% gel) and all less-costly non-formulary alternatives.

VII. REVISION HISTORY:

- **Last Reviewed Date:** 1/8/2025
- **Last Updated Date:** 1/8/2025

Oral Antifungals

Policy Number: Rx046

I. MEDICATION NAME(S):

- itraconazole capsule
- ketoconazole tablet
- Lamisil (terbinafine HCl) gran pack

II. LENGTH OF AUTHORIZATION:

- Initial: up to six months
- Renewal: six months

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug used for an FDA-approved indication or a medically appropriate off-label use with strong evidence supporting safety and efficacy?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 8a])
2. Is the member under age 21?
    a. Yes (go to #3)
    b. No (go to #4)
3. Is there documentation that treating the condition is medically appropriate and necessary in which it will enhance the member's ability to grow, develop, or participate in school per the EPSDT Medicaid benefit?
    a. Yes (go to #6)
    b. No (forward to pharmacist for review [deny 5a])
4. Is the drug prescribed for a condition funded by the Oregon Health Plan (OHP) in a manner consistent with the Health Evidence Review Commission (HERC) Prioritized List of Health Services? (Fungal infections of the skin, scalp, groin and nails are not funded for most members. Some conditions are covered if the member is immunocompromised, like those with AIDS or cancer.)
    a. Yes (go to #6)
    b. No (go to #5)
5. Is there a comorbid condition for which coverage would be allowed? For example, type 2 diabetes or other conditions that may increase the risk of serious secondary skin infections.
    a. Yes (go to #6)

b. No (forward to pharmacist for review [deny 3a/3c])

6. Is the request for itraconazole?
    a. Yes (go to #7)
    b. No (approve for up to six months)
7. Has the member tried and failed terbinafine and ketoconazole, if indicated, and all less costly topical options when appropriate for the submitted condition?
    a. Yes (approve for up to six months)
    b. No (forward to pharmacist for review [deny 5k])

V. RENEWAL CRITERIA:

1. Is the requested drug being used outside of the FDA-approved treatment duration?
    a. Yes (deny 8a)
    b. No (go to #2)
2. Has documentation been submitted to support the continued use of this medication in accordance with clinical guidelines? (Refer to UpToDate or product labeling for appropriate treatment duration.)
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review [deny 5a])

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 12/7/2022
- **Last Updated Date:** 12/7/2022

Rifaximin

Policy Number: Rx047

I. MEDICATION NAME(S):

- Xifaxan (rifaximin)

II. LENGTH OF AUTHORIZATION:

- Length of benefit (LOB)

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the member under age 21?
    a. Yes (go to #2)
    b. No (go to #5)
2. Is there documentation that treating the condition is medically appropriate and necessary in which it will enhance the member's ability to grow, develop, or participate in school per the EPSDT Medicaid benefit?
    a. Yes (go to #3)
    b. No (forward to pharmacist for review [deny 5a])
3. Is the drug used for an FDA-approved indication or a medically appropriate off-label use with strong evidence supporting safety and efficacy?
    c. Yes (go to #4)
    d. No (forward to pharmacist for review [deny 8a])
4. Has the member tried and failed all less costly alternative therapies used to treat the member's condition according to UpToDate)?
    a. Yes (approve for LOB)
    b. No (forward to pharmacist for review [deny 7a and/or 5k])
5. Is the drug used for hepatic encephalopathy associated with chronic liver disease? Note: Irritable bowel syndrome (IBS) and travelers' diarrhea are not funded conditions according to the Oregon Health Plan Prioritized List of Health Services.
    a. Yes ((forward to pharmacist for review [deny 5x, non rebatable]))
    a. No (forward to pharmacist for review [deny 3a or 8a])

V. RENEWAL CRITERIA:

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 12/22/2025
- **Last Updated Date:** 12/22/2025

Palivizumab

Policy Number: Rx048

I. MEDICATION NAME(S):

- Synagis (palivizumab)

II. LENGTH OF AUTHORIZATION:

- Typically, approval is given from November 1st through March 31st of the following year for a maximum of five doses during each season. Authorizations may be allowed outside of this window depending on the start and end of Respiratory Syncytial Virus (RSV) season according to the OHA RSV surveillance data for Southern Oregon (report link: https://www.oregon.gov/oha/PH/DiseasesConditions/CommunicableDisease/DiseaseSurveillanceData/Pages/RespiratorySyncytialVirusSurveillanceData.aspx). As defined by the CDC:
    - RSV season onset is the first of two consecutive weeks during which the mean percentage of specimens testing positive for RSV antigen is ≥10% or the mean percentage of specimens testing positive for RSV by PCR is ≥3%, whichever occurs first.
    - RSV season offset is the last of two consecutive weeks during which the mean percentage of positive specimens by antigen is <10%, or the mean percentage of positive specimens by PCR is <3%, whichever occurs last.
- Qualifying infants born during RSV season may require fewer doses. If any infant or young child receiving monthly palivizumab prophylaxis experiences a breakthrough RSV hospitalization, monthly prophylaxis should be discontinued.

III. QUANTITY LIMITS:

- A maximum of five doses per season.
- A maximum of two seasons may be allowed for some members; until the member's age is 24 months or less at the start of RSV season.

IV. INITIAL CRITERIA:

1. See FFS Approval Criteria
   https://www.orpdl.org/durm/PA_Docs/palivizumab.pdf

V. RENEWAL CRITERIA:

VI. ADDITIONAL INFORMATION:

- UHA aligns with the OHA FFS PDL and prior authorization criteria for the duration of Governor Brown's emergency declaration for the 2022-2023 RSV season, whichever is longer
- Dose: 15 mg/kg via intramuscular injection once monthly throughout RSV season.
- The start date for Synagis® is November 1 each year (or sooner when the Oregon Public Health Division has determined that RSV season onset has occurred) for a total of up to 5 doses.
- Approval for more than 5 doses or additional doses after March 31 will be considered on a case-by-case basis.
- Results from clinical trials indicate that Synagis® trough concentrations greater than 30 days after the 5th dose are well above the protective concentration. Therefore, 5 doses will provide more than 20 weeks of protection.

