Episode	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
8045136	Neurology	ARMODAFINIL	*ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS*	fatigue related to multiple sclerosis	Our prior authorization criteria for Armodafinil have not been met. From the records that we have received, the following caused the denial of Armodafinil. 1) The drug is not being used for narcolepsy, excessive sleepiness, sleep apnea, or shift work sleep disorder. Since the criteria have not been met, we are not able to approve. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Armodafinil have not been met. From the information we have received, the member does not meet number 1, 2, or 3 of our prior authorization criteria for Armodafinil. The reason for denial is explained to the member above. The criteria are listed here. 1) Diagnosis of Narcolepsy or Idiopathic Hypersomnolence and documentation of a full nocturnal polysomnogram and a multiple sleep latency test showing mean onset to sleep less than 10 minutes is provided; OR 2) Diagnosis of Obstructive Sleep Apnea/Hypopnea Syndrome on positive airway pressure (CPAP) therapy; OR 3) Diagnosis of Shift Work Sleep Disorder. Since criteria have not been met, we are unable to approve coverage for this drug at this time.	No	No
8191995	Neurology	MODAFINIL	*ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS*	G20 G47.11	Our prior authorization criteria for modafinil have not been met. From the records that we have received, the following caused the denial of modafinil. 1) Results of a sleep test have not been received. Since the criteria have not been met, we are not able to approve. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for modafinil have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for modafinil. The reason for denial is explained to the member above. The criteria are listed here. 1) Narcolepsy or idiopathic hypersomnolence when full nocturnal polysomnogram and a multiple sleep latency test shows mean onset to sleep less than 10 minutes, OR 2) Obstructive sleep apnea / hypopnea syndrome on positive airway pressure (CPAP) therapy, OR 3) Shift work sleep disorder. Since criteria have not been met, we are unable to approve coverage for this drug at this time.	No	No
7510705	Adolescent Medicine	HUMIRA PEN	*ANALGESICS - ANTI-INFLAMMATORY*	L40.0	Our prior authorization criteria for Humira have not been met. From the records that we have received, the following caused the denial of Humira. 1) Documentation of improvement within the past year has not been received.] Since the criteria have not been met, we are not able to approve. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Humira have not been met. From the information we have received, the member does not meet number 3 of our prior authorization criteria for Humira. The reason for denial is explained to the member above. The criteria are listed here. 1) Must be prescribed by a Dermatologist; AND 2) Member must have demonstrated significant improvement in psoriatic condition; AND 3) Documentation (written explanation accepted) of improvement within the past year must be submitted. Since criteria have not been met, we are unable to approve coverage for this drug at this time.	No	No

Episode	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
7491749	Dermatology	HUMIRA PEN	*ANALGESICS - ANTI-INFLAMMATORY*	L40.0	Our prior authorization criteria for Humira have not been met. From the records that we have received, the following caused the denial of Humira. Documentation of improvement within the past year has not been received. Since the criteria have not been met, we are not able to approve. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Humira have not been met. From the information we have received, the member does not meet number 3 of our prior authorization criteria for Humira. The reason for denial is explained to the member above. The criteria are listed here. 1) Must be prescribed by a Dermatologist; AND 2) Member must have demonstrated significant improvement in psoriatic condition; AND 3) Documentation (written explanation accepted) of improvement within the past year must be submitted. Since criteria have not been met, we are unable to approve coverage for this drug at this time.	Yes	No
8035006	Internal Medicine	SPIRIVA HANDIHALER	*ANTIASTHMATIC AND BRONCHODILATOR AGENTS*	J43.9	Our prior authorization criteria for Spiriva have not been met. From the records that we have received, the following caused the denial of Spiriva. 1) Incruse Ellipta has not been tried and failed. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Spiriva have not been met. From the information we have received, the member does not meet number 2 of our prior authorization criteria for Spiriva. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of Chronic Obstructive Pulmonary Disease (COPD); AND 2) A trial of umeclidinium (Incruse Ellipta) was ineffective, contraindicated, or not tolerated. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.	No	No