VII. REVISION HISTORY:

- **Last Reviewed Date:** 12/7/2022
- **Last Updated Date:** 12/2/2022

Lacosamide

Policy Number: Rx049

I. MEDICATION NAME(S):

- lacosamide tablets

II. LENGTH OF AUTHORIZATION:

- Length of benefit (LOB)

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug used for partial-onset seizures?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 8a])
2. Is the member at least four years of age?
    a. Yes (go to #3)
    b. No (forward to pharmacist for review [deny 8a])
3. Has the member failed to achieve successful control of their seizures with at least two other antiepileptic drugs, such as carbamazepine, oxcarbazepine, phenytoin, topiramate, or valproic acid? (Note: members who are currently taking lacosamide should not be required to try and fail alternative agents.)
    a. Yes (approve for LOB)
    b. No (forward to pharmacist for review [deny 7a])

V. RENEWAL CRITERIA:

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 6/22/2022
- **Last Updated Date:** 12/11/2019

Prior Authorization Criteria
Formulary Exception Criteria

Mesalamine

Policy Number: Rx050

I. MEDICATION NAME(S):

- mesalamine DR 800 mg tab (generic Asacol HD)
- Apriso (mesalamine) 0.375 g cap ER 24h
- mesalamine DR 400 mg cap (generic Delzicol)
- mesalamine DR 1.2 g tab (generic Lialda)
- mesalamine 1000 mg rectal suppository
- *Pentasa (mesalamine) 250 mg cap ER (non-formulary)*
- *Pentasa (mesalamine) 500 mg cap ER (non-formulary)*

II. LENGTH OF AUTHORIZATION:

- Initial: length of benefit (LOB)

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug prescribed for Crohn's disease?
    a. Yes (go to #4)
    b. No (go to #2)
2. Is the drug prescribed for ulcerative colitis?
    a. Yes (go to #3)
    b. No (forward to pharmacist for review [deny 8a])
3. Is the disease described as active in the small bowel (proximal to the colon)?
    a. Yes (go to #5)
    b. No (go to #4)
4. Has the member had an adequate trial and failure of, contraindication to, or intolerance to one of the following: sulfasalazine or balsalazide? (Adequate trial is defined as compliant with therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (approve for LOB)
    b. No (forward to pharmacist for review [deny 7a])
5. Is the request for Pentasa?
    a. Yes (go to #6)

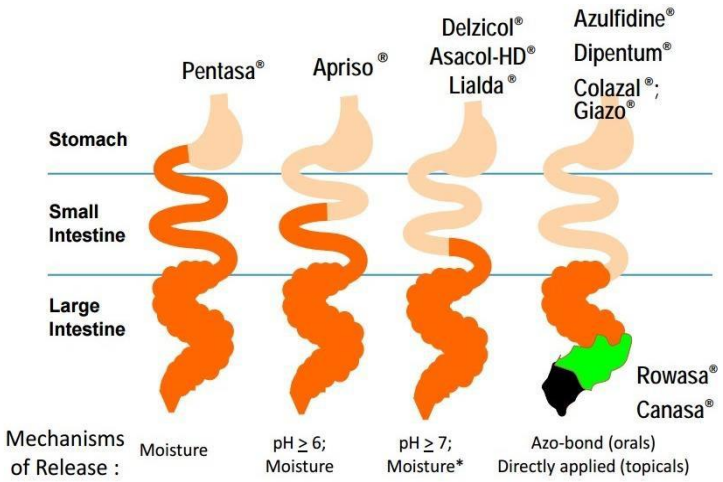
b. No (go to #7)

6. Does the member have full GI tract involvement that requires the Pentasa release mechanism?
    a. Yes (approve for LOB)
    b. No (go to #7)
7. Has the member had an adequate trial and failure of, contraindication to, or intolerance to at least one generic oral mesalamine product (generic Lialda, Asacol, Delzicol) or Apriso? (Adequate trial is defined as compliant with therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (approve for LOB)
    b. No (forward to pharmacist for review [deny 7a])

V. RENEWAL CRITERIA:

VI. ADDITIONAL INFORMATION:

- 5-ASA Release Sites:



- Medications:

Drug Name	Strength	Site of Delivery	Qt/DS	Price	Ulcerative Colitis		Crohn's Colitis		Crohn's Ileitis	
					Active	Maint	Active	Maint	Active	Maint
Pentasa (mesalamine CR) oral cap	500 mg	Jejunum, ileum, colon	240/30	$1,404	4	2-4	4*	2-4*	4*	2-4*
Pentasa (mesalamine CR) oral cap	250 mg	Jejunum, ileum, colon	480/30	$1,404	4	2-4	4*	2-4*	4*	2-4*
Apriso (mesalamine ER) oral cap	0.375 g	Terminal ileum, colon	120/30	$489	1.5-3*	1.5	2.4-4.8*	2.4-4.8*	2.4-4.8*	2.4-4.8*
mesalamine DR (generic Asacol HD) oral tab	800 mg	Distal ileum, colon	180/30	$1,107	2.4-4.8	2.4-4.8	2.4-4.8*	2.4-4.8*	2.4-4.8*	2.4-4.8*
mesalamine DR (generic Delzicol) oral cap	400 mg	Distal ileum, colon	180/30	$395	2.4-4.8	2.4-4.8	2.4-4.8*	2.4-4.8*	2.4-4.8*	2.4-4.8*
mesalamine DR (generic Lialda) oral tab	1.2 g	Distal ileum, colon	120/30	$443	2.4-4.8	2.4	2.4-4.8*	2.4-4.8*	2.4-4.8*	2.4-4.8*
sulfasalazine (generic Azulfidine) oral tab	500 mg	Colon	120/30	$21	2-4	2-4	2-4*	NR	NR	ID
sulfasalazine DR (generic Azulfidine EC) oral tab	500 mg	Colon	120/30	$37	2-4	2-4	2-4*	NR	NR	ID

Dipentum (olsalazine sodium) oral cap	250 mg	Colon	120/30	$1,567	2-3*	1	2-3*	1*	NR	NR
balsalazide disodium (generic Colazal) oral cap	750 mg	Colon	270/30	$104	6.75	3-6*	ID	ID	NR	NR
mesalamine (generic SFRowasa) rectal enema	4 G/60 mL	Sigmoid colon, rectum	1680/28	$353	4	2-4*	4*	ID	NR	NR
mesalamine (generic Rowasa) rectal enema kit	4 G/60 mL	Sigmoid colon, rectum	4/28	$479	4	2-4*	4*	ID	NR	NR
mesalamine (generic Canasa) rectal supp	1000 mg	Rectum	30/30	$750	1	1*	ID	ID	NR	NR

**Off-label indication*

Maint: maintenance; ID: insufficient data; NR: not recommended.

Doses shown are total grams per day and must be divided in 3 or 4 equally divided doses for certain formulations. For details, see Lexi-Comp drug information included with UpToDate and the official prescribing information.

VII. REVISION HISTORY:

- **Last Reviewed Date:** 3/30/2022
- **Last Updated Date:** 3/30/2022

UMPQUA HEALTH

Prior Authorization Criteria
Formulary Exception Criteria

Calcitonin Gene-Related Peptide (CGRP) Antagonists

Policy Number: Rx051

I. MEDICATION NAME(S):

- Vyepti (eptinezumab)
- Aimovig (erenumab)
- Ajovy (fremanezumab)
- Qulipta (atogepant)
- Emgality (galcanezumab)
- Nurtec (rimegepant)
- Ubrelvy (ubrogenpant)
- Zavzpret (zavegepant)

II. LENGTH OF AUTHORIZATION:

- Initial: six months
- Renewal: one year

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug prescribed for an FDA-approved indication AND is the appropriate dose and duration being prescribed consistent with the FDA approved prescribing information? (CGRP antagonists are FDA-approved for adults aged 18 years and older except for Ajovy (fremanezumab) which is the only CGRP approved for children 6 years and older for prevention of epidodic migraines**.** Refer to Table 1. Indications and Dosing in 'Additional Information' section.)
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 8a])

2. Have medication overuse headaches been ruled out (i.e. member is not frequently using opioids, butalbital-containing products, triptans, acetaminophen, aspirin or NSAIDS)?
    a. Yes (go to #3)
    b. No (forward to pharmacist for review [deny 5a])

3. Is the request for migraine prophylaxis/prevention with Nurtec (rimagepant), Vyepti (eptinezumab), Aimovig (erenumab), Ajovy (fremanezumab), Qulipta (atogepant) or Emgality (galcanezumab)?
    a. Yes (go to #6)
    b. No (go to #4)

4. Is the request for acute migraine treatment with Zavzpret (zavegepant), Nurtec (rimegepant) or Ubrelvy (ubrogenpant)?
    a. Yes (go to #8)
    b. No (go to #5)

5. Is the request for Emgality (galcanezumab) for cluster headache prophylaxis?
    a. Yes (go to #10)
    b. No (forward to pharmacist for review [deny 8a])

6. Does the member have episodic migraines (4 - 14 headaches per month) or chronic migraines (at least 15 headaches per month)?
    a. Yes (go to #7)
    b. No (forward to pharmacist for review [deny 5a])

7. Has the member had an adequate trial and failure of, contraindication to, or intolerance to at least three drugs from the following classes (same or different classes): (1) Beta-blockers (e.g. propranolol immediate-release, atenolol, metoprolol, nadolol, timolol); (2) Anticonvulsants (e.g. topiramate, valproate, divalproex sodium); (3) Antidepressants (e.g. amitriptyline, nortriptyline, venlafaxine) AND (4) ARBs (e.g. losartan, irbesartan)? (Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (go to #11)
    b. No (forward to pharmacist for review [deny 7a])

8. Has the member had an adequate trial and failure of, contraindication to, or intolerance to simple analgesics such as NSAIDS (e.g. ibuprofen, naproxen) or acetaminophen, AND at least two different triptans (e.g. naratriptan, rizatriptan, sumatriptan, zolmitriptan) or have a contraindication to triptans?
    a. Yes (go to #9)
    b. No (forward to pharmacist for review [deny 7a])

9. Does the patient have chronic migraines?
    a. Yes (go to #12)
    b. No (approve for six months (only approve up to formulary quantity limit))

10. Has the patient had an adequate trial (2-6 months) without response, or has contraindications, to at least 2 of the following OHP preferred drugs:
    Lithium, Verapamil, Suboccipital steroid injection, Sumatriptan subcutaneous OR Zolmitriptan nasal spray?
    a. Yes (approve for six months (only approve up to formulary quantity limit))
    b. No (forward to pharmacist for review [deny 7a])

11. Has the patient received an injection with botulinum toxin for headache treatment once in the previous 2 months?
    a. Yes (forward to pharmacist for review)
    b. No (go to #13)

12. Does the patient have a history of at least 4 migraines a month AND is on preventative migraine therapy (excluding other CGRP inhibitors)?
    a. Yes (go to #13)
    b. No (forward to pharmacist for review)

13. If applicable, has the member tried and failed other less costly CGRP Antagonists for the <u>indication</u> being treated?
    a. Yes (approve for six months (only approve up to formulary quantity limit))
    b. No (forward to pharmacist for review [deny 7a])

V. RENEWAL CRITERIA:

1. Do chart notes indicate headaches are due to medication overuse?
   a. Yes (forward to pharmacist for review)
   b. No (go to #2)

2. Is the request for Nurtec (rimegepant), Vyepti (eptinezumab), Aimovig (erenumab), Ajovy (fremanezumab), Qulipta (atogepant) or Emgality (galcanezumab) for migraine prophylaxis?
   a. Yes (go to #5)
   b. No (go to #3)
3. Is the request for Nurtec (rimegepant), Ubrelvy (ubrogenpant), or Zavzpret (zavegepant) for acute migraine treatment?
   a. Yes (go to #6)
   b. No (go to #4)

4. Is the request for Emgality (galcanezumab) for cluster headache prophylaxis?
   a. Yes (go to #7)
   b. No (forward to pharmacist for review [deny 8a])
5. Has the patient experienced a documented positive response to therapy, as demonstrated by a reduction in migraine headache frequency and/or intensity from baseline?
   a. Yes (approve for one year (only approve up to formulary quantity limit)
   b. No (forward to pharmacist for review [deny 5a])
6. Has the member had an objective response to therapy as indicated by a reduction in headache frequency and/or intensity?
   a. Yes (approve for one year (only approve up to fomulary quantity limit))
   b. No (forward to pharmacist for review [deny 5a])
7. Has the member had an objective response to therapy defined as a reduction in the number of cluster headaches per month?
   a. Yes (approve for one year (only approve up to formulary qunantity limit)
   b. No (forward to pharmacist for review [deny 5a])

V. ADDITIONAL INFORMATION:

- Table 1. Indications and Dosing

Drug	**Indication**	**Dose**
Qulipta (atogepant)	Migraine Prophylaxis, Episodic Migraine Prophylaxis, Chronic	10mg, 30mg or 60mg orally once daily 60mg orally once daily
Vyepti (eptinezumab)	Migraine Prophylaxis	100 mg IV every 3 months; some patients may benefit from 300 mg IV every 3 months
Aimovig (erenumab)	Migraine Prophylaxis	70 mg SC monthly; some patients may benefit from 140 mg SC monthly
Ajovy (fremanezumab)	Migraine Prophylaxis Migraine Prophylaxis, Episodic	225 mg SC monthly or 675 mg SC every 3 months Children > 6y/o and adolescents <17y/o, >45kg: 225mg SC monthly
Emgality (galcanezumab)	Migraine Prophylaxis	Migraine: 240 mg SC as a single loading dose, then 120 mg SC monthly