8261640	Internal Medicine	INVOKAMET	*ANTIDIABETICS*	No Diagnosis Provided	Our prior authorization criteria for Invokamet tablets have not been met. From the records that we have received, the following caused the denial of Invokamet. 1) Jardiance, Synjardy, or Glyxambi has not been tried and failed. 2) Farxiga, Xigduo/Xigduo XR, or Qtern has not been tried and failed. Since the criteria have not been met, we are not able to approve. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Invokamet tablets have not been met. From the information we have received, the member does not meet number 1 and 2 of our prior authorization criteria for Invokamet. The reason for denial is explained to the member above. The criteria are listed here. 1) Failure of empagliflozin (Jardiance, Synjardy, or Glyxambi); AND 2) Failure of dapagliflozin (Farxiga, Xigduo/Xigduo XR, or Qtern). Since criteria have not been met, we are unable to approve coverage for this drug at this time.	No	No
7860911	Family Practice	SILDENAFIL CITRATE	*CARDIOVASCULAR AGENTS - MISC.*	ED	Based on the information we have received, you do not meet number 1 or 2 of our prior authorization criteria because sildenafil 20mg tablet (Revatio equivalent) is not approved for erectile dysfunction. Additionally, medications used for this purpose are excluded from coverage as indicated in your benefit summary. Based on our Pharmacy and Therapeutics Committee prior authorization criteria for PAH Agents, this drug is covered for members who meet the following criteria: 1) Diagnosis of pulmonary arterial hypertension confirmed by a right heart catheterization AND 2) Prescriber is a Cardiologist or Pulmonologist. Since criteria have not been met, we are unable to approve coverage for this drug at this time.	No	No

Episode	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
7644391	Family Practice	TADALAFIL	*CARDIOVASCULAR AGENTS - MISC.*	N40.1 (Benign prostatic hyperplasia with lower urinary tract symptoms)	Our prior authorization criteria for Cialis have not been met. From the records that we have received, the following caused the denial of Cialis. 1) Cialis was not prescribed by, or in consultation with, a Urologist. 2) A medication, in a class of drugs called androgen hormone inhibitors, has not been tried and failed for a minimum of 90 days. Since the criteria have not been met, we are not able to approve. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Cialis have not been met. From the information we have received, the member does not meet number 2 and 4 of our prior authorization criteria for Cialis. The reason for denial is explained to the member above. The criteria are listed here. 1) Member must have a diagnosis of Benign Prostatic Hyperplasia (BPH); AND 2) Must be prescribed by, or in consultation with, a Urologist; AND 3) An alpha blocker (alfuzosin, doxazosin, tamsulosin, terazosin, prazosin, etc.) must be tried and failed for at least 30 days; AND 4) An androgen hormone inhibitor (dutasteride, finasteride) must be tried and failed for at least 90 days. Since criteria have not been met, we are unable to approve coverage for this drug at this time.	No	No
8133411	Advanced Practice Nurse	DICLOFENAC SODIUM	*DERMATOLOGICALS*	HIP PAIN	Based on the information we have received, you do not meet the prior authorization criteria because you do not have a diagnosis of Actinic Keratosis. Based on our Pharmacy and Therapeutics (P&T) Committee prior authorization criteria for diclofenac gel 3% (Solaraze equiv), this drug is covered for members who meet the following criteria: 1) Prescribed for the treatment of Actinic Keratosis. Since criteria have not been met, we are unable to approve coverage for this drug at this time.	No	No
7686998	Internal Medicine	ULORIC	*GOUT AGENTS*	No Diagnosis Provided	ULORIC requires step therapy. Step therapy means that another drug will need to be tried and failed first. This other drug is allopurinol. Please look at the list of covered drugs, also known as our formulary, for which drugs are covered.	No	No
8045932	Allergy & Immunology	DYMISTA	*NASAL AGENTS - SYSTEMIC AND TOPICAL*	J30.9	Our prior authorization criteria for Dymista have not been met. From the records that we have received, the following caused the denial of Dymista. 1) At least one steroid nasal spray (e.g. fluticasone, flunisolide, triamcinolone) has not been tried and failed. 2) At least one antihistamine nasal spray (e.g. azelastine, olopatadine) has not been tried and failed. Since the criteria have not been met, we are not able to approve. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Dymista have not been met. From the information we have received, the member does not meet number 1 and 2 of our prior authorization criteria for Dymista. The reason for denial is explained to the member above. The criteria are listed here. 1) Trial and failure of at least one steroid nasal spray (e.g. fluticasone, flunisolide, triamcinolone); AND 2) Trial and failure of at least one antihistamine nasal spray (e.g. azelastine, olopatadine). Since criteria have not been met, we are unable to approve coverage for this drug at this time.	No	No