	Cluster Headache Prophylaxis	Cluster HA: 300 mg SC at onset, then monthly until the end of the cluster period
Nurtec (rimegepant)	Acute Migraine Treatment Migraine Prophylaxis	Acute: 75 mg orally as needed for acute migraine attack Prophylaxis: 75 mg every other day
Ubrelvy (ubrogepant)	Acute Migraine Treatment	50 mg, 100 mg orally as needed for acute migraine attack
Zavzpret (zavegepant)	Acute Migraine Treatment	10mg intranasally once as needed for acute migraine attack

VI. REVISION HISTORY:

- **Last Reviewed Date:** 12/12/2025
- **Last Updated Date:** 12/12/2025

Sacubitril-Valsartan

Policy Number: Rx052

I. MEDICATION NAME(S):

- Entresto (sacubitril-valsartan)

II. LENGTH OF AUTHORIZATION:

- Initial: 6 months
- Renewal: 12 months

III. QUANTITY LIMITS:

- Adult: 60 tablets per 30 days

IV. INITIAL CRITERIA:

1. Is the drug prescribed for chronic heart failure with New York Heart Association (NYHA) Class II,III,IV (Refer to Table 1. Heart Failure Classifications in 'Additional Information' section.)
    a. Yes (go to #2)
    b. No (forward to pharmacist for review)
2. Is the member a child age 1 to 17?
    a. Yes (go to #3)
    b. No (go to #5)
3. Does the member have left ventricular systolic dysfuntion (ejection fraction less than 40% (LVEF ≤40%))?
    a. Yes (go to #4)
    b. No (forward to pharmacist for review)
4. Is the drug prescribed at the FDA-approved dose to treat the covered condition? (Refer to Table 2. Recommended Dosage for Pediatric Heart Failure in 'Additional Information' section.)
    a. Yes (approve for 6 months)
    b. No (forward to pharamacist for review)
5. Does the member have heart failure with reduced ejection fraction less than 40% (LVEF ≤40%)
    a. Yes (go to #6)
    b. No (approve for six months; Benefits of therapy are most clearly evident in members with left ventricular ejection fraction below normal. Use judiciously with higher baseline ejection fraction.)

6. Is the member concurrently prescribed one of the following beta-blockers: carvedilol, sustained-release metoprolol succinate, or bisoprolol or is there documented intolerance or contraindiations to each of these beta-blockers? (The above beta-blockers have evidence of mortality reduction in chronic heart failure at target dose and are recommendd by heart failure guidelines.)
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review)

V. RENEWAL CRITERIA:

1. Is the member 18 years or older at least 50 kg?
    a. Yes (go to #2)
    b. No (go to #3)
2. Is the member currently taking the sacubitril/valsartan at the target dose of 97/103 mg twice daily to a maximum dose as tolerated by the member?
    a. Yes (approve for up to 12 months)
    b. No (go to #4)
3. Is the member currently taking sacubitril/valsartan at the target does in Table 2 or to a maximum dose as tolerated by the member?
    a. Yes (approve for up to 12 months)
    b. No (forward to a pharmacist for review)
4. Is there clinical rationale to why the drug has not been titrated to the target dose?
    a. Yes (document rational and approve up to 3 months)
    b. No (forward to pharmacist for review)

VI. ADDITIONAL INFORMATION:

- Table 1. New York Heart Association Functional Classifications

NYHA Functional Classifications	
I	No limitation of physical activity. Ordinary physical activity does not cause symptoms of heart failure.
II	Slight limitation of physical activity. Comfortable at rest but ordinary physical activity results in symptoms of heart failure.
III	Marked limitation of physical activity. Comfortable at rest but less than ordinary physical activity causes symptoms of heart failure.
IV	Unable to carry on any physical activity without symptoms of HF. Experiences symptoms of heart failure at rest.

- Table 2: Recommended Dosage for Entresto in Pediatric Heart Failure

Recommended Dose and Titration for Pediatric Patients Using Tablets

Weight (kg)	**Titration Step Dose (twice daily)**		
	Starting	**Second**	**Final**
Less than 40 kg†	1.6 mg/kg	2.3 mg/kg	3.1 mg/kg
At least 40 kg, less than 50 kg	24 mg/26 mg	49 mg/51 mg	72 mg/78 mg‡
At least 50 kg	49 mg/51 mg	72 mg/78 mg‡	97 mg/103 mg

VII. REVISION HISTORY:

- **Last Reviewed Date:** 3/27/2026
- **Last Updated Date:** 3/27/2026

UMPQUA HEALTH

Prior Authorization Criteria
Formulary Exception Criteria

Acne Agents

Policy Number: Rx053

I. MEDICATION NAME(S):

- adapalene gel
- benzoyl peroxide
- isotretinoin
- Accutane (isotretinoin)
- Amnesteem (isotretinoin)
- Clavaris (isotretinoin)
- Myorisan (isotretinoin)
- Zenatane (isotretinoin)
- tretinoin cream
- multiple non-formulary acne topical agents (must try and fail formulary alternatives if applicable)

II. LENGTH OF AUTHORIZATION:

- Initial: 3 months
- Renewal: 6 months

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the member under age 21?
    a. Yes (go to #2)
    b. No (go to #3)

2. Is there documentation that treating the condition is medically appropriate and necessary in which it will enhance the member's ability to grow, develop, or participate in school per the EPSDT Medicaid benefit?
    a. Yes (go to #4)
    b. No (forward to pharmacist for review [deny 5a])
3. Is the drug prescribed for a condition funded by the Oregon Health Plan (OHP) in a manner consistent with the Health Evidence Review Commission (HERC) Prioritized List of Health Services? (Mild acne is not covered. Refer to Guideline Note 65 for coverage of severe cystic acne or Guideline Note 132 for acne conglobata and acne fulminans: persistent or recurrent inflammatory nodules and cysts AND ongoing scarring OR acne conglobata with recurrent abscesses or communicating sinuses.)
    a. Yes (go to #4)
    b. No (forward to pharmacist for review [deny 5a GLN65 and/or GLN132])
4. Is the drug prescribed for an FDA approved indication or a medically appropriate off-label use with strong evidence supporting safety and efficacy?
    a. Yes (go to #5)

b. No (forward to pharmacist for review [deny 8a])