8331460	Family Practice	DYMISTA	*NASAL AGENTS - SYSTEMIC AND TOPICAL*	F41.1 Anxiety, E03.0 Acquired hypothyroidism, unspecified cause, J30.9 Allergies	Our prior authorization criteria for Dymista have not been met. From the records that we have received, the following caused the denial of Dymista. 1) At least one antihistamine nasal spray (e.g. azelastine, olopatadine) has not been tried and failed. Since the criteria have not been met, we are not able to approve. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Dymista have not been met. From the information we have received, the member does not meet number 2 of our prior authorization criteria for Dymista. The reason for denial is explained to the member above. The criteria are listed here. 1) Trial and failure of at least one steroid nasal spray (e.g. fluticasone, flunisolide, triamcinolone); AND 2) Trial and failure of at least one antihistamine nasal spray (e.g. azelastine, olopatadine). Since criteria have not been met, we are unable to approve coverage for this drug at this time.	No	No

Episode	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
8348522	Internal Medicine	AMPYRA	*PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.*	No Diagnosis Provided	Our prior authorization criteria for dalfampridine ER (Ampyra) have not been met. From the records that we have received, the following caused the denial of dalfampridine ER. 1) Records do not show that you are able to walk. 2) Records do not show an improvement in a timed 25-foot walk test. 3) Records do not show that your kidneys are working well. Since the criteria have not been met, we are not able to approve. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for dalfampridine ER (Ampyra) have not been met. From the information we have received, the member does not meet number 2, 3 or 4 of our prior authorization criteria for dalfampridine ER. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed to improve walking in a member with Multiple Sclerosis (MS); AND 2) Member is ambulatory; AND 3) Member responded to initial therapy as demonstrated by a faster timed 25-foot walk test compared to baseline; AND 4) Member has adequate renal function (creatinine clearance greater than 50 mL/min). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.	No	No
7658298	Internal Medicine	DALFAMPRIDINE ER	*PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.*	G35	Our prior authorization criteria for Ampyra have not been met. From the records that we have received, the following caused the denial of Ampyra. 1) Records do not show a baseline 25 foot walking time. 2) Records do not indicate if there is a history of seizures. Since the criteria have not been met, we are not able to approve. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Ampyra have not been met. From the information we have received, the member does not meet number 3 and 6 of our prior authorization criteria for Ampyra. The reason for denial is explained to the member above. The criteria are listed here. 1) Must be prescribed by a Neurology Specialist; AND 2) Member is diagnosed with Multiple Sclerosis; AND 3) Member is ambulatory and able to perform a timed 25 foot walk test; AND 4) An Expanded Disability Status Scale (EDSS) score of at least 6 must be documented; AND 5) Member has adequate renal function (creatinine clearance greater than 50mL per min); AND 6) Member does not have a history of seizures. Since criteria have not been met, we are unable to approve coverage for this drug at this time.	No	No
8531938	Psychiatry	ARMODAFINIL	*ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS*	F51.11	Our prior authorization criteria for Armodafinil have not been met. From the records that we have received, the following caused the denial of Armodafinil. 1) The drug is being used for narcolepsy or excessive sleepiness, but the records do not include a full nighttime sleep study and a daytime sleepiness test that shows an average time to fall asleep of less than 10 minutes. 3) The drug is being used for sleep apnea, but the records Since the criteria have not been met, we are not able to approve. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Armodafinil have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for Armodafinil. The reason for denial is explained to the member above. The criteria are listed here. 1) Diagnosis of Narcolepsy or Idiopathic Hypersomnolence and documentation of a full nocturnal polysomnogram and a multiple sleep latency test showing mean onset to sleep less than 10 minutes is provided; OR 2) Diagnosis of Obstructive Sleep Apnea/Hypopnea Syndrome on positive airway pressure (CPAP) therapy; OR 3) Diagnosis of Shift Work Sleep Disorder. Since criteria have not been met, we are unable to approve coverage for this drug at this time.	No	No

Episode	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