5. Is the request for oral isotretinoin?
    a. Yes (go to #6)
    b. No (go to #8)
6. Has the member tried and failed three months of oral doxycyline or minocycline?
    a. Yes (go to #7)
    b. No (forward to pharmacist for review [deny 7a])
7. Has the member tried and failed a topical antibiotic (such as clindamycin 1%)?
    a. Yes (go to #8)
    b. No (forward to pharmacist for review [deny 7a])
8. Is the request for adapalene gel, tretinoin cream, clindamycin solution, or benzyoyl peroxide?
    a. Yes (approve for 3 months)
    b. No (go to #9)
9. Has the member had an adequate trial and failure of, condraindication to, or intolerance to adapalene gel, tretinoin cream, clindamycin solution, or benzoyl peroxide?
    a. Yes (approve for three months)
    b. No (forward to pharmacist for review [deny 7a])

V. RENEWAL CRITERIA:

1. Has the prescriber submitted documentation of continued medical necessity in accordance with the initial criteria?
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review [deny 5a])

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 12/7/2022
- **Last Updated Date:** 12/7/2022

Cystic Fibrosis Modulators

Policy Number: Rx054

I. MEDICATION NAME(S):

- Kalydeco (ivacaftor)
- Orkambi (lumacaftor/ivacaftor)
- Symdeko (tezacaftor/ivacaftor)
- Trikafta (elexacaftor/tezacaftor/ivacaftor)

II. LENGTH OF AUTHORIZATION:

- Initial: three months
- Renewal: twelve months

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug prescribed for Cystic Fibrosis with confirmed genetic testing and for an FDA approved age and CFTR gene mutation?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review)
2. Is the drug prescribed by or in consultation with a pulmonologist or practitioner at an accredited Cystic Fibrosis center?
    a. Yes (go to #3)
    b. No (forward to pharmacist for review)
3. Is there documentation of pulmonary function testing completed in the last 90 days with percent forced expiratory volume in 1 second (ppFEV1) between 40-90%?
    a. Yes (go to #4)
    b. No (forward to pharmacist for review)
4. Has the member had an adequate trial and failure of, contraindication to, or intolerance to dornase alpha AND hypertonic saline AND inhaled antibiotic therapy, if appropriate for age and condition? (Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (approve for 3 months)
    b. No (forward to pharmacist for review)

V. RENEWAL CRITERIA:

1. Has the member had an objective response to therapy as defined by lack of decline in FEV1, reduction in incidence of pulmonary exacerbations, significant improvement in BMI by 10% from baseline, or reduction in cystic fibrosis exacerbations?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review)
2. Is there evidence of adherence and tolerance to therapy?
    a. Yes (go to #3)
    b. No (forward to pharmacist for review)
3. Is there ongoing oversite by prescriber including annual liver function tests?
    a. Yes (approve for 12 months)
    b. No (forward to pharmacist for review)

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 12/20/23
- **Last Updated Date:** 3/31/2021

Prior Authorization Criteria
Quantity Exception Criteria

Varenicline

Policy Number: Rx055

I. MEDICATION NAME(S):

- Chantix (varenicline)

II. LENGTH OF AUTHORIZATION:

- Initial and renewal: up to 12 weeks

III. QUANTITY LIMITS:

- 0.5 (11)-1 ORAL TAB DS PK: 53 tablets per 28 days, 106 tablets per year
- 0.5 mg: 11 tablets per 7 days, 22 tablets per year
- 1 mg: 2 tablets per day, 12 weeks per 180 days

IV. INITIAL CRITERIA:

1. Has the member completed two quit attempts in the past year?
    a. Yes (forward to pharmacist for review [deny 5q])
    b. No (go to #2)
2. Has the provider submitted documentation that the member has stopped using tobacco?
    a. Yes (go to #3)
    b. No (forward to pharmacist for review [deny 5a])
3. Is the member enrolled in a tobacco cessation support program, such as Quit 4 Life?
    a. Yes (approve up to 12 weeks)
    b. No (forward to pharmacist for review [deny 5a])

V. RENEWAL CRITERIA:

See Initial Criteria

VI. ADDITIONAL INFORMATION:

- For tobacco cessation support, UHA recommends using Quit 4 Life. Quit 4 Life has a team of trained experts to help members develop a quit plan and provides tools for tobacco cessation. Expert support and assistance is available from coaches who specialize in tobacco cessation. For additonal details or for enrollment, call 1-866-QUIT-4-LIFE (1-866-784-8454), or visit www.quitnow.net.

VII. REVISION HISTORY:

- **Last Reviewed Date:** 6/23/2021
- **Last Updated Date:** 6/23/2021

Prior Authorization Criteria
Formulary Exception Criteria

Insulin Delivery Devices

Policy Number: Rx056

I. MEDICATION NAME(S)

- Omnipod DASH Insulin Management System
- Omnipod 5 G6

II. LENGTH OF AUTHORIZATION:

- Initial: six months
- Renewal: one year

III. QUANTITY LIMITS:

- Personal Diabetes Manager (PDM)/Controller: one every four years
- Pods: 10 per 30 days (see additional information)

IV. INITIAL CRITERIA:

1. Does the member have a diagnosis of type 1 or type 2 diabetes mellitus?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review)
2. Is the member's C-peptide level ≤ 110% below the lower limit of normal; OR does the member have a creatine clearance of ≤ 50 ml/minutes, a fasting C-peptide level ≤ 110% the lower limit of normal, and a fasting blood sugar obtained at the same time as the C-peptide level ≤ 225mg/dl; OR is there a positive beta cell antibody test?
    a. Yes (go to #3)
    b. No (forward to pharmacist for review)
3. Has the member been on a program of multiple daily injections (at least three per day) with frequent self-adjustments for insulin dose for at least the past six months?
    a. Yes (go to #4)
    b. No (forward to pharmacist for review)
4. Has the member or caregiver completed a comprehensive diabetes education program?
    a. Yes (go to #5)
    b. No (forward to pharmacist for review)
5. Is the device prescribed by or in consultation with an endocrinologist?
    a. Yes (got to #6)
    b. No (forward to pharmacist for review)
6. Has the member had suboptimal blood sugar in the past two months despite appropriate management demonstrated by any of the following: (1) A1C > 7%; (2)

Recurring hypoglycemia; (3) Wide fluctuations in blood glucose before mealtime; (4)

Dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dl; OR (5) History of severe glycemic excursions?

a. Yes (approve for six months)
b. No (forward to pharmacist for review)

IV. RENEWAL CRITERIA:

1. Is the member adherent to therapy? (Adherence defined as a MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (go to #2)
    b. No (forward to pharmacist for review)
2. Is the member adherent to provider follow up and diabetes education? (Prescriber should follow up with member at least every three months.)
    a. Yes (go to #2)
    b. No (forward to pharmacist for review)
3. Has the member had a positive clinical response to therapy such as at least a 10% reduction in A1c or A1c is at goal (at or below 7%), or has the prescriber submitted documentation of continued medical necessity in accordance with the initial criteria?
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review)

V. ADDITIONAL INFORMATION:

- All other external insulin infusion pumps, including Omnipod, are considered durable medical equipment (DME):
    - Prior authorization requirements for durable medical equipment can be found on the UHA website at: https://www.umpquahealth.com/prior_authorizations/
    - The Oregon Health Authority rules governing external insulin infusion pumps can be found on the OHA website at: https://secure.sos.state.or.us/oard/viewSingleRule.action;JSESSIONID_OARD=J_CDopJXq6rWEhPNDYybKLZvmyKzqi_G2xCUUqpHW10mnXktZ0f5!849948759?ruleVrsnRsn=84246
- Each pod holds 200 units of insulin. Directions for use: change pod every 72 or 48 hours determined by total daily insulin use.

VI. REVISION HISTORY:

- **Last Reviewed Date:** 12/20/2023
- **Last Updated Date:** 12/20/2023

C1 Esterase Inhibitors

Policy Number: Rx057

I. MEDICATION NAME(S):

- Haegarda (C1 esterase inhibitor)

II. LENGTH OF AUTHORIZATION:

- Initial: six months
- Renewal: up to one year

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Does the member have a diagnosis of hereditary angioedema (HAE) confirmed by genetic testing or normal C1q lab levels with levels below the lab's normal reference range for both C4 and C1INH?
    c. Yes (go to #2)
    d. No (forward to pharmacist for review [deny 5a])
2. Is the drug prescribed at the FDA-approved dose based on patient age and weight?
    a. Yes (go to #3)
    b. No (forward to pharmacist for review [deny 8a])
3. Does the member have a history of at least two attacks per month which are considered severe with swelling of the face, throat or gastrointestinal tract that significantly interrupts usual daily activity despite short-term symptomatic treatment or treatment required in the emergency department? (Note: Prophylactic use has only been evaluated in patients with more than 2 attacks per month)
    a. Yes (go to #4)
    b. No (forward to pharmacist for review [deny 5a])
4. Has the member been evaluated for triggers of HAE attacks and is maximally managed for avoidance of those triggers (such as stress, hormonal changes, dental surgery, trauma, medications including ACE inhibitors and estrogen)?
    a. Yes (go to #5)
    b. No (forward to pharmacist for review [deny 5a])
5. Has the provider documented discussion with the patient of risks (including thrombotic events and/or anaphylaxis) versus benefits of therapy?
    a. Yes (go to #6)
    b. No (forward to pharmacist for review [deny 5a])

6. Is the patient prescribed concurrent epinephrine or do they have epinephrine on hand?
    a. Yes (approve for 6 months)
    b. No (forward to pharmacist for review [deny 5a])

V. RENEWAL CRITERIA:

1. Has there been at least a 50% reduction in the number of angioedema attacks, significant improvement in the severity and duration of attacks, and clinical documentation of functional improvement?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 5a])
2. Has the patient been attack free for at least 6 months?
    a. Yes (go to #3)
    b. No (approve for up to 12 months)
3. Is there documentation from the prescriber that they have evaluated continued necessity of long-term prophylactic treatment at the current dose?
    a. Yes (approve for up to six months)
    b. No (forward to pharmacist for review [deny 5a])

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **P&T Review Date:** 6/22/2022
- **Implementation Date:** 6/22/2022

Finerenone

Policy Number: Rx058

I. MEDICATION NAME(S):

- Kerendia (finerenone)

II. LENGTH OF AUTHORIZATION:

- Initial: three months
- Renewal: twelve months

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug prescribed for an adult with a diagnosis of chronic kidney disease (CKD) associated with type 2 diabetes (T2D)? (CKD is defined as the presence of kidney damage or decreased kidney function for three or more months with an estimated glomerular filtration rate [eGFR] <60 ml/min/1.73 m2 or an albumin-to-creatinine ration [ACR] >30 mg/g.)
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 8a])
2. Is the medication being prescribed in a manner that is supported by the FDA approved indication and dosing recommendations based on estimated glomerular filtration rates (eGFR) and serum potassium levels? (Refer to Table 1 in 'Additional Information' for recommended initial dosing.)
    a. Yes (go to #3)
    b. No (forward to pharmacist for review [deny 8a])
3. Is the medication prescribed by or in consultation with a nephrologist or kidney care specialist?
    a. Yes (go to #4)
    b. No (forward to pharmacist for review [deny 5a])
4. Is the member currently using a maximally tolerated ACE or ARB, OR have a documented contraindication, or intolerance to both? (Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (go to #5)
    b. No (forward to pharmacist for review [deny 5k/5a])
5. Is the member currently using a maximally tolerated dose of an SGLT2 inhibitor with renal benefit (e.g., Farxiga, Invokana) OR have a documented contraindication to or

intolerance? (Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)

a. Yes (approve for three months)
b. No (forward to pharmacist for review [deny 7a])

V. RENEWAL CRITERIA:

1. Is the medication being prescribed in a manner that is supported by the FDA approved indication and dosing recommendations based on estimated glomerular filtration rates (eGFR) and serum potassium levels? (Refer to Table 2 in 'Additional Information' for recommended maintenance dosing.)
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 8a])
2. Has the member had a positive clinical response to therapy OR has the prescriber submitted documentation of continued medical necessity in accordance with the initial criteria?
    a. Yes (approve for 12 months)
    b. No (forward to pharmacist for review [deny 5a])

VI. ADDITIONAL INFORMATION:

- Table 1. Recommended Starting Dose

eGFR (mL/min/1.73²)	Starting Dose
≥ 60	20 mg once daily
≥ 25 to < 60	10mg once daily
< 25	Not Recommended

Measure serum potassium levels and estimated glomerular filtration rate (eGFR) before initiation. Do not initiate treatment if serum potassium is > 5.0 mEq/L. If serum potassium is >4.8 to 5 mEq/L, may consider initiation with increased serum potassium monitoring during the first 4 weeks.

- Table 2. Recommended Maintenance Dose

		Current Kerendia Dose	
		10 mg once daily	**20mg once daily**
Current Serum Potassium (mEq/L)	**≤ 4.8**	Increase the dose to 20 mg once daily.*	Maintain 20 mg once daily.
	> 4.8-5.5	Maintain 10 mg once daily.	Maintain 20 mg once daily.
	> 5.5	Withhold Kerendia. Consider restarting at 10 mg once daily when serum potassium ≤ 5.0 mEq/L.	Withhold Kerendia. Restart at 10 mg once daily when serum potassium ≤ 5.0 mEq/L.

If eGFR had decreased by more than 30% compared to previous, maintain 10 mg dose.

VII. REVISION HISTORY:

- **Last Reviewed Date:** 9/14/2022
- **Last Updated Date:** 9/14/2022

Buprenorphine & Opioid Concurrent Use

Policy Number: Rx059

I. MEDICATION NAME(S):

- buprenorphine HCl sublingual tablet
- buprenorphine HCl/naloxone sublingual HCl film
- buprenorphine HCl/naloxone HCl sublingual tablet

II. LENGTH OF AUTHORIZATION:

- Initial: varies

III. QUANTITY LIMITS:

- Total daily dose of 32 mg buprenorphine

IV. INITIAL CRITERIA:

1. Is the medication being used to transition from a prescribed chronic opiate with planned short term continued use of the opiate to minimize symptoms of opioid withdrawal/cravings?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review)
2. Is there documentaton of an opiod tapering plan?
    a. Yes (go to #3)
    b. No (forward to pharmacist for review)
3. Is the request for less than or equal to an average daily dose of 32 mg of buprenorphine?
    a. Yes (approve)
    b. No (forward to pharmacist for review)

VI. ADDITIONAL INFORMATION:

- Formulary buprenorphine and buprenorphine/naloxone products do not require prior authorization review unless prescribed concurrently with an opioid medication.

VII. REVISION HISTORY:

- **Last Reviewed Date:** 9/20/2023
- **Last Updated Date:** 9/20/2023

Pharmaceutical Weight Management

Policy Number: Rx060

I. MEDICATION NAME(S):

- All FDA approved medications

II. LENGTH OF AUTHORIZATION:

- Initial: six months
- Renewal: six months

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the request for a drug prescribed for the primary purpose of reducing weight for a member age 20 years or younger? (Note: Medications for weight loss are not a covered condition funded by the Oregon Health Plan (OHP) according to the Health Evidence Review Commission (HERC) Prioritized List of Health Services.)
    c. Yes (go to #2)
    d. No (forward to pharmacist for review)
2. Is the member age 8 or older? (Note: Use of pharmacotherapy is not medically appropriate for children under the age of 8 per the American Academy of Pediatrics Clinical Practice Guidelines.)
    a. Yes (go to #3)
    b. No (forward to pharmacist for review)
3. Has the member been engaged in comprehensive, intensive behavioral interventions for at least six months? (Note: Adequate documentation is required.)
    a. Yes (go to #4)
    b. No (forward to pharmacist for review)
4. Is the member, parent, or caregiver, actively participating in a lifestyle or nutrition support program? (Note: UHA requires attestation of participation in a program such as Diabetes Self Management, Food Smart, or a similar clinic based program.)
    a. Yes (go to #5)
    b. No (forward to pharmacist for review and medication therapy management/CM)
5. Is the medication being prescribed in a manner that is supported by the FDA approved indication and dosing recommendations based on age?
    c. Yes (go to #6)
    d. No (forward to pharmacist for review)

6. Is the member's BMI greater than or equal to 30 kg/m^2, or if under 18 is the initial BMI in the 95th percentile or higher for age and sex?
    c. Yes (go to #7)
    d. No (forward to pharmacist for review)
7. Has the member tried and failed all appropriate less costly alternative therapies?
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review)

V. RENEWAL CRITERIA:

1. Is the member adherent to therapy? (Adherence defined as a MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (go to #2)
    b. No (forward to pharmacist for review)
2. Is the member actively participating in a lifestyle or nutrition support program? DPP, DSM, FoodSmart, or similar clinic based program?
    a. Yes (go to #3)
    b. No (forward to pharmacist for review)
3. Has the member had a positive clinical response to therapy OR has the prescriber submitted documentation of continued medical necessity in accordance with the initial criteria?
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review)

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 8/13/24
- **Last Updated Date:** 6/21/2023

Vesicular Monoamine Transporter 2 (VMAT2) Inhibitors

Policy Number: Rx061

I. MEDICATION NAME(S):

- Austedo (deutetrabenazine)
- Ingrezza (valbenazine tosylate)
- tetrabenazine

II. LENGTH OF AUTHORIZATION:

- Initial: 3 months
- Renewal: 12 months

III. QUANTITY LIMITS:

- Deutetrabenazine maximum dose: 48 mg/day
- Valbenazine maximum dose: 80 mg/day
- Tetrabenazine maximum dose: 50 mg/day (chorea as a result of Huntington's disease)

IV. INITIAL CRITERIA:

1. Is the drug prescribed for chorea as a result of Huntington's disease in a patient 18 years or older?
    a. Yes (go to #2)
    b. No (go to #4)
2. Does the patient have a baseline total maximal chorea score of 8 or higher as assessed by the Unified Huntington's disease Rathing Scale Total Chorea Movement subscore (UHDRS-TCS)?
    a. Yes (go to #3)
    b. No (forward to pharmacist for review)
3. Has it been determined that the patient does not have uncontrolled depression or is at risk of violent or suicidal behavior?
    a. Yes (Approve for 3 months)
    b. No (forward to pharmacist for review)
4. Is the drug prescribed for moderate to severe tardive dyskinesia in a patient 18 years or older?
    a. Yes (go to #5)
    b. No (go to #6)
5. Is the request for valbenazine or deutetrabenazine?
    a. Yes (go to #8)
    b. No (forward to pharmacist for review)
6. Is the request for tetrabenazine in a patient with tics associated with Tourette syndrome?
    a. Yes(go to #7)
    b. No (forward to pharmacist for review)