8403853	Internal Medicine	MODAFINIL	*ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS*	G35 MS	Our prior authorization criteria for modafinil have not been met. From the records that we have received, the following caused the denial of modafinil. 1) The drug is not being used for Narcolepsy or Idiopathic Hypersomnolence. Both of these conditions involve too much daytime sleepiness. 2) Results of a sleep test have not been received. 3) The drug is not being used for Obstructive Sleep Apnea / Hypopnea Syndrome. This involves shallow breathing or pauses in breathing during sleep. 4) Positive Airway Pressure (CPAP) therapy has not been tried. 5) The drug is not being used for Shift Work Sleep Disorder. This is the result of a work schedule that overlaps the normal sleep period. Since the criteria have not been met, we are not able to approve. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for modafinil have not been met. From the information we have received, the member does not meet number 1,2 or 3 of our prior authorization criteria for modafinil. The reason for denial is explained to the member above. The criteria are listed here. 1) Narcolepsy or idiopathic hypersomnolence when full nocturnal polysomnogram and a multiple sleep latency test shows mean onset to sleep less than 10 minutes, OR 2) Obstructive sleep apnea / hypopnea syndrome on positive airway pressure (CPAP) therapy, OR 3) Shift work sleep disorder. Since criteria have not been met, we are unable to approve coverage for this drug at this time.	No	No
8563696	Psychiatry	TRINTELLIX	*ANTIDEPRESSANTS*	F32.1	Our prior authorization criteria for Trintellix have not been met. From the records that we have received, the following caused the denial of Trintellix. 1) Two selective serotonin reuptake inhibitor (SSRI) antidepressants, such as sertraline, citalopram, escitalopram, fluoxetine(tried), or paroxetine, have not been tried and failed. 2) One serotonin-norepinephrine reuptake inhibitor (SNRI) antidepressant, such as duloxetine or venlafaxine, has not been tried and failed. Since the criteria have not been met, we are not able to approve. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Trintellix have not been met. From the information we have received, the member does not meet number 2 and 3 of our prior authorization criteria for Trintellix. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of Major Depressive Disorder (MDD), AND 2) Patient has tried and failed, or was intolerant to, two selective serotonin reuptake inhibitors (SSRIs), AND 3) Patient has tried and failed, or was intolerant to, one serotonin-norepinephrine reuptake inhibitor (SNRI). Since criteria have not been met, we are unable to approve coverage for this drug at this time.	No	No

Episode	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
8444172	Urology	ZYTIGA	*ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES*	C61	Our prior authorization criteria for Zytiga have not been met. From the records that we have received, the following caused the denial of Zytiga. 1) The drug is not prescribed by, or together with, an Oncologist. 2) Records showing a Gleason score greater than or equal to 8 OR the presence 3 or more bone lesions OR the presence of measurable visceral metastasis has not been received. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Zytiga (initial coverage) have not been met. From the information we have received, the member does not meet number 1 and 4 of our prior authorization criteria for Zytiga. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, an Oncologist; AND 2) Prescribed in combination with prednisone (twice daily) for member with Metastatic Castration-Resistant Prostate Cancer; OR 3) Prescribed in combination with prednisone (once daily) for member with Metastatic High-Risk Castration-Sensitive Prostate Cancer; AND 4) For members with Metastatic High-Risk Castration-Sensitive Prostate Cancer, at least one of the following high-risk factors associated with poor prognosis is present: Gleason score greater than or equal to 8 OR presence of greater than or equal to 3 bone lesions OR presence of measurable visceral metastasis. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.	No	No
8448807	Dermatology	CLOBETASOL PROPIONATE	*DERMATOLOGICALS*	Diagnosis Not Provided	Our prior authorization criteria for Clobetasol have not been met. From the records that we have received, the following caused the denial of Clobetasol. 1) Lower strength topical steroids such as betamethasone valerate, mometasone furoate or triamcinolone have not been tried and failed. 2) Augmented betamethasone dipropionate or clobetasol solution have not been tried and failed. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Clobetasol have not been met. From the information we have received, the member does not meet numbers 1 and 2 of our prior authorization criteria for Clobetasol. The reason for denial is explained to the member above. The criteria are listed here. 1) A trial of ONE (1) of the following less potent formulary alternative (medium or high potency) topical steroids was ineffective, contraindicated, or not tolerated: betamethasone valerate, mometasone furoate or triamcinolone; AND 2) A trial of ONE (1) of the following equipotent formulary alternative (very high potency) topical steroids was ineffective, contraindicated, or not tolerated: augmented betamethasone dipropionate or clobetasol solution. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.	No	No