7. Has the member tried and failed an adequate trial of at least 2 of the following guideline directed medication: Clonidine or guanfacine OR Topiramate OR One of the following antipsychotics: pimozide, aripiprazole or risperidone? OR Does the patient have a documented intolerance, FDA-labeled contraindication, or hypersensitivity to the guideline directed medications?
    a. Yes (go to #8)
    b. No (forward to pharmacist for review)
8. Is the request for the least costly VMAT2 inhibitor approved for the indication?
    a. Yes (approve for 3 months)
    b. No (go to #16)
9. Has the member had an adequate trial and failure of, contraindication to, or intolerance to the less costly alternative agent? (Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (approve for 2 monthsNo (forward to pharmacist for review)

V. RENEWAL CRITERIA:

1. Is the request for renewal of valbenazine, tetrabenazine, or deutetrabenazine in a patient with chorea as a result of Huntington's disease?
    a. Yes (go to #2)
    b. No (go to #3)
2. Has the patient been taking the requested VMAT2 inhibitor for >3 months and has there been documented evidence of improvement in total maximal chorea score as assessed by the Unified Huntington's disease Rating Scale–Total Chorea Movement subscore (UHDRS-TCS), of at least 2 points from baseline?
    a. Yes (go to #5)
    b. No (forward to pharmacist for review)
3. Is the request for renewal of valbenazine or deutetrabenazine in a patient with tardive dyskinesia?
    a. Yes (go to #4)
    b. No (go to #7)
4. Has the patient been taking the requested VMAT2 inhibitor for >3 months and there has been documented evidence of clinical improvement in AIMS dyskinesia score from baseline?
    a. Yes (go to #5)
    b. No (forward to pharmacist for review)
5. Has it been determined that the mental status of the patient is stable, and there is no indication of uncontrolled depression or risk of violent or suicidal behavior?
    a. Yes (Approve for 12 months)
    b. No (forward to pharmacist for review)
6. Is the request for tetrabenazine in a patient with tics associated with Tourette syndrome?
    a. Yes (go to #7)
    b. No (forward to pharmacist for review)
7. Has the patient been taking tetrabenazine for >3 months and has there been documented evidence of reduced tic severity from baseline as assessed by the Yale Global Tic Severity Score (YGTSS) Total Tic Score (range 0-50)?
    a. Yes (Approve for 12 months)
    b. No (forward to pharmacist for review)

VI. ADDITIONAL INFORMATION:

Vesicular Monoamine Transporter 2 (VMAT2) Inhibitors

VII. REVISION HISTORY:

- **Last Reviewed Date:** 10/29/2025
- **Last Updated Date:** 10/29/2025

Prior Authorization Criteria
Quantity Exception Criteria
Formulary Exception Criteria

Diabetic Diagnostics

Policy Number: Rx062

I. PRODUCT NAME(S):

- Freestyle Libre 14 Day Reader
- Freestyle 14 day Sensor
- Freestyle Libre 2 Plus Sensor Device
- Freestyle 2 Sensor Kit
- Freestyle Libre 3 Plus Sensor Device
- Freestyle 3 Sensor Kit
- Accu-Chek Guide Monitor System
- Accu-Chek Guide Test Strips
- True Metrix Blood Glucose Meter
- True Metrix Go
- True Metrix Glucose Test Strips
- ReliOn Prime
- ReliOn Prime Test Strips
- Insulin syringes
- Insulin pen needles
- Lancets
- Nonformulary products

II. LENGTH OF AUTHORIZATION:

- Initial, CGM: two years
- Initial, CGM Sensors: six months
- Renewal, CGM: two years
- Renewal, CGM Sensors: one year

III. QUANTITY LIMITS:

- Continuous Glucose Monitor (CGM): one every two years
- CGM Sensors: one every 14 days
- Glucose Monitor (GM): one every two years
- Test Strips: 100 per 90 days without insulin use/400 per 90 days with insulin use
- Lancets: 200 per 30 days

IV. INITIAL CRITERIA:

1. Is the request for a quantity exception to exceed the formulary allowable quantity limit (QL)?
    a. Yes (go to #2)
    b. No (go to #3)
2. Has medical rationale been provided supporting exceeding UHA's QL's?
    a. Yes (Approve)
    b. No (forward to pharmacist to review)
3. Does the member have glycogen storage disease type 1a?
    a. Yes (go to #10)
    b. No (go to #4)
4. Does the member have a diagnosis of type 1 diabetes mellitus?
    a. Yes (go to #5)
    b. No (go to #7)
5. Is the member 20 years of age or younger, OR pregnant, or planning to become pregnant within six months or is the member an adult on insulin pump management (including CGM-enabled insulin pump)?
    a. Yes (go to #9)
    b. No (go to #6)
6. Does the member have baseline HbA1c levels greater than or equal to 8.0%, frequent or severe hypoglycemia, or impaired awareness of hypoglycemia (including presence of these conditions prior to initiation of CGM)?
    a. Yes (go to #9)
    b. No (forward to pharmacist for review)
7. Does the member have a diagnosis of type 2 diabetes mellitus, diabetes due to underlying conditions and or drug/chemical induced diabetes or gestational diabetes?
    a. Yes (go to #8)
    b. No (forward to pharmacist for review)
8. Does the member have current use of multiple daily short (including fast or rapid) or intermediate-acting insulin injections AND meet one of the following: 1) Baseline HbA1c levels greater than or equal to 8.0%; 2) Frequent or severe hypoglycemia; 3) Impaired awareness of hypoglycemia; 4) OR Diabetes-related complications (i.e., peripheral neuropathy or end-organ damage)?
    a. Yes (go to #9)
    b. No (forward to pharmacist for review)
9. Has the member received or will receive diabetes education specific to the use of CGM?
    a. Yes (go to #10)
    b. No (forward to pharmacist for review)
10. Is the request for a formulary item?
    a. Yes (approve)
    b. No (go to #11)
11. Is the request for a non-formulary CGM (e.g., Dexcom) intended for use with a previously authorized insulin delivery device (e.g., Omnipod 5G6)?
    a. Yes (approve)

b. No (forward to pharmacist for review)

V. RENEWAL CRITERIA:

1. Has the member had an in-person or telehealth visit with their provider every 6 months following the initial prescription for CGM AND has the member been adherent to therapy by using the device for at least 50% of the time since the last visit? (Note: The prescriber must conduct an in-person or telehealth visit with the member to document adherence to their CGM regimen and ensure that the CGM is used for diabetes treatment planning. Two trials per year of CGM are allowed to meet adherence for continuation of coverage.)
    a. Yes (approve)
    a. No (forward to pharmacist for review)

VI. ADDITIONAL INFORMATION:

- Refer to Guideline Note 108

VII. REVISION HISTORY:

- **Last Reviewed Date:** 12/11/2025
- **Last Updated Date:** 12/11/202